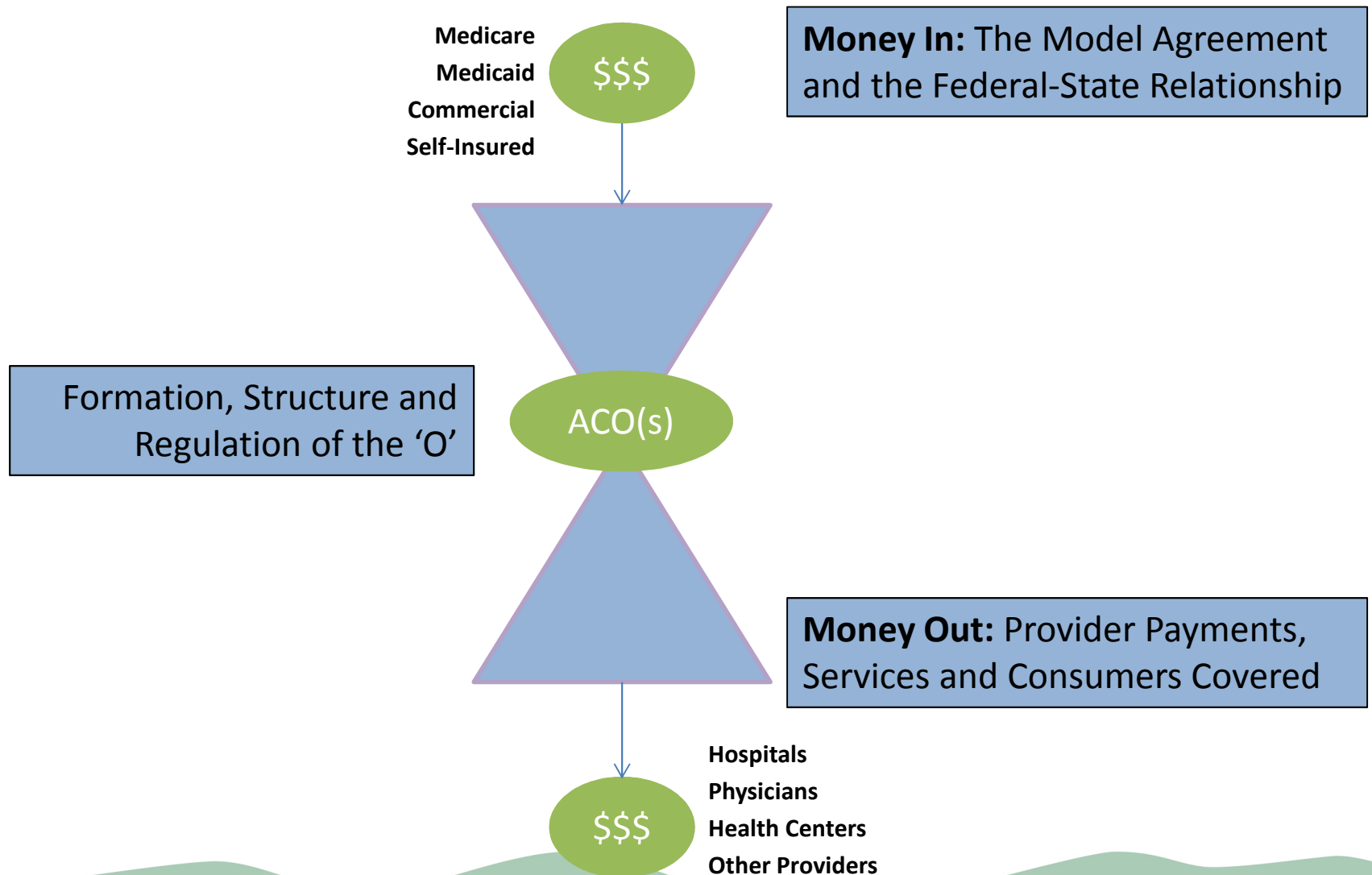


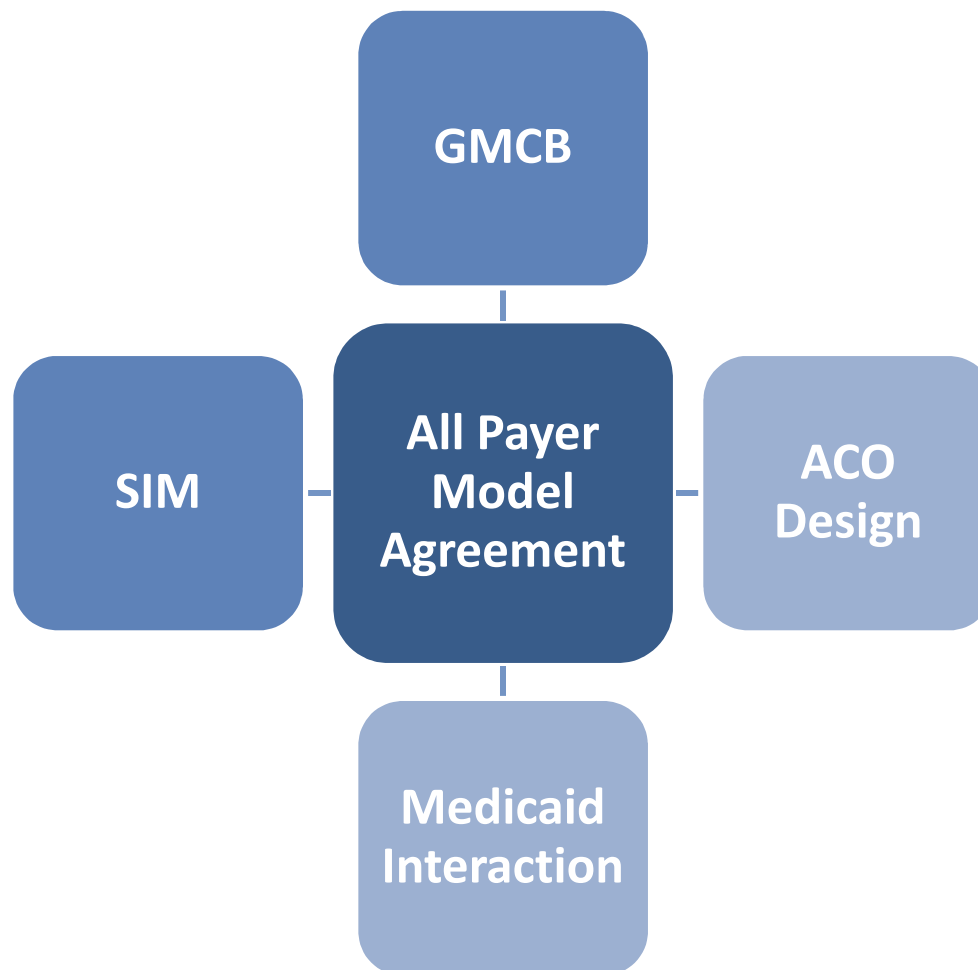
**VERMONT ALL PAYER MODEL
CMMI NEGOTIATION UPDATE
NOVEMBER 12, 2015**

