VT Health Care Innovation Project - Payment Model Design and Implementation Work Group Meeting Agenda
Monday, October 19, 2015 1:00 PM – 3:00 PM.
DVHA Large Conference Room, 312 Hurricane Lane, Williston
Call in option: 1-877-273-4202 Conference Room: 2252454

Item #	Time Frame	Topic	Presenter	Decision Needed?	Relevant Attachments
1	1:00 – 1:15	Welcome and Introductions Approve meeting minutes	Cathy Fulton Andrew Garland	Y – Approve minutes	Attachment 1: September Meeting Minutes
2	1:15-1:40	Population Health Workgroup Overview	Heidi Klein	N	Attachment 2: Population Health Workgroup Overview
3	1:40-2:30	Presentation on SSP Year 1 Results	Richard Slusky, Alicia Cooper, Pat Jones	N	Attachment 3a: Presentation on SSP Year 1 Results Attachment 3b: Pilot Standards Document
4	2:30-2:50	Removal of Year 3 Downside Risk	Georgia Maheras	N	
5	2:50-2:55	Public Comment		N	
6	2:55-3:00	Next Steps and Action Items		N	Next Meeting: November 16th EXE - 4th Floor Conf Room, Pavilion Building 109 State Street, Montpelier

Attachment 1: September Meeting Minutes

Vermont Health Care Innovation Project
Payment Models Work Group Meeting Minutes

Pending Work Group Approval

Date of meeting: Monday, September 21, 2015, 1:00-3:00pm, 4th Floor Conference Room, Pavilion Building, 109 State Street, Montpelier.

Agenda Item	Discussion	Next Steps
1. Welcome and Introductions; Approve Meeting Minutes	Andrew Garland called the meeting to order at 1:02pm. A roll call attendance was taken and a quorum was not present. The group will vote on the August minutes at the October meeting.	
2. Project Updates	Staff provided brief updates on Vermont Health Care Innovation Project activities. • *SSP Year 1 Final Calculations Update:* Alicia Cooper reported that results are now finalized for the Commercial and Medicaid SSPs. The Governor held a press conference earlier this month on the Medicaid SSP results, which showed $14.6 million in total savings shared by Medicaid and the ACOs. Both OneCare and CHAC were both eligible to share in savings for this program. The Commercial SSP did not generate savings for either ACO. Richard Slusky noted that Commercial SSP expenditure targets were set based on Exchange premiums – a challenge in the first year of Exchange plans. Quality results for the Commercial SSP were also impacted by the lack of lookback period – 3 of 7 payment measures were impossible to calculate given the lack of previous enrollment. This was a good learning experience for the ACOs despite lack of savings. GMCB expects similar results for Year 2 (2015), but hopes for better performance in Year 3 (2016). Staff will update the Green Mountain Care Board in early October on the results for all of the SSPs. Richard also noted that there is now publically available information on the Medicare program as well. o Susan Aranoff asked whether analyses will show where savings came from. Alicia noted that DVHA is working on more detailed explanatory analyses examining possible drivers of the savings, and once complete will be able to share that more broadly. Richard noted that GMCB is looking at how premiums were established by plans to get a better sense of premiums and risk adjustment to see whether there are specific areas that are opportunities for improvement. o Susan Aranoff asked why there were Medicaid savings when there were no Medicare or	

Agenda Item	Discussion	Next Steps
	commercial savings, and asked whether DVHA is considering resetting the trend. She also noted that Medicare SSP participants are expected to pay infrastructure payments back to the federal government, and asked what public spend to achieve savings has been. Richard responded to the Medicare question: He noted that OneCare and CHAC each achieved savings for one Medicare SSP year, but savings were below the minimum savings threshold so there was no payout. He also noted that OneCare, CHAC, and ACCGM chose the upside-only contract. Cecelia Wu added that there are no payments for ACO administration through the Medicaid SSP contracts with DVHA. Georgia Maheras noted that we have not done an analysis of SIM and other grant funds that have contributed to ACO infrastructure. Alicia responded to the Medicaid SSP methodology question: There are no plans to drastically alter the methodology set at the start of the program; however, it does take into account a rolling year advancement of the baseline, which impacts trends. Cecelia noted that the Medicaid SSP trend methodology has been reviewed and tested by outside actuaries and CMS's Office of the Actuary. Georgia commented that it is challenging to set premiums and trends for new insurance products (as in the Commercial SSP) – DVHA's trends benefited from many years of data. Cecelia also noted that the first year of the program is not necessarily representative. Subsequent years will help us assess the program more fully. • *VMSSP Year 3 Total Cost of Care Process Update:* Cecelia Wu reported that DVHA is making no change to the TCOC for the Medicaid SSP, and thanked stakeholders for their input. Georgia Maheras added that this strategy makes sense as Vermont is looking ahead to the All-Payer Model currently being negotiated.	

3. Overview of Other VHCIP Work Groups	Andrew Garland introduced a discussion of the other VHCIP work groups' activities. This agenda item is intended to give Payment Models Work Group members a better sense of other groups' work in advance of VHCIP work group consolidation taking place in this fall. (See Attachment 3 for all 7 work groups' original charters.)
	• *Quality and Performance Measures Work Group* (Cathy Fulton):
	  o Current Status: Year 3 measures are approved by QPM and headed to Steering Committee (9/28) and GMCB. There are four measures that need to change based on changes to national measure sets and clinical evidence, and the Work Group has approved appropriate substitutions. QPM members will continue to keep an eye on changes to national measure sets and best practices.
	  o Lou McLaren noted that the measure replacing LDL screening (hypertension control) is a payment measure. This will require chart review. Pat confirmed this, and said that this is not the only clinical measure that requires chart review in the payment measure set. It is also a measure that ACOs have experience collecting. The recommendation was approved unanimously. Pat and Kelly confirmed that chart review is not a payer expense.
	  o Future work will include working toward electronic collection of clinical measures, and looking at measures for upstream factors that impact health.
	• *Disabilities and Long-Term Services and Supports Work Group* (Julie Wasserman on behalf of Deborah Lisi-Baker): Julie reiterated that DLTSS Work Group members are very excited to explore payment models, and noted that many of the DLTSS Work Group's activities have involved exploration of payment models that can support better outcomes for people with disabilities and bridge the gap between acute	

Agenda Item	Discussion	Next Steps
	and long-term care services. DTLSS Work Group members will also be joining the Practice Transformation and Health Data Infrastructure Work Groups, and will continue to meet quarterly as an issue group. • *Population Health* (Tracy Dolan): Tracy was not able to attend the meeting, and will be the first agenda item at the re-convened Payment Models Work Group in October.	
4. All-Payer Model Progress Report Summary	Georgia Maheras presented on changes to the VHCIP governance structure planned for October (Attachment 4). • Remaining work to do in Year 3 within Payment Models focus area: o Year 3 of Medicaid and Commercial SSPs o Medicaid Episodes of Care o Feasibility/Analysis: Accountable Communities for Health and All-Payer Waiver o Home Health Prospective Payment System o Overall goal: 80% of Vermonters in alternatives to fee-for-service by the end of 2016 • New Organizational Structure: o Payment Models Design and Implementation Work Group will combine Payment Models, QPM, Population Health, and a portion of the DLTSS Work Group. o Health Data Infrastructure will combine HIE/HIT and some of DLTSS and CMCM Work Groups. o Practice Transformation will combine CMCM and some of the DLTSS Work Group. o Workforce Work Group will not change. o Workplans have been combined and shared with co-chairs and staff; final versions to be sent to the Core Team in October for approval. o We've asked members to indicate which work groups they would like to participate in under the new structure; co-chairs and staff will review these new lists to ensure there are no gaps in membership. o Year 3 workplans will be developed based on Year 3 milestones; project leadership hopes to develop workplans in December and implement them in January 2016. • Projects within each focus area will have an identified lead and monthly reporting. Monthly reports are simplified and organize work by content for greater ease of understanding.	
6. Public Comment	Lila Richardson requested better notification about major events (i.e., Medicaid SSP results press conference) when they occur between meetings.	
7. Next Steps, and Action Items	**Next Meeting:** Monday, October 19, 2015, 1:00-3:00pm, DVHA Large Conference Room, 312 Hurricane Lane, Williston. For next meeting: • Introduce new members and very brief update on other work groups' activities. • Additional discussion of SSP results with Richard Slusky and Pat Jones. • Tracy Dolan overview of Population Health Work Group activities.	

