

Green Mountain Care Board
89 State Street
Montpelier, VT 05620-3101

[phone] 802-828-2177

Anya Rader Wallack, Ph.D., Chair
Alfred Gobeille
Karen Hein, MD
Con Hogan
Allan Ramsay, MD
Georgia Maheras, Executive Director

MEMORANDUM

To: The House Committee on Health Care and the Senate Committee on Health and Welfare

From: The Green Mountain Care Board, the Department of Banking, Insurance, Securities and Health Care Administration, and the Department of Vermont Health Access

Re: Necessary Modifications to the Regulatory Processes for Health Care Professionals and Managed Care Organizations in Order to Align these Processes with the Payment Reform Strategic Plan

Date: March 15, 2012

CC: Stephen W. Kimbell, Commissioner, BISHCA
Mark Larson, Commissioner, DVHA

The report is submitted pursuant to Act 48 of the Acts of 2011 Section 12:

PAYMENT REFORM; REGULATORY PROCESSES

No later than March 15, 2012, the Green Mountain Care board established in 18 V.S.A. chapter 220, in consultation with the commissioner of banking, insurance, securities, and health care administration and the commissioner of Vermont health access, shall recommend to the house committee on health care and the senate committee on health and welfare any necessary modifications to the regulatory processes for health care professionals and managed care organizations in order to align these processes with the payment reform strategic plan.



**Report to the House Health Care Committee and Senate Health and Welfare
Committee on any Necessary Modifications to the Regulatory Processes for Health
Care Professionals and Managed Care Organizations**

March 15, 2012

Submitted by the Green Mountain Care Board in consultation with the Banking, Insurance,
Securities and Health Care Administration and the Department of Vermont Health
Access

Acknowledgements

We appreciate all of the assistance provided to us by staff at the Green Mountain Care Board, Department of Banking, Insurance, Securities and Health Care and the Department of Vermont Health Access. We are also grateful for the information provided by insurance carriers, providers, Robert Murray, Fletcher Allen Health Care, Centers for Medicare and Medicaid Services, and the California Health Care Foundation.

Table of Contents

Executive Summary	Page 2
Introduction	Page 3
Types of Risk and Issues Affecting its Magnitude	Page 4
Payment Reform in Vermont	Page 7
Emerging Payment Reform Models	Page 8
Federal Payment Reform Models	Page 8
Risk-Sharing Arrangements and Regulatory Approaches in Other States	Page 9
Physician Practice Models – Retainer-based Medicine	Page 13
Recommendations	Page 13
Appendix	Page 15

Executive Summary

Vermont will be testing new health care provider payment models as part of the state's effort to control the rate of growth in health care costs while improving the quality and outcomes of care provided. Likewise, the federal Affordable Care Act (ACA) authorized the Centers for Medicare and Medicaid Services (CMS) to implement new payment methodologies in Medicare, with an emphasis on replacing fee-for-service. Each of these developments raises the issue of provider risk, as each involves some degree of prospective provider payment – the provider payment is set in advance. Therefore, these arrangements involve some risk that there will be a mismatch between the budgeted payment and the actual costs of care. The provider may bear some risk for exceeding cost targets (i.e., the provider pays for at least a portion of the overage on a budgeted amount) or for accepting a fee that does not cover the cost of services ultimately provided.

Bearing financial risk may motivate providers to reduce overuse of inappropriate services and better coordinate care. However, there could be adverse consequences for either the providers themselves, if they become insolvent, or for their patients, if they manage to stay within budget only by denying necessary care. Safeguards against these adverse consequences are necessary. Safeguards might include measurement of access to and quality of care, or requirements that providers demonstrate the financial capacity to withstand a mismatch between the fee accepted and the level of services actually needed.

As required by Act 48, the Green Mountain Care Board (GMCB), the Department of Banking, Insurance, Securities and Health Care Administration (BISHCA) and the Department of Vermont Health Access (DVHA) researched these risk models and their implications for Vermont.

We recommend that no legislative action is needed at this point, but as payment arrangements evolve to allow for providers to bear more financial risk, the state should carefully monitor providers' ability to bear financial risk and to remain solvent; this measurement will be a part of all payment reform projects, consistent with Green Mountain Care's Payment Reform Pilot Policy. It is critical for the state to ensure the stability of our providers, while also offering sufficient flexibility to allow for delivery system innovations and cost savings.

