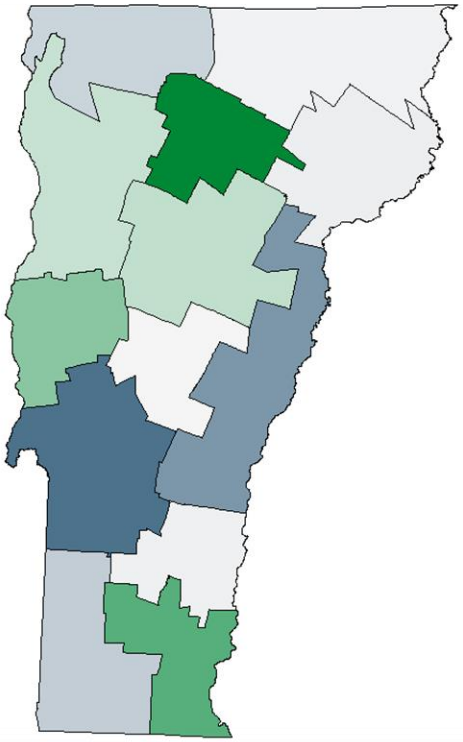

Vermont All-Payer Accountable Care Organization Model Agreement and Required Act 113 Oversight

Accountable Care Organization (ACO) Budget Review

November 2, 2017

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Act 113 of 2016
ACO Oversight and Budget Review

- *(b)(1) The Green Mountain Care Board shall adopt rules pursuant to 3 V.S.A. chapter 25 to establish standards and processes for reviewing, modifying, and approving the budgets of ACOs with 10,000 or more attributed lives in Vermont. To the extent permitted under federal law, the Board shall ensure the rules anticipate and accommodate a range of ACO models and sizes, balancing oversight with support for innovation.*

- *On or before January 1, 2018, the Green Mountain Care Board shall adopt rules governing the oversight of accountable care organizations pursuant to 18 V.S.A. § 9382.*

Act 113 Statutory Requirements for Review

- 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, current, and future years
- 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

Act 113 of 2016
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 coordination of patient care and care transitions through use of technology
- Ensures consultation with the Health Care Advocate

