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FOR IMMEDIATE RELEASE
January 25, 2016

Gov. Shumlin and Health Care Team Outline Details of All Payer Model

MONTPELIER - Gov. Peter Shumlin, his senior health care advisors, and Green Mountain Care Board Chair Al Gobeille today detailed how Vermont will seek to transform its health care system under the so-called All Payer Model from one that rewards fee-for-service, quantity-driven care to one that rewards quality-based care that focuses on keeping Vermonters healthy. That transition caps off years of work that will enable Vermont to address rising health care costs that are squeezing the budgets of families, businesses, and state government.

"From Day 1, reforming the way doctors and other medical providers are paid has been a priority of my administration," Gov. Shumlin said. "This is the only way we will curb the rising cost of health care that gobbles up money faster than Vermonters can make it. Today is the beginning of the rubber hitting the road on cost containment. Our success will mean better health outcomes for Vermonters and the end to health care costs rising faster than our economic growth."

The fee-for-service health care model is over 50 years old and was designed to treat acute medical conditions that required a single visit. Today, treating people with chronic diseases account for 86 percent of health care costs, according to the Centers for Disease Control. The disconnect means that doctors are governed by a payment system that does not address the needs of patients, a situation that results in Vermonters receiving care that is expensive, fragmented, and disorganized.

The All Payer Model seeks to change that by enabling the three main payers of health care in Vermont - Medicaid, Medicare, and private insurance - to pay doctors and hospitals in a different way than they do today. Instead of paying for each test or procedure, doctors and hospitals will receive a set payment for each patient attributed to them, shifting the financial incentive from running tests and procedures to keeping patients healthy.

The heart of the proposal is to keep health care costs below the growth of the general economy. The terms outlined today propose a statewide health care spending target for all payers in the health care system of 3.5 percent with a maximum allowable spending growth of 4.3 percent for the next five years. The financial cap is set approximately 1 percent higher than Vermont's economic growth as measured by gross state product over the past 15 years.

Along with spending targets will be quality ones that ensure Vermonters not only spend less but see better health outcomes. The three goals included in today's proposal are: increasing access to primary care, reducing the prevalence of and improving the management of chronic diseases, and addressing the substance abuse epidemic.

Under the All Payer Model, Vermonters will continue to see the doctor or heath care provider of their choice. Vermonters on Medicare and Medicaid will see no change to their benefits. In fact, Vermont proposes to expand Medicare benefits to seniors, including:

- Services at home for seniors in through the successful Services and Supports at Home (SASH) program by expanding the program statewide

- Addiction treatment services through the Hub and Spoke program

In addition, Vermont proposes to maintain Medicare's participation in the Blueprint for Health medical homes and community health teams, which is set to end in December 2016.

“For Vermonters, our innovation will mean not only a health care system that is more affordable but one that better meets their needs,” Gov. Shumlin said. “We will restore the family physician’s rightful place in Vermonters lives, ensuring they have someone to turn to when they get sick and a partner in keeping them healthy.”

The Administration today released a draft term sheet that sets the basic outline for how the state will implement the All Payer Model, including the legal authority of the state to enter into such an agreement, the federal waivers necessary to facilitate the transition, and a plan for data sharing and evaluation.

The state is finalizing negotiations of the terms of the All Payer Model with the federal government. Attached are general information on the All Payer Model and a draft term sheet.

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All-Payer Model Term Sheet

State of Vermont Proposes Term Sheet to Centers for Medicare and Medicaid Services (CMS)

- The Legislature directed the GMCB and AOA to explore an all-payer model with the Centers for Medicare and Medicaid Services (CMS), resulting in a *term sheet* proposed by Vermont.
- The proposed term sheet describes the basic policy framework that would allow Vermont's health care providers, payers, and the government to operate an all-payer model.
- The proposed term sheet does not bind the state or federal governments.

Another Step Towards Value and Away from an Expensive and Fragmented System

- The proposal is for all payers to approach health care payment in a common way that rewards the health care system for providing high value care.
- Aligned payment creates powerful incentives for new partnerships across the care continuum that make health care more affordable and improve the health of Vermonters.
- The state agrees to coordinate Medicaid and commercial insurers, and commits to financial targets and quality goals, and in return the federal government allows Medicare to participate in Vermont's system.

