State of Vermont
Green Mountain Care Board
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Report to the Legislature

REPORT ON THE GREEN MOUNTAIN CARE BOARD's PROGRESS IN MEETING ALL-PAYER ACO MODEL IMPLEMENTATION BENCHMARKS

for the period of September 15 to December 15, 2017

In accordance with Act 25 of 2017

Submitted to the
House Committees on Appropriations, on Human Services, and on Health Care, the Senate Committees on Appropriations and on Health and Welfare, the Health Reform Oversight Committee, and the Office of the Health Care Advocate

Submitted by the
Green Mountain Care Board

December 15, 2017

Legislative Charge

The Green Mountain Care Board (the Board) is submitting this report pursuant to Act 25 of 2017, "An act relating to Next Generation Medicaid ACO pilot project reporting requirements." Section 2 of the Act provides:

> On or before June 15, September 15, and December 15, 2017, the Green Mountain Care Board shall provide to the House Committees on Appropriations, on Human Services, and on Health Care, the Senate Committees on Appropriations and on Health and Welfare, the Health Reform Oversight Committee, and the Office of the Health Care Advocate written updates on the Board's progress in meeting the benchmarks identified in the Board's Year 0 (2017) All-Payer ACO Model Timeline regarding implementation of the All-Payer ACO Model and the Board's preparations for regulating accountable care organizations.

2017, No. 25, § 2.

Introduction

Act 113 of 2016 set forth principles to guide the state in implementing a value-based payment model allowing participating health care providers to be paid by Medicaid, Medicare, and commercial insurance using a common methodology that may include population-based payments and increased financial predictability for providers. *See* 18 V.S.A. § 9551. Pursuant to 18 V.S.A. § 9373, the Green Mountain Care Board is required to develop rules and standards to provide oversight to Accountable Care Organizations (ACOs) beginning January 1, 2018.

The Vermont All-Payer Accountable Care Organization Model Agreement (All-Payer Model Agreement, or APM Agreement) was signed on October 26, 2016 by Vermont's Governor, Secretary of Human Services, Chair of the Green Mountain Care Board, and the Centers for Medicare and Medicaid Services (CMS). The All-Payer Model aims to reduce health care cost growth by moving away from fee-for-service reimbursement to risk-based arrangements for ACOs; these arrangements are tied to quality and health outcomes. Act 113 complements the All-Payer ACO Model Agreement by providing the Board regulatory authority over ACOs in Vermont. The Board is implementing Act 113 and the All-Payer Model Agreement concurrently, as described in the Year 0 (2017) All-Payer ACO Model Timeline found in Table 1, below.

This report covers Act 113 and the All-Payer ACO Model Agreement implementation for the period of September 15, 2017 to December 15, 2017.

Table 1

Year 0 (2017) All-Payer ACO Model Timeline*	
January-February 2017	• Rule drafting (completed) • Refining quality measure specifications (completed) • Vermont Medicaid Next Generation (VMNG) contract signed (completed)
March-April 2017	• Analytics Request for Proposals released (completed) • Agree on Total Cost of Care Definition with CMS (completed; detailed specifications expected to be completed in July; no negative consequences anticipated) • Site visit from CMMI (completed)
May-June 2017	• Rule pre-filing (completed) • ACOs submit test budget filing to GMCB (completed) • Commercial rate review (part of QHP Rate Review) (completed) • Establish two remaining quality measure targets (one completed; other on track) • Selection of analytics contractor (completed)
July-August 2017	• Rulemaking continues (completed) • ACO test budget review process (on track)
September-October 2017	• Rulemaking continues (completed) • ACO test budget approval (on track; delay in data from CMS)
November-December 2017	• Rulemaking continues (completed) • Medicaid Advisory Rate Case for ACO Services (completed) • Medicare Benchmark trend factor set for 2018 (on track) • ACO test budget approval (on track) • Certification of ACO (on track; to be finalized in early 2018) • Identify remaining quality measure to monitor Medicaid patient caseload for specialists and non-specialists, with associated target (on track)
*Dates and activities based on current information; subject to change.	

