



# VERMONT ALL-PAYER MODEL TERM SHEET PROPOSAL

Companion Paper

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Vermont Agency of Administration  
Green Mountain Care Board

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## Overview

Vermont’s Legislature directed the Green Mountain Care Board (GMCB) and the Agency of Administration (AOA) to jointly explore an all-payer model.<sup>1</sup> An all-payer model is an agreement between the State and the Center for Medicare and Medicaid Services (CMS) that allows Vermont to explore new ways of financing and delivering health care. The all-payer model enables the three main payers of health care in Vermont – Medicaid, Medicare, and commercial insurance, to pay for health care differently than through fee-for-service reimbursement.

In an all-payer model, Vermonters will have the same choice of providers as they have today under Medicare, Medicaid, and commercial insurance. Benefits will not be reduced. By contrast, Medicare beneficiaries may have access to, and coverage for, new services not covered by Medicare today.

The GMCB and AOA have jointly explored an all-payer model through dialogue and negotiation with CMS. The result of this dialogue, and consultation with stakeholders and consultants, is a *term sheet* proposed by the State of Vermont to CMS that broadly reflects a policy framework to enable the waivers of federal law necessary to operate an all-payer model.

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<sup>1</sup> Act 54 of 2015.

It is unusual to divulge the negotiating position of a party in the middle of a negotiation; however, the GMCB and AOA are circulating the *term sheet* and this companion paper to ensure maximum transparency and seek input. Neither this white paper nor the proposed term sheet represent a binding commitment on the part of Vermont or the Federal government. Furthermore, the term sheet may evolve as it works its way through both the state and federal clearance processes. All materials should be considered preliminary until a final agreement is potentially reached later this year. If Vermont decides the final agreement is not better than today's system, it can end the negotiation. Similarly, if CMS is not satisfied that the overall proposal meets its policy and financial goals, it can decline to enter into the agreement.

The paper seeks to answer four key questions important to Vermonters:

- Why do health care payments need to change?
- What is an all-payer model and why are we proposing it?
- What is Vermont proposing in the draft *term sheet*?
- How will the *term sheet* be evaluated?

## Why do health care payments need to change?

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 income and the economy.

Health care is expensive. When the fee-for-service health care payment model was devised over 50 years ago, the average life expectancy of Americans was significantly shorter than it is today, and the burden of chronic disease was smaller. The Centers for Disease Control and Prevention (CDC) reports that treating people with chronic diseases accounts for 86 percent of our nation's health care costs. Health care reimbursement was designed to pay for acute medical conditions that required a single visit to the doctor or a single hospitalization. By contrast, persons with chronic conditions require regular, ongoing care across the continuum of traditional medical services and community-based services and supports. Fee-for-service reimbursement makes it difficult for innovative health care providers to adapt to the changing needs of the population that they serve. The antiquated system provides clear financial incentives to order additional tests and procedures, yet it does not reward doctors and other health care professionals for providing individualized and coordinated care for complex chronic conditions. In the end, patients may receive care that is expensive, fragmented, and disorganized.

A new, all-inclusive population-based model of reimbursement rewards health care professionals that are adapting to the changing needs of the population. In this model

doctors and other health care professionals are freed from restrictive reimbursement policies and the silos of care that these policies create. Doctors and other health care providers are empowered to deliver the care that they know to be most effective in promoting and managing the health of the population that they serve. Positioning health care providers to lead health care delivery change creates a more holistic approach to patient care and is at the heart of the all-payer model proposal.

The federal government recognizes that the fee-for-service payment system is a mismatch for evolving health care needs and goals for population health improvement. CMS has created multiple opportunities to pay for value rather than volume in health care, encouraging providers to invest in the collaborative and well-coordinated care that they know to be best for their patients. For example, Vermont has received \$45 million in State Innovation Model (SIM) funds to encourage transformation in how we pay for health care services to make health care more affordable and accessible, while maintaining high quality standards. Additionally, the federal government has created programs that encourage the use of Accountable Care Organizations (ACOs). ACOs are health care provider led organizations accountable for cost and quality of care and agree to be paid in a way different than standard fee-for-service.

