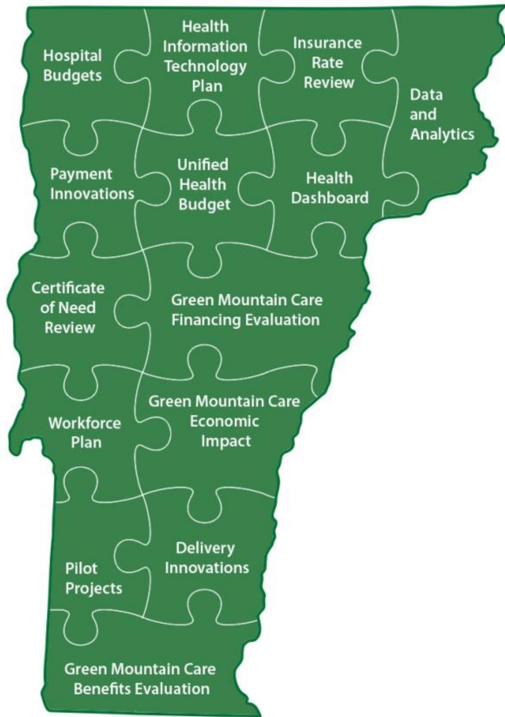


VERMONT ALL PAYER MODEL

PROJECT UPDATE

ELEMENTS OF THE PROPOSED TERM SHEET

HOUSE COMMITTEE ON WAYS AND MEANS

FEBRUARY 5, 2016

VERMONT
GREEN MOUNTAIN CARE BOARD

Part I: All-Payer Model Project Update

- Brief History
- Status of Negotiations with CMS

Act 54 of 2015

The Secretary of Administration or designee and the Green Mountain Care Board shall jointly explore an all-payer model, which may be achieved through a waiver from the Centers for Medicare and Medicaid Services.

- Enacted June 5, 2015

All-Payer Model

- An **all-payer model** is an agreement between the State and the Center for Medicare and Medicaid Services (CMS) that allows Vermont to explore new ways of financing and delivering health care.

- The all-payer model enables the three main payers of health care in Vermont – **Medicaid, Medicare, and commercial insurance, to pay for health care differently** than through fee-for-service reimbursement.

Goals of a Transformative All-Payer Model

- Improve experience of care for patients
- Improve access to primary, preventive services
- Reward high value care
- Construct a highly integrated system
- Empower provider-led health care delivery change
- Control the rate of growth in total health care expenditures
- Align measures of health care quality and efficiency across health care system

Why Pay Differently Than Fee-for-Service?

- Health care cost growth is not sustainable.

- Health care needs have evolved since the fee-for-service system was established more than fifty years ago.
    - More people are living today with multiple chronic conditions.
    - CDC reports that treating chronic conditions accounts for 86% of our health care costs.
- Fee-for-service reimbursement is a barrier for providers trying to coordinate patient care and to promote health.
    - Care coordination and health promotion activities are not rewarded by fee-for-service compensation structure.

Foundation for an All-Payer Model

- Vermont has all-payer reforms in place today
  - Shared Savings Program (SSP) for Accountable Care Organizations (ACOs)
    - Medicare offers a SSP for ACOs
    - Commercial SSP Standards
    - Medicaid SSP Standards
  - The Blueprint for Health
    - Medicare participates through a demonstration waiver
    - Commercial participation
    - Medicaid participation
- Fee-For-Service is still the underlying payment mechanism in these models

Next Generation of Accountable Care

- The federal government has created programs that encourage the use of **Accountable Care Organizations** (ACOs).

- The federal **Next Generation ACO program** allows ACOs to be paid an all-inclusive population-based payment for each Medicare beneficiary attributed to the ACO. CMS will allow ACOs some flexibility in certain payment rules in exchange for accepting this new type of payment.

Leveraging Federal and State Payment Reform Efforts

- Vermont’s proposal is for all payers to approach health care payment to ACOs in a common way.
  - New, all-inclusive population-based model of reimbursement rewards health care professionals that are adapting to the changing needs of the population; leverage Next Generation model.
  - All payers give doctors and other health care professionals the flexibility they need to lead health care delivery change.
- Health care providers’ participation in ACOs is voluntary; the ACO must be attractive to providers and offer an alternative health care delivery model that is appealing enough to join.

Status of Negotiation with CMS

- GMCB and AOA have jointly explored an all-payer model through dialogue and negotiation with CMS.
- The result of this dialogue, and consultation with stakeholders and consultants, is a ***term sheet*** proposed by the State of Vermont to CMS
  - Proposed term sheet describes the basic policy framework that would allow Vermont's health care providers, payers, and the government to operate an all-payer model.
  - The proposed term sheet does not bind the state or federal governments.

Next Steps

- Public Participation and Comment
  - The term sheet is available to the public through distribution to the media and posting on the Agency of Administration and Green Mountain Care Board's websites.
  - The term sheet has been distributed to Legislators.
  - The Green Mountain Care Board will hold open, public meetings to discuss and evaluate the term sheet.
  - A formal public comment period on the term sheet will be initiated by the Green Mountain Care Board.
  - The Agency of Administration will accept public comments at http://hcr.vermont.gov/home.