1. Rulemaking under Act 113

A. Rulemaking process

Since the initial implementation report was filed, the Board held a public hearing and received both oral and written comments from the public on its initial proposal for the ACO Oversight Rule. After reviewing and considering those comments and engaging in further discussion with stakeholders, a number of amendments were made to the initial proposal. The Board approved a final proposal on August 28, 2017 which was filed with the Legislative Committee on

Administrative Rules (LCAR) on August 29, 2017. During LCAR's first hearing of the rule, public comment was provided by the Health Care Advocate and the Vermont Developmental Disabilities Council. In response, the Board modified the rule to address some of the concerns that these organizations raised. LCAR approved the rule at its second hearing. The adopted rule was filed with LCAR and with the Secretary of State's Office on November 2, 2017 and took effect fifteen days thereafter, on November 17, 2017.

B. ACO Annual Reporting and Budget Guidance

On June 23, 2017 OneCare Vermont (OneCare) and Community Health Accountable Care (CHAC) both submitted preliminary information on their governance structure, payer contracts, provider participants, model of care, previous expenditure analysis and 2018 budgets. CHAC withdrew its submission on October 19, 2017, citing the decision of its Board to suspend operations and terminate its Medicare Shared Savings Program (SSP) contract as of December 31, 2017.

OneCare was required to submit its final provider network to the Medicare Next Generation program by September 30, 2017. Medicaid and Commercial networks were finalized at the beginning of October. OneCare provided a second submission on October 20, 2017 reflecting its completed provider networks, proposed payer programs, budget and risk plan. OneCare estimates having more than 120,000 attributed beneficiaries in nine Hospital Service Areas. Six hospitals will have contracts with OneCare that include Medicare, Medicaid, and commercial services. Three additional hospitals will contract with OneCare for the Vermont Medicaid Next Generation ACO program only.

The Board and the Health Care Advocate have exchanged several rounds of questions and answers with OneCare to understand how the new payment model will affect providers and communities. On November 2, 2017, OneCare provided a detailed presentation to the Board and described substantial new investments in primary care and community based providers. As a participant in the Vermont Modified Next Generation ACO Program, made possible through the Vermont All-Payer Accountable Care Organization (ACO) Model Agreement, OneCare will receive and distribute Medicare dollars for the Blueprint for Health, Community Health Teams (CHTs), and Services and Support at Home (SASH). Until 2016, Medicare provided funding for these programs through the now discontinued Medicare Advanced Primary Care Practice Demonstration program. Absent the Vermont All-Payer ACO Model Agreement, Medicare funding would not be available for these activities.

Based on the budget submissions, public presentations, and staff analysis, staff recommendations and conditions for ACO budget approval were provided to the Board on December 12, 2017, with a Board vote anticipated on December 21, 2017. A public comment period regarding the ACO Budget will close on December 19, 2017.

C. Certification

Effective January 1, 2018, the Board has authority to certify ACOs. An ACO must be certified by the Board to receive payments from Medicaid or a commercial insurer through any payment

reform program or initiative. Act 113 allows the Board to begin the certification process prior to January 1, 2018. In the rule approved on November 17, 2017, the Board identified the information and documentation an ACO must submit to complete its application to become certified. Now that the rule is final, the Board has begun analyzing the information submitted through the ACO Annual Reporting and Budget Guidance. The Board anticipates providing a provisional certification to OneCare Vermont in late December 2017 or early January 2018. If the certification is provisional, the Board will complete the certification in the first quarter of 2018.

D. Medicaid Advisory Rate Case for ACO Services

In 2017, the Legislature extended the Board's authority to review and provide advisory input on Medicaid rates and the per-member-per-month (PMPM) amount that is negotiated between the Department of Vermont Health Access (DVHA) and the ACO. (2017, No. 3, sec. 13.) This review is complete and has been provided to DVHA. The report remains confidential until DVHA and the ACO enter into a contract. Once complete, the report will be posted on the Board's website.

