# Payment and Delivery System Reform 101

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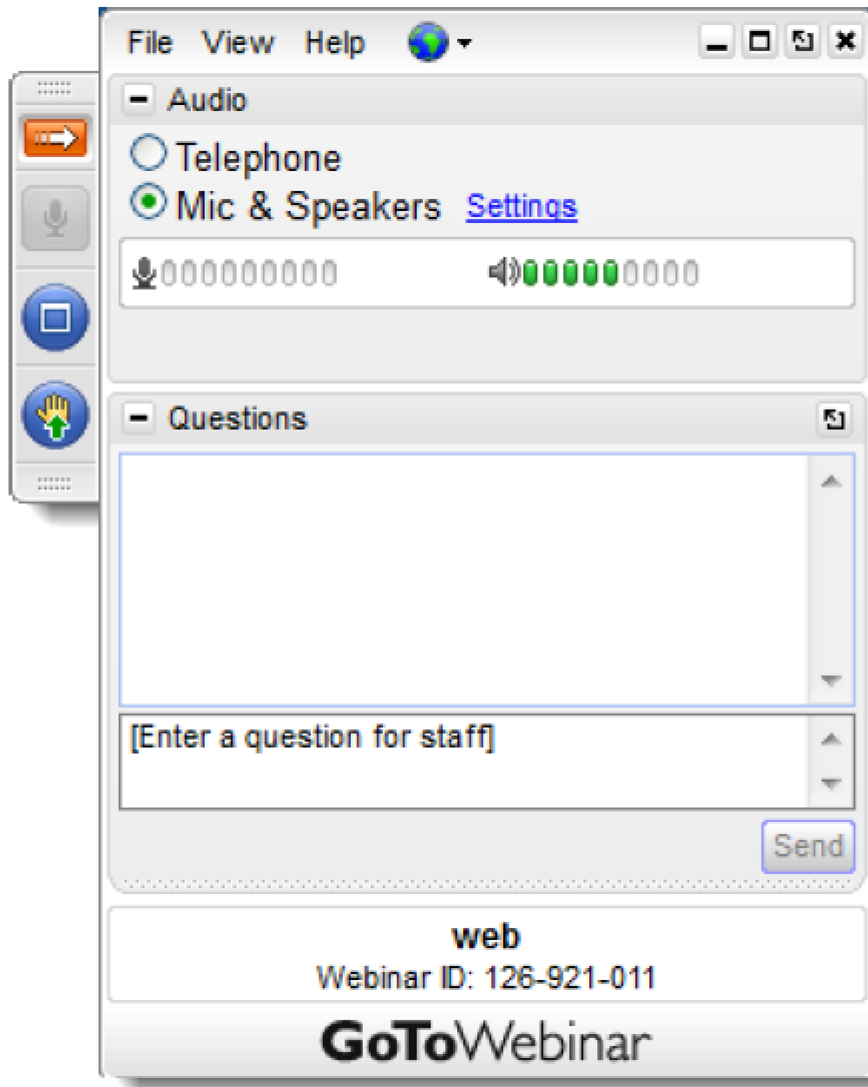
# Before we get started…




- By default, webinar audio is through your computer speakers.
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# Before we get started…

- We've reserved time for Q&A at the end of this event. Submit questions via Questions pane in webinar control panel.
- This webinar is being recorded. Slides and recording will be posted to the VHCIP website following the event: http://healthcareinnovation.vermont.gov/
- Please complete our brief evaluation survey at the end of the event. We value your feedback!

# Agenda

- What is delivery system and payment reform?
- Why do it?
- What lessons have we learned so far?

