



IMPLEMENTATION
IMPROVEMENT PLAN:

Vermont All-Payer
Accountable Care
Organization Model
Agreement

November 19, 2020

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Executive Summary

The State of Vermont is committed to moving away from fee-for-service reimbursement for health care services and to the health care system transforming to deliver value-based care. Instead of paying for every service regardless of the result, participating health care payers in the state have started rewarding high quality care and better health outcomes. Through a federal/state agreement, Vermont is a national leader in aligning Medicare, Medicaid, and commercial payers in a consistent model that aims to curb health care cost growth and increase quality of care and population health outcomes for Vermonters.

Over three performance years (PYs), Vermont has observed promise in paying providers differently, particularly in its Medicaid program where progress is most advanced. Aligned quality measures in the All-Payer Accountable Care Organization (ACO) Model are intended to address areas where Vermont's system has underperformed and to balance the focus on quality with the administrative burden that it places on provider organizations. In addition, predictable payments from the Medicaid program in particular have added stability for Vermont's system of care.

While there are clear indications that value-based and fixed payment programs are demonstrating some promise over traditional fee-for-service, the state will not realize the potential of health care payment and delivery system transformation unless we strengthen the weak points in both the model itself and its implementation through provider operational change.

There are three performance domains in the Vermont All-Payer ACO Model Agreement (Agreement) with the federal Centers for Medicare and Medicaid Services (CMS):

1. Scale Targets
2. Financial Targets
3. Quality and Health Outcomes Targets

Numerous issues can impede the potential for greater success in the Agreement. These issues, detailed in the body of this report, inform **four primary findings** with respect to Vermont's progress on health care reform as well as recommendations for improvement:

Vermont and the CMS can build on their partnership to accelerate payment and delivery system reform. Vermont is the only state in the nation that has agreed to, and is making significant progress, moving away from fee-for-service reimbursement on a statewide basis. The theory behind Vermont's Agreement, that incentives need to be aligned across as many patients and payers as possible for the health care system to change, is evidenced by provider reports that they do not have enough value-based revenue to promote delivery change. The state risks being in limbo in payment and delivery reform if it cannot transition more dollars to true fixed prospective payments. Vermont, through its Agreement, must continue its innovative work with CMS to design and implement prospective payments from Medicare that are no longer reconciled to the fee-for-service payment system.

Health care reform activities in the Agency of Human Services (AHS) are not clearly organized for success in the Agreement's performance domains. Health care reform activities across AHS are critical to success in payment and delivery system reform yet they are not overtly governed by the Agreement or its performance rubric. Key activities such as integrating clinical and claims data through the Health Information Exchange and the alignment of care coordination activities spanning patient centered medical homes and community-based health and social services are happening throughout Agency departments without a central organizing influence. Furthermore, AHS can do more to leverage the success of its Vermont Medicaid Next

Generation (VMNG) ACO program as evidence of the progress that can be achieved through payment and delivery system reform. Specifically, AHS should share its positive experience as an example to commercially insured and self-funded groups.

Vermont’s regulatory framework for curbing health care cost growth, while improving quality, continues to evolve. The Green Mountain Care Board’s (GMCB) health care regulatory approaches, defined in statute, focus on cost containment and were developed in response to unchecked growth in the fee-for-service health care system. Despite their origins, many of these regulatory approaches are in fact agnostic to reimbursement methodology but have not been optimized for value-based care. For example, GMCB’s hospital budget review assesses health care cost growth across both fee-for-service as well as fixed prospective payments. As the shift to fixed prospective payments continues, net patient revenue (NPR) may become less important relative to a hospital’s total budget but is unlikely to disappear entirely as care will continue to be delivered to patients from out of state, who will not be associated with a fixed prospective payment. And while Board members often consider quality performance in their decisions, quality could become a more central tenant of the regulatory framework. The Board and its staff continue to evaluate opportunities for regulatory alignment and how best to evolve their processes with Vermont’s goal of value-based care in mind. Because of the model’s voluntary nature, the success of Vermont’s health reform efforts and its underlying regulatory framework rely on (1) the state’s ability to signal to providers and payers that value-based care is not only the right thing to do, but inevitable, and (2) a preparedness for regulating a more integrated system at scale. A bold shift to value-based payment and delivery system reform over fee-for-service is necessary at this pivotal moment when more reimbursement needs to become value-based.

The leadership strategy at OneCare Vermont (also called OneCare), the only ACO in the state, must prioritize support for providers in transition to value-based payments and delivery system transformation. Provider participants across the state are unclear about how participation in OneCare Vermont is improving care delivery. Providers are also dubious about the information and tools OneCare provides in support of value-based care. Some resistance to change is to be expected, however widespread critique of the most basic tools to facilitate value-based payment suggests that OneCare has not responded quickly enough to address participant feedback. Since the start of the Agreement performance period, OneCare Vermont has identified and engaged in a wide variety of activities to promote health and wellness and to facilitate value-based care. While well intended, this strategy appears to have resulted in a diluted effort to create value for providers through the core tools of value-based contracting, data, and analysis to support delivery system transformation.

Recommendations

Recommendations are described throughout this report in response to detailed findings in each of the primary areas specified above and recommendations from Section I are included in a summary chart in Appendix A. Recommendations in Section I and II include:

- Leveraging the federal/state partnership to address limitations in the federal/state Agreement and to promote further innovation.
- Increasing participation among self-funded groups, including State of Vermont employees.
- Accelerating the transition to fixed prospective payments across all payers.
- Organizing health care reform activities in the Agency of Human Services to uniformly drive towards the performance domains in the state/federal Agreement.
- Offering increased opportunities for stakeholder and patient engagement.

- Advancing a new leadership strategy at OneCare Vermont to demonstrate the value of Accountable Care Organization membership.

Note: This report was developed in consultation with Green Mountain Care Board staff.

Introduction and Background

All Vermont residents should have access to high quality, affordable health care. To achieve this goal, the State of Vermont must address the significant and rising cost of care as well as the quality and experience of health care.

The fee-for-service reimbursement model for health care is widely recognized as a key driver of health care costs and can contribute to both fragmentation of care and poor experience of care. Fee-for-service compensation rewards the quantity of services delivered over the quality of patient outcomes. The fee-for-service model incentivizes providers and facilities to deliver high-margin services over those that are more preventive or potentially more effective, such as addressing health-related social needs. In this system, an emergency department visit by a patient results in high compensation to a hospital while providers who coordinate with one another to prevent certain emergencies are often unable to bill for time spent collaborating. In a fragmented system, coordinating one's own care can feel like an exhausting scavenger hunt; each patient is forced to collect different information from numerous providers and to present each subsequent provider with the discrete pieces of information they have gathered along the way. This can lead to errors, duplicative care, and a poor experience for the patient.

