Vermont Commercial ACO Pilot
Compilation of Pilot Standards
Reflecting Technical and Substantive Changes Approved by the GMCB ~~on September 4, 2014 and Additional Technical Corrections Approved by the GMCB on July 23, 2015.~~ ~~Proposed Substantive Changes to Remove Downside Risk in Year 3, October 7, 2015; and~~ ~~Proposed Technical Correction Related to Year 1 Attribution Methodology, and Methodology for Distribution of Savings~~ ~~October 22, 2015; Approved by the GMCB on~~ as of November 17, 2015 with subsequent updates as of December 8, 2016

This document contains ACO commercial pilot standards originally reviewed and approved by the Green Mountain Care Board and the Vermont Health Care Improvement Project Steering Committee and Core Team during meetings that took place in October and November 2013. These standards have ~~and~~ subsequently been clarified and modified.

ACO pilot standards are organized in the following four categories:

- Standards related to the ACO's structure:
  - Financial Stability
  - ~~Risk Mitigation~~
  - Patient Freedom of Choice
  - ACO Governance

- Standards related to the ACO's payment methodology:
  - Patient Attribution Methodology
  - Calculation of ACO Financial Performance and Distribution of Shared Risk Payments

- Standards related to management of the ACO:
  - Care Management
  - Payment Alignment
  - Data Use Standards

- Process for review and modification of measures.

The objectives and details of each ~~draft~~ standard follow.

I. Financial Stability

Objective: 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

1. The GMCB's Analytics Contractor will assess whether changes in provider coding patterns have had a substantive impact on medical spending, and if so, bring such funding and documentation to the GMCB for consideration with participating pilot ACOs.
2. The Payers and ACOs shall participate in a GMCB-facilitated process to review and consider the financial impact of any identified changes in ACO provider coding patterns.

B. Standards related to downside risk.

1. The Board has established that for the purposes of the pilot program, the ACOs will not assume downside risk in Years 1 through 3 of the pilot program.

C. Standards related to financial oversight.

The payer will furnish financial reports regarding each ACO's risk performance for each six-month performance period to the GMCB, and the VHCIP Payment Models Work Group or its successor in accordance with report formats and timelines defined by the GMCB, through a collaborative process with ACOs and payers.

D. Minimum number of attributed lives for a contract with a payer for a given line of business.

1. For Year 1 of the ACO pilot, an ACO participating with one commercial payer must have at least five thousand (5,000) commercial attributed lives as of June 30, 2014. For Year 1 of the ACO pilot, an ACO participating with two commercial payers must have three thousand (3,000) commercial attributed lives for each of the two payers, for an

aggregate minimum of six thousand (6,000) commercial attributed lives, as of June 30, 2014.

In order to establish the number of an ACO's commercial attributed lives, the payer will, on July 1, 2014, or as soon thereafter as possible, provide the ACO with an account of ACO's commercial attributed lives as of June 30, 2014. Based upon the number of an ACO's commercial attributed lives as of June 30, 2014, the ACO and payer may proceed as follows: if the commercial attributed lives are below the minimum number required for participation, the payer or the ACO may:

a. terminate their agreement for cause as of June 30, 2014; or
b. agree to maintain their agreement in full force and effect.

2. In Performance Years 2 and 3, a participating insurer may elect to not participate with an ACO, if: (1) that ACO is participating with one commercial insurer and that ACO's projected or actual attributed member months with that insurer fall below 60,000 annually; or (2) that ACO is participating with two commercial insurers and that ACO's projected or annual attributed member months with that insurer fall below 36,000 annually.

If an ACO falls below the attribution threshold required for participation in the pilot in Years 2 and 3, it may request that the relevant payers participate in a GMCB-facilitated process to determine whether one or more of the payers would find it acceptable to waive the enrollment threshold and either a) establish a contract with the ACO in the absence of meeting this requirement, or b) permit an already-contracted ACO eligibility to share in any generated savings. While the GMCB will facilitate this process, the decision regarding whether to waive the enrollment threshold and contract with the ACO, or to permit a contracted ACO to share in any savings, remains with the payer.

E. **The ACO will notify the Board if the ACO is transferring risk to any participating provider organization within its network.**

III. Patient Freedom of Choice

1. ACO patients will have freedom of choice with regard to their providers consistent with their health plan benefit.

IV. ACO Governance

1. The ACO must maintain an identifiable governing body that has responsibility for oversight and strategic direction of the ACO, and holding ACO management accountable for the ACO's activities.

2. The organization must identify its board members, define their roles and describe the responsibilities of the board.

3. The governing body must have a transparent governing process which includes the following:
    a. publishing the names and contact information for the governing body members;
    b. devoting an allotted time at the beginning of each in-person governing body meeting to hear comments from members of the public who have signed up prior to the meeting and providing public updates of ACO activities;
    c. making meeting minutes available to the ACO's provider network upon request, and
    d. posting summaries of ACO activities provided to the ACO's consumer advisory board on the ACO's website.

