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**INTEGRATED HEALTH SYSTEM UPDATE**  
**ALL PAYER MODEL & MEDICAID PATHWAY**  
*DAIL ADVISORY BOARD*

# Medicaid Pathway: Payment and Delivery System Reform

## Continuous Cycle

### Key questions for today?

1. What is the all payer model?
2. What is the Medicaid Pathway?
3. How does the State pivot from idea to action?
  - a) Project plan
  - b) Stakeholder engagement
4. How do we know if this is working for SOV?  
Providers?
5. What are we missing?

# One Goal, Two Projects

## Big Goal:

Integrated health system  
able to achieve the triple  
aim

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

## Implementing Next Generation ACO Type Capitated Payment Model:

Way to pursue goal of integrated system  
for certain services and providers.

Implementation led by DVHA with support  
from others.

## Medicaid Pathway:

Task of pursuing goal of integrated system  
for services not subject to financial caps of  
all-payer model.

AHS led project that interacts with ongoing  
AHS reform efforts and SIM.

**CRITICAL TAKE-AWAY:** Implementation of a Medicaid Next-Gen ACO that provides a sub-set of Medicaid services and is subject to financial caps is only one piece of the all-payer model and envisioned delivery system reforms.

# All-Payer Model

- 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.

# Why Pay Differently Than Fee-for-Service?

- Health care cost growth is not sustainable.
- Health care needs have evolved since the fee-for-service system was established more than fifty years ago.
  - More people are living today with multiple chronic conditions.
  - CDC reports that treating chronic conditions accounts for 86% of our health care costs.
- Fee-for-service reimbursement is a barrier for providers trying to coordinate patient care and to promote health.
  - Care coordination and health promotion activities are not rewarded by fee-for-service compensation structure.

# How Do We Pay Differently in APM?

- The federal government has created programs that encourage the use of **Accountable Care Organizations (ACOs)**.
- The federal **Next Generation ACO program** allows ACOs to be paid an all-inclusive population-based payment for each Medicare beneficiary attributed to the ACO. CMS will allow ACOs some flexibility in certain payment rules in exchange for accepting this new type of payment.
- 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.

# Goals of a Transformative All-Payer Model

- Improve experience of care for patients
- Improve access to primary, preventive services
- Reward high value care
- Construct a highly integrated system
- Empower provider-led health care delivery change
- Control the rate of growth in total health care expenditures
- Align measures of health care quality and efficiency across health care system

# Can We Get There?

- Vermont has all-payer reforms in place today
  - Shared Savings Program (SSP) for Accountable Care Organizations (ACOs)
    - Medicare offers a SSP for ACOs
    - Commercial SSP Standards
    - Medicaid SSP Standards
  - The Blueprint for Health
    - Medicare participates through a demonstration waiver
    - Commercial participation
    - Medicaid participation
- Fee-For-Service is still the underlying payment mechanism in these models

# Vermont's Proposed Term Sheet

- The term sheet includes all of the basic legal, policy, and enforcement provisions that would be in a Model Agreement.
- In some cases, terms refer to appendices which will have greater technical detail or to processes that will occur during 2016.

Term	
1.	Legal Authority
2.	Performance Period
3.	Medicare Beneficiary Protections
4.	Medicare Basic Payment Waivers
5.	Medicare Innovation Waivers
6.	Infrastructure Payment Waivers
7.	Fraud and Abuse Waivers
8.	Request for Additional Waivers
9.	Revocation of Waivers
10.	All-Payer Rate Setting System
11.	Provider Participation in Alternative Payment
12.	Regulated Services
13.	Financial Targets
14.	Quality Monitoring and Reporting
15.	Data Sharing
16.	All Payer Model Evaluation
17.	Modification
18.	Termination and Corrective Action Triggers

