

2019 Budget Guidance and Reporting Requirements for Vermont Certified Accountable Care Organization: OneCare Vermont, ACO, LLC

Version 1.0

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Prepared by:

GREEN MOUNTAIN CARE BOARD

144 State Street

Montpelier, Vermont 05602



BACKGROUND

Please see below the Accountable Care Organization Budget Guidance and Reporting Requirements adopted by the Green Mountain Care Board (GMCB) for Budget Year 2019. This document is to be used by the certified Vermont Accountable Care Organization: **OneCare Vermont ACO, LLC**. A certified ACO must maintain its certification in order to receive payments from Vermont Medicaid or a commercial insurer. The GMCB will review a certified ACO's continued eligibility for certification concurrently with its proposed budget.

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 will participate in the budget review process, including hearings.

2018 TIMELINE FOR 2019 BUDGET SUBMISSION (subject to change)

- By August 1: GMCB provides ACOs with reporting guidance
- October 1: ACOs submit budgets to GMCB
- October 17: ACO budget presentation to Board
- November 7: GMCB staff presents analysis to the Board
- November 7-21: Public Comment
- November 28: GMCB votes to establish the ACOs' budgets at public meeting
- December 15: GMCB issues written orders to ACOs

For questions about this guidance, please contact Melissa Miles at 802-828-2177 or melissa.miles@vermont.gov.

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PART I. REPORTING REQUIREMENTS

Section 1: ACO INFORMATION AND BACKGROUND

1. Provide an executive summary of the changes in the Accountable Care Organization's (ACO) budget submission from 2018 to 2019. Include major network changes; program highlights; programmatic, staffing, and operational changes; and any assumptions made to create the budget submission.

Section 2: ACO PROVIDER NETWORK

1. Provide, as an attachment, a completed **2019 ACO Provider Network Template (Appendix 2.1)**.
2. Provide a written summary analysis of the **2019 ACO Provider Network Template (Appendix 2.1)**, highlighting any changes from 2018 to 2019, including changes in network by Health Service Area.
3. Submit, as an Excel spreadsheet (printout not required), your provider list submitted to Medicare for your 2019 Next Generation program.
4. The All-Payer ACO Model Agreement contains Medicare and all-payer scale targets. The State will need to evaluate an ACO's payer contracts to determine if they meet the definition of a "Scale Target ACO Initiative."¹ There are several areas that may impact scale, including payer participation (including self-insured plans), provider participation, and attribution methodology. Please provide a written plan on the ACO's strategies during the remaining years of the Agreement to work with the State and other stakeholders to increase payer participation, increase provider participation, and develop changes to attribution methodology, with the goal of maximizing scale and achieving scale targets. Please provide the ACO's targets by year for both providers and attributed lives, by Health Service Area.
5. Provide, as an attachment, a completed **2019 Summary ACO Provider Network Template (Appendix 2.2)**, which will include, by Health Service Area:
 - a. Count of providers by provider type and specialty; and
 - b. Count of Enrollees.
6. For each ACO provider that will assume risk in 2019, describe the ACO's risk arrangements with the provider, including:

¹ A "Scale Target ACO Initiative" is defined in section 6.b. of the Agreement.

- 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. The risk mitigation measures the ACO requires of or undertakes for the provider, if any (e.g., reinsurance, reserves).
7. Provide, as an attachment, a completed **2019 Health Service Areas and Associated Risk Totals (Appendix 2.3) and a 2019 Budgeted Risk Model (Appendix 2.4)**
 8. Submit copies of each type of your provider contracts and agreements (i.e. risk contracts, non-risk contracts, collaboration agreements).

Section 3: ACO PAYER PROGRAMS

1. Provide copies of existing agreements or contracts with payers if they have been updated since they were submitted to the GMCB. If 2019 contracts are not available, please submit the contracts as an addendum when they are signed. Also include the latest Next Generation benefit enhancement implementation plans.
2. By payer and line of business, provide an analysis of your most recent annual ACO quality reports for measures. In addition, please include a copy of the results for each contract.
3. If applicable, by payer and line of business, describe program arrangement(s) between the payer and the ACO including:
 - a. Full risk, shared risk, shared savings, other (please specify);
 - 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 percentage of upside gain for the ACO, if any;
 - f. The cap on upside gain for the ACO, if any;
 - g. 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)
 - h. Method for setting the budget target;
 - i. Trended historical experience
 - ii. Percentage of premium
 - iii. Other (please describe)
4. Complete **Appendix 3.1 Program Arrangements** with the same information as above.

