AGENDA

STATE INNOVATION MODEL
STEERING COMMITTEE

Wednesday, September 18, 2013
2pm to 4pm
DVHA Large Conference Room, 312 Hurricane Lane, Williston
Call in number is 1-866-951-1151, 4554014

1. Welcome and Introduction: Al Gobeille and Mark Larson

2. Presentation of Revised Commercial Shared Savings ACO Program Standards: Richard Slusky

3. Debrief on CMS "Reverse Site Visit" and CMS Feedback on Vermont's Operational Plan; Update on Project Governance and Management: Anya Rader Wallack

4. Presentation of Revised Medicaid Shared Savings ACO Program Standards: Kara Suter

5. Presentation of Proposed Shared Savings ACO Performance Measures: Pat Jones

6. Steering Committee Discussion of Revised ACO Program Standards and Performance Measures

7. Revisit Discussion of Potential Measures for the Vermont SIM "Driver Diagram"

The Next Steering Committee Meeting is scheduled for Wednesday, October 16, 1:30-3:30 PM, DVHA Large Conference Room

MEMORANDUM

TO: SIM Steering Committee Members

FROM: Anya Rader Wallack, Chair, SIM Core Team

DATE: September 12, 2013

SUBJECT: September 18th SIM Steering Committee Meeting

The State of Vermont is developing standards that will form the basis for two Shared Savings Accountable Care Organization (ACO) programs to be launched in 2014 – a Commercial Insurer Shared Savings ACO Program and a Medicaid Shared Savings ACO Program. Standards for both programs have been recommended by the ACO Standards Work Group, which was originally convened by the Green Mountain Care Board (GMCB) and the Department of Vermont Health Access (DVHA) in December 2012. In March 2013, the State received a State Innovation Model (SIM) grant that will, among other things, support implementation of the two Shared savings ACO models. Under this grant, we have created a governance structure that incorporates input from the SIM Steering Committee into state decision-making about the ACO programs. Accordingly, we shared initial drafts of the ACO Program Standards with the SIM Steering Committee and are now asking for feedback on revised drafts.

An ACO Performance Measures Work Group also was convened by the GMCB and DVHA starting in December 2012. That group has work to develop a list of recommended quality measures to be used to track the performance of ACOs and to influence ACO payments. The group has coordinated their work with the ACO Standards Work Group.

Both sets of ACO program standards will be on the agenda for discussion at the September 18th SIM Steering Committee meeting. Please send comments on the revised drafts to Kara Suter (kara.suter@state.vt.us) and Richard Slusky (richard.slusky@state.vt.us) with a copy to me (anya.wallack@state.vt.us) prior to the 18th if possible. At a minimum, please be prepared to discuss the revised proposals at the meeting. The combined recommendations of the two work groups regarding performance measures also will be reviewed at the meeting on the 18th.

Feedback received from the Steering Committee on these revised drafts and the performance measure recommendations will guide the final decisions of the SIM Core team about ACO Program Standards. The Core Team discussed the feedback from the Steering Committee on the Medicaid standards at their meeting on September 10th and came to consensus on most elements. The Core Team is expected to approve final standards by the end of September. The final standards will structure two subsequent processes:

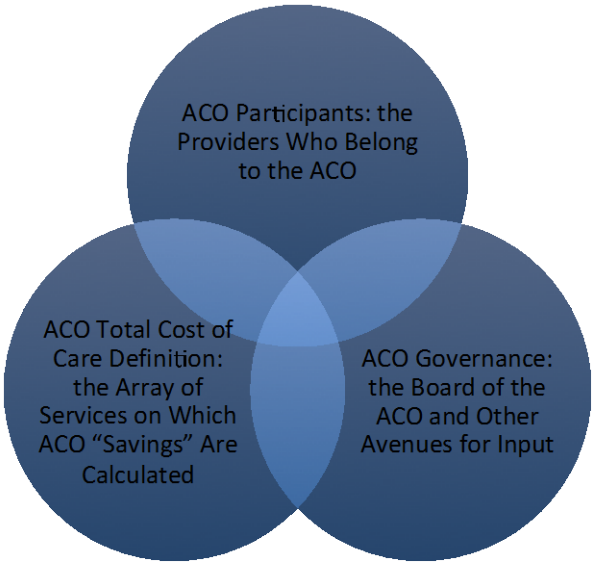
1. Release of a request for proposals by DVHA for potential participants in the

Medicaid ACO, and negotiation of terms and conditions of contracts between DVHA and ACOs; and
2. Negotiation of contracts between commercial insurers and ACOs.

Results of both of those negotiations will be subject to GMCB review and approval.

Thank you very much to those of you who submitted comments on the proposed standards. All of the comments submitted were thoughtful and demonstrated a strong commitment by payers, providers and consumer advocates to continue to find new ways to collaborate across the full continuum of care, working to improve the health and experience of care for all Vermonters. The comments revealed some confusion about core elements of the standards and I therefore offer some clarifying definitions below. These definitions apply to the shared savings ACO, and not necessarily more advanced ACO models. The key point that may not be apparent to all involved is that ACO participants, ACO governance and ACO total costs of care need not necessarily be the same. For example, ACO participants could be a broad group spanning acute and LTSS providers (particularly in the Medicaid ACO program), while total costs of care could be defined more narrowly.

ACO Participants, Total Costs of Care and Governance are Not Necessarily the Same



- **ACO participant**: An ACO participant is an individual provider or provider organization that chooses to sign a participation agreement and join an ACO. By joining the ACO the participant agrees to share data with the ACO and potentially can share in any "savings" realized by the ACO relative to expected total costs of care. In theory, an ACO participant has an incentive to improve

quality performance and reduce total costs of care, regardless of whether those quality measures or costs are tied to the services the participant provides.

- **ACO beneficiary:** An ACO beneficiary is a person who gets their health insurance from a payer (a public program such as Medicare or Medicaid or a private payer such as BCBS or MVP) that contracts with an ACO and gets their primary care from a provider who is an ACO participant. An ACO beneficiary is not restricted in their choice of health care provider.
- **Total costs of care:** Total costs of care are the costs on which an ACO will be tracked and evaluated for whether they reduce costs relative to the expected level. This can be defined fairly narrowly, as it is in the Medicare model (basically, part A and B services) or broadly to include all Medicaid services, or somewhere in-between.
- **ACO governance**: ACO governance refers to the board of directors (both membership and procedures) of the ACO and other mechanisms that feed into or affect ACO decision-making.

I hope this helps clarify these issues, and I welcome feedback on how to continue to un-complicate the ACO concept for everyone involved.

