

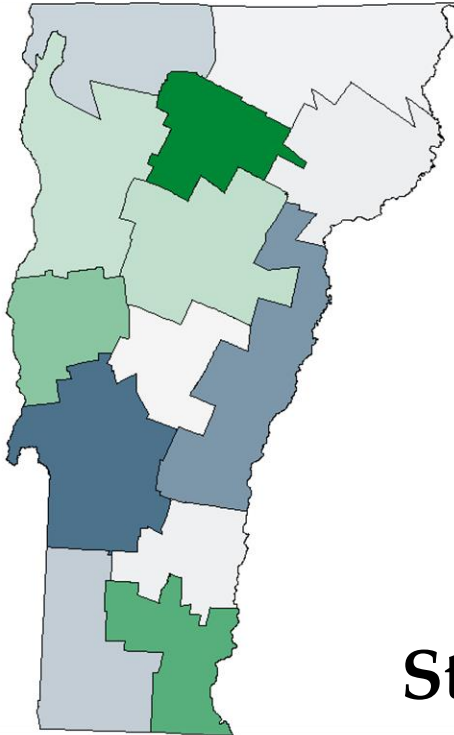
Green Mountain Care Board

ACO Certification

Rule 5.000: Sections 5.201-5.210 Oversight of Accountable Care Organizations

OneCare Vermont Review Staff Discussion and Recommendations

March 14, 2018



Agenda

- Background
- Certification Timeline
- Statutory Criteria
- Certification Review
- Outstanding Issues and Monitoring
- Next Steps

Background:

Act 113 of 2016 and Accountable Care Organization Regulation

- Establishes criteria for implementing all-payer value-based payment models and for entering into an agreement for Medicare's participation.
- Requires review, modification, and approval of Accountable Care Organization (ACO) budgets.
- Requires Certification of ACOs.

ACO Certification

- To be eligible to receive payments from Medicaid or a commercial insurer, an ACO must be certified by the Board. 18 V.S.A. § 9382(a) (effective Jan. 1, 2018).
- The Board must begin certifying ACOs on or before January 1, 2018. Act 113, § 8.
- The Board may provisionally certify an ACO with conditions, in which case the ACO will be eligible to receive payments from Medicaid or a commercial insurer as specified in 18 V.S.A. § 9382(a). GMCB Rule 5.000, § 5.303(e).

OneCare Vermont Review

- ❑ Certification update – December 21, 2017
- ❑ On January 5, 2018, the Board provisionally certified OneCare with the condition that it successfully complete the certification process and comply with the certification criteria to the Board's satisfaction by March 31, 2018.
- ❑ Staff reviewed OneCare's budget submissions against the certification standards in Rule 5.000 and identified additional documentation OneCare would need to provide to proceed with certification.
- ❑ Staff also received a demonstration of Care Navigator and Workbench One, OneCare's care coordination and analytic platforms.

16 Statutory Criteria

(1) The ACO's governance, leadership, and management structure is transparent, reasonably and equitably represents the ACO's participating providers and its patients, and includes a consumer advisory board and other processes for inviting and considering consumer input.

(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.

(3) The ACO has established appropriate mechanisms to receive and distribute payments to its participating health care providers.

(4) The ACO has established appropriate mechanisms and criteria for accepting health care providers to participate in the ACO that prevent unreasonable discrimination and are related to the needs of the ACO and the patient population served.

16 Statutory Criteria

(5) The ACO has established mechanisms and care models to promote evidence-based health care, patient engagement, coordination of care, use of electronic health records, and other enabling technologies to promote integrated, efficient, seamless, and effective health care services across the continuum of care, where feasible.

(6) The ACO's participating providers have the capacity for meaningful participation in health information exchanges.

(7) The ACO has performance standards and measures to evaluate the quality and utilization of care delivered by its participating health care providers.

(8) The ACO does not place any restrictions on the information its participating health care providers may provide to patients about their health or decisions regarding their health.

