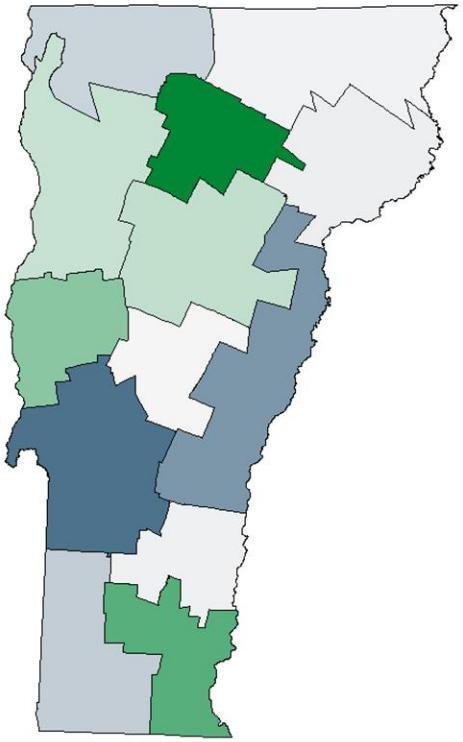

Green Mountain Care Board
All-Payer Model Update

June 27, 2018

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Agenda

- 2018 Scale Target ACO Initiatives and Alignment
- 2019 Vermont Medicare ACO Initiative
- All-Payer Model Reporting

Scale Target ACO Initiatives

- Scale targets = percentages of Vermont Medicare Beneficiaries and Vermont All-payer Scale Target Beneficiaries that are aligned to a Scale Target ACO Initiative.

- Scale Target ACO Initiative = an arrangement offered by Vermont Medicaid, Vermont Commercial Plans, Vermont Self-Insured Scale Target Plans, or Medicare FFS (e.g., Vermont Medicare ACO Initiative, Next Generation ACO Model, Medicare Shared Savings Program) to a Vermont ACO that incorporates, at a minimum:
  - The possibility of Shared Savings for the ACO if it achieves goals related to quality of care or utilization.

Scale Target ACO Initiatives

- The ACO's Shared Savings, as a percentage of its expenditures less than the benchmark, is at least 30%; if the ACO is also at risk for Shared Losses, its Shared Losses, as a percentage of its expenditures in excess of the benchmark, is at least 30%.

- The ACO Benchmark, Shared Savings, Shared Losses, or a combination is tied to the quality of care the ACO delivers, the health of its aligned beneficiaries, or both.

- Services comparable to All-payer Financial Target Services and their associated expenditures are included for determination of the ACO's Shared Losses and Shared Savings.

Scale Target ACO Initiatives

- All-payer Financial Target Services means

  - Medicare Financial Target Services: All Part A services (hospital care, skilled nursing facility care, nursing home care, hospice care, and some home health care) and Part B services (certain doctor visits, outpatient care, medical supplies, and preventative care), including benefit enhancements authorized under a Medicare ACO program; and
  - The following categories of services for Vermont Medicaid, Vermont Commercial Plans, and Vermont Self-insured Plans: acute hospital inpatient and outpatient care, post-acute care, professional services, and durable medical equipment (DME).

2018 (PY1) ACO Initiatives

- Medicare
  - Modified Medicare Next Generation ACO Program
  - 39,702 Attributed Lives as of January 1, 2018
- Medicaid
  - Vermont Medicaid Next Generation ACO Program
  - 42,342 Attributed Lives as of January 1, 2018
- Commercial
  - BCBVT Commercial Next Generation ACO Program
  - 20,838 Attributed Lives as of January 1, 2018
- Self-Funded
  - UVMMC Shared Savings ACO Program
  - Executed in May, but effective January 1, 2018
  - 9,962 Attributed Lives as of January 1, 2018

Scale Target ACO Initiatives: Possibility for Shared Savings

- Medicare: Yes
- Medicaid: Yes
- BCBSVT: Yes
- UVMMC: Yes

Scale Target ACO Initiatives: Minimum Shared Savings/Losses

- Medicare: Yes
  - 80% savings and losses up to 5% cap.
- Medicaid: Yes
  - 100% savings and losses up to 3% cap.
- BCBSVT: Yes
  - 50% savings and losses up to 6% cap.
- UVMMC: Yes
  - 30% savings (no losses) up to 10% cap.