Medicare Beneficiaries Will Receive All the Benefits for Which They Paid

- Medicare beneficiaries will keep the benefits, care, covered services, and choice of providers under the all-payer model. The State is seeking to expand benefits for seniors.

Statewide Financial Targets Will Make Health Care More Affordable

- The proposal aims to make health care more affordable by bringing health care spending closer to economic growth. The term sheet sets a 3.5% spending target and 4.3% spending cap, with a commitment that Medicare will grow more slowly in Vermont than nationally.

Covered Services Build on Vermont's Health Care Reform Progress to Date

- Financial targets are based on health care services in Vermont's Medicare, commercial, and Medicaid shared savings programs today, mostly hospital and physician services.

Proposal Focuses on Quality, Seeking to Create a Healthier Vermont

- The State is proposing three ambitious population health goals: increasing access to primary care, reducing the prevalence of chronic diseases, and addressing the substance abuse crisis.
- The GMCB will continue to hold ACOs financially accountable for a set of quality measures.

Seeking Additional Investments in Vermont's Health Infrastructure

- The State proposes to expand the Services and Supports at Home (SASH) program, which has a track record of saving money while keeping seniors in their home and out of hospitals.
- The State proposes that Medicare participate in the Hub and Spoke opiate addiction treatment program.
- The State proposes to continue Medicare participation in the Blueprint for Health, Vermont's nationally-recognized initiative transforming primary care.

Committed to Creating an Integrated Health System

- The State will continue to work with existing mental health, substance abuse, and long term services and support providers to determine the best path forward to create an integrated health care system.

VERMONT ALL-PAYER MODEL TERM SHEET PROPOSAL

Companion Paper

January 25, 2016

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.[1] 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.

[1] 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 80% 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://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.

Note: This term sheet contains general concepts and proposed principles, but does not constitute a commitment by any party to undertake any particular action. This term sheet is subject to change, and both the State and CMS acknowledge that any agreement arising from the terms discussed herein is subject to the approval of relevant federal and state officials.

Section		Terms & Conditions
1.	Legal Authority	**Medicare Authority:** Section 1115(A) of the Social Security Act ("Act") authorizes CMS, through the Innovation Center, to enter into the Model Agreement. Medicare reimbursement under this Model shall continue to operate consistent with applicable laws, regulations and guidance, as amended or modified, except to the extent these requirements are waived in accordance with Section 1115A(d)(1) of the Act as set forth in the Model Agreement. **Medicaid Authority:** Section 1115A of the Act authorizes CMS, through the Innovation Center, to enter into the Model Agreement. Medicaid reimbursement under the Model shall continue to operate consistent with applicable laws, regulations and guidance, including but not limited to all requirements of Vermont's existing Medicaid State Plan and 1115(a) demonstration waiver(s), as amended or modified from time to time, except to the extent these requirements are explicitly waived or modified in accordance with Section 1115A(d)(1) of the Act pursuant to the Model Agreement or in a relevant 1115(a) demonstration waiver or state plan amendment. Vermont represents and warrants that its Medicaid state plan and/or 1115(a) demonstration waiver(s) will be consistent with the terms and conditions of the Model Agreement with respect to Medicaid no later than January 1, 2017 and, if necessary, that it shall update timely its Section 1115(a) demonstration waiver(s) to accommodate any and all changes in payment methodologies that the State implements pursuant to the Model Agreement. **Vermont Authority:** The State represents and warrants that it has the legal authority to perform the following regulatory functions consistent with the Model Agreement: a. **Enter into this Model Agreement with CMMI**: The Green Mountain Care Board (the Board) is empowered to "[o]versee the development and implementation, and evaluate the effectiveness, of health care payment and delivery system reforms designed to control the rate of growth in health care costs and maintain health care quality in Vermont." 18 V.S.A. § 9375(b)(1); *see also* 18 V.S.A. § 9377 (authorizing Board to

