State of Vermont
Agency of Human Services
Health Care Reform
Waterbury, Vermont

Report on Alignment of Federal and State Regulation over Managed Care Organizations and Accountable Care Organizations

In Accordance with Act 152 of 2016, Section 10. Recommendations for Alignment

Submitted to
House Health Care Committee
Senate Health and Welfare Committee
Senate Finance Committee

Submitted by
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SECTION 1: INTRODUCTION

As part of Act 152, the General Assembly directed the Director of Health Care Reform, in collaboration with the Green Mountain Care Board (GMCB) and the Department of Financial Regulation (DFR), to compare the requirements in federal law applicable to Vermont's accountable care organizations and the Department of Vermont Health Access (DVHA) in its role as a public managed care organization with the rules adopted in accordance with 18 V.S.A. §9414(a)(1) as they apply to managed care organizations to identify opportunities for alignment. The Director was tasked with preparing recommendations to the House Committee on Health Care and the Senate Committees on Health and Welfare and Finance on appropriate ways to improve alignment.

In the time between the enactment of Act 152 and the writing of this report, a number of relevant events have occurred. First, the State signed the *Vermont All-Payer Accountable Care Organization (ACO) Model Agreement* (the APM Agreement) with the Centers for Medicare and Medicaid Services (CMS).[1] Second, CMS extended Vermont's Global Commitment to Health Medicaid 1115 Waiver (Global Commitment).[2] In its approval letter to the Vermont Secretary of Human Services, CMS expressly states that the, "extension would advance an All-Payer ACO Initiative under Center for Medicare and Medicaid Innovation (CMMI) demonstration authority."[3] Third, under the authority of the Global Commitment and in alignment with the APM Agreement, DVHA contracted with a risk-bearing ACO, OneCare Vermont (OneCare) LLC, for participation in the Vermont Medicaid Next Generation (VMNG) ACO pilot program, which is based on the federal Medicare Next Generation ACO model.[4] Fourth, under its oversight authority established in Act 113, GMCB developed annual reporting and budget guidance for ACOs and *Rule 5.000: Oversight of Accountable Care Organizations*. Finally, OneCare has submitted its first budget to GMCB for review and approval. All of these activities were characterized by intentional efforts to improve alignment between federal and state requirements, including requirements pertaining to ACOs and DVHA in its role as a managed care-like organization.

The following report reviews managed care and ACO guiding rules. It also summarizes efforts to align federal and state regulations following the enactment of Act 152 as the state moves toward an integrated health care system through ACO-based reform. These activities have a focus on alignment across payers (Medicare, Medicaid, and commercial) for program design, including consumer protections and integration of mental health and of other community-based services. However, many of these activities are early in their implementation or will soon to go into effect. For example, at the time of this writing, contracts for year 2018 between the OneCare and Vermont Medicaid, CMS, and BlueCross BlueShield of Vermont (BCBSVT) were not yet final. Therefore, the Director of Health Care Reform recommends monitoring the implementation of the APM Agreement through existing status reports by the Agency of Human Services (AHS), DVHA and GMCB, and any reports required of the ACO by GMCB, with the goal of understanding how efforts to date are achieving alignment across payers, especially around mental health.

[1] See http://gmcboard.vermont.gov/sites/gmcb/files/documents/10-27-16-vermont-all-payer-accountable-care-organization-model-agreement.pdf.
[2] Global Commitment to Health 1115 Waiver documents: http://dvha.vermont.gov/global-commitment-to-health/global-commitment-to-health-1115-waiver-2017-documents
[3] Ibid, CMS Approval Letter (10/24/16)
[4] VMNG contract: http://dvha.vermont.gov/administration/onecare-aco-32318-final-searchable.pdf

