Attachment 1 - DLTSS Meeting Agenda 5-02-14

VT Health Care Innovation Project
"Disability and Long Term Services and Supports" Work Group Meeting Agenda
Friday, May 2, 2014; 10:00 AM to 12:00 noon
4th Floor Conference Room, Pavilion Building, Montpelier, VT
Call-In Number: 1-877-273-4202; Passcode 8155970; Moderator PIN 5124343

Item	Time Frame	Topic	Relevant Attachments	Action
1	10:00 – 10:10	**Welcome; Introductions** Deborah Lisi-Baker and Judy Peterson	• Attachment 1: Meeting Agenda	
2	10:10– 11:45	**Shared Savings Programs (SSPs) and Accountable Care Organizations (ACOs) in Vermont** • **Overview of Shared Savings Programs (SSPs) and Accountable Care Organizations in Vermont** Susan Besio, PHPG • **Discussion of DLTSS Questions & Answers Regarding ACOs** Deborah Lisi-Baker and Judy Peterson	• Attachment 2: Vermont SSP ACO Table • Attachment 3: DLTSS Work Group Questions/ Answers Regarding ACOs • Links to Medicaid SSP ACO Contracts: OneCare http://dvha.vermont.gov/administration/onecare-base-contract-signed.pdf CHAC: http://dvha.vermont.gov/administration/chac-signed.pdf	
3	11:45 – 12:00	**Public Comment/Updates/Next Steps** Deborah Lisi-Baker and Judy Peterson		

Attachment 2 - Vermont SSP ACO Table

Overview of Shared Savings Programs (SSPs) and Accountable Care Organizations (ACOs) in Vermont

April 28, 2014

MEDICARE SHARED SAVINGS PROGRAM (MSSP)

ACO Name	Start Date in Program	Geographic Area	ACO Network Participants[1, 2] (Participants with attributed lives)	ACO Network Affiliate Participants[1] (Participants without attributed lives)	ACO Shared Savings Distribution with Provider Network[3]	Estimated Medicare Attributed Lives		
						# and % of Total VT Medicare Enrollees (Total N=126,081)[4]	# and % of VT MSSP Eligible Enrollees (Total N=117,015)[5]	# and % of Dual Eligibles within Attributed Lives (Total N=21,670)
Health*first* - Accountable Care Coalition of the Green Mountains (ACCGM)	Jul 1, 2012	Approved Statewide; current network available in Greater Burlington and North Central Vermont	• 30 Physicians - 10 Primary Care Practices	Committee working on Collaborative Care Agreements (CCAs) with practitioners, including: • Specialists • Other specific entities (e.g., Visiting Nurses Association)	• 50% of shared saving distributed to Healthfirst **Network Participants and CCA Practitioners** o Collaborative Care Agreements (CCAs) will specify responsibilities of **CCA Practitioners** in order to share in these savings, including patient and network engagement • 50% of shared savings to Collaborative Health Systems[6]	6,700 5%	6,700 6%	583 3%
OneCare Vermont (OCV)	Jan 1, 2013	Statewide	• 2 Academic Medical Centers (FAHC and DHMC) • All other VT hospitals • Brattleboro Retreat • 4 Federally Qualified Health Centers (FQHCs) • 4 Rural Health Centers • 300+ Primary Care Physician FTEs • Most of VT Specialty Care Physicians	• 28 of 40 Skilled Nursing Facilities • All but one Home Health and Hospice Agency • All Designated Mental Health (MH), Developmental Services (DS) and Substance Abuse Agencies o Exceptions: 1 DS-only Agency, 1 of the 4 DS Specialized Service Agencies (SSAs), & the only Children's MH SSA	• 90% of shared savings distributed to OCV **Network Participants**; 10% retained by OCV • Separate Incentive Plan Provision for OCV **Affiliate Participants** • Both depend on reporting and performance metrics	53,000 42%	53,000 45%	13,250[7] 61%
Community Health Accountable Care (CHAC)	Jan 1, 2014	8 of 14 Counties (Chittenden, Grand Isle, Franklin, Orleans, Caledonia, Essex, Orange, Washington)	• 5 FQHCs and Bi-State Primary Care Association - 24 FQHC practice sites (includes dental and school based sites) - 97 Primary Care Providers	Network under development. Anticipated to include: • Home Health and Hospice • Area Agencies on Aging • Community MH Centers • One or more Hospitals	Distribution methodology to be determined.	5,980 4.7%	5,980 5.1%	unknown
TOTALS			~427 Primary Care Providers → **~ 67% of 634 Primary Care Providers statewide[8]**			65,680 **52% of all VT Medicare enrollees**	65,680 **56% of all VT MSSP Eligible enrollees**	At least 13,833 **At least 64% of all VT Dual Eligibles**

