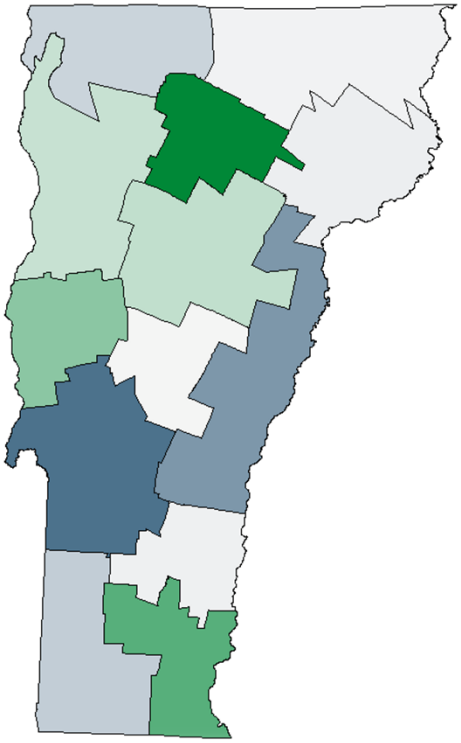

All-Payer Accountable Care Organization Model Overview

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House Committee on Appropriations
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Presentation Overview

1. What is an All-Payer Model?
    - What are the goals of the model?

2. Vermont All-Payer Accountable Care Organization Model Agreement

3. GMCB Duties

What is an All-Payer Model?

- An all-payer model is when all major payers participate in an alternative payment model
    - Vermont's All-Payer Model moves away from Fee-For-Service reimbursement

- Payment incentives are aligned across all payers
    - All payers pay providers using the same payment methodology
    - All payers do not necessarily pay providers the same amount

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 pay differently than Fee-for-Service?

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

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
- In the Vermont APM, ACOs are the organizations that can accept a fee-for-service alternative payment.

All-Payer ACO Model Agreement: Framework for Transformation

- State action on financial trends & quality measures
  - Moves from volume-driven fee-for-service payment to a value-based, pre-paid model for ACOs
    - ✓ All-Payer Growth Target: 3.5%
    - ✓ Medicare Growth Target: 0.1-0.2% below national projections
  - Requires alignment across Medicare, Medicaid, and participating Commercial payers

- Goals for improving the health of Vermonters
  - Improve access to primary care
  - Reduce deaths due to suicide and drug overdose
  - Reduce prevalence and morbidity of chronic disease

10 Key Features of the Model Agreement (1-5)

1. The All-Payer Model is the first step in a multi-step process; it creates an opportunity for provider-led reform.

2. The All-Payer Model would move away from fee-for-service reimbursement on a statewide level and establish an annualized limit of 3.5% on per capita healthcare expenditure growth for all major payers.

3. Medicare beneficiaries would keep all of their current benefits, covered services, and choice of providers, as would persons with Commercial or Medicaid coverage.

4. Vermont is not taking over the health care payment system; all payers continue to directly pay health care providers or organizations.

5. Joining the All-Payer Model would be voluntary for health care providers.

10 Key Features of the Model Agreement (6-10)

6. The proposed Agreement establishes a phased-in approach for implementation.
    - 2017 is a preparatory "Year 0".
    - Incremental scale targets set goal for 70% of all-payer beneficiaries to be attributed to an ACO by 2022.

7. Agreement contains 3 high level health improvement goals:
    - Improving access to primary care
    - Reducing deaths from suicide and drug overdose
    - Reducing prevalence and morbidity of chronic disease (COPD, Diabetes, Hypertension)

8. The State could terminate the Agreement at any time for any reason with at least 180 calendar days' notice.

9. There would be no financial penalty to the State if financial and quality targets were not met.

10. The Agreement would preserve Medicare funding for the nationally-recognized Blueprint for Health program and the Support and Services at Home (SASH) program providing care coordination and preventive services to Medicare beneficiaries.

