Overview of Vermont's All-Payer Accountable Care Organization Model

House Committee on Health Care

January 20, 2016

VERMONT
GREEN MOUNTAIN CARE BOARD

Context: Vermont's Significant Payment & Delivery System Reform Efforts

(1) The Blueprint for Health – Vermont's advanced primary care program, an integrated model of patient-centered medical homes and community health teams

- Initiated in 2008 in pilot health service areas (HSAs)
- Statewide implementation in all 14 HSAs in 2012
- Part of the Center for Medicare and Medicaid Innovation's Multi-Payer Advanced Primary Care Practice demonstration
- Quality results from claims and clinical data regularly reported to each HSA and practice, and selected quality measures impact payment levels

Significant Payment & Delivery System Reform Efforts (cont'd)

(2) Commercial and Medicaid ACO Shared Savings Programs

- Built on Medicare Shared Savings Program; supported by SIM Testing Grant
- Initiated in 2014 by Medicaid, Blue Cross Blue Shield of Vermont, and three Accountable Care Organizations (ACOs) in Vermont

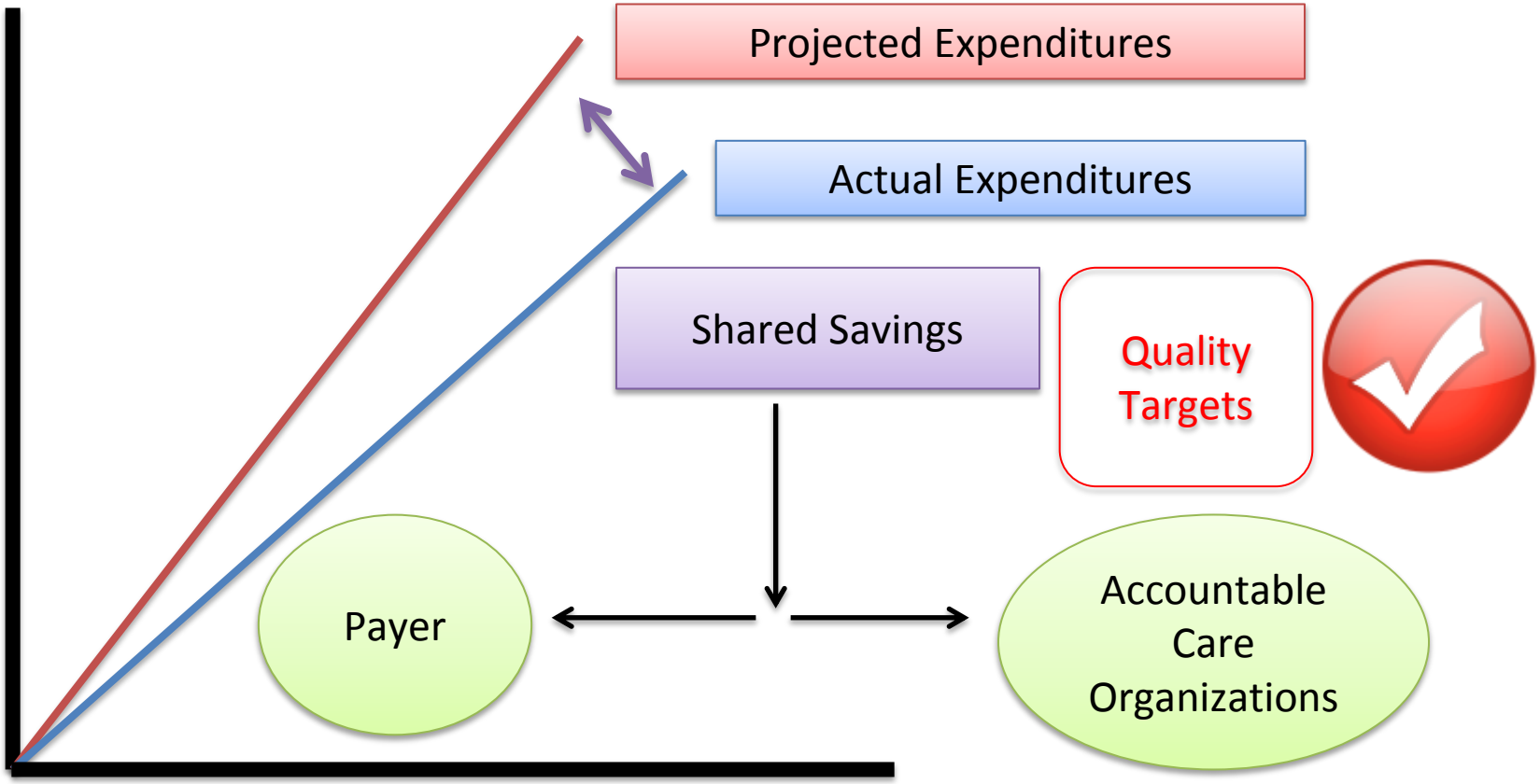
What are Accountable Care Organizations and Shared Savings Programs?

