Vermont Partners for Health Care Reform

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RE: Vermont Agency of Human Service Extension request Section 1115(e) Demonstration Waiver: Global Commitment (GC) to Health

On behalf of a number of organizations belonging to Vermont Partners for Health Care Reform (OneCare Vermont, Vermont Association of Hospitals and Health Systems, Vermont Chamber of Commerce, Vermont Medical Society, and VNAs of Vermont), we are pleased to offer the group's recommendations on the Agency of Human Service's (AHS) proposed no change extension request for a Section 1115(e) Demonstration Waiver: Global Commitment (GC) to Health.

Vermont Partners for Health Care Reform (VPHCR) is a group made up of health care providers, employers, and a health plan interested in contributing essential information based on factual data and research-based analyses to shape the smart and effective reform of Vermont's health care system.

We are collectively commenting on the AHS Section 1115e no change Demonstration Waiver Extension request because we believe the request fails to acknowledge the significant transformation in operation and payment that the Agency and the Department of Vermont Health Access (DVHA) must undertake to continue participating effectively in the state's health care reform efforts.

Even though Vermont's health care reform efforts largely remain a work in progress, the scope and depth of the contemplated changes over the course of the next five years are groundbreaking. As such, a "status quo" extension of the Agency's 1115 waiver just doesn't fit.

Since Medicaid covers one out of every three Vermonters, understanding the State's health care goals in the context of both the AHS no change waiver extension request and the All-Payer

Waiver being negotiated simultaneously by the State of Vermont with the federal government is vitally important.

The general statements that the current waiver's flexibility and general goals will suffice to "cover" Vermont's contemplated reform activities over the course of this waiver extension, including the development of an all-payer model, do not provide the clarity and commitment required toward having Vermont's Medicaid program operationally and programmatically aligned with an all-payer model and a possible state-wide Accountable Care Organization's (ACO) Population Health Improvement Infrastructure or similar structure.

This is especially relevant regarding the need for the State of Vermont to ensure that its Medicaid program is a responsible payer and ends its long-standing practice of paying less that cost of providing care and thereby "cost shifting" to Vermont's employers. Development of a funding model for Vermont's health care system must be easily understood and administered, and must be fair and equitable within and between taxpayer groups.

BACKGROUND

Vermont's Medicaid program is currently operating under a Section 1115(e) waiver called "Global Commitment." The Global Commitment began October 2005 and its latest renewal runs through December 31, 2016.

Under the waiver, the Vermont Department of Health Access (DVHA) acts as a Managed Care Organization (MCO) and is subject to Centers for Medicare & Medicaid Services (CMS) rules regarding such organizations. Vermont is unique in having its MCO a department within state government. The State of Vermont's Agency of Human Services (AHS) pays DVHA a fixed monthly per-member per-month premium (PMPM). The premiums are trued up quarterly to actual expenditures. The premium includes all Medicaid spending except the Long Term Care waiver (Choices for Care), some administrative costs, disproportionate share hospital (DSH) payments and the Children's Health Insurance Program (CHIP).

The current Medicaid fee schedule for primary care services pays 82 percent of Medicare and the Medicaid fee schedule for non-primary care professional services pays 80 percent of Medicare. With a third of Vermonter's population covered by the Medicaid program, State governments' long-standing practice of Medicaid underpayment and the resulting cost-shift has a much larger impact on Vermont's health care providers, employers and insurers.

The State of Vermont is also pursuing a Medicare waiver agreement with the Center for Medicare & Medicaid Innovation (CMMI) for hospital services (Part A) and professional services (Part B) in order to achieve an all-payer model and a more integrated delivery system for the state, beginning on January 1, 2017. The federal government is incentivized to enter into a Medicare waiver with the State of Vermont that reduces the predicted Medicare spending in the state for the five years of waiver.

<u>Vermont's Medicaid Plan Should Operationally and Programmatically Align With a Single Statewide ACO Population Health Improvement Infrastructure</u>

Act 54 of Vermont's 2015 legislative session directs the Director of Health Care Reform in the Agency of Administration, in collaboration with the Green Mountain Care Board and the Department of Financial Regulation, to evaluate the requirements in federal law applicable to DVHA in its role as a public managed care organization in order to identify opportunities for greater alignment between federal law and state requirements on Health Insurers. However, this important effort seems to be outside the scope of the waiver request.

In February 2015 the Green Mountain Care Board (GMCB) convened an Accountable Care Organization (ACO) Payment Subcommittee to discuss and outline the governance structure, provider payment policies and related parameters for an all-payer ACO program for Vermont. The group includes Vermont's three existing ACOs: Community Health Accountable Care (CHAC), OneCare Vermont and Vermont Collaborative Physicians (VCP).

The three existing ACOs have entered into an agreement to pursue a possible single statewide ACO under an all-payer waiver as a means to facilitate an integrated payment and health care delivery system in Vermont. The possible single statewide ACO activities include: determining the structure of the governing body, sharing data to pursue a single approach to analytics and develop a shared understanding of a combined population, developing a performance measurement plan, and developing a business plan by April 1, 2016.

