VERMONT ALL-PAYER
ACCOUNTABLE CARE ORGANIZATION MODEL

SEPTEMBER 28, 2016

VERMONT
HEALTH CARE REFORM

VERMONT
GREEN MOUNTAIN CARE BOARD

Overview

Status of Agreements & Calendar of Events

What Problems Are We Trying to Fix?

Key Terms and Acronyms

All-Payer Model Draft Agreement

- State Action on Financial and Quality Targets
- Opportunity for Providers through an Accountable Care Organization
- Resources for Reform and the Global Commitment for Health Medicaid Waiver
- Why the Model is Good for Patients and Providers

Questions

Status of the Agreements

- All-Payer Model Draft Agreement
  - Vermont and CMMI have reached a ***draft, preliminary*** agreement on the concept and key terms.
  - The next step is a public process to determine if the state should sign the agreement.
  - The draft is currently under legal review by both the State and CMS. The language in the draft released today will change as part of the legal review. The concepts will not.
  - If agreed to, the Agreement would be signed by the Governor, the Secretary of Human Services, and the Chair of the GMCB, after a GMCB vote.

- Global Commitment Medicaid Waiver
  - AHS and CMCS have reached a verbal agreement on the terms of a waiver, but the complete, detailed, written terms and conditions are still in federal clearance at this time.

Calendar of Events

- Green Mountain Care Board Meetings – 89 Main Street, City Center, 2nd floor:
  - Thursday, Sept 29th 1 pm
  - Wednesday, Oct 5th 9 am
  - Thursday, Oct 13th 1 pm
- 3 Public Forums in the coming weeks, details coming shortly
  - Chittenden/Franklin area
  - Rutland area
  - Upper Valley area
- Information will be posted at gmcboard.vermont.gov and hcr.vermont.gov

What Problems Are We Trying To Fix?

- Increasing health care costs, rising faster than economic growth
  - In 2014, the most recent year of data available, health care spending in Vermont grew 4.6%.
  - In the same year, GSP grew only 2.4%.

- Health Outcomes Need to Improve
  - Vermonters struggle to access primary care.
  - Rate of deaths due to suicide and drug overdose are higher in Vermont than nationally.
  - Too many Vermonters suffer chronic disease, and everything that goes with it.

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Income Vs. Health Care Costs

	2015	2025
Income	$60,000	$73,140
Hourly Pay	$30	$36.57
Plan Cost/Hour	$11.52	$19.83
Plan Cost/Hour with Subsidy	$5.92	$8.81
Plan Cost per Year	$23,957	$41,253
Cost/Income	38%	56%

