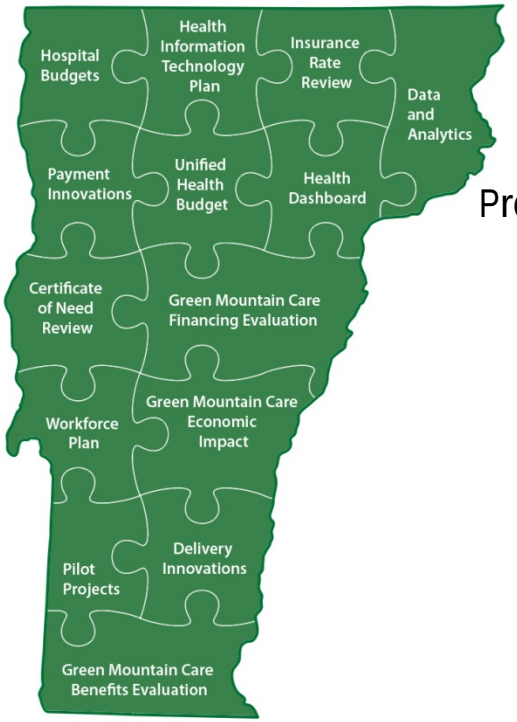


Moving Away from Fee-For-Service

Presentation to the House Committee on Health Care and the House Committee on Health and Human Services

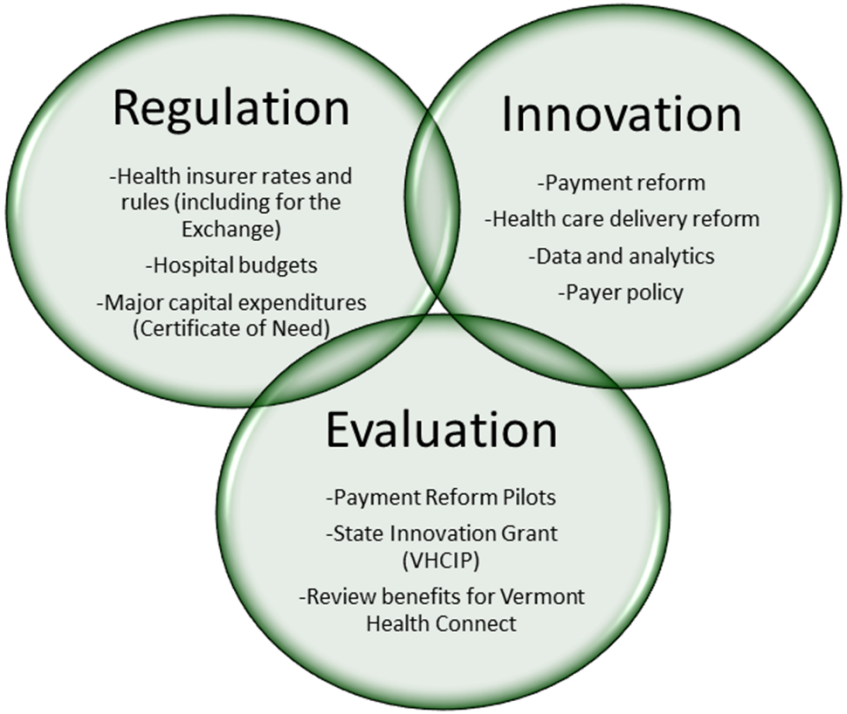
January 13, 2016

Al Gobeille, Chair, GMCB

Ena Backus, Deputy Executive Director, GMCB
Richard Slusky, Director of Payment Reform, GMCB

