Health Care Payment and Delivery System Reform in Vermont

January 17, 2023

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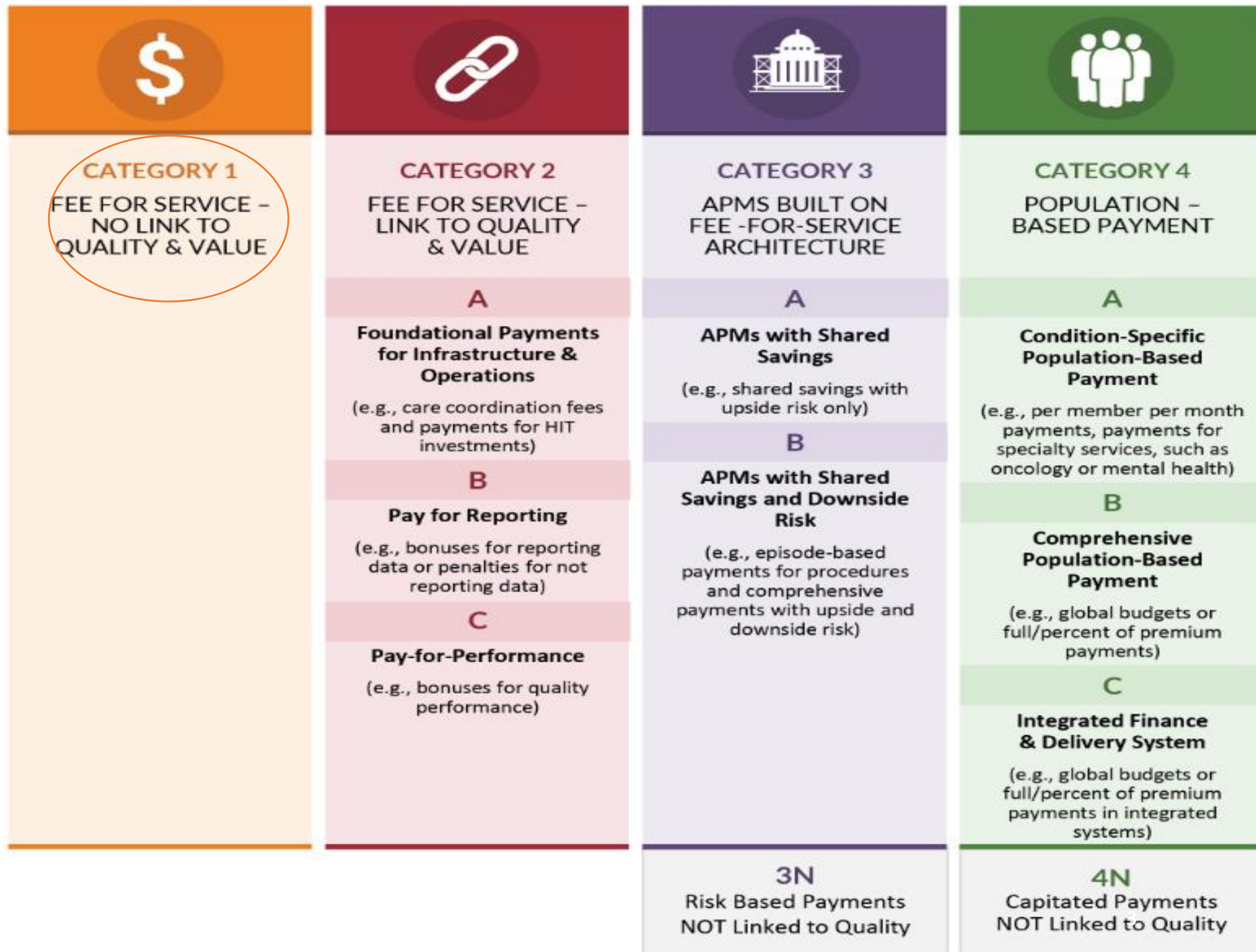
Presentation Outline

- What is Health Care Payment and Delivery Reform and What Problem is it Trying to Solve?
- High-level Timeline of Vermont's Health Care Payment and Delivery System Reform Efforts
- Vermont All-Payer Accountable Care Organization Model Agreement
  - Overview
  - Implementation Improvement Plan

What is Health Care Payment and Delivery System Reform and What Problem is it Trying to Solve?

