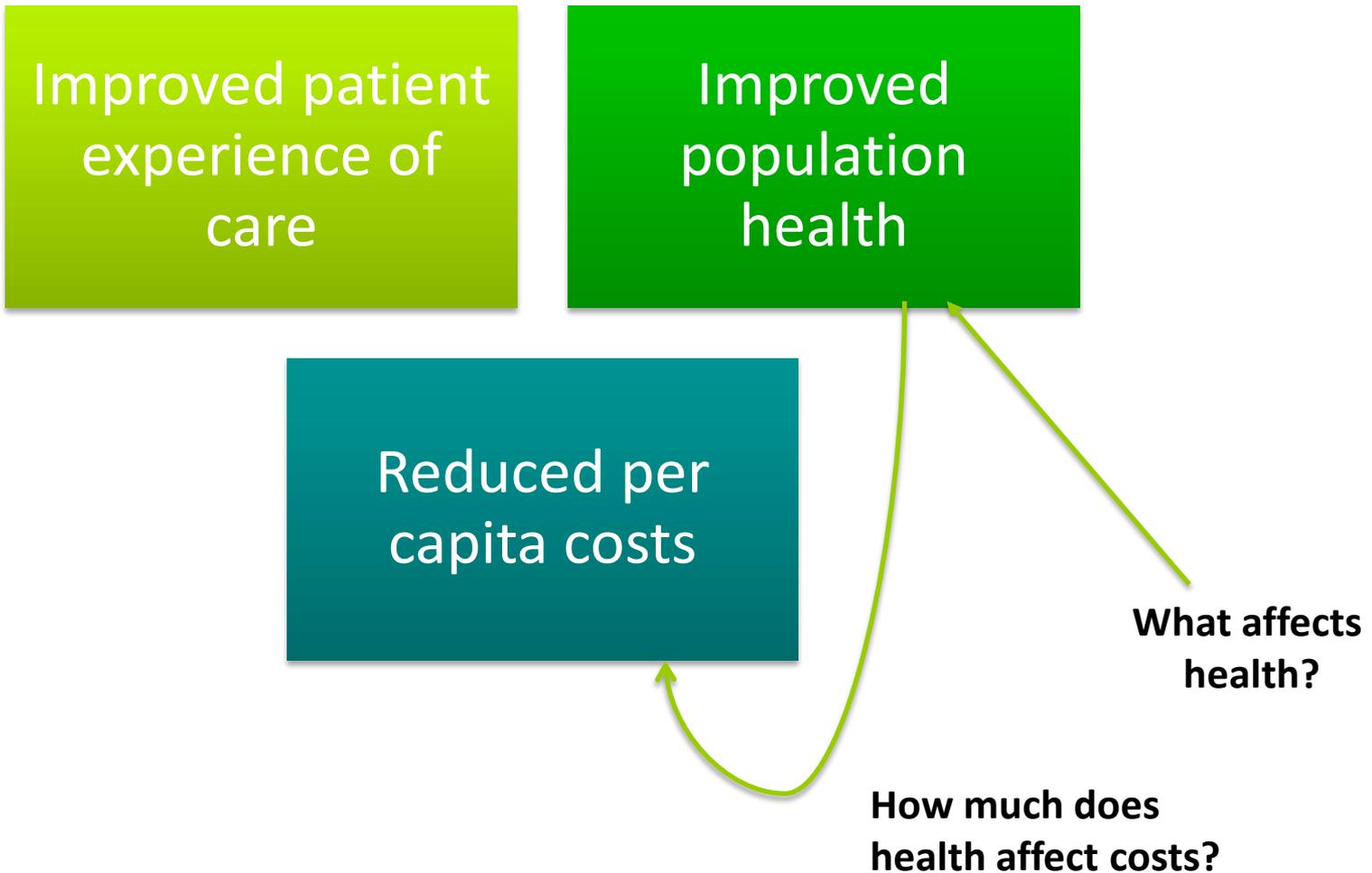

Achieving the Triple Aim in Vermont

QPM Work Group

Lawrence Miller, Chief of Health Care Reform,
Governor's Office

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Goal: Achieve the Triple Aim



Vermont's Delivery Reform Goals

Vermont Health Care

Innovation Project (SIM)

- **Align** financial incentives with the Triple Aim (Multi-Payer Payment Models)
- **Enable** and reward care integration and coordination and support provider transformation (Care Delivery)
- **Develop** a health information system that supports improved care and measurement of value (Health Data Infrastructure)

All Payer Model (APM)