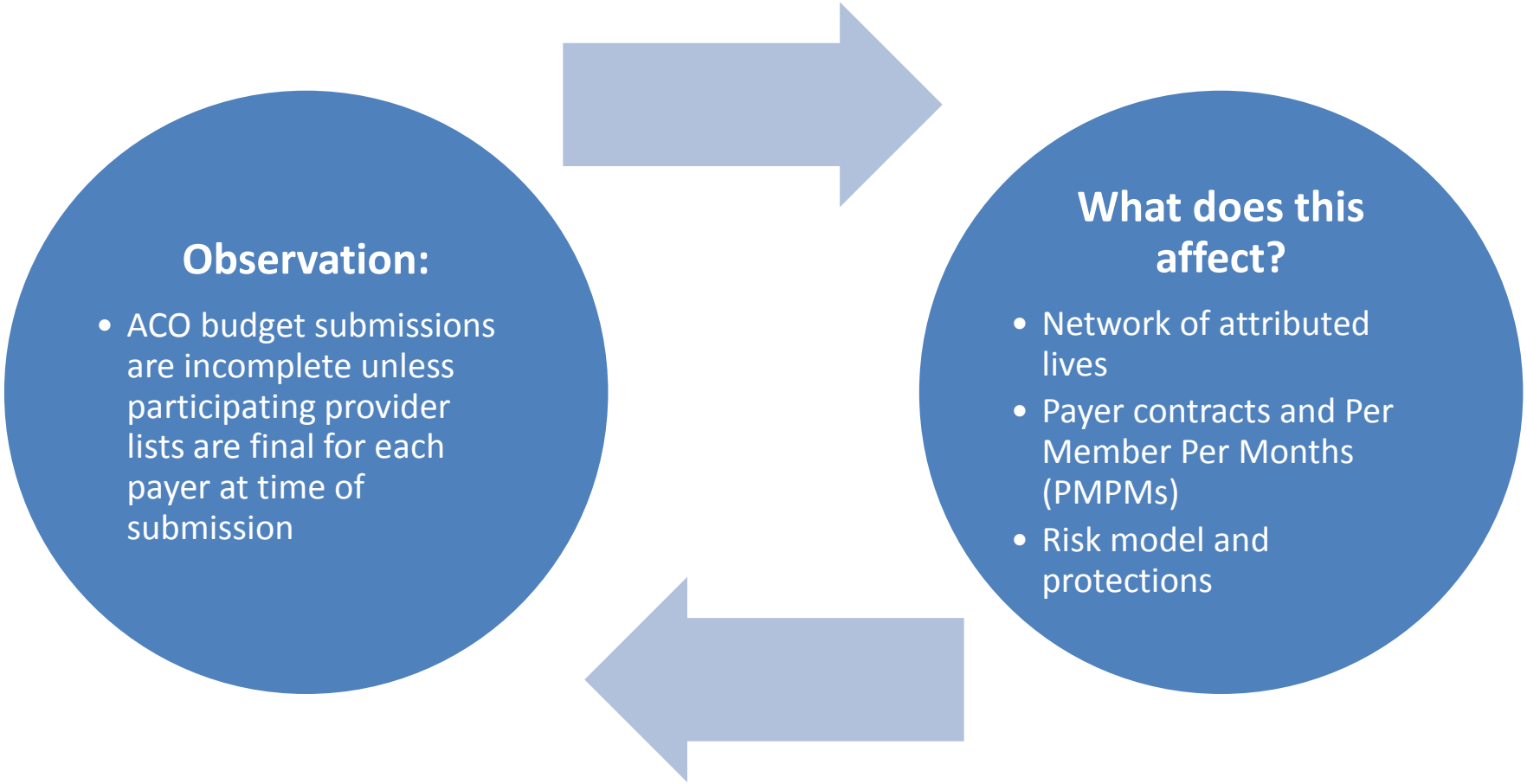
2017 ACO Budget Review Timeline

- May 4: ACO TEST annual reporting and budget criteria released
- June 23: CHAC and OneCare budgets received
- July 6: First ACO presentations
- August 4: GMCB and Health Care Advocate questions sent back to ACOs
- October 19: CHAC withdrew submission
- October 20: OneCare resubmission
- October 27: GMCB staff questions sent back to OneCare
- November 2: Second OneCare presentation

Today's Agenda

- 12:00-12:10 GMCB Board introduction
- 12:20-12:30 GMCB staff introduction
- 12:30-1:45: OneCare Vermont presentation and discussion
- 1:45-3:15: GMCB analysis, to include L&E's draft actuarial recommendations
- 3:15-3:45: Health Care Advocate question and answer
- 3:45-4:00: Board discussion and public comment

Lessons Learned



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GREEN MOUNTAIN CARE BOARD

Overall Observations

- The ACO model is still in development, shifting from a fee-for-service based shared savings to a capitated risk taking model
- The GMCB has applied accounting, policy, and actuarial analysis to the ACO's budget to support the ACO annual reporting and budget review process
- OneCare's model of care (including the Complex Care Coordination Program) combined with their evolving analytics capacity is expected to facilitate comprehensive coordinated care and population health management, especially for high needs patients
- As the regulator, GMCB will be monitoring and evaluating financial solvency, anti-trust, and clinical programs

GMCB and L&E analysis

Part 1: Governance

Part 2: Providers

Part 3: Payers

Part 4: Budget and Risk Model

Park 5: Model of Care

Part 1: Governance

Observations

- OneCare demonstrated the character and competency to be able to carry out the duties of an ACO
- The Board includes the appropriate makeup to satisfy Rule 5.000
- They have a large number of feedback mechanisms
    - ❑ Three board committees
    - ❑ Two advisory committees
    - ❑ Regional clinical performance committees

Additional Information Requested

- None. OneCare has provided sufficient information to meet the requirements of this section.

Part 2: Providers

Observations

- Network is finalized
- ~120,000 lives in the 2018 model
- Nine hospitals taking risk
- Hospitals assume risk for the Health Service Area (HSA), which includes both capitated payments and fee-for service spending

Additional Information Requested

- Description of pooling mechanism in the risk corridor by HSA
- Additional details on the risk mitigation plan and model, including reinsurance, reserves, and maximum risk on fee-for-service spending in Health Service Areas
- Need letter(s) of credit, if applicable

Part 3: Payers

Observations

- Verbal agreement with Medicaid, Medicare, Commercial, and one self-insured plan. The ACO and plans are seeking to maximize alignment between Medicare, Medicaid, and commercial payers in:
  - ❑ Total cost of care
  - ❑ Attribution and payment mechanisms
  - ❑ Patient protections
  - ❑ Provider reimbursement strategies

Additional Information Requested

- Information on truncation of high-cost outlier individuals for Medicaid and Commercial
- History of shared savings program performance
- Clarification on reinsurance/risk mitigation (see Part 2)
- Finalized payer contracts

Part 4: Budget and Risk

Observations

- $18.5 million deductions from hospital fixed payments will be used to fund population health management programs and operations
- $7.1 million will fund the Complex Care Coordination Program, a 629% increase from 2017
- $1.6 million is included for Community Program Investments
- No capital costs were reported

Additional Information Requested

- Days cash on hand increased significantly from 2016 to 2017
- 'Due to Other' liability account on the balance sheet needs further explanation
- Hospitals will confirm risk amounts and projected fixed payments

Part 5: Model of Care

Observations

- OneCare describes a comprehensive model of care that will support quality, patient experience, and cost goals
- $3.25 PMPM payment incentive for attributing providers (primary care), as well as a voluntary primary care capitation model starting in 2018 and efforts to increase primary care capacity through reduced administrative burden and increased flexibility to use non-face-to-face visits
- Complex Care Coordination Program provides $15 PMPM to primary care, DA, HH, and AAA providers involved in care team for complex care patients, with additional payments for patient-identified Lead Care Coordinators
- Current and planned investments in prevention/healthy lifestyles, reducing admissions and readmissions, and addressing social determinants of health

Additional Information Requested

- Provide projections for how the Complex Care Coordination Program will reduce the total cost of care, and how the operations of this program will be integrated with the efforts of risk-bearing hospitals to manage their budget
- Provide the timeline for completing rollout of Care Navigator
- The anticipated return for OneCare's new investments in primary care

Proposed Next Steps

- November 2-30: Public Comment period
- November 6: Send questions to OneCare Vermont
    - November 13: OneCare responds
- November 16: GMCB presentation to the Board (tentative)
- November 20: Send questions to OneCare Vermont
    - November 29: OneCare responds
- December 12: Presentation to the Board (ACO update and rate discussion)
- December 19: Presentation to the Board (Potential vote: Medicare rate and ACO budget)