VT Health Care Innovation Project - Payment Models Work Group Meeting Agenda
Monday, August 24, 2015 1:00 PM – 3:00 PM.
DVHA Large Conference Room 312 Hurricane Lane, Williston
Call in option: 1-877-273-4202 Conference Room: 2252454

Item #	Time Frame	Topic	Presenter	Decision Needed?	Relevant Attachments
1	1:00 – 1:10	Welcome and Introductions Approve meeting minutes	Don George and Andrew Garland	Y – Approve minutes	Attachment 1: June Meeting Minutes
2	1:10-1:35	Project Updates • CMMI Site Visit • SSP Year 1 Final Calculation Process Update • VMSSP Year 2 Contract Amendment Process • VMSSP Yr 3 Total Cost of Care Process Update	Georgia Maheras, Richard Slusky, Alicia Cooper, Cecelia Wu	N	Attachment 2:TCOC Public Comments
3	1:35-2:05	QPM Recommendations for Yr 3 Commercial and Medicaid SSP measure changes	Cathy Fulton and Pat Jones	Y – Vote on Recommendation	Attachment 3: Presentation
4	2:05-2:45	APM Progress Report Summary	Richard Slusky	N	Attachment 4: Presentation to GMCB
5	2:45-2:50	Public Comment		N	
6	2:50-3:00	Next Steps and Action Items		N	Next Meeting: Monday, September 21, 2015 1:00 pm – 3:00 pm EXE-4th Floor Conference Room, Pavilion Building, Montpelier, VT

Attachment 1

Vermont Health Care Innovation Project
Payment Models Work Group Meeting Minutes

Pending Work Group Approval

Date of meeting: Monday, June 22, 2015, 1:00pm-3:00pm, 4th Floor Conference Room, Pavilion Building, 109 State Street, Montpelier.

Agenda Item	Discussion	Next Steps
1. Welcome and Introductions; Approve Meeting Minutes	Andrew Garland called the meeting to order at 1:02pm. A roll call attendance was taken and a quorum was present. Richard Slusky moved to approve the April 2015 meeting minutes by exception. Greg Robinson seconded. A roll-call vote was taken; the motion carried with one abstention.	
2. Project Updates	Georgia Maheras provided a brief update on Vermont Health Care Innovation Project activities. • A project-wide convening was held on June 17th to discuss the project's Year 2 milestones, recently approved by the VHCIP Core Team and submitted to CMMI. Discussion focused on how to achieve the proposed milestones; notes will be distributed soon. • The new milestones were crafted with achievability in mind; the project needs to meet or exceed them within the agreed upon timeline (December 2015 for Year 2 milestones, December 2016 for end-of-grant milestones). • Project leadership continues to discuss the proposed milestones with CMMI; stay tuned for potential changes to Years 2 and 3 Payment Models Work Group activities, including potential expansion of the Shared Savings Programs and launch of an Episodes of Care payment model. The group discussed the following: • Paul Harrington clarified whether Year 2 milestone changes were related to delayed CMMI approval of VHCIP Year 2 contracts. Georgia confirmed that this is the case. Project leadership will be submitting additional information to CMMI this week and next week at CMMI's request.	
3. Vermont Medicaid Shared Savings Program (VMSSP) Year 3	Cecelia Wu presented on initial research on the VMSSP Year 3 Total Cost of Care (TCOC) expansion (Attachments 3a and 3b). The group discussed the following:	**Please send any feedback to amanda.ciecior@state.vt.us by July**

Agenda Item	Discussion	Next Steps

Total Cost of Care Presentation	• Sue Aranoff asked for clarification on Year 3 TCOC requirements for ACOs. Cecelia clarified that DVHA has the right (per VMSSP ACO contracts) to require expanded TCOC, or not to require expanded TCOC.
	• Larry Goetschius asked whether long-term services and supports are currently included in the VMSSP. Long-term services and supports are not part of the Core services, currently required.
	• The two ACOs participating in the VMSSP elected not to participate in expanded TCOC for Year 2 of the program. The proposed expanded TCOC definition for Year 2 included pharmacy and non-emergency transportation. Paul Harrington clarified that in Year 3, DVHA has the right to require expanded TCOC, but ACOs can choose not to participate in the program.
	• Ted Sirotta asked how non-hospital providers are being incentivized to share in risk. Cecelia responded that DVHA tracks historical costs for ACO providers in baseline years to identify a performance year target; ACOs would have to beat targets by a minimum savings rate to receive shared savings. ACO providers are incentivized to beat the performance year target for all services included in the TCOC calculation. Michael Bailit clarified that while the focus thus far has been on hospitals and primary care providers, it is expanding to including additional provider types.
	    o Ted noted that it will be critical to align VMSSP and the State's other ACO programs with any future all-payer model.
	• Larry Goetschius suggested looking at increasing spending in some areas in order to decrease overall health system spending. Cecelia agreed.
	• Sue Aranoff noted that whether ACOs can improve quality is one question, but whether ACOs or DVHA or VHCIP can measure improvements is a different question. She suggested that appropriate quality and performance measures for any expanded services are critical for program success.
	• Lila Richardson asked whether developmental services are included in TCOC research. Cecelia and Jim Westrich clarified that developmental services are included in various categories of TCOC research, but are not broken out on their own.
	• Marlys Waller asked which mental health services are included in TCOC currently. Cecelia clarified that inpatient mental health services are included; services provided by private practices are not. Currently, TCOC includes mostly Medicare Part A and B services.
	    o Larry Goetschius asked why Choices for Care waiver services and other long-term care services are not included in TCOC. Cecelia responded that Year 1 TCOC sought to align with Medicare, which is why it was limited to Part A and Part B services. Georgia Maheras also noted that at the time Year 1 TCOC was being implemented, the State was also renegotiating the Choices for Care waiver with CMS. The State wanted to maximize flexibility in the context of these discussions and ensure the Choices for Care program was not disrupted. Georgia noted that we're starting to see ACOs partner with waiver services providers and will likely see more of this in the future.
	• Marlys Waller asked whether Personal Care Services include services for children; Cecelia responded that yes. However, ACOs may face challenges impacting this area, and payment is fairly complex, so it is unlikely to be included in Year 3 TCOC. Marlys noted that this will be included in Integrated Family
		13th.

