

# Study of Cost Containment Models and Recommendations for Connecticut

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**Principles and Review of Vermont**

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**bailit  
health**

# The Healthcare Cabinet Cost Containment Study is a Partnership



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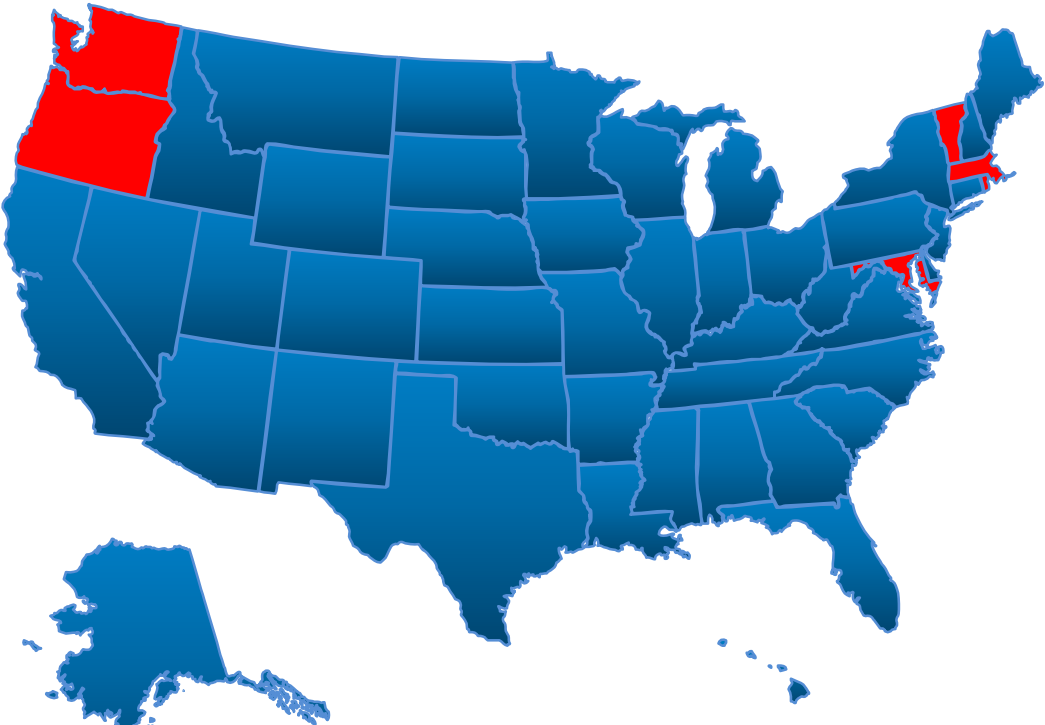
# Agenda

1. Review of Principles
2. Review of Vermont's Cost Containment Strategies
3. Discussion
4. Next Steps

# Principles

- During the last meeting, the Cabinet identified several principles that should guide the Cabinet in making recommendations for a cost containment model
- The principles identified are consistent with
  - PA 15-146
  - Healthcare Cabinet Operating Principles
  - SIM Vision and Guiding Principles
  - Healthy Connecticut 2020 Vision and Principles
- Refer to handout for detailed principles

# State Cost Containment Models



Six States of Inquiry



Vermont

# Key Statistics



## Vermont

Population	626,652
Sources of health coverage	Employer: 52%
	Medicaid: 21%
	Medicare: 13%
	Uninsured: 6%



## Connecticut

Population	3,596,677
Sources of health coverage	Employer: 58%
	Medicaid: 15%
	Medicare: 12%
	Uninsured: 7%

\*As of December 2015, total Medicaid enrollment was 732,619.

# Health Care Market Profile: Hospitals



**Vermont**: 14 hospitals; 8 are critical access hospitals

- All are domestic
- Most serve a single geographic area
- Two leading hospitals (though one is over the border in NH)

**Connecticut**: 28 hospitals

- Most are domestic, but some are operated by larger conglomerate health systems,
- Two health systems control the majority of the statewide market (in terms of discharges)
- Market characterized by extensive consolidation

# Health Care Market Profile: Primary Care



**Vermont:** ~215 PCP sites, with ~600 individual PCPs

- 1076:1 ratio of population to PCPs
- 8 FQHCs and 15 RHCs

**Connecticut:** ~3000 individual PCPs

- 1385:1 ratio of population to PCPs
- ~20% of family medicine and internal medicine physicians are not accepting new patients\*
- 16 FQHCs



# Health Care Market Profile: Health Plans



**Vermont:** Dominated by one domestic plan

- BCBSVT: 88%
- MVP: 10% (plan mostly in NY)
- Cigna: 2%
- Medicaid: No capitated managed care entities

**Connecticut:** Dominated by national plans

- Anthem: 44%
- Cigna: 20%
- Aetna: 18%
- Medicaid: No capitated managed care entities

