Measures Across Programs and Years Handout

Distributed to the SIM Steering Committee
August 22, 2013

SUBJECT TO CHANGE PER WORK GROUP RECOMMENDATIONS

Domain 1: Care Coordination/ Patient Safety (3 measures)

	Measure	Type of Data	Program	Year 1	Year 2	Year 3
1	Plan All-Cause Readmission	Claims	Comm.	Payment	Payment	Payment
			Medicaid	Payment	Payment	Payment
			Medicare	No	No	No
2	Risk-Standardized All-Condition Readmission	Claims	Comm.	No	No	No
			Medicaid	Reporting	Reporting	Payment
			Medicare	Reporting	Reporting	Payment
3	Rate of Hospitalization for Ambulatory Care-Sensitive Conditions: PQI Composite	Claims	Comm.	Monitoring	Monitoring	Monitoring
			Medicaid	Monitoring	Monitoring	Monitoring
			Medicare	No	No	No

SUBJECT TO CHANGE PER WORK GROUP RECOMMENDATIONS

Domain 2: Children and Adolescents (5 measures)

	Measure	Type of Data	Program	Year 1	Year 2	Year 3
4	Adolescent Well-Care Visit	Claims	Comm.	Payment	Payment	Payment
			Medicaid	Payment	Payment	Payment
			Medicare	No	No	No
5	Childhood Immunization Status (Combo 10)	Clinical data	Comm.	Reporting	Payment	Payment
			Medicaid	Reporting	Payment	Payment
			Medicare	No	No	No
6	Developmental Screening in the First Three Years of Life	Clinical data	Comm.	No	No	No
			Medicaid	Reporting	Payment	Payment
			Medicare	No	No	No
7	Follow-up Care for Children Prescribed ADHD Medication	Clinical data	Comm.	Health Systems Monitoring	Health Systems Monitoring	Health Systems Monitoring
			Medicaid	Reporting	Payment	Payment
			Medicare	No	No	No
8	Pediatric Weight Assessment and Counseling	Clinical data	Comm.	Reporting	Payment	Payment
			Medicaid	Reporting	Payment	Payment
			Medicare	No	No	No

SUBJECT TO CHANGE PER WORK GROUP RECOMMENDATIONS

Domain 3: Chronic Conditions; COPD (1 measure)

	Measure	Type of Data	Program	Year 1	Year 2	Year 3
9	Ambulatory Care-Sensitive Conditions Admissions: Chronic obstructive pulmonary disease (PQI 5)	Claims	Comm.	Monitoring	Monitoring	Monitoring
			Medicaid	Reporting	Payment	Payment
			Medicare	Reporting	Payment	Payment

SUBJECT TO CHANGE PER WORK GROUP RECOMMENDATIONS

Domain 4: Chronic Conditions; CVD (5 measures)

	Measure	Type of Data	Program	Year 1	Year 2	Year 3
10	Ambulatory Care-Sensitive Conditions Admissions: Heart Failure	Claims	Comm.	No	No	No
			Medicaid	Reporting	Payment	Payment
			Medicare	Reporting	Payment	Payment
11	Coronary Artery Disease (CAD) Composite	Clinical data	Comm.	Pending	Pending	Pending
			Medicaid	Reporting	Reporting	Payment
			Medicare	Reporting	Reporting	Payment
12	Heart Failure: Beta Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)	Clinical data	Comm.	No	No	No
			Medicaid	Reporting	Reporting	Payment
			Medicare	Reporting	Reporting	Payment
13	Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control (<100 mg/dL)	Clinical data (LDL Screening only is Claims)	Comm.	Payment (Use LDL Screening only)	Payment (TBD which measure)	Payment (TBD which measure)
			Medicaid	Payment	Payment	Payment
			Medicare	Reporting	Payment	Payment

SUBJECT TO CHANGE PER WORK GROUP RECOMMENDATIONS

Domain 4: Chronic Conditions; CVD (cont'd)

	Measure	Type of Data	Program	Year 1	Year 2	Year 3
14	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic	Clinical data	Comm.	No	No	Monitoring
			Medicaid	Reporting	Payment	Payment
			Medicare	Reporting	Payment	Payment

SUBJECT TO CHANGE PER WORK GROUP RECOMMENDATIONS

Domain 5: Chronic Conditions; Diabetes & Hypertension (4 measures)

	Measure	Type of Data	Program	Year 1	Year 2	Year 3
15	"Diabetes Composite (D5) (All or Nothing Scoring): Hemoglobin A1c Control (<8 percent)Low Density Lipoprotein (<100)Blood Pressure <140/90Tobacco Non Use Aspirin Use"	Clinical data	Comm.	Reporting	Decide if payment or monitoring at end of Y1	Decide if payment or monitoring at end of Y1
			Medicaid	Reporting	Payment	Payment
			Medicare	Reporting	Payment	Payment
16	Diabetes Mellitus: Hemoglobin A1c Poor Control (>9 percent)	Clinical data	Comm.	Reporting	Payment	Payment
			Medicaid	Reporting	Payment	Payment
			Medicare	Reporting	Payment	Payment
17	Hypertension (HTN): Controlling High Blood Pressure	Clinical data	Comm.	Pending	Pending	Pending
			Medicaid	Reporting	Payment	Payment
			Medicare	Reporting	Payment	Payment
18	Screening for High Blood Pressure and follow-up plan documented	Clinical data	Comm.	Pending	Pending	Pending
			Medicaid	Reporting	Payment	Payment
			Medicare	Reporting	Reporting	Payment

SUBJECT TO CHANGE PER WORK GROUP RECOMMENDATIONS

Domain 6: Cost (1 measure)

	Measure	Type of Data	Program	Year 1	Year 2	Year 3
19	Total Cost of Care Population-based PMPM Index	Claims	Comm.	Monitoring	Monitoring	Monitoring
			Medicaid	Monitoring	Monitoring	Monitoring
			Medicare	No	No	No

SUBJECT TO CHANGE PER WORK GROUP RECOMMENDATIONS

Domain 7: Chronic Conditions; Elderly & Disabled (3 measures)

	Measure	Type of Data	Program	Year 1	Year 2	Year 3
20	Falls: Screening for Future Fall Risk	Claims/ Registry	Comm.	No	No	No
			Medicaid	Reporting	Payment	Payment
			Medicare	Reporting	Payment	Payment
21	Medication Reconciliation	Clinical data	Comm.	No	No	No
			Medicaid	Reporting	Reporting	Reporting
			Medicare	Reporting	Payment	Payment
22	Pneumococcal Vaccination for Patients 65 Years and Older	Clinical data	Comm.	No	No	No
			Medicaid	Reporting	Payment	Payment
			Medicare	Reporting	Payment	Payment

SUBJECT TO CHANGE PER WORK GROUP RECOMMENDATIONS

Domain 8: End of Life Care (1 measure)

	Measure	Type of Data	Program	Year 1	Year 2	Year 3
23	Proportion not admitted to hospice	Clinical data	Comm.	No	No	Monitoring
			Medicaid	No	No	Monitoring
			Medicare	No	No	No

SUBJECT TO CHANGE PER WORK GROUP RECOMMENDATIONS

Domain 9: Chronic Conditions; Infrastructure (1 measure)

	Measure	Type of Data	Program	Year 1	Year 2	Year 3
24	Percent of Primary Care Physicians who Successfully Qualify for an EHR Incentive Program	Other	Comm.	No	No	No
			Medicaid	Reporting	Payment	Payment
			Medicare	Reporting	Payment	Payment

SUBJECT TO CHANGE PER WORK GROUP RECOMMENDATIONS

Domain 10: Mental Illness and Substance Abuse (4 measures)

	Measure	Type of Data	Program	Year 1	Year 2	Year 3
25	Antidepressant Medication Management	Claims	Comm.	Health Systems Monitoring	Health Systems Monitoring	Health Systems Monitoring
			Medicaid	Reporting	Payment	Payment
			Medicare	No	No	No
26	Depression Screening and Follow Up	Clinical data	Comm.	No	No	Monitoring
			Medicaid	Reporting	Payment	Payment
			Medicare	Reporting	Payment	Payment
27	Follow-up After Hospitalization for Mental Illness, 7 day	Claims	Comm.	Payment	Payment	Payment
			Medicaid	Reporting	Payment	Payment
			Medicare	No	No	No
28	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: a) Initiation, b) Engagement	Claims	Comm.	Payment	Payment	Payment
			Medicaid	Payment	Payment	Payment
			Medicare	No	No	No

SUBJECT TO CHANGE PER WORK GROUP RECOMMENDATIONS

Domain 11: Overuse (2 measures)

	Measure	Type of Data	Program	Year 1	Year 2	Year 3
29	Appropriate Testing for Children with Pharyngitis	Claims	Comm.	Monitoring	Monitoring	Monitoring
			Medicaid	Monitoring	Monitoring	Monitoring
			Medicare	No	No	No
30	Avoidance of Antibiotic Treatment for Adults With Acute Bronchitis	Claims	Comm.	Payment	Payment	Payment
			Medicaid	Payment	Payment	Payment
			Medicare	No	No	No

SUBJECT TO CHANGE PER WORK GROUP RECOMMENDATIONS

Domain 12: Pregnant Women (3 measures)

	Measure	Type of Data	Program	Year 1	Year 2	Year 3
31	Elective delivery before 39 weeks	Clinical data	Comm.	No	No	Monitoring
			Medicaid	Reporting	Payment	Monitoring
			Medicare	No	No	No
32	Frequency of Ongoing Prenatal Care	Clinical data	Comm.	No	No	No
			Medicaid	Reporting	Payment	Payment
			Medicare	No	No	No
33	Prenatal and Postpartum Care Postpartum Timeliness	Clinical data	Comm.	No	No	Monitoring
			Medicaid	Reporting	Payment	Monitoring
			Medicare	No	No	No

SUBJECT TO CHANGE PER WORK GROUP RECOMMENDATIONS

Domain 13: Preventative Care (7 measures)