The predominant fee-for-service reimbursement model for health care provides payment, regardless of quality and value; this methodology creates incentives to deliver more high price health care services.



Why pay differently than Fee-for-Service?

Fee-for-Service

- Each medical service generates a fee
  - Unnecessary services may be provided
- Services that promote health may not be covered
  - phone consultations, time spent making referrals

Population-Based Payments

- Providers receive a monthly amount to cover the health care services for their patients
- Delivering more services that promote health increases system efficiency

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Vermont’s Health Care Payment and Delivery System Reform Efforts

Vermont has successfully partnered with CMS on a series of payment and delivery system reform initiatives that have led to positive outcomes for CMS, Vermont, and the State’s residents.

2011: Green Mountain Care Board

2014-2016: Commercial & Medicaid ACO Shared Savings Programs

- Spending growth slowed for ACO-attributed beneficiaries (savings of **$39.92 PBPM**)
- PBPM expenditures increased less among ACO-attributed beneficiaries with MH/SUD conditions

Source: SIM Evaluation

2023+: Implementation of ***Medicaid*** global budget pilot

Iterative change

Iterative change

Iterative change

Iterative change

2008 - present: Blueprint for Health

- **$82M** saved in Medicare (net of $64M)
- Improved continuity of care, decreased specialist visits, reduced readmissions

Source: MAPCP Evaluation

2016 - present: Vermont All-Payer ACO Model

- Over first three PYs, 6.0 percent (**$655 PBPY**) and 6.8 percent (**$783 PBPY**) decreases in cumulative gross spending at the ACO and state levels, respectively

Source: VTAPM Evaluation

2025+: Future model where Vermont aims to shift more dollars into prospective payment while stabilizing its rural health care system.

Vermont All-Payer Accountable Care Organization (AC0) Model Agreement

- A contract between the State of Vermont and the Federal Government (Center for Medicare and Medicaid Innovation)

- Enables Medicare to join Medicaid and commercial payers in an aligned model to pay ACOs in Vermont differently than fee-for-service
  - services
  - quality measures
  - payment mechanisms
  - risk arrangements

- A cost growth moderation and quality improvement model, not a coverage expansion model.

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Vermont All-Payer ACO Model Agreement Cont.

- Three signatories:
  - Governor
  - Agency of Human Services Secretary
  - Green Mountain Care Board Chair

- Originally Executed in October 2016
- One Year Extension Executed November 2022

Vermont All-Payer ACO Model Agreement Timeline

Original Agreement Term

Agreement Extension

State's Option for Additional Extension Year

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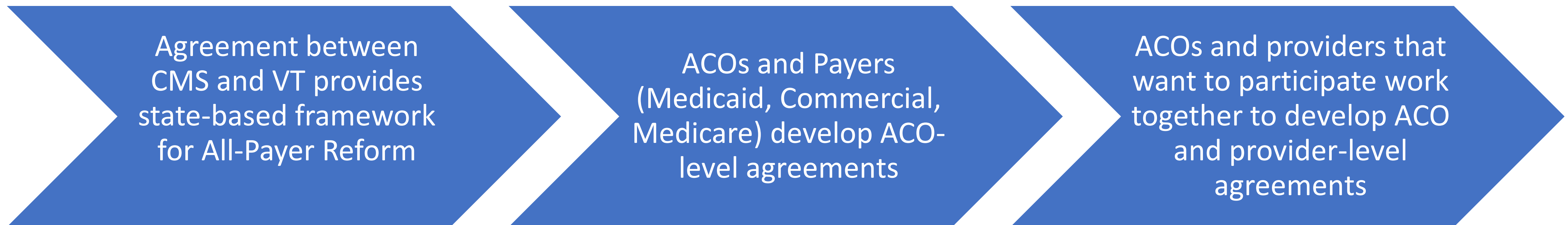
What are Accountable Care Organizations?