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# Vermont's Delivery System

## Hospital Service Areas (HSAs)

**version 5 based on post-2001 data**

**Hospital Service Areas (v.5)**

**Immediate Care HSAs**

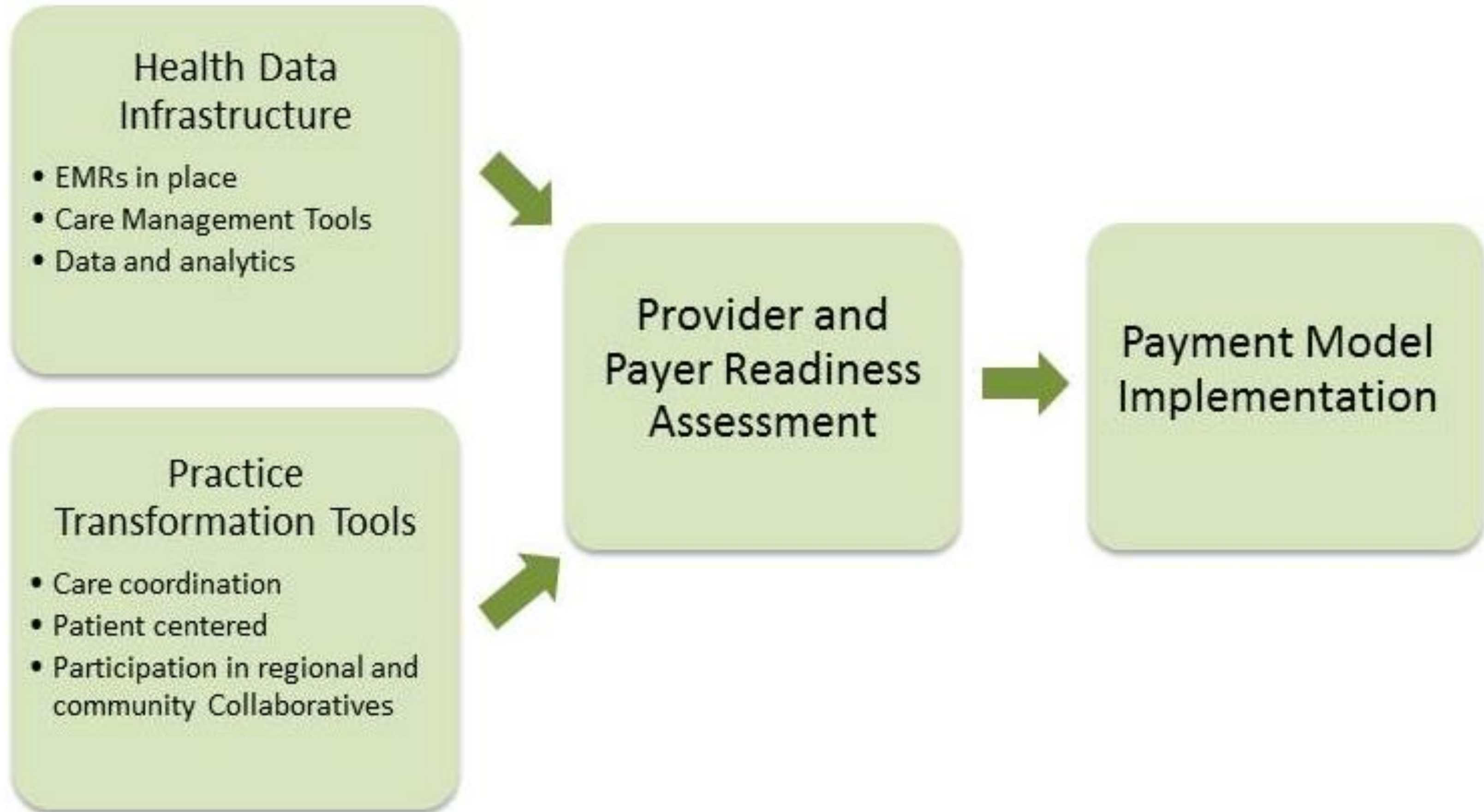
- Barre
- Bennington
- Brattleboro
- Burlington
- Middlebury
- Morrisville
- Newport
- Randolph
- Rutland
- Springfield
- St. Albans
- St. Johnsbury
- White River Jct

- Level 1 Trauma Center
- Hospital
- VA Hospital
- Critical Access
- Vermont Towns
- Lake Champlain

### Some Features of Vermont's Health System

- 14 community hospitals, including 8 critical access hospitals (fewer than 25 beds)
- 1 in-state academic medical center, plus Dartmouth-Hitchcock, provide most tertiary care
- 11 FQHCs serving more than 120,000 Vermonters
- Fewer than 2000 physicians, more than half of whom are employed
- 3 health insurance carriers, only 2 in small group market
- 2.9% uninsured

# Building Blocks to a Successful Payment Model



# A New Payment System Should Promote Value for Money

**"The ultimate objective of any payment reform is to motivate behavioral change that leads to lower costs, better care coordination, and better quality.**

Providers will be better able to achieve these objectives if the payment methodology:

- Is clinically meaningful
- Communicates actionable information in a form and at a level of detail sufficient to achieve sustainable behavior changes."

Cutler, David M., Ph.D., and Ghosh, Kaushik , Ph.D. (March 22, 2012) The Potential for Cost Savings through Bundled Episode Payments, *N Engl J Med 2012*; 366:1075-1077. DOI: 10.1056/NEJMp1113361

# What Does This Mean for Beneficiaries?

The programs are designed to improve beneficiary outcomes and increase value of care by:

- Promoting accountability for the care of beneficiaries.
- Requiring coordinated care for all services provided.
- Encouraging investment in infrastructure and redesigned care processes such as:
  - Lost or unavailable medical charts;
  - Having to share the same information over and over with different doctors;
  - Duplicated medical procedures;
  - Reduce complications;
  - Reduce avoidable readmissions; and
  - Reduce acute admissions and ED visits.

- *The programs do not limit patient choice.*
- *The programs are iterative and require collaboration to succeed.*

# Current System

- **Misaligned financial incentives (ie. FFS)** across payers and providers has led to **fragmentation** in our medical and social systems.

Linking financing to **value** will fill gaps and strengthen the system.



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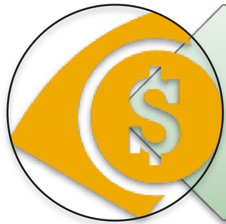
# We Get What We Pay For Under a Fee-for-Service System