- **Align** financial incentives with the Triple Aim (Multi-Payer Payment Models)
- **Enable** and reward care integration and better coordinate care for Vermonters (Care Delivery)
- **Sustain** a health information system that supports the triple aim (Health Data Infrastructure)
- **Create** a sustainable growth trend for Vermonters while ensuring high quality care

Achieving Multi-Payer Payment and Delivery System Reforms: *5 Components for Success*

- **Payment Models**
 - Financial and quality measurement (payer side)
- **Care Delivery**
 - Practice transformation (provider side)
- **Health Data Infrastructure**
 - Information to make it all work (provider, payer, and state)
- **Evaluation**
 - Determine what is working (state side)
- **Federal Waivers & Funding**
 - Regulatory flexibility through the Global Commitment Medicaid waiver and All Payer Model Agreement
 - All Payer Model Implementation funding through the State Innovation Model Testing Grant (SIM)

Payment Models: *Programs*

- **Blueprint for Health, Advanced Practice Medical Homes and Community Health Teams**
 - Multi-Payer Advanced Primary Care Practice (MAPCP) & Medicaid Health Home (opiate addiction).
 - Implemented capitated payments to housing authorities for Support and Services at Home (SASH) as part of MAPCP.
 - Adding a pay for performance payment that ties a portion of medical home payment to service area outcomes (community interdependencies).
 - Payment and Quality measurement aligned across payers & creates a framework for All Payer Model primary care components.
- **Shared Savings Programs with ACOs**
 - Implemented for Medicare and commercial payers.
 - Medicaid program implemented with state plan amendment pending.
 - Quality Measurement largely aligned across payers.
 - “Training Wheels” for providers to get ready for capitation under APM.
- **Episodes of Care/Bundled Payments**
 - In design phase through VHCIP.
 - Low risk method to identify inefficiencies in the health care system, in particular around specialty care.

Care Delivery: *Programs*

■ **Blueprint for Health**

— Practice Transformation

- State staff and contract assistance for practice transformation funded through Global Commitment and other state funding.
- Provides practice facilitation to assist primary care practices with NCQA certification and enables medical homes to change operations on the ground to improve quality and reduce costs.

— Community Health Teams

- Provide care coordination and wrap-around support for advance practices funded through Global Commitment and other state funding.
- Includes Medicaid care coordination staff on team.

— Regional Planning Teams

- integrated and used as the ACO regional teams.
- Directs resources at the community level.

Care Delivery: *Programs*

■ **Accountable Care Organizations**

- Key, provider led organizational component for care delivery.
- Integrate care beyond primary care, establish regional priorities.
- Infrastructure funding through VHCIP.
- Likely to become key organizations in APM.

■ **Learning Collaboratives**

- Provides a forum for sharing information among health care providers in order to ensure readiness for payment reform and to promote change at the service delivery level.
- Organized and funded through VHCIP.
- Assists with provider readiness for capitation through the APM.

Care Delivery: *Programs*

■ **Provider Transformation Sub-Grants**

- Funding through VHCIP to promote innovative delivery or payment reforms at the health care provider level.
- Encourages transformation in care delivery and determines models which may be scaled or shared with other providers.
- Assists with provider readiness prior to capitation through the APM.

Health Data Infrastructure Investments

- **Clinical data** – *providers need information in a usable format in order to create efficiencies and reduce utilization.*
 - **Blueprint for Health Clinical Data Registry** – funded through Global Commitment and other state funding.
 - **Health Information Exchange (VITL)**--funding from multiple sources, including SIM, to create interoperability between electronic medical records and to provide access to high quality clinical information between providers through *VITLAccess*.
 - **Shared Care Plans/Transfer protocols**—design funded through SIM.
 - **Event notification system** -- design and implementation funded through SIM.
- **Claims data** – *the state, providers, and payers need utilization and expenditure for health system planning and regulation.*
 - **VHCURES** –funded through Global Commitment and other state funding.
- **Survey data** – *providers and others need to understand what patients are experiencing in order to ensure quality and access are not compromised.*
 - **Numerous including Patient Experience Surveys**— funded through SIM, Global Commitment, and other state and federal funding.

Evaluation

■ Vermont Health Care Innovation Project

- Ongoing quality measurement & evaluation of specific components of the project.
- Facilitate: a regular, robust reporting to CMMI; inform the need to adjust implementation activities as needed to maximize project impact; provide a rigorous, empirical basis for recommendations to scale-up and broadly diffuse VHCIP initiatives.

