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GREEN MOUNTAIN CARE BOARD

FY 2022 ACO Oversight

Budget Guidance and Certification Form

Review and Discussion

June 9, 2021

Agenda

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1. Background
2. Statutory Authority
3. FY 2022 Certification Eligibility Form
4. FY 2022 Budget Guidance
5. Next Steps
6. Questions and Public Comment

Background

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Guiding priorities for staff:

1. ACO financial and quality performance
2. Data driven analysis and decisions
3. Regulatory alignment
4. Standard reporting and templates (metrics and definitions)

Continued goals and considerations for FY 2022 ACO Oversight process:

1. Streamline information requests across regulated entities (ACO & hospitals)
2. Break out information requests across processes categorically to ensure Rule 5.000 regulatory requirements
3. Emphasis on data over narrative where appropriate
4. Reconsider timing of information requests (e.g., Budget cycle vs. on-going monitoring)
5. Impact of Covid-19
6. 2022 is final year of current APM Agreement
7. Consider how to operationalize core-competencies into review (see 5/12 Bailit presentation)

Statutory Authority

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18 V.S.A. § 9382 and the GMCB Rule 5.000 distinguish between two processes within ACO Oversight:

1. ACO Certification: First time certification and ongoing eligibility
2. ACO Budget: Annual review of an ACO's finances/programs

The standards and requirements by which we review the ACO submissions are set forth in:

1. 18 V.S.A., Chapter 220 (primarily 18 V.S.A. § 9382 "Oversight of Accountable Care Organizations");
2. GMCB Rule 5.000; and
3. All-Payer ACO Model Agreement.

Documents and Workbook

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- Materials posted on GMCB website:
  - FY22 Certification Eligibility Verification Form and Attachments
  - FY22 Budget Guidance, Attachments, and Appendix Workbook
  - ACO Reporting Manual (*coming soon*)
- Slides highlight substantive changes to the guidance from last year
- Posted documents include substantive tracked changes

FY 2022 Certification Eligibility Verification

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Once certified, an ACO must annually submit a form to the GMCB (1) verifying that the ACO continues to meet the requirements of 18 V.S.A. § 9382 and Rule 5.000; and (2) describing in detail any material changes to the ACO's policies, procedures, programs, organizational structures, provider network, health information infrastructure, or other matters addressed in the certification sections of 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

FY 2022 Certification Eligibility Verification

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- Material changes to the FY 2022 Certification Eligibility Verification Form ("Form") include:
  - OneCare's 501(c)(3) status
  - OneCare's executive compensation
  - Updated language on questions about mental health access, "pay parity", and addressing adverse childhood events
  - Added citations
- Form to be posted on the GMCB website under "2022 ACO Budget and Certification" and issued to OneCare by July 1st, 2021, along with the FY 2022 Budget Guidance
- Form to be completed and submitted by OneCare on or before September 1st, 2021

FY 2022 ACO Budget Guidance: Table of Contents

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Timeline for FY22 Budget Submission

Introduction

FY22 Budget and Covid-19

Part I: Reporting Requirements

- Section 1: ACO Information and Background
- Section 2: ACO Provider Network
- Section 3: ACO Payer Programs
- Section 4: Total Cost of Care
- Section 5: Risk Management
- Section 6: ACO Budget
- Section 7: ACO Quality, Population Health, Model of Care, and Community Integration
- Section 8: Other Vermont All-Payer ACO Model Questions

Part II: ACO Budget Targets

Part III: Revised Budget

Part IV: Monitoring

2021 Timeline for FY22 Submission

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- **July 1** – Guidance issued
- **September 1** – Certification Form due
- **October 1** – Budget submission due
- **November 10*** – ACO Budget Hearing
- **November TBD*** – ACO/payer 2020 Quality and Financial Performance
- **December 8*** – GMCB analysis and recommendations
- **By December 31*** – Vote (tentative December 22)
- **Jan/Feb** – Written budget order
- **Spring 2022*** – Revised FY22 budget based on final contracts and attribution

*Board Meeting

Introduction and COVID-19

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Introduction: Summarizes purpose of the document, statutory authority, verifications under oath, participation of the Health Care Advocate (HCA), and requirements for requesting confidentiality. **No changes.**

FY22 Budget and Covid-19: Updated language

"The GMCB recognizes that COVID-19 has posed significant challenges for Vermont's health care providers since March 2020 through 2021 to date. In its role as an ACO managing network participants to achieve cost and quality goals, the GMCB recognizes that OneCare has had to adjust ACO operations and implementation of programs and planning for the future. Last year, GMCB guidance waived certain questions that may not have been relevant under the circumstances. For this year's guidance, the GMCB reviewed those questions and incorporated the relevant questions into this guidance as required. While there is still uncertainty about the pandemic's impacts on utilization and outcomes, the GMCB expects OneCare will have adjusted its operations for 2022 and can fulfill all reporting requirements."