All-Payer ACO Model Agreement: First Step in a Multi-Step Process

Agreement signed in October 2016 is the first of 3 steps in creating an All-Payer ACO Model:

- **Step 1:** Agreement between CMS and VT provides an opportunity for private-sector, provider-led reform in VT
- **Step 2:** ACOs and payers (Medicaid, Medicare, Commercial) work together to develop ACO-level agreements
- **Step 3:** ACOs and providers that want to participate work together to develop provider-level agreements

GMCB Goals and Regulatory Levers

Goal #1:
Vermont will reduce the rate of growth in health care expenditures

GMCB Regulatory Levers:

Hospital Budget Review

ACO Budget Review

ACO Certification

Medicare ACO Program Rate-Setting and Alignment

Health Insurance Rate Review

Certificate of Need

Goal #2:
Vermont will ensure and improve quality of and access to care

GMCB Regulatory Levers:

All-Payer Model Criteria

ACO Budget Review

ACO Certification

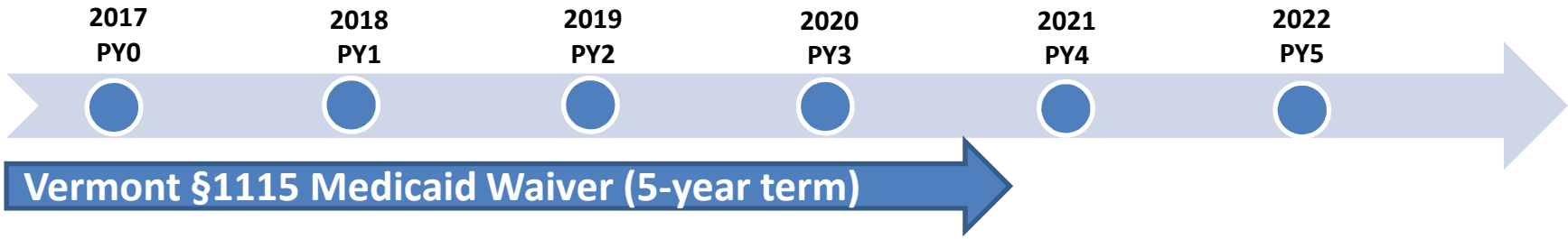
Quality Measurement and Reporting

INTEGRATION OF REGULATORY PROCESSES

All-Payer ACO Model Implementation (cont'd)

- AHS is responsible for developing, offering, and implementing a Medicaid ACO Program
- GMCB is responsible for Regulatory Implementation:
  - Certifying ACOs (includes rulemaking)
  - Reviewing ACO budgets
  - Reviewing and advising on Medicaid ACO rates
  - Setting Commercial and Medicare rates for ACOs
  - Reporting on progress to CMS
  - Tracking financial benchmarks, scale targets and quality targets
  - Implementing changes to other GMCB processes to create an integrated regulatory approach (e.g., hospital budgets; health insurance premium rate review)

Vermont All-Payer ACO Model Agreement Timeline



	2017 PY0	2018 PY1	2019 PY2	2020 PY3	2021 PY4	2022 PY5
	Jan 1– PY0 Begins **TBD -** Medicaid Next Gen ACO begins (tentative) -Medicare SSP continues -Commercial SSP continues (tentative)	**Jan 1–** VT Modified Medicare Next Gen ACO begins Commercial Modified Next Gen ACO begins (tentative)	**Jan 1–** VT Medicare ACO Initiative begins			**Dec 31–** PP ends
Scale Target (% Beneficiaries Aligned to ACO)		All-Payer 36% Medicare 60% Only Aligned VT Medicare Beneficiaries	All-Payer 50% Medicare 75% Only Aligned VT Medicare Beneficiaries	All-Payer 58% Medicare 79% VT Medicare Scale Target ≥ 65% = All Medicare Bene. VT Medicare Scale Target <65% = Only Aligned VT Medicare Bene.	All-Payer 62% Medicare 83% All VT Medicare Beneficiaries	All-Payer 70% Medicare 90% All VT Medicare Beneficiaries

