FY2020 Budget Guidance and Reporting Requirements for Vermont Certified Accountable Care Organization: OneCare Vermont, ACO, LLC

draft

Effective July 1, 2019

(Staff recommendation presented 6/26/19)

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2019 TIMELINE FOR 2020 BUDGET SUBMISSION

(subject to change)

BY JULY 1:	GMCB provides ACO with reporting guidance
OCTOBER 1:	ACO submits budget to GMCB
NOVEMBER 6:	ACO budget hearing
DECEMBER 4:	GMCB staff presentation
DECEMBER 13:	Public comment period on ACO budget closes
DECEMBER 18:	GMCB votes to establish the ACO budget
45 DAYS AFTER BOARD VOTE:	GMCB issues written order to ACO

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INTRODUCTION

Please see below the Accountable Care Organization Budget Guidance and Reporting Requirements adopted by the Green Mountain Care Board (GMCB) for Budget Year 2020. *See* 18 V.S.A. § 9382(b); GMCB Rule 5.000. This document is to be used by the certified Vermont Accountable Care Organization: **OneCare Vermont ACO, LLC** (OneCare or ACO).

A certified ACO must maintain its certification in order to receive payments from Vermont Medicaid or a commercial insurer. The GMCB will verify a certified ACO's continued eligibility for certification concurrently with its proposed budget. *See* 18 V.S.A. § 9382(a); GMCB Rule 5.000, § 5.305. Certification eligibility guidance will be sent to the ACO under separate cover.

Along with its budget submission, the ACO must submit Verifications Under Oath (forms included with the guidance) signed by the ACO's chief executive, the ACO's primary financial officer, and the head of the ACO's governing body. *See* 18 V.S.A. § 9374(i).

In accordance with 18 V.S.A. § 9382(b)(3)(A) and GMCB Rule 5.000, §§ 5.105, 5.404(b), the Office of the Health Care Advocate (HCA), which represents the interests of Vermont health care consumers, must receive ACO budget filings and other materials and will participate in the budget review process, including hearings. It is the responsibility of the ACO to ensure the HCA receives all documents pertaining to the budget.

If the ACO believes materials it provides to the GMCB during this process are exempt from public inspection and copying, the ACO must submit a written request asking the GMCB to treat the materials accordingly. The written request must comply with the requirements set forth in GMCB Rule 5.000, § 5.106(c). The GMCB recommends that the ACO submit the confidentiality request at the same time it submits the materials it considers confidential (or at least notify the GMCB of the confidential nature of the documents), but in any event, the written request must be submitted to the GMCB no later than three (3) days after the potentially confidential information is submitted to the GMCB.

The HCA is bound to respect the GMCB's confidentiality designations and treat the submitted materials as confidential pending the GMCB's final decision on the request. *See* 18 V.S.A. § 9382(b)(3)(B); Rule 5.000, § 5.106(e)-(g).

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PART I. REPORTING REQUIREMENTS

Section 1: ACO Information and Background

1. Provide an executive summary of the budget submission, referencing Part I, Sections 1-5, and Parts II-III.

2. Provide an overview of the changes in the Accountable Care Organization's (ACO) budget submission from 2019 to 2020 (overview should include narrative, tables requested below, or other formats as needed). Include major network changes; program highlights; programmatic, staffing, and operational changes; and any assumptions made to create the budget submission.

    a. Provide an updated OneCare Network Grid for 2020
    b. Provide an updated OneCare Hospital Participation Table for 2020

Section 2: ACO Provider Network

1. Provide, as an attachment, a completed **2020 ACO Provider Network Template (Appendix 2.1)**.

2. Provide a written summary analysis of the **2020 ACO Provider Network Template (Appendix 2.1),** highlighting changes from 2019-2020, including changes in network by Hospital Service Area (HSA).

    a. Discuss implementation of your 2020 Network Development Strategy and Timeline.
    b. In a narrative response, describe your provider network regarding specialty type in 2020. Do you have an expanded network of primary care and mental health providers? Are you having difficulty contracting with certain specialties and why? Have you identified gaps in access to care statewide or by Hospital Service Area?