SECTION 2: ALIGNMENT

MANAGED CARE – RULE H-2009-03

Managed Care organizes the delivery of health care services with the goal of managing the cost and utilization of care to make health care more affordable while maintaining high quality standards. In Vermont, Rule H-2009-03 (Rule 9-03), the *Consumer Protection and Quality Requirements for Managed Care Organizations* (amended effective January 24, 2017), guides DFR's oversight of managed care to ensure Vermonters have access to high quality care and consumer protections. Section 1.3 (A) identifies managed care organizations (MCOs) as "health insurers, health maintenance organizations, preferred provider organizations, exclusive provider organizations, mental health review agents and all other financing mechanisms, systems and other entities that manage health care delivery for members or subscribers of any comprehensive major medical health benefit plan subject to the Department's jurisdiction." Of note, ACOs are not specifically identified in the definition of a managed care organization. The full list of requirements can be found in Rule 9-03.[5]

VERMONT MEDICAID GLOBAL COMMITMENT TO HEALTH

AHS, as Vermont's Single State Medicaid Agency, is responsible for oversight of the managed care-like Medicaid delivery system. Through the Intergovernmental Agreement (IGA), DVHA operates the Medicaid program in accordance with federal managed care regulations and the terms and conditions of Vermont's Section 1115 Demonstration Waiver, the Global Commitment to Health (Global Commitment).[6] Under Section 1115 of the Social Security Act, the federal government can "waive" many, but not all, of the laws governing Medicaid, including eligible people and services, with the goal of encouraging state innovation in the Medicaid program. Global Commitment dates are:

- Initial 5-year term from October 1, 2005 - December 31, 2010
- Two 3-year extensions maintained waiver through December 31, 2016
- The waiver's current 5-year extension is approved from January 1, 2017 - December 31, 2021

Part of the Global Commitment design includes units of state government adhering to federal Medicaid managed care rules found at 42 CFR part 438[7] et. seq. in exchange for certain Medicaid managed care flexibilities. Program requirements and responsibilities are delineated in the IGA between AHS and DVHA. CMS reviews and approves the IGA annually to ensure compliance with Medicaid Managed Care requirements. DVHA also has sub-agreements with the other State entities that provide specialty care for Global Commitment enrollees (e.g., mental health services, developmental disability services, and specialized child and family services).

The Code of Federal Regulations at 42 CFR 438 identifies requirements applicable to all forms of Medicaid managed care. The CFR includes the following standard designed to promote safe, accessible, timely, and quality services:

[5] Rule H-2009-03: http://www.dfr.vermont.gov/reg-bul-ord/consumer-protection-and-quality-requirements-managed-care-organizations

[6] Global Commitment to Health 1115 Waiver documents: http://dvha.vermont.gov/global-commitment-to-health/global-commitment-to-health-1115-waiver-2017-documents

[7] 42 CFR part 438: https://www.gpo.gov/fdsys/pkg/CFR-2011-title42-vol4/pdf/CFR-2011-title42-vol4-part438.pdf

- access to care (e.g., network adequacy, availability of services, coordination and continuity of care, and coverage and authorization);
- structure and operations (e.g., provider selection, enrollee information, confidentiality, grievances and appeals, and sub-contractual relationships and delegation); and
- measurement and improvement (e.g., practice guidelines, quality assessment and performance improvement program, and health information systems).

In addition to internal oversight activities, DVHA and other AHS departments are required to participate in the annual external independent review outlined in Subpart E of 42 CFR 438.

ACCOUNTABLE CARE ORGANIZATION (ACO)

The Patient Protection and Affordable Care Act[8], passed in 2010, included new expectations and guidance for delivery system and payment reform, including care delivery in Medicare through ACOs.[9] ACOs are provider-led and -governed organizations, with a substantial regional clinical leadership role, that have agreed to assume accountability for the quality, cost, and experience of care.

