

VERMONT MEDICAL SOCIETY

Alfred Gobeille, Chair
Green Mountain Care Board
3rd Floor City Center
89 Main Street
Montpelier, Vermont 05620-3601

October 13, 2016

Dear Mr. Gobeille,

On behalf of the physician members of the Vermont Medical Society, I wish to thank you and your colleagues for the extraordinary time and effort you have devoted to working with representatives from the Centers for Medicare and Medicaid Services in negotiating the Draft Vermont All-Payer Accountable Care Organization Model Agreement.¹ As the VMS has publically stated on Vermont Public Radio: "the Medical Society believes this is a sincere effort to move in a good direction."

The agreement is even more noteworthy since to the VMS' knowledge it represents the first time that the federal government and a state have developed a draft reform framework for a statewide all-payer framework focused on improving population health. The VMS also believes the draft agreement is consistent with the GMCB's mission "to improve health care quality and moderate cost for Vermonters."

During its November 7, 2015 annual meeting, the VMS adopted a policy resolution on Criteria for an All-payer ACO Model for Vermont² and the resolution conditions the VMS' willingness to support the State of Vermont's agreement with the Center for Medicare & Medicaid Innovation on the waiver's satisfactory inclusion of a number of provisions. The provisions included the following:

- The agreement should commit the State of Vermont to increasing Medicaid reimbursement to at least the negotiated or applicable Medicare level; and
- The agreement should 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
- The agreement should not reduce Vermont's already low predicted spending per Medicare enrollee; and

¹ http://gmcbboard.vermont.gov/sites/gmcb/files/documents/payment-reform/DRAFT_APM_Agreement_UNDER_LEGAL_REVIEW.pdf

² <http://www.vtmd.org/sites/default/files/files/2015%20Waiver.pdf>

- The agreement should not penalize providers for receiving incentive payments under MACRA’s merit-based incentive system (MIPS) and its alternative payment models (APMS).

The VMS welcomes the opportunity to provide the GMCB with following amendments to the draft agreement in order to suggest modifications that would more closely align the document with the VMS’ provisions.

Increasing Medicaid reimbursement

The draft agreement is at greatest variance with the VMS’ criteria in the area of increasing Medicaid to at least the negotiated or applicable Medicare level. This is in sharp contrast with the February 23, 2014 Maryland All-Payer Model Agreement³ where it states on page 6:

“7(a)(i)(3). Rates are set equitably among all Maryland Payers and Medicare without undue discrimination or preference.”

A CMS factsheet on the Maryland waiver states: “[U]nder the waiver, all third parties pay the same rate.”⁴

The draft Vermont agreement includes the far less specific statement on page 9 that “4(d) [T]he state intends for Vermont Medicaid to be a reliable payer with the model.” While this aspirational statement is appreciated, the past reality of Vermont’s Medicaid reimbursement policy for professional and facility services is at rates less than the cost of care. For example, Medicaid payments for most professional services are 80 percent of Medicare (evaluation and management codes for primary care are 91 percent of Medicare). The VMS believes recent history of Medicaid reimbursement in Vermont to be a significant contributing factor to the loss of pediatric primary care and other health professional capacity in Franklin County. In addition, the statement does not explicitly connect the GMCB to the all-payer issue of under-reimbursement by Medicaid.

VMS Recommendation

Revise the draft agreement to read as follows:

4(d) The state intends for Vermont Medicaid to be a reliable payer with the model. The Green Mountain Care Board will annually provide its recommendations to the Secretary of the Agency Human Services and the Vermont General Assembly to increase Vermont Medicaid reimbursement rates to levels more comparable to Medicare FFS.

³ [http://www.hsrc.state.md.us/documents/md-maphs/stkh/MD-All-Payer-Model-Agreement-\(executed\).pdf](http://www.hsrc.state.md.us/documents/md-maphs/stkh/MD-All-Payer-Model-Agreement-(executed).pdf)

⁴ <https://innovation.cms.gov/initiatives/Maryland-All-Payer-Model/>

Ensuring Physicians' Freedom of Choice

VMS' criteria insists that any agreement 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.