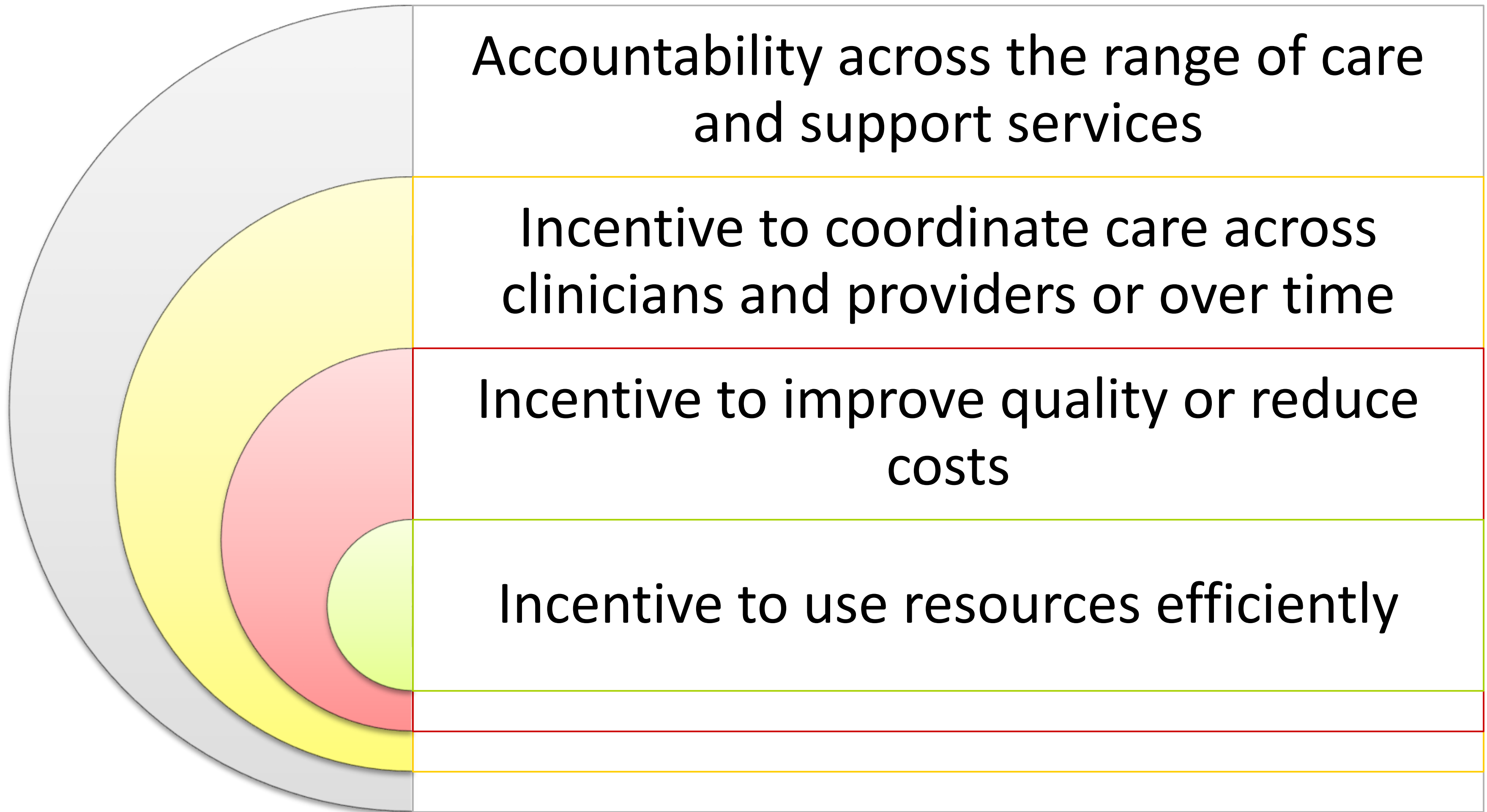
A lack of accountability about the range and types of care that patients may receive

Limited payments for coordinating care across clinicians and providers or over time

Limited incentives for improving quality or reducing costs

No incentives for constraining the volume of care

# New Payment Systems Should Avoid Negative Incentives Created by a Volume-Based, Fee-for-Service System



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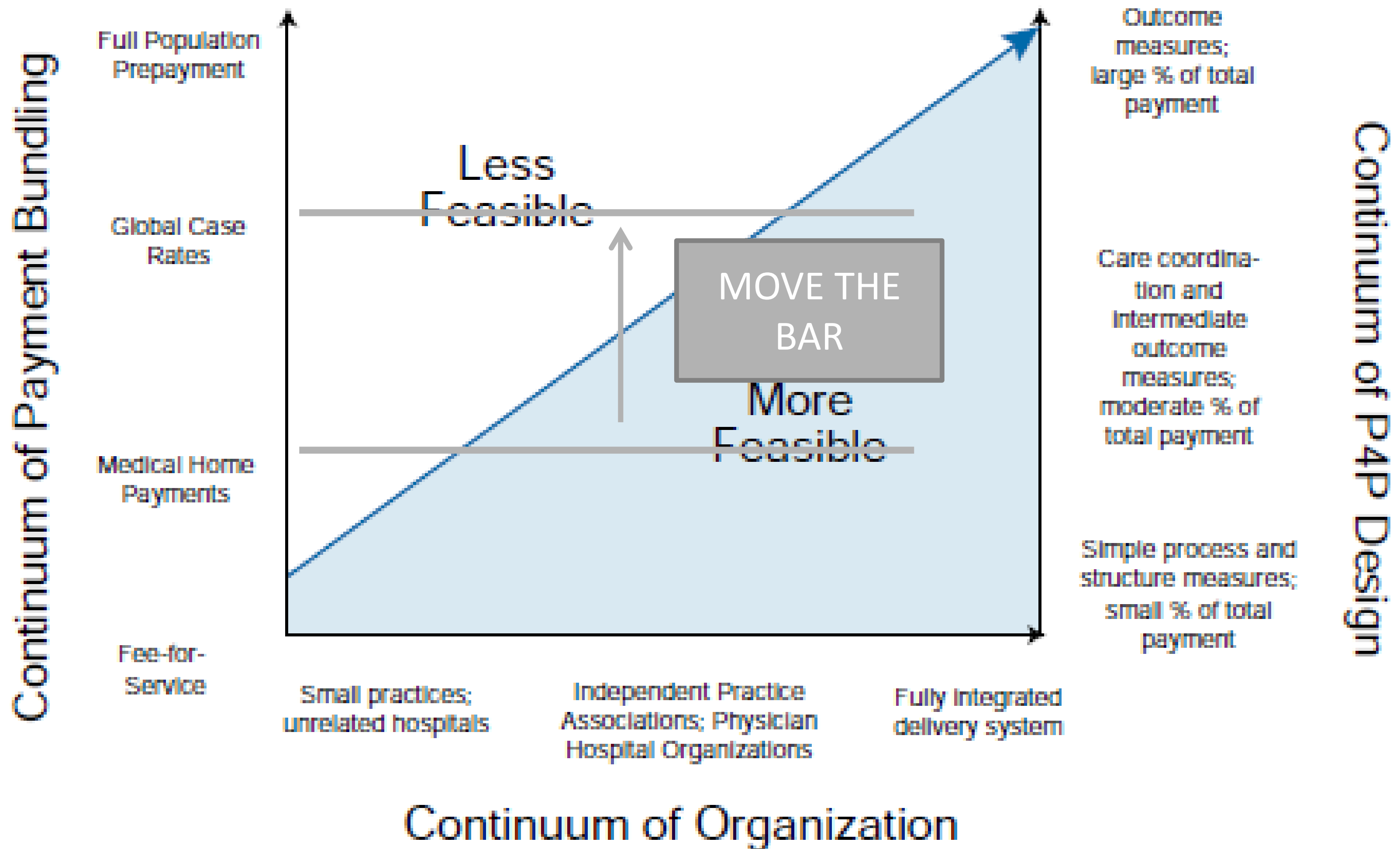
# Moving Away from Fee-for-Service