VHCIP Payment Models Work Group Member List

Roll Call: 9/21/2015

Member		Member Alternate		Minutes	
First Name	**Last Name**	**First Name**	**Last Name**		**Organization**
Mary Alice	Bisbee				Consumer Representative
Diane	Cummings ✓				AHS - Central Office
Michael	Curtis	Melissa	Bailey		Washington County Mental Health Services Inc.
Mike	DelTrecco	Bea	Grause		Vermont Association of Hospital and Health Systems
Catherine	Fulton ✓				Vermont Program for Quality in Health Care
Joyce	Gallimore				CHAC
Maura	Graff ✓				Planned Parenthood of Northern New England
Lynn	Guillett				Dartmouth Hitchcock
Mike	Hall	Angela	Smith-Dieng		Champlain Valley Area Agency on Aging / COVE
Paul	Harrington				Vermont Medical Society
Bard	Hill ✓	Susan	Aranoff ✓		AHS - DAIL
Sara	King	Larry	Goetschius ✓		Rutland Area Visiting Nurse Association & Hospice
Kelly	Lange ✓	James	Mauro		Blue Cross Blue Shield of Vermont
David	Martini ✓				DFR
Lou	McLaren ✓				MVP Health Care
Tom	Pitts				Northern Counties Health Care
Amy	Putnam ✓				Northwestern Counseling and Support Services, Inc.
Paul	Reiss				Accountable Care Coalition of the Green Mountains
Lila	Richardson ✓	Rachel	Seelig		Vermont Legal Aid
Greg	Robinson	Abe	Berman		OneCare Vermont
Howard	Schapiro				University of Vermont Medical Group Practice
Julia	Shaw ✓	Rachel	Seelig		Health Care Advocate Project
Ted	Sirotta				Northwestern Medical Center
Richard	Slusky ✓	Pat	Jones ✓		GMCB
Jeremy	Ste. Marie	Jessica	Oski		Vermont Chiropractic Association
Shannon	Thompson ✓				AHS - DMH
Sharon	Winn	Joyce	Gallimore		Bi-State Primary Care
	26		12		

quorum = 14

VHCIP Payment Models Work Group Participant List

Attendance: 9/21/2015

C	Chair
IC	Interim Chair
M	Member
MA	Member Alternate
A	Assistant
S	VHCIP Staff/Consultant
X	Interested Party

First Name	Last Name		Organization	Pymt Models
Susan	Aranoff ✓		AHS - DAIL	S/MA
Ena	Backus		GMCB	X
Melissa	Bailey		Vermont Care Partners	MA
Michael	Bailit		SOV Consultant - Bailit-Health Purchasing	S
Susan	Barrett		GMCB	X
Susan	Bartlett		AHS	X
Anna	Bassford		GMCB	A
Abe	Berman		OneCare Vermont	MA
Susan	Besio		SOV Consultant - Pacific Health Policy Group	S
Mary Alice	Bisbee		Consumer Representative	M
Martha	Buck		Vermont Association of Hospital and Health Systems	A
Heather	Bushey		Planned Parenthood of Northern New England	X
Gisele	Carbonneau		HealthFirst	A
Amanda	Ciecior ✓		AHS - DVHA	S
Sarah	Clark		AHS - CO	X

Lori	Collins		AHS - DVHA	X
Amy	Coonradt		AHS - DVHA	S
Alicia	Cooper ✓		AHS - DVHA	S
Michael	Counter		Visiting Nurse Association & Hospice of VT & NH	X
Diane	Cummings		AHS - Central Office	S/M
Michael	Curtis		Washington County Mental Health Services Inc.	M
Danielle	Delong		AHS - DVHA	X
Mike	DelTrecco		Vermont Association of Hospital and Health Systems	M
Michael	Donofrio		GMCB	X
Gabe	Epstein ✓		AHS - DAIL	S
Katie	Fitzpatrick		Bi-State Primary Care	A
Erin	Flynn		AHS - DVHA	S
Catherine	Fulton		Vermont Program for Quality in Health Care	M
Joyce	Gallimore		Bi-State Primary Care/CHAC	MA/M
Lucie	Garand		Downs Rachlin Martin PLLC	X
Andrew	Garland ✓		MVP Health Care	C
Christine	Geiler		GMCB	S
Don	George		Blue Cross Blue Shield of Vermont	C
Carrie	Germaine ✓	phone	AHS - DVHA	X
Al	Gobeille		GMCB	X
Larry	Goetschius		Addison County Home Health and Hospice	MA
Maura	Graff		Planned Parenthood of Northern New England	M
Bea	Grause		Vermont Association of Hospital and Health Systems	MA
Lynn	Guillett		Dartmouth Hitchcock	M
Mike	Hall		Champlain Valley Area Agency on Aging / COVE	M
Thomas	Hall		Consumer Representative	X
Paul	Harrington		Vermont Medical Society	M
Carrie	Hathaway		AHS - DVHA	X
Carolynn	Hatin		AHS - Central Office - IFS	S
Erik	Hemmett		Vermont Chiropractic Association	X
Selina	Hickman		AHS - DVHA	X
Bard	Hill		AHS - DAIL	M
Con	Hogan		GMCB	X
Nancy	Hogue		AHS - DVHA	X

Craig	Jones		AHS - DVHA - Blueprint	MA
Pat	Jones ✓		GMCB	S/MA
Joelle	Judge		UMASS	S
Kevin	Kelley		CHSLV	X
Melissa	Kelly		MVP Health Care	X
Sarah	King		Rutland Area Visiting Nurse Association & Hospice	M
Sarah	Kinsler ✓		AHS - DVHA	S
Peter	Kriff		PDI Creative	X
Kelly	Lange		Blue Cross Blue Shield of Vermont	M
Carole	Magoffin ✓		AHS - DVHA	S
Georgia	Maheras ✓		AOA	S
David	Martini ✓		DFR	M
Mike	Maslack			X
John	Matulis			X
James	Mauro		Blue Cross Blue Shield of Vermont	MA
Alexa	McGrath		Blue Cross Blue Shield of Vermont	A
Sandy	McGuire ✓		Howard Center	X
Lee	McKenna		OneCare Vermont	X
Lou	McLaren ✓		MVP Health Care	M
MaryKate	Mohlman ✓		AHS - DVHA - Blueprint	X
Monica	Ogelby		AHS - VDH	X
Jessica	Oski		Vermont Chiropractic Association	MA
Annie	Paumgarten ✓		GMCB	S
Tom	Pitts		Northern Counties Health Care	M
Luann	Poirer		AHS - DVHA	S
Rebecca	Porter		AHS - VDH	X
Amy	Putnam ✓		Northwest Counseling and Support Services, Inc	M
Paul	Reiss		Accountable Care Coalition of the Green Mountains	M
Lila	Richardson ✓		VLA/Health Care Advocate Project	M
Greg	Robinson		OneCare Vermont	M
Howard	Schapiro		University of Vermont Medical Group Practice	M
Rachel	Seelig		VLA/Senior Citizens Law Project	MA
Julia	Shaw ✓		VLA/Health Care Advocate Project	M
Tom	Simpatico		AHS - DVHA	X
Ted	Sirotta		Northwestern Medical Center	M

Shawn	Skafelstad		AHS - Central Office	X
Richard	Slusky		GMCB	S/M
Angela	Smith-Dieng		Area Agency on Aging	MA
Jeremy	Ste. Marie		Vermont Chiropractic Association	M
Beth	Tanzman		AHS - DVHA - Blueprint	X
Shannon	Thompson		AHS - DMH	M
Marlys	Waller		DA - Vermont Council of Developmental and Mental Health Serv	X
Julie	Wasserman ✓		AHS - Central Office	S
Spenser	Weppler		GMCB	S
Kendall	West		Bi-State	X
James	Westrich ✓		AHS - DVHA	S
Bradley	Wilhelm		AHS - DVHA	S
Sharon	Winn		Bi-State Primary Care	M
Cecelia	Wu ✓		AHS - DVHA	S
Erin	Zink		MVP Health Care	X
Marie	Zura		DA - HowardCenter for Mental Health	MA
				100

Simone Rueschemeyer

Attachment 2: Population Health Workgroup Overview

VHCIP Population Health Work Group Activities

The Population Health Work Group has two major work streams underway for the remainder of 2015: the Population Health Plan, required by CMMI; and Accountable Communities for Health. In 2016, the Work Group will continue work in these areas while also reviewing existing models and research related to financing models for population health and prevention activities.

Population Health Plan

<u>Performance Period 3 Milestone</u>: Develop Population Health Plan by 12/31/16.

Work continues to develop the *Plan for Integrating Population Health and Prevention in Health Care Innovation in Vermont*. This plan builds upon the existing *State Health Improvement Plan* which identifies three strategic goals for population health improvement:

Goal 1: Reduce the prevalence of chronic disease
Goal 2: Reduce the prevalence of individuals with or at risk of substance abuse or mental illness
Goal 3: Improve childhood immunization rates

Improvements made through evidence-based strategies for these three preventable conditions will have a positive impact on multiple health outcomes in the future.

The *Plan for Integrating Population Health and Prevention in Health Care Innovation in Vermont* will offer a strategic pathway forward to systematically connect integrated care management efforts with community-wide prevention strategies to improve population health outcomes. The plan will summarize the results of the three primary areas of work carried out through this project:

- Developing consensus on population health measures to be used in tracking the outcomes of VHCIP and to be incorporated in the new payment models;
- Drafting recommendations on how to pay for population health and prevention through modifications to proposed health reform payment mechanisms, and identification of promising new financing vehicles that promote financial investment in population health interventions; and
- Identifying current initiatives where clinical and population health are coming together and the opportunities to enhance new health delivery system models, such as the Blueprint for Health and Accountable Care Organizations (ACOs), to improve population health by better integration of clinical services, public health programs and community based services at both the practice and the community levels.

The *Plan for Integrating Population Health and Prevention in Health Care Innovation in Vermont* is being developed collaboratively by the VHCIP Population Health Work Group, Vermont Department of Health, and VHCIP staff, with support from contractors and key national subject matter experts.

Accountable Communities for Health (ACH)

***Performance Period 3 Milestone*: ACH Implementation Plan incorporated into Sustainability Plan by 10/31/16.**

The Population Health Work Group completed the initial research and design feasibility related to Accountable Communities for Health as an alternated community-based model for integrating clinical care and community health efforts.

Based on the recommendations of the Prevention Institute and members of the Population Health Work group, we are proposing a Year 2 Carryover activity which would move from the conceptual framework developed based on research and interviews to developing implementation guidance based on the real world practical experiences and questions of those who would be the leaders of an Accountable Community for Health in various regions in Vermont. This year will be a year of exploration and peer- learning utilizing the resources of the VHCIP staff, budget and technical assistance providers. The process includes four major components:

1. Establish a statewide framework for population health improvement;

2. Produce guidance to Regions on goals, indicators and evidence based strategies for population health improvement;

3. Build capacity and learning among integrators and team leads from established Regions – UCC and/or Community Wide Health/Prevention Structure; and

4. Explore long term financing opportunities.

The peer learning initiative will build upon the model developed by the Care Models and Care Management Work Group and will be coordinated with existing regional activities to assure alignment across efforts.