Presentation to SIM Steering Committee

September 18, 2013

Richard Slusky

Director of Payment Reform GMCB

ACO Standards for Commercial ACOs

- The Following Slides Outline the Key Commercial ACO Standards Developed and Recommended by the ACO Standards Group for Review and Approval By:
  - The SIM Steering Committee
  - The SIM Core Team
  - The Green Mountain Care Board (GMCB)

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).

Components of proposed Financial Stability Standard:

- Effects of Provider Coding patterns on medical spending patterns
- Downside Risk Limitations
- Financial oversight by GMCB
- Minimum number of attributed lives in the aggregate and by payer

ACO Risk Mitigation Standard

Objective:

The ACO(s) must provide a detailed plan to mitigate the impact of up to 5% downside risk on the ACO and its provider network in Year 3 of the XSSP program as defined in the ACO Standards document. Such a plan must establish a self-executing method for repaying losses to the payers participating in the XSSP program (Payers). This can include funds that may be recouped from payments to its participating providers, stop loss insurance, surety bonds, escrow accounts, a line of credit, or some other payment mechanism such as a withhold of a portion of any previous shared savings achieved.

Any solvency monitoring or requirements as noted above will be the responsibility of the ACO itself, not the participating providers. The burden of holding participating providers financially accountable shall rest with the ACO, and the ACO should be able to exhibit their ability to manage the risk as noted above. This model must not disproportionately punish any particular organization within the ACO.

The GMCB Analytics Contractor will calculate the ACO's losses, but the ACO and the Payers will be asked to certify the accuracy of this calculation prior to a final determination by the Analytics Contractor. Once this certification has been received, the Analytics Contractor will provide written notification to the ACO of its liability for losses. ACOs that generate losses under the interim payment calculation must repay the losses within 90 days of notification by the Analytics Contractor. In addition, any money determined to be owed by an ACO after the first performance year reconciliation, whether as a result of additional shared losses or an overpayment of shared savings (from the interim payment), must be paid to the Payers within 90 days of such notification.

ACO-Patient Freedom of Choice

Objective:

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

ACO Governance Standard

Objective:

To ensure that the ACO maintains a governance structure that provides for accountability and ACO network and consumer engagement.

Components of proposed Governance Standard:

- Define responsibilities of ACO board and board member roles
- Transparent governing process (publish names of board members, provide time at the beginning of each in-person meeting for public comment and public updates, make minutes available to ACO provider network upon request, post summaries of ACO activities on website)
- Fiduciary duty to the ACO
- 75% control of the board must be held by ACO participants (not the same as a governing body of an ACO participant)
- At least one consumer representative on the board for each participating payer category (Medicaid, Commercial, Medicare); regardless of the number of participating payers, ACO board must have at least 2 consumer representatives
- ACO not found in non-conformance regarding consumer representation if GMCB determines that it has recruited consumer representatives with goodwill on an ongoing basis without success
- Must have process for including perspectives of network physicians
- Must have process for inviting and considering consumer input regarding ACO policy, including a consumer advisory board that meets at least quarterly
- Must have conflict of interest policy
- Must have leadership and management structure that includes clinical and administrative systems (Medicaid/Medicare requirement)

ACO Patient Attribution Standard

Objective:

- Closely Follows the Blueprint patient attribution rules
- Some differences between the Commercial process and Medicaid process
  - Look back period
  - Medicaid “super eligibility categories”
  - One additional CPT code
- Attribution based primarily on patient relationship to primary care providers

ACO Shared Savings and Payment Calculation Standard

Commercial:

- Shared Savings only Years 1 and 2
- Up to 5% downside risk in Year 3
- Shared savings and risk based on following formula:
  - 25% Provider/75% Payer between expected and target, 60% Provider/40% Payer below or above target up to 10% of expected
  - Minimum Savings Rate (per Medicare Calculation) establishes the target
- Quality performance score informs savings distribution percentage (gate and ladder)

Medicaid:

- Follows Medicare Two Track Program
  - Track One --- No downside risk for three years: Savings shared 50/50 between ACO and Medicaid
  - Track Two --- Downside risk Year 1 - 5%, Year 2 - 7.5%, Year 3 – 10% Savings and Risk shared 60/40% between ACO and Medicaid
- Quality performance score informs savings distribution percentage (gate and ladder)

ACO Care Management Standards
(Under Development)

Objective:

Effective care management programs close to, if not at the site of care, for those patients at highest risk of future intensive resource utilization is considered by many to be the linchpin of sustained viability for providers entering population-based payment arrangements. 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.

Components of proposed Care Management Standard:

- Under Development ---Referred to Care Management/Care Modeling Work Group
- Alignment between Commercial and Medicaid Standards will be considered to the greatest extent possible

ACO Payment Alignment Standard

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.

Components of proposed Payment Alignment Standard:

- The performance incentives that are incorporated into the payment arrangements between an insurer and an ACO should be appropriately reflected in those that the ACO utilizes with its contracted providers

- ACOs utilizing a network model should be encouraged to create regional groupings (or “pods”) of providers under a shared savings model that would incent provider performance resulting from the delivery of services that are more directly under their control. The regional groupings or "pods" would have to be of sufficient size to reasonably calculate "earned" savings or losses

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

- Alignment between Commercial and Medicaid Standards will be achieved to the greatest extent possible

ACO Data Use Standards
(Under Development)

Objectives:

- ACOs and Payers must share sufficient data to adequately monitor performance, utilization, and expenditures.

Components of proposed Data Use Standard:

- Data Standards are under development by a sub-group of the ACO Standards Work Group
- Currently, Medicaid data use standards are more similar to Medicare than to the Commercial standards
- ACO data provision standards are currently aligned for Commercial and Medicaid

REVISED PROPOSAL FOR MEDICAID SHARED SAVINGS ACO STANDARDS, 9/10/13
Reflecting Feedback from the SIM Steering Committee and SIM Core Team

Summary of Steering Committee Comments Received
(for more complete summary, see separate document)

Comments from the Steering Committee reflected a general agreement that:

- Having diverse partners in a Medicaid ACO will be crucial for success;
- All stakeholders would benefit from gaining experience with the model, and need some time to obtain and analyze data regarding the total costs of care and beneficiary use of services. All generally agreed that risk and uncertainty should be minimized in the first year of the pilot and should increase over time, with a clear positive incentive for those providers who want to organize more broadly or bear more risk than is required;
- Additional time to develop cross-provider relationships would be helpful;
- Consumer protection and involvement are paramount in a Medicaid ACO due to the special needs and potential vulnerabilities of the people served by Medicaid;
- Providers should be allowed to transition to bearing risk for the Medicaid population, given the varying levels of experience in managing services for the program;
- There should be meaningful consumer (beneficiary) input to ACO decisions;
- There should be meaningful provider (participants) input to ACO decisions.

