

# Role of the GMCB in the Vermont All-Payer ACO Model

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# GMCB's role in Health Care Reform



1. Regulates certain private health care entities in support of the state's broader health care reform goals of (1) curbing health care cost growth and (2) improving quality and population health outcomes
2. Stewards of health care data and analytics for the public and policy-makers, supporting a transparent, statewide view of cost and quality across Vermont's system of care

# GMCB role in All Payer Model (APM) Agreement



1. Proxy for Medicare
2. Regulatory Alignment
3. Statewide Health Care Data/Analytics

# GMCB as Medicare Proxy



1. Establish health care spending targets, the mechanism for constraining fee for service health care cost growth
2. Recommend program design modifications to the Medicare ACO initiative to better align with other Vermont health care reform efforts.

# Regulatory Alignment



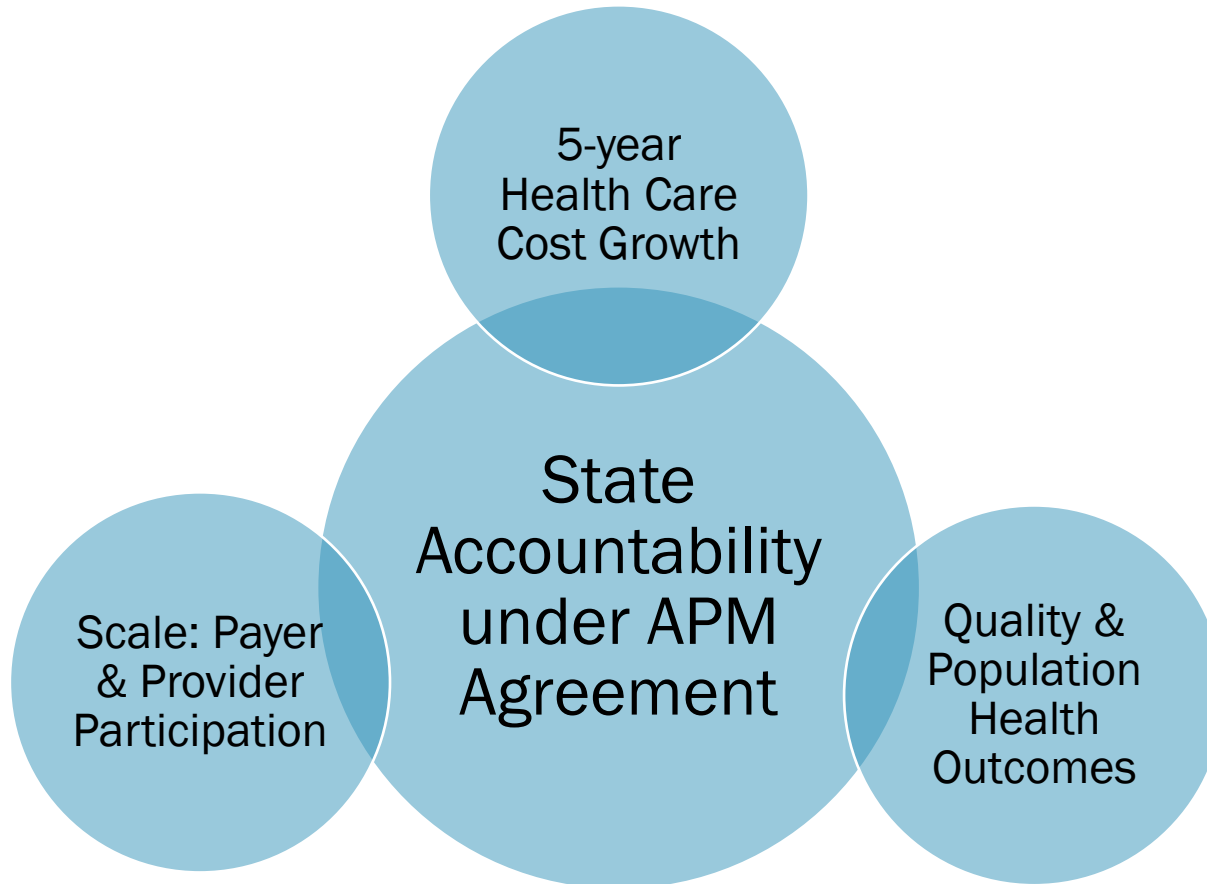
1. Hospital Budget Review
2. Accountable Care Organization (ACO)  
Budget Review and Certification (Act 113)
3. Health Insurance Rate Review

# Health Care Data/Analytics



1. Reports state's performance under APM agreement on scale, cost, quality and population health outcomes
2. Monitors for rationing/cherry picking etc.
3. Analyzes patterns in utilization and costs over time and across the delivery system

# Measuring State Progress per APM Agreement



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## Health Care Cost Growth

Tracks per person spending on certain health care services known as the Total Cost of Care (TCOC).