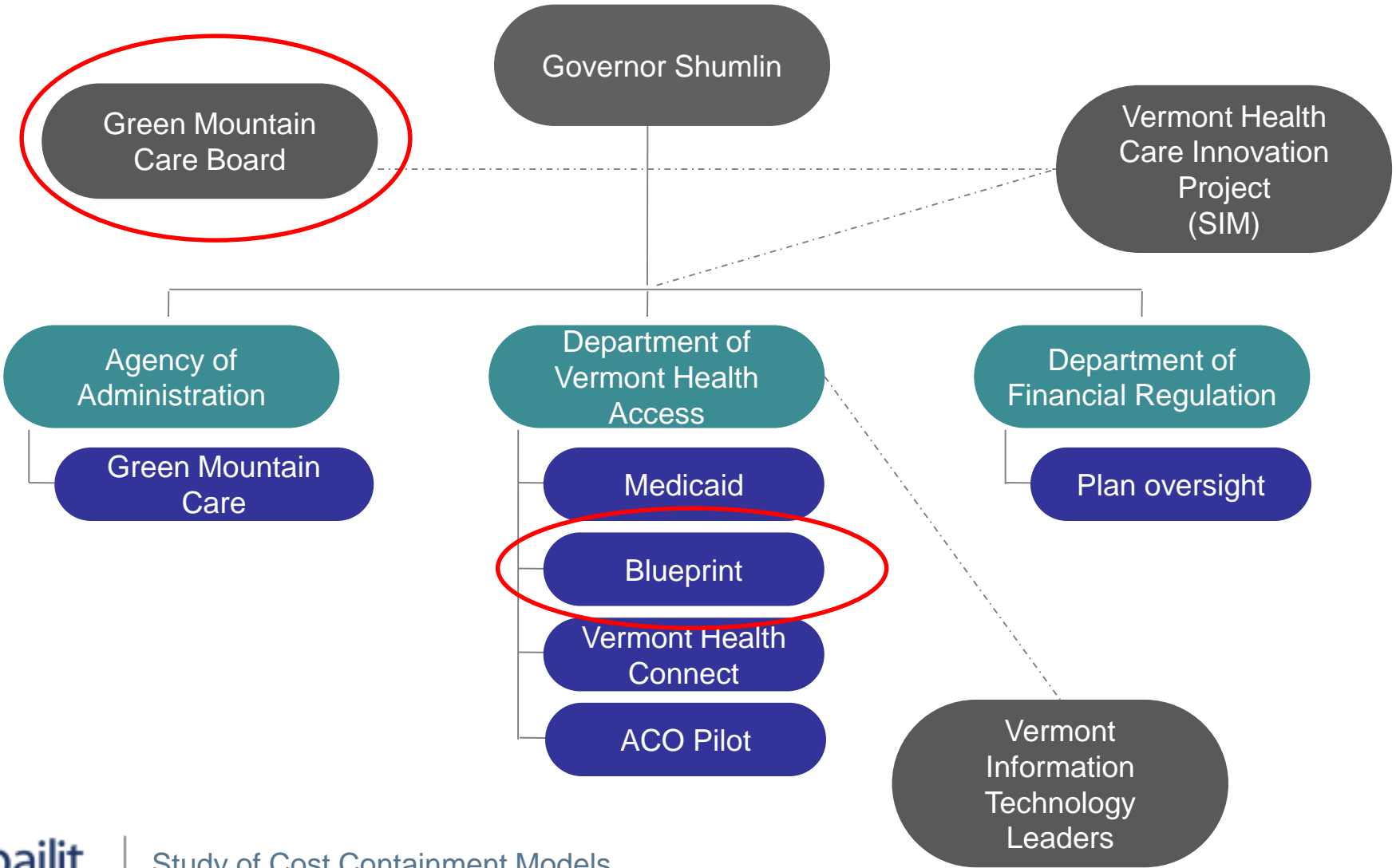
# Other Vermont Characteristics

- Vermont has a reputation of being a collaborative environment where parties with different interests come together to try to forge agreement through compromise.
- Does this mean everything in Vermont goes smoothly?
- No, but it does put in place a steady foundation from which to effect system change.

# VT State Government's Role in Health Reform

- State government plays a major role in Vermont's health care reform initiatives.
- Executive and legislative branches have long been very active in shaping health care for the state.
- The legislature has given state-based agencies and an independent board wide authority to promote and enforce health care reform efforts.

# Vermont Government Oversight of Health Reform



# Blueprint for Health

- Vermont's PCMH Program
- Launched in 2003 and broadened by the state Legislature in:
  - 2006 (Act 191)
  - 2008 (Act 204)
  - 2010 (Act 128)
  - 2014 (Act 144)

