

VERMONT ALL PAYER MODEL

ELEMENTS OF THE PROPOSED TERM SHEET

ACO CONSUMER PROTECTIONS

SENATE COMMITTEE ON HEALTH AND WELFARE
ENA BACKUS, DEPUTY EXECUTIVE DIRECTOR, GMCB

FEBRUARY 11, 2016

Part I: All-Payer Model Project Update

- Brief History
- Status of Negotiations with CMS

Act 54 of 2015

The Secretary of Administration or designee and the Green Mountain Care Board shall jointly explore an all-payer model, which may be achieved through a waiver from the Centers for Medicare and Medicaid Services.

- Enacted June 5, 2015

All-Payer Model

- An **all-payer model** is an agreement between the State and the Center for Medicare and Medicaid Services (CMS) that allows Vermont to explore new ways of financing and delivering health care.
- The all-payer model enables the three main payers of health care in Vermont – **Medicaid, Medicare, and commercial insurance, to pay for health care differently** than through fee-for-service reimbursement.

Goals of a Transformative All-Payer Model

- Improve experience of care for patients
- Improve access to primary, preventive services
- Reward high value care
- Construct a highly integrated system
- Empower provider-led health care delivery change
- Control the rate of growth in total health care expenditures
- Align measures of health care quality and efficiency across health care system

Why Pay Differently Than Fee-for-Service?

- Health care cost growth is not sustainable.
- Health care needs have evolved since the fee-for-service system was established more than fifty years ago.
 - More people are living today with multiple chronic conditions.
 - CDC reports that treating chronic conditions accounts for 86% of our health care costs.
- Fee-for-service reimbursement is a barrier for providers trying to coordinate patient care and to promote health.
 - Care coordination and health promotion activities are not rewarded by fee-for-service compensation structure.

Foundation for an All-Payer Model

- Vermont has all-payer reforms in place today
 - Shared Savings Program (SSP) for Accountable Care Organizations (ACOs)
 - Medicare offers a SSP for ACOs
 - Commercial SSP Standards
 - Medicaid SSP Standards
 - The Blueprint for Health
 - Medicare participates through a demonstration waiver
 - Commercial participation
 - Medicaid participation
- Fee-For-Service is still the underlying payment mechanism in these models

Next Generation of Accountable Care

- The federal government has created programs that encourage the use of **Accountable Care Organizations (ACOs)**.
- The federal **Next Generation ACO program** allows ACOs to be paid an all-inclusive population-based payment for each Medicare beneficiary attributed to the ACO. CMS will allow ACOs some flexibility in certain payment rules in exchange for accepting this new type of payment.

Leveraging Federal and State Payment Reform Efforts

- Vermont's proposal is for all payers to approach health care payment to ACOs in a common way.
 - New, all-inclusive population-based model of reimbursement rewards health care professionals that are adapting to the changing needs of the population; leverage Next Generation model.
 - All payers give doctors and other health care professionals the flexibility they need to lead health care delivery change.
- Health care providers' participation in ACOs is voluntary; the ACO must be attractive to providers and offer an alternative health care delivery model that is appealing enough to join.

Status of Negotiation with CMS

- GMCB and AOA have jointly explored an all-payer model through dialogue and negotiation with CMS.
- The result of this dialogue, and consultation with stakeholders and consultants, is a ***term sheet*** proposed by the State of Vermont to CMS
 - Proposed term sheet describes the basic policy framework that would allow Vermont's health care providers, payers, and the government to operate an all-payer model.
 - The proposed term sheet does not bind the state or federal governments.

Steps Toward an Improved Vermont Health Care System

Develop All-Payer Model and Financial Targets



Create Standards for Accountable Care Organization Program



Exercise GMCB Rate and Regulatory Authority



Attain Quality Improvement and Cost Control

Part II: Elements of the Term Sheet

Vermont's Proposed Term Sheet

- The term sheet includes all of the basic legal, policy, and enforcement provisions that would be in a Model Agreement.
- In some cases, terms refer to appendices which will have greater technical detail or to processes that will occur during 2016.

Term	
1.	Legal Authority
2.	Performance Period
3.	Medicare Beneficiary Protections
4.	Medicare Basic Payment Waivers
5.	Medicare Innovation Waivers
6.	Infrastructure Payment Waivers
7.	Fraud and Abuse Waivers
8.	Request for Additional Waivers
9.	Revocation of Waivers
10.	All-Payer Rate Setting System
11.	Provider Participation in Alternative Payment
12.	Regulated Services
13.	Financial Targets
14.	Quality Monitoring and Reporting
15.	Data Sharing
16.	All Payer Model Evaluation
17.	Modification
18.	Termination and Corrective Action Triggers

Term #1: Legal Authority

Statements affirming the authority of Medicare, Medicaid, and Vermont (through the GMCB) to enter into the All-Payer Model agreement

Medicare authority, through the Innovation Center (CMMI): Section 1115(A) of the Social Security Act

Medicaid authority addresses existing Medicaid laws in relation to the model.

- Specifies that Vermont will ensure that the state-federal agreements in place (in the form of state plans or 1115 demonstration waivers) will be modified to accommodate the all-payer model.

Vermont authority, acting through GMCB, addresses three regulatory functions:

- Authority to enter into the agreement with CMMI
 - GMCB has authority to “[o]versee the development and implementation, and evaluate the effectiveness, of health care payment and delivery system reforms designed to control the rate of growth in health care costs and maintain health care quality in Vermont.” 18 V.S.A. § 9375(b)(1)
- Authority to set rates for providers and require payers to comply with those rates
 - GMCB has authority to “set reasonable rates for health care professionals, health care provider bargaining groups created pursuant to section 9409 of this title, manufacturers of prescribed products, medical supply companies, and other companies providing health services or health supplies based on methodologies pursuant to section 9375 of this title, in order to have a consistent reimbursement amount accepted by these persons.” 18 V.S.A. § 9376(b)(1).
- Authority to regulate an ACO and other components of the health care system
 - Refers to the authorities cited above and GMCB authority to set hospital budgets, regulate insurance rate changes, and regulate capital expenditures of health care facilities.

