Administration Response to HealthFirst Questions/Comments

1. Establish, using data available to the board, **the percentage of physicians, NPs, and mental health and substance abuse professionals who are currently in independent practice** and seek to **maintain or grow** that percentage of providers throughout the years of the All-Payer Model.

The State will be evaluation its data needs for the All-Payer Model during implementation. Vermont classified 2017 as Year Zero in the agreement in order to further build the capacity to implement the All-Payer Model

2. **Improve transparency with regard to the cost of inpatient and outpatient services**, whether they are provided within the hospital setting, at physician offices, or at other locations. Patients are subject to out-of-pocket deductible, co-insurance, and co-pays based on the price/cost of the services provided and this will presumably continue to be the case over the next several years, even if the All-Payer Model is implemented. Therefore, it is in the public's interest to encourage patients having access to price/cost information. There is substantial risk to being able to establish more rational prices and costs, and to effectively engaging patients in their care choices, if service-specific price and cost information are allowed to become entirely obscured under single "global budget" figures, either for ACOs or for hospitals under ACOs.

This question is directed to the Green Mountain Care Board.

3. Recommend as part of the Administration's next Budget Adjustment and Budget Proposal for the coming year that **Medicaid pay independent practices equivalent to Medicare** for resource-based relative value unit physician payments beginning January 1, 2017. Otherwise, at least three independent practices that we know of are considering dissolving their businesses entirely in the next 3-6 months, and many other practices are considering not continuing to accept *new* Medicaid patients. These pending developments will **decrease access to primary care** and specialty care, in direct opposition to the major goal of the GMCB and Administration's All-Payer Model reform proposal.

The Administration shares the concern regarding payer differential, and the agreement reflects that concern. The Administration proposed revenue increases to boost Medicaid rates; however, these efforts failed in the Legislature. The Administration intends to provide the next Governor with budget recommendations that support the All-Payer Model while balancing the budget.

Administration Response to HCA Questions/Comments

Comment 1: The State's decision whether or not to sign this agreement is only the first step toward implementing the all-payer model. If the agreement is signed, many important decisions will be made as the Green Mountain Care Board (the Board) develops its regulatory structures for overseeing the model, and as the Accountable Care Organizations (ACOs) contract with providers. It is essential that there be a transparent, public process overseen by the Board as the ACOs put the components of the model into place, including care models, payment models, quality and access measures, and grievance processes. Accountability and consumer protections, including an appeal process, at the ACO level are necessary to ensure that patients have access to high quality care and that providers are incentivized to make appropriate care decisions with their patients. The Board must take responsibility for ensuring that the model is implemented so that it best serves and protects patients.

The Administration agrees that the implementation of the model, particularly its proper regulation, is crucial to success. Governor Shumlin signed into law Act 113 of 2016 that enables the GMCB to set up a regulatory structure that focuses on high quality care, payment innovation, and consumer protection.

Comment 2: If this model is implemented, the Board must ensure that the ACOs institute evidence-based best practices and consumer-friendly care practices such as Shared Decision Making. While the new "value-based" incentives of the model may begin to move care decisions in the right direction, there must be mechanisms to ensure that best practices are implemented regardless of cost, and that there are not unintended consequences of the new financial incentives. For example, the model appropriately excludes pharmacy costs from the cost growth cap. While we agree with this policy decision, it has the potential to result in inappropriate use of pharmaceuticals in place of other services that are included under the cap. The Board must develop systems to monitor utilization of services both within and outside the cap to ensure that patients receive the best possible care for their health and quality of life and are offered an appropriate range of treatment options.

Act 113 of 2016 required that in order to certify an ACO to receive payments, the GMCB must ensure that ACOs have "established mechanisms and care models to promote evidence-based health care, patient engagement, coordination of care, use of electronic health records, and other enabling technologies to promote integrated, efficient, seamless, and effective health care services across the continuum of care."

Vermont shares the HCA's concern about the potential risk of ACOs shifting costs to services outside the financial model, such as pharmacy. Payers, such as Vermont Medicaid, will monitor pharmacy costs to ensure the ACO model is not resulting in increased pharmacy costs that are unwarranted. The GMCB also monitors health care spending by category.

Comment 3: Further, the Medicare benefits enhancements under the APM should be available for all Medicare beneficiaries in Vermont. The draft agreement only allows individuals attributed to the ACOs to receive Medicare benefits enhancements such as waiver of the 3-day hospital stay normally required for coverage of skilled nursing facility services.