- Accountable Care Organizations (ACOs) are composed of and led by health care providers who have agreed to work together and be accountable for the cost and quality of care for a defined population

- Shared Savings Programs (SSPs), precursors to the All-Payer Model, are payment reform initiatives developed by health care payers. SSPs are offered to providers (e.g., ACOs) who agree to participate with the payers to:
  - Promote accountability for a defined population
  - Coordinate care
  - Encourage investment in infrastructure and care processes
  - Share a percentage of savings realized as a result of their efforts

- Participation in ACOs and SSPs is voluntary

Shared Savings Calculated Annually



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Significant Payment & Delivery System Reform Efforts (cont'd)

(3) All-Payer ACO Model

- In October 2016, Vermont signed Agreement with CMS to pursue All-Payer ACO Model
- Model would enable the three main payers of health care in Vermont – Medicaid, Medicare, and commercial insurance – to pay ACO differently than through fee-for-service reimbursement.
- Quality framework includes goals for improving the health of Vermonters

All-Payer ACO Model: What Is It?

- 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.
  - Facilitated by state law and an agreement between the State and the Centers for Medicare and Medicaid Services (CMS) that allows Medicare's participation
  - All payers pay providers using the same payment methodology

- Provides opportunity to improve health care delivery to Vermonters, changing the emphasis from seeing patients more routinely for episodic illness to providing longitudinal and preventive care.

What does health care look like with Fee-for-Service Payment vs. Value-Based Capitation-Style Payment?

Fee-for-Service

- Each medical service generates a fee
  - Could lead to duplicative services
- Services that promote health may not be covered
  - Phone consultations, time spent coordinating care

Value-Based Capitation-Style Payment

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

Vermont's Foundation for Implementing an All-Payer ACO Model

- Act 48 of 2011 established the GMCB and emphasizes cost containment and quality improvement on a multi-payer basis.
- The GMCB has payment reform pilot authority and successfully implemented ACO Shared Savings Program (SSP) pilot beginning in 2014.
- The SSP pilot established participation standards, developed with a stakeholder coalition, that could serve as a foundation for the All-Payer ACO Model.
- Vermont has a long-standing Medicaid 1115 waiver, with flexibility to pursue payment reform.

Act 113 of 2016
All-Payer Model Agreement Criteria

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

All-Payer ACO Model Agreement: First Step in a Multi-Step Process

Agreement signed in October 2016 is the first of 3 steps in creating an All-Payer ACO Model:

- **Step 1:** Agreement between CMS and VT provides an opportunity for private-sector, provider-led reform in VT
- **Step 2:** ACOs and payers (Medicaid, Medicare, Commercial) work together to develop ACO-level agreements
- **Step 3:** ACOs and providers that want to participate work together to develop provider-level agreements

What Does All-Payer ACO Model Implementation Look Like?