Based on lessons learned from these efforts and progress in participating communities, Vermont will develop an ACH Implementation Plan to be incorporated into our Sustainability Plan by October 2016.

Attachment 3a: Presentation on SSP Year 1 Results

Year 1 (2014) Results for Vermont's Commercial and Medicaid ACO Shared Savings Programs

Richard Slusky, Director of Payment Reform, GMCB
Pat Jones, Health Care Project Director, GMCB
Alicia Cooper, Health Care Project Director, DVHA

Presentation to
VHCIP Payment Models Work Group
October 19th, 2015

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Presentation Overview

- Financial Results
  - Aggregated
  - Per Member Per Month

- Quality Results
  - Payment Measures
  - Reporting Measures
  - Patient Experience Measures

Vermont's ACOs and Shared Savings Programs

ACO Name	2014 Shared Savings Programs
Community Health Accountable Care (CHAC)	Commercial Medicaid Medicare
OneCare Vermont (OCV)	Commercial Medicaid Medicare
Vermont Collaborative Physicians/ Health*first* (VCP)	Commercial Medicare

Financial Summary Aggregated Results

- Medicaid 2014

	Medicaid		
	CHAC	OneCare	VCP
Total Lives	26,587	37,929	N/A
Expected Aggregated Total	$ 67,803,470.45	$ 81,686,552.31	N/A
Target Aggregated Total	N/A	N/A	N/A
Actual Aggregated Total	$ 59,956,030.18	$ 74,931,984.20	N/A
Shared Savings Aggregated Total	$ 7,847,440.27	$ 6,754,568.12	N/A
Total Savings Earned	$ 7,847,440.27	$ 6,754,568.12	N/A
Potential ACO Share of Earned Savings	$ 3,923,720.13	$ 3,377,284.06	N/A
Quality Score	46%	63%	N/A
%of Savings Earned	85%	100%	N/A
Achieved Savings	$ 3,335,162.11	$ 3,377,284.06	N/A

Financial Summary Aggregated Results

- Commercial 2014

	Commercial		
	CHAC	OneCare	VCP
Total Lives	9,353	22,260	8,526
Expected Aggregated Total	$31,829,851	$76,413,313	$23,581,249
Target Aggregated Total	$30,817,275	$74,489,076	$22,796,150
Actual Aggregated Total	$34,377,496	$81,899,734	$25,292,905
Shared Savings Aggregated Total	($2,547,645)	($5,486,421)	($1,711,656)
Total Savings Earned	$0	$0	$0
Potential ACO Share of Earned Savings	$0	$0	$0
Quality Score	56%	67%	89%
%of Savings Earned	75%*	85%*	100%*
Achieved Savings	$ -	$ -	$ -

*If shared savings had been earned

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Financial Summary Aggregated Results

- Medicare 2014

	Medicare		
	CHAC	OneCare	VCP
Total Lives	5,948	55,058	7,639
Expected Aggregated Total	$47,069,176	$466,249,733	$56,724,584
Target Aggregated Total	N/A	N/A	N/A
Actual Aggregated Total	$45,957,103	$470,417,853	$59,486,632
Shared Savings Aggregated Total	$1,112,073^	($4,168,120)	($2,762,048)
Total Savings Earned	$0	$0	$0
Potential ACO Share of Earned Savings	$0	$0	$0
Quality Score	Pay for Reporting	89.15%	92.10%
%of Savings Earned	N/A	N/A	N/A
Achieved Savings	$ -	$ -	$ -

^CHAC did not meet the MSR in the MSSP in order to earn savings

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Financial Summary PMPM Results

- Medicaid 2014

	Medicaid		
	CHAC	OneCare	VCP
Actual Member Months	315,833	452,311	N/A
Expected PMPM	$ 214.68	$ 180.60	N/A
Target PMPM	N/A	N/A	N/A
Actual PMPM	$ 189.83	$ 165.66	N/A
Shared Savings PMPM	$ 24.85	$ 14.93	N/A
Total Savings Earned	$ 7,847,440.27	$ 6,754,568.12	N/A
Potential ACO Share of Earned Savings	$ 3,923,720.13	$ 3,377,284.06	N/A
Quality Score	46%	63%	N/A
%of Savings Earned	85%	100%	N/A
Achieved Savings	$ 3,335,162.11	$ 3,377,284.06	N/A

Financial Summary PMPM Results

- Commercial 2014

	Commercial		
	CHAC	OneCare	VCP
Actual Member Months	98,213	234,663	88,412
Expected PMPM	$ 324.09	$ 325.63	$ 266.72
Target PMPM	$ 313.78	$ 317.43	$ 257.84
Actual PMPM	$ 350.03	$ 349.01	$ 286.08
Shared Savings PMPM	$ (25.94)	$ (23.38)	$ (19.36)
Total Savings Earned	$ -	$ -	$ -
Potential ACO Share of Earned Savings	$ -	$ -	$ -
Quality Score	56%	67%	89%
%of Savings Earned	75%*	85%*	100%*
Achieved Savings	$ -	$ -	$ -

*If shared savings had been earned

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Quality Measurement Overview

- 2014 was baseline year for Vermont's Shared Savings Programs: comprehensive implementation and final Commercial enrollment occurred in Spring of 2014
- Opportunity for improvement was one of the criteria for selection of quality measures
- There is no historical data for Commercial SSP members prior to their enrollment dates, so measures with look-back periods did not have adequate denominators
- Data collection and analysis was challenging, but there was impressive collaboration among ACOs in clinical data collection

Results Should be Interpreted with Caution

- ACOs have different populations

- ACOs had different start dates:
    - VCP - July 2012
    - OneCare – January 2013
    - CHAC – January 2014

- There are no payer-specific benchmarks for Patient Experience Survey; had to combine Commercial and Medicaid results and compare to national all-payer results that include Medicare beneficiaries

Simplified Quality Measure Data Flow

Measures From Claims Data

Payers Send Claims Data to Contractor

Contractor Generates Results for Claims Measures

Results Carefully Reviewed, Sent to ACOs and Reported

Measures From Clinical Data

Contractor Generates Sample from Claims Data

ACO Conducts Chart Review

ACO Sends Results to Contractor; Results Reviewed and Reported

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Simplified Quality Measure Data Flow (cont'd)

Patient Experience Measures

Primary Care Practices Send Sample Lists to Survey Vendor

Survey Vendor Fields Survey

Responses to Survey Vendor

Vendor Sends Practice-Level Aggregated Results to Practices

ACOs Send Lists to Survey Vendor; ACO Respondents Flagged

Contractor Generates ACO-Level Aggregated Results

ACO-Level Results Reviewed and Reported

2014 Quality Results: Commercial Payment Measures

Measure	CHAC Rate/ Percentile/ Points*	OCV Rate/ Percentile/ Points*	VCP Rate/ Percentile/ Points*
Adolescent Well-Care Visits	48.40/Above 75th/ 3 Points	54.42/Above 75th/ 3 Points	46.58/Above 75th/ 3 Points
Alcohol and Other Drug Dependence Treatment	22.73/Above 25th/ 1 Point	21.55/Below 25th/ 0 Points	31.25/Above 50th/ 2 Points
Chlamydia Screening	39.57/Above 25th/ 1 Point	43.47/Above 50th/ 2 Points	47.06/Above 75th/ 3 Points
Mental Illness, Follow-Up After Hospitalization	N/A (denominator too small)	69.77/Above 90th/ 3 Points	N/A (denominator too small)

*Maximum points per measure = 3

Impact on Payment
(if there had been Shared Savings)

Vermont Commercial Shared Savings Program Quality Performance Summary - 2014				
ACO Name	Points Earned	Total Potential Points	% of Total Quality Points	% of Savings Earned*
CHAC	5	9	56%	75%
OneCare	8	12	67%	85%
VCP	8	9	89%	100%
	*If shared savings had been earned			

2014 Commercial Payment Measures: Strengths and Opportunities

- Strengths:
  - 7 of 10 ACO results were above the national 50th percentile
  - 5 of 10 were above the 75th percentile
- Opportunities:
  - 3 of 10 were below the 50th percentile
  - Even when performance compared to benchmarks is good, potential to improve some rates
  - Some variation among ACOs
  - Low Commercial denominators (mostly due to lack of historical data) prevented reporting of some measures; should improve in Year 2

2014 Commercial Reporting Measures

Reporting Measures	CHAC Rate/ Percentile	OneCare Rate/ Percentile	VCP Rate/ Percentile
Testing for Children with Pharyngitis	N/A (denominator too small)	84.38/ Above 50th	88.89/ Above 75th
Immunizations for 2-year-olds	N/A (denominator too small)	50.00/ Above 75th	64.52/ Above 90th
Pediatric Weight Assess./Counseling	55.67/ Above 75th	58.79/ Above 75th	71.37/ Above 90th
Diabetes Care Composite	12.11/ No Benchmark	45.90/ No Benchmark	41.51/ No Benchmark
Diabetes HbA1c Poor Control (lower is better)	13.22/ Above 90th	15.03/ Above 90th	15.09/ Above 90th
Colorectal Cancer Screening	64.97/ Above 75th	70.96/ Above 90th	76.61/ Above 90th
Depression Screen./Follow-Up	23.40/ No Benchmark	22.52/ No Benchmark	19.35/ No Benchmark
Adult BMI Screening and Follow-up	51.30/ No Benchmark	65.04/ No Benchmark	59.68/ No Benchmark