		develop and oversee "[p]ayment reform pilot projects . . . to manage the costs of the health care delivery system, improve health outcomes for Vermonters, provide a positive health care experience for patients and health care professionals"). b. **Set rates for providers and require payers to comply with those rates**: The Board has statutory authority to "set reasonable rates for health care professionals, health care provider bargaining groups created pursuant to section 9409 of this title, manufacturers of prescribed products, medical supply companies, and other companies providing health services or health supplies based on methodologies pursuant to section 9375 of this title, in order to have a consistent reimbursement amount accepted by these persons." 18 V.S.A. § 9376(b)(1). c. **Regulate a statewide ACO and other components of the health care system in a manner consistent with the Model Agreement**: The statutes cited above provide the general authority needed to fulfill this role. In addition, the Board has authority to (1) regulate hospital budgets, 18 V.S.A. §§ 9375(b)(7), 9451-9457; (2) regulate insurance rate changes for major medical health insurance in the individual and small group markets, 8 V.S.A. § 4062, 18 V.S.A. § 9375(b)(6); and (3) regulate significant capital expenditures by health care facilities, 18 V.S.A. §§ 9375(b)(8), 9431-9446.
2.	Performance Period	The performance period shall consist of five performance years, each of 12 months duration beginning on January 1 ("Performance Year"). The performance period of this Model will begin on January 1, 2017 and will end at midnight (EST) on December 31, 2021. The five-year performance period will be preceded by a 9-month "year-zero," which will be an operational capacity building year beginning immediately upon execution of the Model Agreement and ending December 31, 2016.
3.	Medicare Beneficiary Protections	Vermont's goal is to improve access to and utilization of high-quality, low-cost care and services for all Medicare beneficiaries. 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 Original Medicare.

		• Retain coverage of the same care and services provided under Original Medicare. Medicare beneficiaries will not experience any reductions in benefits or covered services under the All Payer Model. • Vermont will seek specified benefit enchancements that will directly improve beneficiary access to care and services.

4.	Medicare Basic Payment Waivers	Under the All Payer Model, CMS waives the requirements of the following provisions of the Act as applied solely to Regulated Services, as defined in Section 12 of this Model Agreement Term Sheet. Such waivers shall include:
		• **Inpatient Prospective Payment Systems (IPPS)**: Sections 1886(d), 1886(g), and 1886(b0(1) of the Act and implementing regulations at 42 CFR 412, Subparts A through M,
		• **Outpatient Prospective Payment Systems (OPPS)**: Section 1883(t) of the Act and implementing regulations at 42 CFR Part 419,
		• Other provisions of the Act regulating Medicare payments for Regulated Services, including, but not limited to payments for:
		  ○ Physician Services
		  ○ Home Health
		  ○ Skilled Nursing Facilities
		  ○ Durable Medical Equipment
		  ○ Hospice
		  ○ Clinical Labs
		  ○ Part B Prescription Drugs.

5.	Medicare Innovation Waivers	CMS shall grant such waivers of Medicare laws and regulations as may be necessary to facilitate care delivery transformation, including: • **Three (3) Day Skilled Nursing Facility (SNF) Rule**: Section 1888(e) of the Act and implementing regulations at 42 CFR 409 Subpart D, • **Telehealth**: Section 1834(m) of the Act and implementing regulations at 42 CFR 410.78 and 414.65, • **Post-Discharge Home Visits**: Section 1834(a)(11)(B)(ii) of the Act and implementing regulations at 42 CFR 410.26,

		• Other innovation waivers that facilitate care delivery transformation. Vermont intends to explore, without limitation, waivers that address:
		  ○ Removing certain eligibility restrictions for home care and hospice care
		  ○ Maximizing the role of nurse practitioners
		  ○ Removing restrictions on reimbursement for Licensed Alcohol and Drug Abuse Counselors, and
		  ○ Removing restrictions on reimbursement for supportive, wrap-around recovery services provided by the Hub and Spoke Model.
		Vermont may propose additional Medicare Innovation Payment Waivers for CMS review and approval in accordance with Section 8 of the Term Sheet.