**MICHAEL COSTA
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All-Payer Model Conceptual Framework



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- Covered services aka “regulated revenue”
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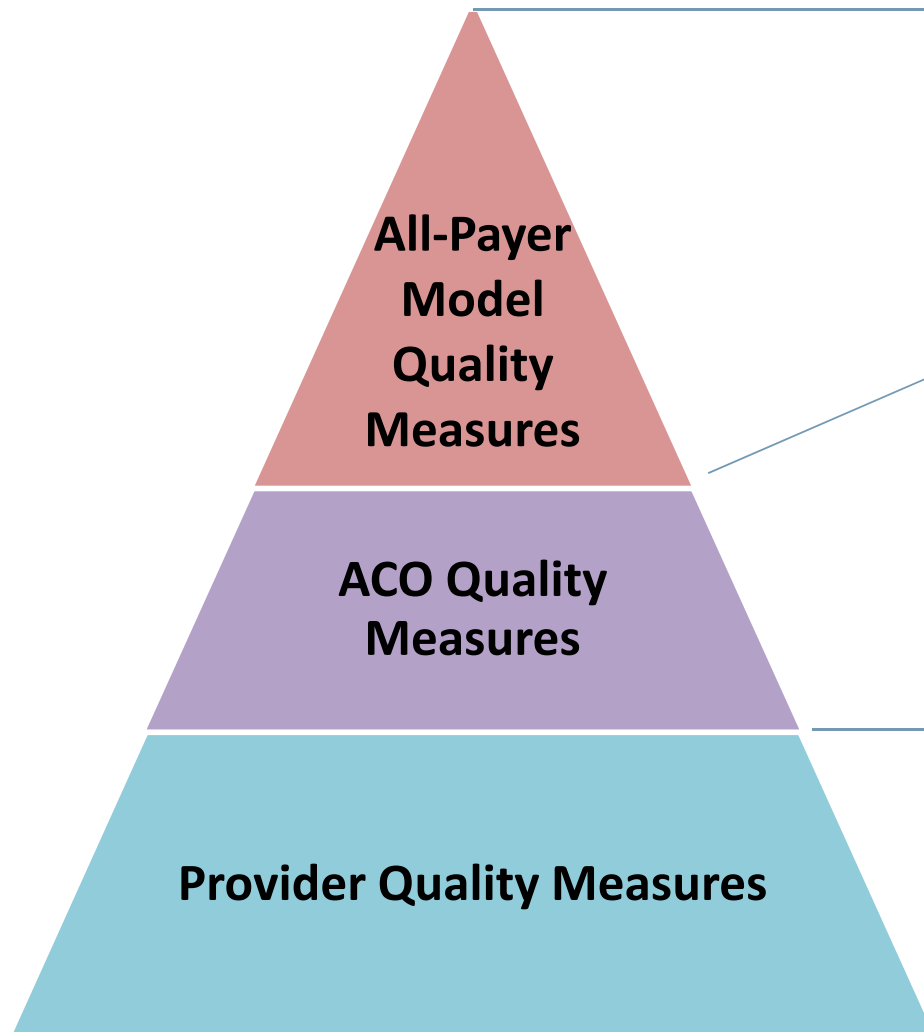
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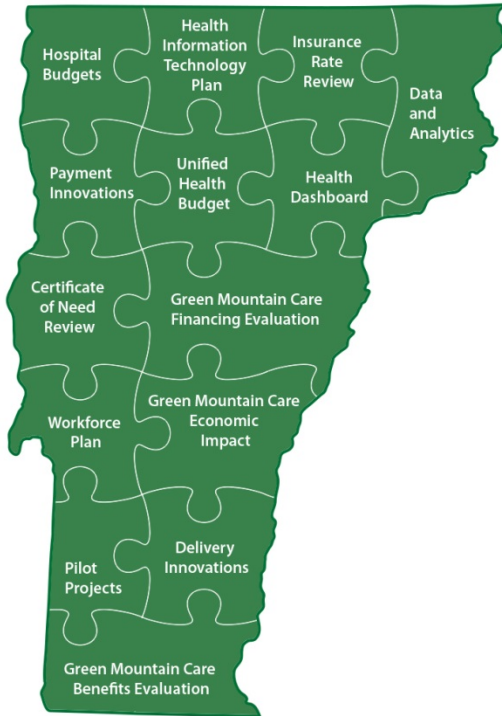
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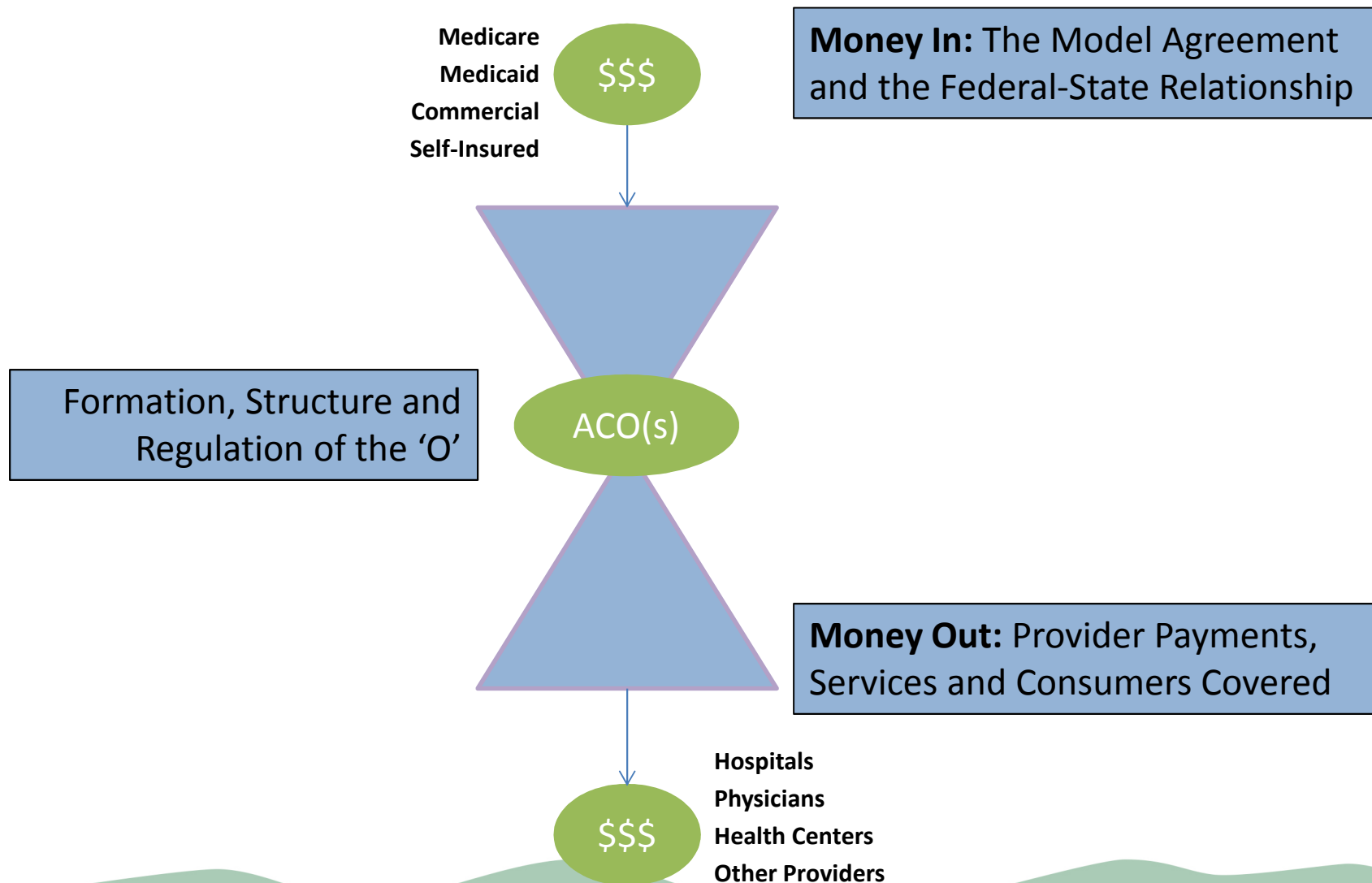
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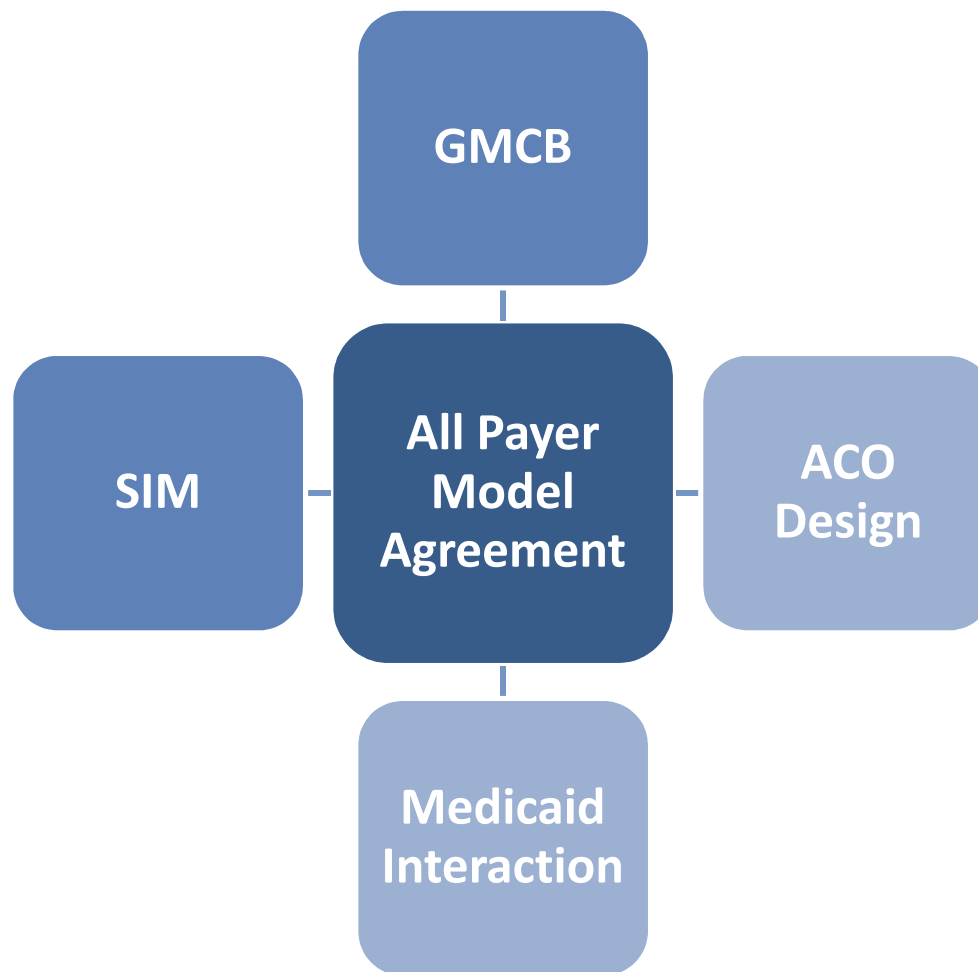
