Vermont All-Payer Model Framework
Final Draft, December 31, 2015

I. Introduction and Purpose

In February 2015 the staff of the Green Mountain Care Board (GMCB) through its Director of Payment Reform, convened and facilitated the ACO Payment Subcommittee to discuss and outline the governance structure, provider payment policies and related parameters for an all-payer ACO model for Vermont. In addition to GMCB staff overseeing the meetings, other participating entities have included Vermont's three existing ACOs (Community Health Accountable Care (CHAC), OneCare Vermont and Vermont Collaborative Physicians (VCP)), Blue Cross and Blue Shield of Vermont, the Department of Vermont Health Access (including the Blueprint for Health), MVP Health Care, the Vermont Association of Hospitals and Health Systems, Bi-State Primary Care Association, Health*first*, and the Vermont Medical Society. In addition, The Office of the Health Care Advocate, and representatives of some of the state's home health agencies (VNAs of Vermont) and of its Designated Agencies (Vermont Care Partners) joined the Subcommittee in the autumn of 2015.[1] This document represents the final product of that effort. It is the intent of the Subcommittee to present its findings to the Green Mountain Care Board for discussion and possible next steps.

It is intended that this "Framework" be used 1) as the basis for the design and operations of an integrated accountable organization operating within an all-payer ACO model, and 2) to inform the GMCB Members and the State's CMS waiver negotiating team regarding the Subcommittee's thinking about how an all-payer model might be implemented in Vermont. The Subcommittee recommends that the elements of this Framework serve as part of the future regulatory and contractual requirements to be developed by the GMCB, the ACO and payers.

II. Reasons to Pursue an All-Payer Model for Vermont

Health care delivery and payment systems are currently very fragmented, and are not designed to provide efficient and well-coordinated health care services. If Vermont is able to achieve the health care payment and delivery system reforms as set forth in state legislation, it should result in a much more integrated system of care based on collaboration among providers, better health outcomes for Vermonters, and better management of overall healthcare costs.

[1] A list of Payment Subcommittee participants can be found in Attachment A.

Having a single accountable organization that could assume financial risk under value-based, population-based payments; have sufficient resources to provide the infrastructure necessary for data collection, analytics, and coordinating improvements in care delivery; and have a sufficient number of attributed lives to impact the delivery system appears to be the best option to achieve a more integrated system of care. The term "ACO" in this document is used as a generic reference to a single statewide organization with the responsibilities defined in this framework.

Here is what an all-payer model could and should mean for Vermonters:

1. **Better access to care.** With more flexibility and payment incentives based on outcomes and value rather than volume, health care providers and payers should be able to create a health care system that offers more timely access to care, and better meet the needs of Vermonters.
2. **More time with your doctor, and the care team.** Under the current system, health care providers are pressured to see more patients and keep appointments short to maximize "fee-for-service" payments. While "fee-for-service" payment for some services will always be a part of health care payment, under a re-designed system, "fee-for-service" payment would be substantially replaced with "value-based" payment that rewards providers for high performance care, and providers would be encouraged to work as a team to better meet the needs of their patients. The team might include doctors, nurses, mental health specialists, care coordinators and others to be sure the right care is provided when needed and is fully coordinated.
3. **Improved care.** Doctors, hospitals and others will be measured for quality of care, including outcomes, and paid, in part, based on the quality of the care they deliver. This will drive all the parties to provide better care. Providers will also be motivated by their increased ability to improve the care they provide to their patients.
4. **More affordable care.** By changing payment incentives across payers, providers will be motivated to reduce delivery system and administrative cost growth, resulting in more affordable care and money being available for other health services, including prevention, wellness, and treatment. Examples of such opportunities include but are not limited to eliminating duplicative services and unnecessary testing and treatment, and moving care to less costly settings.
5. **Greater focus on prevention and early intervention.** The reformed system will provide incentives for providers to focus on the health of individuals and communities, and to invest in primary care, prevention and wellness services and reduce avoidable high cost services by helping Vermonters to both manage chronic illnesses and focus more on staying healthy.
6. **Expanded efforts to keep people healthy.** With reductions in spending for avoidable high cost services, health care funds could be redirected towards programs to help people

stay healthy by investing in important social determinants of health, such as healthy food, housing, and social problems such as drugs and violence.

7. **More flexibility in health care services.** By modifying the payment incentives to move away from service volume, and towards better care, health services can become more targeted to what each person needs and will benefit from, instead of what a program pays for. For example, this could allow for more communication between patients and providers through email, texting, etc. when desired by patients, and reduce the need for inconvenient and sometimes unnecessary face-to-face visits with providers.
8. **Improved communication among the health care team members and their patients.** Providers of care will be encouraged to work more closely together, and will be rewarded for doing so. The result is that providers will communicate better with each other and with their patients.

An all-payer model should also produce benefits for providers and payers, including the following:

1. **Support for high value health care.** An all-payer model will coordinate financing of health care for up to a five-year period with a framework that will support improvement in the value provided by our healthcare system. Payment methods including capitation and fixed revenue budgets will support focus on important clinical outcome improvements and achievement of efficient use of resources while a) giving providers confidence in the stability of funding and b) removing the barriers to improvement associated with reliance on volume-driven fee-for-service funding.
2. **Greater flexibility**. The existing fee-for-service payment system compels providers to focus on generating service volume and delivering billable services. The all-payer model will advance capitation and fixed revenue budgets, with a) freedom to deliver care that best improves health status and reduces avoidable spending, and b) accountability for improving health status and focusing resources on efficient generation of high-value results.
3. **A provider-driven model**. The proposed model will entrust provider organizations with responsibility for achieving patient care quality and cost management goals as they best see fit, and not as administratively managed by the state and/or insurers. Performance will be evaluated with evidence-based clinical metrics important to patients and providers.
4. **Local empowerment**. Most planning activities will emanate from the community level, and clinical care improvement, based on local needs, shall be conceived and directed by local groups of stakeholders working in collaboration. There will be local accountability to a statewide ACO with regard to quality and expenditure goals.

