June 2, 2016
Vermont Commercial ACO Pilot Standards
Last updated and approved by the GMCB on November 17, 2015

Standards Related to the ACO's Structure		
Standard	**Description**	**Information Currently Collected by GMCB**
I. Financial Stability	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** **B. Standards related to downside risk** **C. Standards related to financial oversight** **D. Minimum number of attributed lives for a contract with a payer for a given line of business** **E. The ACO will notify the Board if the ACO is transferring risk to any participating provider organization within its network**	1. ACOs regularly provide updated information to the GMCB on number of attributed lives.

Standards Related to the ACO's Structure		
Standard	**Description**	**Information Currently Collected by GMCB**
III. Patient Freedom of Choice	ACO patients will have freedom of choice with regard to their providers consistent with their health plan benefit.	1. Annual report due by November 30th.

IV. ACO Governance	ACOs must:
	• Maintain identifiable governing body
	• Identify board members
	• Have transparent governing process to include:
	  o publishing of names and contact information for governing body members;
	  o time for comments from public allotted at beginning of meetings;
	  o making minutes available;
	  o posting summaries of activities
	• Governing body members must have fiduciary duty to ACO
	• 75% control of governing body must be held by ACO participants
	• Include at least one consumer member who is a Medicare beneficiary, one who is a member of a commercial insurance plan, and one who is a Medicaid beneficiary (if the ACO participates with these payers)
	• Consult with advocacy groups
	• Have regularly scheduled process for inviting consumer input on ACO policy
	• Establish consumer advisory board to be attended by members of ACO governing body and reported back to the body as a whole
		1. ACO Board Composition one-time report, resubmit within 30 days when there are changes. – Standard IV. 7
		
		2. ACO Consumer Advisory Board Establishment one-time report, resubmit within 30 days when there are changes – Standard IV. 7
		
		3. ACO Consumer Advisory Board Meetings annual report by November 30th – Standard IV. 7
		
		4. ACO Governing Process Transparency one-time report Standard IV. 3

Standards Related to the ACO's Payment Methodology		
Standard	**Description**	**Information Currently Collected by GMCB**
V. Patient Attribution Methodology	Patients will be attributed to an ACO using a 13 step methodology described in detail in the Standards document.	
VI. Calculation of ACO Financial Performance and Distribution of Shared Risk Payments	The Pilot Standards provide for a complete methodology for: • determining targeted spending for an ACO; • reconciling targeted spending with actual spending; • identifying any shared savings; • distributing shared savings based on an ACO's performance on quality measures	Financial information regularly reported to GMCB contractor for annual assessment

Standards Related to Management of the ACO		
Standard	**Description**	**Information Currently Collected by GMCB**
VII. Care Management	**A. Care Management Oversight** (based partially on NCQA ACO Standards PO1, Element B, and PC2, Element A) #1: Supports its participating providers in having a process to assess their success in meeting the following care management standards, as well as the ACO's care management goals. #2: Supports participating primary care practices' capacity to meet person-centered medical home requirements related to care management. #3: Consults with its consumer advisory board regarding care management goals and activities. **B. Guidelines, Decision Aids, and Self-Management** (based partially on NCQA ACO Standards PO2, Elements A and B, and CM4, Elements C) #4: Supports participating providers in consistent adoption of evidence-based guidelines, and supports the exploration of emerging best practices. #5: Supports participating providers in having methods for engaging and activating people families in support of each individual's specific needs, positive health behaviors, self-advocacy, and self-management of health and disability.	1. ACOs meet annually with GMCB staff to describe Care Management activities 2. VII. 3 addressed partially through consumer advisory reports submitted to assess IV. ACO Governance