Measures spending growth for **statewide all-payer** and **Medicare** populations:

1. Is all-payer spending on track to be less than 3.5% or 4.3% over the life of the agreement?
2. Is Vermont's Medicare spending more than 0.2% below the national average

## Scale: Payer & Provider Participation

1. Assess alignment across **ACO-payer** programs and determine if scale qualifying
2. Track **providers** participating in qualifying programs
3. Measure scale by determining which **Vermonters "attribute"**: who is covered under a qualifying payer-program and has an established relationship with a participating provider?

## Quality & Population Health Outcomes

### Population health measures:

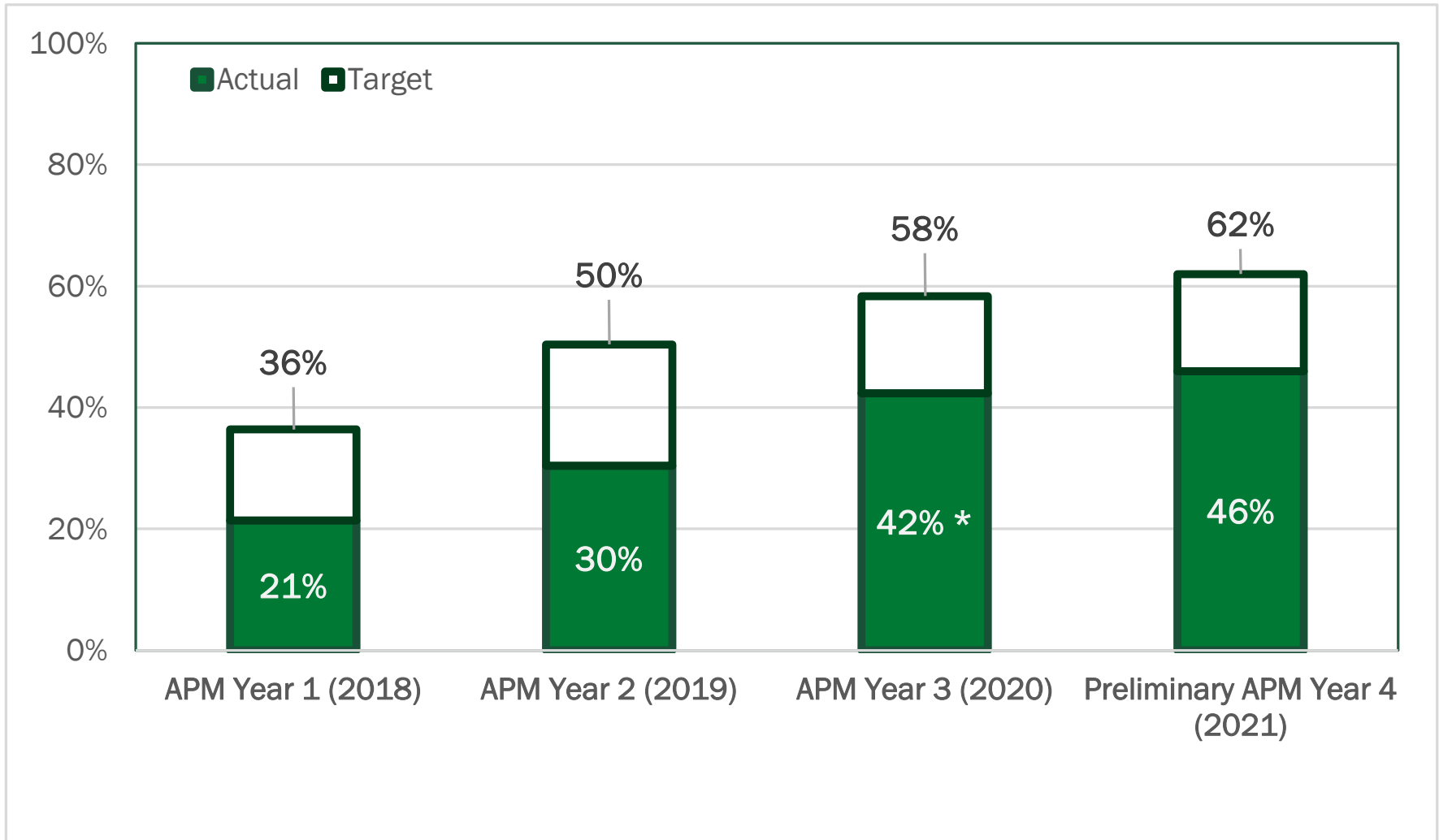
1. Improve access to primary care
2. Reduce deaths due to suicide and drug overdose
3. Reduce the prevalence and morbidity of chronic disease