Of the federal ACO models, Vermont has pursued two: the Medicare Shared Savings and Next Generation. In the Shared Savings model selected by Vermont ACOs, the provider network receives funding back when their actual expenditures are lower than a financial target, and they meet or exceed quality targets. If spending exceeds the financial target or they do not meet quality targets, the network is not penalized. In the Next Generation ACO model, provider networks receive the benefit if their spending is lower, but they are financially responsible for any spending that exceeds the threshold, i.e., a Shared Loss and Shared Savings model.[10]

VERMONT'S ACO REFORM

Since 2012, Vermont's ACOs have been participating in the Medicare Shared Savings Program developed by CMS. Additionally, the Medicare model has served as a template for designing comparable ACO Shared Savings Programs for Medicaid and commercial insurers. Both DVHA and BCBSVT launched ACO Shared Savings Programs in 2014 that were based on the Medicare Shared Savings Program.

CMMI has promoted state-driven, multi-payer delivery system reform through the State Innovation Model initiative, which also served to increase uptake of new accountable care approaches in Medicaid. CMS released guidance in July 2012[11] on the regulatory pathways for implementing integrated care models, including ACOs. Vermont Medicaid worked closely with CMS and CMMI to determine the appropriate authority under which to establish its ACO programs. In 2014, Vermont received authority through a State Plan Amendment (SPA)[12] to implement the Vermont Medicaid Shared Savings Program (VMSSP) with contracted ACOs. In 2017, Vermont received federal approval to implement the Vermont

[8] Patient Protection and Affordable Care Act: https://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf

[9] ibid section 3022 "MEDICARE SHARED SAVINGS PROGRAM"

[10] Description of Medicare Next Generation ACO modelhttps://innovation.cms.gov/initiatives/Next-Generation-ACO-Model/

[11] Letter to State Medicaid Director: https://www.medicaid.gov/federal-policy-guidance/downloads/smd-12-001.pdf

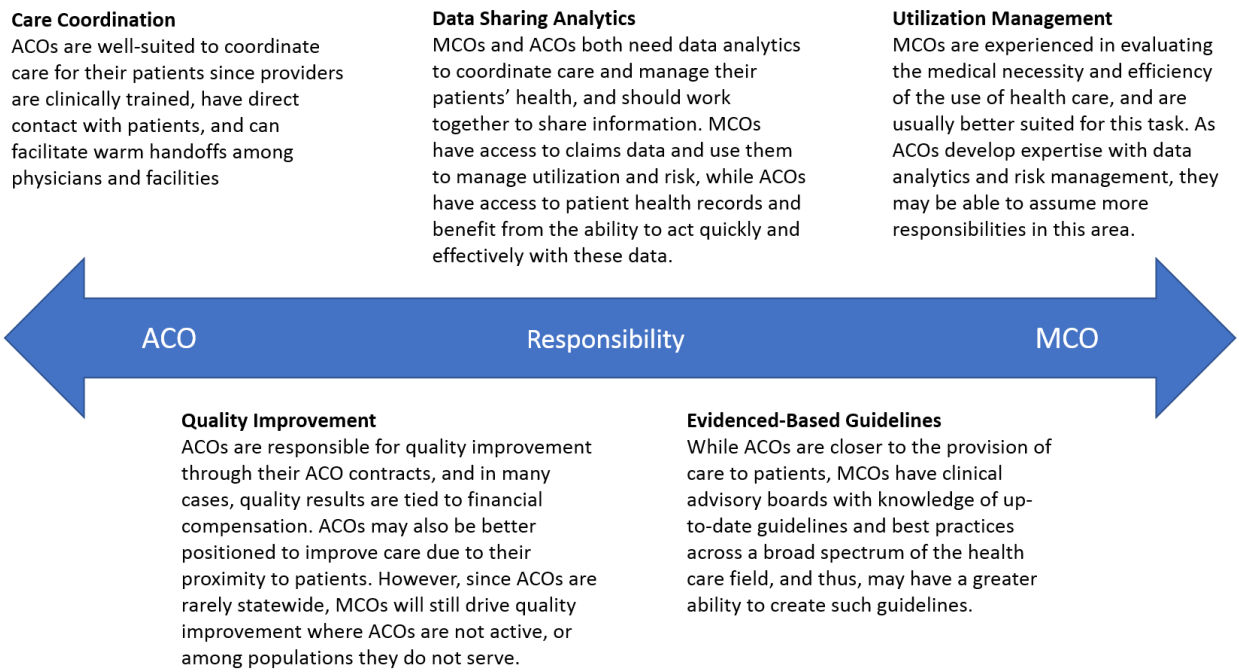
[12] Medicaid State Plan, Attachment 3.1-A, section 29. http://dvha.vermont.gov/administration/29attachment-3.1-a.pdf