Accountable Care Organizations (ACOs) are delivery system transformation models where a group of health care providers agree to collaborate and share accountability for the quality and cost of care delivered to their patients. ACOs strive for clinical integration among those who are responsible for delivering patient care, across the health care continuum. ACOs can be a structure to support providers with developing a culture of high-value health care where the most appropriate services are delivered with the highest quality, and in the most effective way. Under the Affordable Care Act, ACOs are also constructs that allow providers to work together under a shared quality and economic framework without running afoul of anti-trust law.

The All-Payer ACO Model Agreement (Agreement) is a contract between the State of Vermont and the federal Centers for Medicare and Medicaid Services (CMS), specifically with the Center for Medicare and Medicaid Innovation (CMMI). The Agreement enables Medicare to participate in a statewide value-based payment model that is aligned across major payer types (Medicare, Medicaid, commercial). Medicare's participation is critical because Medicare beneficiaries comprise about 20% of the population but represent almost 30% of Vermont's total health care spending. The payment reform model rewards an ACO and its participating providers for efficiently delivering high quality services and maintaining the health and wellness of their patients. This approach differs from the traditional fee-for-service reimbursement model for health care services.

Through the Agreement, Vermont is working to transform payment and care delivery by enabling predictable prospective payments for ACO providers and encouraging financial risk arrangements that prompt proactive approaches to patient care. When providers work within a known budget for care, they have a strong incentive to ensure that people receive the most efficient and high-quality care at the right time and in the most appropriate setting. Providers can work together and with the patient to create a comprehensive person-directed care plan, and to coordinate across settings instead of putting this burden on an individual who is unlikely to be familiar with navigating the health care system.

While the Agreement is customized for Vermont, the federal government has demonstrated its shared commitment to moving away from fee-for-service reimbursement. CMS created the Medicare Quality Payment Program (QPP) to reward high value providers over low value providers.ⁱ Providers who qualify for the Advanced Alternative Payment Model track of the QPP earn bonuses from Medicare for participating in payment and delivery system reform; Vermont's Agreement qualifies participating ACO providers for the Advanced Alternative Payment Model track. Most recently, on September 15, 2020, the CMS issued a letter to State Medicaid Directors encouraging states to consider value-based care (VBC) models and stated that it "believes that value-based payment (VBP) is a key driver of VBC." The letter is a call to State Medicaid Directors to increase Medicaid participation in value-based care and payment.ⁱⁱ

Vermont and CMS have a six-year agreement with five calendar year Performance Years (PYs starting in 2018). As the end of 2020 (PY 3) approaches, the State of Vermont can meaningfully reflect on progress-to-date and see clearly where there are opportunities for improvement.

Vermont, well ahead of many states, can already attribute 88% of Medicaid primary payer enrollees to a value-based payment model in 2020. Given this experience, we have observed that paying providers differently is attractive and shows promise.

- For the third year in a row, providers receiving prospective payments have spent less than expected on services within their control, highlighting the potential of changing financial incentives in this model.
- There has been a steady increase in the percentage of high-risk and very high-risk attributed Medicaid members who received care coordination interventions under OneCare Vermont ACO's Advanced Community Care Coordination model (OneCare Vermont is the only ACO operating in the State).
- The All-Payer ACO Model Agreement quality framework has enabled quality metrics to be aligned across participating payer types reducing administrative burden and increasing focus on areas for improvement.

The COVID-19 pandemic presents a unique test of the health care system and of Vermont's system in transition. As the health care system curtailed elective visits and procedures to reduce the risk of virus transmission in the spring of 2020, revenue for these procedures fell away. However, Vermont providers in alternative revenue models who received fixed prospective payments for some portion of their business were better positioned to weather the loss of fee-for-service revenues. The pandemic has demonstrated that fixed prospective payments can create stability for the health care system and preserve access to care in-light-of changes in health care utilization. Dan Meuse at State Health and Value Strategies underscores Vermont's goals when he writes, "Moving to a system that pays providers for a population of patients, rather than for the individual services provided, would avoid the revenue shortage that providers are facing because of COVID-19. In fact, population-based payment models may provide a greater level of predictability for provider revenues in a way that could encourage longer term planning."

Recognizing the potential of paying for health care differently is not be enough to effectuate broad change nor to maximize Vermont's performance in the Agreement. Where Medicaid is exceling, Medicare and commercial programs are lagging in participation and in keeping a pace with innovation. At this juncture, the State of Vermont must also take bold action to accelerate health care system transformation and to improve performance in the state/federal Agreement with the goal of securing Medicare's future participation in state-based health care reform.

Section I: Maximizing Progress in Each Performance Domain of Vermont’s All-Payer Accountable Care Organization Model Agreement

Vermont’s progress in implementing the Agreement is measured in three domains:

1. Scale Targets,
2. Financial Targets, and
3. Health Care Quality and Outcomes targets.

Each domain and Vermont’s performance to-date are described below along with findings and recommendations for improvement. The Agreement has three signatories from the State of Vermont: The Governor, the Secretary of AHS, and the Chair of the GMCB. All three signatories have responsibility for overall performance in the Agreement, with lead responsibility in different areas. For example, the Secretary of AHS must ensure that the Department of Vermont Health Access (DVHA) offers a scale target qualifying Medicaid ACO Program and the GMCB has the authority to request modifications to Medicare’s national Next Generation ACO Model to create a Vermont-specific Medicare ACO program in PY 2-5 of the Agreement and the obligation to propose the Medicare ACO benchmark (spending target) for federal approval.

Scale Targets

As described by CMS, “CMS and Vermont aim for broad ACO participation throughout the state, across all the significant payers and the majority of the care delivery system, to make redesigning the entire care delivery system a rational business strategy for Vermont providers and payers.”

