VERMONT

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# MEMORANDUM

TO: House Committees on Health Care and on Human Services and the Senate Committees on Health and Welfare and on Finance

FROM: Green Mountain Care Board

RE: Appropriate role of multi-year budgets for Accountable Care Organizations

DATE: January 15, 2017

CC: Al Gobeille, Secretary of Human Services
Cory Gustafson, Department of Vermont Health Access

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## Summary of Findings and Recommendation

Pursuant to Section 14 of Act 113 of 2016, the Green Mountain Care Board (GMCB), in collaboration with the Department of Vermont Health Access, recommends that the budget review of accountable care organizations (ACO) required by Section 5, 16 (b)(1) of Act 113 be done on an annual basis. However, the GMCB may request projections, or other information needed, to ensure that the total cost of health care is on track for meeting the financial targets contained in the All-Payer Model Agreement. This recommendation is based on the following findings:

1) GMCB reviewed data from the following states who have instituted a Medicaid ACO Program: – Colorado, Illinois, Iowa, Maine, Minnesota, New Jersey, Oregon, Utah, and Vermont. [1]
2) Some states with ACO certification programs have a budget review process, which entails examination of budgets quarterly or annually. However, other states request budget information on multi-year basis as well.
3) Blue Cross and Blue Shield of Massachusetts has offered an "Alternative Quality Contract" (AQC), which is an arrangement between providers and insurers to reduce healthcare spending growth. AQC contracts are three to five years with fixed spending and performance goals.

Interviews conducted with AQC providers found that the longer-term contract demonstrates a clear commitment from the payer. The interviews indicated that aligning provider incentives with longer-term spending and quality targets is likely to increase provider buy-in.[13,14]

4) Vermont has shifted substantially in its Accountable Care Organization landscape, adding the Vermont All-Payer Accountable Care Organization Model Agreement (APM) signed October 27, 2016 and Medicaid's All-Inclusive Population-Based Payment (AIPBP). [15]
5) The Board staff are currently implementing the APM and ACO budget criteria provided for in Act 113.
6) The APM requires GMCB to define the Total Cost of Care per Beneficiary and to set the Medicare ACO Initiative Benchmarks yearly.[15]
7) The Board will be promulgating rules prior to January 1, 2018 on ACO budget review for ACOs with 10,000 or more attributed lives in 2018.
8) Under Act 113, GMCB must take into consideration the information provided by the ACOs including service utilization, expenditure analysis from the prior year and proposed year under review by payer, administrative costs, and investments in the health care system.
9) As part of the rule development, the Board staff is working with stakeholders and interested parties on the appropriate information to be submitted as part of the process, including the length of time for budgeting.
10) Stakeholder input to date has been that a yearly budget, at least initially, would make sense until the regulated entities and the Board have been through the cycle.
11) Many state contracts provide for a one year term with options for renewal. Because the ACO will have a contract with Medicaid, initially a one year budget may better align with the contracting process.

Given the multiple factors described above and their potential to change annually as the program evolves, GMCB and DVHA suggest it is premature to request multi-year budgets of the ACOs at this time.

**Introduction and Legislative Charge**

Section 14 of Act 113 charged the Green Mountain Care Board (GMCB) with considering "the appropriate role, if any, of using multi-year budgets for Accountable Care Organizations (ACOs) to reduce administrative burden, improve care quality, and ensure sustainable access to care" and with reporting findings and recommendations to the House Committees on Health Care and on Human Services and the Senate Committees on Health and Welfare and on Finance no later than January 15, 2017. This report was done in collaboration with the Department of Vermont Health Access as required by Section 14.

The next section of this report summarizes the research conducted by the Board staff, including ACO certification programs in other states and the peer-reviewed literature available on ACOs to provide the background information on the findings and recommendations noted above. The remainder of the report provides information about the state and federal context informing the findings and recommendations.

**Background Research on State Certification Programs**

The following chart summarizes the relevant information staff collected about other states with ACO programs. Additional information about each state is contained after the Table.