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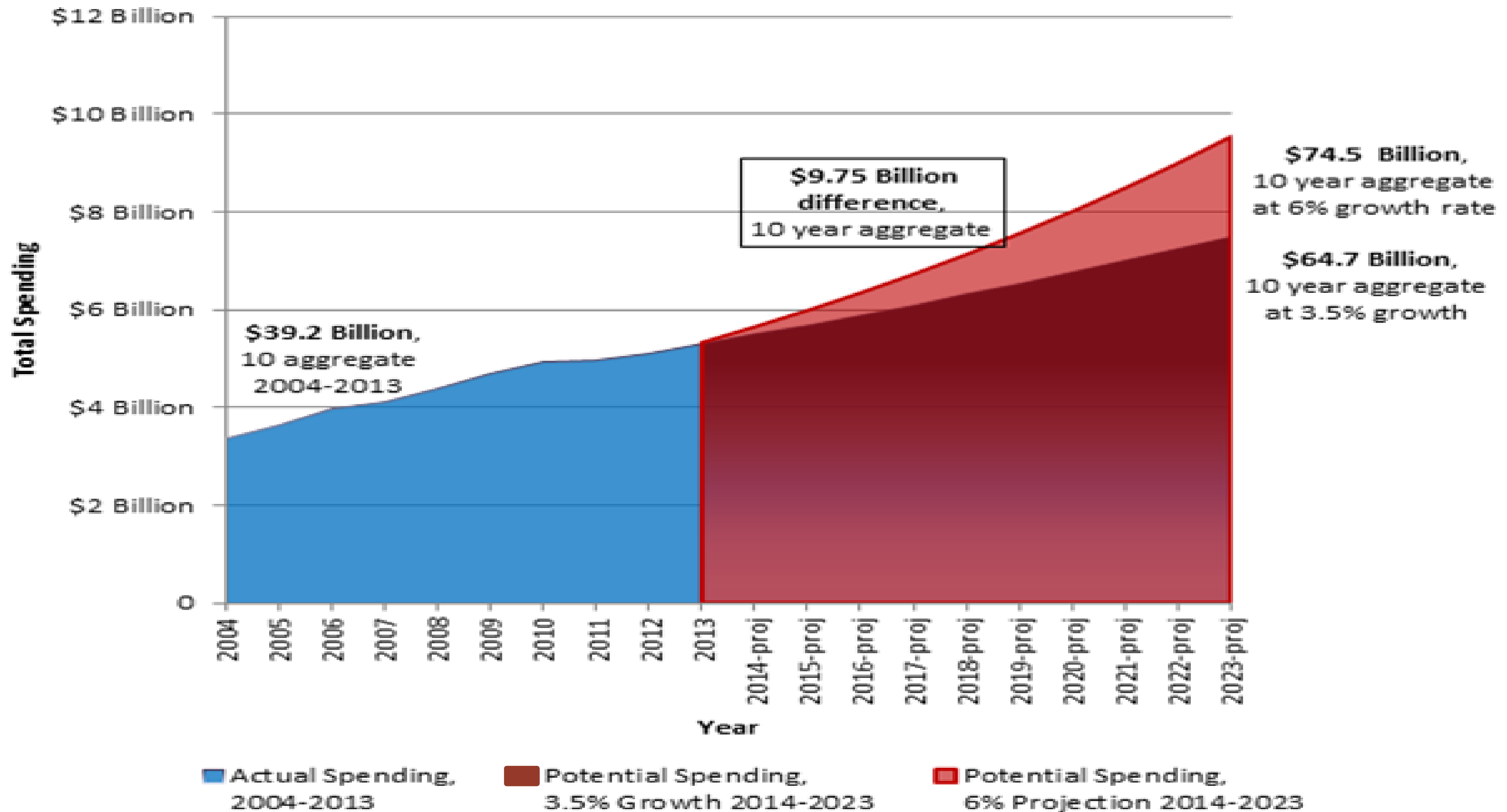
What problem are we trying to solve?



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Big Goal:

Integrated health system able to achieve the triple aim

- ✓ Improve patient experience of care
- ✓ Improve the health of populations
- ✓ Reduce per capita cost growth

All-Payer Model Agreement

- Vermont's potential contract with the federal government for how the All-Payer Model will be administered
- Provides framework to align payers
- Sets targets for quality and total cost of care expenditures

Global Commitment to Health 1115 Waiver

- Vermont's contract with the federal government for how Medicaid will be administered
- Provides framework to align Medicaid with other payers
- Financial and program flexibility to drive innovation

Key Terms & Acronyms

Accountable Care Organization or ACO: An entity, formed by certain health care providers and suppliers that accepts financial accountability for the overall quality and cost of medical care furnished to, and health of, beneficiaries attributed to the entity.

All-payer Total Cost of Care: The total expenditures associated with All-payer Financial Target Services (roughly equivalent to Medicare Parts A and B).

Medicare Part A (Hospital Insurance): Part A covers inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home health care.

Medicare Part B (Medical Insurance): Part B covers certain doctors' services, outpatient care, medical supplies, and preventive services.

Medicare Access and Children Health Insurance Program Reauthorization Act (MACRA) : a new federal law in 2015, which creates two payment reform programs for Medicare. These are: the Merit-Based Incentive Payment System (MIPS) and the Advanced Alternative Payment Models (AAPMs). MIPS and AAPM provides financial incentives for physician’s office who participate in payment reform or quality programs. There are financial disincentives for physicians who do not participate.

VT All-Payer ACO Model Draft Agreement: Framework for Transformation

- State action on financial trends & quality measures
  - Moves from volume-driven fee-for-service payment to a value-based, pre-paid model for Accountable Care Organizations (ACOs).
    - Sets All-Payer Growth Target: 3.5%
    - Medicare Growth Target: 0.1-0.2% below national
  - Requires alignment across Medicare, Medicaid, and participating Commercial payers.

- Goals for improving the health of Vermonters
  - Improve access to primary care.
  - Reduce deaths due to suicide and drug overdose.
  - Reduce prevalence and morbidity of chronic disease.