- **Accountable Care Organizations (ACOs)** are composed of and led by health care providers who have agreed to be accountable for the cost and quality of care for a defined population. These providers share governance and work together to provide coordinated, comprehensive care for their patients.

- Under the All-Payer ACO Model, ACOs are the organizations that can accept alternatives to fee-for-service payment (prospective payment, capitation, budget, full-risk) Vermont has one ACO certified by the Green Mountain Care Board: OneCare Vermont.



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All-Payer ACO Model Agreement

What is Vermont responsible for?

State Action on Financial Trends	State/Provider Action on Quality Measures
• All-Payer Growth Target: Compounded annualized growth rate <3.5% • Medicare Growth Target: 0.2% below national projections • Requires alignment across payers, to strengthen incentives and business case for transformation	• State is responsible for performance on **20 quality measures** *(see next slide)*, including three population health goals for Vermont ✓ Improve access to primary care ✓ Reduce deaths due to suicide and drug overdose ✓ Reduce prevalence and morbidity of chronic disease • ACO/providers are responsible for meeting quality measures embedded in contracts with payers

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Core components and goals of Vermont's All-Payer ACO Model

A Statewide Move Away from Fee-for-Service

All-Payer and Medicare Total Cost of Care Targets

Attribute majority of residents by model end (PY5/2022)

Limit per Capita Health Care Expenditure Growth

(Roughly equivalent to Medicare A & B services)

Improve population health outcomes:

1. Increase access to primary care
2. Decrease deaths due to drug overdose and suicide
3. Reduce prevalence and morbidity of chronic disease

Align Significant Payer Programs for ACOs in Value-Based Model

- Medicare
- Medicaid
- Commercial Payers

Build on Blueprint for Health Foundation for Primary and Community-Based Care

Research, co-design, and implementation of health care payment and delivery models

