

STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

**In re: Vermont All-Payer Accountable Care)
Organization Model Agreement)
)
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Introduction

The rising cost of health care imposes unsustainable financial burdens on Vermonters and their families, impedes equitable access to preventive care, and threatens to cripple our State’s economy. Left unchecked and uncontrolled, it will prevent Vermont from reaching its goal to ensure that all of its citizens have access to affordable, high-quality health care. The problem is not unique to Vermont—Congress enacted the Patient Protection and Affordable Care Act of 2010 (ACA), for example, to address our national health care crisis.

The Vermont All-Payer Accountable Care Organization Model (“All-Payer Model” or “Model”) is an agreement (“the Agreement”) between the State and the Centers for Medicare and Medicaid Services (CMS) that allows Vermont to explore new ways of financing health care with Medicare’s participation, through an Accountable Care Organization (ACO) delivery model. Principle 7 from the Health Care Payment Learning Action Network (LAN) states:

Centers of excellence, patient centered medical homes, and accountable care organizations are delivery models, not payment models. In many instances, these delivery models have an infrastructure to support care coordination and have succeeded in advancing quality. They enable Alternative Payment Models (APMs) and need the support of APMs, but none of them are synonymous with a specific APM.¹

The All-Payer Model is an Alternative Payment Model, facilitated by an ACO, that enables the three main payers of health care in Vermont—Medicaid, Medicare, and commercial insurance—to pay for health care differently than through fee-for-service reimbursement under a common structure, initially including hospital and physician services in Medicare and their commercial and Medicaid equivalents; previously in Vermont, the ACO delivery model has been paired only with a payment model that has a fee-for-service foundation. The Agreement envisions a statewide All-Payer Model that aligns and amplifies incentives across all payers to promote participation, by Model’s end, by the majority of providers in the State.

At its public board meeting on October 26, 2016, this Board voted to enter into the Agreement with CMS, which we believe will transition our provider reimbursement model from one that incentivizes quantity to one that is value-based and rewards positive health outcomes. Below, we discuss the All-Payer Model’s background, the Agreement’s terms, and the reasoning for our support.

Development of the All-Payer Model

The fee-for-service reimbursement model, which compensates health care providers and facilities for each health care service and care component delivered, is the most prevalent form of provider compensation in our country today, yet is widely recognized as a significant driver of health care spending growth. By creating incentives for the health care system to perform a high volume of health care services, fee-for-service reimbursement does not compensate providers for important time spent coordinating care with other providers or community services, sending e-mails, making phone calls, or talking with patients and their families about

¹ Alternative Payment Model Framework and Progress Tracking (APM FPT) Work Group, Health Care Payment Learning & Action Network, *Alternative Payment Model (APM) Framework Final White Paper*, 11 (Jan. 12, 2016), available at <https://hcp-lan.org/workproducts/apm-whitepaper.pdf>.

factors that may be negatively impacting a patient’s health status. The fee-for-service model rewards the quantity of work done, not its quality; it does not incentivize providers based on improved health care outcomes.²

Act 48

In 2011, the Vermont Legislature passed Act 48 in an effort to ensure that all Vermonters could access high-quality, affordable health care. Citing a paramount need for “reformation of the payment system for health services to encourage quality and efficiency,”³ Act 48 created the Green Mountain Care Board and specifically authorized the Board to develop and implement payment and delivery system reforms to control the rate of growth in health care costs and maintain or improve health care quality in Vermont. Defining payment reform as “modifying the method of payment from a fee-for-service basis to one or more alternative methods for compensating health care professionals...while measuring quality and efficiency,”⁴ Act 48 ascribes a series of duties and responsibilities to the Board, guided by fourteen principles for health care reform. Among its other duties, Act 48 expressly empowers the Board to:

[o]versee the development and implementation, and evaluate the effectiveness, of health care payment and delivery system reform designed to control the rate of growth in health care costs and maintain health care quality in Vermont.⁵

Act 48 specifically calls for the Board to develop, implement and evaluate payment reform pilot projects, and makes clear that health insurers, Medicaid, Medicare, and other payers should reimburse health care professionals with consistent payment methodologies that provide incentives to coordinate care and control cost growth.⁶