3. Submit, as an Excel spreadsheet (printout not required), your 2020 provider lists submitted to Medicare, Medicaid, and Commercial payers as **2020 Complete Physician Network – Electronic Only (Appendix 2.2)**.

    a. Provide a count of network providers affiliated by Hospital, FQHC, Independent Primary Care, Independent Specialist, Home Health, Skilled Nursing Facility, Designated Agency, if not already provide elsewhere in the submission.

4. Provide a written plan on the ACO's strategies, by year, during the remaining years of the All-Payer ACO Model Agreement to work with the State and other stakeholders to increase payer participation, increase provider participation, and develop changes to attribution methodology, with the goal of maximizing scale and achieving scale targets as outlined in the Agreement. In your response provide:

    a. The ACO's targets by year for both provider entities and attributed lives, by Hospital Service Area.

b. A strategic plan to include activities implemented in 2019, activities planned for 2020 and for the remaining years of the Agreement, and the anticipated impact of each activity.

5. For each ACO provider that will assume risk in 2020, describe the ACO's risk arrangements with the provider, including:

    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. The risk mitigation measures the ACO requires, undertakes for the provider, or is aware of the provider taking if any (e.g., reinsurance, reserves).
    d. In narrative form, describe changes in the ACO's risk arrangements with providers from 2019 to 2020.

6. Provide, as an attachment, a completed **2020 Hospital Service Areas and Associated Risk Totals (Appendix 2.3)** and a **2020 Budgeted Risk Model (Appendix 2.4)**.

7. Submit copies of each type of your provider contracts and agreements (i.e. risk contracts, non-risk contracts, collaboration agreements, and Memoranda of Understanding).

Section 3: ACO Payer Programs

1. Provide copies of existing agreements or contracts with payers if they have been updated since they were submitted to the GMCB. If 2020 contracts are not available, please submit the contracts as an addendum when they are signed.

    a. When the Medicare contract is submitted, include the latest benefit enhancement implementation plans.

2. Complete attached B20 ACO Scale Target Initiatives and Program Alignment Form (**Appendix 3.2,** including Form Appendices A and B) with your 2020 proposed contractual arrangements, by payer.

3. Provide an explanation for your projected growth rates, referencing Part II: Benchmark Guidance, which provides background on the All-Payer and Medicare Total Cost of Care per Beneficiary Growth outlined in the Vermont All-Payer ACO Agreement. Complete the table **Projected and Budgeted Trend Rates, by Payer Program (Appendix 3.1)**.

    a. Briefly explain the source and assumptions used for the budgeted trend rate for each program (and provided in column D). For programs subject to rate review by the GMCB, include details about how the Board's decision factored into the assumptions for the ACO's budgeted trend.
    b. For each program, contrast the budgeted growth rate (column D) with the expected growth trend for the ACO (column G). Include analysis for reasons why the ACO's performance differs from the trend rates used in the budget.

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Section 4: ACO Budget and Financial Plan

1. Complete the GMCB financial statement sheets in Adaptive, including Income Statement, Balance Sheet, and Cash Flow. Sheets in Adaptive: *A1a-Income Statement (All Accounts); A1b-Income Statement (Excl. Pass-Thru); A2-Balance Sheet; A3-Cash Flow*. Excel versions are **Appendices 4.1-4.3**, for reference.

2. Provide, as an attachment, completed **Appendices 4.4-4.5**. The Appendices request the ACO, by payer and line of business, to provide information on projected revenues and total shared savings or loss flowing through the ACO financial statements (including payer revenues, participating provider dues, and grant funding) 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.

3. Complete all tabs of **Part 4.6 Appendix – ACO 2020 Budget Submission Reporting APM for Participating Hospitals** for the 2020 budget year.

4. Provide a narrative description of the following elements of the ACO's spending plan:

    a. Relevant industry benchmarks used in developing the administrative budget;
    b. Provide brief definitions or narrative descriptions of items that fall under Administrative (Operating) expenses and the Administrative Expense Ratio in Appendix 4.2.
    c. The methodology for determining the qualification for and amount of any provider incentive payments and how those payments align with ACO performance incentives, which may include contractual agreements measures and outcomes.
    d. Quantity of Delivery System Reform dollars and associated goals for stated investments;
    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 for 2020. Include in the narrative description a discussion of any changes in the funds flow from the 2019 submission to the 2020 submission. 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. Referring to Appendix 4.4, Total Shared Savings / (Loss) to ACO, provide a quantitative and qualitative summary of your shared savings distribution plan for 2018.