Term #2: Performance Period

Sets the timeframe for implementing the all-payer model

- Five-year performance period from 2017 to 2021
- Upon signing a model agreement, Vermont enters an “operational capacity building” period until implementation on January 1, 2017

Term #3: Medicare Beneficiary Protections

Provisions to enshrine all existing protections for Medicare beneficiaries in Vermont under the all-payer model

- This term states the principle that access to care and providers for Medicare beneficiaries will not be limited
 - Medicare beneficiaries will have full freedom of choice of participating Medicare providers
 - All existing beneficiary rights and protections (like appeal rights) will be protected
 - Medicare under the all-payer model will include all the same services and coverage as original Medicare

Term #4: Medicare Basic Payment Waivers

The term Sheet contains 4 separate types of waivers of Medicare laws

- **Basic payment waivers** relate to laws that govern rates set for Medicare regulated services
 - Currently this section documents the laws that create the inpatient prospective payment system (IPPS) and the outpatient prospective payment system (OPPS) for hospitals.
 - Ultimately an agreement would need to include the laws that govern reimbursement for all regulated services, including physician services, home health services and others.

Term #5: Medicare Innovation Waivers

The term Sheet contains 4 separate types of waivers of Medicare laws

- **Medicare innovation waivers** remove restrictions on services or authorize expanded services for beneficiaries
 - Eliminate requirement for a 3-day hospital stay before admission to a nursing home
 - Authorize telehealth services for all beneficiaries
 - Enables home visits without physician supervision, allows ACO to contract for home visits with other licensed clinicians
- Language allows Vermont to seek additional waivers under consideration to enhance Medicare services
 - Expanding Medicare coverage rules for Nurse Practitioners
 - Enhancing the availability of home care and hospice services

Term #6: Infrastructure Payment Waivers

The term Sheet contains 4 separate types of waivers of Medicare laws

- **Infrastructure payment waivers** allow Medicare to participate fully in the Blueprint for Health
 - Continuation of CHT payments
 - Expansion of SASH payments
- This term also includes waivers necessary to support the Hub & Spoke Program
 - Payment for medication-assisted therapies at specialty opioid treatment centers
 - Infrastructure support for “Hubs”

Term #7: Fraud and Abuse Waivers

The term sheet contains 4 separate types of waivers of Medicare laws

- **Fraud and abuse waivers** protect providers participating in an ACO
 - These are the same waivers granted to participants in Medicare's existing ACO programs – authorize referrals and sharing of savings across providers
 - Five categories of waivers
 - ACO Pre-Participation Waiver
 - ACO Participation Waiver
 - Shared Saving Waiver
 - Compliance with Physician Self-Referral Waiver
 - Patient Incentives Waiver

Term #8: Request for Additional Waivers

Specifies how Vermont may request additional waivers to carry out the all-payer model

- Additional waivers may be submitted by Vermont along with a rationale for the waiver at any time
 - These are granted only if CMS agrees
 - If CMS denies a request and Vermont determines that the waiver is necessary to achieve the goals of the model agreement, Vermont may terminate the agreement

Term #9: Revocation of Waivers

Authorizes CMS to revoke waivers or terminate the agreement

- CMS may revoke waivers or terminate the agreement if Vermont does not comply with conditions associated with the waiver.
 - Any waiver conditions will be made explicit in the final model agreement

Term #10: All-Payer Rate Setting System

Describes in general terms the operation of the all-payer system

- Vermont will maintain an all payer rate setting system for all regulated services
- Medicare rates will be established in one of two ways
 - Through an ACO-based reimbursement method
 - Using the Medicare fee schedule as a reference
- Language contemplates Vermont and CMS working together to design a claims processing and payment approach for ACO services and payments that conforms to Vermont's plan and CMS operational requirements

Term #11: Provider Participation in Alternative Payment Models

States that Vermont will utilize an ACO model under the all-payer model
Ensures that Vermont will benefit from a new Medicare physician payment law that encourages providers to participate in alternative payment models

Beginning in 2019, a new federal law – the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) – will govern Medicare physician payments

- MACRA creates a new framework for existing quality reporting programs and encourages physicians to participate in alternative payment models
- Alternative payment models include ACOs, patient-Centered medical homes, and bundled payment models
- Providers who qualify can receive incentive payments under MACRA

The term sheet specifies that providers participating in the ACO in Vermont's all-payer model will qualify for the MACRA incentive payments

- Will receive lump sum bonus payments of 5% of a physician's total Medicare payments

Term #12: Regulated Services

Regulated Services: Spending categories subject to the all payer ceiling and from which Medicare savings are derived

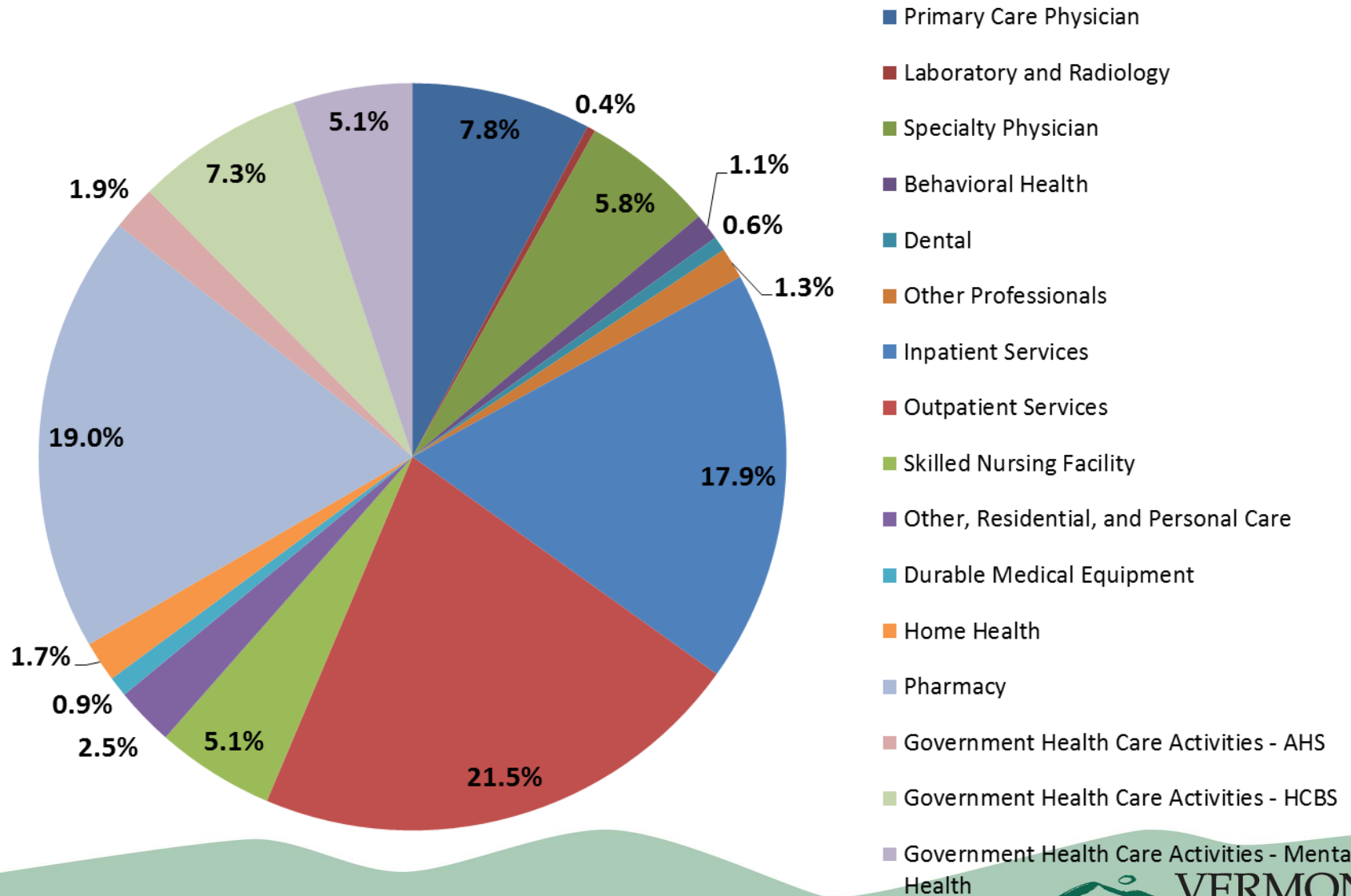
In essence, Regulated Services are those covered by the Model Agreement