6.	Infrastructure Payment Waivers	CMS shall grant such waivers of Medicare laws and regulations as may be necessary to continue participation in Vermont's Blueprint for Health and and expand Medicare funding levels to establish Medicare payment parity with Medicaid and the commercial insurers by: • Continuing and enhancing payments to Blueprint Primary Care Practices on claims with a HCPC Code G9008 (Physician Coordinated Care Oversight Services) and • Continuing and enhancing payments to Northeastern Vermont Regional Hospital on claims with a HCPC code of G9152 (Community Health Teams and Support and Services at Home). CMS shall grant such waivers of Medicare laws and regulations as may be necessary to begin participation in Vermont's Alliance for Opioid Treatment (known as the "Hub & Spoke Program") by: • Paying for Medication Assisted Therapy at specialty opioid treatment programs • Contributing to infrastructure at specialty opioid treatment programs (known as "Hubs") in a manner consistent with existing Medicare Blueprint payments. Medicare's participation in Blueprint for Health and the Alliance for Opioid Treatment is necessary for all-payer participation in these programs which are central to Vermont's care delivery transformation, including improved access and outcomes for Mental Health and Substance Abuse Services.

7.	Fraud and Abuse Waivers	Financial arrangements between and among providers must comply with all applicable laws and regulations, except as explicitly provided in the waivers issued specifically for the state of Vermont All Payer Model pursuant to section 1115A(d)(1) of the Act. Under the Vermont All Payer Model, and irrespective of whether Vermont providers are participating in the Medicare Shared Savings Program, CMS grants all waivers of the requirements of Section 1128A of the Act (Civil Monetary Penalties), Section 1128(B) of the Act (Anti-Kickback Provisions), and Section 1877 of the Action (Physician Self-Referral law) authorized under the "Medicare Program: Final Waivers in Connection with the Shared Savings Program" (CMS-1439-F). Fraud and Abuse Waivers are categorized as follows: • ACO Pre-Participation Waiver • ACO Participation Waiver • Shared Saving Waiver • Compliance with Physician Self-Referral Waiver • Patient Incentives Waiver
8.	Request for Additional Waivers	The State of Vermont may request, and the Secretary may consider, additional waivers of Medicare law, as may be necessary solely for purposes of carrying out this Model. The State of Vermont may request additional waivers by submitting an amendment to the Model Agreement, along with the rationale for the amendment. CMS may grant these waivers in its sole discretion. However, should CMS not grant the waiver, and the State of Vermont determines the waiver is necessary to achieve the Model's goals, the State may terminate the Model Agreement as set out in Section 18 of this Model Agreement Term Sheet. Such waivers, if any, would be set forth in separately issued documentation specific to this Model. Any such waiver would apply solely to this Model and could differ in scope or design from waivers granted for other programs or models.
9.	Revocation of Waivers	CMS reserves the right to withdraw any waiver of Medicare payment requirements or Fraud and Abuse waivers, as described above or any waivers issued by CMS at a future date for the sole purpose of carrying out this Model, or as applicable, to terminate the Model Agreement, pursuant to the procedures set forth in in Section 18 of this Model Agreement Term Sheet, if Vermont does not comply with the conditions associated with the applicable Waivers as set forth in the Model Agreement.

10.	All-Payer Rate Setting System	**Vermont Rate Setting:** This Model is predicated on 18 V.S.A. §§ 9375(b)(1), 9376, and 9377, as discussed in item 1 above. The State shall maintain an all-payer rate setting system for all regulated services, as defined in Section 12 of this Model Agreement Term Sheet, whereby Medicare rates will be established using an ACO-based reimbursement method derived from the Next Generation ACO program or using the Medicare Fee Schedule rates as the reference price. If the Vermont General Assembly makes changes to 18 V.S.A. §§ 9375(b)(1), 9376, or 9377, Vermont must notify CMS in writing of such changes. If CMS determines that such changes are not consistent with the all-payer requirement of this Model, CMS may pursue modification, Corrective Action, or termination. **Medicare Claims Processing**: CMS shall continue to process claims for Medicare services pursuant to established procedures and through the applicable Medicare Administrative Contractor (MAC). For payments to an ACO, CMS and Vermont shall agree on a claims processing and payment approach that will conform to Vermont's all-payer model plan and CMS operational requirements.
11.	Provider Particiption in Alternative Payment Models	Vermont will use an accountable care organization (ACO) model to carry out its payment and delivery system transformations under the All Payer Model Agreement. Vermont will use its rate setting authority consistent with the goals of MACRA to encourage provider participation in alternative payment models. Vermont Medicare providers that participate in the ACO under the All Payer Model Agreement will be deemed compliant with MACRA requirements for participation in alternative payment models.