Medicaid Next Generation (VMNG) Program using 1115 waiver authority for alternative delivery system and provider payment initiatives.

In determining the appropriate forms of regulatory approval, Vermont considered the purpose and scope of its Medicaid ACO as well as alignment with existing programs, such as the Blueprint for Health Patient Centered Medical Home (PCMH) Program with Community Health Teams and the Vermont Chronic Care Initiative, in order to avoid duplication of payments or services. Vermont seeks to build upon these programs effectively and has worked with ACOs to determine how these programs will fit together.

RELATIONSHIP BETWEEN MCOS AND ACOS

The Center for Health Care Strategies developed a tool to highlight the relative role of managed care and ACOs. The below figure is derived from their document: *Delineating Responsibilities across Accountable Care Organizations and Managed Care Organizations*,[13] and demonstrates how ACOs and managed care can complement each other.



VERMONT ALL-PAYER ACCOUNTABLE CARE ORGANIZATION MODEL

The All-Payer ACO Model Agreement (APM Agreement) between the State and the Federal government was approved by the GMCB on October 26, 2016, and signed by the Governor and the Secretary of Human Services on October 27, 2016. The purpose of this Agreement is to test whether changing how payers pay for an agreed set of services will lead to an improvement in quality of care and health and reductions in health care expenditures. The APM Agreement includes a target for a sustainable rate of growth for health care spending across Medicaid, Medicare, and commercial payers and would build on past programs such as Vermont's Medicaid and commercial Shared Savings Programs. When

[13] CHCS Tool: https://www.chcs.org/media/ACO_MCO-Tool_021616.pdf

implemented, this model will focus on a set of health care services roughly equivalent to Medicare Parts A and B (hospital and physician services). Payment methodologies will include Medicare Next Generation's value-based payment models, such as a set amount paid for each attributed individual (i.e., capitation) or global budgets. Quality of care will be evaluated through quality and performance measurement.

The APM Agreement lays out three population health goals: improving access to primary care; limiting the growth in prevalence and morbidity of chronic conditions, specifically hypertension, diabetes, and chronic obstructive pulmonary disease (COPD); and reducing deaths attributed to suicide and drug overdose.

Under the APM Agreement, Vermont is responsible for ensuring that ACO initiatives offered through Vermont Medicaid, Vermont commercial insurers, participating Vermont self-insured plans, and Vermont's Medicare ACO align in their design (i.e., beneficiary alignment methodology, ACO quality measures, payment mechanisms, risk arrangements, and services included for determination of the ACO's Shared Losses and Shared Savings). While the initial agreement has identified services in Medicare Parts A and B, the APM Agreement also calls for the state to develop a plan, due December 31, 2020, to incorporate Medicaid mental health and substance use disorder care into the financial and quality targets of the Agreement.

In 2016, the General Assembly passed, and the Governor signed into law, Act 113, *An Act Relating to Implementing an All-Payer Model and Oversight of Accountable Care Organizations*. This law emphasized the need for alignment. 18 V.S.A. § 9551, Sec. 2(3) establishes that the GMCB and the Agency of Administration "shall ensure that the model… (3) maximizes alignment between Medicare, Medicaid, and commercial payers to the extent permitted under federal law and waivers from federal law, including:

> (A) what is included in the calculation of the total cost of care;
> (B) attribution and payment mechanisms;
> (C) patient protections;
> (D) care management mechanisms; and
> (E) provider reimbursement processes".[14]

