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 January 1 to June 15, 2018

In accordance with Act 124 of 2018 (H.914)

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, the Medicaid and Exchange Advisory Committee, and the Office of the Health Care Advocate

Submitted by the
Green Mountain Care Board

June 15, 2018

Legislative Charge

The Green Mountain Care Board (the Board) is submitting this report pursuant to Act 124 of 2018, "An act relating to reporting requirements for the second year of the Vermont Medicaid Next Generation ACO Pilot Project." Section 2 of the Act provides:

> On or before June 15, September 15, and December 15, 2018, 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, the Medicaid and Exchange Advisory 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 1 (2018) All-Payer ACO Model Timeline regarding implementation of the All-Payer Model and the Board's regulation of accountable care organizations.

2018 Acts and Resolves No. 124, § 2.

Introduction

In Act 48 of 2011, the Vermont Legislature established the Board and charged it with implementing health care payment and delivery system reforms. 18 V.S.A. § 9375(b)(1). In Act 113 of 2016, the Legislature established principles to guide the implementation of a value-based payment model that would allow 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. 18 V.S.A. § 9551.

The Vermont All-Payer Accountable Care Organization Model Agreement (All-Payer ACO Model Agreement or APM Agreement) was signed on October 26, 2016 by Vermont's Governor, Secretary of Human Services, Chair of the Board, and the Centers for Medicare and Medicaid Services (CMS). The APM Agreement 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 APM Agreement by giving the Board regulatory authority over ACOs. 18 V.S.A. § 9382. The Board is implementing Act 113 and the APM Agreement concurrently, as described in the Year 1 (2018) All-Payer ACO Model Timeline found in Table 1 below.

This report covers Act 113 and the APM Agreement implementation for the period of January 1, 2018 to June 15, 2018. Table 1 outlines the major activities the Board is undertaking in 2018 to support Act 113 and APM Agreement implementation. The subsequent narrative describes areas of significant work in the January-June 2018 period.

Table 1: All-Payer ACO Model Year 1 (2018) Timeline*

Quarter 1 *January-March 2018*	• Regulatory/Policy: o ACO Certification (completed) o Develop ACO Certification Monitoring Plan (completed) o 2018 ACO Budget Order monitoring (ongoing) • Reporting: o Launch analytics contract (completed)
Quarter 2 *April-June 2018*	• Regulatory/Policy: o Develop 2019 ACO Budget Guidance (in progress) o Receive and review ACO quarterly reports (in progress) o Develop ACO Primary Care Spend measure (in progress) o Finalize 2019 Vermont Medicare ACO Initiative Quality Measures (in progress) o 2018 ACO Budget Order monitoring (ongoing) • Reporting: o Finalize Total Cost of Care and ACO Scale specifications (in progress)
Quarter 3 *July-September 2018*	• Regulatory/Policy: o File proposed changes to Rule 5.000 o Develop ACO Certification and Budget Manual o Implement ACO Certification Monitoring Plan o 2018 ACO Budget Order monitoring • Reporting: o Test Total Cost of Care specifications, partial 2017 data o Preliminary ACO Scale calculation for Year 1
Quarter 4 *October-December 2018*	• Regulatory/Policy: o Review 2019 ACO Budget o 2018 ACO Budget Order monitoring o Submit 2019 Vermont Medicare ACO Initiative Benchmark to CMS for approval • Reporting: o Report on baseline (Year 0/2017) Total Cost of Care o Report on Q1 2018 Total Cost of Care

**Dates and activities based on current information; subject to change.*

1. ACO Oversight and Monitoring

A. ACO Reporting and Budget Guidance

2018 ACO Reporting and Budget Guidance

As described above, the Board is implementing a value-based payment model under the APM Agreement. In response to Act 113, the Board developed an administrative rule to regulate ACOs, the vehicles of reform under the APM Agreement. This new rule, Rule 5.000, took effect in November of 2017 and governs ACO certification and budget review.