4. The governing body members must have a fiduciary duty to the ACO and act consistently with that duty.

5. At least 75 percent control of the ACO's governing body must be held by or represent ACO participants or provide for meaningful involvement of ACO participants on the governing body. For the purpose of determining if this requirement is met, a "participant" shall mean an organization that:

    a. has, through a formal, written document, agreed to collaborate on one or more ACO programs designed to improve quality, patient experience, and manage costs, and

    b. is eligible to receive shared savings distributions based on the distribution rules of the ACO or participate in alternative financial incentive programs as agreed to by the ACO and its participants.

A "participant" does not need to have lives attributed to the ACO to be considered a participant. An organization may have lives attributed to one ACO but still participate in another ACO as per meeting conditions 5a and 5b above. So long as conditions 5a and 5b above are met, that organization will be considered a "participant" if seated on a governing body.

6. The ACO's governing body must at a minimum also include at least one consumer member who is a Medicare beneficiary (if the ACO participates with Medicare), at least one consumer member who is a Medicaid beneficiary (if the ACO participates with Medicaid), and at least one consumer member who is a member of a commercial insurance plan (if the ACO participates with one or more commercial insurers). Regardless of the number of payers with which the ACO participates, there must be at least two consumer members on the ACO governing body. These consumer members should have some personal, volunteer, or professional experience in advocating for consumers on health care issues. They should also be representative of the diversity of consumers served by the organization, taking into account demographic and non-demographic factors including, but not limited to, gender, race, ethnicity, socioeconomic status, geographic region, medical diagnoses, and services used. The ACO's governing board shall consult with advocacy groups and organizational staff in the recruitment process.

   The ACO shall not be found to be in non-conformance if the GMCB determines that the ACO has with full intent and goodwill recruited the participation of qualified consumer representatives to its governing body on an ongoing basis and has not been successful.

7. The ACO must have a regularly scheduled process for inviting and considering consumer input regarding ACO policy, including the establishment of a consumer advisory board, with membership drawn from the community served by the ACO, including patients, their families, and caregivers. The consumer advisory board must meet at least quarterly. Members of ACO management and the governing body must regularly attend consumer advisory board meetings and report back to the ACO governing body following each meeting of the consumer advisory board. The results of other consumer input activities shall be reported to the ACO's governing body at least annually.

V. Patient Attribution Methodology

Patients will be attributed to an ACO as follows:

1. The look back period is the most recent 24 months for which claims are available.

2. Identify all members who meet the following criteria as of the last day in the look back period:
    - Employer situated in Vermont or member/beneficiary residing in Vermont for commercial insurers (payers can select one of these options);
    - The insurer is the primary payer.

3. For products that require members to select a primary care provider, and for which the member has selected a primary care provider, attribute those members to that provider.

4. For other members, select all claims identified in step 2 with the following qualifying CPT Codes[1] in the look back period (most recent 24 months) for primary care providers where the provider specialty is internal medicine, general medicine, geriatric medicine, family medicine, pediatrics, naturopathic medicine; or is a nurse practitioner, or physician assistant; or where the provider is an FQHC or Rural Health Clinic.

CPT-4 Code Description Summary
Evaluation and Management - Office or Other Outpatient Services • New Patient: 99201-99205 • Established Patient: 99211-99215
Consultations - Office or Other Outpatient Consultations • New or Established Patient: 99241-99245
Nursing Facility Services: • E & M New/Established Ppatient: 99304-99306 • Subsequent Nursing Facility Care: 99307-99310
Domiciliary, Rest Home (e.g., Boarding Home), or Custodial Care Service: • Domiciliary or Rest Home Visit New Patient: 99324-99328 • Domiciliary or Rest Home Visit Established Patient: 99334-99337
Home Services • New Patient: 99341-99345 • Established Patient: 99347-99350
Prolonged Services – Prolonged Physician Service With Direct (Face-to-Face) Patient Contact • 99354 and 99355
Prolonged Services – Prolonged Physician Service Without Direct (Face-to-Face) Patient Contact • 99358 and 99359
Preventive Medicine Services

[1] Should the Blueprint for Health change the qualifying CPT codes to be other than those listed in this table, the VHCIP Payment Models Work Group shall consider the adoption of such changes.

CPT-4 Code Description Summary
• New Patient: 99381–99387 • Established Patient: 99391–99397
Counseling Risk Factor Reduction and Behavior Change Intervention • New or Established Patient Preventive Medicine, Individual Counseling: 99401–99404 • New or Established Patient Behavior Change Interventions, Individual: 99406-99409 • New or Established Patient Preventive Medicine, Group Counseling: 99411–99412
Other Preventive Medicine Services – Administration and interpretation: • 99420
Other Preventive Medicine Services – Unlisted preventive: • 99429
Newborn Care Services • Initial and subsequent care for evaluation and management of normal newborn infant: 99460-99463 • Attendance at delivery (when requested by the delivering physician) and initial stabilization of newborn: 99464 • Delivery/birthing room resuscitation: 99465
Federally Qualified Health Center (FQHC) – Global Visit ***(billed as a revenue code on an institutional claim form)*** • 0521 = Clinic visit by member to RHC/FQHC; • 0522 = Home visit by RHC/FQHC practitioner • 0525 = Nursing home visit by RHC/FQHC practitioner

5. Assign a member to the practice where s/he had the greatest number of qualifying claims. A practice shall be identified by the NPIs of the individual providers associated with it.