It also called out the need to align with mental health standards: Section 2(6) states that the model must adhere to "federal and State laws on parity of mental health and substance abuse treatment, integrates mental health and substance abuse treatment systems into the overall health care system, and does not manage mental health or substance abuse care through a separate entity; provided, however, that nothing in this subdivision (6) shall be construed to alter the statutory responsibilities of the Departments of Health and of Mental Health".[15]

Under its responsibilities under Act 112 of 2016, GMCB submitted a report on January 15, 2017, on *The Green Mountain Care Board's Status of its Efforts to Achieve Alignment between Medicare, Medicaid, and Commercial Payers in the All-Payer Model*.[16] This report lays out GMCB's efforts to build on the alignment efforts under the Shared Savings Program, including alignment across measures collected.

[14] Act 113 of 2016: http://legislature.vermont.gov/bill/status/2016/H.812
[15] Ibid.
[16] Act 112 of 2016: http://legislature.vermont.gov/assets/Legislative-Reports/Act-112-Measure-Alignment-Report-2017-01-10-FINAL-new-cover.pdf

Operating under Act 113, GMCB established ACO budget guidelines and developed *Rule 5.000: Oversight of Accountable Care Organizations.* [17] The budget guidelines require that the ACO's budget submission include a description of the program leadership, provider network, financial arrangements, program elements by payer, model of care including integration with the Blueprint for Health, and grievance and complaint process. Rule 5.000 establishes the "standards and processes the Green Mountain Care Board (Board) will use to certify Accountable Care Organizations (ACOs) and review, modify, and approve the budgets of ACOs."[18] The drafting process involved input from the ACOs, the Vermont Office of the Health Care Advocate, DVHA, BCBSVT, MVP, and other key stakeholders. Building on the budget guidelines, Rule 5.000 also outlines requirements around coordination of care including mental health and substance use disorder services for enrollees, patient protections and support, and "plans for aligning Participant [i.e., provider participating in ACO] payment and compensation and other mechanisms utilized to influence Participants' performance with the ACO's performance incentives and for distributing shared savings".[19]

In Act 25 of 2017, the General Assembly required GMCB to submit progress reports on GMCB's timeline for Year 0 implementation of the APM Agreement. The June 15 and September 15, 2017, reports can be found on Vermont's General Assembly website. [20] The December 15, 2017, report was forthcoming at the time of the writing of this report. GMCB, under the APM Agreement, is also responsible for, in collaboration with AHS, the *Annual ACO Scale Targets and Alignment Report* to CMS, which includes progress on scale targets (i.e., how many Vermont residents are attributed to the ACO) and alignment across payers (including services, risk arrangements, payment mechanisms, quality measures, and beneficiary alignment). These reports are due on June 30th of the year following the performance Years 1 through 5. They are also responsible for, in collaboration with AHS, the *Annual Health Outcomes and Quality of Care Report* (due on September 30th of the year following performance Years 1 through 5), and the *Quarterly Financial Reports*.

At the time of this writing, final contracts between OneCare and CMS, Vermont Medicaid, and BCBSVT were not yet finalized for 2018 or Year 1 of the APM Agreement. Nor was OneCare's budget proposal approved of by GMCB. Reviewing these contracts and the final budget will be important to understanding how the ACO is achieving alignment across payers for their attributed population.

VERMONT MEDICAID NEXT GENERATION (VMNG) ACO MODEL

The VMNG ACO Pilot program represents the initial phase of Medicaid's participation in the integrated health care system envisioned by the Vermont APM Agreement. In February of 2017, DVHA contracted with OneCare to launch the VMNG pilot programs for the 2017 calendar year with four optional one-year extensions. The model's goal is an integrated health care system with incentives aligned to improve quality and reduce unnecessary costs. The VMNG ACO Pilot program pursues this goal by taking the next step in transitioning the health care revenue model from fee-for-service payments to value-based payments. This transition is meant to focus health care payments on rewarding value, meaning low cost and high quality, rather than volume of services provided.