2014 Commercial Reporting Measures: Strengths and Opportunities

- Strengths:
  - Collaboration between ACOs in collecting clinical data
  - For measures with benchmarks, 13 of 13 ACO results were above the national 50th percentile
  - 12 of 13 were above the 75th percentile, and 7 of 13 were above the 90th percentile
- Opportunities:
  - Even when performance compared to benchmarks is good, potential to improve some rates
  - Some variation among ACOs
  - Lack of benchmarks for some Commercial measures hindered further analysis
  - Electronic data capture

2014 Medicaid Payment Measures

Measure	CHAC Rate/ Percentile/ Points*	OCV Rate/ Percentile/ Points*
ACO All-Cause Readmission	14.93/**/ 2 Points	17.90/**/ 2 Points
Adolescent Well-Care Visits	41.82/Above 25th/ 1 Point	49.00/Above 50th/ 2 Points
Cholesterol Screening for Pts w/Cardiovascular Disease	72.87/Below 25th/ 0 Points	73.09/Below 25th/ 0 Points
Mental Illness, Follow-Up After Hospitalization	54.55/Above 50th/ 2 Points	65.88/Above 75th/ 3 Points
Alcohol and Other Drug Dependence Treatment	25.84/Above 50th/ 2 Points	26.22/Above 50th/ 2 Points
Avoidance of Antibiotics in Adults with Acute Bronchitis	31.78/Above 75th/ 3 Points	29.70/Above 75th/ 3 Points
Chlamydia Screening	51.31/Above 25th/1 Point	49.75/Below 25th/0 Points
Developmental Screening	25.55/**/0 Points	45.50/**/3 Points

*Maximum points per measure = 3

**Core Measures 1 and 8 compared to ACO-specific benchmarks, not national benchmarks

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Impact on Payment

Vermont Medicaid Shared Savings Program Quality Performance Summary - 2014				
ACO Name	Points Earned	Total Potential Points	% of Total Quality Points	% of Savings Earned
CHAC	11	24	46%	85%
OneCare	15	24	63%	100%

2014 Medicaid Payment Measures: Strengths and Opportunities

- Strengths:
  - 10 of 16 ACO results were above the national 50th percentile
  - 4 of 16 were above the 75th percentile
  - Both ACOs met the quality gate and were able to share in savings

- Opportunities:
  - 6 of 16 were below the 50th percentile
  - Some variation among ACOs

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2014 Medicaid Reporting Measures

Reporting Measures	CHAC Rate/ Percentile	OCV Rate/Percentile
COPD or Asthma in Older Adults	28.10/Above 75th	30.88/Above 75th
Breast Cancer Screening	53.09/Above 50th	55.80/Above 50th
Prevention Quality Chronic Composite	28.96/ No Benchmark	42.53/No Benchmark
Pharyngitis, Appropriate Testing for Children	77.12/Above 50th	84.31/Above 75th
Childhood Immunization	47.32/Above 90th	60.84/Above 90th
Weight Assessment and Counseling for Children/Adolescents	32.35/Below 25th	47.63/Above 25th
Optimal Diabetes Care Composite	13.28/No Benchmark	33.05/No Benchmark
Diabetes HbA1c Poor Control	23.59/Above 90th	21.47/Above 90th
Colorectal Cancer Screening	53.45/No Benchmark	58.42/No Benchmark
Screening for Clinical Depression and Follow-Up Plan	40.00/No Benchmark	24.55/No Benchmark
Body Mass Index Screening and Follow-Up	47.58/No Benchmark	65.27/No Benchmark

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2014 Medicaid Reporting Measures: Strengths and Opportunities

- Strengths:
  - Impressive collaboration between ACOs in collecting clinical data
  - For measures with benchmarks, 10 of 12 ACO results were above the national 50th percentile
  - 7 of 12 were above the 75th percentile, and 4 of 12 were above the 90th percentile
- Opportunities:
  - Even when performance compared to benchmarks is good, potential to improve some rates
  - Some variation among ACOs
  - Lack of benchmarks for some Medicaid measures hindered further analysis
  - Electronic data capture

2014 Combined Commercial/Medicaid Patient Experience Results (VCP - Commercial Only)

Adult Patient Exp. Composite	CHAC Rate/ Percentile (Comm+Medicaid)	OneCare Rate/ Percentile* (Comm+Medicaid)	VCP Rate/ Percentile (Comm Only)
Access to Care	50%/Below 25th	62%/Above 25th	63%/Above 25th
Communication	77%/Below 25th	82%/At 25th	84%/Above 25th
Shared Decision-Making	63%/Above 25th	67%/At 50th	N/A
Self-Management Support	51%/Above 25th	53%/At 50th	47%/Above 25th
Comprehensiveness	60%/Above 75th	55%/Above 50th	43%/Above 25th
Office Staff	71%/Below 25th	74%/At 25th	84%/Above 50th
Information	72%/No Benchmark	69%/No Benchmark	69%/No Benchmark
Coordination of Care	74%/No Benchmark	75%/No Benchmark	74%/No Benchmark
Specialist Care	49%/No Benchmark	50%/No Benchmark	44%/No Benchmark

*OneCare rate does not include UVMMC practice results; they used a similar survey that can't be combined with these results

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2014 Combined Commercial/Medicaid OneCare Results for UVMMC Practices*

Adult Patient Exp. Composite: Visit-Based Survey	UVM Medical Center/OneCare Top Score Rate/Percentile (Commercial + Medicaid)
Access to Care	90%/Above 90th
Communication	92%/At 50th
Shared Decision-Making	55%/No Benchmark
Self-Management Support	39%/No Benchmark
Comprehensiveness	37%/No Benchmark
Office Staff	95%/Above 50th
Information	56%/No Benchmark
Coordination of Care	79%/No Benchmark
Specialist Care	56%/No Benchmark

*UVMMC-owned practices voluntarily fielded a visit-based survey that was similar to the annual survey used for ACOs; survey differences prevent direct comparison.

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2014 Combined Patient Experience Measures: Strengths and Opportunities

- Strengths:
  - Most ACO primary care practices chose to participate
  - State funding (VHCIP and Blueprint) and vendor management reduced burden on practices
  - Use of same survey for Blueprint and ACO evaluation reduced probability of multiple surveys to consumers
- Opportunities:
  - 12 of 17 ACO results with benchmarks are below national 50th percentile
  - Lack of benchmarks hindered further analysis
  - National all-payer benchmarks might not be comparable to VCP Commercial or CHAC/OneCare combined Commercial/Medicaid results

Summary of 2014 Results

- Implementing Vermont's SSPs in 2014 was complex, and was a learning experience for all participants
- Collaboration among ACOs, providers, payers, state, and contractors was a strength
- Financial results were positive for Medicaid SSP, and were not surprising for Commercial SSP given the use of premiums for setting targets
- Promising quality results for claims/clinical measures
- Opportunities for improvement in Years 2 and 3
- Significant ACO efforts underway to develop data collection, analytic capacity, care management strategies, population health approaches, and ACO/Blueprint collaboration

Questions/Discussion

Attachment 3b: Pilot Standards Document

Vermont Commercial ACO Pilot
Compilation of Pilot Standards
Reflecting Technical and Substantive Changes Approved by the GMCB on September 4, 2014 and Additional Technical Corrections Approved by the GMCB on July 23, 2015.
Proposed Substantive Changes to Remove Downside Risk in Year 3, October 7, 2015.

This document contains ACO commercial pilot standards originally reviewed and approved by the Green Mountain Care Board and the Vermont Health Care Improvement Project Steering Committee and Core Team during meetings that took place in October and November 2013.

ACO pilot standards are organized in the following four categories:

- Standards related to the ACO's structure:
  - Financial Stability
  - Risk Mitigation
  - Patient Freedom of Choice
  - ACO Governance

- Standards related to the ACO's payment methodology:
  - Patient Attribution Methodology
  - Calculation of ACO Financial Performance and Distribution of Shared Risk Payments

- Standards related to management of the ACO:
  - Care Management
  - Payment Alignment
  - Data Use Standards

- Process for review and modification of measures.

The objectives and details of each draft standard follow.

I. Financial Stability

Objective: Protect ACOs from the assumption of "insurance risk" (the risk of whether a patient will develop an expensive health condition) when contracting with private and public payers so that the ACO can focus on management of "performance risk" (the risk of higher costs from delivering unnecessary services, delivering services inefficiently, or committing errors in diagnosis or treatment of a particular condition).

A. Standards related to the effects of provider coding patterns on medical spending and risk scores

1. The GMCB's Analytics Contractor will assess whether changes in provider coding patterns have had a substantive impact on medical spending, and if so, bring such funding and documentation to the GMCB for consideration with participating pilot ACOs.
2. The Payers and ACOs shall participate in a GMCB-facilitated process to review and consider the financial impact of any identified changes in ACO provider coding patterns.

