

FREQUENTLY ASKED QUESTIONS: ALL-PAYER MODEL DRAFT AGREEMENT

Goals of the Model

- 1) What are the goals of the model?
 - a) The goals of the model are to: (1) limit health care cost growth to no more than 3.5% in aggregate across all payers, (2) increase access to primary care, and (3) improve the health outcomes of Vermonters.

Accountable Care Organization (ACO) Issues

- 2) Are ACOs new nationally or in Vermont?
 - a) No. ACOs have been discussed for approximately ten years, and the Centers for Medicare and Medicaid Services (CMS) began offering ACO programs after the passage of the Affordable Care Act. CMS is testing ACOs using various programs to determine their effectiveness in driving health care reform and innovation. The All-Payer Model (APM) builds on Vermont's experience with the Medicare Shared Savings Program for ACOs and Vermont's previous experience aligning commercial insurance and Medicaid with that Medicare ACO program. The APM continues to build on existing federal programs, this time aligning with the federal Next Generation ACO Model.
- 3) How is the Next Generation ACO program different from what Vermont does with ACOs today in the Medicare Shared Savings program?
 - a) Next Generation is distinct from the Medicare Shared Savings Program in a number of ways. The Next Generation program offers financial arrangements with higher levels of risk and reward than current Medicare ACO initiatives and includes a new payment model that moves away from fee-for-service to all-inclusive population based payments (AIPBP), also referred to as capitation. Also central to the Next Generation ACO program are several "benefit enhancement" tools to help ACOs improve engagement with Medicare beneficiaries, such as greater access to post-discharge home visits, telehealth services, and skilled nursing facility services.
- 4) Could an ACO participate in the Next Generation ACO program without this state and federal agreement?
 - a) Yes. ACOs can be accepted into and participate in the Next Generation program without an all-payer model agreement. In fact, OneCare Vermont was accepted into this program independent of any state and federal agreement. The State and ACO OneCare believe that the APM offers more financial support, flexibility, and local control than a Vermont ACO could achieve independent of the proposed agreement.
- 5) The agreement describes the relationship between an ACO and Medicare. How does an ACO partner with Vermont Medicaid or commercial insurance?
 - a) Medicaid and commercial insurers would create programs that are aligned with the Medicare Next Generation program and contract with an ACO willing to participate in those programs. The Medicaid and commercial Next Generation-style programs would focus on similar services, a specified level of risk, and financial incentives based on quality goals. For example, Vermont's

Medicaid program published a request for proposal (RFP) for an ACO to participate in a Next Generation ACO program beginning in 2017. Vermont Medicaid and OneCare Vermont are currently negotiating a contract based on that RFP.

- 6) Why does the ACO have its own participation agreement with the federal government?
 - a) The State will not receive money from Medicare to care for beneficiaries. Medicare continues to pay providers, either directly or via the ACO. Since Medicare is paying an ACO in a manner that is different than Original Medicare and allows the ACO to waive certain rules to benefit patients, a separate agreement is required between the federal government and the ACO. This mirrors the process used in the Medicare Next Generation ACO program. In 2017, there is one-time funding for the Blueprint for Health and Services and Supports at Home (SASH) that will come to the State. This funding would expire on 12/31/16 absent this agreement given the sunset of the federal program.
- 7) What happens if no ACO wants to participate in the APM?
 - a) The APM is premised on the use of an ACO or ACOs. Vermont would need to work with the federal government to either wind down the APM Agreement or substantially alter its terms in the case that there were no ACOs willing to participate. It is important to note that Maryland runs an all-payer model for hospital services that does not utilize ACOs. Accordingly, it is possible that Vermont could design an alternative method to meet the financial and quality goals set forth in the model without an ACO or ACOs, but it would be substantively different than the proposed APM.
- 8) How does the ACO know who is in the APM?
 - a) The program uses prospective attribution. Specifically, the ACO identifies all providers and Vermonters willing to participate in the program beforehand. This is done through contracting between the ACO and willing providers with the providers furnishing a list of patients. The participant list is finalized prior to the start of the performance year and new patients cannot be added once the performance year begins. Vermonters would be attributed to the ACO if their primary care physician has joined the ACO and the beneficiary has not opted out.
- 9) Does the ACO get paid if someone does not require care? What if someone uses a lot of care?
 - a) The ACO will be paid a set amount for each attributed member, and the ACO is financially responsible for each person. This is true whether that person uses little or no care, or whether they require major surgery. One key feature of the APM is to give providers certainty and predictability regarding revenue for a pre-identified population of Vermonters. This should lead to better incentives and provider investments that improve the quality of care when Vermonters need it.
- 10) What services will the State be accountable for financially?
 - a) The financial success of the APM is determined by evaluating Vermont's performance in spending on regulated services. Regulated services, as part of the agreement, include what are traditionally known as Medicare Part A and B services, and the equivalent services covered under Medicaid and commercial insurance. Part A and B services include those services typically provided in a hospital inpatient and outpatient setting and professional services, such as services provided by physicians, nurse practitioners, physicians' assistants, physical therapists, occupational therapists and others. Part A and B services may include services provided at ambulatory surgery centers, urgent care centers, and Skilled Nursing Facilities. Medicare Part