CMS has doubled down on this approach, committing to paying for 50% of its services in alternatives to fee-for-service by 2018. Furthermore, CMS has created the Next Generation ACO program, which creates the opportunity for Vermont and others to explore how a truly integrated health care system would work.

## What is an all-payer model and why are we proposing it?

The CMS Next Generation program allows ACOs to be paid in a different way by Medicare. ACOs could receive an all-inclusive population-based payment for each Medicare beneficiary attributed to the ACO. CMS would allow ACOs some flexibility in certain payment rules in exchange for accepting this new type of payment. Medicare will continue to pay providers directly and all of its patient protections stay in place. The CMS Next Generation program creates a new opportunity for Vermont to align Medicare, commercial, such as Blue Cross Blue Shield of Vermont, and Medicaid payments.

In Vermont's proposal, the all-payer model is about getting commercial insurers and Medicaid to pay the same way Medicare will be paying for health care under its Next Generation program. The proposal is for all payers to approach health care payment to ACOs in a common way and for all payers to give doctors and other health care professionals the flexibility they need to lead health care delivery change. Different rules, standards, and methods of payment across major payers creates inefficiencies and unnecessary administrative costs, while under an all-payer model providers and patients can be served by a more coordinated system that is structured to align quality

goals and reduce costs. The State would agree to coordinate with Medicaid and commercial insurers, and in return the federal government would allow Medicare to participate in the ACO value-based payment model. As is true today, health care providers' participation in ACOs is voluntary; the ACO must be attractive to providers and offer an alternative health care delivery model that is appealing enough to join.

This model builds off federal and state health care reform efforts that have value-based payment components today. The Blueprint for Health, for example, provides an essential foundation for enhancing and supporting primary care in an all-inclusive population-based payment model. In 2014, Vermont created an all-payer Shared Savings Program (SSP) for ACOs. Starting with the Medicare SSP, Vermont modeled and aligned a Medicaid SSP program and a commercial SSP program offered by Blue Cross Blue Shield of Vermont. Again, the state will leverage this experience to move from fee-for-service with shared savings to an all-inclusive population payment with quality incentives across Medicare, Medicaid, and commercial insurers using the Next Generation model parameters, adapted for Medicaid and commercial insurers where needed. This model is intended to shift financial accountability for efficiency and quality of care to provider organizations.

## What is Vermont proposing in the draft term sheet?

The AOA and the GMCB have released a draft *term sheet*, which is a description of Vermont's proposal to the federal government. The term sheet contains the elements of a non-binding proposal for an all-payer model that Vermont and CMS identified through iterative discussions. The term sheet is a framework for a potential agreement, but is not an agreement.

The term sheet sets out the basic outline for a potential all-payer model agreement, including the legal authority of the state to enter into such an agreement, the performance period for the agreement, waivers necessary to facilitate payment change and additional covered services, a plan for data sharing, and an evaluation of the demonstration. Central elements of the proposal are highlighted below:

### Medicare Beneficiary Protections

Medicare beneficiaries' access to care and services and providers will not be limited under the all-payer model. Specifically, Medicare beneficiaries in Vermont will:

- Retain full freedom of choice of providers and suppliers, as well as all rights and beneficiary protections of Medicare.
- Retain coverage of the same care and services provided under Medicare today. Medicare beneficiaries will not experience any reductions in benefits or covered services under the all-payer model.

- Vermont may seek benefit enhancements that will directly improve beneficiary access to care and services.

### Statewide Financial Targets

At the heart of the proposal to CMS is a statewide financial target for certain health care services across Medicare, Medicaid, and commercial insurers. The goal of this financial target is to bring health care spending closer to economic growth. When health care costs grow faster than Vermont's economy, Vermont families find their premiums rising faster than wages. This is also true in the state's Medicaid budget, which grows faster than the revenue sources used to fund it.

Over the course of the five-year agreement, the term sheet proposes a statewide spending target of 3.5% with a maximum spending growth of 4.3%, which is about 1% above the 15-year average for Vermont's gross state product.

