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20233 Budget Guidance and Reporting Requirements for Medicare-Only Non-Certified Accountable Care Organizations

Prepared by:

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BACKGROUND

This guidance, adopted by the Green Mountain Care Board (GMCB) on October 20, 2021, serves as the GMCB's Annual Reporting and Budget Guidance for Budget Year 2022 for any Accountable Care Organization (ACO) that (i) is not certified by the GMCB, (ii) is participating only with Medicare and not Medicaid or any commercial payers, and (iii) that has less than 10,000 attributed lives in the State of Vermont. See 18 V.S.A. § 9382(b) and GMCB Rule 5.000, §§ 5.403, 5.405(c). ACOs that wish to receive payments from Vermont Medicaid or a commercial insurer must, in addition to having their budgets approved, be certified by the GMCB. See 18 V.S.A. § 9382(a). For more information about certification, please contact the GMCB. In accordance with 18 V.S.A. § 9382(b)(3)(A) and GMCB Rule 5.000, §§ 5.105, 5.404(b), the Office of the Health Care Advocate (HCA), which represents the interests of Vermont health care consumers, must receive ACO budget filings and other materials and shall have the right to participate in the budget review process, including hearings.

2021 TIMELINE FOR 2023 BUDGET SUBMISSION (subject to change)

~~By October 2021: GMCB provides ACOs with reporting guidance~~

~~December 31~~October 1, ~~2021~~2022: ACOs submit budgets to GMCB

~~January~~ November 2022: ~~——~~ ACO budget presentation to Board

~~January~~ December 2022: ~~——~~ GMCB staff presents analysis to the Board

~~January~~ December 2022: ~~——~~ Public comment closes when GMCB votes ~~Comment~~

December ~~January~~ 2022: GMCB votes on the ACOs' budgets and reporting submission at a public meeting

February ~~2022~~2023: GMCB issues written orders to ACOs

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The Green Mountain Care Board's Accountable Care Organization Budget Guidance - ~~2022~~2023

Instructions~~:~~

Please answer all questions in this Guidance. For ACOs that are not taking the risk of losses, please mark any question that relates to shared risk with "N/A" or similar response. References to attributed lives, providers, provider network, and payments or spending ~~associated with the foregoing~~ are limited to the ACO's attributed lives, providers, and provider network in the State of Vermont, unless otherwise specified. If a response is not specific to the ACO's Vermont business, it must be noted.

An ACO may respond to questions in this Guidance by incorporating by reference publicly available information maintained or filed by the ACO. If the ACO wishes to incorporate any such public information, a link to a publicly accessible website or other publicly accessible filing must be provided, along with a specific reference to the location (section number, page number, or other appropriate reference) where the required information can be found within the link. Furthermore, submission should not include links to any ~~online shared documents~~documents that are not publicly available (e.g. Dropbox, Google Drive).

If the ACO believes materials it provides to the GMCB during this process are exempt from public inspection and copying, the ACO must submit a written request asking the GMCB to treat the materials accordingly. The written request must specifically identify the materials the ACO claims are exempt from disclosure under 1 V.S.A. § 317(c); provide a detailed explanation citing appropriate legal authority to support the claim; and comply with all other requirements set forth in GMCB Rule 5.000, § 5.106(c). The information for which the ACO seeks confidential treatment must be submitted in separate e-mail with "Confidential" in the subject line. The document itself must include the word "Confidential" in the file name (if electronic) and on the face of the document, in a conspicuous location. The GMCB recommends that the ACO submit the confidentiality request at the same time it submits the materials it considers confidential (or at least notify the GMCB of the confidential nature of the documents), but in any event, the written request must be submitted to the GMCB no later than three (3) days after the potentially confidential information is submitted to the GMCB. The HCA must be copied on all confidentiality requests and related submissions.

The HCA is bound to respect the GMCB's confidentiality designations and treat the submitted materials as confidential pending the GMCB's final decision on the request. See 18 V.S.A. § 9382(b)(3)(B); Rule 5.000, § 5.106(e)-(g).