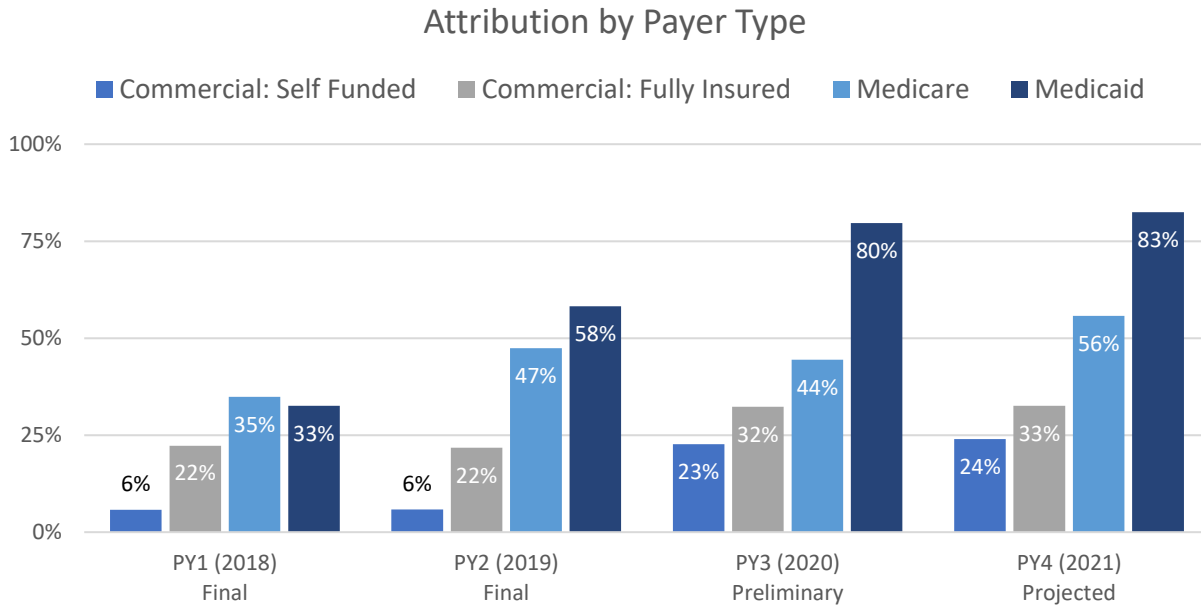
The Agreement specifies that 70% of Vermonters would be attributed to a Scale Target ACO at the end of PY5 and 90% of Vermont Medicare beneficiaries would be attributed to a Scale Target ACO by the end of the Agreement. Each year, progress is monitored against intermediate targets. Vermont underperformed in PY1 and PY2 (see table 1 below) with the percentage of Vermont Medicare beneficiaries attributed to OneCare Vermont lagging more than the overall percentage of individuals attributed to OneCare Vermont across all-payers (Medicaid, commercial and Medicare) see figure 1 below.

Table 1 Scale Target Performance

		PY1 (2018) Final	PY2 (2019) Interim	PY3 (2020) ¹ Preliminary	PY4 (2021)	PY5 (2022)
Vermont All-Payer Scale Target Beneficiaries	Target	36%	50%	58%	62%	70%
	Actual	22%	30%	42%*		
	(Difference)	(-14%)	(-20%)	(-16%)		
Vermont Medicare Beneficiaries	Target	60%	75%	79%	83%	90%
	Actual	33%	47%	44%*		
	(Difference)	(-27%)	(-28%)	(-35%)		

¹ For more information on 2018 and 2019 performance, see [All-Payer Model Reports and Federal Communications](#) (GMCB website). PY3 (2020) preliminary estimates are based on revised attribution as of 6/19/2020 and utilize 2019 population estimates. PY4 (2021) projections are based on Medicare preliminary attribution estimates (provided 11/9/2020) and OneCare Vermont 2021 budget submission to the Green Mountain Care Board and utilize 2019 population estimates.

Figure 1 Attribution by Payer Type



On September 16, 2020, CMS issued a [warning](#) to Vermont after the state fell short on scale targets for two consecutive performance years (PY1 and PY2). OneCare Vermont is estimating that more than 238,000 Vermonters will be attributed in PY4 (2021) and has made strides in attracting more participation from PY1 to PY4. Notably, OneCare Vermont now has contracts with two state-regulated commercial payers: Blue Cross Blue Shield of Vermont (BCBSVT) and MVP as well as with BCBSVT for self-funded clients. As described above, 88% of enrollees for which Medicaid is the primary payer are attributed to OneCare Vermont. Nevertheless, Vermont will again fall short on scale targets unless targets are modified so that they are feasible and payer and provider participation in the model increases.

Scale target performance is an important indicator because the Agreement supposes that provider behavior is more likely to change if incentives are aligned across as many payers and patients as possible. In their paper, *The Seven Characteristics of Successful Alternative Payment Models*, Marc Berg, David Nuzum, and Seema Parmar write, “For an APM [Alternative Payment Model] to succeed, the proportion of the provider’s book of business included in the model must be sufficiently large (high density) to motivate providers to change, justify investments, and adopt dedicated clinical-operational workflows.” Without enough scale in the model, providers face an uphill battle in achieving financial and quality targets.

Findings and Recommendations Related to Scale Target Performance

Findings and recommendations 1-6 pertain to Vermont’s federal/state Agreement

Finding and recommendation 7 pertains to the state’s prioritization of activities to support Value-Based Payment and Delivery System Reform and OneCare Vermont’s leadership strategy.

Finding 1: Scale targets as calculated are unattainable

As described, sufficient scale is required to motivate change. However, the scale targets as specified hold Vermont responsible for some Vermont Medicare beneficiaries and commercially insured individuals who cannot be attributed to the model. These Vermonters receive the preponderance of their health care out-of-state and are therefore ineligible for attribution.

Recommendation 1:

AHS and the GMCB should negotiate with CMS to revise scale targets to reflect growth in domains over which the state has reasonable influence. Targets should be achievable and aligned to scale strategies that could be realistically deployed by the state and its ACO partner(s). For example, there is little the State of Vermont or the ACO can affect as it relates to Vermonters who cannot attribute to an ACO because their primary health care providers are outside the state and not participating in an ACO.

Finding 2: The financial burden of participation in the Vermont Medicare ACO Initiative is onerous for hospitals

The Vermont Medicare ACO Initiative is the component of Vermont's All-Payer ACO Model Agreement that allows Vermont a custom approach to a Medicare ACO program. The Vermont Medicare ACO Initiative has a five percent symmetrical risk corridor. In OneCare Vermont's risk model, they delegate this financial risk to participating hospitals, most of whom must be able to accommodate potential losses of up to five percent. Accommodating this level of risk has been particularly challenging for hospitals with already thin margins (predominantly those that are small and rural) and with the arrival of COVID-19, most providers' financial positions have become more uncertain making the five percent risk even more unmanageable.

Recommendation 2:

The symmetrical risk corridor should be reduced if OneCare Vermont is able to maintain or increase scale. If OneCare Vermont is able to maintain the size of their existing network, the risk corridor should be reduced from 5% to 2.5% to lessen the financial burden of participation in the Vermont Medicare ACO Initiative. If OneCare Vermont can increase scale in the Medicare program by attracting new hospital participants, the risk corridor should be reduced to 2%. If OneCare Vermont is able to increase scale and expand participation to all hospitals in Vermont, then the risk corridor should be reduced to 1.5%.

Finding 3: Critical Access Hospital Participants in the Vermont Medicare ACO Initiative need clear direction on cost reporting

Critical Access Hospitals (CAHs) have a cost reporting structure rooted in the fee-for-service reimbursement system. When CAHs participate in the Medicare ACO Initiative and receive prospective payments that are reconciled against the fee for service equivalent at year end, cost reporting becomes complicated. Currently, there is no written guidance from CMS for the accounting of these prospective payments and their reconciliation.

Recommendation 3:

The GMCB should request that CMS establish written guidance or best practices in cost reporting for CAHs receiving prospective payments from Medicare and the GMCB should disseminate this guidance to participating hospitals.