Agenda Item	Discussion	Next Steps
	Services in the future, and that it will be important to align in the future. Richard Slusky added that the current payment methodologies for this program are siloed and complex, and that in the current upside-risk only environment, ACOs are encouraged to engage with programs like this and educate themselves about the potential benefits; downside risk could convince ACOs to partner financially. However, to take on financial accountability for these organizations and services is a challenge if ACOs can't impact costs. Richard suggested the State could simplify funding for these providers to support this in the future. • Sue Aranoff noted that the Care Models and Care Management Work Group received presentations from a variety of LTSS provider types, and the Steering Committee has received a presentation on the Medicaid spending analysis; presentations like these might benefit this group. • Andrew Garland suggested splitting retail pharmacy and specialty pharmacy when considering pharmacy costs. Retail pharmacy is relatively uniform across the state and ACOs likely couldn't impact cost, but could impact utilization. Specialty pharmacy is more challenging to impact. It could also be helpful to decide on an impact to new drugs, which could protect ACOs from unexpected high costs related to new drugs. Richard Slusky also suggested looking at the 340B drug rebate program. Cecelia noted that DVHA did look at 340B for Year 2. DVHA was able to do adequate data scrubbing for 340B to include pharmacy as an optional expanded TCOC service in Year 2, and is currently providing analyses on pharmacy costs to ACOs participating in the VMSSP. • Richard Slusky asked how ACOs feel about expanding TCOC. Cecelia responded that when DVHA talked with ACOs about this in preparation for suggesting Year 2 TCOC expansions, they expressed they were not ready and wanted to ensure they would have time to launch new programs to impact new service categories. Richard suggested working closely with the ACOs. • Mike Hall asked why long-term care was not included in Year 1 TCOC. Andrew Garland noted that for services included in TCOC, we are incentivizing reduced costs in that area. Mike suggested that long-term care costs could be reduced through expanded use of home- and community-based services, and noted that including services in TCOC doesn't necessarily mean reducing each individual line item. Cecelia agreed and noted that DVHA wants to leverage this service category to reduce costs in other areas. Richard Slusky noted that under Maryland's all-payer model, hospitals are receiving a fixed budget and services that previously resulted in hospital revenue are now costs; as a result, hospitals are investing in services that help them reduce and manage their costs. While this isn't a direct investment in these ancillary services, it's happening naturally through this system. Mike responded that this is a great argument for integrated care, but that it took Maryland hospitals decades to invest in these services, though Richard noted that incentives are newly aligned to support this. Mike concluded by saying that leaving a large portion of the health care budget in a volume-based system is a missed opportunity; Richard agrees. • Sue Aranoff asked Andrew Garland to share any information about quality measures related to pharmacy.	

Agenda Item	Discussion	Next Steps
	Please send any comments on Year 3 TCOC to Amanda Ciecior (Amanda.ciecior@state.vt.us) by July 13th. DVHA will notify ACOs of changes to Year 3 TCOC by October 1 – likely earlier, at ACO request.	
4. Bundled Payment for Care Improvement (BPCI) Presentation	Amanda Ciecior presented on the BPCI program, a CMMI initiative launched in January 2013 (Attachment 4). • 17 Vermont long-term care providers/facilities chose to participate in Phase 1 under Model 3 of BPCI; very few providers nationally chose to move on to the second phase of BPCI (3.5%), and no Vermont facilities that we know of have chosen to move on to Phase 2. The group discussed the following: • Larry Goetschius noted that as a long-term care provider, he had not heard of this program. Amanda clarified that larger facilities and hospitals were more likely to enter this initiative. • Mike Hall noted that the percentage of providers that chose not to pursue Phase 2 participation is striking; he suggested that this might be related to bundle pricing and margins. He noted that this initiative might attract high-performing facilities, who would have a low margin already. Megan Burns of Bailit Health Purchasing commented that she had heard that facilities were struggling with bundle pricing, both because they were already high-performers and because of the 2-3% reduction Medicare was seeking.	
6. Public Comment, Next Steps, and Action Items	Public Comment: • There was no public comment. Next steps: • Larry Goetschius asked whether Year 1 data is available for the Medicaid and commercial SSPs. Alicia Cooper noted that claims run-out takes 6 months; data will be available at the end of June and the Lewin Group will be performing analysis during July. Quality results are likely to be presented to the QPM Work Group in August; this group will receive information about that closer to the date. **Next Meeting:** Monday, July 20, 2015, 1:00-3:00pm, 4th Floor Conference Room, Pavilion Building, 109 State Street, Montpelier.	

Attachment 2

To: Payment Models Workgroup
Fr: DVHA Staff
Date: August 18th, 2015
Re: Comments regarding Yr 3 MSSP TCOC

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lets review core services?

These essential health benefits include at least the following items and services:

1. Outpatient care—the kind you get without being admitted to a hospital
2. Trips to the emergency room
3. Treatment in the hospital for inpatient care
4. Care before and after your baby is born
5. Mental health and substance use disorder services: This includes behavioral health treatment, counseling, and psychotherapy
6. Your prescription drugs
7. Services and devices to help you recover if you are injured, or have a disability or chronic condition. This includes physical and occupational therapy, speech-language pathology, psychiatric rehabilitation, and more.
8. Your lab tests
9. Preventive services including counseling, screenings, and vaccines to keep you healthy and care for managing a chronic disease.
10. Pediatric services: This includes dental care and vision care for kids
11. ---

end of email

comments there are limitations in core services, for example, mental health is so limited, it does not provide any comprehensive services for actual needs associated with chronic disease really? unless you have a addiction issue? if you have ms, rare disease, parkinsons, any chronic condition other than diabetes,, or those top five, there is a struggle to get services, that will really effect outcomes,, if your visually impaired, for example, you see a almost discrimitory issue in core services ,, if you have epilepsy, your seriously at a disadvantage as core services are listed.. but the real problem is support services from community? they connect to support services for core services in healthcare,, they are the very services most at risk of cuts going forward, example, a soup kitchen, kitchens closing,,, to shift money to what is considered to be financing of core services,

in reviewing the presentation it seemed, tcoc was not well defined,, its hard to capture cost of what is not well defined nor trended to produce savings, three year plan may systemically be wrong, should of been five,, ? in the general overview of payment , it looked like there were many gaps, depending on persons model of care for what they have.

as listed in three year plan, i would guess by year three you may project where the savings is, will they occur, they will not occur in year three,, especially with possible budget cuts in future,

why to late for savings, the investment isn't even required tell year three? investments should be in year one, two at absolute latest,

what may be found is good investments with lack of outcomes in money, because you have to do the investment, before you could expect savings.

designated agencies may not be up to task they are given,, they are struggling it seems with accountability issues as is,

going forward, all agencies, departments, will be under extreme budget pressure to contain costs. yet they are to cover non core Services? which i find debatable if they are non core depending on diagnosis.

budget cuts are predicted in very services they will be trying to integrate , co ordinate,

year 1 has investment
year 2 is required,
year 3 flexible core services gets savings, or measured better health,, productivity as savings.

this would align with the savings they are allowed is for performance improvement,

DVHA sims will find they are having very tough conversations with departments, agencies?

you will be talking investments while they are also making budget cuts?

in the end the greater issue may be, what gets cut in community infrastructure prevents this from working except for some?

the agencies will have to , not hide cuts,, have honest on ground assessments what is happening, no favortism in the politics just giving to those services represented by strong advocacy, which does happen in department agencies in how they make cuts, sometimes its about who will not complain because they lack advocates for there case.

