Health Care Reform in Vermont: An Introduction and Brief History

January 27, 2021

Ena Backus

Director of Health Care Reform,

Agency of Human Services

VERMONT

AGENCY OF HUMAN SERVICES

Presentation Overview

- Orientation to and Brief History of Health Reform in Vermont
- Vermont All-Payer Accountable Care Organization Model Agreement

Health in the United States

- The United States spends more money on health care than any other country in the world.

- Yet, more spending on health care is not delivering better outcomes.

- Life expectancy in the United States trails behind other developed nations.
  - Deaths due to suicide, drug overdose, or alcohol-related

Health Care in Vermont

- Health care spending on behalf of Vermont residents was $6.3 billion in 2018, the most recent year for which data is available.

- Health care spending as a share of gross state product was 18.8% in 2018.

- Health outcomes for Vermonters can be improved.

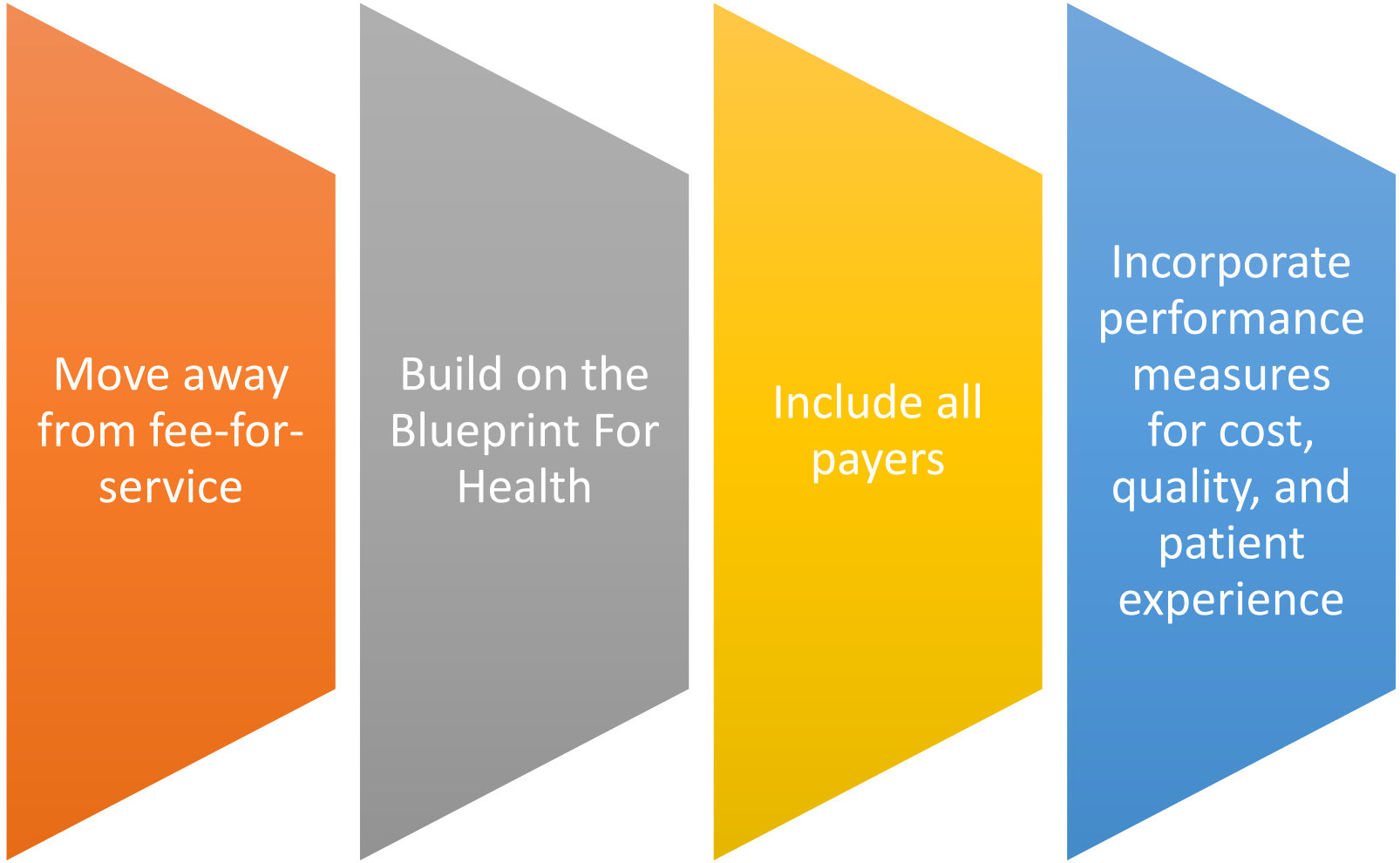
Health Reform: What problem are you trying to solve?