Federal Reform Activity

Federal legislation has helped pave the way for work at the state level. The ACA created the Center for Medicare and Medicaid Innovation (CMMI) to test innovative payment and service delivery models to reduce federal health care program expenditures and to improve the quality of care received by Medicare, Medicaid, and Children’s Health Insurance (CHIP) beneficiaries.⁷ In 2013, CMMI awarded State Innovation Model (SIM) grants to six states, including Vermont, for alternative payment model testing, emphasizing multi-payer payment reforms that are consistent with the goals of Act 48.⁸ With support from the SIM grant, the Board exercised its authority under Act 48 and created an aligned, multi-payer Shared Savings Program (SSP) payment reform pilot for ACOs, modeled after Medicare’s Track 1, one-sided risk SSP. In 2014 and 2015, more than 150,000 Vermonters were attributed to Commercial, Medicaid, or Medicare SSP-participating providers. During the first two years of the Medicaid SSP, the two participating ACOs saved the Medicaid program more

² See Mark McClellan, *Reforming Payments to Healthcare Providers: The Key to Slowing Healthcare Cost Growth While Improving Quality?*, 25 J. of Economic Perspectives No. 2, Spring 2011, at 69 – 92; Ezekiel J. Emanuel & Victor R. Fuchs, *The Perfect Storm of Overutilization*, 299 J. Am. Med. Assoc. 2715, 2789 – 91 (2008); Lorens A. Helmchen & Anthony T. Lo Sasso, *How Sensitive is Physician Performance to Alternative Compensation Schedules? Evidence from a Large Network of Primary Care Clinics*, 19 Health Economics 1259, 1300 – 17 (2010); Steven A. Schroeder & William Frist, *Phasing Out Fee-for-service Payment*, 368 N. Engl. J. Med. 1953, 2029 32 (2013).

³ 3 V.S.A. § 2222a(c)(9).

⁴ 18 V.S.A. § 9373(12).

⁵ 18 V.S.A. § 9375(b)(1).

⁶ 18 V.S.A. § 9377.

⁷ 42 U.S.C. § 1315a (CMMI is created “to test innovative payment and service delivery models to reduce program expenditures . . . while preserving or enhancing the quality of care.”).

⁸ In Vermont, the State Innovation Model work is now called the Vermont Health Care Innovation Project (VHCIP).

than \$15.7 million due to actual expenditures that were below the targets and both ACOs participating in the Medicaid SSP achieved improvements in their overall quality scores from 2014 to 2015. When aggregating financial results across the duration of the Commercial SSP, savings were not realized. However, two of the three ACOs participating in the Commercial SSP achieved improvements in their overall quality scores from 2014 to 2015, and the third ACO maintained a very high overall quality score in both years. In the Medicare SSP, savings were not realized when aggregating financial results across the duration of the program; all three Vermont ACOs that have participated in the program have achieved strong quality scores that exceed the national average. Vermont's all-payer SSP is still built on a fee-for-service foundation, however, providing for savings only if the ACOs spend less than a targeted amount.

CMS has since designed and begun implementation of new population-based payment programs that are not attached to fee-for-service reimbursement. In 2015, CMS announced the Next Generation ACO Program. Next Generation builds on the SSP model, but allows provider groups to assume higher levels of financial risk and reward than are currently available either in an SSP or Pioneer ACO program.⁹ The Next Generation ACO model provides for capitation, in which the ACO receives monthly per-beneficiary-per-month (PBPM) capitation payments and is responsible for paying claims for ACO providers, constituting a considerable move away from fee-for-service.

Moreover, working toward its goal to link 50% of Medicare payments to alternative payment models by 2018,¹⁰ Congress's bipartisan passage of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)¹¹ significantly shifts the Medicare payment system away from one that is volume-driven toward one that is value-based. Under MACRA, all Medicare providers (including physicians, physician assistants, nurse practitioners, clinical nurse specialists and certified registered nurse anesthetists) who deliver a designated threshold of care must participate in one of two payment tracks for Medicare Part B — either an Advanced Alternative Payment Model (APM) or the Merit-based Incentive Payment System (MIPS) — under the law's Quality Payment Program (QPP). Providers who choose to participate in Advanced APMs are exempt from MIPS reporting requirements and can earn 5% incentive payments; providers not in an Advanced APM are subject to MIPS and will receive performance-based payment adjustments that increase incrementally beginning with +/- 4% in 2019, and reach +/- 9% in 2022.