	Measure	Type of Data	Program	Year 1	Year 2	Year 3
34	Adult Weight Screening and Follow-up	Clinical data	Comm.	No	No	Monitoring
			Medicaid	Reporting	Payment	Payment
			Medicare	Reporting	Payment	Payment
35	Annual Dental Visit	Claims	Comm.	No	No	No
			Medicaid	Monitoring	Monitoring	Monitoring
			Medicare	No	No	No
36	Chlamydia Screening in Women	Claims	Comm.	Payment	Payment	Payment
			Medicaid	Payment	Payment	Payment
			Medicare	No	No	No
37	Colorectal Cancer Screening	Clinical data	Comm.	Reporting	Payment	Payment
			Medicaid	Reporting	Reporting	Payment
			Medicare	Reporting	Reporting	Payment

SUBJECT TO CHANGE PER WORK GROUP RECOMMENDATIONS

Domain 13: Preventative Care (cont'd)

	Measure	Type of Data	Program	Year 1	Year 2	Year 3
38	Influenza Immunization	Clinical data	Comm.	No	No	Monitoring
			Medicaid	Reporting	Payment	Payment
			Medicare	Reporting	Payment	Payment
39	Mammography /Breast Screening	Claims	Comm.	Monitoring	Monitoring	Monitoring
			Medicaid	Reporting	Reporting	Payment
			Medicare	Reporting	Reporting	Payment
40	Tobacco Use Assessment and Tobacco Cessation Intervention	Clinical data	Comm.	No	No	Monitoring
			Medicaid	Reporting	Payment	Payment
			Medicare	Reporting	Payment	Payment

SUBJECT TO CHANGE PER WORK GROUP RECOMMENDATIONS

Domain 14: Utilization (12 measures)

	Measure	Type of Data	Program	Year 1	Year 2	Year 3
41	Acute Days/1000, aggregate and by service	Claims	Comm.	Monitoring	Monitoring	Monitoring
			Medicaid	Monitoring	Monitoring	Monitoring
			Medicare	No	No	No
42	Ambulatory surgery/1000	Claims	Comm.	Monitoring	Monitoring	Monitoring
			Medicaid	Monitoring	Monitoring	Monitoring
			Medicare	No	No	No
43	Average # of prescriptions PMPM	Claims	Comm.	Monitoring	Monitoring	Monitoring
			Medicaid	Monitoring	Monitoring	Monitoring
			Medicare	No	No	No
44	Avoidable ED visits- NYU algorithm	Claims	Comm.	Monitoring	Monitoring	Monitoring
			Medicaid	Monitoring	Monitoring	Monitoring
			Medicare	No	No	No

SUBJECT TO CHANGE PER WORK GROUP RECOMMENDATIONS

Domain 14: Utilization (cont'd)

	Measure	Type of Data	Program	Year 1	Year 2	Year 3
45	ED Utilization (ED Visits/1000 – All ED visits)	Claims	Comm.	Monitoring	Monitoring	Monitoring
			Medicaid	Monitoring	Monitoring	Monitoring
			Medicare	No	No	No
46	ED Utilization for Ambulatory Care-Sensitive Conditions	Claims	Comm.	Monitoring	Monitoring	Monitoring
			Medicaid	Monitoring	Monitoring	Monitoring
			Medicare	No	No	No
47	Generic dispensing rate	Claims	Comm.	Monitoring	Monitoring	Monitoring
			Medicaid	Monitoring	Monitoring	Monitoring
			Medicare	No	No	No
48	High-end imaging/1000	Claims	Comm.	Monitoring	Monitoring	Monitoring
			Medicaid	Monitoring	Monitoring	Monitoring
			Medicare	No	No	No

SUBJECT TO CHANGE PER WORK GROUP RECOMMENDATIONS

Domain 14: Utilization (cont'd)

	Measure	Type of Data	Program	Year 1	Year 2	Year 3
49	Inpatient Utilization - General Hospital/Acute Care	Claims	Comm.	Monitoring	Monitoring	Monitoring
			Medicaid	Monitoring	Monitoring	Monitoring
			Medicare	No	No	No
50	Primary care visits/1000	Claims	Comm.	Monitoring	Monitoring	Monitoring
			Medicaid	Monitoring	Monitoring	Monitoring
			Medicare	No	No	No
51	SNF Days/1000	Claims	Comm.	Monitoring	Monitoring	Monitoring
			Medicaid	Monitoring	Monitoring	Monitoring
			Medicare	No	No	No
52	Specialty visits/1000	Claims	Comm.	Monitoring	Monitoring	Monitoring
			Medicaid	Monitoring	Monitoring	Monitoring
			Medicare	No	No	No

SUBJECT TO CHANGE PER WORK GROUP RECOMMENDATIONS

Domain 15: Patient/Caregiver Experience[1] (9 measures)

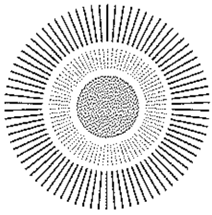
	Measure	Type of Data	Program	Year 1	Year 2	Year 3
53	Access to Care Composite	Survey	Comm.	TBD	TBD	TBD
			Medicaid	Reporting	Payment	Payment
			Medicare	Reporting	Payment	Payment
54	Communication Composite	Survey	Comm.	TBD	TBD	TBD
			Medicaid	Reporting	Payment	Payment
			Medicare	Reporting	Payment	Payment
55	Shared Decision-Making Composite	Survey	Comm.	TBD	TBD	TBD
			Medicaid	Reporting	Payment	Payment
			Medicare	Reporting	Payment	Payment
56	Self-Management Support Composite	Survey	Comm.	TBD	TBD	TBD
			Medicaid	Reporting	Payment	Payment
			Medicare	N/A	N/A	N/A

[1]On August 19th the Patient experience subgroup finalized the recommendation of **nine composites** from the PCMH CAHPS survey for use in the commercial quality measures set. This recommendation will be taken to the Measures work group on August 26th for review. MSSP utilizes **seven composites** from the National Implementation Survey tool in its measures set. Although the survey tools and questions are different, there is general alignment around: Access, Communication, Shared Decision Making, and Specialists (MSSP composites not utilized are: Patient rating of provider, health promotion and education, and health status/functional status).

SUBJECT TO CHANGE PER WORK GROUP RECOMMENDATIONS

Domain 15: Patient/Caregiver Experience (cont'd)

	Measure	Type of Data	Program	Year 1	Year 2	Year 3
57	Comprehensiveness Composite	Survey	Comm.	TBD	TBD	TBD
			Medicaid	Payment	Payment	Payment
			Medicare	N/A	N/A	N/A
58	Office Staff Composite	Survey	Comm.	TBD	TBD	TBD
			Medicaid	Payment	Payment	Payment
			Medicare	N/A	N/A	N/A
59	Information Composite	Survey	Comm.	TBD	TBD	TBD
			Medicaid	Payment	Payment	Payment
			Medicare	N/A	N/A	N/A
60	Coordination of Care Composite	Survey	Comm.	TBD	TBD	TBD
			Medicaid	Payment	Payment	Payment
			Medicare	N/A	N/A	N/A
61	Specialist Composite	Survey	Comm.	TBD	TBD	TBD
			Medicaid	Reporting	Payment	Payment
			Medicare	Reporting	Payment	Payment



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August 21, 2013

Kara Suter
Director of Payment Reform
Department of Vermont Health Access
312 Hurricane Lane, Suite 201
Williston, Vermont 05495

Dear Ms. Suter:

I am writing to provide input on the presentation you made on Monday, August 5, 2013 of Medicaid's proposed ACO Shared Savings Program ("SSP") made to the "ACO Standards" work group, which is being transitioned into the State Innovation Model (SIM) Grant work group on payment reform models. I have conferred with the leadership of both the Vermont Association of Hospitals and Health Systems ("VAHHS") and the Vermont Medical Society ("VMS"), and both have expressed full support of the feedback contained in this letter, but reserve their right for independent input on the program.

I understand that DVHA will publish an upcoming Request for Proposal ("RFP") based on the proposed model and input received. I also understand that the SIM Steering Committee meeting on Thursday, August 22, 2013 will feature a discussion on the Medicaid SSP, which includes a new supporting program document entitled "Compilation of Pilot Standards". After review of that document and any additional information provided at the meeting, additional feedback may be forthcoming.

First, I want to express my strong support for your general approach of making the potential Medicaid Shared Savings program highly consistent with, and in many ways fully mirroring other population-based accountable care programs including the Medicare Shared Savings Program, and the emerging Vermont Commercial Exchange Shared Savings Program. I believe your approach as presented was familiar in terms, concepts, and philosophy. This will allow providers in ACOs to design common clinical approaches and supporting systems and technology across the populations we serve based on healthcare needs, rather than which plan, program, or payer for which individuals are members or beneficiaries. Of course, we fully acknowledge that customized programs focused on the needs of specific patient populations based on unique challenges and needs must be a part of our approach.

I am also pleased that based on recent discussions with both the VAHHS Board, which includes CEOs of VAHHS-participating hospitals all of which are participants in the OneCare Vermont ACO, and the OneCare Vermont Board of Managers, representing founders Fletcher Allen Health Care and Dartmouth-Hitchcock Health plus other network participants, we have seen strong interest in continued engagement around a multi-payer ACO model which could be appropriate for OneCare Vermont. It is clearly an important step to take OneCare beyond the Medicare Shared Savings Program, and support of most or all of its current participants will be essential. OneCare and its hospital participants are open to submitting a response to a Medicaid RFP for an ACO Shared Savings Program beginning on January 1, 2014, but we will need to carefully assess the program included in the coming RFP in conjunction with our network leaders and the OneCare Vermont Board.

At this time, I wish to comment on a few aspects of your presentation and proposed model, many of which will be subject to further assessment when additional details are developed and in broader consultation with the OneCare provider network. My comments on the presentation and model are as follows:

1) **Attribution Model** – Your attribution proposal appears to be a rational initial approach balancing many complexities, but we would encourage both near term and longer term assessment and flexibility. In the short term, we would like to see some attribution test-runs for interested ACOs during the RFP consideration process. This will help both of us assess whether we are on track for the goal of having as many patients as possible attributed (within the model), and maximizing the portion of your covered population that will receive the care coordination and quality improvement focus that is the real benefit to you as a sponsor of an accountable care program. If it turns out that many patients are excluded, when in fact an ACO provider is positioned as the right attachment point for accountability, we may want to collaboratively design modifications or add tiers to the attribution query even for 2014, but certainly envision this dialogue over time as well. We specifically expect this will include a dialogue on adding a specialist physician attribution to the model.