5. **Focus on prevention and population health**. The ACO will be incentivized to promote health through a strong focus on prevention and population health and to invest in a strong primary care infrastructure.
6. **Freedom of choice**. Providers deciding not to join the ACO will be able to elect to continue to operate under traditional Medicare, Medicaid and insurer payment policies. Hospitals, however, may be subject to an enhanced GMCB budget methodology.
7. **Constrain the cost shift.** In order to constrain the cost shift, each payment stream's base amounts and growth rates will have to change over time to equal the average all-payer base amounts and rate growth under a sustainable growth trend.

III. Core Functions of the ACO

The Subcommittee members agree that it is essential to define the core functions of an all-payer ACO and agreed on the following list:

1. Develop a statewide medical expense budget. The budget should be developed using per capita spending assumptions, consistent with pre-defined financial targets, and built upon regional budgeting and planning activities that promote local innovation focused on improving health outcomes.
2. Develop a plan for near-term and long-term pathways to better clinical and population health outcomes. These pathways and the outcomes they are designed to achieve should be important to patients and produce more efficient use of resources.
3. Evaluate the need for, and possible role of, a payer partner in regard to risk assumption and receipt and distribution of provider payments if this becomes a function of the ACO.
4. Model payment initiatives so that employers' and individuals' premiums do not increase specifically as a result of the transition to a value-based payment system. To implement a successful transition, current commercial payer-specific discounts should be retained initially, within hospital budgets and provider fee schedules. However, reducing the variation in payments among all payers, through collaboration with the ACO and GMCB, is a key component of the all-payer model, and should be a goal of all payers, including public payers.
5. Set targets, measure performance and create provider incentives for cost, clinical quality, and patient experience.
6. Assume accountability for and support clinical process and practice improvement. The ACO should utilize existing structures and frameworks within Vermont for setting local and statewide priorities and implementing initiatives. It should carefully balance centralized analysis, opportunity identification and strategy conceptualization with empowerment of community innovation and locally driven improvement initiatives.
7. Establish clinical guidelines for statewide and local implementation.
8. Establish programs and parameters for care management for priority conditions and populations.

9. Provide or arrange for care management for appropriate high-risk patients.
10. Work closely with the Blueprint during 2016 to determine how best to integrate the following Blueprint functions:
    - Transformation infrastructure (practice facilitators and project managers): Determine if the ACO should assume responsibility for the transformation infrastructure for its network primary care practices, and if so, how and when.
    - Performance measurement and reporting: Determine the future location and role for Blueprint data integration, data quality, and analytics.
    - Regional community collaboratives: Determine if the ACO should assume responsibility for support of community collaboratives, and if so, how and when.
    - Community Health Teams: Determine whether the ACO should assume responsibility for funding and management of the CHTs effective 1-1-17.
    - SASH: Determine whether the Designated Regional Housing Organization (DRHO) should continue responsibility for use of local SASH team funding or whether the local community collaborative leadership team should include a DHRO representative on the community collaborative leadership team and assume responsibility for use of local SASH funding. In addition, determine whether the ACO should assume responsibility for funding SASH teams effective 1-1-17.
11. While determining how best to integrate Blueprint and ACO functions, work closely with the Blueprint during 2016 to assist community collaborative development and operations. Such activity should include:
    - Setting strategic priorities (service models, conditions, screening, prevention)
    - Alignment of supportive resources (including program leadership, facilitators, self-management programs, Community Health Team leaders)
    - Blueprint grant planning (priorities, allocations, incentives)
    - Development and use of the data utility (data feeds, data aggregation, linkage, extracts)
    - Measure generation and reporting (profiles and dashboards)
    - Learning health system activities (coaching, local forums, conferences, collaboratives)
12. Improve population health status using population health strategies. The ACO should engage the totality of its network and community partners and the Department of Health to measurably improve the health status and well-being of its attributed population by addressing determinants of health, including those related to health care and to non-health care factors.

13. Provide data management support and analytics. The ACO should perform data analysis for use at the ACO, regional and practice levels. The ACO should work in partnership with statewide data resources including VITL, VHCURES, and the Blueprint.
14. Manage financial risk. The ACO should receive, or account for, capitation payments from payers and ensure that related expenditures do not exceed the sum of capitated payments.
15. Design and execute contracts with ACO network providers.
16. Provide clinical input to commercial benefit design. The ACO should collaborate with insurers for insured product design, and potentially work independently on product design for self-funded business.
17. Cooperate with GMCB evaluation of ACO impact.
18. Self-manage the ACO. The ACO should manage internal administrative functions, including but not limited to: hiring staff, developing and managing an ACO budget funding and sustaining the budget for the ACO, complying with state and federal requirements, perform internal customer service, perform banking functions, perform actuarial functions and apply for government program approval(s) as needed. These functions should be managed in coordination with administrative functions conducted by public and private payers in an effort to avoid duplication where possible.

IV. The ACO and its Governance

A central consideration for the Subcommittee was whether Vermont is large enough to support more than one highly performing ACO given the structure of its delivery system and the size of the state population. The creation of one unified ACO should result in an entity with the capability to assume financial risk, provide infrastructure support for its provider participants, make Vermont more attractive for primary care providers, and have a sufficient number of attributed lives to impact the care delivery system. The Subcommittee members endorsed the concept of one statewide ACO, contingent on finalization of the ACO governance structure, federal waiver terms, and provider payment terms for 2017-2021.

Governance Principles

The Subcommittee has agreed that the ACO should have a governance body based on the following principles:

- have broad geographic representation;
- meet requirements for provider and consumer participation;
- be of reasonable size to ensure effectiveness;
- have balanced representation of provider types, and
- establish voting rules that ensure broad support for major policy decisions.

See Attachment B for the recommended governance body composition and voting parameters.