6. If a member has an equal number of qualifying visits to more than one practice, assign the member/beneficiary to the one with the most recent visit.

7. Insurers can choose to apply elements in addition to 5 and 6 above when conducting their attribution. However, at a minimum use the greatest number of claims (5 above), followed by the most recent claim if there is a tie (6 above).

8. Insurers will run their attributions at least monthly.

9. In order to be considered a primary care practice eligible for attribution of patients under these standards, a practice shall demonstrate the capability of providing the following services at a minimum:

Preventive care	o comprehensive "wellness" visits o immunizations: counseling and administration o injections and medications administered in the office o lipid, diabetes, depression, substance abuse, obesity, and blood pressure screening, and management and initial treatment of abnormal screenings o ordering and managing the results of USPSTF-recommended screening tests for ages /risk groups appropriate to specialty. For example: - Pediatrics/ Family Medicine: newborn screening, developmental screening, lead screening - Internal Medicine/Family Medicine: colon, breast, cervical cancer screenings
Acute care	Acute care of appropriate common problems for age groups of specialty (e.g., sore throat, headache, febrile illness, abdominal pain, chest pain, urinary symptoms, rashes, GI disorders, bleeding) o telephone triage and same-day visit capability o 24/7 telephone availability for triage and care coordination o ordering and managing appropriate testing, prescribing medications, and coordinating referrals and consultations for specialty care
Chronic care	Chronic care of common medical problems, including at least: allergies, asthma, COPD, diabetes (type 2), hypertension, lipid disorders, GERD, depression and anxiety o arranging and managing regular testing, screenings, consultations appropriate to the conditions
Coordination of care	o providing a "Medical Home" for a panel of patients o maintaining a comprehensive, current medical record, including receipt, sign-off and storage of external records, consults, hospitalizations and testing o assisting in transition of care into facilities, and in return to outpatient care
Other	o selected outpatient laboratory tests (lipids, HbA1c and PT/INR[2]) o health education and counseling services performed in the office o routine vision and hearing screening o prescribing common primary care acute and chronic medications using an unrestricted DEA license

[2] Prothrombin time (PT) and its derived measures of prothrombin ratio (PR) and international normalized ratio (INR) are used to determine the clotting tendency of blood.

10. A qualified primary care practitioner to whom lives have been attributed by a payer may only participate as a primary care practitioner in one ACO. If a qualified primary care practitioner works under multiple tax ID numbers, the practitioner may not use a specific tax ID number with more than one ACO.

11. If a member has not selected a primary care provider at time of enrollment, that member will be attributed in accordance with the claims-based patient attribution methodology specified above back to the later of his or her effective date of enrollment or the first date of the performance year.

12. In instances when a provider supplier* terminates his or her participation in an ACO during a performance year, the provider will remain an attributing provider with the ACO for the remainder of the performance year and the claims data for the provider's attributed lives will continue to be shared with the original ACO. Likewise, if a provider supplier joins an already-enrolled ACO participant during a performance year, then the provider will become an attributing provider with that ACO for the remainder of the performance year. The only exception to this latter provision occurs in those instances when a provider is switching from one participating ACO to another; under such circumstances, the provider will remain an attributing provider for the remainder of the performance year with the ACO of origin.

    For purposes of Year One, this policy pertains to: a) ACO Medicaid provider suppliers who are on the Medicaid provider roster as of March 31, 2014; and b) ACO commercial provider suppliers who are on the insurer provider roster as of July 1, 2014. For purposes of Years Two and Three, this policy pertains to Medicaid and commercial provider suppliers who are on the respective provider rosters as of January 1 of that performance year.

    *For purposes of this policy, a "provider supplier" refers to an individual practitioner.

13. For Year 1, if a member has not selected a primary care provider at time of enrollment, that member will be attributed in accordance with the claims-based patient attribution methodology specified above, supplemented by paid pharmacy claim PCP prescriber information for those members not otherwise attributed using the above methodology. In addition, for Year 1, insurers will consider Year 1 claims data for covered primary care services incurred through April 30, 2015 for those members not otherwise attributed using Year 1 date-of-service claims.

VI. Calculation of ACO Financial Performance and Distribution of Shared Risk Payments

(See attached ~~spreadsheet~~9-14-16 memo from Martine B. Lemieux to Abe Berman for additional detail regarding the calculation of expected and targeted PMPM medical expense.)

I. Actions Initiated Before the Performance Year Begins

Step 1: Determine the expected PMPM medical expense spending for the ACO's total patient population absent any actions taken by the ACO.

For Years 1 and 2, ~~T~~the medical expense portion of the GMCB-approved Exchange ("Exchange" shall be defined as Vermont Qualified Health Plans approved by the GMCB) premium for each Exchange-offered product, adjusted from allowed to paid amounts, adjusted for excluded services (see below), high-cost outliers[3], and risk-adjusted for the ACO-attributed population, and then calculated as a weighted average PMPM amount across all commercial products with weighting based on ACO attribution by product, shall represent the expected PMPM medical expense spending ("expected spending").