Scale Target ACO Initiatives: Comparable Services

- Medicare: Yes
  - Part A and Part B services.
- Medicaid: Yes
  - Comparable services (e.g., inpatient and outpatient hospital; professional services; home health and hospice; DME).
- BCBSVT: Yes
  - Medical services covered under an attributed member's QHP (essential health benefits and state-mandated benefits), as well as non-specialty pharmacy.
- UVMMC: Yes (more information may be required)
  - Medical services covered under an attributed member's medical benefit are included.

Scale Target ACO Initiatives: Finances Tied to Quality Performance

- Medicare: Yes
  - If ACO successfully reports on quality measures, benchmark will not be adjusted downward.

- Medicaid, BCBSVT, and UVMMC: Yes
  - Quality incentive pool. Some or all of funds earned by ACO based on its quality performance may be distributed to ACO's network. Of the amounts not distributed to the ACO's network, 50% will go to fund ACO quality improvement initiatives and 50% will go to the payer.

2018 Program Alignment

- "Vermont shall ensure that Scale Target ACO Initiatives offered by Vermont Medicaid, Vermont Commercial Plans, and participating Vermont Self-insured Plans reasonably align in their design (e.g., beneficiary alignment methodology, ACO quality measures, payment mechanisms, risk arrangements, and services included for determination of the ACO's Shared Losses and Shared Savings as described in section 6.b.iii) with the Vermont Modified Next Generation ACO in Performance Year 1 and with the Vermont Medicare ACO Initiative in Performance Years 2 through 5."

Beneficiary Alignment/Attribution

Attribution Element	Medicare	Medicaid	BCBS Next Gen	UVMMC Shared Savings
Provider Types	Primary Care and select specialists	Primary Care	Primary Care	Primary Care
Look-back period	24 months (ending 6 months from beginning of PY)	24 months (ending 6 months from beginning of PY)	Most recent 24 months	Most recent 24 months
Qualifying claims (and tie breakers)	Greatest number of weighted claims (most recent visit)	Greatest number of weighted claims (most recent visit)	Greatest number of claims (most recent visit)	Greatest number of claims (most recent visit)
Alignment based on selection of PCP	No	No	Yes	Yes

2018 Program Alignment: Beneficiary Alignment/Attribution

- Medicare
  - Prospective alignment of beneficiaries to the ACO is determined by looking at claims within a 2-year alignment period. A beneficiary will generally be aligned to an ACO if he or she received the plurality of qualified evaluation and management (QEM) services during the alignment period from the ACO's Next Generation Professionals.
  - The alignment algorithm generally compares QEM services provided by primary care specialists, but may compare QEM services provided by non-primary care specialists (if less than 10% of the QEM services received by a beneficiary during the 2-year alignment period are provided by primary care specialists).

2018 Program Alignment: Beneficiary Alignment/Attribution

- Medicaid
  - DVHA uses a similar methodology to prospectively align Medicaid beneficiaries to the ACO.
  - One difference is that DHVA uses a larger set of evaluation and management codes (the same set used in the Blueprint for Health program and in DVHA's 2016 Shared Savings Program).
  - Another difference is that Medicaid beneficiaries will only be attributed to primary care providers (i.e., there is no alignment by non-primary care specialists).

2018 Program Alignment: Beneficiary Alignment/Attribution

- BCBSVT
  - BCBSVT uses a methodology to that used by CMS and DVHA to align QHP members to the ACO. Differences include that, for products that require members to select a primary care provider, and for which the member has selected a primary care provider, those members are attributed to that provider.
  - Another potential difference is that claims do not appear to be weighted, whereas DVHA and CMS give more weight to claims in most recent year of 2-year alignment period.

- UVMMC
  - Plan uses an methodology similar to that used by BCBSVT.

2018 Program Alignment: ACO Quality Measures

Measure	Vermont All-Payer ACO Model	2018 Vermont Medicaid Next Gen	2018 BCBSVT Next Gen	2018 UVMMC Shared Savings
% of adults with a usual primary care provider	X			
Statewide prevalence of Chronic Obstructive Pulmonary Disease	X			
Statewide prevalence of Hypertension	X			
Statewide prevalence of Diabetes	X			
% of Medicaid adolescents with well-care visits	X	X	X	X
Initiation of alcohol and other drug dependence treatment	X	X	X	X
Engagement of alcohol and other drug dependence treatment	X	X		
30-day follow-up after discharge from emergency department for mental health	X	X	X	X
30-day follow-up after discharge from emergency department for alcohol or other drug dependence	X	X	X	X
% of Vermont residents receiving appropriate asthma medication management	X			
Screening for clinical depression and follow-up plan (ACO-18)*	X	X	X	X
Tobacco use assessment and cessation intervention (ACO-17)*	X	X		
Deaths related to suicide	X			
Deaths related to drug overdose	X			
% of Medicaid enrollees aligned with ACO	X			
# per 10,000 population ages 18-64 receiving medication assisted treatment for opioid dependence	X			

