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 September 15 to December 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

December 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 September 15 to December 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 September-December 2018 period.

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

Quarter 1
January-March 2018
	• Regulatory/Policy:
	  ○ ACO Certification (completed)
	  ○ Develop ACO Certification Monitoring Plan (completed)
	  ○ 2018 ACO Budget Order monitoring (ongoing)
	• Reporting:
	  ○ Launch analytics contract (completed)

Quarter 2
April-June 2018
	• Regulatory/Policy:
	  ○ Develop 2019 ACO Budget Guidance (completed)
	  ○ Receive and review ACO quarterly reports (completed)
	  ○ Develop ACO Primary Care Spend measure (completed)
	  ○ Finalize 2019 Vermont Medicare ACO Initiative Quality Measures (completed)
	  ○ 2018 ACO Budget Order monitoring (ongoing)
	• Reporting:
	  ○ Finalize Total Cost of Care and ACO Scale specifications (completed)

Quarter 3
July-September 2018
	• Regulatory/Policy:
	  ○ File proposed changes to Rule 5.000 (deferred to 2019)
	  ○ Implement ACO Certification Monitoring Plan (ongoing)
	  ○ 2018 ACO Budget Order monitoring (ongoing)
	• Reporting:
	  ○ Test Total Cost of Care specifications, partial 2017 data (completed)
	  ○ Preliminary ACO Scale calculation for Year 1 (completed)

Quarter 4
October-December 2018
	• Regulatory/Policy:
	  ○ Review 2019 ACO Budget (ongoing)
	  ○ 2018 ACO Budget Order monitoring (ongoing)
	  ○ Submit 2019 Vermont Medicare ACO Initiative Benchmark to CMS for approval (ongoing)
	  ○ 2019 ACO Certification (ongoing)
	  ○ 2019 Vermont Medicare ACO Initiative Participation Agreement modifications (ongoing)
	• Reporting:
	  ○ Report on baseline (Year 0/2017) Total Cost of Care (in testing)
	  ○ Report on Q1 2018 Total Cost of Care (in testing)

**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

On January 3, 2018, the Board approved OneCare Vermont's FY 2018 budget with 18 conditions.[1] The Board will continue to monitor OneCare's compliance with these conditions throughout 2018. Table 2, below, lists these conditions, their due dates, and whether or not they are complete. As a part of the budget order monitoring, OneCare has provided final payer contracts; attribution by payer; financial results for quarters one, two and three; analysis of their payer contracts and how they align on risk models, payment mechanisms, quality, and attribution methodology; and a report on their pilot capitation program for independent primary care providers. OneCare also provided a proposal that the Board reviewed and approved to purchase aggregate total cost of care protection for their Medicare contract. The Board will receive a report on their pilot capitation program by the end of this calendar year, which will include an approach to assessing the quality of care for patients in and out of the pilot.

2019 ACO Reporting and Budget Guidance

The 2019 ACO Reporting and Budget Guidance was issued on July 24, 2018, following Board approval and input from OneCare, the Office of the Health Care Advocate, and members of the public. The final guidance is posted on Board's website.[2]

OneCare Vermont submitted their proposed 2019 budget to the Board on October 1, 2018. The budget assumes that OneCare will participate in ACO programs with Medicare, Medicaid, and Blue Cross Blue Shield Vermont in 2019 and will expand its self-funded line of business beyond the University of Vermont Medical Center's self-funded plan. The overall budget is approximately $900 million (this number will change as attribution and targets are finalized) with a vast majority of the dollars flowing to providers either through fixed payments from OneCare or fee-for-service payments from payers.[3] The Board expects to complete its review of the budget by the end of December 2018.

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[1] 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.
[2] Final GMCB ACO Budget Guidance OneCare LLC, *available at:* http://gmcboard.vermont.gov/sites/gmcb/files/files/payment-reform/CY19%20FINAL_GMCB%20ACO%20Budget%20Guidance_OneCareLLC_7-24-2018.docx. Appendices are available here: http://gmcboard.vermont.gov/content/aco-certification-and-budget-review.
[3] In re: OneCare Vermont Accountable Care Organization, LLC, Fiscal Year 2019, *available at:* https://gmcboard.vermont.gov/sites/gmcb/files/documents/GMCB%20ACO%20Budget%20Submission%202019%20Final%20%28Supplemental%20Attachment%29.pdf

Table 2: 2018 ACO Budget Order Items

Item	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 X 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	X

Item	Frequency	Date Due	Complete
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	X
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	X
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	X
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). The Board provisionally certified one ACO, OneCare Vermont LLC, on January 4, 2018 and fully certified OneCare on March 21, 2018.

