State Flex Program
Involvement in Value-based Models

Vermont’s Health Care Reform Context,
Pennsylvania’s Rural Health Model &
Washington’s Rural Access Project
Learning Objectives:

At the conclusion of this session, participants will be able to:

1. Relate the described experience of the panelists with rural models transitioning to value to the current conditions in your state

2. Explain opportunities for state Flex Program involvement in future models of health care

3. Evaluate next steps for your state Flex Program to connect with other Flex peers or state partners to support the rural transition to value-based care
The Vermont All-Payer Accountable Care Organization (ACO) Model

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Flex Grantee Reverse Site Visit

July 13, 2019
Vermont & Health Care Infrastructure:

Population: ~ 623,657 (2017 est.)
Area: 9,616 Density: 67/sq. mi.
Counties: 14 Towns: 251

Comm. Hospitals 13
Tertiary Care Ctrs. 2
Psych Hospitals 2+3 units
VA Hospitals 1

FQHC PC sites 50
RH Clinics 9
Other PC practices 140+
PP Clinics 12
Free Clinics 4+6

MH Agencies 11
SUD Reg Tx Hubs 9
Spoke providers 230+

PH Districts 12
Flex/SHIP FTE: 1.65
Problems: Cost Growth is Unsustainable and Health Outcomes Must Improve

Cost Growth

• In 2017, the most recent year of data available, health care spending in Vermont grew 1.7%.
• Vermont’s health care share of state gross product devoted to health care spending was 18.5% in 2017, vs. 11.8% in 1995.

Health Outcomes

• Chronic diseases are the most common cause of death in Vermont. In 2014, 78% of Vermont deaths were caused by chronic diseases
  • High Blood Pressure: 25% of Vermonters diagnosed (2015)
  • Diabetes: 8% of Vermonters diagnosed (2015)
  • COPD: 6% of Vermonters diagnosed (2015)
  • Obesity: 28% of Vermont adults diagnosed (2016)
• Medical costs related to chronic disease were over $2 billion in 2015, and are expected to rise to nearly $3 billion by 2020
• Vermont’s death rates from suicide and drug overdose are higher than the national average
  • Suicide (2016): 17.3 per 100,000 (VT) vs. 13.4 per 100,000 (US)
  • Drug Overdose (2016): 18.4 per 100,000 (VT) vs. 13.3 per 100,000 (US)

Health Care Reform: Past & Present

Prior to the Affordable Care Act (ACA)

1115 Medicaid Waiver – “Global Commitment”
- Insure Adults & Children: Dr. Dynasaur
- Blueprint for Health – chronic care management, primary care redesign
- Recruitment incentives
- Free Clinic support
- FQHC expansion

Under the ACA
- VHCURES all-payer data set
- Health Benefits Exchange
- Dual-eligible pilots
- State Innovation Model (SIM)
- 1115 Waiver 2: All-Payer Model
- Accountable Care Organization(s)
Vermont’s Solution: The Vermont All-Payer Accountable Care Organization (ACO) Model

Test Payment Changes

- Population-Based Payments Tied to Quality and Outcomes
- Increased Investment in Primary Care and Prevention

Transform Care Delivery

- Invest in Care Coordination
- Incorporation of Social Determinants of Health
- Improve Quality

Improve Outcomes

- Improved access to primary care
- Fewer deaths due to suicide and drug overdose
- Reduced prevalence and morbidity of chronic disease
Vermont All-Payer ACO Model Partners

Center for Medicare and Medicaid Innovation (CMMI)
- Model design, operations, and monitoring to support Agreement implementation
- Implement Vermont Medicare ACO Initiative (payer), a Vermont-tailored Medicare ACO model

Green Mountain Care Board (GMCB)
- Health system regulation to support Model goals (ACO oversight, Medicare ACO program design and rate setting, hospital budgets, and more)
- Monitoring and reporting to CMMI on cost, scale and alignment, quality, and more

Governor, Vermont Agency of Human Services (AHS) Including Medicaid
- Vermont Medicaid Next Generation ACO Program (payer)
- Reporting to CMMI, including plans for integrating public health and mental health, substance use disorder, and long-term care spending into financial targets

ACO (OneCare Vermont) and Vermont Providers
- Contract with payers to accept non-FFS payments and increase Model scale
- Work with provider network to implement delivery system changes intended to control cost growth and improve quality and access

Private Insurers and Vermont Businesses
- Contract with ACO to pay non-FFS payments on behalf of covered lives in alignment with the Model
- Work with self-insured employers as a TPA/ASO to demonstrate Model progress and bring new self-insured lives under the Model

All-Payer Model Agreement Signatories
Partners in Health Care Reform

State: Medicaid, Blueprint for Health, Opioid Treatment, Aging Services, etc.
Health Care Reform Office (Agency of Administration -> Human Services)
Green Mountain Care Board (regulators),
Cross-Government: Health in All Policies work (RWJ Foundation)
   Agriculture, Education, Commerce, Transportation, Natural Resources,
   Housing, Commerce & Comm. Devel, Public Services, Health Dept.

Non-Profits: Hospital Association, Health Care Quality Improvement organization

Health Care: Statewide Accountable Care Organization(s)
   Hospital led:
   - Chronic Care Management, Community Health Teams
   - Accountable Communities for Health
   - ACO Shared Savings / Risk / Attribution
Participation of Flex Program

1. MBQIP - Continuing:
   Technical assistance by VT Program for Quality In Health Care (VPQHC)
   Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) reporting required by statute; Quiet at night lagging
   Emergency Department Transfer Communication (EDTC) – quarterly reporting, now annual on a few lagging measures
   Patient Safety (PS)/Hospital Acquired Infections (HAI)/Inpatient (IP)/Outpatient (OP) – collab w/ state-mandated QI programs

2. Financial & Operational Improvement: Statewide HC reform activities for 15+ years.
   Flex: site visits, monitoring CAHMPAS & recent key financial indicators
   Conditions of Participation in CMS mock surveys (VPQHC)
   2019: Small Rural Hospital Transition (SRHT) by contractor
   System review, CAH self-assessment, interviews at site visits, action planning
Participation of Flex Program (con’t.)

3. Population Health:
   Community Health Needs Assessments (CHNAs) – required collab w/ local public & partners (completed 2018-19)
   Mental health in the Emergency Department (ED): reduce wait times for psychiatric patients in ED

4. EMS Quality & Performance Improvement:
   Community Paramedicine pilot project & policy development
   EMS needs assessment
   Consistent and accurate reporting on drug overdoses
   Improve finances: Days Cash on Hand / 1.0% Operating Margins

6. CAH Conversion or Transition:
   1 CAH may transition to a new model to remain viable
Take away messages / Discussions

Health care is a constantly changing environment – program plans vs. state and local reality

Flex programs need to be flexible and collaborative

How will you adapt to various changes in your communities, hospitals, states and federal partners?