

Green Mountain Care Board
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May 3, 2017

Dear ACO:

Please see below The Green Mountain Care Board's (GMCB) Accountable Care Organization (ACO) Annual Reporting and Budget Guidance test year. The objectives of this guidance are to establish standards and processes for 2016's Act 113 required review, modification, and approval of budgets, and to provide information about additional operations of Accountable Care Organizations (ACOs) in Vermont. To the extent permitted under federal law, the objective is also to ensure the rules anticipate and accommodate a range of ACO models and sizes, balancing oversight with support for innovation. In this guidance, ACOs with 10,000 or more attributed lives or are taking risk will be expected to answer all questions. ACOs with fewer than 10,000 attributed lives or are not taking risk will be expected to address elements marked with an asterisk (*).

ACO annual reporting and budget review supports the overarching goals of Vermont's ACO-based payment and delivery system reform initiatives. Those goals include: controlling the rate of growth in health care costs, encouraging integrated care and services, improving quality of care, and improving the health of Vermonters. One objective of ACO budget review and approval is to ensure ACO solvency, protecting participating provider sustainability and consumer access to care. The budget instructions are meant to be a test year of data collection, to determine what GMCB needs to examine the financial health of the ACOs, the competence of the ACOs if taking on risk, and the provider, payer, and community relationships and investments.

Please find, beginning on page two, five sections. Each has quantitative templates for completion:

1. ACO Background
2. ACO Providers
 - a. Appendix A ACO Provider Network Template
 - i. A.1: ACO Provider Network Template
 - ii. A.2: ACO Non-Physician Network Template
 - iii. A.3: Summary ACO Provider Network Template
3. ACO Programs
 - a. Appendix B.1 and B.2 2018 ACO Program Elements by Payer
4. ACO Financial Plan
 - a. Appendix C 2017 and 2018 ACO Projected Cost and Revenue Data Templates
 - i. C.1: ACO Projected Revenue by Payer



- ii. C.2: ACO Revenues by APM
 - iii. C.3: ACO Medical Costs by Service
 - iv. C.4: ACO Medical Costs by APM
 - v. C.5: ACO Administrative Costs
 - vi. C.6: ACO Other Revenue
5. ACO Model of Care and Community Integration
- a. Appendix D ACO initiatives to address All-Payer ACO Model Quality Measures

In addition to the Board’s regulatory responsibility under Act 113, the GMCB has the responsibility for oversight that the financial growth of the ACO and the state are held below financial targets set in the All-Payer ACO Model Agreement. Attached find two supplemental fact sheets: a) All-Payer ACO Model Agreement Medicare Financial Target Fact Sheet and b) All-Payer ACO Model Agreement All-Payer Financial Target Fact Sheet.

Tentative Reporting Timeline

May	GMCB provides ACOs with reporting guidance
June 23	ACOs submit budgets to GMCB
July	GMCB reviews submissions
July/August	ACO budget presentation to Board
September	GMCB deliberates on ACO budget and setting the APM trend factor
October	GMCB votes to establish each ACO’s budget at public board meeting
November	GMCB submits written order to ACOs

For questions during completion, please call Melissa Miles at 802-272-0101 or email melissa.miles@vermont.gov.

Sincerely,

Susan Barrett
Executive Director

Cc: Green Mountain Care Board Members
Vermont Office of the Health Care Advocate

The Green Mountain Care Board's Accountable Care Organization Budget Guidance (test year)

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.

Part 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 certification, please describe.

Part 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.

Part 3: ACO PROGRAMS

1. Provide copies of existing agreements or contracts with payers. If 2018 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 2018 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 (HAS)*.

Part 4: ACO BUDGET AND FINANCIAL PLAN

1. Submit most recent audited financial statements and profit and loss statement, including balance sheet, that show at a minimum: assets, liabilities, reserves, sources of working capital and other sources of financial support*.

2. Submit financial data on 2016 performance under any contracted shared savings, shared risk or full risk payer contracts, inclusive of medical and administrative expenses, by payer. If 2016 performance data is not available, please submit 2015 and supplement with 2016 when available*.

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, 2018 across all lines of business, submit the ACO's medical expense and administrative expense budget for 2018.
 - b. For ACOs with 10,000 or more attributed lives or taking risk in aggregate forecast for July 1, 2018 across all lines of business, provide, as an attachment, a completed **Appendix C – 2017 and 2018 ACO Projected Cost and Revenue Data Templates**. This will ask 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;
 - c. 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;
 - d. 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);
 - e. Strategy for planned spending on health information technology, at the ACO level and to support individual providers;
 - f. 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
 - g. 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 2018 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 Part 3.
7. Provide actuarial certification that the risk-bearing arrangements between the ACO and payers are not expected to threaten the financial solvency of the ACO.

Part 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.