



Report to the Vermont Legislature

# Delivery System Reform Report: 2017

Act 113, Section 12; Act 82, Section 7

*Submitted by the Secretary of the Agency of Human Services to the Senate Committee on Health and Welfare and the House Committees on Health Care and Human Services*

1-15-2017

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## REPORT REQUIREMENTS

Act 113 of 2016, Section 12 requires the Secretary of the Agency of Human Services to embark upon a multi-year process of delivery system and payment reform for Medicaid providers that is aligned with the *Vermont All-Payer Accountable Care Organization Model Agreement* and other existing payment and delivery system reform initiatives.

### FULL TEXT:

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(a) The Secretary of Human Services, in consultation with the Director of Health Care Reform, the Green Mountain Care Board, and affected providers, shall create a process for payment and delivery system reform for Medicaid providers and services. This process shall address all Medicaid payments to affected providers and integrate the providers to the extent practicable into the all-payer model and other existing payment and delivery system reform initiatives.

(b) On or before January 15, 2017 and annually for five years thereafter, the Secretary of Human Services shall report on the results of this process to the Senate Committee on Health and Welfare and the House Committees on Health Care and on Human Services. The Secretary's report shall address:

- (1) all Medicaid payments to affected providers;
- (2) changes to reimbursement methodology and the services impacted;
- (3) efforts to integrate affected providers into the all-payer model and with other payment and delivery system reform initiatives;
- (4) changes to quality measure collection and identifying alignment efforts and analyses, if any; and
- (5) the interrelationship of results-based accountability initiatives with the quality measures in subdivision (4) of this subsection.

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Additionally, Section 7 of Act 82 of 2017 requires a plan to integrate multiple sources of payment for mental and substance abuse services to the designated and specialized service agencies (DAs and SSAs).

### FULL TEXT

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#### Act 82, Sec. 7. PAYMENTS TO THE DESIGNATED AND SPECIALIZED SERVICE AGENCIES

The Secretary of Human Services, in collaboration with the Commissioners of Mental Health and of Disabilities, Aging, and Independent Living; providers; and persons who are affected by current services, shall develop a plan to integrate multiple sources of payments for mental and substance abuse services to the designated and specialized service agencies. In a manner consistent with Sec. 11 of this act, the plan shall implement a Global Funding model as a successor to the analysis and work conducted under the Medicaid Pathways and other work undertaken regarding mental health in health care reform. It shall increase efficiency and reduce the administrative burden. On or before January 1, 2018, the Secretary shall submit the plan and any related legislative proposals to the Senate Committee on Health and Welfare and the House Committees on Health Care and on Human Services.

This is the second annual report. The first annual progress report on delivery system and payment reform for Medicaid providers can be found here:

- First Annual Report Filed 1/3/2017: <http://legislature.vermont.gov/assets/Legislative-Reports/Act-113-Sec-12-Medicaid-Pathway-Report-12-30-16.pdf>

## EXECUTIVE SUMMARY

2017 was an exciting year for payment and delivery system reform in Vermont. Vermont launched a first in the nation Accountable Care Organization (ACO) pilot program where a network of hospitals and providers took on accountability for the care, health, and cost of their patients. The pilot was limited to Medicaid beneficiaries; however, it laid the foundation for expanding the program to Medicare and commercial insurers. On January 1, 2018, aligned Medicare and commercial programs joined Medicaid in moving Vermont towards the goal of an integrated system of care regardless of payer.

AHS, through Vermont's Medicaid program, has an integral role in shaping payment reform and supporting delivery system reform. Vermont's Medicaid 1115 Waiver, the Global Commitment to Health, provides the authority and flexibility for Vermont to customize its Medicaid program to best serve Vermonters. Vermont has used this authority and flexibility to implement new payment mechanisms, provide covered services not traditionally reimbursable through Medicaid, and launch programmatic innovations such as Blueprint for Health, Hub and Spoke, and Choices for Care. Vermont intends to continue to build on its past health care reform successes. Specifically, AHS, through its constituent departments, has prioritized shifting from fee-for-service payments, which incentivize volume of care, to value-based payments and care, which emphasize better health outcomes and sustainable costs. Beyond the pilot program, AHS has partnered with the ACO OneCare Vermont to develop improved care coordination and integration of services, and the Department of Mental Health is developing alternative payments for services provided to children and adults.

AHS recognizes that the success of payment and delivery reforms relies on a solid foundation that must include equitable payments, accountability for the services rendered, and data by which the first two can be supported and assessed. AHS has taken steps to become a reliable partner in reform. This includes increasing Medicaid primary care reimbursement rates so that they equal Medicare reimbursement, creating equity between in-state and out-of-state academic medical centers that serve many Vermonters, and revamping our payments to health centers, both Federally Qualified Health Centers and Rural Health Clinics, so that they come into compliance with federal law.

Along with equitable payments, accountability is essential to success. Knowing the actual costs of the services and having sufficient information to ensure the quality of the services are important precursors to reforming how AHS pays for the services. AHS and the Department of Disabilities, Aging, and Independent Living are working to improve the accounting of payments paid and services delivered within the developmental disability services system. Moreover, AHS is working to improve how data is collected and managed across the Agency through a new governance system.

The following report fulfills two obligations placed on the Administration by the General Assembly. First, the report fulfills the requirement of Act 113 of 2016, Section 12 for the Secretary of the Agency of Human Services to create a process for payment and delivery system reform for Medicaid providers and services and to report on these activities. Second, the report fulfills the requirements of Act 82 of 2017, Section 7 that directs the Secretary of the Agency of Human Services, in conjunction with Commissioners of the Departments of Mental Health and Disability, Aging, and Independent Living to submit a plan for reforming payments made to the designated agencies and specialized service agencies for mental health

and substance use disorder services. These activities are inextricably linked, particularly given the State's goal of creating an integrated system of care. Accordingly, the Agency believes that the content of the Act 82, Section 7 report falls within the payment and delivery system reforms requested in Act 113, Section 12, and therefore has submitted an integrated report.

We are proud to report in greater detail on the progress that AHS has made towards shifting to value-based payments, improving integration across the continuum of care, and improving accountability and look forward to a discussion of this work with the General Assembly and interested stakeholders.

## SECTION 1: INTRODUCTION

The year 2017 brought substantial transition for state government in general and health care reform specifically. In addition to a new Administration and significant leadership change in the General Assembly, Vermont embarked on the implementation of two new agreements and the extension of a third:

- 1) *The Vermont All-Payer Accountable Care Organization (ACO) Model Agreement (APM Agreement)* with the Centers for Medicare and Medicaid Services (CMS);
- 2) A Medicaid contract with OneCare Vermont ACO LLC (OneCare), which established a pilot Next Generation ACO model for approximately 29,000 Vermont Medicaid beneficiaries; and
- 3) The renewal of the Global Commitment to Health Medicaid 1115 Waiver (Global Commitment to Health), which gives Vermont the ability to be more flexible in the way it uses its Medicaid resources such as new payment mechanisms, coverage of services not traditionally reimbursable through Medicaid, and programmatic innovations.

Through these agreements, Vermont has the opportunity to shape how we pay for and deliver health care in way that is tailored to Vermont needs and improves alignment across payers, including Medicare, Medicaid, and commercial insurers. Collectively, these efforts have the goal of better health, better quality care, and affordable and sustainable health care costs. Furthermore, the changes in payment for and delivery of care that Vermont is pursuing creates incentives to focus on primary and preventive care and to create more alignment between medical, mental health, substance use disorder, and social services.