2018 Program Alignment: ACO Quality Measures

Measure	Vermont All-Payer ACO Model	2018 Vermont Medicaid Next Gen	2018 BCBSVT Next Gen	2018 UVMMC Shared Savings
Rate of growth in mental health or substance abuse-related emergency department visits	X			
# of queries of Vermont Prescription Monitoring System by Vermont providers (or their delegates) divided by # of patients for whom a prescriber writes prescription for opioids	X			
Hypertension: Controlling high blood pressure *	X	X	X	X
Diabetes Mellitus: HbA1c poor control *		X	X	
All-Cause unplanned admissions for patients with multiple chronic conditions *				
Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient experience surveys (survey varies by payer program)*	X	X	X	
All-cause readmissions (HEDIS measure for commercial plans)			X	X
Developmental screening in the first 3 years of life		X	X	X
Follow-up after hospitalization for mental Illness (7-Day Rate)		X	X	X

* = Measure in 2018 Medicare Next Gen ACO Program

2018 Program Alignment: Payment Mechanisms

- Medicare and Medicaid
  - AIPBP to ACO for participating providers (100% fee reduction on claims). Other providers paid FFS.
- BCBSVT
  - Providers paid FFS. BCBSVT will pay ACO $3.25 PMPM to support population heath and care coordination activities (5% withheld and paid based on specific deliverables for ACO's very high risk care coordination program).
- UVMMC
  - Providers paid FFS. Plan will pay ACO $9 PBPM for payment reform initiatives and ACO's population health infrastructure.

2018 Program Alignment: Risk Arrangements & Services Included

- Both subjects are described above in Scale Target ACO Initiative section.

2019 Vermont Medicare ACO Initiative

- **Section 8 of the All-payer ACO Model Agreement states:** "CMS, in collaboration with Vermont, shall design and launch the Vermont Medicare ACO Initiative to begin on January 1, 2019 and its performance period will align with PY 2-5 of the Agreement."

- "The GMCB may propose modifications to the Initiative to better align the Initiative with ACO programs operated by Vermont Medicaid, Commercial, and participating self-insured plans. CMS may accept such proposals at its sole discretion".

CMS and GMCB duties for 2019 Agreement

- Requirements:
  - Set separate prospective Medicare benchmarks for aged and disabled beneficiaries and ESRD beneficiaries, to include a rate of growth
  - Define a quality measure set
  - Set a percentage of the benchmark tied to ACO quality performance

- Modifications to support alignment:
  - Governance requirements
  - Beneficiary notification
  - Attribution (2020)

2019 ACO-CMS Quality Proposal

Why propose a quality framework for the 2019 Vermont Medicare ACO Initiative between the ACO and CMS?

- Language from Section 6.b.iv. Of All-Payer ACO Model Agreement: "Vermont Medicare ACO Initiative…incorporates, at a minimum:…[t]he ACO Benchmark, Shared Savings, Shared Losses, or a combination is tied to the quality of care the ACO delivers, the health of its aligned beneficiaries, or both."

- In 2018, the ACO was responsible for reporting on measures in the national Medicare Next Gen ACO program.

- For 2019-2022, the ACO and CMS have an opportunity to tailor measures for the Vermont Medicare ACO Initiative, including developing a measure set that is more aligned with the quality framework outlined in the Agreement between the State and CMS.

Process for Developing Measure Set

During 2017 and 2018:

- OneCare engaged providers, consumers, and other leaders in extensive review of 44 potential quality measures, resulting in a number of recommended measures:
  - More than 100 providers, administrators and quality improvement experts were asked for feedback; 40 responded, and some of them obtained feedback from additional colleagues in their communities
  - Consumer members of OneCare's Board and Consumer Advisory Group were also asked to provide feedback
- Office of Health Care Advocate (HCA) provided comments on OneCare recommendations
- GMCB staff held several meetings with representatives from OneCare and HCA, resulting in consensus measure set
- Consensus measure set presented to CMMI for feedback
- CMMI feedback incorporated into proposal
- Proposal now presented to Board for consideration and approval

