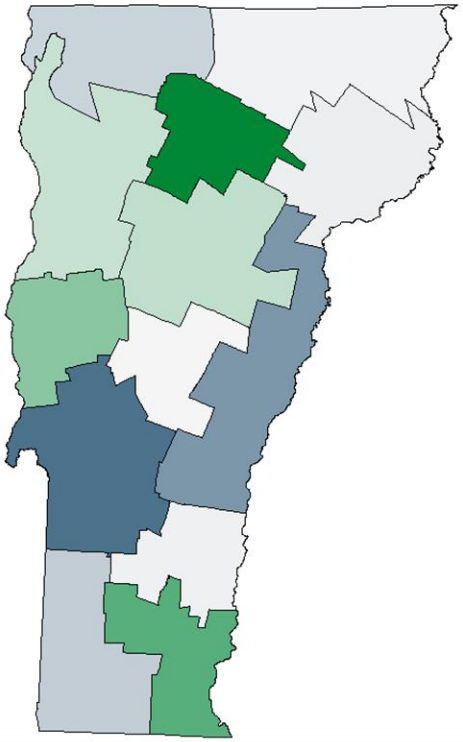

# Vermont Modified Next Generation Accountable Care Organization Medicare Benchmark Trend Factor for OneCare Vermont: Discussion and Staff Recommendations

# Accountable Care Organization Budget Review for OneCare Vermont: Discussion and Staff Recommendations

December 12, 2017
12:30 PM
Green Mountain Care Board
Second Floor Board Room
89 Main Street
City Center, Montpelier VT

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# Agenda

Introduction

Part 1: Vermont Modified Next Generation Accountable Care Organization Medicare Benchmark Trend Factor

- Review Parameters for Medicare Benchmark Trend Factor
  - Statewide Financial Targets
  - Medicare Floor
  - Vermont All-Payer ACO Model All-Payer Growth Targets
- Analysis of Medicare Spending Growth Projections and Vermont Medicare Trends
- Actuary Assessment
- Quality Requirement
- Staff Recommendation

Part 2: Accountable Care Organization Budget Review

- Actuary Assessment
- Rates of Growth by Payer
  - Medicaid Rate

Staff Recommendations:

- Budget Recommendation
- Risk Mitigation Strategy
- Model of Care and Analytics
- Population Health Investments
- Multi-Payer Program Alignment
- Future submissions

# PART I

## Vermont Modified Next Generation Accountable Care Organization Medicare Benchmark Trend Factor

# Statewide Financial Targets

**All-Payer Growth Target:** a defined target for statewide per capita spending growth. This applies to spending across all payers.

**The All-Payer Target: 3.5% compound annualized growth**

**Medicare Growth Target:** a defined target for per capita growth for Medicare beneficiaries. This applies to spending only on Medicare.

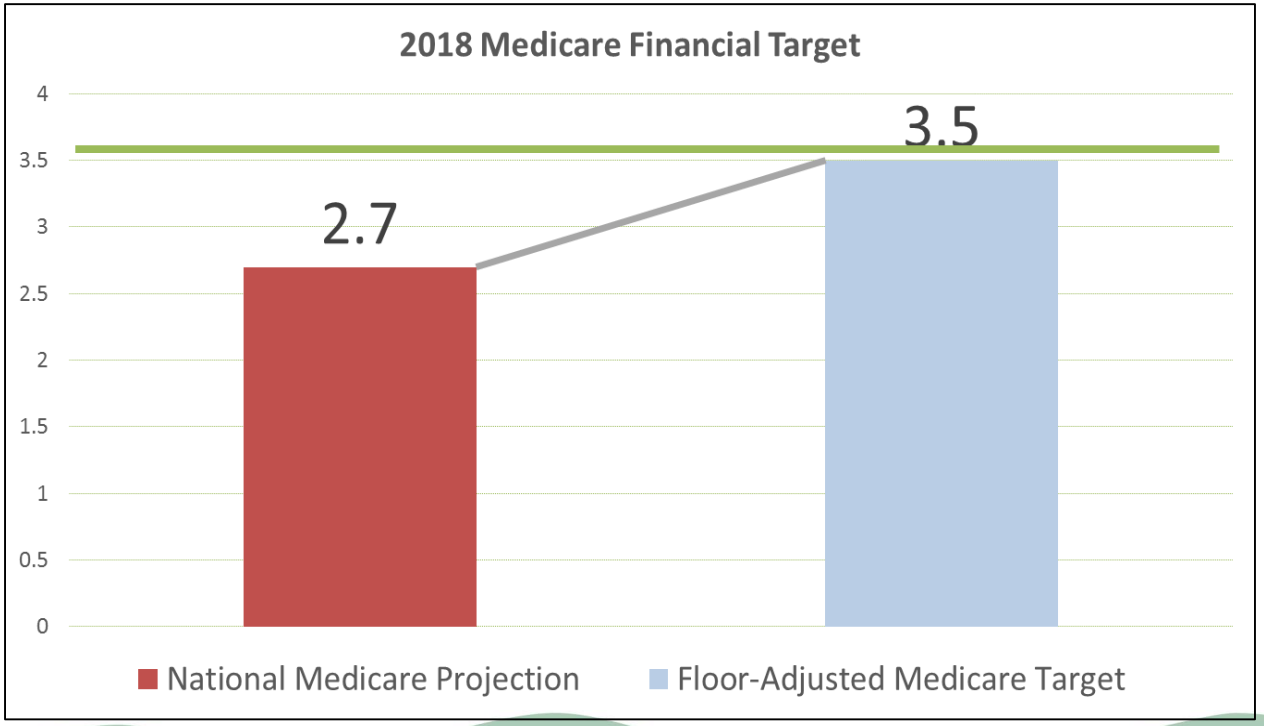
**The Medicare Target: 0.2% below projected national Medicare growth**