12.	Regulated Services	**Regulated Services:** Those services subject to the All-Payer Ceiling. Medicare Regulated Services are those services from which Medicare Savings will be calculated. Regulated Services are more fully defined in Appendix A: Regulated Services.
		
		• Medicaid and Commercial Regulated Services will include the following categories of service consistent with the existing shared savings program currently implemented:
		  ○ Primary Care Physician
		  ○ Laboratory and Radiology

		○ Specialty Physician ○ Mental Health and Substance Abuse Services ○ Other Professionals ○ Inpatient Services ○ Outpatient Services ○ Other, Residential, and Personal Care ○ Durable Medical Equipment ○ Home Health. The State may add additional categories of service to Medicaid and Commercial Regulated Services, subject to CMS approval, by proposing an amendment to the Model Agreement at least 6 months before the beginning of the performance year in which the services will be Regulated Services. • Medicare Regulated Services will include Parts A and B covered services The state may request that CMS work with the state to devise a method to include Medicare Part D covered services in GMCB rate setting authority, irrespective of whether those services are Medicare Regulated Services. **Medicaid Mental Health and Substance Abuse Services and Long Term Services and Supports (LTSS)**: Although Mental Health and Substance Abuse Services are included in the categories of Regulated Services, most Medicaid Mental Health and Substance Abuse Services are delivered through state designated agencies, and will not be initially included in Regulated Services. Vermont will define a pathway for assessing state and provider readiness to consider inclusion of these traditional Medicaid Mental Health and Substance Abuse Services in the all-payer model. As part of this assessment, Vermont will evaluate services for readiness to align with the all-payer model and/or potential inclusion in regulated services, including an evaluation of payer readiness, provider readiness, health information infrastructure readiness, evaluation readiness, and federal readiness. If Vermont determines that these Medicaid Mental Health and Substance

		Abuse Services can be included in the all-payer model, Vermont will submit a plan at least 6 months before the effective date. Similarly, most Medicaid long-term services and supports (LTSS) are provided through separate government health programs and will not initially be included in Regulated Services. Vermont will also use the same analytical approach to assess the appropriateness and state and provider readiness to consider inclusion of these traditional Medicaid LTSS services in the all-payer model. **Modification**: The State of Vermont may propose additional Regulated Services for inclusion in the Model Agreement by submitting an Amendment to the Model Agreement to CMS at any time. By mutual consent, Regulated Services can be modified to include additional services at any time during the course of the Performance Period.
13.	Financial Targets	**A. All-Payer Ceiling:** Vermont will set a cumulative all-payer per capita regulated services growth target and ceiling. The State must limit the cumulative annual all-payer per capita regulated services growth for Vermont residents to less than or equal to the per capita growth ceiling. This calculation will include all Regulated Services for Vermont residents and the per capita calculations will include all Vermont residents. • The "all-payer per capita growth target" will be fixed at 3.5% per capita per year. • The "all-payer per capita growth ceiling" will be fixed at 4.3 percent per capita per year. These figures are derived from historical and expected economic growth in Vermont. In the third quarter of Performance Year 3, Vermont may, subject to prior approval by CMS, update the all-payer per capita growth target or ceiling in the event that economic growth in Vermont is significantly higher or lower than expected. For the purpose of this term sheet, "all payer" means Medicare, Medicaid, and commericial insurance that is regulated by the Green Mountain Care Board. Federal employees, Tri-Care or other military coverage, and self-insured coverage shall not be included as these types of coverage are prohibited from regulation by the state under federal law.