Consensus Proposal for 2019 Vermont Medicare ACO Initiative

Proposed Measures for 2019 ACO-CMS Quality Framework	APM	BCBSVT	Medicaid
Tobacco use assessment and cessation intervention*	X		X
Screening for clinical depression and follow-up plan*	X	X	X
Diabetes: HbA1c poor control (part of APM composite)*	X	X	X
Hypertension: controlling high blood pressure (part of APM composite)*	X	X	X
All-cause unplanned admissions for patients with multiple chronic conditions (part of APM composite)*	X		X
30-day follow-up after discharge from ED for mental health	X	X	X
30-day follow-up after discharge from ED for alcohol or other drug dependence	X	X	X
Initiation of alcohol and other drug dependence treatment	X	X	X
Engagement in alcohol and other drug dependence treatment	X	X	X
Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient experience survey (survey varies by payer program)*	X	X	X
Influenza immunization*			
Colorectal cancer screening*			
Risk-standardized, all-condition readmission*			

* = Measure in 2018 Medicare Next Gen ACO Program

Next Steps

Current Board Decision Point:

- Public comment on proposed measure set
- Board discussion and approval of measure set for 2019 Vermont Medicare ACO Initiative

Future Discussion:

- Financial impact, including:
  - Which measures will impact payment to the ACO?
  - How will those measures impact payment to the ACO?

Vermont All-Payer ACO Model Agreement Implementation: Reporting Timelines

- Ongoing:
  - Total Cost of Care (Quarterly and Annual)
  - ACO Scale Target and Alignment (Annual)
  - Health Outcomes and Quality of Care (Annual)

- One-time reports:
  - Payer Differential Assessment (December 2019)
  - Public Health System Accountability Framework (June 2020 – AHS lead)
  - Report on Options to Reduce Payer Differential (December 2020)
  - Plan to Integrate Medicaid Behavioral Health and HCBS Services within All-Payer Financial Target Services (December 2020 – AHS lead)

Vermont All-Payer ACO Model
Total Cost of Care Report Schedule

YEAR 1				YEAR 2			
Q1 2018	Q2 2018	Q3 2018	Q4 2018	Q1 2019	Q2 2019	Q3 2019	Q4 2019
Q1 2018 claims incurred	Q1 2018 claims paid	Q1 2018 received in VHCURES	**Q1 2018 Report to CMMI**				
	Q2 2018 claims incurred	Q2 2018 claims paid	Q2 2018 received in VHCURES	**Q1-Q2 2018 Report to CMMI**			
		Q3 2018 claims incurred	Q3 2018 claims paid	Q3 2018 received in VHCURES	**Q1-Q3 2018 Report to CMMI**		
			Q4 2018 claims incurred	Q4 2018 claims paid	Q4 2018 received in VHCURES	**2018 Annual Report to CMMI**	
				Q1 2019 claims incurred	Q1 2019 claims paid	Q1 2019 received in VHCURES	**Q1 2019 Report to CMMI**

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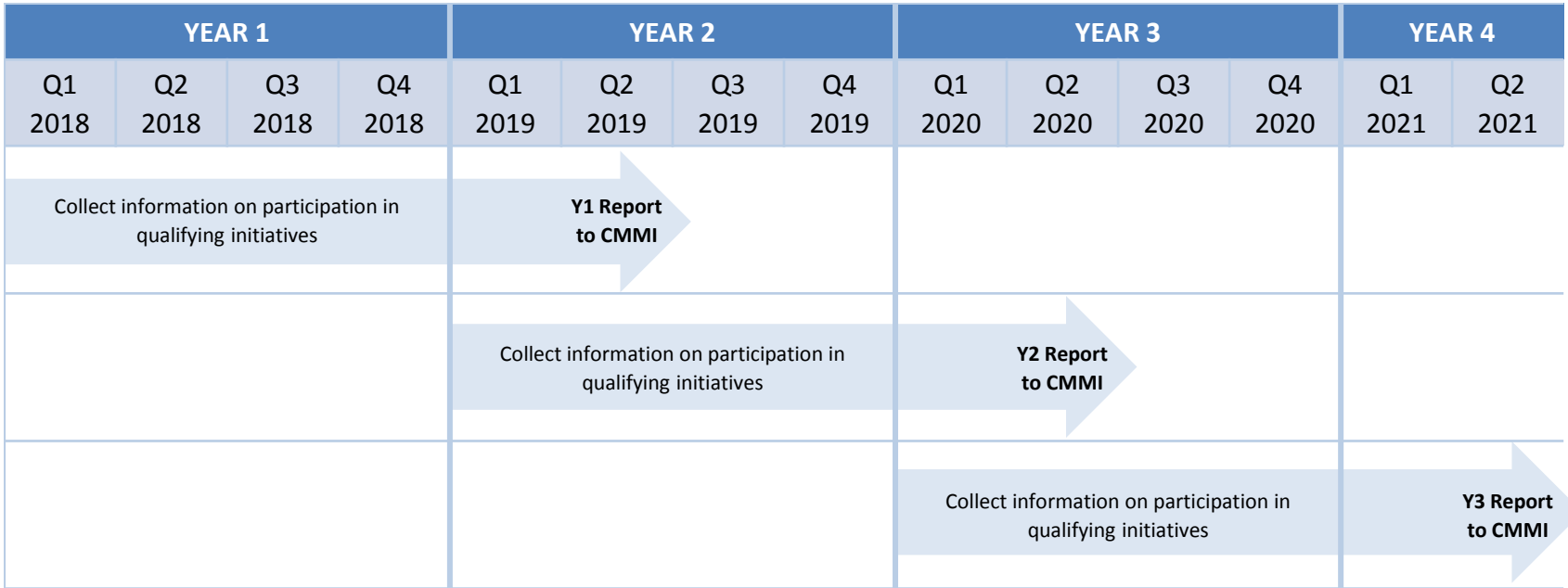
Vermont All-Payer ACO Model
ACO Scale Target and Alignment Report Schedule