Under Rule 5.000, once an ACO is certified, the Board will review its continued eligibility for certification annually. The Board has been reviewing OneCare's continued eligibility for certification, including its compliance with recent amendments to the statutory certification criteria in 18 V.S.A. § 9382(a), contemporaneously with its review of OneCare's proposed 2019 budget. The Board developed a form for OneCare to complete for this review, which was submitted October 1, 2018. The Board will hear staff findings on December 19, 2018 and is expected to complete its review in January 2019 after a public comment period.

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. Staff had planned on presenting the Board with a set of proposed amendments in August 2018 and pre-filing the amendments with the Interagency Committee on Administrative Rules shortly thereafter. However, this timeline has been delayed due to the need to address other, more pressing issues. We now expect to begin the rulemaking process in the first quarter of 2019, and meanwhile have incorporated ACO certification statutory additions into our 2019 ACO review. Rule amendments are still on track, even with a delayed filing.

2. Vermont All-Payer ACO Model Agreement

A. CMS Reporting Readiness

APM Analytics Contract

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 Q4 2018, work has focused on running a test report based on technical specifications for calculating total cost of care according to the All-Payer ACO Model Agreement; developing detailed technical specifications for calculating ACO scale; developing an approach to examining the payer differential among the ACO Benchmarks; and supporting change management at the Board.

Specifying Total Cost of Care and ACO Scale Measures

Board staff collaborated with the Department of Vermont Health Access (DVHA), commercial insurers, OneCare, and Mathematica Policy Research to develop and test detailed technical specifications for the All-Payer Total Cost of Care measure. The Total Cost of Care is being

internally validated, and the first formal Total Cost of Care report (covering health care provided in Q1 2018) is expected in the first quarter of 2019.

GMCB staff and contractors have finalized the technical specification for the ACO Scale measure, which determines the percentage of Vermonters who are participating in qualifying ACO initiatives as part of the All-Payer Model. A report on preliminary Performance Year 1 ACO Scale results, submitted to the Legislature on August 1, 2018, showed that approximately 20% of all Vermonters are participating in a qualifying ACO initiative, including 35% of Vermont Medicare beneficiaries. The report is posted on GMCB's website.[4]

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 and recommend a consensus list of quality measures for the 2019 Vermont Medicare ACO Initiative. This measure list was approved by the Board at its July 18, 2018 meeting. Following Board approval, the measure set was submitted to CMS, which approved it on August 28, 2018. Table 3 below lists the approved measures and how they align with the measures in the APM Agreement and with OneCare's other payer contracts.
- *Percentage of benchmark tied to quality*: Board staff worked with stakeholders to develop a recommendation for the percentage of an ACO's benchmark to be tied to quality under the 2019 Vermont Medicare ACO Initiative. Staff presented a recommendation which was approved by the Board and CMS in November 2018.[5]
- *Operational changes:* OneCare has requested several operational changes, including a revised notice for Vermont Medicare beneficiaries attributed to the ACO and a change to the Medicare program's governance requirements to align with the governance requirements of Rule 5.000. The Board is working to refine these with OneCare and CMS in preparation for 2019.

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.

[4] Preliminary ACO Scale Target Performance Per the All-Payer ACO Model Agreement: Performance Year 1 (2018), available at: https://legislature.vermont.gov/assets/Legislative-Reports/GMCB-Report-on-All-Payer-Model-Scale-Act-124-of-2018-FINAL-8-1-2018.pdf.

[5] Revised Quality Proposal for Vermont Medicare ACO Initiative, available at: https://gmcboard.vermont.gov/sites/gmcb/files/Medicare%20Quality%20Withhold%20Proposal%2011162018_Final.pdf.

Table 3: 2019 ACO-CMS Quality Measures with Alignment Analysis

Measures for 2019 ACO-CMS Quality Framework	APM	BCBSVT	Medicaid
Tobacco use assessment and cessation intervention	Yes	No	Yes
Screening for clinical depression and follow-up plan	Yes	Yes	Yes
Diabetes: HbA1c poor control (part of APM composite)	Yes	Yes	Yes
Hypertension: controlling high blood pressure (part of APM composite)	Yes	Yes	Yes
All-cause unplanned admissions for patients with multiple chronic conditions (part of APM composite)	Yes	No	Yes
30-day follow-up after discharge from ED for mental health	Yes	Yes	Yes
30-day follow-up after discharge from ED for alcohol or other drug dependence	Yes	Yes	Yes
Initiation of alcohol and other drug dependence treatment	Yes	Yes	Yes
Engagement in alcohol and other drug dependence treatment	Yes	Yes	Yes
Influenza immunization	No	No	No
Colorectal cancer screening	No	No	No
Risk-standardized, all-condition readmission	No	No	No
Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient experience surveys	Yes	Yes	Yes