16 Statutory Criteria

- (9) The ACO's participating health care providers engage their patients in shared decision making to inform them of their treatment options and the related risks and benefits of each.
- (10) The ACO offers assistance to health care consumers, including:
- (A) maintaining a consumer telephone line for complaints and grievances from attributed patients;
 - (B) responding and making best efforts to resolve complaints and grievances from attributed patients, including providing assistance in identifying appropriate rights under a patient's health plan;
 - (C) providing an accessible mechanism for explaining how ACOs work;
 - (D) providing contact information for the Office of the Health Care Advocate; and
 - (E) sharing deidentified complaint and grievance information with the Office of the Health Care Advocate at least twice annually.

16 Statutory Criteria

(11) The ACO collaborates with providers not included in its financial model, including home- and community-based providers and dental health providers.

(12) The ACO does not interfere with patients' choice of their own health care providers under their health plan, regardless of whether a provider is participating in the ACO; does not reduce covered services; and does not increase patient cost sharing.

(13) The meetings of the ACO's governing body comply with the provisions of section 9572 of this title (deals with meetings of an ACO's governing body, such as posting the schedule of meetings and agendas and posting recordings or minutes of meetings).

(14) The impact of the ACO's establishment and operation does not diminish access to any health care or community-based service or increase delays in access to care for the population and area it serves.

16 Statutory Criteria

(15) The ACO has in place appropriate mechanisms to conduct ongoing assessments of its legal and financial vulnerabilities.

(16) The ACO has in place a financial guarantee sufficient to cover its potential losses.

ACO Oversight: Certification Criteria

The GMCB must ensure that the ACO meets 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

5.201

Legal Entity

Topics:

- ACO as legal entity separate from its participating providers.
- Registration with Sec. of State and authorization to do business in VT.

Documents Reviewed:

- Certificate of Good Standing
- Operating Agreement
- Budget submission

Status: Complete

5.202

Governing Body

Topics:

- General authority/responsibility of governing body.
- Composition of governing body (representation of Participants and consumers).
- Transparency of governing processes (18 V.S.A. § 9572).
- Mechanisms for consumer input.
- COI policy.

Documents Reviewed:

- Board of Managers (BOM) roster
- Operating Agreement and Bylaws
- Budget submissions (e.g., network information)
- Consumer advisory group documents (e.g., charter and orientation materials)
- Narrative responses to questions
- OneCare website (including minutes and agendas for BOM meetings)
- COI policy

Status: Complete, with proposed monitoring on:

§ 5.202(b). Composition of Board of Managers

Note: Potential rule change identified for future

5.203

Leadership and Management

Topics:

- Leadership and management structure.
- Responsibilities for clinical oversight.
- Compliance Plan.

Documents Reviewed:

- Operating Agreement
- Budget submissions
- Compliance Plan

Status: Complete

5.204

Solvency and Financial Stability

Topics:

- Mechanisms/processes for assessing legal and financial risks.
- Financial stability/solvency.

Documents Reviewed:

- Narrative response

Status: Complete, with previously established monitoring through a quarterly P&L to evaluate financial stability, required by ACO Budget Order.

5.205

Provider Network

Topics:

- Existence of written agreements with ACO Participants that allow ACO to take remedial actions.
- Mechanisms and criteria for accepting providers.
- Provider appeal process.

Documents Reviewed:

- Participant and Affiliate (Preferred Provider) Agreements
- Network Support and Access Policy
- Provider Appeals Policy

Status: In process (see next slide)

5.205

Provider Network

Items in process

§ 5.205(b). Staff asked (3/9/18) OneCare to describe its process/timeline and criteria for accepting providers into its network for 2019.

- OneCare responded that its BOM is scheduled to endorse the 2019 contracting process/timeline and network development/expansion strategy at its March 20, 2018 meeting.

§ 5.205(d). OneCare has a policy that allows ACO Participants to appeal decisions to terminate their participation in the ACO. The policy does not currently allow providers who are denied participation to file an appeal. We discussed the creation of such a process, whereby providers that fall within the ACO's expansion strategy are able to appeal a decision to deny them participation.