Some stakeholders did not think the proposed standards did enough to assure meaningful consumer and provider representation in ACO governance. There also was disagreement about the appropriate definition of total costs of care. Staff and the Core Team have developed a revised proposal (described below) that attempts to identify potential common ground on these areas of disagreement, and we welcome your comments on this proposal.

Revised Proposal in Response to Comments Received

1. <u>Revised proposal for phased-in Medicaid ACO requirements</u>

Vermont has committed to testing the Medicaid Shared Savings ACO model under the SIM grant. Our challenge is to create a Medicaid SSP-ACO program that balances the needs for consumer and provider protections with appropriate incentives for creative change in care delivery. **To address concerns raised about uncertainty and risk, and the total cost of care definition included in the original model**, we are proposing a revised general approach to program design that would expand the scope of Medicaid ACOs over three years in terms of two dimensions: the definition of total costs of care

and provider participation agreements. ACOs also would have the option of assuming limited downside risk, but would not be required to. Minimum savings rates and sharing of savings between the State and the ACO would remain as described in the original proposal.

The parameters for each of the three years in terms of would be as follows:

Year One

Year one of the program will be designed to minimize requirements for provider risk-bearing, while still providing some incentive for providers who want to exceed minimum program requirements: providers will have a choice of track 1 (shared savings only) or track 2 (limited downside risk).

Total costs of care will include "core costs" only – essentially what is included in Medicare parts A and B (see attachment B for details).

Year Two

In year two, ACOs would be eligible for an additional 10 percent in savings, if they:

1. Expand the total cost of care definition to include all additional categories of services (e.g., dental, transportation, LTSS, HCBS)
2. Demonstrate provider participant agreements—with members of MH&SA, HCBS, LTSS, and DS in the geographic regions represented.

Year Three

In year three, ACOs would be required to

1. Expand the total cost of care definition to include all additional categories of services (e.g., dental, transportation, LTSS, HCBS)
2. Demonstrate provider participant agreements—with members of MH&SA, HCBS, LTSS, and DS in the geographic regions represented.

Those who had elected to take the optional track in year two would continue to be eligible for additional savings; those who waited for year three would not.

Additional provisions

In addition:

A. ACOs would be required to participate in collaborative learning to guide any needed adjustments to the risk model and service model in years two and three.
B. Participating ACOs will be asked to do an annual assessment using a validated tool to assess their readiness to be a safety net ACO: http://www.law.berkeley.edu/files/bclbe/Mar6_FINAL_combined.pdf. This data will be used to help the State identify and manage any gaps and would provide useful data on which to compare multiple ACOs in the State.
C. Participating ACOs would be eligible for "capacity grants" that assist them in developing the capacity to include more participants in their organization or more services in their definition of total costs of care

2. Revised proposal for consumer representation in ACO governance and decision-making

NOTE: This proposal was approved by the ACO Standards Work Group on 9/9, and developed with input from Legal Aid, the Health Care Ombudsman and OneCare

1. The ACO must maintain an identifiable governing body that has responsibility for oversight and strategic direction of the ACO, holding ACO management accountable for the ACO's activities.
2. The organization must identify its board members; define their roles; and describe the responsibilities of the board.
3. The governing body must have a transparent governing process which includes the following: publish the names and contact information for the governing body members; devote 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 provide public updates of ACO activities; make meeting minutes available to the ACO's provider network upon request; and post summaries of ACO activities provided to the consumer advisory board on the ACO's website.
4. The governing body members must have a fiduciary duty to the ACO and act consistently with that duty.
5. The ACO's governing body must also include:
   - at least one consumer member who is a Medicare beneficiary (if the ACO participates with Medicare);
   - at least one consumer member who is a Medicaid beneficiary (if the ACO participates with Medicaid); and
   - at least one consumer member who is a member of a commercial insurance plan (if the ACO participates with one or more commercial insurers).
6. Regardless of the number of payers with which the ACO participates, there must be at least two consumer members on the ACO governing body. These consumer members should have some personal, volunteer, or professional experience in advocating for consumers on health care issues. They should also

be representative of the diversity of consumers served by the organization, taking into account demographic and non-demographic factors including, but not limited to, gender, race, ethnicity, socioeconomic status, geographic region, medical diagnoses, and services used. The ACO's governing board shall consult with advocacy groups and organizational staff in the recruitment process.

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

Additional proposal from the SIM Core Team:

The ACO shall submit annual plans for meaningful consumer engagement that informs and impacts organizational policies and practices relating to governance, operations and evaluation.

3. Revised proposal for provider representation in ACO governance and decision-making

The original proposed standards included: At least 75 percent control of the ACO's governing body must be held by ACO participants or provide for meaningful involvement of ACO participants on the governing body.

The Core team did not reach consensus on how to expand on this requirement to provide for more explicit or robust representation of mental health and long-term services and supports providers. We would benefit from your specific suggestions. We agreed that representation of every possible Medicaid provider category would not be workable. We considered a requirement that some percentage of the provider representation (the 75 percent) be MH and/or LTSS providers, and would welcome your thoughts on that approach.

Vermont Commercial ACO Pilot
Compilation of Pilot Standards
September 9, 2013 Draft

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

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

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

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

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

The objectives and details of each draft standard follow.

I. Financial Stability

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

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

1. Payers will assess whether changes in provider coding patterns have had a substantive impact on medical spending, and if so, bring such funding and documentation to the GMCB for consideration with participating pilot ACOs.

B. Standards related to downside risk limitation

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

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

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

C. Standards related to financial oversight.

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

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

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

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

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

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

II. Risk Mitigation

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

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

III. Patient Freedom of Choice

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

IV. ACO Governance

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

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

3. The governing body must have a transparent governing process which includes the following:
    a. publishing the names and contact information for the governing body members;
    b. devoting an allotted time at the beginning of each in-person governing body meeting to hear comments from members of the public who have signed up prior to the meeting and providing public updates of ACO activities;

c. making meeting minutes available to the ACO's provider network upon request, and
d. and posting summaries of ACO activities provided to the ACO's consumer advisory board on the ACO's website.

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

5. At least 75 percent control of the ACO's governing body must be held by ACO participants or provide for meaningful involvement of ACO participants on the governing body.

