Vermont: Accountable Care Organizations and the VT All-Payer ACO Model Agreement

Vermont House Committee on Health Care

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Overview

- Problem
- Platform
- Payers
- Providers
- People
- Program Performance

The Problem

Many problems can be identified and prioritized in health care. It is important to ask, *what problem are we trying to solve* with each intervention or policy initiative. Health care reform does not seek to solve a single problem. Different types of health care reform tackle different problems

Problem	Strategy	Intervention	Result
Increase access to insurance for people who need it most.	Remove known barriers to access. Eliminate adverse selection, i.e. lack of coverage for pre-existing conditions.	Change state or federal law to prohibit adverse selection. ACA eliminated adverse selection across all states in 2010.	Adverse selection is not allowed. People with serious illnesses are not discriminated against in purchasing insurance. Access is improved if coverage is affordable.
Reduce the rate of uninsured.	Require people to have health insurance or pay a tax.	Change state or federal law to require insurance. ACA created this mechanism, no longer enforced.	Reduced the rate of uninsured in tandem with other interventions.

The Problem

What problem is Vermont trying to solve with the Vermont All-Payer Accountable Care Organization Model Agreement?

Problem	Strategy	Intervention	Result
The cost of health care is too high and unsustainable.	Integrate care, move away from Fee for Service, and have providers take financial risk. Use model that ensures high quality service and focus on population health addressing cost.	Utilize a statewide ACO model with aligned programs across all major payers, Medicare, Medicaid, and commercial payers. Agreement signed in 2016.	Performance Year 1 of the agreement began 1/1/18. Aligned programs are running across all three payers with approximately 120,000 Vermonters.

Platform for Reform: How did VT Arrive at an ACO Model?

2010: Congress enacts Affordable Care Act:

- authorizes Medicaid and Medicare to test innovative payment and service delivery models that could be expected to reduce program expenditures while maintaining or improving the quality of beneficiaries' care, including Accountable Care Organizations.

2011: The Vermont Legislature enacts Act 48:

- creates the Green Mountain Care Board (GMCB)and requires it to regulate health care cost growth through Insurance Premium Rate Review, Hospital Budget Review, Certificate of Need Review;
- empowers GMCB to develop and implement payment and delivery system reforms with the goal of controlling the rate of growth in health care costs while maintaining or improving health care quality.

Platform for Reform: How did VT Arrive at an ACO Model?

2013: The federal government awards State Innovation Model (SIM) grants:

- grants awarded to six states, including Vermont;
- tests alternative payment models with an emphasis on multi-payer payment reforms.

2013: GMCB creates a multi-payer ACO Shared Savings Program (SSP) payment reform pilot:

- encourages networks of providers called Accountable Care Organizations (ACOs) in Vermont to join together and be held accountable for the quality and experience of care while reducing the rate of growth in health care spending.
- ACO and its network is allowed to keep a portion of the savings generated.
- Does not change payment, as Fee for Service continues and providers measure success or failure afterward.

Platform for Reform: How did VT Arrive at an ACO Model?

2015: The federal government develops a next generation ACO payment reform model:

- Changes payment model by offering monthly per-beneficiary-per-month (PBPM) payments to ACOs, who are responsible for paying providers;
- permits ACOs to accept higher levels of financial risk and reward than were previously available.

2015: Congress enacts the Medicare Access and CHIP Reauthorization Act (MACRA):

- changes status quo in Medicare significantly;
- moves the Medicare payment system towards incentive and performance-based payments;
- specifically, mandates that providers either take on risk based on quality performance in Fee for Service or join alternative payment models.

2015: The Vermont Legislature enacts Act 54:

- authorizes GMCB and the Secretary of Administration to explore an All-Payer Model (APM) - an alternative payment model in which Medicaid, Medicare, and commercial insurance pay for health care on a capitated basis facilitated through an ACO.

Platform for Reform: How did VT Arrive at an ACO Model?

2016: Vermont presents the All-Payer Model Term Sheet Proposal to the federal government, detailing the terms required by the State.