Introduction

Changing how health care providers are paid was a major focus of Act 48 of the 2011 Vermont legislative session. Act 48 provided a clear legislative directive to move the state away from the predominance of fee-for-service provider payment, toward payment methodologies that reward value. Fee-for-service payment is recognized as a contributor to health care cost inflation and does little to encourage coordination of care or maximize efficiency in health care organizations.

Vermont will be testing new provider payment models as part of the state's effort to control the rate of growth in health care costs while improving the quality and outcomes of care provided. Likewise, the federal Affordable Care Act (ACA) authorized the Centers for Medicare and Medicaid Services (CMS) to implement new payment methodologies in Medicare, with an emphasis on replacing fee-for-service. Each of these developments raises the issue of provider risk, as each involves some degree of prospective provider payment – the provider payment is set in advance. Therefore, these arrangements involve some risk that there will be a mismatch between the budgeted payment and the actual costs of care. The provider may bear some risk for exceeding cost targets (i.e., the provider pays for at least a portion of the overage on a budgeted amount) or for accepting a fee that does not cover the cost of services ultimately provided.

Bearing financial risk may motivate providers to reduce overuse of inappropriate services and to better coordinate care. However, there could be adverse consequences for either the providers themselves, if they become insolvent, or for their patients, if they manage to stay within budget only by denying necessary care. Safeguards against these adverse consequences are necessary. Safeguards might include measurement of access to and quality of care, or requirements that providers demonstrate the financial capacity to withstand a mismatch between the fee accepted and the level of services actually needed.

Health insurers and health maintenance organizations (HMOs) that bear risk for products sold in Vermont are regulated by the Department of Banking, Insurance, Securities and Health Care Administration (BISHCA). BISHCA examines insurers and HMOs on a regular basis to assure, among other things, that they are solvent and have adequate reserves to meet their future obligations. No such regulatory structure exists for health care providers bearing risk.

In light of the potential expansion of payment reforms to shift more risk to health care providers, the legislature directed the Green Mountain Care Board (GMCB), in consultation with BISHCA and the Department of Vermont Health Access (DVHA), to examine the need for new or different regulatory oversight to protect consumers and health care providers from any adverse consequences of providers bearing risk. The legislature directed the GMCB to recommend “modifications to the regulatory processes for health care professionals and managed care

organizations in order to align these processes with the payment reform strategic plan” (Act 48, 2012). The GMCB was required to report back to the legislature with these recommendations by March 15, 2012.

Types of Risk and Issues Affecting its Magnitude

There are at least two kinds of financial risk involved in an attempt to predict health care costs in the future: selection risk and utilization risk. Selection risk is the risk that an entity, such as an insurer or a provider organization, will attract a sicker-than-expected patient population. Utilization risk is the risk that, for a given population, a provider may provide too much or too little service. In designing provider payment methodologies, it is important to understand the likely influence of those methodologies on how providers manage each of these types of risk. Table 1 below attempts to summarize the potential effects of three payment types: fee-for-service, case rates (such as bundled payments), and capitation. The bottom line is that, as the incentive becomes stronger for providers to manage utilization, the incentive to avoid selection risk (sicker patients) also becomes stronger.

Table 1: Likely Provider Response to Selection and Utilization Risk

Unit of Payment	Selection Risk	Utilization Risk
Fee-for-service (for example, office visit)	Almost none; sicker patients lead to greater volume or more intense service mix, or both	Providers try to have their cost intensity (per unit) below other providers’ costs
Case rate (for example, DRG or bundled payment)	Providers may avoid cases of higher-than-average severity if payment is not adjusted for severity	Providers must control the volume and intensity of services for each case
Capitation (for example, per member month)	Providers may avoid individuals with higher-than-average severity of need or illness if payment is not adjusted	Providers must control the volume and intensity of services for each member

Adapted from S. S. Wallack, C. P. Tomkins, “Realigning Incentives in Fee-For-Service Medicare.” *Health Affairs* 2003 Jul-Aug; 22 (4):59-70

These two types of risk sometimes are also referred to as “insurance risk” and “management risk.” Experts often agree that providers should be shielded from insurance risk: the risk of attracting a sicker population or of experiencing higher costs due to factors beyond the control of providers (such as an unexpected outbreak of disease) (Wallack, 2003). These risks are best managed by assuring that they are spread across a sufficiently large pool of people, through an

organization with financial reserves sufficient to cover unpredictable or infrequent high-cost events.

Management risk, however, should be shared with health care providers. As providers assume more responsibility for resource management (the type, location and intensity of the services their patients receive, for example), they better control cost growth and support patient health improvement.