Finding 4: The Vermont Medicare ACO Initiative is not attractive to providers looking for predictable payments

The Vermont Medicare ACO Initiative payment model includes a prospective payment with a year-end reconciliation to fee-for-service equivalents based on shadow claims, or expenditures that would have been incurred if operating under a fee-for-service payment model. This means that if a provider manages to reduce expenditures relative to the prospective payment, the provider will owe CMS the difference between the payment and the actual services delivered. In this arrangement, providers do not have a strong incentive to

deliver care more efficiently than they would in a typical fee-for-service system. Providers' incentive to reduce unnecessary spending is through the end-of-year financial target in the ACO-payer arrangement, which is challenging to estimate on a per-hospital basis. By contrast, The VMNG ACO program offers, through OneCare Vermont, the option to elect a true fixed prospective payment. In this model there is no reconciliation of the prospective payments to the fee-for-service equivalent. Providers prefer this model because fixed prospective payments provide predictability, stability, and flexibility. Providers are participating in the VMNG ACO program in all fourteen Hospital Service Areas (HSAs) in the state, which is a significant contrast to provider participation in the Vermont Medicare ACO Initiative in only seven HSAs.

Recommendation 4:

The GMCB and AHS should work with CMS to establish a path for the Medicare payment model to mirror VMNG ACO program fixed prospective payments.

Finding 5: Uncertainty created by the pandemic poses challenges for prospective payment methodologies based on fee-for-service claims

Claims or shadow claims submitted for each health care service are the foundation for prospective payment models and serve as key components of an ACO's budget. Typically, all of the historical health care claims for a population are trended forward to generate a budget for prospective payments as well as any financial targets against which savings or losses will be measured (e.g. Medicare benchmark). In a year where the health care system functioned very differently and far fewer people sought elective and preventive services, it will be difficult to develop a realistic budget benchmark for the ACO.

Recommendation 5:

The GMCB should propose a benchmark for the 2021 Vermont Medicare ACO Initiative for CMS approval that provides as much stability and predictability as possible to produce financial targets that are adequate and achievable despite the ongoing uncertainty associated with the pandemic.

The Department of Vermont Health Access (DVHA) should design and pilot a benchmarking approach for the VMNG ACO program that is divorced from previous claims experience. Once established, this approach may be applicable to Medicare and commercial payer programs alike.

Finding 6: Federally Qualified Health Centers (FQHCs) need stronger incentives to participate in value-based payment models

Federally mandated "floors" for FQHC payment mean that these entities are effectively unable to assume downside risk in fee-for-service alternatives. However, FQHCs may have interest in fixed, predictable payments or in participating in more value-based payment models for ACOs.

Recommendation 6:

AHS and GMCB should collaborate with CMMI to encourage the Health Resources and Services Administration (HRSA) to prioritize value-based payment models and Federally Qualified Health Center participation in ACOs offering fixed prospective payments.

Finding 7: Commercial payer participation through self-funded groups is low

OneCare Vermont has collaborated with BCBSVT to create an ACO program for large client business yet, significant large client groups including the State of Vermont Employees and the public school teachers have

not yet attributed their members to OneCare Vermont. Other commercial payers with significant business in the State of Vermont, such as CIGNA, do not have contracts with OneCare Vermont.

Recommendation 7:

The AHS and the Agency of Administration (AOA) will:

- Include State Employee Health Plan members for attribution to OneCare Vermont in 2021 (PY4),
- Educate non-participating self-funded groups, including teachers, about the benefits of participation in a value-based payment and delivery system transformation model based on experience with the Medicaid VMNG ACO program,
- Target outreach to self-funded hospitals that are not participating on behalf of their employees, and
- Communicate to the business community about the advantages of paying for health care differently.

Financial Targets

The Agreement includes financial targets for all-payer growth and for Medicare growth specifically. Vermont is expected to maintain a compounding annual growth rate of 3.5% over the term of the Agreement. However, corrective action for this target is not triggered unless Vermont experiences growth of more than 4.3%. For Medicare, Vermont is expected to maintain a compounding annual growth rate that is at least 0.2% below national projections. Corrective action on this target is not triggered unless Vermont Medicare growth exceeds national projections by 0.1% or more. The All-Payer financial target applies to all Vermont residents and in PY3, the Medicare financial target applies to all Vermont Medicare beneficiaries.

As described above, ACOs are groups of providers that take responsibility for the cost and quality of care for a defined group of patients. The ACO can impact health care cost growth and quality by being a conduit for value-based contracting and providing data, analytics, and tools to support delivery system transformation. If the majority of Vermonters are attributed to an ACO, there is greater potential for this ACO to achieve the financial targets as outlined in the Agreement.

Due to data lags, performance against financial targets has only been calculated for PY1 and the assessment of financial target performance is only complete for the All-Payer financial target. In PY1 Vermont's All-Payer financial target growth was 4.1%. Growth exceeded the aspirational target of 3.5% but did not cross the threshold for corrective action. Importantly, in PY1, only 112,756 Vermonters were attributed to an ACO, so health spending growth was calculated primarily for Vermonters who were not attributed to an ACO. OneCare Vermont outperformed the financial targets in both the Medicare and Medicaid programs in PY1.

Although not yet aggregated, some PY2 financial results are now available at the individual payer program level. In the 2019 performance year of the Vermont Medicaid Next Generation ACO program, ACO-participating providers who were paid prospectively (instead of fee-for-service) spent \$8.2M less than expected on the services within their control. Conversely, providers who were paid fee-for-service (both within and outside of OneCare's network) spent \$13.5M more than expected. This highlights how two different financial incentives might impact the delivery and cost of health care. Because financial performance exceeded the agreed-upon price, OneCare was liable for the full amount within a 4% risk corridor—approximately \$8.1 million. After application of other necessary adjustments, OneCare Vermont owed approximately \$6.7 million to DVHA. If DVHA and OneCare did not have this risk-sharing arrangement, the Vermont Medicaid program would have paid the entirety of the amount in excess of the expected price.

Entering PY4 of the All-Payer Model Agreement, OneCare Vermont is anticipating that 238,000 Vermonters will be attributed to the ACO, increasing its potential to impact both the All-Payer and Medicare financial

targets. However, health care spending for more than half of Vermonters will still occur outside of a value-based payment.