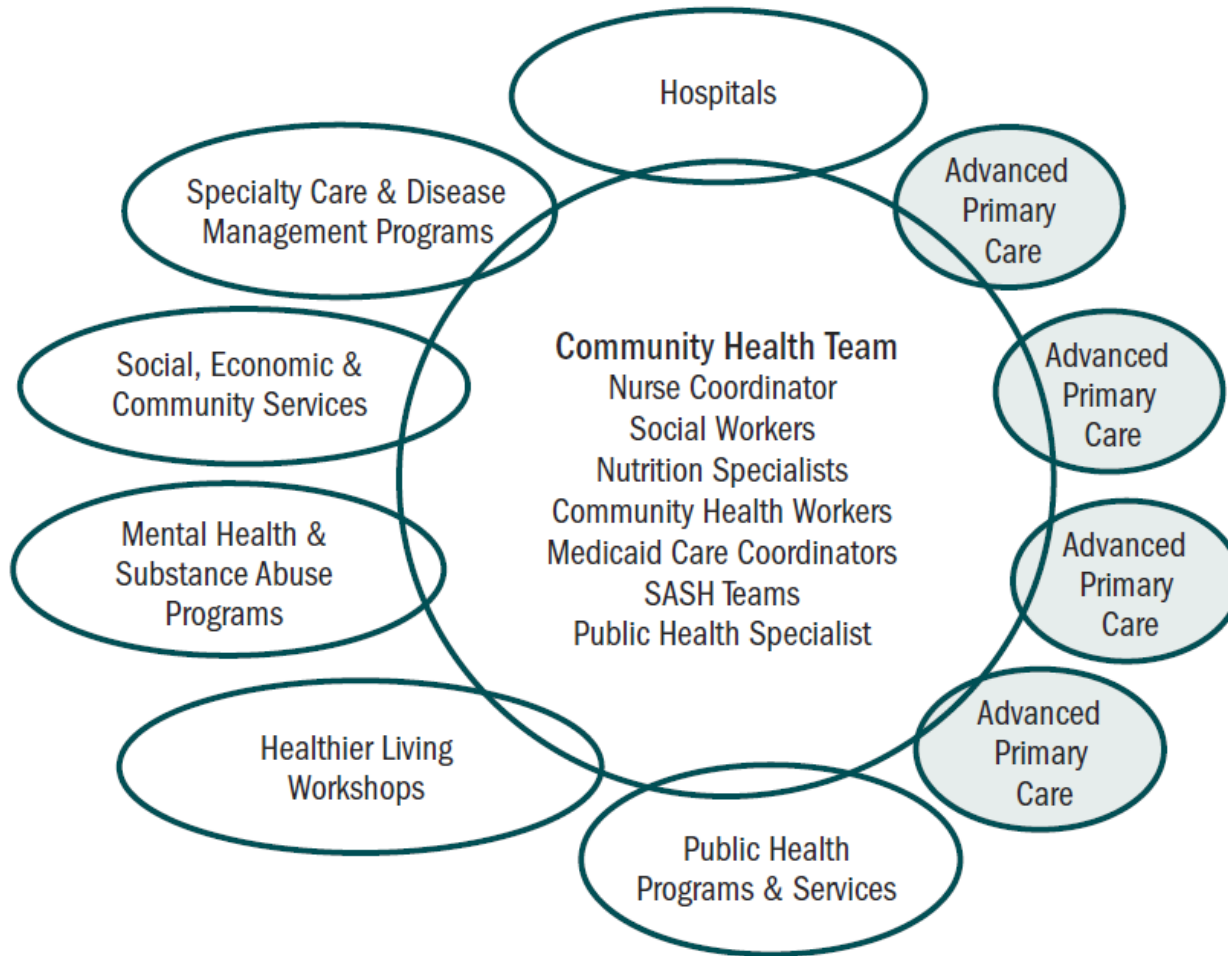


**“Aims for all citizens to have access to high quality primary care and preventive health services, and to establish a foundation for a high value health system in Vermont”**

