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Vermont All-Payer Model
Draft Accountable Care Organization Standards
Updated May 26, 2016

Defined Terms

Alternative Payment Methodology: Method of payment the compensates providers for the provision of health care or support services, including but not limited to shared savings and shared savings/shared risk arrangements, bundled payments for acute care episodes, bundled payments for chronic diseases, and global payments. Payments based on traditional fee-for-service methodologies shall not be considered Alternative Payment Methodologies.

At-risk Enrollee: An Enrollee with a significant burden of illness for whom considerable future health care expenditures are highly likely.

Covered Services: The health care services for which the ACO is financially responsible, as defined by the terms of its contract with a payer.

Enrollee: An individual covered by a payer holding a contract with the ACO (e.g., commercial insurer, Medicaid, Medicare) for whom the ACO has contractually assumed responsibility for managing cost and quality of care and improving population health based on a contractually defined attribution methodology.

Health Plan: An individual or group plan that provides, or pays the cost of, medical care (as defined in section 2791(a)(2) of the Public Health Service Act, 42 U.S.C. 300gg-91(a)(2)).

Medically Necessary: Health care services, including diagnostic testing, preventive services, and aftercare, that are appropriate, in terms of type, amount, frequency, level, setting, and duration to the beneficiary's diagnosis or condition. Medically necessary care must be consistent with generally accepted practice parameters as recognized by health care providers in the same or similar general specialty as typically treat or manage the diagnosis or condition, and

1. help restore or maintain the beneficiary's health; or
2. prevent deterioration or palliate the beneficiary's condition; or
3. prevent the reasonably likely onset of a health problem or detect an incipient problem.

(Source: http://dvha.vermont.gov/for-consumers/1exception-forms-for-web.pdf)

Participant: A provider entity that: a) has, through a formal, written document, agreed to provide care to ACO enrollees and collaborate on one or more ACO programs designed to improve quality, patient experience, and manage costs, and b) is eligible to participate in performance-based financial incentive programs as agreed to by the ACO and its participants.

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ACO Standards

A. Governance and Corporate Structure

1. Legal status
    a. The ACO must be a legal entity registered with the Vermont Secretary of State and identified by a federal tax identification number for the purpose of compliance with these ACO standards and performing ACO activities.

2. ACO Mission
    a. The ACO is accountable for improving the health of the population it serves by facilitating access to Medically Necessary Covered Services, promoting excellence in health care quality and patient-centeredness, increasing the value of health care services for purchasers, and containing health care costs.

3. National Committee for Quality Assurance (NCQA) Accreditation
    a. If an ACO is NCQA-accredited, the GMCB will consider deeming for NCQA requirements with equivalence to specific GMCB standards.

4. Governing body and its responsibilities
    a. The ACO shall maintain an identifiable governing body with sole and exclusive authority to execute the functions of the ACO as described in A.2 and make final decisions on behalf of the ACO.

    b. The ACO's governing body shall have responsibility for oversight and strategic direction of the ACO and be responsible for holding ACO management accountable for the ACO's activities.

5. Governing body composition
    a. The organization must identify members of a governing body, define their roles and describe the responsibilities of the governing body.

    b. The ACO should have a governance body with the following characteristics:
        i. broad geographic representation;
        ii. reasonable size to ensure effectiveness;
        iii. balanced representation of provider types, and
        iv. voting rules that ensure broad support for major policy decisions.

    c. The governing body shall have a transparent governing process, which includes the following:
        i. publishing the names of the governing body members;
        ii. devoting an allotted time at the beginning of each in-person governing body meeting to hear public comments and provide a public report on ACO activities;

iii. making meeting minutes available to the ACO's Participants upon request, and
iv. posting summaries of ACO activities provided to the ACO's consumer advisory board on the ACO's website.

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

e. At least 75 percent control of the ACO's governing body membership must be held by or represent ACO Participants or provide for meaningful involvement of Participants on the governing body. For the purpose of determining if this requirement is met, a "Participant" shall mean a provider entity that:
   i. has, through a formal, written document, agreed to provide care to ACO enrollees and collaborate on one or more ACO programs designed to improve quality, patient experience, and manage costs, and
   ii. is eligible to participate in performance-based financial incentive programs as agreed to by the ACO and its participants.