Next Steps

- Assess and Evaluate All-Payer Model Proposal
  - Taking all points of view into consideration, the Green Mountain Care Board and the Agency of Administration must independently assess the potential of the all-payer model to build a system that offers the right incentives and rewards providers for delivering on the promise of integrated, coordinated, high quality care.
  - At the conclusion of this evaluation, the Green Mountain Care Board and the Agency of Administration will determine whether and how the all-payer model proposal should be adjusted to reflect stakeholder input.

Next Steps

- Based on evaluation of term sheet,
  - Continue negotiations with CMS on All-Payer Model
  - If Vermont decides the final agreement is not better than today's system, it can end the negotiation with CMS.
  - Similarly, if CMS is not satisfied that the overall proposal meets its policy and financial goals, it can decline to enter into the agreement.

Steps Toward an Improved Vermont Health Care System

Develop All-Payer Model and Financial Targets

Create Standards for Accountable Care Organization Program

Exercise GMCB Rate and Regulatory Authority

Attain Quality Improvement and Cost Control

Part II: Elements of the Term Sheet

Vermont's Proposed Term Sheet

- The term sheet includes all of the basic legal, policy, and enforcement provisions that would be in a Model Agreement.
- In some cases, terms refer to appendices which will have greater technical detail or to processes that will occur during 2016.

	Term
1.	Legal Authority
2.	Performance Period
3.	Medicare Beneficiary Protections
4.	Medicare Basic Payment Waivers
5.	Medicare Innovation Waivers
6.	Infrastructure Payment Waivers
7.	Fraud and Abuse Waivers
8.	Request for Additional Waivers
9.	Revocation of Waivers
10.	All-Payer Rate Setting System
11.	Provider Participation in Alternative Payment
12.	Regulated Services
13.	Financial Targets
14.	Quality Monitoring and Reporting
15.	Data Sharing
16.	All Payer Model Evaluation
17.	Modification
18.	Termination and Corrective Action Triggers

VERMONT
GREEN MOUNTAIN CARE BOARD

Term #1: Legal Authority

Statements affirming the authority of Medicare, Medicaid, and Vermont (through the GMCB) to enter into the All-Payer Model agreement

Medicare authority, through the Innovation Center (CMMI): Section 1115(A) of the Social Security Act

Medicaid authority addresses existing Medicaid laws in relation to the model.

- Specifies that Vermont will ensure that the state-federal agreements in place (in the form of state plans or 1115 demonstration waivers) will be modified to accommodate the all-payer model.

Vermont authority, acting through GMCB, addresses three regulatory functions:

- Authority to enter into the agreement with CMMI
  - GMCB has authority to "[o]versee the development and implementation, and evaluate the effectiveness, of health care payment and delivery system reforms designed to control the rate of growth in health care costs and maintain health care quality in Vermont." 18 V.S.A. § 9375(b)(1)
- Authority to set rates for providers and require payers to comply with those rates
  - GMCB has authority to "set reasonable rates for health care professionals, health care provider bargaining groups created pursuant to section 9409 of this title, manufacturers of prescribed products, medical supply companies, and other companies providing health services or health supplies based on methodologies pursuant to section 9375 of this title, in order to have a consistent reimbursement amount accepted by these persons." 18 V.S.A. § 9376(b)(1).
- Authority to regulate an ACO and other components of the health care system
  - Refers to the authorities cited above and GMCB authority to set hospital budgets, regulate insurance rate changes, and regulate capital expenditures of health care facilities.

Term #2: Performance Period

Sets the timeframe for implementing the all-payer model

- Five-year performance period from 2017 to 2021
- Upon signing a model agreement, Vermont enters an "operational capacity building" period until implementation on January 1, 2017

Term #3: Medicare Beneficiary Protections

Provisions to enshrine all existing protections for Medicare beneficiaries in Vermont under the all-payer model

- This term states the principle that access to care and providers for Medicare beneficiaries will not be limited
  - Medicare beneficiaries will have full freedom of choice of participating Medicare providers
  - All existing beneficiary rights and protections (like appeal rights) will be protected
  - Medicare under the all-payer model will include all the same services and coverage as original Medicare

Term #4: Medicare Basic Payment Waivers

The term Sheet contains 4 separate types of waivers of Medicare laws

- **Basic payment waivers** relate to laws that govern rates set for Medicare regulated services
  - Currently this section documents the laws that create the inpatient prospective payment system (IPPS) and the outpatient prospective payment system (OPPS) for hospitals.
  - Ultimately an agreement would need to include the laws that govern reimbursement for all regulated services, including physician services, home health services and others.

