VT Health Care Innovation Project
Core Team Meeting Minutes

November 18, 2013 12:00-2:30 p.m.
AHS Training Room, 208 Hurricane Lane, Williston

Attendees: Anya Rader Wallack, Paul Bengtson, Al Gobeille, Mark Larson, Robin Lunge, Doug Racine, Steve Voigt, Susan Wehry

Others Present and Participating:
Georgia Maheras, Project Director, AOA
Pat Jones, Health Care Project Director, GMCB
Spenser Weppler, Health Care Reform Specialist, GMCB
Kara Suter, Reimbursement Director, DVHA

Agenda Item	Discussion	Next Steps
1	The Chair's report included: an overview of the new agenda format that will be deployed for the Core Team. Additionally, all of the work groups are up and running.	
2	Discussion regarding the decision making process as it relates to the VHCIP, GMCB, AHS and DVHA and the allocation of authority. Al Gobeille reviewed a memo on same. The role of the Core Team will be to resolve inter-agency conflicts and develop consensus recommendations to policy-making agencies, with input from the project participants. Several points were raised in the discussion including: • The Core Team has authority over SIM expenditures. • Participants should not seek to go around this process for decisions. • This project is about teamwork and the CT should be a clearinghouse to find synergy rather than silos. • We need more clarity around the distinction between work produced under this project	**Al will bring a revised memo back to the Core Team at the next meeting.**

Agenda Item	Discussion	Next Steps
	and the payment reform pilots overseen by the GMCB.	
3	Discussion regarding a stipend to the co-chairs of work groups who are not paid by an employer. DVHA would be responsible for the actual payments to these individuals. Expenses and mileage vs. other funding Need to be careful of introducing bias among other voluntary board members. Topic taken under advisement for further research of payment options. Noted open meeting law and the need for public comment period was reviewed. Advance notice of VHCIP Core Team, Steering Committee and Work Group meetings are posted with the Vermont Dept of Libraries and on the VHCIP Website.	**Anya will research the legal parameters and customary practice of state agencies and provide the CT with revised recommendations.**
4	Kara gave an update on the Medicaid ACO. The state has received two ACO proposals, which must remain confidential at this time. This is a non-competitive RFP and Vermont may select more than one vendor. DVHA is working with various state agencies to compile questions and comments regarding these proposals. DVHA is responsible for contracting through the standard RFP contract process.	
5	Anya presented a memo and some background materials from Richard Slusky, including memo from Paul Harrington, EVP, VMS, regarding the proposed Commercial ACO program Standards. There may be some impact on the launch of the Commercial ACO program from the delay in Vermont Health Connect. These details are still being worked out with the carriers. There was discussion of the need for ongoing review of ACO governance. The governance will be reviewed annually for both programs.	
	The Core Team approved the Commercial ACO Standards as presented. Motion made by Anya Rader Wallack and seconded by Paul Bengtson. All approved, with one abstention by Al Gobeille.	**Forward to GMCB for approval**

Agenda Item	Discussion	Next Steps
6	Pat Jones presented a memo and some background materials regarding the proposed Commercial and Medicaid ACO Quality Measures. These are claims based and clinical measures, which the Quality Performance Measures Work Group has identified as improving patient outcomes. The discussion included how these will get at results based accountability and how these process measures can improve patient care. These measures are for the first year of each program and the measures will be reviewed throughout 2014 to determine measures for years two and three. Susan Wehry moved to approve the measure set with the addition of a measure related to alcohol and drug screening. This was seconded and amended by Mark Larson so that the QPM Work Group would be responsible for addressing the issue of screening for substance abuse by identifying an appropriate measure. The final measure should come back to the Core Team if there is an issue in negotiating the specific measure. This motion was approved by all, with Al Gobeille abstaining. The Core Team discussed the Gate and Ladder structure of the two ACO programs. There was an explanation about why specific thresholds were identified and the ways in which Vermont could improve quality of care using this mechanism. Susan Wehry moved to approve the Gate and Ladder structure. This was seconded by Steve Voigt. All approved with Al Gobeille and Doug Racine abstaining. The Core Team discussed the reporting option for the clinical measures that are part of the measure set. This allows an ACO or provider within an ACO to submit a description of a good faith effort in reporting measures that are not easily accessed electronically should the need arise. A motion to approve this was made by Paul Bengtson and seconded by Steve Vought. All approved, with Al Gobeille and Susan Wehry abstaining.	**Forward to GMCB for approval**

Agenda Item	Discussion	Next Steps
7	Anya reviewed the VHCIP grant decision making description and funding allocation program.	
8	Georgia presented a memo regarding the implementation period carry forward and Type 1 contracting expenditures for approval. The Core Team went into executive session to discuss contractual matters related to Independent Evaluation, Actuarial Services and Medicaid ACO Program Design and Implementation. The motion was made by Al Gobeille and seconded by Mark Larson. Steve Voigt left the Core Team meeting during the executive session. The Core Team came out of executive session and took the following actions: The Core Team approved a support position for the Duals work group. Motion was made by Mark Larson, seconded by Al Gobeille. All approved with Doug Racine abstaining. The Core Team approved a extension of an existing contract for actuarial services for $25,000 with Wakely Consulting. Motion was made by Mark Larson, seconded by Al Gobeille. All approved with Susan Wehry abstaining. Anya Rader Wallack passed the Chair of the meeting to Robin Lunge for the following item: The Core Team approved a new contract for Independent Evaluation Services for $1,436,668 with Mathematica Policy Research. Motion made by Mark Larson, seconded by Al Gobeille. Anya Rader Wallack recused herself due to a potential contractual relationship with Mathematica. The relationship is for an unrelated contract for work in another state that is not specific to the contract being approved. All approved, with Susan Wehry abstaining and Anya Rader Wallack recusing herself from the discussion.	**Send all contracts to relevant agencies and CMMI for approval.**

Agenda Item	Discussion	Next Steps
	Robin Lunge passed the Chair of the meeting to Anya Rader Wallack. The Core Team approved a contract amendment to an existing Burns and Associates contract for work related to Medicaid ACO program design and implementation for $150,000. Motion was made by Al Gobeille, seconded by Mark Larson. All approved.	
9	Anya asked that the team review the draft criteria for the Grant Program and provide feedback.	**Provide feedback directly to Anya on the Grant program; revised criteria and proposed roll-out of program will be discussed at next core team meeting.**

VT Health Care Innovation Project
Core Team Meeting Agenda

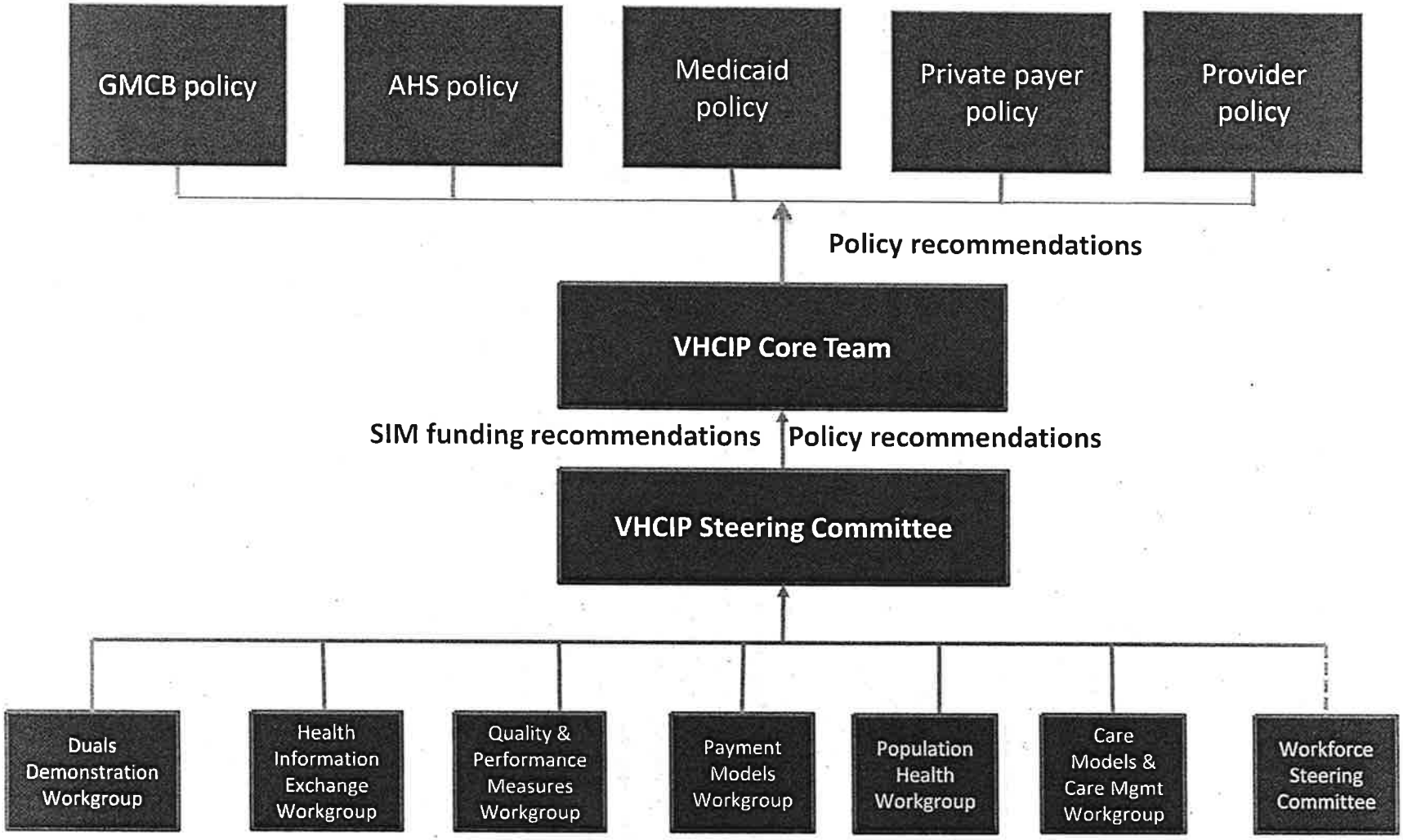
November 18, 2013 12:00-2:00 p.m.
AHS Training Room, 208 Hurricane Lane, Williston
Call-In Number: 1-877-273-4202; Passcode: 8155970

Item #	Time Frame	Topic	Presenter	Relevant Attachments
1	12:00-12:05	Welcome and Chair's Report	Anya Rader Wallack	
Core Team Processes and Procedures				
2	12:10-12:20	Discussion of decision-making and the relationship between CT and others	Anya Rader Wallack	Decision-making chart (ppt) from ARW; Memo from A. Gobeille
3	12:20-12:30	Payment of stipend to co-chairs of work groups who are not paid by an employer	Anya Rader Wallack	
Policy recommendations and decisions				
4	12:30-12:45	Update on Medicaid ACO	Kara Suter	
5	12:45-1:00	Approval of Commercial ACO Standards	Anya Rader Wallack	Memo and background materials (ppt deck and full description of ACO standards) from R. Slusky
6	1:00-1:20	Approval of Performance Measures for both Medicaid and Commercial ACOs	Pat Jones	Memo and background materials (ppt) from P. Jones

Spending recommendations and decisions				
7	1:20-1:25	Review of type 1/type 2 structure	Anya Rader Wallack	VHCIP grant decision-making description; VHCIP Funding Allocation Plan
8	1:25-1:40	Approval of type 1 spending i. Carryforward ($1,562,102.24) ii. Wakely Actuarial Contract ($25,000) iii. Mathematica Policy Research ($1,436,668) iv. Burns and Associates ($125,000)	Georgia Maheras	Memo from G. Maheras
9	1:40-1:55	Discussion of Provider Grant Program	Anya Rader Wallack	Draft criteria from ARW
10	1:55-2:00	Next Steps, Wrap-Up and Future Meeting Schedule	Anya Rader Wallack	

AGENDA ITEM #2A

Decision-making processes related to the VHCIP



AGENDA ITEM 2B

VERMONT

Green Mountain Care Board
89 Main Street
Montpelier, VT 05620

[phone] 802-828-2177
www.gmcboard.vermont.gov

To: Vermont Health Care Innovation Project Core Team
From: Al Gobeille, Chair, Green Mountain Care Board
Date: November 11, 2013
Re: Allocation of authority re: payment and delivery system reform

The purpose of this memo is to clarify how authority with respect to payment and delivery system reform is allocated among the Green Mountain Care Board, the Agency of Human Services (AHS), the Department of Vermont Health Access (DVHA), and the state's Health Care Innovation Project (HCIP).