Under the previous administration, efforts began to introduce payment and delivery reforms to Medicaid-funded programs, including services provided by the Designated Agencies (DAs), Specialized Service Agencies (SSAs), and preferred providers of substance use disorder services. This work occurred through the Medicaid Pathways initiative, which was launched by the Agencies of Human Services (AHS) and the Agency of Administration (AOA) in the Fall of 2015. However, under the incoming Scott Administration, the focus for 2017 shifted to establishing the Vermont Medicaid Next Generation (VMNG) ACO pilot model and to prepare for expanding ACO-based reform to Medicare and commercial insurers as well and expanding the number of hospitals, providers, and Vermonters engaged. Furthermore, while a report produced by Burns and Associates for the Medicaid Pathways project reviewed multiple payment reform models for DAs and SSAs, it also identified several challenges that currently impede implementation. For example, payment reform for DAs and SSAs would benefit from standardization around data quality, consistency, and collection; standardization in reimbursement and billing guidelines; and better readiness for operationalizing reforms.<sup>1</sup> As another example of the current challenges to payment reform, a 2014 report by the State Auditor on DA and SSA budgets found insufficient data on developmental disability services (DDS) to confirm whether services paid for through

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<sup>1</sup> Burns and Associates, Vermont Medicaid Pathway: Alternative Payment Models Final Report – Payment Reform Options for Designated and Specialized Service Agencies, June 1, 2017. Available at: <http://healthcareinnovation.vermont.gov/content/burns-associates-sim-alternative-payment-models-report-june-2017> (last accessed on January 11, 2018).

inclusive payments were actually delivered to the individual.<sup>2</sup> While this finding should be addressed to increase accountability, it also has significant impacts on payment reform. Successful payment reform cannot proceed without a clear understanding of the actual services being delivered, an accurate cost of these services, and the quality of the services. A current review by the Department of Disabilities, Aging, and Independent Living (DAIL) of service delivery, accountability, and reporting mechanisms is currently underway.

Despite these challenges, AHS, using the lessons learned through the Medicaid Pathways process, continues to pursue the goals of a more integrated health care system across the care continuum and the creation of value-based payments. These pursuits are in-line with AHS's responsibilities under the APM Agreement and the Agency's strategic goals. AHS recently advanced its new strategic plan, which contributes to Governor Scott's Priorities and Breakthrough Objectives by establishing cross-agency and departmental goals. The plan lists nine goals, several of which will build upon the Agency's payment and delivery system reform work. These include increasing coordination of AHS services, maximizing the return on investment, increasing the use of cross-agency data, and driving quality, outcomes, and sustainable costs.

In addition to efforts at the state level, OneCare's recently approved budget for Year 1 of the APM agreement also supports a care model that integrates care across multiple organizations and employs alternative payment mechanisms.

## SECTION 2: ACCOUNTABLE CARE ORGANIZATION-BASED REFORM

AHS is committed to value-based Medicaid payment reforms that incentivize increased integration and alignment across the care continuum and have the goals of high-value care and sustainable health care costs. The APM Agreement and ACO-based reforms are the current vehicles through which these reforms occur. The priority for 2017 has been to operationalize the provisions of the APM Agreement.

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### ROLES AND RESPONSIBILITIES UNDER THE APM AGREEMENT

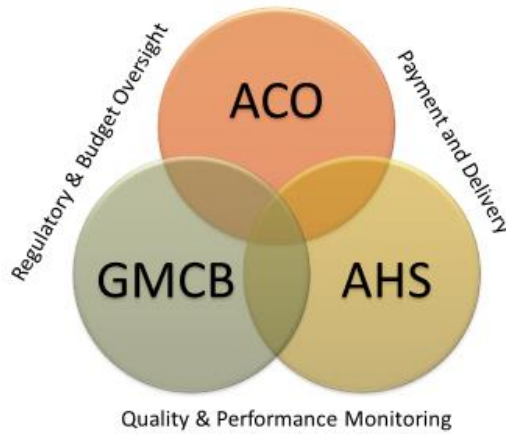
The APM Agreement identifies AHS and Green Mountain Care Board (GMCB) as the key state entities charged with carrying out the responsibilities laid out in the agreement. Specifically, GMCB is tasked, in collaboration with AHS, with monitoring how the model is achieving financial, quality, and outcome targets. The General Assembly, through Act 113, supported this role by granting GMCB regulatory authority over ACOs including approval of their budgets. AHS, in collaboration with GMCB, is tasked with creating the conditions in which the ACO can begin to improve coordination across the care continuum. The ACO accordingly has the role of engaging multiple payers (i.e., Medicare, Medicaid, and commercial insurers) to establish alternative ways of paying hospitals, medical providers, and community providers. Figure 1 describes these relationships.

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<sup>2</sup> Vermont State Auditor, Designated Agencies: State Oversight of Services Could Be Improved, But Duplicate Payments Not Widespread, 2014. Available at: <http://auditor.vermont.gov/sites/auditor/files/files/reports/performance-audits/Final-DA-report-II10.31.2014.pdf> (last accessed on January 11, 2018).



**Figure 1. Key Relationships under the APM Agreement**



Additional Actors: Legislature, Centers for Medicaid and Medicare Innovation, Medicare, Medicaid, commercial insurers



To carry out the responsibilities under the APM Agreement, AHS Central Office, Department of Vermont Health Access (DVHA; including Blueprint for Health), and GMCB meet regularly to review how respective activities are aligning, for example, how progress on developing the VMNG contract coordinates with GMCB’s review of the ACO budget. Additionally, AHS staff and Commissioners of DVHA, DAIL, Department of Mental Health (DMH), Vermont Department of Health (VDH), and Department for Children and Families (DCF) meet with OneCare regularly to review how OneCare’s delivery system reforms align with AHS services. Example agenda items include screening tools, quality and performance measures, and long-term services and supports (LTSS). GMCB works with OneCare in its oversight capacity to ensure the ACO is meeting its requirements for certification and operates in compliance with its budget order.

Finally, an agency-wide group met regularly in the first part of the year to review how the work in each of the departments in AHS connected with the work of other departments and with health care. This group provided valuable level-setting around AHS services and identified common themes across departments. One of these themes was the challenge of capturing funds for acute care or services and investing them in preventive services that could avert the need for expensive acute care or services down the road. One of the goals for payment reform is to address this concern. Moving forward, this cross-agency group will work to ensure that AHS fulfills its role in the APM Agreement in a coordinated way.

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#### APM EXPECTATIONS FOR ALIGNMENT AND INCLUSION OF ADDITIONAL MEDICAID SERVICES

The APM Agreement’s initial focus is on hospital and physician services. DVHA’s VMNG ACO Pilot program with OneCare was the first step in operationalizing these goals and provision of the agreement. In 2018, the state and OneCare extended the Vermont Medicaid ACO program for another year, and OneCare added aligned Medicare and BlueCross BlueShield of Vermont (BCBSVT) programs as well as

expanded to additional communities. However, the APM Agreement also identifies the need to include other services necessary to achieve the population health and quality outcomes over the period of the agreement. These services include mental health, substance use disorder, home- and community-based services, and long-term institutional services. The agreement also calls for close monitoring to ensure the ACO is investing in community-based services such as Blueprint for Health community health teams and preventive services.

Expanding services will involve strategic planning in collaboration with OneCare and GMCB. By December 31, 2020, the state must have developed two plans:

1. Coordinating the financing and delivery of Medicaid mental health and substance use disorder services with the APM Agreement's financial and quality targets
2. Coordinating the financing and delivery of Medicaid home- and community-based services with APM Agreement targets.

Beginning on January 1, 2021, Medicaid Long-Term Institutional Services will be included in the APM Agreement as financial target services. While these deadlines are still a couple years away, initial planning and preparation has already begun. These efforts are summarized in Section 3.

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#### DELIVERING COORDINATED, HIGH-VALUE CARE

Prior to the Medicaid Pathways, the Integrated Community Care Model (ICCM) Learning Collaborative was launched in 2014 by Blueprint for Health, GMCB, the three ACOs, and Vermont Health Care Innovation Project (VHCIP). Many of the core features of this learning collaborative were incorporated into the Medicaid Pathways "Vermont Model of Care".<sup>3</sup> These included;

- Person- and family-centered and/or -directed services;
- Involvement of a primary care physician;
- Identification of a lead care coordinator;
- Development of a comprehensive care plan;
- Establishing an individualized care team that meets through care conferences;
- Support through care transitions; and
- Use of technology for information-sharing

The ICCM Learning Collaborative brought in experts from across the country to work with Vermont organizations to systematically identify individuals and families who would benefit from cross-organization, team-based care. The Learning Collaborative also supported a common set of tools to engage people in their care, brought together providers working with each identified patient in patient-centered teams, developed shared-care plans based on the patient's goals and abilities, and supported communication among team members for more complete, effective, and efficient care and better

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<sup>3</sup> Vermont Agencies of Human Services and Administration, Medicaid Pathway Overview, December 31, 2016 Report. Available at: <http://dvha.vermont.gov/global-commitment-to-health/medicaid-pathway-planning-overview-12.19.16-update.pdf> (last accessed January 11, 2018).

patient outcomes. To support the model, communities used existing local infrastructure including project managers, quality improvement facilitators, and community health teams.