### 22 Quality measures expected to drive population health:

1. Health delivery system quality targets
2. Process milestones



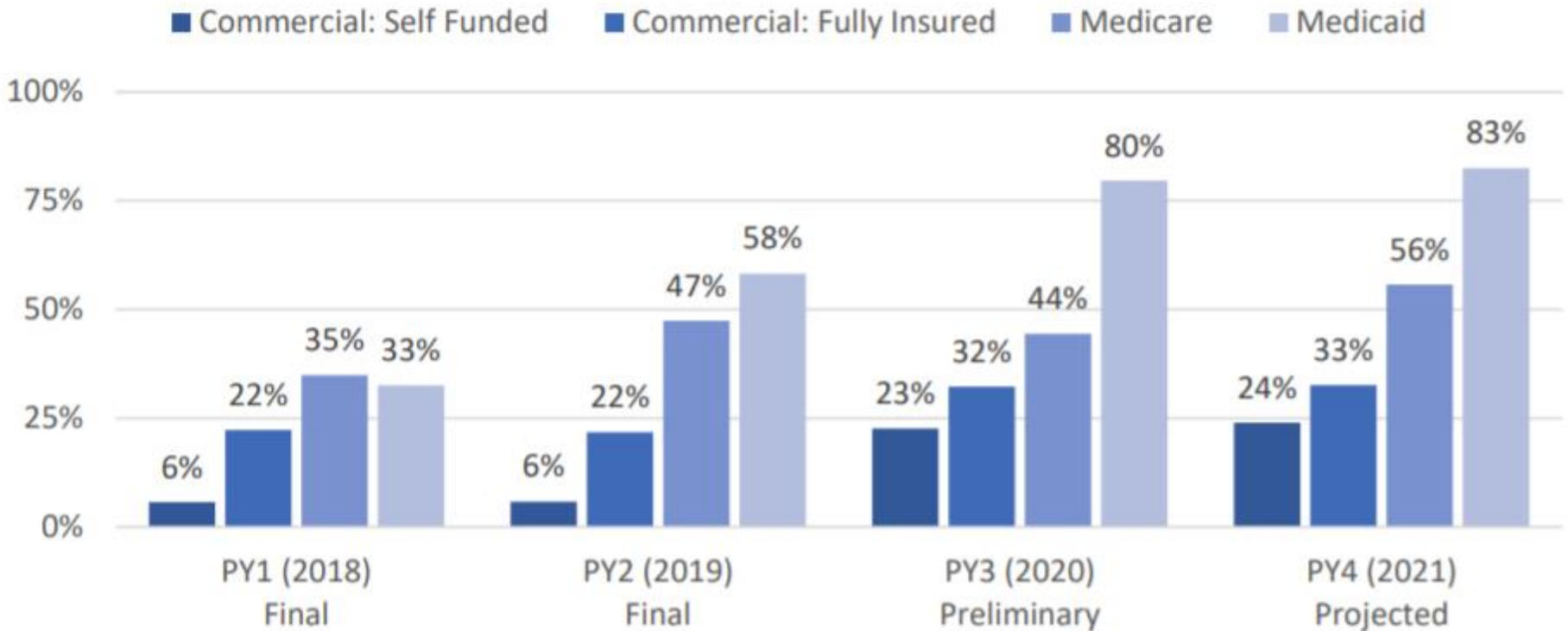
# All-Payer Scale



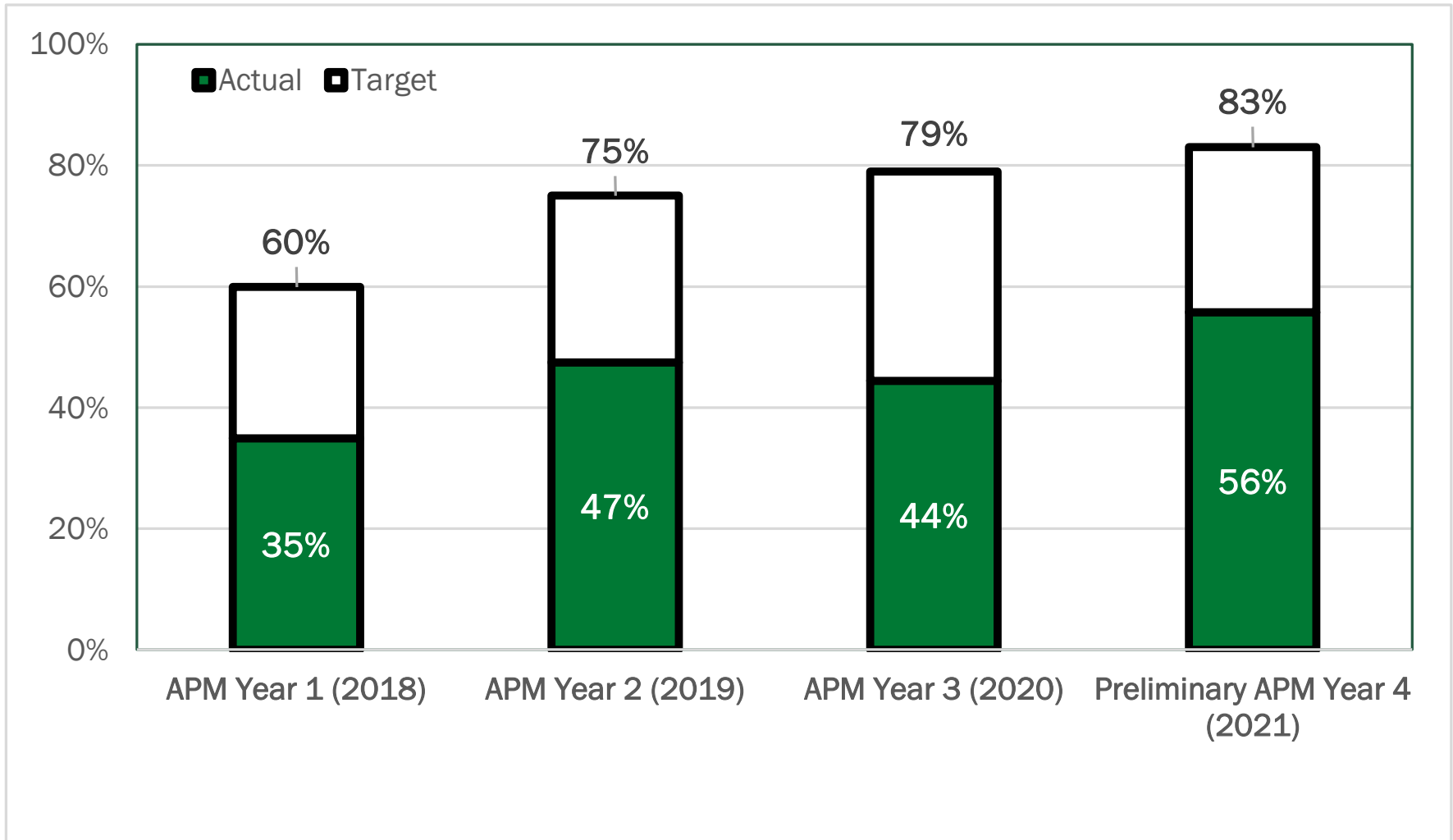
\*Preliminary results based on attributions from payer contracts