B. Standards related to downside risk. ~~limitation~~

1. The Board has established that for the purposes of the pilot program, the ACOs will not assume ~~the following~~ downside risk in ~~each~~ Years 1 through 3 of the pilot program year.~~:~~
   - ~~Year 1: no downside risk~~
   - ~~Year 2: no downside risk~~
   - ~~Year 3: downside risk not less than 3% and up to 5%~~

~~2. ACOs are required to submit a Risk Mitigation Plan to the state that demonstrates that the ACO has the ability to assume not less than 3% and up to 5% downside risk in Year 3 and receive state approval. Such a plan may, but need not, include the following elements: recoupment from payments to participating providers, stop loss protection, reinsurance, a provider payment withhold provision, and reserves (e.g., irrevocable letter of credit, escrow account, surety bond).~~

~~3. The Risk Mitigation Plan must include a downside risk distribution model that does not disproportionately punish any particular organization within the ACO and maintains network adequacy in the event of a contract year in which the ACO has experienced poor financial performance.~~

C. Standards related to financial oversight.

The payer will furnish financial reports regarding each ACO's risk performance for each six-month performance period to the GMCB, and the VHCIP Payment Models Work Group or its successor in accordance with report formats and timelines defined by the GMCB, through a collaborative process with ACOs and payers.

D. Minimum number of attributed lives for a contract with a payer for a given line of business.

1. For Year 1 of the ACO pilot, an ACO participating with one commercial payer must have at least five thousand (5,000) commercial attributed lives as of June 30, 2014. For Year 1 of the ACO pilot, an ACO participating with two commercial payers must have three thousand (3,000) commercial attributed lives for each of the two payers, for an aggregate minimum of six thousand (6,000) commercial attributed lives, as of June 30, 2014.

   In order to establish the number of an ACO's commercial attributed lives, the payer will, on July 1, 2014, or as soon thereafter as possible, provide the ACO with an account of ACO's commercial attributed lives as of June 30, 2014. Based upon the number of an ACO's commercial attributed lives as of June 30, 2014, the ACO and payer may proceed as follows: if the commercial attributed lives are below the minimum number required for participation, the payer or the ACO may:
      a. terminate their agreement for cause as of June 30, 2014; or
      b. agree to maintain their agreement in full force and effect.

2. In Performance Years 2 and 3, a participating insurer may elect to not participate with an ACO, if: (1) that ACO is participating with one commercial insurer and that ACO's projected or actual attributed member months with that insurer fall below 60,000 annually; or (2) that ACO is participating with two commercial insurers and that ACO's projected or annual attributed member months with that insurer fall below 36,000 annually.

If an ACO falls below the attribution threshold required for participation in the pilot in Years 2 and 3, it may request that the relevant payers participate in a GMCB-facilitated process to determine whether one or more of the payers would find it acceptable to waive the enrollment threshold and either a) establish a contract with the ACO in the absence of meeting this requirement, or b) permit an already-contracted ACO eligibility to share in any generated savings. While the GMCB will facilitate this process, the decision regarding whether to waive the enrollment threshold and contract with the ACO, or to permit a contracted ACO to share in any savings, remains with the payer.

E. **The ACO will notify the Board if the ACO is transferring risk to any participating provider organization within its network.**

~~II. Risk Mitigation~~

~~The ACOs must provide the GMCB with a detailed plan to mitigate the impact of the maximum potential loss on the ACO and its provider network in Year 3 of the commercial ACO pilot. Such a plan must establish a method for repaying losses to the insurers participating in the pilot. The method may include recoupment from payments to its participating providers, stop loss reinsurance, surety bonds, escrow accounts, a line of credit, or some other payment mechanism such as a withhold of a portion of any previous shared savings achieved. The ACO must provide documentation of its ability to repay such losses 90 days prior to the start of Year 3.~~

~~Any requirements for risk mitigation, as noted above, will be the responsibility of the ACO itself, and not of the participating providers. The burden of holding participating providers financially accountable shall rest with the ACO, and the ACO must to exhibit their ability to manage the risk as noted above.~~

III. Patient Freedom of Choice

1. ACO patients will have freedom of choice with regard to their providers consistent with their health plan benefit.

IV. ACO Governance

1. The ACO must maintain an identifiable governing body that has responsibility for oversight and strategic direction of the ACO, and holding ACO management accountable for the ACO's activities.

2. The organization must identify its board members, define their roles and describe the responsibilities of the board.

3. The governing body must have a transparent governing process which includes the following:
    a. publishing the names and contact information for the governing body members;
    b. devoting an allotted time at the beginning of each in-person governing body meeting to hear comments from members of the public who have signed up prior to the meeting and providing public updates of ACO activities;
    c. making meeting minutes available to the ACO's provider network upon request, and
    d. posting summaries of ACO activities provided to the ACO's consumer advisory board on the ACO's website.

4. The governing body members must have a fiduciary duty to the ACO and act consistently with that duty.

5. At least 75 percent control of the ACO's governing body must be held by or represent ACO participants or provide for meaningful involvement of ACO participants on the governing body. For the purpose of determining if this requirement is met, a "participant" shall mean an organization that:

    a. has, through a formal, written document, agreed to collaborate on one or more ACO programs designed to improve quality, patient experience, and manage costs, and

    b. is eligible to receive shared savings distributions based on the distribution rules of the ACO or participate in alternative financial incentive programs as agreed to by the ACO and its participants.

    A "participant" does not need to have lives attributed to the ACO to be considered a participant. An organization may have lives attributed to one ACO but still participate in another ACO as per meeting conditions 5a and 5b above. So long as conditions 5a and 5b above are met, that organization will be considered a "participant" if seated on a governing body.

6. The ACO's governing body must at a minimum also include at least one consumer member who is a Medicare beneficiary (if the ACO participates with Medicare), at least one consumer member who is a Medicaid beneficiary (if the ACO participates with Medicaid), and at least one consumer member who is a member of a commercial insurance plan (if the ACO participates with one or more commercial insurers). Regardless of the number of payers with which the ACO participates, there must be at least two consumer members on the ACO governing body. These consumer members should have some personal, volunteer, or professional experience in advocating for consumers on health care issues. They should also be representative of the diversity of consumers served by the organization, taking into account demographic and non-demographic factors including, but not limited to, gender, race, ethnicity, socioeconomic status, geographic region, medical diagnoses, and services used. The ACO's governing board shall consult with advocacy groups and organizational staff in the recruitment process.

    The ACO shall not be found to be in non-conformance if the GMCB determines that the ACO has with full intent and goodwill recruited the participation of qualified consumer representatives to its governing body on an ongoing basis and has not been successful.

7. The ACO must have a regularly scheduled process for inviting and considering consumer input regarding ACO policy, including the establishment of a consumer advisory board, with membership drawn from the community served by the ACO, including patients, their families, and caregivers. The consumer advisory board must meet at least quarterly. Members of ACO management and the governing body must regularly attend consumer advisory board meetings and report back to the ACO governing body following each meeting of the consumer advisory board. The results of other consumer input activities shall be reported to the ACO's governing body at least annually.

V. Patient Attribution Methodology

Patients will be attributed to an ACO as follows:

1. The look back period is the most recent 24 months for which claims are available.

2. Identify all members who meet the following criteria as of the last day in the look back period:
   - Employer situated in Vermont or member/beneficiary residing in Vermont for commercial insurers (payers can select one of these options);
   - The insurer is the primary payer.

3. For products that require members to select a primary care provider, and for which the member has selected a primary care provider, attribute those members to that provider.

4. For other members, select all claims identified in step 2 with the following qualifying CPT Codes[1] in the look back period (most recent 24 months) for primary care providers where the provider specialty is internal medicine, general medicine, geriatric medicine, family medicine, pediatrics, naturopathic medicine; or is a nurse practitioner, or physician assistant; or where the provider is an FQHC or Rural Health Clinic.

[1] Should the Blueprint for Health change the qualifying CPT codes to be other than those listed in this table, the VHCIP Payment Models Work Group shall consider the adoption of such changes.

CPT-4 Code Description Summary
Evaluation and Management - Office or Other Outpatient Services • New Patient: 99201-99205 • Established Patient: 99211-99215
Consultations - Office or Other Outpatient Consultations • New or Established Patient: 99241-99245
Nursing Facility Services: • E & M New/Established patient: 99304-99306 • Subsequent Nursing Facility Care: 99307-99310
Domiciliary, Rest Home (e.g., Boarding Home), or Custodial Care Service: • Domiciliary or Rest Home Visit New Patient: 99324-99328 • Domiciliary or Rest Home Visit Established Patient: 99334-99337
Home Services • New Patient: 99341-99345 • Established Patient: 99347-99350
Prolonged Services – Prolonged Physician Service With Direct (Face-to-Face) Patient Contact • 99354 and 99355
Prolonged Services – Prolonged Physician Service Without Direct (Face-to-Face) Patient Contact • 99358 and 99359
Preventive Medicine Services • New Patient: 99381–99387 • Established Patient: 99391–99397
Counseling Risk Factor Reduction and Behavior Change Intervention • New or Established Patient Preventive Medicine, Individual Counseling: 99401–99404 • New or Established Patient Behavior Change Interventions, Individual: 99406-99409 • New or Established Patient Preventive Medicine, Group Counseling: 99411–99412
Other Preventive Medicine Services – Administration and interpretation: • 99420
Other Preventive Medicine Services – Unlisted preventive: • 99429
Newborn Care Services • Initial and subsequent care for evaluation and management of normal newborn infant: 99460-99463

CPT-4 Code Description Summary
• Attendance at delivery (when requested by the delivering physician) and initial stabilization of newborn: 99464 • Delivery/birthing room resuscitation: 99465
Federally Qualified Health Center (FQHC) – Global Visit ***(billed as a revenue code on an institutional claim form)*** • 0521 = Clinic visit by member to RHC/FQHC; • 0522 = Home visit by RHC/FQHC practitioner • 0525 = Nursing home visit by RHC/FQHC practitioner

5. Assign a member to the practice where s/he had the greatest number of qualifying claims. A practice shall be identified by the NPIs of the individual providers associated with it.

6. If a member has an equal number of qualifying visits to more than one practice, assign the member/beneficiary to the one with the most recent visit.