Vermont All-Payer Model Term Sheet Proposal

The Vermont Legislature has continued to build on the foundation of Act 48 in furtherance of the State's health care reform goals. In 2015, the Legislature enacted Act 54, which allowed the Board and Secretary of Administration to "jointly explore an all-payer model."¹² The Board Chair and staff members, working with the Agency of Administration (AOA), engaged in discussions and negotiations with CMMI to convey Vermont-specific requirements for a workable all-payer reimbursement model and to jointly craft an agreement acceptable to both Vermont and the federal government. As a result of this work, Vermont published and presented to CMMI the All-Payer Model Term Sheet Proposal ("Term Sheet Proposal") in January 2016,

⁹ CMMI has published a Fact Sheet comparing design elements of the Pioneer ACO Model and the Next Generation ACO Model. See Fact Sheet: Pioneer ACO Model and Next Generation ACO Model: Comparison Across Key Design Elements (updated April 28, 2015), available at <https://innovation.cms.gov/Files/fact-sheet/nextgenaco-comparefactsheet.pdf>.

¹⁰ See CMS Press Release, *Better Care. Smarter Spending. Healthier People: Paying Providers for Value, Not Volume* (Jan. 26, 2015), available at <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-01-26-3.html>.

¹¹ The bill was passed overwhelmingly in the U.S. House of Representatives on a 392-37 vote; the Senate voted 92-8 in favor of its passage. See <https://www.congress.gov/bill/114th-congress/house-bill/2/all-info#all-actions>. MACRA was signed by the President and became law on April 16, 2015, and a final rule was released by CMS on October 14, 2016. <https://qpp.cms.gov/docs/CMS-5517-FC.pdf>.

¹² Act 54 of 2015, Sec. 1.

outlining the terms proposed by Vermont if the State were to enter into an All-Payer Model agreement with CMS.

The Legislature took testimony on numerous occasions and in multiple committees during the 2015 and 2016 legislative sessions on the provisions of the All-Payer Model Term Sheet proposal.¹³ Members of the Board and its staff, representatives from the AOA, Vermont's three ACOs, the Office of the Health Care Advocate (HCA), and community-based service providers appeared before committees to provide their input.¹⁴ Statewide media outlets covered and reported on the State's progress moving forward on the proposal.¹⁵

Act 113

Based on the provisions reflected in the Term Sheet Proposal and feedback from stakeholders, the Legislature adopted Act 113 of 2016 ("An act relating to implementing an all-payer model and oversight of accountable care organizations"). Act 113 grants the Board the authority, along with the AOA, to enter into an All-Payer Model agreement that is consistent with health care reform principles articulated in Act 48, and that meets specified statutory criteria. Specifically, in order to implement a value-based, all-payer (Medicaid, Medicare and commercial insurance) payment model, the Board and the AOA must ensure that the model: provides direct payments from Medicare to providers or ACOs without state involvement; maximizes alignment between payers; strengthens investments in primary care; incorporates social determinants of health; integrates mental health, substance abuse treatment and community-based providers into the overall health care system; prioritizes local and regional health care provider collaborations; allows providers to choose whether to participate in an ACO; evaluates access to care, quality of care, patient outcomes and social determinants of health; protects patient rights and includes processes and protocols for shared decision-making while taking into account an individual's needs, preferences, values and priorities; and ensures a robust grievance and appeals process through the HCA.¹⁶ In addition, Act 113 conferred to the Board substantial oversight responsibilities, including requirements for ACO certification and budget review.¹⁷

Since that time and guided by Act 113 and its statutory predecessors, the Board and the AOA have negotiated with CMMI to refine the terms under which an all-payer model agreement makes sense for Vermont, and have publicly discussed the proposal at its board meetings.¹⁸ The Board and the AOA released a draft of the

¹³ See, e.g., Presentation by Chair Gobeille to Senate Committee on Health and Welfare (Jan. 6, 2016); Project Update to House Committee on Health Care (Jan. 24, 2016); Presentation to Senate Committee on Health and Welfare, "Elements of Proposed Term Sheet, ACO Consumer Protections" (Feb. 11, 2016). Copies of these and other presentations to legislative committees can be accessed on the Vermont Legislature's website, <http://legislature.vermont.gov/committee/meetings/2016>.

¹⁴ A word search on the Vermont Legislature's website for "all payer model" indicates that the topic was on legislative committee agendas 18 times from August 12, 2015 to March 16, 2016. The committees include the House committees on Health Care, Ways and Means, and Human Services, and Senate committees on Health and Welfare, Finance, and Appropriations. See <http://legislature.vermont.gov/committee/history/2016/Subject#All Payer Model>.