# All-Payer Scale x Payer Type

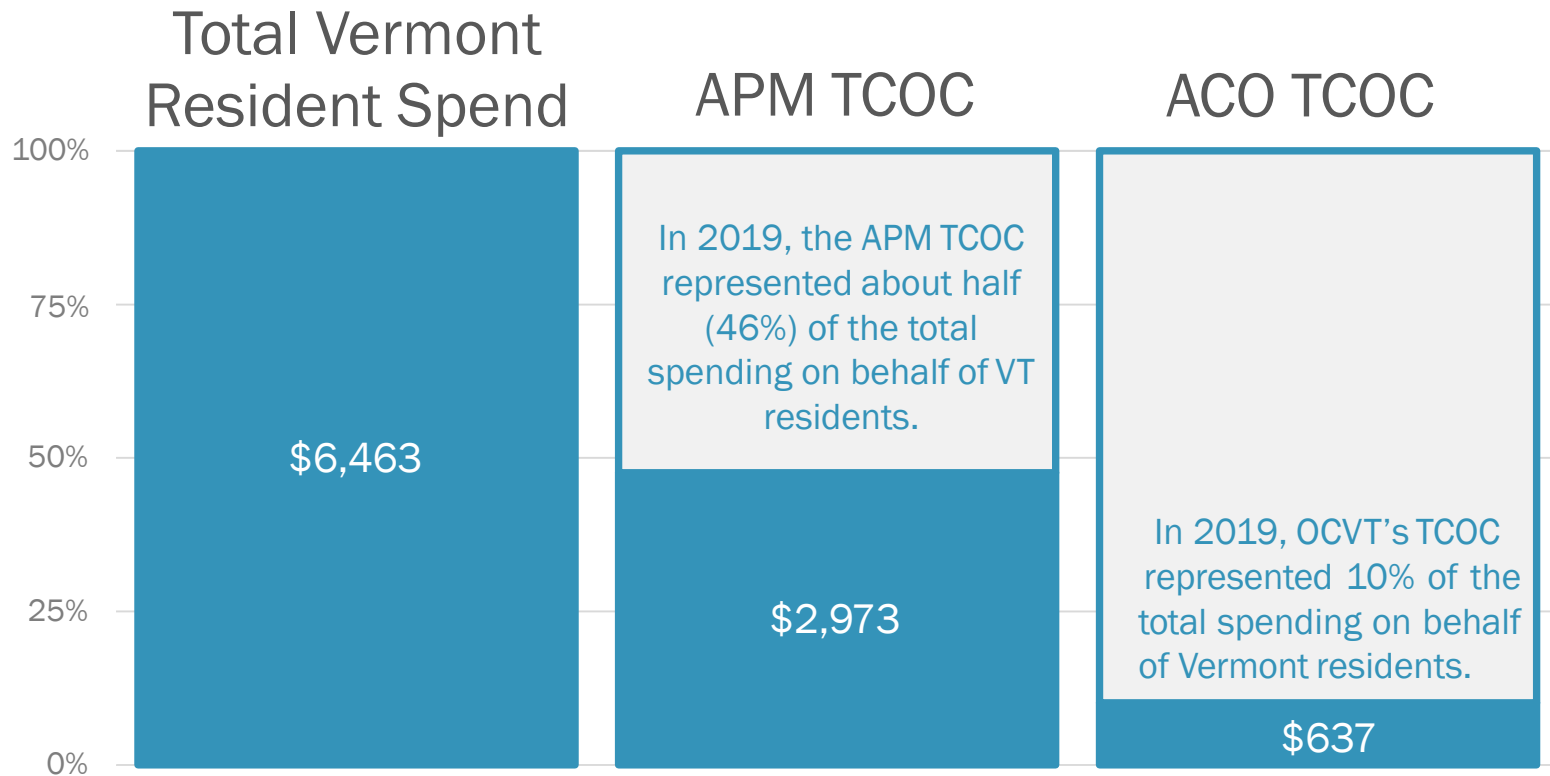
## Scale Target Beneficiaries by Payer Type



