

Vermont All-Payer Accountable Care Organization Model *Draft* Agreement: Explanation and Overview

Green Mountain Care Board
September 29, 2016

Overview

Part I:

- Status Update
- Medicare Participation in State-Sponsored Payment and Service Delivery Models

Part II:

- Comparison of Term Sheet Proposal to Vermont All-Payer Accountable Care Organization Model Agreement *draft*
- Section by Section Overview of Vermont All-Payer Accountable Care Organization Model Agreement *draft*

Part III:

- Implementation Considerations
 - Reporting Requirements

Part I:
**Status Update and Medicare Participation in
State-Sponsored Payment and Service
Delivery Models**

Status Update: January – September 2016

- **January 25, 2016:** After months of discussion with federal partners, Vermont submitted All-Payer Model Term Sheet Proposal to the Center for Medicare and Medicaid Innovation (CMMI)
 - Launched intensive period of continued idea exchange, analysis, and collaboration
- **September 2016:** Vermont and CMMI have reached preliminary *draft* agreement on concept and key terms

Status of Agreements

- Vermont All-Payer Accountable Care Organization Model **draft** Agreement
 - Vermont and CMMI have reached preliminary **draft** agreement on concept and key terms.
 - The next step is a public process to determine if the state should sign the agreement.
 - The draft is currently under legal review by the state and CMS. The language in the draft released today will change as part of the legal review. The concepts will not.
 - If agreed to, the Agreement would be signed by the Governor, the Secretary of Human Services, and the Chair of the GMCB, after a GMCB vote.
- Global Commitment Medicaid Waiver
 - AHS and CMCS have reached a verbal agreement on the terms of a waiver, but the complete, detailed, written terms and conditions are still in federal clearance at this time.

Medicare Participation in State-Sponsored Payment and Service Delivery Models

CMS considers the following principles when assessing proposals for Medicare Participation in State-Sponsored Payment and Service Delivery Models:

Patient centered. Proposals should include a commitment to improve health and to ensure that cost savings are generated by improvements in both patients' health care experience and population health, as well as specific targets for improvement. CMS is interested in measures that assess providers' performance as well as the health of a state's population.

Accountable for the total cost of care. Any model test undertaken by CMMI must provide reasonably high actuarial certainty that the model test will reduce the total cost of care for CMS beneficiaries.

Transformative. Proposals should move the preponderance of payments to providers in the state from models that reward volume to models that reward better care, smarter spending, healthier people.

Part II:
**Sections of the Vermont All-Payer
Accountable Care Organization Model
Agreement Draft**

What is the Vermont All-Payer Accountable Care Organization Model Agreement *draft*?

- The draft Vermont All-Payer Accountable Care Organization Model Agreement includes all of the basic legal, policy, and enforcement provisions to allow the State of Vermont to oversee the Model.
- Any waivers required for the operation of the model will be provided for in forthcoming agreements, referenced in the Model draft, between participating providers and Medicare, similar to Shared Savings and Next Generation Participation Agreements offered to providers today.
- Vermont's Medicaid 1115 waiver will be renewed to include Standard Terms and Conditions to allow Medicaid participation in the Model.

Comparison of 1-25-16 Term Sheet with Agreement *Draft*

#	1/25/16	No Change	Change	Struck	#	Current	New	No Change	Change
1	Legal Authority		X		1	Definitions	X		
2	Performance Period		X		2	Agreement Term			X
3	Medicare Beneficiary Protections	X			3	Legal Authority			X
4	Medicare Basic Payment Waivers			X	4	Medicare Beneficiary Protections		X	
5	Medicare Innovation Waivers			X	5	One-Time Funding	X		
6	Infrastructure Payment Waivers			X	6	ACO Scale Targets	X		
7	Fraud and Abuse Waivers				7	Statewide Health Outcomes and Quality of Care Targets			X
8	Request for Additional Waivers		X		8	Vermont Medicare ACO "Initiative"	X		
9	Revocation of Waivers	X			9	Statewide Financial Targets			X
10	All-Payer Rate Setting System			X	10	Payer Differential	X		
11	Provider Participation in Alternative Payment			X	11	Medicaid Behavioral Health and Long-Term Services and Supports	X		
12	Regulated Services			X	12	Proposal For Subsequent Agreement	X		
13	Financial targets		X		13	Request for Payment Waivers			X
14	Quality Monitoring and Reporting		X		14	Revocation of Payment Waivers		X	
15	Data Sharing	X			15	Data Sharing		X	
16	All Payer Model Evaluation	X			16	Confidentiality	X		
17	Modification	X			17	Model Evaluation		X	
18	Termination and Corrective Action Triggers		X		18	CMS Monitoring of Model	X		
					19	Maintenance of Records	X		
					20	Modification		X	
					21	Termination and Corrective Action Triggers			X
					22	Limitations on Review and Dispute Resolution	X		
					23	Severability	X		
					24	Agency Notifications and Submission of Reports	X		
					25	Entire Agreement	X		
					26	Precedence	X		
					A	1.Statewide Health Outcomes and Quality of Care	X		
					A	2. One-Time Funding	X		

Vermont All-Payer Accountable Care Organization Model Agreement *draft*

1.	Definitions
2.	Agreement Term
3.	Legal Authority
4.	Medicare Beneficiary Protections (12)
5.	One-Time Funding (9)
6.	ACO Scale Targets (4)
7.	Statewide Health Outcomes and Quality of Care Targets (5)
8.	Vermont Medicare ACO “Initiative” (7)
9.	Statewide Financial Targets (6)
10.	Payer Differential (8)
11.	Medicaid Behavioral Health and Long-Term Services and Supports (10)
12.	Proposal for Subsequent Agreement (11)
13.	Request for Payment Waivers
14.	Revocation of Payment Waivers
15.	Data Sharing
16.	Confidentiality
17.	Model Evaluation
18.	CMS Monitoring of Model
19.	Maintenance of Records
20.	Modification
21.	Termination and Corrective Action Triggers
22.	Limitations on Review and Dispute Resolution
23.	Severability
24.	Agency Notifications and Submission of Reports
25.	Entire Agreement
26.	Precedence
A 1	Population-level Health Outcomes Targets, Healthcare Delivery System Quality Targets, and Process Milestones
A 2	One-time Funding Terms

Section #1: Definitions

37 definitions explaining key terminology referred to throughout the draft agreement

Key Definitions

“Accountable Care Organization” or “ACO” means an entity, formed by certain health care providers and suppliers that accepts financial accountability for the overall quality and cost of medical care furnished to, and health of, beneficiaries aligned to the entity.

“ACO Benchmark” means a payer-specific financial target against which the expenditures for healthcare services furnished to an ACO-aligned beneficiary will be assessed. Payer-specific Shared Savings and Shared Losses, including 100% Shared Savings and Shared Losses , for an ACO will be determined based on this assessment.

“Vermont Medicare ACO Initiative” or “Initiative” is the ACO initiative that will start in Performance Years 2 through 5 of this Model and will be executed under a Vermont Medicare ACO Initiative Participation Agreement.

Section #1: Definitions (Cont.)

Key Definitions

“Vermont Modified Next Generation ACO” means an ACO participating in the Next Generation ACO Model that has the majority of its ACO aligned Medicare beneficiaries residing in Vermont at of the start date of Performance Year 1 of the Vermont All-Payer ACO Model. The Participation Agreement for Vermont Modified Next Generation ACOs will be amended to specify that the GMCB shall have a role in developing the Vermont Medicare ACO Initiative Benchmark.

“Medicare Financial Target Services” means all Medicare Part A and Part B services, including services provided to Vermont residents outside of Vermont and benefit enhancements authorized under the Next Generation ACO Model and the Vermont Medicare ACO Initiative. Medicare Advantage and Part D services, wherever provided, are excluded.