The ICCM Learning Collaborative and its core features have served as the foundation for the Care Model currently used by OneCare. This care model uses data to identify health risks across the population. It then groups people into four progressively more intense levels of care, implements community-wide prevention strategies, supports self-management of health conditions, and proactively targets services to individuals who need them most. In support of the Care Model, OneCare has implemented a payment structure that supports team-based care, shared care plans, and a lead care coordinator. For more information on OneCare Vermont's population health initiatives and payment reforms, see provisions 29-43 in the GMCB's FY18 Accountable Care Organization Budget Order.<sup>4</sup> As part of the collaboration between OneCare and AHS, departments have begun to explore how their services align with the Care Model and how to improve coordinated services.

Around the same time the ICCM emerged, VHCIP funding supported a new model of collaborative leadership for population health improvement work, called Accountable Communities for Health. Like the ICCM work, the first step was a year-long learning collaborative. The Accountable Communities for Health Learning Collaborative engaged management- and leadership- level staff from across the spectrum of health care and community service organizations, including mental health, substance use disorder treatment, home health, aging services, food banks, housing organizations, transportation companies, and more. The participating groups from each community often emerged from the Community Collaboratives that are supported by the Blueprint for Health, ACOs, and the Vermont Department of Health. The Accountable Communities for Health Learning Collaborative gave these groups an opportunity to develop or refine their work in nine core areas: Mission, Multi-sectoral Partnership, Integrator Organization, Governance, Data and Indicators, Strategy and Implementation, Community Member Engagement, Communications, and Sustainable Financing. Many Community Collaboratives found this framework so useful that they formally adopted it as their strategy for improving the health of the population in their region. Some have also begun calling their Community Collaboratives "Accountable Communities for Health." These multi-disciplinary population health leadership bodies guide and monitor improvement work in their communities related to care management, prevention and healthy living initiatives, self-management programs, cross-organization clinical quality improvement, substance use disorder and mental health services, and other locally-determined priorities.

### SECTION 3: DEPARTMENTAL REFORM INITIATIVES - 2017

#### CMS RECOGNITION OF 7 NON-FEE-FOR-SERVICE PAYMENT MODELS

One of the goals of implementing the Global Commitment to Health demonstration is to improve the health status of all Vermonters by promoting delivery system reform through value-based payment

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<sup>4</sup> Green Mountain Care Board, FY18 Accountable Care Organization Budget Order, January 2018. Available at: <http://gmcboard.vermont.gov/sites/gmcb/files/FY18%20ACO%20Budget%20Order%20OneCare%20Vermont.pdf> (last accessed on January 11, 2018).

models. As per the Special Terms and Conditions of the currently approved demonstration, AHS must submit certain non-fee-for-service payment models to CMS for approval prior to implementation. To ensure consistency with the state's health care reform vision, all proposed payment models must advance at least one of the goals and objectives in the Global Commitment to Health Comprehensive Quality Strategy (CQS) and use a common set of performance measures across all providers.<sup>5</sup>

During negotiations to extend the Global Commitment to Health waiver in 2016, Centers for Medicaid and CHIP Services (CMCS) and Vermont recognized that the Vermont Medicaid program has made efforts under its demonstration to implement delivery system and payment reforms. Both parties then performed an inventory of payment models that are authorized through the waiver and outside of the Vermont Medicaid State Plan. As a result of the inventory, CMCS and AHS identified seven existing non-fee-for-service payment models that have been approved by CMCS:

1. Vermont Medicaid Next Generation ACO
2. Blueprint for Health- Patient-Centered Medical Home
3. Blueprint for Health- Community Health Teams
4. Blueprint for Health- Women's Health Initiative
5. Dental Incentive Payment
6. Children's Integrated Services
7. Integrating Family Services

These models demonstrate progress through the Vermont Medicaid program to implement alternative payment model approaches that are supportive of delivery system reform. Each of these payment model applications were reviewed to ensure that they were representative of the array of services provided and of the diversity of individuals served, as well as aligned with the broader demonstration goals and objectives.

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## DEPARTMENT OF VERMONT HEALTH ACCESS

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### PROGRESS ON VERMONT MEDICAID NEXT GENERATION ACO PILOT PROGRAM

The VMNG ACO pilot, as one of the approved payment reform models, represents the initial phase of Medicaid's participation in the integrated health care system envisioned in the APM Agreement. In February of 2017, DVHA contracted with OneCare to launch the VMNG Pilot program for the 2017 calendar year with four optional one-year extensions. The model's goal is an integrated health care system with incentives aligned to improve quality and reduce unnecessary costs. The VMNG ACO Pilot program pursues this goal by transitioning how we pay for care from fee-for-service payments to value-based payments. This transition is meant to focus health care payments on rewarding value, meaning low cost and high quality, rather than volume of services provided.

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<sup>5</sup> Department of Vermont Health Access, Comprehensive Quality Strategy, 2018. Available at: <http://dvha.vermont.gov/global-commitment-to-health/comprehensive-quality-strategy> (last accessed on January 15, 2018).

Through the VMNG Pilot program in 2017, DVHA partnered with OneCare to manage the quality and cost of care for approximately 29,000 Medicaid members in four communities. OneCare's network of participating providers includes the University of Vermont Medical Center, Central Vermont Medical Center, Northwestern Medical Center, and Porter Hospital along with their employed physicians and providers. It also includes two Federally Qualified Health Centers; independent practices; home health providers; DAs; Area Agencies on Aging; and skilled nursing agencies in the four participating communities.<sup>6</sup> Together, DVHA and OneCare are piloting a financial model designed to support the clinical and operational capabilities of the ACO provider network with the goal of supporting health care professionals deliver the care they know to be most effective in promoting and managing the health of the population they serve.

The VMNG ACO Pilot program was designed to support the implementation of Vermont's APM Agreement. Most notably, the included services, attribution, and payment methodologies are aligned with the Medicare Next Generation ACO program, including all-inclusive population-based payments. Through the VMNG, DVHA pays OneCare a monthly per member fixed prospective payment for services closely corresponding to Medicare Part A and Part B services provided by hospitals (and hospital-owned practices) participating with the ACO. The OneCare is responsible for both the cost and quality of care for each attributed member, regardless of how much care that person uses. Medicaid fee-for-service payments continue for all other non-hospital providers in the ACO, for all providers who are not a part of the ACO, and for all services that are not included in the fixed prospective payment. Beyond payment, the majority of quality measures align with the APM Agreement. In accordance with Act 25 of 2017, DVHA submitted updates on the VMNG ACO Pilot on June 15, September 15, and December 15, 2017.

DVHA and OneCare elected to exercise one of the four optional one-year extensions permitted by the VMNG contract. A one-year extension enables DVHA and OneCare to continue the program for the 2018 calendar year. DVHA and OneCare highlighted several mutual goals for a 2018 performance year when entering into negotiations:

- Minimize programmatic changes from 2017 to 2018 to provide stability for ACO-based reform as commercial and Medicare Next Generation ACO programs begin.
- Increase the number of communities voluntarily participating in the program.
- Increase the number of Medicaid beneficiaries attributed to the ACO.
- Ensure programmatic alignment between the VMNG, Medicare, and commercial payer programs in 2018 per the requirements of the APM Agreement.

Negotiations concluded during the fourth quarter of 2017, and the final contract was signed by the Commissioner of DVHA and the CEO of OneCare on December 29, 2017. The contract covers approximately 42,000 Medicaid enrollees in 10 communities.

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<sup>6</sup> See <https://www.onecarevt.org/NetworkParticipants>.

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## PRIMARY CARE PAYMENTS

In addition to changing how Medicaid pays for care, DVHA recognizes the importance of primary care in supporting the delivery system reforms needed to respond to payment reforms. One way to support primary care is to create equity between Medicare and Medicaid for primary care rates. DVHA has achieved this goal by aligning payment for certain primary care codes with Medicare through its recent update to its physician fee schedule and primary care incentive payments, which became effective August 1, 2017.<sup>7</sup> Specifically, DVHA increased the rate paid to eligible primary care providers for certain services so as to equal the Medicare calendar year 2017 payment rates.<sup>8</sup> This increase is achieved by using a special conversion factor, which was formerly called an Enhanced Primary Care Payment, or EPCP. For more information on this accomplishment, review DVHA's *Vermont Medicaid Payment Alignment Report, Act 85 of 2017*.<sup>9</sup>

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## DARTMOUTH-HITCHCOCK MEDICAL CENTER SETTLEMENT

The State of Vermont and Dartmouth Hitchcock Medical Center (DHMC) came to an agreement to end longstanding litigation regarding reimbursements. The State of Vermont committed to creating parity between rates paid to DHMC and Vermont's in-state academic medical center. These changes were effective January 1, 2018. It is our hope that the resolution of this lawsuit can renew collaboration on health care reform.