- Performance on these targets is calculated over the 5-year agreement (2018-2022)
- Baseline year is 2017, growth is measured from 2017-2022
- Target growth rates are compared to actual Vermont spending growth
- During the agreement term, failure to be "on track" to meet these targets could require a corrective action plan
- Work underway with GMCB staff to develop quarterly and annual reports

# Medicare Growth Target: The Benchmark Floor Provisions

In 2018, Vermont's Medicare growth target is set at a specific level – 3.5%

- The purpose of this provision in the Model Agreement was to make sure that Vermont's growth target would not be too low in Year 1



# The Medicare Floor: How it Works

The Medicare Floor means that performance on the Medicare target is calculated as if the actuarial projection in 2018 was 3.7%

- Setting the projection at 3.7% means that the target is set at 3.5% (0.2% lower)

*Performance Period Projected National Medicare Total Cost of Care per Beneficiary Growth:*

$$\left(1.037 * \left(\frac{MA\ USPCC\ FFS_{2019}}{MA\ USPCC\ FFS_{2018}}\right)_{Announced\ in\ 2018} * \left(\frac{MA\ USPCC\ FFS_{2020}}{MA\ USPCC\ FFS_{2019}}\right)_{Announced\ in\ 2019} * \left(\frac{MA\ USPCC\ FFS_{2021}}{MA\ USPCC\ FFS_{2020}}\right)_{Announced\ in\ 2020} * \left(\frac{MA\ USPCC\ FFS_{2022}}{MA\ USPCC\ FFS_{2021}}\right)_{Announced\ in\ 2021}\right)^{\frac{1}{5}} - 1$$

**This happens regardless of what GMCB decides to do with the 2018 ACO benchmark**

| | |
|---|---|
| **If the benchmark is set below 3.5%, Vermont gains "room" that can provide more flexibility over the 5-year agreement** | **If the benchmark is set at 3.5%, Vermont is in compliance and needs to remain 0.2% below national projections from 2019-22** |

# The All-Payer Growth Target

- The **All-Payer Total Cost of Care per Beneficiary Growth Target** sets Vermont's goal for overall per capita spending growth: 3.5%

- Performance is calculated over the 5 performance years, so Vermont can create "room" by staying below 3.5%

- Vermont is "on track" to meet the All-Payer Target if it remains below 4.3% growth in each year

# All-Payer Growth

| Payer | Growth |
|---|---|
| Commercial | ACO |
| | FFS |
| Self-Insured | ACO |
| | FFS |
| Medicare | ACO |
| | FFS |
| Medicaid | ACO |
| | FFS |

- All-Payer cost growth is a combination of every payer type.
- The All-Payer Target will count all Vermont residents **regardless of whether they are in an ACO.**
- It includes all spending, but payer types may have different growth rates for ACO and non-ACO populations.
- GMCB has regulatory influence over these different factors in different ways.