2016: The Vermont Legislature enacts Act 113:

- grants GMCB and the Agency of Administration (AOA) authority to enter into an APM agreement with the federal government consistent with the principles outlined in Act 48;
- confers GMCB substantial oversight responsibilities, including requirements for ACO certification and budget review.

2016: GMCB and AOA release a draft of the APM agreement followed by a series of public forums and Board meetings held in different regions of the State.

- the Governor's Office and GMCB receive numerous public comments and letters of support from health care providers, insurers, businesses and consumer advocates.

Platform for Reform: How did VT Arrive at an ACO Model?

2016: Vermont and the federal government enter into the All-Payer ACO Model Agreement. The Agreement provides for:

- protection of Medicare beneficiaries;
- enhanced benefits for Medicare beneficiaries attributed to ACOs;
- a six-year phased-in approach to implementation;
- meaningful measures and targets to support population health improvement;
- provider-led reform;
- Vermont-specific local control;
- preservation of successful Vermont reform programs;
- no financial penalties to the State or Providers should targets not be achieved;
- reasonable targets for limiting health care cost growth;
- addressing the payer differential between Medicaid and Medicare
- accountability of ACOs and oversight by the GMCB.

2016: Department of Vermont Health Access Issues RFP for Vermont Medicaid Next Generation (VMNG) ACO Program, offering all-inclusive population-based payments.

Platform for Reform: How did VT Arrive at an ACO Model?

- 2017: Department of Vermont Health Access Launches VMNG contract with OneCare Vermont
- 2017: GMCB adopts Rule 5.000 relating to oversight of ACOs.
- 2017: GMCB Approves OneCare Vermont Budget for All-Payer ACO program and sets Medicare rate of growth.

Platform for Reform: Accountable Care Organizations

How would I explain ACOs to my constituents?

Let the Kaiser Family Foundation help:

https://www.youtube.com/watch?v=oV5rxViCf9U

Platform for Reform: OneCare Vermont's ACO Model

- Broad network of providers **across the care continuum** allow for most appropriate care to keep Vermonters well.

- Statewide participation in an integrated network.

How are ACOs Doing?
Medicare Shared Savings Programs (MSSP) Track 1 vs. Advance Alternative Payment Models (2016 Results)

Track 1 SSP (First 4 Years)	Track 2 SSP (First 4 Years)	Track 3 SSP (First Year)	Next Generation ACO (First Year)
Track 1 ACOs had overall **net costs** to Medicare relative to their aggregate benchmark. However, Medicare savings were achieved on beneficiary services relative to benchmark, but total bonus payments to eligible MSSP ACOs exceeded these savings. **Nearly one third of MSSP ACOs achieved enough savings to receive Medicare shared savings payments in 2016.**	Track 2 ACOs, which comprise a small fraction of MSSP ACOs, achieved modest net savings relative to their aggregate benchmark in the first three years, but nearly doubled net savings between the third and fourth years. **All Track 2 ACOs achieved enough savings to receive Medicare shared savings payments in 2016.**	Track 3 ACOs, which comprise a small fraction of MSSP ACOs, achieved modest net savings relative to their aggregate benchmark in the first year. **Over half of Track 3 ACOs achieved enough savings to receive Medicare shared savings payments in 2016.**	Next Generation ACOs achieved $63 million in net Medicare savings overall relative to benchmark levels. These net savings incorporate discounted benchmarks. **Of 18 ACOs, 11 received shared Medicare savings and 7 owed Medicare due to 2016 spending results.**

Source: Kaiser Family Foundation Side-by-Side Comparison: Medicare Accountable Care Organization Models http://files.kff.org/attachment/Evidence-Link-Side-by-Side-ACOs-20171110

Payers: Why Would a Payer Want to Partner with an ACO?

- Promote value based payments, moving away from Fee for Service.
  - Hypothesis that it will be a more predictable and sustainable financial model
  - Share financial risk with providers
  - Creates financial incentives for quality and outcome based care
  - Give providers predictability that may help them make different choices and investments
  - Empowers providers to work together in new ways
  - Best chance to work across the care continuum
  - Long-term goal is to better allocate resources across care continuum

Providers: Why would a provider want to participate in an ACO?