	#6: Provides: a) educational resources to assist in self-management of health and disability, b) self-management tools that enable attributed people/families to record self-care results, and c) connections between attributed people/families and self-management support programs and resources. **C. Population Health Management** (based partially on NCQA ACO Standards CM3, Elements A and B, and CT1, Elements A, B, D, and E) #7: The ACO has and/or supports participating providers in having a process for systematically identifying: • attributed people who need care management services; • the types of services they should receive; • the entity or entities that should provide the services The process includes but is not limited to prioritizing people who may benefit from care management, by considering social determinants of health, mental health and substance abuse conditions, high cost/high utilization, poorly controlled or complex conditions, or referrals by outside organizations. #8: The ACO facilitates and/or supports its participating providers in facilitating the delivery of care management services. Facilitating delivery of care management services includes: • collaborating and facilitating communication with people needing such services and their families, as well as with other entities providing care management services, including community organizations, long term service and support providers, and payers; • developing processes for effective care coordination,	

	exchanging health information across care settings, and facilitating referrals; • recognizing disability and long terms services and supports providers as partners in serving people with high or complex needs #9: The ACO facilitates and/or supports its participating providers in facilitating: • promotion of coordinated person-centered and directed planning across settings that recognizes the person as the expert on their goals and needs; • in collaboration with participating providers and other partner organizations, care management services that result in integration between medical care, substance use care, mental health care, and disability and long term services and supports to address attributed people's needs **D. Data Collection, Integration and Use** (partially based on NCQA ACO Standard CM1, Elements A, B, C, E, F and G) #10: To the best of their ability and with the health information infrastructure available, and with the explicit consent of beneficiaries unless otherwise permitted or exempted by law, the ACO uses and/or supports its participating providers in using an electronic system that: • records structured (searchable) demographic, claims, and clinical data required to address care management needs for people attributed to the ACO; • supports access to and sharing of attributed persons' demographic, claims and clinical data recorded by other	

	participating providers; and • provides people access to their own health care information as required by law #11: The ACO encourages and supports participating providers in using data to identify needs of attributed people, support care management services and support performance measurement, including the use of: • a data-driven method for identifying people who would most benefit from care management and for whom care management would improve value through the efficient use of resources and improved health outcomes; • methods for measuring and assessing care management activities and effectiveness, to inform program management and improvement activities	

Standards Related to Management of the ACO		
Standard	**Description**	**Information Currently Collected by GMCB**

VIII. Payment Alignment	• Encourages alignment of payment incentives at the payer-ACO level with the individual and clinician and facility level. Sets requirement for Board to assess:
	  o ACO payment alignment plan
	  o Plan for distribution of earned savings
	• Encourages regional groupings of providers to join in sharing earned savings or losses and taking accountability for quality and cost of care.
	• Insurers shall support ACOs by collaborating with ACOs to align performance incentives and by considering bundled payments or other episode-based payment methodologies
		1. ACO Network Model annual report by September 30th – Standard VIII. 2
		
		2. ACO Payment Alignment annual report by September 30th – Standard VIII. 1

IX. Data use Standards	ACOs and payers must submit the required data reports detailed in the "Data Use Report Standards for ACO Pilot" in the format defined.	ACOs submit all required reports

X. Process for Review and Modification of Measures Used in the Commercial and Medicaid ACO Pilot Program		

• Annual review of Payment and Reporting measures included in the core ACO measure set.
  o Goal of review is to determine whether measures should continue to be used as designated or modified for the next pilot year.
• Annual review of all targets and benchmarks for measures designated for payment purposes.
  o Review is intended to determine ongoing appropriateness of benchmark for next pilot year.
• Review of measures designated as pending to determine if new measures should be added for the next pilot year.
• Process for reviewing Monitoring and Evaluation measures.
• The GMCB will release the **final measure specifications f**or **the next pilot year by no later th**an October 31st of the year prior to the implementation of the changes.
  o The specifications document will provide the details of any new measures and any changes from the previous year.
• If during the course of the year, a national clinical guideline for any measure designated for Payment or Reporting changes or an ACO or payer participating in the pilot raises a serious concern about the implementation of a particular measure, there is a process for redetermination.
• GMCB must notify all pilot participants of the proposed change within 14 days.
	Annual submission of quality data by ACOs and through claims

*** All processes include review and input from the VHCIP Quality and Performance Measures Work Group and in the instance of a change in national clinical guideline, the VHCIP Payment Models Work Group as well as Steering Committee and Core Team will also provide input and vote on any recommended change.	