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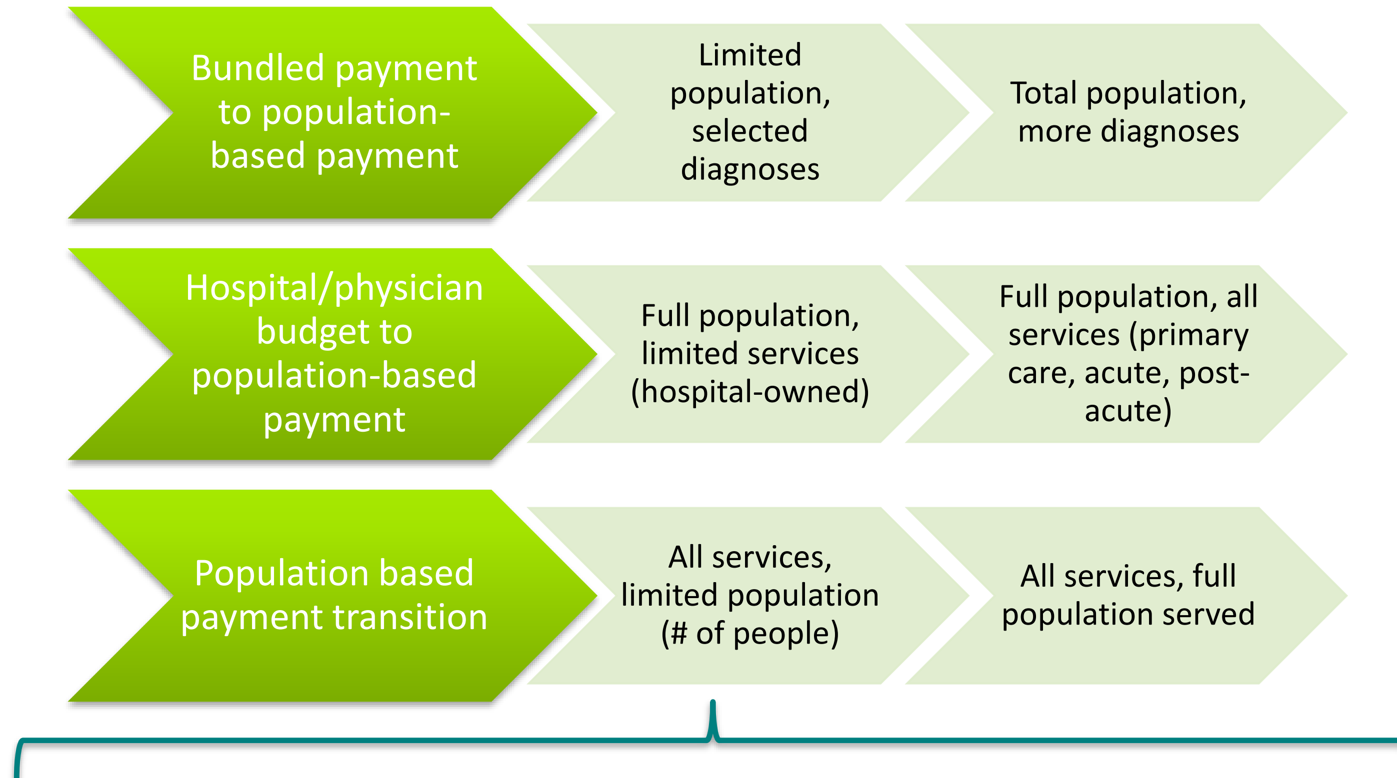
# Transition of Pilot Payment Reform Models to Broader Scope Over Time