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7. Provide both a quantitative and qualitative summary of your quality withhold distribution plan for 2018.

8. Provide a quantitative analysis with accompanying narrative to demonstrate how the ACO would manage the financial liability for 2020 through the risk programs included in Part 3 should the ACO's losses equal 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 delegated through fixed payment models to ACO-contracted providers and the percentage overrun on total expecting spending outside the ACO's fixed payment models that would result in losses of 75% and 100% of the ACO's maximum downside exposure;
   b. Portion of risk covered by ACO providers through mechanisms other than fixed payment models (e.g., withholds, commitment to fund losses at annual settlement, etc.);
   c. Portion of 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;
   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 payers under ACO program contracts appearing in Part 3.

9. 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.

10. Provide any further documentation (i.e. policies) for the ACO's management of financial risk.

<u>Section 5: ACO Quality, Population Health, Model of Care, and Community Integration Initiatives</u>

1. Provide an update on your statewide model of care and how it has changed from 2017 to 2019. Narrative can include but is not limited to:

   a. How ACO clinical consultants collaborate with the Blueprint for Health (include any goals and milestones set or achieved);
   b. How ACO technical assistance has allowed communities to transform care (e.g. have more care coordinators been hired, new programs been instituted, etc.); and
   c. How ACO is aligning with payer care coordination programs.

2. Quantify and describe the transitions communities are making to the Accountable Communities for Health Model. Include a description of how the ACO is involved in these efforts. How have these grown from the Community Collaboratives? What is the team composition? What are the topics the teams are working on? Are the teams meeting more frequently? How is the Blueprint for Health involved?

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3. How have OneCare's population health investments supported transformation in care at the local level? This includes the Complex Care Coordination Program, RiseVT, the Regional Clinical Representatives, and other initiatives directly funded by the ACO. For each program, list the population health investment(s) referenced in Appendix 5.4 that the community or OneCare is using to support the program. If you are providing support other than financial, please describe. ~~Describe additional support, beyond financial, that OneCare provides these programs.~~

4. Describe goals and objectives planned for future model of care initiatives for 2020-2022 (include a workplan if available or embed in a table).

5. Provide a progress report on the network's use of software tools for care management. In **Appendix 2.1, Provider Network,** the ACO will report the organizations that are using the tool by Hospital Service Area. In addition, the ACO shall report:

    a. The number of patients with information in the system by Hospital Service Area;
    b. The number of patients with shared care plans in the system by Hospital Service Area;
    c. A summary of how the ACO is incorporating provider and patient input on software tools (if possible, include a summary of input from providers who have opted not to use Care Navigator and/or are using different software tools); and
    d. Any other key process metrics demonstrating adoption of the care management model.

6. Provide an update on your Care Coordination Effectiveness and Outcomes Analysis Framework using data.

7. Complete **ACO Clinical Priority Areas (Appendix 5.1)**. In the appendix provide the ACO's 2018 clinical and program priorities, metrics, targets, and actual results, by payer. In the appendix also list the 2019 clinical and program priorities, metrics, and targets, by payer. In addition:

    a. Describe in narrative form what changed or stayed the same from 2018-2019 and progress made on your clinical priorities in 2019 to date, including successes and opportunities for improvement.
    b. Describe in narrative form your process for developing 2020 Clinical Priority Areas.
    c. How does each community prioritize and choose their clinical priorities?

8. Complete **ACO Quality Activities Related to the Vermont All-Payer ACO Model Agreement (Appendix 5.2)**, to describe results to date on ACO initiatives to address the quality measures. Be prepared at the budget hearing to respond to questions about the All-Payer Model Statewide Health Outcomes and Quality of Care Targets Report for 2018 that will be submitted to CMMI in September.

9. By payer and line of business, provide an analysis of your most recent annual ACO quality reports for measures. In addition, provide results and analysis for the measures included in each payer contract, including the quality score, benchmark, and percentile

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for each payment and reporting measure for 2018, and any results of patient or provider experience surveys. Describe how these results,- and results from previous years, have informed the ACO's programs and model of care, including the ACO's annual quality improvement workplan. In your discussion of results from previous years, identify and explain any statistical limitations.