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## FQHC PAYMENT RECALIBRATION

DVHA engaged in a multi-year project to evaluate the way it pays health centers, both Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs). The project focused on two goals: (1) to bring DVHA into compliance with federal law related to health center reimbursement, and (2) to align DVHA's payment methodology for health centers with DVHA's overall payment reform goals, including those through the APM Agreement. Additionally, DVHA believes the project will end longstanding confusion and disagreement between DVHA and health centers regarding reimbursement policy. Overall, DVHA anticipates that this will increase the aggregate reimbursement for health centers; however, the change is anticipated to be revenue neutral given previous rate adjustments made in State Fiscal Year (SFY) 2018. The changes are highly technical, and a general description is provided below.

Health centers receive cost-based reimbursement, and DVHA's re-basing project will make sure health centers are paid in compliance with the Prospective Payment System (PPS) set forth in the *Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000*. Overall, the re-basing will include the following changes:

- Set new rates for 2018 based on a proper interpretation of BIPA;

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<sup>7</sup> Vermont's Global Commitment Register (GCR) provides information on Vermont Medicaid policy changes. GCR 17-061 contains information on these primary care payments. Available at: <http://dvha.vermont.gov/global-commitmentto-health/global-commitment-register> (last accessed on January 11, 2018).

<sup>8</sup> The Vermont Medical Society's comments to this proposed change listed creating equity with Medicare payments as a "major public policy milestone."

<sup>9</sup> Department of Vermont Health Access, Vermont Medicaid Payment Alignment Report: Act 85 of 2017, September 14, 2017. Available at: <https://legislature.vermont.gov/assets/Legislative-Reports/Medicaid-Alignment-Report-to-Legislature-FINAL.pdf> (last accessed on January 11, 2018)

- Institute a Change of Scope process that adjusts payments when a health center’s scope of practice changes;
- Impose a Reasonable Cost Cap to protect taxpayers; and
- Sunset health center-specific alternative payment models by 2019 since current health center alternative payment models are neither focused on value nor aligned with the Vermont All-Payer Accountable Care Organization Model and the related VMNG program.

DVHA implemented these changes on January 1, 2018.

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DEPARTMENT OF DISABILITIES, AGING, AND INDEPENDENT LIVING REFORM INITIATIVES

In pursuing LTSS payment reform opportunities, DAIL has built on Vermont’s national and international reputation for excellence in LTSS. Choices for Care was the first statewide program to support complete participant choice of settings and services, with significant reductions in reliance on nursing homes and strong performance in quality measures. In 2017, the SCAN Foundation ranked Vermont #3 in the United States in overall LTSS performance and was awarded first place for affordability and access. Vermont’s Developmental Disabilities Supported Employment was recognized by the Zero Project in Vienna, Austria, for the ZERO PROJECT INNOVATIVE POLICY 2017 award, acknowledging Vermont’s success in supporting people with developmental disabilities in full community-integrated employment. Moving forward, we will continue to improve our LTSS performance through new payment reform opportunities. This work will include a strong focus on LTSS performance measures, accountability, service flexibility, and consumer choice and direction and will involve meaningful participation from consumers, providers, and stakeholders.

DAIL was an active participant in the Medicaid Pathways project. During the process, two “cohorts” were identified, both of which included population overseen by DAIL. The first cohort included Specialized Medicaid Programs and Services within AHS Mental Health (MH), DDS, and Substance Use Disorder (SUD) Treatment Services. The second cohort included Choices for Care (CFC) and traumatic brain injury (TBI).

While the work with these cohorts specific to Medicaid Pathways has ended, DAIL continues to explore reforms to how Medicaid pays for services such that the payment rewards high quality, high value care instead of volume. The below describes these activities. As mentioned above, a cross-agency group met regularly from the beginning of the year to engage in level setting around the Agency’s programs and populations served. DAIL presented overviews of current LTSS (CFC, DDS, TBI) laws, rules, eligibility, provider system, services, reimbursement, quality management, outcome and performance measures. DAIL continues to participate in this group as AHS develops a workplan around aligning LTSS with financial and quality targets of the APM Agreement.

Additionally, in line with a recommendation from the previous CFC Medicaid Pathway group, DAIL convened a DAIL Advisory Board subgroup in May of 2017 to work on redesign of CFC Moderate Needs Group (MNG) payment and services. This group has met and produced draft recommendations for changes to CFC MNG eligibility and reimbursement methodology. Some preliminary recommendations from the group include:

- Expand the flexible funding option versus provider-specific allocations;
- Allow provider carry forward of unspent allocation from one fiscal year to the next;
- Change eligibility standards to more accurately target intended population; and
- Change wait list standards from chronological to need based.

DAIL also convened a group in the fall of 2017 to work on the redesign of DDS payment and services. The workgroup is exploring new payment models to streamline procedures and enhance transparency and accountability for DDS home- and community-based services for adults. The goals are to fully meet the needs of the people served, ensure consistency between assessed need and funded services, improve accountability for the use of public resources, and achieve consistent quality outcomes including high consumer satisfaction. DAIL's work to address financial and performance accountability without destabilizing the developmental disabilities system of care is essential to establishing a sound foundation for payment reform, and will continue in 2018. Elements of the work include:

- A financial and service review of DDS provided by all agencies during SFY 18;
- The development of a new value-based payment methodology that ensures that people receive the services that they need, is transparent and accountable, and provides reasonable funding to allow agencies to cover the cost of service delivery;
- The development process of the new payment methodology will include robust consumer and stakeholder input; and
- The new payment methodology will include accurate encounter data and reasonable operational and infrastructure costs.

The initial workgroup includes DAIL staff, DVHA payment reform staff, and representatives from DA/SSAs. DAIL will engage stakeholders when there is a more concrete outline of a new payment model. Key features of a new model include individualized assessment of needs; a person-centered plan of services; a transparent method of tracking service delivery to ensure people receive what they are determined to need and to account for paid claims; a reimbursement methodology that reflects reasonable costs of services and options for choice of providers; and self/family management of service.

Regarding services for children with developmental disabilities and their families, Developmental Disabilities Services Division (DDSD) has been meeting with the Department of Mental Health (DMH) Child, Adolescent and Family Unit to explore further integration of services across the departments and at the local level. DMH and DDSD staff visited several DAs, who have moved forward with integrating their services for children and families. Staff identified across these agencies common themes resulting from integration that included:

- Previously distinct eligibility rules restricted access and flexibility of services. Removing those opened access, so more children could be served.
- Blended funding allowed a partnership between DDS/MH that created an essential culture change of working with children and families to identify the most appropriate combination of support and treatment. The changes freed up clinicians and other staff to focus on service delivery.
- Agencies no longer needed funding work-arounds for children and families to receive services.



- Agencies could tailor how services were delivered to meet unique needs of a community.
- Improving the focus on natural supports and connections to community allowed agencies to maximize efficiencies in service delivery.
- DDS and MH recognized each had skills to bring to the service delivery for a family such as clinical mental health services, family systems work, and skill development.

DDSD and DMH continue to meet to explore expanding more integrated services to more regions of the state. This work will continue in 2018.

DAIL has also begun internal work to create a list of ‘strengths’ and ‘opportunities’ across DAIL LTSS intended to inform broader reform work across CFC, DDS, and TBI.

In support of implementing the APM Agreement, OneCare invited DAIL (along with other providers and stakeholders) to participate in developing policies and procedures to implement the APM Agreement waiver of the Medicare requirement for a qualifying three-day hospital stay before Medicare coverage of nursing facility services. Draft procedures and workflow have been developed. This work will continue in 2018.

Finally, DAIL has begun initial conversations with other stakeholders about possible changes to Medicaid rate setting and reimbursement for nursing facilities. The AHS Division of Rate Setting has direct responsibility for the current regulations and procedures.

