BUILDING AN INTEGRATED HEALTH SYSTEM:

MEDICAID AND THE VERMONT ALL-PAYER ACCOUNTABLE CARE ORGANIZATION MODEL

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OBJECTIVES

Objectives

Objective 1: Develop a Common Level of Understanding around Goals

Objective 2: Set Initial Expectations Regarding Process

Objective 3: Explain Delivery System Reform Investment Process

The Big Goal:

Integrated health system able to achieve the Triple Aim

- ✓ Improve patient experience of care
- ✓ Improve the health of populations
- ✓ Reduce per capita cost growth

VT All-Payer Model Agreement

Vermont's contract with CMS to enable ACO Based Reform

CMS provides payment flexibility and local control in exchange for meeting quality, financial, and scale targets and alignment across payers

Sets forth planning milestones for future integration

Global Commitment Medicaid Waiver

Vermont's contract for how Medicaid will be administered

Allows Medicaid to participate in APM and pursue delivery system reform

Delivery System Reform (DSR) investment to fund future innovation that will help Vermont integrate and succeed with the APM Agreement

Creating an Integrated Health System

- Strategic choice by Administration and GMCB to move away from feefor-service payment system.
  - Payment reform is moving away from fee-for-service nationally.
    - Medicare is making this transition through the Medicare Access and CHIP Reauthorization Act (MACRA), which starts in 2017. MACRA requires clinicians who bill Medicare to participate in either the Merit-Based Incentive Payment System (MIPS) or an Advanced Alternative Payment Model (Vermont's APM falls into this group).
    - Hundreds[1] of Large Employers and commercial insurance carriers are also shifting through their own programs.

- *Key Question: How do you implement that payment reform?*

1. https://hcp-lan.org/about-us/committed-partners/

BACKGROUND

APM and Global Commitment Waiver: *Complementary Reforms*

- The two agreements allow Vermont to take a “one-model” approach to payment reform and integration
  - ACOs are the vehicle for All-Payer Model Financial Target Services, i.e. Medicare Part A and B services and their commercial and Medicaid equivalents, to engage in payment and delivery system reform.
    - APM agreement sets forth the structure and GC Waiver allows Medicaid to innovate.
  - Medicaid Pathway is the AHS process to create and test ideas for how payment and delivery system reform might further integrate the entire continuum of care.
    - *Medicaid Pathway is designed to test payment reforms where these services could be paid by the State, an ACO, or both.*
- Federal funding is available to further the efforts described above.

Initial Expectations Regarding Process

- We heard loud and clear that stakeholders want a more transparent and collaborative process.
  - This means better communication between government entities and between government entities and stakeholders.

- Multiple ongoing processes:
  - Medicaid Pathway
  - DSR investment applications
  - State budget development
  - GMCB ACO regulation

MEDICAID PATHWAY

Medicaid Pathway

- The Vermont Medicaid Pathway (VMP) advances payment and delivery system reform for services not included in the initial implementation of Vermont's All Payer Model.
- The ultimate goal of this multi-year planning effort is the alignment of payment and delivery system principles through both the All Payer Model and VMP to support a more integrated system of care for all Vermonters.
- The first services under review within the Medicaid Pathway are:
  - Cohort 1: Those provided by Designated and Specialized Service Agencies.
  - Cohort 2: Those provided by Long-Term Services and Supports Providers.

Medicaid Pathway

- Critical steps include:
  - Alignment of these reforms with the APM timeline;
  - Coordination of quality measures, monitoring activities, and delivery system expectations with the APM requirements;
  - Alignment of these reforms with the new Substance Use Disorder Treatment waiver (being submitted in 2017);
  - Expansion of successful components of existing models like Integrating Family Services (IFS).
- Encourage reform through as many services as feasible in the first two cohorts.

DSR INVESTMENTS

DSR Investment Process

- Who can apply by the terms of the federal agreement?
  - Category 1 - ACOs
  - Category 2 - Medicaid community providers
- What are we looking for?
  - Investments that promote collaboration, build capacity across the care continuum, consider social determinates of health, and promote an integrated health care system consistent with the framework set forth in the Vermont All-Payer Model Agreement and the Global Commitment Waiver.
  - The State and CMS are encouraging ACO-based provider led reform that features:
    - (a) collaboration between providers
    - (b) payment models that move away from Fee-For-Service
    - (c) rigorous quality measurement that aligns with the APM quality framework

DSR Investment Process

- When is the application due?
  - 1/15/17
- How we decide?
  - Technical review for compliance with federal application requirements
  - AHS leadership recommendations
  - AHS Secretary decision
- Funds timing
  - Funds will be released based on availability of state matching funds, receipt of federal approval and execution of an agreement.

Next Steps

- Stakeholders can refer questions to AHS.MedicaidPolicy@vermont.gov
- Webinar on how to apply for new DSR Investments posted week of 12/12.
- Medicaid Pathway report to Legislature due January 2017.

Questions?

