VERMONT MEDICAL SOCIETY RESOLUTION

Criteria for an All-payer ACO Model for Vermont

Adopted November 7, 2015

Whereas, The State of Vermont is 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; and

Whereas, 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; and

Whereas, The all-payer model would require the participation of the major payers in Vermont, including, Medicare, Commercial Insurers and Medicaid (DVHA) and the purpose of the all-payer model would be to establish five-year expenditure growth trends for each payer, create value-based payment models, and establish more standardized approaches to care delivery, care management, and performance measurement; and

Whereas, Maryland operates the nation's only all-payer hospital rate regulation system made possible by a 36-year-old Medicare waiver that exempts Maryland from Medicare Part A and its Inpatient Prospective Payment System and Outpatient Prospective Payment System and allows Maryland to set rates for these services; and

Whereas, Under the waiver, Maryland's Medicaid program and its Medicare waiver reimburses hospitals for their reasonable costs less a differential of a minimum of six percent of the amount paid hospitals by commercial payers[1]; and

Whereas, The Medicare waiver requires Maryland to generate $330 million in Medicare savings over a five-year performance period and it requires Maryland to limit its annual all-payer per capita total hospital cost growth to 3.58 percent; and

Whereas, According to Centers for Medicare & Medicaid Services (CMS), in 2009 Vermont's spending per Medicare enrollee was $8,719 and the overall rate of growth from 2004-2009 was 4.1 percent (the lowest spending per Medicare enrollee, and the lowest overall rate of growth in New England) and Maryland's spending per Medicare enrollee for the same period was $11,449, and the overall rate of growth from 2004-2009 was 5.5 percent;[2] and

Whereas, 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; and

Whereas, In addition to the GMCB, other participating entities have included Vermont's three existing ACOs (Community Health Accountable Care (CHAC), OneCare Vermont and Vermont

[1] http://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_hospital/documents/chcf_all_payer_model_agreement.pdf
[2] https://www.cms.gov/mmrr/Downloads/MMRR2011_001_04_A03-.pdf

Collaborative Physicians (VCP)), Blue Cross and Blue Shield of Vermont, the Department of Vermont Health Access (including the Blueprint for Health), MVP Health Care, the Vermont Association of Hospitals and Health Systems, Bi-State Primary Care Association, Health*first*, and the Vermont Medical Society (VMS); and

Whereas, 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; and

Whereas, 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; and

Whereas, Under the draft all-payer waiver framework, providers would have freedom of choice and those providers deciding not to join the ACO would be able to elect to continue to operate under traditional Medicare, Medicaid and commercial insurer payment policies; and

Whereas, The framework states that rates across all payment streams will increases at an equivalent pace so that cost shifting across payers does not continue to grow; and

Whereas, In 2015, Vermont primary care providers saw their Medicaid reimbursement reduced from 100 percent of Medicare to 80 percent of Medicare and, with 30 percent of Vermonter's covered by Medicaid program, State governments' long-standing practice of Medicaid underpayment has a much larger impact on Vermont physicians; and

Whereas, Beginning on July 1, 2015, the Medicaid fee schedule for primary care increased from 80 percent of Medicare to 82 percent of Medicare and the Medicaid fee schedule for non-primary care remained at 80 percent of Medicare; and

Whereas, On April 16, 2015, President Obama signed into law H.R. 2, the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), thereby repealing Medicare's Sustainable Growth Rate (SGR) and setting in place two new Medicare payment models; and

Whereas, Beginning on January 1, 2019, MACRA establishes a merit-based incentive system (MIPS) to consolidate and replace several existing Programs (Meaningful Use of EHRs, PQRS, Value-based modifier) and it incentivizes the development of, and participation in, alternative payment models (APMS); and

Whereas, The MIPS adjustment factor (positive or negative) would be 4 percent in 2019, 5 percent in 2020, 7 percent in 2021, and 9 percent in 2022; and

Whereas, For 2019 and 2020, an eligible professional with at least 25 percent of their Medicare payments through an APM entity (at least 50 percent for 2021 and 2022) would receive an additional 5 percent of their aggregate payment amount from Medicare from preceding year (these incentive payments would not be taken into account for the purposes of determining APM expenditures); now therefore be it

Resolved, The Vermont Medical Society will urge State of Vermont not to enter into a Medicare waiver that would further reduce Vermont's already low predicted spending per Medicare enrollee and its already low predicted overall rate of growth compared to the New England region; and be it further

Resolved, The Vermont Medical Society will urge State of Vermont not to enter into a Medicare waiver that would eliminate the incentive payments for professional services under MACRA's merit-based incentive system (MIPS) and its alternative payment models (APMS); and be it further

Resolved, The Vermont Medical Society will urge the State of Vermont to guarantee that the State of Vermont will increase Medicaid reimbursement to at least the negotiated or applicable Medicare level; and be it further

Resolved, The Vermont Medical Society will urge the State of Vermont to ensure physicians' freedom of choice, so that physicians deciding not to join an ACO would be able to elect to continue to operate under traditional Medicare, Medicaid and commercial insurer payment policies; and be it further

Resolved, The Vermont Medical Society's willingness to support the State of Vermont's Medicare waiver with the Center for Medicare & Medicaid Innovation will be affected by the waiver's satisfactory inclusion of the aforesaid cited provisions.