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#### DEPARTMENT OF MENTAL HEALTH REFORM INITIATIVES

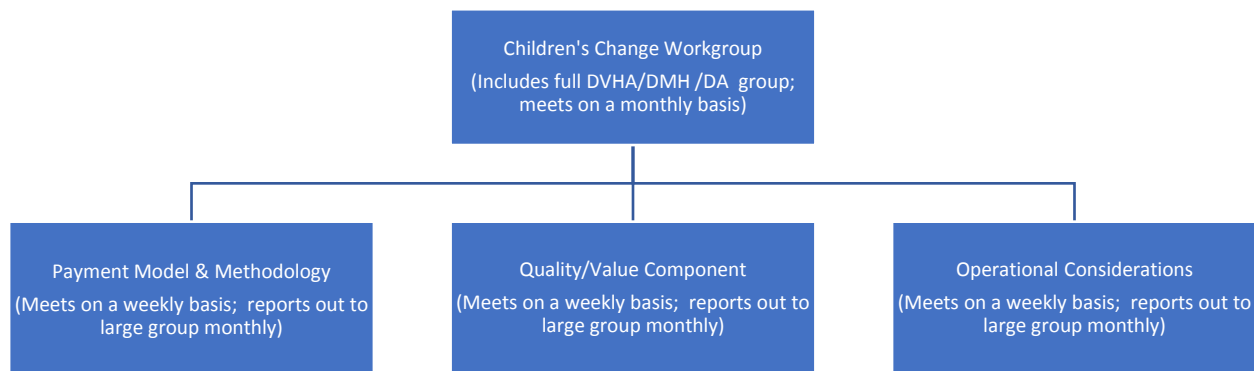
According to the Center for Health Care Strategies, “Many state Medicaid programs have developed VBP [value-based purchasing] approaches to improve quality and slow cost growth for physical health services, but these advances have been slower to emerge in Medicaid behavioral health programs.” Through its continued efforts in the area of payment reform for mental health services, Vermont is in the leading wave of states attempting reforms in this arena. Currently, DMH is working with DVHA’s Payment Reform team and in coordination with the Director of Health Care Reform to develop new payment models for reforming child and adult mental health reimbursement. The new payment structures under development are considered alternative and value-based purchasing approaches. The goal is to create models that can include other AHS departments over time that will align with payment approaches through the APM Agreement and that give providers the flexibility they need to implement effective service delivery approaches.

Work is currently underway in both programs, with the goal that each follow similar paths; however, the work on the children’s program began earlier and has progressed farther. The target for implementing both programs of service is SFY19, but that date may change to achieve the desired scope of reforms rather than reducing scope to meet a fixed timeframe.

The structure of the children’s payment reform approach is depicted in the figure below. The Children’s Change Workgroup oversees the process with three subgroups focused on different components of the work (payments, quality, and operations). All workgroups are facilitated and supported by DVHA’s

Payment Reform team with representation from DMH (including the former Integrating Family Services Director), the DAs, and Vermont Care Partners. Depending on scope and capacity, other Departments may join the effort over time.

Figure 2. The Children’s Mental Health Reimbursement Reform Organization



The DVHA payment reform team, DA representatives, and Vermont Care Partners serve as the bridge for overlapping information and developmental milestones from the child mental health work groups to inform the recently launched adult payment reform work groups.

The Children’s Change Workgroup has reviewed lessons learned from the Integrating Family Services pilot regions to capitalize on effective strategies realized in these pilots and to learn from the challenges of that initiative. Work from the Medicaid Pathway has also been reviewed and incorporated into the planning where relevant, including topics such as the Vermont Model of Care; alignment of delivery system organization and governance expectations with integrated delivery models; payment models that support value-based and population health approaches; quality and performance measurement to support value-based payments; and alternative payment models for services delivered by DAs and SSAs.

The Children’s Change Workgroup has identified the following goals for defining a payment reform model aligned with the Triple Aim:

- Sustainable spending
  - Simplify funding streams
  - Move away from fee-for-service reimbursement
  - Increase payment predictability
  - Increase flexibility for providers
- Better Care (i.e., improved customer experience)
  - Improve access to care
  - Improve satisfaction
  - Strengthen Children’s System of Care
- Healthier People (i.e., improved outcomes and value)
  - Streamline measurement of outcomes

- Improve efficiency of quality review processes
- Focus on improving health across a population

The Children’s Payment Model & Methodology Work Group is tasked with identifying and developing an attribution methodology, the scope of services to be included, a financial methodology, and the provider payment mechanism. To date, the workgroup has identified a preliminary set of core services and funding streams to be included in the payment model. These services require more analysis and broader stakeholder input to be finalized. Additionally, several funding streams have interagency linkages and have been identified for Commissioner review at the beginning of calendar year 2018. The next steps of this work group are to identify the most appropriate value-based purchasing methodology and management of risk. A key principle for the model is that it is flexible enough to adapt to needs of a community.

The Children’s Operational Considerations Work Group intentionally began later than the Payment Model and Quality workgroups to allow some initial development of the payment model and measures. The group has begun to identify the current rules, policies, procedures, guidelines and manuals that relate to the proposed funding streams and services. Activities related to program integrity functions are being explored to determine what processes will be needed to support the new model. The workgroup is also considering developing internal DMH and provider agency readiness assessment tools as both DMH and the agencies will need to consider internal staffing roles and responsibility changes.

The Children’s Quality & Value Component Work Group is looking at quality management and indicators, performance reporting, and information systems. See Section 4 of this report for more information.

Due to its recent launch, there is no additional information about the design and development of Adult Mental Health payment and delivery reform models to be added to the report at this time.

## SECTION 4: QUALITY MEASURE COLLECTION AND RESULTS-BASED ACCOUNTABILITY

### DATA GOVERNANCE

Data plays a key role in supporting program operations, devising reform strategies, informing continuous quality improvement, and evaluating the efficacy of program and reform efforts. As such, AHS has committed to increasing the use of cross-agency data, improving the information technology (IT) that supports the data, and establishing a governance structure to provide essential leadership and decision making around data and health IT.

Data governance is part of the overall AHS governance structure. The AHS Governance Team is a decision-making body at the Agency level responsible for making final decisions on recommendations, including issues around data governance, brought forth by departments and other bodies within the AHS Governance Framework. Membership includes the AHS Secretary, AHS Deputy Secretary, Agency of Digital Services Secretary, AHS Chief Financial Officer, AHS IT Director, the AHS Chief of Operations, the AHS Health Reform Director, and all six AHS Department Commissioners.

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## AHS QUALITY, MEASURES, AND ACCOUNTABILITY

The Global Commitment CQS<sup>10</sup> is intended to serve as a road map for Vermont and its contracted health plans in assessing the quality of care that Medicaid beneficiaries receive, as well as identifying measurable goals and targets for improvement. In doing so, it sets forth specifications for quality assessment and performance improvement activities that AHS will implement to ensure the delivery of quality health care. In addition, this document is designed to support alignment within and among the various health care reform initiatives. During 2017, the Global Commitment CQS was updated to include performance measures for specific DMH and DAIL health care programs as well as those associated with non-fee-for-service Delivery System Reform Payment Models. Performance measures for the APM, VMNG, and Global Commitment to Health demonstration remained unchanged for 2017. In addition, the document was updated to include work done by DMH and DAIL to identify and align performance measures associated with their programs and services to enhance their accountability.

Before submitting non-fee-for-service payment models to CMS for approval, AHS reviewed applications and supporting documents to ensure that they met the following criteria: (1) were consistent with the state's health care reform vision; (2) advanced at least one of the goals and objectives in the Global Commitment CQS; and (3) used a common set of performance measures across all providers. In addition, all payment model applications were reviewed to ensure that their associated measures were representative of the array of services provided and of the diversity of individuals served as well as aligned with the broader demonstration goals and objectives.

Also during this year, both DMH and DAIL continued work begun in the previous year to identify and align quality and performance measures associated with their programs and services to enhance their accountability. This work is a foundational step in preparation for shifting from fee-for-service to value-based reforms.

DAIL spent time this year discussing and debating appropriate LTSS quality and performance measures based on national standards<sup>11,12</sup> to ensure that LTSS payments are linked with high quality, high value care. While specific measures have yet to be selected, potential performance categories and measures were identified. Examples include: "Proportion of people who do things they enjoy outside of their home when and with whom they want to" and "Employment rate of people of working age receiving developmental disabilities services". As AHS works with the OneCare and GMCB to develop a plan for incorporating home- and community-based services and institutional services into the financial and

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<sup>10</sup> Comprehensive Quality Strategy, Department of Vermont Health Access. Available at: <http://dvha.vermont.gov/global-commitment-to-health/comprehensive-quality-strategy> (last accessed on January 11, 2018).