Term #5: Medicare Innovation Waivers

The term Sheet contains 4 separate types of waivers of Medicare laws

- **Medicare innovation waivers** remove restrictions on services or authorize expanded services for beneficiaries
  - Eliminate requirement for a 3-day hospital stay before admission to a nursing home
  - Authorize telehealth services for all beneficiaries
  - Enables home visits without physician supervision, allows ACO to contract for home visits with other licensed clinicians
- Language allows Vermont to seek additional waivers under consideration to enhance Medicare services
  - Expanding Medicare coverage rules for Nurse Practitioners
  - Enhancing the availability of home care and hospice services

Term #6: Infrastructure Payment Waivers

The term Sheet contains 4 separate types of waivers of Medicare laws

- **Infrastructure payment waivers** allow Medicare to participate fully in the Blueprint for Health
  - Continuation of CHT payments
  - Expansion of SASH payments
- This term also includes waivers necessary to support the Hub & Spoke Program
  - Payment for medication-assisted therapies at specialty opioid treatment centers
  - Infrastructure support for "Hubs"

Term #7: Fraud and Abuse Waivers

The term sheet contains 4 separate types of waivers of Medicare laws

- **Fraud and abuse waivers** protect providers participating in an ACO
  - These are the same waivers granted to participants in Medicare's existing ACO programs – authorize referrals and sharing of savings across providers
  - Five categories of waivers
    - ACO Pre-Participation Waiver
    - ACO Participation Waiver
    - Shared Saving Waiver
    - Compliance with Physician Self-Referral Waiver
    - Patient Incentives Waiver

Term #8: Request for Additional Waivers

Specifies how Vermont may request additional waivers to carry out the all-payer model

- Additional waivers may be submitted by Vermont along with a rationale for the waiver at any time
  - These are granted only if CMS agrees
  - If CMS denies a request and Vermont determines that the waiver is necessary to achieve the goals of the model agreement, Vermont may terminate the agreement

Term #9: Revocation of Waivers

Authorizes CMS to revoke waivers or terminate the agreement

- CMS may revoke waivers or terminate the agreement if Vermont does not comply with conditions associated with the waiver.
  - Any waiver conditions will be made explicit in the final model agreement

Term #10: All-Payer Rate Setting System

Describes in general terms the operation of the all-payer system

- Vermont will maintain an all payer rate setting system for all regulated services
- Medicare rates will be established in one of two ways
  - Through an ACO-based reimbursement method
  - Using the Medicare fee schedule as a reference
- Language contemplates Vermont and CMS working together to design a claims processing and payment approach for ACO services and payments that conforms to Vermont's plan and CMS operational requirements

Term #11: Provider Participation in Alternative Payment Models

States that Vermont will utilize an ACO model under the all-payer model

Ensures that Vermont will benefit from a new Medicare physician payment law that encourages providers to participate in alternative payment models

Beginning in 2019, a new federal law – the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) – will govern Medicare physician payments

- MACRA creates a new framework for existing quality reporting programs and encourages physicians to participate in alternative payment models
- Alternative payment models include ACOs, patient-Centered medical homes, and bundled payment models
- Providers who qualify can receive incentive payments under MACRA

The term sheet specifies that providers participating in the ACO in Vermont's all-payer model will qualify for the MACRA incentive payments

- Will receive lump sum bonus payments of 5% of a physician's total Medicare payments

Term #12: Regulated Services

Regulated Services: Spending categories subject to the all payer ceiling and from which Medicare savings are derived

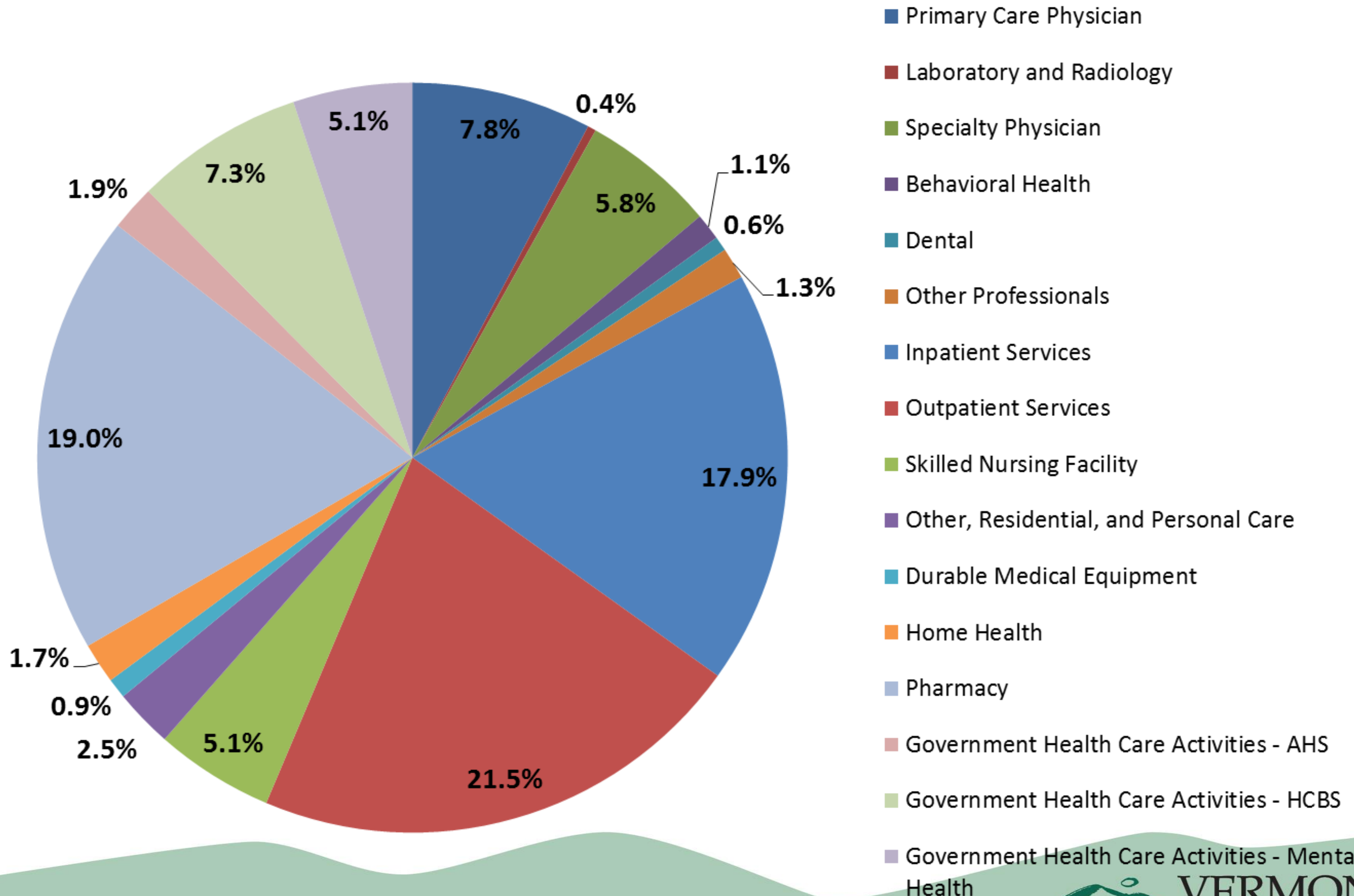
In essence, Regulated Services are those covered by the Model Agreement