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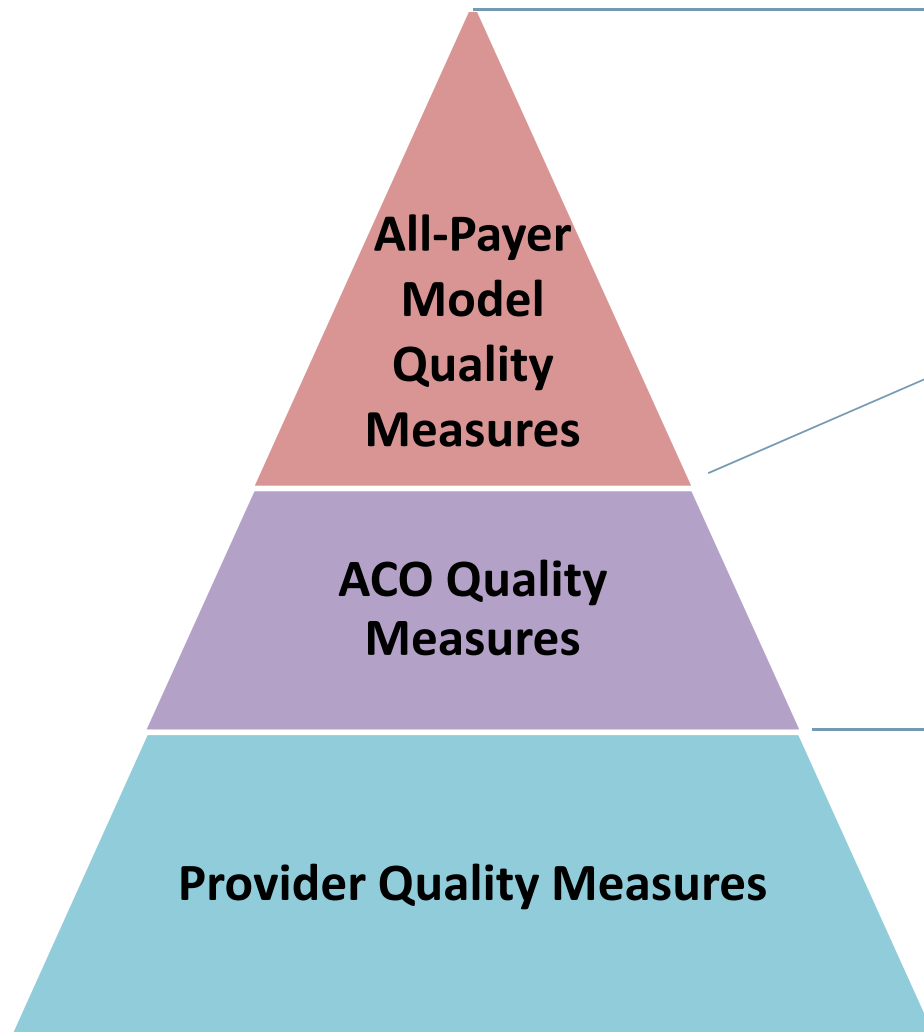
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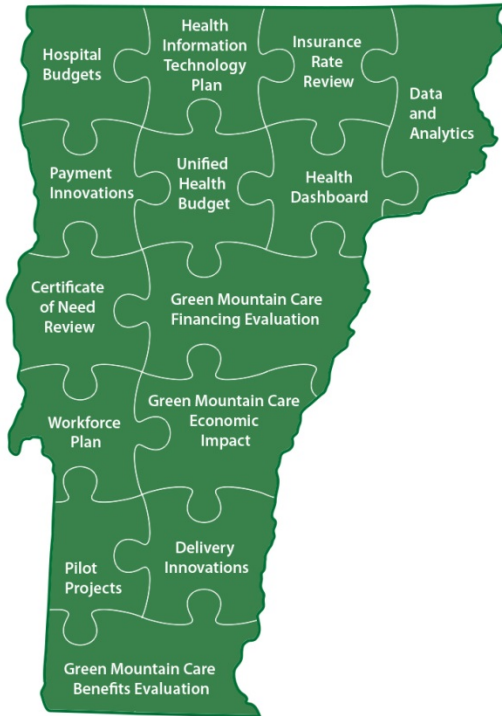
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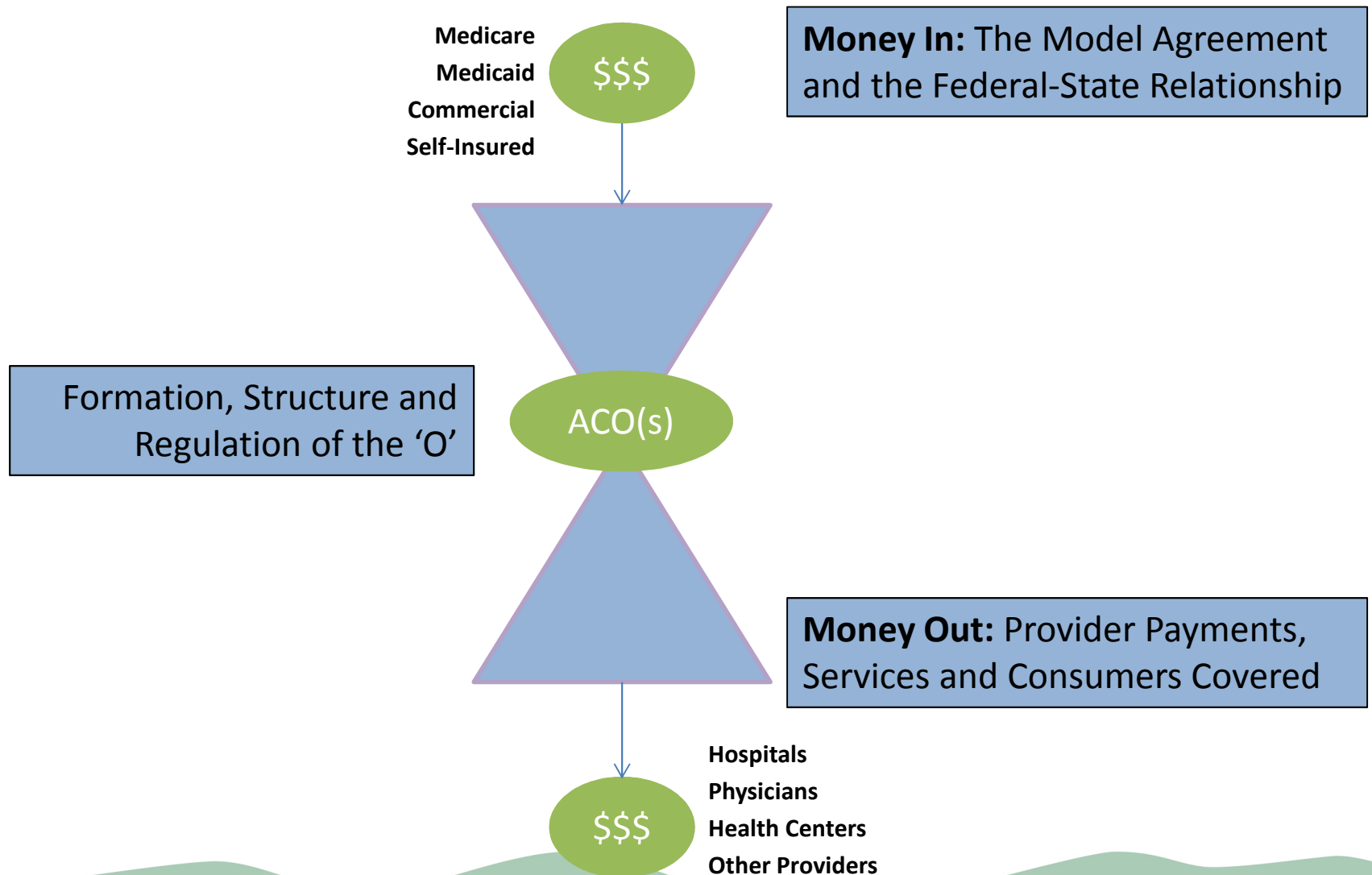
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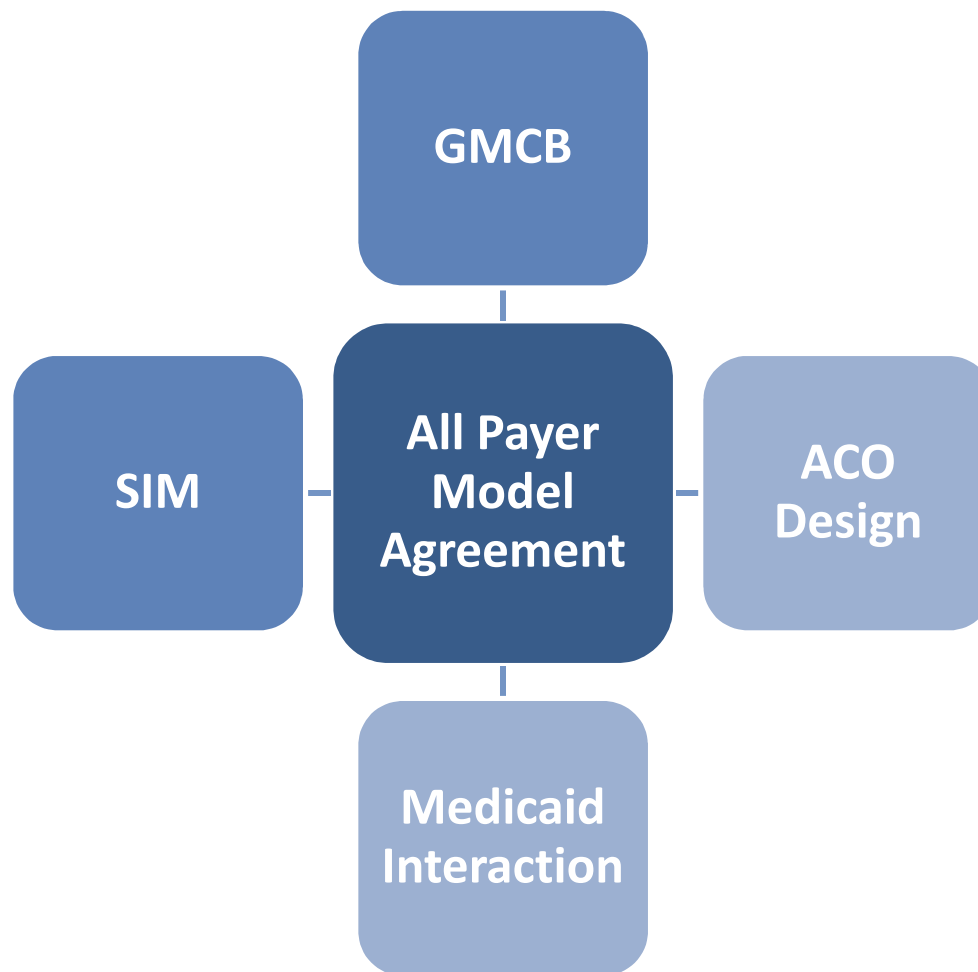
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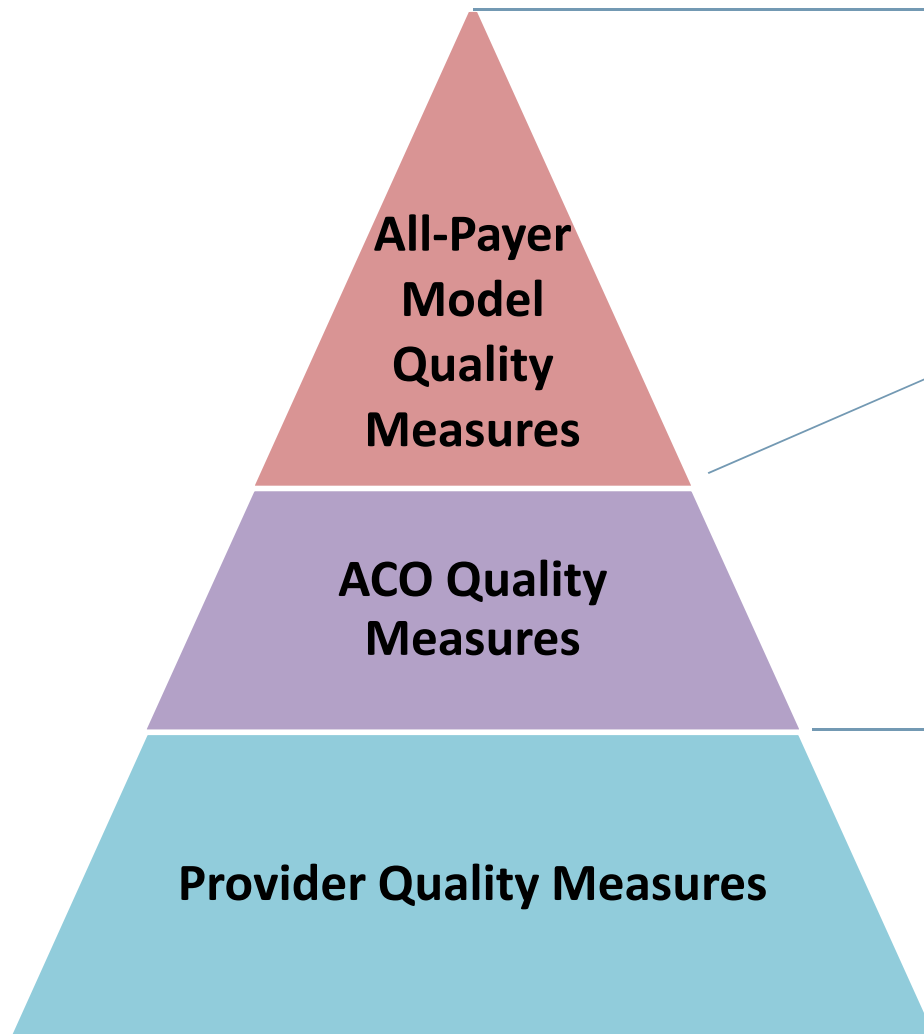
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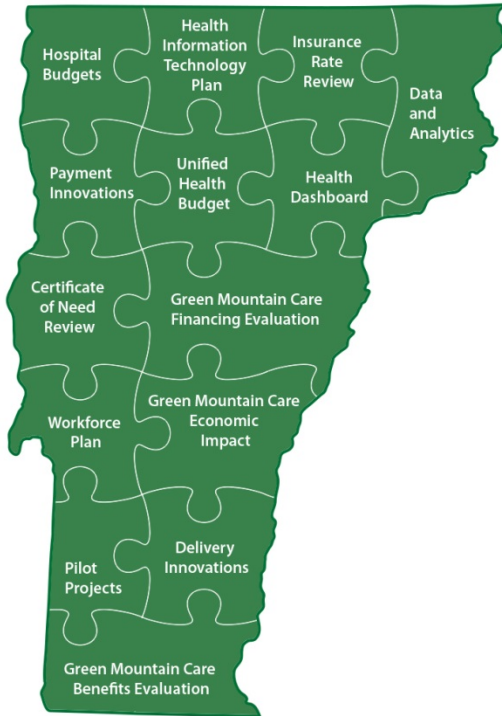