   A "Participant" does not need to have lives attributed to the ACO.

f. The ACO's governing body must at a minimum include:
   i. at least one Enrollee who is a Medicare beneficiary;
   ii. at least one Enrollee who is a Medicaid member, and
   iii. at least one Enrollee who is a member of a commercial insurance plan.

g. The ACO's governing body shall consult with advocacy groups and ACO staff when recruiting Enrollees for the governing body. These Enrollee members of the governing body must:
   i. be representative of the diversity of Enrollees served by the ACO, 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;
   ii. not have a conflict of interest with the ACO, including not having an immediate family member with a conflict of interest with the ACO;
   iii. not be an ACO Participant;
   iv. not have a direct or indirect financial relationship with the ACO or an ACO Participant, except that such person may be reasonably compensated by the ACO for his or her duties as a member of the governing body of the ACO, and
   v. have training or professional experience in advocating for the rights of consumers.

2. <u>Consumer advisory board</u>
   a. The ACO shall 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 Enrollees, their families and caregivers.

i. The consumer advisory board must meet at least quarterly.
ii. 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.
iii. The results of other consumer input activities shall be reported to the ACO's governing body at least annually.

3. Board financial conflict of interest policy
   a. The ACO shall have a conflict of interest policy that applies to members of the governing body and satisfies the following criteria:
      i. requires each member of the governing body to annually disclose relevant financial interests in writing;
      ii. provides a procedure to determine whether a conflict of interest exists and sets forth a process to address any conflicts that arise, and
      iii. addresses remedial actions for members of the governing body that fail to comply with the policy.

4. Management and operations
   a. The ACO's operations shall be managed by an executive whose appointment and removal are under the control of the ACO's governing body and whose leadership team has demonstrated the ability to influence or direct clinical practice to improve the efficiency of processes and outcomes.

   b. The ACO shall maintain a medical director who is a senior-level executive and is:
      i. responsible for population health and quality improvement;
      ii. an ACO Participant;
      iii. a board-certified, Vermont-licensed physician.

B. Patient Protection

1. Access to services
   a. ACO Enrollees shall have freedom of choice with regard to selection of their providers, consistent with their Health Plan benefit.

   b. The ACO shall require its Participants to make Medically Necessary Covered Services available to Enrollees in accordance with applicable laws, regulations and guidance and shall take no action that would deter access to such services.

   c. The ACO and its Participants shall not take any action to avoid treating At-risk Enrollees or to target certain members for services with the purpose of trying to ensure alignment in a future period. "At-risk Enrollees" are those Enrollees with a significant burden of illness for whom considerable future health care expenditures are highly likely.

d. The ACO shall not modify cost-sharing arrangements between Enrollees and their Health Plan.

2. Complaints
   a. The ACO shall maintain a consumer telephone line for complaints from attributed Enrollees. ACO representatives shall provide Enrollees with contact information for the Office of the Health Care Advocate, as appropriate.

   b. The ACO shall respond to, and makes best efforts to resolve, complaints from Enrollees, including providing assistance in identifying appropriate rights under an Enrollee's Health Plan.

C. Performance Improvement

1. Performance standards
   a. The ACO shall maintain access, quality (including Enrollee and caregiver, or family experience), utilization and cost performance standards and associated measures to evaluate the care delivered by Participants and will, to the extent possible, align those standards and measures with requirements defined by state and national entities (e.g., Next Gen requirements).

2. Performance evaluation
   a. The ACO must completely, timely, and accurately report quality and other performance measurement and shall require its Participants to cooperate in measure reporting. Complete reporting means that the ACO meets all of the GMCB regulatory reporting requirements.

3. Performance improvement
   a. The ACO shall utilize ACO-level, community-level and Participant-level performance evaluation measurements defined in C.2.a and seek to improve performance in areas of greatest opportunity for population health and cost impact.

   b. The ACO shall systematically identify and act to reduce unwarranted variation in access, quality, utilization and cost, including instances of overuse, underuse and misuse.

   c. The ACO shall promote evidence-based medicine, including through the adoption, implementation, and periodic assessment and updating of evidence-based guidelines.

   d. The ACO shall ensure Enrollee and caregiver engagement and shared decision making processes are employed by Participants that take into account the

Enrollee's unique needs, preferences, values, and priorities. Measures for promoting Enrollee engagement shall include, but not be limited to:

(i) the use of decision support tools and shared decision making methods with which the Enrollee can assess the merits of various treatment options in the context of his or her values and convictions, and

(ii) methods for fostering health literacy in Enrollees and their families.

e. The ACO shall provide Enrollees access to their own medical records and to clinical knowledge so that they may make informed choices about their care.

f. The ACO shall ensure individualized care for Enrollees, such as through personalized care plans.

g. The ACO shall provide care that is integrated with the community resources Enrollees require.

h. The ACO shall require its Participants to comply with and implement these designated processes and protocols as described in C.2.a-g, and shall institute remedial processes and penalties, as appropriate, for Participants that fail to comply with or implement a required process or protocol.