D pharmacy services and pharmacy services in Medicaid and commercial insurance are currently not included in the regulated services, but may be phased in over time.

- 11) For what services will an ACO be accountable?
 - a) The ACO will be accountable for Medicare Part A and B services for Medicare beneficiaries attributed to the ACO. Separately, the ACO or ACOs will contract with commercial insurers and Medicaid. These contracts could make the ACO accountable for any service that both parties agree to hold the ACO accountable for; however, we anticipate these contracts to focus on services similar to Medicare Part A and B services at the start of the APM.

- 12) What incentives will the ACO have to contract with home health, designated agencies, and other community providers?
 - a) The ACO will be measured on both the quality of services provided, and impact on Vermonters, and the cost of services provided. Community-based services tend to be less expensive than hospital services, while offering necessary high-quality care. The ACO will have an incentive to contract with home health agencies so that Vermonters attributed to the ACO can be better managed at home. Additionally, the ACO will need to rely on the mental health and substance use disorder treatment services provided by designated agencies and preferred providers to ensure their attributed population receives necessary care. Also, Vermont's Legislature has expressed a preference for collaboration between ACOs and Vermont's well-developed home care system. ([See Act 113 of 2016.](#)) There would appear to be little incentive to build a duplicate system of home care.

- 13) How is an ACO different from Medicare Advantage (MA)?
 - a) A Medicare Advantage plan is another way for a Medicare beneficiary to get Medicare coverage, namely through a private insurer that has been approved by Medicare. ACOs, on the other hand, are groups of providers that serve Original Medicare beneficiaries. All of CMS's ACO models are part of the Original Medicare Program and follow Original Medicare rules and processes, and ACO beneficiaries have freedom of choice to go to any Medicare billing provider. Beneficiaries aligned to Next Generation ACOs maintain Original Medicare benefits. For example, there is beneficiary freedom of choice of provider, as opposed to the defined provider network of an MA plan. There is no requirement that a beneficiary receive services from providers within an ACO, nor is there additional premium paid by the beneficiary for being in an ACO.

- 14) How would community-based providers be paid for services for ACO attributed patients?
 - a) The ACO and community based providers, such as home health agencies, designated agencies, developmental disability service providers, emergency medical service providers, adult day service providers, and area agencies on aging would negotiate independent agreements that describe the terms and payment for coordinated care. It is important that the community-based providers be adequately funded to provide the services needed to meet the APM's goals.

- 15) Did Dartmouth Hitchcock Medical Center (DHMC) drop out of the ACO?
 - a) No. DHMC remains a founder and member of OneCare Vermont and an active participant in health care reform activities in Vermont. Separately, DHMC ended its participation in the Medicare Pioneer ACO program in 2015 due to specific challenges within the Medicare Pioneer ACO program.

Consumer Issues

16) How does the All-Payer Model benefit consumers?