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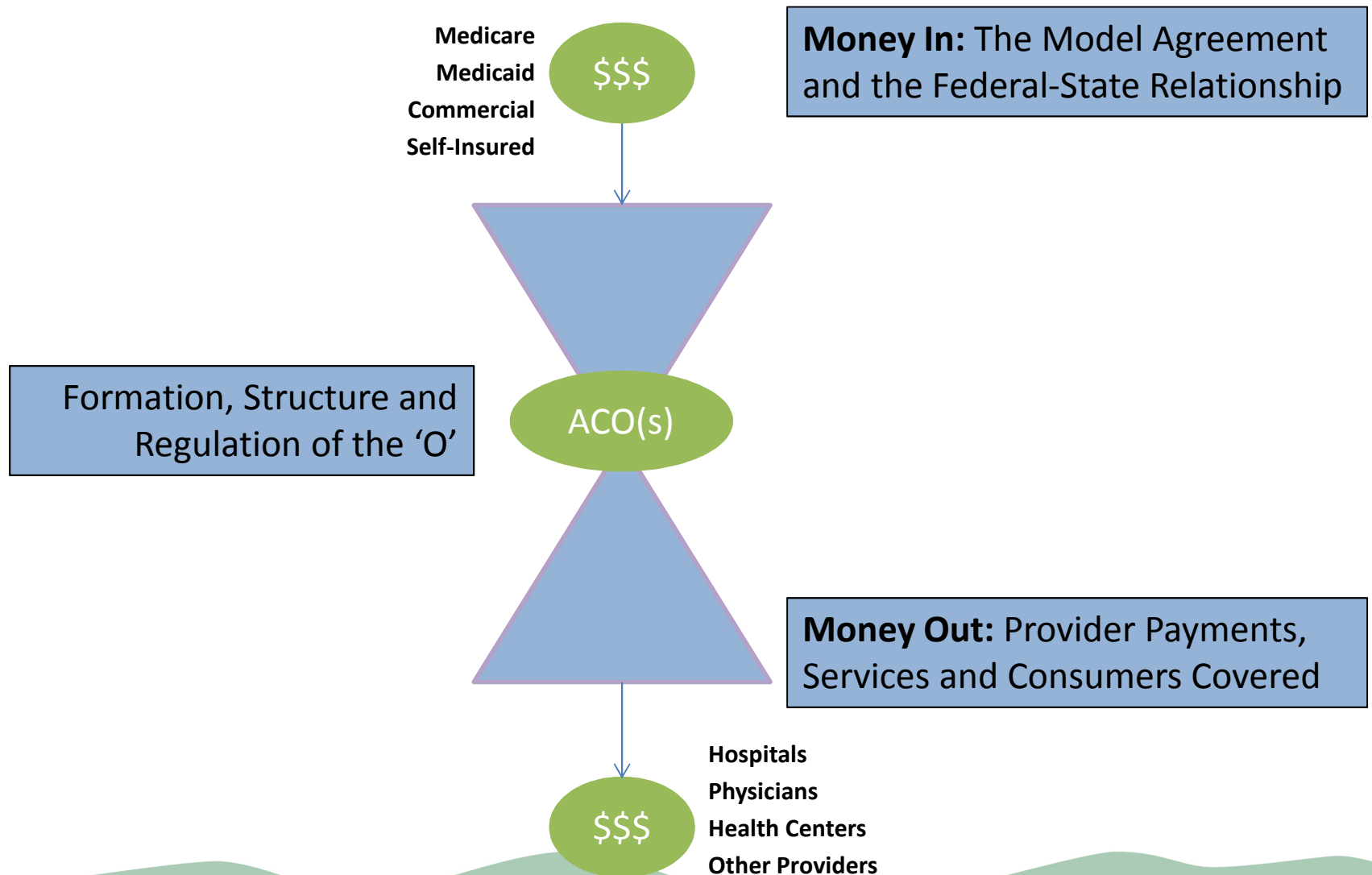
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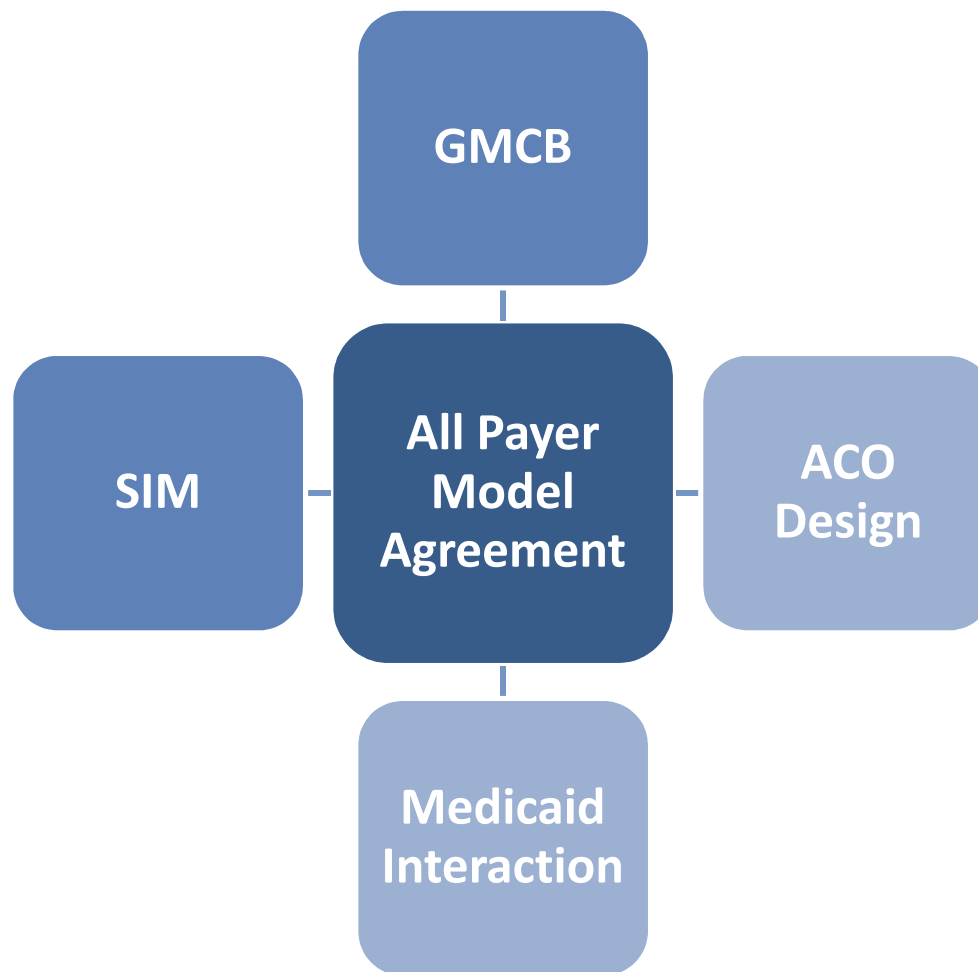
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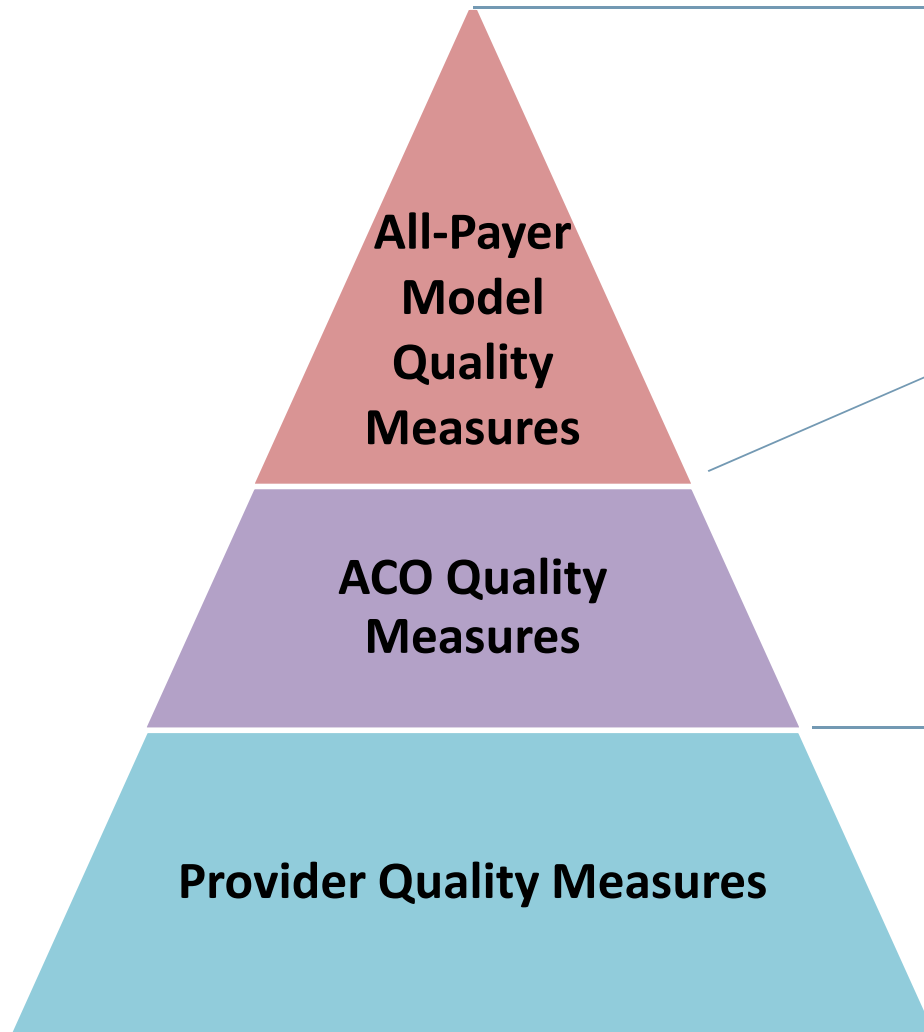
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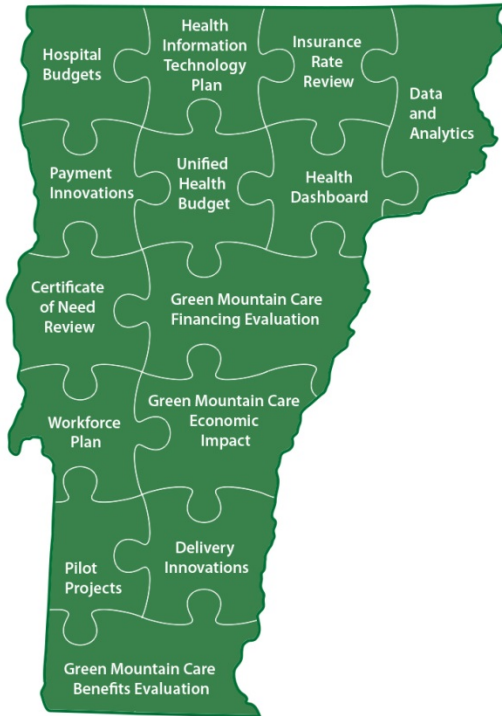
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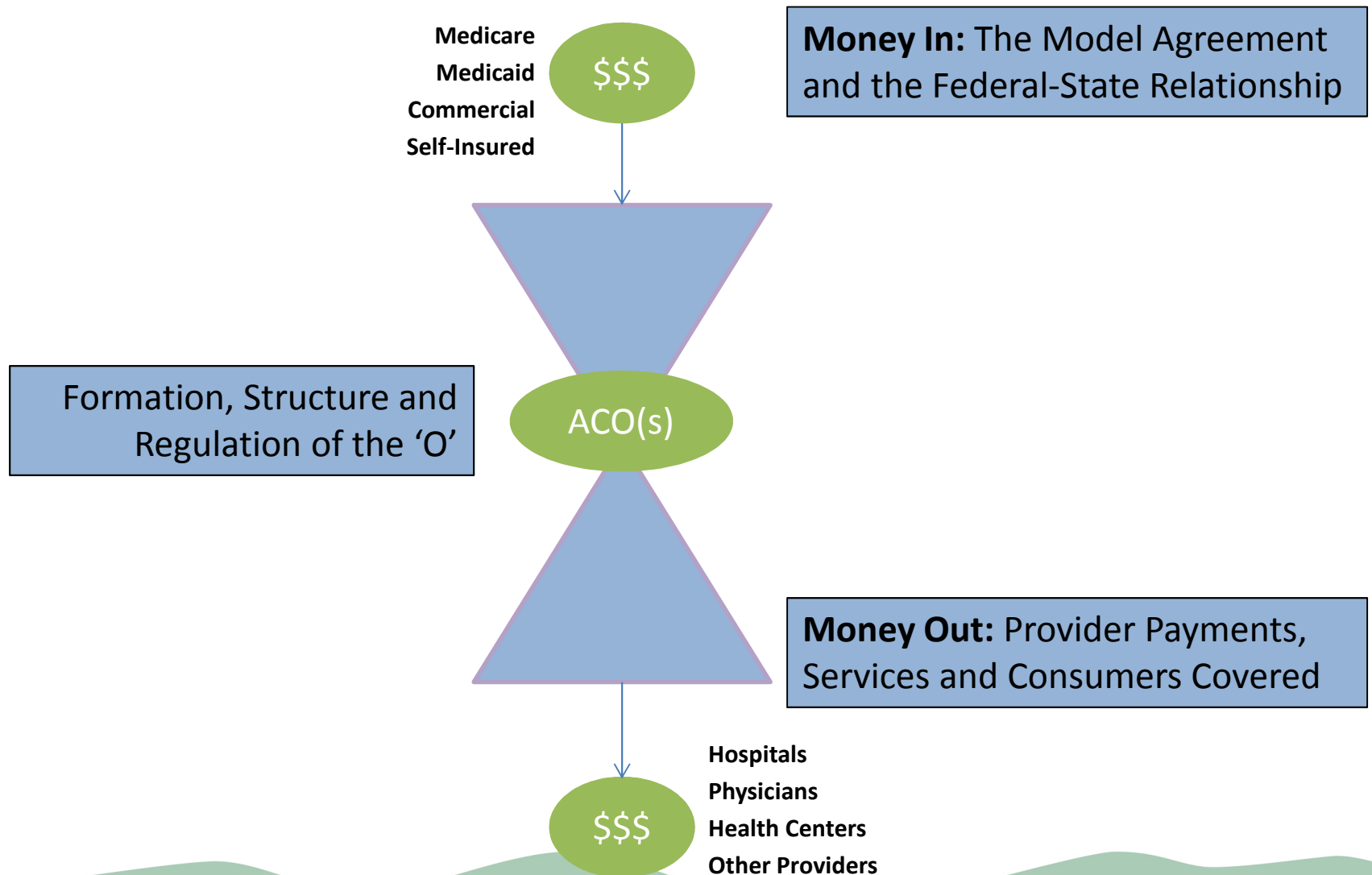
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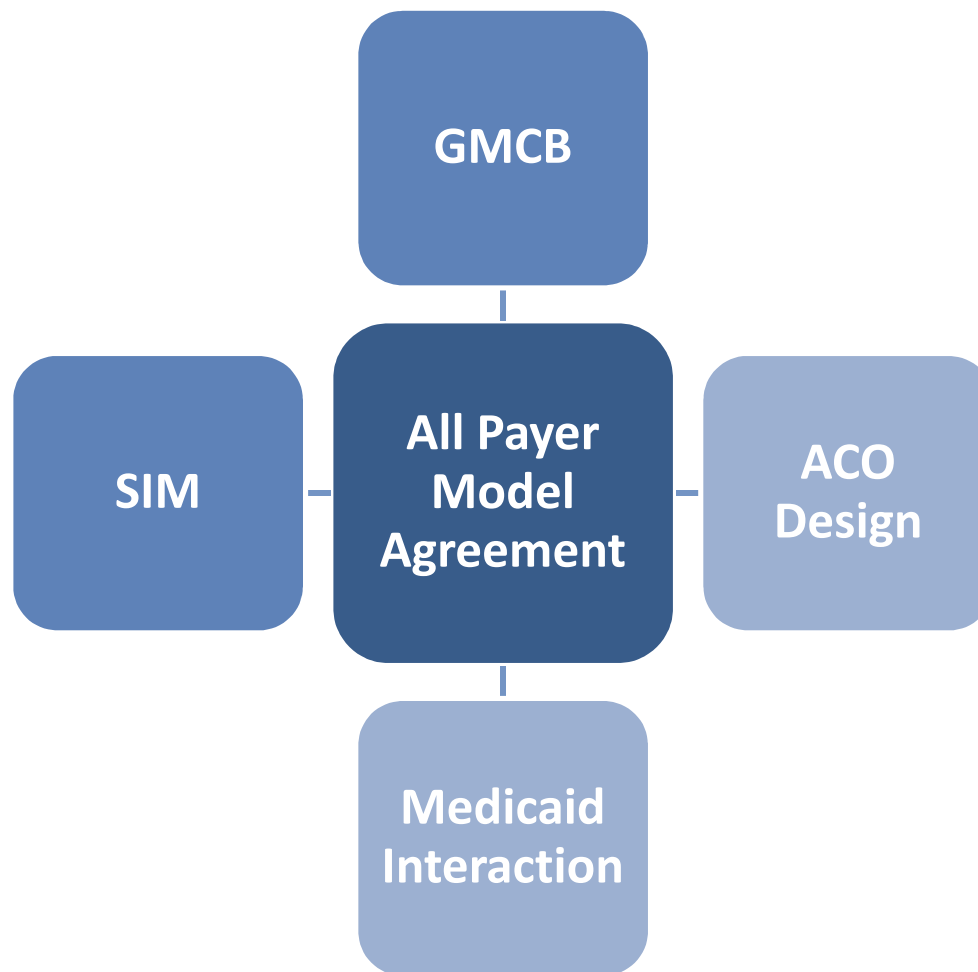
**VERMONT ALL PAYER MODEL
CMMI NEGOTIATION UPDATE
NOVEMBER 12, 2015**