Put simply, the GMCB, AHS, and DVHA each has statutory responsibility and authority over matters within their areas of jurisdiction while the HCIP, through the Core Team, has the authority under the terms of the State Innovation Model (SIM) grant to determine the use of grant funds to support reform projects and the responsibility to make sure that its funding decisions are consistent with the policy decisions of the GMCB, AHS, and DVHA. In addition, the HCIP is a mechanism for gathering input and reaching consensus among stakeholders. The composition of the HCIP Core Team reflects this reality by including the Chair of the GMCB, the Secretary of AHS, the Commissioners of DVHA and DAIL, and two stakeholder representatives—the CEOs of Northeastern Vermont Regional Hospital and King Arthur Flour.

The Legislature has delegated general authority to oversee the development and implementation of payment and delivery system reform to the GMCB. *See* 18 V.S.A. §§ 9375(b)(1) & 9377(b). Placing that authority in the context of the above-described division of labor, the GMCB has the statutory duty and power to review, approve, and evaluate proposed reform initiatives, *id.*, and rulemaking authority to establish those "methodologies for achieving payment reform and containing costs" that prove capable of system-level, sustainable reform. *Id.* § 9375(b)(1)(A). AHS and DVHA retain authority to "engage in additional cost-containment activities to the extent permitted by state and federal law." *Id.* § 9375(b)(1)(D).

Several benefits flow from the Legislature's decision to give general oversight of payment reform and pilot projects to the GMCB. First, by allocating this role to the Board, the Legislature provided for review and oversight designed to ensure that pilot projects "achieve the principles stated in section 9371" of Title 18. *Id.* § 9377(a). Second, the Legislature also

empowered the GMCB to actively facilitate and supervise the planning and implementation of pilot projects, in order to avoid antitrust violations. *Id.* § 9377(c).

Finally, the Board's role in payment reform ensures that Vermont will "achieve health care reform through the coordinated efforts of an independent board, state government, and the citizens of Vermont, with input from health care professionals, businesses, and members of the public." 2011 Vt. Acts & Resolves, No. 48, § 1(a) (legislative intent). As an independent public body, the Board can assess payment reform proposals from a systemwide perspective. Because the Board members have defined statutory terms, the Board can apply an institutional memory over time to proposals it reviews. Board members are also insulated from the political process in that they cannot be replaced with a change in administration. Finally, as a public body, the Board's review processes must be open and transparent and must allow Vermonters to be heard. *See, e.g.,* 18 V.S.A. § 9371(3) (Vermont's "health care system must be transparent in design, efficient in operation, and accountable to the people it serves. The state must ensure public participation in the design, implementation, evaluation, and accountability mechanisms of the health care system."); 18 V.S.A. § 9375(a) (Board must execute its duties consistent with principles in 18 V.S.A. § 9371).

From the GMCB's perspective, the commercial and Medicaid ACO programs currently being developed help illustrate the division of labor outlined above. As a threshold matter, these initiatives are most accurately viewed as pilot projects, within the meaning of 18 V.S.A. § 9377, because each project is an opportunity to implement and evaluate the effectiveness of payment and delivery system reforms.[1] The tables and discussions below attempt to allocate approval authority and review responsibilities with respect to these initiatives.

[1] Because each project applies to a discrete, identifiable subset of Vermonters, not to our health care system as a whole, neither project requires an exercise of the GMCB's rule-making authority set out in 18 V.S.A. § 9375(b)(1)(A).

Commercial ACO program:

Commercial ACO decision points	Who creates/reviews	Who approves
Standards	Workgroup, SIM steering comm., SIM core team	GMCB approves, per 18 V.S.A. § 9377
Measures	Workgroup, SIM steering comm., SIM core team	GMCB approves, per 18 V.S.A. § 9377
Program Agreement	Standards workgroup	Payers, ACOs
ACO formation (participation agreements)	ACO, Providers	ACO, Providers
ACO Pilot application	GMCB	GMCB approves, per 18 V.S.A. § 9377
Evaluation/ enforcement[2]	GMCB	GMCB, per 18 V.S.A. § 9377

- The Standards and Measures workgroups, initially convened by the GMCB and later integrated into the HCIP governance structure, have largely completed developing standards and measures for the commercial and Medicaid ACO programs. The standards and measures will be reviewed by the SIM Steering Committee and the SIM Core Team. The core team will then forward the standards and measures, with any changes by the Steering Committee and Core Team, to the GMCB for approval.

- The payers and potential ACOs will enter into program agreements reflecting the standards and measures approved by the GMCB.

- Each group of providers intending to form a commercial ACO will enter into a participation agreement between the providers and the ACO.

- Each ACO will submit a payment reform pilot application to the GMCB, pursuant to 18 V.S.A. § 9377 and the GMCB's pilot policy and application process. Among other things, the GMCB will review each application to ensure that the proposed ACO will abide by the standards and will use the measures approved by the GMCB. Approval will

[2] The program agreements between payers and ACOs and the participation agreements between ACOs and providers in both the commercial and Medicaid ACO programs will presumably provide additional enforcement mechanisms among the parties to those agreements.

also be conditioned on GMCB evaluation of the ACO's adherence to those standards and measures.

Medicaid ACO program:

Medicaid ACO decision points	Who creates/reviews	Who approves
Standards	Workgroup, SIM steering comm., SIM core team	GMCB approves, per 18 V.S.A. § 9377
Measures	Workgroup, SIM steering comm., SIM core team	GMCB approves, per 18 V.S.A. § 9377
RFP	DVHA	DVHA
ACO formation (RFP responses)	Providers, Payers	Providers, Payers
ACO Pilot application	GMCB; DVHA	GMCB approves, per 18 V.S.A. § 9377
Evaluation/ enforcement	GMCB; DVHA	GMCB, per 18 V.S.A. § 9377; DVHA

- DVHA has issued a Request for Proposals to providers wishing to form Medicaid ACOs. The RFP contains standards and measures substantially similar to the commercial standards and measures developed by the workgroups. Through the RFP process, DVHA will enter into contracts with ACOs according to standard Medicaid contracting procedures.

AGENDA ITEM 5A

TO: SIM CORE TEAM

FROM: RICHARD SLUSKY

SUBJECT: ACO STANDARDS RELATED TO THE COMMERCIAL SHARED SAVINGS PROGRAM

DATE: NOVEMBER 13, 2013

As you are aware, the Vermont ACO Standards Work Group has developed and endorsed recommendations for review and consideration by the SIM Steering Committee, the SIM Core Team, and the GMCB. The work group anticipates that these standards will subsequently become a part of a Program Agreement between the participating commercial insurers and the participating ACOs.

I have attached a Word Document which is a compilation of the Standards that have been approved to date, and a Power Point Document from a presentation I made to the GMCB which illustrates a summary of the Standards Categories. We are requesting that the Core team review and approve the standards as amended.

Two specific areas of concern have been raised regarding the Standards. These are related to Downside Risk and Governance Requirements.

A. DOWNSIDE RISK

Paul Harrington, on behalf of Community Health Accountable Care (CHAC), the FQHC based ACO and the Accountable Care Coalition of the Green Mountains (ACCGM), the Independent physicians ACO, has requested the following language change related to downside risk: (The full content of his letter is Attached)

"I request that the provisions of above Section I (B) 1, be redrafted to reflect the two tracks (one-sided or two-sided model) found in both the Medicare and Medicaid Shared Savings Program for ACOs. Alternatively, I would support revising the Section I (B) 1 lead sentence to read: "The Board has established that for the purposes of the pilot program, the ACO <u>may</u> assume the following downside risk in each pilot program year:"

Richard Slusky response this request:

In his memo to the Core Team, Paul Harrington notes that that the "three potential Commercial ACOs (OneCare Vermont, Accountable Care Coalition of the Green Mountains (ACCGM), and Community Health Accountable Care (CHAC) have radically different size, financial capacity, and organizational maturity." He notes that "imposing...downside risk for ACCGM and CHAC prematurely may be deleterious in their efforts to participate in the commercial market and could be counter to their future success."

The facts he raises are legitimate, and are deserving of serious consideration. In conversations I have had with representatives from both CHAC and ACCGM they have expressed concern about being potentially at risk for the total cost of care of their attributed patients, while, in fact, they have little control over a high percentage of those costs. While they do have control over referrals and some aspects of utilization, they do not have control over what hospitals are paid for their services or the utilization of services within the hospitals. They believe it would be difficult for them to assume downside risk beyond their financial means.

This issue was the subject of a considerable amount of discussion within the ACO Standards Work Group over the course of 9 months, and the concerns that Paul has expressed were known to the group, and were taken into consideration in the course of the deliberations and in the development of the final recommendations.

The Commercial payers and others in the group expressed strong concerns that if some degree of downside risk was not introduced into the Shared Savings Program (SSP), the ACOs would have little or no incentive to change the delivery system in order to achieve savings. Many in the group insisted that downside risk be introduced in Year 2 of the SSP. The ACOs felt that this was too early to introduce downside risk because there would be too little data available that soon to evaluate their performance in Year 1. As a result of these concerns , the introduction of downside risk was postponed until Year 3.

In exchange for the ACOS agreeing to assume downside risk in Year 3, several changes in the Standards were incorporated into the final recommendations. For example, under the Medicare SSP program, providers must meet a minimum savings rate (MSR), or target below Medicare's expected expenditures for the ACOs attributed lives, before the ACO is eligible for any savings at all. In the Commercial SSP program the ACO only has to achieve savings below the expected level of expenditures for its attributed population in order to receive 25% of the savings, and if it exceeds the minimum savings rate (MSR), it will receive 60% of the savings below the MSR. Also, the Program Agreement and the ACO Participation Agreements, now under review, will provide the ACOs and Participating Providers the opportunity to terminate their participation in the SSP program on an Annual basis. The Standards also provide ample time for the ACOS and the Payers to calculate the expected expenditures, financial targets, and downside risk calculations for Year 3.

Taking into consideration all of the above, it would be my recommendation that the SIM Core Team approve the ACO Standards as presented, with the condition that the ACOs and the payers initiate discussions in January 2014 regarding how expected expenditures and downside risk will be calculated in Year 3, bearing in mind the different circumstances of the

participating ACOs . In conversations I have had with representatives from ACCGM and CHAC, I believe they understand the importance of having these Standards approved in order to move this process along, and will support this recommendation as long as they have assurances that their concerns will be addressed in early 2014.

B. Governance Standards

Community Health Accountable Care (CHAC) has proposed that the Governance Standard be amended to define "ACO Participants" more broadly in order to allow representatives from collaborating organizations to hold board seats on the ACO without diluting the 75% participant requirement for the Board. This amendment would be applicable to ACOs participating in the Commercial and Medicaid Shared Savings Programs. The explanation for the change and the proposed language follows:

> **A Community Mental Health Center performs a small amount of primary care, as indicated by the occasional use of E&M codes such as 99213. This CMHC joins one ACO but sees patients for both. The CMHC works with both ACOs to develop programs for identifying and treating depression. Because of the small amount of primary care, they may be deemed ineligible to sit on the Board of one of the two ACOs based on where their patients are attributed. We are simply asking that so long as they are meaningfully participating that they be able to hold a Board seat and not have it count against the 75% requirement.**

Here is the suggested wording:

Current:

1. At least 75% control of the ACO's governing body might be held by or represent ACO participants or provide for meaningful involvement of ACO participants on the governing body.

Proposed:

1. At least 75% 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 requirements A+B above. So long as A+B above is met, that organization will be considered a "participant" if seated on a governing body.

Richard Slusky response to the Core Team:

I don't believe the Standards group would have any objection to this amendment. I would recommend approval of this amendment.

AGENDA ITEM 5B

Vermont Commercial ACO Pilot
Compilation of Pilot Standards
October 10, 2013 Draft

The Vermont ACO Standards Work Group has developed and endorsed the following recommendations for consideration by the SIM Payment Models Work Group and the GMCB. While they represent the consensus of the work group as of the above date, the work group considers them subject to reconsideration and modification by the work group's planned successor, the SIM Payment Models Work Group, as new information becomes available and the pilot ACOs and insurers and GMCB gain experience. The work group anticipates that these standards will subsequently become a part of a three-way contractual agreement among the GMCB, the participating insurers and the participating ACOs.

The Standards Work Group has drafted standards for ACOs in the following 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

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. Payers 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.

B. Standards related to downside risk limitation

1. The Board has established that for the purposes of the pilot program, the ACO will assume the following downside risk in each 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 Three 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.

1. The ACO will furnish financial reports regarding risk performance to the SIM Payment Model Work Group or its successor[1] and to the GMCB on a semi-annual basis by June 30th and December 31st in accordance with report formats defined by the GMCB.

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

1. ACOs are required to demonstrate that projected enrollment meets or exceeds a minimum of 5,000 attributed lives in aggregate.

[1] All future references to the SIM Payment Models Work Group should be understand to mean that work group or its successor,

2. Participating insurers may choose not to participate with a given ACO should projected or actual attributed lives with that ACO fall below 3000.

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 should be able 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, 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. and 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 ACO participants or provide for meaningful involvement of ACO participants on the 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

Patients will be attributed to an ACO as follows: An ACO must have at least 5000 commercial Exchange pilot lives attributed to the participating insurers and at least 3000 commercial Exchange pilot lives attributed to one insurer in order to participate in the pilot with that insurer.