Dale Hackett

I would like to comment on VMSSP proposal. I would like to see more community health services included in the savings formula. Healthcare clinical quality, improved quality of life and savings are possible through the expanded use of community health services to help people with chronic illnesses manage their illness at home and in the community reducing ED visits and hospital admissions.

thank you,
Larry Goetschius
Executive Director
Addison County Home Health and Hospice

1. How are MCD programs such as NEMT, Pharmacy, Substance Abuse (ADAP) being viewed and analyzed?

2. Who from the state is involved in the analysis or discussion? NEMT, Pharmacy fall under DVHA. Substance Abuse (ADAP) and I do not believe in the context of ACO's & yr 3 has there been conversation.

Respectfully,

Aaron

Douglas Aaron French, MSN, RN, BC
Deputy Commissioner, Health Services & Managed Care
Department of Vermont Health Access
312 Hurricane Lane
Williston, VT 05495

Some comments:
Under Dental; what are the 'options' available to members? Once adults reach their Medicaid cap of $510/per calendar year, options are limited.
How are GA vouchers for dental (infection, bleeding, pain) being factored into the total cost listed on page 16?

Transportation- How does CMS rules affect service delivery? One restriction for Medicaid members using this service is that transportation vendor cannot schedule same day or even next day service. This limits service for those who receive same day appointments and live in rural areas so lack of public transportation, thus potentially resulting in ED visit for non-acute sx's or potential IP stay due to exacerbation of symptoms so impact of this could lead to costs.

MH – Access to service; long waiting lists will impact this category. Some of the designate MH agencies are reporting 10 month waiting lists to see psychiatrists.

I will be interested in hearing the discussion about how ACOs can reduce spending in areas that they may not have direct oversight of.

Thank you,

Heather Bollman, RN, CCM
Manager- Vermont Chronic Care Initiative
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July 17, 2015

Don George and Andrew Garland, Co-Chairs
Payment Models Work Group
Vermont Health Care Innovation Project
109 State Street Montpelier, VT 05620
Cc: Mandy Ciecior

Dear Co-Chairs and members of the Payment Models Work Group,
Thank you for the opportunity to comment on the potential addition of non-core services to the total cost of care for year three of the Vermont Medicaid Shared Savings Program (VMSSP). Since non-core services are not monitored for access and quality by the VMSSP quality and performance measures, we do not support adding any of these services to the total cost of care for year three of the program. It would be inadvisable to include these services, which can be costly, in the total cost of care without ensuring that access and quality are maintained or improved.

Sincerely,
s/ Julia Shaw, Health Care Policy Analyst, Office of the Health Care Advocate
s/ Lila Richardson, Staff Attorney, Office of the Health Care Advocate
s/ Rachel Seelig, Staff Attorney, Vermont Legal Aid

Hi Cecilia,
I see you're continuing the interesting conversation around including pharmacy in year 3 of TCOC. I recently participated in a webinar on Payment Models and Pharmacy, I have attached it for your interest, as it talks about how pharmacists can help ACO's realize savings through various means of medication management. I found this slide interesting, including pharmacy in TCOC seems to be more common with the commercial ACO's, and they may be a resource for helpful information on what strategies work:

Survey of 270 ACOs across commercial, Medicare and Medicaid plans showed that 45.7% had engagement with a pharmacy as part of their ACO approach.
●Of commercial ACOs reporting, 76.8% included pharmacy costs as part of the total cost for performance under their largest contract.
O Of commercial ACOs, 53.3% reported having an engagement with a pharmacy inside the ACO or contracted with one outside of the ACO organization.
●The more advanced ACOs were more likely to include a pharmacy as part of their ACO, specifically, those with:
O More payment reform experience
o Multiple contracts
o Diversity of providers
●Authors indicated that these organizations value the importance of ensuring effective and efficient prescribing and adherence to achieving quality and
cost goals and may choose to integrate with pharmacy to accept new payment risk

I would like to continue to be involved in the discussion as the analysis and decision-making process continues. I do believe there are opportunities for ACO's to more effectively manage medication use among their attributed patients, and I welcome participating in that conversation. I also think we need to be careful about offering the 340B program as a possible strategy for the ACO's, as that needs to be carefully examined. The 340B program is not necessarily in alignment with our other cost savings initiatives and strategies. It could affect our formulary compliance, federal rebates, supplemental rebate contracts, and supplemental rebate value for example. And while we are demonstrating some savings attributable to 340B among the Outpatient Hospital Pharmacy claims, I suggest a careful analysis of DVHA's benefit/risk from expanding the 340B program with our current shared savings methodology in the Retail Pharmacy Claims universe. Please let me know if I can be of any assistance. I know I've been unable to attend all the Payment Model meetings due to my commitment to the MMIS PBM DDI process that is ongoing through 2015, but this is also an important project! Thanks very much.

Nancy

Nancy Hogue
802-879-5611
Nancy.Hogue@state.vt.us

Good morning Amanda,

I am writing regarding the proposal to add new categories to the total cost of care for the Medicaid ACOs. While I am generally supportive of the concept of adding more categories as it would include more of the State's actual Medicaid expenditures, I have one overarching concern – which is that by adding new services only to the Medicaid ACOs' total cost of care, we will eliminate the alignment between the Medicaid, Medicare and commercial ACOs we have been committed to maintaining. In addition, I have concerns related specifically to two of the proposed areas of expansion- namely dental and pharmacy expenditures. Each is discussed below.

1. Dental Services:

   As you know, Vermonters who receive Medicaid are eligible to receive approximately $500.00 worth of dental services per year. It is widely acknowledged that this amount is inadequate to meet the true dental care needs of low income Vermonters. Therefore, unless the cap is removed, it seems the only way to accrue savings would be to spend less than $500.00 per person, per year. Incentivizing a reduction in dental expenditures to below $500.00 per person, per year presents too great a risk to the oral health of Vermonters whose dental care needs already exceed the $500.00 annual benefit. If however the $500.00 cap is removed, there would be no objection to adding dental care to the total cost of care for the Medicaid ACOs. However, if the $500.00 cap is removed, it seems unlikely there would be savings – rather quite the opposite might be true.

2. Pharmacy Expense:

   If pharmacy expense is included in the total cost of care, several questions/issues arise, to wit:

A. There would need to be some relevant quality/performance measure(s), given pharmacy is such a large expenditure. Accountability and consumer protection are attained through performance measures. In this instance, under-prescribing is not the issue. The issue is proper medication management. One possible measure is "Medication Review" or "Medication Therapy Management". For example: "Percent of people whose doctor or clinical pharmacist has reviewed a list of all medications at least once a year (prescription and non-prescription drugs, vitamins, herbal remedies, other supplements)."