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

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

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

V. Patient Attribution

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

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

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

3. For products that require members to select a primary care provider, attribute those members to that provider.

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

CPT-4 Code Description Summary
Evaluation and Management - Office or Other Outpatient Services • New Patient: 99201-99205 • Established Patient: 99211-99215
Consultations - Office or Other Outpatient Consultations • New or Established Patient: 99241-99245
Nursing Facility Services: • E & M New/Established patient: 99304-99306 • Subsequent Nursing Facility Care: 99307-99310
Domiciliary, Rest Home (e.g., Boarding Home), or Custodial Care Service: • Domiciliary or Rest Home Visit New Patient: 99324-99328 • Domiciliary or Rest Home Visit Established Patient: 99334-99337

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

CPT-4 Code Description Summary
Home Services • New Patient: 99341-99345 • Established Patient: 99347-99350
Prolonged Services – Prolonged Physician Service With Direct (Face-to-Face) Patient Contact • 99354 and 99355
Prolonged Services – Prolonged Physician Service Without Direct (Face-to-Face) Patient Contact • 99358 and 99359
Preventive Medicine Services • New Patient: 99381–99387 • Established Patient: 99391–99397
Counseling Risk Factor Reduction and Behavior Change Intervention • New or Established Patient Preventive Medicine, Individual Counseling: 99401–99404 • New or Established Patient Behavior Change Interventions, Individual: 99406-99409 • New or Established Patient Preventive Medicine, Group Counseling: 99411–99412
Other Preventive Medicine Services – Administration and interpretation: • 99420
Other Preventive Medicine Services – Unlisted preventive: • 99429
Newborn Care Services • Initial and subsequent care for evaluation and management of normal newborn infant: 99460-99463 • Attendance at delivery (when requested by the delivering physician) and initial stabilization of newborn: 99464 • Delivery/birthing room resuscitation: 99465
Federally Qualified Health Center (FQHC) – Global Visit ***(billed as a revenue code on an institutional claim form)*** • 0521 = Clinic visit by member to RHC/FQHC; • 0522 = Home visit by RHC/FQHC practitioner • 0525 = Nursing home visit by RHC/FQHC practitioner

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

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

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

7. Insurers will run their attributions at least quarterly.

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

VI. Calculation of ACO Financial Performance and Distribution of Reconciliation Payments

(See attached spreadsheet.)

I. Actions Initiated Before the Performance Year Begins

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

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

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

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

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

2. dental benefits [4].

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

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

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

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

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

As noted above, the Year 3 targeted spending shall be calculated using an alternative methodology to be defined by the GMCB with pilot participant input.

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

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

II. Actions Initiated After the Performance Year Ends

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

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

PMPM medical expense spending shall then be adjusted as follows:

- clinical case mix using a common methodology across commercial insurers;
- truncation of claims for high-cost patient outliers whose annual claims value exceed $125,000, and
- conversion from allowed to paid claims value.

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

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

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

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

Once the insurer-specific savings have been calculated, an ACO's share of savings will be determined in two phases. This step defines the ACO's eligible share of savings based on the degree to which actual PMPM spending falls below expected PMPM spending. The share of savings earned by the ACO based on the methodology above will be subject to qualification and modification by the application of quality performance scores as defined in Step 4.

In Years 1 and 2 of the pilot:

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

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

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

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

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

If the sum of ACO savings at the insurer-specific level is greater than that generated in aggregate, the insurer-specific ACO savings will be reduced to the aggregate savings amount. If reductions need to occur for more than one insurer, the reductions shall be proportionately reduced from each insurer's shared savings with the ACO for the performance period. Any

reductions shall be based on the percentage of savings that an insurer would have to pay before the aggregate savings cap [5]

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

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

Comment [MB1]: Precise methodology currently under discussion by the ACO Standards Work Group.

The Gate: In order to retain savings for which the ACO is eligible in accordance with Steps 1-3 above, the ACO must meet a minimum threshold for performance on a defined set of common measures to be used by all pilot-participating commercial insurers and 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:

[5] A reciprocal approach shall apply to ACO excess spending in Year3, such that excess spending calculated at the issuer-specific level shall not exceed that calculated at the aggregate level.

Table 1

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

Comment [MB2]: The adopted measures will be listed following the table once they have been finalized by the ACO Standards Work Group.

Step 5: Distribute shared savings payments

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

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

Step 6: Periodic assessment of pilot utilization and financial experience

During Years 1 and 2, the GMCB, each ACO and pilot insurers shall conduct joint quarterly reviews of utilization and financial performance and discuss the implications for the target-setting methodology for Year 3.

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

Objective: Effective care management programs close to, if not at the site of care, for those patients at highest risk of future intensive resource utilization is considered by many to be the linchpin of sustained viability for providers entering population-based payment arrangements. Any standards will be developed by the SIM Care Management Care Model Work Group. For Year 1 of the pilot emphasis will be placed upon member communication and care transitions.

VIII. Payment Alignment

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

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

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

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

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

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

Summary of Stakeholder Comments

Between August 19th, 2013 and September 4th, 2013, DVHA received comments from the following stakeholders in response to its proposed ACO program standards as presented at the August 22nd SIM Steering Committee Meeting:

- OneCareVermont (In collaboration with VAHHS and VMS)
- Community Health Accountable Care
- Vermont Health Care Association
- Department of Disabilities Aging and Independent Living
- Vermont Legal Aid (in collaboration with the office of the State Health Care Ombudsman and the State Long Term Care Ombudsman)
- Vermont Legal Aid (in collaboration with the Senior Citizens Law Project, and the Community of Vermont Elders)
- Vermont Council of Developmental and Mental Health Services
- Deborah Lisi-Baker (Co-Chair of SIM Duals Work Group)
- DVHA/SIM Payment Models Work Group Staff

The following is a summary of all stakeholder comments and recommendations received by DVHA, organized into the following four key decision making areas:

1. Accountability and Saving Percentages
2. Governing and Participation
3. Total Cost of Care (TCOC) Definition
4. Other

In addition to the included summary of stakeholder comments, DVHA plans to release a *Medicaid ACO Standards FAQ*, based on common themes and areas of inquiry identified throughout the stakeholder comments received.