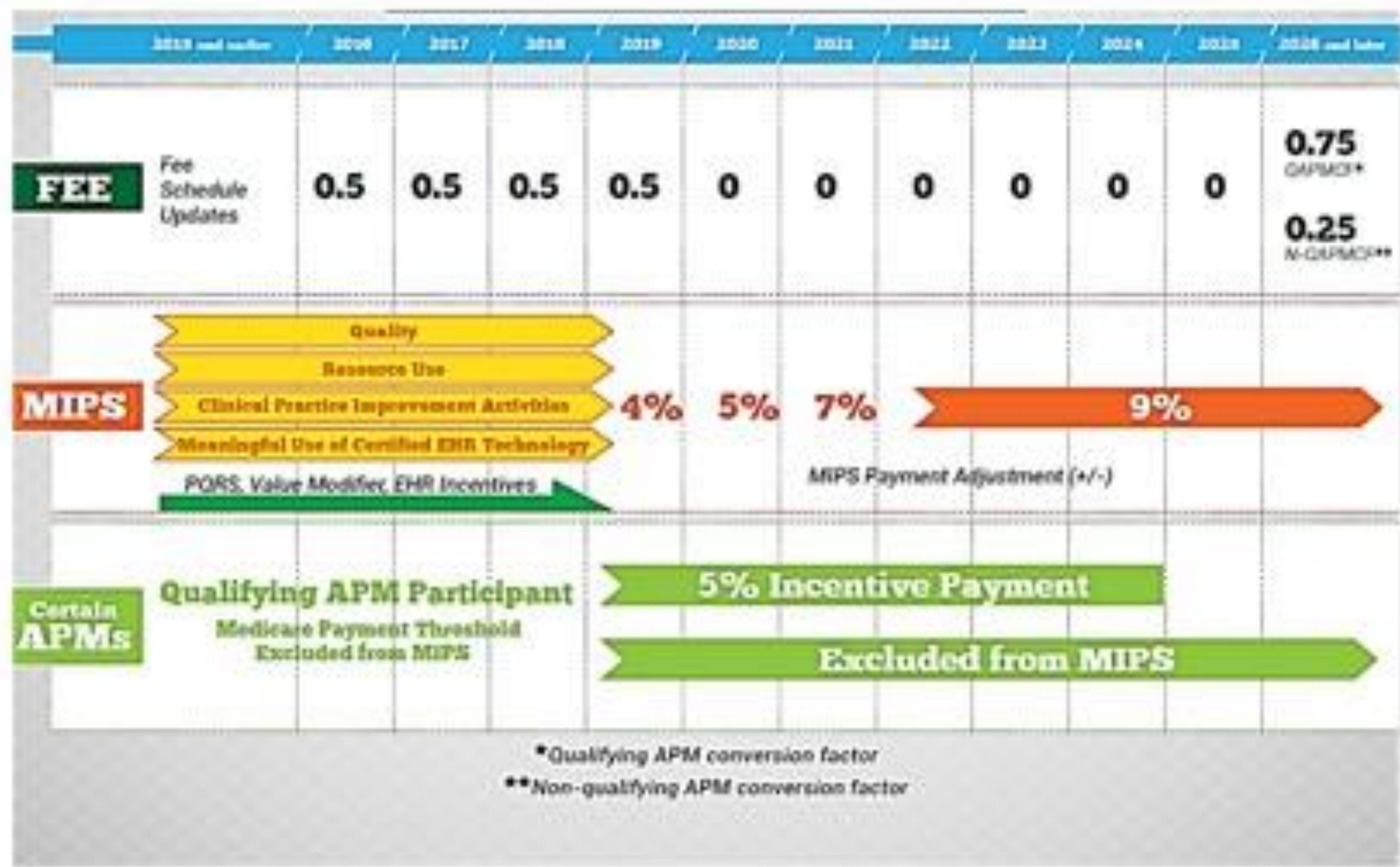

- Move away from Fee-For-Service
- Build on Blueprint for Health
- Include all Payers
- Incorporate performance measures for cost, quality, and patient experience

# Payment Models in Medicare:

- Accountable Care: Pioneer, Shared Savings*, Next Generation.
- Episodes of Care*
- Primary Care Transformation (MAPCP*)
- Hospital-Based Value-Based Purchasing (avoidable readmissions)*