B. We need to identify any unintended consequences of shifting the responsibility for Medicaid pharmacy costs to the ACOs. We would need to ensure the State does not lose money. DVHA needs to do a financial analysis regarding the long term effect on state revenues, especially in relation to 340B and rebates. The Director of DVHA Pharmacy could help with this analysis, however it is my understanding that such an analysis has yet to be performed.

C. Decisions need to be made with respect to which pharmacy drugs are included- e.g. inpatient? outpatient? specialty pharmacies?

D. How will this work given that less than one-third of all VT Medicaid beneficiaries are attributed to a Medicaid ACO? Can there be economies of scale with such small numbers? The SIM report submitted to CMMI on May 1, 2015 shows 42,132 Medicaid attributed lives out of a total of roughly 140,000 – 145,000 VT Medicaid beneficiaries.

I thank you in advance for your consideration of these comments and hope they are helpful. Please do not hesitate to contact me to discuss any of these concerns.

Best,

Susan

Susan L. Aranoff, Esq.

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July 24, 2015

Dear Payment Models Workgoup,

Community Health Accountable Care, LLC (CHAC), appreciates the opportunity to submit comments on the potential expansion of services to be calculated within the Total Cost of Care (TCOC) for the Vermont Medicaid Shared Savings Program (VMSSP) in PY2016. CHAC has participated in the VMSSP since PY2014. CHAC did not elect to expand services under the PY2015 incentives.

CHAC has concerns about any ACO's ability to reduce the spend and/or improve the quality of the majority of additional services under consideration. From our review of the presentation made to the Payment Models Workgroup, there seem to be significant challenges and few advantages to most of the additional services. For some of these services, there may be perverse incentives: an ACO that is responsible for dental services and pushes for preventive (vs. reactive) dental care would likely diagnose significant dental issues (particularly in a population that hasn't prioritized dental care in the past), which increases costs in the short term before it achieves a stabilization. Other services, like non-emergency transportation services, may display great variability in costs depending on geographic location (so an ACO that has a larger number of rural attributed lives would be negatively impacted by the addition of this service, compared to a more urban ACO). There are operational challenges with personal care services (e.g., that many personal care services claims are bundled into other services and cannot be parsed out separately), mental / behavioral health services (e.g., this would require additional contract changes, a new State Plan Amendment, and significant coordination among state agencies), and Alcohol and Drug Abuse Program Services (e.g., this would require additional contract changes, a new State Plan Amendment, and resolution of data sharing concerns relative to 42 CFR Part 2). For none of the above services do the advantages outweigh the challenges, and CHAC does not believe that they make sense as additions for Year 3.

Pharmacy services may present the fewest challenges and greatest possible advantages, though CHAC acknowledges there might be technical challenges in factoring 340B pricing into the TCOC, so additional analysis and explanation would be necessary prior to implementation. As noted in the presentation, an ACO's only possible ability to favorably impact the Pharmacy spend would be through the promotion of 340B programming to Medicaid beneficiaries. CHAC could prioritize an intervention to educate patients about 340B options. This would be even more effective if DVHA were to make an active stand and require beneficiaries to utilize 340B programs.

A final option would be for no additional services to be added to the TCOC calculation in Year 3. This option provides recognition of the frenetic pace of health care reform within the State and allows the ACOs the ability to work within a known and familiar set of parameters for another year. With no changes, the ACOs would be able to build upon their successes to date, and initiatives begun in Year 2 would have an opportunity to come to fruition without the complexity of added variables. CHAC believes this is the best of the options on the table.

In summary, CHAC strongly recommends the continued exclusion of Dental, Transportation, Mental Health, Personal Care Services, and Alcohol and Drug Abuse Programs from the TCOC calculation. CHAC is more open to the inclusion of Pharmacy (solely), though the ACO would need to understand the mechanics of the inclusion in more detail. Most importantly, however, CHAC believes that there is still tremendous opportunity to impact TCOC and quality of care within the original Core Services, and CHAC would welcome a third year with no changes to the services included.

Sincerely,

Joyce M. Gallimore

Joyce M. Gallimore, MPH, CPHQ
Director, Community Health Accountable Care LLLC

Ms. Amanda Ceicor
Health Policy Analyst
Vermont Medicaid Shared Savings Program
State of Vermont

Dear Amanda:

Thank you for the opportunity to review and provide our comments on the Year 3 Total Cost of Care (TCOC) Expansion for the Vermont Medicaid Shared Savings Program VMSSP). OneCare Vermont's (OCV's) leadership has reviewed and discussed the materials that were shared with the Payments Models Workgroup and provide the following comments and recommendations.

The first two years of the VMSSP have been heavily invested in infrastructure development, both internally at OCV and in the field with our network. There has been a tremendous amount of time and energy invested in modifying, enhancing and in some communities creating the Regional Clinical Performance Committees (RCPC's) to be in a position to receive information in the form of data reports we developed and produced for them at the regional level. These RCPC's have been receiving their community specific data as they identify areas worthy of clinical intervention for the population they serve. These efforts have taken the better part of the last 2.5 years to mobilize a statewide network. The purpose of sharing this background with you is to express how critical the receipt of *clean, complete and timely* data is to the task t of taking risk for a population and then having the appropriate time to analyze the data by region and statewide to understand the pockets of opportunities available for intervention. Our analytic department has distinguished itself with the ability to produce timely and actionable data reports on cost and utilization with medical claims data sets that are relatively clean.

Medicaid has identified six categories under consideration for shifting the Year 3 TCOC from Medicaid to the ACOs. These include Dental, Transportation, Mental (Behavioral) Health, Personal Care Services, Alcohol and Drug Abuse Services, and Pharmacy. All of these categories, according to the material provided have challenges in the area of providing *clean, complete and/or timely* data files to the ACOs. There are also additional challenges in all of the six categories. We provide some of those challenges below followed by our proposed recommendations.

Dental:
OCV's network does not include a full compliment of dentists nor would we be able to establish such connections by the beginning of January 2016. The time delay in the reconciliation of a complete set of data for dental claims flowing to OCV would also be a significant challenge for monitoring real time expenditures and determining an accurate total spend. As stated, various dental programs have variable delays in final reconciliation.

Transportation:
OCV does not have contracts with transportation service agencies. It is unclear whether OCV would utilize the contracts currently in place through Medicaid or be expected to engage in creation of our own business relationships. Either way, the ability for the ACO to make successful reductions in expenditures for these services independently is unlikely due to the lack of cross-over with other ACO experience or processes. The lack of a complete data set would be a significant challenge.