Section 1: ACO Information and Background

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The executive summary shall include the following information:

1. Value proposition and business model;
2. Challenges, opportunities and objectives for budget development;
3. Changes to provider network, payer programs, and population health and payment reform programs;
4. Administrative operations details;
5. Key assumptions and limitations made during budget development;
6. Lessons learned from the public health emergency; and
7. Attachments A and B: ACO Network and ACO Hospital Participation grids

Section 2: Provider Network

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- Network development strategy (submitted 5/28/21)
  - OneCare Board approval and final rosters expected Sept/Oct
  - Anticipated changes to the provider network
    - Areas of growth and decline
    - General observations of drivers leading to participation decisions
  - Challenges and opportunities with FY22 network recruitment
- Network Data
  - Provider network, including provider type and program participation details
  - Provider list **updated templates 2.1 Organizations List, 2.2 Provider List**
- Provider contracts
  - Provide copies
  - Explain
    - Payment strategies and methodologies; and their contribution to goals of reducing cost and improving quality
    - New or expanded incentives to strengthen primary care
    - Strategies related to expanding FPP adoption across the provider network

Section 3: Payer Programs

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- Scale Target Initiatives and Program Alignment Form
- Explain changes across portfolio of payer programs
  - New/terminating programs
  - Changes to existing programs
  - Explain if not scale target qualifying per APM Agreement
  - Expansion of FPP offerings (true capitation and otherwise); Explain how FPP amounts calculated for each program
  - If payer contracts are not finalized by the date of the budget submission, please respond as completely as possible to the applicable questions. Contracts must be submitted within 10 days of execution and the GMCB may request an update on the status of contract negotiation at any time.
- What are the lessons learned from the expanded Medicaid population that could be applied to the commercial payer programs?

Section 4: Total Cost of Care (TCOC)

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- **Updated template:** 4.1 TCOC Performance by Payer, Total ACO-Wide (2018-2022)
- **Updated template:** 4.2 Settlement by Payer, by HSA (2018-2022)
- **Objectives:**
  - To report TCOC targets and settlement, by payer (4.1).
  - To report settlement by HSA and HSA accountability strategy (4.2).
  - To provide actuals where available (projections if not) and expected TCOC for the budget year.
  - To discuss assumptions for projections and budget and adjustments for settlement.
  - To collect data 2018-2022.

Section 4: Total Cost of Care (TCOC)

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- **Updated template:** 4.1 TCOC Performance by Payer, Total ACO-Wide (2018-2022)
- **Updated question:** "Explain the drivers of expected vs. actual Total Cost of Care results by payer program. Provide actuals for prior year. If not available, provide projections and the timeline for when actuals will be available. Provide projections for the current year. For the budget year, provide expected TCOC. Please recognize any relevant assumptions for projections and budget figures (e.g., based on historical seasonal spend plus a particular rate of growth, etc.). Describe all adjustment factors used for calculating the settlement result (e.g., risk sharing, other fees, etc.)."

Section 4: Total Cost of Care (TCOC)

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- **Updated template:** 4.2 Settlement by Payer, by HSA (2018-2022)
- **Updated question:** "Explain the methodology by which the ACO distributed funds by HSA, including all adjustment factors used for calculating the settlement distribution (e.g., risk sharing/mitigation, market factor adjustments, adjustments for local performance, case mix, etc.). Discuss the ACO's Total Cost of Care accountability strategy at the HSA level.
    a. How is the ACO using TCOC data at the local HSA level to identify high-value and low-value care?
    b. How is the ACO helping hospitals and other community providers to reduce low-value care and lower their TCOC at the local HSA level?
    c. What evidence do you have that the ACO local accountability strategy is working?

Section 4: Total Cost of Care (TCOC)

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- **No change:** 4.3 Projected and Budgeted Trend Rates by Payer Program
- **Objective:**
  - Discuss underlying assumptions for trend rates
  - Discuss budgeted growth rate vs. ACO growth trend
  - Discuss approach to calculating base experience
  - "Describe how the ACO's TCOC accountability strategy allows providers to benefit from their ability to provide high-value care and impact TCOC growth."