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, attribute those members to that provider.

For other members, select all claims identified in step 2 with the following qualifying CPT Codes[2] 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.

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

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

CPT-4 Code Description Summary
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 • 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

4. 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.

5. 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.

6. 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).

7. Insurers will run their attributions at least quarterly.

8. The SIM Payment Models Work Group will reconsider whether OB/Gyns should be added to the attributing clinician list during Year 1.

VI. Calculation of ACO Financial Performance and Distribution of Reconciliation 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 SIM 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 recommended by the pilot participants (insurers and ACOs) and presented to the SIM Payment Models Work Group, and ultimately to the GMCB Board. 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 targeted 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 defined by the GMCB with pilot participant input.

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 (see Appendix XX). The resulting amount for each insurer is called the "insurer-specific targeted spending."

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

II. Actions Initiated After the Performance Year Ends

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

No later than six months 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 a common methodology across commercial insurers;
- 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, 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 SIM 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, compare the ACO's performance on the payment measures (see Table 1 below) to the PPO HEDIS 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.

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

[5] A reciprocal approach shall apply to ACO excess spending in Year3, 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.

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:

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%

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.

Each insurer will calculate the final performance year medical expense six months following the end of the calendar year to allow for completion of the typical time lag in claims payment. The GMCB or its designee will complete the analysis of savings within two months of the conclusion of the six-month 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.

Step 6: Process for Review and Modification of the Measures

1. The SIM Quality and Performance Measures Work Group will review all **Payment and Reporting measures** included in the Core Measure Set at the beginning of the third quarter of each pilot year, with input from the SIM 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 or dropped for the next pilot year. Recommendations will go to the SIM Steering Committee, GMCB, and the SIM Core Team for review. Final approval for any changes must be received no later than September 30th of the year prior to implementation of the changes. In the interest of maintaining the stability of the measure set, the Year 1 Payment and Reporting measures will not be modified for Year 2 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 SIM Quality and Performance Measures Work Group and the SIM Payment Models Work Group will review all **targets and benchmarks** for the measures designated for Payment purposes at the beginning of the third quarter of each pilot year when NCQA publishes its Quality Compass product. For each measure, these reviews will consider whether the benchmark employed as the performance target (e.g., national xth 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. Recommendations will go to the SIM Steering Committee, GMCB, and the SIM Core Team for review. Final approval for any changes must be received no later than September 30th of the year prior to implementation of the changes.

3. The SIM Quality and Performance Measures Work Group will review all **measures designated as Pending** in the Core Measure Set beginning in the first quarter of each pilot year, with input from the SIM 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 during the review, the SIM Quality and Performance Measures Work Group determines that a measure has the support of the Work Group and is ready to be implemented in the next pilot year, it shall recommend the measure as either a Payment or Reporting measure and indicate whether the measure should replace an existing Payment or Reporting measure. 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 benchmarks. Recommendations will go to the SIM Steering Committee, GMCB, and the SIM Core Team for review. Final approval for any changes must be received no later than September 30th of the year prior to implementation of the changes.

4. The SIM Quality and Performance Measures Work Group will review state **or insurer performance on the Monitoring and Evaluation measures** during the third quarter of each year after NCQA publishes its Quality Compass product, with input from the SIM Payment Models Work Group. The measures will remain Monitoring and Evaluation measures unless the Work Group determines that one or more measures presents an opportunity for improvement and meets measure selection criteria, at which point the SIM 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. Recommendations will go to the SIM Steering Committee, GMCB, and the SIM Core Team for review. Final approval for any changes must be received no later than November 30th of the year prior to implementation of the changes.

5. The GMCB will release the **final measure specifications for the next pilot year by no later than** November 30th[t]. 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 SIM Quality and Performance Measures Work Group will review the measure and recommend a course of action for consideration, with input from the SIM Payment Models Work Group. Recommendations will go to the SIM Steering Committee, GMCB, and the SIM Core Team 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.

VII. Care Management Standards (*still under development*)

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. Any standards will be developed by the SIM Care Management Care Model Work Group. For Year 1 of the pilot emphasis will be placed upon member communication and care transitions.

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 (*still under development*)

1. **Payer Provision of Data to ACOs and ACO Provision of Data to Payers**

AGENDA ITEM 5c

TO: SIM Core Team
FROM: Paul Harrington, EVP, VMS
RE: Request for amendment to Section I (B) Standards related to downside risk limitations found on page 2 of document entitled "Vermont Commercial ACO Pilot, Compilation of Pilot Standards, October 10, 2013 Draft"
DATE: October 17, 2013

During the October 16 SIM steering committee meeting, I objected, on behalf of the Accountable Care Coalition of the Green Mountains (ACCGM) and the Community Health Accountable Care (CHAC), being developed under the auspices of Bi -State Primary Care Association, to the language in Section I (B) Standards related to downside risk limitations found on page 2 of document entitled "Vermont Commercial ACO Pilot, Compilation of Pilot Standards, October 10, 2013 Draft."

The relevant language in Section I (B) states:

1. The Board has established that for the purposes of the pilot program, the ACO will assume the following downside risk in each 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%

As I mentioned in my 10/16 statement, the three potential Vermont Commercial ACOs (OneCareVT, ACCGM and CHAC) have radically different size, financial capacity, and organizational maturity. While OneCareVT may have the ability to accept the year three downside risk of between three and 5%, the Green Mountain Care Board directive imposing such down side risk for ACCGM and CHAC prematurely may be deleterious in their efforts to participate in the commercial market area and could be counter to their future success.

As Susan Barrett, J.D. Director of Vermont Public Policy for Bi-State Primary Care Association wrote in a August 19, 2013 letter to Kara Suter, Director of Payment Reform DVHA relating to Medicaid ACO Standards: "Bi-State strongly recommends that the State offer a "no-down-side risk" option similar to the "Track 1" option within the CMS Shared Savings Program. This will allow for the safest testing of delivery system redesign in a way that is not likely to cause financial harm to the providers."

To her credit, Ms. Suter accepted the validity of Ms. Barrett perspective and page 31 of the October 2, 2013 Medicaid Shared Savings Program for ACOs RFP provides that: "ACOs will be asked to select from two tracks (one-sided or two-sided model) for contract Years One through Three of the program."

Vermont Medicaid recognized the enormous diversity among the three Vermont ACOs and it has adopted payment options that are in harmony with the Medicare Shared Savings Program for ACOs in order to accommodate these differences.

I request that the provisions of above Section I (B) 1, be redrafted to reflect the two tracks (one-sided or two-sided model) found in both the Medicare and Medicaid Shared Savings Program for ACOs. Alternatively, I would support revising the Section I (B) 1 lead sentence to read: "The Board has established that for the purposes of the pilot program, the ACO **may** assume the following downside risk in each pilot program year:"

Following my presentation on October 16, GMCB Director of Payment Reform Richard Slusky objected to revising the Section I (B) 1 language and, instead, he recommended that the concern be resolved by relying on promises of future discussions that may or may not result in the desired change.

I believe strongly that it is in the interest of both those charged with administering regulations and those subject to regulation that standards be clearly stated in a prospective manner and they be administered in a consistent and transparent manner. Leaving the current language in the document and, in lieu of change, relying on promises of future conversations creates an unnecessary degree of subjectivity and discretion in key financial areas that require the utmost certainty and clarity.

I, therefore, respectfully ask you to amend the Section I (B) 1 standards as outlined above consistent with your responsibilities as the SIM Core Team.

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

AGENDA ITEM 6A

November 13, 2013

TO: VHCIP Core Team
FROM: Pat Jones, Health Care Project Director, Green Mountain Care Board
RE: Proposed Commercial and Medicaid ACO Quality Measures
CC: Georgia Maheras, Richard Slusky, Kara Suter

We are seeking the Core Team's decision on two proposals:

1. Review and approval of the recommended 2014 Payment and Reporting Measure Set for Vermont's Medicaid and Commercial ACO Shared Savings Programs, and
2. A proposal on how to evaluate reporting measures.

Background on recommended payment and reporting measure set:

Payment measures are those for which ACO **performance** potentially impacts the amount of shared savings that the ACO gets to retain. Reporting measures are those for which ACO **success in reporting** potentially impacts the amount of shared savings that the ACO gets to retain.

The ACO Measures Work Group spent 9 months developing the recommended payment and reporting measure set. A majority, but not all, of the Work Group's members approved the recommended measure set in October, 2013. The work group process and the measure set are summarized in the attached documents (including a power point slide deck, and a table and graphic depicting Medicare measures and proposed Vermont Medicaid and Commercial measures).

Comments from Work Group and Steering Committee participants are summarized in the attached document. In brief:

- Written comments from Vermont Legal Aid, Blue Cross Blue Shield of Vermont, Bi-State Primary Care Association, and MVP Health Care supported the recommended measure set.
- Vermont Legal Aid recommended adding more measures in future years to cover additional populations. The Howard Center and Betsy Davis, RN recommended adding drug and alcohol screening and memory screening, respectively.
- In discussions at a Measures Work Group meeting and a subsequent Steering Committee meeting in October, the Vermont Medical Society verbally opposed any measures beyond those required for the Medicare Shared Savings Program (MSSP), except for unspecified maternity and pediatric measures.
- Subsequent to those meetings, Fletcher Allen Health Care recommended reclassification of 6 measures from the payment to the reporting categories. The Medical Society's written comments supported the FAHC recommendation.
- Accountable Care Coalition of the Green Mountains provided comments similar to VMS' original verbal comments.

Background on Proposal to Evaluate Reporting Measures:

A number of the recommended reporting measures rely on data from medical records, as opposed to the easier-to-collect measures that rely on claims data. The VHCIP Quality and Performance Measures Work Group (the successor to the ACO Measures Work Group) has recommended the following *if the final Payment and Reporting Measure Set coincides with the recommended measure set* (complete recommendation is attached)[1]:

- A requirement that ACOs make a good faith effort to submit all reporting measures completely and in a timely manner.
- A requirement that measure results be accompanied by an analysis of any barriers and costs identified during the reporting process, and a plan to mitigate those barriers where possible.
- GMCB development of guidelines for the content and format of the analysis and mitigation plan, to include the caveat that ACOs will not be expected to request information from participating ACO providers that would be unreasonably burdensome to those providers.
- Failure to report shall carry no financial consequences to the ACO in Year 1, provided that the ACO makes a good faith effort to report all of the measures in a complete and timely manner.

A key rationale for proposing no financial consequences if ACOs make a good faith effort to report each measure is that, based on preliminary assessments, there appear to be gaps in current capacity to report these measures electronically. The Work Group felt it was important to encourage open assessment of reporting capacity and development of electronic reporting solutions during Year 1, rather than imposing penalties for a lack of capacity to report.

[1] This proposal was discussed and verbally agreed upon at the most recent work group meeting, but is still out for written comment. I do not anticipate any controversy, but will update you on November 18 if any arises.

AGENDA ITEM 6B

Commercial and Medicaid Shared Savings Program: Recommended Year 1 Performance Measures

Vermont Health Care Innovation Project

Quality and Performance Measures Work Group

October 21, 2013

Presentation Overview

ACO Measures Work Group

- Members
- Objectives
- Process

Recommended Measures

- Payment
- Reporting

Impact of Measures on Reporting

ACO Measures Work Group

ACO Measures Work Group Members

Representatives from wide variety of organizations, including:

- Accountable Care Coalition of the Green Mountains
- Agency of Administration
- Agency of Human Services
- Bi-State Primary Care Association
- Blue Cross and Blue Shield of Vermont
- Blueprint for Health
- Department of Financial Regulation
- Department of Mental Health
- Department of Vermont Health Access
- Fletcher Allen Health Care
- Green Mountain Care Board
- MVP Health Care
- OneCare
- Vermont Assembly of Home Health Agencies
- Vermont Association of Hospitals and Health Systems
- Vermont Information Technology Leaders
- Vermont Legal Aid
- Vermont Medical Society
- Vermont Program for Quality in Health Care

ACO Measures Work Group Objectives

To identify standardized measures that will be used to:

Evaluate the performance of Vermont's Accountable Care Organizations (ACOs) relative to state objectives for ACOs,

Qualify and modify shared savings payments, and

Guide improvements in health care delivery.

Criteria for Selecting Measures

Representative of array of services provided and beneficiaries served by ACOs;

Valid and reliable;

NQF-endorsed measures with relevant benchmarks whenever possible;

Aligned with national and state measure sets and federal and state initiatives whenever possible;

Focused on outcomes to the extent possible;

Uninfluenced by differences in patient case mix or appropriately adjusted for such differences;

Not prone to effects of random variation (measure type and denominator size);

Not administratively burdensome;

Limited in number and including only measures necessary to achieve state's goals (e.g., opportunity for improvement);

Population-based; and

Consistent with state's objectives and goals for improved health systems performance.