The challenge, then, in developing provider payment systems, is to separate these types of risk and limit provider exposure to risk that might cause adverse consequences for providers or patients. This involves several factors:

Attribution. Payment models that assign management risk to health care providers do so on the basis of some attribution methodology – a means of assigning a particular patient population to a group of providers and holding groups of providers at least partially responsible for cost and quality outcomes. Attribution that allows or encourages providers to pick and choose among patients (much as insurers historically used underwriting to decide who to cover and who not to cover) is potentially problematic.

Risk pool adequacy. Health care costs generally are more predictable in a larger population than in a smaller population. The number of patients included in a particular risk model therefore is important. The federal government has included some minimum population thresholds in their payment reform models. In general, as a payment arrangement involves more provider risk, it becomes more important that they have a sufficient patient population to create predictability and spread high-cost, infrequent events across a large risk pool.

Risk adjustment. Adjusting provider payments to account for the underlying health and severity of illness of patients helps mitigate the potential incentive for providers to avoid less healthy patients under risk-bearing models. Methodologies for this adjustment are complex, but likely necessary to make advanced payment reforms successful for all providers and all patients.

Monitoring access and quality. To gauge the extent to which providers might minimize care under risk-bearing models, it is absolutely necessary to include in payment reform models data collection that supports assessments of access to care and quality of care.

Risk Corridors. Financial risk to providers can be constrained by creating a risk corridor that establishes a cap on the amount of financial risk the provider will be required to bear. This protects the provider from bearing responsibility for an amount of loss that would be beyond the capacity of the provider to assume. Both financial risk and shared savings could be tied to performance measures. Risk corridors can be linked to limitations on

shared savings, so that providers will have both limited risk and limited opportunities to receive distribution of savings.

Reinsurance or reserves. Many provider organizations that are entering into risk-bearing contracts limit their potential exposure under these contracts by purchasing reinsurance or stop-loss insurance. This type of insurance covers costs that exceed a defined threshold – usually either specific cases that are very costly or total claims payments that exceed an established threshold. This protects the provider organization from large, unpredictable expenses that would be considered insurance risk.

Careful consideration of each of these factors will be necessary as we craft Vermont’s payment reform models and methodologies.

The chart below represents the relationship between how services are paid for and the degree of financial/insurance risk transferred from payers to providers.

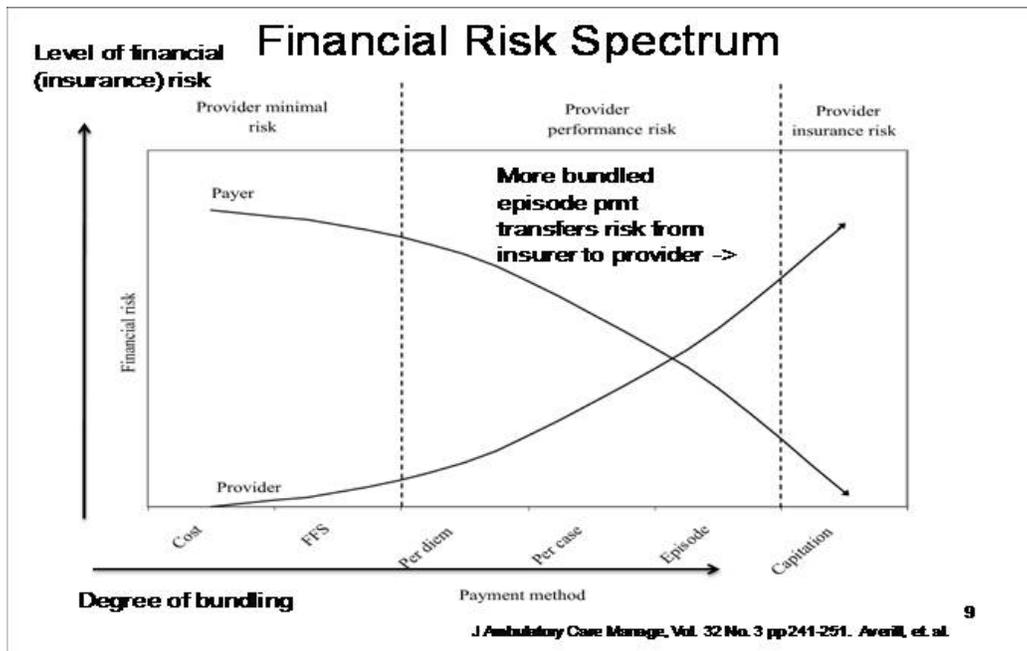


Figure 1: Financial Risk Spectrum (Averill, 2009)

As shown on the above chart, the movement from episode-based payment to capitation involves the further transfer of financial risk (sometimes referred to as “underwriting risk”) from payer to provider. Under capitated or partially capitated payment arrangements, the provider is required to manage a patient’s services within a fixed budget. If a patient requires care that costs more than the revenue reaped from a monthly per beneficiary per month payment (implicit to capitated

or global budget payment arrangements), the provider must bear the financial burden of providing those services (Murray, 2012).