CMS' legal authority only allows for benefit enhancements as part of specific innovation programs and models. In addition, CMS must ensure beneficiaries are not harmed by unintended consequences when payment and beneficiary enhancements are not aligned in a specific model. Therefore, the State could not negotiate to extend these benefit enhancements to all Medicare beneficiaries, in particular Medicare fee-for-service beneficiaries.

Comment 4: It is essential that the Board require the ACOs to operate transparently so that patients and the public are aware of changes that are occurring as a result of the all-payer model. The Board must develop processes for making care protocols easily available to the public and for soliciting public and community input on decisions such as how the ACO will allocate investment dollars. The HCA supports the provision in the draft agreement allowing for reinvestment of dollars under the cap. The spending of these dollars and other investments made by the ACOs should be the result of public and community input, as well as provider input, and the processes for determining where investments are made must be transparent.

The Administration expects that the GMCB will create a transparent regulatory process under Act 113 of 2016.

Comment 5: In our current system, payers and care providers rarely coordinate efforts to lower costs and increase quality of care. ACOs have the potential to add another layer of redundancy for these efforts. Instead, APM implementation should be designed to reduce or even eliminate redundancy in health management and care coordination programs and possible conflicts in their approaches to care. In addition, our current fee for service payment model motivates insurers to save money by reducing access to care through payment barriers such as prior authorization requirements. As the APM moves to capitated payments, insurer-based payment barriers such as prior authorizations should be eliminated.

The Administration agrees that the ACO model of care should not create redundant care coordination. We note, however, that there is likely to be some redundancies until the model gets to scale as there will continue to be fee-for-service payments subject to utilization management by insurers prior to that time. Also, the Administration is open to reconsidering prior authorization requirements as DVHA contracts with an ACO.

Comment 6: Additionally, as the APM is implemented it is important that the Board ensure that the ACOs utilize existing infrastructure, including community resources, whenever possible to reduce duplication and to avoid unnecessary costs. The start-up money from the federal government should be used wisely to develop necessary infrastructure for the APM, and not to create additional unnecessary levels of management.

Act 113 of 2016 requires the GMCB to consider "the ACO's efforts to prevent duplication of high-quality services being provided efficiently and effectively by existing community-based providers in the same geographic area, as well as its integration of efforts with the Blueprint for Health and its regional care collaboratives" while promulgating rules to regulate ACOs.

Comment 7: Finally, the HCA shares the concern expressed by many providers that the APM will not work well if Medicaid continues to pay reimbursement rates that are significantly lower than Medicare and commercial insurance rates. We recognize that this problem exists in the current fee for service payment system as well and that solving it requires an increase in Medicaid funding in the state budget. The provision in the draft APM agreement that adjusts the performance growth targets to exclude growth attributable to efforts to increase Medicaid payment rates is extremely important. We are concerned that the Administration is proposing a level-funded Medicaid budget for FY 2017 at the same time it is advocating for the APM. This approach to the budget can only lead to cuts in Medicaid rates or optional Medicaid services or both at a time when increased funding including investment in mental health and substance abuse services is needed.

The Administration shares the HCA's concern regarding payer differential, and the agreement reflects that concern. The Administration proposed revenue increases to boost Medicaid rates; however, these efforts failed in the Legislature. The Administration intends to provide the next Governor with budget recommendations that support the All-Payer Model while balancing the budget.

Comment 8: In addition to commenting on the draft APM agreement, we wanted to express our concern that the public education and public comment processes for the agreement have been very short, very confusing, and poorly coordinated between the Board and the Agency of Administration. The HCA has tried to provide a complete list of the different forums and the Board meeting schedule on our website, and the information has changed repeatedly in the past two weeks. There is a great deal of public anxiety about the APM proposal and the lack of clear consistent information has been

problematic. Going forward with the APM implementation, the state must take the time to plan ahead to provide information in a clear and consistent manner so that Vermonters can participate in the public process in a meaningful way.