To solicit ACOs' 2018 budgets,[1] the Board developed the 2018 ACO Reporting and Budget Guidance. In response, OneCare Vermont provided an initial budget submission to the Board on June 23, 2017. While comprehensive, it was difficult for the Board to fully evaluate OneCare's proposed budget because ACO provider networks are not finalized until September and an ACO's provider network determines attribution and, in turn, the ACO's financial targets and per member payments. The Board asked OneCare to provide a revised submission in October 2017, which was reviewed by the Board, a national contractor who specializes in ACOs, and Lewis & Ellis, the Board's contracted actuary. The submission described OneCare's governance structure, payer contracts, provider network, risk model, and population health model of care.

On January 3, 2018, the Board approved OneCare's FY 2018 budget with 18 conditions.[2] The Board will monitor OneCare's compliance with these conditions throughout 2018. Table 2, below, lists these conditions, their due dates, and whether or not they are deemed complete.

2019 ACO Reporting and Budget Guidance

Board staff recently drafted the 2019 ACO Reporting and Budget Guidance after consulting with OneCare and the Office of the Health Care Advocate. The 2019 guidance is similar in many respects to the 2018 guidance. However, there are important differences. Most notably, the 2019 guidance will require ACOs to report their spending on primary care, including services billed through insurance claims and other primary care spending. The 2019 guidance is currently being considered by the Board and will be released on or before August 1, 2018, with an anticipated budget submission deadline of October 1, 2018. The Board expects to complete its review of ACO budgets by December 2018.

In conjunction with its review of ACO budgets, the Board will establish benchmarks or financial targets for ACOs participating in the Vermont Medicare ACO Initiative in 2019. The APM Agreement sets limits on the Board's discretion in establishing benchmarks and, to assist ACOs in developing their 2019 budgets, the guidance will describe these limits.

[1] 2018 was referred to as a 'test year," because it allowed the Board to determine the types of data it would need to examine ACOs' financial health and ability to take on risk, and to evaluate ACOs' provider, payer, and community relationships and investments.

[2] In re: OneCare Vermont Accountable Care Organization, LLC, Fiscal Year 2018, *available at* http://gmcboard.vermont.gov/sites/gmcb/files/FY18%20ACO%20Budget%20Order%20OneCare%20Vermont.pdf.

Table 2: 2018 ACO Budget Order Items

	Frequency	Date Due	Complete
OneCare must request and receive an adjustment to its budget prior to executing a contract that would cause it to exceed the following maximum risk levels: 4% of the Medicare benchmark; 3% of the Medicaid benchmark; and 3% of the commercial benchmark.	As needed	1/15/18	X
Provide the Board by January 15, 2018, a policy approved by OneCare's Board of Managers which delegates risk to the risk-bearing hospitals in the manner described in OneCare's budget filings;	One-time	1/15/18	X
OneCare must fund Medicare SASH and Blueprint for Health payments (CHT and PCP) at 2017 levels plus an inflationary rate of 3.5% in both risk and non-risk communities.	One-time	1/15/18	X
OneCare must implement the delegated risk model it described in its budget proposal and provide the Board by January 15, 2018, contracts that obligate each of the risk-bearing hospitals to OneCare's risk sharing policy;	One-time	1/15/18	X
OneCare must consult with the Office of the Health Care Advocate to establish a grievance and appeals process consistent with Rule 5.000 and submit to the Board a final policy that applies to all aligned beneficiaries.	One-time	2/21/18	X
OneCare must submit to the Board an updated P&L after attribution has been finalized and the benchmarks for all payer programs have been calculated. Trend Rates Approved: 3.5% for Medicare; 3.5% - 3.7% for Commercial; 6.1% for Medicaid (1.5% after All-Payer TCOC calculation exclusions)	One-time	2/28/18	X
Provide the Board with irrevocable letters of credit from OneCare's founders committing to cover risk-share for Brattleboro Memorial Hospital and Springfield Hospital;	One-time	2/28/18	X
OneCare must submit a report to the Board that the BCBSVT and UVMMC programs qualify as Scale Target ACO Initiatives under section 6.b. of the APM Agreement.	Annual	3/30/18	X
OneCare must submit a report to the Board describing how BCBSVT and UVMMC contracts align with the Medicare contract in the areas of: total cost of care; attribution and payment mechanisms; patient protections; provider reimbursement strategies; and quality measures, and a rationale for any differences.	Annual	3/30/18	X
Quarterly Operating Results (per the Rule), to also include: population health 3.1%, Reserves, Administrative expense ratio. OneCare must fund its other population health management and payment reform programs at no less than 3.1% of its overall budget. If the percentage decreases, OneCare must promptly alert the Board. OneCare's administrative expense ratio must be consistent with its proposed budget. If the expense ratio increases by more than one percent (1%) from the budget, OneCare must promptly inform the Board.	Quarterly	4/30/18 7/28/18 10/31/18 1/31/19	X
OneCare must report to the Board on the number of Medication Assisted Treatment providers in its network and update the Board on its network's capacity for substance use disorder treatment at all levels of care (including preventive care).	One-time	6/30/18	
Establish reserves of at least $1.1 million by July 1, 2018 and an additional $1.1 million (total $2.2 million) by December 31, 2018.	Semi-Annually	6/30/18 12/31/18	
OneCare must submit a payment differential report that describes: a) its Comprehensive Payment Reform Pilot's payment methodology, and b) analyzes how the capitated payments for primary care services under its program compare to the payments hospitals make to primary care providers that are not participating in the pilot; c) the report should also address how the Comprehensive Payment Reform pilot reduces administrative burden for primary care providers. At the end of the fourth quarter, 2018, OneCare must submit a quality report on the pilot, with a final report due in 2019, at a date to be determined with the Board.	One-time	6/30/18 12/31/18	
OneCare's administrative expenses should be less than health care savings generated through the All-Payer Accountable Care Organization Model.	One-time	1/31/19	
In consultation with GMCB staff, identify a pathway by which potential savings from this model will be returned to participating commercial premium rate payers, initially focusing on those individuals with qualified health plan coverage through Vermont Health Connect.	One-time	1/31/19	
Seek approval from the board prior to reserves being used.	As needed	no date	
Notify the Board promptly regarding its intent to purchase aggregate total cost of care reinsurance for 2018.	As needed	no date	
OneCare must ensure that its administrative expenses are appropriately allocated by state (i.e., between VT and NY).	Annual	no date	