¹⁵ See, e.g., Mansfield, E., *Session Preview 2016: Medicaid, All-Payer Reform, Universal Primary Care to Dominate Health Care Agenda* (VTDigger, Jan. 3, 2016); available at <http://vtdigger.org/2016/01/03/session-preview-2016-medicaid-all-payer-reform-universal-primary-care-to-dominate-health-care-agenda-2/>; Kinzel, B., *Shumlin Unveils Plans for 'All Payer' Health Care*, (Vermont Public Radio, Jan. 25, 2016), available at <http://digital.vpr.net/post/shumlin-administration-unveils-plan-all-payer-health-care#stream/0>; Remsen, N., *A New System for Treating Health Care – the 'All Payer' System* (Seven Days, Feb. 10, 2016), available at <http://www.sevendaysvt.com/vermont/a-new-prescription-for-treating-health-care-andmdash-the-all-payer-system/Content?oid=3166352>.

¹⁶ 18 V.S.A. § 9551 (*eff.* Jan. 1, 2018).

¹⁷ 18 V.S.A. § 9382 ("Oversight of Accountable Care Organizations") (*eff.* Jan. 1, 2018).

¹⁸ Not including our October 26, 2016 public meeting at which we voted to approve the Agreement, review of our agendas, available on the Board's website, indicates that the All-Payer Model was a topic of discussion at twelve of our weekly public meetings since January 2016.

Agreement on September 28, 2016, followed by a series of public forums and Board meetings held in different regions of the State.¹⁹ The provisions found in the current draft Agreement are largely similar to those in the Term Sheet Proposal, with some key areas of divergence: The current Agreement places greater emphasis on addressing the Medicaid payer differential; includes 2017 as “Performance Year Zero”; contains a one-time \$9.5 million CMS investment in Vermont health care reform in 2017; provides more precise guardrails and State accountability for Medicare growth targets; establishes ACO scale targets; and creates a clear path for investment in, and planning for, inclusion of substance abuse and mental health services.

Public Comment and Letters of Support

The Governor’s Office and the Board received numerous public comments and letters of support from health care providers, insurers, businesses and consumer advocates. The public comments are wide-ranging, and express both support and concern about ramifications of the All-Payer Model. The letters in support of the Model recognize its potential to reduce health care cost growth, improve patient experience of care, and ultimately improve the health of Vermonters. In particular, supporters of the Agreement are optimistic that it creates an opportunity to reduce health care costs, increase access to health care services, improve care coordination and integration, and improve population health. Providers cite the importance of the opportunity to participate in a payment model that is aligned across payers and that limits health care cost growth by investing in primary care through provider-led reform. Providers also find significant the Agreement’s provisions which allow for enhanced benefits for Medicare beneficiaries attributed to an ACO, and funding for Medicare’s continued participation in the Blueprint for Health and the Support and Services at Home (SASH) programs.

The public comments and letters of support also raised critical areas of concern with respect to the proposed Model’s implementation were the State to move forward. The Vermont Medical Society (VMS) asked that the Agreement require that the State increase Medicaid reimbursement rates to at least the negotiated or applicable Medicare level; that the Agreement ensure physicians’ freedom of choice; that the Agreement provide a 30-day period for providers to review provider-specific performance data prior to any public disclosures of such data by the State; and that there be no reduction in Vermont’s already low predicted spending per Medicare enrollee. Finally, the VMS requested that the Agreement explicitly not penalize providers for receiving incentive payments under the MACRA QPP. In response to these concerns, the State requested and CMS agreed to modify the final draft of the Agreement to 1) require that the Board annually recommend that the Secretary of the Vermont Agency of Human Services (AHS) and the Vermont General Assembly set Medicaid reimbursement rates at levels comparable to Medicare fee-for-service reimbursement rates, 2) ensure physicians’ freedom of choice, and 3) allow for a 30-day preview period for providers to review their performance data before the data were subject to public disclosure. With respect to penalties for providers receiving incentive payments under the MACRA QPP, Vermont confirmed that under federal law, the 5% bonus to providers for participating in an advanced APM would be excluded from any benchmark, shared savings, and shared losses calculation.