For Year 3, the expected PMPM medical expense spending shall be calculated by:

1. Using the medical allowed claims incurred for each Exchange-offered product;
    a. Medical allowed claims do not include retail pharmacy claims or claims allowed under separate non-medical dental or vision benefits.
2. Splitting medical allowed claims based on actual ACO experience (using attribution information for Year 1);
3. Calculating a unit cost trend for each ACO, using actual hospital budget increases approved by the GMCB;
4. Excluding high-cost outliers (claim amounts exceeding $250,000);
5. As in Years 1 and 2, adjusting (consistently across all ACOs) claims for other rating factors (including demographics, health status of the newly insured, pool morbidity, Blueprint payments, etc.); and
6. Adjusting to account for
    a. Changes in demographic scores from the base period to the performance year, using factors in the Society of Actuaries (SOA) Health Care Costs – From Birth to Death report[4]

[3] The calculation shall exclude the projected value of a~~A~~llowed claims per claimant in excess of $125,000 per performance year ~~for Yyears 1 and 2 and in excess of $250,000 for Yyear 3~~.
[4] "Health Care Costs – From Birth to Death Report," Society of Actuaries, June 2013. Click here to access.

b. Changes in benefit mix from the base period to the performance year, using the HHS induced utilization factors.

~~The ACO responsible services used to define expected spending shall include all covered services except for:~~

- ~~prescription (retail) medications; and~~
- ~~dental benefits, and~~
- ~~vision benefits.~~

~~The GMCB will also calculate the expected spending for the ACO population on an insurer-by-insurer basis. This is called the "insurer-specific expected spending."~~

At the request of a pilot ACO or insurer and informed by the advice of the GMCB's actuary and participating ACOs and insurers, the GMCB will reconsider and adjust expected spending if unanticipated events, or macro-economic or environmental events, occur that would reasonably be expected to significantly impact medical expenses or payer assumptions during the Exchange premium development process that were incorrect and resulted in significantly different spending than expected.

Step 2: Determine the targeted PMPM medical expense spending for the ACO's patient population based on expected cost growth limiting actions to be taken by the ACO.

Targeted spending is the PMPM spending that approximates a reduction in PMPM spending that would not have otherwise occurred absent actions taken by the ACO. Targeted spending is calculated by multiplying PMPM spending by the **target rate**. The target rate(s) for the aggregate Exchange market shall be the expected rate minus the CMS Minimum Savings Rate for a Medicare ACO for the specific performance year, with consideration of the size of the ACO's Exchange population. The GMCB will approve the target rate.

The GMCB will also calculate the targeted spending for the ACO population on an insurer-by-insurer basis in the same fashion, as described within the attached worksheet. The resulting amount for each insurer is called the "insurer-specific targeted spending."

Actions Initiated After the Performance Year Ends

Step 3: Determine actual spending and whether the ACO has generated savings.

No later than eight months (i.e., two months following the six-month claim lag period) following the end of each pilot year, the GMCB or its designee shall calculate the actual medical expense spending ("actual spending") by Exchange metal category for each ACO's attributed population using commonly defined insurer data provided to the GMCB or its designee.

For Yyears 1 and 2, mMedical expense spending shall be defined to include all paid claims for ACO-responsible services as defined above.

PMPM medical expense spending shall then be adjusted as follows:

- clinical case mix using the risk adjustment model utilized by Center for Consumer Information and Insurance Oversight (CCIIO) for the federal exchange. The GMCB may consider alternatives for future years;
- truncation of claims for high-cost patient outliers whose annual claims value exceed $125,000 for Year 1 and 2, and $250,000 for Year 3, and
- conversion from allowed to paid claims value.

For Yyear 3, PMPM medical expense spending shall be defined to include all allowed medical claim charges for ACO-responsible services as defined above.

PMPM medical expense spending shall then be adjusted as follows:

- changes in demographic scores from the base period to the performance year, using factors in the "Health Care Costs – From Birth to Death"[5];
- changes in benefit mix from the base period to the performance year, using the HHS induced utilization factors, and
- truncation of claims for high-cost patient outliers whose annual claims value exceed $250,000.

Insurers will assume all financial responsibility for the value of claims that exceed the high-cost outlier threshold.

The GMCB or its designee shall aggregate the adjusted spending data across insurers to get the ACO's "actual spending." The actual spending for each ACO shall be compared to its expected spending.

- If the ACO's actual aggregate spending is greater than the expected spending, then the ACO will be ineligible to receive shared savings payments from any insurer.
- If the ACO's actual aggregate spending is less than the expected spending, then it will be said to have "generated savings" and the ACO will be eligible to receive shared savings payments from one or more of the pilot participant insurers.
- If the ACO's actual aggregate spending is less than the expected spending, then the ACO will not be responsible for covering any of the excess spending for any insurer.

[5] "Health Care Costs – From Birth to Death Report," Society of Actuaries, June 2013. Click here to access. https://www.soa.org/Research/Research-Projects/Health/research-health-care-birth-death.aspx

Once the GMCB determines that the ACO has generated aggregate savings across insurers, the GMCB will also calculate the actual spending for the ACO population on an insurer-by-insurer basis. This is called the "insurer-specific actual spending." The GMCB shall use this insurer-specific actual spending amount to assess savings at the individual insurer level.