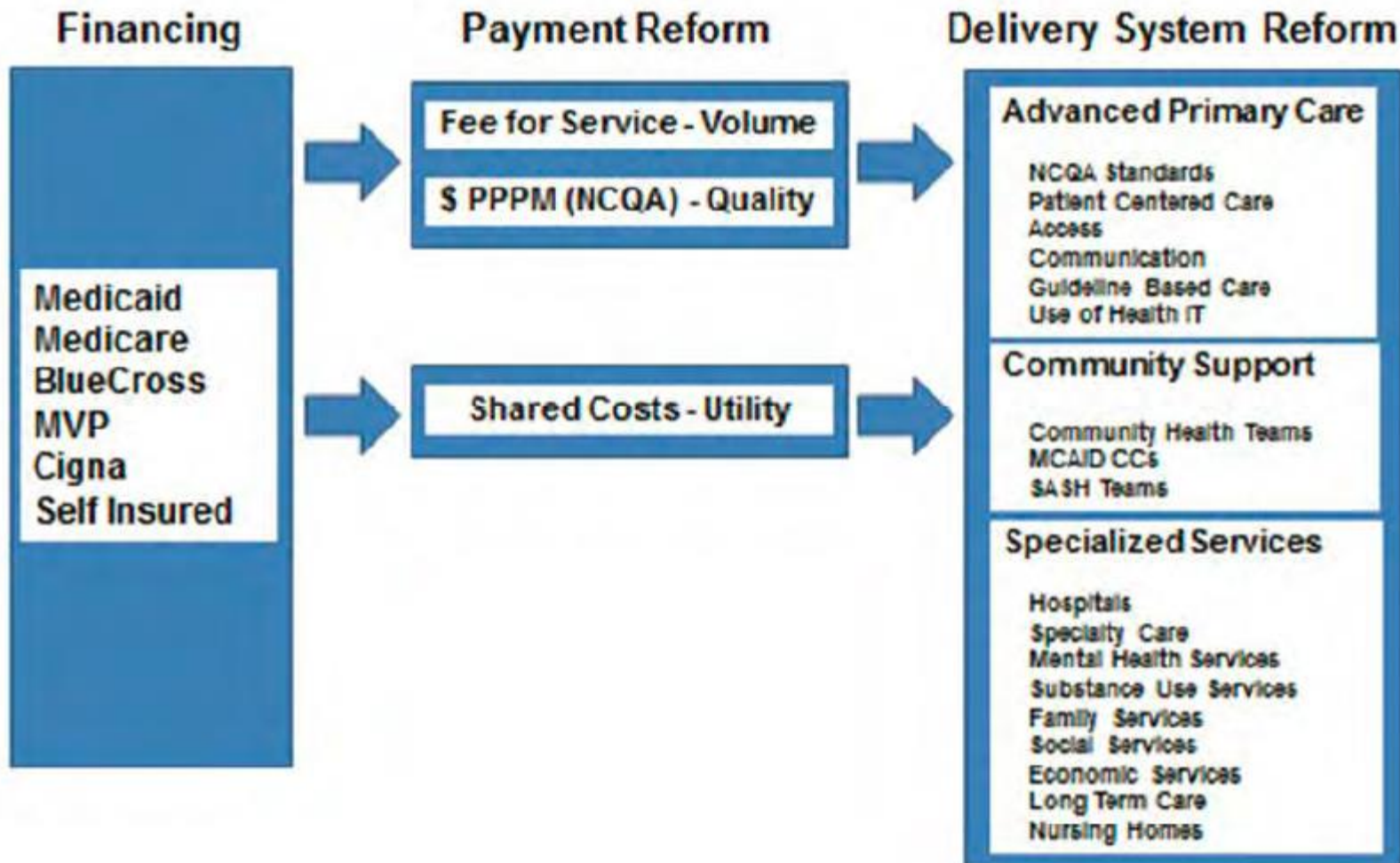
# Blueprint for Health

- The Blueprint for Health consists of:
  1. advanced primary care practices serving as medical homes
  2. support from multidisciplinary community health teams
  3. support from a network of self-management programs
  4. comparative reporting from statewide data systems
  5. locally-led Regional Community Collaboratives
- **All payers** in the state (and Medicare) are participating in the Blueprint for Health program.

# Community Health Team Framework



# Blueprint for Health: Payment Model



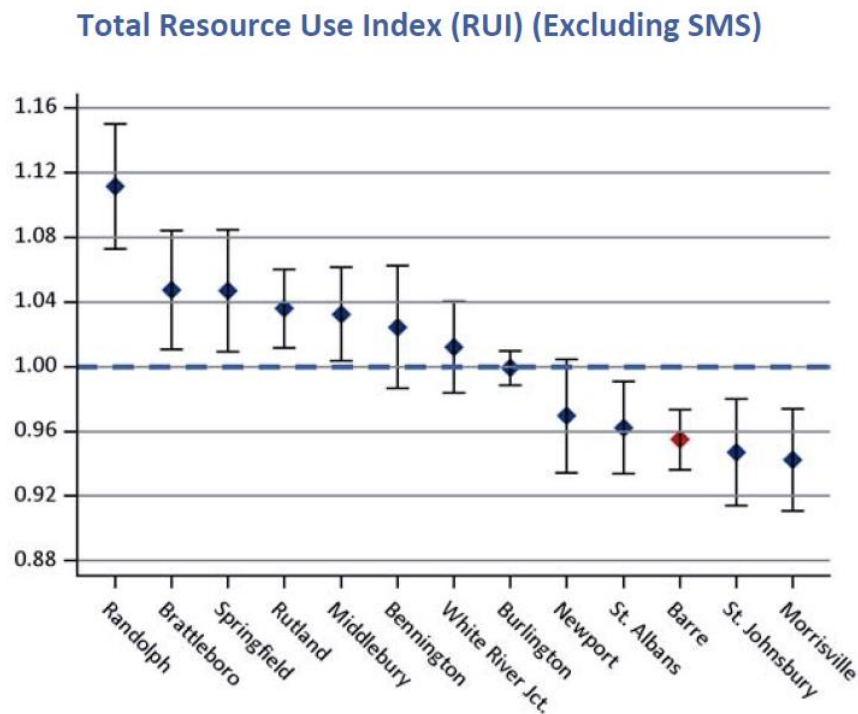


# Statewide Program Participants

Key Components	December 2014
PCMHs (active PCMHs)	124
PCPs (unique providers)	682
Patients (attribution 12/2013 <sup>3</sup> )	347,489
Patients (practice report <sup>4</sup> )	515,619
CHT Staff (core)	218 staff (135 FTEs)
SASH Staff (extenders)	65 FTEs (52 panels)
Spoke Staff (extenders)	58 staff (39 FTEs)