# Medicare scale

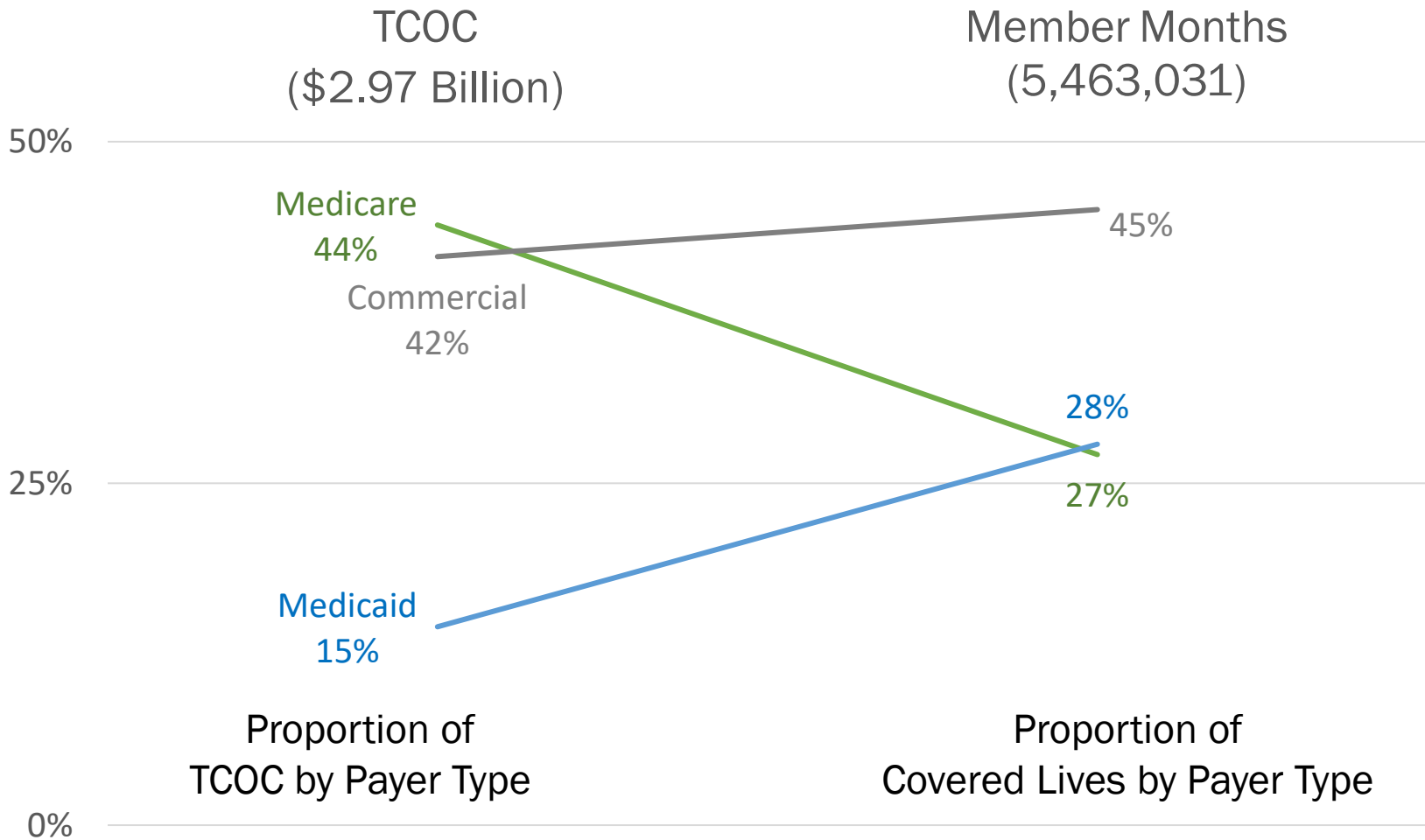


# Comparing Measures of Health Care Spending

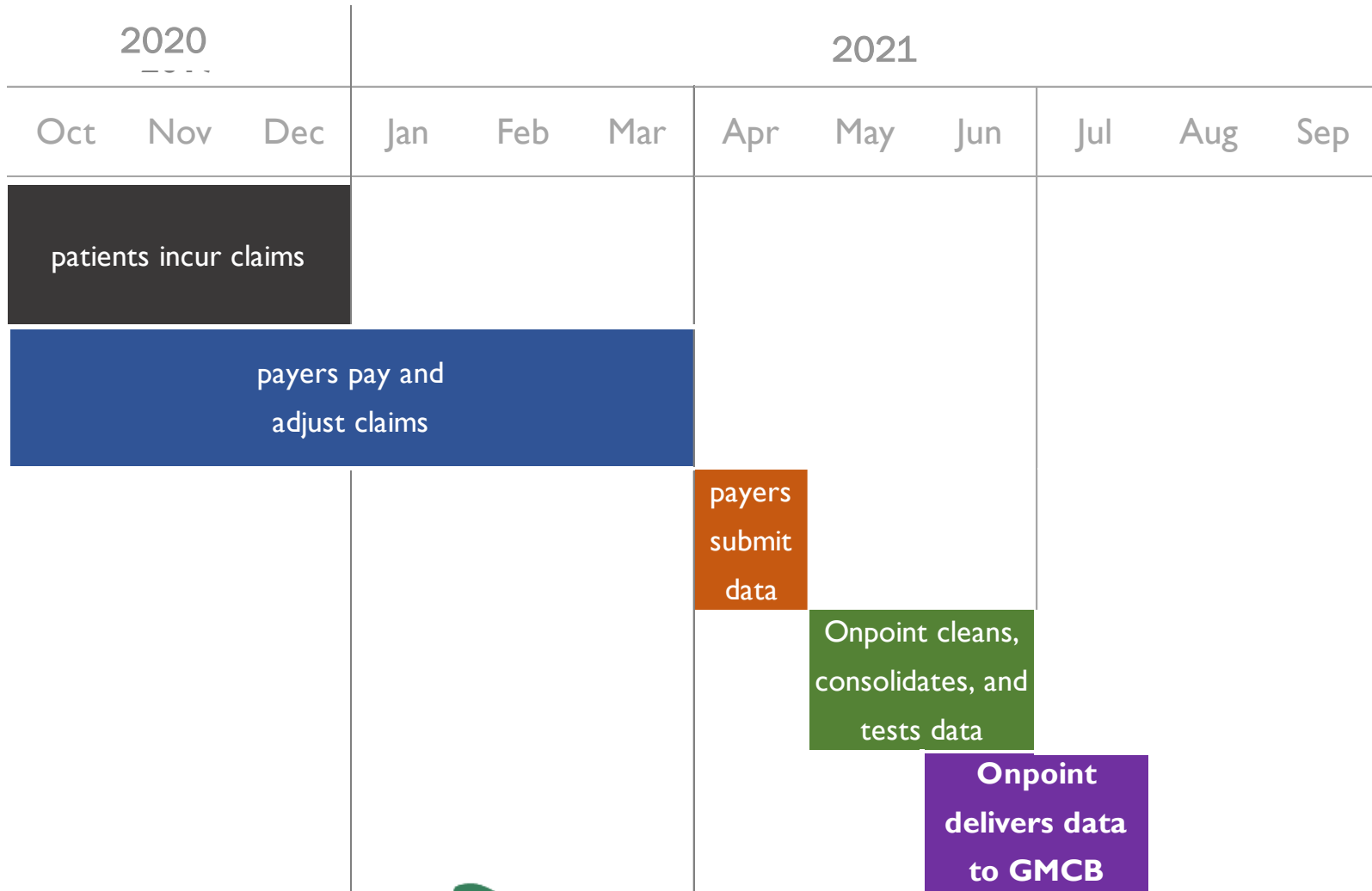


Notes: Spending above are in *millions* based on 2019 actuals for