Advanced Primary and Community-Based Care

Patient Centered Medical Homes

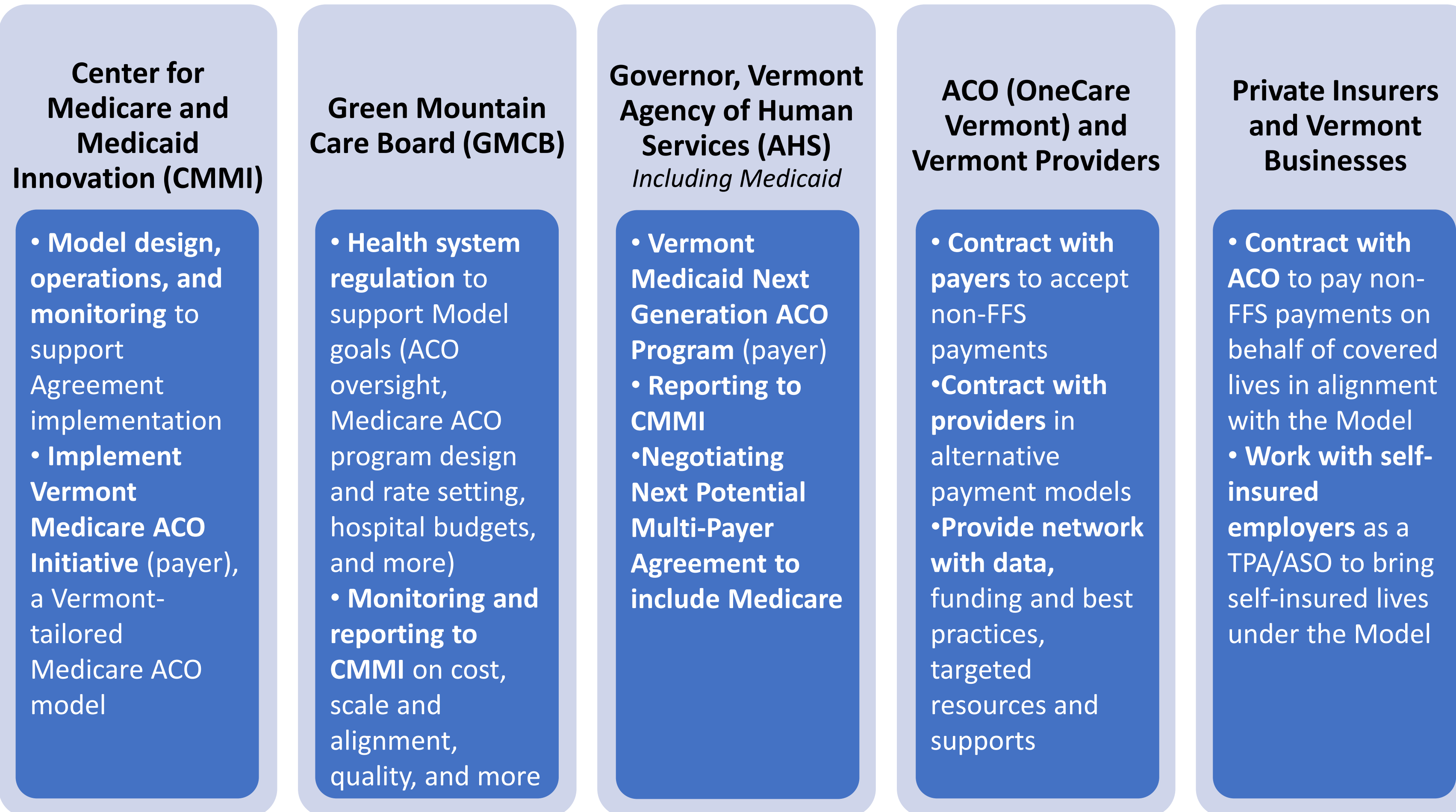
Community Health Teams

Hub and Spoke Program for Opioid Use Disorder

Women's Health Initiative (WHI)

Quality improvement facilitation, learning collaboratives, data-informed transformation

Vermont All-Payer ACO Model Partners



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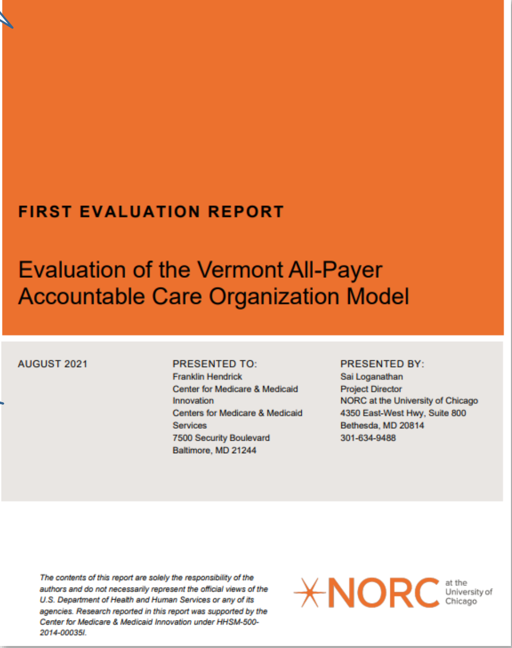
Vermont All-Payer ACO Model Evaluation Reports

“The VTAPM Medicare ACO initiative achieved statistically significant gross spending reductions in total Medicare Parts A & B spending over PY1 (2018) and PY2 (2019), totaling $607.05 per beneficiary per year (PBPY) (-5.5 percent), largely due to gross spending reductions in PY2.”

“In PY2 (2019), we observed decreases of 17.9 percent and 14.7 percent for acute care stays and acute care days, respectively, as well as a 7.7 percent decline in Specialty Evaluation and Management (E&M) visits for the Medicare ACO initiative.”