# Data are Critical to the Blueprint

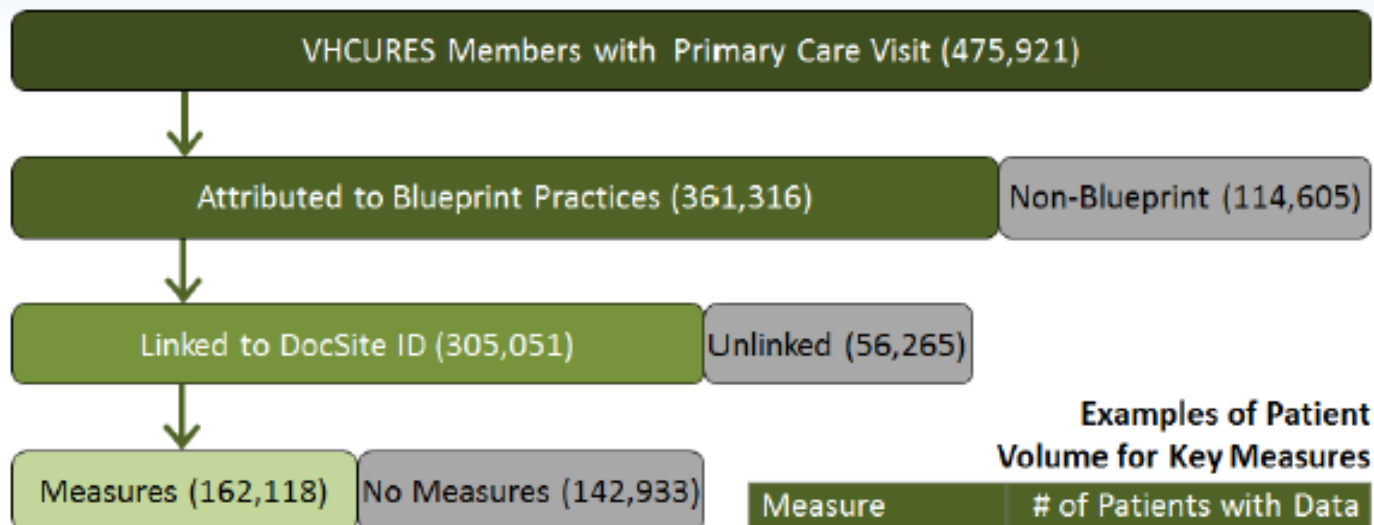
- The Blueprint produces all-payer practice profile reports from the state's APCD.
- The reports compare practices to others in their region and statewide on panel characteristics, risk-adjusted resource utilization and cost and quality (13 HEDIS measures).
- *Next:* incorporating ACO contract measures and integrating clinical data



# Data are Critical to the Blueprint

## Linking Claims & Clinical Data – 2014\*

Enhancing Blueprint Reporting: Clinical Outcomes



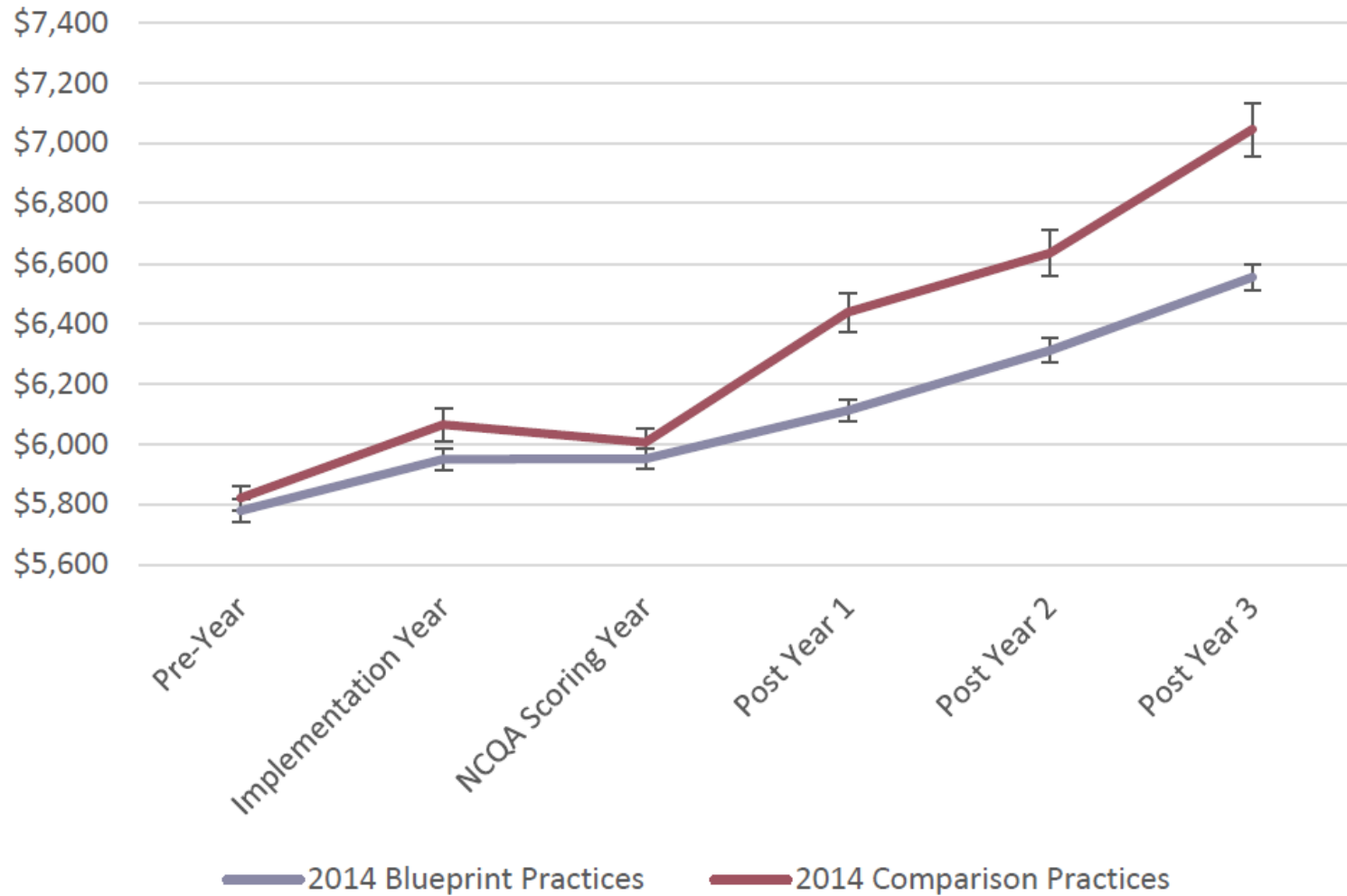
Examples of Patient Volume for Key Measures

Measure	# of Patients with Data
Weight	142,600
Blood pressure	140,286
BMI	122,428
Triglycerides	44,639
LDL-C	43,652
Tobacco use	28,779
HbA1c	21,418

\*CY 2014 represents dates of services on and between 01/01/2014 and 12/30/2014.

