



**2019
Green Mountain Care Board
Accountable Care Organization (ACO)
Regulatory Oversight**

June 13, 2018

ACO Budget Review vs. Certification

- 18 V.S.A. § 9382 and Rule 5.000 distinguish between two processes:
- ACO Budget Review (annual)
- ACO Certification (one-time with annual verification)

Agenda

- ACO Budget Review Criteria
 - Statutory Criteria
 - All-Payer ACO Model Agreement

- 2019 Processes
 - Review ACOs' 2019 Budgets and Payer Programs
 - Verify OneCare's Continued Eligibility for Certification

- ACO Budget Guidance and Reporting Requirements for 2019
 - Timeline for public comment and vote

ACO Budget Review Criteria

- Rule 5.000 says that in deciding whether to approve or modify the proposed budget of an ACO, the Board will consider the criteria listed in 18 V.S.A. § 9382 and any applicable requirements of the All-Payer ACO Model Agreement.

- **Statutory Criteria:** 18 V.S.A. § 9382(b) lists 15 criteria, including, for example,
 - Information re: utilization of health care services delivered by health care providers participating in the ACO and the effects of care models on appropriate utilization, including the provision of innovative services;
 - ACO's efforts to prevent duplication of high-quality services being provided by existing community based providers and its integration of efforts with the Blueprint and its regional care collaborative;
 - Extent to which ACO provides incentives for investments to strengthen primary care;
 - Extent to which ACO provides incentives for systemic integration of community-based providers in its care model or investments to expand capacity in existing community-based providers;
 - Extent to which the ACO provides incentives for systemic health care investments in social determinants of health, such as developing support capacities that prevent hospital admissions and readmissions, reduce length of hospital stays, improve population health outcomes, reward healthy lifestyle choices, and improve the solvency of and address the financial risk to community-based providers; and
 - Information on administrative costs.

ACO Budget Review Criteria

➤ All-Payer ACO Model Agreement requirements include:

- Medicare TCOC per Beneficiary Growth Target
 - At least 0.2 percentage points below national projections
- All-Payer TCOC per Beneficiary Growth Target
 - 3.5% or less
- Requirements for Scale Target Initiatives
 - Services comparable to financial target services; financial incentives tied to quality of care or health of population; shared savings/losses percentages
- Scale Targets
 - Medicare
 - All-payer
- Alignment of programs in terms of attribution, payment mechanisms, etc.
- Population Health Goals & Quality Targets

2019 Process: Reviewing ACOs' 2019 Budgets and Payer Programs

- An ACO other than OneCare may submit a proposed budget.
 - In order to receive payments from Medicaid or a commercial insurer, the ACO would need to be certified by the Board. Certification is not required for Medicare-only ACOs.

- Staff developed two versions of the ACO Budget Guidance and Reporting Requirements.
 - OneCare-Specific: We understand OneCare's model and want to have a tailored guidance that will allow us to efficiently get the most useful information we can up front.
 - Built from 2018 guidance and the materials we have received from OneCare.
 - Generic: For any other ACO.
 - Built from 2018 guidance.

New Statutory Certification Requirements

- 18 V.S.A. § 9382(a) . . . In order to certify an ACO to operate in this State, the Board shall ensure that the following criteria are met:

* * *

- (2) The ACO has established appropriate mechanisms and care models to provide, manage, and coordinate high-quality health care services for its patients, including incorporating the Blueprint for Health, coordinating services for complex high-need patients, and providing access to health care providers who are not participants in the ACO. The ACO ensures equal access to appropriate mental health care that meets the Institute of Medicine's triple aims of quality, access, and affordability in a manner that is equivalent to other aspects of health care as part of an integrated, holistic system of care.

New Statutory Certification Requirements

- (3) The ACO has established appropriate mechanisms to receive and distribute payments to its participating health care providers in a fair and equitable manner. To the extent that the ACO has the authority and ability to establish provider reimbursement rates, the ACO shall minimize differentials in payment methodology and amounts among comparable participating providers across all practice settings, as long as doing so is not inconsistent with the ACO's overall payment reform objectives.
- (17) The ACO provides connections and incentives to existing community services for preventing and addressing the impact of childhood adversity. The ACO collaborates on the development of quality-outcome measurements for use by primary care providers who work with children and families and fosters collaboration among care coordinators, community service providers, and families.

Next Steps: Verifying OneCare's Continued Eligibility for Certification

- We propose to review OneCare's continued eligibility for certification prior to approving its 2019 budget.
- The completed form would need to be received by the Board on or before October 1, 2018.
- Any problems identified during the process could be addressed through corrective action plan or other remedial process (e.g., monitoring plan).
- Considerations for Rule 5.000 update
 - We anticipate OneCare will make changes to its policies, procedures, programs, etc., in 2019.
 - We may need or want to enhance the section of the rule requiring ACOs to automatically notify the Board of certain changes if we want to know about these changes prior to October 2019.