[1] Current Network Participants and Network Affiliates as of April, 2014; may change over time
[2] ACO Participants can only be in the network of one ACO because they could have lives attributed to them to calculate Medicare performance and savings; Outcomes for each "life" can only relate to a single ACO.
[3] Under the Medicare SSP, ACOs must meet a minimum savings rate (MSR) to qualify for savings (which is calculated based on # of attributed lives in the ACO); once this MSR is met, ACOs are eligible to receive up to 50% of the Medicare savings; Actual amount of savings an ACO can receive is determined by ACOs performance regarding reporting on and meeting quality metrics
[4] Source: www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Downloads/2014/Mar/State-County-Penetration-MA-2014-03.zip
[5] MSSP does not include Medicare enrollees in Medicare Advantage Plans. In March 2014, 9,036 Vermonters were enrolled in these Plans. Source: www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Downloads/2014/Mar/State-County-Penetration-MA-2014-03.zip
[6] Healthfirst partnered with Collaborative Health Systems (CHS), a subsidiary of Universal American Corp., to form ACCGM for the Medicare SSP. CHS has partnered with 34 Independent Practice Associations across the country to form Medicare SSP ACOs and provides care coordination, analytics and reporting, technology and other administrative services for the ACOs.
[7] Based on estimated 25% ratio quoted by Vicki Loner of OneCareVermont in email message to SBesio, April 7, 2014
[8] PCP Statewide total from Paul Harrington, Vermont Health Care Reform Update, Health*first* Annual Meeting, November 2, 2013

VERMONT MEDICAID SHARED SAVINGS PROGRAM (VMSSP)								
ACO Name	**Start Date in Program**	**Geographic Area**	**ACO Network Participants[9, 10] (Participants with attributed lives)**	**ACO Network Affiliate Participants[9] (Participants without attributed lives)**	**ACO Shared Savings Distribution with Provider Network[11]**	**Estimated Medicaid Attributed Lives**		
						# and % of Total VT Medicaid Enrollees (Total N= 153,315)[12]	# and % of VT VMSSP Eligible Enrollees (Total N=95,000)[13]	# and % of Dual Eligibles within Attributed Lives (Total N=21,670)
Health*first* - Vermont Collaborative Physicians (VCP)	NA	NA	NA	NA	NA	NA	NA	NA
OneCare Vermont (OCV)	Jan 1, 2014	Statewide	• 2 Academic Medical Centers (FAHC and DHMC) • All but 2 other VT hospitals • Brattleboro Retreat • 0 Federally Qualified Health Centers (FQHCs) • 3 Rural Health Centers • 300+ Primary Care Physician FTEs • Most of VT Specialty Care Physicians	• 22 of 40 Skilled Nursing Facilities • All but one Home Health and Hospice Agency • All Designated Mental Health, Developmental Services (DS) and Substance Abuse Agencies o Exceptions: 1 of 4 DS Specialized Service Agencies	• 90% of shared savings distributed to OCV **Network Participants and Affiliates**; 10% retained by OCV • Provider amount depends on reporting and performance metrics	20,000 13%	20,000 21%	0
Community Health Accountable Care (CHAC)	Jan 1, 2014	13 of 14 Counties (with sites in or significant service to all counties except Bennington)	9 FQHCs and Bi-State Primary Care Association - 49 FQHC practice sites - 233 Primary Care Providers	Network under development. Anticipated to include: • Home Health and Hospice • Area Agencies on Aging • Community Mental Health Centers • One or more Hospitals	Distribution methodology to be determined.	# TBD Data being analyzed by DVHA and CHAC Expected Range: 12,000 - 24,000[14] 8% - 16%	# TBD Data being analyzed by DVHA and CHAC Expected Range: 12,000-24,000 13% - 25%	0
TOTALS			~533Primary Care Providers → **~84% of 634 Primary Care Providers statewide[15]**			At least 32,000 **At least 21% of all VT Medicaid enrollees**	At least 32,000 **At least 34% of all VMSSP Eligible enrollees**	0 **0% of all VT Dual Eligibles**

[9] Current Network Participants and Network Affiliates as of April, 2014; may change over time

[10] ACO Participants can only be in the network of one ACO because they could have lives attributed to them to calculate Medicaid performance and savings; outcomes for each "life" can only relate to a single ACO.