D. Population Health Management

1. Care coordination
   a. The ACO shall coordinate Enrollees' care and care transitions (e.g., sharing of electronic summary records across providers, telehealth, remote monitoring, and other enabling technologies).

2. Population stratification for care management
   a. The ACO shall maintain and/or support Participants in having a process for systematically identifying Enrollees who need care management services, the types of services they should receive, and the entity or entities that should provide the services. The process shall include, but not be limited to, prioritizing Enrollees 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.

   b. The ACO shall encourage and support Participants in using data for identifying Enrollees 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.

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3. Care management
    a. The ACO shall facilitate and/or support Participants in the delivery of care management services for those Enrollees at highest risk of future intensive resource utilization. Facilitating delivery of care management services shall include:
        1. Collaborating and facilitating communication with Enrollees 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.
        2. Ensuring that Enrollee services are directed by a care plan that includes the Enrollee's health and wellness needs and addresses Enrollees' goals.
        3. Developing processes for effective care coordination, exchanging health information across care settings, and facilitating referrals.
        4. Recognizing disability and long-term services and supports providers as partners in serving Enrollees with high or complex needs and in carrying out Enrollees' care plans.
        5. Promoting coordinated person-centered and directed planning across settings that recognizes the person as the expert on their goals and needs.
        6. Integrating planning and delivery of medical care, substance use care, mental health care, and disability and long-term services and supports to address Enrollees' needs.

    b. The ACO shall support Participant primary care practices' capacity to deliver person-centered care and to meet patient-centered medical home requirements related to care management.

    c. The ACO shall encourage and support Participants in using data for measuring and assessing care management activities and effectiveness, to inform program management and improvement activities.

4. Enrollee activation and self-management
    a. The ACO shall maintain and/or support its Participants in adopting and applying methods for engaging and activating Enrollees and their families in support of each Enrollee's specific needs, positive health behaviors, self-advocacy, and self-management of health and disability.

    b. The ACO shall ensure that Participants: a) offer educational resources to assist in self-management of health and disability, b) offer self-management tools that enable attributed people/families to record self-care results, and c) facilitate connections between attributed people/families and self-management support programs and resources.

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5. Integration with Vermont Blueprint for Health functions
    a. The ACO shall work closely with the Blueprint and define how to integrate the following Blueprint functions with ACO population health activities:
        - Transformation infrastructure (practice facilitators and project managers)
        - Performance measurement, analytics and reporting
        - Regional community collaboratives
        - Community Health Teams
        - Support and Services at Home (SASH)

E. Provider Network

1. Provider network composition
    a. The ACO shall establish written agreements with Participants who agree to adhere to the policies of the ACO.

    b. The ACO shall arrange for the provision of the following health care services by Participants and non-Participants for Enrollees (at a minimum): primary care, specialty care, urgent and emergency care, inpatient and outpatient hospital care and defined community and home-based services.

    c. The ACO shall establish formal collaborative relationships with providers not participating in its shared savings and/or shared risk payer arrangements, e.g., home-and community-based service providers and oral health providers.

    d. The ACO Participant selection criteria shall not be established in a manner that could exclude providers because they treat or specialize in treating At-risk Enrollees or provide a higher-than-average level of uncompensated care.

F. Provider Payment

1. General payment strategy
    a. The ACO or its agent shall maintain the required functionality for, and demonstrated proficiency in, administering service payments on behalf of Enrollees.

    b. The ACO shall make broad use of value-based payment methods for the majority of services and Enrollees for which the ACO is responsible. Initially, however, such methods may focus on payments to hospitals (including employed clinicians and their practices) and non-hospital-employed primary care practices.

    c. The ACO will ensure that capitation, fixed revenue budgets, and other non-fee-for-service payment models incorporate implications for quality performance in a manner judged to be meaningful by the GMCB.

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2. Payment to ACO network primary care providers
    a. The ACO shall make increased investment in primary care practices relative to the aggregate historic percentage of total medical spending made to primary care. Investments may take the form of enhanced payment rates, with practices given the option of capitated or fee-for-service payment, and/or other forms of financial investment (e.g., supplemental PMPM payment).

    b. The ACO shall promote adoption of enhanced capitation payments by those practices for which it would be suitable based on sufficient size and other considerations.

    c. FQHCs and RHCs participating in the ACO network should continue to be reimbursed for services to Medicaid and Medicare beneficiaries in accordance with federal rules related to FQHC and RHC payments.

    d. All ACO network primary care payment models shall be complemented by a performance incentive, defined by the ACO, against defined quality indicators and serves to counter any financial incentives to reduce access to Medically Necessary Covered Services.

    e. The ACO shall present its primary care payment methods for review by the GMCB annually, or as specified by the GMCB.