5. Provide an explanation for your projected growth rates, referencing Part II: Budget Guidance, which provides background on the All-Payer and Medicare Total Cost of Care per Beneficiary Growth outlined in the Vermont All-Payer ACO Agreement.

6. The All-Payer ACO Model Agreement requires Scale Target ACO Initiatives to be aligned on key design dimensions, including categories of services, benchmark tied to savings, beneficiary alignment, and quality measures. Complete the table below to describe how your ACO Initiatives are aligned across all payers, how they are different, and a justification for the differences. In addition, provide a written summary if any of the following categories are significantly different from 2018-2019.

a. By payer, for 2019, include any categories of services for aligned beneficiaries that will be included in your contracts for determination of the ACO's savings or losses that are different from Medicare Part A and B services. In addition, please include a copy of each contract's language.	
Commercial	
Commercial Self-Funded	
Medicaid	
Medicare	

b. By payer, describe how the proposed ACO benchmark, capitation payment, AIPBP, shared savings and losses, or any other financial incentive programs are tied to quality of care or health of aligned beneficiaries (i.e. percentage of revenues withheld for quality incentive payments, uses of withholds: incentives tied to provider-level, HSA-level or ACO-level results). In addition, please include a copy of each contract's language.	
Commercial	
Commercial Self-Funded	
Medicaid	
Medicare	

c. By payer and line of business, describe the current or proposed methodology for beneficiary/member alignment (also known as attribution). In addition, please include a copy of each contract's language.	
Commercial	
Commercial Self-Funded	
Medicaid	
Medicare	

d. By payer and line of business, 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. In addition, please include a copy of each contract's language.	
Commercial	
Commercial Self-funded	
Medicaid	
Medicare	

Section 4: ACO BUDGET AND FINANCIAL PLAN

1. Submit most recent audited financial statements.
2. Complete the GMCB financial statement templates (**Appendices 4.1-4.3**).
3. Provide, as an attachment, a completed **Appendix 4.4-4.7**. The Appendix requests the ACO, by payer and line of business, to provide information on projected revenues and expenses to flow through the ACO financial statements (including payer revenues, participating provider dues, and grant funding), medical costs and administrative costs (including contracted services, community investments and contribution to reserves), in total dollars and per member per month (PMPM) dollars when applicable. The GMCB may request additional information or copies of grants or agreements as part of the review.

4. Complete all tabs of **Part 4.8 Appendix – ACO 2019 Budget Submission Reporting APM for Participating Hospitals** for the 2019 budget year.
5. Provide a narrative description of the following elements of the ACO's spending plan:
 - a. Relevant industry benchmarks used in developing the administrative budget;
 - b. The methodology for determining the qualification for and amount of any provider incentive payments and how those payments align with ACO performance incentives, which may include contractual agreements measures and outcomes.
 - c. Quantity of Delivery System Reform dollars and associated goals for stated investments;
 - d. Strategy for planned spending on health information technology, at the ACO level and to support individual providers;
 - e. Budget assumptions related to service utilization, including anticipated changes from prior years' utilization, including anticipated changes in care delivery including but not limited to new and innovative services, service mix, value-based payment model adoption (including risk assumption); and
 - f. Anticipated changes in provider network configuration, and the expected impact on service utilization.
6. Provide a narrative description of the flow of funds in the system or, if described in the ACO's 2018 budget submission, any changes from that submission. The description should include the flow of funds from payers to the ACO, and from the ACO to its providers. The description should demonstrate the ability of the ACO to maintain sufficient funds to support its administrative operations and meet provider payment obligations.
7. Provide a quantitative analysis with accompanying narrative to demonstrate how the ACO would manage the financial liability for 2019 through the risk programs included in Part 3 should the ACO's losses equal to 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 delegated through fixed payment models to ACO-contracted providers and the percentage overrun on total expecting spending outside the ACO's fixed payment models that would result in losses of 75% and 100% of the ACO's maximum downside exposure;
 - b. Portion of risk covered by ACO providers through mechanisms other than fixed payment models (e.g., withholds, commitment to fund losses at annual settlement, etc.);

- c. Portion of 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;
 - d. Portion of the risk covered by reinsurance;
 - e. Portion of the risk covered through any other mechanism (please specify);
 - f. Any risk management or financial solvency requirements imposed on the ACO payers under ACO program contracts appearing in Part 3.
8. Provide an actuarial opinion that the risk-bearing arrangements between the ACO and payers are not expected to threaten the financial solvency of the ACO.
 9. Provide any further documentation (i.e. policies) for the ACO's management of financial risk.