7. Insurers can choose to apply elements in addition to 5 and 6 above when conducting their attribution. However, at a minimum use the greatest number of claims (5 above), followed by the most recent claim if there is a tie (6 above).

8. Insurers will run their attributions at least monthly.

9. In order to be considered a primary care practice eligible for attribution of patients under these standards, a practice shall demonstrate the capability of providing the following services at a minimum:

Preventive care	o comprehensive "wellness" visits o immunizations: counseling and administration o injections and medications administered in the office o lipid, diabetes, depression, substance abuse, obesity, and blood pressure screening, and management and initial treatment of abnormal screenings o ordering and managing the results of USPSTF-recommended screening tests for ages /risk groups appropriate to specialty. For example: - Pediatrics/ Family Medicine: newborn screening, developmental screening, lead screening - Internal Medicine/Family Medicine: colon, breast, cervical cancer screenings
Acute care	Acute care of appropriate common problems for age groups of specialty (e.g., sore throat, headache, febrile illness, abdominal

	pain, chest pain, urinary symptoms, rashes, GI disorders, bleeding) o telephone triage and same-day visit capability o 24/7 telephone availability for triage and care coordination o ordering and managing appropriate testing, prescribing medications, and coordinating referrals and consultations for specialty care
Chronic care	Chronic care of common medical problems, including at least: allergies, asthma, COPD, diabetes (type 2), hypertension, lipid disorders, GERD, depression and anxiety o arranging and managing regular testing, screenings, consultations appropriate to the conditions
Coordination of care	o providing a "Medical Home" for a panel of patients o maintaining a comprehensive, current medical record, including receipt, sign-off and storage of external records, consults, hospitalizations and testing o assisting in transition of care into facilities, and in return to outpatient care
Other	o selected outpatient laboratory tests (lipids, HbA1c and PT/INR[2]) o health education and counseling services performed in the office o routine vision and hearing screening o prescribing common primary care acute and chronic medications using an unrestricted DEA license

10. A qualified primary care practitioner to whom lives have been attributed by a payer may only participate as a primary care practitioner in one ACO. If a qualified primary care practitioner works under multiple tax ID numbers, the practitioner may not use a specific tax ID number with more than one ACO.

11. If a member has not selected a primary care provider at time of enrollment, that member will be attributed in accordance with the claims-based patient attribution methodology specified above back to the later of his or her effective date of enrollment or the first date of the performance year.

12. In instances when a provider supplier* terminates his or her participation in an ACO during a performance year, the provider will remain an attributing provider with the ACO for the remainder of the performance year and the claims data for the provider's attributed lives will continue to be shared with the original ACO. Likewise, if a provider supplier joins an already-enrolled ACO participant during a performance year, then the provider will become an attributing provider with that ACO for the remainder of the performance year. The only

[2] Prothrombin time (PT) and its derived measures of prothrombin ratio (PR) and international normalized ratio (INR) are used to determine the clotting tendency of blood.

exception to this latter provision occurs in those instances when a provider is switching from one participating ACO to another; under such circumstances, the provider will remain an attributing provider for the remainder of the performance year with the ACO of origin.

For purposes of Year One, this policy pertains to: a) ACO Medicaid provider suppliers who are on the Medicaid provider roster as of March 31, 2014; and b) ACO commercial provider suppliers who are on the insurer provider roster as of July 1, 2014. For purposes of Years Two and Three, this policy pertains to Medicaid and commercial provider suppliers who are on the respective provider rosters as of January 1 of that performance year.

*For purposes of this policy, a "provider supplier" refers to an individual practitioner.

VI. Calculation of ACO Financial Performance and Distribution of Shared Risk Payments

(See attached spreadsheet.)

I. Actions Initiated Before the Performance Year Begins

Step 1: Determine the expected PMPM medical expense spending for the ACO's total patient population absent any actions taken by the ACO.

~~Years 1 and 2:~~ The medical expense portion of the GMCB-approved Exchange premium for each Exchange-offered product, adjusted from allowed to paid amounts, adjusted for excluded services (see below), high-cost outliers[3], and risk-adjusted for the ACO-attributed population, and then calculated as a weighted average PMPM amount across all commercial products with weighting based on ACO attribution by product, shall represent the expected PMPM medical expense spending ("expected spending") ~~for Years 1 and 2~~.

The ACO-responsible services used to define expected spending shall include all covered services except for:

1. services that are carved out of the contract by self-insured employer customers
    - prescription (retail) medications ~~(excluded in the context of shared savings in Years 1 and 2, with potential inclusion in the context of shared (upside and downside) risk in Year 3 following VHCIP Payment Models Work Group discussion~~, and

[3] The calculation shall exclude the projected value of Allowed claims per claimant in excess of $125,000 per performance year.

2. dental benefits [4].

~~Year 3: The Year 3 expected spending shall be calculated using an alternative methodology to be developed through the Payment Models Work Group and recommended to the GMCB Board for approval. The employed trend rate will be made available to the insurers prior to the deadline for GMCB rate submission in order to facilitate the calculation of premium rates for the Exchange. It is the shared intent of the pilot participants and the GMCB that the methodology shall not reduce expected spending based on any savings achieved by the pilot ACO(s) in the first two years.~~

The GMCB will also calculate the expected spending for the ACO population on an insurer-by-insurer basis. This is called the "insurer-specific expected spending."

At the request of a pilot ACO or insurer and informed by the advice of the GMCB's actuary and participating ACOs and insurers, the GMCB will reconsider and adjust expected spending if unanticipated events, or macro-economic or environmental events, occur that would reasonably be expected to significantly impact medical expenses or payer assumptions during the Exchange premium development process that were incorrect and resulted in significantly different spending than expected.

Step 2: Determine the <u>targeted</u> PMPM medical expense spending for the ACO's patient population based on expected cost growth limiting actions to be taken by the ACO.

Targeted spending is the PMPM spending that approximates a reduction in PMPM spending that would not have otherwise occurred absent actions taken by the ACO. Targeted spending is calculated by multiplying PMPM spending by the **target rate**. The target rate(s) ~~for Years 1 and 2~~ for the aggregate Exchange market shall be the expected rate minus the CMS Minimum Savings Rate for a Medicare ACO for the specific performance year, with consideration of the size of the ACO's Exchange population. The GMCB will approve the target rate.

~~As noted above, the Year 3 targeted spending shall be calculated using an alternative methodology to be developed by the VHCIP Payment Models Work Group and approved by the GMCB.~~

The GMCB will also calculate the targeted spending for the ACO population on an insurer-by-insurer basis in the same fashion, as described within the attached worksheet. The resulting amount for each insurer is called the "insurer-specific targeted spending."

<u>Actions Initiated After the Performance Year Ends</u>

[4] The exclusion of dental services will be re-evaluated after the Exchange becomes operational and pediatric dental services become a mandated benefit.

Step 3: Determine actual spending and whether the ACO has generated savings.

No later than eight months (i.e., two months following the six-month claim lag period) following the end of each pilot year, the GMCB or its designee shall calculate the actual medical expense spending ("actual spending") by Exchange metal category for each ACO's attributed population using commonly defined insurer data provided to the GMCB or its designee. Medical spending shall be defined to include all paid claims for ACO-responsible services as defined above.

PMPM medical expense spending shall then be adjusted as follows:

- clinical case mix using the risk adjustment model utilized by Center for Consumer Information and Insurance Oversight (CCIIO) for the federal exchange. The GMCB may consider alternatives for future years;
- truncation of claims for high-cost patient outliers whose annual claims value exceed $125,000, and
- conversion from allowed to paid claims value.

~~For Years 1 and 2, i~~Insurers will assume all financial responsibility for the value of claims that exceed the high-cost outlier threshold. ~~The GMCB and participating pilot insurers and ACOs will reassess this practice during Years 1 and 2 for Year 3.~~

The GMCB or its designee shall aggregate the adjusted spending data across insurers to get the ACO's "actual spending." The actual spending for each ACO shall be compared to its expected spending.

- If the ACO's actual aggregate spending is greater than the expected spending, then the ACO will be ineligible to receive shared savings payments from any insurer.
- If the ACO's actual aggregate spending is less than the expected spending, then it will be said to have "generated savings" and the ACO will be eligible to receive shared savings payments from one or more of the pilot participant insurers.
- If the ACO's actual aggregate spending is less than the expected spending, then the ACO will not be responsible for covering any of the excess spending for any insurer.

Once the GMCB determines that the ACO has generated aggregate savings across insurers, the GMCB will also calculate the actual spending for the ACO population on an insurer-by-insurer basis. This is called the "insurer-specific actual spending." The GMCB shall use this insurer-specific actual spending amount to assess savings at the individual insurer level.

Once the insurer-specific savings have been calculated, an ACO's share of savings will be determined in two phases. This step defines the ACO's eligible share of savings based on the degree to which actual PMPM spending falls below expected PMPM spending. The share of

savings earned by the ACO based on the methodology above will be subject to qualification and modification by the application of quality performance scores as defined in Step 4.

~~In Years 1 and 2 of the pilot:~~

- If the insurer-specific actual spending for the ACO population is between the insurer-specific expected spending and the insurer-specific targeted spending, the ACO will share 25% of the insurer-specific savings.
- If the insurer-specific actual spending is below the insurer-specific targeted spending, the ACO will share 60% of the insurer-specific savings. (The cumulative insurer-specific savings would therefore be calculated as 60% of the difference between actual spending and targeted spending plus 25% of the difference between expected spending and targeted spending.)
- An insurer's savings distribution to the ACO will be capped at 10% of the ACO's insurer-specific expected spending and not greater than insurer premium approved by the Green Mountain Care Board.

