The Green Mountain Care Board, the All-Payer Accountable Care Organization Model Agreement and Medicaid

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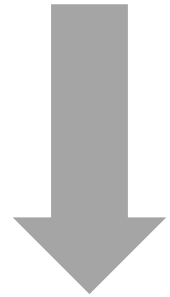
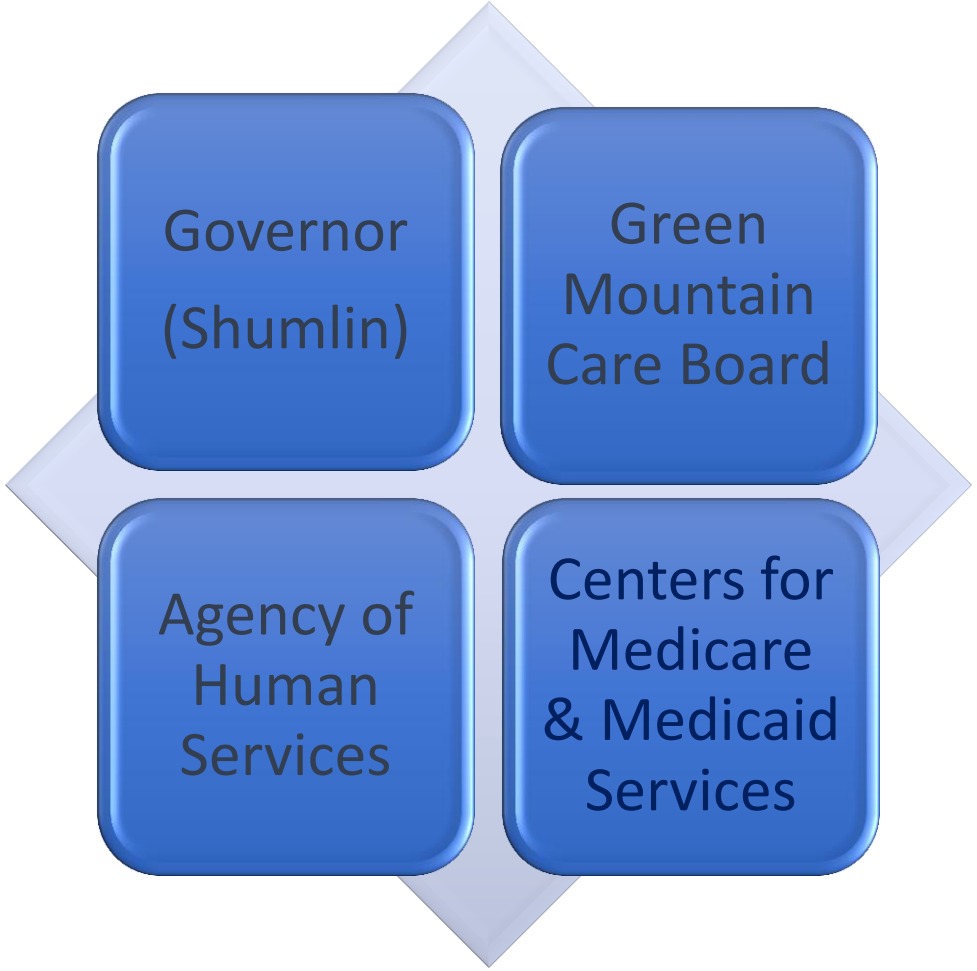
Legislature passes Act 113 (H. 812) authorizing the Green Mountain Care Board and the Agency of Administration to enter into an agreement with the Center for Medicaid and Medicare Services, if it aligns with the goals of Act 48.

May 2016



Parties to the All Payer ACO Agreement Signed 10/27/16



What services are included in the All Payer ACO Agreement?

Now

- All Medicare Part A and B services and equivalents
- Doctors, hospitals, specialists

Future

- Medicaid Behavioral Health
- Medicaid Developmental Services
- Medicaid Skilled Nursing Facilities Long Term Care
- Medicaid Home and Community Long Term Care

Pilot vs Federal Agreement

- The All Payer ACO Agreement began in January 2018 comprising a 5-Year formal agreement between the State and CMS with payments from Medicaid, Medicare, and Blue Cross/Blue Shield. It is not a pilot.
- Vermont's agreement with CMS "Vermont All-Payer Accountable Care Organization Model Agreement" signed October 27, 2016 can be found here: http://gmcboard.vermont.gov/sites/gmcb/files/files/payment-reform/All%20Payer%20Model%20ACO%20Agreement.pdf

Does the All Payer ACO Agreement promote universal access, affordability, choice, equity? Does it Align with the Principles of Act 48?

- The All Payer ACO Agreement does not increase coverage or access.
- The All Payer ACO Agreement does not reduce the number of uninsured Vermonters.
- Regarding choice, an individual cannot “opt-out” of the ACO.

The GMCB is a promoter and regulator of ACOs.

LCAR has questioned the duality of the GMCB's roles and expressed concerns regarding similarities with EB-5.