Section 4: Total Cost of Care (TCOC)

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- **Remove:** 4.4 TCOC Budget Year Targets by Payer, by HSA
  - **Rationale:** Budget year incorporated into new templates 4.1 and 4.2
- **Remove:** 4.5 Service Risk by Payer, by HSA
  - **Rationale:** This template reflects data collection on home hospital spend vs. spend at UVMMC, DH, or other hospitals and was created for outdated risk model where TCOC targets were set by HSA.

Section 5: Risk Management

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- No changes from last year.
- 5.1 ACO Risk by Payer (and any payer-specific risk mitigation strategies);
- 5.2 Risk by Payer by Risk-Bearing Entity (RBE), i.e., Hospitals (and any RBE-specific risk mitigation strategies); and,
- 5.3 and 5.4 Summary of Shared Savings and Losses: Actual and expected distribution and methodology

Section 6: ACO Budget

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- ACO Financial Data:
  - Projected and Budgeted financial statements (Income Statement w/Accountability, Balance Sheet, Cash Flow)
  - Variance analysis
  - Budgeted sources and uses documentation
  - PMPM revenues by payer
  - Details of hospital participation and risk
  - Management compensation
  - PHM expense breakout
- Budget narrative includes explanation of:
  - Significant variations over prior year (revised budget)
  - Any expected gains/losses, their rationale, or to the extent applicable, how OneCare intends to balance to a break-even budget (surplus to reserves, etc.).
    - Discuss any prior or current year surplus or losses and their intended use and how they were earned. How does non-profit status affect treatment of reserves?

Section 6: ACO Budget

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- **Financial Templates:**
  - 6.1 Balance Sheet
  - 6.2 Income Statement with Accountability **Updated**
  - 6.3 Cash Flow
  - 6.1-6.3 Variance Analysis **New**
  - 6.4 Sources and Uses **Updated**
  - 6.5 Per Member Per Month Revenues by Payer
  - 6.6 Hospital ACO Participation **Under review**
  - 6.7 ACO Management Compensation
  - 6.8 PHM Expense Breakout **Updated**

Section 7: Quality, Population Health, Model of Care, and Community Integration Initiatives

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Key areas:

1. Model of Care
2. Clinical Focus Areas
3. Quality Improvement
4. Population Health and Payment Reform
5. Care Coordination and Care Navigator
6. Integration of Social Services
7. Childhood Adversity **moved to certification**
8. All-Payer Model Quality and Population Health Goals

Questions across topics:

- Progress to date (including HSA-level statistics where appropriate)
- Methods, metrics, and measuring impact
- Proposed budget year objectives

Section 7: Quality, Population Health, Model of Care, and Community Integration Initiatives

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Data collected:

- Clinical Focus Areas results as available
- Variations in care (utilization measures) by HSA
- Variations in outcomes (outcomes measures) by HSA
- Five most prevalent chronic conditions
- Five most prevalent high-cost conditions
- Population risk stratification and spend
- Care Navigator and Care Coordination statistics

Section 7: Quality, Population Health, Model of Care, and Community Integration Initiatives

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Model of Care: "What elements of the care model has OneCare eliminated or not adopted because they were not successful? What elements have been scaled up and where would OneCare like to put more resources? What is the data behind these decisions?"

Section 7: Quality, Population Health, Model of Care, and Community Integration Initiatives

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Clinical Focus Areas: "Report any results on your 2020 Clinical Focus Areas (interim, if available) and progress to date on 2021 Clinical Focus Areas using Appendix 7.1 ACO Clinical Focus Areas. Provide a narrative description of the ACO's implementation strategy for its Clinical Focus Areas in the current year and in planning for the budget year. How does the ACO support providers in achieving the goals of the Clinical Focus Areas? How are results shared with providers at the HSA and/or the organization level? Does the ACO prepare a final report on Clinical Focus Areas at the close of the year?"

Section 8: Other—Vermont All-Payer ACO Model Questions

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1. How are you ensuring that your portfolio of programs are coordinated in such a way that allocates resources most efficiently for supporting the goals (scale, cost, quality) under the Vermont All-Payer ACO Model?
2. What other actions can healthcare stakeholders be taking to support the goals of the Vermont All-Payer ACO Model?
3. All Payer Model Quality and Population Health Goals. Please complete Appendix 8.1, ACO Activities related to the Vermont All-Payer Model ACO Agreement Population Health and Quality Goals to describe results to date and explain your strategies for assisting the state to achieve its quality and population health goals as specified in the APM. In doing so, please also discuss the expected impact of COVID-19 on 2021 performance, sharing any early indicators or relevant insights.