ONPOINT HealthData

# Blueprint Impact on Cost: Total Expenditures Per Capita All Insurers, Ages 1 + (2008-2014)



# Blueprint's ROI for 2014

	2014 All Payers	2014 Medicaid	Projected 2016 All Payers
ROI in total expenditures <u>w/o</u> Special Medicaid Services (SMS)	6.5 : 1	3 : 1	5.3 : 1
ROI in total expenditures <u>with</u> Special Medicaid Services (SMS)	5.8 : 1	0.9 : 1	4.8 : 1

\*Special Medicaid Services (SMS) are services targeted at meeting social, economic, and rehabilitative needs (e.g., transportation, dental, HCBS, residential treatment, school-based services, mental health facilities).

# Green Mountain Care Board



Working  
to Improve  
Health Care Quality  
and Moderate Cost  
for  
Vermonters

# Green Mountain Care Board

- Established by the Vermont Legislature in 2011.
- Five-person independent board appointed by the legislature with full authority to make decisions.
- GMCB has three main functions:
  1. Regulate
    - Insurance rates, hospital budgets, major hospital expenditures
  2. Innovate
    - Payment and delivery system reform
  3. Evaluate
    - Impact innovation has on Vermont's economy, and proposals for funding the health care system

# Hospital Budget Review

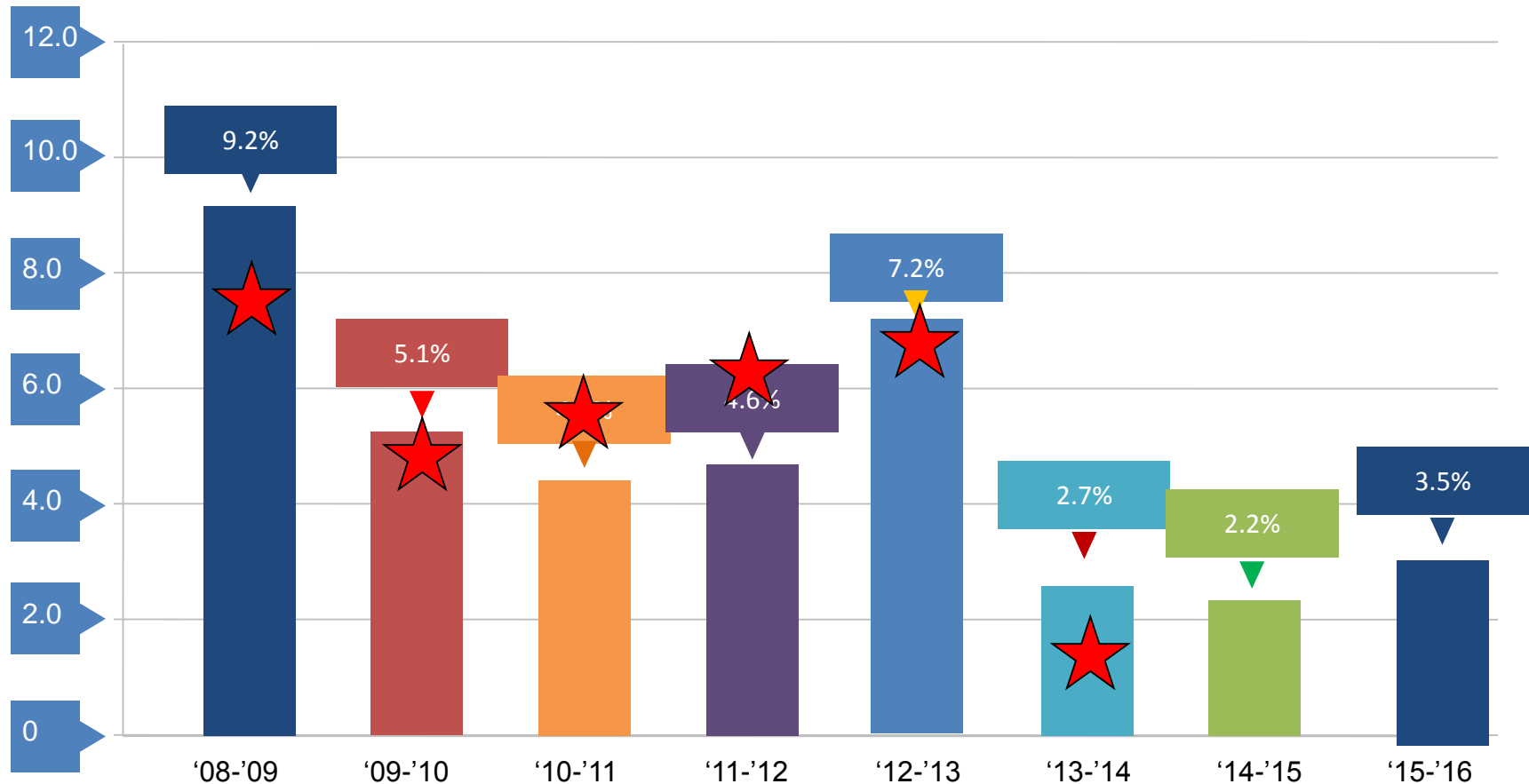
- Hospitals account for about 40% of the total spending on health care in Vermont and their budgets have been regulated since the early 1980s.
- Review process was created to slow the rising costs of health care and ensure hospital budgets were reasonable and fair.
- Prior to the GMCB, hospital budgets were reviewed within state agencies that did not have any authority to penalize a hospital that went over budget.