Along with its responses to this Guidance, the ACO must submit a Verification Under Oath (on forms provided by the GMCB) signed by an officer of the ACO with responsibility for such matters. See 18 V.S.A. § 9374(i) and (j).

Section 1: ACO INFORMATION, BACKGROUND AND GOVERNANCE

1. Date of Application:

2. Name of ACO:

3. Tax ID Number:

4. Identify and describe the ACO and its governing body, including:
    a. Legal status of the ACO (e.g., corporation, partnership, not-for-profit, LLC);
    b. Members of the governing body and their organizational affiliation (and identifying the designated Beneficiary member of the governing body and the Consumer Advocate);
    c. Officers of the ACO;
    d. Committee and subcommittee structure of the governing body, as applicable;
    e. Description of governing body's voting rules; and
    ~~f. Copy of ACO bylaws, operating agreement, or equivalent.~~

5. Identify and describe each member of the ACO's executive leadership team, including name, title, tenure in current position, and qualifications for current position.
    ~~a. Please provide a copy of any conflict of interest policy that applies to your governing body.~~
    ~~b.~~a. Does the ACO have any executive leadership compensation structure that is tied to reducing the amount paid for patient care?

6. Describe any material pending legal actions taken against the ACO or its affiliates, ~~or against~~ any members of the ACO's executive leadership team or Board of Directors related to their duties. Describe any such actions known to be contemplated by government authorities.

7. With respect to the ACO's executive leadership team or Board members, describe any legal, administrative, regulatory, or other findings indicating a wrongful action involving or affecting the performance of their duties, or professional fiscal irresponsibility.

8. If the ACO has been accredited, certified, or otherwise recognized by an external review organization (e.g., for NCQA accreditation or payer assessments), submit the review organization's determination letter, associated assessment documents and results. If the ACO is working toward accreditation or certification, please describe.

Section 2: ACO PROVIDER NETWORK

~~1. Provide the following information w~~With respect to the ACO's provider network in Vermont, ~~: as an attachment, a~~ complete~~d~~ **Appendix A-1 – ACO Provider Network Summary Template** and, in the box starting on row 25, provide ~~which will include:~~

~~2. Name~~

~~3. Provider type: (e.g., academic medical centers; critical access, sole community and other hospital types; federally qualified health centers; independent physician office practices; mental health and substance use treatment providers; home health providers, skilled nursing facilities, community long-term services and supports providers; facility post-acute care providers, SASH providers, Blueprint for Health Community Health Teams.)~~

~~4. Contract type and payment model: Payer-defined and administered fee-for-service (FFS); ACO-defined FFS; ACO capitation, including all-inclusive population-based payment (AIPBP); global budget; shared savings; shared risk, or as otherwise defined.~~

~~5. Count of providers by provider type and specialty, by county.~~

~~6. Percent of each provider's patient population expected to be attributed to the ACO, if known~~

Commented [A1]: Removing since we ask targeted questions above, and requirement for this doc is a certification requirement, not budget review

Commented [A2]: Removing because this is a certification requirement in Rule 5, not a budget review requirement.

~~7.~~

~~8.~~1. ~~Provide~~ a brief narrative summary of each ~~contract types and~~ payment model that the ACO identified in ~~question 1.c.,~~**Appendix A-1**, column K ~~above~~, that the ACO utilizes in its provider network.

2. For ~~existing~~ ACOs that were operating in Vermont prior to 2023, complete **Appendix A-2** to quantify the number and type of providers that have dropped out of the network 2021-2023 (prior, current, and budget years) and to the best of your knowledge, their reasons for exiting;

~~9.~~3. For provider contracts for which the provider is assuming risk, describe the ACO's current contract with the provider:
   a. The percentage of downside risk assumed by the provider, if any;
   b. The cap on downside risk assumed by the provider, if any, and
   c. What risk mitigation requirements does the ACO place~~s~~ on ~~the~~ provider~~s~~, if any (e.g., reinsurance, reserves).