2) **Savings Model** – In your presentation, you anticipate a 50%-50% share between Medicaid and the ACO after meeting a Minimum Savings Rate ("MSR"). You also propose mirroring the commercial downside risk introduction model. Our comments on this important topic are:

    a. We assume your proposed MSR model assumes the 50%-50% sharing goes back to dollar one of savings as with the Medicare SSP program once the MSR is eclipsed. A model in which sharing only applies to dollars of savings beyond the MSR would be very unattractive. We are open to reviewing a model where an ACO receives some share on first dollar savings even if the MSR is never met. Such tangible reward for bona fide efforts to limit cost growth and improve care coordination and quality would be a motivator to both join and make best attempts to succeed in your program. As with the emerging commercial model, the share could be much lower until the MSR is passed, and then jump up to fuller sharing at that point. However, we are prepared to accept that a Medicare-style MSR model must be Medicaid's approach, again assuming the model applies back to the first dollar of savings.

b. We strongly encourage Medicaid to offer a no downside risk track for three years, either as an option or the standard offering. The current "Track 1" Medicare SSP model has no downside risk and the same 50%-50% model with an MSR that you propose, therefore we would expect this to be a no downside risk option for the Medicaid SSP program. We would be open to reviewing a program with a more attractive sharing model that includes a commitment to downside risk, but would expect that differential would have to be very high in order to truly consider the downside risk option a feasible consideration. Our network has strongly expressed a need to "stage" the implementation of downside risk by payer. With 2016 expected to be the first year of OneCare's second three-year commitment to the Medicare SSP, we are already on track for 5% downside risk (under current CMS rules) on Medicare. The commercial shared savings model being considered seems very likely to include some material level of downside risk in its third year, which would also be 2016. Combined with the complexity of the Medicaid population, our strong suggestion is that Medicaid must offer at a track which involves no downside risk for the three year program, 2014 through 2016, with discussions to occur on a responsible introduction of fixed revenue risk for this population, no earlier than 2017.

c. We wish to have significant and detailed discussions on how the "expected" spending will be calculated and how the three year trend factor will be applied and relate to the expected spending for each year of the program. We also will want to have detailed discussions on the risk adjustment methodology and how it will factor into the expected spending and trend as applied to an individual ACO. We would desire that the expected spending levels for an ACO be calculable in advance for each performance year of the program based on initial attribution models, even if they are adjusted later based on the actual attributed population. Given the importance of targets in any shared savings model, we request that expected spending models undergo "test runs" for ACOs during the RFP consideration phase.

d. We encourage Medicaid to consider that its share of savings through this program be contributed toward remedying the Medicaid cost shift, rather than accrue to the State of Vermont general fund or be applied toward operational expenses at DVHA. We understand this would have to be reincorporated into expected spending models, as would any changes to underlying provider reimbursement during the three year program.

3) **Quality Standards** – We applaud efforts to date to embed and coordinate quality measures for the Medicaid population in a general list through the Performance Measurement Work Group. We would further encourage Medicaid and other programs to continue to envision fewer measures initially, adding over time, to ensure that ACOs have access to baseline performance, ongoing measurement at reasonable cost, and clear standards and targets for our performance. We believe that explicit goals for individual measures and overall report card performance should be set in advance. If the goal is demonstrable and consistent high quality performance across populations, then success should be envisioned as all ACOs getting full credit for high quality performance against the pre-set standards assuming they are set at achievable levels. We see this as superior to a "forced winners

and losers" model based on final performance (grading on the "curve") or through retrospective targets which demoralize an ACO in setting and attempting to meet quality performance goals, never knowing what will be "enough".

4) **Included/Excluded Costs** – We would like to comment on the inclusion in the cost per beneficiary target of dental, retail pharmacy, and transportation benefits. Although we understand the dental benefit might be of relatively small magnitude, OneCare does not have expertise in the direct management of dental service. We believe there is a dental-health component of overall health status, but would prefer to set a mutually-accepted goal of encouraging regular dental health and visits to dental professionals rather than direct accountability for that spend. On inclusion of the spend on prescription benefits through retail pharmacy claims, we would want significant information on this benefit, level of spending, and time to analyze benchmarks before agreeing to take accountability in year one. We believe a more acceptable model might be a "tracking and access to data" for the ACO in year one, with potential inclusion in the spending target pool in years two and three. For transportation benefits, along the same lines, we first (at the very least) would like to ensure a dialogue to understand the actual benefits and covered services, plus the baseline level of spend on these items before issuing final comments on whether we find this item acceptable for inclusion.

5) **ACO Network Model** – We are comfortable that it may be a requirement in the RFP that an ACO provide a plan or approach for cooperation with LTSS and MH&SA providers, which may be reviewed for success from time to time by Medicaid. We would ask that acceptable models of collaboration be flexible and non-directive, in order for ACO providers and these organizations to have freedom on creative approaches and processes to work together on behalf of Medicaid beneficiaries under the accountability incentives on spending growth and quality measurement.

6) **Operational Requirements** – Although there are few details included in your presentation, I do wish to advocate for minimal specific operational requirements or processes under the program. As expressed earlier in this letter, the vision for ACO providers is to have common processes and systems across populations and programs, while having the accountable care incentives to design specialized programs for certain patient populations where necessary. For example, in the table of "Key Program Elements", you list "Care Management Requirements" with a "TBD". We are comfortable that you anticipate this discussion in the SIM Care Management Work Group to ensure who in the system is on point for what types of patient management, but we intend to position the design and implementation of "Care Management" processes as being central to what it means for a group of providers to be an ACO.

7) **Data Release with RFP** – It would be helpful to have an actuarial breakdown of current spend for all Medicaid to-be-attributed beneficiaries, and have DVHA prepared to offer an ACO-specific provisional attribution run and actuarial spend upon request during the consideration period for responding to the RFP.

I also wish to communicate some general concerns and comments not specifically focused on the Medicaid SSP model itself.

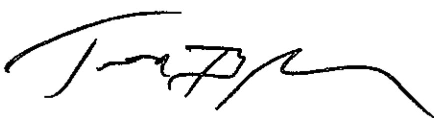
8) **ACO Operations and Technology Support** – In order to consider responding to the RFP for the Medicaid Shared Savings Program, our expectation is that SIM grant funds and/or other GMCB and State-supported financial support must be available to private ACOs including OneCare to support both core clinical and administrative operations as well as focused technologic or clinical projects implemented by ACOs in support of reform priorities. We hope that DVHA supports us in this vision, and in fact believe that responding affirmatively to the RFP of the Medicaid SSP may depend on a clear vision of operational cost support for OneCare. We acknowledge that much of this will be funded by OneCare founders and participants, but that the investments required to fully position OneCare for success must be balanced against financial needs for maintaining OneCare providers' care delivery operations through the transition of our revenue models, and while also meeting ever-increasing obligations from many other directions, such as ICD-10 and "meaningful use".

9) **DVHA Readiness –** We wish to encourage DVHA to conduct a readiness assessment to administer its obligations under the proposed program, including its claims adjudication vendor and other partners. This will include beneficiary attribution, baseline and target calculations, and ability to feed claims to ACO information systems.

10) **Future of the Medicaid SSP –** Although we are hopeful that the SIM Grant structure and workgroups will provide a forum for real discussion and decision-making, we wish to convey in our strongest terms that we envision a true joint design for whether the dually eligible population (and perhaps other populations) will over time be included in the Medicaid or Medicare Shared Savings Program and how.

In conclusion, I thank you for this initial opportunity to provide input on the design of a Medicaid SSP. I believe such a program, if designed to be attractive to willing providers and ACOs, will result in even better healthcare and public health outcomes for Vermont's Medicaid populations, while limiting avoidable cost growth. At OneCare, we look forward to continued engagement with you on this model, and will be working to ensure our statewide network of providers is kept informed about this program.

Sincerely,



Todd Moore
Chief Executive Officer
OneCare Vermont Accountable Care Organization

TM/jh

Vermont Medicaid ACO Shared Savings Program (SSP) Pilot
Compilation of Pilot Standards
Draft as of August 20, 2013

INTRODUCTION

The Vermont Medicaid Shared Savings Program (SSP) is a performance-based contract which governs the calculation and distribution of financial incentives, via shared savings, to Accountable Care Organizations (ACOs) that proactively invest in new care management programs and redesign care processes to improve the quality, efficiency and effectiveness of care delivered to Medicaid beneficiaries. The Vermont Medicaid ACO pilot will be an Agency of Human Service initiative administered by the Department of Vermont Health Access (DVHA).

One or more ACOs will be selected through a competitive bid that will be administered through DVHA's Request for Proposals (RFP) process. It is DVHA's intent to release the RFP in early September 2013 for a pilot start date of January 1, 2014. Similar to what is being proposed for the Vermont Commercial ACO pilot, the Medicaid ACO pilot will be for three years (this is also the time period used by Medicare in its ACO pilot).

To the extent that an ACO's investments generate savings for the Medicaid program, ACOs may share in a portion of the savings based on financial and quality performance. However, ACOs may also be required to repay Medicaid for shared losses. For this pilot, ACOs will have an option between two tracks. Track 1 ACOs will not agree to share downside risk, but their upside share of savings will be less than what may be earned by ACOs that agree to Track 2 which will have a downside risk share component.

DVHA has made every effort to align its standards with those defined by the Medicare SSP, the Commercial ACO Pilot, or both. In some situations, differences in the Medicaid SSP are related to the unique requirements of the Medicaid program or the attributes of the enrollees that it serves. Throughout this document, when specific standards are cited, a reference is provided in italics to indicate whether the standard is similar to either a Medicare standard or a proposed Commercial standard.

Medicaid standards for ACOs are shown in the categories shown below. These standards may change over time as ACOs gain experience and grow in terms of covered lives.