The draft agreement-related educational materials developed by the State of Vermont also seems to guarantee physicians' freedom of choice. For example, in the State's document entitled Frequently Asked Questions: All-Payer Model Draft Agreement,⁵ questions 33 states:

- 33) I'm a provider and if I join the ACO, how am I going to be paid? a) Providers would only be paid by an ACO if they choose to contract with an ACO. The APM does not require providers to join an ACO. An ACO using the AIPBP payment mechanism will set payment rates for participating providers. ***Non-participating providers will be paid in exactly the same way that they are today***; however, it's important to note that payment methodologies are changing with or without the APM. Current federal law will change the way Medicare providers are paid over time starting in 2020, adjusting payment up or down based on quality measures. Also, commercial insurers and Vermont Medicaid retain the right to change the payment rates for providers independent of the APM.

However, the draft agreement includes a provision that is in direct conflict with this statement and strongly implies that the State could penalize providers for not joining an ACO.

Under draft agreement paragraph 13, Request for Payment Waivers, on page 23, is the statement: "[I]n particular, the State may suggest a Medicare payment waiver in the future to implement a discount on fee-for-service payments to Vermont providers and/or supplier not participating in an ACO."

VMS Recommendation

Revise the draft agreement as follows:

Delete the sentence in paragraph 13 that reads: "[I]n particular, the State may suggest a Medicare payment waiver in the future to implement a discount on fee-for-service payments to Vermont providers and/or supplier not participating in an ACO."

Support for receiving enhanced Medicare reimbursement under MACRA

The VMS applauds the draft agreement's support for the State of Vermont increasing "Medicaid reimbursement rates to levels more comparable to Medicare reimbursement rates" by excluding these increases from Medicaid spending towards the All Payer Total Cost of Care per Beneficiary Growth target (see paragraphs 6ciii and 8(d)).

⁵ http://gmcboard.vermont.gov/sites/gmcb/files/documents/payment-reform/APM_FAQ.pdf

Further, paragraph 7c on page 21 states that “CMS and Vermont intend to explore any potential modifications to the Vermont Medicare ACO Initiative that may be necessary such that the Initiative be considered an Advanced Alternative Payment Model under the Quality Payment Program, pending final rulemaking.”

Under proposed MACRA regulation, physicians who participate in an Advanced Alternative Payment Model may be determined to be qualifying APM participants and receive 5 percent Medicare bonus payments for years 2019-2024. In addition, those physicians participating in the Merit-based Incentive Payment System (MIPS) will have their Medicare reimbursement increase or decrease by up to 4 percent in 2019, 5 percent in 2020, 7 percent in 2021, and 9 percent in 2022.

In a manner similar to the treatment of increased Medicaid reimbursement, the VMS believes that the state should not be penalized for bonus Medicare payments under APM and MIPS and they should therefore not be included in the Vermont Medicare Total Cost of Care per Beneficiary Growth calculations.

VMS Recommendation

Add at the end of paragraph 6.c.i on page 17 the following sentence: “The Vermont Medicare Total Cost of Care per Beneficiary Growth calculations shall be adjusted to exclude growth attributable to efforts by Vermont providers to receive bonus payments under the Merit-based Incentive Payment System or Advanced Alternative Payment Models.”

Public Disclosure of Provider Performance Data

Paragraph 15c, on page 25, of the draft agreement states: “[V]ermont may publically disclose, with consent from CMS, provider-specific performance for purposes of accountability for the quality of care delivered under the model.”

Under its Physician Compare program, CMS hosts webinars about public reporting and its 30 day preview period. Under the 30 day preview period, physicians and group practices have the opportunity to review the provider-specific performance information before it goes live and flag problematic information.

VMS Recommendation

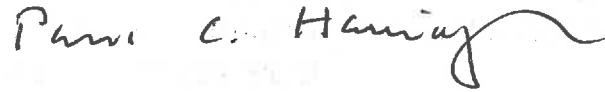
Revise the draft agreement as follows:

To achieve consistency with CMS policy, in paragraph 15c add the following new sentence at the end of the paragraph: “Any public disclosure of provider-specific performance shall include a 30 day preview period.”

Again, thank for the opportunity to provide the GMCB with suggested amendments to the draft agreement in order to more closely align the document with the VMS' provisions for support of the Vermont All-Payer Accountable Care Organization Model Agreement.

Please let me know if you have any questions or if I can be of further assistance.

Sincerely,

A handwritten signature in black ink that reads "Paul C. Harrington". The signature is written in a cursive style with a long, sweeping flourish at the end.

Paul C. Harrington
Executive Vice President

Cc: Green Mountain Care Board
VMS Council