# Hospital Budget Review (cont'd)

- When the GMCB was given authority to review hospital budgets, it was also given broad enforcement authority for hospitals that went over budget, including financial penalties.
- The first year the GMCB conducted the budget reviews was “rocky,” but the GMCB has earned respect for being fair and transparent and has set clear goals for cost growth increases.
  - This isn’t a “gotcha game”
- Subsequent years has been quite successful in holding down cost growth.

# Hospital Budget Review, Results



**New Patient Revenue Budget vs.  
Actual % Increase**

 Actual NPR

# Insurance Rate Review

- The GMCB also has the authority to regulate insurance rates, as do many states, to ensure that Vermonters pay a fair price for their insurance coverage.
- GMCB, however, works to link the hospital budget review process with in the insurance rate review process to ensure that slowed growth in hospital budgets means slowed growth in insurance rate increases.
- The insurance rate review process has been estimated to save Vermonters **\$66 million.**

# GMCB “Innovative” Authority: Payment Reform and Delivery System Reform

- The GMCB was given the authority to design and test new ways of paying for and delivering high quality health care.
- It has exercised this authority in three ways:
  - Vermont Shared Savings Program pilot
  - All-Payer Model
  - Pilots focused on smaller payment and delivery system reform innovations (e.g., oncology PMPM in St. Johnsbury)

# Vermont Shared Savings Program

- GMCB organized a planning process in late 2012 to establish a multi-payer ACO pilot.
- Implemented 1-1-14 with three ACOs, BCBSVT and Medicaid (MVP lacked sufficient covered lives). ACOs:
  - One organized by the two leading hospitals
  - One organized by FQHCs
  - One organized by a physician IPA
- The ACOs also had joined or would join the Medicare Shared Savings Program.
- GMCB facilitated development of common program standards, performance measures and a payment model.

# Vermont Shared Savings Program

- Vermont has tried to build connections between the Blueprint and the Vermont Shared Savings Program pilot
  - Integrating ACO representatives into the Regional Community Collaboratives
  - Adding ACO performance measures to practice profiles
  - Active planning for future incorporation of the Blueprint into the future All-Payer Model on multiple dimensions (see next slide...)

# Vermont's All-Payer Model

- The Vermont Shared Savings Program and the collaboration between the Blueprint and the ACOs laid the foundation for the state exploring what Vermont calls the “All-Payer Model.”
  - Political will from the Governor also helped!
- For the past year, Vermont has been designing a model in which all three ACOs in the state would come together as one single ACO and all payers would pay the single ACO a prospective, capitated payment. Target start date: 1-1-17.
  - This will require a federal waiver for Medicare participation.

# Vermont's All Payer Model, cont'd.

- The majority of health care services will initially be included in the all-payer model, with the exception of pharmacy, long term care, and some behavioral health care.
- Those services are targeted to grow at 3.5% per year *across all payers* for five years with a ceiling of 4.3% per year.
- For providers that do not participate in the single ACO, the GMCB may exercise its authority to determine the payment rules for the providers.
  - In effect, regulated fee-for-service