- a) We know that Vermont families are struggling to afford health care today. This problem will grow worse over time if health care costs continue to grow faster than personal income and the economy. The APM seeks to fix an antiquated health care payment system that provides clear financial incentives for health care professionals to order additional tests and procedures, and replace it with one that rewards health care professionals to deliver the care they know to be most effective in promoting and managing the health of the population they serve. The result will be a health care system that has aligned incentives to improve quality and reduce unnecessary costs, and thereby increase affordability for Vermonters. The APM will also focus on improving the quality of care for Vermonters. The APM, through the ACO(s), will allow Vermont communities to take further steps in a coordinated approach to population health management while addressing the overall health and health care needs including social determinants of health. The APM supports a model of care that focuses on the individual receiving services. The ACO(s) will work to invest in and strengthen primary care including recruitment and capacity expansion, while simultaneously working collaboratively with community-based services (home health, mental health, developmental disabilities, substance abuse, and social services) and community hospitals. The ACO will focus on improving the health care quality within and across communities with an aim to positively impact the health of the population by promoting effective processes and reducing variation.

17) How will consumers of health care be engaged in an ACO?

- a) Consumers own involvement in their health care management is recognized as a vital component of the health care delivery process. The consumer perspective is critical for ACOs and they will ensure mechanisms to solicit consumer input and incorporate it into clinical and business initiatives and policies. The ACO(s) will incorporate consumer involvement and engagement at the governance level through the governing board and through consumer advisory bodies. In both of these forums the consumers' voice and input is directly received and highly valued. Consumer input is also incorporated by clinical advisory group. Consumers will continue to have freedom of choice in selecting their health care providers and will be supported in building relationships with their provider(s). Consumers will also have access to a complaint process through the ACO. With efforts to ensure the consumer is both involved and has appropriate protections in place there is room for a well-balanced relationship to be formed.

18) What extra benefits may a Medicare beneficiary get?

- a) The Medicare Next Generation program allows ACOs to participate in certain benefit enhancements, such as: greater access to post-discharge home visits, telehealth services, and skilled nursing facility services. Vermont and CMS may negotiate for additional benefit enhancements for the APM over time. An ACO may choose not to implement all or any of the offered benefits enhancements.

19) How can you guarantee that I get all the Medicare benefits I earned over my lifetime?

- a) Vermonters entitled to Medicare keep all their benefits and freedom of choice. The ACO and State cannot in any way change Medicare benefits or access. This can only be done by an Act of Congress.

- 20) How can you guarantee I can still see my same doctor?
- a) A core principle of the Next Generation ACO program is to protect Original Medicare fee-for-service beneficiaries' freedom to seek the services and health care providers of their choice. Beneficiaries retain full freedom of choice of providers, as well as all rights and beneficiary protections of Original Medicare. The ACO cannot change the benefits or freedom of choice for any Medicare beneficiary. Medicare benefits can be changed only by an Act of Congress. Similarly, the ACO cannot change any benefits or freedom of choice for Vermonters with Medicaid or commercial insurance.
- 21) What if my doctor chooses not to join an ACO?
- a) You will not be attributed to the APM. Patients are generally attributed to the APM via their primary care physician, and physicians and their practice are only part of the the APM if they choose to contract with a participating ACO.
- 22) I can't find a primary care doctor now, how will this increase access to primary care?
- a) A theory behind the APM is that it will promote greater investments in primary care physicians and other primary care providers. These investments should, over time, create incentives that increase the number of primary care clinicians in Vermont, creating greater access. For example, people are only attributed to the model if they have a primary care physician. This means the ACO only gets paid when an individual has a primary care physician, creating a powerful incentive for improved access.
- 23) Will there be cherry picking? Specifically, won't the participating providers in the ACO/APM have a financial incentive to underserve Vermonters?
- a) This concern will be addressed through a variety of means, including patient surveys, access reports, and transparent measures of quality and performance at an institutional, practice, and provider level. This is the primary reason why the collection of performance information and the transparent reporting of quality and performance results, under the regulatory oversight of the Green Mountain Care Board, is so critical to the success of this initiatives. These safeguards must be employed to make our efforts to improve the health of Vermonters successful.
- 24) Will patients be aware that they are in an ACO?
- a) The State of Vermont and CMS support the dissemination by ACOs of information identifying all participants associated with the ACO and making beneficiaries aware of their participation. This has been true in previous ACO models in Vermont. For example, the current Medicaid Shared Savings program required ACOs to notify Vermonters that they could opt out of any data collection done by an ACO. As always, Vermonters should discuss ACO concerns with their primary care physician.
- 25) What if the services or prescriptions that I want are more expensive, but I know that they are the only thing that work for me, will my doctor still provide them to me?
- a) Doctors and patients will continue to make shared decisions about a patient's care. The ACO cannot limit doctors and patients to less expensive services if the doctor and patient believe that a different service is the best choice. ACOs empower your doctor by providing information and data regarding best practices, but doctors and patients always make the final decision. While