# GMCB Regulatory Processes

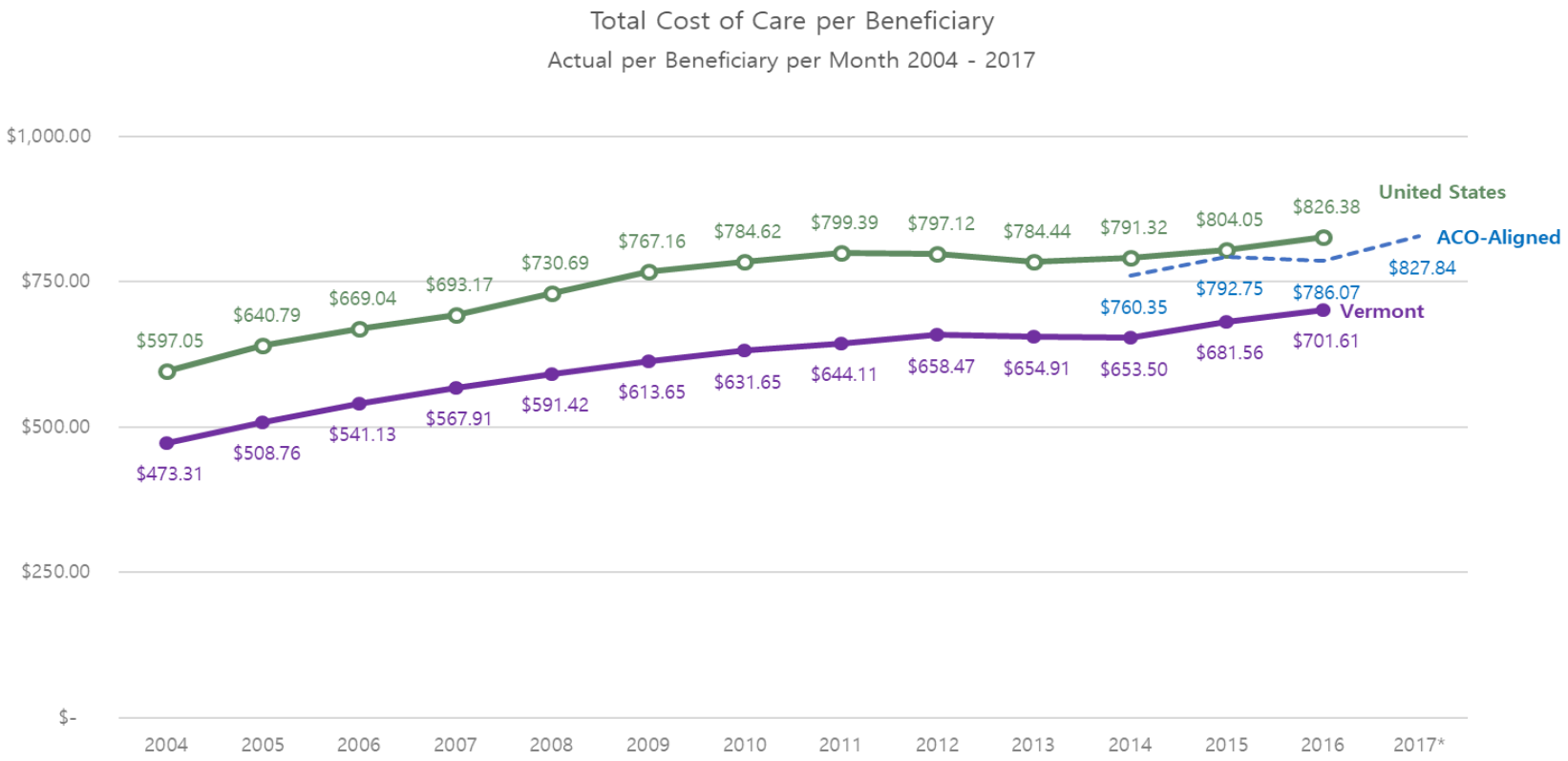
| | Commercial | Self Insured | Medicare | Medicaid |
|---|---|---|---|---|
| **Hospital Budget Review** | X | X | X | X |
| **Health Insurance Rate Review** | X | | | |
| **ACO Budget Review** | X | X | X | X |
| **Medicare ACO Rate Setting** | | | X | |
| **Medicaid ACO Rate Review** | | | | X |

This includes all hospital spending: ~60% of APM TCOC

This affects small/nongroup: ~45% of all Commercial

These affect all ACO spending; relative weight will change as ACO gains scale

# Historical Medicare Spending: US and Vermont (Total and ACO-Aligned)

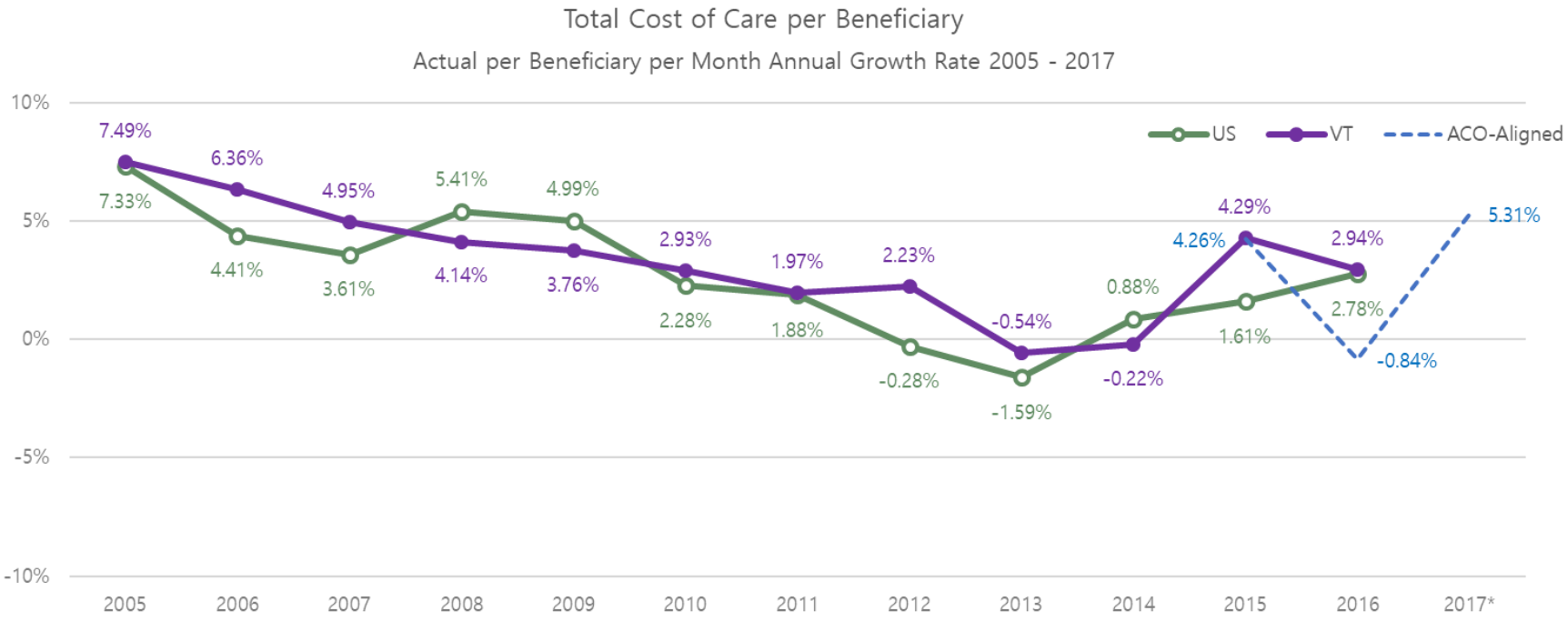



*Note:* Spending for ACO-aligned beneficiaries is based on their historical spend. They will not officially be aligned to an ACO until January 1, 2018.