The hypothesis is that this will provide predictability, sustainability, and flexibility.

Let's let the providers speak for themselves:

Brattleboro Memorial Hospital (2018 Hospital Budget Narrative)

- *Participating in the risk contracts mitigates the risk of Medicare Dependent Hospital and Low Volume reimbursement for 9 months of FY2018.*
- *Stabilize Medicare Funding for Attributed Lives*

Central Vermont Medical Center (2018 Hospital Budget Narrative)

- *As CVMC makes the shift from fee-for-service into the ACO environment, more emphasis is being placed on wellness and primary care*
- *By 2018, UVM Health Network will have 40% of its revenues under capitated payments--A tipping point*
- *Redirects resources from high-acuity settings (hospitals) into primary care and community services (OneCare Vermont's 2018 budget anticipates channeling $29.3 million into primary care and community providers)*

Providers:

Springfield Hospital (2018 Hospital Budget Presentation)

- *The major risk for a CH hospital in our situation is the cost report effect. You get more efficient, you get penalized. Last year we had to pay back, like, one and a half million dollars because our costs were down. It's kind of counterintuitive. You know, you want to be efficient, but efficiency isn't rewarded in this system. That's one of the reasons we're looking at the ACO. It kind of takes that off the board. You get supported for being efficient.*

Dr. Joe Haddock, Thomas Chittenden Health Center, Independent Primary Care Practice

The biggest risk to primary care is not to change the reimbursement program in this country," Haddock said. "So we see this as a change which might work, and it might not.

(McCullum, BFP, Leap of Faith, 11/3/17)

People: How will the ACO impact Vermonters?

- *The mechanics of this transformation are complicated even for the most advanced health policy thinkers. I find it useful to consider changes in health care policy as they relate to real Vermonters - and to a typical Emergency Department day.*

- *A young woman in the first trimester of her first pregnancy comes to the ER with abdominal pain, worried about a miscarriage. It's straightforward work getting an ultrasound and referring her to an obstetrician. But if I don't recognize that what she's really worried about is how her opioid dependence may affect her baby and her ability to be a mother, I will have done little to truly help her. If I can get her into a drug treatment program today that's integrated into her perinatal care, I will have moved the goal post closer toward a healthy mother raising a healthy child in our community.*

(Depman, Commentary, VTDigger, Treating the Whole Patient, 7/18/17)

Program Performance: How Act 113 of 2016 Created Accountability for ACOs and the All-Payer Model Agreement

- Establishes Criteria for Implementing All-Payer Value-Based Payment Model and Medicare Agreement Criteria
- Requires Certification of ACOs
- Requires Review, Modification, and Approval of ACO Budgets
- Required Medicaid advisory rate case for ACO Services (one time per 113, reinstated in Act 3 of 2017, Section 80)

Act 113 of 2016
Setting All-Payer Model/Medicare Agreement Criteria

- Consistent with the principles of health care reform established in Act 48 of 2011
- Preserves consumer protections, including not reducing Medicare covered services, not increasing Medicare patient cost sharing, and not altering Medicare appeals processes
- Allows providers to choose whether to participate in ACOs
- Allows Medicare patients to choose any Medicare-participating provider
- Includes outcomes measures for population health
- Continues to provide payments from Medicare directly to providers or ACOs

Accountable Care Organization Oversight: *Certification Criteria*

The GMCB must ensure that the ACO meets criteria in the following categories:

- Leadership and Governance
- Population Health Management and Care Coordination
- Performance Evaluation and Improvement
- Patient Protections and Support
- Solvency and Risk Management
- Provider Payments

