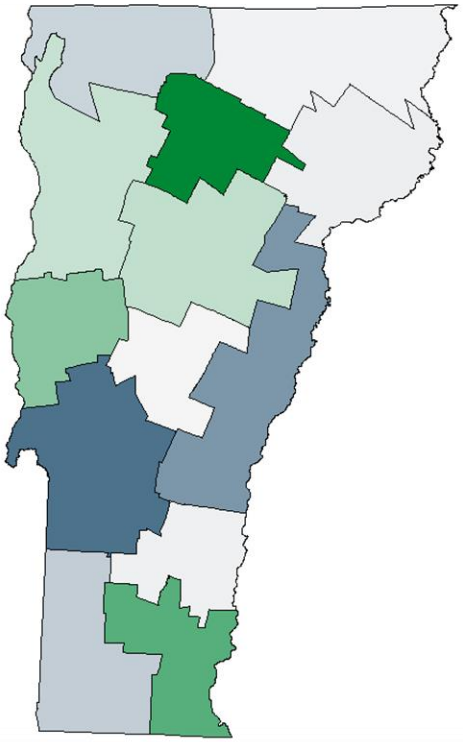

Rule 5.000
Oversight of Accountable Care Organizations

Year One Regulatory Update

Green Mountain Care Board Advisory Board Meeting

April 11, 2018

VERMONT
GREEN MOUNTAIN CARE BOARD

Agenda

- Oversight of Accountable Care Organizations: Year 1
- ACO Budget Review Requirements
- ACO Budget Review Overview of Conditions
- ACO Certification Requirements
- Certification Monitoring

ACO Oversight Year 1 Implementation

2016 Act 113 Statutory Duties	Green Mountain Care Board Actions
Established criteria for implementing all-payer value-based payment models and for entering into an agreement for Medicare's participation.	All-Payer Model Accountable Care Organization Agreement, signed October 26, 2016.
Required the Board to develop rules governing Accountable Care Organizations (ACOs).	Rule 5.000 Oversight of Accountable Care Organizations, adopted November, 2017.
Requires the Board to annually review and approve ACO budgets.	OneCare Vermont budget approved, December 21, 2017 for 2018 performance year.
Required the Board to certify ACOs.	OneCare Vermont certified, March 24, 2018.

Act 113 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 patient's coordination of care and transitions through technology
- Ensures consultation with the Health Care Advocate

Act 113 Annual Budget Requirements

- 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 and future year
- 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

OneCare Vermont Budget Highlights

Payer Contract	Attribution	Total Payer Dollars	Actual PMPM
Medicare Next Generation	39,702	$408,047,628	$856.48
Medicaid Next Generation	42,342	$123,931,647	$243.91
Commercial Next Generation (BCBSVT)	20,838	$106,568,866*	$426.18
Self-Funded (UVMMC)	9,962	TBD	N/A
Total	**112,844**	$638,548,140	

**Still being finalized*

Rates of Growth
3.5% for Medicare
3.5% for Commercial
6.1% for Medicaid (1.5% after All-Payer TCOC calculation exclusions)

Budget Order and Monitoring

18 Budget Order Conditions, which include:

- Risk arrangements with hospitals
- Quarterly operating results of ACO and hospitals
- Solvency, administrative, and reserve requirements
- Investments in population health
- Attribution and TCOC by Health Service Area
- Reports examining:
    - Alignment of contracts
    - Substance use disorder network
    - Capitated payment models and administrative burden
    - Potential for savings in the model

Green Mountain Care Board OneCare Vermont Budget Order:
http://gmcboard.vermont.gov/sites/gmcb/files/FY18%20ACO%20Budget%20Order%20OneCare%20Vermont.pdf

OneCare Vermont Budget Order

- *A combined all-payer rate increase of less than 3%, after exclusion of Medicaid pricing changes;*
- *Ability to review OneCare's contracts with participating payers;*
- *Robust risk assumption, delegation, and mitigation strategy must be in place;*
- *Guaranteed funding for Medicare portion of SASH, Blueprint for Health, and Community Health Team payments;*
- *Investment of no less than 3.1% of overall budget in population health and primary care strengthening initiatives;*
- *OneCare must consult with the Office of the Health Care Advocate to identify a grievance and appeals policy that applies to all enrollees, across payers;*

OneCare Vermont Budget Order

- *Report that examines the capitation payment methodology, quality outcomes, and administrative burden;*
- *Verification of appropriate administrative expenses;*
- *Alignment of payer contracts;*
- *Examination of network capacity;*
- *Pathway by which potential savings from this model will be returned to commercial rate payers.*

GMCB ACO Oversight: Certification Criteria

The GMCB must ensure that the ACO meets the 16 statutory criteria in the following ten sections from Rule 5.000:

- 5.201 - Legal Entity
- 5.202 - Governing Body
- 5.203 - Leadership and Management
- 5.204 - Solvency and Financial Stability
- 5.205 - Provider Network
- 5.206 - Population Health Management and Care Coordination
- 5.207 - Performance Evaluation and Improvement
- 5.208 - Patient Protections and Support
- 5.209 - Provider Payment
- 5.210 - Health Information Technology

Reporting Under Rule 5.000

§ 5.501(c): In addition to [other reporting the GMCB may require], an ACO must report the following to the Board within fifteen (15) days of their occurrence:

- Changes to the ACO's bylaws, operating agreement, or similar documents;
- Changes to the ACO's senior management team;
- Changes to the ACO's provider selection criteria;
- Changes to the ACO's Enrollee grievance and complaint process; and
- Any notice to or discussion within the ACO's governing body of the ACO's potential dissolution or bankruptcy, the potential termination of a Payer program, or a potential new Payer program.

2018 Next Steps

- Spring: 2019 Budget Guidance Development
- Summer: 2019 Budget Guidance Released by the Board
- Fall: 2019 Budget and Annual Reporting Deadline
- Winter: 2019 Budget Approval