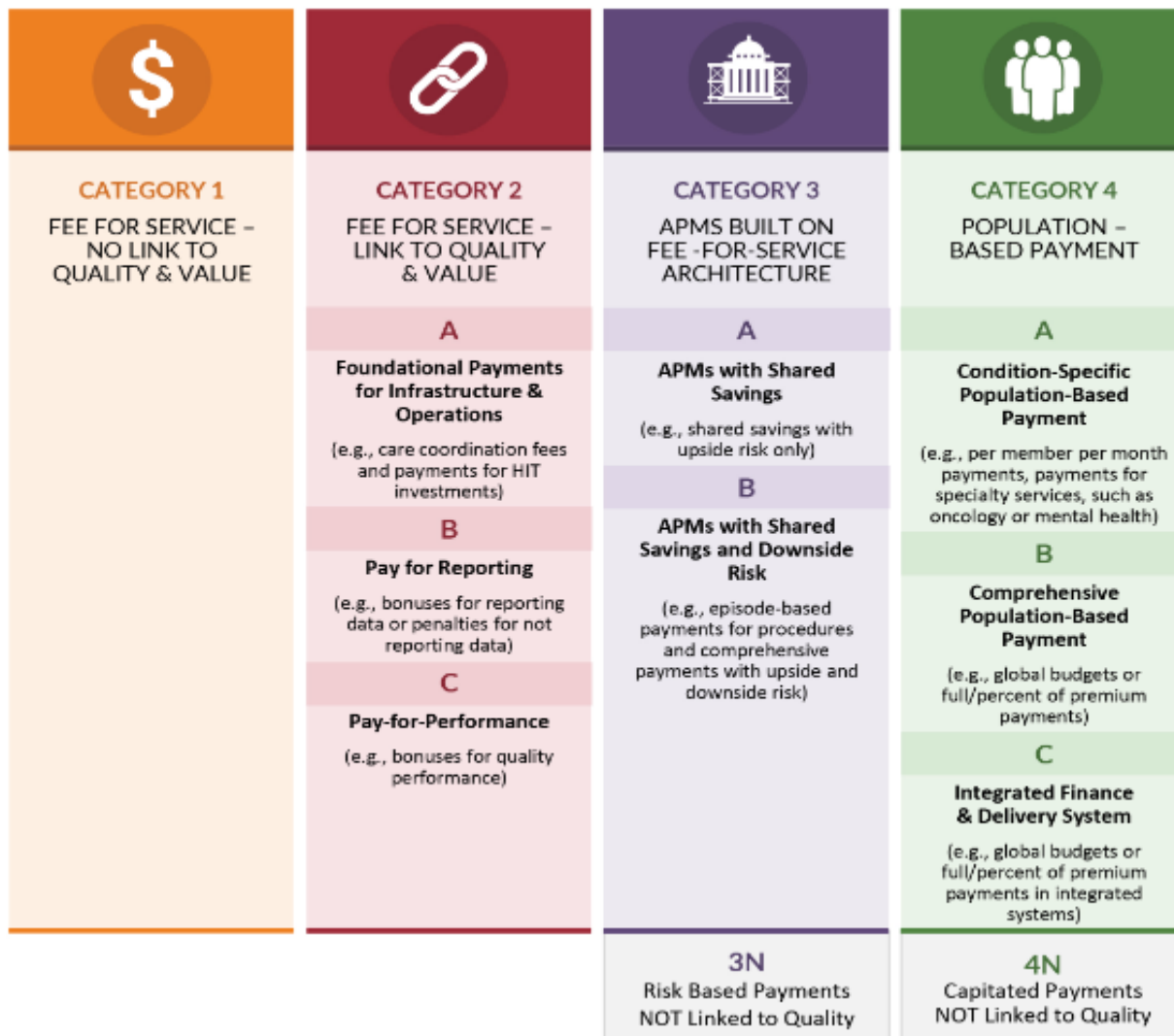
Findings and Recommendations Related to Financial Target Performance

Findings and recommendations in this section relate to the evolving regulatory approach for curbing cost growth and improving quality

Finding 8: Provider incentives must be properly calibrated to maximize savings potential

According to the Health Care Payment Learning Action Network Framework for Alternative Payment Models (see figure 2 below), the most advanced APM is designed with population-based payments linked to quality like the payments in the VMNG ACO program. Because population-based payments are fixed and offered prospectively, they provide the strongest incentive for providers to engage in delivery system transformation. Were providers not paid prospectively, such transformation would have a negative impact on revenue in a fee-for-service payment model. When only a segment of provider payments are population-based or fixed prospective payments, the incentive to go “all-in” on transformation isn’t there. In fact, fully redesigning the delivery system, changing provider behavior, and potentially decreasing a large volume of certain services would have a strong negative impact on the remaining fee-for-service revenue streams.

Figure 2 HCP LAN Updated APM Framework



Recommendation 8:

Accelerate the transition to population-based payments for all payers contracting with OneCare Vermont and increase the percentage of fixed prospective payments in the VMNG ACO program contract by initiating the following actions:

- The GMCB and AHS will negotiate with CMS per Scale Target Recommendation 4 to establish a path for the Medicare payment model to mirror the VMNG ACO program,
- The GMCB and AHS will request that BCBSVT, MVP, and OneCare Vermont identify clear milestones for including fixed prospective payments in contract model design, and
- OneCare Vermont should negotiate with its network participants to increase the percentage of fixed prospective payments in the VMNG ACO program contract.

Finding 9: Incentives for providers should be aligned with value-based payment

The population-based payment model for an ACO is an aggressive move away from fee-for-service reimbursement. However, provider incentives at every level should be aligned with the population-based payment methodology to induce transformation and realize greater value.ⁱⁱⁱ

Recommendation 9:

Under authorities for both ACO and hospital budgets, the GMCB should explore how ACO participants can move incrementally towards value-based incentives for the providers they employ, building on the narrative responses and testimony requested through Hospital Budget processes on this topic to date.

Finding 10: OneCare Vermont has not demonstrated focus on core business of cost reduction and quality improvement

ACOs must have strong systems in place for identifying areas for improvement against the ACO cost and quality measure benchmarks. Once a deficiency is identified, resources need to be deployed to address the cost or quality concern and ACO leadership needs to regularly communicate the strategies for improvement and the progress that is being made.^{iv} McKinsey and Partners write, “The clearer it is to providers how to achieve high-value performance, the more likely it is they will succeed.”^v

Recommendation 10:

- a.) Annually, in its budget presentation to the GMCB, OneCare Vermont should identify cost growth drivers across its network and detail its approach to curb spending growth and improve quality. The GMCB should consider whether a framework can be applied to help organize the ACO’s strategies for curbing cost growth and improving quality and consider requiring the ACO to identify opportunities for system level efficiencies within hospitals, between hospitals, and across the continuum of care.
- b.) OneCare should communicate its strategic objectives, plan of action, and how it will monitor progress. OneCare Vermont must determine and be clear to providers about the following:
 - Expectations about the change that providers need to make,
 - The standard for this change,
 - How real-time data is being used to monitor and track progress, and
 - The available incentives to drive this change.

Health Outcomes and Quality of Care Targets

The Vermont All-Payer ACO Model Agreement contains three high level population health outcomes goals with six associated measures and targets:

1. Increase access to primary care (the measure is the percentage of Vermont adults reporting that they have a personal doctor or health care provider);
2. Reduce the prevalence and morbidity of chronic disease (the three measures are the percentage of Vermont adults reporting that they have been told by a health care provider that they have diabetes, high blood pressure, and chronic obstructive pulmonary disease); and
3. Reduce deaths due to suicide and drug overdose (the two measures are deaths from drug overdose and deaths from suicide).