# Steps Toward an APM

Develop All-Payer Model and Financial Targets

Create Standards for Accountable Care Organization Program

Exercise GMCB Rate and Regulatory Authority

Attain Quality Improvement and Cost Control

# Next Steps

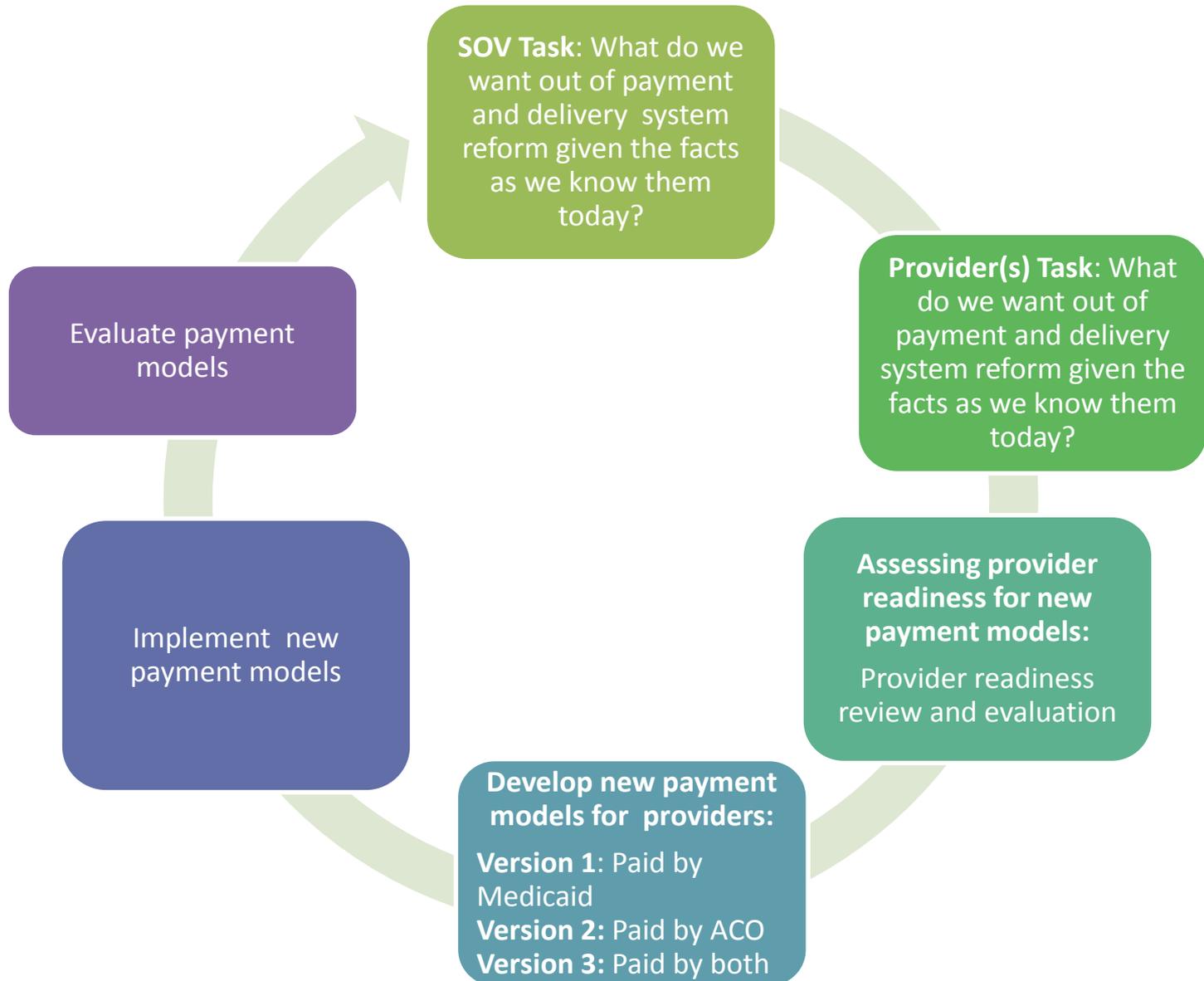
- Assess and Evaluate All-Payer Model Proposal
  - Taking all points of view into consideration, the Green Mountain Care Board and the Agency of Administration must independently assess the potential of the all-payer model to build a system that offers the right incentives and rewards providers for delivering on the promise of integrated, coordinated, high quality care.
- Based on evaluation of term sheet,
  - Continue negotiations with CMS on All-Payer Model
  - If Vermont decides the final agreement is not better than today's system, it can end the negotiation with CMS.
  - Similarly, if CMS is not satisfied that the overall proposal meets its policy and financial goals, it can decline to enter into the agreement.