Core Team Decision Area: Introduction of Down-Side Risk and Sharing Percentages	
Stakeholder	**Comment**
OneCareVermont (in collaboration with VAHHS and VMS)	• Assume that the 50%-50% proposed MSR model 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. Open to reviewing a model where an ACO receives some share on first dollar savings even if the MSR is never met. • Open to reviewing a program with a more attractive sharing model that includes a commitment to downside risk. Differential would have to be very high in order to truly consider the downside risk option a feasible consideration. Given that in 2016 OneCare will potentially be on the hook for 5% downside risk with MSSP and a yet to be determined percentage of risk with the Commercial ACO program, in combination with the complexity of Medicaid's population; OneCare Strongly encourages Medicaid to offer a no downside risk track for the first three years of the program. • Encourages Medicaid to apply its portion of savings to remedying the Medicaid cost shift, rather than accrue to the General Fund or apply to DVHA operational costs.
Community Health Accountable Care	• Strongly recommends that the State offer a "no-down-side risk" option similar to the "track 1" option within the CMS Shared Savings Program to allow for the safest testing of delivery system redesign in a way that in not likely to cause financial harm to providers.
Vermont Health Care Association	• TCOC for nursing facilities, ERC, and assisted living settings includes: 24/7 supervision, room, meals, personal care, skilled and routine nursing, medical supplies and DME, OTC medications, all therapies, medication administration, dental, mental health, case management, and transportation. Medicaid does not reimburse at actual cost of care (estimate that Medicaid reimbursement is lagging by $13 million). Any efforts to produce savings must first address under-reimbursement.
Department of Disabilities Aging and Independent Living	• As opposed to commercial payers, DVHA is subject to state law and budget constraints, and some of DVHA's providers (DA's and HHA's) are limited in capacity to handle risk in comparison with commercial providers. • Request that DVHA's legislative budgetary process be taken into consideration.
Vermont Legal Aid	• Believe that decreased financial risk in first three years make ACOs better suited to include consumer participation in all aspects of the program. *(in collaboration with the office of the State Health Care Ombudsman and the State Long Term Care Ombudsman)*

Vermont Council of Developmental and Mental Health Services	• Recommend that the ACO start with upside risk only. • Recommend inclusion of standards regarding distribution of savings within an ACO. Suggest that the following are considered when determining how to distribute savings amongst participants: how a provider contributed to overall savings; provider performance on quality indicators; and investments needed to improve health outcomes of specific populations.
Deborah Lisi-Baker (Co-Chair of SIM Duals Work Group)	• Recommend that in order to support transition from fee-for-service to bundled payment models, goals need to be planned for and tested within a demonstration period. • Recommend that the State provide oversight and direction to ACOs on the distribution and use of savings, supporting improved services and better health outcomes for Medicaid population. Suggest that the State and ACOs negotiate these percentages annually.
DVHA/SIM Payment Models Work Group Staff	• Alignment between the payer models minimizes the complexity of the programs for both payers and participants. • Less programmatic complexity means more focus on care delivery transformation and less on navigating red tape. • Evidence suggests that joint accountability is necessary to achieve success under an ACO model. In the absence of downside risk, the performance-based component of the program must be strong and effective.

Core Team Decision Area: Governing and Participation	
Stakeholder	**Comment**
OneCareVermont (in collaboration with VAHHS and VMS)	• No official comments submitted on this topic to date. • Subsequent workgroup conversations (since 8/22 Steering Committee) have led us to believe that OneCareVermont will likely oppose making ACO board meetings and minutes fully available to the public; and would be open to supporting quarterly meetings between the ACO governance board and the "Consumer Advisory Group", either in lieu of or in addition to beneficiary representation on the ACO board itself. • This discussion will be continued in more detail in September 5, 2013 ACO Governance/Consumer Advocacy Subgroup.
Community Health Accountable Care	• No official comments submitted on this topic to date. • This discussion will be continued in more detail in the September 5, 2013 ACO Governance/Consumer Advocacy Subgroup.
Vermont Health Care Association	• Request representation from each provider type participating in ACO.
Vermont Health Care Association	• The lower the downside risk the more providers will be incentivized to participate, especially those who haven't participated in past reform efforts.

Department of Disabilities Aging and Independent Living	• Recommends that the beneficiary experience (rather than provider interest) drive the mission and governance. Specifically:
	  • Change "participant" to "partner"
	  • ACO should not exclude Medicaid beneficiaries from governing board. One beneficiary will not represent diverse population, recommend inclusion of one beneficiary from each Medicaid subpopulation.
	  • Also recommend including one provider from each HCBS-MH, HCBS-DS, and LTSS on the ACO governing board.

Vermont Legal Aid	*(in collaboration with the office of the State Health Care Ombudsman and the State Long Term Care Ombudsman)* • Suggest that current proposed standard does not offer sufficient means for consumers to learn about their ACO, offer ideas and input, or participate in strategic decision making on processes that will affect patients' experience with the health care system. Therefore recommend that ACOs must have a governance structure that promotes patient engagement and gives consumers a meaningful voice. Main components include: • **At least three to four consumers on governing board, including a patient representative from the Medicare ACO program, the Medicaid ACO program, and one or two from the Commercial ACO program.** Even if an ACO does not participate in a particular program, their board should still be required to include at least three consumers. Specifically the RFP should require the ACO to: adopt a process for selecting consumer representatives; specify what (financial, organizational, and experiential) resources they will

	provide to support consumer board members; identify a conflict of interest policy; and seek input from ACO participants in identifying potential consumer reps.
	
	• **At least one consumer advocate on governing board, including an explanation of how the ACO will engage the GMCB in either selection or approval of said advocate**. Consumer advocate is defined as someone who has professional, volunteer, or personal experience advocating for consumers on health care issues.
	
	• **Establishment of a consumer advisory board,** acknowledging that consumer representation on an ACO governing board is distinct from consumer representation on an ACO advisory board. Recommend that the ACO RFP require the ACO to describe how it would establish a consumer advisory board including its plan for soliciting and selecting members, and what (financial, organizational, and experiential) resources they will provide to support the consumer advisory board.
	
	• **Establishment of patient and family councils for all participating hospitals in year 2 of the program.**
	
	• **Transparency standards including:**
	  • Public invitation to all governing board meetings
	  • Make public board meeting minutes
	  • Make public ACO/Participant contracts
	  • Make public ACO/State contract

Vermont Legal Aid	*(in collaboration with the Senior Citizens Law Project, and the Community of Vermont Elders)* • Fully support the comments provided by Vermont Legal Aid in collaboration with the office of the State Health Care Ombudsman and the State Long Term Care Ombudsman, and recommend that consumer participation and input in the Medicaid ACO governance structure is an essential component of this reform effort in Vermont.
Vermont Council of Developmental and Mental Health Services	• Recommend a more comprehensive integration of the voice of people who use and are actively involved in mental health, disability and long term care services in the planning, development and implementation stages. • Request that DA/SSAs are actively represented in the governance and advisory structures. Express concern that one spot is not enough to represent nursing homes, home health, and DA/SSAs on a Medicaid ACO board.