Section 5: ACO QUALITY, POPULATION HEALTH, MODEL OF CARE, AND COMMUNITY INTEGRATION INITIATIVES

1. List in the table in **Appendix 5.1, 2018 and 2019 ACO Clinical Priority Areas**, the ACO's 2018 clinical and program priorities, including metrics, targets, and results to date. In addition, list 2019 clinical and program priorities, metrics, and targets. Describe in narrative form progress made on your clinical priorities in the past year, including successes and opportunities for improvement.
2. Provide a completed **Appendix 5.2, 2018 and 2019 Network and/or ACO Initiatives to Address All-Payer ACO Model Quality Measures**, to briefly describe results to date on ACO initiatives to address the quality measures.
3. Describe how you are using surveys, qualitative input, or other methods to assess and improve patient experience and provider satisfaction with the state's transition to a value-based payment model.
4. In **Appendix 5.3, ACO Population Risk Stratification Summary Analysis 2018/2019**, provide a summary analysis of your population, including variations in risk by health service area; a breakdown of population distribution and associated spend into the four population health quadrants, by health service area.
5. Provide a progress report on the implementation of Care Navigator. In **Appendix 2.1, Provider Network**, the ACO will report the organizations that are using the tool by health service area. In addition, the ACO shall report:
 - a. The number of active users (i.e. those who use the tool daily by Health Service Area);
 - b. The number of patients with information in the system by Health Service Area;
 - c. The number of patients with shared care plans in the system by Health Service Area;

- d. A summary of how you are incorporating provider and patient input on Care Navigator (if possible, include a summary of input from providers who have opted not to use Care Navigator); and
- e. Progress made on the evaluation plan for Care Navigator, as described in your 2018 budget submission.
6. Describe how you are measuring success of the care model, including numbers of patients receiving care management interventions, the number of care management encounters by type of intervention, and measures of success (e.g., utilization by category of service, quality measure results). Provide results if available.
7. Describe the ACO's network capacity for substance use disorder (SUD) treatment programs, including number of practices and/or providers participating in MAT programs, wait time information, and available slots for treatment. This may include current or planned initiatives.
8. Describe implementation of the ~\$1,577,600 outlined in your 2018 Community Program Investments 2018 Guidance for, which included expansion of RISE VERMONT. Include goals, metrics, outcomes, and achievements and opportunities for improvement thus far.
9. Populate **Appendix 5.4, 2018 Projected Population Health Investments Update** with information submitted in last budget cycle and complete **Appendix 5.5: 2019 Budgeted Population Health Investments** to include:
- Program name
 - Program description
 - Investment amount
 - Operational models
 - Financial models
 - Recipients
 - Program goals

Per 18 V.S.A. § 9382, population health program financial investments should include:

- a. Strategies to bring primary care providers into the network
 - b. Strategies for expanding capacity in existing primary care practices, including but not limited to reducing administrative burden on such practices
 - c. Integration of community-based providers, including expanding capacity to promote seamless coordination of care across the care continuum
 - d. Population health programs, including:
 - i. preventing hospital admissions or readmissions
 - ii. reducing length of hospital stays
 - iii. improving population health outcomes, with a focus on the All-Payer ACO Model measures found in Appendix 5.2 APM Quality Measures
 - iv. addressing social determinants of health
 - v. addressing childhood experiences and trauma
 - vi. supporting and rewarding healthy lifestyle choices.
10. Describe planned ACO investments in community-based provider capacity, efforts to include community-based providers in decision-making and policy development, and efforts to avoid duplication of resources.
11. Refer to PART III: Primary Care Spend Measurement and use the specifications provided to report on your proportion of primary care spent by payer for 2017, 2018, and 2019.

PART II. BUDGET GUIDANCE

In deciding whether to approve or modify an ACO's proposed budget, the Board will take into consideration the requirements of the Vermont All-Payer Accountable Care Organization Model Agreement (the Agreement), including the All-payer Total Cost of Care per Beneficiary Growth Target, the Medicare Total Cost of Care per Beneficiary Growth Target, the ACO Scale Targets, and the Statewide Health Outcomes and Quality of Care Targets. GACB Rule 5.000, § 5.405(b), (c). As described in more detail below, the Agreement also limits the Board's discretion in prospectively establishing benchmarks for the Vermont Medicare ACO Initiative (i.e., the financial targets against which expenditures for services furnished to ACO-aligned Medicare beneficiaries will be assessed).

