State of Vermont
Green Mountain Care Board
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Report to the Legislature

REPORT ON THE GREEN MOUNTAIN CARE BOARD'S PROGRESS IN MEETING ALL-PAYER ACO MODEL IMPLEMENTATION BENCHMARKS

for the period of January 1 to May 31, 2017

In accordance with Act 25 of 2017

Submitted to the
House Committees on Appropriations, on Human Services, and on Health Care, the Senate Committees on Appropriations and on Health and Welfare, the Health Reform Oversight Committee, and the Office of the Health Care Advocate

Submitted by the
Green Mountain Care Board

June 15, 2017

Legislative Charge

The Green Mountain Care Board (the "Board") is submitting this report pursuant to Act 25 of 2017, 'An act relating to Next Generation Medicaid ACO pilot project reporting requirements'. Section 2 of that Act provides as follows:

> On or before June 15, September 15, and December 15, 2017, the Green Mountain Care Board shall provide to the House Committees on Appropriations, on Human Services, and on Health Care, the Senate Committees on Appropriations and on Health and Welfare, the Health Reform Oversight Committee, and the Office of the Health Care Advocate written updates on the Board's progress in meeting the benchmarks identified in the Board's Year 0 (2017) All-Payer ACO Model Timeline regarding implementation of the All-Payer ACO Model and the Board's preparations for regulating accountable care organizations.

Introduction

Act 113 of 2016 set forth principles in 18 V.S.A. §9551 to guide the state in implementing a value-based payment model allowing participating health care providers to be paid by Medicaid, Medicare, and commercial insurance using a common methodology that may include population-based payments and increased financial predictability for providers. 18 V.S.A. §9373 established requirements for the Green Mountain Care Board (GMCB) to develop rules and standards to provide oversight to Accountable Care Organizations (ACOs), beginning January 1, 2018.

The Vermont All-Payer Accountable Care Organization Model ("All-Payer ACO Model" or "APM") Agreement (the "Agreement") was signed on October 26, 2016 by Vermont's Governor, Secretary of Human Services, Chair of the Green Mountain Care Board, and the Centers for Medicare and Medicaid Services (CMS). The All-Payer Model aims to reduce health care cost growth by moving away from fee-for-service reimbursement to risk-based arrangements for Accountable Care Organizations (ACOs); these arrangements are tied to quality and health outcomes. Act 113 complements the All-Payer ACO Model Agreement by providing the Board regulatory authority over ACOs in Vermont. The Board is implementing Act 113 and the All-Payer Model Agreement concurrently, as described in the Year 0 (2017) All-Payer ACO Model Timeline found in Figure 1 of this document.

This report will cover Act 113 and the All-Payer ACO Model Agreement implementation for the period of January 1 to May 31, 2017.

Figure 1

Year 0 (2017) All-Payer ACO Model Timeline*	
January-February 2017	• Rule drafting (completed) • Refining quality measure specifications (completed) • Vermont Medicaid Next Generation (VMNG) contract signed (completed)
March-April 2017	• Analytics Request for Proposals released (completed) • Agree on Total Cost of Care Definition with CMS (completed; detailed specifications expected to be completed in July; no negative consequences anticipated) • Site visit from CMMI (rescheduled to July)
May-June 2017	• Rule pre-filing (completed) • ACOs submit test budget filing to GMCB (due June 23) • Commercial rate review (part of QHP Rate Review) (underway) • Medicaid advisory ACO rate review (moved to July) • Establish two remaining quality measure targets (on track) • Selection of analytics contractor (on track)
July-August 2017	• Rulemaking continues • GMCB ACO test budget review process
September-October 2017	• Rulemaking continues • ACO test budget approval
November-December 2017	• Rulemaking continues • CMS preliminary trend factor set for 2018 (4th quarter) • Certification of ACO • Identify quality measure to monitor Medicaid patient caseload for specialists and non-specialists, with associated target (on track)
*Dates and activities based on current information; subject to change.	

1. 113 Rule Development

1.a) 5.000 'Oversight of Accountable Care Organizations' rule

The Board began developing the ACO Oversight Rule, GMCB Rule 5.000, in the fall of 2016. The Board convened a stakeholder group in January 2017 to provide input on the rule development process. The group comprised representatives of OneCare Vermont Accountable Care Organization, Community Health Accountable Care, the Vermont Care Organization, Office of the Health Care Advocate, Blue Cross & Blue Shield of Vermont, MVP Health Care, Department of Vermont Health Access, and Vermont Association of Hospitals and Health Systems. Based on feedback from these stakeholders over the course of several months, Board staff made numerous revisions to the first draft of the rule. The Board then voted at its April 27, 2017 meeting to proceed to the statutory rulemaking process with this revised draft.

The Board pre-filed the proposed rule with the Interagency Committee on Administrative Rules (ICAR) on April 27, 2017. ICAR heard the proposed rule on May 8, 2017 and approved it with several recommendations. The Board then filed the proposed rule with the Office of the Secretary of State on May 19, 2017.

A public hearing is scheduled for June 29, 2017 at 1:00 PM at the Board's Montpelier offices to take comments on the proposed rule. The public comment period is currently open and will remain open until July 14, 2017. The Board anticipates being able to file a final proposal with the Secretary of State and the Legislative Committee on Administrative Rules by early August 2017.