<sup>11</sup> National Quality Forum's home- and community-based services measures: [http://www.qualityforum.org/Publications/2016/09/Quality\\_in\\_Home\\_and\\_Community-Based\\_Services\\_to\\_Support\\_Community\\_Living\\_Addressing\\_Gaps\\_in\\_Performance\\_Measurement.aspx](http://www.qualityforum.org/Publications/2016/09/Quality_in_Home_and_Community-Based_Services_to_Support_Community_Living_Addressing_Gaps_in_Performance_Measurement.aspx); and [https://www.qualityforum.org/Publications/2017/09/Medicaid\\_Innovation\\_Accelerator\\_Project\\_Final\\_Report.aspx](https://www.qualityforum.org/Publications/2017/09/Medicaid_Innovation_Accelerator_Project_Final_Report.aspx)

<sup>12</sup> CAHPS HCBS consumer survey module: <https://www.medicare.gov/medicaid/quality-of-care/performance-measurement/cahps-hcbs-survey/index.html>

quality targets of the APM Agreement, development of appropriate measures for these services will need to continue.

Evidence of this work can be found in DMH as well – specifically with the work of the children’s mental health payment reform Quality and Value Component Workgroup. During this past year, the group explored measures that could be used to evaluate program success, identified key qualities for measure selection<sup>13</sup>, and considered how providers should report on their performance. Each measure was evaluated using the Medicaid Pathway Measure Selection Criteria created in 2016. Measures were sorted into three categories based on how well they meet the criteria and how they fit with the APM Agreement and Results Based Accountability frameworks.

Next steps for the group include identifying which of the selected measures are most appropriate for value-based payments. Once the workgroup has finalized the recommended list of measures and proposed value-based payment measures, feedback will be solicited from the overarching Children’s Change Workgroup and leadership. The finalized measures will be incorporated into the payment model.

In addition, over the past year, DMH has put considerable effort into creating a system of accountability for the DA Master Grant agreements. The Department has created a system to monitor performance measure submission and evaluation by Departmental program directors. DAs are expected to follow a unified set of performance measures for each program, as well as one performance measure that reflects what each DA mental health program uses to evaluate its own performance. The intent is to create a system that reinforces Results Based Accountability with both top-down and bottom-up approaches. The top-down method uses state agency-selected performance measures and outcomes; the bottom-up method uses program-selected performance measures. The Department is also piloting the potential of using the Results Based Accountability *Clear Impact Scorecard* software as a tool for DAs to use to submit performance measure information to the Department, which will eliminate some administrative effort and delays in reporting between the agency and the Department.

As mentioned above, these processes were informed by the Results Based Accountability methodology. Results Based Accountability framework helps programs improve the lives of children, families, and communities and their performance through:

- moving from talk to action quickly;
- using a simple, common sense process that is easily understood;
- helping groups to identify and challenge assumptions that can block innovation;
- building collaboration and consensus; and
- using data and transparency to ensure accountability for both program performance and ensuring the well-being of people.

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<sup>13</sup> These measures should: (1) include population level outcomes; (2) increase the quality and value of the programs and services provided; (3) be feasible to collect; and (4) provide meaningful data for continuous quality improvement efforts.

The AHS uses *Clear Impact Scorecards* to strengthen continuous improvement practices, including how they measure, monitor, and improve performance. Scorecards organize, present, and share data to tell a story. According to the Results Based Accountability methodology, each card has two parts: population accountability and program accountability. The former is accountability by a community for the well-being of a population and involves examining results for whole populations. The latter is accountability by the managers of a program for the performance of a particular program and involves examining results for the consumers or clients served by the specific program.

In addition to promoting population accountability through statewide trends in Scorecards, AHS uses Scorecards to demonstrate the performance of Departments responsible for implementing programs, services, and various activities – many of which support the Medicaid program. For example, AHS Departments currently use scorecards to enhance regular monitoring of their Global Commitment Investments. The AHS Performance Accountability Committee is examining the feasibility of using scorecards to enhance regular monitoring and reporting of Global Commitment evaluation and payment model performance measures. Monitoring performance measures in this manner allows AHS to gauge success or failure against a performance target or baseline and ultimately engage in a data-driven decision-making process. In addition to maintaining a cohesive dashboard of data and information across departments, this approach is also consistent with AHS’s commitment to enhancing understanding and use of Results Based Accountability within a broader system of accountability for all programs and services. The goal is to move continually toward improved quality of service and outcomes.

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#### APM AGREEMENT AND VMNG – QUALITY, MEASURES, AND ACCOUNTABILITY

The APM Agreement included three broad population health measures: increasing access to primary care, reducing the growth in prevalence of chronic conditions (diabetes, hypertension, and chronic obstructive pulmonary disease), and reduce the number of deaths due to suicide and substance use disorder. More information on the specifics of those measures can be found in Appendix 1 of the APM Agreement.<sup>14</sup> The GMCB, in collaboration with AHS, is responsible for monitoring the progress OneCare and the state are making towards achieving health outcomes and quality of care. Progress towards these targets will be reported annually in the *Annual Health Outcomes and Quality of Care Report*, which is due the September 30<sup>th</sup> following each performance year one through five.

In the VMNG 2018 contract, Attachment B, Section J lists the quality and outcome measures for which the OneCare is responsible. It also describes the Quality Incentive Pool Program, which aims to incentivize OneCare to ensure high quality care and good health outcomes under an all-inclusive population-based payment.<sup>15</sup>

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<sup>14</sup> Vermont All-Payer Accountable Care Organization Model Agreement, October 27, 2016. Available at: <http://gmcboard.vermont.gov/sites/gmcb/files/files/payment-reform/All%20Payer%20Model%20ACO%20Agreement.pdf>. (Last accessed on January 11, 2018).

<sup>15</sup> State of Vermont, Contract between Department of Vermont Health Access and OneCare Vermont Accountable Care Organization LLC. Available at: <http://dvha.vermont.gov/administration/onecare-32318-am2-final-signed.pdf> (last accessed on January 11, 2018).

## SECTION 5: CONCLUSION

In 2017, AHS moved forward with payment and delivery reforms that shift the emphasis to quality and outcomes of care. Much of the focus was on establishing the VMNG ACO Pilot Program. AHS also worked closely with OneCare to prepare for 2018, which included the expansion to Medicare and BCBSVT, and the expansion in the number of hospitals, providers, and Vermonters participating in the reforms under the APM Agreement. AHS also took steps to improve the foundation on which additional payment and delivery reforms can be made. Throughout the year, AHS looked closely at the work under its purview to evaluate equity in payments, accountability for the services rendered, and the data and IT available. In some areas, the Agency was able to take significant steps forward, such as increasing primary care reimbursement rates and establishing a clear decision-making process around IT. In other areas, progress continues to be made on developing new payment and delivery reforms and improving accountability. The goal is that each step brings Vermont closer to an integrated system built around value-based care.

As we look ahead at the state's responsibilities under the APM Agreement in mind, the state will continue to work closely with OneCare, the DAs, SSAs, and other community providers to build on 2017's progress in 2018 and to identify services and providers that are prepared to undertake the changes necessary for successful payment and delivery reform.