- In Maryland, the model agreement only regulates hospital payments. In Vermont, regulated services are more expansive
- Derived from current federal and state SSPs
    - For Medicare: Parts A and B Services
    - For Medicaid and Commercial: The closest analogue to those Medicare services
- Defined by **categories of service**

Regulated Revenue can be different from the services for which the ACO is at risk.

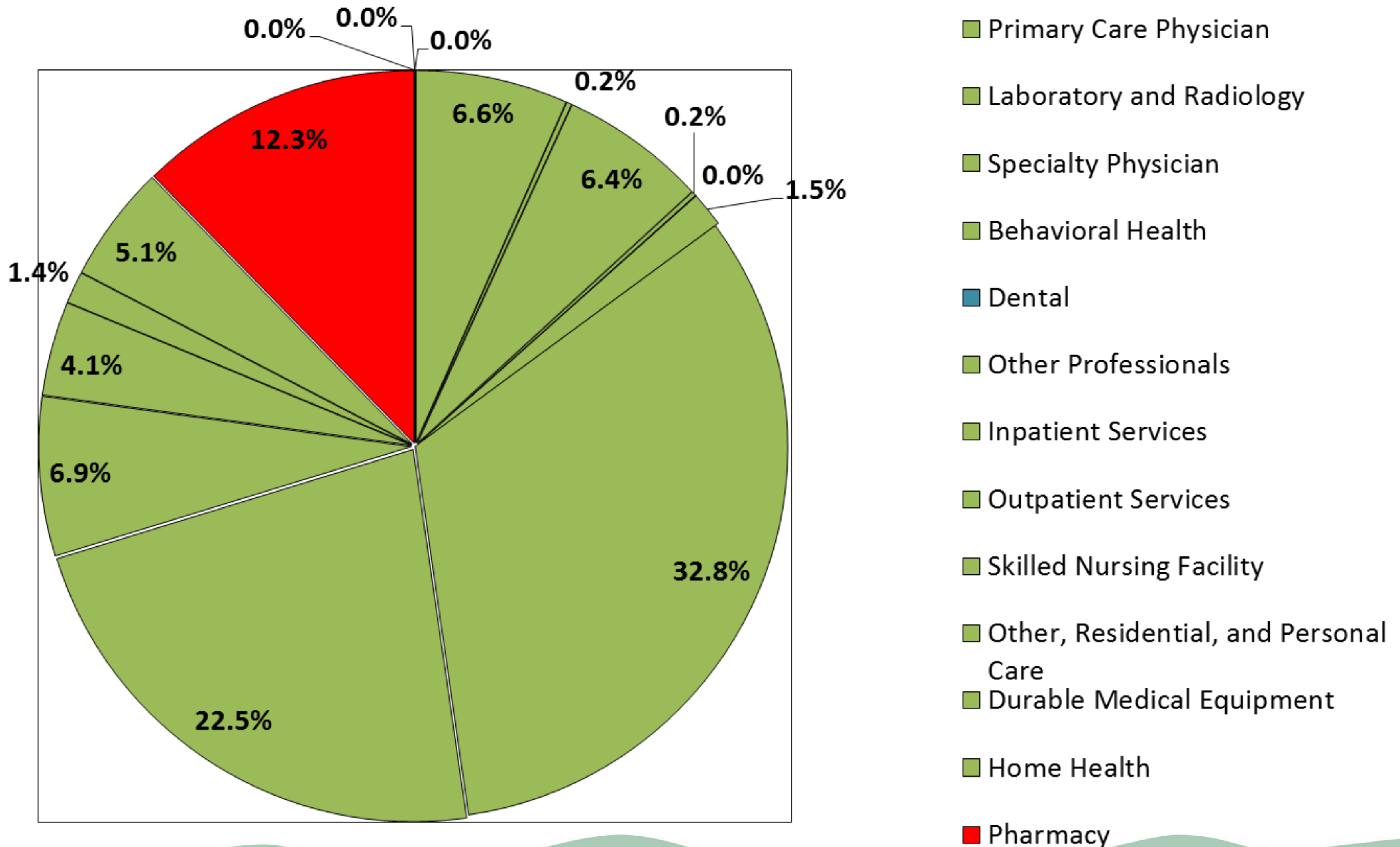
- Term sheet indicates an interest in pursuing pharmacy as an ACO-covered service