~~In Year 3 of the pilot:~~
~~The formula for distribution of insurer-specific savings will be the same as in Years 1 and 2, except that the ACO will be responsible for a percentage of the insurer-specific excess spending up to a cap equal to an amount no less than 3% and up to 5% of the ACO's insurer-specific expected spending.~~

~~All participating ACOs shall assume the same level of downside risk in Year 3, as approved by the VHCIP Payment Models Work Group and the GMCB.~~

~~The calculation of the ACO's liability will be as follows:~~

- ~~If the ACO's total actual spending is greater than the total expected spending (called "excess spending"), then the ACO will assume responsibility for insurer-specific actual medical expense spending that exceeds the insurer-specific expected spending in a way that is reciprocal to the approach to distribution of savings.~~
- ~~If the insurer-specific excess spending is less than the amount equivalent to the difference between expected spending and targeted spending, then the ACO will be responsible for 25% of the insurer-specific excess spending.~~
- ~~If the ACO's excess spending exceeds the amount equivalent to the difference between expected spending and targeted spending, then the ACO will be responsible for 60% of the insurer-specific excess spending over the difference, up to a cap equal to an amount no greater than 5% of the ACO's insurer-specific expected spending.~~

If the sum of ACO savings at the insurer-specific level is greater than that generated in aggregate, the insurer-specific ACO savings will be reduced to the aggregate savings amount. If reductions need to occur for more than one insurer, the reductions shall be proportionately

reduced from each insurer's shared savings with the ACO for the performance period. Any reductions shall be based on the percentage of savings that an insurer would have to pay before the aggregate savings cap. ~~[5]~~

Step 4: Assess ACO quality performance to inform savings distribution.

The second phase of determining an ACO's savings distribution involves assessing quality performance. The distribution of eligible savings will be contingent on demonstration that the ACO's quality meets a minimum qualifying threshold or "gate." Should the ACO's quality performance pass through the gate, the size of the distribution will vary and be linked to the ACO's performance on specific quality measures. Higher quality performance will yield a larger share of savings up to the maximum distribution as described above.

Methodology for distribution of shared savings: ~~For year one of the commercial pilot,~~ C~~c~~ompare the ACO's performance on the payment measures (see Table 1 below for ~~Year 1 values~~an example) to the ~~PPO~~ HEDIS PPO national percentile benchmark[6] and assign 1, 2 or 3 points based on whether the ACO is at the national 25th, 50th or 75th percentile for the measure. These calculations will be performed annually using the most currently available HEDIS benchmark data at the time final shared savings calculations are performed.

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For purposes of calculations pertaining to the distribution of any shared savings payment, an ACO's performance on a payment measure will be excluded from the calculation in those instances in which the ACO's denominator for that payment measure is less than 30. For purposes of public reporting of the ACO's performance, an explanation of the ACO's small denominator and its significance will accompany reporting of any payment measure with a denominator less than 30.

~~[5] A reciprocal approach shall apply to ACO excess spending in Year 3, such that excess spending calculated at the issuer-specific level shall not exceed that calculated at the aggregate level.~~

[6] NCQA has traditionally offered several HEDIS commercial product benchmarks, e.g., HMO, POS, HMO/POS, HMO/PPO combined, etc.

Table 1. Core Measures for Payment in Year One of the Commercial Pilot

#	Measure	Data Source	2012 HEDIS Benchmark (PPO)
Core-1	Plan All-Cause Readmissions NQF #1768, NCQA	Claims	Nat. 90th: .68 Nat. 75th: .73 Nat. 50th: .78 Nat. 25th: .83 *Please note, in interpreting this measure, a lower rate is better.
Core-2	Adolescent Well-Care Visits HEDIS AWC	Claims	Nat. 90th: 58.5 Nat. 75th: 46.32 Nat. 50th: 38.66 Nat. 25th: 32.14
Core-3	Cholesterol Management for Patients with Cardiovascular Conditions (LDL-C Screening Only for Year 1)	Claims	Nat. 90th: 89.74 Nat. 75th: 87.94 Nat. 50th: 84.67 Nat. 25th: 81.27
Core-4	Follow-Up After Hospitalization for Mental Illness: 7-day NQF #0576, NCQA HEDIS FUH	Claims	Nat. 90th: 67.23 Nat. 75th: 60.00 Nat. 50th: 53.09 Nat. 25th: 45.70
Core-5	Initiation and Engagement for Substance Abuse Treatment: Initiation and Engagement of AOD Treatment (composite) NQF #0004, NCQA HEDIS IET CMMI	Claims	Nat. 90th: 35.28 Nat. 75th: 31.94 Nat. 50th: 27.23 Nat. 25th: 24.09
Core-6	Avoidance of Antibiotic Treatment for Adults With Acute Bronchitis NQF #0058, NCQA HEDIS AAB	Claims	Nat. 90th: 28.13 Nat. 75th: 24.30 Nat. 50th: 20.72 Nat. 25th: 17.98
Core-7	Chlamydia Screening in Women NQF #0033, NCQA HEDIS CHL	Claims	Nat. 90th: 54.94 Nat. 75th: 47.30 Nat. 50th: 40.87 Nat. 25th: 36.79

The Gate: In order to retain savings for which the ACO is eligible in accordance with Steps 1-3 above, the ACO must earn meet a minimum threshold for performance on a defined set of common measures to be used by all pilot-participating commercial insurers and ACOs. For the commercial pilot, the ACO must earn 55% of the eligible points in order to receive savings. If the ACO is not able to meet the overall quality gate, then it will not be eligible for any shared savings. If the ACO meets the overall quality gate, it may retain at least 75% of the savings for which it is eligible (see Table 2).

The Ladder: In order to retain a greater portion of the savings for which the ACO is eligible, the ACO must achieve higher performance levels for the measures. There shall be six steps on the ladder, which reflect increased levels of performance (see Table 2).

Table 2. Distribution of Shared Savings in Year One of Commercial Pilot

% of eligible points	% of earned savings
55%	75%
60%	80%
65%	85%
70%	90%
75%	95%
80%	100%

Eligibility for shared savings based on performance improvement.

Should the ACO, in Years 2 or 3, fail to meet the minimum quality score, it may still be eligible to receive shared savings if the GMCB determines, after providing notice to and accepting written input from the insurer and ACO (and input from ACO participants, if offered), that the ACO has made meaningful improvement in its quality performance as measured against prior pilot years. The GMCB will make this determination after conducting a public process that offers stakeholders and other interested persons sufficient time to offer verbal and/or written comments related to the issues before the GMCB.

Step 5: Distribute shared savings payments

The GMCB or its designee will calculate an interim assessment of performance year medical expense relative to expected and targeted medical spending for each ACO/insurer dyad within four months of the end of the performance year and inform the insurers and ACOs of the results, providing supporting documentation when doing so. If the savings generated exceed the insurer-specific targeted spending, and the preliminary assessment of the ACO's performance on the required measures is sufficiently strong, then within two weeks of the notification, the insurers will offer the ACO the opportunity to receive an interim payment, not to exceed 75% of the total payment for which the ACO is eligible.

The GMCB or its designee will complete the analysis of savings within two months of the conclusion of the six-month claim lag period and inform the insurers and ACOs of the results, providing supporting documentation when doing so. The insurers will then make any required savings distributions to contracted ACOs within two weeks of notification by the GMCB. Under no circumstances shall the amount of a shared savings payment distribution to an ACO jeopardize the insurer's ability to meet federal Medical Loss Ratio (MLR) requirements. The amount of the shared savings distribution shall be capped at the point that the MLR limit is reached.

VII. Care Management Standards

Objective: Effective care management programs close to, if not at, the site of care for those patients at highest risk of future intensive resource utilization is considered by many to be the linchpin of sustained viability for providers entering population-based payment arrangements. The following care management standards were developed in early 2015 by the VHCIP Care Models and Care Management Work Group and subsequently approved by the VHCIP Steering Committee, the VHCIP Core Team and the GMCB.

Definition of Care Management:

Care Management programs apply systems, science, incentives and information to improve services and outcomes in order to assist individuals and their support system to become engaged in a collaborative process designed to manage medical, social and mental health conditions more effectively. The goal of care management is to achieve an optimal level of wellness and improve coordination of care while providing cost effective, evidence based or promising innovative and non-duplicative services. It is understood that in order to support individuals and to strengthen community support systems, care management services need to be culturally competent, accessible and personalized to meet the needs of each individual served.

In order for care management programs to be effective, we recommend that ACOs agree to the following standards:

A. Care Management Oversight (based partially on NCQA ACO Standards PO1, Element B, and PC2, Element A)

#1: The ACO has a process and/or supports its participating providers in having a process to assess their success in meeting the following care management standards, as well as the ACO's care management goals.

#2: The ACO supports participating primary care practices' capacity to meet person-centered medical home requirements related to care management.

#3: The ACO consults with its consumer advisory board regarding care management goals and activities.

B. Guidelines, Decision Aids, and Self-Management (based partially on NCQA ACO Standards PO2, Elements A and B, and CM4, Elements C)

#4: The ACO supports its participating providers in the consistent adoption of evidence-based guidelines, and supports the exploration of emerging best practices.

#5: The ACO has and/or supports its participating providers in having methods for engaging and activating people and their families in support of each individual's specific needs, positive health behaviors, self-advocacy, and self-management of health and disability.

#6: The ACO provides or facilitates the provision of and/or supports its participating providers in providing or facilitating the provision of: a) educational resources to assist in self-management of health and disability, b) self-management tools that enable attributed people/families to record self-care results, and c) connections between attributed people/families and self-management support programs and resources.