* Estimated

Data Source: Centers for Medicare & Medicaid Services (CMS), December 2017

# Historical Rate of Growth: US and Vermont (Total and ACO-Aligned)




*Note:* Spending for ACO-aligned beneficiaries is based on their historical spend. They will not officially be aligned to an ACO until January 1, 2018.

* Estimated

Data Source: Centers for Medicare & Medicaid Services (CMS), December 2017



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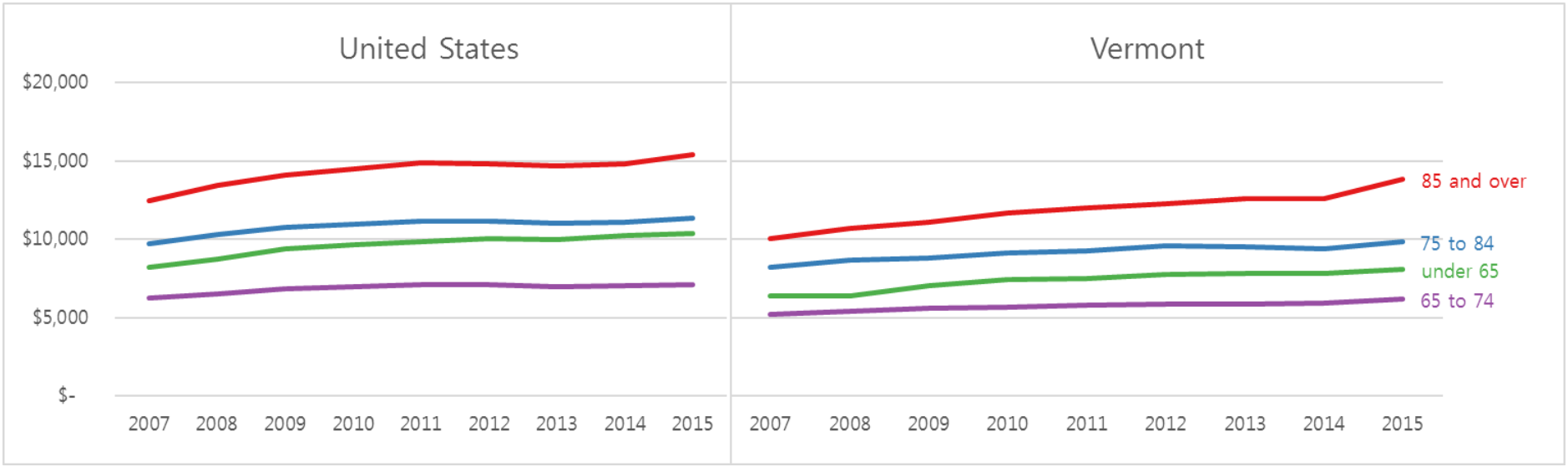
# Total Cost of Care by Age Group




Data Source: Centers for Medicare & Medicaid Services (CMS), December 2017



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# Projected National Growth Rates

**Final Projected Fee-for-Service United States per Capita Cost (FFS USPCC) Expenditures**

| | | Projection Year | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 |
| **Beneficiaries without End Stage Renal Disease (ESRD)** | Performance Year | | | | | | | | | | | | |
| | 2014 | $750.39 | $761.65 | $762.43 | $780.97 | $795.11 | $817.18 | $845.06 | | | | | |
| | 2015 | $746.57 | $754.93 | $745.21 | $752.81 | $757.46 | $768.84 | $785.58 | $813.66 | | | | |
| | 2016 | $747.98 | $758.20 | $751.25 | $761.67 | $774.78 | $784.97 | $800.21 | $831.70 | $872.08 | | | |
| | 2017 | $744.81 | $758.28 | $751.64 | $761.57 | $774.74 | $794.53 | $801.41 | $825.20 | $853.21 | $894.50 | | |
| | 2018 | $746.08 | $754.40 | $751.11 | $761.35 | $774.96 | $800.29 | $806.68 | $825.00 | $847.73 | $888.97 | $929.95 | |
| | 2019* | $746.08 | $754.40 | $751.11 | $761.22 | $774.91 | $801.42 | $822.82 | $822.82 | $844.82 | $884.14 | $926.76 | $975.03 |
| **Beneficiaries with ESRD** | Performance Year | | | | | | | | | | | | |
| | 2014 | $6,834.14 | $6,770.39 | $6,834.71 | $7,039.85 | $7,063.55 | $7,324.21 | $7,945.05 | | | | | |
| | 2015 | $6,834.14 | $6,770.39 | $6,719.08 | $6,780.23 | $6,813.82 | $6,951.56 | $7,239.14 | $7,529.40 | | | | |
| | 2016 | $6,834.14 | $6,770.39 | $6,719.08 | $6,779.61 | $6,863.06 | $6,997.24 | $7,155.20 | $7,413.51 | $7,731.47 | | | |
| | 2017 | $6,834.14 | $6,770.39 | $6,719.08 | $6,779.61 | $6,762.22 | $6,815.23 | $6,862.30 | $7,023.24 | $7,213.94 | $7,455.35 | | |
| | 2018 | $6,834.14 | $6,770.39 | $6,719.08 | $6,882.85 | $6,900.22 | $6,836.71 | $6,796.37 | $6,933.11 | $7,133.42 | $7,434.24 | $7,745.31 | |

