VERMONT

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Vermont All-Payer Accountable Care Organization (ACO) Model and ACO Performance
Clarifying Information

Did OneCare Vermont ACO's quality performance decline in 2018?

At this point, it is inappropriate to make year-over-year comparisons of ACO quality performance for multiple reasons. First, the All-Payer ACO Model launched in 2018. Because of the amount of time it takes insurers and others to gather and validate health care payment information from providers, we are only just now receiving information on 2018 quality performance. Without two years of data, it is impossible to track performance over time. (Note that an earlier ACO model, known as the Shared Savings Program, operated from 2013-2017; however, this program included different providers, patients, and measures, and is not comparable to the current program).

The only ACO-payer program that began prior to 2018 is the Vermont Medicaid Next Generation program, which launched a pilot year in 2017. Even with similar quality measures, it is not possible to make statistically sound year-over-year comparisons of quality performance at this time given the change in program population. The 2017 program included approximately 29,000 "attributed lives" (patients); the program expanded to 42,000 lives in 2018. With a population change this significant, it is impossible to know whether results – including quality measure performance or measures of health care utilization, for example, primary care visits – reflect the ACO's performance or the addition of new patients who might be either healthier or sicker.

Looking ahead, GMCB will use 2018 as the starting point to track ACO performance and performance on All-Payer ACO Model quality measures.

Do rising medical inflation and continued health care affordability challenges for Vermonters mean that OneCare is failing to control health care cost growth?

The APM and the ACO structure are set up to incentivize increased investment in primary care and preventative services, with the long-term expectation that a healthier population will be less likely to require frequent and more costly specialty and acute care. Medical inflation growth is not a measure of the ACO's success: some of the largest drivers of medical inflation and health care unaffordability are not included in the Model's financial goals.

The All payer model (APM) and the ACO structure are not set up to tackle ALL drivers of health care cost growth. The services included in the APM total cost of care (TCOC, the Model's financial target) were selected to align with Medicare Part A and Part B services (hospital services and physician or "professional" services). This allowed Vermont's model to match the federal Medicare Next Generation ACO Model on which Vermont's APM was based.

Vermont and the federal government chose to specifically exclude some services and costs from the model during their negotiations. For example, pharmaceuticals (including specialty medications) are currently outside of the APM's "total cost of care" (TCOC, the Model's financial target), and therefore are not included in the ACO's spending targets, because Medicare and the State of Vermont have limited ability to reduce pharmacy costs.

Vermont's total cost of care (TCOC) rose 4.1% in FY 2018, exceeding the 3.5% target specified in the APM. Will the state be put on a corrective action plan?

Vermont's All-Payer Model Agreement aims to align health care cost growth with the *growth of the Vermont economy*. The target range for health care cost growth in the APM agreement is based on Vermont's historical economic growth rates (3.5% to 4.3%). In the first performance year of the model (FY 2018), Vermont's TCOC growth reached 4.1%, and while exceeding the 3.5% target, this is still below the 4.3% trigger. (For more information, see GMCB Staff Presentation on FY2018 Total Cost of Care Results, February 26, 2020).

It is too soon to tell how Vermont will perform relative to this five-year target. The GMCB sets the annual Medicare growth rate ("the benchmark") with this five-year target in mind, taking into consideration performance to date and a range of possible growth trajectories. If Vermont were to exceed the 4.3% growth in the future, the federal government and Vermont may assess the model to see if there are changes or improvements to promote cost containment if appropriate. There are no penalties associated with missing the target.

Does lack of consistent savings mean that OneCare and the ACO model are not a worthwhile strategy for curbing cost growth?

Achieving savings under the model is an important mechanism used to drive system-wide behavior change, but it is not the only measure of success, and does not take into account all of the factors that might impact financial performance (e.g., patient population changes, as mentioned above). As stated previously, the real metric for evaluating the financial success of the ACO model is comparing cost growth for both patients participating in the ACO and patients not participating in the ACO, after adjusting for the underlying health of the population.

Most importantly, it is critical to remember that 2018 is the first year of a 5-year model. The ACO model asks providers to change their business models and the care they deliver, and this major transformation requires patience and time, as well as large-scale participation from providers and patients.

Is the ACO just another layer of administrative expense? What value do Vermonters get for the cost of administering this program?

Most of OneCare's proposed FY20 budget represents spending that already exists in our health care system, with 95% of OneCare's overall budget reflecting payments made directly to providers for health care services – now just having the option to be paid differently.

Reform is not possible without investment in transformative change and the infrastructure to support it. The ACO allows for this investment to be centralized rather than duplicated for each provider. The administrative budget of OneCare is $19.3 million, or 1.4% of OneCare's 2020 proposed budget. Through this administrative budget, OneCare provides information and communication tools to help health care providers to identify and better serve our most vulnerable Vermonters, and to improve quality in their practices and hospitals. If OneCare did not exist, the administrative work they perform would be duplicated across the system as an administrative burden to our providers, because each hospital and provider's office would have to do the data and analytical work.

OneCare also supports innovative programs that invest in public health and prevention at the community level and better link health care to social services. The APM, through OneCare, also makes it possible for Medicare to continue participation in the Blueprint for Health and Support and Services at Home (SASH), both programs proven to drive savings and improve care.