- The dual roles of the GMCB inhibit it from holding ACOs fully accountable.
- Examples: All Payer party status, GMCB policies, surgical center,

The Green Mountain Care Board enabling legislation mandates public engagement and an Advisory Board.

- Improved Public engagement could be achieved by an improved Advisory Board.

OneCare is a for-profit LLC

- In the All Payer ACO Agreement, Medicaid savings accrue to the ACO instead of the State. "Savings" become OneCare's profits.
- Will the All Payer ACO initiative result in privatizing Vermont's health care system?
- OneCare is owned and operated by UVM Medical Center. Does this create conflicts of interest?
- OneCare has been given millions of dollars in grants, contracts, and public money. Is there adequate transparency? What is the public getting in return?
- There are no mechanisms to ensure that ACO savings will be used to improve, enhance, and expand services. The ACO can use any "savings" as it chooses.

Will State and Federal Medicaid funding to stand up OneCare and the All Payer ACO Agreement supplant money that might otherwise have gone for service delivery or wage increases?

- "Delivery System Reform Investments" in the Governor's FY 2019 Budget Request (DVHA UPS) would use Global Commitment dollars to pay OneCare for infrastructure costs.

All Payer Model's risk-based model to reduce health care expenditures

- The All Payer Model requires OneCare to bear financial risk for the care of its participants, something that has not been done previously. OneCare will pay a set amount of money for each person attributed to its ACO. If a person's care costs more than the set fee, OneCare will have to make up the difference. If a person's care costs less, OneCare will benefit.
- Do we need to worry about care being withheld? Once health care providers are subject to financial incentives, withholding of care becomes a potential concern. Well-established traditional HMOs like Kaiser address this issue by putting all their physicians on salary, especially specialists where the higher costs reside.
- The All Payer ACO Agreement's lump-sum payment approach is considered another form of "managed care".
- Have OneCare's solvency, risk mitigation and reinsurance policies been adequately evaluated for actuarial soundness now that it has taken on "insurer" functions?
- Should OneCare be subject to Rule 10?

Budget Discipline: How well has OneCare's ACO performed over the last 3 years?

- OneCare exceeded its spending targets in eight out of nine ACO contracts with Medicare, Medicaid and Blue Cross/Blue Shield during the last 3 year period.

OneCare ACO Performance with Shared Savings Programs			
Payer	2014	2015	2016
Medicaid	Under Budget by $6.7 million Savings Earned	Over Budget by $1.3 million No Savings Earned	Over Budget by $1.5 million No Savings Earned
Medicare	Over Budget by $4.1 million No Savings Earned	Over Budget by $26.9 million No Savings Earned	Over Budget by $18.5 million No Savings Earned
Commercial	Over Budget by $5.4 million No Savings Earned	Over Budget by $3.7 million No Savings Earned	Over Budget by $1.9 million No Savings Earned

Administrative Costs

- OneCare will spend $12.5 million on administrative costs in the first year (2018) of the All Payer Model for 120,000 participants. These new administrative costs are ***in addition to*** current administrative costs borne by Medicare, Medicaid and the Commercials for the other four-fifths of Vermonters who are not participating in the All Payer ACO Model.
- There is no formal cap on OneCare's administrative expenses.
- Are there adequate protections to prevent Vermont Medicaid from being the primary payer for OneCare's administrative expenses?

Value-Based Payment

- Do we need ACOs to implement value-based payment mechanisms?

  DVHA can implement value-based payment mechanisms and currently does with the following programs:
  - Blueprint Patient Centered Medical Homes
  - Medication Assisted Treatment for Opioid Addiction (Hub and Spoke)
  - Integrated Family Services
  - Community Rehabilitation and Treatment (CRT)

OneCare as a monopoly / Anti-trust issues

- OneCare is the only ACO opera in Vermont.
- How does OneCare's statewide market share impact competition in Vermont? Will smaller entities be put out of business?
- The State Action Doctrine requires to Vermont to determine that the benefits of an ACO engaging in anti-competitive practices are greater than its costs. Has an assessment been performed to determine that benefits outweigh costs?

“Monopoly hospitals, those that dominate a local market with no other competing hospital, have 15.3% higher prices than hospitals in more competitive markets, and hospital consolidation is responsible for sharp price increases across markets within states.”

Reassessing ACOs and Health Care Reform, Kevin Schulman MD and Barak D. Richman JD, PhD *JAMA* 2016; 316

A few small repairs:

Hold Joint Health Care Oversight Committee Meetings year round.

Amend Act 113 so that it is not mandatory to move all Medicaid funded services to OneCare and/or into the All-Payer ACO Agreement caps or process.

Beef up the GMCB Advisory Board.
Add ACOs to Billback statute

Basic Studies:
For anti-trust regulation and healthcare reform planning purposes - Vermont needs to know what it costs to operate OneCare and the All Payer ACO Agreement

Study cost / benefit of ACO APM total cost of operation/regulation/stand up, technology.
If benefits out weigh costs - who benefits?

Evaluate the alignment of Act 48 and the All Payer Accountable Care Organization Agreement