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

- Standards related to the ACO's payment methodology:
  - Patient Attribution Methodology
  - Services to be Excluded from ACO Budget Calculations
  - 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

ACO Governance

Objective: Ensure that the governance of the ACO is primarily provider driven and that the leadership team of the ACO has the ability to influence or direct clinical practice to improve outcomes.

Standards: (*summarized from the Final Rule for Medicare ACOs*)

1. **The ACO must establish and maintain a governing body with adequate authority to execute the statutory functions of an ACO.**
   a. The governing body must be separate and unique to the ACO and not the same as a governing body of an ACO participant. However, individuals may serve on the governing body of both the ACO and an ACO participant.
   b. 75% of the governing board must be chosen by ACO participants.
   c. Participants in the governing body need not be proportional to ACO participants, but must be representative of a variety of practitioners participating in the ACO (e.g., primary care, specialties, behavioral health, waiver services).
   d. The governing body must include a Medicaid beneficiary served by the ACO. If the ACO cannot meet this requirement, it must identify alternative ways to meaningfully involve its beneficiaries in the governance process.
   e. The governing body shall possess broad responsibility for the ACO's administrative, fiduciary and clinical operations.
   f. The governing board must have a conflict of interest policy calling for disclosure of relevant financial interests and for a procedure to determine whether conflicts exist and an appropriate process to resolve conflicts.

2. **The ACO must have a leadership and management structure that includes clinical and administrative systems.**
   a. Operations are managed by an executive who must certify that all ACO participants are willing to become accountable to and report on quality, cost and overall care of the Medicaid beneficiaries assigned to the ACO.
   b. The appointment and removal of the executive must be under the control of the organization's governing body.
   c. The executive leadership team must have demonstrated the ability to effectively direct clinical practice to improve efficiency processes and outcomes.
   d. The ACO must establish and maintain an ongoing quality assurance and process improvement program overseen by an appropriately qualified health care professional.
   e. The ACO must have a medical director, who is an ACO physician, who may be part-time, but must be physically present at one of the ACO's locations on a regular basis, must be board-certified and licensed in the State of Vermont.
   f. The ACO must have a compliance officer who reports directly to the governing board. The compliance officer cannot be legal counsel to the ACO.

Financial Stability Standard

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

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. (*same as commercial standard*)

B. Standards related to downside risk limitation

1. DVHA's proposed that, for ACOs selecting Track 2 in the pilot program, the ACO will assume the following downside risk in each pilot program year (*same as Medicare standard, different from commercial standard*):
    - Year 1: risk limited to 5.0% of total benchmark expenditures
    - Year 2: risk limited to 7.5% of total benchmark expenditures
    - Year 3: risk limited to 10.0% of total benchmark expenditures

2. ACOs are required to submit a Risk Mitigation Plan to the state that demonstrates that the ACO has the ability to assume 1% downside risk in Year Two and 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). (*same as commercial standard*)

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. (*same as commercial standard*)

4. The ACO will notify DVHA if the ACO is transferring risk to any participating provider organization within its network. (*same as commercial standard*)

C. Standards related to financial oversight.

1. The Green Mountain Care Board (referred here within as "the Board") may require the ACO to furnish financial reports regarding risk performance to the state on a [*monthly, quarterly or annual*] basis. (*decision not yet made for commercial either, but Medicaid will follow commercial standard*)

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. (*same as Medicare and commercial standards*)

Patient Freedom of Choice

1. ACO patients will have freedom of choice with regard to their providers consistent with their health plan benefit. For Medicaid, ACOs and payers will not create a limited provider network product nor will they create any financial penalties or other incentives for patients to choose certain providers. The Board will reconsider this standard for 2015 and 2016 for commercial standards. (*same as commercial standard to the extent that it applies to Medicaid*)

Patient Attribution Methodology

Patients will be attributed to an ACO using a modification of the Blueprint attribution methodology as detailed below.

1. The look back period is the most recent 12 months for which claims are available. (*differs from commercial standard which is 24 months*)

2. Identify all members who were enrolled for the entire 12 months of the look back period in one of the following Medicaid "super eligibility categories" (*this is a Medicaid-specific standard*):
   - Aged, Blind or Disabled Adults who are not eligible for Medicare;
   - Blind or Disabled Children who are not eligible for Medicare;
   - General Adult;
   - New Adult (many previous VHAP enrollees);
   - General Child; and
   - SCHIP Child

3. If attribution criteria are met, the member is assigned to the super category where they were enrolled on the last day of the look back period. (*similar to commercial standard*)

Select all claims for members identified in step 2 with the following qualifying CPT Codes in the look back period (most recent 12 months) for primary care providers included on Blueprint payment rosters, 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. (*same as commercial standard with the exception of T10105 at end of the list*)

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:

CPT-4 Code Description Summary
• Domiciliary or Rest Home Visit New Patient: 99324-99328 • Domiciliary or Rest Home Visit Established Patient: 99334-99337
Home Services • New Patient: 99341-99345 • Established Patient: 99347-99350
Prolonged Services – Prolonged Physician Service With Direct (Face-to-Face) Patient Contact • 99354 and 99355
Prolonged Services – Prolonged Physician Service Without Direct (Face-to-Face) Patient Contact • 99358 and 99359
Preventive Medicine Services • New Patient: 99381–99387 • Established Patient: 99391–99397
Counseling Risk Factor Reduction and Behavior Change Intervention • New or Established Patient Preventive Medicine, Individual Counseling: 99401–99404 • New or Established Patient Behavior Change Interventions, Individual: 99406-99409 • New or Established Patient Preventive Medicine, Group Counseling: 99411–99412
Other Preventive Medicine Services – Administration and interpretation: • 99420
Other Preventive Medicine Services – Unlisted preventive: • 99429
Newborn Care Services • Initial and subsequent care for evaluation and management of normal newborn infant: 99460-99463 • 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 • HCPCS T1015 (*specific to Medicaid*)

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. (*same as commercial standard*)

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. (*same as commercial standard*)

6. For members that do not have claims experience, identify the primary care provider who the member is assigned to (either through the member's selection of the provider or through

DVHA's auto assignment process). Assign the member to this provider. (*this is standard specific to Medicaid*)

7. Remove any members identified in Step 2 that are not attributed either through Step 4/5 or Step

<u>Services to be Excluded from ACO Expected Medical Spending Calculations</u>

<u>Objective</u>: To create consistency around the services that are excluded from the ACO expected medical spending calculations.

A. Included Services that Differ from Other Payer Models

1. *Unlike the commercial and Medicare standards*, the Medicaid ACOs will be responsible for spending in the following service categories:
    - Prescription medications
    - Dental benefits
    - Transportation

2. The Medicaid ACOs will be responsible for spending in the following service categories:
    - Waiver services
    - Mental Health and Substance Abuse services
    - Services administered through the Department of Education

<u>Calculation of ACO Financial Performance and Distribution of Reconciliation Payments</u>

In general, for this section the Medicaid standards are more closely aligned with Medicare's standards in Parts A through E. The Medicaid standards are more closely aligned with the commercial standards in Parts F and G.

A. Actions Initiated Before the Initial Performance Year Begins

Determine the <u>historical benchmark</u> PMPM medical expense spending for the ACO's total patient population absent any actions taken by the ACO by doing the following:

1. Identify members who would have been attributed in each of the calendar years 2010, 2011 and 2012 (the "benchmark years") using the attribution methodology described previously.

2. Calculate the total expenditures (using the allowed amount value) for all services (that will be included in the calculation) for each attributed member within a calendar year. Make adjustments to these expenditures in the following manner:
    a. For inpatient hospital, outpatient hospital and professional services paid under DVHA's Resource Based Relative Value Scale, the service utilization is re-priced as if it was paid using DVHA CY 2013 prices. This is done because there were considerable changes to both the methodology and level of payments for these services during the benchmark period.
    b. For all other services, trend forward the expenditures in CY 2010 (benchmark year, or BY, 1), CY 2011 (BY 2) and CY 2012 (BY 3) to CY 2013 using factors established by the CMS Office of the Actuary (OACT).

3. Apply a risk adjustment factor to the benchmark expenditures for each member using the CMS-HCC prospective risk adjustment model to calculate member risk scores. This step is done to adjust for changes in the health status of the population assigned to the ACO. These adjustments will account for changes in case mix between the first and third benchmark years and between the second and third benchmark years.
   a. Risk adjustment factors will be developed within a DVHA eligibility "super category" (as defined in the Patient Attribution section).
   b. Risk adjustment scores will be separately computed for members who are "newly assigned
4. The trended, risk-adjusted expenditures are translated to a per member per year (PMPY) expenditure value. Within each of the super categories of eligibility, annualized expenditures are truncated for those extremely costly members that may significantly impact the weighted average PMPY value within a super category. Within the super category, the threshold for truncating expenditures is the 99th percentile. In other words, if a particular member incurred expenditures above the 99th percentile value within the super category of eligibility, this member's expenditures are truncated so that their total expenditures in the calculation will equal the value set at the 99th percentile.

5. The truncated, risk-adjusted, trended expenditures from each of the three benchmark years are then blended into a single per member per month value for all members within the eligibility super category. The blending assigns BY1 a 10% weight, BY2 a 30% weight, and BY3 a 60% weight in the calculation.

6. The blended PMPM for each super category shall represent the historical benchmark PMPM medical expense spending within the super category. A single historical benchmark is computed which represents the average PMPM across all super categories, weighted by volume (members) ("historical benchmark").

At the request of a pilot ACO, the DVHA will reconsider and adjust expected spending if unanticipated events, such as macro-economic or environmental events, occur that would reasonably be expected to significantly impact medical expenses in a way that is significantly different than expected.

B. Actions Initiated Prior to the Start of a Performance Year

Determine the updated benchmark PMPM medical expense spending for the ACO's patient population.

1. The updated benchmark expenditures equal the sum of the risk-adjusted historical benchmark expenditures with an inflationary cost adjustment applied to get to the performance year. The updated benchmark is represented as a PMPM for each eligibility super category.
2. To get the updated benchmark for a performance year (PY), the average updated benchmark PMPMs for each eligibility super category are weighted by volume.
3. Updated benchmark values in PY2 and PY3 will be computed in a similar manner by adding to the historical benchmark expenditures the compounded inflationary cost factors since the historical benchmark period.
4. The updated benchmark in each PY is adjusted relative to the risk profile of the PY.