- ACOs and Payers (including Medicaid) are responsible for ACO Development and Implementation:
  - Establishing ACO Initiatives through ACO/Payer agreements (including financial incentives and linkage to ACO quality)
  - Developing analytic and reporting capacity
  - Implementing payment mechanisms
- ACOs and Providers are responsible for Delivery System Implementation:
  - Establishing ACO/provider agreements
  - Developing programs to improve care coordination and quality of care
  - Meeting scale targets

All-Payer ACO Model Implementation (cont'd)

- AHS is responsible for developing, offering, and implementing a Medicaid ACO Program
- GMCB is responsible for Regulatory Implementation:
  - Certifying ACOs (includes rulemaking)
  - Reviewing ACO budgets
  - Reviewing and advising on Medicaid ACO rates
  - Setting Commercial and Medicare rates for ACOs
  - Reporting on progress to CMS
  - Tracking financial benchmarks, scale targets and quality targets
  - Implementing changes to other GMCB processes to create an integrated regulatory approach (e.g., hospital budgets; health insurance premium rate review)

GMCB Goals and Regulatory Levers

Goal #1:
Vermont will reduce the rate of growth in health care expenditures

GMCB Regulatory Levers:

- Hospital Budget Review
- ACO Budget Review
- ACO Certification
- Medicare ACO Program Rate-Setting and Alignment
- Health Insurance Rate Review
- Certificate of Need

Goal #2:
Vermont will ensure and improve quality of and access to care

GMCB Regulatory Levers:

- All-Payer Model Criteria
- ACO Budget Review
- ACO Certification
- Quality Measurement and Reporting

INTEGRATION OF REGULATORY PROCESSES

All-Payer ACO Model 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 ACOs
    - ✓ All-Payer Growth Target: 3.5%
    - ✓ Medicare Growth Target: 0.1-0.2% below national projections
  - 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

Scale Targets in All-Payer ACO Model Agreement

Percent (%)	By end of PY1 (2018)	By end of PY2 (2019)	By end of PY3 (2020)	By end of PY4 (2021)	By end of PY5 (2022)
Vermont All-Payer Scale Target Beneficiaries	36%	50%	58%	62%	70%
Vermont Medicare Beneficiaries	60%	75%	79%	83%	90%

Note: The Agreement's Quality Framework includes a measure, "Increase Percentage of Vermont Medicaid Beneficiaries Aligned with a VT ACO." The target for that measure is that the percentage of aligned Medicaid beneficiaries will be no more than 15 percentage points below the percentage of aligned Medicare beneficiaries.