“All-payer Financial Target Services” means the Medicare Financial Target Services and the following categories of services for Vermont Medicaid, Vermont Commercial Plans, and Vermont Self-insured Plans: acute hospital inpatient and outpatient care, post-acute care, professional services, and durable medical equipment. All-payer Financial Target Services includes these services to Vermont residents whether provided in or outside of Vermont. All-payer Financial Target Services excludes dental services provided in Vermont Medicaid, Vermont Commercial Plans, and Vermont Self-insured Plans ; Medicaid Behavioral Health Services; and Medicaid Home and Community-based Services. All-payer Financial Target Services excludes Medicaid Long-Term Institutional Services for Performance Year 1 through Performance Year 3 but includes Medicaid Long-Term Institutional Services for Performance Year 4 and Performance Year 5.

Section #2: Agreement Term

Sets the timeframe for implementing the all-payer model (6 years)

Effective Date. This Agreement will become effective when it is signed by all parties.

Term of Agreement. The term of this Agreement begins on the Effective Date and concludes at the end of Performance Year 5, or, in the case of early termination of this Agreement by either party in accordance with section 21, on the date of such termination.

Performance Period. The Performance Period for this Model begins on January 1, 2017 and concludes on December 31, 2022, notwithstanding early termination.

Performance Years. There are a total of 6 Performance Years, beginning with Performance Year 0 in 2017 and ending with Performance Year 5 in 2022.

Section #3: Legal Authority

Statements affirming the authority of Medicare, Medicaid, and Vermont to enter into the Vermont All-Payer ACO Model Agreement

Medicare authority, through the Innovation Center (CMMI): Sections 1115(A)(b), 1115A(b)(2), and 1115A(d)(1) of the Social Security Act.

Medicaid authority addresses existing Medicaid laws in relation to the Model.

- Specifies that Vermont will ensure that the state-federal agreements in place (in the form of state plans or 1115 demonstration waivers) will be modified and then maintained in order to accommodate the Model.

Vermont authority, acting through GMCB, under Titles 8, 18, 33 of Vermont Statutes Annotated to:

- Implement methodologies for payment reforms
- Set rates for providers
- Require payers to comply with provider rates
- Regulate Vermont ACO(s)
- Perform regulatory functions consistent with the Model

Section # 4: Medicare Beneficiary Protections

Provisions to enshrine all existing protections for Medicare beneficiaries in Vermont

- This term states the principle that access to care, services, providers and suppliers for Medicare beneficiaries will not be limited
 - Medicare beneficiaries will have full freedom of choice of providers
 - All existing beneficiary rights and protections (like appeal rights) will be protected
 - Medicare under the all-payer model will include all the same services and coverage *at a minimum* as original Medicare
- **Beneficiaries will not experience any reductions in their rights to benefits or covered services under this agreement.**

Section #5: One-time Funding

One-time funding is provided in Performance Year 0 (2017) to continue Medicare's participation in programs that otherwise would have ended with the sunset of the Medicare Advanced Primary Care Program Demonstration and to provide start-up investment in the Model

- \$9.5M will be provided in 2017 to fund care coordination, connections to community-based resources, and practice transformation for Medicare FFS beneficiaries in support of the Model including but not limited to:
 - Blueprint for Health
 - Support and Services at Home (SASH)
- 2017 funding for Blueprint for Health and SASH programs will be included in Medicare baseline used to calculate spending benchmarks based on target growth rates.

Section #6: ACO Scale Targets

Sets targets for the number of Vermonters attributed to an ACO arrangement offered by participating payers throughout the Performance Period of the agreement. Sets criteria for ACOs to qualify for the purposes of Scale Targets.

- Includes ACO arrangements offered by Vermont Medicaid, Vermont Commercial Plans, participating Vermont Self-insured plans, Vermont Medicare ACO Initiative, Vermont Modified Next Generation ACO Model and the Medicare Shared Savings Program.
- CMS and Vermont expect that the majority of providers and/or suppliers operating in Vermont and participating in Vermont ACOs will choose to participate in a Vermont Medicare ACO Initiative or a Vermont Modified Next Generation ACO.

Percent (%)	By end of PY1 (2018)	By end of PY2 (2019)	By end of PY3 (2020)	By end of PY4 (2021)	By end of PY5 (2022)
Vermont All-Payer Scale Target Beneficiaries	36%	50%	58%	62%	70%
Vermont Medicare Beneficiaries	60%	75%	79%	83%	90%

Section #7: Statewide Health Outcomes and Quality of Care Targets

Identifies 3 priority goals for improving the health of Vermonters within 3 “Measurement Domains”. Establishes targets for improvement and provides for collaboration with the Agency of Human Services and Vermont Department of Health.

Goals:

- 1. Improve access to primary care**
- 2. Reduce deaths from suicide and drug overdose**
- 3. Reduce prevalence and morbidity of chronic disease (COPD, Diabetes, Hypertension)**

Measurement Domains:

- 1. Population Health Outcome Measures and Targets**
- 2. Health Care Delivery System Quality Measures and Targets**
- 3. Process Milestones**

Overarching Population Health Goals

Federal-state priority goals to improve the health of
Vermonters:

#1: Improving access to primary care

**#2: Reducing deaths from suicide and drug
overdose**

**#3: Reducing prevalence and morbidity of
chronic disease (COPD, Diabetes, Hypertension)**

Vermont's priorities helped inform these goals
(e.g., State Health Improvement Plan)

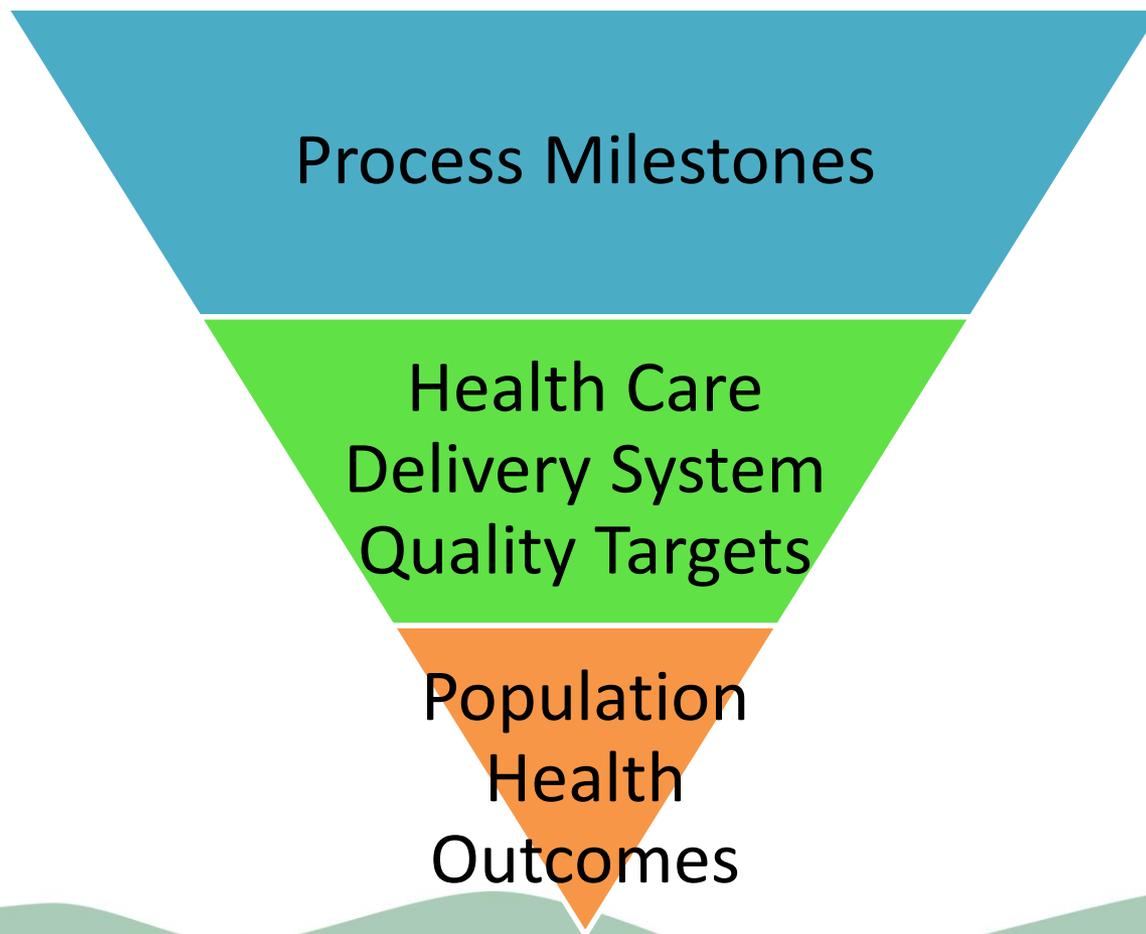
Three “Measurement Domains”