VPHCR believes it is important to not have duplication and "competition" on population health management (PHM) infrastructure and capabilities between DVHA and a statewide ACO. Based on the CMS regulations for Medicaid MCOs, for example, DVHA is currently required to fund staffing and capacity that are duplicative of the capacity for the same population offered by Vermont's ACOs. That includes, potentially, functions that currently account for 108 out of DVHA's total 207 positions: Vermont Chronic Care Initiative (VCCI) – 28 FTES; Blueprint for Health – 16 FTEs; Quality and Clinical Integrity – 10 FTEs; Clinical Operations – 10 FTEs; Payment Reform – 20 FTEs; Managed Care Compliance – 8 FTEs; Program Integrity – 11 FTEs; and Data Management and Analysis – 5 FTEs.[1]

Vermont's emerging single statewide ACO model will have a population health model that stratifies a large population of attributed patients across a broad spectrum of health care services and institutes initiatives

We firmly believe that this structure should be designed to include Medicaid beneficiaries, and that DVHA should anticipate and articulate in this waiver extension proposal the program and operational changes that would be required over the next five years to reduce its care management and care delivery services that are unnecessarily duplicative of those that will provided in the single statewide ACO structure under development.

<u>The Extension Request Should Fully Outline Medicaid's Payment Reform Participation in the APM</u>

[1] http://dvha.vermont.gov/budget-legislative/sfy201602042015.pdf.

Health care in Vermont is transforming to enhance care for patients, improve outcomes, and control costs. Central to the state's progress is the effort to move away from traditional fee-for-service reimbursement to other payment structures that reward the value, not the volume, of health services.

Success requires the participation of all health care payers in Vermont. All-payer reform allows clinicians to hire new staff to help patients, to invest in prevention and wellness, and to build innovative partnerships to improve health – without worrying whether some of these new steps are permitted or penalized under traditional payment approaches for certain patients.

The current health care system unfairly burdens Vermont businesses and individuals who pay health insurance premiums by requiring them to subsidize the services that government programs (Medicaid and Medicare) provide but don't fully pay for. The total cost of hospital services shifted into the commercially insured population has grown from $154 million in 2005 to approximately $425 million in 2015 and in some years accounts for nearly 50% of the increase to private payer premiums. To constrain the cost shift the State must develop a responsible funding model for the expansion of Medicaid.

Vermont's upcoming renegotiation of its 1115 waiver represents a critical opportunity to align Medicaid with this all-payer vision. What's more, Vermont can use a new 1115 waiver to accelerate clinical transformation across the state in order to more rapidly realize the vision of better health and lower costs – and the agency's plan to accelerate this transformation should be articulated in this extension request.

Our organizations therefore request that the Agency of Human Service respond to the following recommendations relating to proposed no change extension request for a Section 1115(e) Demonstration Waiver:

- The 1115 waiver should align delegation of risk to health care providers with steps being taken by other payers. The State has the opportunity in the 1115 waiver to shift financial risk-bearing responsibility from DVHA to provider-led clinically-integrated networks, similar to efforts in Medicare and among private insurers. This would allow for the fullest shift from volume-based care to outcomes-based care and allow for the reduction in duplicative capacity and infrastructure.

- Changing payment models is simply not possible through existing shared-savings constructs that provide bonuses but do not change basic revenue models. Moreover, prolonging a system that requires clinicians to engage with multiple care management entities undermines the opportunity for true clinical transformation.

- The 1115 waiver should include incentives for provider/community collaboration. Federally Qualified Health Centers, behavioral health organizations, home health agencies and social services agencies are essential to providing the highest-quality care to Medicaid patients. The State has the opportunity to offer these groups clear financial

incentives to collaborate with risk-bearing health care organizations to achieve common aims for improving patient outcomes. Reducing clinical and payment fragmentation through shared responsibility for outcomes would bring considerable lasting benefit to Vermont's health care system.

- The 1115 waiver should increase investments in population health infrastructure. Risk-based payments could be coupled with supplementary programs to reward utilization and quality outcomes with funds to support the infrastructure required for ongoing transformation.

- Clinical infrastructure could include embedded case managers in primary care offices, interdisciplinary teams visiting patients at home after discharge, co-located behavioral health and primary care services, and other proven interventions. Whether through a Delivery System Reform Incentive Payment (DSRIP)-type program or a concept unique to Vermont, the State should pursue new federal funds to improve care through supporting ACOs in deploying resources as close to the patient-provider interaction as possible.

- The 1115 waiver request should articulate the importance of the strategic integration of the Blueprint of Health with the anticipated statewide ACO, in order to avoid having separate programs to address chronic disease.

- The all-payer model being negotiated by the State of Vermont would require the participation of the Medicaid program, as well as Medicare and commercial insurers, in creating value-based payment models and establishing more standardized approaches to care delivery, care management, and performance measurement. VPHCR recommends that the 1115(e) waiver be explicit on the importance of alignment between the 1115 waiver and all-payer waiver. Most importantly, in order to constrain the cost shift, the State must develop a responsible funding model for the expansion of Medicaid that ends the cost shift to employers and insurers.

- VPHCR recommends that the 1115(e) extension request indicate planned changes to DVHA's current population health management (PHM) infrastructure and capabilities if they are duplicative of those needed by a single statewide private-sector health care provider network (ACO) that is assuming fixed revenue risk for the Medicaid population. If they are duplicative of those needed by a single statewide ACO or similar organization, reducing DVHA's current population health management infrastructure and capabilities could provide significant savings and help reduce the administrative cost of Vermont's Medicaid program.