
**State of Vermont**
**Green Mountain Care Board**
89 Main Street
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Report to the Legislature

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# REPORT ON THE GREEN MOUNTAIN CARE BOARD'S STATUS OF ITS EFFORTS TO ACHIEVE ALIGNMENT BETWEEN MEDICARE, MEDICAID, AND COMMERCIAL PAYERS IN THE ALL-PAYER MODEL

## In accordance with Act 113 of 2016

*Submitted to the*
*House Committee on Health Care and Senate Committees on Health and Welfare and on Finance*

*Submitted by the*
*Green Mountain Care Board*

*January 15, 2017*

## Introduction and Legislative Charge

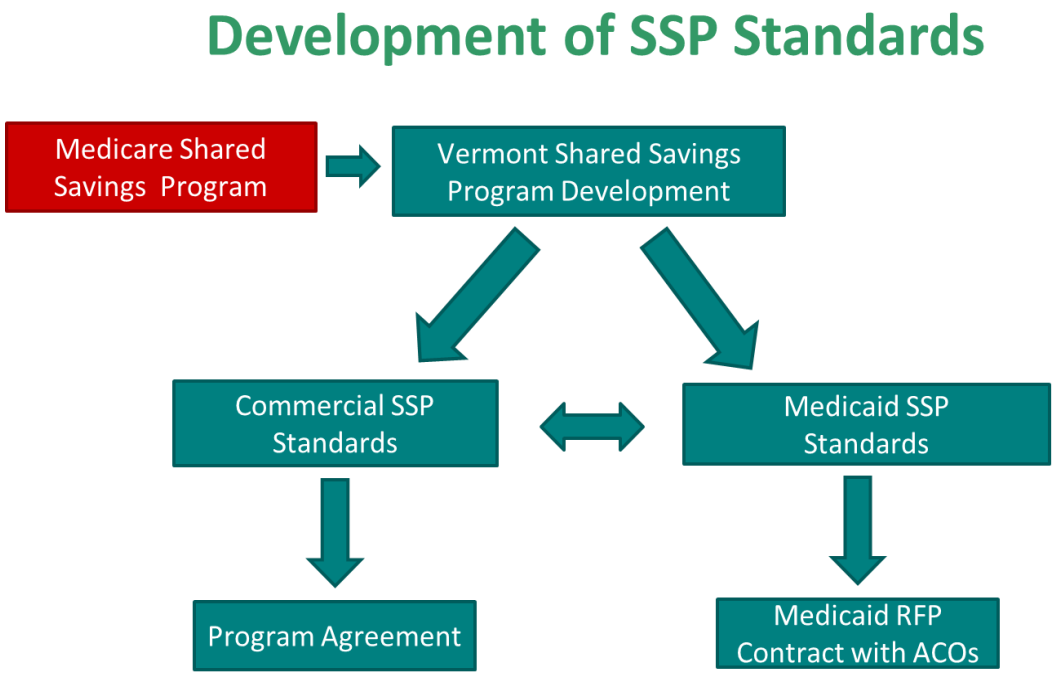
Section 16 of Act 113 of 2016 requires the Green Mountain Care Board (GMCB, or the Board) to submit a report to the House Committee on Health Care and the Senate Committees on Health and Welfare and on Finance. The report is to address "the status of its efforts to achieve alignment between Medicare, Medicaid, and commercial payers in the all-payer model as required by 18 V.S.A. § 9551(a)(3)."

The GMCB and the payers have worked towards alignment of ACO programs initially in the development of ACO shared savings programs, and now in terms of the All-Payer Model (APM). The alignment work completed for the shared savings program serves as a foundation for further alignment efforts now underway in the APM. This report will speak to the Board's work to date as well as work continuing for implementation of the All-Payer ACO Model (APM).

## Shared Savings Programs

In 2014 the GMCB established the Commercial and the Medicaid Accountable Care Organization (ACO) shared savings programs (SSPs) under its pilot payment reform authority. The programs are governed by standards set up by the GMCB, and by Commercial program agreements and Medicaid contracts that provide operational guidance. The GMCB modeled the Commercial and Medicaid standards on standards that were previously developed by the Centers for Medicare and Medicaid Services (CMS) for the Medicare Shared Savings Program (MSSP) initiated in 2012. Figure 1 on the following page depicts the development of Vermont's SSP standards, Commercial program agreement, and Medicaid contract and how these documents interrelate.