Once the insurer-specific savings have been calculated, an ACO's share of savings will be determined in two phases. This step defines the ACO's eligible share of savings based on the degree to which actual PMPM spending falls below expected PMPM spending. The share of savings earned by the ACO based on the methodology above will be subject to qualification and modification by the application of quality performance scores as defined in Step 4.

- If the insurer-specific actual spending for the ACO population is between the insurer-specific expected spending and the insurer-specific targeted spending, the ACO will share 25% of the insurer-specific savings.
- If the insurer-specific actual spending is below the insurer-specific targeted spending, the ACO will share 60% of the insurer-specific savings. (The cumulative insurer-specific savings would therefore be calculated as 60% of the difference between actual spending and targeted spending plus 25% of the difference between expected spending and targeted spending.)
- For Year 3, since expected and actual claims are based on allowed charges, the insurer-specific savings shall be multiplied by the actual paid--to--allowed ratio for each ACO.
- An insurer's savings distribution to the ACO will be capped at 10% of the ACO's insurer-specific expected spending and not be greater than insurer premium approved by the Green Mountain Care Board. An insurer will not be obligated to distribute shared savings if the insurer realizes a loss on its Exchange business where overall Qualified Health Plan business allowable costs are above the target amount set by the ACA Risk Corridor program.

If the sum of ACO savings at the insurer-specific level is greater than that generated in aggregate, the insurer-specific ACO savings will be reduced to the aggregate savings amount. If reductions need to occur for more than one insurer, the reductions shall be proportionately reduced from each insurer's shared savings with the ACO for the performance period. Any reductions shall be based on the percentage of savings that an insurer would have to pay before the aggregate savings cap.

Step 4: Assess ACO quality performance to inform savings distribution.

The second phase of determining an ACO's savings distribution involves assessing quality performance. The distribution of eligible savings will be contingent on demonstration that the ACO's quality meets a minimum qualifying threshold or "gate." Should the ACO's quality performance pass through the gate, the size of the distribution will vary and be linked to the

ACO's performance on specific quality measures. Higher quality performance will yield a larger share of savings up to the maximum distribution as described above.

Methodology for distribution of shared savings: Compare the ACO's performance on the payment measures (see Table 1 below for an example) to the HEDIS PPO national percentile benchmark[6] and assign 1, 2 or 3 points based on whether the ACO is at the national 25th, 50th or 75th percentile for the measure.

- An exception to this methodology will be the treatment of measure Core-12 (Rate of Hospitalization for Ambulatory Care ~~–~~ Sensitive Conditions) due to its lack of a HEDIS benchmark. For Core-12, a 2-point scoring approach shall apply to the Year 2 distribution of shared savings calculation. If the ACO's performance for Core-12 stays statistically significantly the same from ~~Year 1 to Year 2~~one performance year to the next, the ACO will receive 2 points, and if the ACO's performance declines in a statistically significant manner from ~~Year 1 to Year 2~~one performance year to the next, the ACO will receive 0 points.

These calculations will be performed annually using the most currently available HEDIS benchmark data at the time final shared savings calculations are performed.

For purposes of calculations pertaining to the distribution of any shared savings payment, an ACO's performance on a payment measure will be excluded from the calculation in those instances in which the ACO's denominator for that payment measure is less than 30. ~~For purposes of public reporting of the ACO's performance, an explanation of the ACO's small denominator and its significance will accompany~~ The GMCB will not report~~ing~~ ~~of~~ any payment measure with a denominator less than 30.

Table 1. Core Measures for Payment in Year ~~Two~~~~One~~ Three of the Commercial Pilot

#	Measure	Data Source	2015~~2~~ HEDIS Benchmark (PPO)[7]	2016 HEDIS Benchmark (PPO)[8]
Core-1	~~Plan~~ ACO All-Cause Readmissions NQF #1768, NCQA	Claims	Nat. 90th: 0.596360 Nat. 75th: 0.6766 Nat. 50th: 0.7216 Nat. 25th: 0.7735 ~~Nat. 90th: .68~~ ~~Nat. 75th: .73~~	Nat. 90th: 0.67 Nat. 75th: 0.75 Nat. 50th: 0.80 Nat. 25th: 0.87

[6] NCQA has traditionally offered several HEDIS commercial product benchmarks, e.g., HMO, POS, HMO/POS, HMO/PPO combined, etc.

[7] 2015 HEDIS National Commercial Benchmarks for Performance Year 2014.

[8] 2016 HEDIS National Commercial Benchmarks for Performance Year 2015.