Work Group Process

Over the course of nine months (January 2013-October 2013), the ACO Measures Work Group met about every two weeks.

Two sub-groups also held several meetings:

- Patient Experience of Care Survey Sub-group
- End-of-Life Care Measures Sub-group

11/13/2013

7

Work Group Process (continued)

Created "crosswalk" of over 200 measures from numerous measure sets, including:

- BCBSMA Alternative Quality Contract
- Blueprint for Health
- Buying Value
- CHIPRA
- CMS Medicare Shared Savings Program
- Initial Core Set of Adult Health Care Quality Measures for Medicaid Eligible Adults
- Maine ACO
- Meaningful Use
- NCQA
- OneCare
- PQRS
- Uniform Data System (required for FQHCs)
- Vermont reporting requirements for providers and health plans

Work Group Process (continued)

Work Group Participants:

- Identified their priority measures for consideration
- Eliminated measures through application of criteria and extensive discussion
- Expressed support for and concerns about measures
- Focused on measures in various domains, with national specifications, with benchmarks, and with opportunities for improvement
- Compromised
- Expressed widespread support, but not quite unanimity

Recommended Measures

Two Measure Sets

Core Set

- The Core Measure Set consists of measures for which the ACO has current or pending responsibility for collection, for either reporting or payment purposes.

Monitoring and Evaluation (M&E) Measure Set

- The Monitoring & Evaluation Measure Set consists of measures that will be used for programmatic monitoring, evaluation, and planning. Collection of these measures will not influence the distribution of shared savings.

Measure Use Terminology: Core Measure Set

- Performance on these measures will be considered when calculating shared savings.

Reporting

- ACOs will be required to report on these measures. Performance on these measures will be not be considered when calculating shared savings; ACO submission of the clinical data-based reporting measures will be considered when calculating shared savings.

Pending

- Measures that are included in the core measure set but are not presently required to be reported. Pending measures are considered of importance to the ACO model, but are not required for initial reporting for one of the following reasons: target population not presently included, lack of availability of clinical or other required data, lack of sufficient baseline data, lack of clear or widely accepted specifications, or overly burdensome to collect.

Recommended Year 1 Payment Measures

(Claims data)

Commercial and Medicaid Shared Savings Programs:

- All-Cause Readmission
- Adolescent Well-Care Visits
- Follow-Up After Hospitalization for Mental Illness (7-day)
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
- Avoidance of Antibiotic Treatment for Adults with Acute Bronchitis
- Chlamydia Screening in Women
- Cholesterol Management for Patients with Cardiovascular Disease (LDL Screening)*

Medicaid Shared Savings Program:

- Developmental Screening in First 3 Years of Life
- Depression Screening by 18 Years of Age

*Related to Medicare Shared Savings Program Measure

Recommended Year 1 Reporting Measures
(Claims data)

Commercial and Medicaid Shared Savings Programs:

- Ambulatory Sensitive Conditions Admissions: COPD or Asthma in Older Adults*
- Breast Cancer Screening*
- Rate of Hospitalization for Ambulatory Care-Sensitive Conditions: PQI Composite
- Appropriate Testing for Children with Pharyngitis

*Medicare Shared Savings Program Measure

Recommended Year 1 Reporting Measures
(Clinical Data)

Commercial and Medicaid Shared Savings Programs:

- Adult BMI Screening and Follow-Up*
- Screening for Clinical Depression and Follow-Up Plan*
- Colorectal Cancer Screening*
- Diabetes Composite
  - HbA1c control*
  - LDL control*
  - High blood pressure control*
  - Tobacco non-use*
  - Daily aspirin or anti-platelet medication*
- Diabetes HbA1c Poor Control*
- Childhood Immunization Status
- Pediatric Weight Assessment and Counseling

*Medicare Shared Savings Program Measure

Recommended Year 1 Reporting Measures
(Survey Data)

Patient Experience Survey Composite Measures:

- Access to Care
- Communication
- Shared Decision-Making
- Self-Management Support
- Comprehensiveness
- Office Staff
- Information
- Coordination of Care
- Specialist Care

Impact of Measures on Payment

Impact of Payment Measures: Commercial

Commercial "Gate and Ladder" Approach:

Compare each payment measure to the national benchmark and assign 1, 2 or 3 points based on whether the ACO is at the national 25th, 50th or 75th percentile for the measure.

If the ACO does not achieve at least 55% of the maximum available points across all payment measures, it is not eligible for any shared savings ("quality gate").

In proposed commercial SSP "quality ladder," ACO earns:

- 75% of potential savings for achieving 55% of available points,
- 85% of potential savings for achieving 65% of available points,
- 95% of potential savings for achieving 75% of available points.

Commercial Shared Savings Program Ladder
(proposed)

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

Impact of Payment Measures: Medicaid

Medicaid "Gate and Ladder" Approach:

(Core-2 – Core-7) Compare each payment measure to the national benchmark and assign 1, 2 or 3 points based on whether the ACO is at the national 25th, 50th or 75th percentile for the measure.

(Core-1 & Core-8) Compare each payment measure to VT Medicaid benchmark, and assign 0, 2 or 3 points based on whether the ACO declines, stays the same, or improves relative to the benchmark.

Statistical significance; targets associated with each point value to be calculated when initial ACO attribution estimates are available

If the ACO does not achieve at least 35% of the maximum available points across all payment measures, it is not eligible for any shared savings ("quality gate").

In proposed commercial SSP "quality ladder," ACO earns:

75% of potential savings for achieving 35% of available points,

85% of potential savings for achieving 45% of available points,

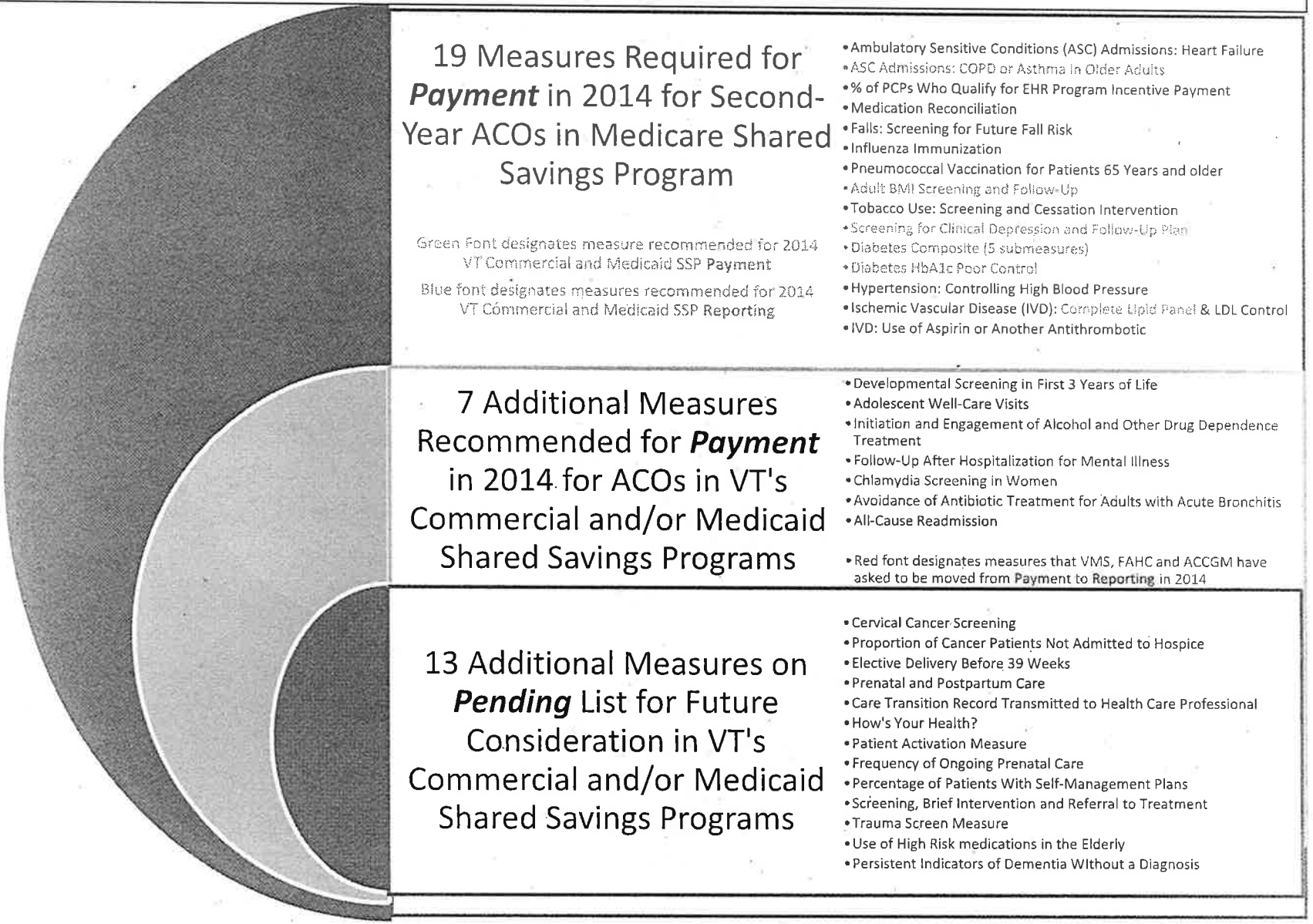
95% of potential savings for achieving 55% of available points.

Medicaid Shared Savings Program Ladder
(proposed)

Percentage of available points	Percentage of earned savings
35%	75%
40%	80%
45%	85%
50%	90%
55%	95%
60%	100%

AGENDA ITEM 6 C

Comparison of Payment Measures in Medicare and Recommended VT Medicaid and Commercial Shared Savings Programs



19 Measures Required for ***Payment*** in 2014 for Second-Year ACOs in Medicare Shared Savings Program

Green Font designates measure recommended for 2014 VT Commercial and Medicaid SSP **Payment**

Blue font designates measures recommended for 2014 VT Commercial and Medicaid SSP **Reporting**

- Ambulatory Sensitive Conditions (ASC) Admissions: Heart Failure
- ASC Admissions: COPD or Asthma in Older Adults
- % of PCPs Who Qualify for EHR Program Incentive Payment
- Medication Reconciliation
- Falls: Screening for Future Fall Risk
- Influenza Immunization
- Pneumococcal Vaccination for Patients 65 Years and older
- Adult BMI Screening and Follow-Up
- Tobacco Use: Screening and Cessation Intervention
- Screening for Clinical Depression and Follow-Up Plan
- Diabetes Composite (5 submeasures)
- Diabetes HbA1c Poor Control
- Hypertension: Controlling High Blood Pressure
- Ischemic Vascular Disease (IVD): Complete Lipid Panel & LDL Control
- IVD: Use of Aspirin or Another Antithrombotic

7 Additional Measures Recommended for ***Payment*** in 2014 for ACOs in VT's Commercial and/or Medicaid Shared Savings Programs