[11] Under the Medicaid SSP, ACOs must meet a minimum savings rate (MSR) to qualify for savings (which is calculated based on # of attributed lives in the ACO); once this MSR is met, ACOs are eligible to receive up to 50% of the Medicaid savings; Actual amount of savings an ACO can receive is determined by ACOs performance regarding reporting on and meeting quality metrics

[12] Based on DVHA SFY'15 Budget Document Insert 2, using SFY '14 BAA enrollment figures; excludes Pharmacy Only Programs and VHAP ESI, Catamount, ESIA, Premium Assistance For Exchange Enrollees < 300%, and Cost Sharing For Exchange Enrollees < 350% (i.e., all programs that financially assist individuals to enroll in commercial products)

[13] Number provided in DVHA's VMSSP RFP; the following populations are excluded from being considered as attributed lives: Individuals who are dually eligible for Medicare and Medicaid; Individuals who have third party liability coverage; Individuals who are eligible for enrollment in Vermont Medicaid but have obtained coverage through commercial insurers; and Individuals who are enrolled in Vermont Medicaid but receive a limited benefit package.

[14] 12,000 is based on DVHA's 12/2013 estimate for 7 FQHCs in CHAC VMSSP initial network; 24,000 is 62% of the 9 FQHC's total 40,000 unduplicated annual Medicaid patients, where 62% represents the percentage of Total VT Medicaid Enrollees that are VT VMSSP Eligible Enrollees)

[15] PCP Statewide total from Paul Harrington, Vermont Health Care Reform Update, Health*first* Annual Meeting, November 2, 2013

COMMERCIAL SHARED SAVINGS PROGRAM (XSSP) – Blue Cross Blue Shield of Vermont (BCBS-VT) and MVP Health Care (MVP)								
						Estimated Commercial Plan Attributed Lives		
ACO Name	**Start Date in Program**	**Geographic Area**	**ACO Network Participants[16] (Participants with attributed lives)**	**ACO Network Affiliate Participants[15] (Participants without attributed lives)**	**ACO Shared Savings Distribution with Provider Network[17]**	# and % of Total VT Commercial Plan Enrollees (Total N=155,479)[18]	# and % of VT XSSP Eligible Enrollees (Total N=70,000)[19]	# and % of Dual Eligibles within Attributed Lives (Total N=21,670)
Health*first* - - Vermont Collaborative Physicians (VCP)	Jan 1, 2014 ***(Not in MVP XSSP)***	Statewide	• 69 Physicians - 24 Primary Care Practices	Committee working on Collaborative Care Agreements (CCAs) with practitioners, including: • Specialists • Other specific entities (e.g., Visiting Nurses Association)	• **PCP**'s to retain the majority of shared savings • VCP to retain a portion for administration and reserves • Collaborative Care Agreements (CCAs) will specify responsibilities of **CCA Practitioners** in order to share in these savings, including patient and network engagement	TBD Health Plan has not as yet provided attribution	TBD Health Plan has not as yet provided attribution	0
OneCareVermont (OCV)	Jan 1, 2014 ***(In both BCBS-VT and MVP XSSP)***	Statewide	• 2 Academic Medical Centers (FAHC and DHMC) • All but 3 other VT hospitals • Brattleboro Retreat • 1 FQHC • 2 Rural Health Centers • 300+ Primary Care Physician FTEs • Most of VT Specialty Care Physicians	• 23 of 40 Skilled Nursing Facilities • All but two Home Health and Hospice Agencies • All Designated Mental Health, Developmental Services (DS) and Substance Abuse Agencies o Exceptions: 1 DS-only Agency and the 4 DS Specialized Service Agencies	• 90% of shared savings distributed to OCV **Network Participants**; 10% retained by OCV • Separate Incentive Plan Provision for OCV **Network Affiliates** • Both depend on reporting and performance metrics	30,000 19%	30,000 43%	0
Community Health Accountable Care (CHAC)	Jan 1, 2014 ***(In BCBS-VT; anticipated to be in MVP XSSP)***	12 of 14 Counties (with sites in or significant service to all counties except Bennington and Lamoille)	8 Federally Qualified Health Centers (FQHCs) and Bi-State Primary Care Association - 45 FQHC practice sites - 218 Primary Care Providers	Network under development. Anticipated to include: • Home Health and Hospice • Area Agencies on Aging • Community Mental Health Centers • One or more Hospitals	Distribution methodology to be determined.	# TBD Data still being by Health Plan and CHAC	# TBD Data still being analyzed by Health Plan and CHAC	0
TOTALS			~587 Primary Care Providers → **~ 93% of 634 Primary care Providers statewide[20]**			At least 30,000 **At least 19% of all VT Commercial Plan enrollees**	At least 30,000 **At least 43% of all VT XSSP Eligible enrollees**	0 **0% of all VT Dual Eligibles**