the ACO cannot deny services, it is important to remember that your insurance benefits remain those offered by your insurer and subject to the terms of your insurance plan.

- 26) Is the ACO involved in prescription drug spending?
- a) Medicare Part D prescription spending is not included in the APM at this time. Prescription drugs will not be part of the program for commercial insurance or Medicaid.
- 27) What if I go to a doctor out of the ACO network?
- a) Vermonters will continue to have full freedom to visit doctors, per the terms of their insurance benefits. The ACO cannot in any way limit a person's choice of doctors. The deductible or co-insurance set by your insurance plan still applies.
- 28) How will payments be made on behalf of attributed individuals who seek services at a non-participating provider?
- a) Non-participating providers will be paid as they are currently. However, the ACO will be at risk for those expenditures.
- 29) What if I go to a doctor out of state?
- a) Out-of-state providers serving Vermont residents, whether attributed to an ACO or not, will be paid fee-for-service payments based on the payers' standard payment rules for out-of-state services. For example, a Vermonter with Medicare visiting Florida could go to the doctor and Medicare would pay that doctor exactly the same way it does today.

Quality Measurement Issues

- 30) How did Vermont and CMS choose the four major quality measures?
- a) The GMCB, AHS, Vermont Department of Health, and CMS selected big-picture population health measures that would be meaningful to Vermonters, based on the health of our population, in assessing the impact of the model on the State as a whole. These measures are:
 - Reduction of substance abuse deaths;
 - Reduction in suicide deaths;
 - Reduction in chronic diseases, including Chronic Obstructive Pulmonary Disorder (COPD); diabetes, and hypertension; and
 - Access to a primary care physician.These measures would function as a scorecard that would help Vermonters assess the APM's effect on big picture population health challenges. Additional quality measures were selected to provide incentives to encourage the behavior needed to drive success in the big picture population health measures. These measures are, by and large, rooted in quality measures that exist for Vermont's Shared Savings ACO programs today.

Provider Issues

- 31) How does the All-Payer Model benefit health care providers?
- a) The All-Payer Model produces a number of benefits for Vermont providers. First, during a time of upheaval in the Medicare program, it provides five years of predictable revenue growth, and provides Vermont the opportunity to benefit from the CMS [MACRA MIPS](#) program that rewards providers who participate in alternative payment models. Second, the APM waives some challenging Medicare policies, such as the restriction on coverage of nursing facility services

unless the admission is preceded by a hospital stay of at least three days. Third, the new payment models reduce the unpredictability found in the current fee-for-service models for many providers. Fourth, it creates an aligned set of performance measures for use across Medicare, Medicaid, and commercial payers, thereby reducing administrative burden. Fifth, it creates a provider-led and governed organization, with a substantial role for regional clinical leadership, that will allow providers to determine how best to deliver care, improve quality, and marshal resources. Sixth, the model proposes to continue Medicare financial support that would otherwise expire on 12/31/16 for the Vermont Blueprint for Health, including Community Health Teams (CHTs), physician PMPM payments, and Support and Services at Home (SASH). Seventh, it better aligns Vermont's Medicaid waiver with the process of integrating the entire health care system across payers.