VERMONT
GREEN MOUNTAIN CARE BOARD

Role of Green Mountain Care Board Created by Act 48 of 2011



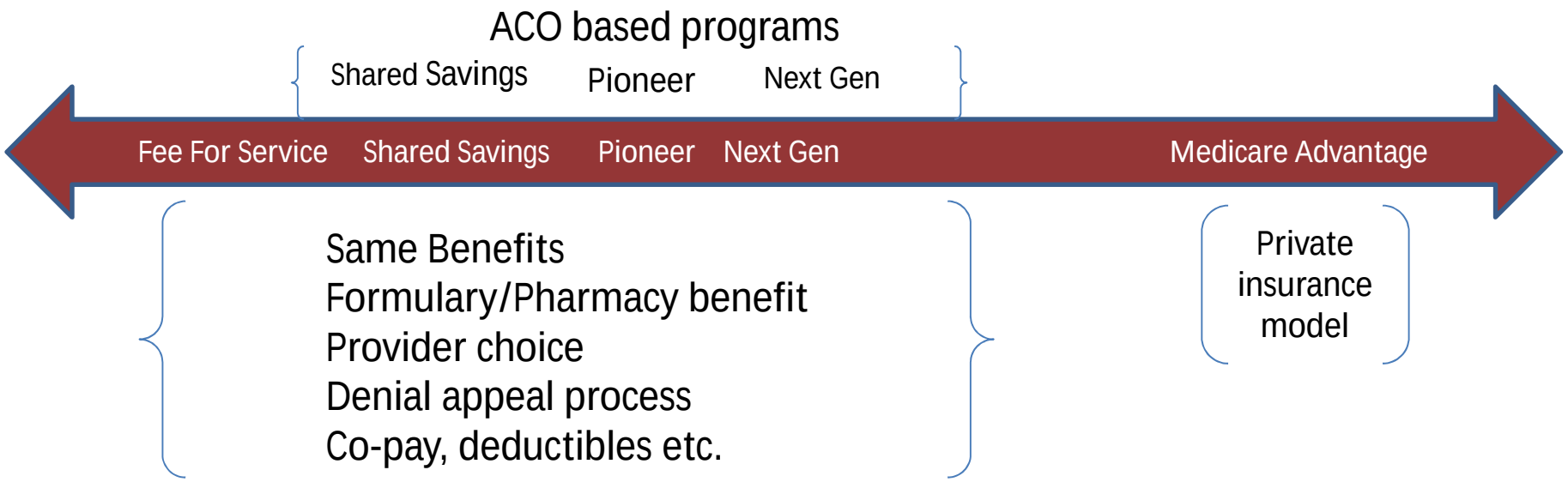
Income Vs. Health Care Costs

	2015	2025
Income	$60,000.00	$73,140.00
Hourly Pay	$30.00	$36.57
Plan Cost/Hour	$11.52	$19.83
Plan Cost/Hour with Subsidy	$5.92	$8.81
Plan Cost per Year	$23,957.00	$41,253.00
Cost/Income	38%	56%

How did we get here?

- Fee-For-Service (FFS) reimbursement encourages health care providers to deliver more services and more expensive services
- Separate fees for each individual service lead to fragmented care delivery
- Fees are typically the same, no matter the quality of the care provided

Medicare is Moving Away from Fee-For-Service



What is the Difference Between an ACO and an HMO?

ACO

- Patients can go anywhere for their care
- Quality measurement and improved patient outcomes are linked to payment
- Incentivizes care coordination
- Jury still out on potential

HMO

- Narrow networks limit Patient choice
- Primary care providers as “gatekeepers”
- Private insurance platform

Act 54 of 2015

The Secretary of Administration or designee and the Green Mountain Care Board shall jointly explore an all-payer model, which may be achieved through a waiver from the Centers for Medicare and Medicaid Services.

CMMI Term Sheet Elements

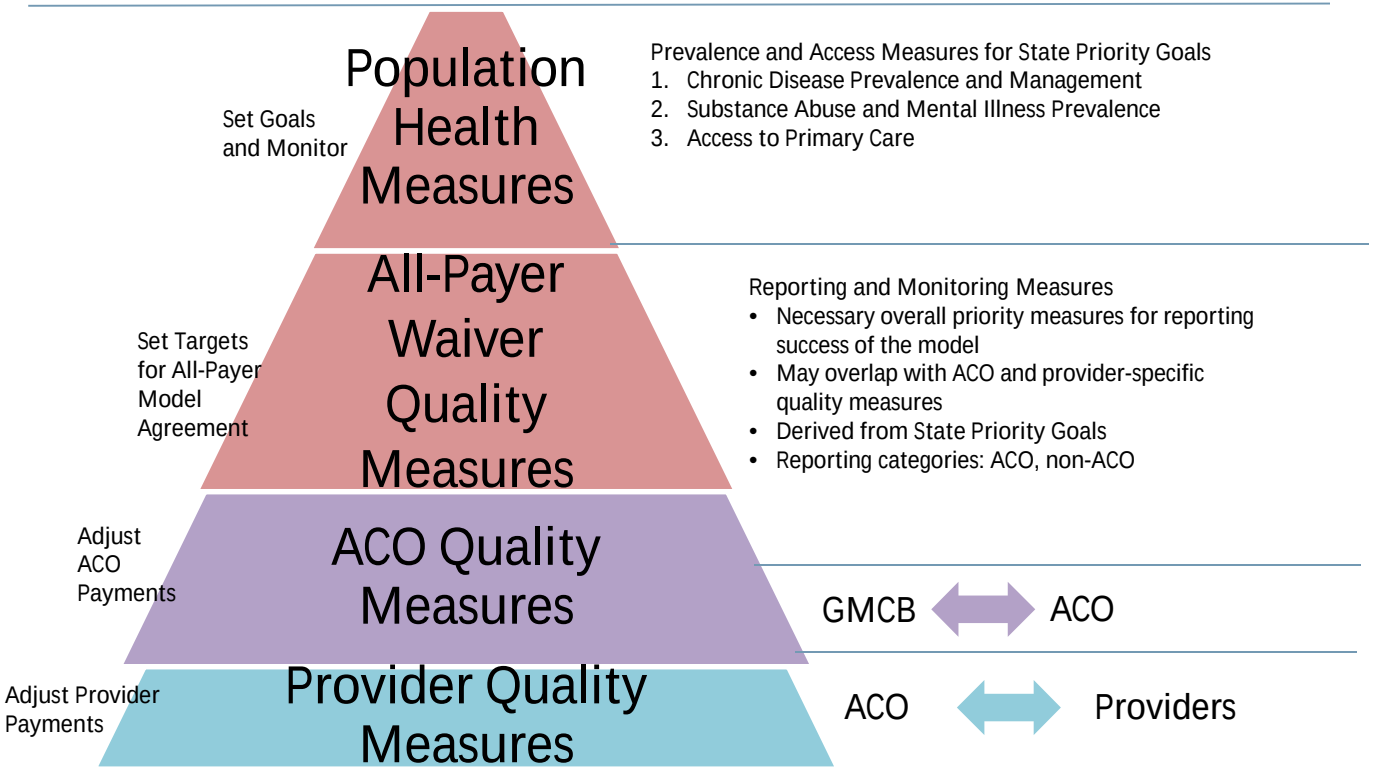
- *Performance Period*
- *Regulated Revenue*
- *Financial Targets*
- *Quality Framework*
- *Payment Waivers*
- *Fraud and Abuse Waivers*