Deborah Lisi-Baker(Co-Chair of SIM Duals Work Group)	• Suggest that the role of beneficiaries in providing direction and leadership to the ACO needs to be better defined. • Recommend to change governance objective from "provider driven" to "active engagement of providers, beneficiaries and other essential partners" • Recommend that one beneficiary representative is not sufficient, and that no exemption be provided from having more than one beneficiary on governing board. Ideal recommend is a beneficiary from each of Medicaid beneficiary groups. • Recommend that governing board be required to define and adopt policies on involving advisory committee members and other beneficiaries in ways that meaningfully inform and influence governing board actions. • Recommend that ACOs be required to develop annual plans for broader beneficiary engagement (workgroups, focus groups, and other evaluations). • Recommend that ACOs are required to include representatives of the diverse organizations and practitioners serving the six Medicaid enrollment groups, including disability and long term care populations.

Core Team Decision Area: Total Cost of Care (TCOC) Definition	
Stakeholder	**Comment**
OneCareVermont (in collaboration with VAHHS and VMS)	**Included/Excluded Costs:** • **Dental:** understand the dental benefit is small, nonetheless do not have expertise in direct management of dental service. Believe that there is a dental-health component to overall health, but prefer to set a goal of encouraging regular dental health and visits to dental professionals rather than direct accountability for that spend. • **Prescription benefits through retail pharmacy claims:** want significant information on this benefit, level of spending, and time to analyze benchmarks before agreeing to take accountability in year one. Suggest "tracking and access to data" model in year one, with potential inclusion in spending target pools in years two and three. • **Transportation Benefits:** request a dialogue to better understand the benefit and baseline level of spend before issuing final comments on inclusion. **ACO Participant Network:** • Comfortable with model of collaboration with LTSS and MH&SA providers, request that collaboration be flexible and non-directive to ensure freedom of creative approaches and processes.
Community Health Accountable Care	• **Exclusion of Specialized Populations:** understand the rationale for excluding specialized populations, request that information be given on the specific populations and criteria that would be used to identify specialized populations. Concerned that cutting too many potential participants out might affect populations of patients that would be ideal for care coordination models like the ACO model. Request information about the total number of patients impacted by ACOs. • **ACO Participant Network:** recommend that Medicaid adopt a model in which formal inclusion of LTSS, Mental Health, and Substance Abuse is encouraged by the compensation mechanisms and quality measures of the ACO but is not a formal requirement. Request that Medicaid define the precise requirement early in the process. Primary concern is being excluded from participation if an insufficient number of providers are formally contracted within the limited window of time to apply. • **Inclusion of Dental, Pharmacy, and Transportation:** Support inclusion over time. As the management of any cost data and accountability is relatively new to all ACOs, recommend that each ACO be given the data to manage these three buckets in year 1, but that they not be used to determine the shared savings baseline and actual spending in year 1.
Vermont Health Care Association	• Request that ACO model align with ongoing efforts to restructure payment for dementia and mental health/behavioral care.

Department of Disabilities Aging and Independent Living	**Included/Excluded Costs:** • Recommend that transportation services are deleted from ACO spending responsibility. • Recommend including community-based Medicaid services for individuals who are aging and with disabilities.
Vermont Council of Developmental and Mental Health Services	**Included/Excluded Costs:** • Recommend inclusion of all costs in Medicare part A and B; plus dental, pharmacy, transportation, long term support services, mental health and substance abuse, and developmental services. Generally support this integration of all costs, but request a slow-down of the implementation time table. **ACO Participant Network:** • Recommend that designated agencies continue statutory role and are included in ACOs, particularly the Medicaid ACO as an option for services and as health homes.
Deborah Lisi-Baker(Independent Consultant/Co-Chair of SIM Duals Work Group)	**Excluded Populations:** • Supports exclusion of duals in year 1, expresses concern about excluding individuals with TBI and when they will be added back into the ACOs attributed population.

Core Team Decision Area: Other	
Stakeholder	**Comment**
OneCareVermont (in collaboration with VAHHS and VMS)	**Attribution Model:** • Encourage both near and long term assessment and flexibility. Short term – request attribution test-runs for interested ACOs during RFP process in order to identify need to collaboratively design modifications or add tiers to attribution query (as early as 2014), envision a dialogue over time (specifically addressing specialist physician attribution). **Calculation of Savings:** • Request discussion on how "expected" spending will be calculated, and how three year trend factor will be applied. • Request discussion on risk adjustment methodology. • Request that expected spending levels be calculable in advance for each performance year based on initial attribution models, even if adjusted later based on actual attributed population. **Quality Standards:** • Encourages fewer measures initially, adding over time. Ensure that ACOs have access to baseline performance, ongoing measurement at reasonable cost, and clear standards and targets for performance. **Operational Requirements:** • Encourage minimal specific operational requirements, encourage common processes and systems across populations and programs. **Data Release with RFP:** • Request actuarial breakdown of current spend for all Medicaid to-be-attributed beneficiaries, and to be prepared to do an attribution run during RFP negotiation. **Technical Support:** • Expect that SIM grant or other funds will be available to support core clinical and administrative operations as well as focused technologic or clinical projects in support of reform. **DVHA Readiness:** • Encourage DVHA to conduct a readiness assessment to administer its obligations under proposed program, including beneficiary attribution, baseline and target calculations, and ability to feed claims to ACO information systems. **Future of Medicaid SSP:** • Envision a true joint design for whether and how dually eligible (and other) populations will be included over time.

Community Health Accountable Care	**Timeline/Limited Funding:** • Concern of limited funding and time to support RFP response. **State Plan Amendment:** • Concern that CMS will change the program after program is launched. **Mid-Level and Specialist Attribution:** • Support inclusion of mid-levels for attribution as these providers are providing primary care in a PCMH. Does not support attribution of patients to specialists. **Continuous Enrollment:** • Express concern that patient churn could have impact on ability to participate in savings. Request medical claims data on number of patients and length of time covered by Medicaid. **12/24 Month Look back:** • Support 24 month look back and feel that members will be disadvantaged by limited look back period. PCMHs that work with patients via non-billable mechanisms (phone/email) will be disadvantaged as their populations may not be attributed. **High-Cost Outliers:** • support elimination, recommend eliminating entirely when calculating performance against benchmark. **Payment Lag:** • Encourage an advance payment to help offset implementation costs (model after advanced payment demonstration offered by CMS). **Risk Adjustment Methodology:** • Encourage a component of social determinants of health for any method used to alter premiums. **Year One Quality Metrics Reporting**: • Encourage "reporting" status for all measures in year one to allow normalization of challenges such as churn, and establishment of baseline data and feasibility of benchmarks.
Department of Disabilities Aging and Independent Living	**Financial Stability Standard:** • Recommend to change "patients" to "person/individual/beneficiary" **Financial Oversight:** • Recommend Medicaid ACO program financial reports be submitted quarterly. **Freedom of Choice:** • Recommend that reconsideration of this standard in y2-3 not apply to Medicaid.