32) What are the reasons that I, as a provider, would want to participate in the APM?

- a) The APM is focused on value-based payment reform and the population health management approach to care delivery. The goal is to have the broadest possible coalition of providers across the continuum of health care and health-related social service organizations participate in an ACO under the APM. By providing access to ACO projects and well-designed alternative reimbursement models, along with provider- and community-focused supporting infrastructure and tools, the APM will allow for a coordinated approach to population health management across the continuum. ACO interventions will target preventive services through complex acute care, addressing overall health needs including social determinants of health.

33) I'm a provider and if I join the ACO, how am I going to be paid?

- a) Providers would only be paid by an ACO if they choose to contract with an ACO. The APM does not require providers to join an ACO. An ACO using the AIPBP payment mechanism will set payment rates for participating providers. Non-participating providers will be paid in exactly the same way that they are today; however, it's important to note that payment methodologies are changing with or without the APM. Current federal law will change the way Medicare providers are paid over time starting in 2020, adjusting payment up or down based on quality measures. Also, commercial insurers and Vermont Medicaid retain the right to change the payment rates for providers independent of the APM.

34) How does the APM address the payment differential between independent and employed doctors?

- a) The APM does not require ACOs to address pay parity between independent and employed doctors. However, we believe that the APM should better align those payments over time should independent physicians and other providers choose to contract with an ACO.

35) If hospitals are on fixed budgets, what if they run out of money part way through the year?

- a) Hospitals and the ACO(s) need to have a risk mitigation plan in place to deal with any financial losses. For example, the ACO(s) may have insurance to cover unexpected losses. Also, payers may work with an ACO to mitigate risk. For example, Medicare will have certain provisions in place to limit ACO losses on any specific patient, true outliers with extremely high costs, and within the program overall. Also, it is important to note that the number of lives within the APM will start low and grow over time providing more stability.

- 36) How is the All-Payer Model going to simplify administrative costs and create savings?
- a) An all-inclusive population based payment capitation for professional services and hospitals, over a phased period of time, should reduce some administrative burdens that currently exist under fee-for-service payment system, such as: prior authorization, payer utilization reviews, responding to payer-specific performance measures, resubmitting lost claims, etc... However, most of these efficiencies can only be realized if a high percentage of Vermonters are attributed to an ACO.
- 37) How will hospital market-share adjustments work, including: changes related to shift in market share from one hospital to another; changes related to new developments in medicine; and changes related to unmet community needs? Will market-share payment adjustments take into account the variation in variable/fixed costs related to the size of a hospital?
- a) The Green Mountain Care Board engaged many members of the provider community in a stakeholder process throughout 2015 and 2016. The process developed a framework that tried to craft potential processes and solutions to the nuts and bolts aspects of operating the APM. The framework did not provide definitive guidance; however, it provided a starting point to address difficult challenges. As described in the framework, hospital budgets may be adjusted to account for changes in hospital utilization of attributed lives based on GMCB and ACO(s) analysis of utilization. Any change in utilization above or below a minimum percentage floor may subject a hospital to an adjustment for the next budget year. The minimum percentage adjustment may vary based on hospital size and/or the affected services. At this time, it is not intended that there will be mid-year adjustments except in extraordinary circumstances. The proposed rules for how these market share adjustments will be made should be included in an ACO business plan and will be subject to review and approval by the GMCB.
- 38) How will other revenue be accounted for, including: Medicare DSH payments, medical education, Blueprint payments to administrative entities and PMPM payments to practices, grant revenue, care coordination fees, and Medicare volume payments?
- a) As noted above, initially only Medicare Part A and B payments and their equivalents in Medicaid and commercial insurance will be included in the “regulated revenue.” Medicare Blueprint payments will also be counted in Vermont’s baseline and financial targets. Additional non-claims based payments will not be part of the financial targets but may be included in the GMCB hospital budget review process and ACO regulation. For participating providers, the ACO(s), CMS, GMCB, and AHS will need to work collaboratively to determine whether and how these non-claims based payments will be made under the APM.
- 39) How will the All-Payer Model manage cost report settlements for Critical Access Hospitals? How will the model handle other Medicare status such as Sole-Community and Medicare-Dependent hospitals, etc.?
- a) The All-Payer Model will follow the federal Next Generation payment structure for these types of circumstances. Next Generation does allow participation by Critical Access Hospitals and the others mentioned above. How these settlements and/or enhanced payments will be made needs to wait for direction from CMS. Vermont is proposing that the revenue associated with these payments will be included in the base budget for the All-Payer Model and trended forward.

