

VERMONT ALL PAYER MODEL CMMI NEGOTIATION UPDATE NOVEMBER 30, 2015

AGENDA

- National Health Service (NHS) Forward view
- All Payer Model update
- Gobeille V. Liberty Mutual

National Health Service Forward View

Multispecialty Community Providers

- Combines nurses, community health services, hospital specialists and perhaps mental health and social care to create integrated out of hospital care

Primary and Acute Care systems

- Combining for the first time general practice and hospital services, similar to Accountable Care Organizations now developing in other countries too.

National Health Service Forward View

What factors are driving this change in the United States, England, and in other developed nations?

“ Changes in patients health needs and personal preferences. Long term health conditions, rather than illnesses susceptible to a one-off cure- now take 70% of the health service budget. At the same time many (but not all) people wish to be more informed and involved with their own care...”

“The future health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain all now depend on a radical upgrade in prevention and public health.”

Turning to Vermont....

- Fee for Service can create silos; distorts care continuum
- Primary Care reimbursement, access and quality of practice life must improve
- Multiple payers, multiple measures, multiple programs are dizzying for providers and patients
- The future of Government reimbursement is ambiguous; and the only clarity is a potential decrease in resources
- In 2025, \$41,253 for a platinum plan will cause even greater pressure on patients, providers and society in general

Approach to the Model Agreement and CMMI

- CMMI has authority to allow “States to test and evaluate systems of all-payer payment reform for the medical care of residents of the state”
- A necessary element to motivate CMMI is demonstrating that Vermont is serious about testing a truly innovative delivery model
- Under the agreement, Vermont “stands in the shoes” of Medicare
 - As a result Vermont needs to demonstrate authority (to set Medicare rates) and a willingness to act (i.e., to implement an innovative model)
- Vermont’s strategy is to maximize flexibility under the Model Agreement and minimize federal specifications for the all-payer delivery system
- Certain areas may require operational changes from Medicare – those are high-priority areas to identify and address
- As we finalize a term sheet we will learn more about how much detail CMMI needs about the ACO to approve the model agreement

The Model Agreement

Matters between Vermont and CMS

- Financial targets
 - All-payer and Medicare growth
- Legal authority
 - State and Federal
- Covered services aka “regulated revenue”
- Description of the innovation, including quality goals and targets
- Evaluation, monitoring and enforcement

Matters between Vermont and ACO

- Payment rates and methods
- Risk arrangements
- Attribution methodology
- Structure of payments to ACO providers
- Rates of payment to ACO providers
- Quality measures for the ACO
- ACO Governance

Financial Targets in the Model Agreement

- **All-Payer Target** – a defined goal for spending
- **All-Payer Ceiling** – upper limit on spending, actual spending must be lower
- **Medicare Savings** – minimum savings required under the agreement
 - Separately calculated and benchmarked to national growth
- **Regulated Revenue** – Spending categories subject to the all payer ceiling and from which Medicare savings are derived