Certification Criteria Assessment: Example

Rule 5.202: Governing Body

* See handout

Act 113 of 2016 ACO Budget Review Statutory Requirements

- (b) (1) The Green Mountain Care Board shall adopt rules pursuant to 3 V.S.A. chapter 25 to establish standards and processes for reviewing, modifying, and approving the budgets of ACOs with 10,000 or more attributed lives….In its review, the Board shall review and consider:
  - Character, competence, fiscal responsibility, and soundness of the ACO and its principals, including reports from professional review organizations
  - Arrangements with ACO's participating providers
  - How resources are allocated in the system
  - Expenditure analysis of previous, current, and future years
  - Integration of efforts with Blueprint for Health, community collaboratives and providers
  - Systemic investments to:
    - Strengthen primary care
    - Address social determinants of health
    - Address impacts of adverse childhood experiences (ACEs)
  - Solvency
  - Transparency

ACO Budget Review, Modification and Approval: Example Conditions from GMCB FY18 Accountable Care Organization Budget Order

- *A combined all-payer rate increase of less than 3%, after exclusion of Medicaid pricing changes;*
- *Ability to review OneCare's contracts with participating payers;*
- *Robust risk assumption, delegation, and mitigation strategy must be in place;*
- *Guaranteed funding for Medicare portion of SASH, Blueprint for Health, and Community Health Team payments;*
- *Investment of no less than 3.1% of overall budget in population health and primary care strengthening initiatives;*

ACO Budget Review and Approval: Example Conditions from GMCB FY18 Accountable Care Organization Budget Order

- *OneCare must submit a payment differential report describing how the Comprehensive Primary Care Payment Reform pilot's payment methodology compares to the reimbursement that hospitals provide to employed primary care. The report must also assess quality outcomes in the pilot compared to outside the pilot, and address the degree to which the pilot is or is not reducing administrative burden;*

- *Administrative Expenses must be appropriately allocated between Vermont and New York and may not exceed the amount budgeted by more than 1%;*

- *OneCare must consult with the Office of the Health Care Advocate to identify a grievance and appeals policy that applies to all enrollees, across payers; and*

- *OneCare must work in consultation with the GMCB to identify a pathway by which potential savings from this model will be returned to commercial rate payers*

- *Administrative expenses must not increase beyond ratio in budget submission*

Program Performance: How GMCB Operates the All-Payer Model

- Meeting federal requirements in collaboration with AHS
- Financial Reporting
- Quality Reporting

Operating the All-Payer Model: State/Federal Agreement Statewide Financial Targets

All-Payer Growth Target: a defined target for statewide per capita spending growth. This applies to spending on certain services across all payers.

The All-Payer Target: 3.5% compound annualized growth

- **Medicare Growth Target:** a defined target for per capita growth for Medicare beneficiaries. This applies to spending only on Medicare, as these deals must save federal dollars compared to the status quo.
  - **The Medicare Target: 0.2% below projected national Medicare growth**

- Performance is calculated over the 5-year agreement (2018-2022)
- Baseline year is 2017, growth is measured from 2017-2022
- Target growth rates are compared to actual Vermont spending growth
- During the agreement term, failure to be "on track" to meet these targets could require a corrective action plan
- Work underway with GMCB staff to develop quarterly and annual reports

GMCB Accountability for the All-Payer Model: State/Federal Agreement

State action on quality measures

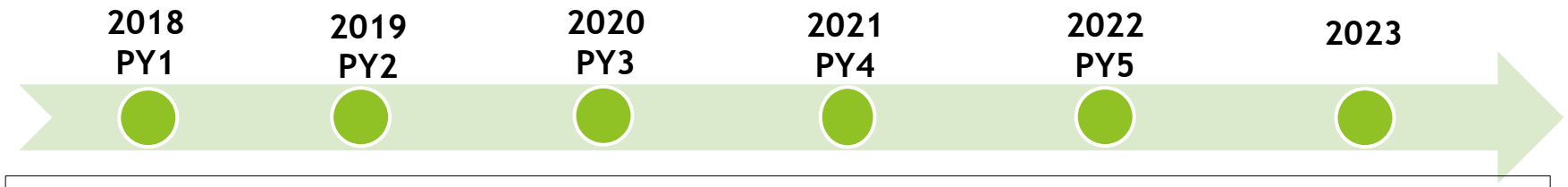
- Medicare ACO Benchmark must be tied to ACO-level quality measures included in participation agreement
- Requires quality and payment model alignment across Medicare, Medicaid, and

  participating Commercial payers

Goals for improving the health of Vermonters (20 indicators, including statewide and ACO-level)