Services in the All-Payer Model Agreement

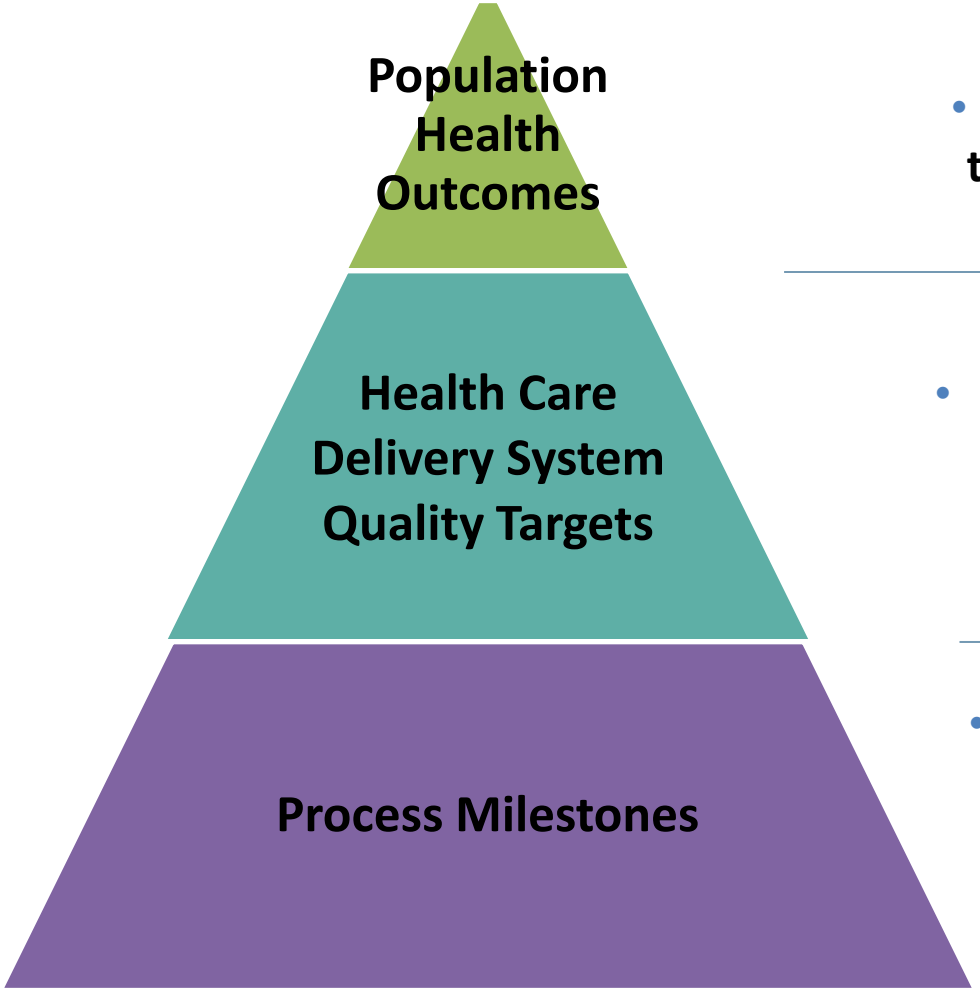
- Medicare Part A and B type services for all payers are already included as "Regulated Services" in the Agreement, which means that they are included in calculations of financial targets.
- Other Medicaid-funded mental health and home and community-based services are intended to be considered over time: "By the end of Performance Year 3 [2020], AHS, in collaboration with the GMCB, shall submit to CMS a plan to coordinate financing and delivery of Medicaid Behavioral Health Services and Medicaid Home and Community-based Services with the All-Payer Financial Target Services."

17

Collaboration with Public Health

"The State shall submit by June 30th of Performance Year 3 [2020] a plan signed by Vermont's Department of Health, AHS, the GMCB, and Vermont ACO(s) that provides an accountability framework for the public health system to ensure that any Vermont ACO funding allocated to community health services is being used towards achieving the Statewide Health Outcomes and Quality of Care Targets."