Engagement of Consumers to Inform Governance

In addition to including consumers on its governance body (see Attachment B) the ACO should have a regularly scheduled process for inviting and considering consumer input regarding ACO policy. Such a process should include the establishment of a consumer advisory board, with membership drawn from the communities served by the ACO, including patients, their families, and caregivers. The consumer advisory board should meet at least quarterly. Members of ACO management and the governing body should regularly attend consumer advisory board meetings and report back to the ACO governing body following each meeting of the consumer advisory board. The results of other consumer input activities should be reported to the ACO's governing body at least annually.

V. Payment Model Principles

Prior to discussing the manner in which ACO-contracted providers should be paid by the ACO for attributed lives, the Subcommittee identified the following consensus set of principles to govern the content of the provider payment methodologies to be used by the ACO.

The all-payer payment model should:

1. Be Holistic in Orientation
    a. Considers the entire system - the collective "we"
2. Be Equitable
    a. Strives to reduce the cost shift among payers
    b. Supports uniformity of payment for similar services and outcomes
    c. Is actuarially sound
    d. Allocates funds to defined regions in an equitable manner
3. Reward Desired Outcomes
    a. Rewards both excellence and performance improvement relative to clinical, experience and cost outcomes
    b. Rewards services that focus on prevention and early intervention
    c. Rewards allocation of health resources consistent with performance goals
    d. Reduces waste and inappropriate variation
    e. Anticipates and mitigates unintended adverse consequences
4. Encourage Improved Care Delivery and Health Investment
    a. Supports early and ongoing success and reduces risk of failure
    b. Encourages creative and effective patient/provider connections
    c. Has a population health orientation and reinvests savings/margins in population health
    d. Reinvests in community-based services influencing the social determinants of health

    e. Supports provider practice transformation
5. Support Integration with Existing State Assets and Innovations
    a. Recognizes the need for investment and considers ROI over time
    b. Integrates community-based care partners, e.g., home health agencies, AAAs, designated and specialized service agencies, incorporating budgeted dollars for those services over a planned transition period, and identifies ways to invest further in effective services
    c. Stabilizes the base for community providers as part of their financially entering into the all-payer model in order that they may contribute to service delivery on an equitable basis
    d. Builds on the Blueprint PCMH model of care and incentives and on specialized health homes
    e. Maximizes use of the current workforce to broaden access within the scope of provider's scope of practice and strengthens workforce in mental health and substance abuse services
    f. Integrates care management efforts across payers and providers
6. Provide Delivery System Stability Where Needed
    a. Preserves and strengthens primary care and the community-based system of care, including access to such services
    b. Supports development of a model that enables adequate financial resources for Designated Agencies, including home health agencies, and specialized service agencies and other community-based providers to meet the needs of a population-based management approach
    c. Creates a sustainable and financially viable business model throughout the transformation of the health care delivery system
    d. Provides predictive delivery system cost growth
    e. Allows reasonable amount of time for transitions
    f. Does not increase administrative burden on providers and payers
7. Ensure Consistent Payer Rules and Performance Incentives and Measures
    a. Utilizes measures based on national standards whenever possible
8. Promote Wellness and Healthy Lifestyle Choices by Patients
9. Provide Affordable Health Care Coverage to Employer Purchasers, Public Programs and the Consumers for Whom They Purchase Care

VI. Provider Payment Models: Introduction

The Subcommittee envisions that, through a phased-in process, the ACO should make broad use of value-based payment methods for the vast majority of services and attributed lives for which the ACO is responsible. Initially, however, the Subcommittee agrees that such methods should focus on payments to hospitals (including employed clinicians and their practices) and non-

hospital-employed primary care practices. The Subcommittee recognizes the importance of integrating community-based services and social service agencies that are tightly coordinated with primary care services and developing appropriate payment models for those services and agencies as soon as possible.

VII. Provider Payment Model: Primary Care

The Subcommittee recognizes that primary care providers (PCPs) are the foundation of Vermont's health care system and are critical to the success of the State's health care reform initiatives. The Subcommittee acknowledges that primary care provider payment should more accurately reflect the value of primary care, and that steps should be taken to increase payments to PCPs either through enhanced fee-for-service payments, or preferably, through capitation payments based on the enhanced fee-for-service payments. It further recognizes special issues regarding a) adequacy of primary care services in Vermont, b) support for pediatric practices, and c) the need for social service supports to primary care practices and their patients.

Based on the above premise, the Subcommittee recommends that primary care practices participating in the ACO should be offered the option of primary care capitation or enhanced fee-for-service payment. Preference should be given for adoption of capitation payments by those practices for which it would be suitable based on sufficient size and other considerations. The committee recognizes that capitation may never be a viable option for some practices (e.g., very small practices that may never have enough attributed patients). However, those practices participating in the ACO should be entitled to enhanced FFS payments and be eligible for performance incentive payments. The GMCB should require that primary care providers are paid based on approved payment methods by either the insurer or ACO.

Special Considerations for Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs)

FQHCs and RHCs participating in the ACO network should continue to be reimbursed in accordance with federal rules related to FQHC and RHC payments. The State should not ask CMS to waive its FQHC and RHC payment regulations, FQHC and RHC service requirements, and/or FQHC and RHC HRSA grants, as part of the waiver negotiations. An exception to the above would provide that the State may ask CMS for flexibility to pay FQHCs and RHCs for Medicare services through an alternative reimbursement method if the payment model is mutually agreed upon by the ACO, FQHCs and RHCs. FQHCs and RHCs may also accept Medicaid alternative payment models that are mutually agreed upon by the ACO, FQHCs and RHCs. Commercial payments to FQHCs and RHCs participating in the ACO should be based on capitation payments or enhanced fee-for-service payments approved by the GMCB and the ACO for primary care practices. FQHCs and RHCs participating in the ACO should be eligible for enhanced performance-based payments as approved by the ACO and the GMCB.