C. Actions Initiated After the Performance Year Ends

Determine actual spending and whether the ACO has generated savings.

No later than six months following the end of each pilot year, DVHA or its designee shall calculate the actual medical expense spending for each ACO's attributed population using DVHA utilization and enrollment files. Medical spending shall be defined to include all paid claims for ACO-responsible services as defined above.

1. Rerun the attribution algorithm as described in the Patient Attribution Methodology section for the Performance Year period.
2. Calculate per member per year expenditures.
3. Apply the risk adjustment logic as described in Section A, Step 3 above.
4. Truncate expenditures as described in Section A, Step 4 above.
5. Compute a single actual spending PMPM which represents the average PMPM across all super categories, weighted by volume ("actual spending").

D. Annual Financial Reconciliation Calculation – One-Sided Model

Determine if total updated benchmark minus total assigned beneficiary PY expenditures is greater than zero (potential savings). If so, then determine whether or not the savings are greater than or equal to the minimum savings rate (MSR), which is based on the number of members assigned to the ACO. The MSR is the minimum threshold necessary to share savings. In the one-sided model, the MSR is based on a sliding scale relative to the size of the ACO's assigned membership, ranging from 2.0% to 3.9% of the ACO's updated benchmark.

If total savings are greater than or equal to the MSR, then savings occurred. Otherwise, there are neither shared savings nor shared losses since any ACO participating under the one-sided model is not responsible for any losses.

The shared savings percentage is then calculated. The maximum quality performance rating sharing rate percentage is 50% under the one-sided model (with the remaining percent going to DVHA). The final sharing rate is equal to the product of the ACO's quality score and the maximum sharing rate of 50%. The computation of the quality score is discussed further in Section F.

E. Annual Financial Reconciliation Calculation – Two-Sided Model

Determine if total updated benchmark minus total assigned beneficiary PY expenditures is greater than zero (potential savings) or less than zero (potential losses). If so, then determine whether or not the savings are greater than or equal to the minimum savings rate (MSR) or if losses are greater than or equal to the minimum loss rate (MLR). In the two-sided model, the MSR is a flat 2.0%; the MLR is -2.0%. For example, with a MSR of 2.0%, the total updated benchmark expenditures multiplied by 2.0% is the MSR in dollars. The MLR dollar amount is the total updated benchmark expenditures multiplied by -2%.

If total savings are greater than or equal to the MSR, then the ACO is eligible to receive a share of these savings. If total losses are equal to or greater than the MLR, then the ACO will be accountable for repaying a share of these losses. Otherwise, there are neither shared savings nor shared losses.

The shared savings percentage is then calculated. The maximum quality performance rating sharing rate percentage is 60% under the two-sided model (with the remaining percent going to DVHA). The final sharing rate is equal to the product of the ACO's quality score and the maximum sharing rate of 60%. The final loss rate is equal to one minus the final sharing rate. The final loss rate will not exceed 60%. The computation of the quality score is discussed further in Section F.

F. 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.

The Gate: In order to retain savings for which the ACO is eligible in accordance with Steps D or E above, the ACO must meet a minimum threshold for performance on a defined set of common measures to be used by all pilot-participating ACOs. If the ACO fails to meet the quality gate for a given measure, it may still be eligible for savings if it demonstrates meaningful improvement relative to prior year performance (assuming prior year performance data are available). 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 1 below).

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:

Table 1

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

G. Distribute Shared Savings Payments

The DVHA or its designee will calculate an interim assessment of performance year medical expense relative to expected and targeted medical spending for each ACO within four months of the end of the performance year and inform the ACO of the results, providing supporting documentation when doing so. If it determined that savings are generated beyond the MSR, and the preliminary assessment of the ACO's performance on the required quality measures is sufficiently strong, then within two weeks of the notification, DVHA will offer the ACO the opportunity to receive an interim payment, not to exceed 80% of the total payment for which the ACO is eligible.

DVHA 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. DVHA or its designee will complete the analysis of savings within two months of the conclusion of the six-month period and inform ACO of the results, providing supporting documentation when doing so. DVHA will then make any required savings distributions to contracted ACOs within two weeks of notification.

<u>Care Management Standards</u> (*still under development*)

Because these standards are still under development in a workgroup that represents public and private payers, the draft Medicaid standards shown below are a replica of the commercial standards.

<u>Objective</u>: 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. These standards are designed to define the role(s) of ACOs in delivering care management in order to improve the likelihood that ACOs attain their cost and quality improvement goals through effective and coordinated care management. The Care Management work group will discuss whether or not the Board should accomplish these goals through the exercise of regulatory authority.

<u>Standards</u>:

1. **The Board may require ACOs to develop a defined and coordinated strategy for care management.**
   a. The Board may require ACOs to define their methods and processes to coordinate care throughout an episode of care and during its transitions, such as discharge from a hospital or transfer of care from a primary care physician to a specialist (both inside and outside the ACO). (CMS MSSP[1], URAC[2])
   b. The Board may require ACOs to define their individualized care management program. (CMS MSSP)
   c. If entities external to the ACO will be providing care management services, the Board may require a detailed description of the specific services that will be provided by the external entity, the plan for coordinating such services and the mechanism(s) used to ensure accountability for the quality of such services.

2. **The Board may require that the ACO has a system to facilitate timely information exchange between multiple providers.**
   a. The Board may require ACOs to proactively identify patients at risk of transitioning. (NCQA)
   b. The Board may require ACOs to have agreements with providers to exchange information in a timely manner. (NCQA)
   c. The Board may require the ACO to monitor follow-up time after a care transition.
   d. The Board may require a system to facilitate a coordinated process and information exchange among multiple providers.
   e. The Board may require the ACO to develop protocols to coordinate care management services between the ACO and the payers and between the ACO and Community Health Teams.

3. **The Board may establish requirements for the individual care plan.**
   a. The Board may require ACOs to define how their individualized care program is used to promote improved outcomes for, at a minimum, its high-risk and multiple chronic condition patients. (CMS MSSP)

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[1] CMS Medicare Shared Savings Program Final Rule: www.gpo.gov/fdsys/pkg/FR-2011-11-02/pdf/2011-27461.pdf
[2] The URAC information is based on the draft standards for the "Basic Level of Accreditation" for "Clinically Integrated Networks" released on November 13, 2012, which may be found here: www.urac.org/publiccomment/documents/draft_CLIN_STDS_for_PUB_COMMENT.pdf

b. The Board may require ACOs to demonstrate that they have in place systems, policies and procedures to define target populations that would benefit from individualized care plans.
c. The Board may require that individual care plans take into account the community resources available to the individual. (CMS MSSP)

Payment Alignment

(*the standards in this section are the same as the commercial standards*)

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 DVHA and an ACO should be appropriately reflected in those that the ACO utilizes with its contracted providers. ACOs will share with DVHA their written plans for:
   a. aligning provider payment 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 create regional groupings (or "pods") of providers. ACO provider groupings should be incentivized individually and collectively to support accountability for quality of care and cost management.

3. DVHA 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.

Vermont ACO Data Use Standards (*still under development*)

Standards:

1. **Payer Provision of Data to ACOs** (*similar to Medicare, not similar to commercial standard*)

   DVHA shall provide ACOs with the following data on their assigned population and financial performance at the start of the agreement period and routinely during the course of the performance year:
   a. A report on the members assigned for the most recent benchmark year, quarterly reports on the ACO's preliminary prospectively assigned population, and a year-end report on retrospectively assigned members. Information provided will include member identifiable information.
   b. Aggregate expenditure and utilization reports provided for each benchmark year, for each quarter during the agreement period, and annually for each performance period (for interim payment calculation and for each performance year).
   c. Financial reconciliation reports specifying the calculation of the ACO's historical benchmark, updated benchmark, and determination of shared savings or losses.
   d. Daily hospital inpatient admissions and emergency department census for in-state hospitals (data source: VITL)
   e. Registry of DVHA-led care management cases involving ACO patients *(protocols to be developed by Care Management Subgroup)*

2. ACO Provision of Data to DVHA

(*the standards in this section are the same as the commercial standards*)

a. Monthly detailed EHR extracts— detailed medical history on the payer's population
b. Daily hospital inpatient admissions and emergency department census
c. Registry of ACO care management cases involving payer patients
d. Reports—including
    i. Results of the ACOs patient satisfaction surveys
    ii. ACO efforts to close gaps in preventive care (include dates for preventive visits)
    iii. Patient safety indicator occurrence (based on AHRQ's methodology)
    iv. Access reports for primary care and specialists
        1. Third available preventive visit
        2. Next available urgent visit
    v. Evidence of coordination of care from medical <-> mental health/substance abuse setting and/or between settings (outpatient –inpatient)
    vi. EHR report of lab results for chronic disease management (e.g. LDL-C, HbA1c) monthly
    vii. EHR report on BMI (must have recorded BMI in chart)
e. Notice of monthly or quarterly (TBD) provider changes within the PCP practices for attribution purposes.
f. Notice of any new practices, PCP or specialty physician, that joins the ACO.

3. The following provisions are pending a recommendation from the HIE/ SIM Work Group:

(*the standards in this section are the same as the commercial standards*)

a. ACO Capture and Analysis of Data from Multiple Sources
    i. ACO Data Capture
    ii. Data Integration
b. ACO Applications and Systems that Enable Population Health Management
    i. Data Use
    ii. Practice Access to Registry Data
    iii. ACO Use of Data for Waste Reduction, Variation Reduction and Patient Protection
    iv. Information Exchange for Care Coordination and Transitions
    v. Practice Performance Reporting
c. ACO Use of Health Information Exchange

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To: Kara Suter, Director of Payment Reform DVHA

From: Bi- State Primary Care Association

RE: Medicaid ACO Standards August 19, 2013

Dear Ms. Suter,

Thank you for the opportunity to provide comments on the Medicaid ACO Standards that you presented to the ACO Standards group on August 5, 2013. We will have additional comments when we meet with Community Health Accountable Care members on August 20th.