		B. Medicare Savings: Over the performance period of this Model, the State must produce aggregate savings in the Medicare per beneficiary total regulated expenditure for Vermont resident fee-for-service ("FFS") Medicare beneficiaries, regardless of the state in which the service was provided. The Medicare savings calculation methodology will be jointly developed by the State and CMS and specified in the Model Agreement. Aggregate savings will be no less than the sum of savings in each performance year that would result from Vermont Medicare per beneficiary total regulated expenditure growth equaling 0.2 percentage points less than actual non-Vermont Medicare per beneficiary total regulated expenditure growth, subject to the provisions of Subsection C below. **C. Calculation of Medicare Savings:** CMS will calculate Medicare per beneficiary total expenditures for regulated services, both for the State of Vermont and the nation, using a jointly developed Medicare savings calculation methodology that will be specified in the Model Agreement. This calculation will be done for both national Medicare fee-for-service beneficiaries and Vermont resident Medicare fee-for-service beneficiaries. The per beneficiary total expenditure calculation for Vermont resident Medicare fee-for-service beneficiaries will include all regulated services for Vermont Medicare fee-for-service beneficiaries per these specifications, regardless of the state of service. • Medicare savings will be calculated by age band (under 65, 65-74, 75-84, over 85) in order to appropriately adjust for relative differences in age mix between Vermont resident beneficiaries and national Medicare beneficiaries. • Medicare savings will be calculated in the following manner**:** ○ Using the calculated Medicare per beneficiary total expenditure described above, a baseline that is the actual Medicare per beneficiary total expenditures for Vermont Medicare fee-for-service beneficiaries in 2016 will be established. ○ For any given Performance Year, the baseline will be trended forward by the actual growth rate in national Medicare per beneficiary expenditures to establish a benchmark. The national Medicare per beneficiary expenditure amount will be calculated in the same manner as the Vermont Medicare per beneficiary expenditure amount.

- For the same performance year, the savings amount will be determined by comparing actual Vermont Medicare per beneficiary total expenditures to the benchmark.
- CMS shall total all Performance Years to determine the cumulative savings/excess expenditure.

In Performance Year 1, if the actual growth rate in national Medicare per beneficiary expenditures is less than the Vermont all-payer per capita growth target, the baseline will be trended forward by 3.5% to establish the benchmark.

In Performance Years 2-5, if the actual growth rate in national Medicare per beneficiary expenditures is less than 2%, the baseline will be trended forward by 2% to establish the benchmark.

D. Adjustments to All-Payer Ceiling and Medicare Savings Calculations:

- **Payments Made under the Medicare Program and Medicare Demonstrations or Models:** CMS may make adjustments to the Medicare savings calculation, as necessary and as specified in this sub-section, to avoid duplicative accounting for, and payment of, amounts made to or received by providers in the State that are participating in any existing or future Medicare program, demonstration or model, including but not limited to those that involve shared savings or incentive payments. In order to assure a fair comparison, CMS will adjust national Medicare fee-for-service expenditures in a manner similar to any adjustments made for Vermont Medicare fee-for-service expenditures. By no later than December 31, 2016, CMS, in consultation with the State, will finalize an adjustment methodology, including any provider reporting requirements regarding incentive payments or penalties, to apply to each Performance Year of the Model, beginning with Performance Year 1.
- **Exogenous Factors**: CMS recognizes that Medicare per beneficiary cost increase or cumulative annual all-payer per capita regulated services growth may occur due to factors unrelated to the Model, including changes in Medicare law and regulation. The State may submit, in writing, a request that such exogenous factor(s) be taken into

		consideration when assessing performance on the All-Payer Ceiling and calculating Medicare savings. Vermont must explain the impact of such factors on Regulated Services and recommend how CMS should adjust the All-Payer Ceiling, Medicare savings, or both to reflect these factors.
14.	Quality Monitoring and Reporting	Providers in Vermont will continue to measure and report all applicable Medicare quality measures as required under federal law, currently and as amended during the course of the Performance Period. **<u>Population Health Goals</u>** Vermont will establish population health measures for the state that will be monitored and evaluated during the Performance Term. Such population health goals will include defined methods to measure progress toward defined goals and will include: • Increasing access to primary care • Reducing the prevalence of and improving the management of chronic diseases • Addressing the substance abuse epidemic. **All-Payer Model Quality Targets** Vermont will define specific statewide quality measures and establish performance targets to evaluate the quality of care during the Performance Period. Such quality targets will be established to support Vermont's population health goals. Vermont and CMS will work together to establish and document, by June 1, 2016, the purposes of the Model Agreement: 1) population health goals and a process for monitoring performance toward achievement of those goals; and 2) statewide quality measures and performance targets. Vermont will submit to CMS a report following the end of each Performance Year cataloging its performance with respect to the population health quality goals and statewide performance targets. Vermont will make available to CMS the datasets and methodologies used for this evaluation.