CMMI has proposed a framework that consists of the following measurement domains:

- **Population Health Outcome Measures and Targets** -- Statewide measures and targets related to the health of the population, regardless of whether the population seeks care or not. These measures generally include all state residents, whether or not they are aligned with an ACO.
- **Health Care Delivery System Quality Measures and Targets** -- Measures and targets related to the performance of care delivered by an All Payer ACO. These measures generally evaluate ACO performance and include people attributed to the ACO. They can be multi-payer or payer-specific.
- **Process Milestones** – Process-related measures to ensure that the State and ACO are striving towards improvement on quality and population health.

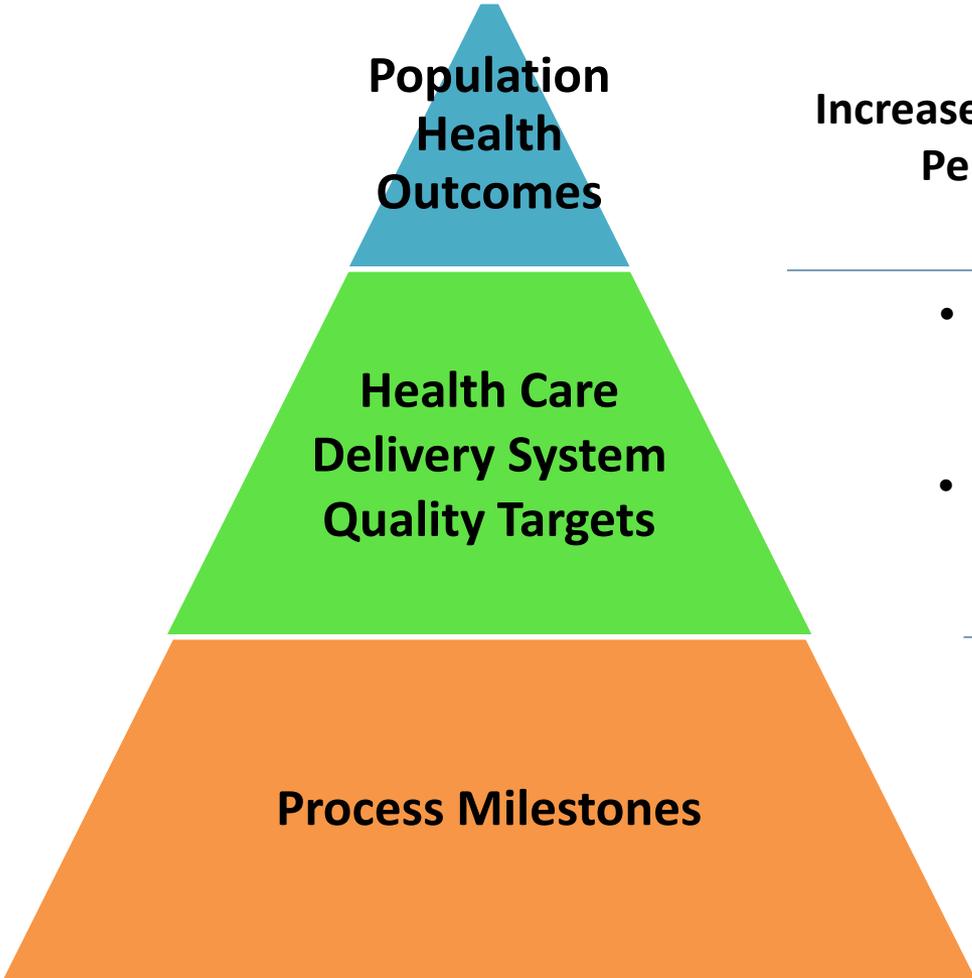
Focus on Improving Population Health

Process Milestones and Health Care Delivery System Quality Targets support achievement of ambitious Population Health Outcomes



Population Health Goal #1

Improving Access to Primary Care



**Population
Health
Outcomes**

**Health Care
Delivery System
Quality Targets**

Process Milestones

**Increase % of VT Adults Reporting that they have a
Personal Doctor or Health Care Provider**

- **Increase % of VT Medicare Beneficiaries Reporting Getting Timely Care, Appointments and Information**
 - **Medicaid Patient Caseload for Specialist and Non-Specialist Physicians (monitoring only to start)**
-
- **Increase % of VT Medicaid Adolescents with Well-Care Visits**
 - **Increase % of VT Medicaid Beneficiaries Aligned With a VT ACO**

