State of Vermont
Green Mountain Care Board
89 Main Street
Montpelier VT 05620

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 June 15 to September 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

September 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 June 15, 2017 to September 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) (complete) • Establish two remaining quality measure targets (one completed; other on track) • Selection of analytics contractor (completed)
July-August 2017	• Rulemaking continues (on track) • GMCB ACO test budget review process (on track)
September-October 2017	• Rulemaking continues • Medicaid advisory ACO rate review
November-December 2017	• Rulemaking continues • CMS preliminary trend factor set for 2018 (4th quarter) • ACO test budget approval • Certification of ACO • Identify 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.	

<u>Rulemaking under Act 113</u>

A. Rulemaking process

Since the initial implementation report was filed, the Board has 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. A hearing before LCAR is scheduled for September 14, 2017.

The Board continues to be on track in its rule development process and anticipates it can meet its requirement under section 6 of Act 113 that the rule be in effect by January 1, 2018.

B. ACO Annual Reporting and Budget Guidance

As reported in June, ACOs are participating in a "test" budget submission in preparation for required approval and certification in 2018. This learning year enables the Board to understand what information is required to assess an ACO's budget, and when the information is available. In May 2017, the Board issued budget guidance requesting that the ACOs submit information regarding governance structure, payer contracts, provider participants, model of care, previous expenditure analysis, and their 2018 proposed budgets. OneCare Vermont and Community Health Accountable Care both submitted preliminary budgets on June 23, 2017. Board staff reviewed the materials, and asked the ACOs to give an initial presentation to the Board on July 13, 2017 that focuses on the model of care. The ACOs will provide the Board updated information including finalized contracts, participating providers, and rate requests in mid-October 2017. The Agreement requires the Board to set the Medicare growth rate for ACOs participating in the Vermont Modified Medicare Next Generation Program, and the budget review helps ensure that the Board will determine the most appropriate Medicare growth rate, within the Agreement's parameters.

C. Certification

Beginning January 1, 2018, ACOs must be certified by the Board to receive payments from Medicaid or a commercial insurer through any payment reform program or initiative. In drafting the ACO oversight rule, the Board has identified the information and documentation ACO must submit to complete its application to become certified. The Board is in the process of developing a draft application form, and expects to finalize the form this fall. Because the rule may not be in effect before the January 1, 2018 deadline mandated by Act 113, however, the Board may begin reviewing certification materials from ACOs before the rule takes effect.

D. Medicaid advisory ACO Rate Review

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 scheduled to begin late September 2017.

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

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 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. DVHA staff have worked with insurers BCBSVT and MVP on non-claims-based Commercial specification, which must still be refined and tested.

- Continue 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 has been submitted to annually field the Hypertension Prevalence measure to 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).

- Created draft reporting templates for submitting total cost of care and quality information to CMS, as required by the Agreement.

B. Refining Quality Measure Specifications

The twenty quality measures outlined in the Agreement are specified in Appendix 1, with corresponding targets established for most. Vermont and CMS must still establish targets for two of these measures.

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 has been provided recently by VDH; that data will help inform the negotiations.

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. 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.

C. Analytics Request for Proposals (RFP)

Vermont has written and posted an RFP for an all-payer 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 is drafting and negotiating the contract's scope and terms. Pursuant to state law, information related to the bidders is confidential until a contract is awarded.