FIRST EVALUATION REPORT

Evaluation of the Vermont All-Payer Accountable Care Organization Model

AUGUST 2021

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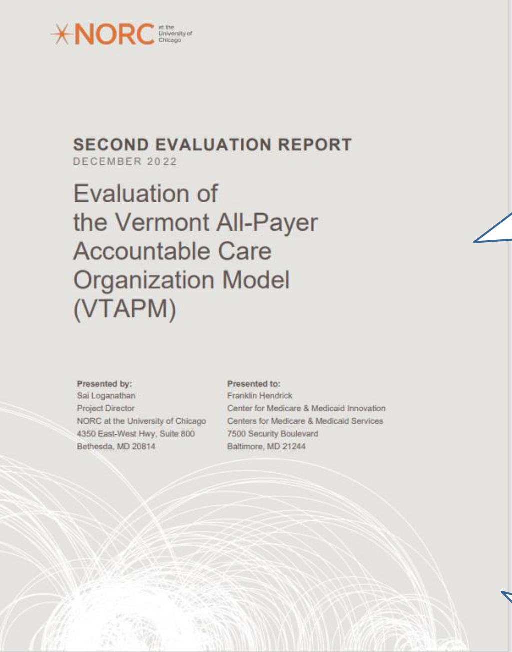
The contents of this report are solely the responsibility of the authors and do not necessarily represent the official views of the U.S. Department of Health and Human Services or any of its agencies. Research reported in this report was supported by the Center for Medicare & Medicaid Innovation under HHSM-500-2014-00035I.

NORC at the University of Chicago



NORC at the University of Chicago

SECOND EVALUATION REPORT

DECEMBER 2022

Evaluation of the Vermont All-Payer Accountable Care Organization Model (VTAPM)

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“Impact estimates for PY3 should be interpreted with caution. For outcomes that are relatively rare (e.g., post-acute care outcomes), the small sample size will increase uncertainty around the impact estimates. Due to the complexity of the factors impacting care utilization and care-seeking behavior in PY3 in Vermont [cyberattack] and across the United States [covid-19], we are generally unable to identify clear drivers of improvements or declines in performance.”

“The Model maintained statewide chronic disease prevalence (chronic obstructive pulmonary disease, diabetes, hypertension); increased the Model population’s initiation and engagement of treatment for alcohol and other drug dependence and timely follow-up after ED discharge; and almost halved the percentage of Medicare beneficiaries with diabetes experiencing poor HbA1c control.”

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All-Payer ACO Model Implementation Improvement Plan

The Agency of Human Services issued a plan in November 2020 for improving performance in the All-Payer Agreement.

The plan has four key categories of recommendations:

1. State/Federal work to maximize Agreement framework
2. Reorganization and prioritization of health reform activities within the Agency of Human Services
3. Evolving the regulatory framework for value-based payments
4. Strengthening ACO Leadership Strategy

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Report Rec. Number	Activity: Federal/state Partnership	Timing*	Lead (s)	Agreement Domain Impact
1.	Negotiate with CMS to revise scale targets to reflect realistic capacity for participation.	Short-Term	AHS, GMCB	Scale, Financial, Quality
2.	Reduce Medicare risk corridor thresholds and decrease the financial burden of participation for hospitals.	Short-Term	AHS, GMCB	Scale, Financial, Quality
3.	Request that CMS establish written guidance or best practices in cost reporting for CAHs. GMCB should disseminate any guidance.	Short-Term	GMCB, AHS	Scale, Financial, Quality
4.	Establish a path for the Medicare payment model to mirror Vermont Medicaid Next Generation fixed prospective payments.	Short/Medium-Term	GMCB, AHS	Scale, Financial, Quality
5.	Ensure Medicare 2021 benchmark provides as much stability and predictability as possible despite the ongoing uncertainty associated with the pandemic.	Short-Term	AHS, GMCB	Scale, Financial, Quality
6.	Collaborate with CMMI to encourage Health Resources and Services Administration to prioritize Value-Based Payment for Federally Qualified Health Centers	Longer Term	AHS, GMCB	Scale, Financial, Quality