- In Maryland, the model agreement only regulates hospital payments. In Vermont, regulated services are more expansive
- Derived from current federal and state SSPs
 - For Medicare: Parts A and B Services
 - For Medicaid and Commercial: The closest analogue to those Medicare services
- Defined by **categories of service**

Regulated Revenue can be different from the services for which the ACO is at risk.

- Term sheet indicates an interest in pursuing pharmacy as an ACO-covered service

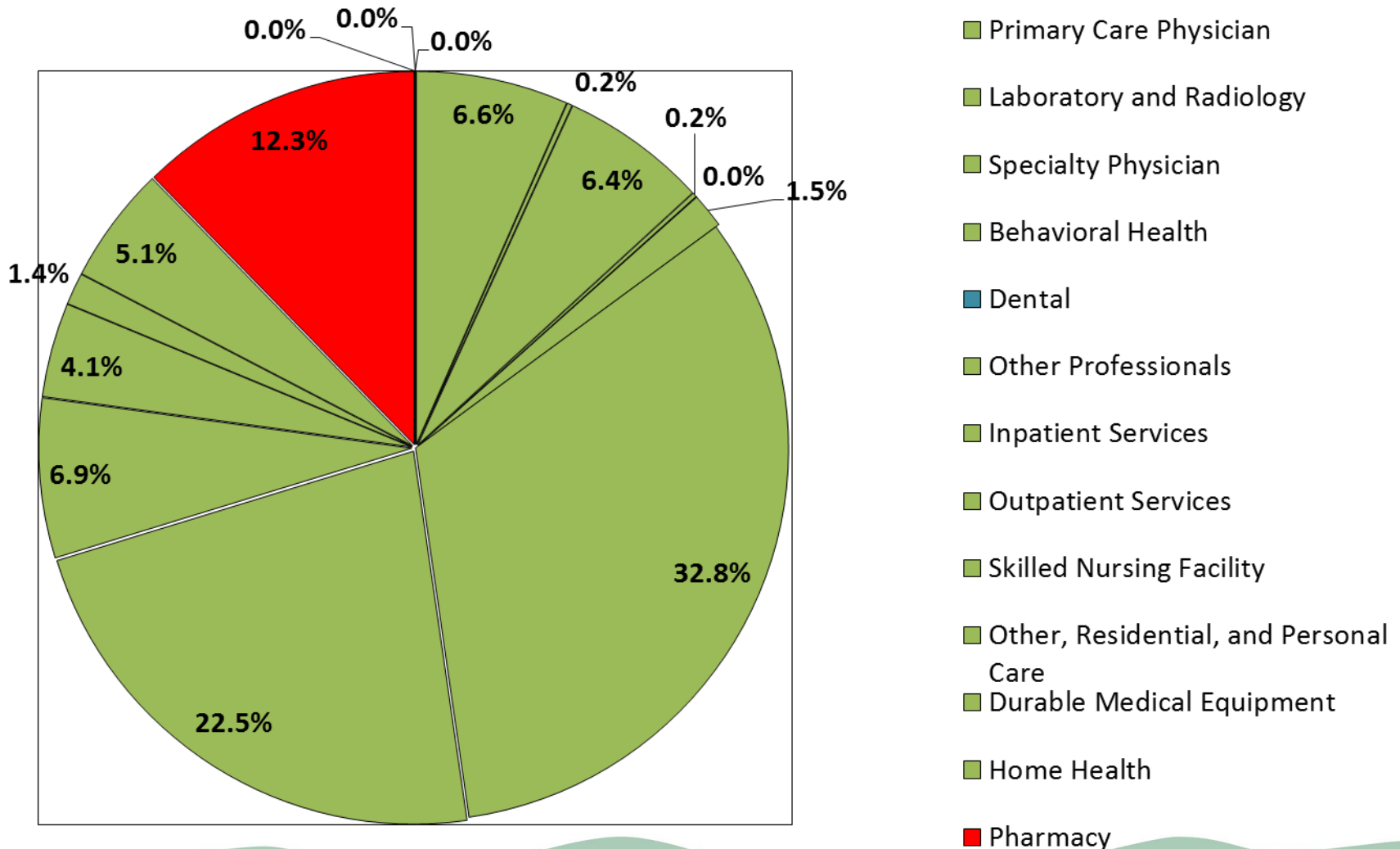
All Payer Baseline