[16] Current Network Participants and Network Affiliates as of April, 2014; may change over time

[17] Under the Commercial SSP, ACOs can receive up to 25% of savings achieved between the expected amount and the minimum savings rate (MSR) (which is calculated based on # of attributed lives in the ACO), and up to 60% of their savings if they exceed the MSR, with a maximum savings of 10% of their expected expenditures. Actual amount of savings an ACO can receive is determined by ACOs performance regarding reporting on and meeting quality metrics

[18] Vermont residents covered in Private Insurance Market, 2012; Source: 2011 Vermont Health Care Expenditure Analysis, Green Mountain Care Board, page 14.
[19] The XSSP eligible population for attribution to an ACO includes individuals who have obtained their commercial insurance coverage through products available on the VT Health Connect Exchange (obtained through the exchange website or directly from the insurer.
[20] PCP Statewide total from Paul Harrington, Vermont Health Care Reform Update, Health*first* Annual Meeting, November 2, 2013

ACO Governance and Advisory Structure

ACO	Governing Body	Formal Advisory Groups
Health*first* - Accountable Care Coalition of the Green Mountains (ACCGM)	ACCGM Management Committee: Comprised of physician participants, Executive Director and Medicare beneficiary. This committee meets quarterly. The ACCGM Management Committee governs the affairs of ACCGM and has broad authority to act on behalf of and execute the functions of the ACO.	Care Coordination and Quality Improvement Sub-Committee: Comprised of Physician Participants, Executive Director and Clinical Manager of ACCGM. Committee meets quarterly to review clinical data and make recommendations to the Management Committee for implementation of policies and programs. Compliance and Clinical Implementation Committee: Comprised of participating practice administrators, Executive Director, Clinical Manager and Network Administrator. This committee meets every other month and reviews compliance and operational aspects of the ACO. Recommendations are made to the Management Committee for adoption/approval.
Health*first* - - Vermont Collaborative Physicians (VCP)	VCP Management Committee: Comprised of physician participants, Executive Director and consumer representative. This committee will meet quarterly and will govern the affairs of VCP.	VCP Clinical Quality and Care Coordination Committee: VCP will implement a Clinical Quality and Care Coordination Committee responsible to the Management Committee for: (1) performance monitoring and improvement; (2) care management and coordination; and (3) protocol adaptation and implementation.
OneCare Vermont (OCV)	The OCV Governing Body includes a beneficiary representative from each of the three Shared Savings Programs, and representatives of the ACO hospitals, physicians and other OCV network providers, including mental health and substance abuse providers and post-acute and long-term care and support services providers.	Clinical Advisory Board (CAB): Comprised of OCV physicians and other providers from across Vermont representing expertise appropriate to the attributed beneficiaries (the CAB membership is expanding to include additional providers and specialties to reflect the needs of the broader Medicaid and Commercial populations). Consumer Advisory Group: Will be comprised of representatives from communities served by OCV. Group will meet at least quarterly, with reports from the meetings shared at OCV board meetings. Purpose of the Consumer Advisory Group is to ensure consumer's input and comments are heard, considered, and reported to OCV's board.
Community Health Accountable Care (CHAC)	The CHAC Board includes a beneficiary representative from each of the three Shared Savings Programs, a representative from each FQHC and a representative from Bi-State. Seats are open for representation from a hospital, from behavioral health, and from long-term support services. There are two additional at large seats.	The Clinical Committee is responsible for producing clinical guidelines to be used in the care of CHAC patients as well as a network annual quality improvement plan, which prioritizes areas where CHAC overall could improve its performance against its own clinical standards and guidelines as well as against Shared Savings Program goals. The Clinical Committee is also responsible for conducting quarterly performance updates. The Beneficiary Engagement Committee serves to engage additional beneficiary input into the design of CHAC programs and strategies. The Beneficiary Engagement Committee will seek input from a broader set of CHAC beneficiaries than are able to sit on the Governing Board, and will review all feedback from beneficiaries and representatives of beneficiaries in order to make recommendations to the Governing Board about how to best ensure that patients are represented in CHAC's decision making.

