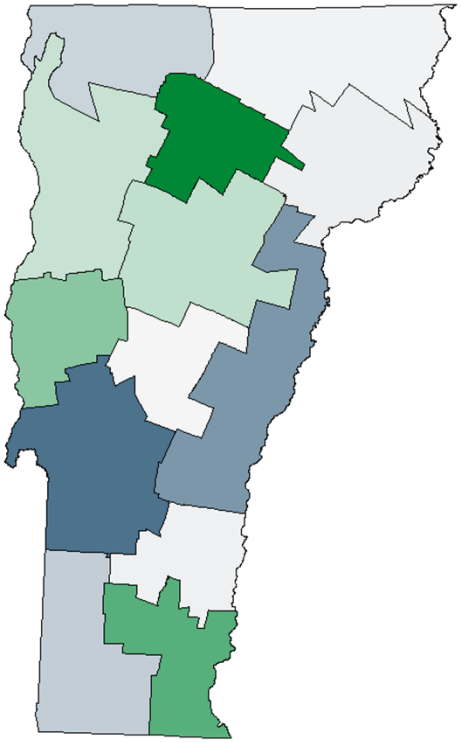

Vermont All-Payer Accountable Care Organization Model

Health Care Reform Oversight Committee
October 25, 2016

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Green Mountain Care Board

VERMONT
GREEN MOUNTAIN CARE BOARD

Overview

1. Background

2. Release of *Draft* Vermont All-Payer Accountable Care Organization Model Agreement for Comment and Feedback
   - 10 Key Features of the Model Agreement

3. Feedback Received
   - Changes requested based on input

4. Draft Agreement in Context
   - Step 1 in multi-step, phased implementation
   - Act 113: ACO Oversight

5. Next Steps
   - Green Mountain Care Board Vote

Background

- **Act 54 of 2015:** Directed the Green Mountain Care Board and the Secretary of the Agency of Administration or designee to "jointly explore an all-payer model, which may be achieved through a waiver from the Centers for Medicare and Medicaid Services [CMS]."

- **January 25, 2016:** Green Mountain Care Board and Agency of Administration jointly released Vermont's All-Payer Model term-sheet proposal to CMS.
    - Launched period of public discussion including legislative testimony, presentations and discussions at public GMCB meetings, and meetings and presentations with stakeholders.

- **May 17, 2016:** Act 113 of 2016 enacted.
    - Establishes criteria for an All-Payer Model Agreement between Vermont and CMS
    - Establishes Accountable Care Organization (ACO) Oversight Role for GMCB
        - Certification of ACOs
        - ACO Budget Review

Release of *Draft* Vermont All-Payer Accountable Care Organization Model Agreement for Comment and Feedback

- **September 28, 2016**: The Green Mountain Care Board (GMCB) and Agency of Administration (AOA) released a *Draft* Vermont All-Payer Accountable Care Organization Model Agreement for public comment and feedback.

- Materials made available on GMCB and AOA websites, gmcboard.vermont.gov and hcr.vermont.gov:

    - *Draft* Vermont All-Payer Accountable Care Organization Model Agreement
    - All-Payer Model Protections for Medicare Beneficiaries
    - Summary of All-Payer Model Agreement
    - FAQs
    - All-Payer Model presentations to the Board

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

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

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

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

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

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

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

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

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

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

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

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

Feedback Received: High-Level Overview

Draft Agreement

- Support for an alternative payment model aligned across all payers with a focus on improving population health.
- Request for a stronger focus on the payment differential between Medicaid, Medicare and Commercial payers and the predictability of Medicaid as a payer.
- Request that provider choice to participate is fully protected and enshrined.

Implementation of All-Payer Model

- Clear emphasis on investing in, and enhancing primary care and existing community-based systems of care.
- Identification of specific Medicare Payment waivers that could improve the model.

Changes to Draft Requested By Vermont

- Requested to include an annual reporting requirement for the Green Mountain Care Board to submit to CMMI its analysis of the steps necessary to increase Medicaid rates to Medicare payment levels.

- Requested to remove example of a potential future waiver request to enable the GMCB to set fee-for-service rates.

- Requested 30 day preview period for providers to review any data related to their performance in the model before it would be made public by the State.

VT All-Payer ACO Model Draft Agreement in Context

Draft Agreement is the first of 3 steps in creating an All-Payer Model:

- **Step 1:** Agreement between CMS and VT provides an opportunity for private-sector, provider-led reform in VT.

- **Step 2:** ACOs and payers (Medicaid, Medicare, Commercial) work together to develop ACO-level agreements.

- **Step 3:** ACOs and providers that want to participate work together to develop provider-level agreements at two depths:
  - ACOs and health care entities (hospitals, provider practices)
  - Health care entities and their employed providers

Act 113: ACO Oversight

Certification Criteria

GMCB certifies that the ACO meets criteria in the following categories:

- Governance
- Care management and coordination
- Provider participation, payment, and collaboration
- Participation in health information exchanges
- Quality and performance measures
- Patient engagement and information sharing
- Consumer assistance, access, and freedom of provider choice
- Appropriate financial protections against potential losses

Act 113: ACO Oversight

Review, Modification, Approval of Budgets

GMCB shall review and consider the following categories of information with respect to budgets for ACOs with 10,000 or more attributed lives:

- Health care services utilization
- Health Resource Allocation Plan
- Fiscal responsibility
- Reports from professional review organizations
- Avoidance of duplicative service provision
- Extent of investment in primary care
- Extent of investment in social determinants of health
- Extent of investment in prevention of Adverse Childhood Experiences
- Administrative costs
- Medicaid cost-shift
- Extent to which ACO costs are made transparent to consumers

Next Steps

Notice of potential Green Mountain Care Board vote on the draft Vermont All-Payer Accountable Care Organization Model Agreement:

- Wednesday, October 26 at 9 AM
- Thursday, October 27 at 1 PM

Meetings will be held at the GMCB board room on the 2nd floor of Montpelier's City Center at 89 Main Street