- 40) Will more consistency be needed in how hospitals account for charity care and bad debt within budgets?
- a) It certainly makes sense that there will need to be more consistency in how hospital accounts in general (including bad debt and charity care) are recorded in their budgets. Without this consistency, it will not be possible to compare the financial performance of hospitals participating in the system. This may require more standardization regarding the definitions of the hospital chart of accounts and how revenue and expenses are recorded. This is something that may be considered in an ACO business plan, and may be incorporated into provider participation agreements. This approach could be phased in over time, and may not be a Year 1 requirement.
- 41) What about out-of-state patients seen in Vermont? How are claims paid on their behalf? Are they in the APM?
- a) Payments for out-of-state residents seen by Vermont providers are currently included in the hospital budget Net Patient Revenue (NPR) caps in accordance with the GMCB hospital budget rules. It is expected that this revenue will continue to count against the hospital budgets caps as it currently does. These payments are not part of the ACO(s) responsibility under the capitated payments, nor do they count against the financial targets in the model.

State Issues

- 42) How does the All-Payer Model benefit the State of Vermont?
- a) As is true for families, the state experiences the rising costs of health care. A large portion of the state's budget is devoted to health care and it is in the best interest of the state, as well as consumers and providers, to pursue a model that will reduce the growth of costs of health care for the state, while simultaneously improving the quality of care. The APM seeks to fix an antiquated health care payment system that is inherently inflationary. The APM builds off federal and state value-based health reform efforts, and moves the financial accountability for cost efficiency and quality of care away from the state and consumers, to provider organizations who are in the best position to influence quality and costs.
- 43) What is different about the APM and the roughly 3.5% target that the GMCB already sets for hospital growth?
- a) Both numbers express Vermont's policy goal of aligning overall health care spending with economic growth. The two targets are not linked in the agreement, but the APM's financial targets will likely interact with hospital growth targets in two ways. First, the GMCB will likely use hospital budgets as a tool to keep health care spending aligned with the APM's financial targets. Second, ACO revenue will comprise a portion of hospital budgets for participating hospitals. This will inform hospital budget submissions.
- 44) How does the APM reduce the cost-shift?
- a) The APM does not require Vermont to address the cost shift. The model agreement provides clear expectations that Vermont Medicaid will be a reliable payer, not exacerbating the historical cost shift for regulated services. Vermont is required to report on the payment

differential by payer annually to the federal government. Additionally, the agreement provides incentives to address the cost shift for regulated services. Specifically, any progress Vermont makes in increasing rates and narrowing the cost shift does not count against the financial targets in the agreement. For example, let's imagine that Medicare pays \$100 for Service X and Medicaid pays \$80 for Service X today. In 2018, Performance Year 1 of the model, Medicare continues to pay \$100 for Service X and Medicaid increases its reimbursement to \$100. The \$20 to eliminate the payer differential would not count against the financial cap.