Part II: ACO Budget Targets

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All-Payer Model Agreement Growth and ACO Financial Targets

In deciding whether to approve or modify an ACO's proposed budget, the Board will take into consideration the requirements of the APM, 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).

Table 1. Medicare Advantage United States Per Capita Fee-For-Service Projections

	Aged and Disabled		**ESRD**		**Blended** (0.36% ESRD)	
2017 to 2018	Floor	3.70%	Floor	3.70%	Floor	3.70%
2018 to 2019	$891.07 $856.41	4.05%	$7,833.28 $7,586.28	3.26%	$916.06 $880.64	4.02%
2019 to 2020	$940.81 $903.21	4.16%	$7,795.38 $7,563.53	3.07%	$965.49 $927.19	4.13%
2020 to 2021	$975.06 $932.34	4.58%	$8,110.21 $7,910.87	2.52%	$1,000.75 $957.46	4.52%
2021 to 2022	$1,028.38 $929.69	10.62%	$8,515.64 $7,897.64	7.83%	$1,055.33 $946.80	11.46%
Compounding Projection to Date		5.39%		4.06%		5.53%
Compounding Target to Date		**5.19%**		**.86%**		**5.33%**

Calculation:

Blended Compounding Projection = (1.037*1.0402*1.0413*1.0452*1.1146) ^ (1/5) -1 = 5.53%

Blended Target to date = 5.53% - 0.2% = 5.33%

Source:

https://www.cms.gov/files/document/2022-announcement.pdf

Part II: ACO Budget Targets

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- Other Targets/Benchmarks
  - The Board generally sets ACO Budget targets/benchmarks during the budget submission process after taking into account the ACO's proposed budget, expected growth in programs and in scale (attribution) etc.
  - The Board may establish guidelines for managing certain portions of the ACO's budget (e.g., admin expense ratio, population health ratio).

Part III: Revised Budget

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Revised Budget Deliverables due May 2022 (or spring TBD), upon execution of payer contracts:

1. Final attribution by payer;
2. Copies of all payer contracts;
3. Final descriptions of population health initiatives and sources of funds;
4. Expected hospital dues by hospital;
5. Expected hospital risk by hospital and by payer;
6. Any changes to the overall risk model;
7. Any requests for amendments to the budget order; and
8. Any other information the board deems relevant to ensuring compliance with the budget order.
9. **Moved to reporting:**
   - Details of expansion of fixed prospective payments (FPP) across payer programs, payment calculation methodologies, and adoption rates by providers; and
   - 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.

Part IV: Monitoring

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- ACO Reporting Manual outlines standard reporting and other deliverables to be provided by the ACO to the GMCB, along with the deadlines for their submission.
- Enables GMCB to monitor performance against the Budget.
- Work in progress as reports are due, preparing to post. *coming soon*

Next Steps

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- **June 16** – Public comment due
- **June 23*** — Potential Board vote on FY22 ACO Budget Guidance
- **July 1** — FY22 ACO Budget Guidance and Certification Eligibility Verification Form sent to OneCare and posted
- **September 1** — OneCare to submit FY22 Certification Eligibility Verification Form
- **October 1** — OneCare to submit FY22 Budget

*Board meeting

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Questions

Public Comment

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- Please submit written comment to the GMCB by June 16 to allow for review prior to potential vote on June 23.

Intersection of Regulatory Processes at the GMCB

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Reminder: Oversight of ACO budget interacts with other GMCB regulatory processes:

1. Hospital Budget Process
   - FPP and % of NPR
   - Risk related to TCOC performance
   - Reserves related to reconciliation of FPP vs FFS (Medicare only)
   - Hospital participation fees paid to ACO
   - Hospitals receive PMPM payments to support infrastructure, care coordination, and other initiatives
2. Rate Review
   - Board-approved QHP premium rates are an input to QHP ACO trend
   - Business associated with value-based payment models
3. APM
   - ACO contribution to All-Payer and Medicare TCOC (proportionate to scale)
   - Population Health and Quality Outcomes
   - Scale
   - GMCB authority to modify Medicare Next Generation ACO Model