- OneCare responded that they will be amending their current appeals policy, which will be presented at their March 20, 2018 BOM meeting.

GMCB staff will provide Board with a status update after the March 20 meeting of OneCare's BOM.

5.206

Population Health Management and Care Coordination

Topics:

- How an ACO effectively coordinates services with Payers, Participants, and non-Participant providers, including community-based provider organizations for Attributed Enrollees, including the Blueprint for Health.
- How an ACO supports Participants in care coordination using a Population Health Management Model using data and analytics.

Documents and Materials Reviewed:

- SASH Statement of Work
- Medicare Next Generation Implementation Plans
- Care Coordination and Disease Management Program within an Integrated Care Delivery Model Policy
- Johns Hopkins ACG for risk stratification and OCV's Population Health Approach to Care Coordination
- Workbench One and Care Navigator Platforms
- Care Navigator Training Procedure and training calendar
- OCV Utilization Management Plan
- Budget and certification narratives

Status: Complete

5.207

Quality Evaluation and Improvement

Topics:

- A Quality Improvement Program actively supervised by the ACO's clinical director or designee that identifies, evaluates, and resolves potential problems and areas for improvement.

Documents Reviewed:

- Quality Improvement Procedure
- Clinical Priorities 2018
- Quality Improvement Procedure Work Plan

Status: Complete

5.208

Patient Protections and Support

Topics:

- Enrollee freedom to select their own health care providers.
- Prohibition against increasing cost sharing or reducing services covered under Enrollee's health plan.
- Ensuring patients are not billed in the event an ACO does not pay a provider.
- ACO's grievance and complaint process, including a consumer telephone line.

Documents Reviewed:

- Network Support and Access Policy
- Quality Improvement Workplan Policy
- Patient Complaint and Grievance Policy
- Internal Operations Inquiry Tracking Form (for tracking grievance and complaints)

Status: Complete, with monitoring on:

§ 5.208(j). Completion of Enrollee notification

§ 5.208(i). Regular reporting of grievance and complaint information

5.209

Provider Payment

Topics:

- Ability to administer provider payments.
- Coupling of alternative payment methodologies with mechanisms to improve or maintain performance on quality/access measures.
- Alignment of ACO-payer incentives and ACO-provider incentives.
- Provider appeals re: payments from ACO.

Documents Reviewed:

- Fixed Prospective Payment Distribution Procedure
- Primary Care Case Mgmt. and Population Health Management Payment Distribution Procedure
- Advanced Community Care Coordination Payment Procedure
- Budget submissions (e.g., Value-Based Incentive Funds Calculation & 2018 Savings Losses Sharing Model Policy)
- Provider Appeals Policy
- Quality Improvement Procedure

Status: Complete

5.210

Health Information Technology

Topics:

- Data collection and integration: consent of enrollees, data sharing to support care coordination, trainings and support.
- Data analytics: integrate data to make it actionable, measure care process improvements and costs of care.
- Integration of clinical and financial data system to manage financial risk.

Documents Reviewed:

- Budget submission
- BOM minutes re: vote to establish OHCA
- OneCare Data Use Policy
- OneCare Privacy and Security Policy
- Care Coordination & Disease Management Program within an Integrated Care Delivery Model
- Care Coordination Training and Responsibilities Procedures
- Site visit to view Workbench One and Care Navigator

Status: Complete

Recommendation for Certification

Recommendation: To certify the Accountable Care Organization, OneCare Vermont LLC, upon receipt of:

- A 2019 contracting process, timeline and network development/expansion strategy
- An amended appeals policy

Existing 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.

Suggestions for Additional Monitoring/Reporting

- § 5.202(b). Composition of Board of Managers
- § 5.208(j). Documentation of enrollee notification
- § 5.208(i). Regular reporting of grievance and complaint information

Next Steps

- March 14th to March 20th - Public Comment
- March 20nd – OCV submission to satisfy 5.205 Provider Network criteria
- March 21st – Report back and potential vote
- March 28th – Potential vote