Commenters broadly agreed that investments in primary care, preventive care, and community-based services will be essential for successful implementation of the All-Payer Model. Increased investments in substance abuse and mental health services and in Medicaid home and community-based services were also identified as requirements for an integrated model designed to improve health by spanning care delivery across the health care continuum. Some comments stressed that certain additional Medicare payment waivers should be explored as potential means to improve care delivery and accelerate innovation. In addition, commenters emphasized that individual Vermonters should receive support to enable them to improve personal health, and must be informed about their health care choices through shared decision-making tools. Finally, a majority of

¹⁹ The Draft Agreement, meeting agendas, All-Payer Model forum dates and other information are available on the Board’s website.

commenters representing payers, providers, and consumer advocates agreed that Medicaid provider reimbursement rates should be increased, and that Medicaid must operate as a predictable and reliable payer in the All-Payer Model. The Board's regulatory authority and role in overseeing ACOs, as outlined in the Agreement and in Act 113, were identified as instrumental for the All-Payer Model's success.

Decision

The Vermont Legislature in 2011 specifically tasked this Board with developing and implementing health care payment reform.²⁰ Our work on the All-Payer Model has spanned an extended period of time during which the Board and its staff, the AOA, Vermont health care providers and others have appeared before legislative committees, at public meetings and at forums. At each of these venues they have engaged in public discussions about the All-Payer Model's potential impact on the quality and cost of health care in the State, how an Agreement with CMS could be customized to Vermont's needs, and the consequences of both accepting and declining the opportunity to pursue the All-Payer Model.

As an initial matter, the Population Health Goals included in the All-Payer Model reflect Vermont's statewide priorities for health system reform, as well as for improving the health of the population. The Agreement outlines three fundamental Population Health Goals: 1) increased access to primary care, 2) reduction of deaths caused by suicide and drug overdose, and 3) reduction in the prevalence and morbidity of chronic disease.

The first goal, increasing Vermonters' access to primary care, is imperative to the success of the Model. There is strong consensus that improved access to primary care, with an enhanced focus on preventive services, can improve health care quality, improve the health of the population, and help reduce growth in health care costs.²¹ We believe that investing in this area can be achieved through provider-led care delivery changes driven by financial incentives to maintain health, achieve early diagnosis, and provide timely treatment.

The remaining two Population Health Goals align with our State Health Improvement Plan²² and are key areas where we must strive for improvement. The rate of suicide deaths among Vermont residents in 2014 was 17.2 per 100,000, statistically higher than that for the U.S. (12.9 per 100,000).²³ Like other states, Vermont is grappling with the impacts of the opioid addiction epidemic. In 2015, there were 108 drug-related fatalities in Vermont (not including deaths from motor vehicle accidents, consequences of chronic substance use, or medical errors). The State is seeing increases in heroin- and fentanyl-related fatalities.²⁴

The final Population Health Goal is to reduce the prevalence and morbidity of chronic disease (specifically diabetes, COPD and hypertension). According to the Centers for Disease Control and Prevention,

²⁰ 18 V.S.A. § 9375(b)(1).

²¹ See, e.g., Barbara Starfield et al., *Contribution of Primary Care to Health Systems and Health*, 83 *The Milbank Quarterly* 329, 457-502 (2005); Mark W. Friedberg et al., *Primary Care: A Critical Review Of The Evidence On Quality And Costs Of Health Care*, 29 *Health Affairs* 757, 766-72 (2010); Barbara Starfield et al., *The Contribution of Primary Care Systems to Health Outcomes within Organization for Economic Cooperation and Development (OECD) Countries, 1970-1998*, 38 *Health Services Research* 777, 831-65 (2003), World Health Org., *World Health Report 2008, Primary Health Care – Now More Than Ever* (2008).

²² The State Health Improvement Plan is a five-year plan that sets three broad goals and 13 indicators, with recommended strategies and interventions, as the top public health priorities for 2013-2017. See *Healthy Vermonters 2020*, available at <http://healthvermont.gov/hv2020/ship.aspx>.

²³ Vt. Dep't of Health Data Brief, *Suicide Mortality* (August 2016), available at http://healthvermont.gov/family/injury/documents/data_brief_suicide.pdf.

²⁴ Vt. Dep't of Health Data Brief, *Drug Related Fatalities 2010-2015* (updated Sept. 22, 2016) available at http://healthvermont.gov/research/documents/databrief_drug_related_fatalities.pdf.

chronic diseases are the cause of 7 of 10 deaths each year, and treatment for chronic diseases accounts for 86% of our nation's health care costs.²⁵

As we assessed whether to enter into the Agreement and to better understand the All-Payer Model's potential impact on health care cost growth in Vermont, the Board sought the advice of consultants specializing in publicly funded health care²⁶ who constructed an actuarial model based on Vermont data that includes the categories of health care spending that would be subject to the Agreement's financial targets. By making adjustments to the price and utilization of the subject service categories, the actuarial model compared projected future health care spending by payer if fee-for-service reimbursement was continued for the term of the Agreement, with future spending by payer if ACO-based reform were implemented. This analysis allowed the Board to assess the impact of various health care cost growth scenarios and the value of protective guardrails, such as a floor for Medicare growth in Performance Year One, and their impact on the Medicare savings targets in subsequent performance years.