The Board is on track in its rule development process and does not anticipate any problem having the final rule in effect by January 1, 2018, as required by Act 113, sec. 6.

1.b) ACO Annual Reporting and Budget Guidance

As required by Act 113, OneCare VT, Community Health Accountable Care, and any other qualifying ACOs will begin submitting their budgets for review and reporting on how they meet the ACO certification criteria. The Board and the ACOs agreed to perform a 2017 'test' year in preparation for 2018. After a Board vote, the GMCB issued guidance for the 2018 ACO budget submissions and established a submission deadline of June 23, 2017. The 2018 budget guidance asks the ACOs to report on governance, payer contracts, providers, model of care, previous expenditure analysis, and their 2018 proposed budgets. The ACOs will present their budgets to GMCB on July 13, 2017 so that the Board may consider the potential impact on hospital budgets and insurance premium rates for qualified health plans (QHPs).

The Agreement allows the Board to set the Medicare growth rate for ACOs participating in the Vermont Modified Medicare Next Generation Program. Therefore, the ACO budget review will be an essential component for the Board to arrive at the most appropriate Medicare growth rate within the given parameters.

1.c) Certification

In drafting the ACO oversight rule, the Board has identified the types of documents and information an ACO will need to submit as part of its application for certification. The Board will develop an application form over the next several months.

Beginning January 1, 2018, ACOs must be certified by the Board to receive payments from Medicaid or a commercial insurer through any payment reform program or initiative. If there are any significant delays in the Board's rule adoption timeline, the Board may need to obtain and begin reviewing certification materials from ACOs before the rule takes effect.

2. Vermont All-Payer ACO Model Agreement

2.a) Agreement on Total Cost of Care Definition with CMS

GMCB and DVHA staff are working with CMS to define the All-Payer Total Cost of Care measure that is a critical reporting metric in the Agreement. Specifically, State staff have identified the financial target services for Medicaid and Commercial spending that will serve as the basis for the All-Payer Total Cost of Care calculation. To accomplish this, staff:

1. Carefully reviewed the description of included and excluded services contained in the Agreement.
2. Met with colleagues from DVHA and Blue Cross Blue Shield of Vermont to obtain information on covered services, and how they compare to the included services identified in the Agreement.
3. Worked with staff from DVHA to analyze Medicaid expenditures at a category of service level.
    a. Medicaid is the most complex payer because of the variation and scope of services provided to Medicaid beneficiaries and because the Agreement explicitly excludes certain Medicaid services. State staff identified included services that correspond with the services outlined in the Agreement, and cross-walked those services with commercial services, to demonstrate how the two payers will be aligned in defining financial target services.

4. Initiated the development of detailed specifications to calculate All-Payer Total Cost of Care, using code level specifications from payers when available, and exploring existing expenditure measures that might be helpful. One such measure is the Total Expenditures Per Capita metric contained in the Vermont Blueprint for Health's Blueprint Hospital Service Area (HSA) Healthcare Data Profiles.

CMS has concurred with the financial target services proposed by Vermont. In addition to developing detailed specifications for All-Payer Total Cost of Care, next steps include:

1. Identifying the best sources of data for claims-based expenditures.
2. Creating reporting templates for payers to report non-claims expenditures.

3. Performing test analyses in advance of the start of required reporting to CMS in mid-2018.

2.b) Refining Quality Measure Specifications

The quality measures outlined in the Agreement are specified in Appendix 1, with corresponding targets established for most of the measures. Of the twenty measures in Appendix 1, targets still need to be established by Vermont and CMS for two measures by June 30, 2017.

A target was not established for the measure related to increasing utilization by prescribers of the Vermont Prescription Monitoring System because it is a new measure collected by VDH, and there was not yet any baseline data. VDH recently provided GMCB with baseline data for calendar year 2016. GMCB staff are preparing a proposed target for CMS' consideration, with input from VDH.

A target was also not established for the measure related to reducing the rate of growth in the number of mental health and substance abuse-related emergency department visits. GMCB staff have obtained input from Vermont emergency department medical directors and a community psychiatrist that indicates that the emergency room still serves as a frontline access point to treatment. Vermont and CMS are currently discussing potential unintended consequences that could result if we set a target to reduce visits, and how that could negatively impact access to needed care. State staff and CMS agree that a target should be set very cautiously, and GMCB is currently negotiating with CMS on this issue.

CMS recommended a 21st measure in Section 7.g. of the Agreement. The potential measure is described as "Medicaid patient caseload for specialist and non-specialist physicians." AHS and GMCB staff have proposed potential measures, and CMS is reviewing the proposal. In the meantime, GMCB staff are working on obtaining baseline data to assist in setting targets for this measure, should it be adopted.

2.c) Analytics Request for Proposals (RFP)

Vermont has written and posted an RFP for an all-payer model analytics vendor. Ten proposals were received and are being reviewed by a team consisting of GMCB and AHS staff. Selection of an apparently successful bidder is anticipated by the end of June. Pursuant to state law, information related to the bidders is confidential until a contract is awarded.