- 45) What happens if there is a big and unexpected change in Vermont's economic or health care situation during the term of the APM?
- a) The agreement includes a provision to re-open the financial terms if there is a shock to the system, such as a major recession or unexpected and expensive health care crisis.
- 46) What is OACT?
- a) OACT is the Office of the Actuary for CMS. OACT serves many functions for CMS, including publishing cost projections and economic analyses, providing actuarial, technical advice, and consultation to CMS, governmental entities, Congress, and outside organizations. The agreement uses OACT projections to set the financial targets and Medicare savings targets of growth and savings targets for the APM. Additionally, OACT projections will inform GMCB rate setting.
- 47) Who determines the base? Who determines the trend?
- a) It is important to think about base and trend in two distinct ways. The GMCB will set the base and trend prospectively for a Vermont ACO subject to CMS approval. This will be set based on the CMS Office of the Actuary (OACT) projections published each year and subject to the principles set forth in the agreement. Separately, CMS will use base and trend retrospectively to assess whether the APM met its financial goals. In this case, CMS evaluators will use Medicare data to determine the actual spending in 2017 and compare it to actual spending growth (trend) in performance years one through five, 2018 – 2022.
- 48) Does the model take into account the age and health of Vermonters?
- a) Yes. Financial targets and payments are adjusted based on demographic factors, including age, health, and whether a Medicare beneficiary is suffering from End Stage Renal Disease.
- 49) How did we pick 3.5% as the financial target for Total Cost of Care?
- a) Vermont wanted a target that reflected economic growth over time. The past 15 years of Vermont's nominal economic growth is between 3.4% and 3.5% based on data that informs the Legislature's consensus economic forecast.
- 50) Why not wait for new President/governor?
- a) Both federal and state law are clear: health care cost containment is a clear policy goal for the Country and State regardless of the President or Governor. (See the Affordable Care Act and Act 48 of 2011.) Furthermore, the APM will generally be operated by federal and state officials who will retain their positions regardless of the transition to a new Federal and State Administration.

51) What is Legislature's role?

- a) The Legislature plays two critical roles, as the appropriator of Medicaid monies and overseer of the Medicaid and ACO regulatory programs. First, the Legislature appropriates all monies for Vermont's Medicaid program. Vermont cannot be a reliable payer in the APM without support from the Legislature. The Legislature appropriates monies within Vermont's 1115 Medicaid waiver, which is a vital source of dollars to achieve health care innovation and integration. This will be particularly important as the State evaluates how additional Medicaid services, such as substance use treatment, home based services, and nursing care, could be included in the APM over time. Second, the Legislature retains its traditional oversight function. For example, in 2016 the Legislature created a regulatory system for ACOs to be administered by the GMCB. (Act 113 of 2016.) The Legislature will likely work to assess the GMCB's performance in administering the principles set forth in that law. Also, the Legislature would likely compare the performance of the Medicaid program, in both cost and quality, for ACO attributed Medicaid beneficiaries versus Medicaid fee-for-service beneficiaries not attributed to the ACO.

52) Why is 2017 called Year Zero.

- a) CMS and Vermont need time to prepare for the model. 2017 will be a capacity building year that allows CMS, GMCB, AHS, the ACO(s), and providers to finalize the many nuts and bolts issues that go into standing up and operating the APM.

53) Is Vermont or the ACO going to seek additional waiver over time?

- a) The GMCB, AHS, ACO(s), and other members of the provider community will need to work collaboratively over time to identify other Medicare waivers that would benefit beneficiaries and help achieve the goals of the APM. Whether these are waivers that run between CMS and the ACO or CMS and the State will depend on the specific waiver request.

54) Are we able to get timely data from CMS that would help Vermont and the ACO(s)?

- a) Yes. CMS has committed to helping Vermont and the ACO(s) get better and more timely data to inform the APM.

55) What happens to SASH and Blueprint?

- a) Medicare has committed to continue funding a portion of SASH and Blueprint throughout the APM. These programs will work similar to how they work today in 2017. The ACO, AHS, GMCB, and these programs must work collaboratively in 2017 to determine the mechanics of the programs in future performance years.

56) How closely aligned will Medicaid's program be in the APM?

- a) The Medicaid ACO program is based upon the Medicare Next Generation ACO program in order to align these programs as closely as possible. There will be some reasonable variation based on one of two factors: (1) quality measures will vary slightly since Medicaid has different demographics than the Medicare program. For example, very few newborns are covered by Medicare; and (2) Medicaid and the ACO may agree to accept a different level of risk based on negotiations. The APM requires Vermont to report upon these variations annually and either justify them or remove them from the Medicaid program.