Primary Care Capitation Rate Characteristics

Primary care capitation rates should be structured with a goal of similar payment for panels with similar patient characteristics. While the ACO may receive different capitation payments from different types of payers (Medicare, Medicaid, commercial), the ACO should be allowed to blend those payments into a common risk-adjusted capitation payment for primary care practices based upon the health status of the patients that are included in the practice panel, and not related to the payer mix of the panel. These capitation payments should be sufficient to produce income for primary care providers in the practice that would be consistent with the goal to increase payments to primary care providers. Measures of the adequacy of these payments may be related to market payments to hospitalists and/or emergency department providers and should result in a re-balancing of primary care payments as a percentage of total health care expenditures. It is assumed that these increased payments to primary care providers will be funded within the context of an overall cap in annual growth of health care expenditures, and will likely result in lower percentage increases from year to year in the expenditure growth rates for hospitals and specialists in Vermont relative to primary care clinicians.

Capitation rates should:

1. Be clinically risk-adjusted using a method(s) other than HCCs for commercial and Medicaid, with possible additional future adjustment for socioeconomic risk following investigation of potential methods;
2. Be based on enhanced primary care fee-for-service rates using a common service set, and with any rate increases financed by improved management of hospital and specialist services and expenses as part of a population health management approach;
3. Be developed based on aggregate utilization experience across all practices by line of business (i.e., commercial, Medicaid, Medicare), rather than based on the utilization experience of each individual practice;
4. Account for some portion of the capitated primary care services being delivered by other providers;
5. Be complemented by a performance incentive that, in a to-be-defined fashion, blends practice-specific, regional and statewide performance;
7. Be potentially complemented by a performance incentive *or* disincentive specifically related to ED visit and specialty referral rates;
8. Replace Blueprint practice support payments for qualifying practices;
9. Be supplemented for newly attributed patients to cover the costs of outreach and an expanded assessment, and
10. Not obviate the obligation of the practice to submit claims for information tracking purposes.

A methodology for incorporating patient cost sharing into capitation rate calculation will need to be developed.

A more detailed discussion of the primary care capitation methodology is contained in the Primary Care Payment Work Group report, incorporated into this document by reference. A list of services recommended for inclusion in the capitation rate can be found in Attachment C.

Use of Fee-for-Service Rates with ACO Primary Care Practices
Fee-for-service rates should be utilized in the following scenarios:

- ACO practices under a to-be-defined minimum panel size threshold;
- ACO practices delivering services to patients attributed to capitated primary care practices;
- ACO practices initially electing to not receive capitation payment;
- non-primary care services delivered by a primary care practice that also delivers specialty services (e.g., cardiology), and
- services not in the list of services included in the capitation rate.

For participating ACO primary care practices, fee-for-service rates should:

- be more attractive than regulated FFS rates paid to non-ACO practices;
- be equitable statewide for ACO practices in the ACO;
- include codes for selected to-be-defined traditionally non-reimbursable services under limited circumstances for practices within the ACO[2], and
- be supplemented by performance incentive payments for practices in the ACO.

The ACO should define either a fee schedule enhancement or supplemental practice support payment amounts for practices that meet ACO-determined medical home criteria and community collaborative participation for fee-for-service ACO-participating primary care practices.

Regulated payment rates should be defined by the ACO and reviewed and approved by the GMCB for practices inside of the ACO.

Primary Care Practice Patient Attribution
Attribution is important for payment and for establishing/recognizing relationships between patients and primary care providers. To the extent possible, patients should be prospectively attributed ("rostered") using patient PCP selection as a preferred method, and claims-based attribution with an auditable methodology, as a secondary method.

[2] The Subcommittee agreed that such exceptions should follow Medicare guidance for new codes.

- Rostering (and practice selection changes) should be implemented in two ways:
    - patients designate their primary care provider through an enrollment process, or
    - patients communicate their preference to an ACO primary care practice, which is conveyed to the appropriate payer using agreed-upon processes, or patients communicate directly to a payer.
- For patients communicating their selection of an ACO primary care practice, the practice and patient should whenever possible enter a written agreement.
- One or more designated parties should distribute lists of attributed patients to primary care practices and payers on a routine basis.
- Implementation of patient rostering should follow a phased implementation schedule, with a 2016 pilot, ideally commercial and Medicaid implementation in 2017 and Medicare implementation in 2018, the latter if agreeable to CMS.
- Over time, the ACO should determine the feasibility of using Vermont's HIE or an alternative data repository to support the rostering system.
- Should a patient regularly utilize a different primary care provider than the one selected, the payer or the ACO should assume responsibility for reaching out to the individual and confirming the patient's primary care provider of choice.
- Attribution-eligible practices should include physicians, nurse practitioners and physician assistants working within capitation-eligible practices and assuming responsibility for patient panel management.

Policy for Capitated Services Delivered by Non-Capitated Providers

- Request for fee-for-service payment to another practice that is part of the same tax ID (i.e., the same corporate provider entity) as the capitated practice for a capitated service to a capitated practice-attributed patient should be *denied*.
- Request for fee-for-service payment to another practice that is not part of the same tax ID (i.e., the same corporate provider entity) as the capitated practice for a capitated service to a capitated practice-attributed patient should be *paid*.
- The ACO should run attributions monthly and if a capitated provider is not providing capitated services to a practice-attributed member, but another ACO primary care practice is doing so based on an ACO-defined algorithm, the ACO should switch patient attribution to the ACO primary care provider who is providing the services.
- Capitated primary care providers who make unexpectedly heavy use of urgent care providers, emergency departments and/or specialists should perform less well than other ACO-capitated primary care providers on their practice-specific performance-based incentive assessment.

Payer Creation of Primary Care Capitation Complementary Benefit Designs

For future waiver years, payers should support primary care capitation objectives by advancing benefit design features that will support primary care objectives such as:

- PCP selection requirements;
- waiving some or all co-payments and, where possible, deductibles for primary care encounters, and
- creating incentives for patients to see their designated primary care provider and/or maintain a relationship with their designated primary care provider.