[17] GMCB ACO Certification and Budget Review: http://gmcboard.vermont.gov/content/aco-certification-and-budget-review
[18] Ibid, see Rule 5.000: Oversight of Accountable Care Organizations
[19] Ibid, see Rule 5.000: Oversight of Accountable Care Organizations
[20] See: http://legislature.vermont.gov/reports-and-research/find/2018

Through the VMNG program in 2017, DVHA partnered with OneCare to manage the quality and cost of care for approximately 29,000 Medicaid members in four communities. OneCare's network of participating providers includes the University of Vermont Medical Center, Central Vermont Medical Center, Northwestern Medical Center, and Porter Hospital along with their employed physicians and providers. It also includes two Federally Qualified Health Centers, independent practices, home health providers, Designated Agencies, Area Agencies on Aging, and skilled nursing agencies in the four participating communities.[21] Together, DVHA and OneCare are piloting a financial model designed to support the clinical and operational capabilities of the ACO provider network with the goal of supporting health care professionals in delivering the care they know to be most effective in promoting and managing the health of the population they serve.

The VMNG ACO Pilot program was designed with the goal of supporting the implementation of Vermont's APM Agreement. Most notably, the included services, attribution, and payment methodologies are aligned with the Medicare Next Generation ACO program, including all-inclusive population-based payments. Through the VMNG, DVHA pays OneCare a monthly per member fixed prospective payment for services closely corresponding to Medicare Part A and Part B services that are provided by hospitals (and hospital-owned practices) participating with the ACO. The ACO is responsible for both the cost and quality of care for each attributed member, regardless how much care that person uses. Medicaid fee-for-service payments continue for all other non-hospital providers in the ACO, for all providers who are not a part of the ACO, and for all services that are not included in the fixed prospective payment. Beyond payment, the majority of quality measures align with the APM Agreement. In accordance with Act 25 of 2017, AHS submitted an update on the VMNG ACO pilot on June 15, 2017, and DVHA submitted the second update on September 15, 2017. A third update is due on December 15, 2017.

The APM Agreement and Global Commitment are complementary frameworks that support Vermont's health care reform efforts. Each agreement provides federal support to further Vermont's strategic goal of creating an integrated health care system, including increased alignment across payers and providers. Under the Global Commitment authority, Vermont sought and obtained CMS approval for this payment model in 2017 and focused on the following broad areas to define expectations for the Medicaid ACO program:

1. beneficiary eligibility
2. patient attribution/assignment
3. providers and services eligible for inclusion in the model
4. payment methodology
5. quality measurement and improvement strategies
6. accountability and oversight

As mentioned previously, Vermont operates its Medicaid program in adherence to rules and regulations governing Medicaid Managed Care. Any ACO contracting with DVHA in a risk-based service agreement is also subject to federal Medicaid Managed Care regulations for services that are sub-delegated to the ACO by DVHA. Key areas of performance for Vermont's Medicaid managed care-like model are documented in the IGA between AHS and DVHA, which is reviewed and approved by CMS annually

[21] See https://www.onecarevt.org/NetworkParticipants.

under the terms of the currently approved demonstration. Most expectations are foundational to Medicaid and flow through all levels of program operations.

DVHA has a Grievance and Appeals process for all members, whether they are attributed to the ACO or not. The VMNG contract requires the ACO to maintain a Grievances and Appeals process in addition to (and coordinated with) the DVHA Grievances and Appeals process. In the event that an ACO-attributed member wishes to pursue an appeal, the ACO must cooperate with DVHA throughout the State fair hearing process; the ACO will not have a separate fair hearing process for addressing member appeals.

The VMNG contract has allowed DVHA and OneCare to partner in innovative ways. While many of the functions DVHA performs as a payer in compliance with federal Medicaid Managed Care regulations have not changed as a result of the first year of VMNG implementation, DVHA and OneCare have been able to test innovations in shared responsibility for ensuring patient protections are in place and coordinated and in implementing alternative approaches to utilization management. As the VMNG program increases in scale, further evolution of roles and responsibilities for both DVHA and OneCare will be needed. This evolution will be informed by broader state efforts toward multi-payer program alignment within the APM Agreement.