To measure progress against these goals, the quality framework also contains process milestones and health care delivery system targets that contribute to the identified population health outcomes goals. Taken together, this framework includes 22 measures with PY5 (2022) targets by which progress is determined, some of which are at the state level and some of which are ACO-level measures. The framework, negotiated by the State of Vermont and CMS, is intended to identify meaningful health care system improvement goals for the state in part based on the 2013-2018 State Health Improvement Plan. The framework acknowledges that the high-level population health outcomes goals cannot be achieved by a health care system in isolation and it creates accountability for both the State of Vermont and participating ACOs to address both health and the social determinants of health.



High performing ACOs maximize alignment of measures across payer contracts to amplify focus on improvement and to reduce administrative burden. OneCare Vermont's ACO-level quality measures are highly aligned with the Agreement's quality framework and across payer contracts, reflecting years of ACO standards building, partnership with the GMCB to customize the measure set for the Vermont Medicare ACO Initiative, and collaboration with Medicaid and participating commercial payers to reflect Vermont's priorities for quality improvement. In the 2020 contracts, eight measures are found in measure sets for all three payer types, and five more are reflected in measure sets for two payer types.

Performance to date on the quality framework may reflect benefits of this measure alignment. The most recent data for the state's performance on the 22 measures in the Agreement is from PY1 (2018). The requirement for PY1 was for the state to show movement toward the PY5 targets. In PY1, the state's performance met the PY5 targets for three of the six population health outcomes measures (the measures of prevalence of diabetes, hypertension, and COPD). Results were closer to the PY5 targets for two additional measures (deaths from suicide and drug overdose). The primary care access measure did not show improvement in PY1. The state's

performance also showed promising movement toward PY5 targets. Performance moved closer to the PY5 targets for seven of the nine health care delivery system quality measures and for six of the seven process milestones.

OneCare Vermont results for each of the payer programs are available for PY2 (2019). Year-over-year improvements should be considered with caution, given that attribution has increased in all three payer programs and populations vary from year to year. In PY2:

- OneCare received a score of 91.88% for the 20 quality measures in the Medicare ACO Initiative.² For the 14 measures that could be compared to national Medicare results, OneCare performed at the 70th percentile or higher for 11 of the measures. Of the 16 measures that carried over from 2018, 12 measures saw improved results.
- OneCare received a score of 95% for the ten quality measures that were in the Vermont Medicaid Next Generation ACO Program. For the eight measures that could be compared to national Medicaid results, OneCare performed at the 75th percentile or higher for five of the measures. Results improved from 2018 for nine of the ten measures (improvement was statistically significant for 5 of those measures).
- For eight measures in the BCBS VT commercial program, OneCare saw improvement in four of the measures (with statistically significant improvement in two of them). Performance was at the 75th percentile or higher for four of the measures.

The degree of alignment in measures across payer programs and the early results are encouraging, but there is still opportunity for improvement in many areas. Together, the state and OneCare Vermont need to continue to focus efforts on population health outcomes goals to maintain performance on the targets that have been met and to make meaningful progress on the targets that have not been met. Health Information Technology (HIT) improvements and programmatic alignment between OneCare Vermont and the State of Vermont are necessary to realize significant improvement on population health outcomes goals.

Findings and Recommendations Related to Health Outcomes and Quality of Care Targets

Findings and Recommendations 11, 14-18 relate to state prioritization of activities to support payment and delivery system reform

Findings and Recommendations 12 and 13 relate to leadership strategy at OneCare Vermont

Finding 11: The Health Information Exchange (HIE) does not provide access to integrated claims and clinical data to inform cost and quality of care

Alternative payment and delivery system models depend on robust data systems and tools that meaningfully harness, present, and interpret the data for its users to be effective.^{vi viiviii} McKinsey and Company write, “We have found that there are specific capability areas that are most critical to invest in... Examples of these capabilities include integration of claims and clinical data...”^{ix} In its 2017 study of Vermont’s HIE, HealthTech Solutions writes, “Reform efforts, including the Vermont All-Payer Accountable Care Organization Model, assume that providers, payers, and Accountable Care Organizations (ACOs) will use data to understand program impacts to increase quality and reduce costs. HIE is meant to be the backbone of that data.” Vermont’s HIE does not yet offer integrated claims and clinical data, either for OneCare Vermont or other providers participating in value-based payment and care arrangements.

² Five of the Medicare ACO Initiative measures in the payment category (scoring based on performance) were moved to the reporting-only category (full score earned for reporting the measure) as all activities related to the Quality Measure Validation audit for PY2019 were cancelled.

Recommendation 11:

Responsibility and oversight of the Vermont HIE (VHIE) and Health Information Exchange Strategic Plan should be redirected to the Office of Health Care Reform within the AHS Central Office (also known as the Secretary's Office), given the necessary collaboration with the GMCB, and the critical role of the Vermont Health Information Exchange (VHIE) in forwarding Vermont's health care delivery system reform goals. The Health Information Exchange Strategic Plan and oversight of HIT progress is a shared responsibility between the AHS and the GMCB. The DVHA holds the contract with Vermont Information Technology Leaders (VITL, which operates Vermont's health information exchange) and authors the Health Information Exchange Strategic Plan. The GMCB oversees VITL's budget and approves the Health Information Exchange Strategic Plan.

Consistent with the Health Information Exchange Strategic Plan, the AHS, VITL, the State HIE Steering Committee and the GMCB need to accelerate progress in making integrated claims and clinical health data available to providers.

Finding 12: Health care providers participating in OneCare Vermont are frustrated by care coordination tools

OneCare Vermont employs Care Navigator as its primary tool for care coordination purposes. OneCare describes this tool as "a common platform in which all members of the care team, including the patient, can communicate regarding updates and needs, and a place where all team members can access the patient's shared plan of care." Providers' anecdotal assessments of Care Navigator range considerably but there is consistent agreement that all members of the care team should be able to access Care Navigator but are not currently allowed access.^x

Recommendation 12:

OneCare Vermont in partnership with the AHS and delivery system users should evaluate the efficacy of Care Navigator to determine whether investments should be made to improve Care Navigator specifically, or if other care coordination tools offer greater value. At a minimum, this evaluation should determine the feasibility of allowing expanded care teams access to Care Navigator and whether Care Navigator is the optimal tool to support care coordination.

Finding 13: Health care providers report mixed value in the data they receive from OneCare Vermont

In a survey of high-performing ACOs, greater transparency on provider-level performance and utilization variation was the best tool identified to support continuous improvement and behavior change.^{xi} Data must be accurate, understandable, actionable and timely to encourage continuous improvement and provider behavior change. Providers in OneCare's network have said either they do not know how to use the data provided or that the data they receive adds no value over the information that is already available to them.