# Vermont's All Payer Model

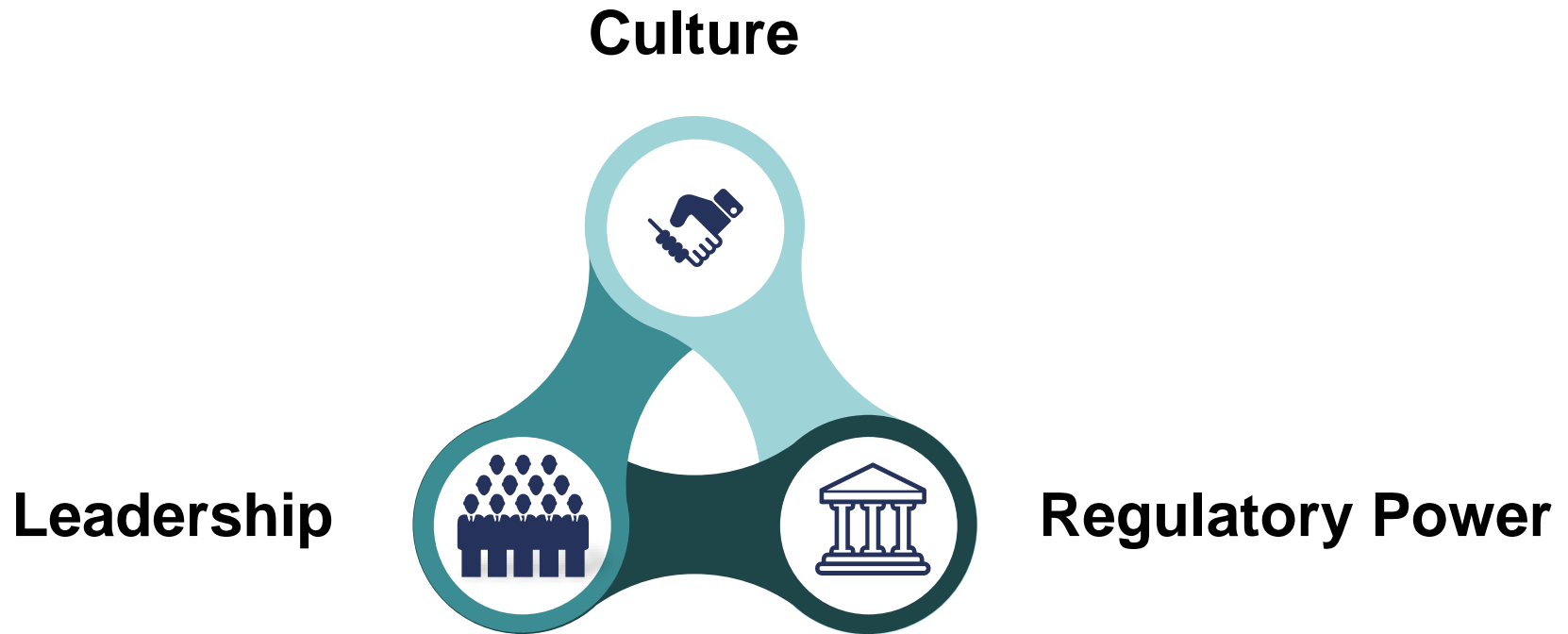
**“Today is the beginning of the rubber hitting the road on cost containment. Our success will mean better health outcomes for Vermonters and the end to health care costs rising faster than our economic growth.” – Governor Shumlin 1/25/16**

# Road Ahead for Vermont: Much Work Yet to Do

- The waiver with CMS for the All-Payer Model has yet to be finalized.
- The regulatory functions to govern the All-Payer Model have yet to be developed.
- The providers in Vermont need to formally agree to come together as one ACO to ensure the success of an All-Payer Model.



# Keys to Success in Vermont



# Keys to Success in Vermont



## Culture

- Vermont has had a long history of collaboration in the state around health care reform.
- Mutual respect between GMCB and providers, and acceptance of the active role of the state.
- Culture of transparency.

# Keys to Success in Vermont



## Leadership

- Committed leaders have been driving change in Vermont.
- Governor
- Legislature
- GMCB and its staff
- Provider organizations

# Keys to Success in Vermont



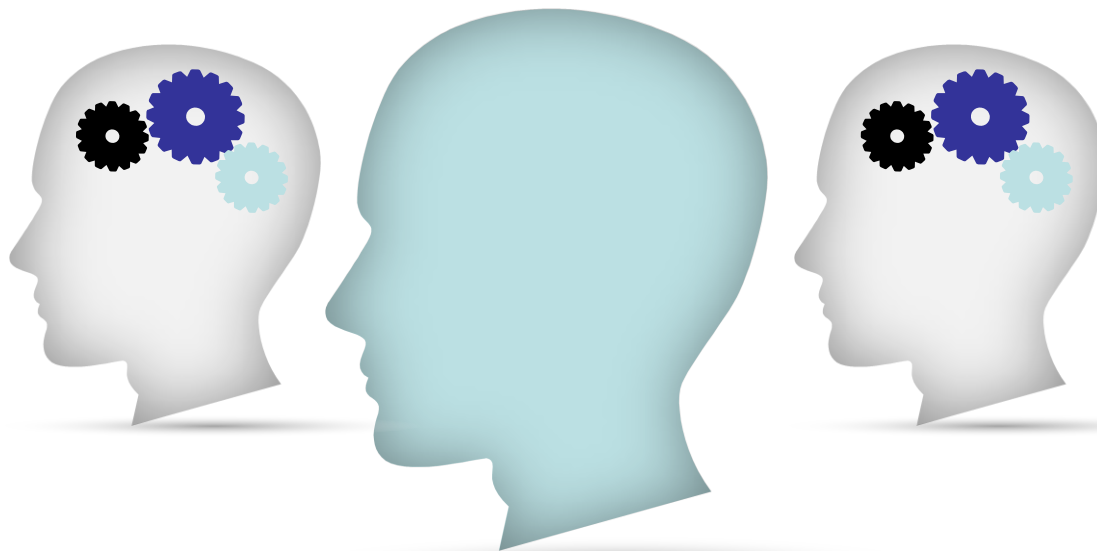
## Regulation

- Board powers to regulate health care rates, hospital budgets and compel providers to participate in payment and delivery system reform

# Summary of Vermont Strategies

- **Payment and Delivery System Reform:**
  - Legislatively supported patient centered medical home (Blueprint)
  - GMCB facilitated ACO strategy
    - (Vermont Shared Savings Program)
    - Vermont All Payer Model
- **State Regulatory Actions:**
  - Hospital Budget Review
  - Insurance Rate Review
- **Data Collection and Reporting:**
  - APCD and HIE support of delivery system reform

# Questions and Discussion



1. Which of Vermont's strategies are transferrable to CT?
2. Are there any strategies about which you would like more detail?



# Next Steps

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# Next Steps

- Continue to conduct stakeholder interviews
- Next meeting:
  - Brief report on stakeholder interviews
  - Review of analytical framework
  - Review of Rhode Island and Massachusetts