APPENDIX 1

Designation of Lead Agencies in the All-Payer Model Agreement

Agreement Text	Topic Heading	Mandatory	Location	Operational Lead
AHS intends to work collaboratively with the GMCB within its ACO regulatory process under the direction of the Governor’s Director of Health Care Reform, established in 3 V.S.A. § 2222a.	ACO Scale Targets	No	§ 6.d	AHS
AHS shall ensure that Vermont Medicaid offers a Scale Target ACO Initiative to Vermont ACOs no later than January 1, 2018.	ACO Scale Targets	Yes	§ 6.d	AHS
If any Vermont ACO does not have a single network of providers for All-payer Financial Target Services regardless of payer by the beginning of Performance Year 2, then AHS shall require the Vermont ACO, as a condition of its Medicaid contract, to ensure that at least 90 percent of all providers in the Vermont ACO's network accept Vermont Medicaid beneficiaries.	Payer Differential	Conditional	§ 10.e.ii	AHS
Any such funding will be executed under a separate agreement with AHS and will incorporate terms described in Appendix 2.	Start-up Funding	No	§ 5	AHS
By the end of Performance Year 3, AHS, in collaboration with the GMCB, shall submit to CMS a plan to coordinate the financing and delivery of Medicaid Behavioral Health Services and Medicaid Home- and Community-based Services with the All-payer Financial Target Services.	Medicaid Behavioral Health and Long-Term Services and Supports.	Yes	§ 11	AHS (see section <b>Error! Reference source not found.</b> )
Vermont shall ensure that the percentage of Vermont Medicare Beneficiaries and the percentage of Vermont All-payer Scale Target Beneficiaries aligned to a Scale Target ACO Initiative, as defined in section 6.b, meet or	ACO Scale Targets	Yes	§ 6.a	GMCB



Agreement Text	Topic Heading	Mandatory	Location	Operational Lead
exceed the following percentages for each Performance Year ("ACO Scale Targets"):				
The GMCB will annually provide its recommendations to the AHS Secretary and the Vermont General Assembly to increase Vermont Medicaid reimbursement rates to levels more comparable to Medicare FFS reimbursement rates.	ACO Scale Targets	Yes	§ 6.d	GMCB
Vermont shall encourage opportunities for Vermont Commercial Plans and Vermont Self-insured Scale Target Plans to offer Scale Target ACO Initiatives to Vermont ACOs.	ACO Scale Targets	Yes	§ 6.e	GMCB
Vermont shall ensure that Scale Target ACO Initiatives offered by Vermont Medicaid, Vermont Commercial Plans, and participating Vermont Self-insured Plans reasonably align in their design . . . with the Vermont Modified Next Generation ACO in Performance Year 1 and with the Vermont Medicare ACO Initiative in Performance Years 2 through 5.	ACO Scale Targets	Yes	§ 6.f	GMCB
Vermont shall encourage providers and suppliers operating in Vermont to participate in Vermont ACOs to achieve the ACO Scale Targets as specified in sections 6.a, 6.b, and 6.c.	ACO Scale Targets	Yes	§ 6.h	GMCB
Vermont shall limit All-payer Total Cost of Care per Beneficiary Growth to 3.5 percent	All-payer Total Cost of Care per Beneficiary Growth Target	Yes	§ 9.a	GMCB
In accordance with section 6.f, the GMCB, in collaboration with AHS, shall submit to CMS for its approval, no later than June 30th of the year following the conclusion of each of the Performance Years 1 through 5, an assessment describing how the Scale Target	Annual ACO Scale Targets and Alignment Report	Yes	§ 6.j.i	GMCB

Agreement Text	Topic Heading	Mandatory	Location	Operational Lead
ACO Initiatives' designs compare against each other				
The GMCB shall submit to CMS for its approval, no later than June 30th of the year following the conclusion of each of the Performance Years I through 5, the State's performance on the ACO Scale Targets described in sections 6.a, 6.b, and 6.c.	Annual ACO Scale Targets and Alignment Report	Yes	§ 6.j.ii	GMCB
Over the Performance Period of the Model, CMS is willing to accept requests from the GMCB for Medicare data necessary to achieve the purposes of the Model.	CMS Data Sharing	No	§ 15.b	GMCB
...the State and its agents shall cooperate with CMS and its contractor(s) and provide all data needed by CMS to monitor and evaluate the Model in accordance with applicable law, including, but not limited to, individually-identifiable health information. The State shall ensure the production of such data through statutory or regulatory mandates on entities holding the required data, or through alternative legal arrangements.	CMS Evaluation	Yes	§ 17.a	GMCB
The State shall cooperate with all CMS monitoring and oversight requests and activities, and ensure that all Vermont ACOs similarly cooperate to the extent allowed by law.	CMS Monitoring of the Model	Yes	§ 18.c	GMCB
The State shall develop procedures to protect the confidentiality of all information that identifies individual Medicare and Medicaid beneficiaries in accordance with all applicable laws.	Confidentiality	Yes	§ 16	GMCB
The GMCB, in consultation with AHS where appropriate, may submit, in writing to CMS, a request that exogenous factor(s) (e.g., changes in Medicare law and regulation or	Exogenous Factors	No	§ 9.c.v	GMCB

Agreement Text	Topic Heading	Mandatory	Location	Operational Lead
Vermont-localized health or economic shocks) be taken into consideration when assessing performance on the All-payer or Medicare Total Cost of Care per Beneficiary Growth Targets.				
In accordance with applicable law, the State shall maintain, ensure Vermont ACOs maintain, and provide to the Federal Government... access to all books, contracts, records, documents, software systems, and other information... sufficient to enable the audit, evaluation, inspection, or investigation of the State's compliance with the requirements of this Agreement	Maintenance of Records	Yes	§ 19	GMCB
The State shall maintain and ensure Vermont ACOs maintain such books, contracts, records, documents, and other information for a period often (10) years after the final date of the Performance Period . . .	Maintenance of Records	Yes	§ 19	GMCB
Vermont and CMS shall ensure that Medicare FFS beneficiaries' access to care, services, providers, and suppliers will not be limited under the Model.	Medicare beneficiary protections	Yes	§ 4	GMCB
Starting in Performance Year 3, CMS or the GMCB may request modifications to the Performance Period Projected National Medicare Total Cost of Care per Beneficiary Growth calculation	Medicare Total Cost of Care per Beneficiary Growth Target	No	§ 9.c.iv	GMCB
Vermont shall limit Vermont Medicare Total Cost of Care per Beneficiary Growth to at least 0.2 percentage points less than Performance Period Projected National Medicare Total Cost of Care per Beneficiary Growth	Medicare Total Cost of Care per Beneficiary Growth Target	Yes	§ 9.b	GMCB
If neither of the network access tests set forth in sections 10.e.i and 10.e.ii are satisfied, then	Payer Differential	Conditional	§ 10.e.iii	GMCB

Agreement Text	Topic Heading	Mandatory	Location	Operational Lead
CMS shall determine it a Triggering Event and issue the State a Warning Notice as described in section 21. The GMCB and AHS shall submit to CMS, for its approval, a CAP for this Triggering Event as set forth in section 21.				
The GMCB, after collaboration with AHS, may submit a written request that specific changes in payments to Medicaid providers be taken into consideration when assessing performance on the All-payer Total Cost of Care per Beneficiary Growth Target.	Payer Differential	No	§ 10.d	GMCB
Beginning in Performance Year 2, the GMCB, after collaboration with AHS, shall submit to CMS. . . the percent ACO Benchmarks will increase by payer for Vermont ACOs, an explanation for any differences in ACO Benchmark increases between payers, and the impact such differences may have on the Payer Differential as it affects Vermont ACOs.	Payer Differential	Yes	§ 10.a	GMCB
The GMCB, after collaboration with AHS, shall submit to CMS by the end of Performance Year 2 an assessment of the Payer Differential as it affects Vermont ACOs.	Payer Differential	Yes	§ 10.b	GMCB
The GMCB and AHS shall submit to CMS by the end of Performance Year 3 a report on options to reduce the Payer Differential between payers during and after the Performance Period.	Payer Differential	Yes	§ 10.c	GMCB
The GMCB shall ensure that a Vermont ACO shall not interfere with a patient's choice of health care providers under the patient's health plan, regardless of whether a provider is participating in the ACO.	Payer Differential	Yes	§ 10.e	GMCB
The State shall ensure that Vermont ACOs have a single network of providers, regardless	Payer Differential	Yes	§ 10.e.i	GMCB