The term sheet proposes that Medicare will grow more slowly than the national average in Vermont. The term sheet proposes to reduce growth in Medicare costs by .2% off of the national trend for services covered by the agreement at the end of the 5 years.

### Regulated Services

These financial targets are calculated using the health care services currently included in the shared savings programs, although Vermont has the option under the agreement to expand these services for Medicaid. The proposal includes a commitment to develop a path to ensure that services not subject to the financial targets, such as mental health, substance abuse, and long term services and supports, are part of an integrated provider network and eligible to receive funding as part of an ACO network. The proposal does not restrict spending on mental health, substance abuse, and long term services and supports. Critical to the success of the model is the integration of and emphasis on community-based services and supports not traditionally unified with medical services. Additional investments to allow the care continuum to better provide substance abuse and mental health services may save costs by keeping Vermonters healthier and out of the hospital.

### Statewide Quality Targets

The State is proposing three ambitious, population health goals, which are derived from the State's Health Improvement Plan created by the Vermont Department of Health. Vermont will establish population health measures for the State that will be monitored and evaluated over the course of a potential demonstration agreement. Population health goals include:

- Increasing access to primary care.
- Reducing the prevalence of and improving the management of chronic diseases.
- Addressing the substance abuse epidemic.

Vermont will identify existing claims and clinical measures that will help it achieve its broader goals. In addition to these high level goals, the proposal indicates that the GMCB would establish statewide quality measures for the ACO based on the measures currently required in the shared savings programs. ACOs will be held accountable for a wide range of quality measures through a coordinated and consolidated measurement strategy. Just as today, the ACO's performance on the identified measures will impact its all-inclusive population payment.

## Payment & Delivery System Reforms

### Vermont Blueprint for Health and Services and Supports at Home (SASH)

The Blueprint for Health currently includes Medicare payments to its medical homes and community health teams (CHTs) through a demonstration agreement with Medicare that expires at the end of this year, 2016. The State proposes to continue and enhance Medicare participation through the all-payer model agreement. Absent this agreement, Medicare will no longer participate in the Blueprint for Health and the payments will be discontinued by the federal government.

Vermont proposes to expand Medicare's participation in the successful and proven Supports and Services at Home (SASH) program. SASH is a partnership between affordable housing providers, Area Agencies on Aging, Home Health agencies, Mental Health and Developmental Services agencies, Blueprint Medical Homes (and CHTs) and local hospitals. The SASH model provides both individualized and population-based service and supports to Vermont's most vulnerable adults, primarily those on Medicare living in congregate non-profit owned and/or managed affordable housing.

### Expansion of Medicare Services

Vermont proposes to expand Medicare services to Vermont seniors through the all-payer model by allowing an ACO to provide care differently than is currently allowed under Medicare. By allowing additional flexibility in certain areas, health care providers will be able to better care for seniors in the following specific circumstances:

- Three Day Skilled Nursing Facility Rule: This waiver removes the requirement that Medicare beneficiaries have a three-day stay in the hospital before being admitted to a skilled nursing facility to ensure Medicare payment for the skilled nursing facility.
- Telehealth Rule Waiver: Telehealth is currently limited to rural health professional shortage areas. This waiver removes restrictions and allows beneficiaries to receive telehealth services in their homes, whether they are in a rural area or not.



- **Post-Discharge Home Visits:** Today Medicare beneficiaries can receive a post-discharge home visit when they return home from a hospital stay. This waiver eliminates the direct supervision by a physician requirement and allows the ACO to contract with other licensed clinicians to provide a home visit.

#### [Additional Expansion of Medicare Services](#)

Medicare currently does not participate in Vermont's Hub and Spoke opiate addiction treatment program. Vermont proposes that Medicare begin participating in this program in order to ensure that the model addresses the substance abuse needs of Vermont's seniors.

The term sheet proposal also describes Vermont's interest in obtaining additional waivers to facilitate care delivery transformation in the State and enhance the services that Medicare beneficiaries can receive. Throughout the term of the agreement, Vermont will specifically consider whether and how to expand the scope of practice for Nurse Practitioners in Medicare, how to improve the coverage of long term services and supports to enable more continuity of care, and earlier access to the hospice benefit.