Provider Payment Model: Primary Care - for PCPs Not Participating in the ACO

Primary care providers not participating in the ACO may be subject to GMCB regulation of the percentage rate by which commercial insurers may annually increase payment rates to such providers. The Subcommittee further recommends that over time these growth rate limitations vary by provider and be applied in a manner that will compress the degree of rate variation in the state for commonly defined services.

For non-ACO primary care practices fee-for-service rates for Medicare and Medicaid should be based on standard payment rates for Medicare and Medicaid;

VIII. Provider Payment Model: Hospitals and Specialist Physicians

The Subcommittee recommends a fair and equitable method of payment that ties specialist physician and other providers into the ACO's population health approach. The Subcommittee has elected to defer developing the specifics of a payment model for specialists at this time, but has recommended convening a workgroup to develop principles upon which specialist payments should be structured. In the meantime, reimbursement should continue as fee-for-service, with the intent of moving toward reimbursement models that meet the principles outlined below:

1. Reimbursement for specialist care will be transparent.
2. Reimbursement will be equitable for services provided.
3. Referrals will not be inhibited based on specialists' employer.
4. Data will be available on the quality and cost of specialist services, to the extent that statistically significant measurements are available, so that high value specialists can be easily identified.
5. Performance incentives for specialist physicians should be aligned with overall ACO incentives.

Provider Payment Model: Hospital – for Hospitals Participating in the ACO

For hospitals participating in the ACO, fixed revenue budgets should be the payment model for inpatient and outpatient services, and will include professional services provided by hospital-employed physicians and allied health professionals.

Budget Development and Operation

Hospital budgets should be proposed by each Vermont hospital and submitted to the GMCB annually in accordance with guidelines developed by the ACO and the GMCB. The GMCB should conduct a public review process resulting in approval, approval with modification or rejection of the proposed budget. The hospital budget should include the following components:

1. Be based off of the hospital's total historical revenue for all payers, including costs incurred for the treatment of non-Vermont residents;
   i. The hospital base year should be established by utilizing the hospital's most recent GMCB-approved budget.
   ii. The hospital base budget should be apportioned by each payer population utilizing historical payer-specific percent-of-budget experience and discount positions of the hospital's most current year.
   iii. The hospital base budget may be adjusted to reflect unique circumstances of the hospital, including, but not limited to critical access hospitals.
2. The hospital's base year allocation of percentage of budget by payer should be adjusted to reflect the portion of the budget received as a fixed periodic payment from the ACO based on historical expenditures for the ACO's attributed lives;
3. Utilize an annual overall targeted trend factor adjustment applied to historical spending. The trend factor may vary by payer population but should be based on a GMCB benchmark which takes into consideration medical inflation and a demographic adjuster;
4. Include revenues received for hospital-employed providers, including primary care and specialist providers;
5. May include non-claims-based (medical) revenue such as ACO care management support, Blueprint funding, and other non-claims operating revenue;
6. Be adjusted to account for changes in hospital utilization of attributed lives based on GMCB and ACO analysis of utilization. It is recommended that the ACO establish a committee within its governing body that specifically reviews ACO-wide utilization patterns and trends for the purposes of tracking budget allocation fairness. Utilization patterns may change due to shifts in market share, population shifts, and/or changes in the mix of service line offerings. Any change in utilization above or below a minimum percentage floor, to be established by the GMCB based on recommendations by the ACO and its providers, should make a hospital subject to an adjustment (up or down) to its budget for the next budget year. The minimum percentage floor may vary by hospital, service line and by year. The adjustments to the budget should reflect the fact that many costs in both organizations are fixed;

7. Not be adjusted mid-year. However, the ACO should provide regular data analytics to the hospitals for the purposes of planning and early identification of potential utilization pattern shifts;
8. Not shift more than a percentage amount, to be determined by the ACO, during the first two years of the contract, to allow hospitals to have revenue stability and time to adjust;
9. Be subject to modification in subsequent years if payer mix substantially changes during the performance year. A payer or hospital may request the GMCB review and modify hospital budget payer allocations due to payer population changes;
10. Allow for payer-specific value-based reimbursement mechanisms that deviate from the prescribed payer-specific budget discount in support of alternative forms of reimbursement (e.g., bundled payments), and
11. Include accounting for a potential performance incentive; hospital performance incentive payments should include incentives at some mix of the regional level (i.e., potentially one or more HSAs) and the state level.
    i. Incentive funding, if not funded as an added base factor (one-time Year 1 higher trend percentage) or an augmented trend factor (higher trend percentage for a defined period of time), should be funded through a lower "base revenue" trend factor for hospital budget annual increase.

Reimbursement Mechanisms

The following two methods of payment to the hospitals are viable options for the ACO.

Double Channel Model: The ACO, or contracted payers, may pay hospitals on a capitated basis using the methodology established by the ACO for all ACO-attributed patients. The ACO should use the following methodology:

1. Calculate the base year dollar amount of care provided to the ACO-attributed population by each hospital and add the trend factor (same for all hospitals).
2. Divide that amount by 26 and pay as a single bi-weekly lump sum to each hospital out of ACO-collected "total cost of care" capitated funds received from payers/programs for attributed populations.
3. Claims should be submitted for patients in the ACO-attributed population, but should not result in remitting any individual payment, since care is in effect "pre-paid."
4. Bi-weekly payment should not change based on the number or nature of claims submitted, and should be adjusted annually only based on factors and rules above.
5. All other elements of Section 1 should apply and be incorporated into the actual reimbursement structure to the extent necessary (e.g., rate of increase, rebasing, incentive funding, etc.).
6. A methodology for incorporating patient cost sharing into the revenue calculation will need to be developed.