Medicare Services

Parts A-B = 87.7%

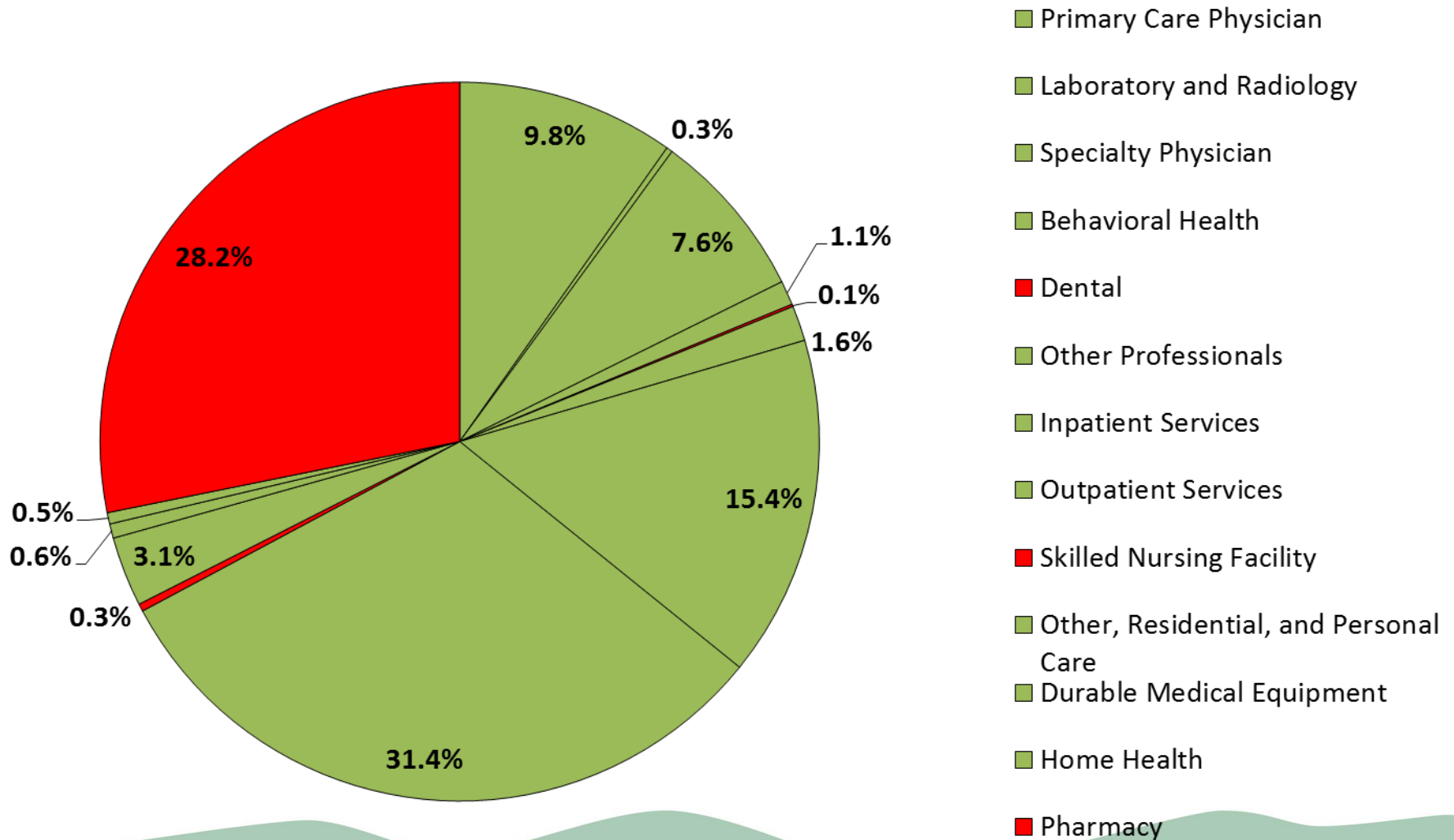
Part D = 12.3%



Commercial Services

Covered = 71.4%

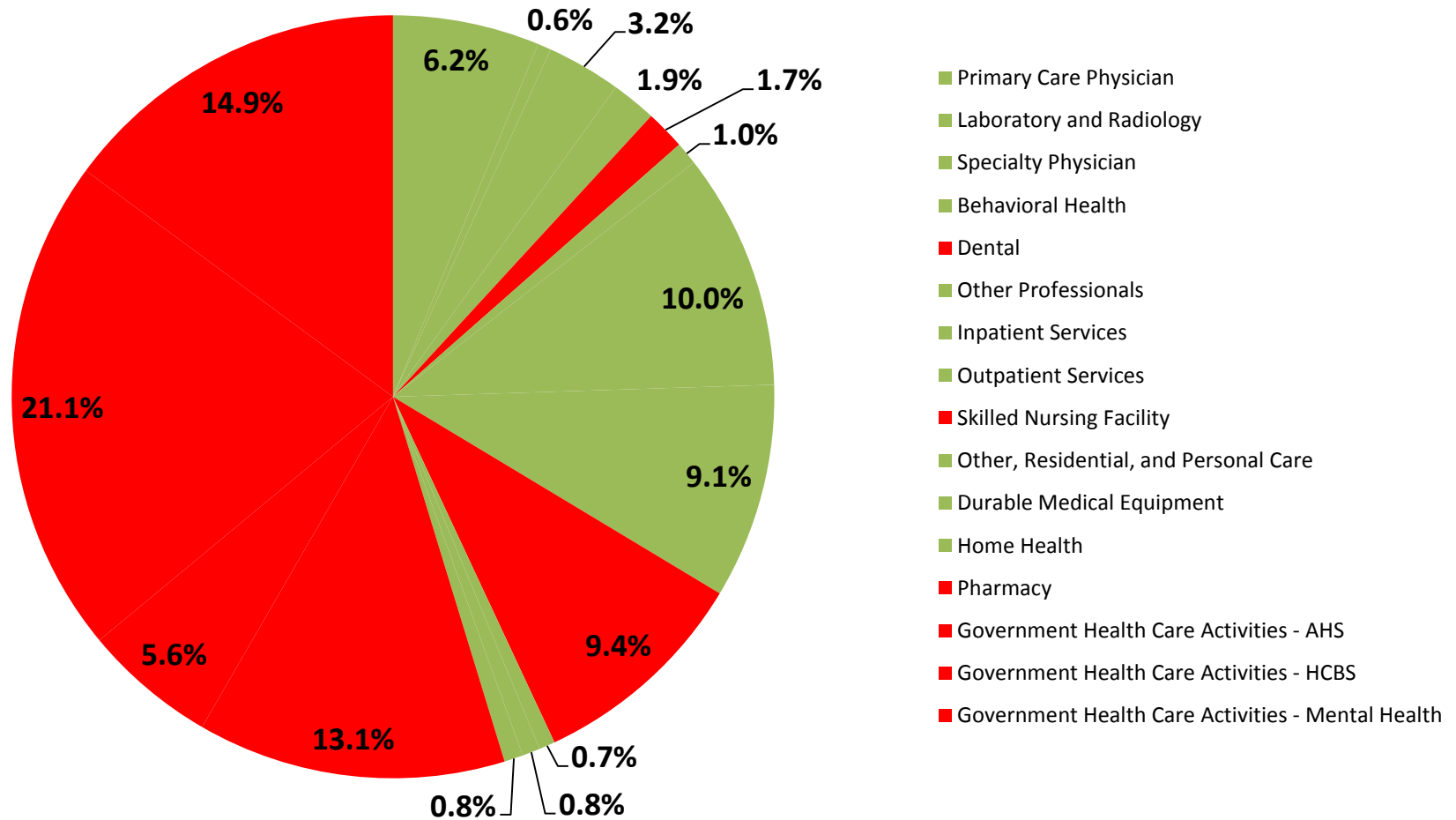
Non-covered = 28.6%



Medicaid Services

Covered = 34.3%

Non-covered = 65.7%



Regulated Services in Relation to the Overall Delivery System

The goal of all of the work Vermont is doing and will do is **to create an integrated system**. Vermont is **committed to payment and delivery reform across all services**, whether inside or outside of the all-payer model.