Additional Descriptive Information about the Shared Savings Programs that is Similar across all ACOs

	Medicare SSP	Medicaid SSP	Commercial SSP
Benefits Included in Cost Calculations for Shared Shavings between SSP and ACO	Generally comparable to Medicare Part A and Part B services	All 3 years—Services include inpatient hospital, outpatient hospital, professional services, ambulatory surgery center, clinic, federally qualified health center, rural health center, chiropractor, independent laboratory, home health, hospice, prosthetic/orthotics, medical supplies, durable medical equipment, emergency transportation, dialysis facility; Optional for year 2 and required for year 3—Pharmacy, dental, personal care, non-emergency transportation, and services administered by state agencies (Mental Health; Alcohol and Drug Abuse; Disabilities, Aging and Independent Living; Children and Families; and Education), including services of the Designated Agencies and Specialized Services Agencies	Most benefits offered through exchange insurance plans, with the following exceptions: 1 Services that are carved out of the contract by self-insured employer customers: • prescription (retail) medications [potential inclusion in the context of shared (upside and downside) risk in Year 3 following VHCIP Payment Models Work Group discussion] 2 Dental benefits (the exclusion of dental services will be re-evaluated after the Exchange becomes operational and pediatric dental services become a mandated benefit).
Risk Profile	Upside Risk Only for 3 Years, with Up and Downside Risk starting Year 4 if the ACO decides to continue in the Program	Upside Risk Only for 3 Years; silent regarding future Years	Upside Risk Only for 2 Years; Upside and Downside risk in Year 3; silent regarding future Years
Quality Measures which ACOs must meet to Share in Savings	33 Measures Year 1: Only must report on measures Years 2 and 3: Must report on some measures and meet defined performance metrics on others	29 Measures, 22 Others pending Years 1 - 3: Must report on some measures and meet defined performance metrics on others	29 Measures, 22 Others pending Years 1 - 3: Must report on some measures and meet defined performance metrics on others

ACRONYMS

ACCGM:	Accountable Care Coalition of the Green Mountains
ACO:	Accountable Care Organization
BAA:	Budget Adjustment Act
BCBS-VT:	Blue Cross Blue Shield of Vermont
CCA:	Collaborative Care Agreements
CHAC:	Community Health Accountable Care
CHS:	Collaborative Health Systems
DA:	Designated Agency
DHMC:	Dartmouth-Hitchcock Medical Center
DS:	Developmental Services
DVHA:	Department of Vermont Health Access
ESI:	Employer-Sponsored Insurance
ESIA:	Employer-Sponsored Insurance Assistance
FAHC:	Fletcher Allen Health Care
FQHC:	Federally Qualified Health Center
FTEs:	Full-time Equivalents
MH:	Mental Health
MSR:	Minimum Savings Rate
MSSP:	Medicare Shared Savings Program
MVP:	MVP Health Care
NA:	Not Applicable
OCV:	OneCareVermont
SSA:	Specialized Service Agency
SSP:	Shared Savings Program
TBD:	To Be Determined
VCP:	Vermont Collaborative Physicians
VHAP:	Vermont Health Access Program
VMSSP:	Vermont Medicaid Shared Savings Program
VT:	Vermont
XSSP:	Commercial Shared Savings Program

Attachment 3 - DLTSS Work Group Questions/ Answers Regarding ACOs

DLTSS Work Group
Questions/Answers Regarding ACOs
April 29, 2014

1. *What is a Shared Savings Program?*
   A Shared Savings Program (SSP) is a performance-based contract between a payer and provider organization that sets forth a value-based program to govern the determination of sharing of savings between the parties. There are three SSPs operating in Vermont: the Medicare SSP (MSSP), the Vermont Medicaid SSP (VMSSP), and the Vermont Commercial SSP (XSSP). Within these SSPs, each of the payers (i.e., Medicare, Medicaid, and Commercial Plans) contract with one or more of the Accountable Care Organizations (ACOs) in Vermont.

2. *What is an Accountable Care Organization* (*ACO)?*
   An ACO is a legal entity comprised of providers of health care services that agree to work together to be accountable for the quality, cost and overall care of "attributed lives". Under the SSP, an ACO cannot restrict provider choice or access, nor place providers on a budget.
   There are three ACOs in Vermont:
   - Community Health Accountable Care (CHAC)
   - Health*first* - Accountable Care Coalition of the Green Mountains (ACCGM) and Vermont Collaborative Physicians (VCP)
   - OneCareVermont (OCV)

3. *What are "attributed lives"?*
   Attributed lives are beneficiaries who are assigned to an ACO in accordance with the Shared Savings Program (SSP) Standards and whose cost of care is calculated in the Shared Savings calculation performed under those Standards. Details of the mechanisms used for attribution differ across the three SSPs. However, in general, beneficiaries are assigned to ACOs based on where they receive primary care services during the most recent 12 months (and 24 months for the Commercial SSP). Beneficiaries are assigned to ACOs that serve the most of the beneficiaries' primary care services. Since not all primary care providers are part of an ACO network, some Vermonters may not have their cost of care included in an SSP.