Goals of a Transformative All-Payer Model

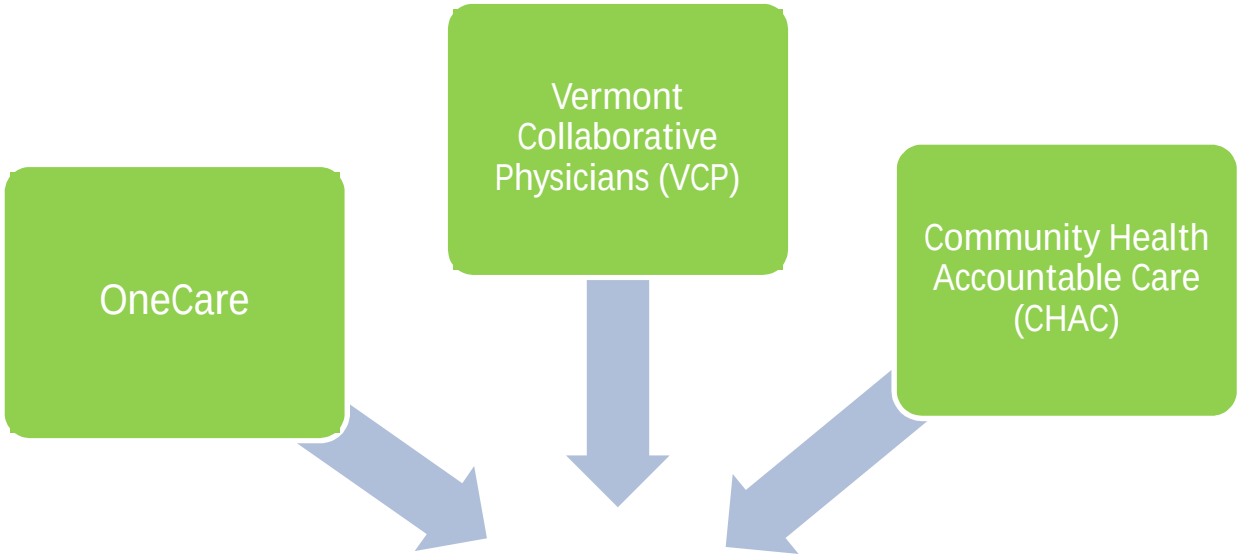
- Improve experience of care for patients
- Improve access to primary, preventive services
- Incent value rather than volume
- Construct a highly integrated system
- Control the rate of growth in total health care expenditures

Align measures of health care quality and efficiency across health care system

All-Payer Model Quality Framework



ACO Collaboration Meetings



Proposed Goals:

- Highly Functional State-Wide HIE System
- Single Clinical Advisory Board to facilitate the development of clinical standards and performance measures
- Sharing of resources including analytics and infrastructure needs
- Coordinated Care Management Protocols

ACO Collaboration

Vermont's three ACOs continue to discuss ways they can collaborate.

Purpose: Build upon the foundation created by the work that has been achieved to date, and take additional steps to build trust, develop shared knowledge about the populations served, and collaborate on activities that are essential to managing an integrated system of care.

Activities:

- Developing a single ACO that could be accountable for financial risk; having sufficient resources to provide the infrastructure for data collection, analytics, and care coordination; and having a sufficient number of attributed lives appears to be the best option to achieve a more integrated system of care.

- Determine the composition of governance body for possible unified ACO based on the following principles:
  - Have broad geographic representation
  - Meet requirements for provider and consumer participation
  - Be of reasonable size to ensure effectiveness
  - Have balanced representation of provider types
  - Establish voting rules that ensure broad support for major policy decisions

ACO Collaboration
(cont'd)

Activities: (cont'd)

- Negotiating data sharing agreements (2016)
  - Sharing data and analytics
  - Pursue a single approach to data collection and analytics
- Modeling merging of attributed populations (2016)
- Collaborating to improve care management and care coordination (2016)
  - Participate in community collaboratives as the foundation to improved care
- Be transparent in all aspects of the process of health care reform
- Establish milestones and timelines to meet goals and prepare for 2017