*Table 1. Summary of State ACO Budget Submission Requirements*

| State | Threshold | Required with Submission | Reporting Timeframe |
|---|---|---|---|
| Massachusetts | A 'significant' downside risk test is performed, which results in a waiver or request of the contractor to submit documents for certification. | • Most recent audited financial statements, or the financial statements and documents that show the assets, liabilities, reserves and sources of working capital and other sources of financial support<br>• A signed actuarial certification<br>• Operating projections for the succeeding three years | Annual |
| New York | Participation in a New York State Medicaid ACO | • Projected 5-year pro forma budget<br>• Cash flow analysis for the ACO<br>• Document financial arrangements among the ACO and its participants including but not limited to asset purchases, loans, donations, compensation under management or service agreements, joint purchasing agreements, shared risk or shared savings arrangements, obligated group financing programs | Annual |
| Oregon | Participation in Oregon CCO (Coordinated Care Organization) | • Submittal of a five-year pro forma fixed global budget, that includes reporting on restricted reserves, actual or projected liabilities, and net worth.<br>• Quarterly reporting on assets, liabilities, salaries, and services rendered | Quarterly |
| Illinois | Any ACO | • Detailed three-year budget<br>• Most recent audited financial statements Description of reimbursement structure<br>• Data on savings in care coordination<br>• Distribution of shared savings | Annual |

A. Massachusetts

In 2012, the Massachusetts Legislature signed into law Chapter 224 of the Acts of 2012, entitled "An Act Improving the Quality of Health Care and Reducing Costs through Increased Transparency, Efficiency and Innovation". This legislation offered ACO budget certification requirements for provider organizations engaged in Alternative Payment Contracts, including shared savings arrangements, bundled payments, global budgets, and fee-for-service payments settled or reconciled with a bundled or global payment.[2,3] Those who are in Medicare Advantage agreements only are excluded.[4]

The Division of Insurance must weigh key factors to determine whether the RBPO's Alternative Payment Contracts contain "significant" Downside Risk. These include:

- The total amount of the applicant's net patient services revenue ("NPSR"), where NPSR is defined as the total dollar amount of a Provider Organization's charges for services rendered in a Fiscal Year, less any contractual adjustments;
- The amount of the applicant's NPSR that is subject to Downside Risk;
- The percentage of the RBPO's total NPSR that is subject to Downside Risk;
- The total maximum loss that the RBPO would be subject to through Alternative Payment Contracts subject to Downside Risk; and
- The maximum loss that the RBPO would be subject to through Alternative Payment Contracts subject to Downside Risk as a percentage of its total NPSR.

Massachusetts Division of Insurance states that under most circumstances, the Commissioner would allow for a Risk Certificate Waiver if in their most recently audited financial statements the revenue from the RBPO's Alternative Payment Contracts with Downside Risk account for less than 5% of the RBPO's NPSR (and the RBPO has the net worth – where "net worth" is defined to be the RBPO's assets less its liabilities – sufficient to fund the maximum losses from its Alternative Payment Contracts with Downside Risk).[4]

If an organization is found to have Significant Risk, they must obtain a Risk-Bearing Provider Organization (RBPO) certificate. The certificate application requires submittal of most recent audited financial statements, or the financial statements and documents that show the assets, liabilities, reserves and sources of working capital and other sources of financial support. The provider organization must obtain a signed actuarial certification that speaks to solvency of the ACO. Once approved, annually ACOs may reapply for certification.[5] At the time of reapplication, the ACO must provide operations projections for the succeeding three years. [3]

B. New York

New York State instituted an ACO Certificate of Authority application as of December 31, 2014, and within the certificate application are budget requirements. This application applies to New York State Medicaid ACOs, while Medicare Shared Savings Program ACOs are only subject to submit a limited amount of documentation.[6]

The application requires the ACO to submit a business plan that shows projected cost savings to the ACO and efficiencies over a 5-year period and how they will be achieved. They request that the cost savings detail a) reductions in administrative and capital costs and b) improvements in the utilization of health care provider resources and equipment. Pro forma financial statements for the first day of operation, a projected 5-year budget, and a cash flow analysis for the ACO with its proposed activities are elements of the submission requirement. The ACO must also document financial arrangements among the ACO and its participants including but not limited to asset purchases, loans, donations, compensation under management or service agreements, joint purchasing agreements, shared risk or shared savings arrangements, and obligated group financing programs. ACOs report annually thereafter. [7]

C. Oregon

In 2011, Oregon's Legislature voted into law approval of a Coordinated Care Organization (CCOs) model to allow prepayments to communities to manage their Medicaid program. [8] Oregon's CCOs must apply to operate in the state. They are local or state run, and include a broad network of health care providers (physical health care, addictions and mental health care and sometimes dental care providers).[9]

The criteria adopted by Oregon to certify CCOs includes, but is not limited to, the organizations demonstrated experience and capacity to 1) manage financial risk, 2) establish financial reserves, and 3) manage the following minimum financial requirements:

a) Maintaining restricted reserves of $250,000 plus an amount equal to 50 percent of the coordinated care organizations total actual or projected liabilities above $250,000,
b) Maintaining a net worth in an amount equal to at least five percent of the average combined revenue in the prior two quarters of the participating health care entities, and
c) Operating within a fixed global budget. [9]