4. *What are the "Standards"?*
   "Standards" means the set of written standards and guidelines that govern the SSP. Standards for the Medicare SSP were developed by the federal government. Standards for the Vermont Medicaid and Commercial SSPs were developed by a multi-stakeholder working group and approved by the Green Mountain Care Board.

5. *Who is an ACO Participant?*
   An ACO Participant is an individual or group of ACO providers/suppliers that is identified by a Medicare/Medicaid/Insurer enrolled provider number, that alone or together with one or more other ACO participants comprises the ACO, and that is included on the list of ACO participants required to be submitted as part of an ACO program. An ACO participant bills Medicaid/Medicare/Commercial Insurer for services through its Medicaid/Medicare/Insurer enrolled provider number.

6. *What is the difference between an "ACO Participant" and an "ACO Provider"?*
   Within the Medicaid SSPs, an ACO Provider/Supplier is an individual or entity that is a Medicaid provider or supplier enrolled in Medicaid and bills for services under an ACO Participant Medicaid provider number. For example, a large group practice may qualify as an ACO Participant (comprising the ACO). A Medicaid enrolled physician billing under the practice Medicaid provider number would be an ACO Provider/Supplier.

7. *Who are the ACO Affiliates and which ones have signed agreements with the ACOs?*
   Please see the "Vermont SSP ACO Table" for a description of ACOs' relationships with other providers.

8. *Is it possible that a given provider may have to sign multiple contracts with multiple ACOs? (3 Medicare ACOs, 2 Medicaid ACOs, and 4 Commercial ACOs) And would that provider also continue serving people who are not attributed to any ACO?*
   Currently in Vermont, there are 9 SSP Agreements between ACOs and the SSP payers:

   1. OneCare – Medicare SSP
   2. CHAC – Medicare SSP
   3. Health*first* ACCGM – Medicare SSP
   4. OneCare – Medicaid SSP
   5. CHAC – Medicaid SSP
   6. OneCare - Commercial BC/BS SSP
   7. CHAC - Commercial BC/BS SSP
   8. Health*first* VT Collaborative Physicians - Commercial BC/BS SSP
   9. OneCare - Commercial MVP SSP

Please see the "Vermont SSP ACO Table" for a description of ACOs by payer, ACOs' relationships with other providers, and the estimated percent of attributed lives.

Within each SSP, providers that have attributed lives can only sign contracts with one ACO. All other providers can sign contract agreements with multiple ACOs. Providers also continue to serve people who are not attributed to an ACO.

9. *Can a beneficiary who is attributed to an ACO opt-out?*
   In all three SSPs, ACOs must ensure that the beneficiary has been notified that his/her provider is a participant in the SSP and allow the beneficiary to opt-out of the payer sharing his/her medical claims data with the ACO. However, even if beneficiaries opt out, it will not impact their assignment to an ACO for purposes of calculating the ACO's Total Cost of Care and potential savings.

10. *How does "Shared Savings" work?*
    ACOs are eligible to share in the savings if the actual "Total Cost of Care" for attributed lives is less than the expected total cost of care in a given year. The amount of shared savings the ACO will receive depends on 1) how the savings adheres to the SSP-defined "Minimum Savings Rate", and 2) how they perform regarding quality and performance measures. Please see the "Vermont SSP ACO Table" for specific SSP shared savings methodologies.

11. *Are there preconditions on how Shared Savings can be spent by ACOs?*
    The Medicare SSP only allows ACOs to share their Medicare savings with ACO eligible practitioners (i.e., hospitals, medical physicians and other clinicians, a subset of critical access hospitals, rural health clinics and federally qualified health clinics). ACOs participating in the Vermont Medicaid and Commercial SSPs are required to share their written plan for distribution of any earned shared savings with the State each year. For more detail on how savings are shared, please see the "Vermont SSP ACO Table".

12. *Will ACOs share savings with DLTSS providers?*
    Please see the "Vermont SSP ACO Table" for a description of ACOs' relationships with providers.