The Board also compared the financial terms of the Vermont All-Payer Model against those for an ACO participating in the Next Generation Program. The Board found that by allowing ACOs to use a more recent year of base spending than offered by the Next Generation Program, the Vermont Model would more accurately and appropriately reflect the State's recent growth in per-capita Medicare spending. The Model further guarantees that in Performance Year One, the State can offer participating ACOs a Medicare growth rate that will be higher than the projected national average, and that for the duration of the Agreement, the target rate for Vermont Medicare growth, compared with projected national growth, is more beneficial to ACOs than if they were subject to the federal Next Generation program. Additionally, the Agreement includes approximately \$7.5 million dollars beginning in Performance Year One, trended forward annually, to continue funding for Vermont's proven primary care and prevention programs, the Blueprint for Health and Support and Services at Home (SASH). These financial improvements, coupled with the programmatic flexibility contained in the All-Payer Model Agreement, convince the Board that this Model is better tailored to our State's needs than the federal Next Generation program.

As discussed above, the Board has listened to and considered the comments and opinions voiced by a wide spectrum of Vermonters, enlisted the assistance of capable staff and experienced consultants, reviewed health care data on system performance on a national and statewide basis, and apprised itself of national policy trends in health care reform. Based on our review and with the valuable input of Vermonters and the assistance of CMMI, we believe, as discussed at the October 26, 2016 public hearing, that the terms of the Agreement are favorable to Vermont, meet criteria set by the Legislature in Act 113, and align with concerns of Vermont's providers and citizens. We therefore highlight and explain the provisions of the Agreement that support our decision to approve the Agreement:

Central Terms of the Proposed Agreement with CMS

- *Protection of Beneficiaries:* The Agreement confirms that Medicare beneficiaries will not experience any reductions in covered services, provider networks, or their right to Medicare benefits under federal law. Similarly, no part of the Agreement impacts the current benefits, covered services or choice of providers for persons with Medicaid or commercial coverage; the Agreement does not modify or limit their access to provider networks and provides that all patients will retain their choice of provider,

²⁵ <http://www.cdc.gov/chronicdisease/index.htm>.

²⁶ For this work, the Board contracted with Health Management Associates (HMA), an independent national research and consulting firm specializing in publicly funded health care, see <https://www.healthmanagement.com/>, and Optumas, an actuarial firm focusing on health care reform programs. See <http://www.optumas.com/>

whether or not such provider participates in the ACO. Vermonters can also continue to be covered for care delivered out-of-state.

- *Enhanced Benefits for Medicare Beneficiaries*: While the Agreement confirms that Medicare beneficiaries will not experience any reductions in covered services, it also provides for benefit enhancements for those Medicare beneficiaries that are attributed to an ACO. Benefit enhancements include: availability of telehealth services regardless of where a beneficiary lives, post-discharge home visits, and admission to a Skilled Nursing Facility without the requirement of first having a three-day hospital stay. The Agreement also creates the opportunity for the State to explore additional Medicare waivers that may enhance beneficiaries' access to covered services.
- *Phased-in Approach to Implementation*: The Agreement spans six years, but affords a "Year Zero" in 2017. "Year Zero" gives providers critical time to determine how best to participate in and contract with an ACO. The Agreement also provides for a phased-in approach for expanding the All-Payer Model to include the majority of willing providers in the state, meaning that on day one, not all providers and not all types of health care coverage, such as self-insured coverage, must commit to the Model.

Furthermore, the Agreement underscores the importance of including those Medicaid mental health, substance abuse, and Long-Term Services and Supports that are not equivalent to hospital and physician services, but that are essential to improving health. The Agreement specifies that the State must develop a plan and strategy by the end of Performance Year Three for including Medicaid mental health, substance abuse, and Long-Term Services and Supports in the State's delivery system reform efforts. This stepwise approach does not preclude inclusion of these services in the care delivery model, but allows the State a reasonable amount of time to determine how best to financially integrate components of the care continuum that have been long been funded in disparate ways.