All Payer Baseline



VERMONT
GREEN MOUNTAIN CARE BOARD

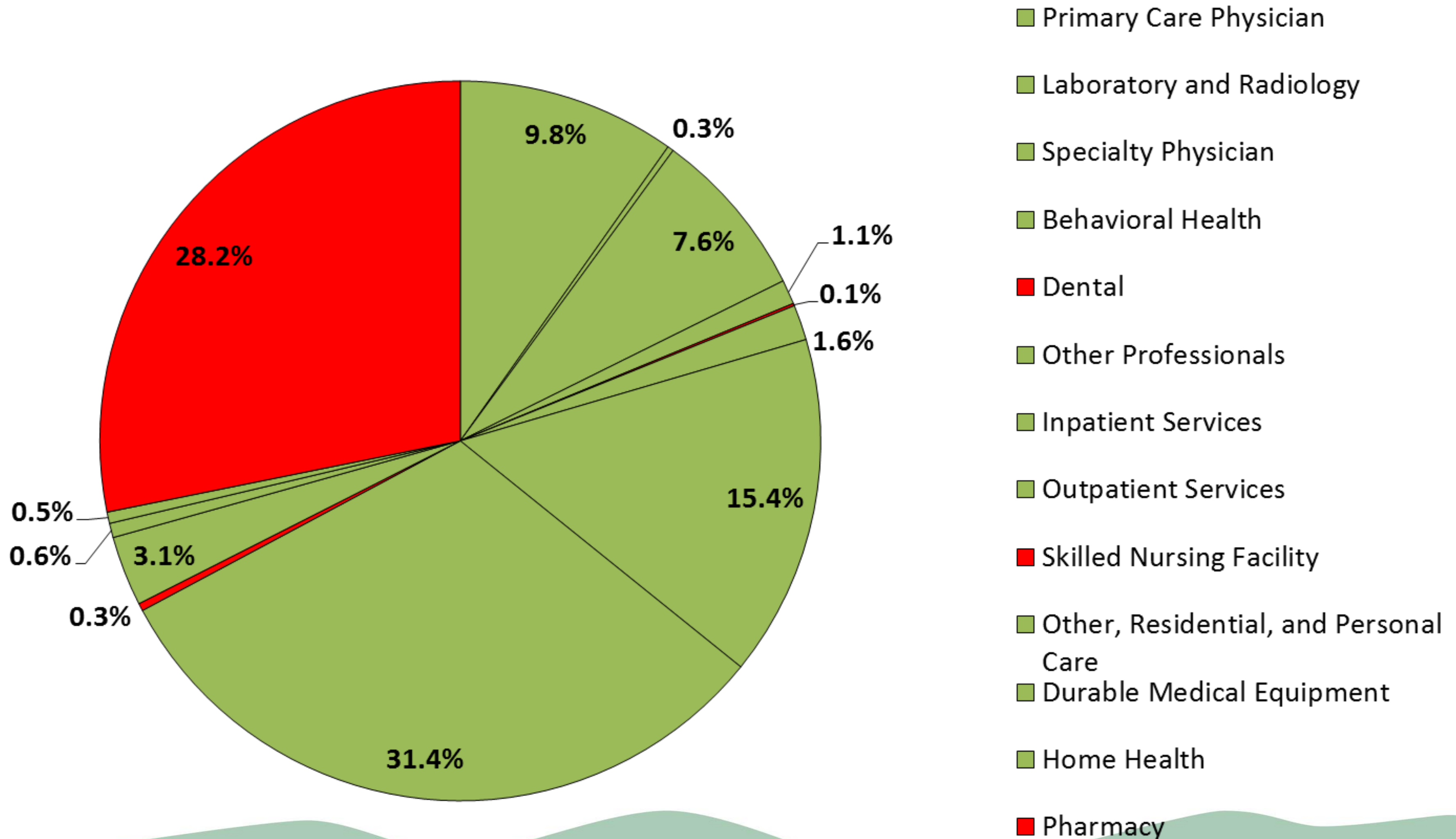
Medicare Services



VERMONT
GREEN MOUNTAIN CARE BOARD

Commercial Services

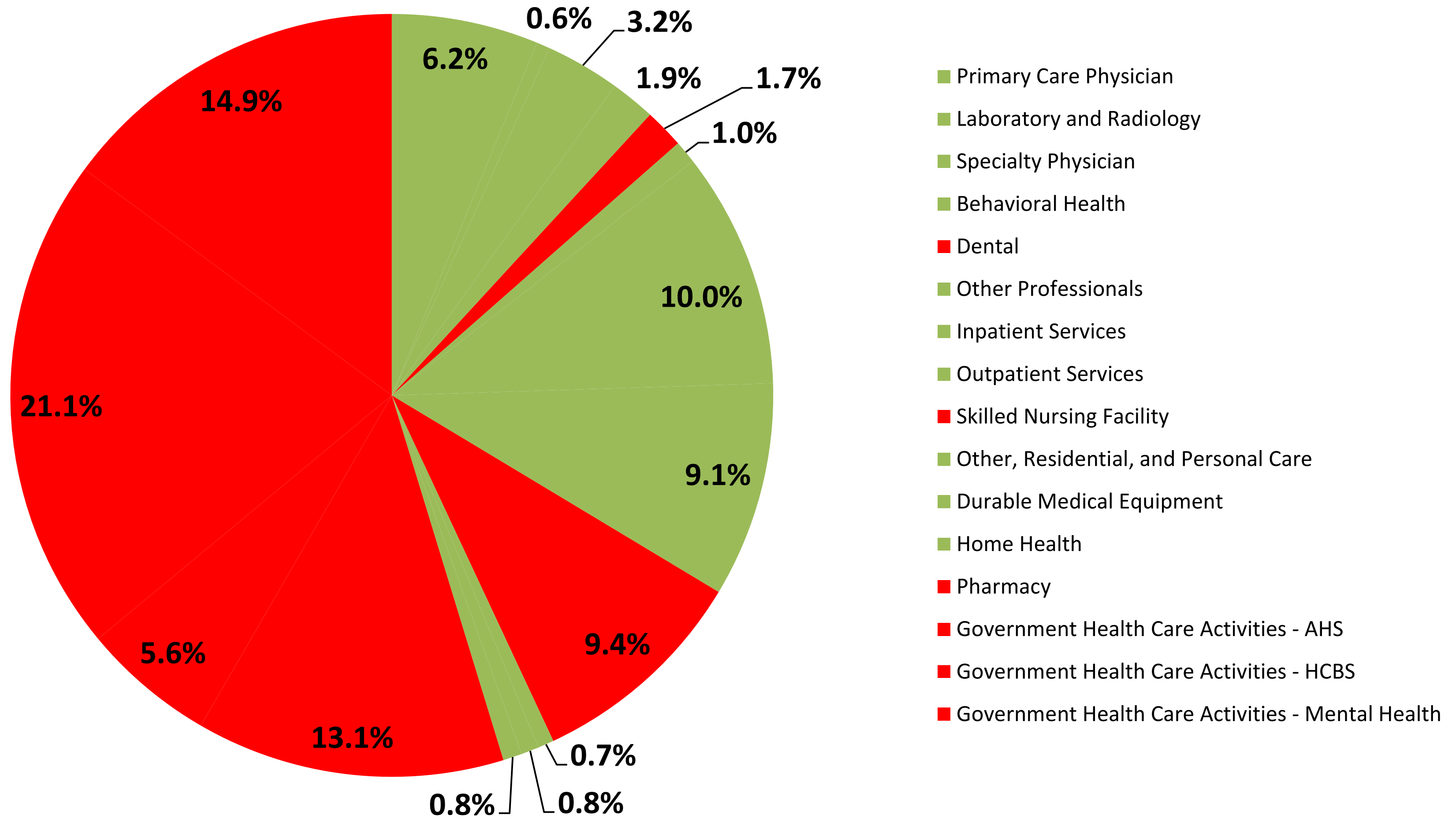
Covered = 71.4% Non-covered = 28.6%



VERMONT
GREEN MOUNTAIN CARE BOARD

Medicaid Services

Covered = 34.3% Non-covered = 65.7%



Regulated Services in Relation to the Overall Delivery System

The goal of all of the work Vermont is doing and will do is **to create an integrated system**. Vermont is **committed to payment and delivery reform across all services**, whether inside or outside of the all-payer model.

Under this language, Vermont **may phase in additional services** into the regulated environment and include more health care spending over time based on mutual agreement with CMMI/CMS

Vermont can define a **pathway for assessing readiness to consider inclusion** of these services in the all-payer model. Vermont will evaluate

- Payer and provider readiness
- Health information infrastructure
- Evaluation readiness
- Federal readiness

Term #13: Financial Targets: All-Payer Ceiling

- **All-Payer Ceiling:** a defined upper limit on per capita spending growth
- **All-Payer Target:** a defined target for per capita spending growth
  - The All-Payer Target is Vermont's goal for spending growth
  - The All-Payer Ceiling is Vermont's obligation under the Model Agreement

Measure	Growth
15-Year Economic Growth (Gross State Product)	*3.3%*
All-Payer Target	3.5%
All-Payer Ceiling	**4.3%**

Failure to meet ceiling or Medicare savings 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
- Term sheet spells out what constitutes a "triggering event"