**MICHAEL COSTA
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All-Payer Model Conceptual Framework



All Payer Model Areas of Activity



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CMMI Term Sheet Elements

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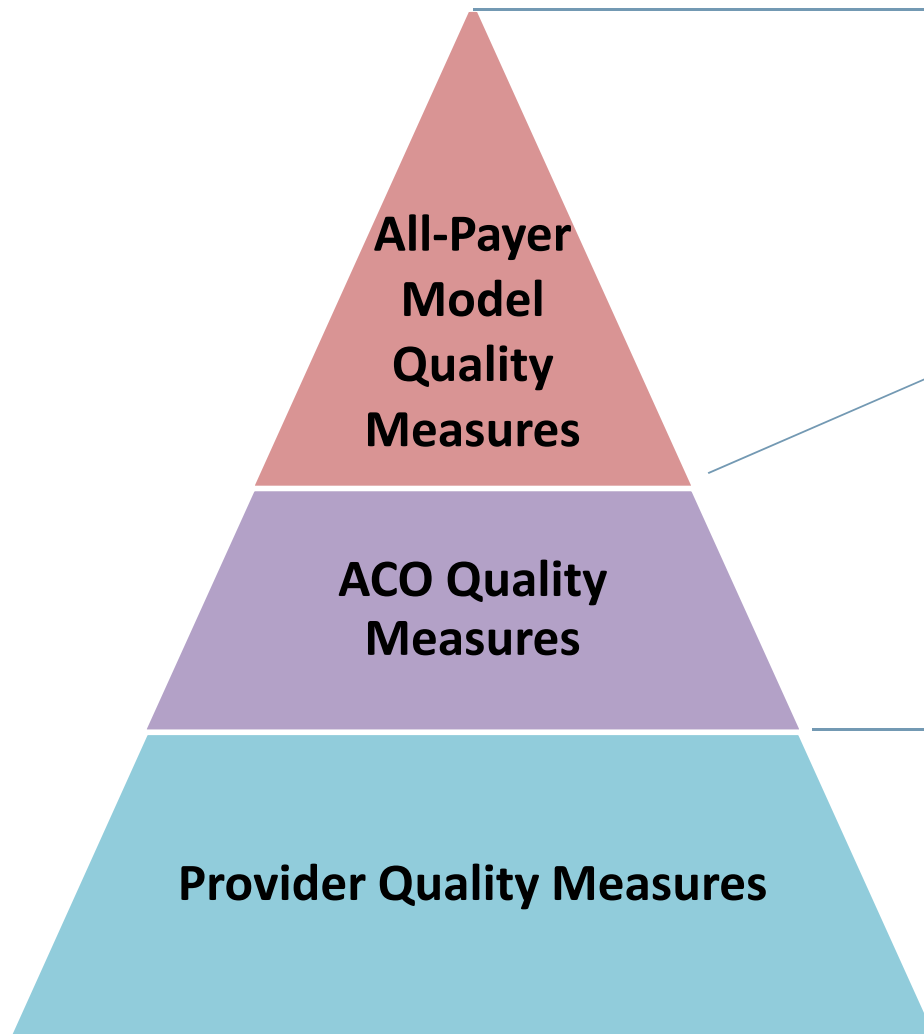
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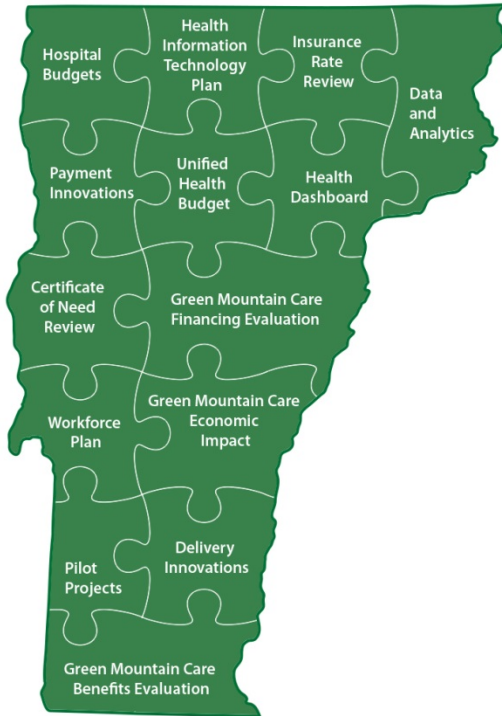
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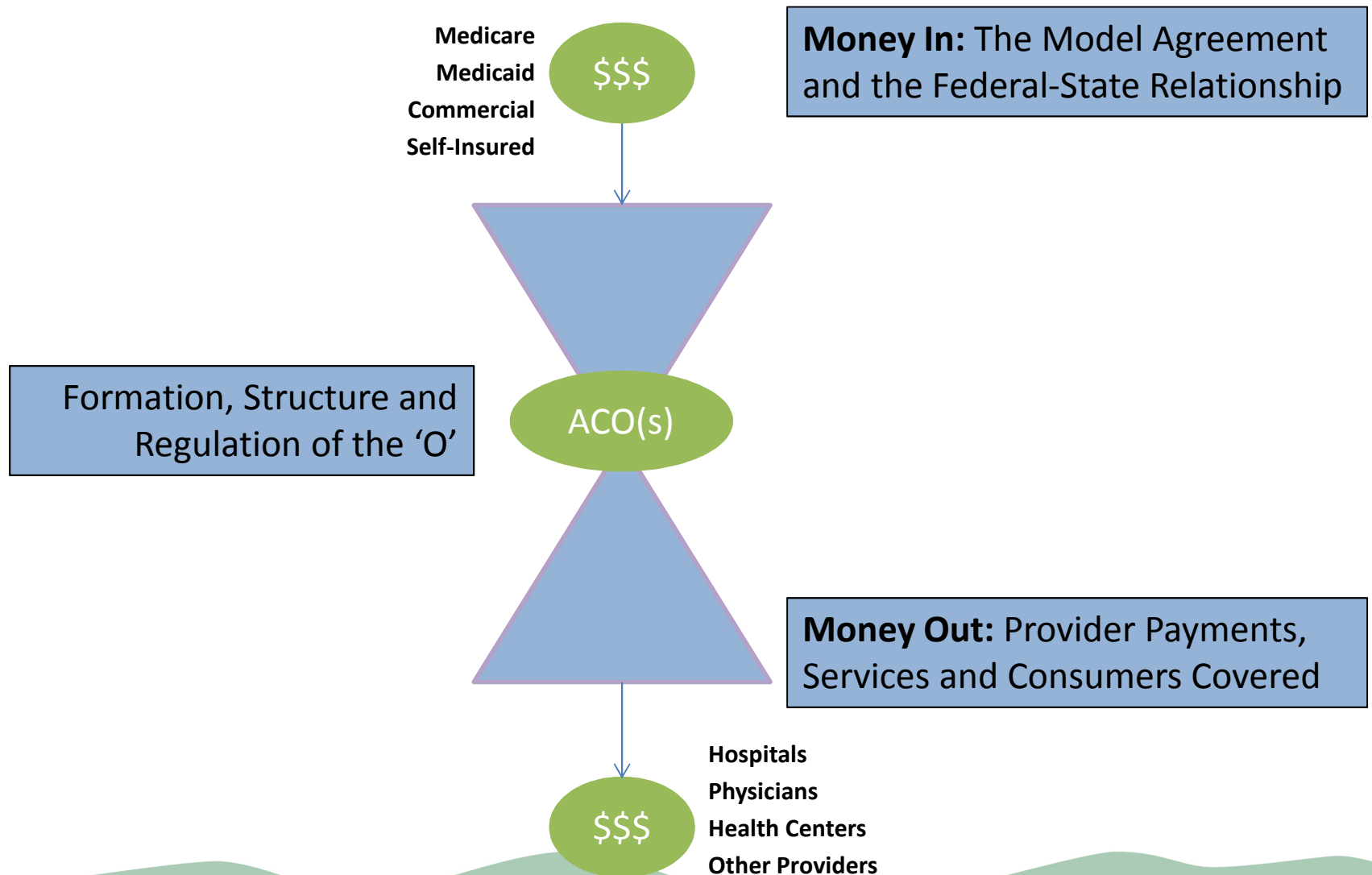
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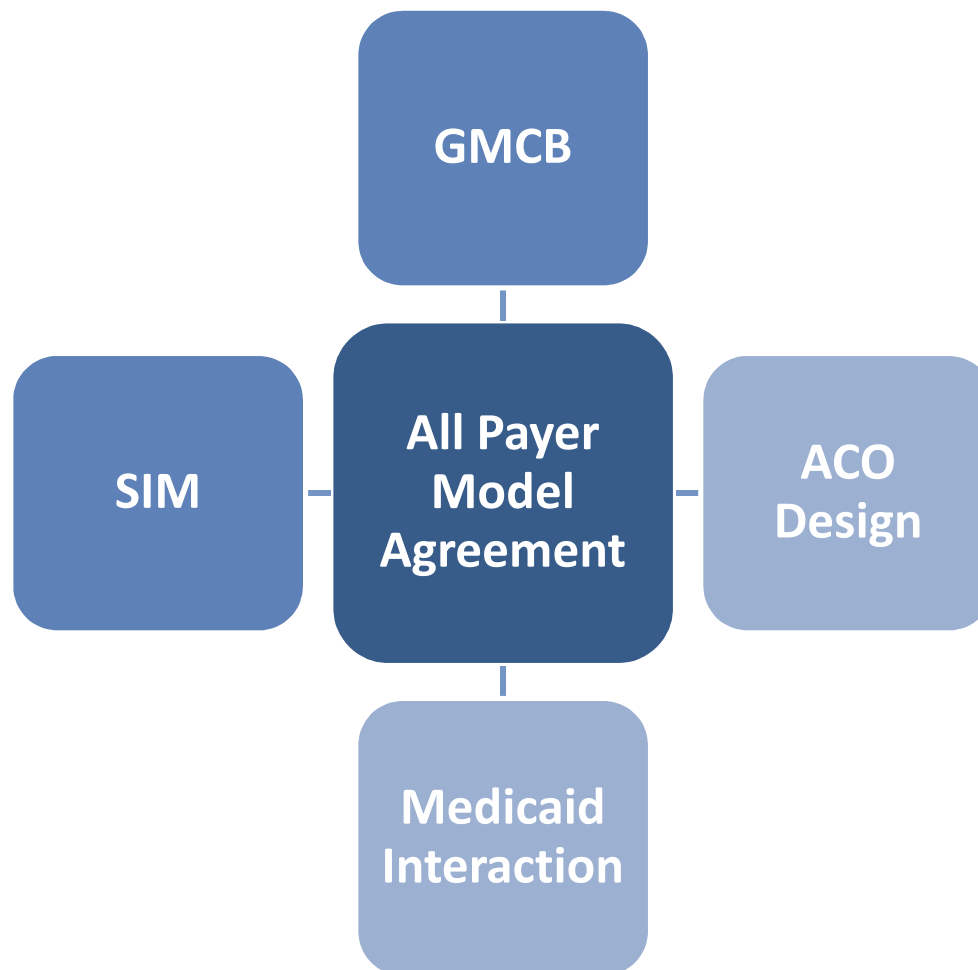
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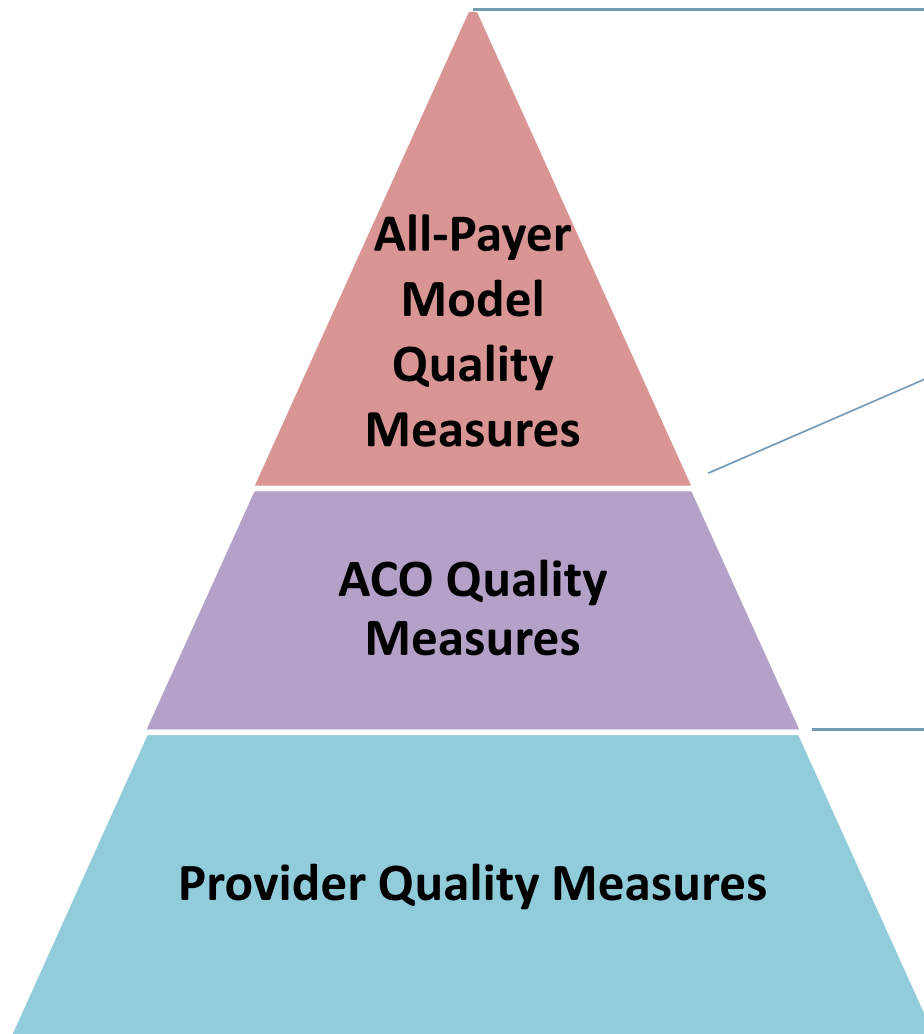
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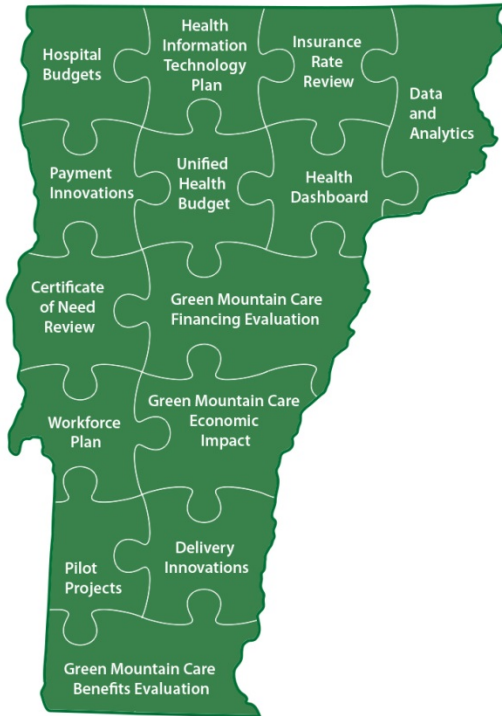