~~10.~~4. Submit the template of the ACO's provider contract to GMCB.

~~11.~~ Does the ACO have plans to expand their provider network in Vermont in future years? (yes/no)
If yes, please describe the ACO's recruitment strategies: ~~Describe new strategies for bringing new Vermont primary care and other providers into the network.~~

~~12.~~5.
   a. Describe the ACO's recruitment strategy and criteria for accepting providers into the network.
   b. Describe the ACO's outreach strategy and contact methods (phone calls, mailings, in-person outreach, etc.).
   c. Are there any differences in your approach to independent versus hospital-owned practices?
   d. What is the ACO's network development timeline and contracting deadline?
   ~~a.~~e. Are there any challenges to network development?
   ~~b. Do you reach out to all providers with certain features? If yes, what are those features and why were these selected?~~

~~Do you intentionally limit the number or type of providers you work with? If yes, what are these limits and why are they applied?~~If no (the ACO is not planning to expand in future years in Vermont), explain why.

Section 3: ACO PAYER PROGRAMS

1. Provide copies of existing agreements or contracts with Medicare governing the ACO~~'~~s in the applicable Medicare program, including the participation agreement and any amendments. If 2022 contracts not available, please submit as an addendum when signed.

2. Provide a completed **Appendix B – 2022 ACO Program Elements** ~~template which will include:~~
   ~~a. Attributed lives~~
   ~~b. Attribution methodology~~
   ~~c. Projected spending or payments associated with attributed lives.~~

Commented [A3]: Deleted the remainder of this question and the following because all information is captured in Appendix B

d. Benefit enhancements or beneficiary engagement incentives that the ACO will provide (e.g., 3-Day SNF Rule Waiver Benefit Enhancement, Telehealth Benefit Enhancement, Post-Discharge Home Visits Benefit Enhancement, Care Management Home Visits Benefit Enhancement, Home Health Homebound Waiver Benefit Enhancement, Concurrent Care for Beneficiaries that Elect Medicare Hospice Benefit Enhancement, Part B Cost-Sharing Support Beneficiary Engagement Incentive, Chronic Disease Management Reward Beneficiary Engagement Incentive).

3. If applicable, describe program arrangement(s) between the payer and the ACO including:
   a. Full risk, shared risk, shared savings, other (please specify); for Direct Contracting Entities, whether participating in Global or Professional risk sharing option;
   b. The use of a minimum savings rate, minimum loss rate, or similar concept;
   c. The percentage of downside risk assumed by the ACO;
   d. The cap on downside risk assumed by the ACO, if any;
   e. The cap on upside gain for the ACO, if any;
   f. Risk mitigation provisions in the payer contract:
      i. Exclusion or truncation of high-cost outlier individuals (please describe)
      ii. Payer-provided reinsurance
      iii. Risk adjustment: age/gender, clinical (identify grouper software)
   g. Method for setting the budget target;
      i. Trended historical experience
      ii. Percentage of premium
      iii. Other (please describe)

4.3. Describe proposed categories of services included for determination of the ACO's savings or losses, if applicable, and if possible, projected revenues by category of service and type of payment model (e.g., FFS, capitation or AIPBP).

5.4. Describe how the proposed ACO benchmark, capitation payment, AIPBP, shared savings and losses, or any other financial incentive program are tied to quality of care or health of aligned beneficiaries (e.g., designated mental health agencies, specialized services agencies, area agencies on aging, and others). .

6.5. Provide a comprehensive list of ACO quality measures that will, or are proposed to, affect payment or be monitored, according to the terms of the agreement with the payer. The applicant may provide a link to publicly-available materials. Provide the most recent annual ACO quality reports for all measures included in agreements with CMS, including Risk-Standardized, All-Condition Readmission; All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions; Days at Home (for High Needs Population DCE); Timely Follow-Up After Acute Exacerbations of Chronic Conditions (for Standard DCE or New Entrant DCE); Consumer Assessment of Healthcare Providers and Systems® (CAHPS). To the extent practicable, please provide segmented reports for Vermont operations.