ALIGNMENT OF MENTAL HEALTH STANDARDS

At each stage of developing a more integrated system of health care under the APM Agreement, AHS, the GMCB, and the General Assembly have focused on not only achieving better alignment across payers, but also incorporating mental health services in an all-payer model of reform. As mentioned above, the APM Agreement requires that Vermont submit a plan for integrating Medicaid mental health and substance use disorder services into the quality and financial targets of the APM Agreement. Act 113 calls on GMCB and the Agency of the Administration to ensure any "value-based model" involving Medicare, Medicaid, and commercial payers adheres to "parity of mental health and substance abuse treatment, integrates mental health and substance abuse treatment systems into the overall health care system, and does not manage mental health or substance abuse care through a separate entity".[22] Rule 5.000 calls on ACOs to improve quality of care through enhanced "coordination and management of the services Enrollees receive", including mental health.[23] In its budget submission, OneCare discusses the ways it will address mental health in its model of care and in alignment with the goals of the APM Agreement. Specifically, the budget discusses how OneCare is collaborating with Designated Mental Health and Substance Abuse Agencies in its model of care.[24]

Regarding VMNG, the 2017 contract excludes any service funded through the departments within the Agency of Human Services other than DVHA, as well as all services provided by the Designated Agencies and Specialized Service Agencies regardless of funding source. This decision was made to ensure alignment with Medicaid services for which ACOs had previously been accountable in the VMSSP and to ensure alignment with the services for which ACOs would be accountable in other payer ACO programs under the APM Agreement. As the VMNG program evolves for subsequent years, other services will receive consideration.

[22] Act 113 of 2016: http://legislature.vermont.gov/bill/status/2016/H.812
[23] GMCB ACO Certification and Budget Review: http://gmcboard.vermont.gov/content/aco-certification-and-budget-review; see Rule 5.000: Oversight of Accountable Care Organizations
[24] GMCB ACO Certification and Budget Review: http://gmcboard.vermont.gov/content/aco-certification-and-budget-review; see 2018 ACO Budget Submissions

SECTION 3: RECOMMENDATIONS FOR ALIGNMENT

Since the enactment of Act 152 of 2016, considerable attention has been paid to achieving alignment across payers. These efforts include the *Vermont All-Payer ACO Model Agreement*, Act 113 of 2016, Rule 5.00, VMNG ACO Pilot, and the OneCare budget submissions. While the state has achieved alignment across program design, many of these activities are early in their implementation or will go into effect on January 1, 2018, so the effects of alignment remain to be seen. Furthermore, at the time of this writing, the 2018 contracts between OneCare and Vermont Medicaid, CMS, and BCBSVT were not yet finalized. Given the current state of transition in Vermont's health care system as it pursues ACO-based reform under the APM Agreement, a full review of ACO and MCO alignment as outlined in Act 152 at this time would miss key elements.

Therefore, the Director of Health Care Reform recommends continued monitoring of alignment across payers, alignment of mental health services, and support of consumer protection through GMCB's monitoring and enforcement role outlined in Section 5.501 of the *Oversight of Accountable Care Organizations Rule*, and its responsibility under the APM Agreement, in collaboration with AHS, to submit the following reports to CMS: the *Annual ACO Scale Targets and Alignment Report* (due annually beginning June 30, 2019), the *Annual Health Outcomes and Quality of Care Report* (due annually beginning September 30, 2019), and the *Quarterly Financial Reports*. Additionally, the annual and quarterly reports on the Global Commitment provide regular updates on Vermont's Medicaid managed care and alignment with the APM Agreement. Finally, once the BCBSVT contract is final, it should be reviewed to assess whether any of Rule 09-03 provisions are delegated to the ACO and if so, to determine the implications.