APM and ACO spending and estimated expenditures for total resident spend based on the [Vermont Expenditure Analysis](#).

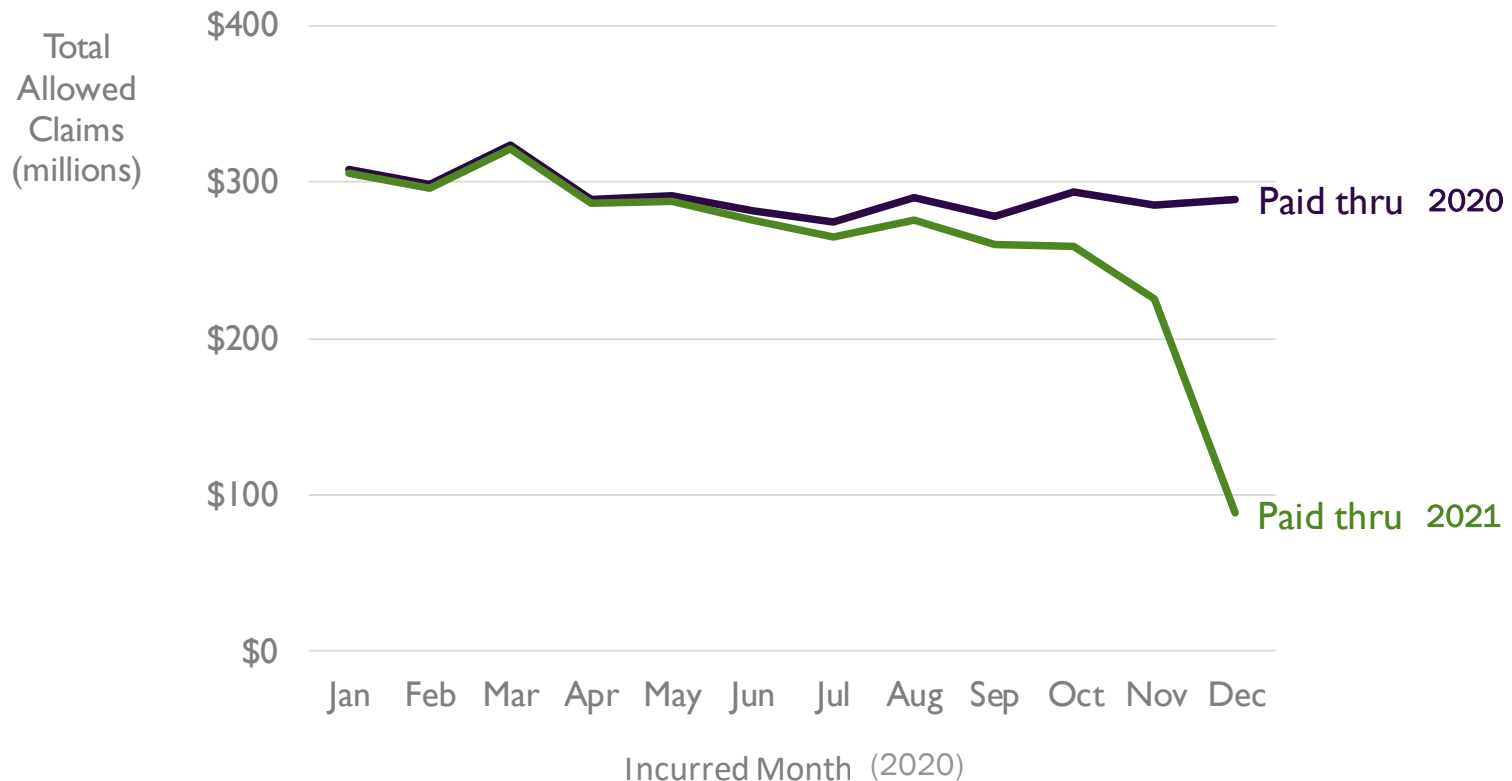
# Share of TCOC vs Population by Payer Type (2019)