Under this language, Vermont **may phase in additional services** into the regulated environment and include more health care spending over time based on mutual agreement with CMMI/CMS

Vermont can define a **pathway for assessing readiness to consider inclusion** of these services in the all-payer model. Vermont will evaluate

- Payer and provider readiness
- Health information infrastructure
- Evaluation readiness
- Federal readiness

Term #13: Financial Targets:

All-Payer Ceiling

- **All-Payer Ceiling:** a defined upper limit on per capita spending growth
- **All-Payer Target:** a defined target for per capita spending growth
 - The All-Payer Target is Vermont's goal for spending growth
 - The All-Payer Ceiling is Vermont's obligation under the Model Agreement

Measure	Growth
<i>15-Year Economic Growth (Gross State Product)</i>	3.3%
All-Payer Target	3.5%
All-Payer Ceiling	4.3%

Failure to meet ceiling or Medicare savings is a “triggering event” – can lead to a “corrective action plan”

- Requires a written response and an actual plan
- Could include programmatic changes, model changes, or rate adjustments
- Term sheet spells out what constitutes a “triggering event”

Term #13: Financial Targets: Medicare Savings

- **Medicare Savings** – minimum savings required under the agreement
 - Separately calculated and benchmarked to national per capita growth
- **Benchmark Floor** – proposes a floor to guard against low national Medicare growth

Medicare Savings Target	0.2% below national per capita growth
Benchmark Floor	Performance Year 1: 3.5% Performance Years 2-5: 2.0%

Savings are calculated at the end of the potential 5-year agreement

- This provides considerable flexibility, but places emphasis on strong performance in the early years of the agreement

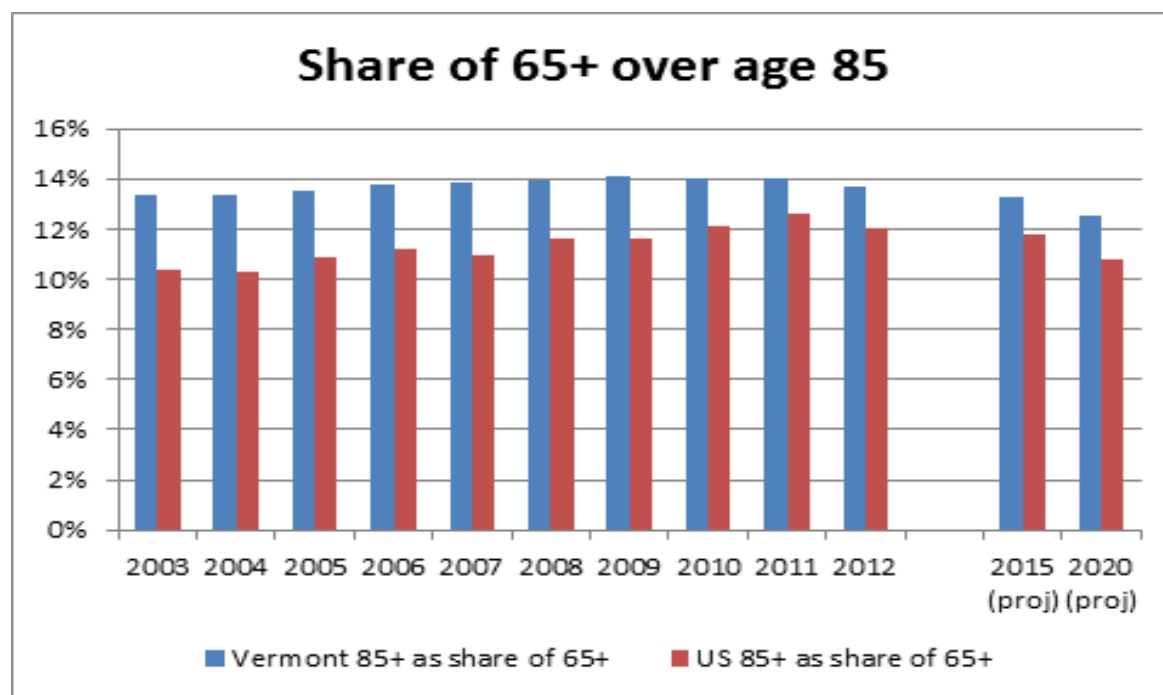
The benchmark floor is a novel idea

- CMS understands Vermont's concerns and will try to address them
 - To guard against being put in a deficit in Year 1
 - To recognize that Vermont is a very low-cost state

Medicare Savings with an Aging Population

The term sheet addresses the challenge that Vermont faces by having a larger share of 85+ year old Medicare enrollees than the national average.

- Contemplates an age-adjusted Medicare savings calculation to adjust for relative differences between the national and Vermont population



Term #14: Quality Monitoring and Reporting

Vermont is proposing to establish **population health goals** and measures to be monitored and will set **all-payer model quality targets** related to those goals
Both sets of measures will be established together with CMMI by June 1, 2016