Population Health Goal #2

Reducing Deaths from Suicide and Drug Overdose

**Population
Health
Outcomes**

**Health Care
Delivery System
Quality Targets**

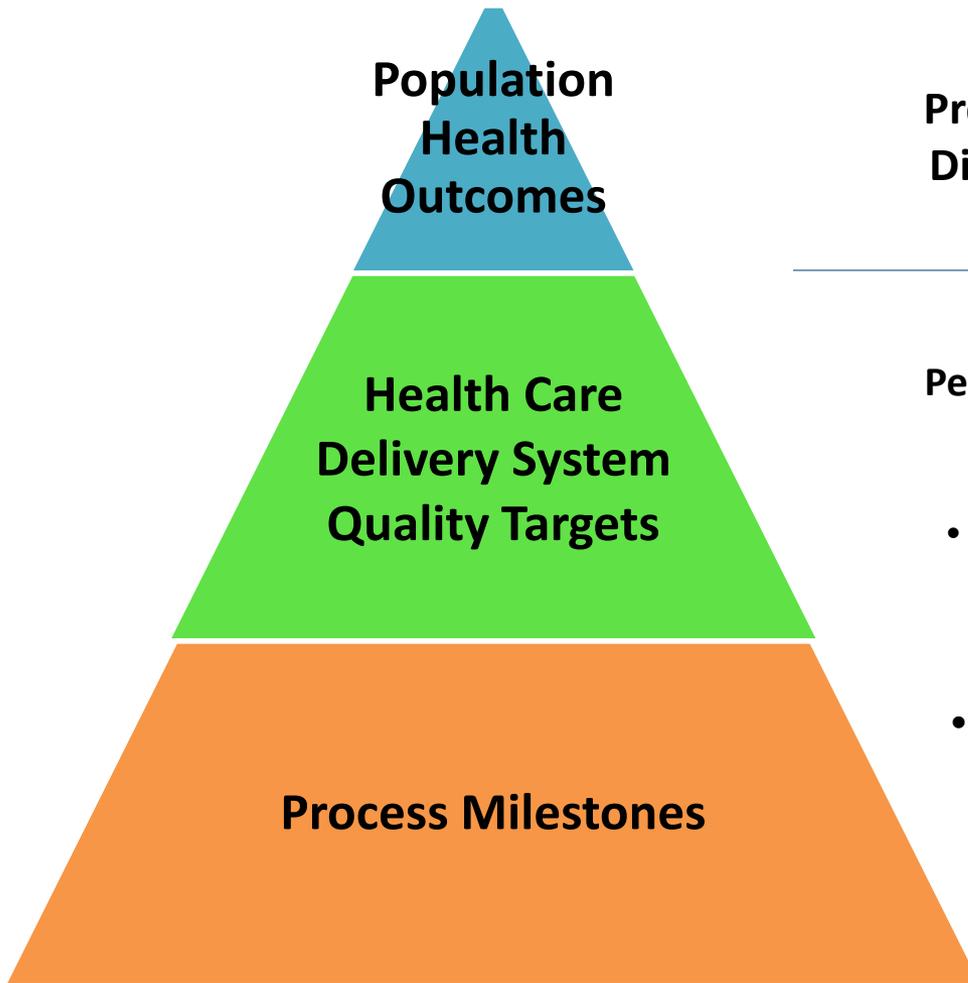
Process Milestones

- Reduce Deaths from Drug Overdose
 - Reduce Deaths from Suicide

-
- Increase Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (*2 measures*)
 - Improve Follow-Up After Discharge from ED for MH and SA Treatment (*2 measures*)
 - Reduce Rate of Growth of ED Visits for MH/SA Conditions
-
- Increase Use of VT's Rx Monitoring Program
 - Increase # of VT Residents Receiving Medication-Assisted Treatment for Opioid Dependence
 - Increase Screening for Clinical Depression and Follow-Up Plan

Population Health Goal #3

Reducing Prevalence and Morbidity of Chronic Disease



Prevalence of Chronic Obstructive Pulmonary Disease, Diabetes and Hypertension Will Not Increase by More Than 1% (3 measures)

For VT Medicare Beneficiaries, Improve Performance on Composite Measure that Includes:

- **Diabetes Hemoglobin A1c Poor Control**
 - **Controlling High Blood Pressure**
 - **All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions**
-
- **Improve Rate of Tobacco Use Assessment and Cessation Intervention**
 - **Improve Rate of Medication Management for People with Asthma**

Vermont's Input to CMMI

Vermont provided baseline data, expertise on measures and specifications, and information on national benchmarks.

Vermont consistently advocated for:

- Ambitious but realistic targets
- Measures that address key priorities
- Alignment with other measure sets
- Consideration of collection burden – begin with measures that are already prioritized and collected in Vermont; minimize medical record review for any new measures

Measure (Source) ✓ = Currently collected and reported in VT * = Current ACO SSP Measure	Domain	Proposed Target
Goal #1: Increase Access to Primary Care		
✓ Percentage of adults with usual primary care provider (BRFSS Survey)	Population Health	89% of adults statewide <i>Baseline: 87% (2014)</i>
✓ Medicare ACO composite of 5 questions on Getting Timely Care, Appointments, and Information (ACO CAHPS Survey)*	Health Care Delivery System	75 th percentile compared to Medicare nationally <i>Baseline: 70th-80th percentile</i>
Medicaid Patient Caseload for Specialist and Non-Specialist Physicians (TBD)	Health Care Delivery System	Monitoring only for at least first 2 years <i>Baseline: None</i>
✓ Percentage of Medicaid adolescents with well-care visits (Claims)	Process	50 th percentile compared to Medicaid nationally <i>Baseline: 25th percentile</i>
✓ Percentage of Medicaid enrollees aligned with ACO (PCP selection and claims)	Process	No more than 15 percentage points below % of VT Medicare beneficiaries aligned to VT ACO <i>Baseline: 55.5% (Jan. 2016)</i>

Measure (Source) ✓ = Currently collected and reported in VT ✓ * = Current ACO SSP Measure	Domain	Proposed Target
Goal #2: Reduce Deaths Related to Suicide and Drug Overdose		
✓ Deaths related to suicide (Vital Statistics)	Population Health	16 per 100,000 VT residents <u>or</u> 20 th highest rate in US <i>Baseline: 16.9 (2013)</i>
✓ Deaths related to drug overdose (Vital Statistics)	Population Health	Reduce by 10% <i>Baseline: 108 (2015)</i>
✓ Multi-Payer ACO Initiation and engagement of alcohol and other drug dependence treatment (Claims)*	Health Care Delivery System	Initiation: 50 th percentile <i>Baseline: 25th Percentile</i> Engagement: 75 th percentile <i>Baseline: 75th percentile</i>
Multi-Payer ACO 30-day follow-up after discharge from ED for mental health (Claims)	Health Care Delivery System	60% <i>Baseline: 56.2% (2014)</i>
Multi-Payer ACO 30-day follow-up after discharge from ED for alcohol or other drug dependence (Claims)	Health Care Delivery System	40% <i>Baseline: 35.9% (2014)</i>
✓ Number of Mental Health and Substance Abuse-Related ED Visits (Hospital Discharge Data)	Health Care Delivery System	Reduce rate of growth (specific target TBD) <i>Baseline: ~6% (2014-15)</i>

Measure (Source) ✓ = Currently collected and reported in VT * = Current ACO SSP Measure	Domain	Proposed Target
Goal #2: Reduce Deaths Related to Drug Overdose and Suicide (continued)		
✓ % of Vermont providers checking prescription drug monitoring program before prescribing opioids (VPMS; VT will start routinely collecting and reporting in Fall 2016)	Process	Increase percentage (specific target TBD) <i>Baseline: None</i>
✓ Multi-Payer ACO Screening for clinical depression and follow-up plan (Clinical)*	Process	75 th percentile compared to Medicare nationally <i>Baseline: 60th-70th percentile (2014)</i>
✓ # per 10,000 population ages 18-64 receiving medication assisted treatment (VDH Data)	Process	150 per 10,000 (or up to rate of demand) <i>Baseline: 123 per 10,000 (Q4 2015)</i>

Measure (Source) ✓ = Currently collected and reported in VT * = Current ACO SSP Measure	Domain	Proposed Target
Goal #3: Reduce Prevalence and Morbidity of Chronic Disease (COPD, Hypertension, Diabetes)		
✓ Statewide prevalence of chronic disease: 3 measures including chronic obstructive pulmonary disease, hypertension, and diabetes (BRFSS Survey)	Population Health	Increase statewide prevalence by no more than 1% <i>Baseline: COPD-6%, diabetes-8%, hypertension-27% (2014)</i>
✓ Medicare ACO chronic disease composite, consisting of: Diabetes HbA1c Poor Control; Controlling High Blood Pressure; and All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions (Claims and clinical)*	Health Care Delivery System	75 th percentile compared to Medicare nationally <i>Baseline: Unknown</i>
Percentage of Vermont residents receiving appropriate asthma medication management (Claims)	Process	25 th percentile compared to national <i>Baseline: <25th percentile (2014)</i>
✓ Multi-Payer ACO Tobacco use assessment and cessation intervention (Clinical)*	Process	75 th percentile compared to Medicare nationally <i>Baseline: 75th percentile (2014-15)</i>

Cumulative Improvement Approach

- Recognition that quality improvement interventions can take time to design and implement
- General approach for each measure is that:
 - ✓ Cumulatively across Year 1-Year 2, the State experiences improvement
 - ✓ There is improvement relative to target of at least 30 percent by the end of Year 3; 65 percent by the end of Year 4; 100 percent by the end of Year 5
- Improvement requirements by Measurement Domain:
 - ✓ 4 of 6 Population Health Outcomes Targets
 - ✓ 4 of 7 Health Care Delivery System Quality Targets
 - ✓ 5 of 7 Process Milestones

Section #8: Vermont Medicare ACO Initiative

Establishes the Vermont Medicare ACO Initiative and provides opportunity for Vermont to propose modifications to better align with other ACO programs operated by Vermont Medicaid, Commercial Plans or participating Self-Insured Plans

- The Vermont Medicare ACO Initiative will be launched in 2019 – PY 2.
- In 2018 the APM will operate with a Modified Next Generation ACO, with the GMCB assuming the same benchmarking process as laid out for the Vermont Medicare ACO Initiative.
- Spells out CMS and GMCB duties in connection with the Vermont Medicare ACO Initiative.