* Preliminary estimates from Early Preview, November 2016

# Targets over Time

**Projected USPCC FFS Expenditures**

***Blended Based on Vermont's ESRD case mix***

| | | Projection Year | | | | | | | Annual Projected TCOC per Beneficiary Growth |
|---|---|---|---|---|---|---|---|---|---|
| | | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | |
| Performance Year | 2014 | $806.01 | $820.18 | | | | | | 1.76% |
| | 2015 | | $781.69 | $793.57 | | | | | 1.52% |
| | 2016 | | | $809.82 | $825.63 | | | | 1.95% |
| | 2017 | | | | $825.65 | $849.99 | | | 2.95% |
| | 2018 | | | | | $849.43 | $872.87 | | 2.76% |
| | *2019** | | | | | | *$844.82* | *$884.14* | *4.65%* |

** Preliminary estimates without ESRD component of projection*

# Early Preview vs. Final Projections

| | | | PY-2 | PY-1 | PY | PY+1 | PY+2 |
|---|---|---|---|---|---|---|---|
| Performance Year (PY) | 2016 | Early Preview | $ 764.81 | $ 773.86 | $ 784.38 | $ 808.82 | $ 844.93 |
| | | Final | $ 774.78 | $ 784.97 | $ 800.21 | $ 831.70 | $ 872.08 |
| | | *Difference* | *$ 9.97* | *$ 11.11* | *$ 15.83* | *$ 22.88* | *$ 27.15* |
| | 2017 | Early Preview | $ 788.54 | $ 800.94 | $ 825.00 | $ 848.48 | $ 889.45 |
| | | Final | $ 794.53 | $ 801.41 | $ 825.20 | $ 853.21 | $ 894.50 |
| | | *Difference* | *$ 5.99* | *$ 0.47* | *$ 0.20* | *$ 4.73* | *$ 5.05* |
| | 2018 | Early Preview | $ 817.81 | $ 841.40 | $ 862.40 | $ 901.00 | $ 942.33 |
| | | Final | $ 806.68 | $ 825.00 | $ 847.73 | $ 888.97 | $ 929.95 |
| | | *Difference* | *$ (11.13)* | *$ (16.40)* | *$ (14.67)* | *$ (12.03)* | *$ (12.38)* |

# Annual vs Compounding Targets

| | Annual Growth Rates | | Compounding Growth Rates (2014 Base) | |
|---|---|---|---|---|
| | USPCC Projected Growth | VT Actual Growth | USPCC Projected Growth | VT Actual Growth |
| 2014 | 1.76% | -0.22% | | |
| 2015 | 1.52% | 4.29% | 1.64% | 2.01% |
| 2016 | 1.95% | 2.94% | 1.74% | 2.32% |
| 2017 | 2.95% | | 2.04% | |
| 2018 | 2.76% | | 2.19% | |
| *2019** | *4.65%* | | *2.59%* | |

**Preliminary estimates without ESRD component of equation*

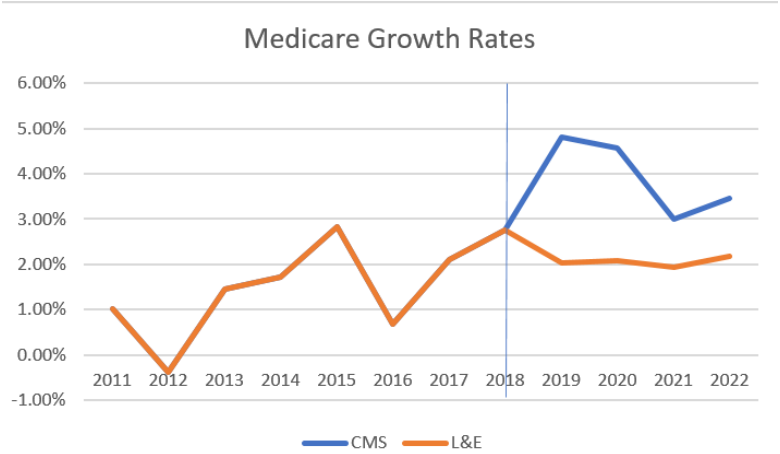
# National Medicare Growth Rate
# Lewis and Ellis

| Year | Blended FFS USPCC | Growth Rate | L&E's Blended FFS USPCC | Growth Rate |
|---|---|---|---|---|
| 2010 | $806.96 | | $806.96 | |
| 2011 | $815.16 | 1.02% | $815.16 | 1.02% |
| 2012 | $811.98 | -0.39% | $811.98 | -0.39% |
| 2013 | $823.79 | 1.45% | $823.79 | 1.45% |
| 2014 | $838.05 | 1.73% | $838.05 | 1.73% |
| 2015 | $861.86 | 2.84% | $861.86 | 2.84% |
| 2016 | $867.77 | 0.69% | $867.77 | 0.69% |
| 2017 | $886.08 | 2.11% | $886.08 | 2.11% |
| 2018 | $910.59 | 2.77% | $910.59 | 2.77% |
| 2019 | $954.42 | 4.81% | $929.04 | 2.03% |
| 2020 | $998.10 | 4.58% | $948.42 | 2.09% |
| 2021 | $1,027.95 | 2.99% | $966.77 | 1.93% |
| 2022 | $1,063.43 | 3.45% | $987.89 | 2.18% |

