

**Green Mountain Care Board**  
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**To:** Green Mountain Care Board Members  
**From:** Michael Barber, General Counsel  
Alena Berube, Director of Value Based Programs & ACO Regulation  
Michele Degree, Health Policy Advisor  
**Date:** February 26, 2020  
**Re:** Summary of Proposed Technical Changes to the All-Payer ACO Model Agreement

In carrying out its responsibilities under the Vermont All-Payer Accountable Care Organization Model (APM) Agreement, the Green Mountain Care Board (GMCB) works closely with the Center for Medicare and Medicaid Innovation (CMMI), an agency within the Centers for Medicare and Medicaid Services (CMS) that is tasked with designing, implementing, and testing health care payment models. Through this work, CMMI and GMCB staff have discussed potential technical changes to the Agreement to:

- 1) **Define a process by which the GMCB could submit one or more proposals to modify to the Medicare ACO Initiative.**
- 2) **Address data sharing between CMS and the GMCB for health oversight activities.**
- 3) **Improve the accuracy of financial and quality performance reports by revising reporting deadlines to allow for more complete data.**
- 4) **Update certain quality reference points to better reflect actual quality performance for existing measures.**

**Section-by-Section Summary:** The changes being contemplated by the GMCB and CMMI are reflected in the attached draft amendment. Below is a brief section-by-section summary of the attached draft.

**Section 1:** Specifies the effective date of the amendment.

**Section 2:** Specifies the effect of the amendment (i.e., all other terms of the Agreement remain in effect and the amendment prevails in the event of inconsistency).

**Section 3:** Conforming amendment to section 6.f required by the addition of section 8.c.

**Section 4.a:** Amends section 7.c. to reflect the disaggregation of the composite healthcare delivery system quality measure specified in Appendix 1.b.v. into three measures that will be calculated and reported separately.

**Section 4.b:** Amends section 7.e by changing the due date for the Annual Health Outcomes and Quality of Care Report from September 30 of the year following the performance year to December 31 of the year following the performance year to allow for complete data.

**Section 5.a:** Amends section 8 by replacing the first paragraph in its entirety. The language changes clarify that the GMCB, as described in new section 8.c., may propose one or more modifications to the Vermont Medicare ACO Initiative.

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**Section 5.b:** Conforming amendment to section 8.a.iii to reflect new section 8.c.

**Section 5.c:** Amends section 8.a.iv to clarify that the Vermont Medicare ACO Initiative will offer a Care Management Home Visits benefit enhancement—a benefit enhancement CMS began to offer under the Medicare Next Generation ACO Model after the Agreement was signed.

**Section 5.d:** Amends section 8 by adding a new subsection (c) to specify the information that the GMCB would need to include in a proposal to modify the Vermont Medicare ACO Initiative and to specify that, in developing the proposal, the GMCB must collaborate with AHS and any Medicare ACOs.

**Section 6:** Amends section 9.f by changing the date by which each Performance Year’s All-payer Total Cost of Care per Beneficiary Growth Target results must be finalized, from June 30 to December 31, to allow for claims runout.

**Section 7.a:** Replaces section 15.b in its entirety. The revised language would clarify that the GMCB may request individually-identifiable health information needed to carry out health oversight activities under 45 CFR § 164.512(d)(1), subject to minimum necessary requirements; specify that disclosure of such data would be in CMS’s sole discretion; and make certain non-substantive language changes.

**Section 7.b:** Amends section 15.b by adding subdivisions (i) and (ii) to describe expectations regarding the GMCB’s use of carry out health oversight activities.

**Section 8:** Replaces Appendix 1 in its entirety with new Appendix 1 (see table below).

Quality Measure	Proposed Technical Change	Rationale
Medicaid adolescents with well-care visits (All VT Medicaid)	Update PY5 target to 53%	Removes reference to national benchmarks and sets a PY5 target. National benchmark data (Quality Compass) is proprietary and cost prohibitive.
Initiation and Engagement of alcohol and other drug dependence treatment (ACO-aligned)	Updates PY5 targets: - Initiation: 40.8% - Engagement: 14.6%	Removes reference to national benchmarks and sets a PY5 target. Calculation to determine comparison to national benchmarks was not methodically accurate. National benchmark data (Quality Compass) is proprietary and cost prohibitive.
Medication management for people with asthma (All VT residents)	Updates PY5 target to 65%; codifies use of the 50% compliance rate	Removes reference to national benchmark and sets a PY5 target. Calculation to determine comparison to national benchmarks was not methodically accurate. National benchmark data (Quality Compass) is proprietary and cost prohibitive.



<b>Quality Measure</b>	<b>Proposed Technical Change</b>	<b>Rationale</b>
Getting timely care, appointments and information  (Medicare ACO-aligned)	Update benchmark to appropriate decile range (70 <sup>th</sup> – 80 <sup>th</sup> )	Reference to MSSP percentiles is inaccurate – Medicare only reports decile ranges, therefore no 75 <sup>th</sup> percentile reference exists.
Composite of diabetes, hypertension and multiple chronic conditions  (Medicare ACO-aligned)	Report as three individual measures. Update benchmark to appropriate decile range (70 <sup>th</sup> – 80 <sup>th</sup> ).	Disaggregation is in line with MSSP, bringing total number of reported measures to 22. Reference to MSSP percentiles is inaccurate – Medicare only reports decile ranges, therefore no 75 <sup>th</sup> percentile reference exists.
Tobacco use assessment and cessation intervention  (ACO-aligned)	Update benchmark to appropriate decile range (70 <sup>th</sup> – 80 <sup>th</sup> ); correctly identifies that the reported rate is weighted and aggregated only for those participating payer programs.	Removes reference to national benchmarks. Calculation to determine comparison to national benchmarks was not methodically accurate. Updates language to reflect calculation only occurs for participating payer programs due to the chart review component of this measure. Reference to MSSP percentiles is inaccurate – Medicare only reports decile ranges, therefore no 75 <sup>th</sup> percentile reference exists.
Screening for clinical depression and follow-up plan  (ACO-aligned)	Update benchmark to appropriate decile range (70 <sup>th</sup> – 80 <sup>th</sup> ); correctly identifies that the reported rate is weighted and aggregated only for those participating payer programs.	Removes reference to national benchmarks. Calculation to determine comparison to national benchmarks was not methodically accurate. Updates language to reflect calculation only occurs for participating payer programs due to the chart review component of this measure. Reference to MSSP percentiles is inaccurate – Medicare only reports decile ranges, therefore no 75 <sup>th</sup> percentile reference exists.



**Section 9:** Amends the Agreement by adding Appendix 3 (amendment).