Payment Reform in Vermont

Under Act 48, responsibility for provider payment reform policy rests with the Green Mountain Care Board (GMCB). The GMCB is responsible for approving, overseeing and evaluating payment reform pilots that test alternatives to fee-for-service payment. Act 48 made clear that these efforts should, to the greatest extent possible, include all payers (both public and private), reduce cost-shifting between the public and private sectors, be consistent with the Blueprint for Health and assure fair payment to health care providers (Act 48, 2011). It is therefore critical that the Department of Vermont Health Access, which oversees the Blueprint, also have a role in payment reform.

The GMCB has focused on three main types of reimbursement for testing payment reform pilots. These models are building blocks to achieve the ultimate goal of a population-based budget covering a broad array of health care services for most Vermonters. The three general models are:

- ***Bundled payments.*** These provide physicians, hospitals and, in some cases, post-acute providers such as rehabilitation facilities and nursing homes, a fixed payment for the total care of people with specific diagnoses or surgical procedures for a set period of time.
- ***Hospital/physician budgets.*** These provide a fixed amount of revenue for a given hospital and affiliated physicians based on historical utilization and expenditure patterns. A global budget contains strong financial incentives to reduce hospital utilization, and to better manage costs.
- ***Population-based global payments.*** These provide revenue to integrated delivery systems on a per capita basis and are designed to cover the broadest possible array of inpatient, outpatient and physician services to a defined population in a specific geographic area

Because of the varying nature of the pilots, providers will assume different amounts of risk, related in part to their ability to manage that risk. Population-based payments involve the greatest degree of risk, and therefore require the greatest amount of capacity within the provider organization to spread and manage that risk. It should be noted that Fletcher Allen Health Care already engages in some contracting under a population-based payment model, and that activity is described in more detail below (Murray, 2012).

Emerging Payment Reform Models

Federal Payment Reform Models

The Affordable Care Act (ACA) allows the federal government to experiment with payment and delivery system reform to create savings for Medicare through Accountable Care Organizations (ACOs) (Iglehart, 2011). Federal ACOs are provider-led organizations that are accountable for the care of the patient population they serve. They are reimbursed based on their ability to improve health care quality of their patients and reduce costs. ACOs are designed to hold providers accountable for the full continuum of care for Medicare beneficiaries. This is an effort to shift payment policy in Medicare from paying on a fee-for-service basis to paying for value-based care. These programs are an opportunity for providers, purchasers and Medicare to improve patient outcomes while testing new reimbursement models and shared savings methods.

The federal ACO programs allow providers significant flexibility in how they are structured and how they operate, but they must also meet requirements laid out in the federal ACO regulation. In all federal ACOs, CMS bears the financial risk and ACOs are not required to maintain any reserves or reinsurance. However, ACOs do need to demonstrate an ability to repay CMS in the event they exceed targeted expenditures. This may include reinsurance, surety, bonds, a line of credit, or a withhold of a portion of any previous shared savings received (Department of Health and Human Services, 2011).

There are two types of federal ACOs: The Medicare Shared Savings Program (MSSP) and the Pioneer model (CMS Fact Sheet). The MSSP offers bonuses to ACOs that achieve their stated savings goals while the Pioneer model removes limits on rewards and risks after two years and allows provider organizations to receive population based payments and to assume financial risk for their patients' care (CMS Fact Sheet). The MSSP ACO does not bear financial risk because they will not provide care in return for a prepaid charge, like a capitated payment (Bernstein, Frohlich, LaPallo, Patel, & Thompson, 2011). Instead these ACOs will receive fee for service payments and additional payments if cost and quality targets are met. In the third year, Pioneer ACOs will continue to receive fee for service payments but at 50% of their regular rates. In addition, CMS will provide a per-beneficiary (PMPM) payment equal to the remainder of the ACOs projected fee-for-service revenue for its aligned beneficiaries. ACOs that are successful in managing utilization risk have a greater bonus potential under this model (Health Care Advisory Board, 2011).