			~~Nat. 50th: .78~~ ~~Nat. 25th: .83~~ *Please note, in interpreting this measure, a lower rate is better.*	
Core-2	Adolescent Well-Care Visits HEDIS AWC	Claims	Nat. 90th: 61.71 Nat. 75th: 47.83 Nat. 50th: 39.39 Nat. 25th: 33.07 ~~Nat. 90th: 58.5~~ ~~Nat. 75th: 46.32~~ ~~Nat. 50th: 38.66~~ ~~Nat. 25th: 32.14~~	Nat. 90th: 61.18 Nat. 75th: 48.86 Nat. 50th: 41.52 Nat. 25th: 33.87
~~Core-3~~	~~Cholesterol Management for Patients with Cardiovascular Conditions (LDL-C Screening Only for Year 1)~~	~~Claims~~	~~Nat. 90th: 89.74~~ ~~Nat. 75th: 87.94~~ ~~Nat. 50th: 84.67~~ ~~Nat. 25th: 81.27~~	
Core-4	Follow-Up After Hospitalization for Mental Illness: 7-day NQF #0576, NCQA HEDIS FUH	Claims	Nat. 90th: 63.59 Nat. 75th: 57.1 Nat. 50th: 50.37 Nat. 25th: 42.11 ~~Nat. 90th: 67.23~~ ~~Nat. 75th: 60.00~~ ~~Nat. 50th: 53.09~~ ~~Nat. 25th: 45.70~~	Nat. 90th: 62.74 Nat. 75th: 56.53 Nat. 50th: 49.14 Nat. 25th: 41.42
Core-5	Initiation and Engagement for Substance Abuse Treatment: Initiation and Engagement of AOD Treatment (composite) NQF #0004, NCQA HEDIS IET ~~CMMI~~	Claims	Nat. 90th: 31.14 Nat. 75th: 28.27 Nat. 50th: 24.63 Nat. 25th: 21.94 ~~Nat. 90th: 35.28~~ ~~Nat. 75th: 31.94~~ ~~Nat. 50th: 27.23~~ ~~Nat. 25th: 24.09~~	Nat. 90th: 29.78 Nat. 75th: 26.63 Nat. 50th: 23.60 Nat. 25th: 21.05
Core-6	Avoidance of Antibiotic Treatment for Adults With Acute Bronchitis NQF #0058, NCQA HEDIS AAB	Claims	Nat. 90th: 33.52 Nat. 75th: 28.18 Nat. 50th: 24.80 Nat. 25th: 21.43 ~~Nat. 90th: 28.13~~ ~~Nat. 75th: 24.30~~ ~~Nat. 50th: 20.72~~ ~~Nat. 25th: 17.98~~	Nat. 90th: 34.63 Nat. 75th: 28.49 Nat. 50th: 24.33 Nat. 25th: 20.91

Core-7	Chlamydia Screening in Women ~~– Total~~ NQF #0033, NCQA HEDIS CHL	Claims	Nat. 90th: 56.36 Nat. 75th: 46.72 Nat. 50th: 41.62 Nat. 25th: 37.29~~Nat. 90th: 54.94~~ ~~Nat. 75th: 47.30~~ ~~Nat. 50th: 40.87~~ ~~Nat. 25th: 36.79~~	Nat. 90th: 56.75 Nat. 75th: 47.79 Nat. 50th: 42.18 Nat. 25th: 37.21
Core-12	Prevention Quality Chronic Composite (Rate of Hospitalization for Ambulatory Care-Sensitive Conditions: PQI Composite) AHRQ PQI #92	Claims	No benchmark available.	No benchmark available.
Core-17	Diabetes Mellitus: Hemoglobin A1c Poor Control (>9 percent) NQF #0059, NCQA HEDIS	Clinical	Nat. 90th: 25.29 Nat. 75th: 29.93 Nat. 50th: 35.60 Nat. 25th: 41.36 *Please note, in interpreting this measure, a lower rate is better.*	Nat. 90th: 27.41 Nat. 75th: 32.12 Nat. 50th: 38.20 Nat. 25th: 50.00 *Please note, in interpreting this measure, a lower rate is better.*
Core-39	Controlling High Blood Pressure CMS MSSP ACO 28[9]	Clinical	Nat. 90th: 67.25[10] Nat. 75th: 62.77 Nat. 50th: 58.38 Nat. 25th: 52.61	Nat. 90th: 68.06 Nat. 75th: 58.79 Nat. 50th: 52.32 Nat. 25th: 46.78

The Gate: In order to retain savings for which the ACO is eligible in accordance with Steps 1-3 above, the ACO must earn meet a minimum threshold for performance on a defined set of common measures to be used by all pilot-participating commercial insurers and ACOs. For the commercial pilot, the ACO must earn 55% of the eligible points in order to receive savings. If the ACO is not able to meet the overall quality gate, then it will not be eligible for any shared savings. If the ACO meets the overall quality gate, it may retain at least 75% of the savings for which it is eligible (see Table 2).

The Ladder: In order to retain a greater portion of the savings for which the ACO is eligible, the ACO must achieve higher performance levels for the measures. There shall be six steps on the ladder, which reflect increased levels of performance (see Table 2).

[9] Replaces Core-3 Cholesterol Management for Patients with Cardiovascular Conditions.
[10] Benchmark for Core-39 is a HEDIS 2014 National Commercial Benchmark (Performance Year 2013).

Table 2. Distribution of Shared Savings in Years One, Two and ~~Two~~ Three of Commercial Pilot

% of eligible points	% of earned savings
55%	75%
60%	80%
65%	85%
70%	90%
75%	95%
80%	100%

Eligibility for shared savings based on performance improvement.

Should the ACO, in Years 2 or 3, fail to meet the minimum quality score, it may still be eligible to receive shared savings if the GMCB determines, after providing notice to and accepting written input from the insurer and ACO (and input from ACO participants, if offered), that the ACO has made meaningful improvement in its quality performance as measured against prior pilot years. The GMCB will make this determination after conducting a public process that offers stakeholders and other interested persons sufficient time to offer verbal and/or written comments related to the issues before the GMCB.