- *Meaningful Measures and Targets to Support Population Health Improvement*: The Agreement establishes the three Population Health Goals, outlined above, and changes the health care system's payment incentives, allowing providers to focus on those services that keep patients well. To support achievement of the Goals, the Agreement includes seven related Health Care Delivery System Measures and Targets, and seven related Process Milestones. All of the measures are collected at the statewide or ACO level, rather than the individual practice or provider level. This comprehensive and novel quality framework links health care delivery to population health improvement and public health. The measures, targets and milestones in the Agreement are the result of numerous discussions with and input from providers, consumer advocates and State leaders.²⁷
- *Provider-Led Reform*: Medicare providers have the choice to participate in an Advanced APM through the All-Payer Model. As such, under the QPP created by MACRA, participating providers will be afforded a 5% annual payment increase. Providers who choose not to participate, and who are not participating in other Advanced APMs, will be reimbursed as otherwise stipulated under current federal law and will be subject to payment adjustments, up or down, based on participation in MIPS. MIPS will require specific new quality reporting by providers. Providers in Advanced APMs will only be subject to the quality reporting already existing in the Advanced APMs specified above. The Agreement does not require hospitals or other providers to join an ACO. The Agreement allows providers to drive

²⁷ Board staff met with providers, consumer representatives and State leaders seven times between October 14, 2015 and September 9, 2016.

innovation, including the design of reimbursement methodologies that enhance and support primary care and prevention.

- *Vermont-specific Local Control*: The Agreement provides for a Modified Next Generation ACO Program in 2018 and in the following year, the Vermont Medicare ACO Initiative. Both allow Vermont to make changes to Medicare’s Next Generation ACO program and to create a risk-based alternative payment model that is more favorable than the original Next Generation ACO Program. As provided for in the Agreement, benchmarking in these models is tailored to Vermont and preferential to the standard benchmarking available in Medicare’s Next Generation program. Moreover, in the Vermont Medicare ACO Initiative, the State has the opportunity to tailor ACO attribution methodology and quality measures to better align with Medicaid and commercial payers. The Agreement enables the State to make investments in the ACO and community-based services through its Medicaid waiver.
- *Preservation of Two Successful Vermont Programs*: CMS will make available \$9.5 million in start-up funding in calendar year 2017, or “Year Zero,” to support care coordination and bolster collaboration between practices and community-based resources. A portion of the funding will be used to extend Medicare participation in two successful Vermont initiatives, otherwise scheduled to sunset at the end of 2016: The Blueprint for Health, Vermont’s nationally recognized initiative for transforming primary care, and SASH, which has a track record of saving money—the most recent evaluation indicates annual savings of \$1,536 per participating Medicare beneficiary— while keeping Medicare beneficiaries in their homes and out of institutional settings.²⁸
- *No Financial Penalties to the State or to Providers Should Targets not be Achieved*: The State is not required to return the one-time funding described above or to return federal funding if targets or milestones are not achieved as projected in the Agreement. Importantly, the State may terminate the Agreement, for any reason, with 180 days’ written notice.
- *Reasonable Targets for Limiting Health Care Cost Growth*: The Agreement establishes a 3.5% aggregate per-capita cost growth target across all payers at the conclusion of Performance Year Five. For Medicare specifically, the Agreement establishes a Vermont Medicare per-capita growth target of .01-.02 percentage points below national per-capita Medicare growth at the conclusion of Performance Year Five. Vermont projections and growth cap are predicated on Medicare Advantage growth projections, and can be age adjusted to account for Vermont’s older population of Medicare beneficiaries.
- *Addresses Payer Differential*: The Agreement requires that Vermont Medicaid participates as a part of the All-Payer Model and that Vermont Medicaid offers a Scale Target ACO Initiative to Vermont ACOs no later than January 1, 2018. The Board will annually provide its recommendations to the Secretary of AHS and the Vermont General Assembly to increase Vermont Medicaid reimbursement rates to levels more comparable to Medicare fee-for-service reimbursement rates. The State intends that payments paid by Vermont Medicaid to Vermont ACOs be set for a calendar year to provide predictability. Finally, increases in Medicaid reimbursement rates to providers will be excluded from the Agreement’s 3.5% aggregate per-capita growth target across all payers.

²⁸ Office of the Assistant Sec. for Planning and Evaluation, U.S. Dept. of Health & Human Services, *Support and Services at Home (SASH) Evaluation: Second Annual Report*, 35 (Jan. 1, 2016), available at <https://aspe.hhs.gov/basic-report/support-and-services-home-sash-evaluation-second-annual-report#execsum>.