13. *When would DLTSS services be included in the Medicaid ACOs' Total Cost of Care?*
    Under the Medicaid SSP, the State has the option to expand the Total Cost of Care (TCOC) beginning in Year 2 (January 1, 2015) of the program. ACOs will have the option to adopt the expanded TCOC in Year 2 and will be mandatory beginning in Year 3 (January 1, 2016). Medicaid will seek recommendations from

VHCIP Work Groups prior to adopting the expanded TCOC definition—which could include DLTSS or other specialized services.

14. *What protections are in place to ensure ACO savings are not realized through a reduction in necessary and effective DLTSS services?*
As part of Medicaid's Monitoring and Evaluation (M&E) Plan, Medicaid will monitor utilization of all services for attributed beneficiaries. An increasingly robust set of quality and performance metrics will also be collected during the course of the SSPs, including patient satisfaction, which will help guard against negative unintended consequences. Finally, calls to the call center and appeals and grievances also will be monitored.

    Given that effective community-based DLTSS can help reduce unnecessary acute events such as hospitalizations and emergency room visits, it is possible that there may be an increased demand for these effective, community-based services.

15. *How will the proposed DLTSS Model of Care elements be incorporated into the Care Models and Care Management Work Group standards? What is the process by which the VHCIP Care Models and Care Management standards will be adopted by the Medicaid and Commercial SSP ACOs, given the Medicaid ACO contracts state that AHS will cooperate with the Care Model developed by the ACOs? (See contract language below.) How can stakeholders and beneficiaries be assured the ACOs' Models of Care abide by Federal and State mandates, regulations and guidelines?*

    The ACOs must comply with Federal and State mandates, regulations and guidelines as described in the section below. The VHCIP Care Models/Care Management (CM/CM) Work Group is in the process of developing recommendations for updated SSP CM/CM Standards as well, which includes a DLTSS Work Group presentation on the Model of Care recommended by that group for DLTSS services.

    The Medicaid SSP contracts between DVHA and the ACOs state the following (Section VI. Care Management Standards, C, page 22 of both the OneCare and CHAC Medicaid ACO Contracts):

    > "Any AHS employee and/or contractor who provides care coordination services to Medicaid eligible persons shall, to the best of his/her ability, and so long as it is consistent with AHS programs or procedures and with Medicaid's legal obligations, cooperate with the Clinical Model or Care Model developed by the ACO. Should there be a conflict between the ACO's Clinical Model or Care Model and AHS programs or procedures, AHS employees and contractors shall cooperate with and implement the Clinical Model or Care Model of the

ACO for a mutually agreeable time frame. DVHA and AHS acknowledge that this cooperation is critical to ACO in order to meet the quality, patient experience and financial performance thresholds under this Agreement. In the event of a dispute regarding the Clinical Model or Care Model, the parties may invoke the Dispute Resolution process set forth in Section 5 of Attachment A."

The Medicaid SSP OneCare contract (page 8) and CHAC contract (page 7) both state:

" 6.2 The Parties intend, at a minimum, to amend this Agreement for Performance Years 2 and 3 to maintain its consistency with any changes to relevant standards adopted by the Vermont Health Care Innovation Project (VHCIP). Any such amendments must be mutually agreed to by the Parties in writing."

These questions have also been posed to the VHCIP Core Team for further discussion and guidance.

16. *How will ACOs address beneficiary engagement?*

The "Governance" section of the Medicaid SSP contracts between DVHA and the ACOs includes the following provisions:

D. 2. 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 the Contractor's activities;

D. 4. Post summaries of Contractor activities provided to the Contractor's consumer advisory board on the ACO's website.

G. The Contractor's governing body must include at least one consumer member who is a Medicaid beneficiary. Regardless of the number of payers with which the Contractor participates, there must be at least two consumer members on the Contractor governing body. Consumer members shall have some prior personal, volunteer, or professional experience in advocating for consumers on health care issues. The Contractor's governing board shall consult with advocacy groups and organizational staff in the recruitment process for the consumer member. The Contractor shall not be found to be in non-conformance with this provision if the Contractor has in good faith recruited the participation of qualified consumer representatives to its governing body on an ongoing basis and has not been successful.

H. The Contractor must have a regularly scheduled process for inviting and considering consumer input regarding ACO policy, including but not limited to a consumer advisory board with membership drawn from the community served by the Contractor, including patients, their families, and caregivers. The consumer advisory board must meet at least quarterly. Members of the Contractor's

management and the governing body must regularly attend consumer advisory board meetings and report back to the Contractor's governing body following each meeting of the consumer advisory board. Other consumer input activities shall include but not be limited to hosting public forums and soliciting written comments. The results of other consumer input activities shall be reported to the ACO's governing body at least annually.