	Attribution: • Recommend replacing "member" with "individual". • Request clarification on how Medicaid beneficiaries who also have commercial insurance will be attributed. • Request clarification on how churn will affect attribution. • Question if all Medicaid beneficiaries will be attributed to an ACO, and if not how this will affect beneficiaries not attributed to ACOs. **Calculation of Financial Performance and Distribution of Savings:** • Request consideration of legislative budgetary process when addressing payment changes • Request change from "medical expense" to "expense" • Recommend that RFP permit bidders to propose a rational distribution of funds, then allow DVHA to negotiate specifics through contract award process. **Care Management Standards:** • Request that workgroup include customer representatives and DVHA/provider staff who provide care management in work group. **General:** • Request that "may" be changed to "shall" throughout the standards document.
Vermont Council of Developmental and Mental Health Services	**Impact of Multiple ACOs** • Express concern that DA/SSAs will potentially be subjected to overly burdensome processes (payment, clinical protocols, care management, quality assurance, utilization management, data and financial reporting) for dealing with multiple ACOs. **Distribution of Resources** • Recommend that SIM funds are invested at the provider level (particularly DA/SSAs who have very limited resources) to support IT and other infrastructure needed to participate in payment and delivery models, and to manage the presence of financial risk. **Regional Provider Groupings** • Recommend that ACOs support regional collaborations to develop care coordination and service delivery models that work best regionally. **Medicaid Eligibility Categories** • Recommend that the following Medicaid eligibility categories are included (except court ordered psychiatric patients): aged, blind or disabled adults, new adults previously in VHAP, general adults, blind or disabled children, general children, and SCHIP children. **Attribution:** • Recommend a 12 month look back period.

Performance Measures for Vermont Commercial and Medicaid ACOs: Recommended Year 1 Measures

SIM Steering Committee

September 18, 2013

Two Measure Sets

Core Measure Set

- The Core Measure Set consists of measures for which the ACO has current or pending responsibility for collecting for either reporting or payment purposes. The measures that are designated for monitoring purposes or for tracking utilization are not considered Core Measures.

Monitoring and Evaluation (M&E) Measure Set

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

Measure Use Terminology: Core Measure Set

Payment

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

Reporting

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

Pending

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

YEAR 1 RECOMMENDED CORE MEASURES: Summary

Year One Core Measure Use	Data Source	Medicaid-Commercial Alignment
Payment	Claims	9
Reporting	Claims	4
Reporting	Clinical	7
Reporting	Survey	9
Pending (for potential use in Years 2-3)	All	22
TOTAL YEAR 1 PAYMENT/REPORTING	All	29

YEAR 1 RECOMMENDED CORE MEASURES: Payment/Claims (9)

All Payers	• (Core-3/ MSSP-29)* Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control (<100 mg/dL) (LDL Screening Only)	1
Commercial & Medicaid	• (Core-1) Plan All-Cause Readmission • (Core-2) Adolescent Well-Care Visit • (Core-4) Follow-up After Hospitalization for Mental Illness, 7 day • (Core-5) Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: a) Initiation, b) Engagement • (Core-6) Avoidance of Antibiotic Treatment for Adults With Acute Bronchitis • (Core-7) Chlamydia Screening in Women	6
Medicaid-Only	• (Core-8) Developmental Screening in the First Three Years of Life • (Core-9) Depression Screening by 18 years of age	2

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*Please note that Core-3 is counted in both the "payment" and "pending" categories since the claims-based LDL-screening will be used for payment until the clinical data-based Complete Lipid Panel and LDL Control are ready to be used for payment, at which point it will replace LDL screening.

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YEAR 1 RECOMMENDED CORE MEASURES: Reporting/Claims (4)

All Payers	• (Core-10/ MSSP-9) Ambulatory Care-Sensitive Conditions Admissions: COPD • (Core-11/ MSSP-20) Mammography /Breast Cancer Screening	2
Commercial & Medicaid	• (Core-12) Rate of Hospitalization for Ambulatory Care-Sensitive Conditions: PQI Composite • (Core-13) Appropriate Testing for Children with Pharyngitis	2

YEAR 1 RECOMMENDED CORE MEASURES: Reporting/Clinical (7)

All Payers	• (Core-16/ MSSP-22-26) Diabetes Composite (D5) (All-or-Nothing Scoring): Hemoglobin A1c Control (<8 percent), Low Density Lipoprotein (<100), Blood Pressure <140/90, Tobacco Non Use, Aspirin Use • (Core-17/ MSSP-27) Diabetes Mellitus: Hemoglobin A1c Poor Control (>9 percent) • (Core-18/ MSSP-19) Colorectal Cancer Screening • (Core-19/ MSSP-18) Depression Screening and Follow-up • (Core-20/ MSSP-16) Adult Weight (BMI) Screening and Follow-up	5
Commercial & Medicaid	• (Core-14) Childhood Immunization Status (Combo 10) • (Core-15) Pediatric Weight Assessment and Counseling	2

YEAR 1 RECOMMENDED CORE MEASURES: Reporting/Survey (9)

Patient Experience Survey Composites:

Commercial & Medicaid

- (Core-21) Access to Care Composite
- (Core-22) Communication Composite
- (Core-23) Shared Decision-Making Composite
- (Core-24) Self-Management Support Composite
- (Core-25) Comprehensiveness Composite
- (Core-26) Office Staff Composite
- (Core-27) Information Composite
- (Core-28) Coordination of Care Composite
- (Core-29) Specialist Composite

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Note: Medicare will use 7 similar patient experience composite measures from the Medicare National Implementation Survey.

YEAR 1 RECOMMENDED CORE MEASURES: Pending (22)

All Payers

- (Core-3*/ MSSP-29)* Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control (<100 mg/dL) (the combined screening/control measure will eventually replace CORE-3 “screening only”)
- (Core-31/ MSSP- 30) Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic
- (Core-35/ MSSP-14) Influenza Immunization
- (Core-36/ MSSP-17) Tobacco Use Assessment and Tobacco Cessation Intervention
- (Core-38/ MSSP-32-33) Coronary Artery Disease (CAD) Composite
- (Core-39/ MSSP-28) Hypertension (HTN): Controlling High Blood Pressure
- (Core-40/ MSSP-21) Screening for High Blood Pressure and follow-up plan documented

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*Please note that Core-3 is counted in both the “payment” and “pending” categories since the claims-based LDL-screening will be used for payment until the clinical data-based Complete Lipid Panel and LDL Control are ready to be used for payment, at which point it will replace LDL screening.