- Health care financing?
- Health care coverage?
- Health care spending growth?
- Health care delivery and quality?

Reform	Problem	ACA/Post
1989: Dr. Dynasaur created as a state-funded program to increase coverage for pregnant women and children	Financing Coverage	
1992: Small group and individual health insurance market reforms including guaranteed issue and community rating	Coverage	X
1992: Hospital budget oversight and certificate-of-need law	Spending	
1995: Vermont Health Access Program (VHAP)section of 1115 waiver covers low income, childless adults	Financing Coverage	X
2005: Choices for Care 1115 waiver continues coverage of community-based long-term care services and supports	Coverage Delivery	
2006: Global Commitment waiver creates Catamount Health for adults (subsidies for individuals to purchase private insurance)	Financing Coverage	X
2006: Delivery system reform through Blueprint for Health Medical Home model	Delivery	X
2011: Act 48 created a publicly financed universal health care program to be implemented after the general assembly enacts a law to finance the program. Act 48 also created the Green Mountain Care Board to reduce the rate of growth in health care expenditures and improve quality and created the Vermont Health Benefit Exchange.	Financing Coverage Spending Delivery	
2013: Hub and Spoke model created for medication-assisted treatment (MAT), supporting people in recovery from opioid use disorder. Nine regional Hubs (or “opioid treatment programs”) offer daily support for patients with complex addictions. At local Spoke practices (or “office-based opioid treatment”), doctors, nurses, and counselors offer ongoing opioid use disorder treatment fully integrated with general health care and wellness services.	Delivery	X
2016: Act 113 allows GMCB and AOA to enter into an agreement with CMS to implement an all-payer model. Defines an Accountable Care Organization and directs the GMCB to adopt ACO standards and budget review criteria by rule. Requires the Agency of Human Services to establish a process for integrating Medicaid providers and services into payment and delivery system reform.	Spending Delivery	
2019: Act 63 establishes in Vermont law certain consumer protections for health insurance plans that are currently in place pursuant to federal law: prohibition on preexisting condition exclusions, the setting of annual limitations on cost sharing, a ban on annual and lifetime limits on the dollar amount of essential health benefits, a prohibition on cost sharing for certain preventive services and a requirement that major medical health insurance plans cover an insured’s adult child up to 26 years of age.	Coverage	

VERMONT
AGENCY OF HUMAN SERVICES

Health Reform Trajectory (Circa 2013)



VERMONT
AGENCY OF HUMAN SERVICES

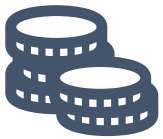
Addressing Health Care Spending Growth

Change how we pay for and deliver health care:

- Set a budget for the health care system instead of paying for each service performed (fee-for-service), regardless of quality or outcomes.

- Tie the budget to the quality of care delivered and improved health outcomes.

Logic Model



Test Payment Changes	Transform Care Delivery	Improve Population Health Outcomes
Population-Based Payments Tied to Quality and Outcomes	Invest in Care Coordination	Improved access to primary care
Increased Investment in Primary Care and Prevention	Incorporation of Social Determinants of Health	Fewer deaths due to suicide and drug overdose
	Improve Quality	Reduced prevalence and morbidity of chronic disease

VERMONT
AGENCY OF HUMAN SERVICES

Vermont All-Payer Accountable Care Organization (AC0) Model Agreement

- A contract between the State of Vermont and the Federal Government.

- Enables Medicare to join Medicaid and commercial payers in an aligned model to pay ACOs in Vermont differently than fee-for-service.
  - attribution methodologies
  - services
  - quality measures
  - payment mechanisms
  - risk arrangements

- A cost containment and quality improvement model, not a coverage expansion model.