For non-ACO-attributed patients the hospital should receive fee-for-service payments from the responsible payers. Adjustments to the rates employed for fee-for-service payments should be authorized by the GMCB on a quarterly basis, if necessary, to ensure that the budget is not exceeded for this portion of the population.

Targeted trend factors employed for hospital fixed revenue budgets may be adjusted in 2017 and 2018 based on an assessment of changes in hospital revenue from sources outside of the ACO. In 2019 and beyond, a charge adjustment or quarterly reconciliation should occur to adjust for changes in non-ACO-based hospital revenue.

Overall system incentives should favor ACO participation for both hospital and non-hospital providers. These providers should assume accountability for population performance and maximized ACO attribution. The total base revenue budget number should be divided into capitation for ACO attributed lives and adjusted fee-for-service payment for non-ACO-attributed lives, with the same trend rate calculation applied to each payment "channel" going forward. In this sense it would make little or no difference for the hospitals what the mix of the two models is to start and how it shifts over time. It needs to be determined whether including the ACO capitation payment model (in a two-channel construct) provides more benefit than "cost" (versus exclusive use of just the adjustable FFS model) on general incentives, administrative/financial simplicity, and true movement away from FFS.

The desired overall system incentive for ACO attribution would be easiest to achieve by providing for "above-the-line" funding (i.e., above current provider base payments) for the population performance incentive pool and ACO operational expense on a PMPM basis to the ACO. Therefore the more attributed lives, the bigger the pool of added available revenue to reward population outcomes, and the greater the chance that the full ACO expenses will be covered versus self-funding the ACO incentive pool under the ACO payment channel's revenue, and continuing to support payment for the ACO through dues or fees.

Single Channel Model: An alternative model for hospital reimbursement should also be considered by the ACO. This model is being called the "Single Channel Model." Under this model, hospital budgets would be based upon total historical revenue for all payers, including costs incurred for the treatment of Vermont and non-Vermont residents, and non-claims-based payments:

- Payments to the hospitals should be made by the individual payers based upon instructions from the ACO (upon approval by the GMCB). The aggregate of all payments should constitute the hospital's revenue budget for the performance year.
- The GMCB should review and approve hospital budgets on an annual basis under an enhanced budget review process.

- The ACO should be accountable for hospital costs incurred for patients attributed to the ACO.

Regardless of hospital payment method, hospitals should continue to submit claims for rendered services.

Provider Payment Model: Hospital – for Hospitals Not Participating in the ACO
Hospitals not participating in the ACO should be subject to an annual GMCB budget review process, differentiated from the review process for ACO-participating hospitals, with specific rules regarding net patient revenue, rate increases, and compliance set by the GMCB.

The GMCB should consider promulgating rules related to non-participating hospitals that would include the following: Non-Participating hospitals would:

1. Not be eligible for fixed revenue budgets.
2. Not be eligible for an additional increase in the NPR growth target available to participating hospitals
3. Be subject to performance incentives and penalties, established by the payers.

Provider Payment Model: Specialist - for Specialists Not Participating in the ACO
Specialists not participating in the ACO may be subject to GMCB regulation of the percentage rate by which commercial insurers may annually increase payment rates to such providers. The Subcommittee further recommends that over time these growth rate limitations vary by provider and be applied in a manner that will compress the degree of rate variation in the state for commonly defined services.

IX. Performance Incentives

The Subcommittee considered the following model for the distribution of provider incentive payments. A phased-in approach may be necessary based on available funding. These payments should be in addition to payment-reformed base revenue models that are appropriate, adequate, and equitable for providers.

<u>Targeted Incentive Eligibility</u> (For illustrative purposes only)

The percentages below are placeholders, do not reflect final consensus and may require a phased implementation.

- Hospitals – Target eligibility in range of 2% to 4% incentive payment (as a percentage of their base revenue).
- Physician Practices – Target eligibility to 5% to 10% incentive payment (as a percentage of their base revenue).

- Other Provider Types – Target eligibility to 5% to 10% incentive payment (as a percentage of their base revenue).

NOTE: This should be a single number maximum eligibility, which must be earned (i.e., the ranges are relevant for discussion of a single number and do not mean a minimum payout).

Scoring and Distribution

Distribution of the statewide incentive pool, once funded, should be allocated as follows, with the calculation of eligibility for incentive payment distribution weighted most heavily towards provider-specific performance:

- x% - Statewide utilization/quality score
    - Single unified, state-wide population score calculated as 50%-50% average of scores on a TCOC/utilization/RUI metric <and> a multi-measure population-level quality report card
- y% - HSA[3] utilization/quality score
    - HSA-level population performance on the same quality report card
- z% - Provider-specific score on utilization/quality <and/or> accreditation or other demonstrable criteria
    - Measures and scoring should be provider-type specific to incent performance that the specific type of provider can directly impact
        - This element may require bundling of like-type providers as necessary to achieve statistical significance (e.g., could be HSA, or "pods" within an HSA).
    - This provider-specific component of the incentive pool may also include incentive payment for maintaining accreditation or recognition (e.g., NCQA PCMH), other demonstrable process or technical capabilities, and/or compliance with the local community collaborative or statewide clinical model priorities.

Some measures may be applied solely at the regional and/or state level due to measure-specific concerns about adequate denominator size at the provider level.

X. Payer Risk Model and Administration

The Subcommittee agrees that the ACO should assume at least 80% risk within a risk corridor of +/-15% for the delivery of non-pharmacy covered services linked to population-based targets for total cost of care for attributed lives. The Subcommittee is undecided as to whether the ACO should assume full risk during the five-year period for one or more lines of business.

[3] The Subcommittee agreed to use the HSA definitions employed by the community collaboratives.

Claims for high-cost outliers should be truncated at or above $125,000 per individual per year and may vary by line of business, using a to-be-defined methodology that is applied to the expected attributed populations and defined in terms of a percentile of total medical spend (e.g., 99%).