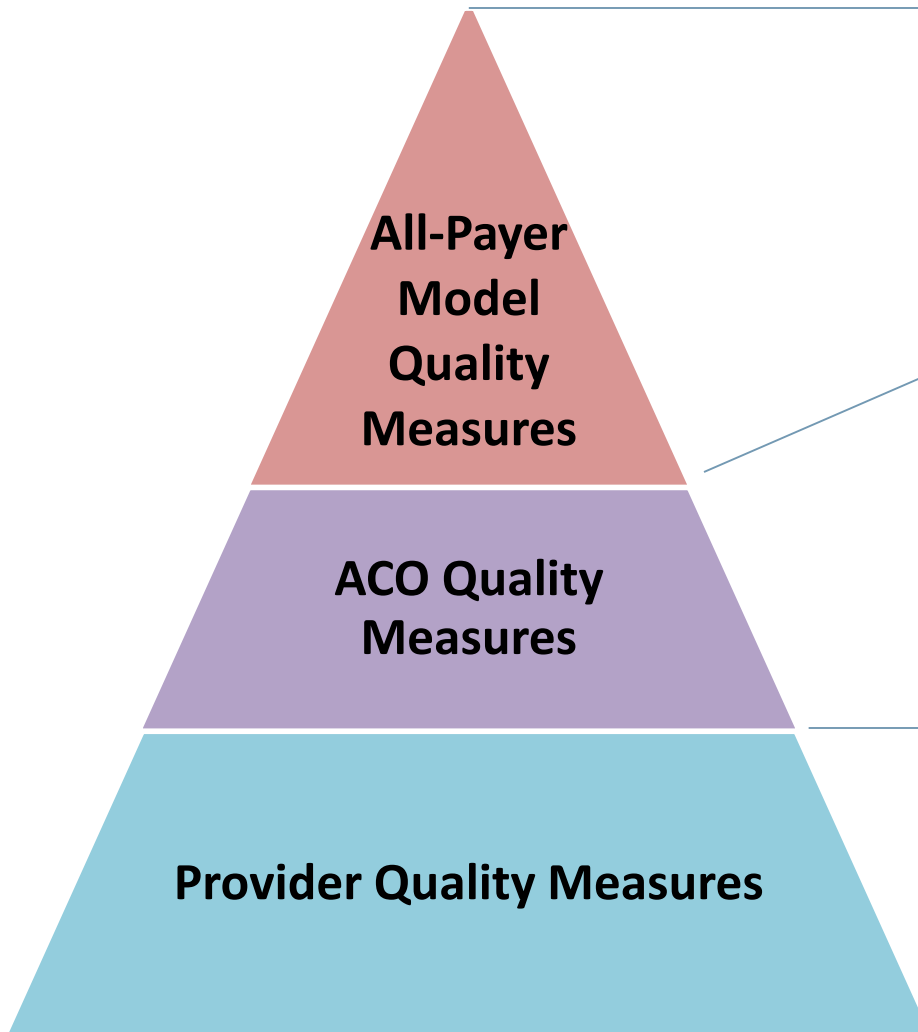
Implications of Missing the Targets

- Failure to meet ceiling or savings targets is a triggering event -- can lead to a corrective action plan
 - Requires a written response and an actual plan
 - Could include programmatic changes, model changes, or rate adjustments
 - Maryland agreement spells out what constitutes a “triggering event” – focused on Medicare savings provisions
 - Ultimately, failure to meet targets can lead to termination of the agreement -- a return to Medicare FFS

Financial Targets: The All-Payer Target and Ceiling

- We have agreement on the following provisions
 - All-Payer Target: 3.5% per capita growth
 - All-Payer Ceiling: 4.3% per capita growth
- The target represents GMCB's goal for the all-payer model, while the ceiling is the state's obligation under the model agreement
- These numbers are derived from Gross State Product, but will be set for the period of the agreement
- The state will be able to propose modifications in the event of unforeseen events, including significant unanticipated economic downturn
- Spending and growth rates may be different across payers so long as the all-payer rate is below the all-payer ceiling

All-Payer Model Quality Framework



CMMI ↔ GMCB

Reporting and Monitoring Measures

- Necessary overall priority measures for reporting success of the model
- May overlap with ACO and provider-specific quality measures
- Will include population health

GMCB ↔ ACO

GMCB will determine quality adjustment to all-payer PMPM payments to the ACO, based on an aligned quality measure set.

- Currently collected and generally aligned: Medicare SSP/NextGen, Commercial SSP, Medicaid SSP

ACO ↔ Providers

ACO will administer specific provider reimbursement strategies that rely on quality metrics:

- Methods subject to GMCB approval
- Affected by payment model
- May affect necessary waivers

Gobeille v. Liberty Mutual

At Issue- Whether the Employee Retirement Income Security Act of 1974(ERISA) preempts Vermont's health care database law as applied to third party administrator for a self-funded ERISA plan.

Oral Arguments December 2nd 2015

Amicus curiae includes 18 states, the Solicitor General, the American Hospital Association, the Association of American Medical Colleges and the National Governors Association.