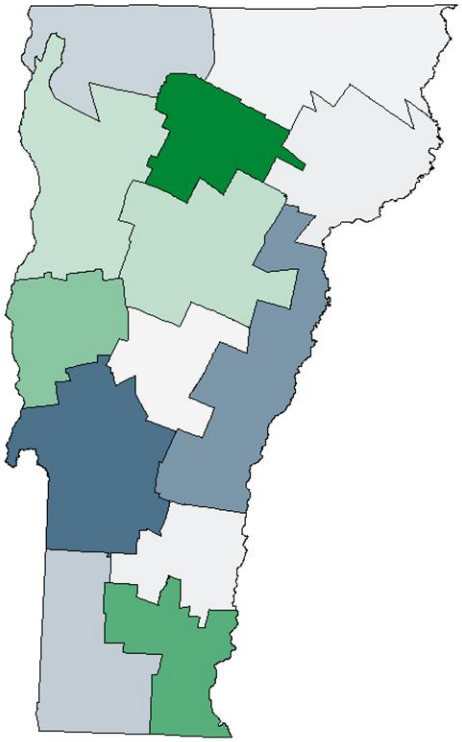

Accountable Care Organization Reporting and Budget Review

Test Year

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VERMONT
GREEN MOUNTAIN CARE BOARD

Agenda

- 113 Statutory Requirements for ACO Budget Review
- All-Payer ACO Model Agreement
- 2017 ACO Annual Reporting and Budget Review Guidance for 2018 Calendar Year - Test Year
- Timeline for review

GMCB Goals and Regulatory Levers

Goal #1:
Vermont will reduce the rate of growth in health care expenditures

GMCB Regulatory Levers:

- Hospital Budget Review
- ACO Budget Review
- ACO Certification
- Medicare ACO Program Rate-Setting and Alignment
- Health Insurance Rate Review
- Certificate of Need

Goal #2:
Vermont will ensure and improve quality of and access to care

GMCB Regulatory Levers:

- All-Payer Model Criteria
- ACO Budget Review
- ACO Certification
- Quality Measurement and Reporting

INTEGRATION OF REGULATORY PROCESSES

Act 113 Statutory Requirements

The GMCB must adopt rules to establish standards and processes for reviewing, modifying, and approving budgets of ACOs with 10,000 or more attributed lives in Vermont.

- 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
  - Social determinants of health
  - Address impacts of adverse childhood experiences (ACEs)

Act 113 Statutory Requirements

- ACO makes its costs transparent and easy to understand
- Information filed by an ACO must be made available to the public upon request
- Public comment on the ACO's proposed budget and administrative costs
- The HCA has the right to intervene in any ACO budget review
- GMCB must supervise the parties as necessary to avoid federal antitrust violations
- GMCB has the discretion regarding standards and processes for reviewing budgets of ACOs with fewer than 10,000 attributed lives in Vermont

Alignment with the All-Payer ACO Model Agreement

- All-Payer ACO Agreement moves state from volume-driven fee-for-service payment to a value-based, pre-paid model for ACOs
  - All-Payer Growth Target: 3.5%
  - Medicare Growth Target: 0.1-0.2% below national projections

- Requires alignment, to the extent possible, across Medicare, Medicaid, and participating Commercial payers in quality measures, risk arrangements, payment mechanisms, and beneficiary attribution

- All-Payer ACO Agreement has three overarching population health goals
  - Improve access to primary care
  - Reduce deaths due to suicide and drug overdose
  - Reduce prevalence and morbidity of chronic disease

2017 ACO Annual Reporting and Budget Review Guidance for 2018

- Guidance is divided into 5 sections
  - Part 1: ACO Information, Background and Governance
  - Part 2: ACO Provider Network
  - Part 3: ACO Programs
  - Part 4: ACO Budget and Financial Plan
  - Part 5: Model of Care and Community Integration

- Designed to review the ACOs' models of care and their relationships with providers, payers and the community

- Examines the budget and risk models

- This is a learning year

Part 1: ACO Information and Background

- Governing body
  - Members of the Board and their affiliations
  - Board committees and subcommittees
  - Board voting rules and bylaws
- Executive team description
- Organizational chart
- Legal or wrongful action findings affecting their performance
- Accreditation by external review organization

Part 2: ACO Provider Network

- List of providers
  - Hospitals, FQHCs, independent physicians, mental health and substance use providers, home health, Skilled Nursing Facilities, SASH, Blueprint for Health

- Payment models with providers
  - Fee-for-Service
  - Capitation
  - Global budget
  - Shared savings
  - Shared risk

- Risk assumed by providers
  - Percentage of downside risk
  - Cap on downside risk
  - Risk mitigation requirements imposed by the ACO

Part 3: ACO Programs

- Payers contractual agreements with the ACO
  - Attributed lives
  - Projected spending and revenue
  - Risk models
  - Risk mitigation provisions in the contract
  - Projected percentage growth rate for APM targets
  - Incentives tied to quality
  - List of quality measures
  - Attribution methodology

Part 4: ACO Budget and Financial Plan

- 2016 audited financial statements
- 2017 and 2018 projected revenues and expenses, administrative costs, community investments
- Planned spending
  - SASH and Blueprint
  - Community investments
  - Services
  - Changes in population or providers in coming year
- ACOs' risk arrangements and risk mitigation plan
  - Percentage of risk assumed
    - Is there risk delegated to providers?
  - Risk covered by reserves or other arrangements
  - Actuarial certification

Budget Template Samples

REPORT: ACO Financial Transparency
Appendix B: ACO Revenue and Cost Data

Template #1:	Revenue by payer, payer line of business
Responsible party:	ACO
Frequency of reporting:	Annual
Measurement periods:	Projected: January 1st through December 31st of next calendar year
	Actual: January 1st through December 31st of prior calendar year
Template creation:	3/17/2017

Revenue by payer	**Prior CY (Actual)**		**CY 2018 (Projected)**		**$ Change**		**% Change**	
Line of business	**Total $**	**PMPM $**	**Total $**	**PMPM $**	**Total $**	**PMPM $**	**Total $**	**PMPM $**
Medicaid								
TANF								
Persons eligible due to disability								
Expansion								
Subtotal Medicaid								
Medicare								
Medicare/Medicaid (dually eligible)								
Commercial								
Exchange								
Large Group								
Self-insured								
Medicare Advantage								
Subtotal Commercial								
Total All Payers, All Lines of Business								

Part 5: Model of Care and Integration

- ACO Model of Care
  - Person-centered care
  - Community provider relationships
  - Integration efforts with the Blueprint for Health and community collaboratives
  - Investments in primary care
  - Information technology enhancements
  - Care management model
  - Identification of high-risk patients

- Population Health
  - Current and planned initiatives
  - Vermont All-Payer ACO Agreement measures

Potential Timeline for ACO Budget Review and Reporting Requirements

- Board Review April 13
- Public comment period April 13-April 20
- Potential board vote April 19 or 20
- Annual Reporting and Budget Review Guidance sent to ACOs thereafter
- ACOs submit reporting in May/June timeframe
- ACOs present to board in July/August timeframe
- Board deliberates and issues final determination by October/November timeframe
- Board submits 2018 trend increase to Medicare by November to be approved by December

Discussion