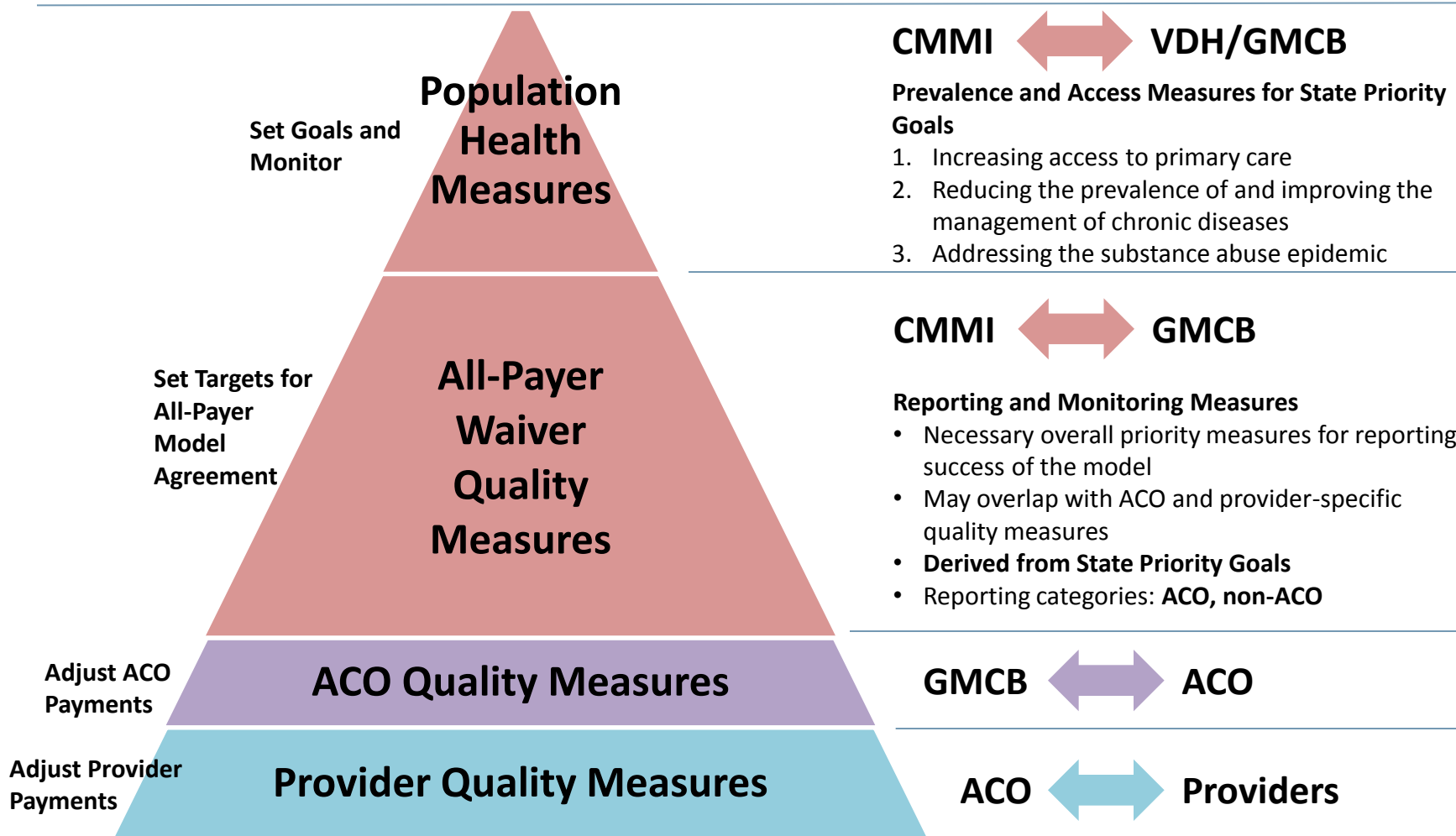
POPULATION HEALTH

- Established goals and population health measures will allow the state and CMS to monitor progress on the health of the population in priority areas
 1. Increasing access to primary care
 2. Reducing the prevalence of and improving the management of chronic diseases
 3. Addressing the substance abuse epidemic
- Statewide measures will be collected using statewide tools (BRFSS, surveillance data, death data)

ALL-PAYER MODEL QUALITY TARGETS

- Established targets will measure clinical interventions that lead to health improvements related to the population health priority areas
- These measures are currently collected and reflect proven clinical interventions
- Establishing quality targets directly related to population health goals will ensure that the clinical delivery system is aligned with state priorities

All-Payer Model Quality Framework



Term #15: Data Sharing

Describes expectations about data sharing and the process for data requests

- Vermont supplies all-payer claims from VHCURES on a quarterly basis
- CMS will accept data requests from Vermont to further the purposes of the model, and will approve, deny or modify within 30 days of any request, subject to privacy and security laws
- Proposes that CMS will share with Vermont data necessary to determine provider performance, and authorizes Vermont to disclose such performance data

Term #16: All-Payer Model Evaluation

Describes efforts by Vermont and CMS to evaluate the implementation of the all-payer model

- CMS will evaluate the model in accordance with Section 1115(a)(b)(4)
 - This is a substantial evaluation and will compare Vermont to national Medicare and to other states
- Vermont will submit an annual report to CMS concerning its performance on the financial and quality requirements of the model agreement
 - This will include performance on the all-payer ceiling, and performance on quality measures established under Term #14.
- Contains technical language about maintenance of records

Term #17: Modification

Specifies the process for either party to suggest amendments to the model agreement

- Both parties may amend the agreement at any time by mutual consent
- CMS may amend the agreement for good cause or if necessary to comply with federal or state law or regulation
 - CMS provides 30 days notice
 - If Vermont disagrees with the modification, or cannot adopt it because it is contrary to state law, CMS or the state may terminate the agreement

Term #18: Termination and Corrective Action Triggers

Specifies the process for termination of the model agreement

Describes the enforcement of the agreement, in the form of corrective action plans based on defined triggering events

- Enforcement of the model is driven by the occurrence of specified “triggering events”
 - A material breach of the Model Agreement
 - A determination by CMS that Vermont has not produced agreed-upon Medicare savings for 2 consecutive Performance Years
 - A determination by CMS that Vermont has exceeded the all-payer per capita growth ceiling by 1.0 percentage point or more for 2 consecutive Performance Years
 - A determination by CMS that the quality of care provided to Medicare, Medicaid or CHIP beneficiaries has deteriorated
 - A determination by CMS that the State and/or ACO have taken actions that compromise the integrity of the Model or the Medicare trust funds

Term #18: Termination and Corrective Action Triggers (continued)

- If a triggering event occurs, CMS provides a warning notice within 6 months of the end of a performance year
- Vermont has 90 days to respond to the notice, and within 90 days of its response CMS can require Vermont to produce a corrective action plan (CAP)
- Vermont has 1 year to successfully implement the CAP
- If the CAP is not implemented, CMS can rescind part of the agreement or terminate it
- In general, the state may terminate the agreement for any reason with 180 days written notice
- Upon termination, Vermont has 2 years to transition back to the national Medicare program

Part III: Consumer Protections

Developing All-Payer Standards

Medicare Shared Savings Program Participation Agreement

Commercial Shared Savings Program Standards

Medicaid Shared Savings Program Contract Provisions

Developing All-Payer Standards

Medicare Next Generation
ACO Participation Agreement

Commercial Shared Savings Program
Standards

Medicaid Shared Savings Program
Contract Provisions

Consumer Protections for Accountable Care Organizations (ACOs): Consumer Participation in Governance Body

Standard	GMCB SSP	Medicaid SSP Contract	Next Generation ACO Participation Agreement	H. 812
Consumer Participation Governance Body	Must at a minimum 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).	The Contractor's governing body must include at least one consumer member who is a Medicaid beneficiary .	The ACO governing body shall include at least one Beneficiary served by the ACO.	Should include at least 3 consumer members including 1 Medicaid, 1 Medicare, and 1 Commercial beneficiary.