# Medicaid Pathway

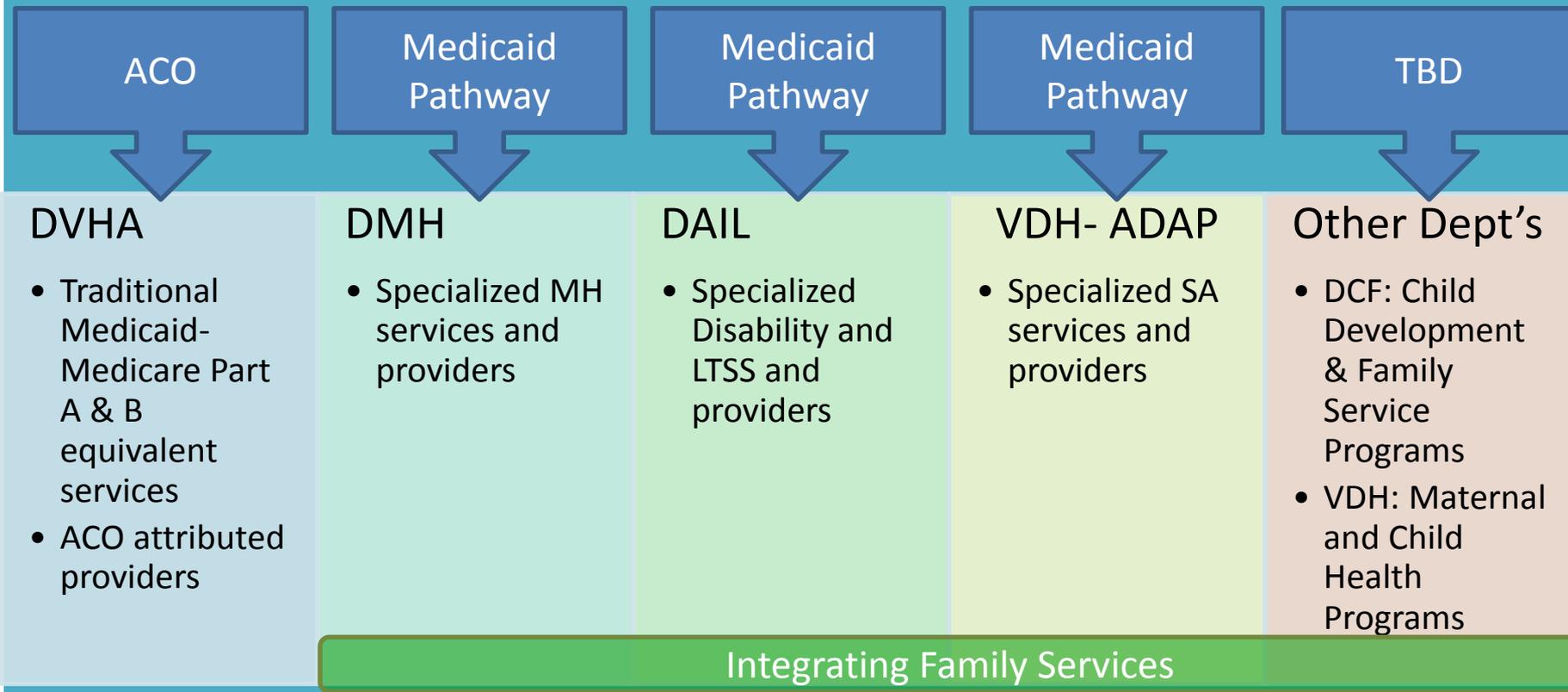
## What is it?