Pharmacy risk assumption may be implemented for commercial and Medicaid lines of business, and for Medicare if approved by CMS, in the following manner:

1. During 2017 the ACO and contracted payers should investigate options and plan for a four-year phased assumption of risk (2018-2021).
2. The ACO may assume pharmacy risk relative to population-based targets for attributed lives that is not to exceed 50%.
3. The ACO may be afforded appropriate protection for newly introduced high cost drugs and drugs that experience exorbitant price increases in the course of a contract year.

ACO payment should be value-based, meaning that a portion of the ACO's per capita spending target should be at risk based on performance relative to a set of to-be-defined multi-payer aligned quality and potentially other performance measures comprising a "scorecard." The scorecard should reflect a consistent measure set developed by the ACO in collaboration with state, payer and consumer partners and approved by the GMCB. The ACO's per capita spending target may be discounted (reduced) if it fails to perform well relative to the pre-defined performance measures in the scorecard.

As described in Sections VI-IX of this document, ACO risk may be distributed to providers through fixed revenue budgets for hospitals, and through capitation payments to some primary care providers.

Provider performance incentives should be financed through payer payments and allocated based upon ACO-defined, GMCB-approved incentive payment policy. The Subcommittee did not resolve how the ACO should handle, or be instructed to handle, treatment of unearned provider incentive payments.

Initially, participating payers should either:

1. make capitation payments to the ACO based on an agreed upon schedule, <u>or</u>
2. make payments to ACO participating providers under the capitated target on behalf of ACO attributed lives using payment rates and methodologies specified by the ACO, in consultation with payers, and approved by the GMCB.

XI. Addendum

Subsequent to the final Payment Subcommittee meeting to develop this Framework, two Subcommittee participants submitted language suggested for Framework inclusion. Because this language was not considered by the Payment Subcommittee, it has been appended to this document as Attachment D.

Attachment A
ACO Payment Subcommittee Participants

The following individuals participating to varying degrees in the Payment Subcommittee process between February and December 2015. While the Framework represents the general consensus of the Subcommittee participants, this acknowledgement of their participation does not indicate their individual or organizational endorsement of all of the elements of this document.

Carmone Austin, UVM Health Network
Ena Backus, GMCB
Kristie Bailey, MVP Health Care
Michael Bailit, Bailit Health Purchasing
Abe Berman, OneCare Vermont
Dominick Bizzarro, MVP Health Care
Rob Buchanan, Health Management Associates
Megan Burns, Bailit Health Purchasing
Gisele Carbonneau, Health*first*
Ron Cioffi, VNAs of Vermont
Alicia Cooper, DVHA
Amy Cooper, Health*first*
Tom Boyd, DVHA
Tom Dehner, Health Management Associates
Mike Del Trecco, VAHHS
Patrick Flood, Northern Counties Health Care
Michealle Gady, Health Management Associates
Joyce Gallimore, CHAC
Bea Grause, VAHHS
Susan Gretkowski, MVP Health Care
Lynn Guillette, Dartmouth-Hitchcock Health
Joe Haddock, Health*first*
Paul Harrington, Vermont Medical Society
Tom Huebner, Rutland Regional Medical Center
Craig Jones, DVHA
Pat Jones, GMCB
Todd Keating, UVM Health Network
Kevin Kelley, Community Health Services of Lamoille Valley
Trinka Kerr, Office of the Health Care Advocate
Kelly Lange, BCBSVT
Bill Little, MVP Health Care

Andy Majka, Springfield Medical Care System
Todd Moore, OneCare Vermont
Mark Podrazik, Burns and Associates
Paul Reiss, Health*first*
Lila Richardson, Office of the Health Care Advocate
Greg Robinson, OneCare Vermont
Simone Rueschemeyer, Vermont Care Partners
Jenney Samuelson, DVHA
Julia Shaw, Office of the Health Care Advocate
Richard Slusky, GMCB
Beth Wennar, OneCare Vermont
Spenser Weppler, GMCB
Sharon Winn, Bi-State Primary Care Association
Cecilia Wu, DVHA

Attachment B
ACO Governance Body Composition

Board Position	# Seats	Eligibility	Initial Nomination Process
Community Hospital	1	PPS hospital that is not part of Dartmouth-Hitchcock Health's network or the UVM Health Network	• Community hospitals to make final decision • Community hospitals can self-nominate or be nominated by VAHHS
Critical Access Hospital	1	• CAH unaffiliated with a teaching hospital • FQHC-owned hospitals are not eligible	• CAHs to make final decision • CAHs can self-nominate or be nominated by VAHHS
Home Health	1	A home health agency not owned by another network provider	• Home health agencies each receive one vote to make the final decision • The ACO nominating committee will solicit nominations and prepare a ballot
Mental Health / Substance Use Care	1	Must be a Designated Agency representative	• DAs select the nominee (should consider the interests of private mental health providers) • Vermont Care Partners asked to facilitate the process
Primary Care: FQHC	2	Could be a physician or non-physician	FQHCs collaborate with Bi-state and CHAC to select the two nominees
Primary Care: Independent Practice	2	• Preference to be a provider (e.g., MD/DO, NP, PA) • Representative cannot be from another organization represented on the Board • Representatives cannot come from the same organization	Health*first* delegated to define the nomination process; nominee not limited to Health*first* clinicians
Skilled Nursing Facility	1	SNF cannot be owned by another provider organization	VHCA selects the nominee