# National Medicare Growth Rate
# Lewis and Ellis

| Nat'l Avg | Medicare | L&E |
|---|---|---|
| No Floor | 3.72% | 2.20% |
| With Floor | 3.90% | 2.38% |

| Target | Medicare | L&E |
|---|---|---|
| No Floor | 3.52% | 2.10% |
| With Floor | 3.70% | 2.28% |



# Medicare Growth Rate
# Vermont All-Payer Model Scenarios
# Lewis and Ellis

| Year | Scenario 1 | Scenario 2 | Scenario 3 |
|---|---|---|---|
| 2018 | 3.50% | 3.50% | 2.50% |
| 2019 | 3.50% | 1.95% | 2.10% |
| 2020 | 3.50% | 1.85% | 1.90% |
| 2021 | 3.50% | 1.80% | 1.80% |
| 2022 | 3.50% | 1.80% | 1.70% |
| Average | 3.50% | 2.18% | 2.00% |

# Rates of Growth: Lewis and Ellis Recommendations

Medicare: 3.5% - the Floor – to ensure the rate is in a reasonable range to include population health investments.

Medicaid: OneCare's budget states 6.1%. This amount includes one-time rate changes and benefit changes. L&E recommends that the GMCB approve a budget that is contingent upon the Medicaid rates and trends fall within Wakely's range.

Commercial: 3.5 to 3.7% - based on the hospital budget orders and similar to the 2018 QHP filings

**Recommendations**

***The Board request a derivation of Medicaid's 6.1% to ensure the exclusion of one-time changes and benefit changes from the All-Payer TCOC Calculation.***

# Vermont Modified Next Generation ACO Benchmark Calculation

## Benchmark Calculation

2018 VT ACO benchmark = non ESRD benchmark calculation + ESRD benchmark calculation + Adjustments

= ( 2017 historical PMPY non ESRD x # of prospectively aligned ACO benes for 2018 non ESRD x 2018 trend factor non ESRD ) + ( 2017 historical PMPY ESRD x # of prospectively aligned ACO benes for 2018 ESRD x 2018 trend factor ESRD ) + ( $7.5M x blended 2018 trend factor )

| *2017 Membership* | Beneficiary Group | 2017 Historical | 2018 Projected at 3.5% |
|---|---|---|---|
| *99.60%* | non ESRD | $9,625.10 | $9,961.98 |
| *0.40%* | ESRD | $87,278.60 | $90,333.35 |
| | Blended | $9,935.71 | $10,283.46 |

# Quality Requirement in Vermont All-Payer ACO Model Agreement

**Excerpt from the Agreement:**

"A Scale Target ACO Initiative is an ACO arrangement offered by Vermont Medicaid, Vermont Commercial Plans, Vermont Self-insured Scale Target Plans, or Medicare FFS… to a Vermont ACO that incorporates, at a minimum, the following:

…The ACO Benchmark, Shared Savings, and/or Shared Losses are tied to the quality of care the ACO delivers, the health of its aligned beneficiaries, or both."

# Recommendation for Medicare Scale Target Initiative

**Goals:**

- **Quality improvement support**
- **Multi-payer alignment regarding impact of quality performance on payment**

**Recommendation #1:** Use pay-for-reporting approach to quality in 2018, consistent with first year approach in Medicare Next Gen ACO program and prior CMMI initiatives. If ACO successfully reports on quality measures, it would receive full payment.

**Recommendation #2:** From 2019-2022, mirror current Vermont Medicaid Next Generation (VMNG) model agreement negotiated between OneCare and DVHA. VMNG agreement includes a quality-related incentive pool (in addition to two-sided risk based on financial performance). Under first year of VMNG, ACO withholds 0.5% of all-inclusive population based payments received from DVHA. Withhold finances an incentive pool, which ACO uses to encourage strong and improved performance among participating providers. Recommend similar approach for Medicare Scale Target ACO Initiative, possibly increasing amount of withhold in 2020-2022.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# Medicare:
# Staff Recommendations

- Submit to CMMI for approval, a 3.5% trend factor for the Vermont Modified Next Generation ACO Program Medicare Benchmark.
    - Provides for investments at the start of the Performance Period that may be essential to achieving savings in later years.
    - Is a significantly lower rate of growth per capita than preliminary data for aligned beneficiaries suggests has been the trend.

- Use pay-for-reporting approach to quality in 2018, consistent with first year approach in Medicare Next Gen ACO program and prior CMMI initiatives. If ACO successfully reports on quality measures, it would receive full payment.