https://innovation.cms.gov/initiatives/index.html

# Timeline for Medicare Payment Adjustments




APM = Alternative Payment Models

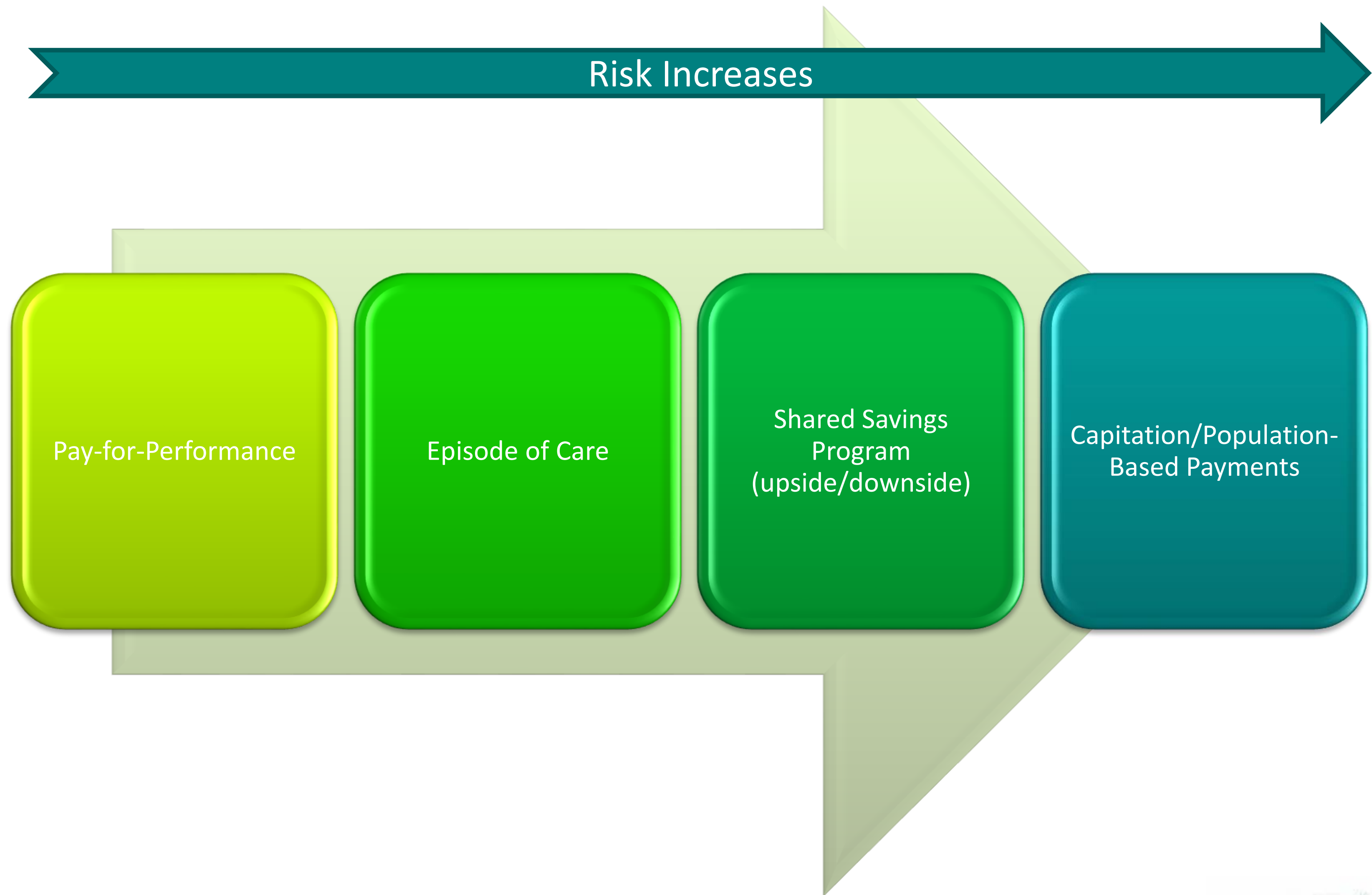
Slide adapted from: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-MIPS-and-APMs.html

# Payment Models in Vermont:

- Pay-for-Performance
  - Commercial; Medicaid
  - *Health Homes
- Shared Savings Programs:
  - Commercial; Medicaid
- Episode of Care/Bundled Payments
  - Commercial
- Capitation (Population-Based Payments)

*Payments are linked to quality of care across care and support services.*

# Payment Models in Vermont:



# SIM Models

| ACO SSP | EOC | P4P |
| --- | --- | --- |
| • System-wide performance<br>• Wide range of providers across specialty types and sites of care<br>• Total resource use and quality for attributed population across all providers who provide care<br>• Focus on collaboration and use of data to inform better care delivery and experience of care<br>• Leads to more organized system of care | • Performance related to treatment of specific condition<br>• Providers specifically accountable for care of a particular condition<br>• Resource use and quality of treatment of a condition for sub-set of population<br>• Focus on collaboration and use of data related to treatment of specific condition<br>• Leads to more organized system of care | • Individual /Practice/Site of Care performance<br>• Providers accountable for population they serve<br>• Resource use and quality of treatment under their individual control<br>• Focus on individual performance and how to use data for internal quality improvement |



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# Pay-for-Performance (P4P) Programs

| Performance Drives Reward | |
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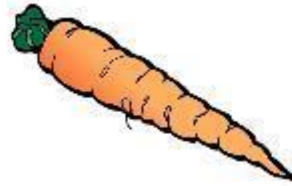
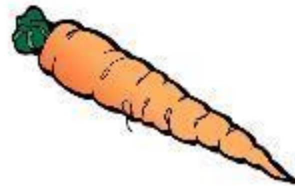
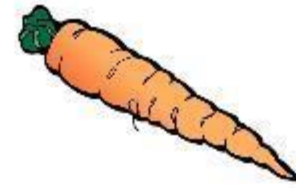
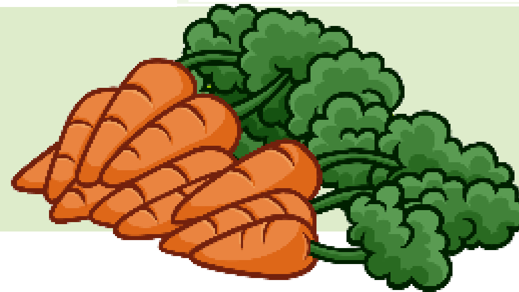
| 1 |  |
| 2 |   |
| 3 |  |