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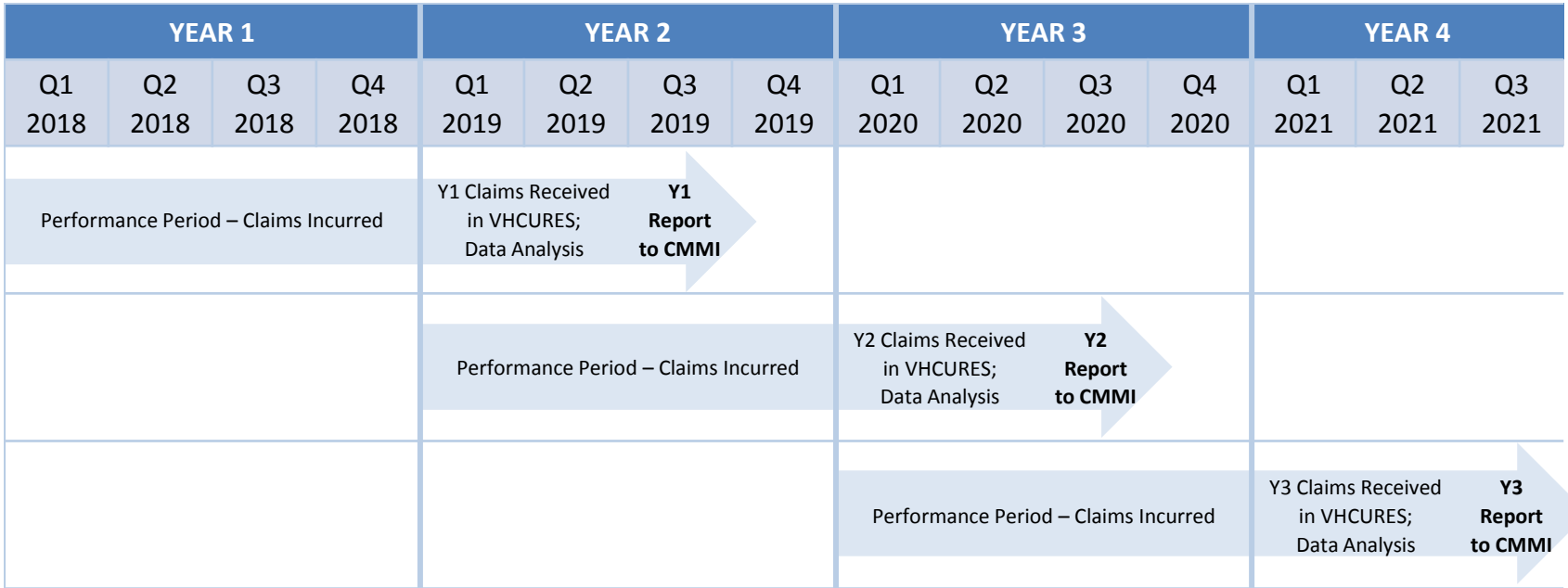
Vermont All-Payer ACO Model
Health Outcomes and Quality of Care Report Schedule



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Vermont Act 124 Legislative Report Timeline

- All-Payer ACO Model Timeline Implementation
  - June 15, 2018
  - September 15, 2018
  - December 15, 2018

- Preliminary ACO attribution scale target analysis
  - August 1, 2018

- Preliminary ACO Total Cost of Care and Quality Information
  - November 1, 2018

Discussion