Consumer Protections for ACOs: Consumer Advocate Participation in Governance Body

Standard	GMCB SSP	Medicaid SSP Contract	Next Generation ACO Participation Agreement	H. 812
Consumer Advocate Participation in Governance Body	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.	Regardless of the number of payers with which the Contractor participates, there must be at least two consumer members on the Contractor governing body . Consumer members shall have some prior personal, volunteer, or professional experience in advocating for consumers on health care issues.	The ACO governing body shall include at least one person with training or professional experience in advocating for the rights of consumers ("Consumer Advocate"), who may be the same person as the Beneficiary.	Should include at least one consumer advocate with training or professional experience in advocating for rights of consumers.

Consumer Protections for ACOs: Regional Representatives

Standard	GMCB SSP	Medicaid SSP Contract	Next Generation ACO Participation Agreement	H. 812
Regional Representatives Participation in Governing Body	X	X	X	Should include at least two consumer representatives in the region (s) an entity serves.

Consumer Protections for Accountable Care Organizations: Governance Transparency

Standard	GMCB SSP	Medicaid SSP Contract	Next Generation ACO Participation Agreement	H. 812
Governance Transparency	The governing body must have a transparent governing process which includes the following: publishing the names and contact information for the governing body members; 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; making meeting minutes available to the ACO's provider network upon request, posting summaries of ACO activities provided to the ACO's consumer advisory board on the ACO's website	<p>A. The Contractor must maintain an identifiable governing body that has responsibility for oversight and strategic direction, holding the Contractor's management accountable for its activities.</p> <p>B. The Contractor must identify its board members, define their roles and describe the responsibilities of the board in writing to the State.</p> <p>D. The Contractor's governing body must have a transparent governing process which includes the following:</p> <ol style="list-style-type: none"> 1. Publishing the names and contact information for the governing body members, for example, on a website; 2. Devoting an allotted time at the beginning of each in-person governing body meeting to hear comments from members of the public who have signed up prior to the meeting and providing public updates of the Contractor's activities; 3. Making meeting minutes available to the Contractor's provider network upon request, and 4. Post summaries of Contractor activities provided to the Contractor's consumer advisory board on the ACO's website. 	The governing body has a transparent governing process.	<p>The Accountable Care Organization's governing body should have a transparent process and open meetings.</p> <p>47</p>

Consumer Protections for Accountable Care Organizations: Consumer Advisory Board

Standard	GMCB SSP	Medicaid SSP Contract	Next Generation ACO Participation Agreement	H. 812
Consumer Advisory Board	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.	The Contractor must have a regularly scheduled process for inviting and considering consumer input regarding ACO policy, including but not limited to a consumer advisory board with membership drawn from the community served by the Contractor, including patients, their families, and caregivers. The consumer advisory board must meet at least quarterly. Members of the Contractor's management and the governing body must regularly attend consumer advisory board meetings and report back to the Contractor's governing body following each meeting of the consumer advisory board. Other consumer input activities shall include but not be limited to hosting public forums and soliciting written comments. The results of other consumer input activities shall be reported to the ACO's governing body at least annually	X	Consumer advisory board. An accountable care organization should have a regularly scheduled process for inviting and considering consumer input regarding the accountable care organization's policy, including a consumer advisory board with membership drawn from the community the accountable care organization serves. The consumer advisory board should include patients, their families, and caregivers, as well as beneficiaries of Medicaid, Medicare, and commercial insurance plans

Consumer Protections for Accountable Care Organizations: Quality

Standard	GMCB SSP	Medicaid SSP Contract	Next Generation ACO Participation Agreement	H. 812
Quality	<p>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. Measures include measures of patient experience of care per the CAHPS (Consumer Assessment of Health Care Providers) tool.</p>	<p>Current contract calls for quality, outcome, and experience measures, (some that are linked to \$) but no measures of access to care.</p> <p>The ACO reports some measures directly; the independent analytics contractor reports other measures on behalf of the ACOs, etc. But all of the requirements around frequency of and responsibility for reporting measure results are outlined in the payer contracts with ACOs.</p>	<p>CMS shall assess quality performance using the quality measures set forth in Appendix F and the quality measure data reported by the ACO. Notwithstanding Section XXI.D, CMS may amend the quality measures to be used in a Performance Year without the consent of the ACO prior to the beginning of the Performance Year. CMS shall notify the ACO of any measure set change prior to the beginning of each Performance Year.</p>	<p>An accountable care organization should measure progress toward improving access to care, quality of care, and health outcomes. The accountable care organization should be responsible for reporting its measures at least quarterly to the Department of Vermont Health Access, the Green Mountain Care Board, and participating commercial payers. Medicaid and participating commercial payers should incorporate these measures into their contracts with an accountable care organization to hold the organization responsible for quality of care, access to care, and health outcomes, as well as a positive patient experience.</p>

Consumer Protections for Accountable Care Organizations: Quality Cont.