Provider-Driven Reform
What are Accountable Care Organizations?

- **Accountable Care Organizations (ACOs)** are composed of and led by health care providers who have agreed to be accountable for the cost and quality of care for a defined population. These providers share governance and work together to provide coordinated, comprehensive care for their patients.

- Under the All-Payer ACO Model, ACOs are the organizations that can accept alternatives to fee-for-service payment (prospective payment, capitation, budget, full-risk) Vermont has one ACO certified by the Green Mountain Care Board: OneCare Vermont.

- **Step 1:** Agreement between CMS and VT provided an opportunity for private-sector, provider-led reform in Vermont that can be aligned across all major payer categories
- **Step 2:** ACOs and payers (Medicaid, Medicare, Commercial) work together to develop ACO-level agreements
- **Step 3:** ACOs and providers that want to participate work together to develop provider-level agreements

All-Payer ACO Model Agreement

What is Vermont responsible for?

State Action on Financial Trends	State/Provider Action on Quality Measures
• All-Payer Growth Target: Compounded annualized growth rate <3.5% • Medicare Growth Target: 0.2% below national projections • Requires alignment across payers, which supports participation from providers and increases **"Scale"**	• State is responsible for performance on **20 quality measures** *(see next slide)*, including three population health goals for Vermont ✓ Improve access to primary care ✓ Reduce deaths due to suicide and drug overdose ✓ Reduce prevalence and morbidity of chronic disease • ACO/providers are responsible for meeting quality measures embedded in contracts with payers

VERMONT
AGENCY OF HUMAN SERVICES

Vermont All-Payer ACO Model Partners

Center for Medicare and Medicaid Innovation (CMMI)

- **Model design, operations, and monitoring** to support Agreement implementation
- **Implement Vermont Medicare ACO Initiative** (payer), a Vermont-tailored Medicare ACO model

Green Mountain Care Board (GMCB)

- **Health system regulation** to support Model goals (ACO oversight, Medicare ACO program design and rate setting, hospital budgets, and more)
- **Monitoring and reporting to CMMI** on cost, scale and alignment, quality, and more

Governor, Vermont Agency of Human Services (AHS)
Including Medicaid

- **Vermont Medicaid Next Generation ACO Program** (payer)
- **Reporting to CMMI**, including plans for integrating public health and mental health, substance use disorder, and long-term care spending into financial targets

ACO (OneCare Vermont) and Vermont Providers

- **Contract with payers** to accept non-FFS payments and increase Model scale
- **Work with provider network** to implement delivery system changes intended to control cost growth and improve quality and access

Private Insurers and Vermont Businesses

- **Contract with ACO** to pay non-FFS payments on behalf of covered lives in alignment with the Model
- **Work with self-insured employers** as a TPA/ASO to demonstrate Model progress and bring new self-insured lives under the Model

All-Payer Model Agreement Signatories

VERMONT
AGENCY OF HUMAN SERVICES

Vermont All-Payer ACO Model Agreement Highlights

- Preserves all current beneficiary protections consistent with Medicare, Medicaid, or a Vermonter's commercial coverage plan.
- Medicare offers the opportunity, through an ACO, to receive benefit enhancements:
  - Post-discharge home visit
  - Easier access to Skilled Nursing Care
  - Telemedicine Services
- Encourages health care providers to better coordinate patient care and services.
- May lead to more meaningful time spent with your doctor.
- Links health care outcomes for the population with the health care delivery system.
- Provides federal monies to continue funding for the Blueprint for Health and SASH (Support and Services at Home) through ACO.
- Moves away from fee-for-service reimbursement on Vermont's terms yet consistent with sustained, bi-partisan federal direction.

All-Payer ACO Model Implementation Improvement Plan

The Agency of Human Services issued a plan in November 2020 for improving performance in the All-Payer Agreement.

The plan has four key categories of recommendations:

1. State/Federal work to maximize Agreement framework
2. Reorganization and prioritization of health reform activities within the Agency of Human Services
3. Evolving the regulatory framework for value-based payments
4. Strengthening ACO Leadership Strategy

VERMONT
AGENCY OF HUMAN SERVICES