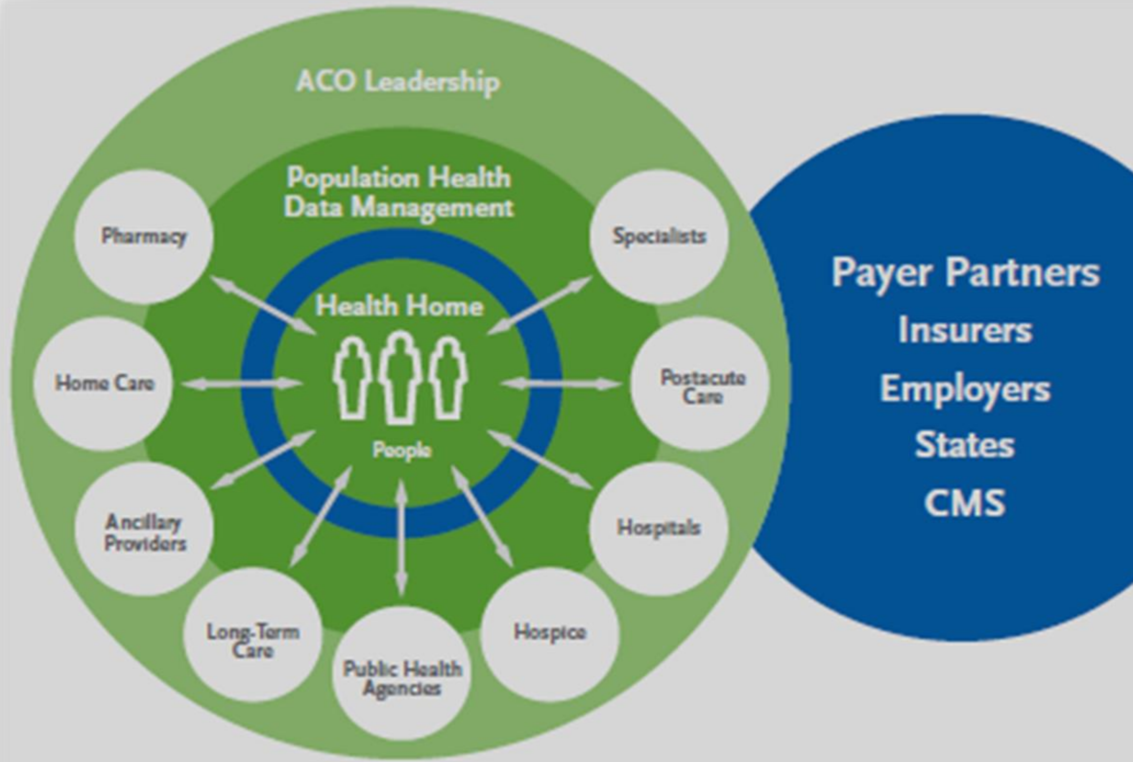
FFS is Base Payment

# Health Homes

- Medicaid State Plan Option under the Affordable Care Act.
- CMS expects states' health home providers to operate under a "whole-person" philosophy. Health Homes providers will integrate and coordinate all primary, acute, mental health, and long-term services and supports to treat the whole person.
- States can receive enhanced federal Medicaid matching dollars for federally-defined Health Home services.
  - Eligible Patients: Have 2 or more chronic conditions; have one chronic condition and are at risk for a second; OR have one serious and persistent mental health condition.
  - Eligible chronic conditions include mental health, substance abuse, asthma, diabetes, heart disease, and being overweight.
  - Additional chronic conditions, such as HIV/AIDS, may be considered by CMS for approval.
- In Vermont: Hub & Spoke Initiative

FFS is Base Payment

# Shared Savings ACO Program




A **performance-based contract** between a **payer and provider organization** that sets forth a **value-based program** to govern the **determination of sharing of savings** between the parties.

FFS is Base Payment

http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2012/Aug/1618_Forster_accountable_care_strategies_premier.pdf

# How Shared Savings Programs Work

People see their PCPs as they usually do

If their PCP belongs to an ACO, the ACO accepts responsibility for the cost and quality of care provided to that person

Providers bill FFS as they usually do

# Episodes of Care

**What is an episode of care (EOC)?**

All related services for:

- one patient
- a specific diagnostic condition
- from the onset of symptoms until treatment is complete