Commented [A4]: Deleting because this information is covered in section 6

Commented [A5]: Removing list and adding "all" earlier in the sentence

~~7.~~6. Describe the current or proposed methodology used for beneficiary/member alignment (also known as attribution).

Section 4: ACO BUDGET AND FINANCIAL PLAN

1. Submit most recent audited financial statements and the most recent publicly available quarterly financial reports, or incorporate by reference to public filings with the Securities and Exchange Commission. ~~-~~Responses to this question do not need to be specific to Vermont operations.

2. Provide a ~~narrative~~ description of the flow of funds between payer, ACO, provider, and patients using the below chart, include narrative descriptions in the "Notes" column for each row. ~~-~~Please also describe the ACO's business model. ~~-~~The description should indicate how the ACO expects to realize savings and should demonstrate the ability of the ACO to maintain sufficient funds to support its administrative operations and meet provider payment obligations. ~~The description should also include the dollar values of anticipated payments to Vermont providers for 2022 and related anticipated savings.~~

Commented [A6]: Covered in Q5 below

Funds Flow

From	To	Payment Type (Funds)	Notes

~~2.~~3. If the ACO is taking risk of loss, provide a narrative explaining how the ACO would manage the financial liability for 202~~2~~3 through the risk programs included in Part 3 should the ACO's losses equal i) 75% of maximum downside exposure, and ii) 100% of maximum downside exposure. ~~-~~As part of the narrative response, describe your full risk mitigation plan to cover this liability and the mitigation plan for any contracted providers to which risk is being delegated or with which risk is being shared. This response is to include, but is not limited to:

a. Portion of the risk covered by reserves, collateral, or other liquid security whether established as a program contractual requirement or as part of the ACO's risk management plan;
b. Portion of the risk delegated through fixed payment models to ACO-contracted providers;
c. Portion of the risk covered by ACO providers through mechanisms other than fixed payment models (e.g., withholds, commitment to fund losses at annual settlement, etc.);
d. Portion of the risk covered by reinsurance or through any other mechanism (please specify); ~~Portion of the risk covered through any other mechanism (please specify);~~
e. Any risk management or financial solvency requirements imposed on the ACO by third-party health care payers under ACO program contracts appearing in Section 3; and
f. Whether any liability of the ACO could be passed along to providers in its network if the ACO failed to pay any obligation related to its assumed risk.

~~3.~~4. Provide any further documentation (i.e. policies) for the ACO's management of financial risk that provide additional context or support of the narrative response to question 3 above.

~~4.~~5. Please provide the following information for 2021-2023 ~~and for 2022~~, as an estimated budget:

a. The amount of any fixed payments and any shared savings distributed to Vermont Participant Providers and Preferred Providers;
b. The amount of any shared savings or shared losses on a total ACO-wide basis;
c. The proportion of shared savings invested in infrastructure, redesigned care processes, and other resources necessary to improve outcomes and reduce Medicare costs for beneficiaries on a total ACO-wide basis; and
d. The proportion of shared savings distributed to Participant Providers and Preferred Providers on a total ACO-wide basis.