Recommendation 13:

OneCare Vermont should elevate data as a value-added product for its participants. Payers must be held to the terms of their contracts to deliver this data on time so that it can be as close to real-time and actionable as possible.

The ACO should focus on improving the data available to providers to clearly demonstrate:

- Utilization and intensity trends,
- Performance against financial targets,
- Performance on quality targets, and

- Comparison to peers.

In addition to timely and actionable data, OneCare should strengthen its program of technical assistance and quality improvement to assist providers in interpreting and responding to the data.

Finding 14: The Blueprint for Health and OneCare Vermont can be further aligned

Vermont's readiness for a statewide move away from fee-for-service towards two-sided risk models and prospective payment for providers is based on a strong foundation of all-payer primary care reform. The Blueprint for Health Advanced Primary Care program (Blueprint for Health) created a statewide system of Patient-Centered Medical Home (PCMH) primary care practices and a multi-disciplinary Community Health Team (CHT) in each Health Service Area (HSA). The CHT includes social service providers, care coordinators, and other types of providers, and is intended to offer comprehensive supports to people with complex health needs and the PCMHs that provide them with care. In each HSA, PCMHs and CHTs are supported by a Program Manager and a Quality Improvement Facilitator. The Blueprint for Health also includes implementation of a Chronic Disease Self-Management Program in each HSA.

In crafting the ACO care model and care coordination functions, OneCare Vermont and the Blueprint for Health have consistently worked to create alignment between programs. However, the Blueprint for Health has not been explicitly framed as a steppingstone for participation in more advanced value-based payment models. While work remains to continuously align the PCMH program with the work of Accountable Care Organizations, policy needs to mirror this approach.

Recommendation 14:

Through a phased approach, over a multi-year period, the AHS will condition provider participation in the Blueprint for Health's Patient Centered Medical Home payments on participation in a value-based payment arrangement with an ACO. This condition is intended to marry the state's payment and delivery system transformation priorities and to promote participation in alternatives to fee-for-service reimbursement.

Finding 15: Complex care coordination competencies can be improved

The Agency of Human Services (AHS), community providers, and OneCare Vermont can be productive partners in improving the complex care model for diverse populations. This collaboration is particularly critical for making progress on population health outcomes goals to reduce the prevalence and morbidity of chronic disease and to reduce deaths due to suicide and drug overdose.

The populations for which AHS, community providers, and OneCare Vermont share accountability include persons with complex medical needs and medical and social needs. Coordinating care and developing care competencies for these populations requires focus and direct experience with programs across the expanded care continuum, to include social services.

AHS' departments have multiple points of intersection with existing care coordination models, with community-based providers, and with OneCare Vermont, yet this work has not been clearly unified by the All-Payer ACO Model Agreement Health Outcomes and Quality of Care Targets, which are informed by the SHIP. While well intended, separate care coordination priorities within each department of AHS can lead to confusion and fragmentation for members and providers alike.

Recommendation 15:

AHS, OneCare Vermont, and community providers should improve collaboration to strengthen integrated primary, specialty, and community-based care models for people with complex medical needs and medical and social needs. These populations include older adults, people with disabilities and people with lived experience of mental health concerns and/or substance use dependency.

To collaborate more effectively, AHS will organize its Vermont Chronic Care Initiative (VCCI) and the Blueprint for Health within the Office of the Secretary and the Office of Health Care Reform. Within this office, these activities can be better coordinated to improve collaboration on implementing the care model and finding further points of intersection and integration with Field Services Local Interagency Teams responsible for coordinating and meeting the social services' needs of Vermonters.

Priorities for refining competency building and care coordination models will be based on stakeholder input. Bi-directional data sharing between these organizations and the AHS will be necessary for improving complex care coordination.

Finding 16: Social determinants of health screenings are not standardized across the health care system

Screening to assess social determinants that are influencing an individual's health is a key activity in a system seeking to impact health across the health and human services care continuum. A consistent approach to screening for social determinants of health in Vermont care settings has not been implemented.

Recommendation 16:

Aligning with the All-Payer ACO Model Agreement's goals to reduce deaths due to suicide and drug overdose, the Office of Health Care Reform in the Secretary's office along with AHS departments, OneCare Vermont, and community provider partners should identify a timeline and milestones for incorporating social determinants of health screening into the standard of care in health and human services settings. Prioritization should be given to screening and navigation to services for substance use dependency and suicidality.

Finding 17: Vermonters need a meaningful avenue to provide real-time feedback on access to care and experience of health care

The Agreement seeks to improve access to primary care and to improve care coordination across settings. While the Agreement's measurement framework includes measures of access to primary care and measures reported through the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, this information is not available on a rapid cycle to inform providers about patient experience nor does it give patients a routine way to comment on and impact an evolving system of care.

Recommendation 17:

The AHS, through the Blueprint for Health, will jointly explore with OneCare Vermont and stakeholders the best available tools for capturing real-time patient feedback and to pilot such a methodology with willing primary care practices.

Finding 18: Vermonters need a regular opportunity for stakeholder input on implementation of the All-Payer ACO Model Agreement and to inform any future agreement

As Vermont seeks to improve performance in the Agreement and prepares to consider a proposal for a next agreement, interested stakeholders need an opportunity for regular input.

Recommendation 18:

Together with the GMCB, the Office of Health Care Reform in the AHS Central Office will prioritize stakeholder engagement to inform both the ongoing implementation of the Agreement and to inform the state in its approach to a renewed state-federal Agreement in furtherance of Vermont's goals to address the rising cost of health care and to improve the quality of care and health outcomes for its citizenry.

The GMCB and the AHS will convene a quarterly public stakeholder meeting with the following standing agenda items:

1. All-Payer Accountable Care Organization Model Agreement implementation and performance update,
2. Required activities to inform potential Agreement renewal, and
3. Stakeholder input

Section II: Accountable Care Organization Leadership Strategy

Advancing a New Leadership Strategy for OneCare Vermont

In their Health Affairs Blog post on *How the Most Successful ACOs Act As Factories of Innovation*, Claire Pierce-Wrobel and Jeff Micklos write, *No organization gets it perfectly right on the first try. High-performing ACOs understand that overhauling the delivery of care and succeeding under new financial incentives is a long-term endeavor that requires many adjustments along the way.*^{xii}

Today, OneCare Vermont is the only ACO operating in the state and is the only ACO participating in Vermont's All-Payer ACO Model Agreement. As such, OneCare Vermont must appreciate its outsize role in Vermont's health care reform initiatives and the necessity of building trust and faith with Vermonters, health care providers, and its partners in state government. To foster confidence, the leadership team at OneCare Vermont needs to be strengthened to better deliver:

- Mastery of core business,
- Data-driven entrepreneurship,
- Transparency, and
- A statewide culture of continuous improvement

Mastery of Core Business

OneCare Vermont needs relentless focus on the core business of becoming a high-value health care system, which means delivering actionable, useful data and tools to the participants in its network. ACO Leadership must be able to challenge flawed care protocols and practices and push the system towards process improvement. This work requires unwavering attention to tracking progress against goals and to building a culture of continuous improvement with a large and diverse network of providers. Vermont benefits from considerable existing health care reform infrastructure as well as strong public health programming. OneCare Vermont should lean on existing infrastructure and add to it the real-time data and point-of-care tools for transformation. Attempting to commandeer or recreate existing resources divide the necessary focus for mastering data driven cost growth moderation and quality improvement.