RESOURCE SLIDES

Medicaid Section 1115 Demonstration Waivers

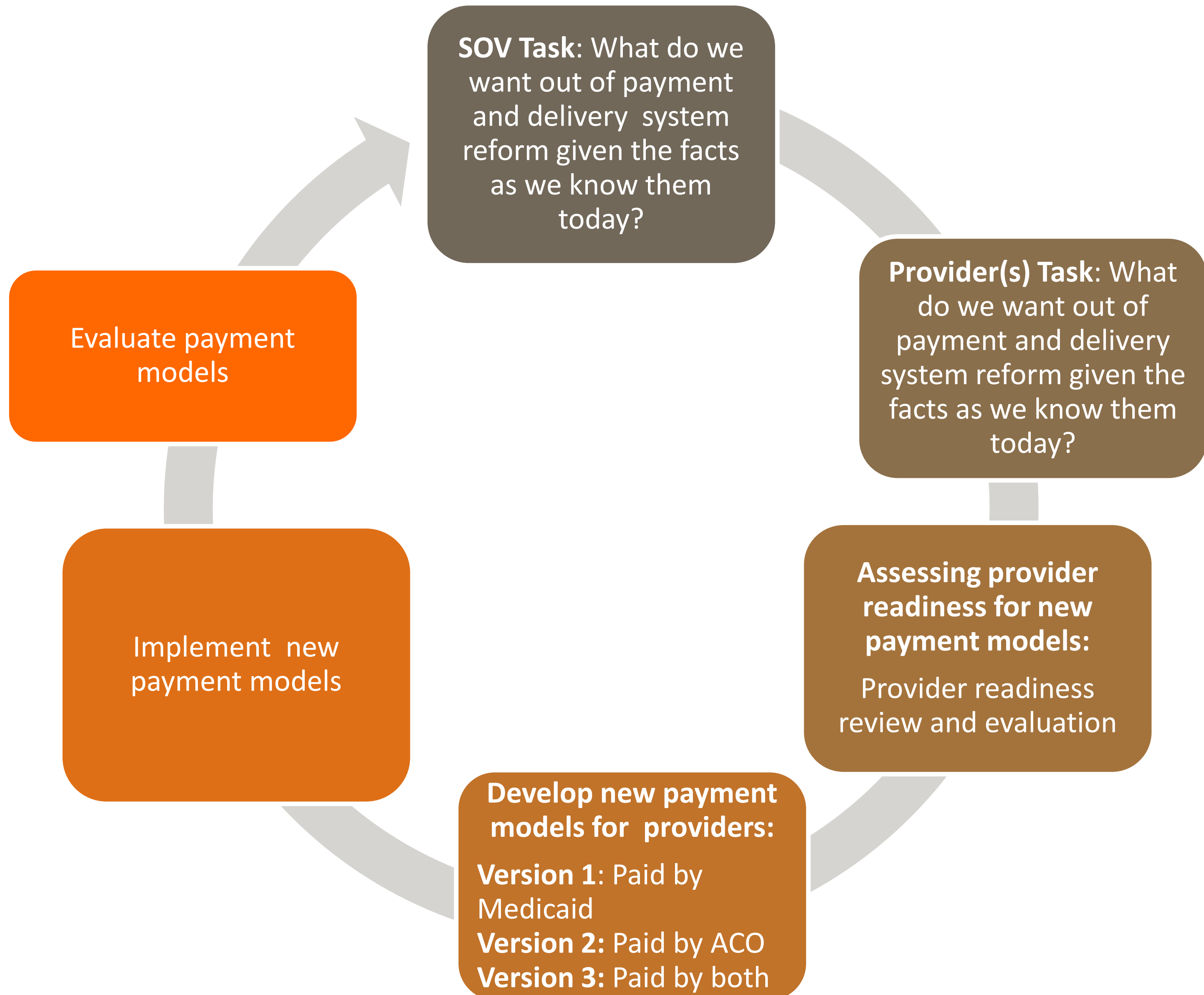
- Under Section 1115 of the Social Security Act, the federal government can “waive” many, but not all, of the laws governing Medicaid, including eligible people and services.
- 1115 demonstration waivers are intended to encourage state innovation in the Medicaid program.
- Often, states identify ways to save Medicaid funds and are permitted to use the savings to expand coverage.
- The Federal government approves Section 1115 Demonstrations for five-year terms, and existing Demonstrations can be extended for 3-5 year terms.