2019 Budget Guidance and Reporting Requirements for OneCare Vermont

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➤ **Part II: Budget Guidance**

- Section 1: Medicare Benchmark Ceiling for 2019

➤ **Part III: Primary Care Spend (test year)**

- Section 1: Primary Care Spend by Payer Claims Specification
- Section 2: Primary Care Spend by Payer Non-Claims Specification

Timeline for 2019 ACO Submission

Annual Reporting and Budget Guidance Approval

- June 13: Staff presentation to Board
- June 13-June 30: Public Comment
- July 11: GMCB votes on 2019 Guidance (potential)
- July 18: GMCB votes on 2019 Guidance (potential)

Annual Reporting and Budget Submission (Subject to Change)

- By August 1: GMCB provides ACOs with reporting guidance
- October 1: ACOs submit budgets to GMCB
- October 17: ACOs budget presentations 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
- December 15: GMCB issues written orders to ACOs

Part I: Reporting Requirements

Section 1: ACO Information and Background

➤ Executive Summary

- Network changes
- Program highlights
- Operational changes
- Assumptions made in budget proposal

Section 2:

ACO Provider Network

- **Network Provider Participants** (Appendices 2.1, 2.2)
 - Providers by type and contract participation by payers
 - Specialists by Health Service Area
- **Network Development**
 - Scale and recruitment strategy for next five years
- **Provider Contracting** (Appendices 2.3, 2.4)
 - Provider risk models
 - Total risk amounts
 - Provider Agreements

Section 3:

ACO Payer Programs

- **Program Arrangements (Appendix 3.1)**
 - ACO-Payer Risk Model
 - Shared Savings and Losses
 - Risk Mitigation
 - PMPM Methodology
 - Rates of Growth (Part II: Budget Guidance)

- **Scale Target ACO Initiatives**
 - Categories of Service
 - Payment Mechanisms
 - Attribution Methodology
 - Quality Measures

Section 4:

ACO Financial Plan

- **Audited financial statements**
- **Financial statement templates (Appendix 4.1-4.3)**
- **Financial performance and breakdown of revenue and expenses (Appendix 4.4-4.7)**
 - Similar to last year's reporting
 - Multiple breakdowns
- **Reporting for participating hospitals (Appendix 4.8)**
 - Same as last year's post submission request
- **Narratives related to budgeted spending**
- **Risk**
 - Risk mitigation plan
 - Actuarial opinion

Section 5:

ACO Quality, Population Health, Model of Care and Community Integration Initiatives

- **Quality** (Appendices 5.1, 5.2)
 - ACO Clinical Priorities
 - All-Payer ACO Model Quality Measures
 - Patient and Provider Satisfaction in Value-Based Model

- **Population Health** (Appendix 5.3)
 - ACO Risk Stratification by Payer
 - Care Management Updates

- **Community Integration Initiatives** (Appendices 5.4, 5.5, 5.6)
 - Substance Use Disorder Capacity
 - Investments
 - Prevention, Community-Based Care, and Primary Care (Part III)

Part II:

Budget Guidance

- The Board's criteria for decision on an ACO's budget include the requirements of the All-Payer ACO Model. These requirements are not restated in the guidance.
- To help ACOs develop their 2019 budgets, the guidance does describe the growth rate ceiling for the 2019 Vermont Medicare ACO Initiative benchmark – the maximum rate of growth the All-Payer ACO Model Agreement will allow the Board to use in developing the benchmark.
- Under the terms of the All-payer ACO Model Agreement, the Vermont Medicare ACO Initiative Benchmark 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; 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.

2019 Medicare Benchmark Growth Rate

- Medicare Advantage USPCC FFS Projections 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	\$880.64	\$916.06	See calc.

Blended using the Vermont proportion of 2017 ESRD beneficiaries, 0.360%.

2019 Annual Projected National Medicare TCOC per Beneficiary Growth =

$$\frac{\$916.06}{\$880.64} - 1 = 4.0\% \quad \text{2019 CAGR} = (1.037 * 1.040)^{1/2} - 1 = 3.8\%$$

- **When developing the Vermont Medicare ACO Initiative Benchmarks for 2019, the Agreement requires the Board to use no more than: 3.8% (annual growth rate) or 3.7% (CAGR).**

Part III: Primary Care Spend



- Presented at the all-payer and payer-specific level

Primary Care Spend

Claims-Based Spending

- Subset of provider types and CPT codes

Non-Claims-Based Spending

- Payments to primary care providers and practices within the ACO, including:
 - Capitation
 - Patient Centered Medical Home (PCMH) recognition
 - Value-Based Incentive Fund
 - Comprehensive payment pilot
 - Complex Care Coordination Program
 - Payments for Community Health Teams

Timeline for Public Comment and Vote

Budget Guidance Approval

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