YEAR 1 RECOMMENDED CORE MEASURES: Pending, cont'd (22)

Commercial & Medicaid

- (Core-30) Cervical Cancer Screening
- (Core-32) Proportion not admitted to hospice (cancer patients)
- (Core-33) Elective delivery before 39 weeks
- (Core-34) Prenatal and Postpartum Care
- (Core-37) Care Transition-Transition Record Transmittal to Health Care Professional *(Meaningful Use measure)*
- (Core-41) How's Your Health? *(Patient engagement measure)*
- (Core-42) Patient Activation Measure

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YEAR 1 RECOMMENDED CORE MEASURES: Pending, cont'd (22)

Medicaid-Only

- (Core-43) Frequency of Ongoing Prenatal Care
- (Core-44) Percentage of Patients with Self-Management Plans
- (Core-45) Screening, Brief Intervention, and Referral to Treatment
- (Core-46) Trauma Screen Measure
- (Core-47/ MSSP-13) Falls: Screening for Future Fall Risk *(duals-specific measure)*
- (Core-48/ MSSP-15) Pneumococcal Vaccination for Patients 65 Years and Older *(duals-specific measure)*
- (Core-49) Use of High Risk Medications in the Elderly *(duals-specific measure)*
- (Core-50) Persistent Indicators of Dementia without a Diagnosis *(duals-specific measure)*

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Measure Use Terminology: Monitoring and Evaluation Measure Set

Collection of these measures will not influence shared savings eligibility.

Monitoring

- These are measures that all participants would benefit from tracking and reporting. They are distinctive from Reporting and Payment in that they will have no bearing on shared savings and will not be collected at the ACO level; nonetheless, they are important to collect to inform programmatic evaluation and other activities. These measures will be reported at the plan or state level (or both). Data for these measures will be obtained from sources other than the ACO (e.g., health plans, VHCURES). Performance on the monitoring measures will be reviewed at the plan or state level on an annual basis. The measures will remain monitoring measures unless the performance falls to a level of concern, at which point the ACO Measures Work Group or its successor entity may determine that the measure should be moved to the Core Measure Set to be assessed at the ACO level and used for either payment or reporting.

Utilization or Cost

- These measures reflect utilization and cost metrics to be monitored on a quarterly basis for each ACO. How the data will be collected and who will calculate measures is yet to be determined. Data for these measures may be obtained from sources other than the ACO (e.g., health plans, VHCURES).

YEAR 1 RECOMMENDED M&E MEASURES: Monitoring (9)

Commercial & Medicaid: Plan Level — 6

- (M&E-1) Appropriate Medications for People with Asthma
- (M&E-2) Comprehensive Diabetes Care: Eye Exams for Diabetics
- (M&E-3) Comprehensive Diabetes Care: Medical Attention for Nephropathy
- (M&E-4) Use of Spirometry Testing in the Assessment and Diagnosis of COPD
- (M&E-5) Follow-up Care for Children Prescribed ADHD Medication
- (M&E-6) Antidepressant Medication Management

Commercial & Medicaid: State Level — 3

- (M&E-7) Family Evaluation of Hospice Care Survey
- (M&E-8) School Completion Rate*
- (M&E-9) Unemployment Rate*

*May be measured at plan level as well, if feasible.

YEAR 1 RECOMMENDED M&E MEASURES: Utilization/Cost (14)

Commercial & Medicaid

- (M&E-10) HealthPartners Total Cost of Care (TCOC) Total Cost Index (TCI)
- (M&E-11) HealthPartners Total Cost of Care (TCOC) Resource Use Index (RUI)
- (M&E-12) Ambulatory surgery/1000
- (M&E-13) Average # of prescriptions PMPM
- (M&E-14) Avoidable ED visits- NYU algorithm
- (M&E-15) Ambulatory Care (ED rate only)
- (M&E-16) ED Utilization for Ambulatory Care-Sensitive Conditions
- (M&E-17) Generic dispensing rate
- (M&E-18) High-end imaging/1000
- (M&E-19) Inpatient Utilization - General Hospital/Acute Care
- (M&E-20) Primary care visits/1000
- (M&E-21) SNF Days/1000
- (M&E-22) Specialty visits/1000

13

Medicaid-Only

- (M&E-23) Annual Dental Visit

1

Medicare Shared Savings Program (MSSP) Only Measures (12)

Please note that these measures are not required by either Commercial or Medicaid VT ACO Pilot Program.

MSSP-only Measures

- (MSSP-8) Risk-Standardized All-Condition Readmission
- (MSSP-10) Ambulatory Care-Sensitive Conditions Admissions: Heart Failure
- (MSSP-11) Percent of Primary Care Physicians who Successfully Qualify for an EHR Incentive Program
- (MSSP-12) Medication Reconciliation
- (MSSP-31) Heart Failure: Beta Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)

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MSSP-only Patient Experience Measures*

- (MSSP-1) Getting Timely Care, Appointments and Information
- (MSSP-2) How Well Your Providers Communicate
- (MSSP-3) Patient Rating of Provider
- (MSSP-4) Access to Specialist
- (MSSP-5) Health Promotion and Education
- (MSSP-6) Shared Decision Making
- (MSSP-7) Health Status/ Functional Status

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*Uses the Medicare-specific National Implementation Survey

Future Action Items

- Obtain final endorsement of the measure recommendations from the ACO Measures Work Group.
- Propose recommended measure sets to the ACO Standards Work Group, SIM Steering Committee, SIM Core Group, and GMCB.
- The joint ACO Standards and Measures Work Group will recommend targets for performance on payment measures, as well as a definition of “complete submission” for the reporting measures.
- The SIM HIE Performance Measures Subgroup will evaluate the status of recommended measures in EHRs throughout the state, and develop a plan of action to ensure that ACOs will be able to capture, transmit, and receive reports on their performance in a timely, accurate, and useful format.

Attachment B: Core Services Considered in the Total Cost of Care Calculation

Inpatient hosptial
Outpatient hospital
Nursing facility (will be very limited based on the six enrollment categories selected)
Physician (primary care and specialty)
Nurse Practitioner
Nursing
Ambulatory Surgery Center
Clinic
Federally Qualified Health Center
Rural Health Center
Chiropractor
Podiatrist
Psychologist
Optometrist
Optician
Independent laboratory
Home health
Hospice
Personal Care
Therapies
Prosthetic/Orthotics
Medical Supplies
DME
Ambulance
Dialysis Facility