The federal laws that govern these programs do not preempt state laws. Therefore, individual states must consider how ACOs should be regulated with regard to the amount of risk that providers will begin to assume (Bernstein, Frohlich, LaPallo, Patel, & Thompson, 2011). The chart below briefly describes the federal ACOs and compares them to a generic commercial or Medicaid ACO that may be developed:

ACO Models

The **MSSP ACO** is described in the proposed Rule and allows entities to enter into new contractual arrangements with CMS. There are two options for ACOs in this model: the first allows for shared savings in the first two years of the program and then shared savings and losses in the third year; the second requires shared savings and losses for all three years of the program. The minimum savings for the first track is based on the number of assigned beneficiaries and for the second track is 2%.

The **Pioneer ACO** is described in the Innovation Center announcement and allows entities to enter into contracts with CMS. There is one arrangement for this ACO: over the three years of the program, there are escalating shared savings and losses with a transition to population-based payment in the third year. The minimum savings is 1% over the duration of the program.

The **commercial or Medicaid ACO** is a catch-all for current pilot programs being undertaken across the U.S., which are designed to advance delivery system improvements in quality and efficiency through innovative payment arrangements.

Adapted from Bernstein, Frohlich, LaPallo, Patel, & Thompson, 2011.

Risk-Sharing Arrangements and Regulatory Approaches in Other States

ACOs and California's Knox-Keene Law

In California, the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene) states that any entity that assumes global financial risk for the provision of health care must obtain a license from the California Department of Managed Health Care (Bernstein, Frohlich, LaPallo, Patel, & Thompson, 2011). Knox-Keene regulates the financial stability of health plans, but does not regulate provider organizations or medical groups (Cubanski and Schauffler, 1999). The Act does not prescribe solvency requirements for medical groups or Independent Practice Associations (IPAs). However, health plans that have capitation or risk-sharing contracts with providers are required by Knox-Keene to ensure that providers have the capacity, both financially and administratively, to meet their contractual obligations (Cubanski and Schauffler, 1999).

In the late 1990s, the issue of provider risk caused California's Department of Managed Health Care (DMHC) to establish a Financial Solvency Standards Board. This board created standards

for provider organizations and regulated them by requiring that they report quarterly to the DMHC. An organization's failure to meet the financial solvency standards laid out by the board results in corrective action. Since the board was established, risk-bearing organizations have become more stable, in part because of regulations (Robinson and Dolan 2010).

The two federal ACO models do not necessarily meet the Knox-Keene test for regulation. The MSSP model does not receive, provide, or arrange for care in return for a capitated payment and is therefore exempt from Knox-Keene. The Pioneer ACO model appears to meet the test for regulation because it can receive a population-based prepayment for the care of its patients and thus resembles a health care service plan that receives, provides, and arranges for care. However, another argument can be made that the Pioneer ACO is simply receiving a cash advance for investing in care coordination efforts (Bernstein, Frohlich, LaPallo, Patel, & Thompson, 2011).

One example of how California is approaching new provider payment arrangements is HealthCare Partners:

- HealthCare Partners (HCP) and Anthem are developing a federal ACO to provide care coordination for 50,000 Anthem PPO members. HealthCare Partners is physician-owned and governed and has extensive experience taking on full risk capitation contracts. HCP does not have a Knox-Keene license and was exempted from obtaining one because of business agreements it has with health plans regulated by the California Department of Managed Care, the entity that issues Knox-Keene licenses (Van Citters, Larson, Carluzzo, Gbemudu, Kreindler, Wu, Shortell, Nelson, and Elliott S. Fisher, 2012).

Massachusetts Alternative Quality Contract

Blue Cross Blue Shield of Massachusetts (BCBSMA) introduced the Alternative Quality Contract (AQC) in 2009 (Chernew, Mechanic, Landon, Gelb-Safran, 2011). Under the AQC, provider groups become accountable for patient care over a specific time period. Provider groups receive a global payment for patient care and are eligible for bonuses if savings are achieved and quality targets are met (Song, Gelb-Safran, Landon, Ellis, Mechanic, Day, Chernew, 2011). The AQC includes inpatient, outpatient, pharmacy, behavioral health, and other services required by patients (Blue Cross Blue Shield of Massachusetts). The AQC contract is for a five-year time period and requires that physicians and hospitals budget for utilization over the life of the contract. Providers are allowed to share risk with BCBSMA, if they choose. However, providers can achieve more savings if they manage the risk themselves (Chernew, Mechanic, Landon, Gelb-Safran, 2011). BCBSMA requires all providers to carry reinsurance for high cost cases. The reinsurance must cover 70-90 percent of the cost if medical expenditures exceed a given threshold, for instance, \$100,000. A "unit cost corridor" is put in place to adjust the AQC budgets if BCBSMA negotiates considerably higher or lower fees with a network of providers than was projected at the start of the contract (Blue Cross Blue Shield of Massachusetts). The

Massachusetts Division of Insurance does not require AQC providers to file financial documentation or other information with the division for review.