- It refers to several critical ideas:
  - There is payment and delivery system reform that must happen alongside the all-payer model (APM) regulated revenue/cap conversation.
  - There is a process for Medicaid providers to engage in with the State alongside the APM regulated revenue/cap conversation.
  - This process is led by AHS-Central Office in partnership with the Agency of Administration and includes Medicaid service providers who provide services that are not included in the initial APM implementation, such as LTSS, Mental Health, substance abuse services and others.
  - The Medicaid Pathway advances payment and delivery system reform for services not subject to the additional caps and regulation required by the APM. The goal is alignment of payment and delivery principles that support a more integrated system of care.

# Medicaid Pathway: Payment and Delivery System Reform Continuous Cycle

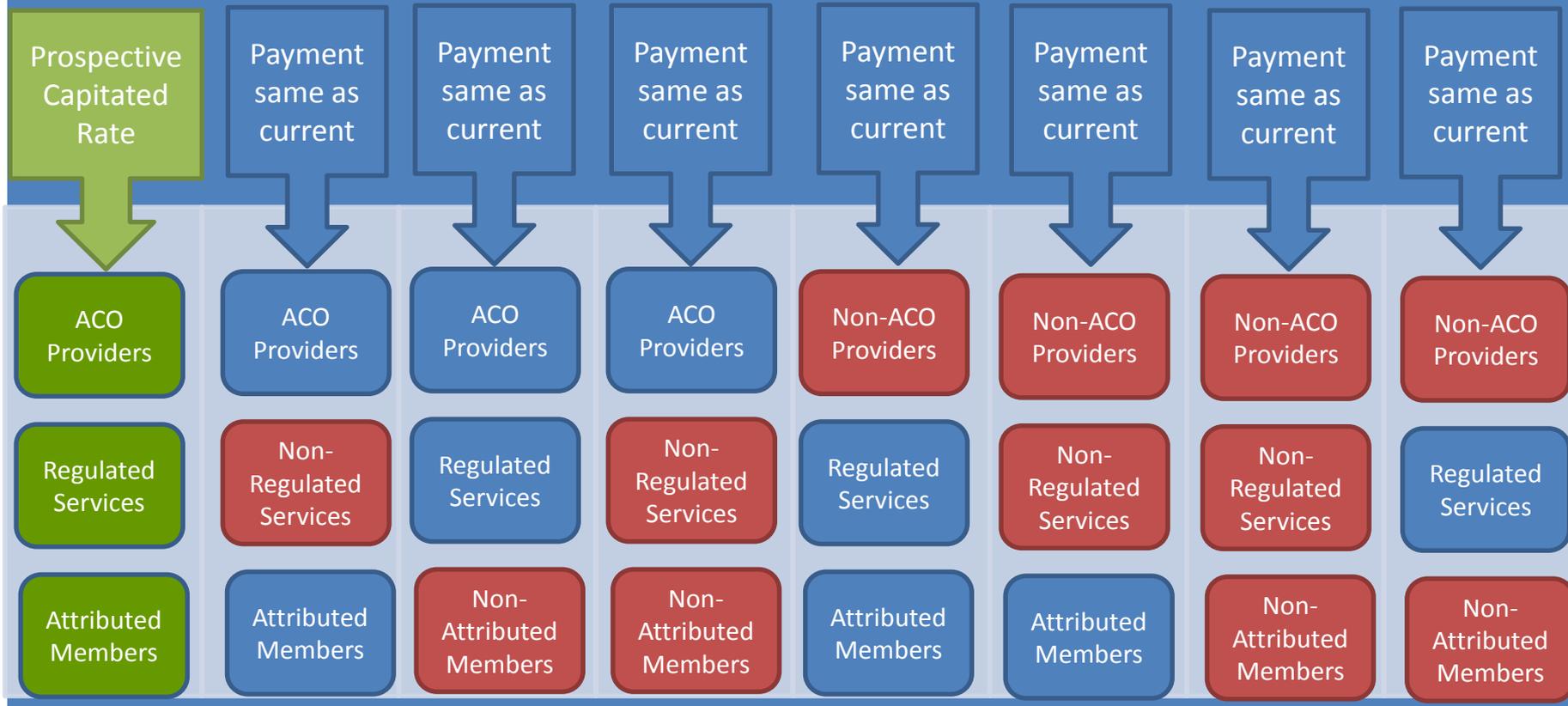


# Current Medicaid APM payment reform efforts



# DVHA and the Medicaid Pathway

DVHA is implementing a new payment model that impacts some, but not all, providers, services and members.