- Demonstration dates:
  - October 1, 2005- December 31, 2010
  - Currently extended through December 31, 2016
  - **WAIVER EXTENSION: January 1, 2017 - December 31, 2021**

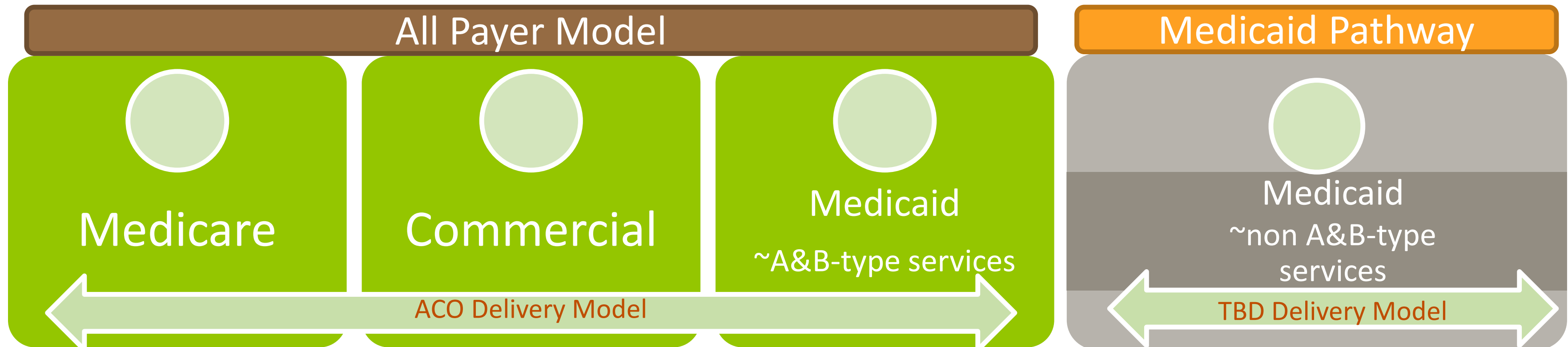
Medicaid Waiver Extension

- Vermont and CMS agreed to an extension of the Global Commitment to Health waiver that achieves the following:
  - Continues current Medicaid coverage of essential services for Vermont's most vulnerable populations.
  - Promotes health care reform by ensuring Medicaid participation and alignment with the All-Payer Model by providing Vermont with additional financial capacity to invest in healthcare reform concurrent with the All-Payer Model.
  - Continues flexibility in using Medicaid dollars to invest in health care priorities. Without this authority, Global Commitment investments would require new general fund appropriations or elimination.
  - Align with other state Demonstration expectations
  - Align with changes to federal Medicaid Managed Care regulations

Medicaid Pathway: Payment and Delivery System Reform Continuous Cycle



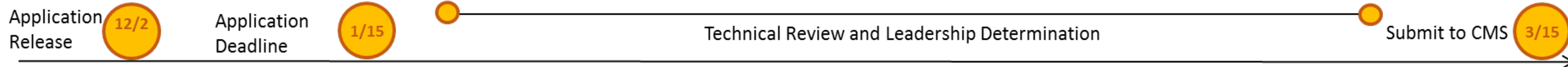
Integrated Delivery System



Year	All Payer Model	Medicaid Pathway
PY 0 2017	*APM Agreement: "Medicaid Behavioral Health and Long-Term Services and Supports. By the end of Performance Year 3, AHS, in collaboration with the GMCB, shall submit to CMS* ***a plan to coordinate the financing and delivery of Medicaid Behavioral Health Services and Medicaid Home and Community-based Services with the All-payer Financial Target Services****. The plan shall describe a strategy for including Medicaid Behavioral Health Services and Medicaid Home and Community-based Services in the State's delivery system reform efforts and for supporting the inclusion of such Medicaid services in the definition of All-payer Financial Target Services in a subsequent agreement, as described in Section 12."*	*ACT 113: "Sec. 12. MEDICAID PATHWAY; REPORT (a) The Secretary of Human Services, in consultation with the Director of Health Care Reform, the Green Mountain Care Board, and affected providers, shall create a process for payment and delivery system reform for Medicaid providers and services. This process shall address all* ***Medicaid payments to affected providers and integrate the providers to the extent practicable into the all-payer model and other existing payment and delivery system reform initiatives****. […]"*
PY 1 2018		
PY 2 2019		
PY 3 2020		
PY 4 2021		
PY 5 2022		

Medicaid Services in the APM Total Cost of Care

- For Medicaid, the APM Total Cost of Care includes the equivalent of Medicare A & B services. These services will be paid through the ACO.
- By the end of 2020, the State must submit a plan to CMMI regarding how, when, and if certain Medicaid services will be incorporated into the APM Total Cost of Care. The State will explicitly be trying to expand the Total Cost of Care and the responsibility of the ACO.



Provider Application

AHS Universal Intake
Policy Unit will send to appropriate Dept(s) + cc CO staff.

Department to complete "Dept. Only" sections

Technical Review
- Confirm State/Fed fund source
- Review Medicaid Reqs/Authority

No

Yes

Notify Applicant

Leadership Review

Approve?

No

Yes

Perform CMS required process per fund source determination

Implementation activities

APD

MCO Investment

Program (Base Cost)

If rate review is required

Submit to CMS

45 days for CMS Review*
5/1

Implementation on or before
7/1

CMS may move to 120 day review period if investment does not appear allowable according to CMS requirements at Att. B.