**Figure 1:**




The Vermont SSP standards cover the following topics:

- Financial stability
- Patient Freedom of Choice
- ACO Governance
- Patient Attribution Methodology
- Calculation of ACO Financial Performance
- Distribution of Savings
- Impact of Performance Measures on Savings Distribution
- Care Management
- Payment Alignment
- Data Use
- Process for Review and Modification of Measures
- Quality Measures

Quality measurement has received a great deal of attention and is important to the provider community, because conflicting or voluminous measures create administrative work for primary care providers. The GMCB has been cognizant of this concern in the development of

the SSP program and will continue to be so in the further alignment required by the All Payer Model Agreement and Act 113 of 2016.
In developing the quality measures for the Commercial and Medicaid SSP program, the GMCB and DVHA drew from the Medicare SSP (MSSP) measures to ensure that specifications for the Commercial and Medicaid measures mirrored the MSSP specifications for the measures that all programs have in common. In addition, the Medicaid and Commercial quality measures are fully aligned.

Because the Medicaid and Commercial SSPs were developed in tandem, the Commercial and Medicaid programs are aligned across all of the standards detailed above and are aligned to a great degree with the MSSP.

## All-Payer ACO Model

As the state moves forward with the implementation of the All-Payer ACO Model, new alignment efforts are necessary to ensure that new or changed elements of program design, in particular payment models, are aligned across the three major payers.

In 2016, the Department of Vermont Health Access began a procurement process to contract with a risk-bearing Accountable Care Organization (ACO) for participation in a population-based payment model that is based on the Centers for Medicare and Medicaid Services (CMS) *Next Generation* ACO Model. While appropriate modifications have been made to the CMS Next Generation model to account for a different population served by Medicaid and to accommodate state-specific needs, the CMS Next Generation framework was drawn upon in the establishment of:

- a set of services for which a participating ACO is accountable;
- a prospective attribution methodology;
- a mechanism for making prospective payments; and
- a framework for risk sharing.

The Vermont Medicaid Next Generation program differs from the CMS Next Generation framework in particular, with respect to the specific financial methodology, the impact of quality performance on overall payment, and in the waiver of certain prior authorization requirements.

Looking ahead, the All-Payer ACO Model Agreement (the Agreement) between the State and the Centers for Medicare & Medicaid (CMS) is predicated on alignment between the three major payer types. The Agreement, signed on October 27, 2016, expressly requires that Vermont "ensure that Scale Target ACO Initiatives offered by Vermont Medicaid, Vermont Commercial Plans, and participating Vermont Self-insured Plans reasonably align in their design . . . with the Vermont Modified Next Generation ACO in Performance Year 1 and with the Vermont Medicare ACO Initiative in Performance Years 2 through 5. CMS and Vermont will

work together to explore modifications to the Vermont Medicare ACO Initiative in order to facilitate design alignment."

The Agreement's quality framework is intended to closely align measures among payer types and existing programs. Of the twenty measures included, six will be collected for attributed beneficiaries across all three of the major payer types, and another ten will be collected for the entire state population, regardless of payer. In addition to alignment across payer types, there is also alignment across programs: seven of the twenty measures are current ACO SSP measures, and 17 of the twenty measures are already routinely collected and reported in Vermont for various program and monitoring purposes. A complete list of the measures in the Agreement can be found in Table 1, below.[1]

**Table 1:** Vermont All-Payer Accountable Care Organization Model Agreement Measures

| Domain | Measure | Data Source | Proposed Target |
|---|---|---|---|
| **Goal #1: Increase Access to Primary Care** | | | |
| Population Health | Percentage of adults with usual primary care provider* | Behavioral Risk Factor Surveillance System Survey (BRFSS) | 89% of adults statewide |
| Health Care Delivery System | Medicare ACO composite of 5 questions on Getting Timely Care, Appointments and Information*‡ | ACO CAHPS Survey | 75$^{th}$ percentile compared to Medicaid Nationally |
| Health Care Delivery System | Medicaid patient caseload for specialist and non-specialist physicians | TBD; potential measure | Monitoring only for at least first 2 years |
| Process | Percentage of Medicaid adolescents with well-care visits*‡ | Claims | 50$^{th}$ percentile compared to Medicaid Nationally |
| Process | Percentage of Medicaid enrollees aligned with ACO* | PCP selection and Claims | No more than 15 percentage points below % of VT Medicare beneficiaries aligned to VT ACO |
| **Goal #2: Reduce Deaths Related to Suicide and Drug Overdose** | | | |
| Population Health | Deaths related to suicide* | Vital Statistics | 16 per 100,000 VT residents or 20$^{th}$ highest rate in US |
| Population Health | Deaths related to drug overdose* | Vital Statistics | Reduce by 10% |