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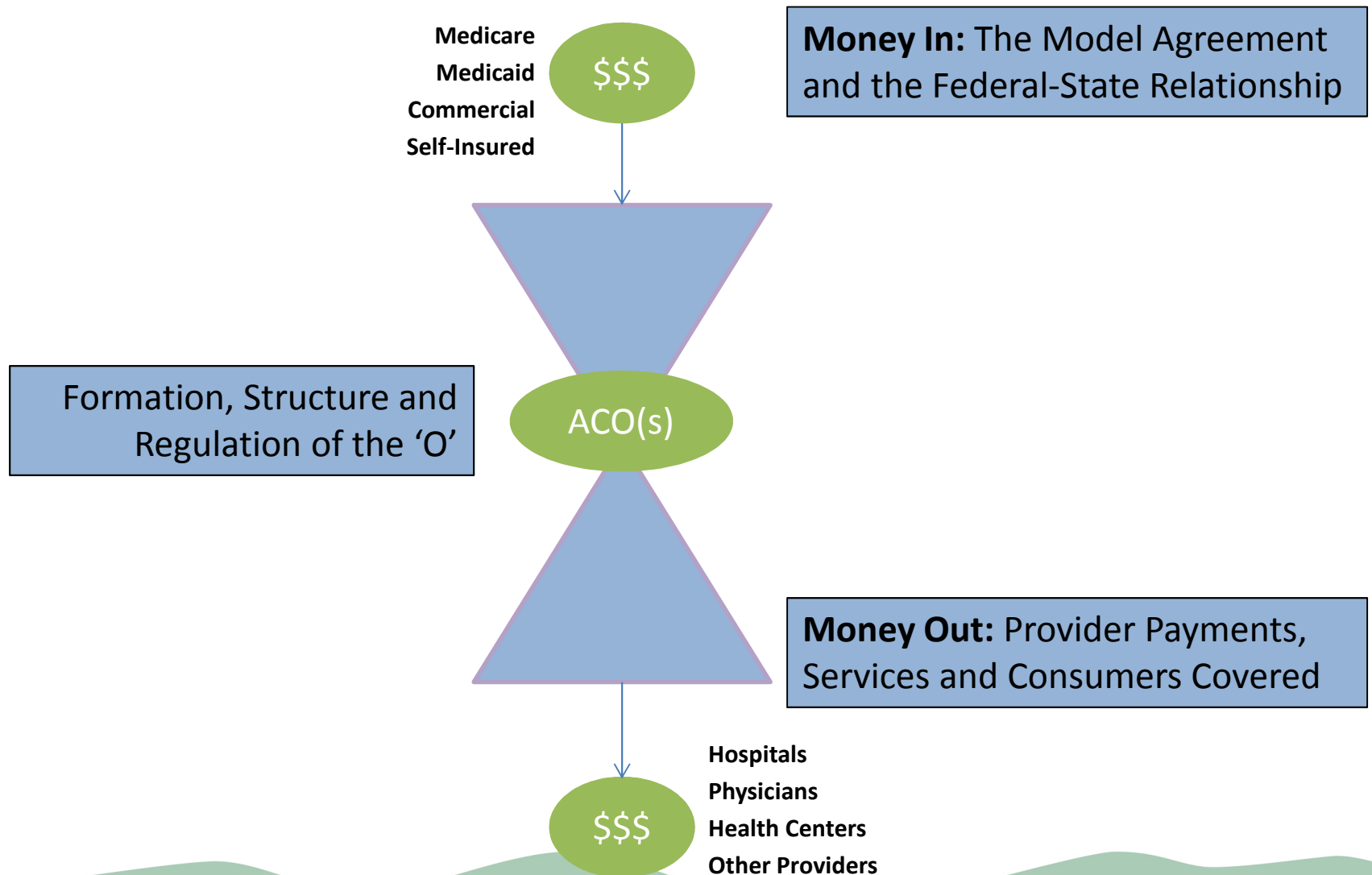
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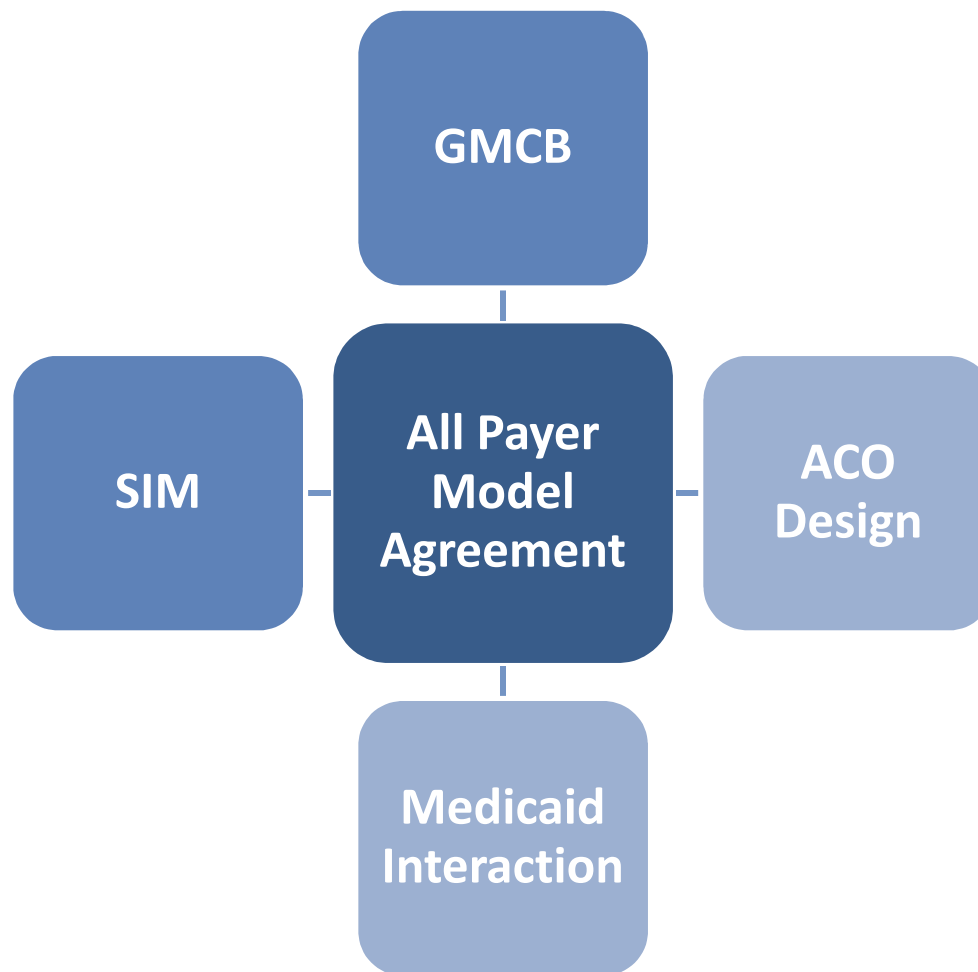
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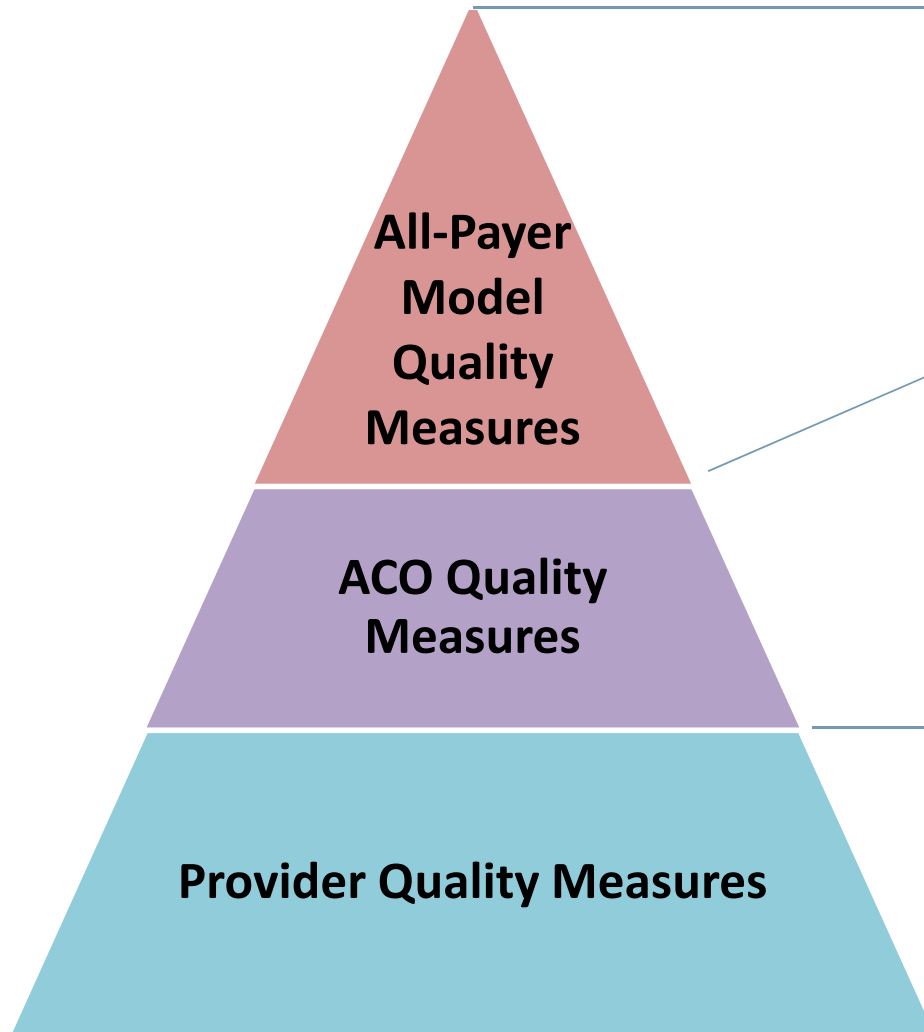
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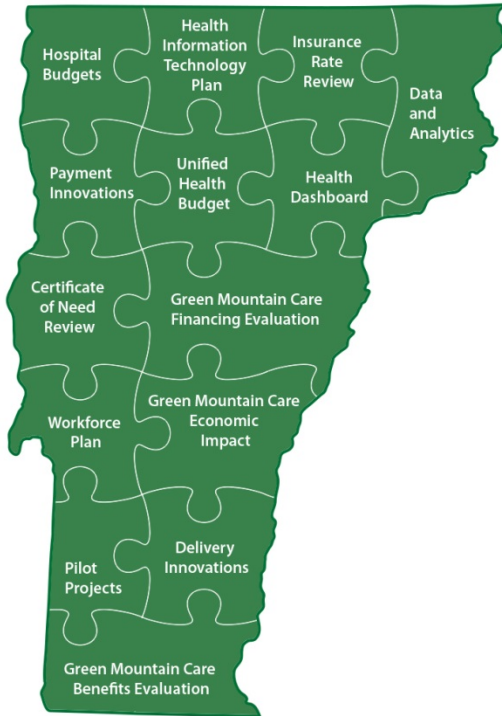
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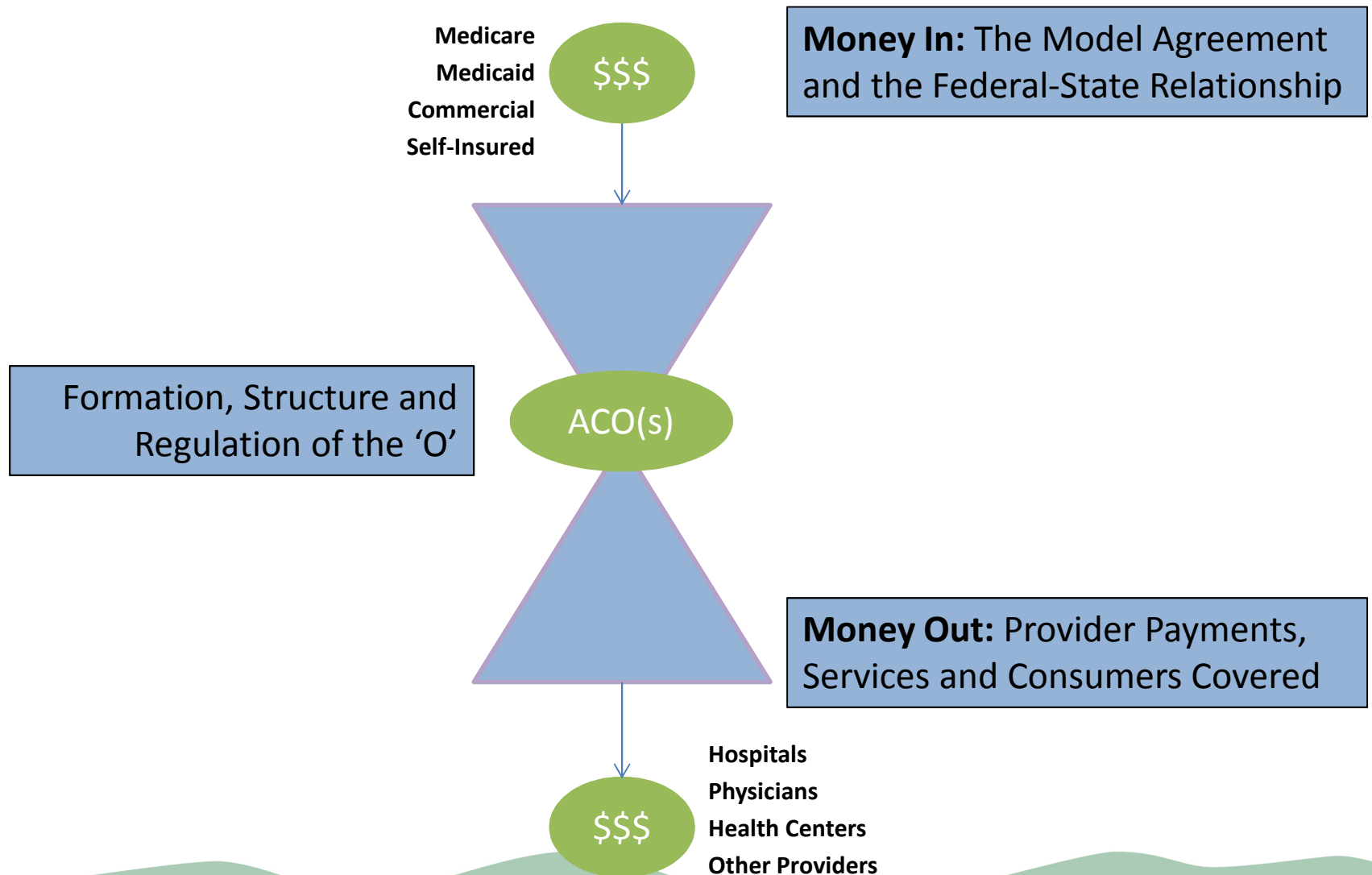
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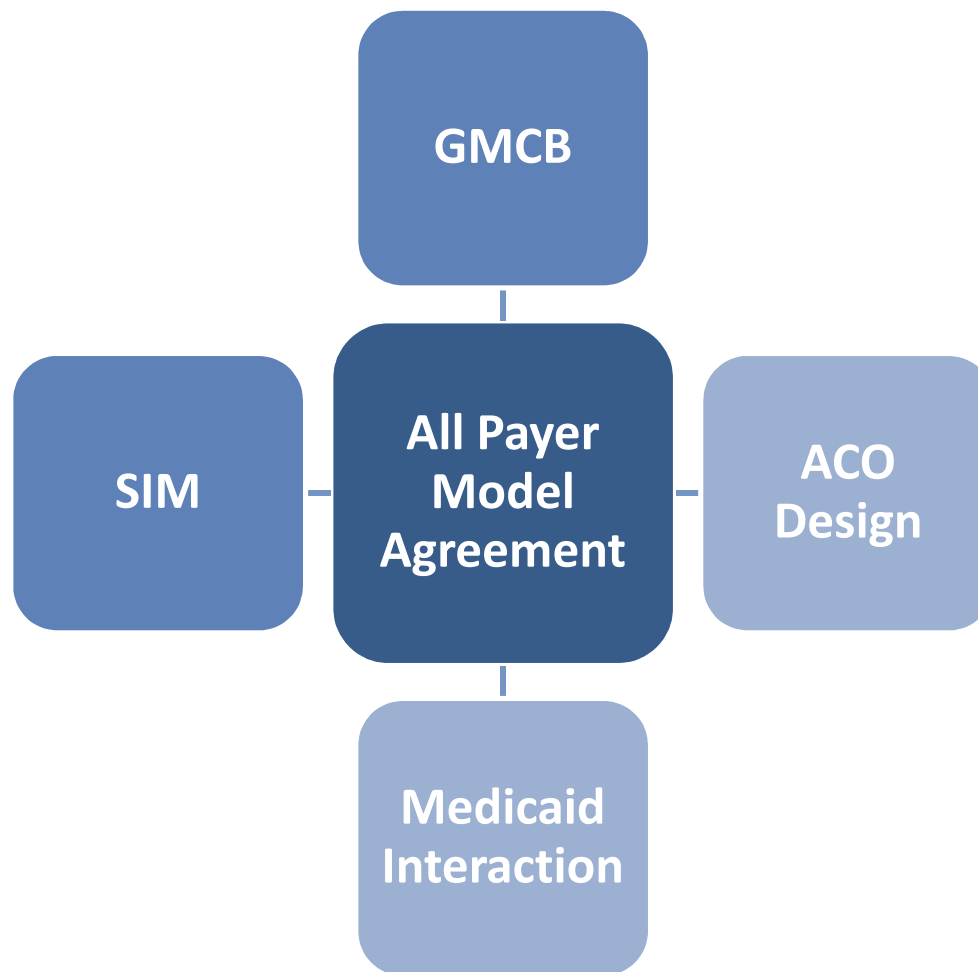
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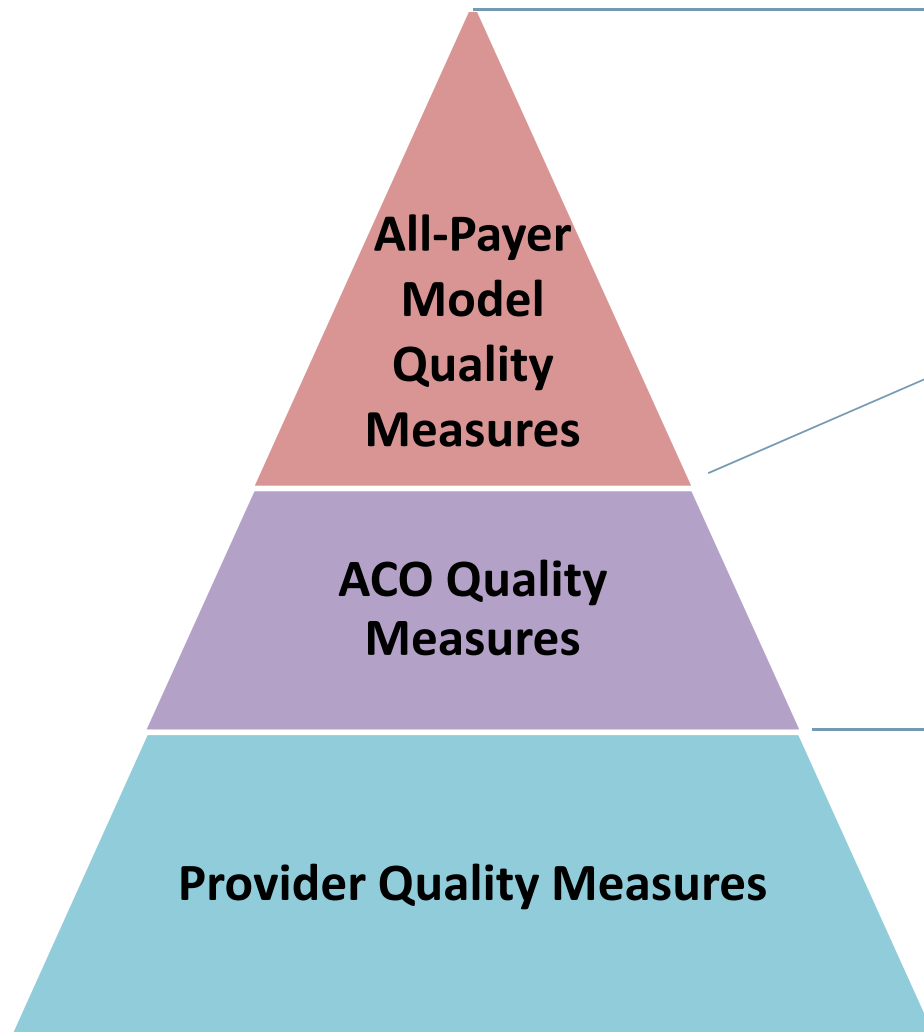
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Telehealth expansion