We apologize for the confusion caused by updating the public forum schedule, but felt it was important to be responsive to requests as they were made. That said, the All-Payer Model has been the subject of much discussion during the past two years. The Legislature passed Act 54 of 2015 and Act 113 of 2016 related to the All-Payer Model after extensive testimony. The GMCB held over a year of stakeholder meetings and multiple board meetings on the subject. Multiple updates were given to SIM workgroups. The Administration and GMCB released a draft term sheet in January 2016, which was similar to the draft agreement. Finally, the Administration held public forums in Norwich, Burlington, Rutland, and Brattleboro. The GMCB also held a board meeting in Newport to solicit comments on the APM.

Administration Response to PHA Questions/Comments

Question/Comment 1: Primary Care Inclusion. While the Agreement is broad enough to allow the GMCB to ensure primary care is a key component of the ACO, there is no specific language clarifying the impact on primary care within this total cost of care system or how support of clinical programs in the primary care setting will be established.

The multi-year stakeholder process convened by the GMCB included the perspective of primary care physicians through the ACOs HealthFirst, CHAC, and OneCare Vermont, all of which include primary care. Materials developed by the stakeholder group establish the importance of primary care to the All-Payer Model. The All-Payer Accountable Care Organization Model draft agreement between CMS and VT would provide an opportunity for private-sector, provider-led reform in the state and would allow the ACO to determine how to reimburse primary care within the total cost of care system.

The All-Payer Model agreement reflects the importance of primary care in several ways. One of the high level Statewide Health Outcomes Targets in the draft agreement is to improve access to primary care, thereby emphasizing and elevating the importance of primary care in the All-Payer Model. Additionally, the agreement contains specific Medicare funding for primary care by extending the Blueprint for Health funding.

Question/Question 2: Blueprint/SASH Funding. How will funds in 2017 be distributed and impact current Blueprint payments for both provider practices and Community Health Teams? How will funds be distributed in 2018 and beyond? Will the current Blueprint program continue with provider participation being outside the scope of the ACO model? How will programs such as SASH, Hub and Spoke (MAT services) and other programs under the Blueprint umbrella be reimbursed and sustained? What infrastructure will be supported through this one time funding? (Will the process be grant request like, such as SIM funds, subject to review and detailed accounting reports?)

i. One-time funds in 2017 will be distributed by AHS for Blueprint and SASH activities, consistent with how the programs were funded in 2016, with oversight by the GMCB.

ii. *Medicare funding for Blueprint and SASH programs will be provided for through the ACO model in 2018 through the end of the agreement. Commercial and Medicaid participation in the Blueprint will continue to be structured as it is today. The Hub and Spoke Program stands alone as a Medicaid Health Home initiative, with commercial participation.*

iii. *In 2018 through the end of the agreement, the ACO will be responsible for distributing Blueprint and SASH payments from Medicare consistent with the scope of the programs today. If the program scope changes over time, the ACO's responsibility may also change. Changing the scope of the program would require legislative input and, potentially, statutory change.*

iv. *One-time funding in 2017 will be distributed to the ACO participating in the all-payer model through the Agency of Human Services, consistent with the funding purposes laid out in Appendix 2 of the Draft Agreement, and will have sub-grantee reporting requirements.*

Question/Comment 3: MACRA The GMCB FAQ document notes APM will support provider compliance with MACRA but the Draft Agreement is silent as to qualification as an Alternative Payment Model. Given this program is a deviation from NextGen in 2017 and a new model from 2018 on, will the CMS clarify that this program would be considered an Alternative Payment Model?

The All-Payer Model is designed so that the Vermont Modified Next Generation Program and the Vermont Medicare ACO initiative meet the requirements of an alternative payment model under MACRA and likely an advanced alternative payment model. Both the Next Gen ACO Program and Shared Savings Programs have been noted in the rule as potentially qualifying as alternative payment models. A key distinction should be made between an alternative payment model and an advanced alternative payment model, for the purposes of providers being exempted from MIPS and receiving a 5% increase. Not all shared savings programs tracks are indicated as potentially qualifying as advanced alternative payment models, because not all tracks provide for assuming nominal risk. CMS has a process for designating Vermont's All Payer Model as an advanced alternative payment model. If the APM is approved, we expect verification to be posted on CMS' website shortly after approval by Vermont.

Question/Comment 4: Chronic Conditions Targets Measuring prevalence on the basis of self-reported survey allows for subjective, inconsistent and flawed responses. Data are available in claims and clinical systems to identify patients who are at risk and incidence rates. Has such been considered? Is incidence being considered relative to measurement of how we reduce the prevalence of disease rather than how we manage the high cost care associated with it?