Section 5: ACO MODEL OF CARE AND COMMUNITY INTEGRATION

1. Describe the ACO's Model of Care, including but not limited to how it may address:
   a. All population health initiatives;
   b. Benefit enhancements offered;
   ~~a. Support for person-directed care;~~
   ~~b.~~c. Support for appropriate utilization of health care services;
   d. Support for coordination of care across the care continuum, including primary care, hospital inpatient and outpatient care, specialty medical care, post-acute care, mental health and substance abuse care and disability and long-term services and supports, especially during care transitions;
   ~~c. Seamless coordination of care across the care continuum, including primary care, hospital inpatient and outpatient care, specialty medical care, post-acute care, mental health and substance abuse care and disability and long-term services and supports, especially during care transitions;~~
   ~~d.~~e. Participation and role of community-based providers (e.g., designated mental health agencies, specialized services agencies, area agencies on aging, home health services, and others) that are included in the ACO, including any proposed investments to expand community-based provider capacity and efforts to avoid duplication of existing resources;
   f. Integration efforts with the Vermont Blueprint for Health, regional care collaboratives and other state care coordination initiatives;
   g. Efforts that incentivize systemic health care investments in social determinants of health; and
   ~~e.~~h. Efforts that incentivize for preventing and addressing the impacts of adverse childhood experiences and other traumas.

2. Describe any strategies for expanding capacity in existing primary care practices, including but not limited to reducing administrative burden on such practices.
   ~~f. Identification of, and care coordination interventions for, high risk and very high risk patients;~~
   ~~g. Use of comprehensive integrated/shared care plans and interdisciplinary care teams; and~~

Commented [A7]: Question updated to align with budget section of rule 5, removed certification specific elements

Commented [A8]: Not included as a requirement in rule

Commented [A9]: Requirements for certification, but not for budgets

~~h. Improving health care outcomes in line with social determinants of health, any plans for integrating or facilitating the integration of healthcare and social services in FY22, and any plan to provide incentives for investments to address social determinants of health in FY22~~

Commented [A10]: Now covered in 1g

3. How is the ACO addressing health equity concerns such as access to care and racial disparities in care? If the ACO has specific goals in this area, describe any specific actions the ACO is taking to achieve these goals.

~~2.~~4. Does the ACO ~~'s Model of Care improve performance on any of the following measures? Does the ACO~~ have any specific programs or initiatives intended to improve performance on any of these measures? ~~Does the ACO have evidence supporting its approach (such as peer reviewed studies or past performance)?~~ For additional information about the measures, please see Appendix 1 of the State of Vermont All-Payer ACO Model Agreement.[1]

Commented [A11]: Question was moved to section 5

a. Substance Use Disorder: reducing deaths from drug overdoses, increasing initiation and engagement of alcohol and drug dependence treatment, increase follow-up after discharge from the emergency department for alcohol or other drug dependence, reduce rate of growth of emergency department visits with a primary diagnosis of substance abuse condition, increase the utilization of Vermont's prescription drug monitoring program, and increase the number of Vermont residents receiving medication-assisted treatment (MAT) for substance use.
b. Suicide: reduce the number of deaths due to suicide.
c. Mental Health: increase follow-up care within 30 calendar days after discharge from a hospital emergency department for mental health, reduce rate of growth of emergency department visits with a primary diagnosis of mental health, increase screening for clinical depression (and if depression was detected, include a follow-up plan).
d. Chronic Conditions: decrease the prevalence of COPD, diabetes, and hypertension for Vermont residents, reduce composite measure comprising of diabetes, hypertension, and multiple chronic condition morbidity,
e. Access to Care: increase number of Vermont residents reporting that they have a personal doctor or care provider, and increase percent of Vermont residents who say they are getting timely care, appointments, and information.
f. Tobacco Use and Cessation: increase percent of Vermont residents who are screened for tobacco use and who receive cessation counseling intervention.
g. Asthma: increase percent of Vermont residents who receive appropriate asthma medication management.

~~3.~~

5. Describe the evidence (such as peer reviewed studies, past performance, etc.) that informs the ACO's programs and processes, including point of care systems, population health efforts, and referral practices.

6. Please describe any referral program that the ACO employs to coordinate patient care, including home-based care providers and community-based providers. Specifically:

Commented [A12]: This question was moved from above because it is related to population health. The out of network element was put into part b.