Section #8: Vermont Medicare ACO Initiative

CMS DUTIES

- Work with Vermont to design the basic elements of the Initiative
 - Governance requirements
 - Alignment methodology
 - Risk arrangements
 - Benefit enhancements
- Provide ACOs with ACO participation agreements
- Include benefit enhancements currently authorized in NextGen
 - Telehealth
 - Post-discharge home visits
 - 3-day skilled nursing facility rule

Section #8: Vermont Medicare ACO Initiative

GMCB DUTIES

- Submit a letter to CMS, jointly signed by the ACO, attesting that the entities will work together to achieve the goals and financial and quality targets in the Model Agreement.
- GMCB may require ACOs to make specific infrastructure or care delivery investments.
- **Set prospective growth benchmarks for ACOs.**

Section #8: Vermont Medicare ACO Initiative

A core responsibility of GMCB under the agreement is setting Medicare ACO growth benchmarks

- Benchmarks are a financial target against which costs are measured. Saving and losses or monthly capitation amounts are based on the benchmark target.
- The GMCB process for establishing prospective benchmarks must:
 - Incentivize high-quality and efficient care
 - Enable achievement of the financial targets in the Model Agreement
 - Place a set percentage (consistent with NextGen) of the benchmark at risk for ACO quality performance
 - Set separate benchmarks for Aged and Disabled beneficiaries and ESRD beneficiaries.

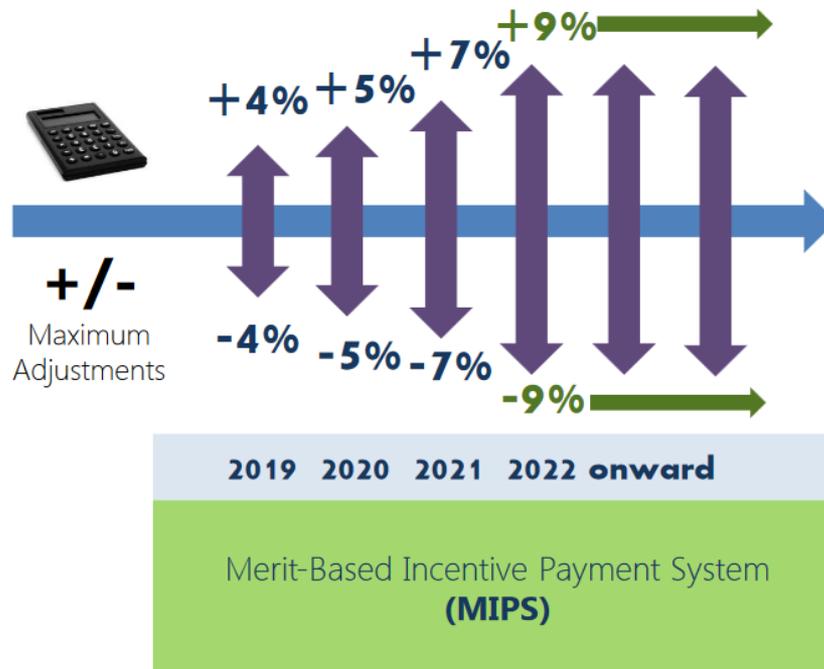
Section #8: Vermont Medicare ACO Initiative

The Model Agreement anticipates that GMCB and CMS will work closely together in designing the Initiative and setting the benchmarks

- GMCB provides Medicare ACO benchmarks to CMS for approval 30 days before the beginning of the Performance Year.
 - The process is intended to be collaborative and ongoing throughout the year.
- GMCB and CMS will work together to determine whether and how the ACO Initiative should be modified to be considered and Advanced Alternative Payment Model under the MACRA Quality Payment Program.
 - These regulations are not final but this is an important statement of intent concerning MACRA and the Vermont APM.
 - Providers in Advanced Alternative Payment Models will qualify for a 5% Medicare Part B incentive payment under the proposed rule.

How much can MIPS adjust payments?

Based on a MIPS Composite Performance Score, clinicians will receive **+/- or neutral** adjustments **up to** the percentages below.



Adjusted
Medicare Part
B **payment** to
clinician

The potential maximum adjustment % will increase each year from 2019 to 2022

MIPS: First Step to a Fresh Start

- ✓ **MIPS is a new program**
 - Streamlines 3 currently independent programs to work as one and to ease clinician burden.
 - Adds a fourth component to promote ongoing improvement and innovation to clinical activities.



Quality



Resource use



Clinical practice
improvement
activities

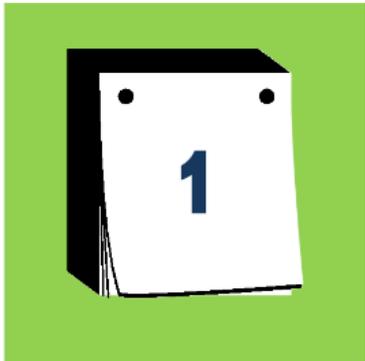


Advancing care
information

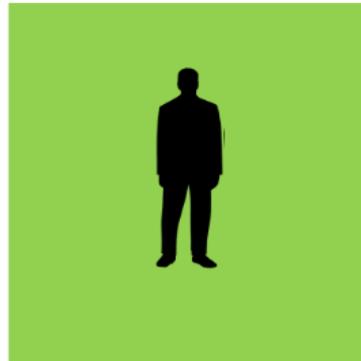
- ✓ **MIPS provides clinicians the flexibility to choose the activities and measures that are most meaningful to their practice to demonstrate performance.**

Who will NOT Participate in MIPS?

There are 3 groups of clinicians who will NOT be subject to MIPS:



FIRST year of Medicare Part B participation



Below **low patient volume** threshold



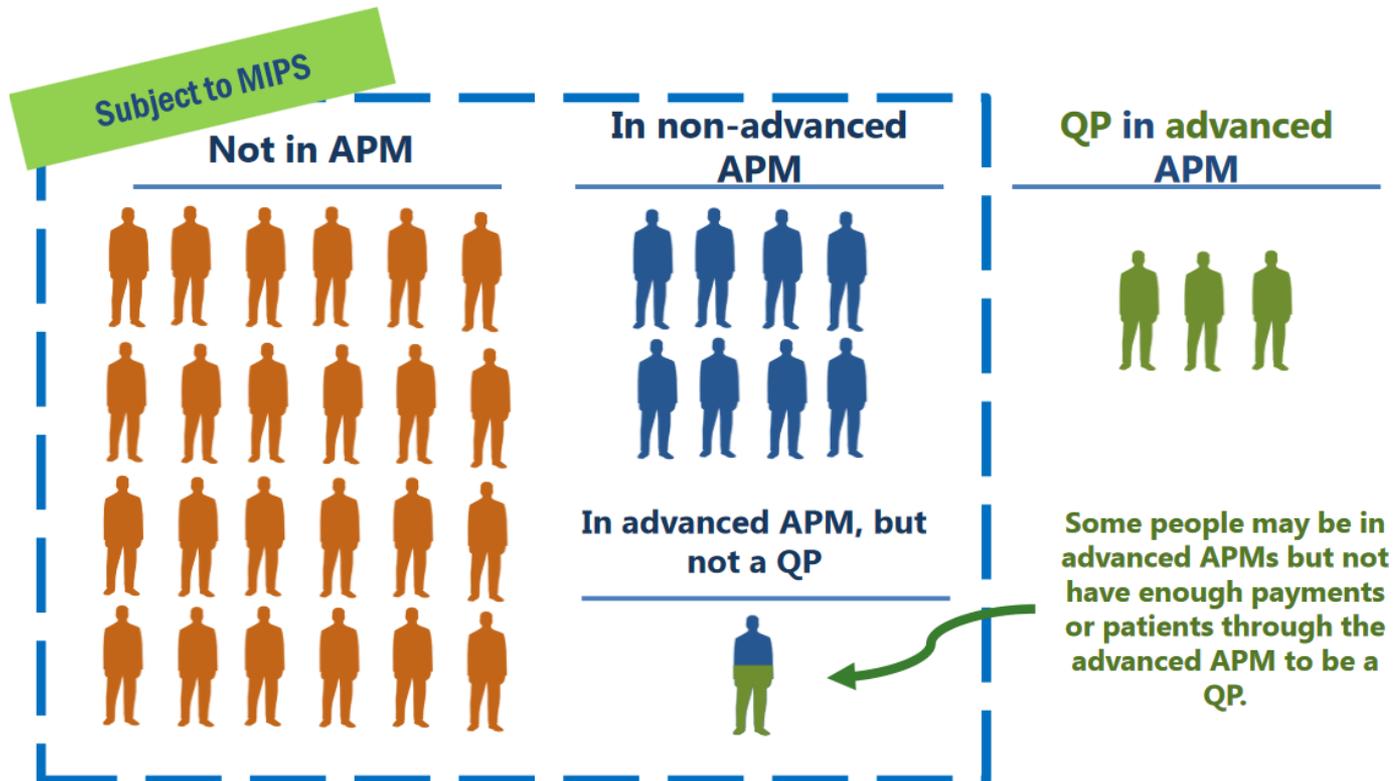
Certain participants in **ADVANCED** Alternative Payment Models