17. *How will the DLTSS quality and performance measures be used and how will they relate to payment reform?*
    The DLTSS Work Group will recommend DLTSS-related quality and performance measures to the VHCIP Quality and Performance Measures Work Group to be considered for inclusion in the performance and reporting measures required in the Medicaid and Commercial SSPs. It is also important to note that dual eligible individuals, and others aged 65+ are included in the Medicare SSP, and therefore, the Medicare SSP includes more measures appropriate for this population than currently included in the Medicaid or Commercial SSPs.

18. *Will dually eligible individuals be part of the ACOs?*
    At least 64% of the 22,000 dually eligible Vermonters will be attributed to one of the three Medicare Shared Savings ACOs. However, no dually eligible individuals will be attributed to the two Medicaid SSP ACOs because these individuals are excluded from the Medicaid SSP.

19. *Dually eligible individuals are carved out of the Vermont Medicaid SSP; as a result, the Medicare SSP ACOs are not responsible for the Medicaid costs of their attributed dually eligible individuals. What mechanisms will the State develop to prevent Medicare SSP ACOs from shifting costs to Medicaid for those attributed individuals who are dually eligible?*
    As part of the State's M&E plan, it will monitor changes in resource use for this population to identify unexpected or higher trends in utilization of Medicaid services. Also, since there are no changes to eligibility requirements for programs like Choices for Care, programs like these would continue to serve beneficiaries based on demonstrated need.

20. *Given items #18 and #19 above, how will the State ensure integrated care across all needs for dually eligible individuals, especially those who are high use/high need?*
    One goal of all the SSPs is to foster more collaboration and integration across the medical and DLTSS communities. The CM/CM Work Group is developing Model of Care (MOC) guidelines for the Medicaid and Commercial SSPs, which should include a focus on people with DLTSS needs. It is hoped that all providers

in Vermont will adopt the same MOC for individuals who are dually eligible, regardless of whether they are in a SSP.

21. *What happens to people who are not attributed to an ACO?*
Individuals who are not attributed to an ACO will receive care as they normally do.

22. *Are there circumstances where a person attributed to a Medicaid ACO may receive a different set of Medicaid services than someone who is not attributed to a Medicaid ACO? For example, a dually eligible beneficiary in the Choices for Care Program will not be part of a Medicaid ACO and will receive customary Waiver services while an ACO attributed Medicaid-only Choices for Care participant would be subject to the ACO's care model standards. Will this make Vermont vulnerable to potential law suits?*
Attribution to the program does not change any beneficiaries' access to services. A dually eligible beneficiary who qualifies for CFC would continue to have the same access to services as a beneficiary attributed to an ACO.

23. *Is "informed consent" required of individuals in order to share their clinical data with Vermont's data warehouses? Are people required to "opt in" or is it simply an "opt out" option? What is "Global Consent" and how does it work*
As noted in the response to Question #9, beneficiaries are allowed to opt-out from the SSP payer sharing his/her medical claims data with an ACO. Generally speaking, consent is required before a person's protected health information (PHI) can be shared or exchanged between or among providers. A growing number of providers in VT have established agreements (called Business Associates Agreements) with VITL that allows for the sending of patient records to the Vermont Health Information Exchange (VHIE). In this instance, VITL acts as an extension of a provider and each provider's PHI is stored in a separate and secure place in the VHIE (think of separate vaults). Except for a few pilot projects, this is the current situation at VITL and each provider has access only to PHI from their own organization. Starting in June, VITL will begin rolling out a new provider portal called VITL Access that will allow providers, with appropriate patient consent, to see or view all information that may exist in the VHIE for a person. Vermont's Patient Consent Policy requires providers to gather or affirm consent before a person's PHI can be shared or viewed broadly across the VHIE – this is often referred to as an "opt in" policy. Vermont's Policy specifies a "global" opt in, which means that a person consents (or not) globally across all providers; it is not possible to allow consent for some providers and not others. A person may give or revoke consent at any time.

One important exception to all of the above is that it does not apply to substance abuse treatment providers who are covered under 42 CFR Part 2 of the federal regulations. How these federal requirements apply to the electronic exchange of PHI is unfortunately complicated and unclear. However, the State and VITL have recently started a significant project to work through the legal and technical issues related to Part 2 programs and hope to implement solutions within the next 6-12 months. These solutions will likely require changes to VT's Consent Policy before they will be implemented.