# Medicaid Pathway Principles and Goals

## **Ensure Access to Care for Consumers with Special Health Needs**

- Access to Care includes availability of high quality services as well as the sustainability of specialized providers
- Ensure the State's most vulnerable populations have access to comprehensive care

## **Promote Person and/or Family Centered Care**

- Person and/or Family Centered includes supporting a full continuum of traditional and non-traditional Medicaid services based on individual and/or family treatment needs and choices
- Service delivery should be coordinated across all systems of care (physical, behavioral and mental health and long term services and supports)

## **Ensure Quality and Promote Positive Health Outcomes**

- Quality Indicators should utilize a broad measures that include structure, process and experience of care measures
- Positive Health Outcomes include measures of independence (e.g., employment and living situation) as well as traditional health scores (e.g., assessment of functioning and condition specific indicators)

## **Ensure the Appropriate Allocation of Resources and Manage Costs**

- Financial responsibility, provider oversight and policy need to be aligned to mitigate the potential for unintended consequences of decisions in one area made in isolation of other factors

## **Create a Structural Framework to Support the Integration of Services**

- Any proposed change should be goal directed and promote meaningful improvement
- Departmental structures must support accountability and efficiency of operations at both the State and provider level
- Short and long term goals aligned with current Health Care Reform effort

# Medicaid Pathway Process

## **Delivery System Transformation (Model of Care)**

- What will providers be doing differently?
- What is the scope of the transformation?
- How will transformation support integration?

## **Payment Model Reform (Reimbursement Method, Rate Setting)**

- What is the best reimbursement method to support the Model of Care (e.g. fee for service, case rate, episode of care, capitated, global payment)?
- Rate setting to support the model of care, control State cost and support beneficiary access to care
- Incentives to support the practice transformation

## **Quality Framework (including Data Collection, Storage and Reporting)**

- What quality measures will mitigate any risk inherent in preferred reimbursement model (e.g. support accountability and program integrity); allow the State to assess provider transformation (e.g. structure and process); and assure beneficiaries needs are met?

## **Outcomes**

- Is anyone better off?

## **Readiness, Resources and Technical Assistance**

# Who is on the Medicaid Pathway?

Group 1: Under the SIM demonstration Providers of MH and SA are working with State reps to answer the MP process questions. This group started meeting 11/2015 and aims to have an implementation proposal by 7/2016.