Medicare billing charges less than or equal to \$10,000 and provides care for 100 or fewer Medicare patients in one year

Note: MIPS **does not** apply to hospitals or facilities

Note: Most clinicians will be subject to MIPS.



Note: Figure not to scale.

Section # 9: Statewide Financial Targets

All-Payer Total Cost of Care Target: a defined target for statewide per capita spending growth. This applies to spending across all payers.

The All-Payer Target: 3.5%

Medicare Growth Target: a defined target for per capita growth for Medicare beneficiaries. This applies to spending only on Medicare.

The Medicare Target: 0.1%-0.2% below projected national Medicare growth

- Performance on these targets is calculated across Performance Years 1-5.
- During the agreement term, failure to be “on track” to meet these targets could require a corrective action plan.
- Vermont is “on track” to meet the All-Payer Target if it remains below 4.3% growth.
- Baseline year is 2017 and includes \$7.5M, approximately the sum of Medicare payments made to Vermont providers in 2016 as part of the Multipayer Advanced Primary Care Practice demonstration.
- Benchmark growth rates are compared to actual Vermont spending.

All-Payer and Medicare Financial Target Services

Spending categories subject to the all-payer target and from which Medicare growth targets are calculated

In essence, All-Payer and Medicare Financial Target Services Services are those covered by the Model agreement

- In Maryland, the agreement only regulates hospital payments. In Vermont, regulated services are more expansive.
- Derived from current federal and state SSPs
 - For Medicare: Parts A and B Services
 - Part A covers inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home health care.
 - Part B covers certain doctors' services, outpatient care, medical supplies, and preventive services.
 - For Medicaid and Commercial: The closest analogue to those Medicare services
- Defined by **categories of service**

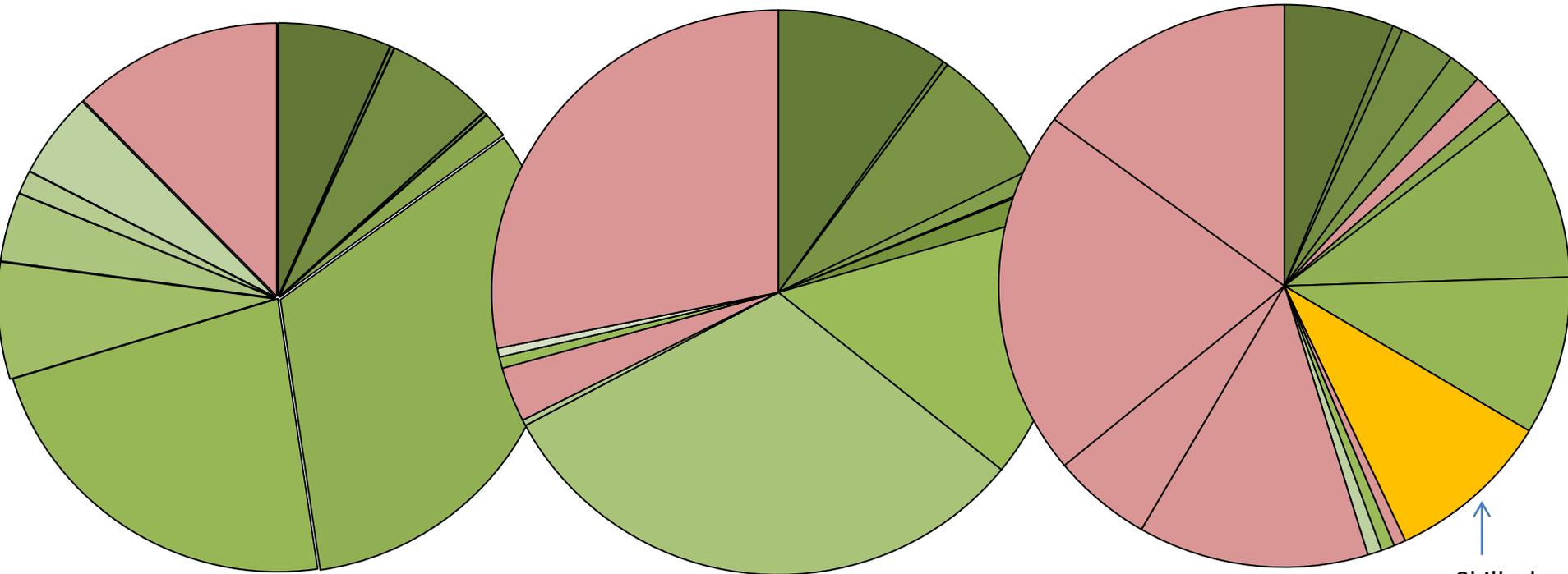
All-Payer and Medicare Financial Target Services can be different from the services for which the ACO is at risk.

Financial Target Services By Payer

Commercial:
\$1.5B

Medicare
\$.9B

Medicaid
\$1.3B



Excluded Services	Pharmacy	Pharmacy Residential and Personal Care Dental	AHS, HCBS and Mental Health Pharmacy Residential and Personal Care Dental

↑
Skilled
Nursing
Facilities

Section #9: Statewide Financial Targets: Medicare Growth Target

- The ***Medicare Total Cost of Care per Beneficiary Growth Target*** limits Medicare growth – intended to ensure that the model saves CMS money.
- Significant change during the negotiation was to relate the Medicare Growth Target to national **projections of Medicare spending**.
 - Original proposal was to assess growth relative to actual national growth – that structure created uncertainty and risk.
- Vermont negotiated other important provisions to protect the state.
 - Benchmark floor in Performance Year 1
 - Intended to protect Vermont from very low growth in PY1, when the model is being launched
 - Exclusion of Medicare FFS spending in PY1-2, with ACO scale “trigger” in PY 3
 - Intended to protect Vermont from being accountable for spending it does not regulate, as the ACO program is ramping up
 - Adjustments for age and specific high-need enrollees

Medicare Growth Target: The Benchmark Floor Provisions

Projected growth in 2018 affects both PY1 growth benchmarks and requirements over the remaining 4 years.

	Medicare Projections 2017	Benchmark Growth 2018 (PY1)	Benchmark Growth 2019-22 (PY2-5)
No Floor	Above 3.7%	0.1% below projected	0.1% below projected
Floor	2.7 – 3.7%	3.5%	0.2% below projected
Soft Floor	Below 2.7%	1% above projected	0.2% below projected

The Soft Floor is to address very low Medicare growth and avoid a windfall.