Agreement Text	Topic Heading	Mandatory	Location	Operational Lead
of payer, for All-payer Financial Target Services				
The State may publicly disclose, with consent from CMS, provider-specific performance and performance summary comparisons to other states for purposes of provider accountability for the quality of care delivered under the Model. (note: this information is shared w/the GMCB by CMMI).	Public Disclosure of Provider Performance Data	No	§ 15.c	GMCB
The GMCB, in collaboration with AHS, shall submit to CMS quarterly reports on the State's performance on the All-payer Total Cost of Care per Beneficiary Growth Target	Quarterly Financial Report	No	§ 9.f	GMCB
The GMCB, in collaboration with AHS, shall submit to CMS for its approval, on or before September 30 <sup>th</sup> following each Performance Year 1 through 5, an annual report on the State's efforts to achieve the Statewide Health Outcomes and Quality of Care Targets.	Reports and Data for CMS Evaluation	Yes	§ 8.e	GMCB
The State shall submit by June 30 <sup>th</sup> of Performance Year 3 a plan signed by Vermont's Department of Health, AHS, the GMCB, and Vermont ACO(s) that provides an accountability framework to the public health system to ensure that any Vermont ACO funding allocated to community health services is being used towards achieving the Statewide Health Outcomes and Quality of Care Targets.	Reports and Data for CMS Evaluation	Yes	§ 7.f	AHS  (GMCB will submit to CMS)
AHS, in collaboration with the GMCB, shall develop with CMS by December 31, 2017, a measure to monitor Medicaid patient caseload for specialist and non-specialist physicians.	Reports and Data for CMS Evaluation	Yes	§ 8.g	AHS

Agreement Text	Topic Heading	Mandatory	Location	Operational Lead
<p>CMS, and the GMCB in consultation with AHS, may choose by the end of Performance Year 2 to add this measure and an associated target as an additional health delivery system quality target.</p>	<p>Reports and Data for CMS Evaluation</p>	<p>Yes</p>	<p>§ 8.g</p>	<p>GMCB</p>
<p>The GMCB shall submit to CMS the Annual ACO Scale Targets and Alignment Report, the Annual Health Outcomes and Quality of Care Report, and the Quarterly Financial Report, as described in sections 6, 7, and 9, respectively.</p>	<p>Reports and Data for CMS Evaluation.</p>	<p>Yes</p>	<p>§ 17.b</p>	<p>GMCB</p>
<p>the GMCB, in collaboration with AHS, shall provide CMS with Vermont Medicaid claims data, Vermont Commercial Plans claims data, and available Vermont Self-insured Plan claims data that are necessary for CMS to monitor and evaluate the Model.</p>	<p>Reports and Data for CMS Evaluation.</p>	<p>Yes</p>	<p>§ 17.b</p>	<p>GMCB</p>
<p>The State must make available to CMS and CMS's contractors, for validation and oversight purposes, the datasets and methodologies used by the State to make calculations required under this Agreement, including and as applicable, access to contractors, contract deliverables, and software systems used to make calculations required under this Agreement.</p>	<p>Reports and Data for CMS Evaluation.</p>	<p>Yes</p>	<p>§ 17.b</p>	<p>GMCB</p>
<p>The GMCB may request, and the CMS may consider, Medicare payment waivers as may be necessary solely for purposes of carrying out this Model.</p>	<p>Request for Medicare Payment Waivers</p>	<p>No</p>	<p>§ 13</p>	<p>GMCB</p>
<p>The GMCB, in consultation with AHS, may request modifications to the definitions of Medicare Financial Target Services and All-payer Financial Target Services, subject to CMS approval,</p>	<p>Request for modifications to Medicare and All-payer Financial Target Services.</p>	<p>No</p>	<p>§ 9.e</p>	<p>GMCB</p>

Agreement Text	Topic Heading	Mandatory	Location	Operational Lead
the GMCB, in collaboration with AHS, shall supply CMS reports, information, and data. on ACO Scale Targets, Statewide Health Outcomes and Quality of Care Targets, and Statewide Financial Targets. The GMCB, in collaboration with AHS, shall submit this information on a regular basis. . .	State of Vermont Data Sharing	Yes	§ 15.a	GMCB
Vermont shall achieve the population-level health outcomes targets, healthcare delivery system quality targets, and process milestones . . . as described in Appendix 1.	Statewide Health Outcomes and Quality of Care Targets	Yes	§ 7.a	GMCB
Population-level Health Outcomes Targets (various)	Statewide Health Outcomes and Quality of Care Targets	Yes	App. 1	GMCB
The GMCB may propose modifications to the Initiative to better align the Initiative with ACO programs operated by Vermont Medicaid, Vermont Commercial Plans, and participating Vermont Self-insured Plans.	Vermont Medicare ACO Initiative	No	§ 8	GMCB
To the extent it has the authority, the GMCB may direct a VMA ACO, a Vermont Modified Next Generation ACO, or both to make specific infrastructure and care delivery investments.	Vermont Medicare ACO Initiative	No	§ 8.b.iii	GMCB
CMS, in collaboration with Vermont, shall design and launch the Vermont Medicare ACO Initiative to begin on January 1, 2019, and its performance period will align with Performance Years 2 through 5 of this Agreement.	Vermont Medicare ACO Initiative	Yes	§ 8	GMCB
In order for a Vermont ACO to be eligible to participate in the Vermont Medicare ACO Initiative or be eligible to become a Vermont Modified Next Generation ACO, the GMCB	Vermont Medicare ACO Initiative	Yes	§ 8.b.i	GMCB

Agreement Text	Topic Heading	Mandatory	Location	Operational Lead
<p>must submit to CMS a letter jointly signed by the GMCB and the Vermont ACO attesting that the two entities will work together to achieve the ACO Scale Targets, Statewide Financial Targets, and Statewide Health Outcomes and Quality of Care Targets of the Vermont All-payer ACO Model.</p>				
<p>Except as described in sections 7.c and 9.d, the GMCB shall prospectively develop the Vermont Medicare ACO Initiative Benchmarks for both Vermont Modified Next Generation ACOs and VMA ACOs for Performance Years 1 through 5 in accordance with the terms of this Agreement and subject to CMS approval.</p>	<p>Vermont Medicare ACO Initiative</p>	<p>Yes</p>	<p>§ 8.b.ii</p>	<p>GMCB</p>
<p>The GMCB shall submit to CMS for approval the Vermont Medicare ACO Initiative Benchmarks for each VMA ACO at least 30 calendar days prior to the beginning of each Performance Year for which the benchmarks would be applicable.</p>	<p>Vermont Medicare ACO Initiative</p>	<p>Yes</p>	<p>§ 8.b.ii.2</p>	<p>GMCB</p>
<p>The GMCB and CMS shall collaborate throughout the year prior to each Performance Year to analyze and understand data to inform how Vermont Medicare ACO Initiative Benchmarks are set for Vermont Modified Next Generation ACOs and VMA ACOs.</p>	<p>Vermont Medicare ACO Initiative</p>	<p>Yes</p>	<p>§ 8.b.iv</p>	<p>GMCB</p>
<p>The State shall notify CMS of any such dispute in writing within 30 calendar days of the date on which the State becomes aware, or should have become aware, of the act giving rise to the dispute.</p>	<p>Dispute Resolution</p>	<p>Conditional</p>	<p>§ 21.b.i</p>	<p>N/A (see section <b>Error! Reference source not found.</b> above)</p>
<p>...within 90 calendar days of receipt of the Warning Notice, the State shall submit a written response to CMS...If CMS requires the State to submit a CAP, the State shall do so within 30 calendar day of CMS notice that the</p>	<p>Warning Notice and Corrective Action Plan</p>	<p>Conditional</p>	<p>§ 21.a</p>	<p>N/A (see section <b>Error! Reference</b></p>



Agreement Text	Topic Heading	Mandatory	Location	Operational Lead
State's response is not sufficient. In its CAP, the State shall address all actions the State will take that will include, but are not limited to, implementation of new safeguards or programmatic features to correct any deficiencies and remain in compliance with the Agreement.				<b>source not found.</b> above)
Unless otherwise specified in this Agreement, the State shall successfully implement any required CAP as approved by CMS no later than one year from the date of the Warning Notice unless otherwise modified or agreed to by CMS	Warning Notice and Corrective Action Plan	Conditional	§ 21.c	N/A (see section <b>Error! Reference source not found.</b> above)
The parties may amend this Agreement, including any appendix to this Agreement, at any time by mutual written consent.	Modification	No	§ 20	N/A (see section <b>Error! Reference source not found.</b> above)
Before December 31 of Performance Year 4, the GMCB, in collaboration with AHS, may submit to CMS a proposal for a subsequent model spanning five (5) performance years and detailing operations to be effective beginning 2023 through 2027.	Proposal for Subsequent Agreement.	No	§ 12	N/A (see section <b>Error! Reference source not found.</b> above)
The State may terminate this Agreement at any time for any reason with at least 180 calendar days written advance notice to CMS.	Termination by the State	No	§ 21.f	N/A (see section <b>Error! Reference source not found.</b> above)