Maryland: population based rate methodology

Similar to Vermont, Maryland has a rate-setting commission for its hospitals. The rate-setting commission reviews and approves annual hospital budgets and ensures that the institutions remain solvent, while lowering health care cost increases. In the early 1980s, Maryland developed the conceptual framework for a new methodology—the “Population Based Rate” (PBR) system—that is designed to allow the regulatory body in the state to establish budgets that are tied to identifiable populations for hospitals that have strong but not dominant market positions. PBR hospitals would be assigned aggregated Target Budgets that would cover the base year aggregate charges for included hospital services for all residents in that hospital’s core Service Area (as defined by the Maryland Commission). Thus, PBR hospitals are placed at-risk for any hospital cost incurred by residents of the core service area even if the services are provided by other hospitals. The “individual stop-loss” provisions and “aggregate stop-loss” provisions could be provided as appropriate to prevent PBR hospitals from bearing excessive risk. Maryland’s rate-setting commission monitors the financial health of these hospitals and does not require them to be regulated as insurance companies (Murray, 2012).

In 1980 Maryland introduced global budgets into their hospital regulatory structure. The basic characteristic of a global budget system is that a given hospital is assured a certain amount of revenue for a given budget year independent of the number of patients treated and the amount of services provided to those patients. The hospital has an incentive to reduce length of stay, reduce ancillary usage, improve efficiency in the production of services, develop care infrastructures that help prevent avoidable admissions and readmissions, and generally treat their patient population in the most economical way consistent with proper patient care (Murray, 2012).

The Maryland rate-setting commission oversees hospitals engaged in global budgets. As a result of this pre-existing regulatory relationship, Maryland is able to carefully monitor these hospitals and ensure they remain solvent and achieve quality and cost targets. These hospitals enter into a contract with the Maryland rate-setting commission (others?), which requires that they participate in an evaluation of the global budget (Murray, 2012).

The main purpose and advantage to Global Budgets (from a purchaser’s standpoint) is that it is effective in controlling the aggregate spending on a particular healthcare institution or groups of institutions across a geographic area. However, these budgets can be refined to enable the more flexible application of funds within the overall total. Global Budgets can also encourage changes to service delivery patterns and accommodate the inclusion of incentives to help health care providers transition their operations and management and reward appropriate clinical practice and high quality care (Murray, 2012).

Maryland: The Total Patient Revenue System

The Total Patient Revenue (TPR) system was initiated in Maryland in the early 1980s for rural hospitals that had highly discrete service areas—i.e., they were located a substantial distance from competitor hospitals. The TPR establishes fixed budgets for the TPR hospitals on a prospective basis by trending the prior year’s budgets of the hospitals forward using a trend factor that is meant to reflect hospital cost inflation. In the first years of the TPR arrangements, the trend factor is typically increased by “seed money” to account for limited volume increases. The TPR budgets make limited adjustments for case-mix changes and usually provide limited volume adjusters driven by underlying population changes. The TPR budgets have been adjusted in some instances for other costs (such as the impact of certificate of need projects) but these adjustments are ad hoc rather than mandated by the TPR agreements (Murray, 2012).

Under the TPR system, the budgets that are established are fixed based on the particular hospital’s previous revenues trended forward to the rate year. The TPR budgets are not tied to any particular population, such as the individuals who reside in the immediate service area of the TPR hospital or the individuals who are covered by primary care physicians (PCPs) who are affiliated with the TPR hospital. Instead, the TPR budgets cover all services that are provided by the hospitals during the rate year regardless of the source, geographic origin or primary care affiliations of the patients. In practice, most of the services provided by the TPR hospitals in any given year are delivered to local residents. However, the TPR hospitals also provide services to patients who live in other areas who use them on an elective or emergency basis. The TPR hospitals are not responsible for the cost of services that are provided by other hospitals, or by other health care providers—whether the services are routine or tertiary in nature—even when those services are provided to persons who are residents of the TPR hospital’s service area who obtained the same kinds of services from the TPR hospital in the past (Murray, 2012).

