Overview of Act 113 ACO/All-payer model provisions

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February 14, 2017

Act 113: All-payer model

- All-payer model: A value-based payment model allowing participating health care providers to be paid by Medicaid, Medicare, and commercial insurance using a common methodology that may include population-based payments
- Medicare participation in all-payer model requires the Centers for Medicare and Medicaid Services (CMS) to waive provisions under Title XVIII (Medicare) of the Social Security Act

Medicare waiver

- Act 113 establishes parameters for a permissible Medicare waiver agreement with the federal government:
  - Must be consistent with Act 48 principles, to the extent permitted under federal law
  - Must preserve Medicare consumer protections, including:
    - Not reducing Medicare covered services
    - Not increasing Medicare patient cost-sharing
    - Not altering Medicare appeals processes

Medicare waiver (cont.)

- Must allow providers to choose whether to participate in an accountable care organization (ACO), to the extent permitted under federal law
- Must allow Medicare patients to choose any Medicare-participating provider
- Must include outcome measures for population health
- Must continue to provide Medicare payments directly to providers or ACOs without conversion, appropriation, or aggregation by the State of Vermont

All-payer model criteria

- Act 113 establishes 14 criteria for all-payer model:
  - Maintains consistency with Act 48 criteria
  - Continues to provide Medicare payments directly to providers or ACOs without conversion, appropriation, or aggregation by the State of Vermont
  - Maximizes alignment between Medicaid, Medicare, and commercial payers to the extent permitted under federal law and waivers from federal law, including:
    - What is included in calculation of total cost of care
    - Attribution and payment mechanisms
    - Patient protections
    - Care management mechanisms
    - Provider reimbursement processes

All-payer model criteria (cont.)

- Strengthens and invests in primary care
- Incorporates social determinants of health
- Mental health and substance abuse treatment parity:
  - Adheres to federal and State laws on parity of mental health and substance abuse treatment
  - Integrates these treatment systems into overall health care system
  - Does not manage mental health or substance abuse care through a separate entity
- Includes a process to integrate community-based providers and their funding streams into a transformed, fully-integrated health care system that may include transportation and housing
  - Providers include home health agencies, mental health agencies, developmental disability service providers, emergency medical service providers, adult day service providers, area agencies on aging

All-payer model criteria (cont.)

- Continues to prioritize use of existing local and regional community health provider collaboratives that develop integrated health care initiatives to address regional needs and evaluate best practices for replication and return on investment
- Pursues an integrated approach to data collection, analysis, exchange, and reporting to simplify communication across providers and drive quality improvement and access to care
- Allows providers to choose whether to participate in ACOs, to extent permitted under federal law
- Evaluates access to care, quality of care, patient outcomes, and social determinants of health

All-payer model criteria (cont.)

- Requires processes and protocols for shared decision making between patient and providers that take into account patient's unique needs, preferences, values, and priorities, including:
  - Use of decision support tools and shared decision making methods that allow patient to assess merits of various treatment options in context of his or her own values and convictions
  - Providing patients access to their medical records and to clinical knowledge to enable informed choices about care
- Supports coordination of patients' care and care transitions through use of technology, with patient consent
  - Such as sharing electronic summary records across providers and using telemedicine and home telemonitoring
- Ensures, in consultation with Health Care Advocate, that robust patient grievance and appeal protections are available

Accountable care organizations

- Act 113 defines an accountable care organization (ACO) as an organization of health care providers with a formal legal structure and federal Taxpayer Identification Number that agrees to be accountable for the quality, cost, and overall care of the patients assigned to it
- Act 113 adds to Green Mountain Care Board's (GMCB) duties a duty to "promote seamless care, administration, and service delivery"
- Act 113 requires GMCB to adopt by rule by January 1, 2018 standards that the GMCB deems necessary and appropriate to the operation and evaluation of ACOs, including:
  - Reporting requirements
  - Patient protections
  - Solvency and ability to assume financial risk
- GMCB must ensure rules anticipate and accommodate a range of ACO models and sizes, balancing oversight with support for innovation

ACO certification

- Act 113 requires ACOs to obtain and maintain certification from GMCB in order to be eligible to receive payments from Medicaid or commercial insurance through any payment reform program or initiative, including all-payer model
- Specifies 16 criteria that GMCB must ensure are met in order to certify an ACO:
  - ACO's governance, leadership, and management structure is transparent, reasonably and equitably represents its providers and patients, and includes consumer advisory board and other processes for inviting and considering consumer input
  - ACO has appropriate mechanisms and care models to provide, manage, and coordinate high-quality health care services for its patients, including:
    - Incorporating Blueprint for Health
    - Coordinating services for complex high-need patients
    - Providing access to health care providers not participating in the ACO

ACO certification (cont.)

- ACO has appropriate mechanisms to receive and distribute payments to participating health care providers
- ACO has appropriate mechanisms and criteria for accepting health care providers to participate in the ACO that prevent unreasonable discrimination and are related to needs of ACO and patient population served
- ACO has mechanisms and care models to promote evidence-based health care, patient engagement, coordination of care, use of electronic health records, and other enabling technologies to promote integrated, efficient, seamless, effective health care services across continuum of care, where feasible
- ACO's participating providers have capacity for meaningful participation in health information exchanges

ACO certification (cont.)