- Improve access to primary care
- Reduce deaths due to suicide and drug overdose
- Reduce prevalence and morbidity of chronic disease

VT All-Payer ACO Model Agreement Reporting Timeline



Quarterly, starting in September 2018:
VT reports performance on All-Payer Total Cost of Care per Beneficiary Growth Target (TCOC) to CMS

Sept. 30- Annual TCOC Report

Annual ACO Scale Targets & Alignment Report

Sept. 30- Annual Quality Report

Dec. 31- Assessment of Payer Differential

Sept. 30- Annual TCOC Report

Annual ACO Scale Targets & Alignment Report

Public Health Accountability Framework

Sept. 30- Annual Quality Report

Dec. 31- Financing & delivery of Medicaid MH/SA and HCBS

Options to narrow Payer Differential

Sept. 30- Annual TCOC Report

Annual ACO Scale Targets & Alignment Report

Sept. 30- Annual Quality Report

Dec. 31- Optional proposal for subsequent 5-year Model (2023-2027)

Sept. 30- Annual TCOC Report

Annual ACO Scale Targets & Alignment Report

Sept. 30- Annual Quality Report

Sept. 30- Annual TCOC Report

Annual ACO Scale Targets & Alignment Report

Sept. 30- Annual Quality Report

Annual Reports are for prior year

Orange Font = One-time report

Common Questions 2018

Governance

- Are you concerned about ACO/OneCare ownership and governance? What protections does the State (DVHA and GMCB) have?

Resource Allocation

- How is the state allocating resources to facilitate the move to ACO based reform and the All-Payer Model?
- How will the APM shift financial risk in our health care system?
    - Will commercial insurers continue to bear more or less risk?
    - How will providers bear risk relative to OneCare?
    - How will GMCB assess the appropriate amount of risk?
    - Who is providing the capital/reserves for OneCare?

- How do we take cost out of the system when so much of it is fixed?
- Doesn't OneCare add an additional layer of management into an already complex system?
- Does this make it more challenging for DHVA/GMCB to alter the Medicaid and VHC programs?

Common Questions 2018

Care Model

- How is this model empowering primary care?
- Will an APM have an effect of alleviating the shortage of primary care in the state? How?
- How will the model expand across the care continuum? For example, how are DAs and Parent Child Centers incorporated in the ACO/capitation model?

Reporting

- The General Assembly mandated reporting from DHVA on "Year 0" of the APM. What reporting requirements should be relevant to the GMCB and the legislative oversight committees for Year 1 and beyond?

Provider Burden

- How will an APM/ACO streamline the quality measure overload that is overwhelming doctors and, some would say, interfering with the practice of medicine? It appears that the APM/ACO is increasing complexity and quality measures.

Further Resources Regarding Provider Interest in ACO: Articles, Opinion

- http://www.addisonindependent.com/201712community-forum-carrie-wulfman-vermont-healthcare-system-changing-better
- https://vtdigger.org/2017/10/12/fred-kniffin-payer-model-vermonts-best-kept-secret/
- https://vtdigger.org/2017/10/16/health-care-providers-see-a-future-around-one-big-table/
- https://www.washingtonpost.com/business/economy/experimental-program-in-vermont-pays-doctors-to-keep-patients-healthy/2017/09/17/ddb47cfe-9320-11e7-aace-04b862b2b3f3_story.html?utm_term=.96491e7d3e38
- http://www.burlingtonfreepress.com/story/news/local/vermont/2017/11/03/leap-faith-new-health-payment-system-expected-touch-122-000-vermonters/754968001/
- http://digital.vpr.net/post/779-million-experiment-looks-change-health-care-vermont#stream/0
- https://vtdigger.org/2017/07/18/mark-depman-treating-whole-patient/