3. Payment to ACO network hospitals
    a. For the majority of ACO hospital payments, fixed revenue budgets shall be the payment model for inpatient and outpatient services, and shall include professional services provided by hospital-employed physicians and allied health professionals.

    b. All ACO network hospital fixed revenue budgets shall be complemented by a performance incentive, defined by the ACO, against defined quality indicators and serves to counter any financial incentives to reduce access to Medically Necessary Covered Services.

    c. The ACO shall present its hospital payment methods for review by the GMCB annually, or as specified by the GMCB.

4. Payment to ACO network specialists
    a. The ACO shall design and implement (non-fee-for-service) alternative payment methodologies for specialty physician and mental health providers who together constitute the majority of ACO-associated specialty care spending no later than January 1, 2019.

    b. All ACO network specialty physician and mental health provider payment models shall be complemented by a performance incentive, defined by the ACO,

which blends consideration of performance against defined quality indicators and serves to counter any financial incentives to reduce access to Medically Necessary Covered Services.

c. The ACO shall present its specialist payment methods for review by the GMCB annually, or as specified by the GMCB.

5. Payment to other community-based service and social service agencies
   a. The ACO shall design and implement appropriate payment models that are supportive of integration of community-based services and social service agencies with primary care services.

   b. Any alternative payment models shall be complemented by a performance incentive, defined by the ACO, using defined quality indicators.

   c. The ACO shall present its specialist payment methods for review by the GMCB annually, or as specified by the GMCB.

6. Incentive alignment
   The performance incentives incorporated into the payment arrangements between a payer and the ACO should be appropriately reflected in the performance incentives the ACO utilizes with its contracted providers. The ACO shall report in a manner specified by the GMCB its 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.

G. Health Information Technology

1. Data Collection and Integration to Support ACO Management
   a. To the best of its ability and with the health information infrastructure available, and with the explicit consent of Enrollees unless otherwise permitted or exempted by law, the ACO shall use and/or supports its Participants in using an electronic system that:
      (i) records structured (searchable) demographic information, claims data, clinical data, and any other data or information required to address care management needs for people attributed to the ACO;
      (ii) supports access to and sharing of attributed persons' information and data as referenced in subsection (ii) above, and
      (iii) provides people access to their own health care information as required by law.

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2. Data Analytics
    a. The ACO shall apply health information technology to consolidate, standardize, and analyze data collected as described in section G.1.a.
    b. The ACO shall distill data collected across multiple sources to make it actionable, including for the following purposes:
        i. detecting practice and physician patterns (e.g., referrals, high costs, variations from best practices);
        ii. predictive modeling and patient risk stratification;
        iii. identifying variations in care provided to Enrollees; and
        iv. understanding Enrollee population characteristics.
    c. The ACO shall support quality measurement and performance reporting and feedback, including the ability to retrieve information about individual provider performance.
    d. Clinical and financial data are regularly updated, integrated, and maintained across clinical partners and from multiple sources.
    e. The ACO has in place information systems to measure care process improvement, quality improvement, and costs of care.
    f. Physicians and other clinical staff have access to actionable, up-to-date, and accurate clinical data at the time of office visits, as needed.
    g. Financial data systems are sufficient for assessing and managing financial risk, and they are integrated with clinical data systems.

H. Budget Approval

1. The ACO's annual budgets for operations and for medical expense shall be submitted annually for review and approval by the GMCB.

2. In order to support the GMCB budget review, the ACO shall submit GMCB-defined information that may include, but shall not be limited to:
    - information regarding the historical and projected utilization of the health care services delivered by Participants;
    - expenditure analysis for the previous year and the proposed expenditure analysis for the year under review;
    - administrative costs, and
    - changes in provider rates.