Mental (Behavioral) Health:
The current funding sources for these services come from a variety of programs making it very complex to identify the full financial picture. Due to the various mechanisms by which services are paid, there is not a single source of claims data that could be available to OCV for monitoring real time expenditures and establishing an accurate year-end reconciliation. Additionally, the quality of service being delivered is affected by the lack of statewide access to providers in certain types of specialties such as pediatric psychiatry. This issue is broader than what the ACO has the ability to impact independently.

Personal Care Services:
These services are bundled with many other Long Term Care Services and DAIL programs. Medicaid stated in their background materials for this category that the ACO does not have any ability to reduce the financial spend in this category. It appears that the way these services are provided and paid for by the State pose a high level of complexity within the State and would become even more complex by asking a third party, the ACOs, to become involved. Due to the complexity in how services are paid, it is unlikely that OCV would be able to obtain clean, complete and timely claims data for this category.

Alcohol and Drug Abuse Programs:
42 CFR Part 2 rules make assumption of risk for this category of services highly problematic. This relates to not only the inability to share claims and documentation of this type with other clinicians but may even impair the ability of the ACO to coordinate care for such services in any meaningful way. Unfortunately, we are not able to move forward in this category for TCOC involvement until changes at the federal level are made.

Pharmacy:
The Medicaid materials indicate that the ACO has the ability to reduce the overall spend in this category through the 340B program. Presently, OCV does not have a network of pharmacies nor would we be able to launch this by January 2016 and this would be a requirement for the OCV beneficiaries to benefit from the 340B pricing discounts from the in network pharmacies. Additionally, it is our understanding that individual physician practices are not eligible to participate in the 340B program so savings under this program would not be gained from that type of network participant. We also understand that in order to maintain a 340B program status, the enrolled entity must maintain a minimum Medicaid threshold on the Medicare cost report. It is unclear at this point if OCV can enroll as the 340B enrollee on behalf of its network participants bringing a larger number of entities into the program through a single organization. It is also unclear at this time how the reconciliation of this program is handled, the timing of that reconciliation, and if OCV were to be at risk, would we be granted the financial benefits or would these continue to go to the state. The federal rules are unknown to us at this time. Another area of concern to OCV is in the arena of formulary development. OCV would be

subject to the TCOC financial risk, however, OCV would not have direct input into the PBM for Medicaid, creation of the preferred drug list, and the rebate negotiations process.

Recommendations:
OCV recognizes there are a few categories where we and Medicaid could "pilot" some additional collaboration without taking TCOC risk. This would allow both parties to begin to assess the complexities that currently exist and gradually identify mechanisms to impart change where both parties have the proper elements in place for that change to be a possibility. These areas include the following:

Dental:
Medicaid could share historical and future claims data for the "regular dental claims" paid through MMIS. OCV would propose to monitor this partial data set for 2016 and provide assistance to Medicaid in the form of education with the dental community of providers and with other participants about best practices for dental referrals likely to reduce total cost.

Transportation:
In 2016, begin to work with Medicaid to investigate ifthere are cross-over areas with other ACO experience or processes that could be pursued to capitalize on improvement(s) in the unnecessary use of transportation services.

Mental (Behavioral) Health:
We would be happy to discuss pilot opportunities in this category where we work beside Medicaid to improve the gaps in this category from both a clinical and financial perspective. However, in order for OCV to be in a position to consider TCOC risk we would need clean, complete and timely data which is not currently available according to the information provided by Medicaid.

Pharmacy:
OCV is willing to begin a dialogue with Medicaid around the category of pharmacy throughout 2016. We would be interested in investigating how the expansion of the 340B program could occur with our network participants or even at the ACO level and what the federal conditions and requirements would be. We would be willing to pilot this if possible to decrease the state's overall spend in this category and ultimately decrease the state's overall liability in health care costs.

In summary, it is our opinion that due to a variety of complexities in the Medicaid system, Medicaid is not in a position to successfully pass on the TCOC risk in any of the categories for the reasons referenced above. Subsequently, OCV is not in a position to successfully accept TCOC for January 2016. We do, however, believe, there are a few categories which we could collaboratively work on over the course of 2016. We have recommended categories where we could initiate collaborative efforts with Medicaid to make strides toward improving the quality of services being delivered to the population as well as investigating how to improve the overall financial expense to the State. We would be more than willing to begin a dialogue to assess which of these recommendations would be most viable for both parties to consider during 2016. Ifthe pilot(s) selected are viable and worthy of continuation, OCV is open to continuance beyond 2016.

Again, thank you for the opportunity to provide our thoughts and comments toward this very important topic and one that OCV wants to support in ways that are realistic for both our network and the Medicaid program.

Sincerely,

Norman S. Ward, MD
Chief Medical Officer

Martita I. Giard
Dir. Govt. Programs Strategy & Network Development

Dear Mandy,

As I understand our current TCOC methodology, the savings calculation proposes to measure a change in spending over the course of a year for a given population. However, is it correct that the methodology ignores savings that generate entirely from averted costs, such as preventing unintended pregnancy? If this is correct, then the savings calculation methodology could be improved by including a mechanism to distribute risk payments for those ACOs that attempt to prevent the need for expensive services or treatment – not just slow the spending that is already occurring. One way to do this is to have the ACOs report on quality measures that avert costs such as contraception utilization. Another approach would be to create a payment methodology that rewards the use of particularly effective preventive measures such as long acting reversible contraceptives (LARCs) (e.g., IUDs and implants).

Thanks in advance for your reply.

Best wishes,
Maura

Maura Graff, MPH
Director of Project to Reduce Unintended Pregnancy
Planned Parenthood of Northern New England
128 Lakeside Ave, Suite 301 | Burlington, VT 05401
Office: 802-448-9763 | Fax: 802-448-9437
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Hello VHCIP Team,

Thanks for the opportunity to provide comment on the TCOC Expansion in VMSSP.

1. We recommend including dental services as a category for year three. Please see below for the rationale and please find documents attached describing the impact of oral health on other healthcare costs.

2. We noted the process of determining which costs to be considered as part of the TCOC expansion and in the research parameters, there appeared to be little emphasis on the third element of the triple aim, improving the health of the population. While we understand the need to create a payment system with the ACOs that is feasible, manageable and provides incentives for providers, it is equally as important, especially now in the innovative stages of Vermont's work on health reform, to consider health in the broadest sense possible in order to allow for a health system that incorporates programs and services across the health continuum. We would welcome a discussion with VDH senior leadership on how to continue to broaden the definitions of total cost of care to reflect a system where improving the health of the population continues to play a large role in determining payment and delivery systems.