15.	Data Sharing	**State of Vermont Data Sharing:** The State of Vermont will supply all-payer claims data, as captured in its All Payer Claims Database (APCD), on a quarterly basis with CMS. CMS may use this data to conduct analyses and may publish the data and analyses, subject to Vermont's review and approval and co-publication with Vermont. **CMS Data Sharing:** Over the Performance Period of the Model, CMS will accept data requests from the State or its agents for data necessary to achieve the purposes of the Model. Such data could include de-identified (by patient or provider) data or individually identifiable health information such as claims level data. All such requests for individually-identifiable health information must clearly state the HIPAA basis for requested disclosure. CMS will make best efforts to approve, deny, or request additional information within 30 calendar days of receipt. Appropriate privacy and security protections will be required for any data disclosed under this Model. **Public Disclosure of Provider Performance Data:** CMS will share with Vermont the data necessary to determine provider performance on the quality measures identified in Section 14 Quality Monitoring and Reporting. Vermont may publicly disclose provider-specific performance for purposes of provider accountability for the quality of care delivered under the Model.
16.	All Payer Model Evaluation	**CMS Evaluation:** CMS shall evaluate the Model in accordance with Section 1115A(b)(4) of the Act, and in comparison with the national Medicare program in other states. **Vermont Evaluation:** For any given Performance Year the State must submit to CMS a report cataloging its performance with respect to the financial and quality requirements described in the Model Agreement. The State must make available to CMS and CMS' contractors for validation and oversight purposes Vermont's datasets and methodologies used for this evaluation, including, as applicable, access to contractors, contract deliverables, and software systems used to make calculations required under the Model Agreement. Any information provided to CMS will be used by CMS solely for the purposes described in the Model Agreement.

		Maintenance of Records: In accordance with applicable law, the State must maintain and give CMS, DHHS, the Department of Justice, the Government Accountability Office, and other federal agencies or their designees access to all books, contracts, records, documents, software systems, and other information (including data related to calculations required under the Model Agreement, Medicare utilization and costs, quality performance measures, shared savings distributions, and other financial arrangements) sufficient to enable the audit, evaluation, inspection, or investigation of the States' and/or Accountable Care Organization's (ACO)compliance with the requirements of this Model. The State must maintain such books, contracts, records, documents, and other information for a period of 10 years after the final date of the Performance Period or from the date of completion of any audit, evaluation, inspection, or investigation, whichever is later.
17.	Modification	The Parties may amend the Model Agreement, including any appendix to the Model Agreement, at any time by mutual written consent. CMS may amend the Model Agreement for good cause shown or as necessary to comply with applicable federal or State law, regulatory requirements, accreditation standards or licensing guidelines or rules. CMS shall include with any proposed amendment an explanation of the reasons for the proposed amendment. To the extent practicable, CMS shall provide the State with 30 calendar days advance written notice of any such amendment, which notice shall specify the amendment's effective date. If State law precludes application of the amendment to the Model Agreement, the Parties will promptly seek modification of the amendment. If modification of the amendment is impracticable or consensus cannot be reached, CMS or the State may terminate the Model and/or Waivers under the Termination section of the Model Agreement.
18.	Termination and Corrective Action Triggers	**Warning Notice and Corrective Action Plan (CAP):** If CMS determines that a Triggering Event has occurred, CMS shall provide written notice to the State that it is not meeting a requirement of the Model Agreement (Warning Notice) with an explanation and, as permitted by applicable law, data supporting its determination. CMS shall provide the State with the Warning Notice no later than six (6) months following the end of the applicable Performance Year for any Triggering Event. Within 90 calendar days of receipt of the Warning Notice, the State must submit a written response to CMS. CMS will review the State's response within 90 calendar days and will