Step 5: Distribute shared savings payments

The GMCB or its designee will calculate an interim assessment of performance year medical expense relative to expected and targeted medical spending for each ACO/insurer dyad within four months of the end of the performance year and inform the insurers and ACOs of the results, providing supporting documentation when doing so. If the savings generated exceed the insurer-specific targeted spending, and the preliminary assessment of the ACO's performance on the required measures is sufficiently strong, then within two weeks of the notification, the insurers will offer the ACO the opportunity to receive an interim payment, not to exceed 75% of the total payment for which the ACO is eligible.

The GMCB or its designee will complete the analysis of savings within two months of the conclusion of the six-month claim lag period and inform the insurers and ACOs of the results, providing supporting documentation when doing so. The insurers will then make any required savings distributions to contracted ACOs within two weeks of notification by the GMCB. Under no circumstances shall the amount of a shared savings payment distribution to an ACO jeopardize the insurer's ability to meet federal Medical Loss Ratio (MLR) requirements. The amount of the shared savings distribution shall be capped at the point that the MLR limit is reached.

VII. Care Management Standards

Objective: Effective care management programs close to, if not at, the site of care for those patients at highest risk of future intensive resource utilization is considered by many to be the linchpin of sustained viability for providers entering population-based payment arrangements. The following care management standards were developed in early 2015 by the VHCIP Care Models and Care Management Work Group and subsequently approved by the VHCIP Steering Committee, the VHCIP Core Team and the GMCB.

Definition of Care Management:

Care Management programs apply systems, science, incentives and information to improve services and outcomes in order to assist individuals and their support system to become engaged in a collaborative process designed to manage medical, social and mental health conditions more effectively. The goal of care management is to achieve an optimal level of wellness and improve coordination of care while providing cost effective, evidence based or promising innovative and non-duplicative services. It is understood that in order to support individuals and to strengthen community support systems, care management services need to be culturally competent, accessible and personalized to meet the needs of each individual served.

In order for care management programs to be effective, we recommend that ACOs agree to the following standards:

A. Care Management Oversight (based partially on NCQA ACO Standards PO1, Element B, and PC2, Element A)

#1: The ACO has a process and/or 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: The ACO supports participating primary care practices' capacity to meet person-centered medical home requirements related to care management.

#3: The ACO 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: The ACO supports its participating providers in the consistent adoption of evidence-based guidelines, and supports the exploration of emerging best practices.

#5: The ACO has and/or supports its participating providers in having methods for engaging and activating people and their families in support of each individual's specific needs, positive health behaviors, self-advocacy, and self-management of health and disability.

#6: The ACO provides or facilitates the provision of and/or supports its participating providers in providing or facilitating the provision of: 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 its participating providers in having a process for systematically identifying attributed people who need care management services, the types of services they should receive, and 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: a) records structured (searchable) demographic, claims, and clinical data required to address care management needs for people attributed to the ACO, b) supports access to and sharing of attributed persons' demographic, claims and clinical data recorded by other participating providers, and c) 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.

VIII. Payment Alignment

Objective: Improve the likelihood that ACOs attain their cost and quality improvement goals by aligning payment incentives at the payer-ACO level to the individual clinician and facility level.

1. The performance incentives that are incorporated into the payment arrangements between a commercial insurer and an ACO should be appropriately reflected in those that the ACO utilizes with its contracted providers. ACOs will share with the GMCB their written plans for:
    a. aligning provider payment (from insurers or Medicaid) and compensation (from ACO participant organization) with ACO performance incentives for cost and quality, and
    b. distributing any earned shared savings.

2. ACOs utilizing a network model should be encouraged to create regional groupings (or "pods") of providers under a shared savings model that would incent provider performance resulting from the delivery of services that are more directly under their control. The regional groupings or "pods" would have to be of sufficient size to reasonably calculate "earned" savings or losses. ACO provider groupings should be incentivized individually and collectively to support accountability for quality of care and cost management.

3. Insurers shall support ACOs by collaborating with ACOs to align performance incentives by considering the use of alternative payment methodology including bundled payments and other episode-based payment methodologies.

IX. Vermont ACO 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.

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

1. The VHCIP Quality and Performance Measures Work Group will review all **Payment and Reporting measures** included in the Core Measure Set beginning in the second quarter of each pilot year, with input from the VHCIP Payment Models Work Group. For each measure, these reviews will consider payer and provider data availability, data quality, pilot experience reporting the measure, ACO performance, and any changes to national clinical guidelines. The goal of the review will be to determine whether each measure should continue to be used as-is for its designated purpose, or whether each measure should be modified (e.g. advanced from Reporting status to Payment status in a subsequent pilot year) or dropped for the next pilot year. The VHCIP Quality and Performance Measures Work Group will make recommendations for changes to measures for the next program year if the changes have the support of a majority of the voting members of the Work Group. Such recommendations will include annual updates to the Payment and Reporting measures included in the Core Measure Set narrative measure specifications as necessary upon release of updates to national guidelines (e.g., annual updates made by the National Committee for Quality Assurance to HEDIS® specifications for that year's performance measures). Such recommendations will be finalized no later than July 31st of the year prior to implementation of the changes. Recommendations will go to the VHCIP Steering Committee, the VHCIP Core Team and the GMCB for review. Approval for any changes must be finalized no later than September 30th of the year prior to implementation of the changes. In the interest of retaining measures selected for Payment and Reporting purposes for the duration of the pilot program, measures should not be removed in subsequent years unless there are significant issues with data availability, data quality, pilot experience in reporting the measure, ACO performance, and/or changes to national clinical guidelines.