Board Position	# Seats	Eligibility	Initial Nomination Process
Specialist Care: Independent – physician or other	1	Preference to be an independent practice physician for the first term	Health*first* delegated to define the nomination process; nominee not limited to Health*first* clinicians
Tertiary Hospital Referral Center	2	Dartmouth-Hitchcock Health and UVM Health Network are eligible	D-H Health and UVMMC select the nominees
Social Services Provider	1	*Not defined*	The ACO nominating committee defines the process and selects the nominee based on pre-determined criteria
Faculty Practice Physicians	2	• Representatives from Dartmouth-Hitchcock Health and UVM Health Network faculty practices • Clinically practicing physicians without hospital or health system management role (can be physician service leaders)	• Nominated by the deans of the faculty practices • Physicians with a senior practice role and not involved in an administration role in the practice
Non-Health Care Business Representative	1	Representative from the business community	The ACO nominating committee will solicit nominations from the Vermont Business Roundtable, Chamber of Commerce and any other business organizations identified by the board. The nominating committee makes the selection from the list of nominees
Consumer	3	Medicare, Medicaid and commercial consumer representatives	• The ACO nominating committee solicits names from consumer organizations and then makes a selection, taking patient experience into consideration. • Employees of ACO-participating providers excluded from consideration.
At-large Member	2	To be left vacant initially, and filled in the future at the discretion of the board.	Not applicable

A two-thirds majority of the ACO's nominating committee should be required to fill a board seat.

Voting

In order to ensure that major policy decisions have the support of key ACO participating provider interests, the following governance body voting rules should apply:

- A two-thirds super-majority should be required for major policy-setting votes, including budgets, service network configuration, provider payment policies and internal quality performance measurement and accountability policies, and any other topics agreed upon by the governance body.
- An FQHC representative, an independent primary care practice representative, a non-tertiary hospital representative, and both tertiary hospital representatives must support the two-thirds majority in all super-majority votes.

Attachment C
Capitated Services

The following CPT codes represent the services to be included under the ACO's primary care capitation arrangements:

90460, 90461, 90471, 90472, 90473, 90474, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99354, 99355, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99406, 99407, 99408, 99409, 99411, 99412, 99420, 99429, 99495, 99496, G0008, G0009, G0402, G0438, G0439, G0463 (to be utilized only for Medicare population capitation with hospital-owned practices), T1015 (to be utilized only for FQHC capitation by non-commercial payers)

These services represent approximately 87% of historical payments to primary care providers across payer type (i.e., commercial, Medicaid, Medicare).

Attachment D

Proposed Language Suggested Subsequent to the ACO Payment Subcommittee's Final Meeting to Develop the All-Payer Model Framework

Language for Framework Insertion Suggested by Vermont Care Partners

The ACO network recognizes the value of Designated and Specialized Service Agencies (DA/SSA) providing mental health, substance use disorder and developmental disability services in integrated community based care that results in controlled health care costs and improved population based outcomes. The social determinants of health address behaviors, as well as socioeconomic factors that have an important impact on health and well-being which can prevent or improve the outcomes of most chronic medical conditions.

As essential community based agencies, the DA/SSA provide a broad variety of services impacting health including: substance use disorder services such as prevention and education programs in the schools, outpatient counseling, intensive outpatient programs, and family and group counseling services; emergency services that are available 24 hours a day, seven days a week in every community in Vermont. These services are intensive and time-limited, focused on resolving or stabilizing adults, families and children who are in acute mental health crisis; children's mental health services including therapeutic, case management, residential and respite care services to children and adolescents with mental health conditions and their families. These services are part of a larger system of care designed to offer support and safe community environments that foster growth, development, health and mental health and positive relationships; adult mental health services including a range of prevention and intervention services, such as counseling, to help individuals, families and groups cope during times of stress and crisis, as well as to address emotional and behavioral difficulties; community-based supports for children and adults with developmental disabilities, such as intellectual disabilities or pervasive developmental disorders which occur before age 18. Services include residential, vocational, case management, service coordination, respite and flexible family supports; and an array of therapeutic, day, and residential services to adults with severe and persistent mental illness and their families. These services promote community living and minimize the need for inpatient and custodial care.

The State of Vermont has committed to move forward with the development of payment and delivery system reforms for these agencies during the 3rd year of the SIM demonstration and in preparation for participation in the All-Payer Model waiver.

The State of Vermont and Vermont Care Partners will design a value based payment methodology for designated and specialized services agencies providing mental health, developmental disability and/or substance use disorder services and will invest in provider readiness for this change. The new payment methodology will align with the all-payer model arrangement and pathways for inclusion in the APM and in the ACO network will be designed within the first year of APM implementation.

Language for Framework Insertion Suggested by VNAs of Vermont

The Subcommittee recognizes the value of home health in achieving the triple aim of health reform, - improve quality, improve patient experience and reduce costs. The Subcommittee acknowledges that Home Care is a full service community-based operation with its existing skilled multi-discipline staff managing highly complex patients with multiple chronic conditions in the patient’s home; utilizing a case management model to assess and coordinate an individualized plan of care; using existing relationships with community partners to connect its patients with necessary services and supports, utilization of telehealth equipment to maintain consistent contact with patients, and a stable infrastructure that can support all administrative functions. Partnering with home health services is essential for reducing hospitalizations and re-hospitalizations, providing medication management, early symptom recognition and management, chronic disease management, minimizing risk of falls, patient education re: disease self-care, reducing Emergency Department use, supporting patients and families in end of life care and overall care coordination – all while patients remain in a lower cost setting, their own home.

Home Health goes beyond skilled staff and is also a primary provider of long-term care services in Vermont’s Choices for Care Program.

The Subcommittee recognizes that Home Health offers a variety of services which will require different payment methodologies. The following is our recommendation:

- Acute skilled care (including Palliative Care) – Prospective Payment System consistent with current Medicare methodology
- Hospice – tiered daily rates based on level of care consistent with current Medicare methodology
- Long-term Care Choices for Care – bundled payment rate based on levels of care such as Moderate, High or Highest Needs
- Case Management – per member per month rate based on the level of care and case coordination needed.

Payments for Home Health services should be established utilizing the Medicare Cost report for a base year and adjusted annually with an overall trend factor applied to historical costs that take into consideration inflation and a demographic adjuster such as wage index.

Home Health would give future consideration to a Value Based Purchasing Program.