High Medicare growth leads to lower savings requirement over the 5 years.

Preliminary Medicare growth projections for 2018: 3.4%

Section #10: Payer Differential

Provides for monitoring of the Payer Differential with respect to increasing ACO benchmarks and the impact that differences in increases between payers may have on Vermont ACOs

- GMCB must submit a report on options to narrow reduce the Payer Differential between payers during and after the Performance Period by the end of Performance Year 3.
- This section provides a hold harmless provision for Vermont. If the state chooses to increase Medicaid reimbursement rates to health care providers these rate increases will be excluded from the All-payer Total Cost of Care per Beneficiary Growth Target.
- This section also ensures that Medicaid beneficiaries receive the same access to services under an ACO as other beneficiaries.
 - ACOs will be required to have a single network of providers for all payers by Performance Year 2.
 - AHS must ensure that at least 90% of all providers in the Vermont ACO's network accept Vermont Medicaid beneficiaries for those ACOs that do not have a single network of providers by Performance Year 2.

Section #11: Medicaid Behavioral Health and Long-Term Services and Supports

Requires Vermont to have a plan for inclusion of not-yet-included Medicaid Behavioral Health and Long-Term Services and Supports in the All-Payer Financial Target Services

Note: Behavioral Health spending, when reimbursed through specialists, clinics, or hospitals, is included in Financial Target services. The Medicaid services addressed in this provision relate primarily to services delivered through the designated agencies in Vermont to Medicaid members.

- End of Performance Year 3, 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.
- Describe a strategy for including Medicaid Behavioral Health Services and Medicaid Home and Community-based Services in the State's delivery system reform efforts and for supporting the inclusion of these services in the definition of All-payer Financial Target Services in a subsequent agreement.

Section #12: Proposal for Subsequent Agreement

This section provides that Vermont would submit a renewal proposal by December 31, 2021 if it would like to continue the APM

At a minimum, a proposal for subsequent agreement would include:

- A Medicare total cost of care per beneficiary growth target that is similar to the one described in this agreement.
- An all-payer total cost of care per beneficiary growth target that is similar to the one described in this agreement, but that also includes expenditures related to Medicaid Behavioral Health Services and the Home and Community-based Services.
- Statewide health outcomes and quality of care targets that are similar in scope to the ones described in this agreement.

Section #13: Request for Payment Waivers

Specifies how Vermont may request waivers to carry out the all-payer model

- Waiver requests may be submitted by Vermont along with a rationale for the waiver at any time.
- Examples of waiver requests include:
 - Additional beneficiary enhancements deemed necessary to maximize ability to perform under the Model.
- Waivers are granted only if CMS agrees and would be issued through separate agreements.

Section #14: Revocation of Waivers

Authorizes CMS to terminate the any payment waivers issued under section 13

- CMS may terminate the payment waiver if Vermont does not comply with conditions associated with the payment waiver agreement.

Section #15: Data Sharing

Describes expectations about data sharing and the process for data requests

- Vermont supplies all-payer claims data on a regular basis, which can be from a combination of sources, but should include 80 percent of Vermont residents with health insurance provided under a Vermont Commercial Plans or participating Vermont Self-insured Plans.
- CMS will share with the GMCB in de-identified form the data necessary to determine provider performance on the Statewide Health Outcomes and Quality of Care Targets, and the Medicare Total Cost of Care per Beneficiary Growth Target.
- Authorizes Vermont to disclose such performance data, with consent from CMS.
- Provides for CMS to use reports, information, and data to conduct analyses and may publish, and potentially co-publish with Vermont, in a manner consistent with all applicable federal and state laws and regulations, including the Health Insurance Portability and Accountability Act (“HIPAA”) and the Employee Retirement Income Security Act (“ERISA”).

Section #16: Confidentiality

Vermont will protect the confidentiality of Medicare and Medicaid beneficiaries in compliance with federal and state law

- 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.

Section #17: Model Evaluation

Describes efforts by Vermont and CMS to evaluate the implementation of the all-payer model

- CMS will evaluate the model in accordance with Section 1115(a)(b)(4)
 - This is a substantial evaluation and will compare Vermont to national Medicare and to other states.
- Vermont will submit an annual report to CMS concerning its performance on the financial and quality requirements of the model agreement.
 - This will include performance on the all-payer financial targets, and performance on Statewide Health Outcomes and Quality of Care Targets.

Section #18: CMS Monitoring of Model

CMS will monitor compliance with the Model agreement

Establishes monitoring activities that may include:

- Interviews with any members of the State involved in operating the Vermont Medicare All-payer ACO Model;
- Interviews with beneficiaries and their caregivers;
- Interviews with Vermont ACOs;
- Audits of the Annual ACO Scale Targets and Alignment Report, the Annual Health Outcomes and Quality of Care Report, and the Quarterly Financial Report;
- Audits of regulatory approach, implementation plans, and other data from the State;
- Site visits to the State and Vermont ACOs; and
- Documentation requests sent to the State and to Vermont ACOs.

Expectation for a plan from CMS for annual audits

Expectation that Vermont cooperate with monitoring activities

Sections #19, 20: Maintenance of Records, Modification

Establishes expectation for maintenance of records and process for modifying the agreement

Section 19: The state will maintain records for a set period of time and provide access to the federal government.

Section 20: The Parties may amend the Model Agreement, including any appendix to the Model Agreement, at any time by mutual written consent.

Section #21: Termination and Corrective Action Triggers

Defines events which may trigger CMS to impose a Corrective Action Plan (CAP) upon Vermont and the process and timelines for remediation. Also includes the process by either party may terminate the Model Agreement.

- Triggering events may or may not require a CAP. The Agreement provides CMS the flexibility to assess the totality of circumstances and determine whether a factor unrelated to the Agreement caused the Triggering Event.
- The State shall successfully implement any required CAP as approved by CMS, by no later than 365 calendar days from the date of postmark of the Warning Notice unless otherwise modified or agreed to by CMS.
- If the Triggering Event is related to an aspect of the Model involving a payment waiver, the Secretary, may decide whether to allow the State to maintain such a waiver during the time period that the State is under the CAP.

Section #21: Termination and Corrective Action Triggers

- If the Secretary determines that the State has not successfully implemented a CAP, he/she may amend or rescind the relevant aspect of the Model.
- In addition, CMS may take control over setting benchmarks for a VT Medicare ACO, including how benchmarks are tied to quality performance, if the State does not successfully implement a CAP triggered by CMS' determination that:
 - Vermont is not on track to achieve the All-payer or Medicare Total Cost of Care per Beneficiary Growth Targets.
 - Vermont is not making sufficient progress on the Healthcare Delivery System Quality Targets.
 - If one year after implementation of the CAP, the State is still not on track with 4 of 7 of the healthcare delivery system quality targets, or if the Innovation Center rejects the CAP, CMS may:
 - Determine the quality measures and targets to which the Vermont Medicare ACO Initiative Benchmark is tied.
 - Determine the percentage of the Vermont Medicare ACO Initiative Benchmark that is tied to quality for Medicare FFS beneficiaries aligned to the VMA ACO or Modified Next Generation ACO.

Technical Sections #22, 23, 24, 25, 26

These sections provide for necessary legal processes necessary to protect all parties to the agreement

Section 22: Limitations on Review and Dispute Resolution

This section describes the limits on judicial review and the process for dispute resolution.

Section 23: Severability

Technical legal section.

Section 24: Agency Notifications and Submission of Reports

This section has names and addresses for submitting notices and reports. It will be revised to reflect positions, not solely names parties.

Section 25: Entire Agreement

The Agreement and the Appendices constitute the entire agreement.

Section 26: Precedence

If any provision of this Agreement conflicts with a provision of any document incorporated herein by reference, the provision of this Agreement shall prevail.