Can be FFS, DRG, or other Base Payment

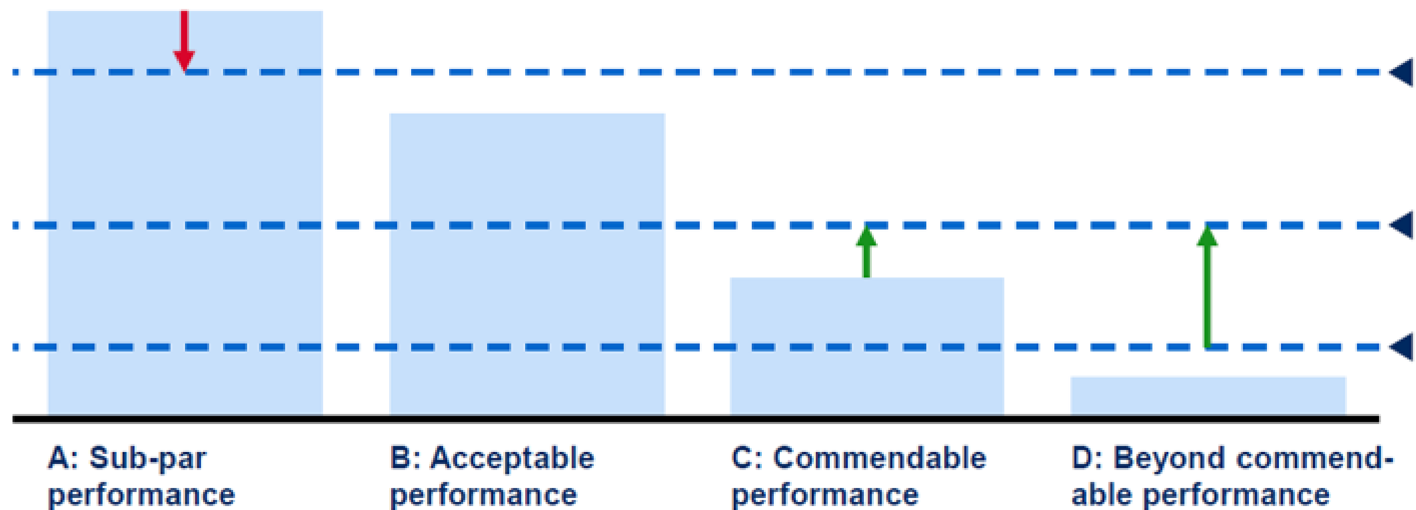
Bundled Payments for Care Improvement (BPCI) Initiative: General Information
http://innovation.cms.gov/initiatives/bundled-payments

# Episodes of Care

Aggregating payment into clinically meaningful episodes

Bundled payments reward quality care and introduce risk to providers

Average cost per episode, for each Principal Accountable Provider



# Capitation

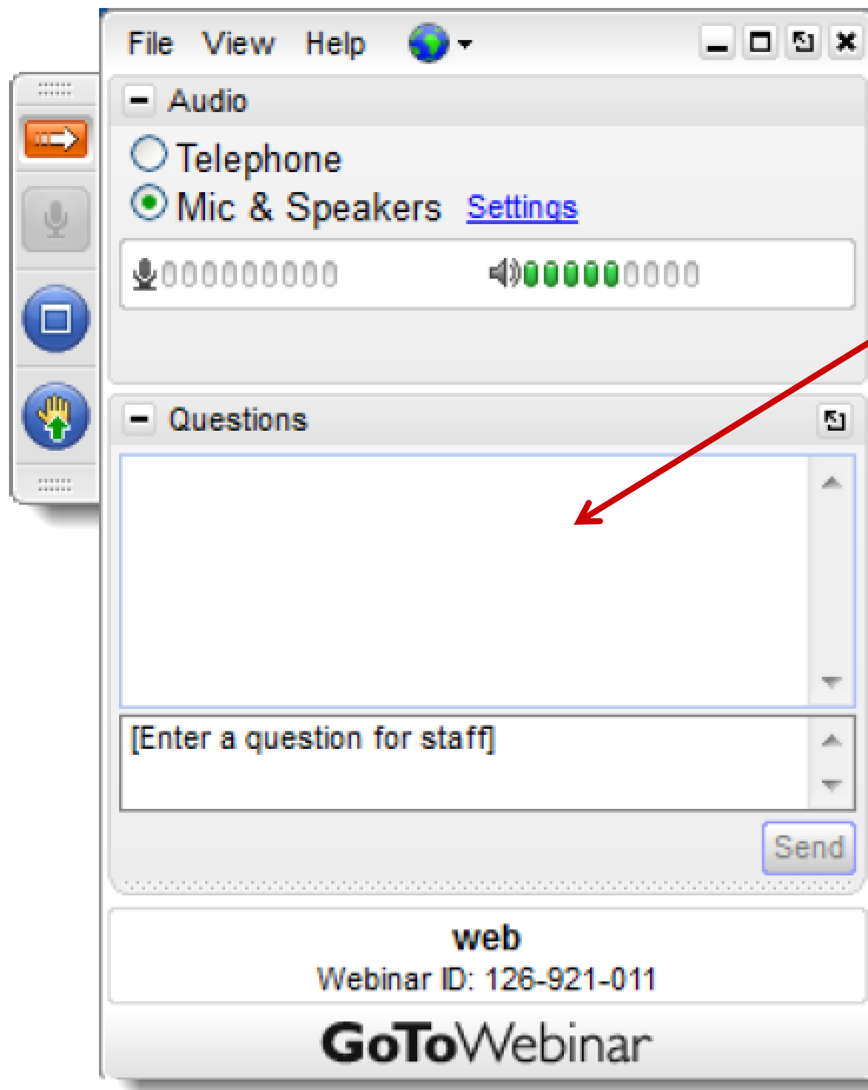
- Providers take on risk for a whole population for a set of services over a defined time period, like a year.
- Payment is based on the person not on the services they use.
- There can be payments underneath the capitation level to encourage high-value care (sub-capitation).
- Risk arrangements vary depending on the payer.

PMPM or other population-based payment rate

# Lessons Learned

- Provider readiness is critical.
- Data drives all of these changes.
- Any payment model takes time to design and requires a combination of public and private entities to develop.
- Payment model design requires technical skills and understanding of the current payment arrangement and the goals for the future.
- This is systems and behavioral change.

# Questions?




- Enter questions in Questions pane of GoToWebinar control panel.

# Thank you!

Additional Questions:

Email Georgia Maheras (georgia.maheras@vermont.gov)