B. Certification and Ongoing Oversight

An ACO must be certified by the Board in order to receive payments from Medicaid or a commercial insurer through any payment reform program or initiative, including an all-payer model. 18 V.S.A. § 9382(a). Based on its review of OneCare's extensive budget submissions, the Board provisionally certified OneCare on January 4, 2018. The Board fully certified OneCare on March 21, 2018, after requesting and receiving additional documentation and information, including OneCare's policies and procedures, care management manuals, plans, and written answers to questions, and after Board staff visited OneCare's Colchester offices to observe its analytics capabilities.

Under Rule 5.000, once an ACO is certified, the Board will review its continued eligibility for certification annually. The Board will review OneCare's continued eligibility for certification, including its compliance with recent amendments to the statutory certification criteria, contemporaneously with its review of OneCare's proposed 2019 budget.

C. Revisions to Rule 5.000

Board staff have identified several potential improvements to Rule 5.000. For example, the timeline for ACO budget review needs to be amended to better track an ACO's budget development process.

The need for rule changes this year was not unexpected. When developing the rule, it was understood that valuable lessons would be learned as the Board began to administer the new processes described in the rule, and that the rule may need to be updated to reflect these lessons learned.

A list of recommended rule changes is expected to be presented to the Board in July or August of 2018. Any amendments approved by the Board will be pre-filed with the Interagency Committee on Administrative Rule soon after they are approved by the Board.

2. Vermont All-Payer ACO Model Agreement

A. CMS Reporting Readiness

Analytics Contractor Procurement

Following a standard RFP process in 2017, Mathematica Policy Research was selected from a field of ten bidders to be the Board's All-Payer ACO Model analytics vendor. A contract was executed in January 2018. In Q1-Q2 2018, work has focused on developing detailed technical specifications for calculating total cost of care according to the All-Payer ACO Model Agreement; developing detailed technical specifications for calculating ACO scale; and supporting change management at the Board.