[1] ~~Available on the GMCB website, at~~ **Error! Hyperlink reference not valid.**

a. Describe how providers access the referral program information;
b. ~~What information is considered in the referral program, and what referral opportunities are available in Vermont;~~How do providers select to whom they make referrals? -What information ~~is taken i~~does the ACO supply to providers~~nto consideration~~ when evaluating referral options for both in- and out-of-network providers?

7. Does the ACO benchmark performance measures against similar entities? If no, explain why not. If yes, in what areas and how does the ACO use the results?

Commented [A13]: A similar question was asked in follow up questions in FY22, so we are adding it to the guidance for FY23

~~Describe any strategies for expanding capacity in existing primary care practices, including but not limited to reducing administrative burden on such practices.~~

~~Describe the ACO's population health initiatives, including programs aimed at preventing hospital admissions or readmissions, reducing racial/ethnic disparities, reducing length of hospital stays, providing benefit enhancements resulting from delivery system flexibility, improving population health outcomes, addressing social determinants of health (e.g., Adverse Childhood Events), and supporting and rewarding healthy lifestyle choices. Describe how the ACO will evaluate these initiatives, what methods will be used, who will conduct the assessment, and how you define success.~~

Commented [A14]: This question was integrated in number 1 of this section

~~Provide a copy of your grievance and complaint process.~~

Commented [A15]: In last year's review we learned that this is a CMS policy that is part of the participation agreement

Section 6: VERMONT ALL-PAYER ACCOUNTABLE CARE ORGANIZATION MODEL AGREEMENT SCALE TARGET ACO INITIATIVE

1. These tables seek to assist the GMCB in determining whether the ACO's payer contract meet the requirements of a Scale Target ACO Initiative (defined in Section 6.b of the All-Payer ACO Model Agreement). The GMCB may require additional information if required to satisfy the State of Vermont's reporting obligations under the All-Payer ACO Model Agreement.

Payer Contract: Click or tap here to enter text. **Contract Period**: Start Date to End Date **Date Signed**: Click or tap here to enter text.
Financial Arrangement – Shared Savings and/or Shared Risk Arrangements
Are shared savings possible? * Choose an item.
Does shared savings arrangement meet minimum requirements of 30% of the difference between actual and expected spending (see Section 6.b of the All-Payer ACO Model Agreement)? * Choose an item.
Describe shared savings and shared risk arrangement(s): Click or tap here to enter text.

Contract Reference(s): Click or tap here to enter text.
Payment Mechanisms – Payer/ACO Relationship
Describe payment mechanism(s) between payer and ACO (AIPBP, FFS, etc.): Click or tap here to enter text.
Contract Reference(s): Click or tap here to enter text.
Payment Mechanisms – ACO/Provider Relationship
Describe payment mechanism(s) between ACO and ACO provider network: Click or tap here to enter text.
ACO Provider Agreement Reference(s): Click or tap here to enter text.
For payments to providers, please complete the table below, identifying the applicable category of the payments (or percentage of payments in each category) based on HCP-LAN categories:

HCP-LAN Category	**ACO / provider arrangements**	**$ value**
Category 1: FFS-No link to Quality and Value		
1: FFS-No link to Quality & Value		
Category 2: FFS-Link to Quality and Value		
2A: Foundational payments for infrastructure & operations		
2B: Pay for reporting		
2C: Pay for performance		
Category 3: APMs Built on FFS Architecture		
3A: APMs with shared savings		
3B: APMs with shared savings and downside risk		
3N: Risk based payments NOT linked to quality		
Category 4: Population-Based Payment		
4A: Condition-specific population-based payment		
4B: Comprehensive population-based payment		

4B with reconciliation to FFS and ultimate accountability for TCOC	**Medicare AIPBP (Per CMMI and LAN)**: *CMMI actually includes VT All payer in the Annual LAN APM measurement effort and currently categorizes VT All payer as Category 4B (See definition from the LAN's APM Framework):* "*Payments in Category 4B are prospective and population-based, and they cover all an individual's health care needs. Category 4B encompasses a broad range of financing and delivery system arrangements, in which payers and providers are organizationally distinct."*	
4B with NO reconciliation to FFS	**Medicaid**	
4C: Integrated finance & delivery system		
4N: Capitated payments NOT linked to quality		