1. **Timeline/Limited Funding:**
   Bi-State is concerned that there is limited funding to support the work that we will need to do to respond appropriately to the Medicaid ACO RFP. We are also concerned that the timeline to respond to the RFP will be very tight.
2. **State Plan Amendment:**
   We understand that the State Plan Amendment will be implemented before CMS approval. Bi-State is concerned CMS may change the program after we have responded to the RFP and the program has been launched.
3. **Timing of Auto Assignment:**
   Slide twelve references the use of self or auto assignment if no PCP has been assigned to the beneficiary. How soon after auto assignment will the ACO know whether the patient has been attributed to their ACO population?
4. **Mid- Level and Specialist Attribution:**
   Bi-State strongly supports the inclusion of mid-levels for the purpose of attribution of patients as these providers are providing primary care in a PCMH. Bi-State does not support attribution of patients to specialists.
5. **High Cost Outlier Issue:**
   Bi-State supports the elimination of high-cost outliers, but recommends that they be eliminated entirely when calculating performance against benchmark.
6. **Payment Lag:**
   Bi-State encourages the State to consider an advance payment option to help offset the costs necessary to implement the ACO program. Modeled after the “Advanced Payment

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Demonstration" offered by CMS, this money would be used to cover the cost of methods and techniques applied to the population of patients served to reduce costs.

7. **Risk Adjustment Methodology:**
   Bi-State encourages the State to ensure that any risk adjustment methods used to alter premiums have a component of social determinants of health.
8. **No Down-side Risk Option:**
   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.
9. **Year 1 Reporting:**
   Consider allowing ACOs that report all measures in year 1 to meet the requirements. This will allow for the studying of the challenges associated with the quality reporting and the use of claims data sets for a population of patients that is likely to churn between payment sources. This will also allow the State to use benchmarks set by previous years data within a population, rather than attempt to set benchmarks without an understanding of the underlying risk of each unique population served.

Thank you for attention to these comments please contact me with any questions.

Best,

Susan Barrett, J.D.
Director of Vermont Public Policy
Bi-State Primary Care Association
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Medicaid's Proposed ACO Shared Savings Program Standards

Presentation to the SIM Steering Committee
August 22, 2013
Kara Suter, MS
Director of Payment Reform, DVHA

Goals for Steering Committee

- Shared Savings ACO Programs 101 (1 of 3 Models to Test)
- Understand Proposed Medicaid Standards and Process to Date
- Understand Key Milestones and Timing for Medicaid ACO SSP
- Identify Key Areas for Input and Recommendations
- Agree to Schedule for Receiving Additional Input and Making Recommendations to Core Team

Shared Savings ACO Programs, 1 of 3 Models to Test

Using Complementary Financial Models to Drive System Change and Bend the Cost Curve

Payments based on Population Health and System Performance

Provider Performance

Collaborative Performance

State Innovation Model Proposal
http://gmcboard.vermont.gov/sites/gmcboard/files/Project%20Narrative.pdf

SHARED SAVINGS ACO PROGRAMS 101

Background and Definitions

WHAT IS AN ACO SHARED SAVINGS PROGRAM?

What is an ACO Shared Savings Program (SSP)?

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.

http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2012/Aug/1618_Forster_accountable_care_strategies_premier.pdf

What is an ACO?

Accountable Care Organizations (ACOs) are comprised of and led by health care providers who have agreed to be accountable for the cost and quality of care for a defined population.

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*SIM Payment Standards Work Group Definition 2013

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Attributing Patients & Calculating Savings

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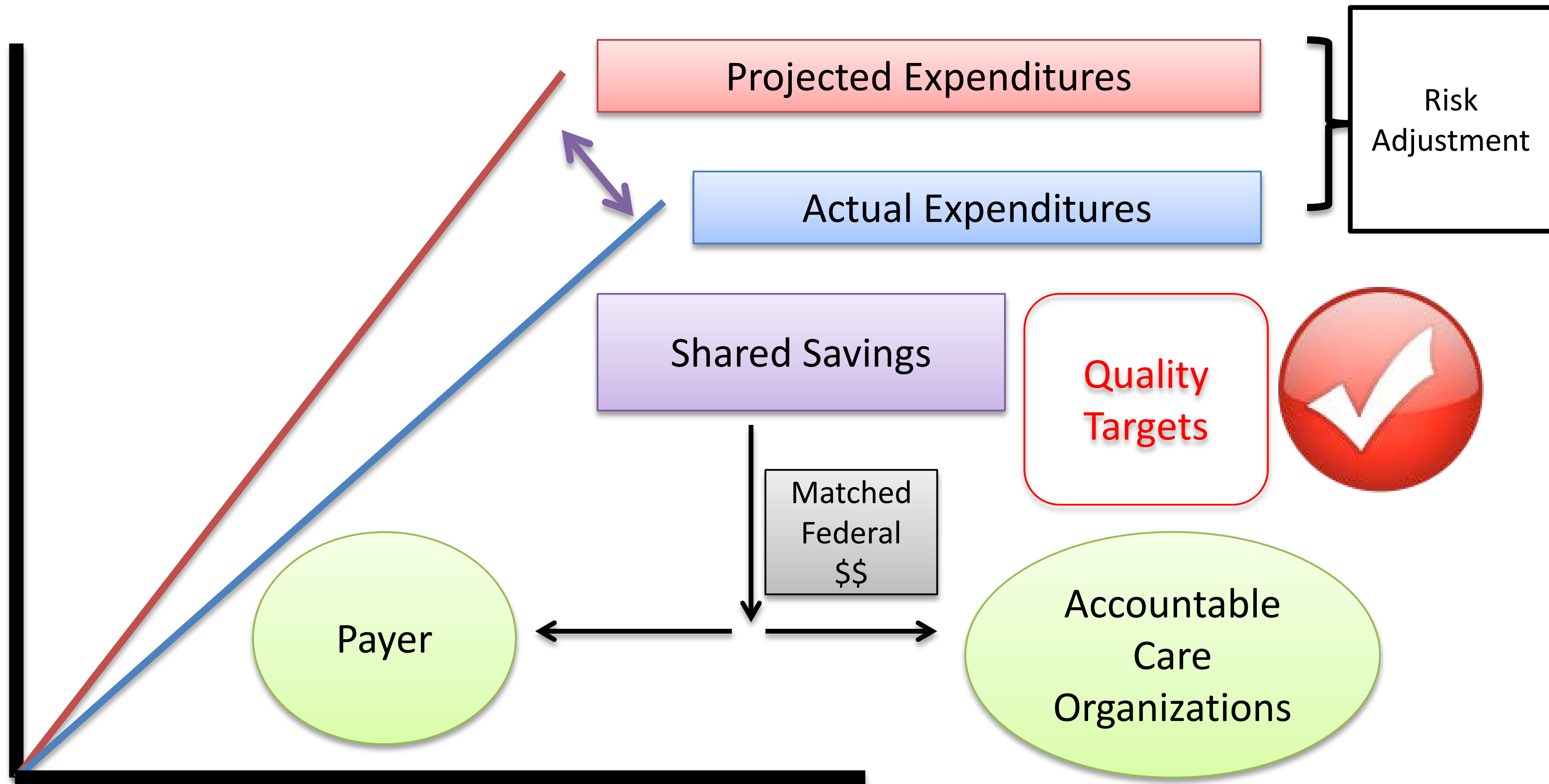

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- Two Track Option: Downside Risk Introduction and Savings Percentages
- Broad Provider Participation and Governance Requirements
- Included/Excluded Costs
- Enrollment/Excluded Populations
- Attribution
- Quality Metrics

Comments by September 4, 2013

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Proposed Timeline for Medicaid ACO SSP

Timeframe	Milestone
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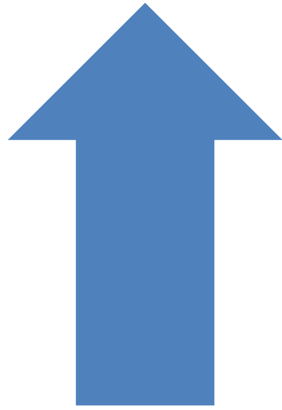
STANDARDS FOR DISCUSSION

TWO TRACK OPTION

Medicare "Two Track Option"



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- No Downside Risk for 3 Years
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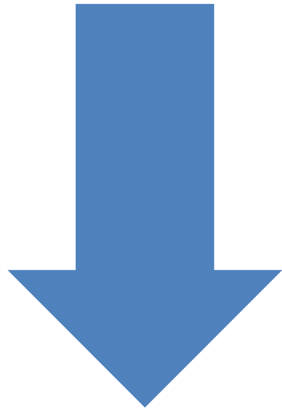

Track Two

- Accept Downside Risk
  - Year 1: 5.0%
  - Year 2: 7.5%
  - Year 3: 10%
- Savings 40% to Payer, 60% to ACO

Pro's

- Increases potential for broad ACO participation

Con's

- Delays "accountability" which is key element of the model

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Risk and Savings Percentages

Key Input from Steering Committee Requested

- Should Medicaid propose a "variation" to Medicare?
  - What would the variation look like? Would it include slower and smaller introduction of risk?
  - If yes, what savings percentages are appropriate given any changes to the introduction in risk?
- If Medicaid should adopt the Medicare approach, are these savings percentages appropriate?

PARTICIPATION AND GOVERNANCE REQUIREMENTS

Provider Participation Requirements

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- Medicaid would like to include requirements for ACOs to include LTSS and MH&SA providers

Pro's

- Incents linkages between providers across broad continuum of care, important for Medicaid beneficiaries
- Emphasizes importance of access and coordination between medical and LTSS and MH&SA services
- Is consistent with quality metrics

Con's

- ACOs may not yet have established relationships with these providers

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- Model after Medicare
  - "75%" provider-led governance structure
  - Medicaid beneficiary representative
- Medicaid also considering including requirement that at least one LTSS and MH&SA provider be part of 75%

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- Does Medicaid require governance structure to include certain types of providers?
- Do we phase-in these requirements over time (i.e., how strict should the requirements be?)