- ACO has performance standards and measures to evaluate the quality and utilization of care delivered by its providers
- ACO does not restrict information that its providers may provide to patients about their health or decisions about their health
- ACO's providers engage their patients in shared decision making to inform them of treatment options and related risks and benefits of each
- ACO offers assistance to health care consumers, including:
  - Maintaining consumer telephone line for complaints and grievances from attributed patients
  - Responding and making best efforts to resolve complaints and grievances, including helping identify appropriate rights under patient's health plan
  - Providing accessible mechanism to explain how ACOs work
  - Providing contact information for Office of Health Care Advocate
  - Sharing deidentified complaint and grievance information with Office of Health Care Advocate at least twice annually

ACO certification (cont.)

- ACO collaborates with providers outside its financial model, including home- and community-based providers and dental health providers
- ACO does not:
  - Interfere with patients' choice of their own health care providers under their health plan, regardless of whether provider is in ACO
  - Reduce covered services
  - Increase patient cost-sharing
- All meetings of ACO's governing body include public session where all business that is not confidential or proprietary is conducted and public is provided opportunity to comment
- Impact of ACO's establishment and operation does not diminish access to any health care or community-based service or increase delays in access to care for population and area ACO serves
- ACO has appropriate mechanisms to conduct ongoing assessments of its legal and financial vulnerabilities
- ACO has a financial guarantee sufficient to cover potential losses

ACO budget review

- Requires GMCB to adopt rules by January 1, 2018 to establish standards and processes for reviewing, modifying, and approving budgets of ACOs with 10,000 or more attributed lives in Vermont
  - Must ensure rules anticipate and accommodate a range of ACO models and sizes, balancing oversight with support for innovation
- In its budget review, GMCB must review and consider:
  - Information about utilization of health care services delivered by ACO-participating providers and effects of care models on appropriate utilization, including provision of innovative services;
  - Health Resource Allocation Plan goals and recommendations
  - Expenditure analysis for previous year and proposed expenditure analysis for year under review by payer

ACO budget review (cont.)

- Character, competence, fiscal responsibility, and soundness of the ACO and its principals
- Any reports from professional review organizations
- ACO's efforts to prevent duplication of high-quality services being provided efficiently and effectively by existing community-based providers in same geographic area, as well as integration of efforts with Blueprint for Health and its regional care collaboratives
- Extent to which ACO provides incentives for systemic health investments to strengthen primary care, including:
  - Strategies for recruiting additional primary care providers
  - Providing resources to expand capacity in existing primary care practices
  - Reducing administrative burden of reporting requirements for providers while balancing need for sufficient measures to evaluate adequately quality of and access to care

ACO budget review (cont.)

- Extent to which ACO provides incentives for systemic integration of community-based providers in its care model or investments to expand capacity in existing community-based providers, in order to promote seamless coordination of care across care continuum
- Extent to which ACO provides incentives for systemic health care investments in social determinants of health, such as developing support capacities that:
  - Prevent hospital admissions and readmissions
  - Reduce length of hospital stays
  - Improve population health outcomes
  - Reward healthy lifestyle choices
  - Improve solvency of and address financial risk to community-based providers participating in the ACO

ACO budget review (cont.)

- Extent to which ACO provides incentives for preventing and addressing impacts of adverse childhood experiences (ACEs) and other traumas, such as:
  - Developing quality outcome measures for use by primary care providers working with children and families
  - Developing partnerships between nurses and families
  - Providing opportunities for home visits
  - Including parent-child centers and designated agencies as participating providers in the ACO
- Public comment on all aspects of ACO's costs and use and on ACO's proposed budget
- Information gathered from meetings with ACO to review and discuss proposed budget

ACO budget review (cont.)

- Information on ACO's administrative costs, as defined by GMCB
- Effect, if any, of Medicaid rates on rates for other payers
- Extent to which ACO makes its costs transparent and easy to understand so patients are aware of the costs of the health care services they receive

- Directs GMCB to adopt rules to establish standards and processes for reviewing, modifying, and approving budgets of ACOs with fewer than 10,000 attributed lives in Vermont
  - In its review, GMCB may consider as many of the factors for larger ACOs as the GMCB deems appropriate to an ACO's size and scope
- Creates role for Office of Health Care Advocate in ACO budget review

Additional ACO provisions

- All information ACO files with the GMCB related to ACO certification and budget review must be available to the public upon request
  - But not any patient- or provider-identifiable information
- GMCB must provide update on rulemaking for oversight of ACOs by January 15, 2017
- Department of Financial Regulation and Department of Vermont Health Access must ensure their rules protect against wrongful denial of services under an insured's or Medicaid beneficiary's health benefit plan for an insured or Medicaid beneficiary attributed to an ACO
- GMCB must conduct a Medicaid advisory rate case for ACO services by December 31, 2016

Medicaid Pathway

- Medicaid Pathway – Secretary of Human Services, in consultation with others, to create a process for payment and delivery system reform for Medicaid providers and services
  - Must address all Medicaid payments to affected providers
  - Must integrate providers to extent practicable in all-payer model and other existing payment and delivery system reform initiatives
  - Report due by January 15, 2017 and annually for five more years; must address:
    - All Medicaid payments to affected providers
    - Changes to reimbursement methodology and services impacted
    - Efforts to integrate affected providers into all-payer model and other initiatives
    - Changes to quality measure collection and identifying alignment efforts and analyses, if any
    - Interrelationship of results-based accountability initiatives with quality measures

Questions?