Entrepreneurship

To attract and maintain participants in its provider network, OneCare Vermont must adopt an entrepreneurial posture and devote staff and resources to being responsive to both the monetary and non-monetary needs of

providers. While OneCare Vermont cannot be something different to every provider, it can be more responsive to the needs of its provider participants.

Transparency

As the only ACO in the state and with a large, geographically distributed network, OneCare needs complete transparency with its members, partners, and the public. OneCare must be clear and dedicated to its priorities and forthcoming when there are challenges. Payer partners need to rely on OneCare as a teammate in problem solving; OneCare needs to make information available to payer partners and regulators who are collectively gauging the progress of transformation. In keeping with this principle, OneCare Vermont needs to be responsive to requests for information from the GMCB and AHS.

Statewide Culture of Continuous Improvement

Vermont's small population and relatively non-competitive provider landscape suggest that provider coordination and delivery system transformation through a single ACO could have advantages: efficiencies from shared data and information infrastructure and opportunities for coordination across provider types and settings. A unified network of providers also presents an opportunity to more quickly advance systemwide goals such as improving health equity or reducing deaths due to suicide or drug overdose.

On the other hand, a single ACO needs to demonstrate value to a significant variety of provider types, both to maintain current participants and to attract "fence sitters." While knowledge about what makes a successful ACO is still evolving, the existing literature is clear that leadership matters.^{xiiiiv} Stakeholders at every level of the organization should feel engaged in a culture of continuous improvement or a high-value culture. To achieve such a culture, leaders need to repeatedly test new approaches, involve providers across the care continuum, and focus on their core business.

Appendix A: Section I Recommendations Summary

*Short-Term = 2020, 2021; Medium-Term = 2022; Longer Term = 2022 and beyond

	Activity to Improve Performance in the All-Payer Accountable Care Organization Model Agreement	Timing*	Lead (s)	Agreement Domain Impact
1.	Negotiate with CMS to revise scale targets to reflect realistic capacity for participation.	Short-Term	AHS, GMCB	Scale, Financial, Quality
2	Reduce Medicare risk corridor thresholds and decrease the financial burden of participation for hospitals.	Short-Term	AHS, GMCB	Scale, Financial, Quality
3	Request that CMS establish written guidance or best practices in cost reporting for CAHs. GMCB should disseminate any guidance.	Short-Term	GMCB, AHS	Scale, Financial, Quality
4	Establish a path for the Medicare payment model to mirror Vermont Medicaid Next Generation fixed prospective payments.	Short/Medium-Term	AHS, GMCB	Scale, Financial, Quality
5	Ensure Medicare 2021 benchmark provides as much stability and predictability as possible to produce financial targets that are adequate and achievable despite the ongoing uncertainty associated with the pandemic.	Short-Term	GMCB, AHS	Scale, Financial, Quality
6	Collaborate with CMMI to encourage Health Resources and Services Administration to prioritize Value-Based Payment for Federally Qualified Health Centers.	Longer Term	AHS, GMCB	Scale, Financial, Quality
7	AHS and the Agency of Administration will conduct education and outreach to non-participating self-funded groups about the benefits of participating in value-based payment models and Include State Employee Health Plan members for attribution to OneCare Vermont in 2021 (PY4).	Short/Medium-Term	AHS	Scale, Financial, Quality
8	Prioritize increasing the percentage of fixed prospective payments in the VMNG/OneCare Vermont contract. The GMCB and AHS will request that BCBSVT, MVP, and OneCare Vermont identify clear milestones for including fixed prospective payments in contract model design.	Short/Medium-Term	AHS GMCB Payers OneCare	Financial
9	Under authorities over both ACO and Hospital budgets, the GMCB should explore how ACO participants can move incrementally towards value-based incentives with the providers they employ.	Longer Term	GMCB	Financial
10	Annually, in its budget presentation to the Green Mountain Care Board, OneCare Vermont should identify cost growth drivers across its network and detail its approaches to curb spending growth and improve quality. OneCare should communicate its	Short-Term	GMCB	Financial

	strategic objectives, plan of action, and how it will monitor progress.			
11	Prioritize the integration of claims and clinical data in the HIE and organize and align the HIE with the Office of Health Care Reform within the AHS Secretary's office. Coordinate with the HIE Steering Committee.	Short/Medium-Term	AHS HIE Steering Committee	Financial Quality
12	Partner with OneCare Vermont and delivery system users to evaluate efficacy of Care Navigator platform.	Short/Medium-Term	AHS, OneCare, Delivery system users	Quality Financial
13	OneCare Vermont should elevate data as value-added product for its network participants and support providers in leveraging the information for change.	Short/Medium-Term	OneCare	Quality Financial Scale
14	AHS will condition provider participation in the Blueprint for Health PCMH payments on participation in value-based payment arrangement with an ACO.	Longer Term	AHS	Quality Financial Scale
15	AHS, OneCare Vermont, and community providers should improve collaboration to strengthen integrated primary, specialty, and community-based care models for people with complex medical needs and medical and social needs. Organize VCCI and Blueprint for Health in Office of Health Reform in Secretary's Office.	Short-Longer Term	AHS, Community providers, OneCare	Quality Financial
16	AHS, OneCare Vermont, and community provider partners should identify a timeline and milestones for incorporating social determinants of health screening into the standard of care in health and human services settings.	Medium-Term	AHS OneCare Community providers	Quality
17	AHS, through the Blueprint for Health, will jointly explore with OneCare Vermont and stakeholders the best available tools for capturing real-time patient feedback and to pilot such a methodology with willing primary care practices.	Longer Term	AHS	Quality
18	AHS and the GMCB will prioritize regular stakeholder engagement opportunities.	Short Term	AHS GMCB	Quality Financial Scale

ⁱ Centers for Medicare & Medicaid Services. (n.d.). *Quality Payment Program*. <https://qpp.cms.gov/>

ⁱⁱ Centers for Medicare & Medicaid Services. (2020). *SMD #20-004 RE: Value-Based Care Opportunities in Medicaid*. Retrieved November 18, 2020, from <https://www.medicare.gov/Federal-Policy-Guidance/Downloads/smd20004.pdf>

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^{iv} Ibid.

^v Berg, M., Nuzum, D., & Parmar, S. (2020, March 01). The seven characteristics of successful alternative payment models. *McKinsey & Company*. Retrieved November 18, 2020, from <https://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/the-seven-characteristics-of-successful-alternative-payment-models>

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