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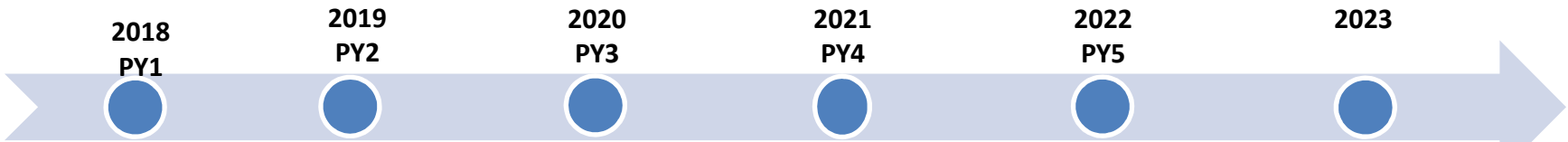
Vermont All-Payer ACO Model Agreement Reporting Timeline



Quarterly during PP– VT submits a Quarterly Financial Report of the State's performance on the All-Payer TCOC per Beneficiary Growth Target

Jun 30– All-Payer TCOC per Beneficiary Growth final results PY1

Jun 30– Annual ACO Scale Targets & Alignment Report for PY1

Sep 30– Annual Health Outcomes & Quality of Care Report for PY1

By end of PY2– Submit assessment of the Payer Differential as it affects VT ACOs

Jun 30– PY2 All-Payer TCOC final results, Annual ACO Scale Targets & Alignment Report for PY2, and a Plan for Public Health Accountability Framework

Sep 30– PY2 Annual Health Outcomes & Quality of Care Report

Dec 31–Plan for financing & delivery of Medicaid BH and HCBS with the All-payer Financial Target Services

By end of PY3– Submit options to narrow the Payer Differential during and after the PP

Jun 30– All-Payer TCOC per Beneficiary Growth final results PY3

Jun 30 – Annual ACO Scale Targets & Alignment Report for PY3

Sep 30– Annual Health Outcomes & Quality of Care Report for PY3

Dec 31– Optional proposal for subsequent 5 year Model (2023-2027)

Jun 30– All-Payer TCOC per Beneficiary Growth final results PY4

Jun 30 –Annual ACO Scale Targets & Alignment Report for PY4

Sep 30– Annual Health Outcomes & Quality of Care Report for PY4

Jun 30– All-Payer TCOC per Beneficiary Growth final results PY5

Jun 30 – Annual ACO Scale Targets & Alignment Report for PY5

Sep 30– Annual Health Outcomes & Quality of Care Report for PY5

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Examples of Implementation Activity

Federal and State collaboration	Legal & Regulatory	Reporting	Process Review
• Ensuring funding for PY0 2017 • Medicaid Advisory Rate Case	• ACO Certification and budget review for 2018 enactment • Timing of 2017 regulatory activities • Determining ACO rate for Medicare	• Financial • Quality • Scale Targets • Payer Differential • Ad-Hoc	• Insurance rate review & ACO commercial rate interplay • Hospital budget reviews & ACO budget review interplay

GMCB Implementation Activities Completed
(as of January 11, 2017)

- Establishing communication mechanisms with CMMI
- Establishing communication mechanisms with State government partners
- Establishing communication mechanisms with private sector partners
- Scheduling regular reporting to GMCB and public
- Applying for one-time funding for Blueprint, SASH and ACO *(Agreement)*
- Conducting advisory Medicaid ACO rate case *(Act 113)*
- Establishing and convening Primary Care Advisory Group *(Act 113)*
- Issuing report on multi-year ACO budgets *(Act 113)*
- Providing consultation on AHS Medicaid Pathway Report *(Act 113)*

Questions?