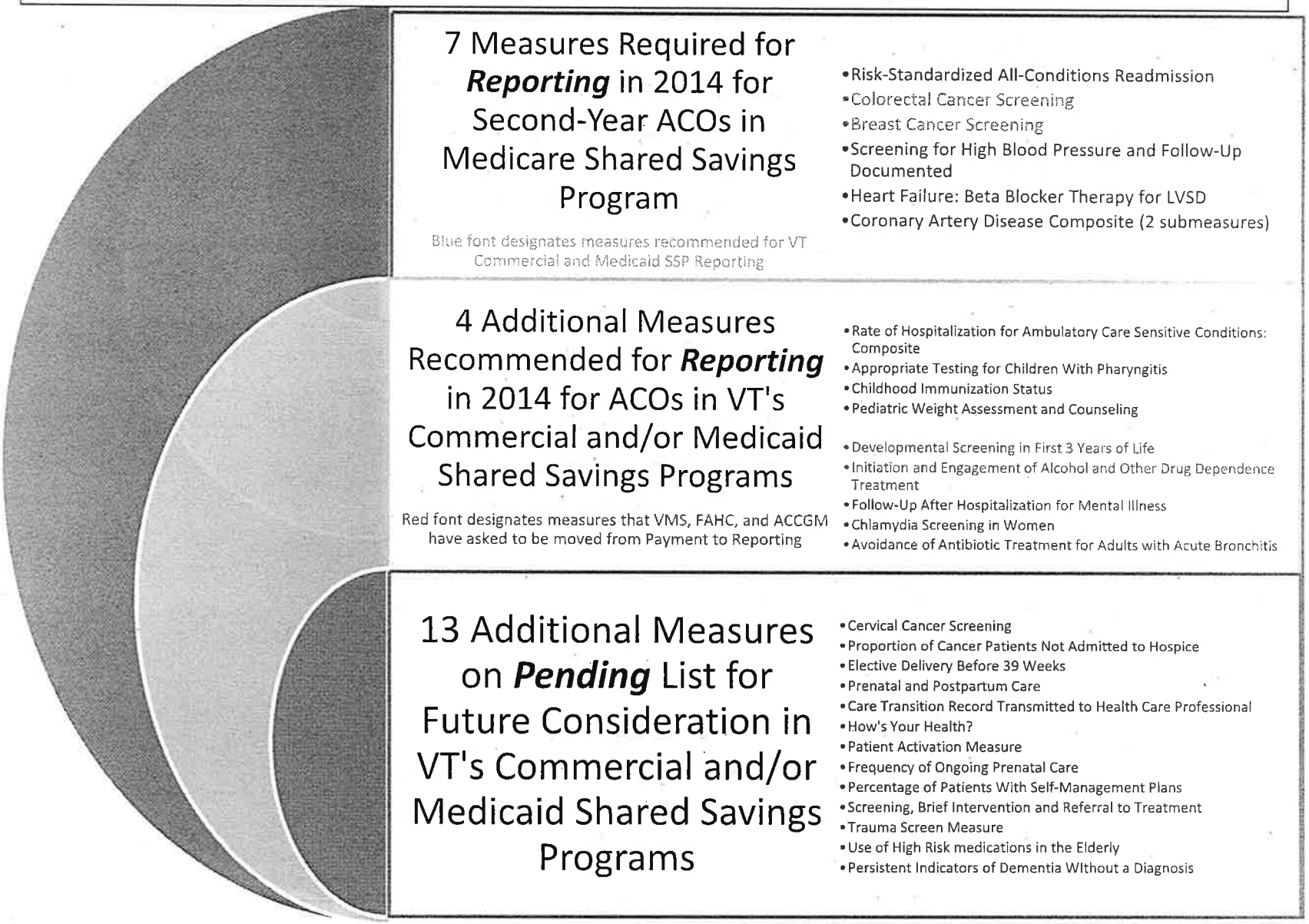
- Developmental Screening in First 3 Years of Life
- Adolescent Well-Care Visits
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
- Follow-Up After Hospitalization for Mental Illness
- Chlamydia Screening in Women
- Avoidance of Antibiotic Treatment for Adults with Acute Bronchitis
- All-Cause Readmission

- Red font designates measures that VMS, FAHC and ACCGM have asked to be moved from **Payment** to **Reporting** in 2014

13 Additional Measures on ***Pending*** List for Future Consideration in VT's Commercial and/or Medicaid Shared Savings Programs

- Cervical Cancer Screening
- Proportion of Cancer Patients Not Admitted to Hospice
- Elective Delivery Before 39 Weeks
- Prenatal and Postpartum Care
- Care Transition Record Transmitted to Health Care Professional
- How's Your Health?
- Patient Activation Measure
- Frequency of Ongoing Prenatal Care
- Percentage of Patients With Self-Management Plans
- Screening, Brief Intervention and Referral to Treatment
- Trauma Screen Measure
- Use of High Risk medications in the Elderly
- Persistent Indicators of Dementia WIthout a Diagnosis

Comparison of Reporting Measures in Medicare and Recommended VT Medicaid and Commercial Shared Savings Programs



7 Measures Required for ***Reporting*** in 2014 for Second-Year ACOs in Medicare Shared Savings Program

Blue font designates measures recommended for VT Commercial and Medicaid SSP Reporting

- Risk-Standardized All-Conditions Readmission
- Colorectal Cancer Screening
- Breast Cancer Screening
- Screening for High Blood Pressure and Follow-Up Documented
- Heart Failure: Beta Blocker Therapy for LVSD
- Coronary Artery Disease Composite (2 submeasures)

4 Additional Measures Recommended for ***Reporting*** in 2014 for ACOs in VT's Commercial and/or Medicaid Shared Savings Programs

Red font designates measures that VMS, FAHC, and ACCGM have asked to be moved from Payment to Reporting

- Rate of Hospitalization for Ambulatory Care Sensitive Conditions: Composite
- Appropriate Testing for Children With Pharyngitis
- Childhood Immunization Status
- Pediatric Weight Assessment and Counseling
- Developmental Screening in First 3 Years of Life
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
- Follow-Up After Hospitalization for Mental Illness
- Chlamydia Screening in Women
- Avoidance of Antibiotic Treatment for Adults with Acute Bronchitis

13 Additional Measures on ***Pending*** List for Future Consideration in VT's Commercial and/or Medicaid Shared Savings Programs

- Cervical Cancer Screening
- Proportion of Cancer Patients Not Admitted to Hospice
- Elective Delivery Before 39 Weeks
- Prenatal and Postpartum Care
- Care Transition Record Transmitted to Health Care Professional
- How's Your Health?
- Patient Activation Measure
- Frequency of Ongoing Prenatal Care
- Percentage of Patients With Self-Management Plans
- Screening, Brief Intervention and Referral to Treatment
- Trauma Screen Measure
- Use of High Risk medications in the Elderly
- Persistent Indicators of Dementia WIthout a Diagnosis

Comparison of Patient Experience Measures in Medicare and Recommended VT Medicaid and Commercial Shared Savings Programs

Medicare Shared Savings Program: National Implementation Survey

- More than 80 questions
- Geared toward Medicare population
- 7 composites (6 required for payment in 2014 for second-year ACOs in Medicare SSP, 1 required for reporting)

VT Commercial and Medicaid Shared Savings Programs: Patient Centered Medical Home Survey

- Less than 60 questions
- Includes areas of interest to ACOs (e.g., coordination of care, shared decision-making, self-management support, specialist care)
- 9 composites (all required for reporting in 2014 for VT Commercial and Medicaid SSPs)
- Used by about 70 of VT's Blueprint primary care practices; sent to about 27,000 Vermonters in 2013

Comparison of Proposed 2014 ACO Reporting or Payment Measures for MSSP (Medicare ACO), Vermont Commercial ACO, and Vermont Medicaid ACO

Key: Y=Yes; N=No; C=Claims; MR=Medical Record; S=Survey; R=Reporting; P=Payment

MSSP	Measure Description	Data: Claims, Medical Record, or Survey?	Medicare ACO Use Year 2 2014	Commercial ACO Use Proposed 2014	Medicaid ACO Use Proposed 2014
Y	Risk-Standardized All Condition Readmission	C	R		
Y	Ambulatory Sensitive Conditions Admissions: COPD or Asthma in Older Adults	C	P	R	R
Y	Ambulatory Sensitive Conditions Admissions: Heart Failure	C	P		
Y	% of PCPs who Successfully Qualify for an EHR Program Incentive Payment	Other	P		
Y	Medication Reconciliation	MR	P		
Y	Falls: Screening for Future Fall Risk	MR	P		
Y	Influenza Immunization	MR	P		
Y	Pneumococcal Vaccination for Patients 65 and Older	MR	P		
Y	Adult BMI Screening and Follow-Up	MR	P	R	R
Y	Tobacco Use: Screening and Cessation Intervention	MR	P		
Y	Screening for Clinical Depression and Follow-Up Plan	MR	P	R	R
Y	Colorectal Cancer Screening	MR	R	R	R
Y	Breast Cancer Screening	C	R	R	R
Y	Screening for High Blood Pressure and Follow-Up Documented	MR	R		
Y	Diabetes Composite (HbA1c control)	MR	P	R	R
Y	Diabetes Composite (LDL Control)	MR	P	R	R
Y	Diabetes Composite (High Blood Pressure Control)	MR	P	R	R
Y	Diabetes Composite (Tobacco Non Use)	MR	P	R	R
Y	Diabetes Composite (Daily Aspirin or Antiplatelet Medication)	MR	P	R	R
Y	Diabetes HbA1c poor control	MR	P	R	R
Y	Hypertension: Controlling High Blood Pressure	MR	P		
Y	IVD: Complete Lipid Panel and LDL Control	MR/C*	P	P*	P*
Y	IVD: Use of Aspirin or Another Antithrombotic	MR	P		
Y	Heart Failure: Beta Blocker Therapy for LVSD	MR	R		
Y	Coronary Artery Disease Composite (Lipid control)	MR	R		
Y	Coronary Artery Disease Composite (ACE or ARB for LVSD)	MR	R		

*Recommendation for Vermont Commercial/Medicaid ACO is to substitute the claims based Cholesterol Management for Patients with Cardiovascular Conditions (LDL Screening only) for the medical record based IVD: Complete Lipid Panel and LDL Control measure, due to data collection challenges.

MSSP	Measure Description	Data: Claims, Medical Record, or Survey?	Medicare ACO Use Year 2 2014	Commercial ACO Use Proposed 2014	Medicaid ACO Use Proposed 2014
N	All-Cause Readmission	C		P	P
N	Adolescent Well-Care Visit	C		P	P
N	Follow-Up After Hospitalization for Mental Illness (7 day)	C		P	P
N	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	C		P	P
N	Avoidance of Antibiotic Treatment for Adults with Acute Bronchitis	C		P	P
N	Chlamydia Screening in Women	C		P	P
N	Developmental Screening in First 3 Years of Life	C			P
N	Depression Screening by 18 Years of Age	C			P
N	Rate of Hospitalization for Ambulatory Care-Sensitive Conditions: PQI Composite	C		R	R
N	Appropriate Testing for Children With Pharyngitis	C		R	R
N	Childhood Immunization Status	MR		R	R
N	Pediatric Weight Assessment and Counseling	MR		R	R
	Patient Experience Surveys				
Y	NIS Patient Experience: Getting Timely Care, Appointments, Information	S	P		
Y	NIS Patient Experience: How Well Providers Communicate	S	P		
Y	NIS Patient Experience: Patients' Rating of Provider	S	P		
Y	NIS Patient Experience: Access to Specialists	S	P		
Y	NIS Patient Experience: Health Promotion and Education	S	P		
Y	NIS Patient Experience: Shared Decision Making	S	P		
Y	NIS Patient Experience: Health Status/Functional Status	S	R		
N	PCMH Patient Experience: Access to Care	S		R	R
N	PCMH Patient Experience: Communication	S		R	R
N	PCMH Patient Experience: Shared Decision-Making	S		R	R
N	PCMH Patient Experience: Self-Management Support	S		R	R
N	PCMH Patient Experience: Comprehensiveness	S		R	R
N	PCMH Patient Experience: Office Staff	S		R	R
N	PCMH Patient Experience: Information	S		R	R
N	PCMH Patient Experience: Coordination of Care	S		R	R
N	PCMH Patient Experience: Specialist Care	S		R	R
	Total Measures for Payment or Reporting 2014		33	31	33

*Recommendation for Vermont Commercial/Medicaid ACO is to substitute the claims based Cholesterol Management for Patients with Cardiovascular Conditions (LDL Screening only) for the medical record based IVD: Complete Lipid Panel and LDL Control measure, due to data collection challenges.

AGENDA ITEM 6c

Summary of Comments on Proposed Measures for Commercial/Medicaid Shared Savings Programs (11-11-13)

Individual or group	General thrust of comments	Specific recommendations for adding measures to the set	Specific recommendations for removing measures from the set	Justification
Accountable Care Coalition of the Green Mountains	The MSSP and proposed Vermont SSP measures come with no funding for practices to collect and report data, nor are there any guarantees of shared savings. Each measure should be accompanied by estimate of financial resources needed to collect and report; funding responsibility should rest with SIM/insurers, not providers. Agree that claims based measures are less onerous, but measures selected may not be most important, and will draw resources away from more meaningful clinical matters. Suggest additional clinical discussion on measure utility. Number of reporting measures should be reduced. Add limited number of maternity and pediatric measures, vetted by experts in maternal child health, to MSSP measures for Commercial and Medicaid pilots. Selected measures should be used for the three years of the program.	Add maternity measures to Medicare measure set, and possibly different pediatric measures.	Fewer reporting measures. Limit additional Vermont Commercial and Medicaid measures to selected pediatric and maternity measures.	Measurement is arduous and resource intensive for providers and ACOs. The more measures, the higher the risk of failure to recoup the significant resources invested in the programs.
Bob Bick, Howard Center	Surprised that while there are measures for tobacco use screening, depression screening, and high blood pressure screening there does not appear to be a comparable screening expectation for alcohol and drug use.	Add alcohol and drug use screening measure.		Given known impact of untreated alcohol and/or drug abuse/ dependence on health care costs, should have screening measure.