The TPR rate setting system provides strong financial incentives to hospitals to curb volume increases and to pursue volume decreases. In this way, it is compatible with and supportive of Primary Care Medical Home incentive models for PCPs. As noted, if a TPR hospital were to experience an overall volume decline, it would be permitted to raise its unit rates enough to recapture the lost revenue, but the unit rate increases would be spread across all payers. Therefore, even in circumstances where volume declines in total at a TPR hospital, those payers that experienced differentially large volume decreases would benefit from their reduced utilization level (Murray, 2012).

Vermont experience with capitated Payments

Vermont Managed Care (VMC) is a capitated reimbursement model centered primarily in and around the Chittenden County health service area. VMC is a physician hospital organization comprised of over 2,700 primary and specialty care providers and 10 hospitals that coordinates the delivery of health care services for approximately 47,000 people in our region. It does so by

contracting with managed care organizations on behalf of its network and accepting accountability for financial and quality outcomes. VMC received NCQA certification in 2009. It is a subsidiary of Fletcher Allen Health Care (Fletcher Allen Health Care, 2012).

VMC is similar to an ACO in that it contracts with payers to deliver services to a specific patient population. The Vermont Health Plan (TVHP), MVP and Fletcher Allen Partners are the three contracted payers in the VMC that bear the financial risk for this population. Pre-negotiated expenditure targets are established between the payers and VMC. The payers reimburse VMC on a fee for service basis based on claims submitted by the providers. VMC withholds a percent of those payments as a reserve in the event that targeted expenditures are exceeded. If the providers are able to keep their service expenditures below the negotiated target, then VMC distributes the withhold to the providers plus any savings below the expenditure target up to an agree upon percent. If the provider claims exceed the negotiated expenditure target, then a reserve fund is used to reimburse the payer. VMC is not obligated to pay more than the agreed upon withhold back to the payer. If expenditures exceed the amount in the reserve fund then the payers are responsible for that cost. This risk sharing arrangement creates corridors around financial risk and savings distribution to the providers (Fletcher Allen Health Care, 2012).

Physician Practice Models – Retainer-based Medicine

Some primary care physicians in Vermont and other states have begun providing so-called “concierge medicine,” whereby they agree to provide patients with ready access to a certain range of services in exchange for a set annual fee. Over the years, retainer medicine practices have evolved into various forms. Each model varies in the type of services offered and payments between patient and doctor. These practices are providers taking a fee to guarantee access; not providers bearing risk for patient utilization like the models discussed above. These arrangements do not fall under the same scrutiny as ACOs and other payment reforms. However, it is possible that some retainer-based physicians are providing a form of insurance, particularly those who have assumed a level of financial risk (capitation) in conjunction with their offered services.

Recommendations

Over the next several years, Vermont will be testing a variety of payment methods in our efforts to contain health care costs and change the delivery system to promote higher quality, more affordable health services for Vermonters. Providers will be taking different types of financial risk as they enter these new payment arrangements with payers. As these payment arrangements are actively in development, it is too soon to suggest specific statutory changes to Vermont’s insurance law.

In order to ensure that payment reform models appropriately take risk into account, they have to address patient attribution models and risk adjustment for the severity of illness in the patient served. Additionally, these models need to ensure there are enough patients in the risk pool and reinsurance is available to providers in these alternate payment arrangements. Finally, it is critical to evaluate patient access and quality.

As payment arrangements evolve to bear more financial risk, the state should carefully monitor providers and their ability to bear financial risk and remain solvent. It is critical for the state to ensure the stability of our providers, while also offering sufficient flexibility to allow for delivery system innovations and cost savings. Monitoring may include requiring reporting of financial information, consumer satisfaction and evaluating delivery of quality of care to ensure that the new reimbursement methods are achieving the goals laid out in Act 48.

The Green Mountain Care Board, the Department of Banking, Insurance, Securities and Health Care Administration and the Department of Vermont Health Access are committed to monitoring the various models under development and making recommendations in the future if we determine that there need to be any changes.