This year, in its consideration of commercial rate increase requests for Qualified Health Plans (QHP) on Vermont Health Connect, the Board incorporated information obtained from the hospital budget process to help establish consistency across hospital budget and insurance rate filings. Likewise, the Board has incorporated information from the hospital budget process and the approved QHP rate into its review of ACO budgets.

2. Vermont All-Payer ACO Model Agreement

A. Agreement on Total Cost of Care Definition with CMS; Developing Readiness for Reporting to CMS

Staff members from the Board and DVHA continue to develop detailed specifications for the All-Payer Total Cost of Care measure, a critical reporting metric in the Agreement. With assistance from contractors, staff have:

- Identified the financial target services for Medicaid and commercial spending that will serve as the basis for the All-Payer Total Cost of Care calculation, after reviewing the description of included and excluded services contained in the Agreement and consulting with payer colleagues from DVHA and Blue Cross Blue Shield of Vermont (BCBSVT). CMS has agreed to Vermont's proposal for financial target services.

- Worked to develop detailed specifications to calculate the All-Payer Total Cost of Care using code level specifications from payers when available and examining existing expenditure measures that could assist in Vermont's analysis. Specifications have been drafted for claims-based and non-claims-based sub-measures for both Medicaid and commercial Total Cost of Care. Board staff have worked with DVHA, BCBSVT, and MVP on non-claims-based specifications, which must still be refined and tested.

- Continued to identify and refine potential data sources for financial and quality measures. An attribution flag has been developed and is being tested for VHCURES, Vermont's all-payer claims database, and additional data validation checks have been instituted. DVHA and BCBSVT have been informed of the reporting requirements contained in the Agreement; their databases are potential data sources. A proposal was submitted to field the Hypertension Prevalence measure in 2018 in Vermont's Behavioral Risk Factor Surveillance System Survey (this annual population health measure from the Agreement's quality framework is currently fielded only during odd years). That proposal was accepted.

- Created draft reporting templates for submitting Total Cost of Care and quality information to CMS, as required by the Agreement.

B. Medicare Benchmark Trend Factor for 2018

CMS has provided data to the Board to inform the Board's decision for setting the Medicare rate of growth for the ACO for 2018. The ra
te will be submitted to CMS for their approval before the next calendar year. On 12/12/17, staff recommended to the Board that the Medicare Benchmark Trend Factor for 2018 be set at 3.5%.

C. Refining Quality Measure Specifications

The twenty quality measures outlined in the Agreement are specified in Appendix 1, with corresponding targets established for most.

- The State and CMS did not establish a target for the measure related to increasing utilization by prescribers of the Vermont Prescription Monitoring System because it is a new measure collected by the Vermont Department of Health (VDH), and there was not yet any baseline data. Recently, VDH provided the Board with baseline data for calendar year 2016 and with input from VDH, Board staff proposed a target for CMS's consideration. CMS accepted the target in June 2017.

- A target was also not established for the measure related to reducing the rate of growth in the number of mental health and substance abuse-related emergency department visits. Staff and CMS agree that a target should be set cautiously, and the Board continues to negotiate with CMS on this issue. Preliminary 2016 data for this measure was requested by CMS and provided by VDH. Based on that and previous data, Board staff proposed a target and recently received feedback from CMS. Negotiations are continuing.

Additionally, CMS recommended a 21st measure in Section 7.g. of the Agreement. The potential measure is described as "Medicaid patient caseload for specialist and non-specialist physicians." The Vermont Agency of Human Services (AHS) and Board staff have reviewed several potential measures for consideration in a final proposal for CMS. AHS staff are currently developing a final proposal, with input from Board staff, for CMS consideration. The Board and its staff will

continue to work on obtaining baseline data to assist in setting targets for this measure, should this additional measure be adopted.

D. Analytics Request for Proposals (RFP)

Vermont has written and posted an RFP for an All-Payer ACO Model analytics vendor. Ten proposals were received and reviewed by a team consisting of Board and AHS staff. A proposal has been selected and staff drafted and negotiated the contract's scope and terms. The contract is currently being routed for approval by other state agencies. Pursuant to state law, information related to the bidders is confidential until a contract is awarded.