Individual or group	General thrust of comments	Specific recommendations for adding measures to the set	Specific recommendations for removing measures from the set	Justification
Bi-State Primary Care Association	Supports Year 1 measure set developed through many compromises by the ACO Measures Work Group. May advocate to delay implementation of additional measures until burden of reporting and improving quality for Year 1 measures is fully understood. Some payment measures have no 2012 benchmarks. If no valid benchmarks can be identified, recommends that these measures be characterized as reporting measures in Year 1 so that benchmarks can be developed. *Note they have concerns around the reporting measure scoring methodology that are not included in this summary.			The size of the measure set, especially the pending measures that may add burden to the measure set over the years, is a concern.
Blue Cross Blue Shield of Vermont	Supports measure set as presented at the Steering Committee meeting in October. The work group endorsed 38 clinical measures, 26 of which are also MSSP measures. The additional 12 measures cover clinical areas that otherwise would not be addressed, including pediatric care, MHSA care, and overuse of antibiotics. Supports reviewing the additional 31 clinical measures, and several patient satisfaction measures because they are important guideposts for our future work.			Given VT's challenges in all three of these areas "... hard-pressed to understand why" we would not include these measures. Of the 38 total measures, only 7 are included for commercial payment in 2014, a number so low that in many forums it will be hard to defend.
Betsy Davis, RN, MPH	Add measure related to memory screen. Medicare reimburses for this, so may be tracked by Medicare.	Add annual memory screen measure.		Increase in over-65 population; early diagnosis and treatment can delay cognitive decline.

Individual or group	General thrust of comments	Specific recommendations for adding measures to the set	Specific recommendations for removing measures from the set	Justification
Fletcher Allen Health Care	Use measures that are actionable, drive the improvement that we are seeking, are easily validated and do not require extensive chart review. Pick a manageable number of measures. Do not change measures or add additional measures for at least 36 months. Focus the measures on improving the health of our population.	Add to Year 1 Reporting Measure Set: • Depression Screening by 18 • Developmental Screening in first 3 years of life • Chlamydia screening in women • Avoidance of antibiotic treatment for adults with acute bronchitis • Initiation and engagement of alcohol and other drug dependence treatment • Follow-up after hospitalization for mental illness (7 day)	Remove from Year 1 Payment Measure Set: • Depression Screening by 18 • Developmental Screening in first 3 years of life • Chlamydia screening in women • Avoidance of antibiotic treatment for adults with acute bronchitis • Initiation and engagement of alcohol and other drug dependence treatment • Follow-up after hospitalization for mental illness (7 day)	Use "pay for reporting" instead of "pay for performance" until the ramp-up of measures is reasonably accomplished across the provider network in Vermont.
MVP Health Care	MVP supports the measures developed collaboratively by the stakeholder workgroup.			Changing measures so late in process could delay implementation.
Vermont Council of Developmental and Mental Health Services	Designated agencies raised questions related to access to data, ability to report, the relationship between screening tools and clinical practice, the appropriateness of measures, implications for practice, which members of the population they would be accountable for, and regional variations in the health care landscape.			
Vermont Information Technology Leaders	Concern about ability to capture measures in electronic form, in a complete and accurate manner. Assess provider organization's ability to collect data; select measures based on value of measure vs. complexity and cost of collection.			Potential trade-off between the value of performance measures versus the cost and complexity of obtaining the data.

Individual or group	General thrust of comments	Specific recommendations for adding measures to the set	Specific recommendations for removing measures from the set	Justification
Vermont Legal Aid, Office of Health Care Ombudsman	Payment measures list is too small to effectively measure overall quality or provide consumer protection over the three-year demonstration period. Improved quality in these few areas may not be reflective of the level of care provided to all ACO patients. Does not include any measures related to Patient Experience, Pregnant Women, Elderly & Disabled or End of Life Care. There are no Payment or Reporting measures for pregnant women, and the only women's health Payment or Reporting measures at all are for Chlamydia Screening and Breast Cancer screening. Strenuously disagrees that measure set is too large and onerous for providers. There may be too few measures to adequately monitor the scope of care provided to specific populations. Medicaid and Commercial ACOs will serve broader spectrum of Vermonters; more measures are needed to assess the quality of care provided to all served by ACOs. Over-emphasis on criterion that measures "not be administratively burdensome." ACO participation is voluntary, and some administrative burden is necessary in order for ACOs to be *accountable* to patients. Recommend that Core Team dedicate significant resources to improving data	Add in additional measures, including those that ensure excellent preventive care. Add Medicaid pediatric measures to Commercial measure set.		Important to foster strong consumer focus in ACO model; includes ensuring that health care quality improves at the same time that shared savings are earned. Quality measures are one of the only ways to protect consumers against under-serving as a means of achieving savings. Payment tied to high quality performance serves as a counter-balance against such an approach. Fewer than ten payment measures risks severely diminishing the effectiveness of that counterbalance. Measure set must be expandable throughout demonstration period. Need measures for Duals, and those needing LTSS.

Individual or group	General thrust of comments	Specific recommendations for adding measures to the set	Specific recommendations for removing measures from the set	Justification
	collection for quality measures. This would allow for expansion of payment measures, and better quality monitoring with less burden to providers, in years 2 and 3. Support language in Process for Review and Modification of Measures Standard to provide for addition of new measures to include LTSS in years 2 and 3. Several proposals currently under consideration by the Quality and Performance Measures Work Group would allow ACOs to avoid collecting and reporting on at least some percentage of reporting measures. These types of gaps in reporting should be kept to a minimum. The ACOs should be required to report all of the Reporting Measures unless they can demonstrate extraordinary circumstances that make it impossible for them to do so. *Note there are other concerns raised regarding the gate and ladder payment methodology. These are not included in this document.			
Vermont Medical Society	The addition of 21 new measures, on top of the 33 existing Medicare measures, would create a total of 54 ACO accountability measures and it would impose too great an administrative burden for physicians. Such a large number of measures would make targeted quality improvement activities extremely difficult.	Add to Year 1 Reporting Measure Set: • Depression Screening by 18 • Developmental Screening in first 3 years of life • Chlamydia screening in women • Avoidance of antibiotic	Remove from Year 1 Payment Measure Set: • Depression Screening by 18 • Developmental Screening in first 3 years of life • Chlamydia screening in women • Avoidance of antibiotic	Physicians are not going to differentiate between the sources of payment with respect to the clinical care they provide to their patients and would feel accountable for all of the relevant 54

Individual or group	General thrust of comments	Specific recommendations for adding measures to the set	Specific recommendations for removing measures from the set	Justification
	Maintain the stability of the measure set for the entire three years of the Commercial and Medicaid ACO pilot. Due to the high degree of uncertainty the process described in paragraphs 3 and 4 of the Process for Review and Modification of Measures Standard would create regarding adding new measures to the measure set for the second and third years of the three year pilot, the VMS recommends the deletion of paragraph 3 and 4.	treatment for adults with acute bronchitis • Initiation and engagement of alcohol and other drug dependence treatment • Follow-up after hospitalization for mental illness (7 day) The addition of a limited set of relevant and easily reported pediatric and maternity measures to the existing 33 Medicare measures in order to create the Commercial and Medicaid ACO measures set.	treatment for adults with acute bronchitis • Initiation and engagement of alcohol and other drug dependence treatment • Follow-up after hospitalization for mental illness (7 day)	measures. Implementation of ICD-10 on October 1, 2014; Stage II of Meaningful Use on January 1, 2014; and Medicare's alue-Based Modifier on October 15, 2013 for physician groups over 100 is going to be especially challenging for physicians. Reporting HEDIS measures is complex and hasn't been done well in the past.

AGENDA ITEM 7A

Type 1 expenditures:

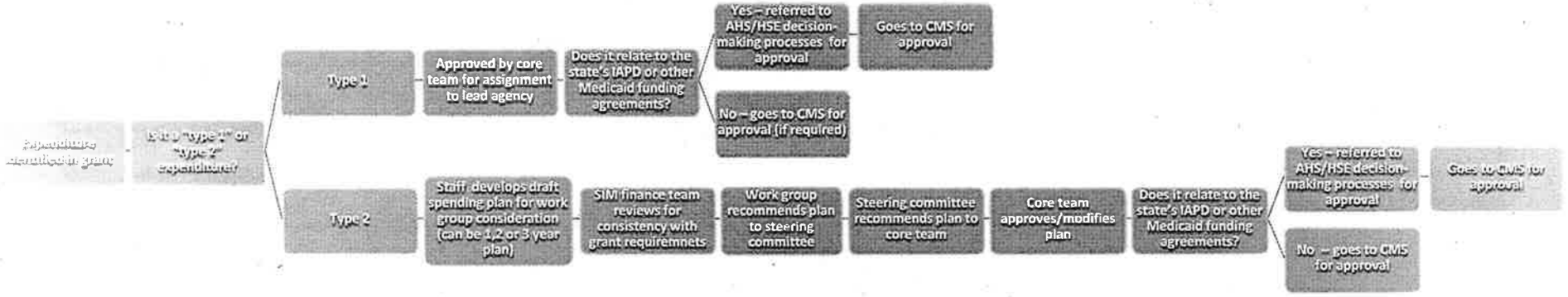
- Personnel, fringe, travel, equipment, supplies, other, overhead, interagency coordination, staff training and change management (as identified in approved grant budget)
- Provider grant program (with input from work group and steering committee on criteria)
- Expenditures approved by the Core Team prior to 10/1/13 (Project Management contract $, Evaluation contract $, VITL contract $)
- Ongoing project management resources, with Core Team approval
- Base support for each work group (extension of existing contractor technical assistance or new contract), with Core Team approval
- Base support for each lead agency, with Core Team approval

Type 2 expenditures:

- All other

NOTE: all contract expenditures are subject to state procurement rules and all recommendations/decisions of work groups, Steering Committee and Core team are subject to conflict-of-interest rules

Proposed decision-making process for SIM grant expenditures
Approved by SIM Core Team, 10/14/13



Agenda Item 7B

VHCIP Funding Allocation Plan (red text indicates proposed carryforward)

Funding Type	Implementation (March-Oct 2013)	Year 1	Year 2	Year 3	Total grant period	
Type 1A (appproved by the SIM Core Team on 10/14/13)						
Personnel, fringe, travel, equipment, supplies, other, overhead	$ 107,898	$ 3,412,103	$ 3,412,103	$ 3,412,103	$ 10,344,207	Includes new .5FTE in AOA for work force
Duals personnel and fringe		$ 110,000			$ 110,000	Year 1 paid out of Carryover
Project management	$ 30,000	$ 775,000	$ 700,000	$ 670,000	$ 2,175,000	Year 1 paid out of Carryover
Evaluation		$ 1,000,000	$ 1,000,000	$ 1,000,000	$ 3,000,000	
Outreach and Engagement		$ 100,000			$ 100,000	Year 1 paid out of Carryover
Interagency coordination		$ 110,000	$ 110,000	$ 110,000	$ 330,000	
Staff training and Change management		$ 100,000	$ 100,000	$ 100,000	$ 300,000	Support Conferences and Educational Opportunities
VITL Contract		$ 1,177,846			$ 1,177,846	
Subtotal	$ 137,898	$ 6,784,949	$ 5,322,103	$ 5,292,103	$ 17,537,053	

VHCIP Funding Allocation Plan (red text indicates proposed carryforward)

		Year 1	Year 2	Year 3	Grant Total	
Type 1B						
Grant program		$ 1,510,435	$ 933,333	$ 933,334	$ 3,377,102	Allow workgroups to recommend or suggest criteria they think is important for allocation of money. Additional $577,102.24 paid out of Carryover from Implementation Period.
Payment Models						
Bailit/Murray		$ -	$ 200,000	$ 200,000	$ 400,000	To develop EOC program and P4P programs
Burns and Associates or other vendor		$ 200,000	$ 200,000	$ -	$ 400,000	To develop EOC program and P4P programs
					$ -	
Measures					$ -	
Bailit/Murray		$ -	$ 200,000	$ 200,000	$ 400,000	
Patient Experience Survey		$ 300,000			$ 300,000	Paid for with funds previously allocated to Project Management for Year 1 only. There is an existing survey being fielded by the Blueprint.
					$ -	
HIT/HIE		$ 150,000	$ 150,000	$ 150,000	$ 450,000	No contractor identified
					$ -	
Population Health		$ 100,000	$ 100,000	$ 100,000	$ 300,000	No contractor identified
					$ -	
Workforce		$ 43,000	$ 43,000	$ 43,000	$ 129,000	No contractor identified
					$ -	
Care Models		$ 250,000	$ 250,000	$ 250,000	$ 750,000	No contractor identified

VHCIP Funding Allocation Plan (red text indicates proposed carryforward)

					$ -	
Duals					$ -	
Hogan/Besio/Wakely		$ 250,000	$ 250,000	$ 250,000	$ 750,000	
Sub Total		$ 1,293,000	$ 1,393,000	$ 1,193,000	$ 3,879,000	

VHCIP Funding Allocation Plan (red text indicates proposed carryforward)