Progress on Specifying Total Cost of Care and Scale

Board staff have collaborated with the Department of Vermont Health Access (DVHA), commercial insurers, OneCare, and Mathematica Policy Research to develop detailed technical specifications for the All-Payer Total Cost of Care measure, a critical reporting metric included in the APM Agreement. Tasks have included:

- Identifying 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 APM Agreement and consulting with payers. CMS agreed to Vermont's proposal for financial target services in 2017.
- Working to develop detailed specifications to calculate All-Payer Total Cost of Care, including both claims payments (using data from the Vermont Health Care Uniform Reporting and Evaluation System or VHCURES) and non-claims payments. Draft specifications were completed in May 2018 and are being reviewed by OneCare. They will be submitted to CMS for review in June.
- Continuing work to ensure data systems readiness for reporting. A VHCURES attribution flag has been developed and tested, and additional data validation checks have been instituted. Work is ongoing with State of Vermont partners (e.g., Vermont Department of Health) and with payers, including DVHA and Blue Cross and Blue Shield of Vermont, to ensure reporting readiness.
- Submitting draft templates for reporting total cost of care and quality information to CMS, as required by the APM Agreement. Templates have been approved by CMS.

Quality Measure Refinement

The APM Agreement includes 20 quality measures in Appendix 1, with corresponding targets to be met by Performance Year 5 (2022). Since the last legislative report, after negotiations with CMS, targets for two measures have been implemented – increasing utilization by prescribers of the Vermont Prescription Monitoring System (1.80 provider queries per opioid prescription recipient, up from 1.65 in 2016) and reducing the rate of growth in the number of mental health and substance abuse-related Emergency Department visits (3% growth, down from 6% in 2014-2015).

CMS recommended a 21st measure in Section 7.g. of the APM 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 submitted a proposal to CMS on March 9, 2018 recommending a measure comparing the number of primary care and non-surgical specialist visits. Visits would be defined based on claims-based measures used by CMMI and its contractor in the Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration. This proposal was accepted on April 2, 2018, as a monitoring measure only for at least 2018 and 2019. After that, the measure and an associated target could potentially be added to the quality framework as an additional health care delivery system quality measure, if CMS and the GMCB, in consultation with AHS choose to do so.

Table 3: Updated All-Payer ACO Model Quality Measures, with Baselines and Targets

Measure (Source)	Domain	Proposed 2022 Target and Baseline
Goal #1: Increase Access to Primary Care		
Percentage of adults with usual primary care provider (BRFSS Survey)	Population Health	89% of adults statewide *Baseline: 87% (2014)*
Medicare ACO composite of 5 questions on Getting Timely Care, Appointments, and Information (ACO CAHPS Survey)	Health Care Delivery System	75th percentile compared to Medicare nationally *Baseline: ~70th-80th percentile*
Primary care visits per 1,000 beneficiary-quarters; Specialist care visits per 1,000 beneficiary-quarters (Claims)	*Health Care Delivery System*	*Monitoring only for at least first 2 years* *Baseline: Not yet specified*
Percentage of Medicaid adolescents with well-care visits (Claims)	Process	50th percentile compared to Medicaid nationally *Baseline: 25th percentile*
Percentage of Medicaid enrollees aligned with ACO (PCP selection and claims)	Process	No more than 15 percentage points below % of VT Medicare beneficiaries aligned to VT ACO *Baseline: 55.5% (Jan. 2016)*
Goal #2: Reduce Deaths Related to Suicide and Drug Overdose		
Deaths related to suicide (Vital Statistics)	Population Health	16 per 100,000 VT residents or 20th highest in US *Baseline: 16.9 (2013)*
Deaths related to drug overdose (Vital Statistics; Vermont residents)	Population Health	Reduce by 10% *Baseline: 129 (2016)*
Multi-Payer ACO initiation of alcohol and other drug dependence treatment (Claims)	Health Care Delivery System	Initiation: 50th percentile *Baseline: 25th Percentile*
Multi-Payer ACO engagement of alcohol and other drug dependence treatment (Claims)	Health Care Delivery System	Engagement: 75th percentile *Baseline: ~75th percentile*
Multi-Payer ACO 30-day follow-up after discharge from ED for mental health (Claims)	Health Care Delivery System	60% *Baseline: 56.2% (2014)*
Multi-Payer ACO 30-day follow-up after discharge from ED for alcohol or other drug dependence (Claims)	Health Care Delivery System	40% *Baseline: 35.9% (2014)*
Number of mental health and substance abuse-related ED visits (Hospital Discharge Data)	Health Care Delivery System	Reduce rate of growth to 3% *Baseline: ~6% (2014-15)*
The number of Vermont Prescription Monitoring System (VPMS) queries by prescribers who have written at least one opioid analgesic prescription divided by the number of unique recipients who have received at least one opioid analgesic prescription (VPMS)	Process	Increase to 1.80 *Baseline: 1.65 (2016)*
Multi-Payer ACO screening for clinical depression and follow-up plan (Clinical)	Process	75th percentile compared to Medicare nationally *Baseline: 60th-70th percentile (2014)*
# per 10,000 population ages 18-64 receiving medication assisted treatment (VDH Data)	Process	150 per 10,000 (or rate of demand) *Baseline: 123 per 10,000 (Q4 2015)*
Goal #3: Reduce Prevalence and Morbidity of Chronic Disease (COPD, Hypertension, Diabetes)		
Statewide prevalence of chronic disease: 3 measures including chronic obstructive pulmonary disease, hypertension, and diabetes (BRFSS Survey)	Population Health	Increase statewide prevalence by no more than 1% *Baseline: 6% (2015)*
Statewide prevalence of hypertension (BRFSS Survey)	Population Health	Increase statewide prevalence by no more than 1% *Baseline: 27% (2014)*
Statewide prevalence of diabetes (BRFSS Survey)	Population Health	Increase statewide prevalence by no more than 1% *Baseline: 8% (2015)*
Medicare ACO chronic disease composite, consisting of: Diabetes HbA1c Poor Control; Controlling High Blood Pressure; and All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions (Claims and Clinical)	Health Care Delivery System	75th percentile compared to Medicare nationally *Baseline: TBD*
Percentage of VT residents receiving appropriate asthma medication management (Claims)	Process	25th percentile compared to national *Baseline: <25th percentile (2014)*
Multi-payer ACO tobacco use assessment and cessation intervention (Clinical)	Process	75th percentile compared to Medicare nationally *Baseline: ~75th percentile (2014-15)*