Services Included in Financial Targets (Total Cost of Care)
Services Included in Financial Targets: *Complete **Appendix A, Services Included in Financial Targets**, for all ACO-payer contracts. (Services must be comparable to All-Payer Financial Target Services as defined in section 1.f of the All-Payer ACO Model Agreement, to qualify as Scale Target ACO Initiative) ****
Contract Reference(s): Click or tap here to enter text.
Quality Measurement
Is financial arrangement tied to quality of care or the health of aligned beneficiaries? * Choose an item.
Describe methodology for linking payments to quality of care or health of aligned beneficiaries (e.g., withhold, gate and ladder, etc.): Click or tap here to enter text.
Quality Measures: *Complete **Appendix B, Quality Measures**, for all ACO-payer contracts.*
Contract Reference(s): Click or tap here to enter text.
Attribution Methodology
Describe attribution methodology: Click or tap here to enter text.
Contract Reference(s): Click or tap here to enter text.
Patient Protections
Describe patient protections included in ACO contracts or internal policies: Click or tap here to enter text.
Contract and Policy Reference(s): Click or tap here to enter text.

Table 2: Services Included in Financial Targets

Indicate with "x" if category is included

Category of Service or Expenditure Reporting Category	Medicare ~~Direct Contracting~~ACO Program
Hospital Inpatient	
Mental Health/Substance Abuse - Inpatient	
Maternity-Related and Newborns	
Surgical	
Medical	
Hospital Outpatient	
Hospital Mental Health / Substance Abuse	
Observation Room	
Emergency Room	
Outpatient Surgery	
Outpatient Radiology	
Outpatient Lab	
Outpatient Physical Therapy	
Outpatient Other Therapy	
Other Outpatient Hospital	
Professional	
Physician Services	
Physician Inpatient Setting	
Physician Outpatient Setting	
Physician Office Setting	
Professional Non-physician	
Professional Mental Health Provider	
Post-Acute Care	
DME	
Dental	
Pharmacy	

Table 3: Quality Measures

Indicate with "x" if category is included

Quality Measure	Medicare ACO Program~~Direct Contracting~~
Screening for clinical depression and follow-up plan	
Tobacco use assessment and cessation intervention	
Hypertension: Controlling high blood pressure (ACO composite)	
Diabetes Mellitus: HbA1c poor control (ACO composite)	
All-Cause unplanned admissions for patients with multiple chronic conditions (ACO composite)	
Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient experience surveys*	

% of Medicaid adolescents with well-care visits	
30-day follow-up after discharge from emergency department for mental health	
30-day follow-up after discharge from emergency department for alcohol or other drug dependence	
Initiation of alcohol and other drug dependence treatment	
Engagement of alcohol and other drug dependence treatment	
Risk-standardized, all-condition readmission	
Skilled nursing facility 30-day all-cause readmission	
Influenza immunization	
Pneumonia vaccination status for older adults	
Colorectal cancer screening	
Number of asthma-related ED visits, stratified by age	
HEDIS: All-Cause Readmissions	
Developmental screening in the first 3 years of life	
Follow-up after hospitalization for mental illness (7-Day Rate)	
Falls: Screening for future fall risk	
Body mass index screening and follow-up	
All-cause unplanned admissions for patients with Diabetes	
All-cause unplanned admissions for patients with Heart Failure	
Breast cancer screening	
Statin therapy for prevention and treatment of Cardiovascular Disease	
Depression remission at 12 months	
Diabetes: Eye exam	
Ischemic Vascular Disease: Use of aspirin or another antithrombotic	
Acute ambulatory care-sensitive condition composite	
Medication reconciliation post-discharge	
Use of imaging studies for low back pain	
Add Additional Measures as Needed	