		Year 1	Year 2	Year 3	Grant Total	
Type 1C						
GMCB/DVHA						
ACO Analytics Contractors		$ 400,000	$ 400,000	$ 200,000	$ 1,000,000	This contractor would support the development of spending targets, whether an ACO met those targets and how potential savings are distributed
					$ -	
GMCB					$ -	
Model testing support		$ 125,000	$ 125,000	$ 125,000	$ 375,000	Support GMCB analytics related to payment model development
					$ -	
DVHA					$ -	
Modifications to MMIS, etc...		$ 350,000	$ 150,000	$ -	$ 500,000	Resources to support updates to adjudication or analytic systems and processes like MMIS.
Broad dissemination of programmatic information to providers and consumers		$ 100,000	$ 100,000	$ 100,000	$ 300,000	Communications to providers and consumers regarding program/billing changes.
Analytics support to implement models		$ 250,000	$ 50,000	$ 50,000	$ 350,000	
Technical support of web-based participation and attestation under the P4P program		$ 125,000	$ 100,000	$ 25,000	$ 250,000	Aimed to reduce administrative burden to implement and improve participation in P4P programs

VHCIP Funding Allocation Plan (red text indicates proposed carryforward)

Analytic support		$ 100,000	$ 100,000	$ 100,000	$ 300,000	Support Medicaid analytics related to payment model development
Sub-Total		$ 1,450,000	$ 1,025,000	$ 600,000	$ 3,075,000	

VHCIP Funding Allocation Plan (red text indicates proposed carryforward)

		Year 1	Year 2	Year 3	Grant Total	
Type 2						
HIT/HIE						
Practice Transformation Teams		$ 440,321	$ 856,666	$ 856,667	$ 2,153,654	
Clinical Registry		$ 466,666	$ 466,666	$ 466,667	$ 1,399,999	
Integrated Platform		$ 666,666	$ 666,666	$ 666,667	$ 1,999,999	
Expanded Connectivity between SOV and providers		$ 833,333	$ 833,333	$ 833,334	$ 2,500,000	
Telemedicine		$ 416,666	$ 416,666	$ 416,667	$ 1,249,999	
Expanded Connectivity HIE		$ 346,346	$ 661,077	$ 661,077	$ 1,668,500	
					$ -	
Workforce					$ -	
Surveys		$ 80,000	$ 80,000	$ -	$ 160,000	
Data analysis		$ -	$ 150,000	$ 150,000	$ 300,000	
System-wide analysis		$ 546,666	$ 546,666	$ 546,667	$ 1,639,999	
					$ -	
					$ -	
Care Models					$ -	
Service delivery for LTSS, MH, SA, Children		$ 533,333	$ 533,333	$ 533,334	$ 1,600,000	
Learning Collaboratives		$ 500,000	$ 325,000	$ 325,000	$ 1,150,000	This item could support outreach and mailings associated with notification and education on new care delivery and payment reform models.
Analysis of how to incorporate LTSS, MH/SA		$ 100,000	$ 100,000	$ 100,000	$ 300,000	This includes technology support to Medicaid Home Health Initiatives including Hub and Spoke.

VHCIP Funding Allocation Plan (red text indicates proposed carryforward)

Practice Facilitators		$ 170,000	$ 170,000	$ 170,000	$ 510,000	
Integration of MH/SA		$ 50,000	$ 50,000	$ 50,000	$ 150,000	
					$ -	
Sub-Total		$ 5,149,997	$ 5,856,073	$ 5,776,080	$ 16,782,150	

$ 17,537,053	Type 1 A
$ 3,879,000	Type 1 B
$ 3,075,000	Type 1 C
$ 16,782,150	Type 2
$ 3,735,967	Balance Avail.
$ 45,009,170	Grant Total

AGENDA ITEM 8A

VERMONT

State Innovation Model

109 State Street
Montpelier, VT 05609
www.gmcboard.vermont.gov/sim_grant

TO: Core Team
FROM: Georgia Maheras
Date: 11/11/2013
RE: Implementation Period Carryforward and Type 1 contracting for Approval on November 18

This memo is a proposal for expending SIM funds under the Implementation Period Carryforward ($1,562,102.24) and Type 1 Contracting ($25,000-Wakely; $1,436,668-Mathematica; $125,000-Burns and Associates).

A summary of each request and a table explaining it in more detail are provided below.

Implementation Period Carryforward:

The VHCIP Implementation Period budget included funding for personnel and one contractual item, project management. *This request is to carryover $1,562,102.24 from the Implementation Period into Year 1 for Project Management, Stakeholder Engagement, Funding 1 FTE related to Duals and Expansion of the Grant Program*. These funds must be expended in Year 1.

Due to Vermont's statutory structure, we were not able to begin recruitment for SIM positions until May, 2013. While we have engaged in significant recruitment efforts, we have not been able to fill the SIM positions as quickly as we had hoped. The result is that we spent significantly less in personnel in the Implementation Period resulting in vacancy savings. Vermont's expectation is that we will have completed the recruitment process in the first quarter of Year 1. Additionally, we initially anticipated expending $418,766.76 for a project management contract in the Implementation Period. The procurement process took longer than expected. The result is that we spent less in this area during the Implementation Period. We shifted the work for this contractor to the beginning of Year 1 due to these contracting delays.

We have identified four areas where we would like to apply the carryover funds: project management, stakeholder engagement, expansion of the existing grant program, supporting one additional staff person. Justification for this request is provided below.

Table 1: Explanation of Proposed Carryforward Allocation

Expenditure Title	Amount	Justification
Project Management	$775,000 for one year	This item was originally budgeted for the implementation period. Vermont has identified the need for continuing this support through Year 1 of the project. Rationale: Vermont's SIM project cuts across multiple agencies and requires significant stakeholder involvement. We have determined that we need assistance in planning some of this during the implementation period. The contractor performing this work will do the following tasks: • Work Plan and Development and Management: Develop and maintain project work plan and timeline, provide cross project monitoring of timelines, deliverables, milestones, risks and status and assure timely task follow-up and project completion. • Project Facilitation and Monitoring Tools: Develop and maintain project tasks and issues list, project communications and status update tools. • Meeting Schedules and Agendas: Develop leadership group and workgroup meeting schedules, agenda and materials to facilitate exchange establishment progress and decision making. • Meeting Summaries: Prepare summary meeting notes including discussion, decisions and next steps to support project leadership, workgroups, and contractors. • Project Website Development and Maintenance: Maintain and further develop project management website and public website. This amount will support project management for one year based on the current contract with UMass Commonwealth Medicine.
Stakeholder Engagement	$100,000 for one year	Vermont submitted a stakeholder engagement plan in May, 2013. We expanded on that plan in the Operations Plan submitted on August 1, 2013. As we have started fully activating the SIM work Groups, we are pleased to find strong interest in this project. We have several parties who are interested in the work and want to be informed through newsletters, email blasts and other informational conversations. In order to support this work, and ensure the information is understandable by lay people, we are seeking

		contract support. The contractor will work with the Project Management team, Project Director and Core Team Chair to ensure we provide clear, understandable information to all SIM stakeholders. The state would need to go through the procurement process for these services. Examples of work include: maximizing the website, developing newsletters and other outreach tools.
Support 1 FTE related to Duals	$110,000 (est. salary and fringe for one year)	Vermont's SIM project is a combination of the SIM testing project and Duals project. As described in the Operational Plan, this is to ensure alignment between these two programs at the state level and ensure that Vermonters receive the quality health care they need. One of the reasons that Vermont needs to ensure specific alignment of these two programs is because some Duals are currently attributing to MSSP ACOs. Vermont's providers are eager to participate in reforms and one of the goals of the SIM/Duals integration is to make sure all providers can participate to the greatest extent possible without conflicts or concerns. The State has identified the need for additional staffing support of this work in Year 1. Our expected budget in Year 1 is $110,000 based on staff currently working at the Agency of Human Services on Duals.
Expansion of grant program to Vermont providers	$577,102.24 for one year	This adds funding to the existing capacity grant program being developed. There is strong interest in this program and the need is likely to exceed the budgeted amount. In developing the SIM application, the State of Vermont received numerous requests from providers and associations representing providers to provide them with grants and support to develop models and innovate. These requests demonstrate that there is significant interest among Vermont's providers to test alternative payment mechanisms and innovative care models/interventions. The State has determined that a competitive grant process will serve to maximize success of these providers and foster innovation.

Type 1 Contracting:

1. ***Wakely Actuarial Consulting: $25,000 to support Type 1b Duals Work Group***

In February, 2013, Vermont contracted with Wakely Consulting to develop financial projections related to the Duals Demonstration. This analysis is critical for the state's negotiations with the Centers for Medicare and Medicaid Services (CMS). The initial analyses cost $75,000.

Given Wakely Consulting's familiarity with this specific set of analyses, the revision would cost approximately $20,000-$25,000. Engaging with another vendor would cost upwards of $75,000, similar to the initial data analyses, and significant state staff time to educate the contractor on the Duals Demonstration.

This request is to expend up to a maximum of $25,000 of SIM funds for a revised analysis related to the Duals Demonstration. This will be through an amendment to an existing state contract and is a one-time expenditure.

Background: The State of Vermont is engaged in discussions with CMS for a demonstration related to Vermont's Duals population, those who are Medicare and Medicaid eligible. As part of the formal documents required by the federal government, the State of Vermont must develop financial projections. The State of Vermont needs to utilize the services of actuaries to properly develop this model and ensure we have the information necessary for the conversations with CMS. Wakely Consulting has worked with the State of Vermont in several other instances, understands our claims data and provided a similar analysis earlier in the year. Wakely's experience with the information, and project development will provide cost savings to the State.

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Table 2: Explanation of Contracting Agency, Scope of Work and Original Budget Category for Proposed Wakely Contract

Contracting Agency	Scope of Work	Budget Narrative Category
DVHA	The projections would include the following components: • Funding: Funding projections would include both Medicare and Medicaid components. • Under the Dual Demonstration projection, the Medicare funding would be based on projected risk scores and benchmark rates and the Medicaid funding would be based on the current Medicaid funding mechanisms (see section "Understanding Funding" below for more detail). • Acute and Long Term Services and Supports (LTSS) Expenses: Claim expense projections would be based on iMMRS and VHCURES data that has been aggregated for the dual members covered by the demonstration. • Administration Costs: Administration costs will include the current cost associated with the dual members covered by the demonstration, the additional investment/start-up costs associated with the demonstration, and the ongoing additional expenses associated with running the demonstration. • Savings estimates for Dual Demonstration: Based on discussions with the State on potential savings opportunities under the Dual Demonstration, Wakely will estimate potential savings and incorporate these savings into the projection. Detailed information on the areas for savings is detailed below.	Advanced Analytics: Financial Analyses

2. ***Mathematica Policy Research Team:* $1,436,668 *for* *Independent Evaluation***

Evaluation is a critical component of the SIM project. CMMI expects states that have received model testing grants to design and implement evidence-based evaluation frameworks, meaningful self-evaluation, and continuous improvement monitoring for the planned transformations contained in their SIM plans.

On September 4, 2013, the Green Mountain Care Board (GMCB) released a Request for Proposals (RFP) for evaluation services related to the State Innovation Model (SIM) grant. The RFP was previously released on June 17, 2013, and subsequently revised and released on July 10, 2013. It was released again on September 4 in an effort to obtain a larger pool of bidders; six bids were received in response. The RFP can be found at: http://gmcboard.vermont.gov/sites/gmcboard/files/SIM_RWJF_Evaluation_RFP092013.pdf

With this RFP, the GMCB is seeking a contractor to assist in developing performance measures, benchmarks, and an evaluation process for payment reform pilots approved by the GMCB, and to conduct overall evaluation of the SIM grant received by Vermont. The goal is to determine which payment reform initiatives are successful, so that these successful initiatives can be expanded to contribute to the state's overarching health care reform aims: reducing costs, improving care, and improving health. The scope of work is described below.

The GMCB convened a bid review team consisting of the following: Craig Jones, MD and Alicia Cooper from DVHA; Allan Ramsay, MD, Betty Rambur, PhD, and Pat Jones from the GMCB; Catherine Fulton from VPQHC; and Annie Paumgarten, the recently hired Evaluation Director for the GMCB.

This team reviewed the six bids and determined that one bid (from Mathematica Policy Research) was superior to the others in addressing the core criteria outlined in the RFP. The bid review team recommends selecting Mathematica for the following reasons:

1. They will provide a strong team to fully address the GMCB's requirements.
2. They understand the complexity of the services and data sources required for this SIM evaluation, as well as the nature of Vermont's health care reform landscape.
3. Their approach and methodology is thorough and creative, and includes a strong provider experience component.
4. They provide a realistic, detailed and well-supported budget proposal.

It should be noted that Mathematica's proposal identifies Market Decisions as a sub-contractor.