10. Describe strategies for expanding capacity in existing primary care practices, including but not limited to reducing administrative burden on such practices.

11. Provide a summary analysis of your population in **ACO Population Risk Stratification Summary Analysis (Appendix 5.3)**, including variations in risk by Hospital Service Area; a breakdown of population distribution and associated spend into the four population health quadrants, by Hospital Service Area, for 2018 and 2019.

    a. Provide a narrative overview of the risk stratification methodology and rationale.
    b. How does OneCare use risk stratification data to inform 2020 budget assumptions and model of care?
    c. Provide the prevalence of the most common conditions among ACO attributed lives, by Hospital Service Area.

12. Provide an evaluation of variations in your 2018 and 2019 data by Hospital Service Area. Are there specific trends by Hospital Service Area that you have identified? If so, how is this data being used to drive clinical progress and change within the network?

13. Refer to **Part III: All-Payer Total Cost of Care, Per Member Per Month, 5-Year Compounding Growth Rate, 2012-2017** to answer the questions below:

    a. When comparing these HSA-specific resident estimates to those experienced by the population attributed to your ACO, do the trends appear to be similar? Are there notable differences? Provide an analysis that might help explain the variation observed in the ACO population across HSA.
    b. In looking at the per member per month spending and growth for each Hospital Service Area, what observations can you share with the GMCB? Explain any insights you may have as to why an HSA is above or below the 3.5% growth rate, or whose baseline TCOC is above or below the Statewide PMPM.
    c. What strategies will the Accountable Care Organization be undertaking to support the State's goal of limiting Total Cost of Care (TCOC) per member growth to 3.5% or less from 2017 to 2022? How are these strategies aligned with the goals of the APM Agreement? How do strategies differ by HSA?
    d. What specific action steps can healthcare stakeholders be doing to support the goals of the Vermont All-Payer ACO Model?
    e. Finally, as we look to better align our regulatory processes with our federal obligations, please provide any suggestions for how the GMCB could better assess the relationship between hospital spending and the All-Payer TCOC growth targets.

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14. Populate **2020 Population Health Program Investments (Appendix 5.4)**. The table includes:

    - Primary and Secondary Investment Type
    - Program Name
    - Program Description
    - Investment Amount
    - Operational Model
    - Financial Model
    - PMPM Amount (if applicable)
    - Recipients

    Per 18 V.S.A. § 9382, population health program financial investments should include:

    a. Strategies to bring primary care providers into the network
    b. Strategies for expanding capacity in existing primary care practices, including but not limited to reducing administrative burden on such practices
    c. Integration of community-based providers, including expanding capacity to promote seamless coordination of care across the care continuum
    d. Population health programs, including:
        i. preventing hospital admissions or readmissions
        ii. reducing length of hospital stays
        iii. improving population health outcomes, with a focus on the All-Payer ACO Model measures found in Appendix 5.2 APM Quality Measures
        iv. addressing social determinants of health
        v. addressing childhood experiences and trauma
        vi. supporting and rewarding healthy lifestyle choices.

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PART II. BENCHMARK GUIDANCE

In deciding whether to approve or modify an ACO's proposed budget, the Board will take into consideration the requirements of the Vermont All-Payer Accountable Care Organization Model Agreement (the Agreement), 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). As described in more detail below, the Agreement also limits the Board's discretion to prospectively establishing benchmarks for the Vermont Medicare ACO Initiative (i.e., the financial targets against which expenditures for services furnished to ACO-aligned Medicare beneficiaries will be assessed).

Under the Agreement, the second year of the Vermont Medicare ACO Initiative ("Initiative") will begin on January 1, 2020. The Board will prospectively develop, in accordance with the requirements of the Agreement and subject to CMS approval, a benchmark for each ACO participating in the initiative.[1] To guide ACOs in developing their 2020 budgets, this section outlines the factors the Board considers when setting the Initiative benchmarks.