Appendix

Works Cited

- Averill, Richard F.; Goldfield Norbert I.; Hughes, John S; Eisenhandler, Jon; Vertrees, James C. Developing A Prospective Payment System Based on Episodes of Care. *Journal of Ambulatory Care Management*. 2009.Vol. 32, No. 3, pp. 241–251.
- Bernstein, W. S., Frohlich, J. P., LaPallo, F. J., Patel, A. R., & Thompson, M. J. (2011). *Accountable Care Organizations in California: Programmatic and Legal Considerations*. Manatt Health Solutions.
- Berry, E. (2012 , February 1). Oregon Requires Concierge Physicians to Register With Insurance Department. *American Medical News*, pp. <http://www.ama-assn.org/amednews/2012/01/30/bise0201.htm>.
- Blue Cross Blue Shield of Massachusetts. The Alternative Quality Contract: Year One Results. Available at: <http://www.bluecrossma.com/visitor/pdf/aqc-results-white-paper.pdf>
- Chernew, Michael E., Mechanic, Robert E., Landon, Bruce E., Gelb Safran., Dana. (2011). Private-Payer innovation in Massachusetts: The “Alternative Quality Contract”. *Health Affairs*. 30(1): 51-61.
- CMS Fact Sheet. (2011). Pioneer Accountable Care Organization Model: General Fact Sheet. *CMS Media Relations Group*.
- Cubinksi, Juliette and Helen H. Schauffler. (1999). A Risky Proposition? Risk Bearing and Solvency in California’s Medical Groups. *California Health Policy Roundtable Issue Brief*.
- Department of Health and Human Services. Centers Medicare and Medicaid Services. 42 CFR Part 425. Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations and Medicare Program: Waiver Designs in Connection With the Medicare Shared Savings Program and the Innovation Center; Proposed Rule and Notice. Accessed at: <http://edocket.access.gpo.gov/2011/pdf/2011-7880.pdf>
- Fletcher Allen Health Care and Vermont Managed Care. Direct communications with authors. March, 2012.

- Hargrave, E., Mahmud, A., Quirk, K., & Sumner, L. a. (2010). *Retainer-Based Physicians: Characteristics, Impact, and Policy Considerations*. Washington, DC: MedPac.
- Health Care Advisory Board. (2011). The Pioneer ACO Model. *The Advisory Board Company*. Accessed at: http://www.genesys.org/GRMCWeb.nsf/GHW_ACOModel.pdf
- Hirshfeld, E. (1996). Assuring the Solvency of Provider-Sponsored Organizations. *Health Affairs*, 28-30.
- Iglehart, John K. (2011). The ACO Regulations--Some answers, More Questions. *The New England Journal of Medicine*. E35-e37.
- Kreidler, M. (2011). *Direct Practices: Annual Report to the Legislature*. Washington State Office of the Insurance Commissioner.
- Levy, M. J. (2007). *Understanding the Issues Related to Concierge Medicine*. Kern Augustine Conroy & Schoppmann.
- Maryland Insurance, A. (2009). *Report on "Retainer" or "Boutique" or "Concierge" Medical Practices and the Business of Insurance*. MIA-2008-12-002: Maryland Insurance Administration.
- Murray, Robert. E-mail communications to authors. March 11, 2012.
- Knapp, Spencer and Dr. Barbara Walters. General Counsel, FAHC and Senior Medical Director, Dartmouth-Hitchcock).Email communications to authors. March, 2012.
- Portman, R. M. (2008). Concierge Medicine: Legal Issues, Ethical Dilemmas, and Policy Challenges. *Journal of Health & Life Sciences Law*, 1-38.
- Robinson, James C. and Emma L. Dolan. (2010). Accountable Care Organizations in California: Lessons for the National Debate on Delivery System Reform. *Integrated Healthcare Association*. 1-28.
- Song, Zirui., Gelb Safran, Dana., Landon, Bruce E., He, Yulei., Ellis, Randall., Mechanic, Robert., Day, Matthew., Chernew., Michael E. (2011). Health Care Spending and Quality in Year 1 of the Alternative Quality Contract. *The New England Journal of Medicine*. 365: 909-18.
- State of Vermont. (2011). No. 48 An Act Relating to a Universal and Unified Health System. Section 12. Montpelier, Vermont.
- Van Citters, Arrica D., Larson, Bridget K., Carluzzo, Kathleen L., Gbemudu, Josette N.,

Kreindler, Sara A., Wu, Frances M., Shortell, Stephen M., Nelson, Eugene C., and Elliott Fisher. (2012). Four Health Care Organizations Efforts to Improve Patient Care and Reduce Costs. *Commonwealth Fund*. Pub. 1571 Vol. 1.

Wallack, S. S. (2003). Realigning Incentives in Fee-For-Service Medicare. *Health Affairs*, 59-70.