



Green Mountain Care Board ACO Oversight

House Health Care Committee

January 25, 2018

Vermont All-Payer Accountable Care Organization Agreement and Regulation of Accountable Care Organizations in Vermont

- All-Payer Model Agreement: Flyover
- Green Mountain Care Board Accountability for All-Payer Model and Regulation of Vermont Accountable Care Organizations
- Major Milestones in 2017
- All-Payer Model and ACO Regulation Follow-Up: Potential Topics

All-Payer ACO Model: Flyover

The All-Payer Model enables the three main payers of health care in Vermont – Medicaid, Medicare, and commercial insurance – to pay an Accountable Care Organization (ACO) differently than through fee-for-service reimbursement.

- Sets an aggregate price for services, based on historical expenditures and rate of growth for the ACO
- Creates a more predictable revenue stream to support providers in initiating delivery system reforms that improve quality and reduce costs

Facilitated by state law and an agreement between the State and the Centers for Medicare and Medicaid Services (CMS) that allows Medicare to participate in a custom Vermont model that recognizes:

- Vermont's unique Medicare trends
- Vermont's aging population
- Statewide accountability for population health level outcomes

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 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.

The Medicare Target: 0.2% below projected national Medicare growth

- Performance on these targets 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 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

All-Payer Growth

Payer	Growth
Commercial	ACO
	FFS
Self-Insured	ACO
	FFS
Medicare	ACO
	FFS
Medicaid	ACO
	FFS

- All-Payer cost growth is a combination of every payer type.
- The All-Payer Target will counts Vermont residents **regardless of whether they are in an ACO.**
- It includes all spending, but payer types may have different growth rates for ACO and non-ACO populations.
- GMCB has regulatory influence over these different factors in different ways.

GMCB Regulatory Processes

Commercial Self Insured Medicare Medicaid

	Commercial	Self Insured	Medicare	Medicaid
Hospital Budget Review	X	X	X	X
Health Insurance Rate Review	X			
ACO Budget Review	X	X	X	X
Medicare ACO Rate Setting			X	
Medicaid Advisory ACO Rate Review				X

This includes all hospital spending: ~60% of APM TCOC

This affects small/nongroup: ~45% of all Commercial

These affect all ACO spending; relative weight will change as ACO gains scale

GMCB Accountability Per Act 113 of 2016: All-Payer Model and Accountable Care Organization (ACO) Oversight

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

2017 Major Milestones for All-Payer Model and ACO

Oversight:

We can have a follow-up slide highlighting Accomplishments in Each Activity Area? I will give an Example Using ACO Budget

1. Finalization of Rule 5.000 governing ACO Oversight
2. Completion of ACO Budget Review and Approval of Budget
3. Analysis, Vote, and CMMI Approval of Medicare rate of growth for ACO
4. Provisional ACO Certification

ACO Budget Review and Approval: Example Conditions

- 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

- 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

ACO Oversight and All-Payer Model Potential Topics for Follow-Up

1. Investments in Primary Care
2. Quality and Performance Measures
3. Consumer Protections
4. Financial Regulation through Hospital Budget and Insurance Premium Rate Review
5. Suggestions from the Committee?

Resource Section

Act 113 of 2016

All-Payer Model Criteria for Implementing a Value-Based Payment Model

- Alignment of payers
- Strengthens and invests in primary care
- Incorporates social determinants of health
- Includes process for integration of community-based providers
- Prioritizes use of existing local and regional clinical collaboratives
- Pursues an integrated approach to data collection, analysis, exchange
- Requires process and protocols for shared decision making
- Supports coordination of patient care and care transitions through use of technology
- Ensures consultation with the Health Care Advocate

Act 113 of 2016

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

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

Accountable Care Organization Oversight Certification Criteria

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

- Governance
- Care management and coordination
- Provider participation, payment, and collaboration
- Participation in health information exchanges
- Quality and performance measures
- Patient engagement and information sharing
- Consumer assistance, access, and freedom of provider choice
- Appropriate financial protections against potential losses

All Payer Model Implementation Reports

[Report of the GMCB Progress in Meeting All-Payer Model ACO Implementation Benchmarks \(June 15, 2017\)](#)

[Report of GMCB Progress in Meeting All-Payer Model ACO Model Implementation Benchmarks \(September 15, 2017\)](#)

[Report of GMCB Progress in Meeting All-Payer Model ACO Model Implementation Benchmarks \(December 15, 2017\)](#)

Resource Slides

[Annual Report](#)

[Legislative Reports](#)

[Insurance Rate Review](#)

[All-Payer Model Information](#)