[1] In addition to the twenty specified measures, there is one potential measure that has not yet been specified, related to Medicaid patient caseloads for specialist and non-specialist physicians.

| Domain | Measure | Data Source | Proposed Target |
|---|---|---|---|
| Health Care Delivery System | Multi-Payer ACO initiation of alcohol and other drug dependence treatment*‡ | Claims | 50th percentile |
| Health Care Delivery System | Multi-Payer ACO engagement of alcohol and other drug dependence treatment*‡ | Claims | 75th percentile |
| Health Care Delivery System | Multi-Payer ACO 30-day follow-up after discharge from ED for mental health | Claims | 60% |
| Health Care Delivery System | Multi-Payer ACO 30-day follow-up after discharge for alcohol or other drug dependence | Claims | 40% |
| Health Care Delivery System | Number of mental health and substance abuse-related ED visits* | Hospital Discharge Data | Reduce rate of growth (target TBD) |
| Process | % of Vermont providers checking prescription drug monitoring program before prescribing opioids* | Vermont Prescription Monitoring System (VPMS) | Increase percentage (target TBD) |
| Process | Multi-Payer ACO screening and follow-up for clinical depression and follow-up plan*‡ | Clinical | 75th percentile compared to Medicare Nationally |
| Process | # per 10,000 population ages 18-64 receiving medication assisted treatment (MAT)* | Vermont Department of Health (VDH) | 150 per 10,000 (or up to rate of demand) |
| **Goal #3: Reduce Prevalence and Morbidity of Chronic Disease (COPD, Hypertension, Diabetes)** | | | |
| Population Health | Statewide prevalence of chronic disease: COPD* | BRFSS | Increase statewide prevalence by no more than 1% |
| Population Health | Statewide prevalence of chronic disease: hypertension* | BRFSS | Increase statewide prevalence by no more than 1% |
| Population Health | Statewide prevalence of chronic disease: diabetes* | BRFSS | Increase statewide prevalence by no more than 1% |
| Health Care Delivery System | Medicare ACO chronic disease composite: Diabetes HbA1c poor control; controlling high blood pressure; and all-cause unplanned admissions for patients with multiple chronic conditions*‡ | Claims, Clinical | 75th percentile compared to Medicare nationally |
| Process | Percentage of VT residents receiving appropriate asthma medication management | Claims | 25th percentile compared to national |

| Domain | Measure | Data Source | Proposed Target |
|---|---|---|---|
| Process | Multi-Payer ACO tobacco use assessment and cessation intervention*‡ | Clinical | 75th percentile compared to Medicare nationally |

* Currently collected and reported in VT

‡ Current ACO SSP Measure

Under the Agreement, 2017 is an implementation year (Performance Year 0). Since the Agreement was signed, work on alignment has been continuous. The GMCB is working to define the alignment strategies in four main categories: payment methodologies, services included in the ACO contract, attribution methodologies, and care management approaches. It is important to note that alignment does not necessarily mean that the programs will be identical. Differences in populations could and should lead to appropriate differences in the programs. For example, the Medicaid program has a lot of attributed children, whereas the Medicare program has very few. This will result in some modifications of quality measurement to ensure that the different populations needs are taken into consideration.

Moving forward, the GMCB has multiple regulatory levers for achieving alignment across payers participating in the APM. First, the Agreement requires the Board to work with the Center for Medicare & Medicaid Innovation (CMMI) on modifications to the Next Generation ACO Program/Vermont Medicare ACO Initiative through 2022. Second, the Vermont Legislature has tasked the Board with ACO oversight through Certification and Budget Review processes. *See* 18 V.S.A. § 9382. And finally, the Board is required to review Commercial major medical insurance. 8 V.S.A. § 4062.

## Conclusion

As seen in the Commercial and Medicaid Shared Savings Programs and the All-Payer ACO Model Agreement, the GMCB has worked diligently to improve alignment in measure selection and reporting. Additionally, within the Shared Savings Programs, payment methods – although not identical – are substantially aligned between the two state programs and the Medicare program. There is also considerable work being done at DVHA in the Medicaid Next Gen ACO program in terms of alignment with federal Medicare Next Gen requirements. Finally, the GMCB's regulatory levers will support alignment across payers in areas such as: payment and attribution methodologies, services included in the ACO contract, and care management approaches.