■ Blueprint for Health

- On-going quality measurement & evaluation of the program interventions on cost impacts.
- Recent Medicare evaluation shows model is one of most successful in MAPCP program.
- For more information see the Blueprint for Health Annual Report
 - http://blueprintforhealth.vermont.gov/sites/blueprint/files/BlueprintPDF/AnnualReports/VTBlueprintforHealthAnnualReport2014_Final.2015.01.26.pdf

Federal Waivers and Funding

- Global Commitment to Health Waiver
 - An 1115 Medicaid waiver that:
 - Creates a public managed care entity with flexibility and funding to support the health of Vermont's Medicaid beneficiaries.
 - Must comply with Medicaid Managed Care regulations
 - Creates flexible eligibility for long-term services and supports to allow access to home and community based services on the same basis as nursing home care.
- State Innovation Model Grant
 - Testing grant to provide funding for payment and delivery reform innovations.
- All Payer Model Agreement
 - See next slides!

What is an all-payer model?

- A system of health care provider payment under which all payers – Medicare, Medicaid and commercial insurers such as Blue Cross and Blue Shield – pay doctors, hospitals and other health care providers on a consistent basis, within rules prescribed by a state or national government
- Can be used to promote desirable outcomes and reduce or eliminate cost-shifting between payers
- In the U.S., the only example of an all-payer model is in Maryland (currently only for hospital payments)
- A number of other countries use all-payer systems to assure that provider payments are fair, transparent and consistent with desired policies such as promoting primary care, prevention, quality of care and cost containment

Why an All Payer Model as the next evolution?

- The all-payer model/system will encourage providers to strengthen their relationships with patients and better coordinate care for Vermonters.
- The system will have incentives to promote health and support Vermonters in choosing healthier behaviors.
- The system will allow Vermonters to better understand the total and out-of-pocket costs they face and the quality of the services they receive.
- The system will ensure treatment is done in the least costly setting and that patients are engaged in their health care and health outcomes.

Implementing an All Payer Model

- Create a rate-setting agency at GMCB, which allows for regulation across all payers and which provides cost control while improving quality.
 - APM agreement and Global Commitment create the flexibility through waivers necessary to do this.
 - APM agreement and GC create the base, trend, and savings targets.
- Evolve payment methodologies from payment models implemented by payers and supported by Blueprint & SIM grant.
 - APM agreement and Global Commitment create the flexibility through waivers necessary to do this.
- Evolve quality measures from payment models implemented by payers and supported by Blueprint & SIM grant.
 - APM agreement and Global Commitment create the flexibility through waivers necessary to do this.

One project, two major components

Vermont All-Payer Model Project Structure and Responsibilities

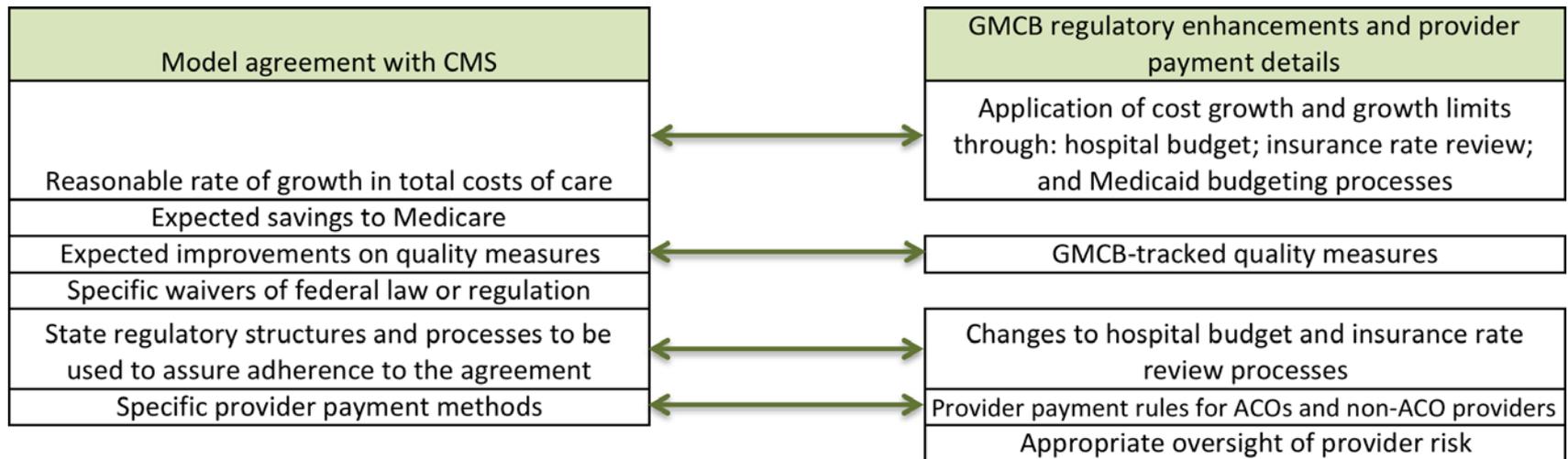
	Model agreement with CMS	GMCB regulatory enhancements and provider payment details
Purpose	To establish the parameters of an agreement with the federal government that would permit Medicare inclusion in a Vermont all-payer system	To establish the specific rules and processes governing provider payment, ACO oversight and all-payer oversight
Lead agency(ies)	GMCB and AOA	GMCB
Coordinating agencies	AHS	DFR, AHS, AOA