INCLUDED/EXCLUDED COSTS

Total Cost of Care

Medicaid Proposes

- All those included in Medicare and Commercial that can be associated with an individual PLUS:
  - Dental
  - Pharmacy
  - Transportation
  - LTSS (beyond those covered and paid for by Medicare/Commercial)
  - MH&SA (beyond those covered and paid for by Medicare/Commercial)

Pro's

- Medicaid has consistent coverage of pharmacy and dental benefits across eligible populations
- Emphasizes importance of access to preventative dental care and prudent use of pharmaceuticals
- Emphasizes importance of services beyond traditional "medical care"
- Is consistent with quality metrics

Con's

- ACOs may have less experience managing costs and quality in these areas
- Statutory and/or internal IGAs may need modification—in the case of LTSS/MH&SA

Inclusion/Exclusion of Costs

Key Input from Steering Committee Requested

- Does the SC agree that broad inclusion of cost is best approach?
- If not, which costs would they recommend be excluded and why?

ATTRIBUTION

Attribution

Attribution

- Medicaid Proposes a 2 step process
  - Blueprint with look-back modification*
  - Self-designated/Auto-Assigned

**While Blueprint requires PCPs to be NCQA certified, Medicaid proposes the SSP attribution would not contain this requirement in the first three years*

Attribution

Attribution

- Step One
  - Look-back period adjusted from 24 to 12 months

Pro's

- Ensure beneficiaries attributed to ACO were actually under the care of ACO provider in performance period

Con's

- Fewer beneficiaries included in ACO SSP

Key Input from Steering Committee Requested

- Does the SC agree with the two step approach?
- If not, what would they recommend and why?

ENROLLMENT AND POPULATION EXCLUSIONS

Medicaid's Proposed ACO SSP Six Enrollment Categories

	Enrollment Category	Brief Description (with estimate of SFY 14 enrollment)
1	ABD Adult	Individuals who are 18 year of age or older who are aged, blind or disabled and who are not dually eligible for Medicare. For the ACO, ABD adults must be eligible for the full range of Medicaid services. (approximately 14,360)
2	New Adult	Adults who had previously been enrolled in the VHAP program (eligibility based on income—childless adults up to 150% FPL, adults with children up to 185% FPL—and who had been uninsured for 12 months or more prior to enrolling). Of the former VHAP enrollees, those with incomes above 133% FPL are assigned here and will be eligible for services that had not been covered under VHAP (e.g., dental, transportation, eyeglasses). (approximately 34,490)
3	General Adult	Parents/caretaker relatives of minor children including cash assistance recipients and those receiving transitional Medicaid after the receipt of cash assistance. (approximately 11,993)
4	BD Child	Blind or Disabled children under age 21. Eligibility criteria similar to ABD Adult. (approximately 3,740)
5	General Child	Children under age 21 who are eligible for cash assistance (including foster care payments). (approximately 55,762)
6	SCHIP	Children up to age 18, uninsured, living in families up to 300% FPL who are not otherwise classified under BD Child or General Child. (approximately 4,180)

Currently any member with other insurance (TPL, Medicare) would be excluded; Dual eligible would be revisited in year two should the financial alignment demonstration proceed

Inclusion/Exclusion of Costs

Key Input from Steering Committee Requested

- How many months of continuous enrollment should be required?
- Are there any special populations that should be excluded and why?
- Does the SC agree with exclusions of beneficiaries with other insurance?

PROPOSED PERFORMANCE METRICS (PRIOR TO AUG 26 WORK GROUP MTG)

REFER TO MEASURES ACROSS PROGRAMS AND YEARS HANDOUT

OVERVIEW

Medicaid ACO SSP Development Update

Key Program Elements	Medicaid Proposal if Different from Medicare or Commercial	Status
Eligible Population	• Propose to exclude beneficiaries with third party insurance including Medicare. • Require some months continuous enrollment.	Discussed
Attribution Methodology	• Variation of Blueprint PMPM attribution using 12 instead of 24 month look-back; for remaining patients, default to self or auto-assigned PCP.	Discussed
Cost Inclusion/Exclusion Criteria	• Include pharmacy and dental costs. • Other exclusions have not been identified but this is subject to change.	Discussed
High Cost Outlier Exclusion	• TBD	Proposing truncating at 99% percentile of each eligible category

Medicaid ACO SSP Development Update

Key Program Elements	Medicaid Proposal if Different from Medicare or Commercial	Status
Projected Savings Calculation	• Mirror Medicare SSP with minor adjustments to estimating projected costs. • Medicare's approach does not use "target spending" threshold, just "actual" against "expected.	Estimating a three year utilization trend and payment trend separately to allow for accounting of expected Medicaid rate increases.
Determination of actual spending will be conducted on a 6 month lag from performance period end date	• Medicaid proposed to make an interim 3 to 4 then true up after 6 months lag.	This is proposed but will adopt the commercial approach to simplify process.
Risk Adjustment Methodology	• CMS-Hierarchical Condition Categories (HCC) risk-adjustment model	Recommended by risk-adjustment sub-committee of Standards Work Group
Minimum Number of Lives (MNL)	• Mirror Medicare and Commercial 5,000	

Medicaid ACO SSP Development Update

Key Program Elements	Medicaid Proposal if Different from Medicare or Commercial	Status
Minimum Savings Threshold (MSR) or Minimum Loss Ratio (MLR)	Mirror Medicare's sliding scale related to total number of attributed lives	Would depend on which "track" is chosen
Savings Percentages	Propose 50%, 50% after MSR	Discussed
Down-side Risk Introduction	Mirror Commercial	Discussed
Quality and Performance Standards	Adopt Quality Work Group Standards	Awaiting final recommendation from Quality Work Group
Additional Requirements (Provider Relationships, Financial Stability, Risk Mitigation)	Mirror Commercial and/or Medicare Standards	Discussed
Care Management Requirements	TBD	Awaiting input from Care Management Work Group
Information and Data Exchange Requirements	TBD	Statewide Data Analytics Contractor; HIE Work Group Recommendations
Fraud and Abuse Monitoring	Plan in Development	Internal; not included in RFP or standards

WRAP UP

Discussion and Next Steps

Discussion

Comments and Recommendations to Core Team by September 4th

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Medicaid's Proposed ACO Shared Savings Program Standards

Presentation to the SIM Steering Committee
August 22, 2013
Kara Suter, MS
Director of Payment Reform, DVHA

Goals for Steering Committee

- Shared Savings ACO Programs 101 (1 of 3 Models to Test)
- Understand Proposed Medicaid Standards and Process to Date
- Understand Key Milestones and Timing for Medicaid ACO SSP
- Identify Key Areas for Input and Recommendations
- Agree to Schedule for Receiving Additional Input and Making Recommendations to Core Team

Shared Savings ACO Programs, 1 of 3 Models to Test

Using Complementary Financial Models to Drive System Change and Bend the Cost Curve

Payments based on Population Health and System Performance

Provider Performance

Collaborative Performance

State Innovation Model Proposal
http://gmcboard.vermont.gov/sites/gmcboard/files/Project%20Narrative.pdf

SHARED SAVINGS ACO PROGRAMS 101

Background and Definitions

WHAT IS AN ACO SHARED SAVINGS PROGRAM?

What is an ACO Shared Savings Program (SSP)?

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.

http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2012/Aug/1618_Forster_accountable_care_strategies_premier.pdf

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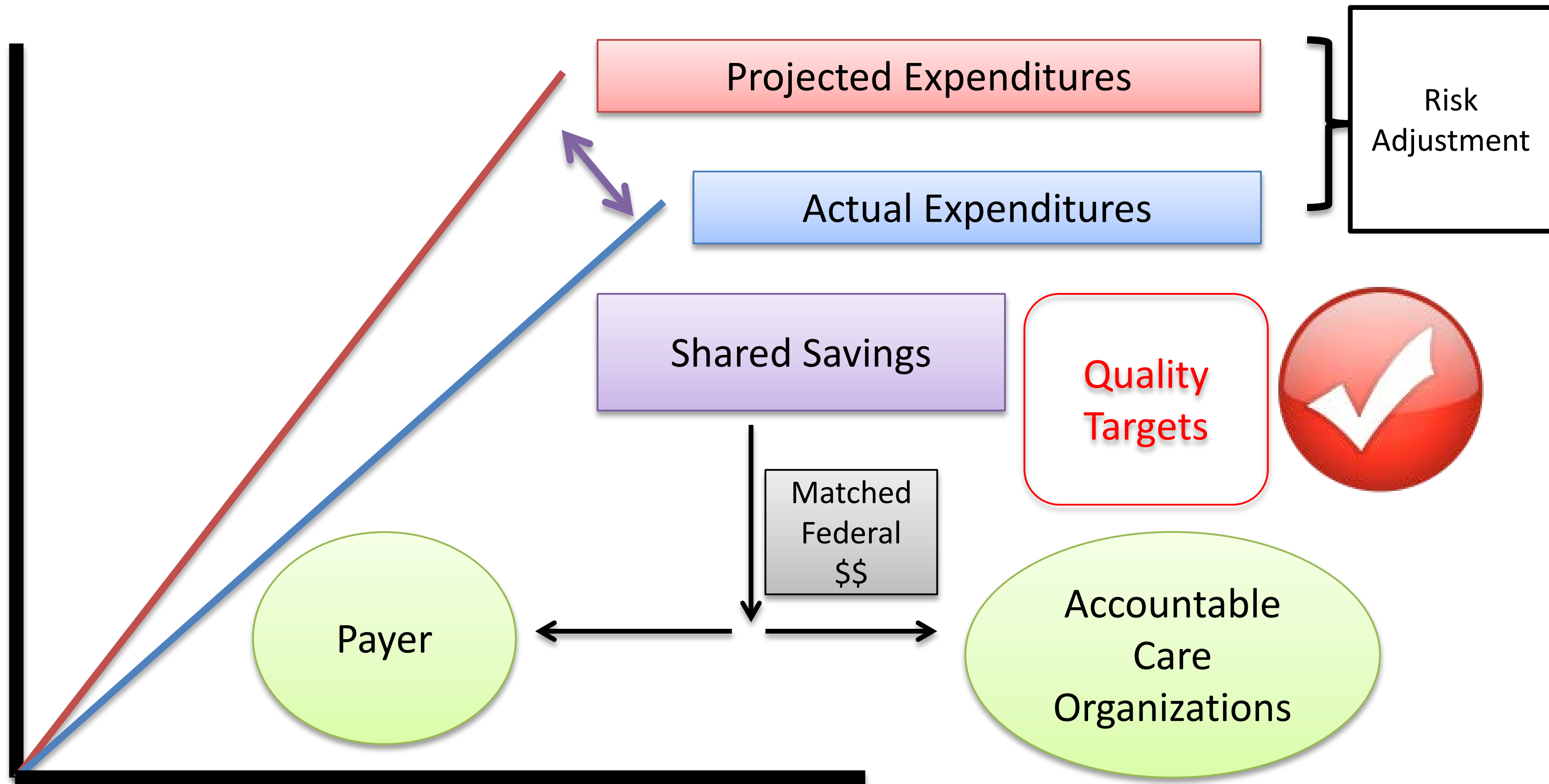