Under the terms of the Agreement, the Vermont Medicare ACO Initiative Benchmarks for 2020, Performance Year 3 of the Agreement, must be established so that either:

1) The annual growth rate is at least 0.2 percentage points below the projected annual growth from 2019 to 2020 for Medicare nationally; or
2) The compounded annualized growth rate (CAGR) is less than 0.1 percentage points above the projected CAGR from 2017 to 2020 for Medicare nationally.

See Agreement, §§ 8(b)(ii)(1)(c)(i) & (iii).

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[1] Underneath the overall benchmark, separate benchmarks will be established for two Medicare fee-for-service populations, the End-Stage Renal Disease (ESRD) population and the Aged and Disabled (A/D or non-ESRD) population.

Table 1: Medicare Advantage United State 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%
Compounding Projection to Date		3.97%		3.34%		3.95%
Compounding Target to Date		**3.77%**		**3.14%**		**3.75%**

Calculation:

Blended Compounding Projection = (1.037*1.0402*1.0413) ^ (1/3) -1 = 3.95%

Blended Target to date = 3.95% - 0.2% = 3.75%

Source:

https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents.html

Additionally, the benchmarks must enable achievement of the financial targets in the Agreement. *See id.* § 8(b)(ii)(1)(e).

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PART III. ALL-PAYER TOTAL COST OF CARE, PER MEMBER PER MONTH, 5-YEAR COMPOUNDING GROWTH RATE, 2012-2017

Background:

The GMCB is responsible for tracking the change in population-wide spending of Vermont residents over the course of its All-Payer Model Agreement with the federal government. The following table shows the All-Payer Total Cost of Care (TCOC) per member per month along with the compounding growth rate from 2012 through 2017. The results include breakouts based on the Hospital Service Area where the patients live.

The results are raw, unadjusted estimates of spending regardless of the provider location (e.g. out-of-state spending is included). Differences in PMPM are impacted by demographics (e.g. age of the patients in that area), payer mix (e.g. proportion of Medicaid as a primary payer), and other factors.

The results are derived from medical claims data available in the state's All-Payer Claims Database, VHCURES. For example, VHCURES does not have complete information for self-insured employer spending. The spending excludes retail pharmacy and approximately half of Medicaid spending (i.e. funds that are not paid through the Department of Vermont Health Access).

The TCOC PMPM in the HSAs is the way that the State will be held accountable for its growth through the All-Payer Model Agreement. The intent in sharing this information is to provide a different view of spending consistent with the APM Agreement and to begin to understand the complexities of cost containment efforts. See Table III.1 below.

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Table III.1: All-Payer Total Cost of Care, Per Member Per Month, with 5-Year Compounding Growth Rate, 2012-2017

Hospital Service Area of Patient Residence	2012	2013	2014	2015	2016	2017	5-Year Compounding Growth Rate
Barre	$386.25	$412.15	$430.99	$445.12	$489.67	$479.57	4.4%
Bennington	$439.97	$453.64	$464.43	$479.16	$496.70	$508.14	2.9%
Brattleboro	$408.98	$409.73	$419.43	$420.34	$453.89	$486.41	3.5%
Burlington	$351.29	$378.03	$389.47	$402.99	$429.12	$445.53	4.9%
Middlebury	$377.55	$412.63	$415.64	$431.85	$464.06	$469.07	4.4%
Morrisville	$375.35	$378.53	$387.37	$388.78	$404.79	$420.88	2.3%
Newport	$416.06	$424.26	$426.08	$434.80	$452.52	$479.65	2.9%
Randolph	$434.81	$448.97	$467.31	$512.82	$522.98	$574.90	5.7%
Rutland	$459.60	$486.65	$487.80	$504.74	$528.24	$551.08	3.7%
Springfield	$470.82	$477.60	$472.21	$518.65	$527.10	$549.65	3.1%
St Albans	$393.96	$407.67	$432.73	$448.26	$456.28	$466.19	3.4%
St Johnsbury	$404.04	$423.11	$425.58	$441.02	$481.44	$495.53	4.2%
White River Jct	$419.70	$440.18	$451.56	$458.47	$450.32	$493.91	3.3%
Statewide	**$399.27**	**$418.51**	**$428.40**	**$443.13**	**$466.32**	**$483.50**	**3.9%**