Related processes

Legislative oversight:
Regulatory and
Medicaid budgets

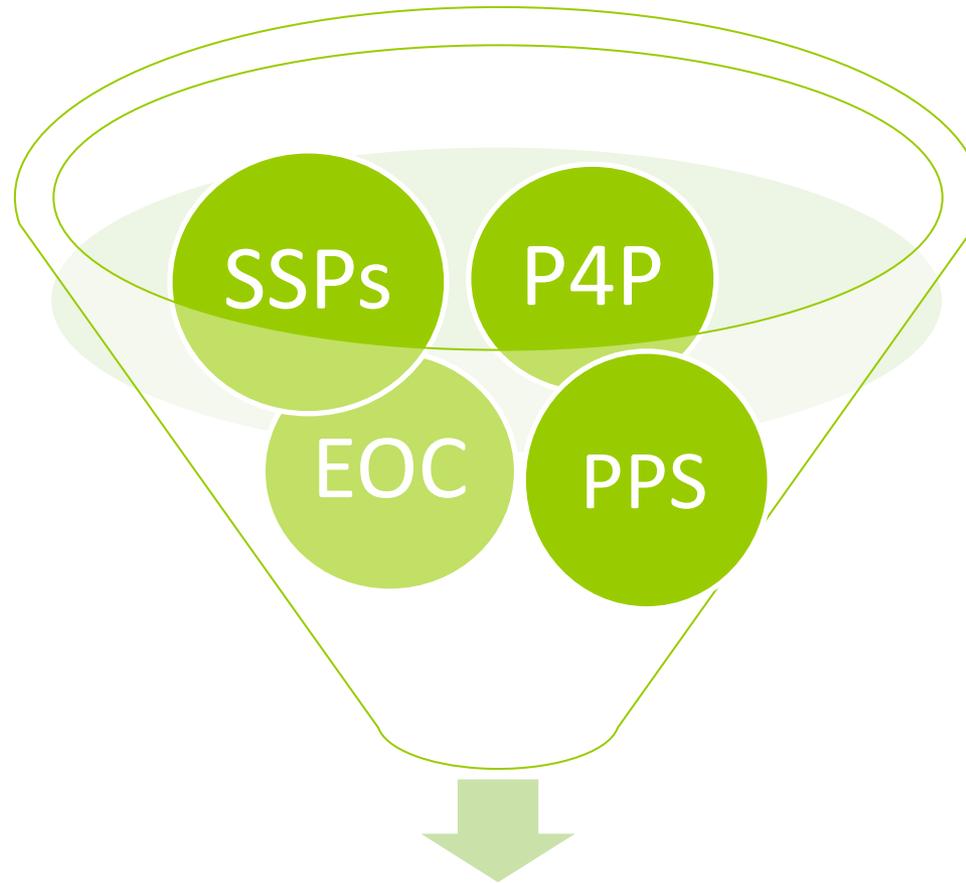
Administrative rules
process

Examples of technical issues to be addressed in each process, and inter-relationship between them



All-Payer Model: Payment Models

- Builds on reforms:



All-Payer Model

All Payer Model: Care Delivery

- **Builds on reforms by:**
 - Ensuring more providers, including DLTSS providers, are ready to take accountability for cost and quality over time.
 - Creating provider readiness for capitation prior to implementation to ensure that patient access and quality of care is not compromised.
 - Enabling providers to change operations on the ground, so savings do not compromise quality of care, patient experience, or access to care.

All Payer Model: Health Data Infrastructure

- **Use current investments and continue to build infrastructure over time by:**
 - Continuing to build an interoperable health data infrastructure for clinical decision-making to ensure provider community is ready to take accountability for cost and quality prior to implementation of rate-setting and capitation.
 - Building infrastructure across more provider types, such as DLTSS, over time.
 - Using and continuing to refine the data infrastructure necessary for quality reporting after capitation.
 - Reducing duplication in reporting and simplifying, where possible.
 - Demonstrating reliable information in order to build trust by providers in the data provided and to ensure it is used by providers to create efficiencies.