2. The VHCIP Quality and Performance Measures Work Group and the VHCIP Payment Models Work Group will review all **targets and benchmarks** for the measures designated for Payment purposes beginning in the second quarter of each pilot year. For each measure, these reviews will consider whether the benchmark employed as the performance target (e.g., national xth percentile) should remain constant or change for

the next pilot year. The Work Group should consider setting targets in year two and three that increase incentives for quality improvement. The VHCIP Quality and Performance Measures Work Group will make recommendations for changes to benchmarks and targets for the next program year if the changes have the support of a majority of the voting members of the Work Group. Such recommendations will include annual updates to the targets and benchmarks for measures designated for Payment purposes as necessary upon release of updates to national guidelines (e.g., annual updates made by the National Committee for Quality Assurance to HEDIS® specifications for that year's performance measures). Such recommendations will be finalized no later than July 31st of the year prior to implementation of the changes. Recommendations will go to the VHCIP Steering Committee, the VHCIP Core Team and the GMCB for review. Approval for any changes must be finalized no later than September 30th of the year prior to implementation of the changes.

3. The VHCIP Quality and Performance Measures Work Group will review all **measures designated as Pending** in the Core Measure Set and consider any new measures for addition to the set beginning in the first quarter of each pilot year, with input from the VHCIP Payment Models Work Group. For each measure, these reviews will consider data availability and quality, patient populations served, and measure specifications, with the goal of developing a plan for measure and/or data systems development and a timeline for implementation of each measure. If the VHCIP Quality and Performance Measures Work Group determines that a measure has the support of a majority of the voting members of the Work Group and is ready to be advanced from Pending status to Payment or Reporting status or added to the measure set in the next pilot year, the Work Group shall recommend the measure as either a Payment or Reporting measure and indicate whether the measure should replace an existing Payment or Reporting measure or be added to the set by July 31st of the year prior to implementation of the changes. Such recommendations will include annual updates to measures designated as Pending in the Core Measure Set narrative measure specifications as necessary upon release of updates to national guidelines (e.g., annual updates made by the National Committee for Quality Assurance to HEDIS® specifications for that year's performance measures). New measures should be carefully considered in light of the Work Group's measure selection criteria. If a recommended new measure relates to a Medicare Shared Savings Program (MSSP) measure, the Work Group shall recommend following the MSSP measure specifications as closely as possible. If the Work Group designates the measure for Payment, it shall recommend an appropriate target that includes consideration of any available state-level performance data and national and regional benchmarks. Recommendations will go to the VHCIP Steering Committee, the VHCIP Core Team and the GMCB for review. Approval for any changes must be finalized no later than September 30th of the year prior to implementation of the changes.

4. The VHCIP Quality and Performance Measures Work Group will review **state or insurer performance on the Monitoring and Evaluation measures** beginning in the second quarter of each year, with input from the VHCIP Payment Models Work Group. The measures will remain Monitoring and Evaluation measures unless a majority of the voting members of the Work Group determines that one or more measures presents an opportunity for improvement and meets measure selection criteria, at which point the VHCIP Quality and Performance Measures Work Group may recommend that the measure be moved to the Core Measure Set to be assessed at the ACO level and used for either Payment or Reporting. The VHCIP Quality and Performance Measures Work Group will make recommendations for changes to the Monitoring and Evaluation measures for the next program year if the changes have the support of a majority of the members of the Work Group. Such recommendations will include annual updates to the Monitoring and Evaluation measures included in the Monitoring and Evaluation Measure Set narrative measure specifications as necessary upon release of updates to national guidelines (e.g., annual updates made by the National Committee for Quality Assurance to HEDIS® specifications for that year's performance measures). Such recommendations will be finalized no later than July 31st of the year prior to implementation of the changes. Recommendations will go to the VHCIP Steering Committee, the VHCIP Core Team and the GMCB for review. Approval for any changes must be finalized no later than September 30th of the year prior to implementation of the changes.

5. The GMCB will release the **final measure specifications for the next pilot year by no later than** October 31st of the year prior to the implementation of the changes. The specifications document will provide the details of any new measures and any changes from the previous year.

6. 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, the VHCIP Quality and Performance Measures Work Group will review the measure and recommend a course of action for consideration, with input from the VHCIP Payment Models Work Group. If the VHCIP Quality and Performance Measures Work Group determines that a change to a measure has the support of a majority of the voting members of the Work Group, recommendations will go to the VHCIP Steering Committee, the VHCIP Core Team and the GMCB for review. Upon approval of a recommended change to a measure for the current pilot year, the GMCB must notify all pilot participants of the proposed change within 14 days.