Sincerely,

Tracy Dolan

Here is a brief comment related to the oral health component of the TCOC:

The Total Cost of Care (TCOC) includes spend for specified categories of services for which the ACO will be held accountable during a performance year. Including dental services as a category for year three would provide an unprecedented opportunity to promote the integration of medical and dental health in Vermont. Although dental health is often viewed as separate from medical health, research indicates that a person's oral health has a direct effect on their systemic health, especially when it comes to cardiovascular issues, diabetes, and pregnancy. In fact, research conducted by insurance companies that cover both medical and dental expenditures illustrate a cost savings when providing enhanced oral health services for beneficiaries with these conditions (see attachment).

ACOs and hospital systems bear significant costs from preventable emergency department visits due to oral health issues. A number of studies based on individual hospitals, cities or states have reported an increase in dental-related emergency department (ED) visits in the U.S. since 2000. Studies have also shown that, for the U.S. as a whole, dental ED visits are growing as a percentage of all ED visits. Most dental ED visits are for non-traumatic dental conditions and, in most cases, ED healthcare providers provide prescriptions for pain or antibiotics for infections. This treats the symptoms but not the underlying cause of the visit, thus often perpetuating repeat ED visits.

Policy makers are beginning to look at other innovations to improve access to dental care for adults. Pilot programs in several states have demonstrated the effectiveness of ED diversion programs targeted to patients who present at an ED with a dental-related complaint. A program at a Virginia hospital was developed to divert ED patients with a dental complaint to a special urgent dental care clinic located in

the hospital's oral and maxillofacial surgery clinic. Dental ED visits decreased more than 52% during the first year of the pilot program.

Without further interventions from policy makers, dental ED visits are likely to increase in the future, straining our health care system and increasing overall health care costs. Now more than ever, innovative solutions are needed to improve access and oral health. By including dental services in TCOC, ACOs would have the incentive to seek innovative approaches to managing dental costs with the potential for significant long term savings both in emergency care and in long-term chronic disease expenditures.

This is also attached as a word document along with another document that had been drafted re: adding oral health as a benefit. That has some good information about potential PMPM savings from a number of insurers that cover both medical and dental care.

Please let me know if you need this in another format or need additional information.

Thanks,

Julie

Please note change of email address in your contacts list to Julie.arel@vermont.gov. Thank you!

Julie Arel, MSW, MPH
Director, Division of Health Promotion and Disease Prevention
Vermont Department of Health
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Attachment 3

Proposed Changes for Year 3 ACO Shared Savings Program Measures

VHCIP Payment Models Work Group

August 24, 2015

Language from GMCB’s Suggested Hiatus

- “…If a measure is no longer supported by evidence, the measure should be considered for elimination. If a measure is eliminated, the VHCIP Quality and Performance Measures work group could recommend replacing it with a measure that is supported by evidence…”

Rationale for Proposed Changes

- Quality measures can and do change as the evidence base changes.
- The QPM Work Group's consultant, Bailit Health Purchasing, provided a summary of national changes to measures in Vermont's SSP measure sets.
- There have been recent national changes to one measure in the payment measure set:
  - Cholesterol Management for Patients with Cardiovascular Disease (LDL Screening), a claims-based payment measure (Core-3a)

Rationale for Proposed Changes (cont'd)

- There have been recent national changes to one set of measures in the reporting measure set:
  - Optimal Diabetes Care Composite ("D5"), a set of 5 clinical data-based reporting measures (Core-16)

- There have been recent national changes to two measures in the monitoring & evaluation measure set:
  - Appropriate Medications for People with Asthma (M&E-1)
  - ED Utilization for Ambulatory Care-Sensitive Conditions (M&E-16)

Proposed Year 3 Measure Changes

- During recent meetings, the QPM Work Group voted unanimously to recommend replacements for the LDL Screening, Diabetes Composite, Asthma Medications, and ED Utilization measures.
- Changes to the LDL Screening and Diabetes Composite measures were effective for Year 2 (2015) after being approved by the Steering Committee, Core Team and GMCB. The QPM Work Group is seeking approval to continue these changes into Year 3 (2016).
- Changes to Asthma Medications and ED Utilization measures would be effective for Year 3 (2016).

Recommendation: Replace LDL Screening with Controlling High Blood Pressure

Previous Measure	Recommended Measure
Cholesterol Management for Patients with Cardiovascular Conditions (LDL Screening) (Payment Measure)	Hypertension: Controlling High Blood Pressure (Payment Measure)

- LDL screening is no longer considered best practice; as a result, this measure has been dropped by the Medicare Shared Savings Program (MSSP) and NCQA HEDIS.
- Newly proposed HEDIS cholesterol measure (Statin Therapy for Patients with Cardiovascular Disease) has not yet been adopted, and will lack benchmarks when it is.
- QPM Work Group recommendation is to replace LDL Screening with a nationally-endorsed MSSP measure in Year 3, as was done for Year 2:
  - Hypertension: Controlling High Blood Pressure

Recommendation: Replace Optimal Diabetes Care Composite with MSSP Diabetes Composite

Previous Measure	Recommended Measure
Optimal Diabetes Care Composite ("D5," includes LDL Screening, hemoglobin A1c control, blood pressure control, tobacco non-use, and aspirin use) (Reporting Measure)	MSSP Diabetes Composite ("D2," includes hemoglobin A1c poor control and eye exam) (Reporting Measure)

- CMS has retired this measure from the MSSP measure set, most likely because one of the 5 measures that make up the composite is the LDL Screening measure.
- QPM Work Group recommendation for Year 3 is to replace "D5" with the new MSSP Diabetes Composite Measure ("D2"), which consists of 2 measures, as was done for Year 2.
- For the D2 measure, HbA1c Poor Control is already in the Commercial and Medicaid measure sets, Eye Exam is new.

Recommendation: Replace Appropriate Medications for People with Asthma with Medication Management

Current Measure	Recommended Measure
Appropriate Medications for People With Asthma (Monitoring and Evaluation Measure)	HEDIS® Medication Management for People With Asthma (Monitoring and Evaluation Measure)

- NCQA is proposing retiring Appropriate Medications for People With Asthma 2016 due to consistently high HEDIS® performance rates and little variation in plan performance for both commercial and Medicaid plans.
- Medication Management for People with Asthma was first introduced in HEDIS® 2012. NCQA views it as a more effective way of assessing asthma medication management. National benchmarks are available, and the measure can be calculated with claims.
- This M&E measure is collected at the Health Plan (statewide) level, rather than at the ACO level.

