Green Mountain Care Board
144 Main Street
Montpelier, VT 05602

[phone] 802-828-2177
www.gmcboard.vermont.gov

2019 Budget Guidance and Reporting Requirements for Vermont Non-Certified Accountable Care Organizations

Draft – June 13, 2018

Prepared by:

GREEN MOUNTAIN CARE BOARD

144 State Street

Montpelier, Vermont 05602

BACKGROUND

Please see below The Green Mountain Care Board's (GMCB) Accountable Care Organization (ACO) Annual Reporting and Budget Guidance for Budget Year 2019. This document is to be used by any Accountable Care Organization that is not certified. 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. 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 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
November 7:	ACO budget presentation to Board
November 14:	GMCB staff presents analysis to the Board
November 14-27:	Public Comment
December 12:	GMCB votes to establish the ACOs' budgets at public meeting
December 12 or 19:	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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The Green Mountain Care Board's Accountable Care Organization Budget Guidance - 2019

Instructions: For ACOs with less than 10,000 lives or who are not taking risk, please answer questions or sections with an (*). For ACOs with more than 10,000 lives or are taking risk, please answer all questions in this Guidance.

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 Board and their organizational affiliation (for consumer members, identify whether the member is a Medicaid beneficiary, a Medicare beneficiary and/or a commercial insurance plan member);
    c. Board officers;
    d. Board committee and subcommittee structure, as applicable;
    e. Description of Board voting rules; and
    f. Copy of ACO bylaws, 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.

6. Provide a list of ACO employees, direct or contracted, their titles, and an organizational chart.

7. Describe any legal actions taken against the ACO or against any members of the ACO's executive leadership team or Board of Directors related to their duties.

8. 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 his or her duties, or professional fiscal irresponsibility.

9. 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, as an attachment, a completed **Appendix A1 – ACO Provider Network Template** which will include*:
    a. Name
    b. 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.)
    c. 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.

2. Provide, as an attachment, a completed **Appendix A2 – Summary ACO Provider Network Template** which will include*:
    a. Count of providers by provider type and specialty, by county

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 the ACO places on the provider, if any (e.g., reinsurance, reserves).

4. Submit provider contracts as requested by the GMCB.

Section 3: ACO PAYER PROGRAMS

1. Provide copies of existing agreements or contracts with payers. If 2019 contracts not available, please submit as an addendum when signed*.

2. Provide a completed **Appendix B – 2018 ACO Program Elements by Payer** template which will include*:
    a. Payer and line of business with which the ACO has agreements:
        i. Medicaid
        ii. Medicare
        iii. Commercial: Individual and Small Group (Vermont Health Connect)
        iv. Commercial: Large Group
        v. Commercial: Self-insured
        vi. Commercial: Medicare Advantage
    b. Attributed lives by payer and line of business
    c. Projected spending associated with attributed lives by payer and line of business
    d. Projected percentage growth rate or projected PMPM for 2019 for All-Payer ACO Model targets. If not available, please use prior years' data and describe.

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

5. By payer, 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*.

6. 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. For public payers, the applicant may provide a link to publicly-available materials. Provide the most recent annual ACO quality reports for measures included in agreements with payers*.

7. By payer and line of business, describe the current or proposed methodology used for beneficiary/member alignment (also known as attribution). If these differ significantly by payer, please describe. Complete a master table in template to be provided of attribution for each program and by Health Service Area (HSA)*.

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. Answer a or b, according to your type of contractual agreements with payers*:

a. For ACOs who have fewer than 10,000 attributed lives or who are not taking risk, in aggregate forecast for July 1, 2019 across all lines of business, submit the ACO's medical expense and administrative expense budget for 2019.

b. 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. Provide a narrative description of the following elements of the ACO's spending plan:
   a. ACO industry benchmarks used in developing the administrative budget;
   b. The methodology determining the qualification and amount of eligible 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. Planned spending on SASH and Blueprint for Health by payer (including practice payments and Community Health Team payments), in comparison with 2016 and 2017 spending levels;
   e. Strategy and spending on community investments (e.g. early childhood development, housing, mental health, substance use, and other services that address social determinants of health);
   f. Strategy for planned spending on health information technology, at the ACO level and to support individual providers;
   g. 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
   h. Anticipated changes in provider network configuration, and the expected impact on service utilization.