Appendices #1 and #2

Appendix 1: Population-Level Health Outcomes Targets, Health Care Delivery System Quality Targets, and Process Milestones

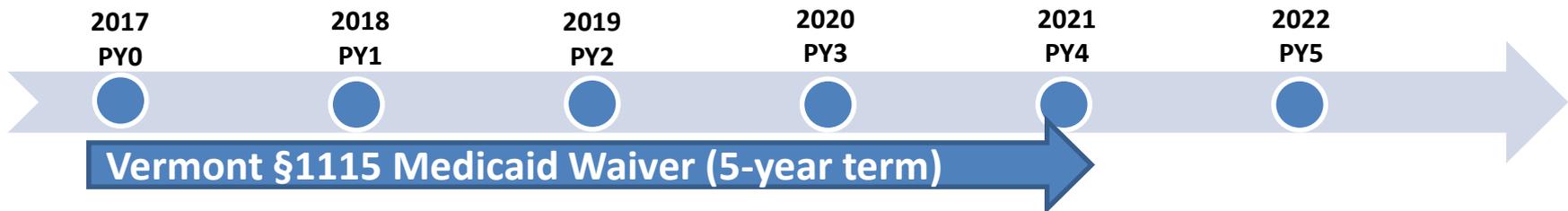
Provides for detailed description of measure targets and calculation methodology for all measures.

Appendix 2: One-Time Funding Terms

Details permissible uses for One-time Funding. Informed by current allowable spending on the Blueprint for Health and Services and Supports at Home programs.

Part III: Implementation Considerations

Vermont All-Payer Model Agreement Timeline



Jan 1-- Performance Period Begins

Jan 1-- VT Modified Next Gen ACO Begins

Jan 1-- VT Medicare ACO Initiative Begins

Scale Target (% Beneficiaries Aligned to ACO)

All-Payer 36%
Medicare 60%

All-Payer 50%
Medicare 75%

All-Payer 58%
Medicare 79%

All-Payer 62%
Medicare 83%

All-Payer 70%
Medicare 90%

VT Medicare TCOC per Beneficiary Calculation

Only Aligned VT Medicare Beneficiaries

Only Aligned VT Medicare Beneficiaries

VT Medicare Scale Target $\geq 65\%$ = All Medicare Bene.

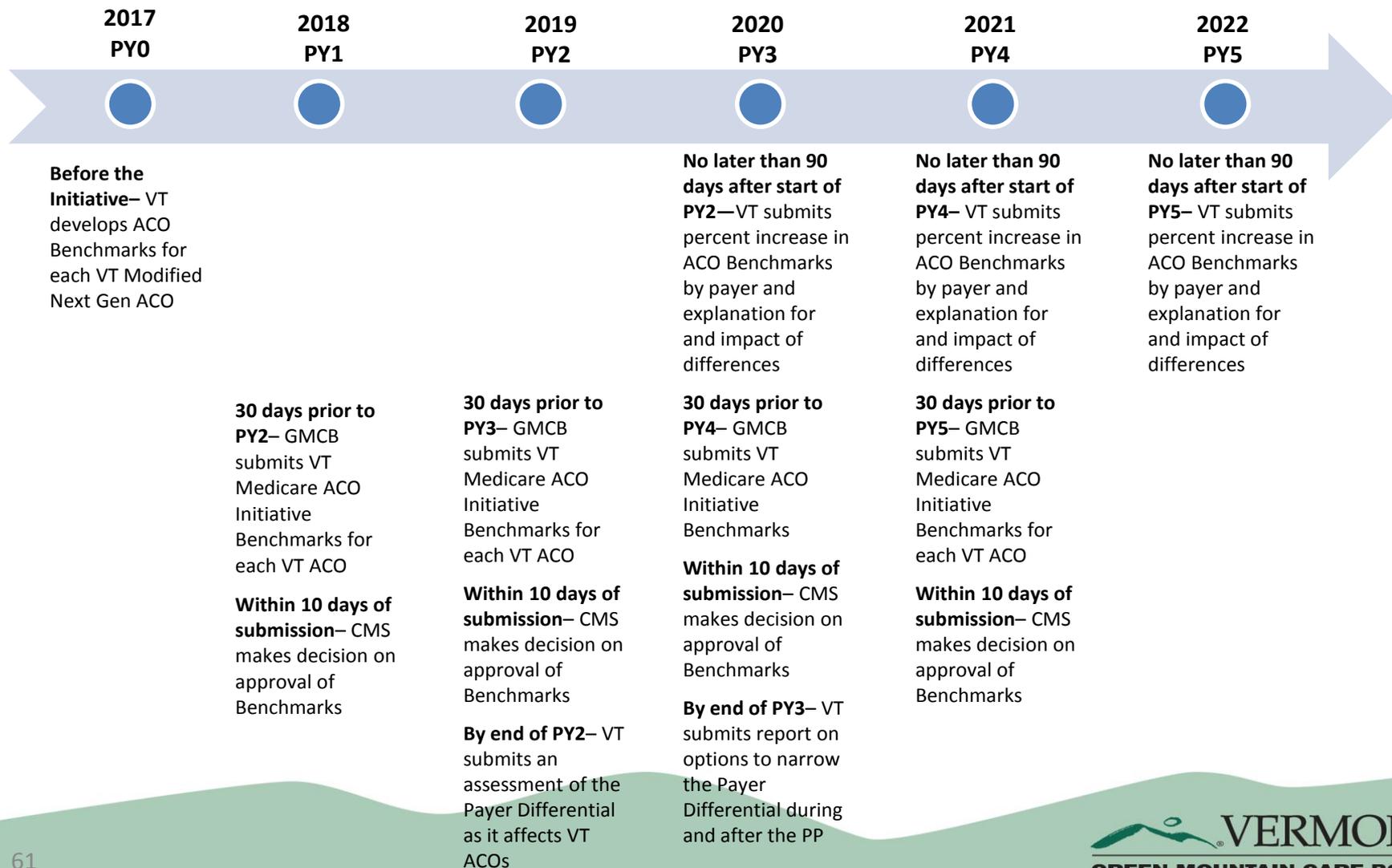
VT Medicare Scale Target $< 65\%$ = Only Aligned VT Medicare Bene.

All VT Medicare Beneficiaries

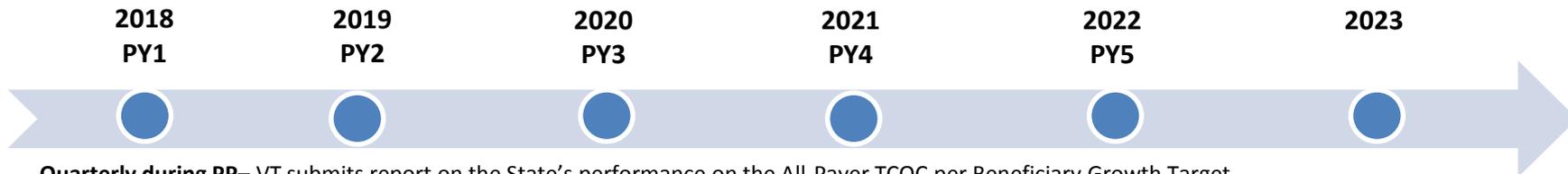
All VT Medicare Beneficiaries

Vermont All-Payer Model Agreement

Benchmark Setting and Payer Differential Timeline



Vermont All-Payer Model Agreement Reporting Timeline



Quarterly during PP– VT submits report on the State’s performance on the All-Payer TCOC per Beneficiary Growth Target

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

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

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

Jun 30– All-Payer TCOC per Beneficiary Growth final results PY2

Jun 30-- Annual ACO Scale Targets & Alignment Report for PY2

Jun 30– Accountability framework to public health system signed by VDH, GMCB and VT ACOs

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

Dec 31–Submit a plan to coordinate the financing and delivery of Medicaid BH and HCBS with the All-payer Financial Target Services

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

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

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

Dec 31– Submit proposal for subsequent 5 year Model

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

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

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

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

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

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