Section 1: Growth Rate Ceiling for the Vermont Medicare ACO Initiative Benchmarks

Under the Agreement, the Centers for Medicare and Medicaid Services (CMS), in collaboration with the State of Vermont, will launch the Vermont Medicare ACO Initiative, which will begin on January 1, 2019. The Board will prospectively develop, in accordance with the requirements of the Agreement and

subject to CMS approval, a benchmark for each ACO participating in the initiative.² To guide ACOs in developing their 2019 budgets, this section describes the growth rate ceiling for these benchmarks—the maximum rate of growth the Agreement will allow the Board to use in developing the benchmarks, as the Board understands it based on current data. The actual growth rate approved by the Board may be lower than described below and is subject to CMS approval.

Under the terms of the Agreement, the Vermont Medicare ACO Initiative Benchmarks for 2019, Performance Year 2 of the Agreement, must be established so that either:

- 1) the *annual* growth rate is at least 0.2 percentage points below the projected *annual* growth from 2018 to 2019 for Medicare nationally³; or
- 2) the *compounded annualized* growth rate is at least 0.1 percentage points below the projected *compounded annualized* growth rate (CAGR) from 2017 to 2019 for Medicare nationally.

National Medicare estimates are derived from the annual announcements of Medicare Advantage United States Per Capita Fee-For-Service Projections (“MA USPCC FFS Projections”). The projections⁴ for Performance Year 2 were:

Population	Calendar Year		Rate
	2018	2019	
Aged and Disabled	\$856.41	\$891.07	4.0%
End Stage Renal Disease	\$7,586.28	\$7,833.28	3.3%
Blended ⁵	\$880.64	\$916.06	See calc.

$$2019 \text{ Annual Projected National Medicare TCOC per Beneficiary Growth} = \frac{\$916.06}{\$880.64} - 1 = 4.0\%$$

$$2019 \text{ CAGR} = (1.037 * 1.040)^{\frac{1}{2}} - 1 = 3.8\%$$

Thus, as the Board currently understands it, the Agreement requires the Board to use a growth rate of no more than 3.8% (using the annual growth rate) or 3.7% (using the CAGR) when developing the Vermont Medicare ACO Initiative Benchmarks for 2019.

² Underneath the overall benchmark, separate benchmarks will be established for two Medicare fee-for-service populations, the End-Stage Renal Disease (ESRD) population and the Aged and Disabled (A/D or non-ESRD) population.

³ This is so under section 8.b.ii.1.c.i because the Annual Projected National Medicare Total Cost of Care per Beneficiary Growth for Performance Year 1 of the APM Agreement (2018) was less than 3.7 percent.

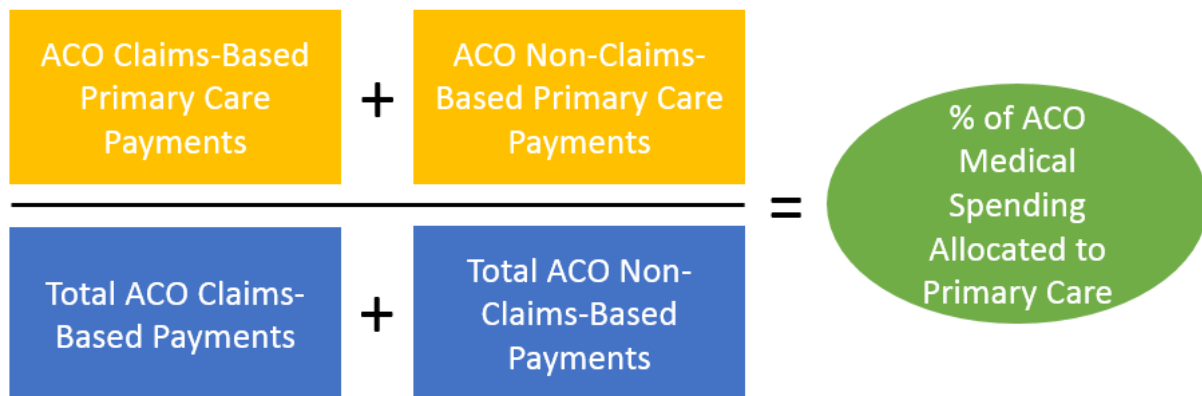
⁴ <https://www.cms.gov/Medicare/Health-Plans/MedicareAdvgtgSpecRateStats/Downloads/Announcement2019.pdf>

⁵ Using the Vermont proportion of 2017 ESRD beneficiaries, 0.360%.