5. Provide a narrative description of the flow of funds in the system. 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.

6. 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 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;
e. Portion of the risk covered through any other mechanism (please specify);
f. 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.

7. 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.
8. Provide any further documentation (i.e. policies) for the ACO's management of financial risk.

Section 5: ACO MODEL OF CARE AND COMMUNITY INTEGRATION*

Of note: The board will consider size and scope of ACO when reviewing responses to this section.

1. Describe the ACO's Model of Care, including but not limited to how it may address:
    a. Support for person-directed care;
    b. Support for appropriate utilization;
    c. Seamless coordination of care across the care continuum, including 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. Integration efforts with the Vermont Blueprint for Health, regional care collaboratives and other state care coordination initiatives;
    e. Identification of, and care coordination interventions for, high risk and very high risk patients; and
    f. Use of comprehensive integrated/shared care plans and interdisciplinary care teams.

2. Describe new strategies for bringing primary care providers into the network.

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

4. Describe the participation and role of community-based providers that are included in the ACO, including any proposed investments to expand community-based provider capacity and efforts to avoid duplication of existing resources.

5. Describe the ACO's population health initiatives, including programs aimed at preventing hospital admissions or readmissions, 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 measure success of these initiatives, and what will constitute success.

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

7. Provide a completed **Appendix D – ACO initiatives to address All-Payer ACO Model Quality Measures** to briefly describe ACO initiatives to address measures.

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. GMCB 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.[1] 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 nationally[2]; 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 projections[3] for Performance Year 2 were:

	Calendar Year		Rate
Population	2018	2019	
Aged and Disabled	$856.41	$891.07	4.0%

[1] 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.
[2] 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.
[3] https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2019.pdf

End Stage Renal Disease	$7,586.28	$7,833.28	3.3%
Blended[4]	$880.64	$916.06	See calc.

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

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

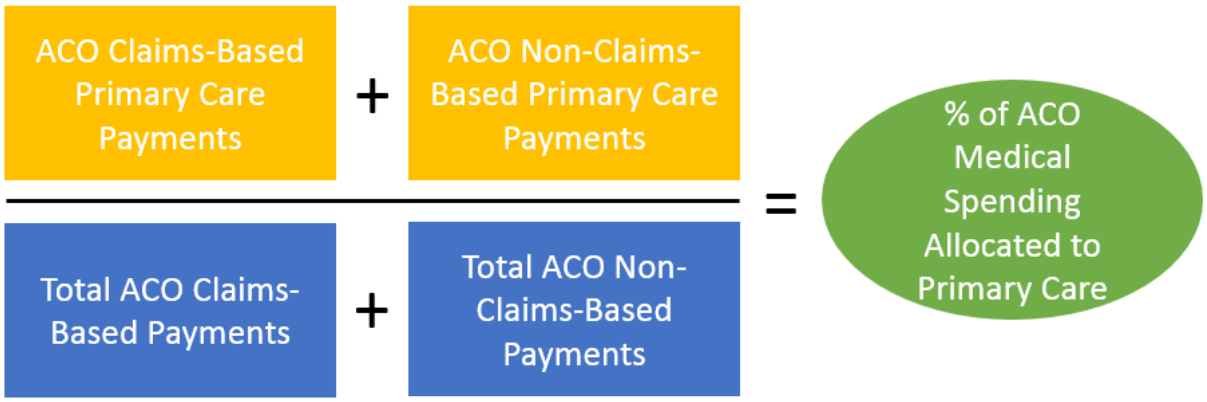
Thus, as the Board currently understands it, the Agreement requires the Board to use a growth rate of no more than 3.8% (using the annual growth rate) or 3.7% (using the CAGR) when developing the Vermont Medicare ACO Initiative Benchmarks for 2019.

[4] 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