Opportunities for Providers Through an ACO

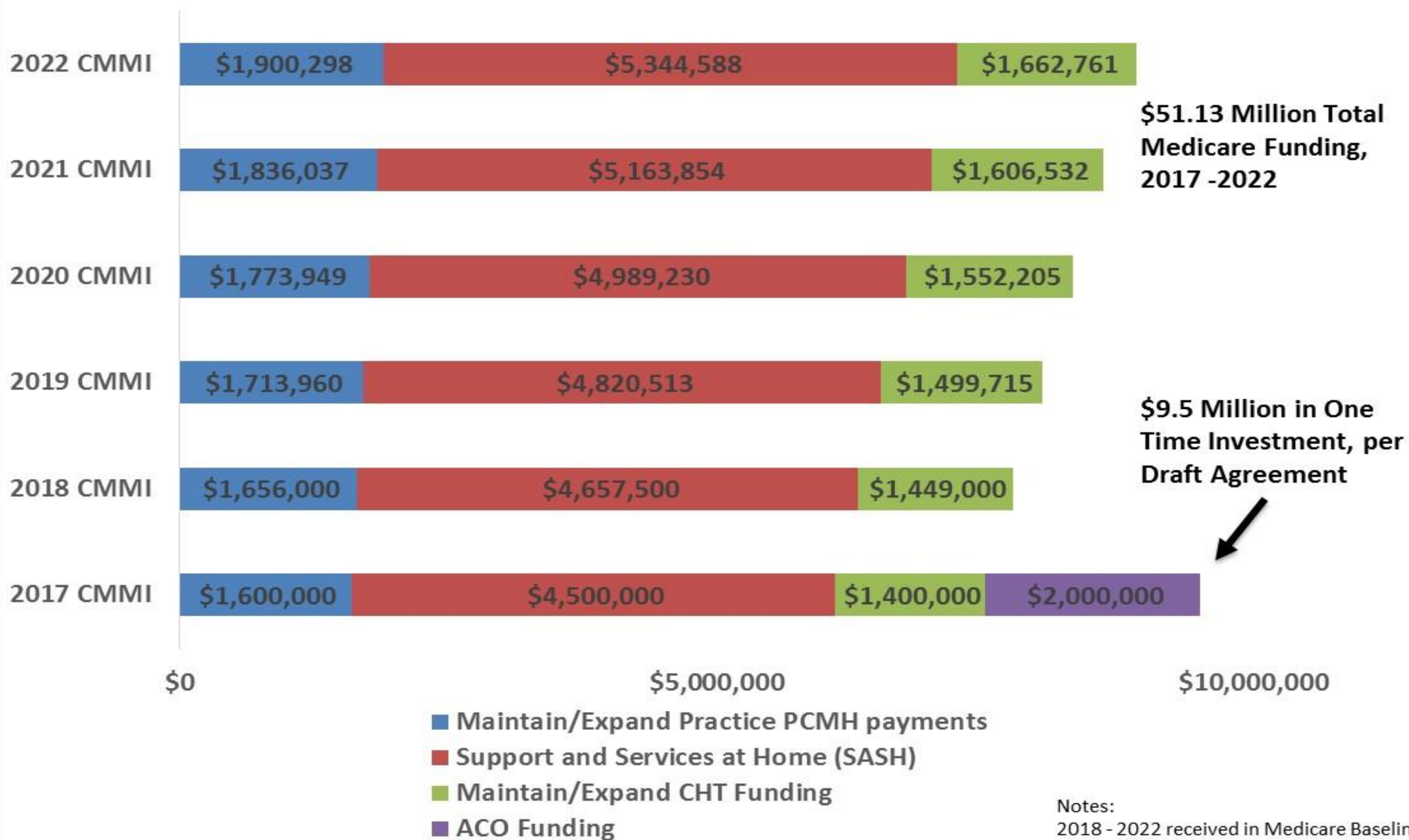
- Allows some providers to continue to participate in Medicare program without taking on risk.
  - Medicare Shared Savings Program

- Allows providers to earn incentive payments in Medicare's new payment model in a way that is consistent with the goals of the Secretary of Health and Human Services, yet customized to Vermont.
  - Medicare Next Generation-Style ACO Program
    - Vermont trend
    - Vermont quality measures
    - Full capitation (Pre-paid model)

- Medicaid Next Generation-Style ACO Program.
  - Aligned with Medicare

Resources for Reform

- Extends Medicare participation in the Blueprint for Health, Vermont's nationally recognized initiative transforming primary care.
- Continues federal Medicare funding for the Services and Supports at Home (SASH) program, which has a track record of saving money while keeping seniors in their homes and out of hospitals.
- Enables Vermont, through its Medicaid waiver, to support investments in the ACO and in community-based providers.
- Opportunity to use remaining State Innovation Model Grant to support transition.