Recommendation: Replace ED Utilization for ACSCs with Onpoint Avoidable ED Measure

Current Measure	Recommended Measure
ED Utilization for Ambulatory Care Sensitive Conditions (Monitoring and Evaluation Measure)	Onpoint Health Data's Potentially Avoidable ED Utilization (Monitoring and Evaluation Measure)

- AHRQ has retired the ED Utilization for ACSCs measure for unidentified reasons, but is working on other ED-specific measures that have not yet been finalized.
- The Onpoint Health Data Measure looks at ED visits with primary diagnoses for which outpatient ED use was frequent, treatment was commonly provided in another setting (i.e., physician office), and inpatient hospitalizations were extremely rare. The measure is currently used in the Blueprint practice and health service area profiles.
- The measure set also contains M&E-14: Avoidable ED visits-NYU algorithm.

SUMMARY – Year 3 Recommended Measure Changes for Commercial and Medicaid ACO SSPs

Previous/Current Measure	Recommended Replacement Measure	Measure Set
Year 1 Measure: Cholesterol Management for Patients with Cardiovascular Conditions (LDL Screening)	MSSP Hypertension: Controlling High Blood Pressure (Payment Measure)	Payment
Year 1 Measure: Optimal Diabetes Care Composite ("D5") D5 includes: • LDL Screening • hemoglobin A1c control • blood pressure control • tobacco non-use • aspirin use	MSSP Diabetes Composite ("D2") D2 includes: • hemoglobin A1c poor control (already in measure set) • eye exam	Reporting

SUMMARY – Year 3 Recommended Measure Changes Commercial and Medicaid Programs (cont'd)

Current Measure	Recommended Replacement Measure	Measure Set
Appropriate Medications for People with Asthma	Medication Management for People with Asthma	Monitoring and Evaluation
ED Utilization for Ambulatory Care Sensitive Conditions	Onpoint Health Data's Potentially Avoidable ED Utilization	Monitoring and Evaluation

Attachment 4

Payment and Delivery System Reform in Vermont: 2016 and Beyond

Richard Slusky, Director of Reform
Green Mountain Care Board

Presentation to GMCB

August 13, 2015

Agenda

- **Transition Year 2016**
  - 1. Medicare Waiver Overview
  - 2. ACO Options in 2016
  - 3. ACO Collaboration
  - 4. All-Payer Model Framework

- **Regulatory Role of GMCB**
  - 5. Responsibilities to Consider and Resources Required

- **Next Steps**

Members of the ACO Payment Sub-Committee

- **Vermont's 3 ACOs**
  - CHAC
  - OneCare Vermont
  - VCP/Health*first*
- **Provider Leaders and Associations**
  - Bi-State Primary Care Association
  - University of Vermont Medical Center
  - Vermont Association of Hospitals and Health Systems
  - Vermont Medical Society
- **Payer Organizations**
  - Blue Cross Blue Shield of Vermont
  - MVP Health Care
  - Department of Vermont Health Access

Glossary of Acronyms

ACO – Accountable Care Organization

CAH – Critical Access Hospital

CHAC – Community Health Accountable Care

CMS – Centers for Medicare and Medicaid Services

CMMI – Center for Medicare and Medicaid Innovation

FFS – Fee-for-Service

FQHC – Federally Qualified Health Center

GMCB – Green Mountain Care Board

SSP – Shared Savings Program

- MSSP – Medicare SSP
- VMSSP – Vermont Medicaid SSP
- XSSP – Commercial SSP

TCOC – Total Cost of Care

VCP – Vermont Collaborative Physicians

1. Medicare Waiver

Reach Agreement with CMS by Fall 2015 for Start Date 1/1/2017:

- 2016 becomes a transition year

Discussions with CMMI Involve:

- Base and Trend for All Payers
- Medicare Savings
- Potential Payment Models for 2017
  - ACO/Network Providers
  - Non-Participating Providers

2. ACO Options in 2016

<u>Medicare SSP (MSSP)</u>

- **OneCare VT**
  - Continue participation in MSSP
  - Participate in the Next Generation ACO (should they receive approval) in 2016 or 2017
- **CHAC**
  - Continue participation in MSSP

<u>Medicaid SSP (VMSSP)</u>

- **OneCare VT and CHAC**
  - 3 year program ending in 2016

<u>Commercial SSP (XSSP)</u>

- All three ACOs currently participating
- Current ACO XSSP standards call for downside risk in 2016
- Need to determine formula for calculating expenditure targets and savings calculations for 2016

3. ACO Collaboration

Vermont's three ACOs continue to discuss ways they can collaborate.

Purpose: *Build upon the foundation created by our work together that has been achieved to date, and take additional steps to build trust, develop shared knowledge about the populations served, and collaborate on activities that are essential to managing an integrated system of care.*

Activities:

- Establishing a single entity ("the ACO") if pre-established governance and other organizational and financial criteria are met (2017)
- Determine the composition of governance body for possible unified ACO 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
  - Establish voting rules that ensure broad support for major policy decisions

3. ACO Collaboration
(cont'd)

Activities: (cont'd)

- Negotiating data sharing agreements (2016)
  - Sharing data and analytics
  - Pursue a single approach to data collection and analytics
- Modeling merging of attributed populations (2016)
- Collaborating to improve care management and care coordination (2016)
  - Participate in community collaboratives as the foundation to improved care
- Be transparent in all aspects of the process of health care reform
- Establish milestones and timelines to meet goals and prepare for 2017

4. Vermont All-Payer Model Framework (Currently Under Consideration by the ACOs)

This Framework is intended to be used to inform the GMCB and the State's CMS waiver negotiating team regarding this group's thinking about how an all-payer model might be implemented in Vermont. This document represents the understandings reached by this group as of its meeting of August 10, 2015, recognizing that many details are yet to be resolved.

The document continues to be a "work in progress."

Vermont All-Payer Model Framework
(cont'd)

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 reform as set forth in state legislation, the result could be a much more integrated system of care, better health outcomes, and better management of overall health care costs (including reducing health insurance premium inflation).

- Developing a single ACO that could be accountable for financial risk; having sufficient resources to provide the infrastructure for data collection, analytics, and care coordination; and having a sufficient number of attributed lives appears to be the best option to achieve a more integrated system of care.

Vermont All-Payer Model Framework
(cont'd)

This is what an all-payer model could mean for Vermonters:

- Better access to care
- More time for patients with doctor and care team
- Improved care
- More affordable care
- Greater focus on prevention and early intervention
- Expanded efforts to keep people healthy
- More flexibility in health care services
- Improved communications among health care team and patients

Vermont All-Payer Model Framework
(cont'd)

This is what an all-payer model could mean for providers and payers:

- Support for high value health care
- Greater flexibility
- Provider driven model
- Local empowerment
- Focus on prevention and population health
- Freedom of choice
- Reducing cost shift growth

Vermont All-Payer Model Framework
(cont'd)

Core Functions of the ACO:

- Develop a plan for near-term and long-term pathways to better clinical and population health outcomes.
- Set targets, measure performance and create provider incentives for cost, clinical outcomes and patient experience.
- Work closely with the Blueprint and other local organizations to assist community collaborative partnerships and coordinated approaches to care management.
- Improve population health status using population health strategies.
- Provide data management support and analytics.
- Manage financial risk.