Standard	GMCB SSP	Medicaid SSP Contract	Next Generation ACO Participation Agreement	H. 812
Quality Cont.	<p>Outcomes measures are included in quality and performance measures for an ACO, but participation in the ACO is not predicated on meeting specific quality, performance, outcomes, and access thresholds.</p> <p>Quality and performance measures include measures related to primary care, specialty care, inpatient care, substance use disorders, and mental health treatment services.</p> <p>The GMCB does not have authority to enforce thresholds.</p>	<p>Quality thresholds are in place in order for an ACO to share in savings, but their overall participation is not predicated on quality performance.</p> <p>Quality and performance measures include measures related to primary care, specialty care, inpatient care, substance use disorders, and mental health treatment services.</p>	<p>The Next Generation Participation agreement does not include quality, access, and outcomes thresholds for participation, but does include lengthy Monitoring and Compliance provisions for ACOs.</p>	<p>In order to ensure that the health of Vermonters is improved by the accountable care organization, measurement should include metrics of outcomes related to primary care, specialty care, inpatient care, substance use disorder treatment, and mental health treatment services. An accountable care organization should be required to meet specific quality, access, and outcome thresholds in order to participate in alternative payment methodologies such as capitated payments, shared savings, and global budgets. The Green Mountain Care Board should enforce these thresholds.</p>

Consumer Protections for Accountable Care Organizations: Access

Standard	GMCB SSP	Medicaid SSP	Next Generation ACO Participation Agreement	H. 812
Access	Monitoring and Evaluation measures are in place to gauge under/over utilization of services.	Monitoring and Evaluation measures are in place to gauge under/over utilization of services.	<p>The ACO shall require its Next Generation Participants and Preferred Providers to make Medically Necessary Covered Services available to Next Generation Beneficiaries in accordance with applicable laws, regulations and guidance. Next Generation Beneficiaries and their assignees retain their right to appeal claims determinations in accordance with 42 CFR § 405, Subpart I.</p> <p>The ACO and its Next Generation Participants and Preferred Providers shall not take any action to avoid treating At-Risk Beneficiaries or to target certain Beneficiaries for services with the purpose of trying to ensure alignment in a future period.</p>	<p>An accountable care organization should measure progress toward improving access to care, quality of care, and health outcomes. The accountable care organization should be responsible for reporting its measures at least quarterly to the Department of Vermont Health Access, the Green Mountain Care Board, and participating commercial payers. Medicaid and participating commercial payers should incorporate these measures into their contracts with an accountable care organization to hold the organization responsible for quality of care, access to care, and health outcomes, as well as a positive patient experience</p>

Consumer Protections for Accountable Care Organizations

Standard	GMCB SSP	Medicaid SSP	Next Generation ACO Participation Agreement	H. 812
Grievances and Appeals	No provision regarding grievances and appeals. Beneficiaries continue to access existing grievance and appeals process through his/her insurer.	Medicaid has it's own grievance and appeal processes that are maintained independently of the SSP administration on the DVHA side. The current contract does not specify any role for the GMCB in this area.	The ACO shall require its Next Generation Participants and Preferred Providers to make Medically Necessary Covered Services available to Next Generation Beneficiaries in accordance with applicable laws, regulations and guidance. Next Generation Beneficiaries and their assignees retain their right to appeal claims determinations in accordance with 42 CFR § 405, Subpart I.	<p>Grievances and appeals. The Green Mountain Care Board should adopt rules to protect against wrongful denial of services and to address grievances of patient attributed to an accountable care organization. The rules should provide for internal and external review processes.</p> <p>GMCB Currently has no authority to take action related to grievances and appeals.</p>

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Consumer Protections for Accountable Care Organizations: Attributing Provider Choice

Standard	GMCB SSP	Medicaid SSP	Next Generation ACO Participation Agreement	H. 812
Attributing Provider Choice	<p>ACO patients will have freedom of choice with regard to their providers consistent with their health plan benefit.</p> <p>No requirement that beneficiaries choose a provider for attribution purposes</p>	<p>There is no requirement that a beneficiary choose a provider for attribution purposes; they are attributed based on the PCP with whom they have the most visits during the year, or whom they have selected upon Medicaid enrollment.</p>	<p>ACOs have the option to choose a “voluntary alignment” for attribution purposes. See slide 13.</p>	<p>Provider choice. Patients should be allowed to identify their own primary care provider through an attestation process as the primary method of attribution. An accountable care organization should not interfere in any way with the ability of a patient to receive services from any provider of his or her choice.</p>

Consumer Protections for ACOs: Next Generation Participation Agreement, Monitoring and Compliance

A. CMS Monitoring and Oversight Activities

1. CMS shall conduct monitoring activities to evaluate compliance by the ACO, its Next Generation Participants, and Preferred Providers with the terms of this Agreement. Such monitoring activities may include, without limitation:
 - (a) Interviews with any individual or entity participating in ACO Activities, including members of the ACO leadership and management, Next Generation Participants, and Preferred Providers;
 - (b) Interviews with Next Generation Beneficiaries and their caregivers;
 - (c) Audits of charts, medical records, Implementation Plans, and other data from the ACO, its Next Generation Participants and Preferred Providers;
 - (d) Site visits to the ACO and its Next Generation Participants and Preferred Providers; and
 - (e) Documentation requests sent to the ACO, its Next Generation Participants, and/or Preferred Providers, including surveys and questionnaires.
2. In conducting monitoring and oversight activities, CMS or its designees may use any relevant data or information including, without limitation, all Medicare claims submitted for items or services furnished to Next Generation Beneficiaries.
3. CMS shall, to the extent practicable and as soon as practicable, provide the ACO with a comprehensive schedule of planned comprehensive annual audits related to compliance with this Agreement.
 - (a) Such schedule does not preclude the ability of CMS to conduct more limited, targeted or ad hoc audits as necessary.
 - (b) CMS may alter such schedule without the consent of the ACO. CMS shall notify the ACO within 15 days of altering such schedule.

VI. Care Improvement Objectives

A. General

1. The ACO shall implement processes and protocols that relate to the following objectives for patient-centered care:
 - (a) Promotion of evidence-based medicine, such as through the establishment and implementation of evidence-based guidelines at the organizational or institutional level. An evidence-based approach would also regularly assess and update such guidelines.
 - (b) Process to ensure Beneficiary/caregiver engagement, and shared decision making processes employed by Next Generation Participants that takes into account the Beneficiaries' unique needs, preferences, values, and priorities. Measures for promoting Beneficiary engagement include, but are not limited to, the use of decision support tools and shared decision making methods with which the Beneficiary can assess the merits of various treatment options in the context of his or her values and convictions. Beneficiary engagement also includes methods for fostering what might be termed "health literacy" in Beneficiaries and their families.
 - (c) Coordination of Beneficiaries' care and care transitions (e.g., sharing of electronic summary records across providers, telehealth, remote Beneficiary monitoring, and other enabling technologies).
 - (d) Providing Beneficiaries access to their own medical records and to clinical knowledge so that they may make informed choices about their care.
 - (e) Ensuring individualized care for Beneficiaries, such as through personalized care plans.
 - (f) Routine assessment of Beneficiary and caregiver and/or family experience of care and seek to improve where possible.
 - (g) Providing care that is integrated with the community resources Beneficiaries require.
2. The ACO shall require its Next Generation Participants to comply with and implement these designated processes and protocols, and shall institute remedial processes and penalties, as appropriate, for Next Generation Participants that fail to comply with or implement a required process or protocol.