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Vermont Proposed Medicaid Capacity for System Transformation

	2017	2018	2019	2020	2021	NEW WAIVER 2022	TOTAL
Advance Consumer Health Engagement	$ 1,000,000	$ 5,000,000	$ 4,000,000	$ 3,000,000	$ 3,000,000	$ 3,000,000	$ 19,000,000
Advanced Community Care/Case Management	$3,000,000	$ 5,000,000	$5,000,000	$ 4,000,000	$ 3,000,000	$2,000,000	$22,000,000
Community Primary and Secondary Prevention	$ 2,000,000	$ 7,000,000	$7,000,000	$ 5,000,000	$ 3,000,000	$ 3,000,000	$27,000,000
Information Infrastructure	$15,000,000	$ 9,000,000	$6,000,000	$ 4,000,000	$ 4,000,000	$4,000,000	$42,000,000
Community based services- Medicaid Pathway	$15,000,000	$ 12,000,000	$ 10,000,000	$ 8,000,000	$ 6,000,000	$ 4,000,000	$55,000,000
Quality and PHM Measurement and Improvement	$ 3,000,000	$ 8,000,000	$ 6,000,000	$ 4,000,000	$ 2,000,000	$ 0	$23,000,000
Socio-Economic Risk and Mitigation	$2,000,000	$ 5,000,000	$5,000,000	$ 4,000,000	$ 3,000,000	$2,000,000	$21,000,000
Total	**$41,000,000**	**$51,000,000**	**$43,000,000**	**$ 32,000,000**	**$ 24,000,000**	**$18,000,000**	**$209,000,000**

- These represent potential, proposed expenditures in Medicaid Programs, Administration and Technology that are under negotiation. All require some level of state dollars in order to draw down federal match.
- Spending would focus on building AHS, GMCB, community service provider, and ACO capacity for reform.

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How the 1115 Waiver Drives an Integrated Health System

- Allows Vermont Medicaid to design an ACO payment model that aligns with Next Generation.
- Gives Vermont flexibility to design alternative payment models for services that will be integrated into the model over time.
- Provides opportunity for Vermont to draw down federal funding to support the transformation of Vermont's the health care system.
- Positions Vermont to take a "one model" approach across federal payers.
- CMCS and Vermont are aligned conceptually; however, negotiations are not yet complete.

Why is this Good for Patients?

- Preserves all current beneficiary protections consistent with Medicare, Medicaid, or a Vermonter's commercial coverage plan.
- Medicare offers the opportunity, through an ACO, to receive benefit enhancements:
  - Post-discharge home visit
  - Easier access to Skilled Nursing Care
  - Telemedicine Services
- Encourages health care providers to better coordinate patient care and services.
- May lead to more meaningful time spent with your doctor.
- Links health care outcomes for the population meaningfully with the health care delivery system
- Creates a coordinated public/private approach to improving access to primary care, mental health, and substance abuse services.

VT All-Payer ACO Model Draft Agreement: Beneficiary Protections

- Medicare and Medicaid beneficiaries keep all their current benefits, covered services, and choice of providers, and an ACO cannot narrow their networks.

- Protects Vermonters with private insurance, with care decisions and provider choice remaining a matter between Vermonters and their insurers.

Why is this Good for Providers?

- Participation is by choice.
- Removes barriers to practicing in an integrated, coordinated care delivery system.
- Rewards providers for delivering high quality care.
- Rewards providers for improving health outcomes.
- Potential to provide more meaningful time with patients.
- Payment change across all payers may lead to administrative efficiencies.
- Maintains Medicare participation in proven programs to support providers in delivering comprehensive wrap-around care: Blueprint for Health, SASH.
- Creates path to maximize quality performance and reimbursement under new Medicare payment models (MACRA/MIPS).
- Offers participation in a unified, statewide system of care with shared cost moderation and quality improvement goals.

Questions?