Moving Away from Fee-For-Service
Presentation to the House Committee on Health Care and
the House Committee on Health and Human Services

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

Regulation
- Health insurer rates and rules (including for the Exchange)
- Hospital budgets
- Major capital expenditures (Certificate of Need)

Innovation
- Payment reform
- Health care delivery reform
- Data and analytics
- Payer policy

Evaluation
- Payment Reform Pilots
- State Innovation Grant (VHCIP)
- Review benefits for Vermont Health Connect
**Income Vs. Health Care Costs**

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

ACO based programs
- Shared Savings
- Pioneer
- Next Gen

Same Benefits
- Formulary/Pharmacy benefit
- Provider choice
- Denial appeal process
- Co-pay, deductibles etc.

Private insurance model

Fee For Service
Shared Savings
Pioneer
Next Gen
Medicare Advantage
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

Population Health Measures
- Prevalence and Access Measures for State Priority Goals
  1. Chronic Disease Prevalence and Management
  2. Substance Abuse and Mental Illness Prevalence
  3. Access to Primary Care

All-Payer Waiver Quality Measures
- Reporting and Monitoring Measures
  - Necessary overall priority measures for reporting success of the model
  - May overlap with ACO and provider-specific quality measures
  - Derived from State Priority Goals
  - Reporting categories: ACO, non-ACO

ACO Quality Measures

Provider Quality Measures
- GMCB ↔ ACO

ACO ↔ Providers

Set Goals and Monitor
Set Targets for All-Payer Model Agreement
Adjust ACO Payments
Adjust Provider Payments

ACO Providers

GMCB

ACO

Providers
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
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