- *Accountability of ACO and Oversight by the GMCB*: To the extent of its statutory oversight as provided for in Act 113,²⁹ the Board may direct the Vermont Medicare ACO, a Vermont Modified Next Generation ACO, or both, to make specific infrastructure and care delivery investments. The Agreement requires that the State submit, by June 30th of Performance Year Three, a plan signed by Vermont’s Department of Health, AHS, the Board, and Vermont ACO(s) that provides an accountability framework to the public health system to ensure that any Vermont ACO funding allocated to community health services is being used towards achieving the Statewide Health Outcomes and Quality of Care Targets. Finally, through its regulatory authority in Act 113, the Board, in its oversight and approval of ACO budgets, can determine the extent to which ACOs are investing in primary care and prevention services.

Although many ACOs have been active in alternative payment models with one payer, there is a strong hypothesis that “efforts to improve quality and reduce costs will be more successful if multiple payers adopt these models.”³⁰ The All-Payer Model’s ACO-based delivery model encourages the integration of providers from across the health care continuum into a potentially more coordinated model of care. Coupled with payment change that rewards value instead of volume of services and that is consistent across all major payer groups, providers may have more flexibility to ensure that patients receive the right kind of services at the right time.

Vermont’s unique ACO-based All-Payer Model may also help eliminate inefficiencies and waste in the health care system which are widely recognized as chief drivers of increased health care cost growth. These include the duplication of services, overtreatment, and failures of care coordination and care delivery, which may result from the failure to implement “best care” processes.³¹ Further, an All-Payer Model characterized by integrated, unified care delivery fosters the adoption of programs that assist physicians and patients in making smart decisions about their care, such as Choosing Wisely. The Choosing Wisely program is targeted at avoiding unnecessary medical tests, treatments and procedures, and encourages informed conversations between patients and providers and evidence-based decision-making about appropriate patient care and treatment.³² As envisioned by the Agreement, the All-Payer Model’s ACO-based delivery, paired with a payment system that no longer rewards providers for each discrete service that they perform, creates a promising environment for the health care system to more fully embrace Choosing Wisely and other similar initiatives.

²⁹ Act 113 added 18 V.S.A. § 9382 (*eff.* Jan. 1, 2018), “Oversight of Accountable Care Organizations,” which provides criteria by which the Board can certify an ACO and considerations pertaining to the Board’s ACO budget oversight. Both processes are subject to rulemaking. *See* 18 V.S.A. § 9375(b)(13) (the Board shall “adopt by rule such standards as [it] deems necessary and appropriate to the operation and evaluation of accountable care organizations . . . including reporting requirements, patient protections, and solvency and ability to assume financial risk”); 18 V.S.A. § 9382(a) (*eff.* Jan. 1, 2018) (the Board shall adopt rules for ACO certification); 18 V.S.A. § 9382(b) (the Board shall adopt rules to “establish standards and processes for reviewing, modifying, and approving” ACO budgets). Section 6 of Act 113 requires that the Board adopt such rules no later than January 1, 2018.

³⁰ Rahul Rajkumar et al., *CMS—Engaging Multiple Payers in Payment Reform*, 311 J. Am. Med. Assoc. 1939, 1967 (2014).

³¹ Donald M. Berwick & Andrew D. Hackbarth, *Eliminating Waste in US Health Care*, 307 J. Am. Med. Assoc. 1459, 1513 (2012).

³² Choosing Wisely was initiated in 2012 by the American Board of Internal Medicine (ABIM) Foundation. More detailed information is available on its website: <http://www.choosingwisely.org/>.

Conclusion

Based on our discussion above, we believe that our approval to sign the Agreement for the All-Payer Model is built on a solid foundation, complies with our responsibilities under Acts 48 and 113, and provides an opportunity for Vermont to move forward towards a more efficient health care system that rewards quality care and positive health outcomes. We acknowledge that our decision is only one of many steps that the State and providers choosing to participate in the All-Payer Model must take to transform our health care system to one that is affordable, sustainable, and beneficial to Vermonters. Without the guarantee of Medicare's participation in such a model, as provided in the Agreement, the health care system would continue to face changing incentives that differ by payer, competing programs with different rules, and a lack of funding for programs (including the Blueprint for Health and SASH) that have become core components of care delivery in Vermont.

The Board's decision became effective following its vote on October 26, 2016.

Dated: October 31, 2016 at Montpelier, Vermont

s/ Alfred Gobeille)

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s/ Cornelius Hogan)

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s/ Jessica Holmes)

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s/ Betty Rambur)

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