# VHCURES Data Timeline



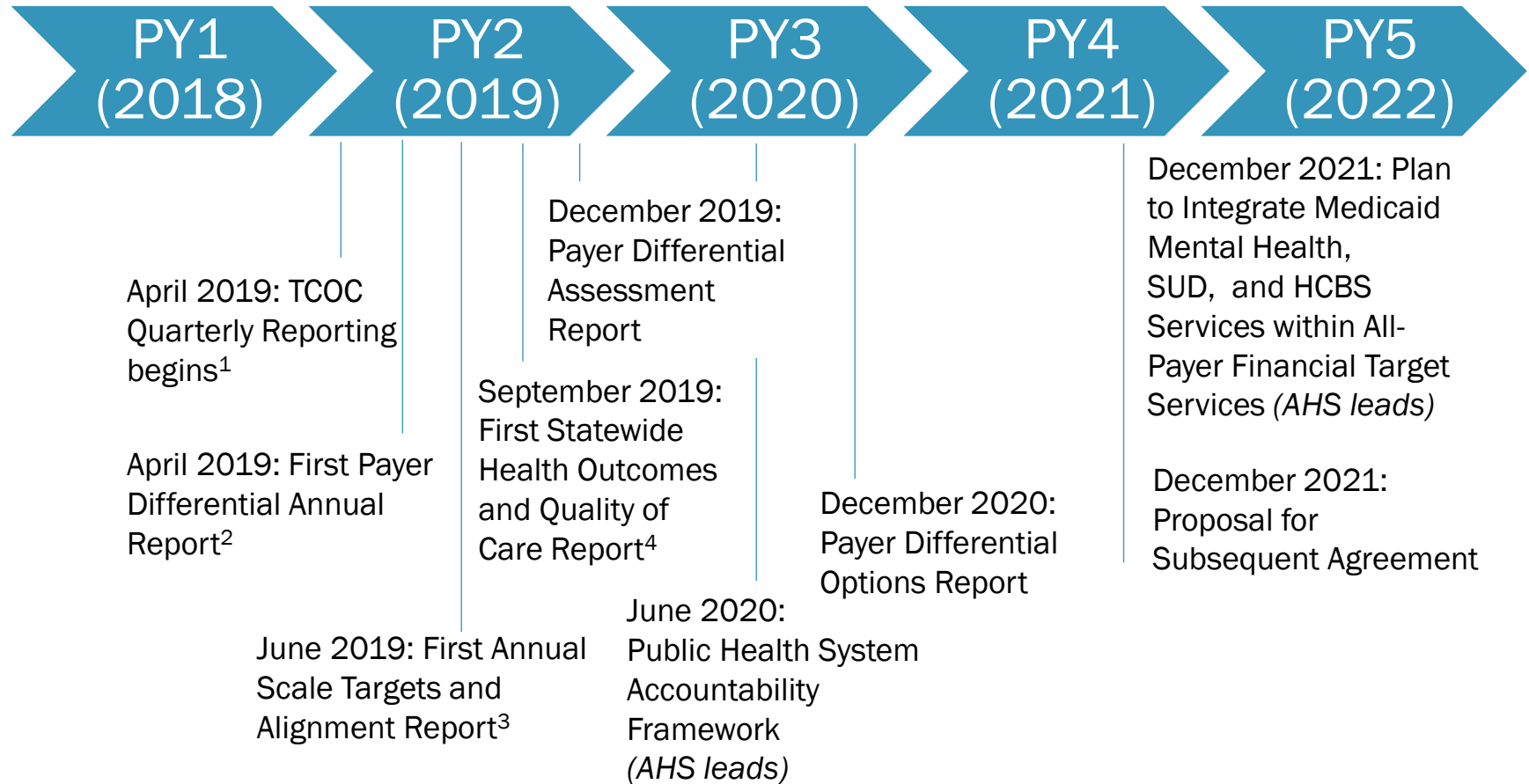
# Claims Incurred: Timeline



Source: VHCURES

Allowed amounts are for primary payments from commercial, Medicaid, Medicare

# Reporting to CMS



<sup>1</sup> Submitted quarterly (reports produced approximately 9 months following final date of service); annual reports completed as data allow. <sup>2</sup> Submitted annually on 4/1. <sup>3</sup> Submitted annually on 6/30. <sup>4</sup> Submitted annually on 12/30, or as data allow.



# Questions?