		either accept the response as sufficient or require the State to submit a CAP within 30 calendar days addressing all actions the State and/or Accountable Care Organization will take to correct any deficiencies and remain in compliance with the Model Agreement. The CAP may include, but are not limited to, new safeguards or programmatic features, modification of the Model, and/or prospective adjustments to Regulated Services rates. CMS will review and approve the CAP within 30 calendar days or request modification to the CAP. • **Review factors considered by CMS**: A Triggering Event may or may not require corrective action, depending on the totality of the circumstances. CMS will consider whether the State can demonstrate a factor unrelated to the Model caused the Triggering Event. **Implementation of CAP:** The State shall successfully implement any required CAP as approved by CMS, by no later than 365 calendar days from the date of postmark of the Warning Notice. **Triggering Event:** A triggering event may include, but is not limited to, any of the following: • A material breach of any provision set forth in the Model Agreement, • A determination by CMS that Vermont has not produced aggregate savings in the Medicare per beneficiary regulated expenditures for Vermont resident FFS beneficiaries, regardless of the state in which the service was provided, for two (2) consecutive Performance Years, as calculated in accordance with Medicare Savings Calculation. • A determination by CMS that Vermont has exceeded the all-payer per capita growth ceiling by 1.0 percentage point or more for two (2) consecutive Performance Years. • A determination by CMS that the quality of care provided to Medicare, Medicaid or CHIP beneficiaries has deteriorated. • A determination by CMS that the State and/or Accountable Care Organization have taken actions that compromise the integrity of the Model and/or the Medicare trust funds.

		Rescission or Modification of Aspects of Model and/or Waivers: If CMS determines that the State has not successfully implemented a required CAP in the time period specified under a Warning Notice, CMS may amend or rescind the relevant aspect of the Model and/or relevant accompanying Waiver. If CMS rescinds a Medicare Payment Waiver provided, Vermont must comply with applicable national Medicare requirements by a date determined by CMS. **Termination of the Performance Period** • **Termination by CMS:** If CMS determines that the State has not successfully implemented a CAP or complied with an alternative CMS-provided CAP in the time period specified under a Warning Notice, CMS may immediately terminate the performance period of the Model Agreement. • **Termination by the State:** The State may terminate the Performance Period of the Model Agreement at any time for any reason upon 180 calendar days written advance notice to CMS. • **Transition to national Medicare Program**: If either CMS or the State terminates the Performance Period of the Model Agreement, the State shall have two (2) years from the date of termination to transition payment to providers under the national Medicare program, whereupon the Model Agreement shall terminate immediately. **Termination under Section 1115A(b)(3)(B):** CMS may terminate the Model Agreement immediately if the Secretary makes findings under Section 1115A(b)(3)(B) of the Act requiring the termination of the Model. The State shall have two (2) years from the date of termination to transition payment to providers under the national Medicare program.

Vermont-CMMI All-Payer Model Term Sheet

Appendix A: Regulated Services

Categories of Service	Components
Primary Care Physician	Primary Care
	Physician Assistant
	Registered Nurse, Office of Physician
	Rural Health
	Family Medicine
	Internal Medicine
	Obstetrics
	Pediatrics
	Physician Clinics
Laboratory and Radiology	Labs
	Clinical Medical Laboratory
	Radiology, Physician Clinic
	Radiology
Inpatient Services	Community Hospitals
	Veterans Hospitals
	Psychiatric Hospitals
Outpatient Services	Community Hospitals
	Veterans Hospitals
	Psychiatric Hospitals
Specialty Physician	Allergy & Immunology
	Anesthesiology
	Dermatology
	Emergency Medicine
	Neurological Surgery
	Neurology
	Neuromusculoskeletal
	Ophthalmology
	Orthopedic Surgery
	Otolaryngology
	Pathology
	Physical Medicine
	Plastic Surgery
	Psychiatry
	Radiology
	Surgery
	Thoracic Surgery
	Urology

Categories of Service	Components
Other Professionals	Chiropractor
	Optometrist
	Audiologist
	Naturopath
	Physical Therapist
	Podiatrist
	Speech-Language Pathologist
	Occupational Therapist
	Rehabilitation
	Respiratory Therapy
Behavioral Health	Psychiatric Nurse
	Counselor, Behavioral Health & Social Services
	Psychological Services
	Mental Health
	Rehabilitation, Substance Use Disorder
Home Health	Home Health Care
Skilled Nursing Facility	Nursing Home Care
	Nursing Facility - Intermediate Care Facility
	Community Hospitals, Nursing Home Unit
	Skilled Nursing Facility
Durable Medical Equipment	DME
	Vision Products
Other, Residential, and Personal Care	Residential Treatment
	Transportation
	Non-Durable Medical Equipment
	Personal Care Attendant