# PART II

## Accountable Care Organization Budget Review

# Actuarial Budget Overview

The GMCB employed Lewis and Ellis to provide a comprehensive review of the budget and rates. Jackie Lee, with Lewis and Ellis, will provide her impressions and recommendations at this time.

# Rates of Growth: Lewis and Ellis Recommendations

Medicare: 3.5% - the Floor – to ensure the rate is in a reasonable range to include population health investments.

Medicaid: OneCare's budget states 6.1%. This amount includes one-time rate changes and benefit changes. L&E recommends that the GMCB approve a budget that is contingent upon the Medicaid rates and trends fall within Wakely's range.

Commercial: 3.5% - 3.7% based on the hospital budget orders and similar to the 2018 QHP filings.

**Recommendations**

***The Board request a derivation of Medicaid's 6.1% to ensure that the removal of one-time changes and benefit changes.***

# DVHA

# Budget: Staff Recommendations

## Observations

Operating margin: 0.0%

Total margin: 0.0%

Administrative expense ratio: 2.0%

Debt ratio: 1.0

Current ratio: 1.0

| PHM/Payment Reform Programming | Budgeted Amount | % of Revenue |
|---|---|---|
| Value-Based Incentive Fund | $4,305,223 | 0.7% |
| Basic OCV PMPM | $4,781,010 | 0.8% |
| Complex Care Coordination Program | $7,064,722 | 1.1% |
| PCP Comprehensive Pmt. Reform Pilot | $1,800,000 | 0.3% |
| Community Program Investments (RiseVT) | $1,577,600 | 0.2% |
| CHT/SASH/PCP (Risk & Non-Risk) | $7,762,501 | 1.3% |
| Total | $27,291,056 ($18.55 PMPM) | 4.4% |

## Recommendations

- ***GMCB should monitor the ratio of PHM/Reform payments to total revenue throughout the year to ensure it remains constant as attrition occurs.***
- ***Administrative expense is appropriately allocated by state (i.e. VT vs. NY)***
- ***The administrative expense ratio is consistent with the budget as submitted and will be monitored year over year based on national data. ***
- ***If the administrative expense ratio, due to attrition, increases more than 1%, the ACO must alert the Board.***

# Monitoring ACO Related Hospital Spend

**Maximum Risk for Hospitals by Payer**

| Hospital | Medicare | VT Medicaid | Commercial | Total Risk |
|---|---|---|---|---|
| BMH | $975,363 | $142,879 | $228,331 | **$1,346,573** |
| CVMC | 2,414,137 | 472,455 | 610,906 | **3,497,498** |
| DHMC | 0 | 147,978 | 348,955 | **0** |
| Mt. Ascutney | 0 | 83,530 | 0 | **83,530** |
| NCH | 0 | 260,281 | 0 | **260,281** |
| NMC | 1,162,374 | 267,472 | 198,260 | **1,628,106** |
| Porter | 1,565,707 | 303,793 | 228,205 | **2,097,705** |
| Springfield | 1,324,004 | 221,081 | 228,205 | **1,773,290** |
| SVMC | 0 | 404,598 | 0 | **404,598** |
| UVMMC | 6,448,026 | 1,260,931 | 1,892,954 | **9,601,911** |
| **Total** | **$13,889,611** | **$3,564,998** | **$3,735,816** | **$21,190,425** |

The GMCB is monitoring how the hospitals are accounting for risk.

GMCB will ensure that the amounts match information from the ACO through monthly monitoring of hospital budgets.

# Risk Mitigation: L&E Recommendations

**Summary**

Risk Corridor

Reinsurance

Prospective Hospital Payments

| Risk Corridor Arrangements by Payer | | |
|---|---|---|
| **Payer** | Corridor | OneCare's Share |
| **Medicaid** | 97% - 103% | 100% |
| **Medicare** | 95% - 105% | 80% |
| **Commercial** | 94% - 106% | 50% |

**Observations**

In 2018, OneCare will start having shared risk with the added downside.

OneCare has a $1.5M expense for reinsurance.

OneCare does not have a reserve.

OneCare has shifted most risk.

**Recommendations**

***The Board should order that OneCare maintain the risk arrangements represented in the budget submission. The Board should order that OneCare secure reinsurance coverage or establish a reserve that covers a significant portion of its downside risk.***

# Model of Care:
# Staff Recommendation

**Summary**

OCV presented a comprehensive model of care that complied with elements of Act 113 criteria in the areas of governance, care coordination, and analytics. This is a decentralized case management and clinical prioritization approach that relies on the foundation built by the Blueprint for Health and existing community collaboratives.

**Recommendation**

***If OCV's model of care is not effective in supporting achievement of Total Cost of Care (TCOC) and quality targets, the ACO may need to consider refining the current approach or seek a different approach in future years.***

# Population Health Measures: Staff Recommendation

**Summary**

OCV has quality measures to meet within their three payer contracts. GMCB noted that they also have strategies in place to begin to address two of the three population health measures. GMCB staff hypothesize that OCV must support its network in providing care that will contribute to the reduction of deaths due to substance use.

**Recommendation**

***OCV should assess the number of Medication Assisted Treatment (MAT) providers in their network to determine its capacity for Substance Use (SUD) treatment. Staff suggest that OCV make such an assessment and report and identify next steps by the end of the second quarter of 2018.***

***OCV will continue to provide information on ACO initiatives to address APM measures as requested by GMCB.***

# Multi-Payer Program Alignment: Staff Recommendation

**Summary**

OCV will be contracting with three or more payers. Per the Agreement, GMCB must analyze the scale target initiatives and determine how they compare and contrast. The Vermont Medicaid Next Generation contract closely aligns. The Commercial agreement is not yet available for review.