Vermont All-Payer Model Framework
(cont'd)

Payment Model Principles: Prior to discussing the manner in which contracted providers should be paid by the ACO, the Subcommittee identified the following consensus set of principles to govern the provider payment methodologies.

- Be holistic in orientation
- Be equitable
- Reward desired outcomes
- Encourage improved care delivery and health investment
- Ensure consistent payer rules and performance incentives and measures
- Promote wellness and healthy lifestyle choices by patients

Vermont All-Payer Model Framework
(cont'd)

Provider Payment Models:
Introduction

The Subcommittee envisions that, through a phased-in process, the ACO will make broad use of value-based payment methods for the vast majority of services for which it is responsible. Initially, however, the Subcommittee agrees that such methods should focus on payments to hospitals (including employed physicians), FQHCs, and independent primary care and specialty practices.

<u>The language that follows describes the consensus elements of those payment models, tentatively settled upon as of August 10, 2015, recognizing that many details are yet to be resolved.</u>

Vermont All-Payer Model Framework
(cont'd)

Provider Payment Model – Participating Primary Care Providers:

- 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 payments.
  - Be eligible for performance based incentive payments.
  - Be paid by all Vermont licensed insurers based on payment methods approved by the GMCB.

- The Subcommittee recommends Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) participating in the ACO should:
  - Be reimbursed in accordance with federal rules related to FQHC and RHC payments.
  - Be eligible for CMS Medicare, Medicaid, and commercial alternative reimbursement programs
  - Be eligible for performance based incentive payments.

Vermont All-Payer Model Framework
(cont'd)

Non-Participating Primary Care Providers:

- The Subcommittee recommends non-participating primary care providers receive standard payments regulated by the GMCB to ensure compliance with agreed upon statewide expenditure targets.

Vermont All-Payer Model Framework
(cont'd)

Primary Care Practice Patient Attribution:

- Attribution is important for payment and for establishing/ recognizing relationships between patients and primary care providers
- Patients should be prospectively attributed using voluntary patient selection as a preferred method, and claims-based attribution as a secondary method.
- Goals of attribution:
  - Attribute as many patients as possible.
  - Avoid attribution to multiple providers.
  - Administrative simplicity and feasibility.
  - Prospective rather than retrospective attribution.

Vermont All-Payer Model Framework
(cont'd)

Specialist Physicians & Other Non-Hospital Providers:

- The subcommittee's goal is to recommend a fair and equitable method of payment that ties specialist physician and other providers into the ACO's population health approach. The subcommittee has organized a work group to address this topic.

Vermont All-Payer Model Framework
(cont'd)

Hospitals – Participating Hospitals:

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

Option 1 – Double Channel Model

- The ACO would make payments to hospitals on a fixed payment basis using the methodology established by the ACO for all ACO-attributed patients.

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

Vermont All-Payer Model Framework
(cont'd)

Hospitals – Participating Hospitals: (cont'd)

Option 2 -- Single Channel 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 would be made by the individual payers based upon instructions from the ACO (upon approval by the GMCB). The aggregate of all payments would constitute the hospital's revenue budget for the performance year.
- The GMCB would review and approve hospital budgets on an annual basis under an enhanced budget review process.
- The ACO would be accountable for hospital costs incurred for patients attributed to the ACO.

Vermont All-Payer Model Framework
(cont'd)

Hospital Payments – Non-Participating Hospitals:

- Non-participating hospitals would be subject to an annual enhanced budget review process set by the GMCB, with specific rules regarding net patient revenue, rate increases, and compliance.

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GREEN MOUNTAIN CARE BOARD

Vermont All-Payer Model Framework
(cont'd)

Payer Risk Model

- The Subcommittee agreed that the proposed CMS Next Gen ACO payment model could be the framework for Vermont's all-payer model, and that payment should incorporate some type of fixed payment risk from all payers starting in 2017.

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5. Regulatory Role of the Green Mountain Care Board (GMCB)

The GMCB will need to demonstrate to CMMI that it has the authority, willingness and capacity to assume the necessary regulatory and rate setting role required in the context of a Medicare Waiver Agreement that would lead to the creation of a fully integrated statewide all-payer model.

Regulatory Role of the Green Mountain Care Board
(cont'd)

Issues the Board will need to address in 2015 and 2016

- **Delineation of GMCB Regulatory Roles related to ACO(s), Hospitals, Payers and Other Providers**
  - ACO Budget and Operations Review Process
  - Hospital Budget Review Process
    - Hospitals inside the ACO/Network
    - Hospitals outside the ACO/Network
    - Critical Access Hospitals
  - Provider Payments (PCP and other providers)
    - Participating in the ACO/Network
    - Non-Participating Providers
    - FQHCs
  - Payers
    - Commercial: Annual Rate Review and Payment Variation
    - Medicaid (DVHA): GMCB regulatory authority, if any, over Medicaid payments

Regulatory Role of the Green Mountain Care Board
(cont'd)

Issues the GMCB will need to address in 2015 and 2016 (cont'd)

- **Other Regulatory Issues**
  - Will the ACO(s) be subject to State insurance regulations and licensing
  - If there is one ACO, does this raise market competition issues (Anti-Trust/FTC/DOJ etc.)
  - Who will enforce patient protection regulations (e.g., Rule 9-03)
    - Appeals
    - Fraud and Abuse (Medicaid retains its own F&A oversight?)
    - Patient Safety
    - Patient Access
  - What regulations, if any, will self-funded employer organizations be subjected to
  - Other

Regulatory Role of the Green Mountain Care Board
(cont'd)

Issues the GMCB will need to address in 2015 and 2016 (cont'd)

- **Resources the GMCB will need to implement this authority**
  - Current positions
  - Positions approved by the legislature in 2015 for SFY 2016
  - Additional positions needed, if any, for SFY 2017
  - Consultants/Lawyers
  - Space/Software/Bandwidth, etc.
  - Other

Next Steps

Time is short and much needs to be done if we decide to travel down this path:

ACOs:

- Reach agreement on collaboration by September 1, 2015
- Begin working on activities and milestones in 2016
- Develop a work plan that prepares for implementation of a statewide integrated delivery system and all-payer model in 2017

GMCB:

- Complete negotiations with CMMI and decide whether or not to execute a waiver agreement for an all-payer model in 2017 by December 2015
- Consider the scope of the regulatory role the Board wants to assume in 2017, and develop a work plan and timelines necessary to assume that role
- Based on the above, prepare a legislative agenda and any legislative language for consideration by November/December 2015

Questions?