#### [Pathway for Integration of Mental Health and Substance Abuse Services and Long Term Services and Supports](#)

Vermont proposes to continue to work with mental health, substance abuse, and long term services and support providers to determine the best path forward to create an integrated health care system. Specifically, the State intends to facilitate a process that sets forth specific steps, analyses, and milestones that will result in an understanding of how payment and delivery system reform could progress for these providers whether they are paid by Medicaid or an ACO. Currently, through the Vermont Health Care Innovation Project (VHCIP), funded with the SIM grant, the Agency of Human Services and VHCIP staff are working with several of these providers on payment reforms.

Examples include:

- Expanding the integrated family services program, which currently provides more flexible funding for children with special health needs;
- Simplifying the structure and administration of the services offered by the designated agencies to provide more flexible funding and streamlined care to improve the availability of mental health and developmental disability services.
- Implementing prospective payments for home health agencies, which is on track to begin in July 2016.

The state is committed to working with providers of these services to ensure integration of care across different types of health care providers. If it makes sense, at some point in the future, these services could be included in the financial targets. At this point in

time, however, there is concern that these service providers may be underfunded and limiting future funding would not improve services. Exclusion from the funding target would not limit the ability of these service providers partnering with an ACO to be included in the population based payment to the ACO or to otherwise work together to integrate care for Vermonters while maintaining independent payment models.

## How will the term sheet be evaluated?

As stated earlier, the term sheet is a non-binding proposal from the State of Vermont to the federal government for an all-payer model facilitated by necessary waivers to allow Medicare's participation. The term sheet sets out the basic outline for a potential all-payer model agreement, but is not an agreement. Major elements of the term sheet include Medicare beneficiary protections, statewide financial targets, statewide quality improvement goals, regulated services, and potential expansions of Medicare covered services. The term sheet also lays out the legal authority of the State to enter into a potential waiver agreement, the performance period for the agreement, waivers necessary to facilitate payment change, a plan for data sharing, and an evaluation of the demonstration.

To determine if the policy framework represented in the term sheet proposal benefits the State of Vermont, the term sheet must be evaluated from multiple points of view including but not limited to:

- Patients;
- Medicare beneficiaries;
- Medicaid beneficiaries;
- Commercial insurance enrollees;
- Uninsured Vermonters;
- Health care providers;
- Providers of community-based services and supports;
- Health care payers: Commercial and Medicaid;
- Legislators; and
- Businesses.

To gather these points of view, the following will occur:

- The term sheet will be made available to the public through distribution to the media and posting on the Agency of Administration and Green Mountain Care Board's websites:
  - [www.gmcboard.vermont.gov](http://www.gmcboard.vermont.gov)
  - <http://hcr.vermont.gov/home>
- The term sheet will be distributed to Legislators.

- The Green Mountain Care Board will hold open, public meetings to discuss and evaluate the term sheet.
- A formal public comment period on the term sheet will be initiated by the Green Mountain Care Board.
- The Agency of Administration will accept public comments at <http://hcr.vermont.gov/home>.

Taking all points of view into consideration, the Green Mountain Care Board and the Agency of Administration must independently assess the all-payer model proposal. The evaluation will reflect the multi-faceted proposal for a new health care delivery model. For example, the Green Mountain Care Board must assess the financial terms laid out in the proposal as well as the parameters it has to work within to implement and govern the model responsibly. In its entirety, the evaluation of the proposal will assess the potential of the all-payer model to build a system that offers the right incentives and rewards providers for delivering on the promise of integrated, coordinated, high quality care.

At the conclusion of this evaluation, the Green Mountain Care Board and the Agency of Administration will determine whether and how the all-payer model proposal should be adjusted to reflect stakeholder input. If the evaluation does not find the proposal to have potential to meet such goals as reducing the rate of growth in health care spending, improving access to high quality health care, maintaining the ability to recruit and retain health care professionals, building a more integrated health care system inclusive of the care continuum, and to be of economic benefit to the state, the Board and Agency of Administration will end the negotiation with CMS.