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3-day skilled nursing facility rule

Fraud and Abuse Waivers

Pre-participation Waiver

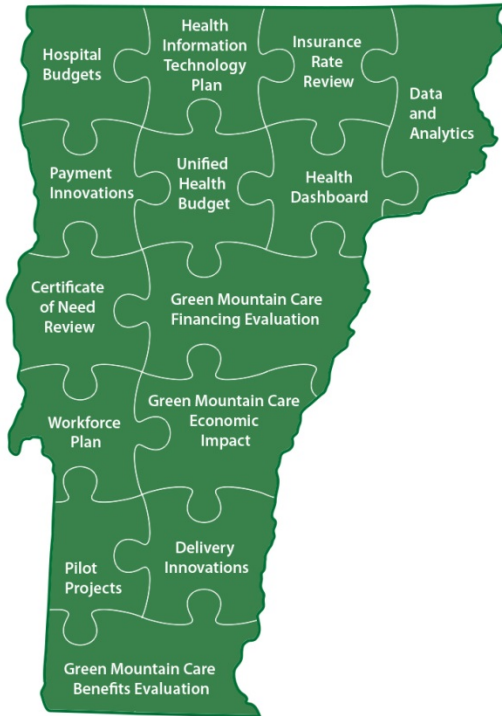
Participation Waiver

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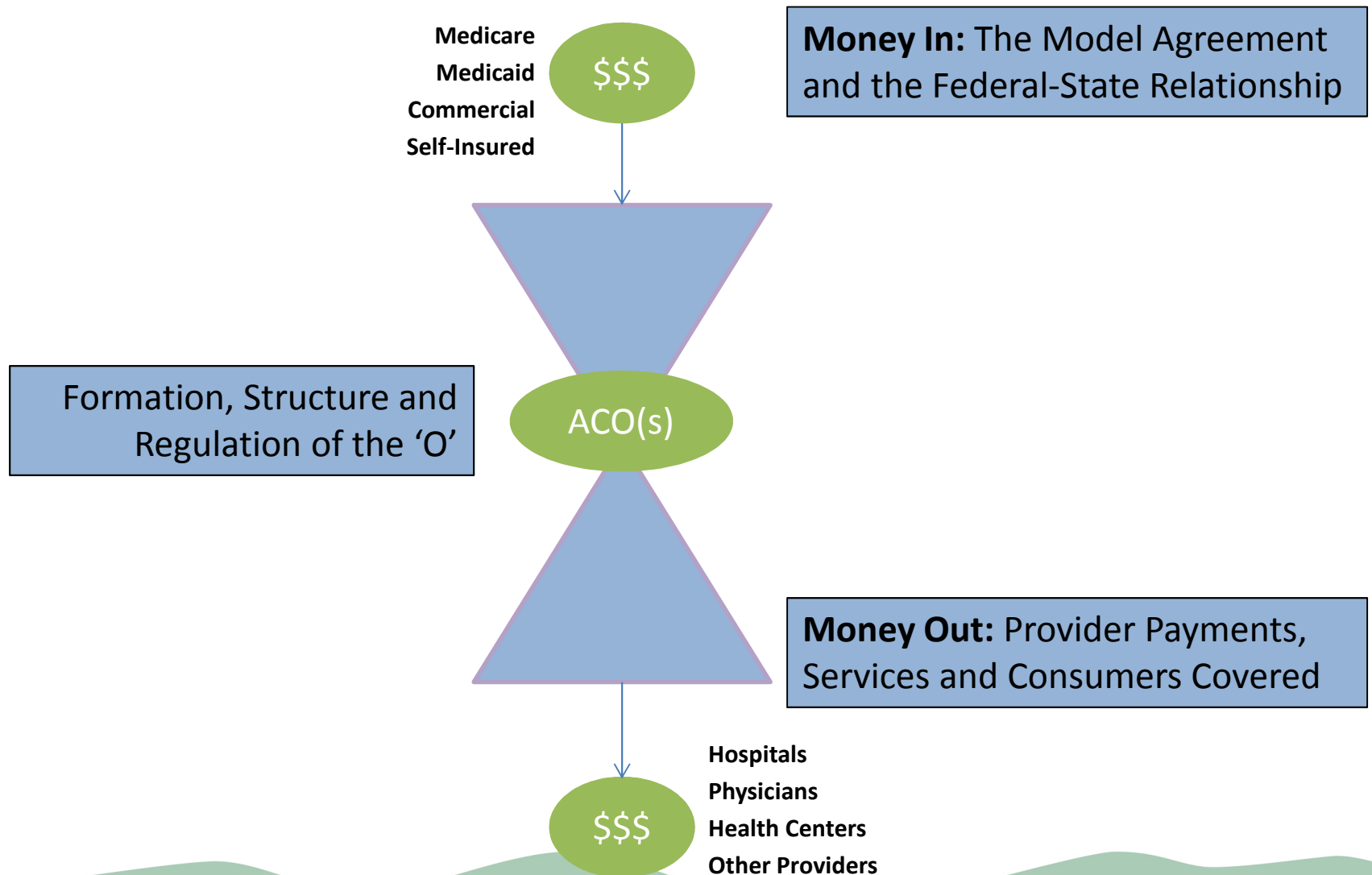
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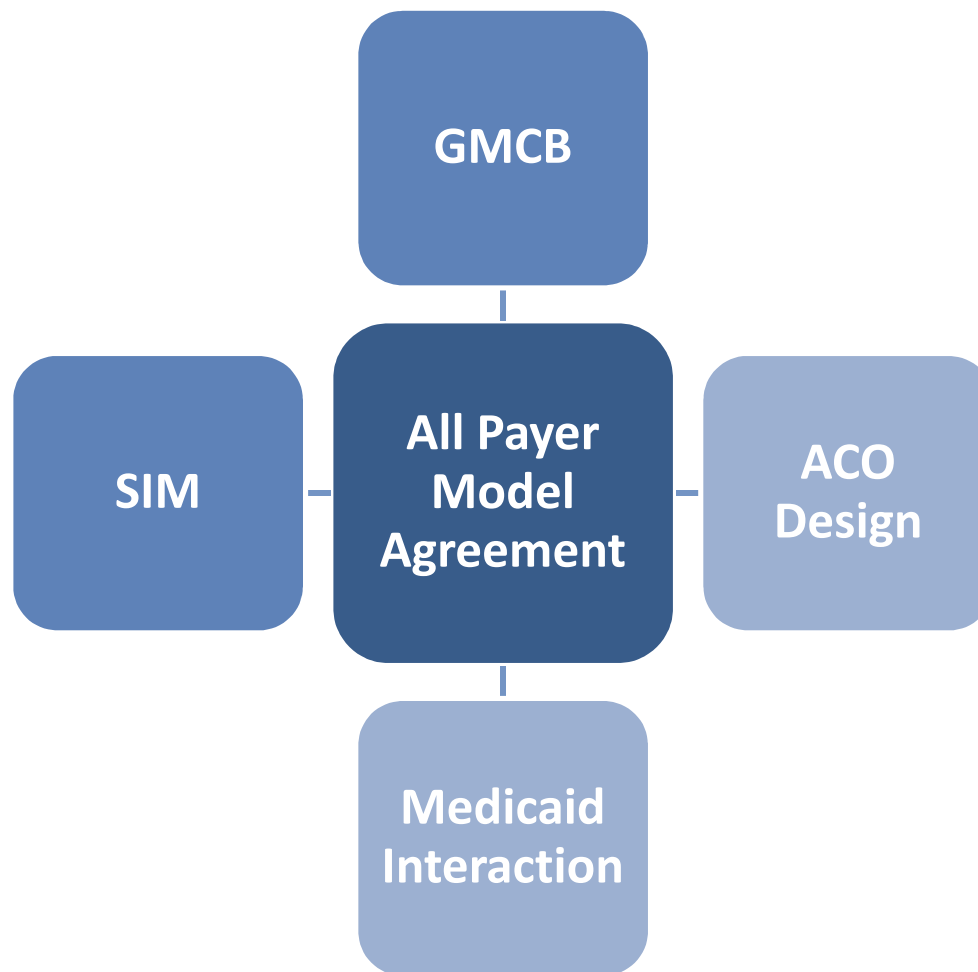
**VERMONT ALL PAYER MODEL
CMMI NEGOTIATION UPDATE
NOVEMBER 12, 2015**

**MICHAEL COSTA
DEPUTY DIRECTOR FOR HEALTH REFORM, AOA
ENA BACKUS
DEPUTY EXECUTIVE DIRECTOR, GMCB**

All-Payer Model Conceptual Framework



All Payer Model Areas of Activity



Approach to the Model Agreement and CMMI

- CMMI has authority to allow “States to test and evaluate systems of all-payer payment reform for the medical care of residents of the state”
- A necessary element to motivate CMMI is demonstrating that Vermont is serious about testing a truly innovative delivery model
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The Model Agreement

Matters between Vermont and CMS

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

Matters between Vermont and ACO

- Payment rates and methods
- Risk arrangements
- Attribution methodology
- Structure of payments to ACO providers
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CMMI Term Sheet Elements

Performance Period

Regulated Revenue

All-Payer Ceiling

Medicare Savings

Quality Framework

GMCB Rate Setting Milestones

ACO Milestones

Payment Waivers

Fraud and Abuse Waivers

Financial Targets in the Model Agreement

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

Implications of Missing the Targets

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

Financial Targets: The All-Payer Target and Ceiling

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

Financial Targets: Medicare Savings

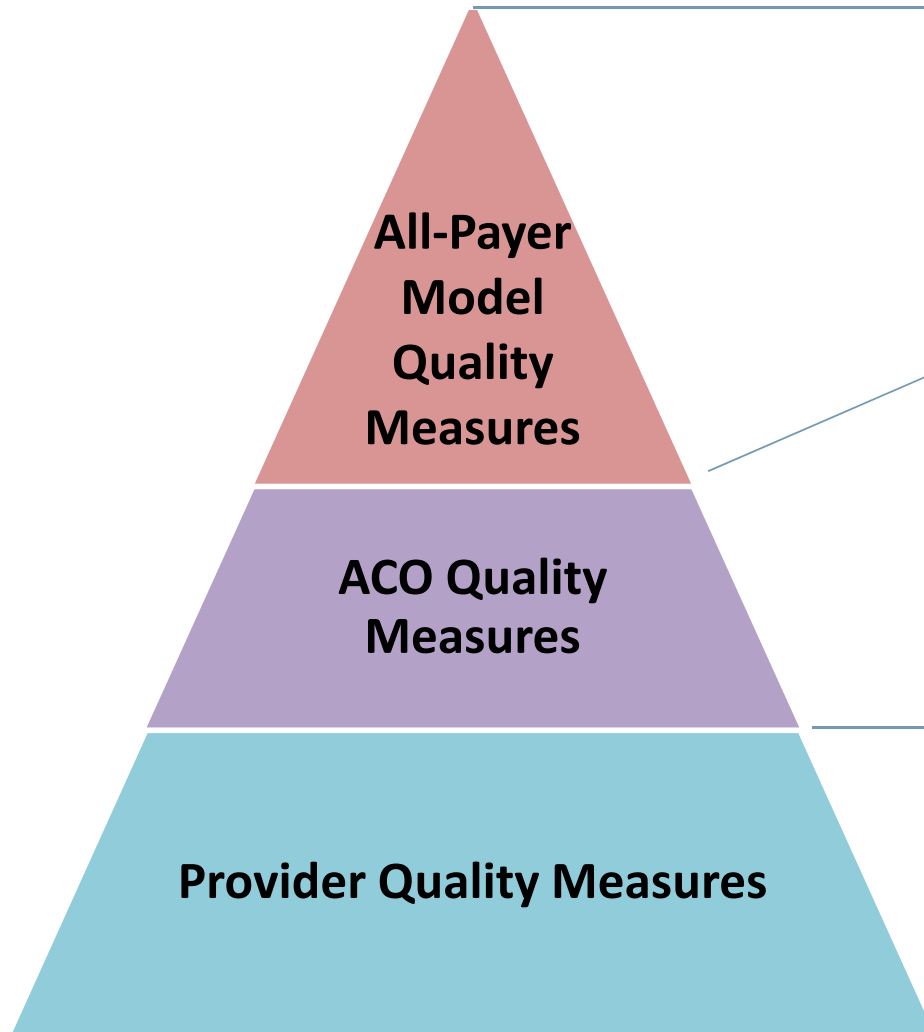
- Federal concept is that “savings” are achieved when actual state Medicare spending growth is slower than actual national Medicare growth
- After extensive negotiation, CMMI has proposed that savings be based on Vermont per capita growth at .2 percentage points below national actual per capita growth
 - Vermont base spending is set in 2016, then each year’s national growth less .2% establishes a Medicare savings benchmark
 - Savings will be calculated in the aggregate over 5 years, so state can “bank” savings in earlier years
- A risk of this type of provision is that Medicare grows slowly, requiring Vermont to operate below low Medicare growth levels. Vermont has proposed provisions to mitigate this risk
 - A benchmark floor set in year one at the all-payer level (3.5%); set in other years at 2%
 - In the event Medicare growth is below the floor, the state’s “savings” obligation would be calculated from the floor, not actual growth
 - It is very likely that negotiations on this idea of risk mitigation will be difficult

