
# All-Payer Model Update
# House Committee on Health Care
# January 20, 2016

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VERMONT
GREEN MOUNTAIN CARE BOARD

# Update Overview

- Background
- What is an All-Payer Model?
- Accountable Care Organizations and Consumer Protections
- What is a “Term Sheet”?
- Elements of a Term Sheet

# Background

Act 54 of 2015 directs the Green Mountain Care Board (GMCB) and the Agency of Administration (AOA) to jointly explore an all-payer model, which may be achieved through a waiver from the Centers for Medicare and Medicaid Services (CMS)

GMCB and AOA have been in discussions with the Center for Medicare and Medicaid Innovation (CMMI), within CMS, about the necessary elements of a proposal, or term sheet, for an all-payer model

# What is an All-Payer Model?

- An all-payer model is when all major payers participate in an alternative payment model

- Payment incentives are aligned across all payers
  - All payers pay providers using the same payment methodology

# 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

# Why are We Exploring an All-Payer Model?

- Fee-for-service payment creates incentives for the health care system to provide more services, more expensive services, and does not tie quality of care to payment
- Medicare is moving away from fee-for-service with a goal of tying 50% of payments to alternative payment models, such as ACOs, by the end of 2018
- The Medicare Next Generation Program offers a capitation-style payment to an ACO that Vermont could replicate with Medicaid and Commercial payers
- Vermont is exploring how a Medicare waiver for the state could improve on the terms offered by the Next Generation ACO Program while maintaining the key components of the model framework

# Key Components of Medicare Next Generation Accountable Care Organization Program

- Financial incentives with higher levels of risk and reward than current Medicare ACO initiatives, such as SSP
- Enables graduation from fee-for-service reimbursement to capitation
- Greater access to home visits, telehealth services, and skilled nursing facility services
- 10,000 (7,500 for rural) beneficiaries needed for participation in the program

# Accountable Care Organizations

- Accountable Care Organizations (ACOs) are composed of and led by health care providers who have agreed to be accountable for the cost and quality of care for a defined population

- These providers work together to coordinate care for their patients and have established mechanisms for shared governance

# What does health care look like with Fee-for-Service Payment vs. Value-Based Capitation-Style Payment?

**Fee-for-Service**

- Each medical service generates a fee
  - Unnecessary services may be provided
- Services that promote health may not be covered
  - phone consultations, time spent making referrals

**Value-Based Capitation-Style Payment**

- Providers receive a monthly amount to cover the health care services for their patients
- Providing services that promote health increases system efficiency

# What Protections are in place for Vermonters in ACOs?

- Full freedom of provider choice
- Risk Adjustment
- Utilization Monitoring
- Payment tied to performance on quality measures

# Provider Choice

- All of CMS' ACO models, including any Vermont specific demonstration, are part of the Original Medicare Program and follow Original Medicare rules and processes, and ACO beneficiaries have freedom of choice to go to Original Medicare providers
- Beneficiaries aligned to Next Generation ACOs maintain Original Medicare benefits
- Just as in SSP, Commercial and Medicaid beneficiaries would have the same choice and protections as Medicare beneficiaries

# Risk Adjustment and Utilization Monitoring

- Risk adjustment modifies payments to account for differences in expected health costs of individuals
- Adjustment can take into account demographic information (age, sex, eligibility) and health status (diagnoses)
- Risk Adjustment guards against ACOs avoiding higher risk and more expensive populations
- ACO utilization is monitored to safeguard against and flag potential underutilization i.e. denial or limiting of medically necessary care

# Quality and Performance Measurement

Performance on quality measures impacts the payments the ACO receives

- 8 out of 33 measures are of patient experience of care survey results
  - 1 Consumer Assessment of Healthcare Providers Survey (CAHPS) ACO Survey
  - 8 Composite Measures

# What is a "Term Sheet" for an All-Payer Model?

- The term sheet contains the elements of a non-binding proposal for an all-payer model that Vermont and CMMI identified through iterative discussions

- The term sheet is a framework for a potential agreement, but is not an agreement

- To determine if the all-payer model proposal benefits Vermont, the following will occur:
  - The term sheet will be made available to the public
  - The term sheet will be shared with the Legislature
  - The term sheet will be evaluated by the Green Mountain Care Board in open, public meetings
  - A formal public comment period on the term sheet will be initiated

# CMMI Term Sheet Elements

- *Performance Period*
- *Financial Targets*
- *Regulated Revenue*
- *Quality Framework*
- *Payment Waivers*
- *Fraud and Abuse Waivers*