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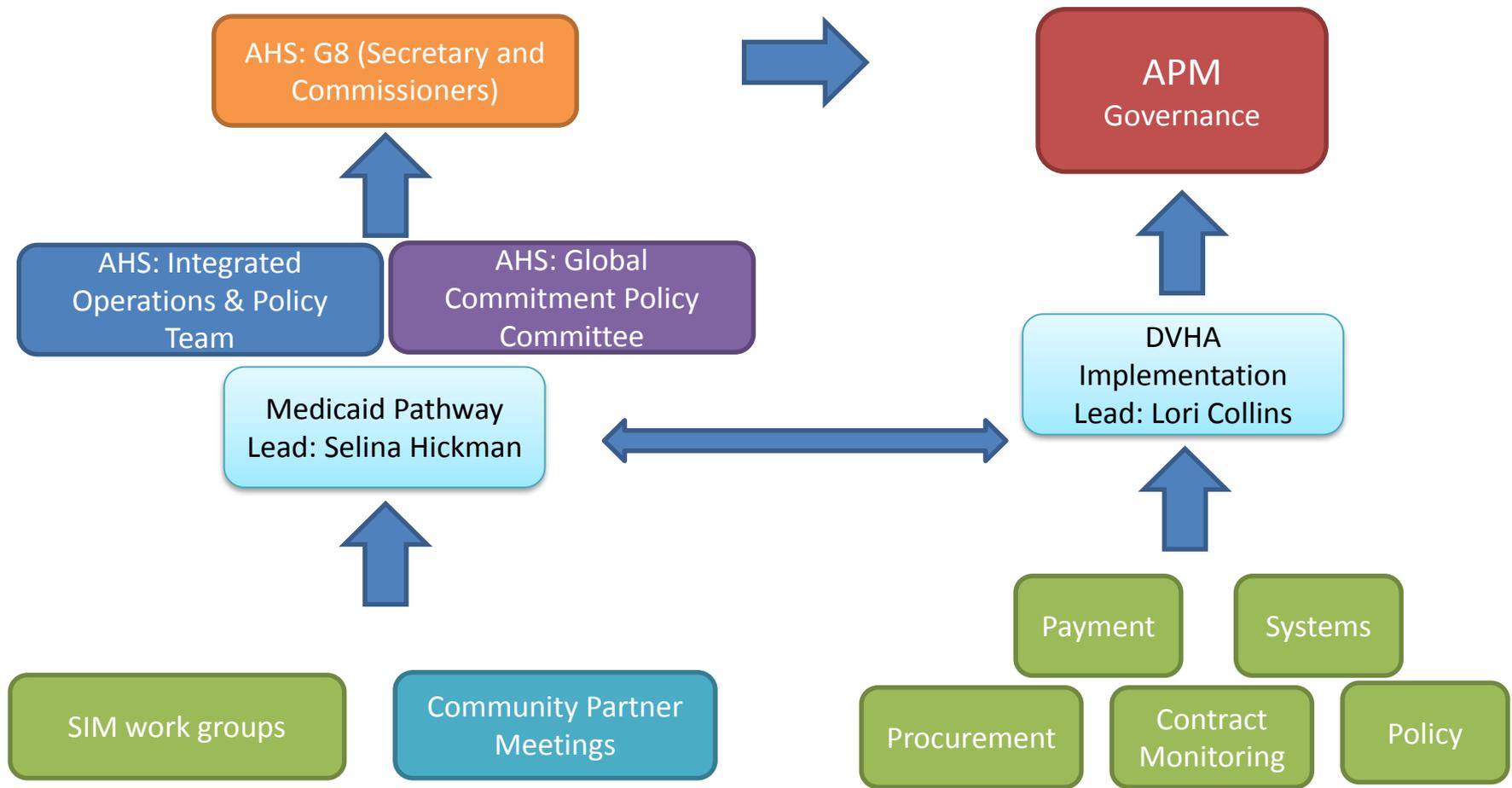


Group 2: The DLTSS Work Group under SIM has also started to engage in a similar planning process.

Group 3: AHS needs to engage with other community providers in a planning process to determine how and when other services and providers will enter the Medicaid Pathway process.

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# Medicaid Pathway **DRAFT** Governance



# Resource Slide: Key Terms and Concepts

- **All-payer model**: catch all term to describe (1) an agreement with CMS that waives federal laws so that (2) Medicare will pay a capitated payment to an ACO for hospital and physician services in exchange for (3) a State commitment to meet financial targets and quality goals. The State would then (4) align commercial insurers and Medicaid to pay the ACO the same way as Medicare.
- **Next Generation**: a Medicare ACO program that offers several waivers and four payment models, including a capitated payment. Next Generation provides the programmatic base for the all-payer model.
- **Regulated revenue**: the covered services and revenue within the all-payer model and subject to the financial and quality targets.
- **Medicare infrastructure waivers**: a fancy way of saying that we are asking Medicare to (1) keep making Blueprint payments, (2) expand SASH, and (3) invest in Hub and Spoke.
- **All-payer financial targets**: Limitation on spending for services and spending inside the all-payer model. The target is 3.5% and ceiling 4.3%. These numbers are limits, not guaranteed annual revenue increases to providers participating in the model. The State proposed a floor as well, a minimum rate of Medicare growth. This protects the State against unexpectedly low Medicare growth.
- **Medicaid Pathway**: a process through which AHS advances payment and delivery system reform outside of the additional caps and regulation required by the APM. The goal is alignment of payment and delivery principles that support a more integrated system of care