Regulated Revenue: Current and Tentative 2017

Category of Service	Medicare NextGen	Medicaid SSP	Commercial SSP
Primary Care Physician	Y	Y	Y
Laboratory and Radiology	Y	Y	Y
Specialty Physician	Y	Y	Y
Behavioral Health	Y	Y	Y
Dental	Y	N	N
Other Professionals	Y	Y	Y
Inpatient Services	Y	Y	Y
Outpatient Services	Y	Y	Y
Skilled Nursing Facility	Y	N	N
Other, Residential, and Personal Care	Y	N	N
Durable Medical Equipment	Y	Y	Y
Home Health	Y	Y	Y
Pharmacy	N	N	N
Government Health Care Activities - AHS	N/A	N	N/A
Government Health Care Activities - HCBS	N/A	N	N/A
Government Health Care Activities - Mental Health	N/A	N	N/A
Total	87.7%	33.5%	68.2%
Grand Total			61%

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

All-Payer Model Quality Framework



CMMI ↔ GMCCB

Reporting and Monitoring Measures

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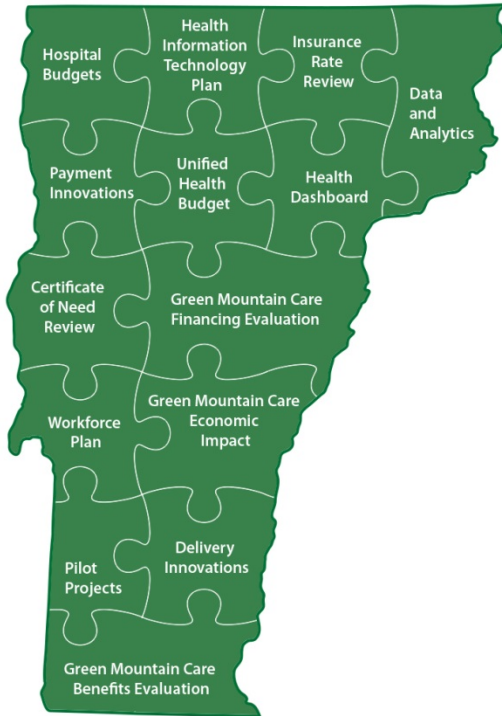
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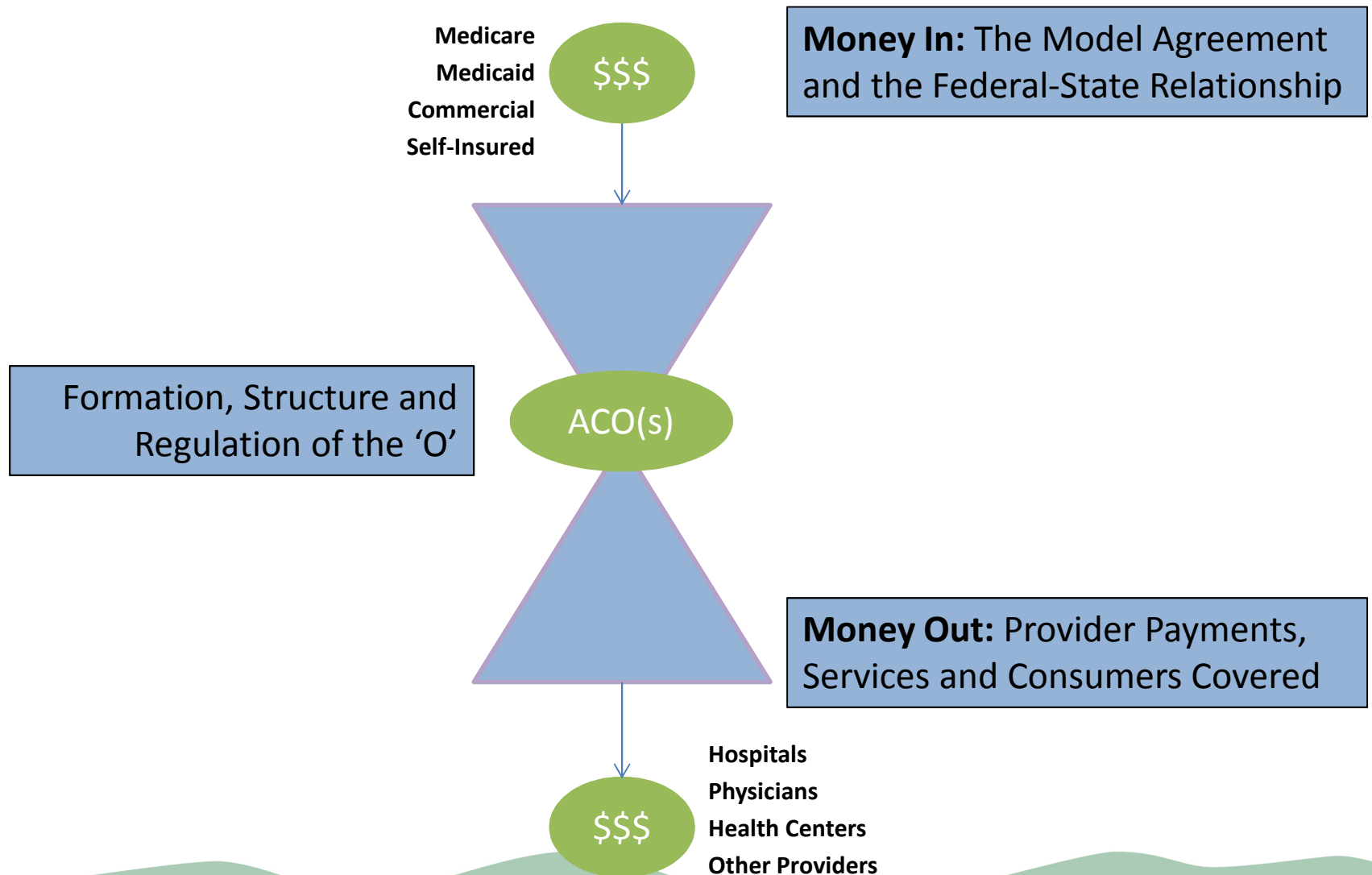
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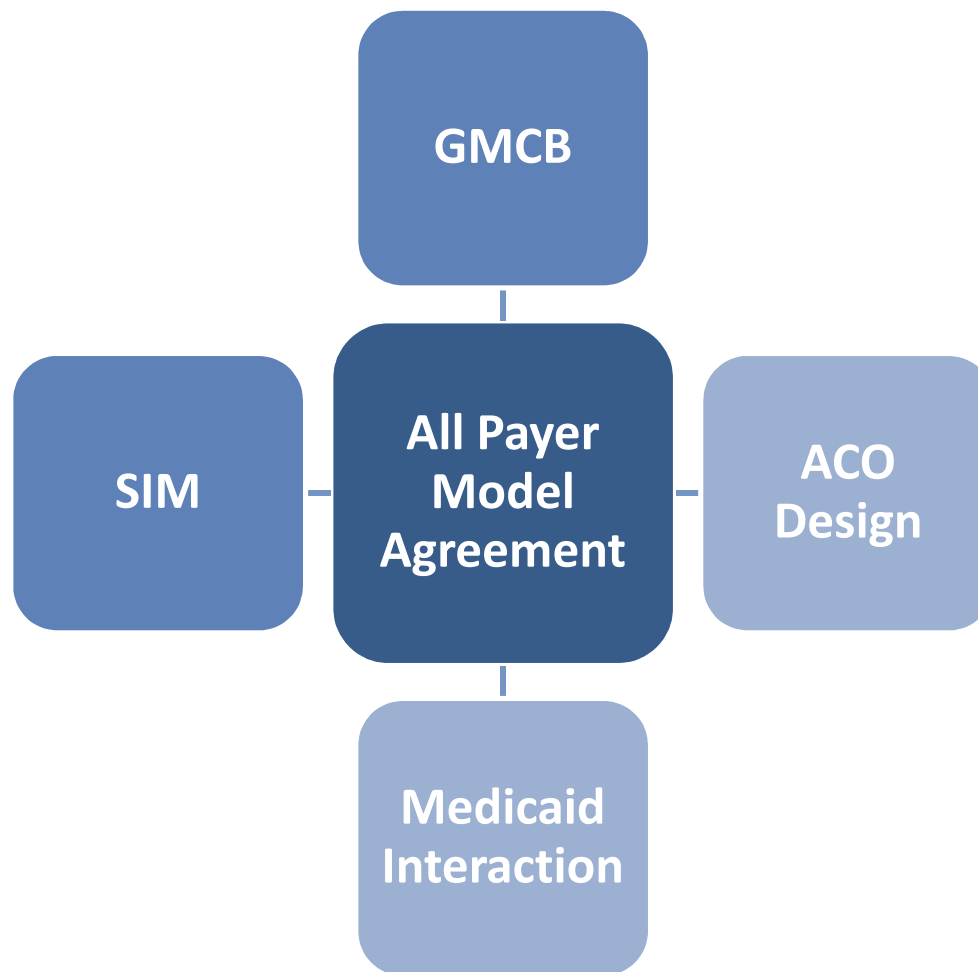
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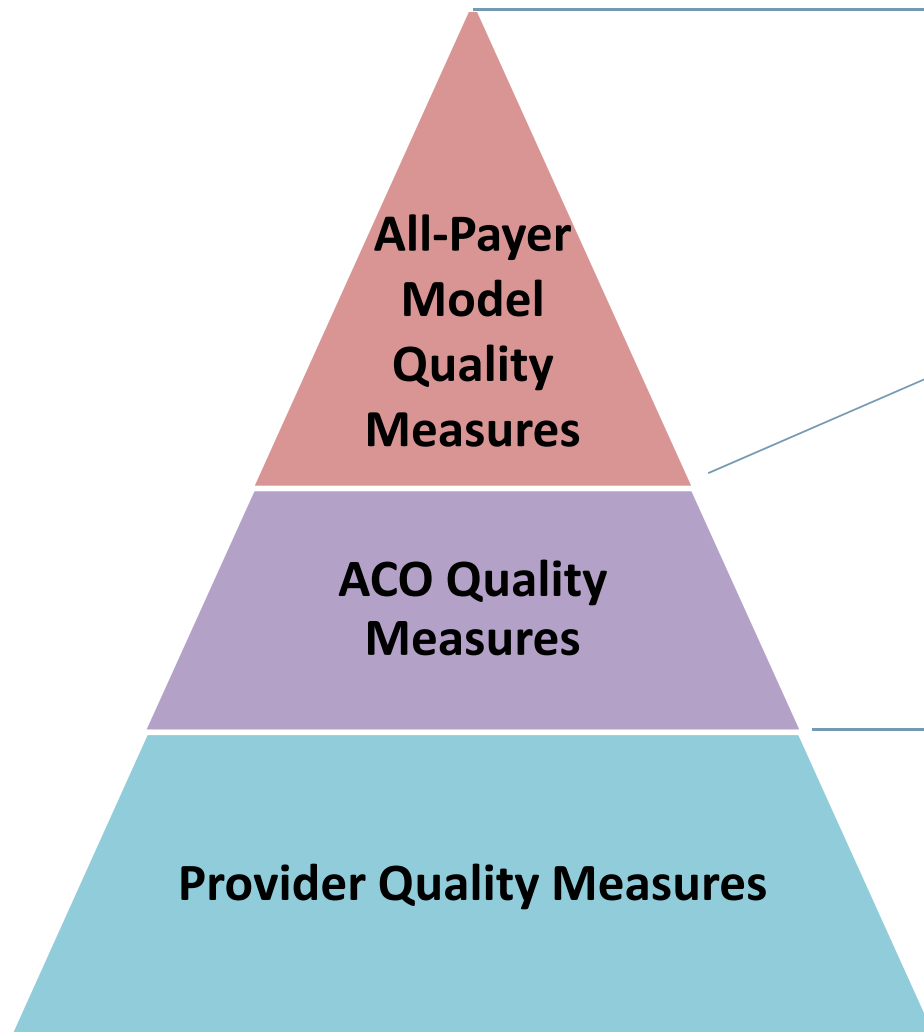
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