Term #13: Financial Targets: Medicare Savings

- **Medicare Savings** – minimum savings required under the agreement
  - Separately calculated and benchmarked to national per capita growth
- **Benchmark Floor** – proposes a floor to guard against low national Medicare growth

Medicare Savings Target	0.2% below national per capita growth
Benchmark Floor	Performance Year 1: 3.5% Performance Years 2-5: 2.0%

Savings are calculated at the end of the potential 5-year agreement

- This provides considerable flexibility, but places emphasis on strong performance in the early years of the agreement

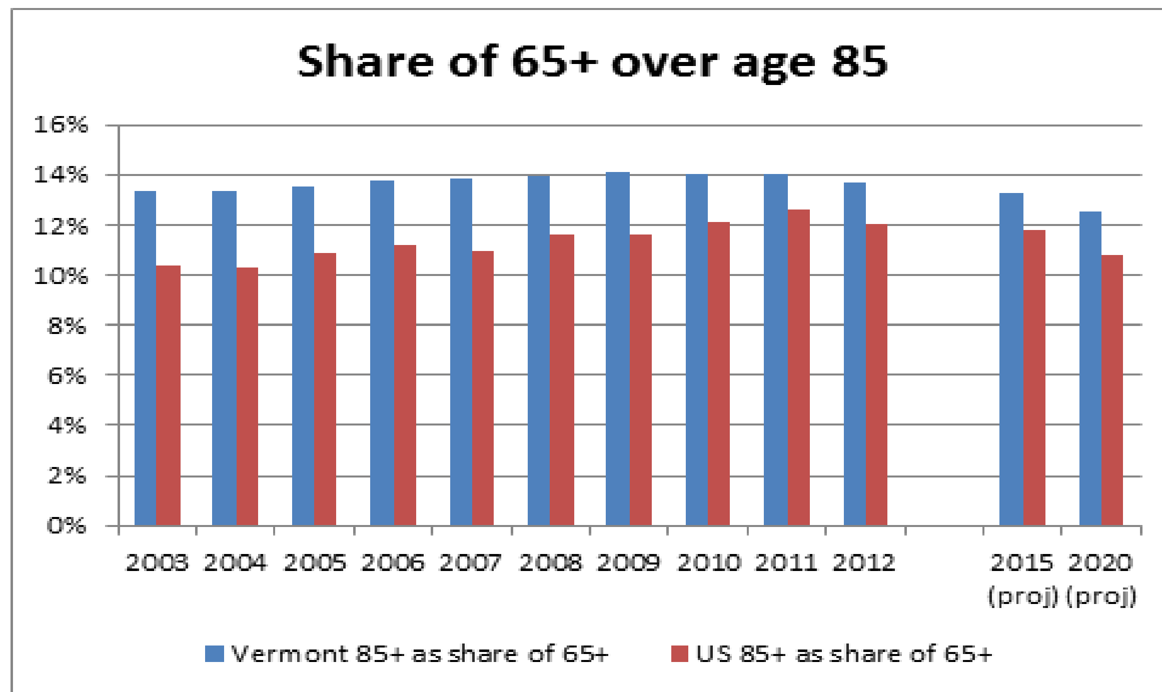
The benchmark floor is a novel idea

- CMS understands Vermont's concerns and will try to address them
  - To guard against being put in a deficit in Year 1
  - To recognize that Vermont is a very low-cost state

Medicare Savings with an Aging Population

The term sheet addresses the challenge that Vermont faces by having a larger share of 85+ year old Medicare enrollees than the national average.

- Contemplates an age-adjusted Medicare savings calculation to adjust for relative differences between the national and Vermont population



VERMONT
GREEN MOUNTAIN CARE BOARD

Term #14: Quality Monitoring and Reporting

Vermont is proposing to establish **population health goals** and measures to be monitored and will set **all-payer model quality targets** related to those goals
Both sets of measures will be established together with CMMI by June 1, 2016