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Table 3: Explanation of Contracting Agency, Scope of Work and Original Budget Category for Proposed Mathematica Contract

Contracting Agency	Scope of Work	Budget Narrative Category
GMCB	The specific tasks in the contract are outlined in detail in the RFP, and include conducting broad SIM project evaluation, as well as evaluation of approved payment and delivery system pilot projects related to shared savings accountable care payment models, bundled payment models, and pay-for-performance models. The activities within these tasks include: • Development of performance measures for broad SIM evaluation and for each approved pilot project, including: o Development of appropriate measures relating to financial targets, clinical processes, clinical outcomes, patient satisfaction/experience, and provider satisfaction, o Identification of benchmarks, o Identification of how measures will be retrieved from various data sources, o Recommendations on minimum number of patients enrolled in each pilot in order for the evaluation to achieve statistical significance, and o Recommendations on timing of evaluation after pilot project initiation. • Evaluation of results for consumers who are subject to more than one intervention, using multiple regression analysis. • Assessment of impact of delivery system improvements on health care costs, quality and access, with specific focus on:	Evaluation: Independent Evaluation

	○ Expenditures, ○ Savings, ○ Cost trends, ○ Utilization, ○ Quality (including process and outcomes), ○ Patient, provider and caregiver satisfaction/experience of care ○ Promotion of provider behavior that leads to continuous improvement and better outcomes, ○ Promotion of patient behavior that leads to improved outcomes, and ○ Unintended consequences or behaviors. • Independent evaluation of entire SIM project for Vermont and for the Center for Medicare and Medicaid Innovation. • Recommendations to the Green Mountain Care Board based on the results of the evaluation of the payment reform pilots and models.	

3. *Burns and Associates: $150,000 to support Type 1c DVHA Agency Funding*

DVHA has identified the need for continuing support of Burns and Associates, the consultant who assisted in development of the Medicaid shared savings ACO program. Burns and Associates would assist the state in activities related to the launch, implementation, reporting, monitoring and evaluation of the Medicaid shared savings ACO program throughout the first performance year (2014).

Table 4: Explanation of Contracting Agency, Scope of Work and Original Budget Category for Proposed Burns and Associates Contract

Contracting Agency	Scope of Work	Budget Narrative Category
DVHA	• Until the state-wide data analytics contract is fulfilled, the contractor will assist with conducting provider attribution and other relevant programmatic analytics for reporting purposes, and will also work with internal DVHA data analytics unit to prepare Limited Data Settings files for release to ACOs under the shared savings program. • While the state-wide data analytics contract is in the early stages of implementation, the contractor will work together with the state-wide data analytics contractor on technical issues related to data feeds and reporting under the program and any other Medicaid data issues. • Once the work of the state-wide data analytics contractor is fully operational, the contractor will conduct an internal validation of their analysis of Medicaid data, and work through any other technical issues that might pursue. • Contractor will continue to provide technical assistance on all communications and activities with CMCS and CMMI, including ad hoc analysis to	Advanced Analytics: Policy and Data Analyses

	support and explain programmatic activities. • Contractor will conduct analytics to support the Monitoring and Evaluation components of the program, shadow payments, calculation of the expanded Total Cost of Care, computation of performance measures, and any other ad hoc requests for information.	

AGENDA ITEM 8B

DRAFT FOR SIM CORE TEAM DISCUSSION ONLY, 11/13/13

Vermont Health Care Innovation Project Provider Grants Program

Background

The State Innovation Model (SIM) grant was awarded to Vermont by the federal Centers for Medicare and Medicaid Innovation (CMMI). The grant provides funding and other resources to support health care payment and delivery system reforms aimed at improving care, improving the health of the population, and reducing per capita health care costs, by 2017. To maximize the impact of provider involvement in this health care reform effort, Vermont identified funding within its SIM grant to directly support providers engaged in payment and delivery system transformation. The State has determined that a competitive grant process will foster innovation and promote success among those providers eager to engage in reforms. Grants will fund data analysis, facilitation, quality improvement, evaluation, and project development. Applicants can seek technical assistance support as well as direct funding. The total amount available for direct funding is $3,377,102.

Vermont will establish a Provider Grants Program (PGP) to fulfill the intent of this grant provision. Below are proposals for:

- The general areas of provider activity eligible for support;
- Grant submission requirements;
- The criteria to be used to evaluate requests for support; and
- The technical assistance resources that might be available to grantees, in addition to SIM funds.

General areas of activity eligible for support

PGP grants will support provider-level activities that are consistent with overall intent of the SIM project, in two broad categories:

1. Activities that directly enhance provider capacity to test one or more of the three alternative payment models approved in Vermont's SIM grant application:
    a. Shared Savings Accountable Care Organization (ACO) models;
    b. Episode-Based or Bundled payment models; and
    c. Pay-for-Performance models.
2. Infrastructure development that is consistent with development of a statewide high-performing health care system, including:
    a. Development and implementation of innovative technology that supports advances in sharing clinical information across provider organizations;
    b. Development and implementation of innovative systems for sharing clinical or other core services across provider organizations;

c. Development of management systems to track costs and/or quality at the provider level in innovative ways.

Preference will be given to applications that demonstrate:

- Support from and involvement of multiple provider organizations that can demonstrate the grant will enhance integration across the organizations;
- A scope of impact that spans multiple sectors of health care service delivery (for example, primary care, specialty care, mental health and long term services and supports);
- Innovation, as shown by evidence that the intervention proposed represents best practices in the field;
- Consistency with the Green Mountain Care Board's specifications for Payment and Delivery System Reform pilots.

Grant submission requirements

Applicants will be expected to provide the following in support of their application:

- A clear description of the activities for which they are requesting funding or technical assistance;
- A budget for the proposed project, consistent with specified budget formats;
- A description of technical assistance services sought;
- A description of any available matching support, whether financial or in-kind;
- A description of the project's potential return-on-investment in terms of cost savings and quality improvement, and plans for measuring both;
- A summary of the evidence base for the proposed activities;
- A project plan and timeline for completion of the proposed activities;
- A Memorandum of Understanding or other demonstration of support from partner providers, if applicable;
- A project management plan, with implementation timelines and milestones.

Grant review criteria

Grants will be evaluated based on the following criteria:

- Consistency with overall SIM project activities;
- Involvement of and support from multiple provider organizations and/or provider types;
- Demonstration of lead organization's commitment to the SIM project activities;
- Quality, clarity and soundness of the project description, project budget, project plan and timeline;
- The evidence base for the proposed activity;

- The overall cost and expected return-on-investment of the proposed activity.

State resources available to grantees

Projects supported by the Provider Grants Program may be provided the following supports, to the extent that a need has been clearly established in the grant application:

- Supervision to ensure compliance with federal antitrust provisions;
- Assistance in aligning with other testing models in the state;
- Assistance with the appropriately attributing outcomes and savings to testing models;
- Overall monitoring of health care quality and access;
- Funding for specific activities;
- Technical Assistance:
  - Meeting facilitation
  - Stakeholder engagement
  - Data analysis
  - Financial modeling
  - Professional learning opportunities

SIM Core Team
Meeting Notes for
Tuesday, September 10, 2013

At 8:00 a.m., Chair, Anya Rader Wallack welcomed everyone to the meeting.

Draft memo to SIM Steering Committee Members:

Anya presented her draft memo to the Steering Committee regarding the ACO standards, which included an overview of the comments received from Stakeholders and the revised proposals in response to the comments received. The comments revealed:

- There was some confusion about core elements of the standards.
    - Anya provided some clarifying definitions.
- There were concerns about Uncertainty and Risk, and the Total Cost of Care definition
    - Year 1 will be designed to minimize requirements for provider risk bearing.
    - Year 2 would not require but incent additional 10% savings for choosing an optional track.
    - Year 3 would require adoption of the optional track.
    - The optional track would include components to expand the total cost of care definition to include all additional categories of services and demonstrate provider participant agreements.
    - ACOs will be required to participate in collaborative learning.
    - ACOs will be asked to do an annual assessment using a validated tool.
    - Participating ACOs will be eligible for "capacity grants"
- There was concern that the proposed standards did not do enough to assure meaningful consumer and provider representation in ACO governance.
    - The ACO Standards Work Group approved a revised proposal, developed with input from Legal Aid, Health Care Ombudsman and OneCare.

Additional Proposals:

1. ACO shall submit annual plans for meaningful consumer engagement.
2. Mandatory representation for Acute/chronic medical care providers.

Key Comments/Concerns/Questions:

- There needs to be a set of common definitions for ease of communicating with various stakeholders and advisory groups.
- What incentives are being created unintentionally?
- There has been a lot of attention to provider risk and consumer involvement however transparency has yet to be addressed. What is public/reportable?
- Will we have legislative issues? Need to compare standards to statute.
- What is the status of the ACO Measures? There should be an alignment of the ACO Standards and the ACO Measures. How do we define the metrics?

- Need broad participation in total cost of care. How do we accomplish and measure?
- Should year three exclude additional savings from ACOs who waited until year three?
- What will be the availability of "capacity grants"?
- Should there be the creation of a consumer advisory board?
- Who will negotiate with ACOs? How prescriptive should we be?
    - Initially DVHA, with ultimate approval from GMCB
    - Proposal from evaluation team needs input from the Core Team. Need to clarify expectations as part of the review process and comment on responses.

Discuss the proposal for revising the standards in response to comments received from the SIM Steering Committee members:

The SIM Core Team will vote on the revised standards at a subsequent meeting after the SIM Steering Committee has time to discuss and submit comments.

The goal is to reach agreement on Medicaid ACO standards before the end of September so that the Department of Vermont Health Access (DVHA) can issue an RFP shortly thereafter to prospective Medicaid ACOs.

Misc:

Waiting on response from CMS regarding Operational Plan.

Adjournment:

At approximately 9:15 a.m., Anya Rader Wallack ended the meeting.

SIM Core Team
Meeting Notes for
Monday, October 14, 2013

At approximately 1:30 p.m., Chair, Anya Rader Wallack welcomed everyone to the meeting.

Chair's Report:

Anya gave a briefing on the CMS "Reverse Site Visit", meeting of SIM testing states in Chicago, Operational Plan follow-up and approval for testing (documents provided), project staff hiring, Medicaid ACO update, Commercial ACO update, and upcoming Project Kick-Off and Steering Committee agendas.

- We had a good show of force at the "reverse site visit", met the project director Karen Murphy.
- There are 6 test states with whom we can collaborate.
- Georgia has been hired as the Project Director.
- The Medicaid ACO RFP went out.
- Richard gave a briefing on the Commercial ACO which will be presented to the Steering Committee on 10-16-13.
- Evaluation RFP is out to bid again. GMCB declined the Core Team's chosen vendor.

Key Comments/Concerns/Questions:

- What are some of the shared issues amongst the testing states?
  - Duals demonstration presents a need for flexibility.
  - Complexities of including various LTS providers.
  - Need for data.
  - Arkansas has been working on episodes of care.
- How flexible will CMS be?
  - We will need to develop specific requests.
- Were the CMS operational plan questions similar amongst the testing states?
  - Yes, nature of the questions centered on timelines and accountability targets.

Discussion of SIM Funding Allocation Proposal:

Anya explained that the grant application and the approved grant budget identified categories of project spending. Now that Vermont has been approved to move to the "testing" period of the SIM grant there is an urgency for defining the rules and processes for how funding allocation decisions are made and, in particular, to recommend how and when we include SIM stakeholders meaningfully in project spending decisions.

Documents Provided - Flow chart showing how type 1 and type 2 expenditures would gain approval, and spreadsheet that showing a proposed allocation of grant funds based on the distinction between type 1 and type 2 expenditures.

- SIM expenditures are sorted into two categories – type 1 and type 2.

- Type 1 expenditures will be reviewed on a "fast track" with only approval of the Core Team.
- Type 2 expenditures will be reviewed by SIM work groups.
- Some expenditures may be subject to review and approval by the State's Health Services Enterprise Executive Committee and possibly other approval processes within the Agency of Human Services.
- All contracts are subject to the state's procurement rules.
- All recommendations arising from SIM work groups, the SIM Steering Committee and the SIM Core Team will be subject to conflict of interest policies to be developed.
- All contracts are subject to approval from CMS.
- GMCB has a draft of the grant program. This will be further developed by the Chair before it is submitted to CMS for approval.

Key Comments/Concerns/Questions:

- GMCB should be removed from SIM funding process if possible, leave decision making to the Core Team.
- What is the IAPD?
    - Integrated Advanced Planning Document
- How will our agreements affect other AHS agreements with CMS?
- Work groups will have the greatest potential for conflicts of interest.
- Will grant money be used for ACO funding/implementation?
    - The Core team will develop draft criteria
- How much flexibility will there be with these budgets?
- Are we moving too many funding decisions away from the work groups?
- Should certain organizations with statutory approval apply for a waiver to avoid conflict of interest?
- Should certain organizations be allowed to comment on grant criteria if they might submit a bid?
- We should avoid the appearance of conflict.

Action Items:

1. Approval of funding allocation proposal type 1 and type 2 designations and processes
    - Core team approved
2. Approval of selected type 1 expenditures
    - Core team approved
3. Robin to work on conflict of interest rules.
4. Robin sought approval for funding of half-time staff member to perform duties for the Workforce Committee.
    - Core team approved

Adjournment:

At approximately 3:30 p.m., Anya Rader Wallack ended the meeting.