Part III. ACO Primary Care Spend Measurement

In an effort to best capture current spending on both an ACO and Statewide basis, the GMCB, along with stakeholders, has developed a metric to measure primary care spending. Over time, this metric could be used to assess ACO investments in primary care. Per Rule 5.000, “[t]he ACO must submit: information on the extent to which the ACO provides incentives for systemic health care investments to strengthen primary care, including strategies for recruiting additional primary care providers, providing resources to expand capacity in existing primary care practices, and reducing the administrative burden of reporting requirements for providers while balancing the need to have sufficient measures to evaluate adequately the quality of and access to care...” (5.403 (a)(17)).

To calculate the annual (calendar year) percentage of total medical spending on primary care for ACO-attributed lives, the sum of ACO claims-based and ACO non-claims-based payments to primary care providers is divided by the sum of total ACO claims-based and ACO non-claims-based payments to all providers.



Frequency: For this test year submission, the GMCB is requesting the ACO to submit information for CY 2017 actuals, CY 2018 projected and CY 2019 budget. Moving forward, this measure will be collected annually through the ACO budget process and on an ad hoc basis as requested for monitoring purposes.

Calculation: Using the formula outlined above, the percent of ACO spending allocated to primary care should be presented in the following ways, as both a percentage of total spend, and as a PMPM measure:

1. All-Payer ACO primary care medical spending
2. Medicaid ACO primary care medical spending
3. Medicare ACO primary care medical spending
4. Commercially-insured ACO primary care medical spending
 - a. QHP
 - b. Self-insured

Section 1. Claims-Based Spending

Numerator: The total ACO primary care claims spend by payer as calculated using the taxonomies and CPT codes identified below.

Included Provider Types:

- Family Practice
- Internal medicine with no subspecialty
- Internal medicine with subspecialty of geriatrics
- Pediatrics with no subspecialty
- General practice
- Nurse practitioner
- Physician assistant
- Naturopath
- Osteopath
- OB/GYN

Included CPT Codes:

Group	Description	Codes
Office Visit	Office Visit	99201-99205, 99211-99215
	Prolonged Service Office Visit	99354, 99355
	Hospital Outpatient Clinic Visit	G0463 (Medicare only)
Encounter Payment	Clinic Service (FQHCs)	T1015
Preventive Visit	Comprehensive Preventive Medicine	99381-99387, 99391-99397
	Preventive Counseling	99401-99404, 99411, 99412
	Smoking Cessation Counseling	99406, 99407
	Alcohol/Substance Abuse Screening	99408, 99409
	Health Risk Assessment	99420
	Unlisted Preventive Service	99429
	Initial Preventive Physical Exam	G0402
	Annual Wellness Visit	G0438, G0439
Vaccine Administration	Immunization Administration	90460, 90461, 90471-90474
	Flu Vaccine Administration	G0008
	Pneumonia Vaccine Administration	G0009

Care Management	Transitional Care Management	99495, 99496
CCM Codes	Chronic Care Management	99490, 99487, 99489, G0506
OB/GYN	Routine Obstetric Care	59400, 59510, 59610, 59618

Denominator: Total ACO expenditures by payer.

Section 2. Non-Claims-Based Spending

Numerator: payments to primary care providers and practices within the ACO, by payer, including:

- Capitation payments
- Payments for PCMH recognition (ex. percent of extended Blueprint funding to PCMH practices)
- Payments to reward achievement of quality or cost-savings goals (ex. percent of VBIF allocated to primary care)
- Payments aimed at developing capacity to improve care for a defined population of patients, such as patients with chronic conditions (ex: pilot program for comprehensive payment to primary care practices)
- Payments to help providers adopt HIT
- Payments or expenses for supplemental staff or activities, such as practice coaches, patient educators, patient navigators or nurse care managers (ex. percent of Care Coordination Model)
- Complex Care Coordination Program
- Payments for CHT
- Process improvement/other quality management activities
- Recruitment and retention incentive payments for primary care providers within the ACO network
- Shared Savings payments to ACO network primary care providers

Denominator: payments to all ACO providers and practices, by payer, including:

- Capitation payments
- Payments for PCMH recognition
- Payments to reward achievement of quality or cost-savings goals (ex. VBIF)
- Payments aimed at developing capacity to improve care for a defined population of patients, such as patients with chronic conditions
- Payments to help providers adopt HIT
- Payments or expenses for supplemental staff or activities, such as practice coaches, patient educators, patient navigators or nurse care managers (ex. Care Coordination Model)
- Complex Care Coordination Program
- Payments for CHT

- Process improvement/other quality management activities
- Recruitment and retention incentive payments for ACO network providers
- Shared Savings payments to ACO network providers

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