DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS-5521-N]

Medicare Program; Start-up Funding in Support of the Vermont All-Payer Accountable Care Organization (ACO) Model - Cooperative Agreement

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Notice.

SUMMARY: The purpose of this notice is to announce issuance of the November 23, 2016 single-source cooperative agreement funding opportunity available solely to Vermont's Agency of Human Services in order to provide care coordination and bolster collaboration for practices and community-based health care providers as part of the Vermont All-Payer Accountable Care Organization (ACO) Model.

DATES: The performance period of the Vermont All-Payer ACO Model will begin on January 1, 2017, and conclude on December 31, 2022.

FOR FURTHER INFORMATION CONTACT:

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SUPPLEMENTARY INFORMATION:

I. Background

The Vermont All-Payer Accountable Care Organization Model (Model) is the Centers for Medicare & Medicaid Services' (CMS) new test within the Center for Medicare and Medicaid Innovation of an alternative payment model in which the major health care payers — Medicare, Medicaid, and commercial health care payers — incentivize health care value and quality under the same payment structure for health care

providers throughout the state's care delivery system to transform health care for the entire state and its population. An Accountable Care Organization (ACO) is an entity formed by certain health care providers that accepts financial accountability for the overall quality and cost of medical care furnished to, and health of, beneficiaries attributed to the entity.

CMS believes that states can be critical partners of the federal government and other health care payers to facilitate the design, implementation, and evaluation of community-centered health systems that can deliver significantly improved cost, quality, and population health performance results for all state residents, including Medicare, Medicaid, and Children's Health Insurance Program (CHIP) beneficiaries. States have policy and regulatory authorities, as well as ongoing relationships with commercial healthcare payers, health plans, and health care providers that can accelerate delivery system reform. CMS has previously partnered with states to accelerate delivery system reform through initiatives such as the State Innovations Model (SIM). SIM provides state-based healthcare transformation efforts with funding to test the ability of states to utilize policy and regulatory levers to accelerate multi-payer health care transformation.

Vermont, a SIM state awardee, approached CMS with a desire to include Medicare in the state's multipayer payment and care delivery model, and Vermont publicly released its proposal on January 25, 2016. CMS reviewed Vermont's proposal and determined that it met the necessary requirements to explore a potential Vermont-specific model in which Medicare aligns with Vermont's healthcare transformation efforts. In October 2016, CMS and the State of Vermont entered into the Vermont All-Payer Accountable Care Organization Model Agreement ("State

Agreement") to implement the Vermont All-Payer ACO Model. The Vermont All-Payer ACO Model will be a 6-year model beginning in 2017 and ending in 2022.

As part of the Model, Vermont health care providers will participate in a Vermont-specific Medicare ACO initiative (the Vermont Medicare ACO Initiative), which is largely based on CMS' Next Generation ACO Model. CMS will provide one-time start-up funding in the amount of $9,500,000 to the State to assist Vermont health care providers with care coordination and bolster their collaboration with community-based resources. CMS will provide the start-up funding as a cooperative agreement funding opportunity available solely to Vermont's Agency of Human Services, as announced in this notice. More information about the Vermont All-Payer ACO Model can be found at https://innovation.cms.gov/initiatives/vermont-all-payer-aco-model/.

Through the Model, CMS will test whether the quality of health care for Vermont residents improves and healthcare expenditures for beneficiaries across payers (including Medicare fee-for-service, Vermont Medicaid, Vermont commercial plans, and Vermont self-insured plans) decrease if—

- The aforementioned payers offer Vermont ACOs risk-based arrangements tied to health outcomes and healthcare expenditures;
- The majority of Vermont health care providers enter into such risk-based arrangements; and
- The majority of Vermont residents across payers are aligned to an ACO bound by these arrangements.

CMS and Vermont aim for broad ACO participation throughout the state, across all the significant payers and the majority of the care delivery system, to make redesigning the entire care delivery system a rational business strategy for Vermont health care providers and payers. As set forth in the State Agreement, Vermont commits to achieving statewide health outcomes, financial targets, and ACO scale (percentage of Vermont residents aligned to an ACO) targets – both for Medicare and across all significant healthcare payers. Additionally, CMS and Vermont aim for this Model to deliver meaningful improvements in the health of a state's entire population by transforming the relationships between and amongst care delivery and public health systems across Vermont.

II. Provisions of the Notice

The purpose of this notice is to announce a single source cooperative agreement funding opportunity in the amount of $9,500,000 available solely to Vermont's Agency of Human Services (AHS) to support care coordination and bolster collaboration for practices and community-based health care providers as part of the Vermont All-Payer ACO Model. A single-source award to the AHS will enable CMS to provide assistance to Vermont for the following purposes: to connect Medicare fee-for-service beneficiaries with community-based resources, coordinate transitions across care settings with appropriate involvement of the Medicare fee-for-service beneficiaries' primary care providers, coordinate care across health care providers, support health promotion and self-management by Medicare fee-for-service beneficiaries, and support practice improvement and transformation. These activities are necessary for Vermont to achieve

the health outcomes and financial goals required under the Vermont All-Payer ACO Model.

CMS and Vermont believe the Vermont All-Payer ACO Model can support health care providers, including physicians in small practices, to succeed as health care moves from fee-for-service to value-based payment systems. Participation by health care providers and payers in the model will be voluntary, and CMS and Vermont expect to work closely together to achieve sufficient uptake. In particular, this Model is being implemented using the Secretary's authority in section 1115A of the Social Security Act (the Act) and Vermont's Global Commitment to Health demonstration project authorized under section 1115 of the Act. Together these authorities make it possible for physicians and other clinicians in Vermont to participate the aligned and state-specific Vermont Medicare ACO Initiative and Medicaid ACO initiative. Under the Quality Payment Program, the two-sided risk portion of the Vermont Medicare ACO Initiative meets the criteria to be an Advanced Alternative Payment Model. Health care providers participating in the two-sided risk portion of the Vermont Medicare ACO Initiative may potentially qualify for the APM Incentive Payments starting in performance year 2018.

This single-source funding opportunity to the AHS is designed to meet the goals of the cooperative agreement based on the AHS' existing knowledge and role in supporting the Model, its existing partnerships and collaborations with Vermont health care providers, and its resources and ability to deploy the funding immediately.

III. Collection of Information Requirements

This document does not impose information collection requirements, that is, reporting, recordkeeping or third-party disclosure requirements. Consequently, there is

no need for review by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 et seq.).

CMS-5521-N

Dated: December 6, 2016

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Andrew M. Slavitt,

Acting Administrator,

Centers for Medicare & Medicaid Services.

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