The survey proposed to capture results for these statewide prevalence measures is the Behavioral Risk Factor Surveillance System (BRFSS) survey conducted by all 50 states and 3 territories (it has been conducted since 1990 in Vermont). The Vermont Department of Health website indicates that "More than 6,000 Vermonters are randomly and anonymously selected and called annually." The use of this survey permits comparison with other states, and with prior year Vermont results. There was some discussion of seeing whether we could use Medicare claims data, but the BRFSS survey was ultimately proposed to provide comparability and to capture a broader population (including people who have other insurance or have no claims during a given year). A measure in the proposed set that speaks to reducing prevalence is Tobacco Use Assessment and Cessation Intervention.

Question/Comment 5: Access to Care Target This target relates to Issue #1 when primary care has not been specified within the Draft Agreement. The deliverable to satisfy this target will be based on a well-supported primary care system that is able to increase access, increase focus on preventive and primary

care, while ensuring patient centric care is provided. How does the State intend to engage with primary care providers to attain this goal?

See question 1.

Question/Comment 6: Chronic Conditions Target—Composite of Diabetes, Hypertension, and Multiple Chronic Conditions This form of measurement obviates the good done for people with the advanced disease (as is often the case for the Medicare population) in controlling their levels (e.g. HbA1C from 14 to 8, and that's real progress when achieving an arbitrary national percentile of 6.5 or below does not acknowledge improvement actually achieved). How were metrics and measurement standards selected for items such as this?

For this composite measure for Medicare ACO beneficiaries, Diabetes Poor Control measures the percentage of diabetics with HbA1c greater than 9.0. All three sub-measures are part of the Medicare Shared Savings Program measure set, so they are familiar to ACOs and to provider organizations. There was an effort to support national measures that have been tested and are already being collected (particularly when they rely on clinical data, as is the case with two of the three sub-measures).

Question/Comment 7: The GMCB Role What exactly will the GMCB's role be and how does the GMCB see including primary care providers in this process? While not the subject of the agreement, how does the GMCB plan to ensure any total cost of care increased spending resulting from increases in hospital budget spend does not have a negative impact on reimbursement professional services, specifically preventive and primary care services?

The GMCB will work with CMS to create the Vermont ACO Initiative. In partnering with CMS, the Board will have the opportunity to define components of an ACO program, based on the Next Generation ACO Model. For instance, the Board and CMS may find that to better align with an all-payer model, the Medicare ACO Initiative in Vermont may need to alter the quality measures, attribution methodology, or beneficiary enhancements. As is true today, an ACO working within a Vermont Medicare ACO Initiative will be responsible for ensuring that the model promotes preventive and primary care, and reimburses primary care accordingly.

Through its role assigned by the Vermont State Legislature in Act 113 of 2016, the GMCB will be responsible for oversight of ACO budgets. It is through this mechanism, not the All-Payer Accountable Care Organization Model draft Agreement that the Board could establish parameters for ACO investment in primary care. However, the Board has not yet written a rule for ACO Oversight through Budget Review; these discussions and related policy development will be forthcoming.

Administration Response to AAPVT Questions/Comments

Comment 1: The Affordable Care Act (ACA) included an important provision to address the problem of low Medicaid physician payment. This was a historic investment in care provided in the Medicaid program. However, since January 1, 2015, following the expiration of the federal ACA Medicaid payment increase, Medicaid payment levels in Vermont have been cut by 20%. Coupled with the expansion of eligibility this has resulted in an even deeper cut for pediatric offices. We simply can't afford to turn back the clock on the inroads we have made for children enrolled in Medicaid. The agreement must commit the State of Vermont to increasing Medicaid reimbursement to at least the negotiated or

applicable Medicare level. We believe that this would have a favorable impact on our ability to attract and retain child health care professionals, a critical force in our efforts to improve child and family health care delivery and outcomes, across the life course.

The Administration shares the concern regarding the sufficiency and sustainability of Medicaid payment rates. Previously, the Administration proposed revenue increases to boost Medicaid rates, which were rejected by the Legislature. The agreement reflects that concern by (1) setting the expectation that Medicaid be a reliable payer, (2) requiring reporting about the payer differential, and (3) creating an incentive for increasing Medicaid rates by exempting those rate increases from the financial targets in the model.