B. Potential Agreement Changes and Preparation for Performance Years 2-5

Potential Changes in Performance Year 2 (2019): In 2019, the Medicare ACO program active in Vermont will shift to the Vermont Medicare ACO Initiative. The parameters and requirements of this initiative may differ from those of the standard Medicare Next Generation ACO program. Board staff have been working with stakeholders to consider changes that could be made to the standard Medicare Next Generation ACO program as part of the initiative, including:

- *Quality Measure Changes*: Board staff worked with stakeholders, including OneCare and the Office of the Health Care Advocate, to develop a recommended consensus list of quality measures for the Vermont Medicare ACO Initiative in 2019. This measure list was submitted to CMS in May for feedback; it will require GMCB and CMS approval to be finalized.
- *Percentage of Benchmark Tied to Quality*: Board staff are working with stakeholders to develop a recommendation for the percentage of an ACO's benchmark to be tied to quality under the Vermont Medicare Initiative in 2019.
- *Operational changes:* OneCare has requested two operational changes: a) a revised beneficiary letter for Vermont Medicare beneficiaries attributed to the ACO, which would reflect Vermont-specific information; and b) a change to the governance requirements to align with the governance requirements of Rule 5.000.

This list is not necessarily complete or final; it is possible that additional changes may arise later in 2018. Any changes must be approved by the Board. The potential changes described above would be reflected in the participation agreement between CMS and OneCare; they would not require changes to the APM Agreement between CMS and the State.

Potential Changes in Year 3 (2020): The Board is also considering and planning for potential changes to the Vermont Medicare ACO Initiative in 2020, Performance Year 3 of the APM Agreement. As with Performance Year 2 changes, it is likely that this list will change prior to the start of Performance Year 3.

- Medicare Next Generation ACO program benefit enhancement waivers. As part of the Medicare Next Generation ACO program, CMS is offering participating ACOs a small number of waivers which would grant them flexibility from current Medicare rules to enhance benefits or reduce provider burden. Waivers would apply to qualifying Medicare beneficiaries who are attributed to a participating ACO only. Under consideration for the Vermont Medicare ACO Initiative in 2020 are a benefit enhancement to allow beneficiaries to receive IV therapy in their homes; and the expansion of an existing waiver that allows for payment of post-hospital discharge home visits for qualifying beneficiaries.