I. Reporting

1. Public Reporting and Transparency
   The ACO shall report the following information to the GMCB in accordance with a schedule established by the GMCB. The GMCB may publish some or all of this information on the GMCB website.
    a. Organizational information including all of the following:
        i. name and location of the ACO;
        ii. primary contact information for the ACO;
        iii. identification of all Participants;

a. The ACO will submit a report identifying Participants on an annual basis.

iv. identification of all joint ventures between or among the ACO and any of its Participants;
v. identification of the ACO's key clinical and administrative leaders and the name of any company by which they are employed, and
vi. identification of members of the ACO's governing body and the name of any entity by which they are employed.

b. Savings and losses information, including:
   i. the amount of any savings or losses for any Performance Year;
   ii. the proportion of savings invested in infrastructure, redesigned care processes, and other resources necessary to improve outcomes and reduce costs for members, and
   iii. the proportion of savings distributed to Participants.

"Savings" and "losses" shall be reported by ACO line of business (i.e., commercial, Medicaid and Medicare) and shall be calculated consistent with a method adopted by the GMCB.

c. The ACO's performance on the quality measures adopted by the GMCB.

d. The ACO's performance on the utilization and cost measures adopted by the GMCB.

2. Other Reporting
   a. The ACO shall share de-identified complaint and grievance information with the Office of the Health Care Advocate at least twice annually. The ACO shall share the report it provides to the Office of the Health Care Advocate with the GMCB.

   b. The ACO shall provide information about the ACO and how it operates in alternative formats (e.g., non-English, large print, braille) to Enrollees and/or non-Enrollees as requested.

J. Precertification Review, Monitoring, and Compliance

1. Precertification Review
   a. The ACO shall provide the GMCB with documentation and other information to be specified by the GMCB in order for the GMCB to ascertain the ACO's compliance with these standards. The GMCB review will be carried out through an assessment of the documentation submitted by the ACO and of any other examinations as deemed necessary by the GMCB.
   b. Following review of the materials submitted by the ACO, the GMCB will provide the ACO with a report of its performance against the standards. The report will conclude if the ACO has successfully met the requirements or identify those requirements for which the ACO must more adequately demonstrate

compliance. The GMCB will indicate the time by which the ACO must respond to a request for additional information.

c. A certification process governed by Rule 113 will follow the precertification review process, effective January 1, 2018.

2. GMCB Monitoring and Oversight Activities

a. GMCB shall conduct monitoring activities to evaluate ongoing compliance by the ACO and its Participants with these standards. Such monitoring activities may include, but not be limited to:
   i. interviews with any individual or entity participating in ACO activities, including but not limited to members of the ACO leadership and management, and ACO Participants;
   ii. interviews with Enrollees and their caregivers;
   iii. review of other information from the ACO and its Participants to ensure ACO compliance with these standards;
      (a) site visits to the ACO and its Participants, and
      (b) documentation requests sent to the ACO and/or its Participants, including but not limited to, surveys and questionnaires.

b. In conducting monitoring and oversight activities, the GMCB or its designee(s) may use any relevant data or information including, without limitation:
   i. all claims submitted to VHCURES and/or submitted to the GMCB at its request;
   ii. performance and financial data; and/or
   iii. other information deemed necessary by the GMCB.

d. The ACO shall cooperate with, and the ACO shall require its Participants and other individuals and entities performing functions and services related to ACO activities to cooperate with, all GMCB monitoring and oversight requests and activities.

3. Remedial Action

a. If GMCB determines that any provision of these standards may have been violated, GMCB may take one or more of the following actions:
   i. notify the ACO and, if appropriate, the Participant of the violation;
   ii. require the ACO to provide additional information to GMCB or its designees;
   iii. conduct on-site visits, interview members, or take other actions to gather information;
   iv. place the ACO on a monitoring and/or auditing plan developed by the GMCB;
   v. request a corrective action plan ("CAP") from the ACO that is acceptable to the GMCB, in which case, the following requirements apply:
      (i) the ACO shall submit a CAP for GMCB approval by a deadline established by GMCB, and

(ii) the CAP must address what actions the ACO will take (or will require any Participant or other individual or entity performing functions or services related to ACO activities to take) within a specified time period to ensure that all deficiencies will be corrected and that the ACO will be in compliance with these standards.

b. The GMCB may impose additional remedial actions if the GMCB determines that remedial actions were insufficient to correct noncompliance with the terms of these standards.

K. ACO Contracts with Payers

1. Delegated Responsibilities
   a. Should any ACO assume delegated responsibilities for Utilization Management, the GMCB will develop and apply appropriate standards, inclusive of Enrollee appeals rights.

2. ACO contracts with payers shall include meaningful financial incentives and/or disincentives for quality performance. The GMCB will make determinations about the meaningfulness of the financial incentives and/or disincentives tied to performance.

3. Contracts with payers shall acknowledge the ACO's obligation and commitment to meeting these standards.