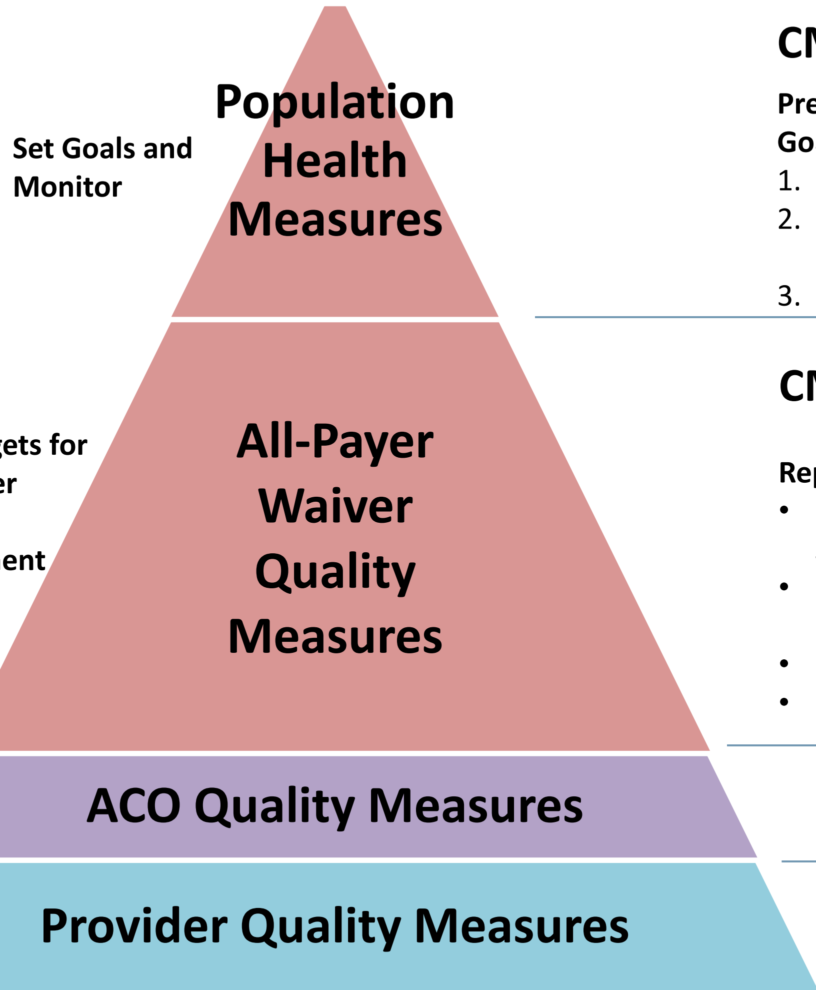
POPULATION HEALTH

- Established goals and population health measures will allow the state and CMS to monitor progress on the health of the population in priority areas
    1. Increasing access to primary care
    2. Reducing the prevalence of and improving the management of chronic diseases
    3. Addressing the substance abuse epidemic
- Statewide measures will be collected using statewide tools (BRFSS, surveillance data, death data)

ALL-PAYER MODEL QUALITY TARGETS

- Established targets will measure clinical interventions that lead to health improvements related to the population health priority areas
- These measures are currently collected and reflect proven clinical interventions
- Establishing quality targets directly related to population health goals will ensure that the clinical delivery system is aligned with state priorities

All-Payer Model Quality Framework



CMMI ↔ VDH/GMCB

Prevalence and Access Measures for State Priority Goals

1. Increasing access to primary care
2. Reducing the prevalence of and improving the management of chronic diseases
3. Addressing the substance abuse epidemic

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
- **Derived from State Priority Goals**
- Reporting categories: **ACO, non-ACO**

GMCB ↔ ACO

ACO ↔ Providers

VERMONT
GREEN MOUNTAIN CARE BOARD

Term #15: Data Sharing

Describes expectations about data sharing and the process for data requests

- Vermont supplies all-payer claims from VHCURES on a quarterly basis
- CMS will accept data requests from Vermont to further the purposes of the model, and will approve, deny or modify within 30 days of any request, subject to privacy and security laws
- Proposes that CMS will share with Vermont data necessary to determine provider performance, and authorizes Vermont to disclose such performance data

Term #16: All-Payer Model Evaluation

Describes efforts by Vermont and CMS to evaluate the implementation of the all-payer model

- CMS will evaluate the model in accordance with Section 1115(a)(b)(4)
  - This is a substantial evaluation and will compare Vermont to national Medicare and to other states
- Vermont will submit an annual report to CMS concerning its performance on the financial and quality requirements of the model agreement
  - This will include performance on the all-payer ceiling, and performance on quality measures established under Term #14.
- Contains technical language about maintenance of records

Term #17: Modification

Specifies the process for either party to suggest amendments to the model agreement

- Both parties may amend the agreement at any time by mutual consent
- CMS may amend the agreement for good cause or if necessary to comply with federal or state law or regulation
  - CMS provides 30 days notice
  - If Vermont disagrees with the modification, or cannot adopt it because it is contrary to state law, CMS or the state may terminate the agreement

Term #18: Termination and Corrective Action Triggers

Specifies the process for termination of the model agreement

Describes the enforcement of the agreement, in the form of corrective action plans based on defined triggering events

- Enforcement of the model is driven by the occurrence of specified "triggering events"
  - A material breach of the Model Agreement
  - A determination by CMS that Vermont has not produced agreed-upon Medicare savings for 2 consecutive Performance Years
  - A determination by CMS that Vermont has exceeded the all-payer per capita growth ceiling by 1.0 percentage point or more for 2 consecutive Performance Years
  - A determination by CMS that the quality of care provided to Medicare, Medicaid or CHIP beneficiaries has deteriorated
  - A determination by CMS that the State and/or ACO have taken actions that compromise the integrity of the Model or the Medicare trust funds

Term #18: Termination and Corrective Action Triggers (continued)

- If a triggering event occurs, CMS provides a warning notice within 6 months of the end of a performance year
- Vermont has 90 days to respond to the notice, and within 90 days of its response CMS can require Vermont to produce a corrective action plan (CAP)
- Vermont has 1 year to successfully implement the CAP
- If the CAP is not implemented, CMS can rescind part of the agreement or terminate it
- In general, the state may terminate the agreement for any reason with 180 days written notice
- Upon termination, Vermont has 2 years to transition back to the national Medicare program