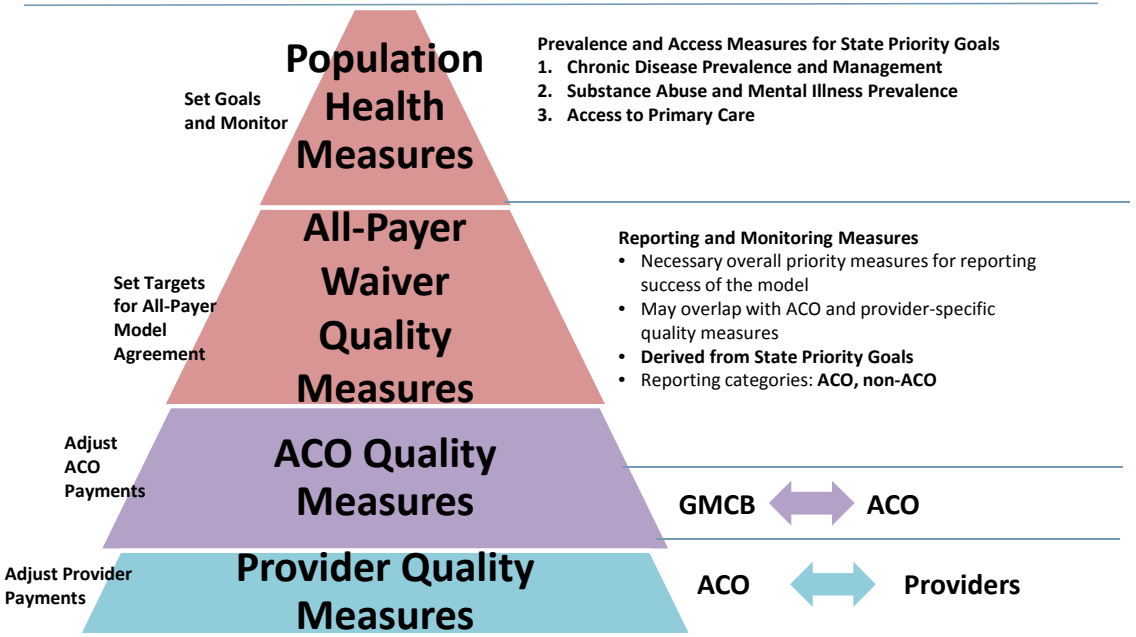
# Financial Targets

- **All-Payer Target** – a defined goal for spending
- **All-Payer Ceiling** – maximum upper limit on spending
- **Medicare Savings** – minimum savings required under the agreement

# Regulated Revenue

- Spending categories subject to the all-payer ceiling
  - Services are based on the categories covered in the Shared Savings Program today
- Integration of services across the care continuum, including Mental Health, Substance Abuse Services, and Long-Term Services and Supports are essential to the success of the model
  - All Services included in an all-payer care delivery model do not have to be subject to the all-payer ceiling
- A pathway for potential inclusion of Mental Health, Substance Abuse Services, and Long-Term Services and Supports under all-payer ceiling is necessary

# All-Payer Model Quality Framework



# Anticipated Payment/Fraud and Abuse Waivers

| | |
|---|---|
| **Payment Rules (Next Gen)** | Telehealth expansion |
| | Post-discharge visits |
| | 3-day skilled nursing facility rule |
| **Fraud and Abuse Waivers** | Pre-participation Waiver |
| | Participation Waiver |
| | Shared Savings Distribution Waiver |
| | Physician Self-Referral Compliance Waivers |
| | Patient Incentive Waiver |

- Our expectation is that all of these waivers will be granted to enable the model, including authorities needed to continue ongoing Medicare participation in Vermont's Blueprint and SASH Initiatives
- In addition, certain basic Medicare payment laws will be "waived" by definition for the demonstration (e.g., Outpatient Prospective Payment System and Inpatient Prosective Payment System)
    - If other quality or payment waivers are needed will we have the opportunity to justify and request additional waivers – likely after Year 1
    - The implementation of the Medicare Access and Chip Reauthorization Act (MACRA) of 2015 may also affect additional quality/payment waivers

# Resources

Medicare Accountable Care Organizations (ACOs) Overview
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/index.html

Next Generation Accountable Care Organization Overview
https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-01-11.html

Medicare Access and Chip Reorganization Act (MACRA) Overview
https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-MIPS-and-APMs.html

# Questions?

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