Population Health Goal #1
Improving Access to Primary Care

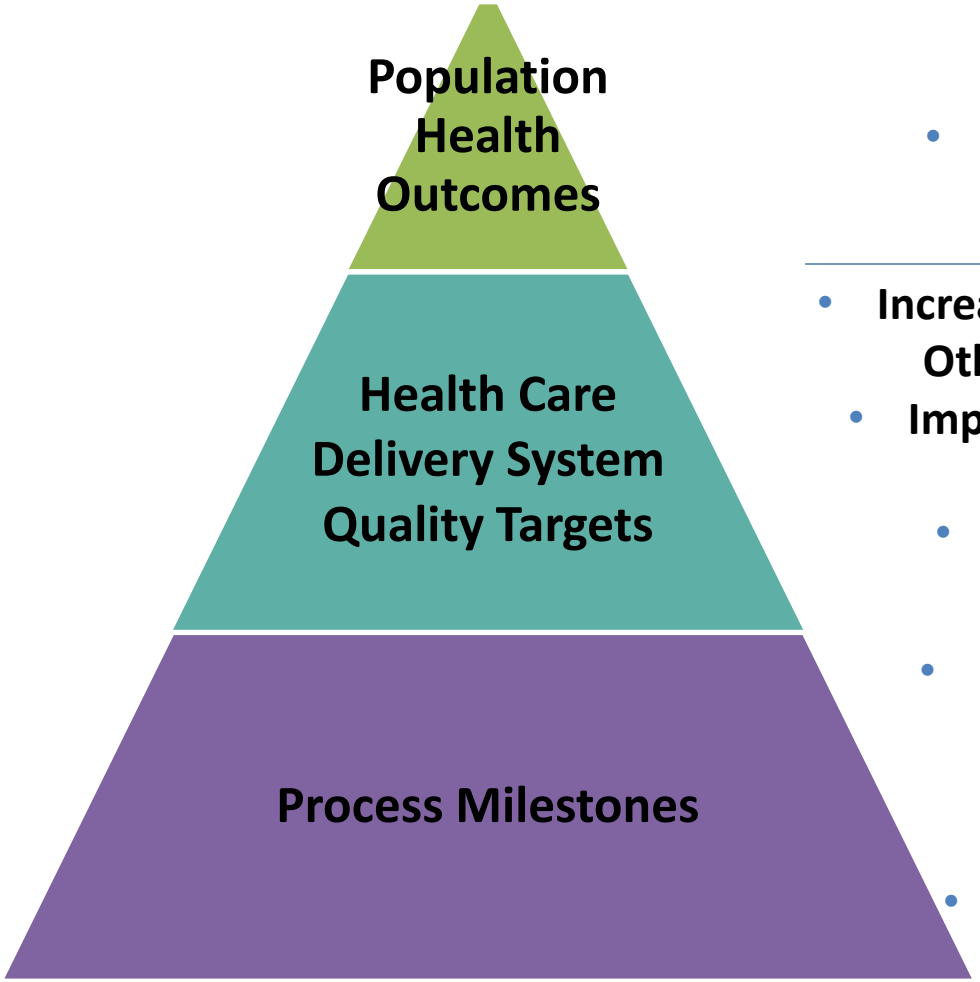


- **Increase % of VT Adults Reporting that they have a Personal Doctor or Health Care Provider**

- **Increase % of VT Medicare Beneficiaries Reporting Getting Timely Care, Appointments and Information**

- **Increase % of VT Medicaid Adolescents with Well-Care Visits**
- **Increase % of VT Medicaid Beneficiaries Aligned with a VT ACO**