C. Population Health Management (based partially on NCQA ACO Standards CM3, Elements A and B, and CT1, Elements A, B, D, and E)

#7: The ACO has and/or supports its participating providers in having a process for systematically identifying attributed people who need care management services, the types of services they should receive, and the entity or entities that should provide the services. The process includes but is not limited to prioritizing people who may benefit from care management, by considering social determinants of health, mental health and substance abuse conditions, high cost/high utilization, poorly controlled or complex conditions, or referrals by outside organizations.

#8: The ACO facilitates and/or supports its participating providers in facilitating the delivery of care management services. Facilitating delivery of care management services includes:

- Collaborating and facilitating communication with people needing such services and their families, as well as with other entities providing care management services, including community organizations, long term service and support providers, and payers.
- Developing processes for effective care coordination, exchanging health information across care settings, and facilitating referrals.
- Recognizing disability and long terms services and supports providers as partners in serving people with high or complex needs.

#9: The ACO facilitates and/or supports its participating providers in facilitating:

- Promotion of coordinated person-centered and directed planning across settings that recognizes the person as the expert on their goals and needs.
- In collaboration with participating providers and other partner organizations, care management services that result in integration between medical care, substance use care, mental health care, and disability and long term services and supports to address attributed people's needs.

D. Data Collection, Integration and Use (partially based on NCQA ACO Standard CM1, Elements A, B, C, E, F and G)

#10: To the best of their ability and with the health information infrastructure available, and with the explicit consent of beneficiaries unless otherwise permitted or exempted by law, the ACO uses and/or supports its participating providers in using an electronic system that: a) records structured (searchable) demographic, claims, and clinical data required to address care management needs for people attributed to the ACO, b) supports access to and sharing of attributed persons' demographic, claims and clinical data recorded by other participating providers, and c) provides people access to their own health care information as required by law.

#11: The ACO encourages and supports participating providers in using data to identify needs of attributed people, support care management services and support performance measurement, including the use of:

- A data-driven method for identifying people who would most benefit from care management and for whom care management would improve value through the efficient use of resources and improved health outcomes.
- Methods for measuring and assessing care management activities and effectiveness, to inform program management and improvement activities.

VIII. Payment Alignment

Objective: Improve the likelihood that ACOs attain their cost and quality improvement goals by aligning payment incentives at the payer-ACO level to the individual clinician and facility level.

1. The performance incentives that are incorporated into the payment arrangements between a commercial insurer and an ACO should be appropriately reflected in those that the ACO utilizes with its contracted providers. ACOs will share with the GMCB their written plans for:
    a. aligning provider payment (from insurers or Medicaid) and compensation (from ACO participant organization) with ACO performance incentives for cost and quality, and
    b. distributing any earned shared savings.

2. ACOs utilizing a network model should be encouraged to create regional groupings (or "pods") of providers under a shared savings model that would incent provider performance resulting from the delivery of services that are more directly under their control. The regional groupings or "pods" would have to be of sufficient size to reasonably calculate "earned" savings or losses. ACO provider groupings should be incentivized individually and collectively to support accountability for quality of care and cost management.

3. Insurers shall support ACOs by collaborating with ACOs to align performance incentives by considering the use of alternative payment methodology including bundled payments and other episode-based payment methodologies.

IX. Vermont ACO Data Use Standards

ACOs and payers must submit the required data reports detailed in the "Data Use Report Standards for ACO Pilot" in the format defined.

X. Process for Review and Modification of Measures Used in the Commercial and Medicaid ACO Pilot Program

1. The VHCIP Quality and Performance Measures Work Group will review all **Payment and Reporting measures** included in the Core Measure Set beginning in the second quarter of each pilot year, with input from the VHCIP Payment Models Work Group. For each measure, these reviews will consider payer and provider data availability, data quality, pilot experience reporting the measure, ACO performance, and any changes to national clinical guidelines. The goal of the review will be to determine whether each measure should continue to be used as-is for its designated purpose, or whether each

measure should be modified (e.g. advanced from Reporting status to Payment status in a subsequent pilot year) or dropped for the next pilot year. The VHCIP Quality and Performance Measures Work Group will make recommendations for changes to measures for the next program year if the changes have the support of a majority of the voting members of the Work Group. Such recommendations will include annual updates to the Payment and Reporting measures included in the Core Measure Set narrative measure specifications as necessary upon release of updates to national guidelines (e.g., annual updates made by the National Committee for Quality Assurance to HEDIS® specifications for that year's performance measures). Such recommendations will be finalized no later than July 31st of the year prior to implementation of the changes. Recommendations will go to the VHCIP Steering Committee, the VHCIP Core Team and the GMCB for review. Approval for any changes must be finalized no later than September 30th of the year prior to implementation of the changes. In the interest of retaining measures selected for Payment and Reporting purposes for the duration of the pilot program, measures should not be removed in subsequent years unless there are significant issues with data availability, data quality, pilot experience in reporting the measure, ACO performance, and/or changes to national clinical guidelines.

2. The VHCIP Quality and Performance Measures Work Group and the VHCIP Payment Models Work Group will review all **targets and benchmarks** for the measures designated for Payment purposes beginning in the second quarter of each pilot year. For each measure, these reviews will consider whether the benchmark employed as the performance target (e.g., national x^{th} percentile) should remain constant or change for the next pilot year. The Work Group should consider setting targets in year two and three that increase incentives for quality improvement. The VHCIP Quality and Performance Measures Work Group will make recommendations for changes to benchmarks and targets for the next program year if the changes have the support of a majority of the voting members of the Work Group. Such recommendations will include annual updates to the targets and benchmarks for measures designated for Payment purposes as necessary upon release of updates to national guidelines (e.g., annual updates made by the National Committee for Quality Assurance to HEDIS® specifications for that year's performance measures). Such recommendations will be finalized no later than July 31st of the year prior to implementation of the changes. Recommendations will go to the VHCIP Steering Committee, the VHCIP Core Team and the GMCB for review. Approval for any changes must be finalized no later than September 30th of the year prior to implementation of the changes.

3. The VHCIP Quality and Performance Measures Work Group will review all **measures designated as Pending** in the Core Measure Set and consider any new measures for addition to the set beginning in the first quarter of each pilot year, with input from the VHCIP Payment Models Work Group. For each measure, these reviews will consider

data availability and quality, patient populations served, and measure specifications, with the goal of developing a plan for measure and/or data systems development and a timeline for implementation of each measure. If the VHCIP Quality and Performance Measures Work Group determines that a measure has the support of a majority of the voting members of the Work Group and is ready to be advanced from Pending status to Payment or Reporting status or added to the measure set in the next pilot year, the Work Group shall recommend the measure as either a Payment or Reporting measure and indicate whether the measure should replace an existing Payment or Reporting measure or be added to the set by July 31st of the year prior to implementation of the changes. Such recommendations will include annual updates to measures designated as Pending in the Core Measure Set narrative measure specifications as necessary upon release of updates to national guidelines (e.g., annual updates made by the National Committee for Quality Assurance to HEDIS® specifications for that year's performance measures). New measures should be carefully considered in light of the Work Group's measure selection criteria. If a recommended new measure relates to a Medicare Shared Savings Program (MSSP) measure, the Work Group shall recommend following the MSSP measure specifications as closely as possible. If the Work Group designates the measure for Payment, it shall recommend an appropriate target that includes consideration of any available state-level performance data and national and regional benchmarks. Recommendations will go to the VHCIP Steering Committee, the VHCIP Core Team and the GMCB for review. Approval for any changes must be finalized no later than September 30th of the year prior to implementation of the changes.

4. The VHCIP Quality and Performance Measures Work Group will review **state or insurer performance on the Monitoring and Evaluation measures** beginning in the second quarter of each year, with input from the VHCIP Payment Models Work Group. The measures will remain Monitoring and Evaluation measures unless a majority of the voting members of the Work Group determines that one or more measures presents an opportunity for improvement and meets measure selection criteria, at which point the VHCIP Quality and Performance Measures Work Group may recommend that the measure be moved to the Core Measure Set to be assessed at the ACO level and used for either Payment or Reporting. The VHCIP Quality and Performance Measures Work Group will make recommendations for changes to the Monitoring and Evaluation measures for the next program year if the changes have the support of a majority of the members of the Work Group. Such recommendations will include annual updates to the Monitoring and Evaluation measures included in the Monitoring and Evaluation Measure Set narrative measure specifications as necessary upon release of updates to national guidelines (e.g., annual updates made by the National Committee for Quality Assurance to HEDIS® specifications for that year's performance measures). Such recommendations will be finalized no later than July 31st of the year prior to implementation of the changes. Recommendations will go to the VHCIP Steering

Committee, the VHCIP Core Team and the GMCB for review. Approval for any changes must be finalized no later than September 30th of the year prior to implementation of the changes.

5. The GMCB will release the **final measure specifications f**or **the next pilot year by no later th**an October 31st of the year prior to the implementation of the changes. The specifications document will provide the details of any new measures and any changes from the previous year.

6. If during the course of the year, a national clinical guideline for any measure designated for Payment or Reporting changes or an ACO or payer participating in the pilot raises a serious concern about the implementation of a particular measure, the VHCIP Quality and Performance Measures Work Group will review the measure and recommend a course of action for consideration, with input from the VHCIP Payment Models Work Group. If the VHCIP Quality and Performance Measures Work Group determines that a change to a measure has the support of a majority of the voting members of the Work Group, recommendations will go to the VHCIP Steering Committee, the VHCIP Core Team and the GMCB for review. Upon approval of a recommended change to a measure for the current pilot year, the GMCB must notify all pilot participants of the proposed change within 14 days.