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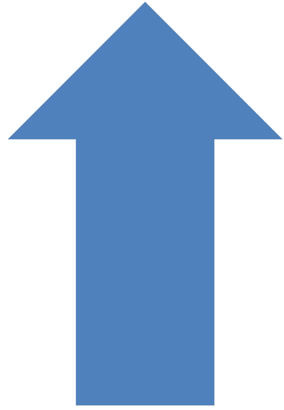

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**While Blueprint requires PCPs to be NCQA certified, Medicaid proposes the SSP attribution would not contain this requirement in the first three years*

Attribution

Attribution

- Step One
  - Look-back period adjusted from 24 to 12 months

Pro's

- Ensure beneficiaries attributed to ACO were actually under the care of ACO provider in performance period

Con's

- Fewer beneficiaries included in ACO SSP

Attribution

Attribution

- Step Two
  - If not attributed in BP 12 month logic, use self or auto-assignment PCP on file

Pro's

- Early analysis suggests that of 8,000 who would not attribute, almost all would be assigned via the second step
- Avoids having to attribute beneficiaries via their specialty physician visits

Con's

- Analysis shows that only 40% of the time, on average, do beneficiaries actually seek care from those chosen at the time of enrollment

Inclusion/Exclusion of Costs

Key Input from Steering Committee Requested

- Does the SC agree with the two step approach?
- If not, what would they recommend and why?

ENROLLMENT AND POPULATION EXCLUSIONS

Medicaid's Proposed ACO SSP Six Enrollment Categories

	Enrollment Category	Brief Description (with estimate of SFY 14 enrollment)
1	ABD Adult	Individuals who are 18 year of age or older who are aged, blind or disabled and who are not dually eligible for Medicare. For the ACO, ABD adults must be eligible for the full range of Medicaid services. (approximately 14,360)
2	New Adult	Adults who had previously been enrolled in the VHAP program (eligibility based on income—childless adults up to 150% FPL, adults with children up to 185% FPL—and who had been uninsured for 12 months or more prior to enrolling). Of the former VHAP enrollees, those with incomes above 133% FPL are assigned here and will be eligible for services that had not been covered under VHAP (e.g., dental, transportation, eyeglasses). (approximately 34,490)
3	General Adult	Parents/caretaker relatives of minor children including cash assistance recipients and those receiving transitional Medicaid after the receipt of cash assistance. (approximately 11,993)
4	BD Child	Blind or Disabled children under age 21. Eligibility criteria similar to ABD Adult. (approximately 3,740)
5	General Child	Children under age 21 who are eligible for cash assistance (including foster care payments). (approximately 55,762)
6	SCHIP	Children up to age 18, uninsured, living in families up to 300% FPL who are not otherwise classified under BD Child or General Child. (approximately 4,180)

VERMONT STATE INNOVATION MODEL

Currently any member with other insurance (TPL, Medicare) would be excluded; Dual eligible would be revisited in year two should the financial alignment demonstration proceed

Inclusion/Exclusion of Costs

Key Input from Steering Committee Requested

- How many months of continuous enrollment should be required?
- Are there any special populations that should be excluded and why?
- Does the SC agree with exclusions of beneficiaries with other insurance?

PROPOSED PERFORMANCE METRICS (PRIOR TO AUG 26 WORK GROUP MTG)

REFER TO MEASURES ACROSS PROGRAMS AND YEARS HANDOUT

OVERVIEW

Medicaid ACO SSP Development Update

Key Program Elements	Medicaid Proposal if Different from Medicare or Commercial	Status
Eligible Population	• Propose to exclude beneficiaries with third party insurance including Medicare. • Require some months continuous enrollment.	Discussed
Attribution Methodology	• Variation of Blueprint PMPM attribution using 12 instead of 24 month look-back; for remaining patients, default to self or auto-assigned PCP.	Discussed
Cost Inclusion/Exclusion Criteria	• Include pharmacy and dental costs. • Other exclusions have not been identified but this is subject to change.	Discussed
High Cost Outlier Exclusion	• TBD	Proposing truncating at 99% percentile of each eligible category

Medicaid ACO SSP Development Update

Key Program Elements	Medicaid Proposal if Different from Medicare or Commercial	Status
Projected Savings Calculation	• Mirror Medicare SSP with minor adjustments to estimating projected costs. • Medicare's approach does not use "target spending" threshold, just "actual" against "expected.	Estimating a three year utilization trend and payment trend separately to allow for accounting of expected Medicaid rate increases.
Determination of actual spending will be conducted on a 6 month lag from performance period end date	• Medicaid proposed to make an interim 3 to 4 then true up after 6 months lag.	This is proposed but will adopt the commercial approach to simplify process.
Risk Adjustment Methodology	• CMS-Hierarchical Condition Categories (HCC) risk-adjustment model	Recommended by risk-adjustment sub-committee of Standards Work Group
Minimum Number of Lives (MNL)	• Mirror Medicare and Commercial 5,000	

Medicaid ACO SSP Development Update

Key Program Elements	Medicaid Proposal if Different from Medicare or Commercial	Status
Minimum Savings Threshold (MSR) or Minimum Loss Ratio (MLR)	Mirror Medicare's sliding scale related to total number of attributed lives	Would depend on which "track" is chosen
Savings Percentages	Propose 50%, 50% after MSR	Discussed
Down-side Risk Introduction	Mirror Commercial	Discussed
Quality and Performance Standards	Adopt Quality Work Group Standards	Awaiting final recommendation from Quality Work Group
Additional Requirements (Provider Relationships, Financial Stability, Risk Mitigation)	Mirror Commercial and/or Medicare Standards	Discussed
Care Management Requirements	TBD	Awaiting input from Care Management Work Group
Information and Data Exchange Requirements	TBD	Statewide Data Analytics Contractor; HIE Work Group Recommendations
Fraud and Abuse Monitoring	Plan in Development	Internal; not included in RFP or standards

WRAP UP

Discussion and Next Steps

Discussion

Comments and Recommendations to Core Team by September 4th

VERMONT

GreenMountainCare
A HEALTHIER STATE OF LIVING

VCDR
VERMONT COALITION FOR DISABILITY RIGHTS
Nothing About Us Without Us

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SIM/Duals Steering Committee Members,

I am unable to attend our meeting on Thursday, so I am submitting written comments on behalf of the Vermont Coalition for Disability Rights.

The state and many private partners are contemplating major changes in the way that health care is delivered and paid for in Vermont. It is currently envisioned that the ACO model could reward "organizations" willing to deliver comprehensive care and reduce the rate of increase in the cost of care.
The ACO approach divides populations served by payer and soon to be considered is an RFP for Medicaid ACOs. It is crucial at this point to acknowledge that the envisioned ACO structure and some of the entities that may end up with control are institutions very much in the "medical model" and NOT the most qualified for delivering long term care.

Vermont's biggest successes have been when we have tailored long term care to meet individuals' needs - and on their terms. Among those reliant on Medicaid we have the least institutional mental health care system in the country, we have one six bed ICF-DD and no other state "institutions" for people with developmental disabilities, and older Vermonters have the right to choose between receiving care in their homes and nursing facilities.

Our state's long term care services have been thoughtfully developed over time and, insofar as the major payer is Medicaid, their costs are under tough annual review by both

the administration and the legislature. They are among the country's most cost effective. They are administered mostly by the private non-profit sector and fairly strongly regulated by the state. Much of what they deliver is offered in the social service model, and appropriately so. They make living in an integrated society at least POSSIBLE for elders and people with serious disabilities.

If your only tool is a hammer, everything looks like a nail. If hospital-based ACOs become the state's central mechanisms for cost containment in Medicare, and especially Medicaid, it doesn't take a lot of imagination to see an erosion of support for our long term care services. Even if institutions were to accept that their share of the state's economic "pie" is to decrease, their first priority is unlikely to be excellence in long-term care, an area quite outside their experience of acute care delivery.

We all need to be concerned about the strength and vitality of our acute care system in the new world of health care reform; we all rely on it and are grateful for it when we get all sorts preventive, emergency, crisis, and acute care. But we need to be aware that long term needs are often very different and require a different sort of infrastructure to be successful. Reforms in the business model of acute care delivery shouldn't mean sacrifice of what we have achieved for elders and people with disabilities.

Cost control of the acute care system has been elusive for years, but in long-term care we have legislative control over Medicaid budgets and hence direct control over inflation in the system. Every year we advocate to keep an adequate level of funding for numbers of elders and people with disabilities that increase as we all age and as prevalence of disability goes up. This is a GOOD thing, it means that both our acute and long-

term care systems are helping people to live longer and better. Similar control is less clear in acute care because of the system's ability to cost shift when there is a need to make up for tight control of Medicaid/Medicare, for uncompensated care, or changes in technology. Any of us in the private market RARELY see insurance rates only go up by single digits! Elders and people with disabilities need to have a more central place in reform of the system if key decisions about long term care delivery are to be folded into corporate structures with no real experience in their delivery. A new payment structure for long term care that is tied in with hospital reimbursement can easily be envisioned. However a new system is structured it should have enforceable and clearly defined safeguards and standards to preserve Vermont's long term care system.–Those standards must be arrived at through real public input. People with disabilities and elders are the real experts in living with long term needs.

Sincerely,

Ed Paquin
President, Vermont Coalition for Disability Rights