Population Health Goal #2
Reducing Deaths from Suicide and Drug Overdose

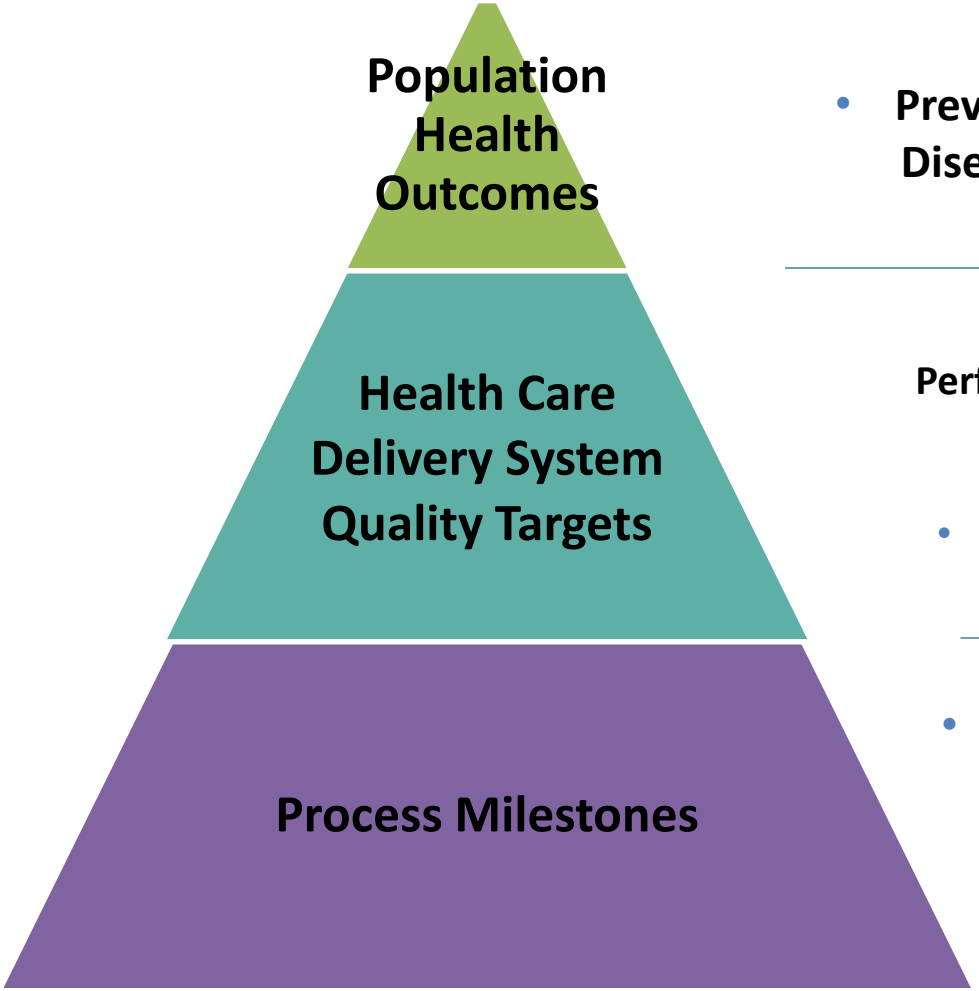


- **Reduce Deaths from Drug Overdose**
- **Reduce Deaths from Suicide**

- **Increase Initiation and Engagement of Alcohol and Other Drug Dependence Treatment** *(2 measures)*
- **Improve Follow-Up After Discharge from ED for MH and SA Treatment** *(2 measures)*
- **Reduce Rate of Growth of ED Visits for MH/SA Conditions**

- **Increase Use of VT's Rx Monitoring Program**
- **Increase # of VT Residents Receiving Medication-Assisted Treatment for Opioid Dependence**
- **Increase Screening for Clinical Depression and Follow-Up Plan**

Population Health Goal #3
Reducing Prevalence and Morbidity of Chronic Disease



- **Prevalence of Chronic Obstructive Pulmonary Disease, Diabetes and Hypertension Will Not Increase by More Than 1%** *(3 measures)*

For VT Medicare Beneficiaries, Improve Performance on Composite Measure that Includes:

- **Diabetes Hemoglobin A1c Poor Control**
- **Controlling High Blood Pressure**
- **All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions**

- **Improve Rate of Tobacco Use Assessment and Cessation Intervention**
- **Improve Rate of Medication Management for People with Asthma**

All-Payer Model Agreement: Resources for Reform

- Federal government is willing to make a substantial financial investment in Vermont.
  - CMS is willing to provide Vermont more than $50 million in Medicare funding to support Blueprint for Health, Vermont's nationally recognized initiative transforming primary care, and 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.

- Federal government is willing to provide over $200 million in Medicaid funding capacity to support investments in the ACO and in community-based providers.

Benefits for Providers

- Participation is by choice.
- Removes barriers to practicing in an integrated, coordinated care delivery system.
- Rewards providers for delivering high quality care and improving health outcomes.
- 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.
- Offers participation in a unified, statewide system of care with shared cost moderation and quality improvement goals.

Benefits for Vermonters

- Preserves all current beneficiary protections consistent with Medicare, Medicaid, or commercial coverage.
- 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.
- Unifies health care delivery system, public health, and community health programs around a common set of health improvement goals.
- Creates a coordinated public/private approach to improving access to primary care and other services.

More information at:

gmcboard.vermont.gov