**Recommendation**

***Require OCV to submit an analysis of how their commercial program/contract aligns with Medicare and Medicaid programs on the categories of:***

- ***Total cost of care***
- ***Attribution and payment mechanisms***
- ***Patient protections***
- ***Provider reimbursement strategies***
- ***Quality measures***

# Summary of Next Steps and Recommendations for 2018

1. Submit final information when available, including contracts
2. Suggest rates of growth for 2018:
    - Medicare 3.5%
    - Medicaid – approve within the Wakely range
    - Commercial 3.5%-3.7%
3. The ACO should maintain current risk model, and document reinsurance or reserves.
4. GMCB should monitor the ratio of PHM/Reform payments to total revenue throughout the year to ensure it remains constant as attrition occurs.
5. Ensure that administrative expense is appropriately allocated by state (i.e. VT vs. NY).
6. OCV's administrative expense ratio should be consistent with the budget as submitted and will be monitored year over year based on national benchmark(s).
7. If OCV's administrative expense ratio, due to attrition, increases more than 1%, the ACO must alert the board.
8. OCV should report to GMCB on how the commercial contract aligns with other payers.
9. OCV should perform an assessment of MAT prescribers in OCV network.

# Recommendations for 2019 Budget Guidance

1. Submissions from the ACO should include an analysis of spending growth that considers the ACO's populations and services. This analysis should be used to devise strategies for savings and efficiencies to be reported to the Board.
2. Budget submissions should include multi-year projections.
3. The Board should consider developing a measure of ACO Primary Care Spend that differentiates between investments in primary care and spending on primary care service delivery, both in terms of price and utilization. Staff advise seeking stakeholder input on such a measure.
4. The Board should discuss possible conditions for investments in future years, including how any new population health investments are 1) related to the needs of the community 2) balance a state-wide approach with regional innovation and 3) are consistent with the CHNA done by the hospital.
5. Subsequent budget submissions should provide program evaluation results, and/or the evidence-base, for each targeted investment. If no evidence-base is available, justification for the investment should be provided.
6. The Board should monitor the administrative expense ratio year over year, based on national data.

# Recommendations for 2019 Budget Guidance

7. Staff appreciate DFR suggestions for potential mechanisms to further mitigate solvency concerns. Where the DFR suggestions are not already being met by this budget review, staff will engage the DFR to further develop an understanding of risk sharing arrangements and their impact on ACOs as well as insurers' rate filings, liabilities, and financial statements.

8. The Board should work with payers and the ACO to determine the best and final date for submission of materials for 2019.

9. The Board should examine the degree to which the Medicaid rate provided to the ACO maintains, lessens, or widens the differential with other payers participating in the ACO Model for same services.

10. The Board may want to consider evaluating how ACOs use health resources data in planning.

# Recommendations for 2019 Budget Guidance

11. The Board should debrief with the HCA and OCV to consider potential improvements for next year.

12. The Board should utilize APCD to monitor ACO's impact on cost and quality measures, as required by APM.

13. The Board should review commercial contract for alignment and the presence of anti-steering or anti-tiering provisions, restrictions on insurer's ability to provide cost and quality information to members, and other types of conduct the FTC and DOJ have identified as potentially problematic.

14. The Board should work on additional guidance/policy regarding antitrust issues and what would be appropriate for an AG referral.

# Resources

# Act 113 of 2016
# ACO Budget Criteria Statutory Requirements

(b) (1) The Green Mountain Care Board shall adopt rules pursuant to 3 V.S.A. chapter 25 to establish standards and processes for reviewing, modifying, and approving the budgets of ACOs with 10,000 or more attributed lives….In its review, the Board shall review and consider:

- Character, competence, fiscal responsibility, and soundness of the ACO and its principals, including reports from professional review organizations
- Arrangements with ACO's participating providers
- How resources are allocated in the system
- Expenditure analysis of previous, current, and future years
- Integration of efforts with Blueprint for Health, community collaboratives and providers
- Systemic investments to:
  - Strengthen primary care
  - Address social determinants of health
  - Address impacts of adverse childhood experiences (ACEs)
- Solvency
- Transparency

# Act 113 of 2016
# All-Payer Model Criteria for Implementing a Value-Based Payment Model

- Alignment of payers
- Strengthens and invests in primary care
- Incorporates social determinants of health
- Includes process for integration of community-based providers
- Prioritizes use of existing local and regional clinical collaboratives
- Pursues an integrated approach to data collection, analysis, exchange
- Requires process and protocols for shared decision making
- Supports coordination of patient care and care transitions through use of technology
- Ensures consultation with the Health Care Advocate

# 2018 ACO Budget Review: Timeline

June 23, 2017 – OneCare Vermont and CHAC first submission

July 13, 2017 – OneCare Vermont and CHAC presentations

October 19, 2017 – CHAC submits budget withdrawal

October 20, 2017 – OneCare Vermont second submission

November 2, 2017 – OneCare Vermont second presentation

December 12, 2017 – Staff recommendations

December 21, 2017 – ACO budget (potential vote)