*Short Term= 2020, 2021; Medium Term = 2022; Longer Term = 2022 and Beyond

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Report Rec. #	Activity: AHS Prioritization and Reorganization	Timing	Lead (s)	Agreement Domain Impact
7.	AHS and the Agency of Administration will conduct education and outreach to non-participating self-funded groups about the benefits of participating in value-based payment models and Include State Employee Health Plan members for attribution to OneCare Vermont in 2021 (PY4).	Short/ Medium-Term	AHS	Scale Financial Quality
11.	Prioritize the integration of claims and clinical data in the HIE and organize and align the HIE with the Office of Health Care Reform within the AHS Secretary's office. Coordinate with the HIE Steering Committee.	Short/ Medium-Term	AHS	Quality Financial Scale
12.	Partner with OneCare Vermont and delivery system users to evaluate efficacy of Care Navigator platform.	Short/Medium-Term	AHS	Quality Financial
14.	Taking a phased approach, AHS will condition provider participation in the Blueprint for Health PCMH payments on participation in value-based payment arrangement with an ACO.	Longer Term	AHS	Financial Scale
15.	AHS, OneCare Vermont, and community providers should improve collaboration to strengthen integrated primary, specialty, and community-based care models for people with complex medical needs and medical and social needs. Organize VCCI and Blueprint for Health in Office of Health Reform in Secretary's Office.	Short-Longer Term	AHS	Quality Financial
16.	AHS, OneCare Vermont, and community provider partners should identify a timeline and milestones for incorporating social determinants of health screening into the standard of care in health and human services settings.	Short-Term	AHS	Quality Financial Scale
17.	AHS, through the Blueprint for Health, will jointly explore with OneCare Vermont and stakeholders the best available tools for capturing real-time patient feedback and to pilot such a methodology with willing primary care practices.	Longer Term	AHS	Quality
18.	AHS and the GMCB will prioritize regular stakeholder engagement opportunities.	Short-Term	AHS	Quality Financial Scale

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Report Rec. Number	Activity: Regulation	Timing	Lead (s)	Agreement Domain Impact
8.	The GMCB and AHS will request that BCBSVT, MVP, and OneCare Vermont identify clear milestones for including fixed prospective payments in contract model design.	Short/ Medium-Term	GMCB AHS	Financial
9.	Under authorities over both ACO and Hospital budgets, the GMCB should explore how ACO participants can move incrementally towards value-based incentives with the providers they employ.	Longer Term	GMCB	Financial Quality
10.	Annually, in its budget presentation to the Green Mountain Care Board, OneCare Vermont should identify cost growth drivers across its network and detail its approaches to curb spending growth and improve quality.	Short-Term	GMCB	Quality Financial Scale

Report Rec. #	Activity: Strengthening ACO Leadership Strategy	Timing	Lead (s)	Agreement Domain Impact
13.	OneCare Vermont should elevate data as value-added product for its network participants and support providers in leveraging the information for change.	Short/ Medium-Term	OneCare Vermont	Quality Financial Scale
Section II	Focus on entrepreneurship; how can an ACO ease providers' transition to value-based payment and delivery system redesign?	Short-Term	OneCare Vermont	Scale, Financial, Quality
Section II	Identify and perfect core business	Short-Term	OneCare Vermont	Scale, Financial, Quality
Section II	Provide useful, actionable information and tools to participating providers. OneCare should improve how it packages data for providers.	Short/ Medium Term	OneCare Vermont	Scale, Financial, Quality
Section II	Foster a culture of continuous improvement, innovation, and learning through focus on data, systems for improvement, and tracking of results.	Short-Term	OneCare Vermont	Scale, Financial, Quality
Section II	Improve transparency and responsiveness to partner requests for information.	Short-Term	OneCare Vermont	Scale Financial Quality

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