The application submission requires a five-year pro forma budget and capitation rates. Once approved, CCOs submit quarterly reporting that includes detail on assets, liabilities, salaries, and services rendered, including type and to whom.[10,11]

D. Illinois

The State of Illinois began an Accountable Care Entities (ACE) program to manage their Medicaid program in 2014. These are flexible networks of providers to manage physical and behavioral health care, with the intent to allow Providers to design and implement integrated delivery systems that coordinate delivery of a broad range of health services and promote accountability for the care delivered to the populations they serve. Illinois plans to move from P4P payments to shared savings to full accountability in a three-year phased approach.[1]

Illinois requires ACEs to apply with a detailed three-year budget, most recent audited financial statements, and description of reimbursement structure for months one through eighteen and months

nineteen through thirty-six. They must demonstrate how they will reduce healthcare costs by an amount equal to or greater than their care coordination fees and propose a distribution plan for shared savings among providers that is designed to incent practice redesign and care coordination activity. For months nineteen on, they must demonstrate the flow of financial reimbursement among participating providers down to the PCP including sharing in financial savings.[11]

**Vermont Considerations**

Vermont Medicaid and Commercial payers have offered an ACO Shared Savings Program since 2014. There have been three ACOs who have participated, OneCare, Community Health Accountable Care (CHAC), and HealthFirst. Vermont has shifted substantially in its Accountable Care Organization landscape, adding the Vermont All-Payer Accountable Care Organization Model Agreement (APM) signed October 27, 2016. In 2017, Medicaid is expected to award OneCare an All-Inclusive Population Based Payment contract that consists of a risk arrangement. OneCare and CHAC are also both participating for another year in the Medicare Shared Savings Program. In 2018, the Board anticipates that there will be provider participation in a Medicare NextGen ACO.

In 2016, the general assembly passed Act 113, which establishes regulatory authority by the Board over accountable care organizations, including a certification process and budget review. The Board will be promulgating rules prior to January 1, 2018 on the ACO budget review process, which applies to ACOs with 10,000 or more attributed lives in 2018. Under Act 113, GMCB must take into consideration the information provided by the ACOs including: service utilization, expenditure analysis from the prior year and proposed year under review by payer, administrative costs, and investments in the health care system. As part of the rule development, the Board staff is working with stakeholders and interested parties on the appropriate information to be submitted as part of the process, including the length of time for budgeting. Stakeholder input to date has been that a yearly budget, at least initially, would make sense until the regulated entities and the Board have been through the cycle.

The All Payer Model requires GMCB to define the Total Cost of Care per Beneficiary and to set the Medicare ACO Initiative Benchmarks yearly, which makes annual ACO budget review necessary. Lastly, many state contracts provide for a one year term with options for renewal. Because the ACO will have a contract with Medicaid, initially a one year budget may better align with the contracting process.

**Conclusion**

At this time, the Board recommends establishing an annual budget cycle for ACO budget review in order to align with the APM requirements and to allow for modifications in the first cycles of the new regulatory process.

## References


[1]Jim Lloyd, Rob Houston, and Tricia McGinnis. Medicaid Accountable Care Organizations State Profiles. Center for Health Care Strategies, June, 2015. http://www.chcs.org/media/Medicaid-Accountable-Care-Organization-Programs-State-Profiles.pdf.

[2]Commonwealth of Massachusetts, Certification of Accountable Care Organizations; Standards. https://malegislature.gov/Laws/GeneralLaws/PartI/TitleII/Chapter6D/Section15

[3]Commonwealth of Massachusetts, Department of Insurance. Risk-Bearing Provider CMS 155.00. http://www.mass.gov/ocabr/docs/doi/legal-hearings/211-155.pdf, accessed 9/13/2016.

[4]Commonwealth of Massachusetts, Department of Insurance. *Application for Risk Certificate for the Term March 1, 2017 - February 28, 2018.* http://www.mass.gov/ocabr/government/oca-agencies/doi-lp/risk-certificate-application-information.html, accessed 9/13/2016.

[5]Massachusetts Division of Insurance, *Risk Bearing Provider Organization Frequently Asked Questions*. http://www.mass.gov/ocabr/docs/doi/rbpo/rbpo-faqs.pdf, accessed 9/15/2016.

[6]State of New York. Accountable Care Organization. http://www.health.ny.gov/health_care/medicaid/redesign/aco/, accessed 9/27/2016.

[7]State of New York. Accountable Care Organization. http://www.health.ny.gov/regulations/recently_adopted/docs/2014-12-31_accountable_care_organizations.pdf, accessed 9/27/2016.

[8]State of Oregon. *Senate Bill 1580.* https://cco.health.oregon.gov/Documents/sb1580.intro.pdf, accessed 9/27/2016.

[9]State of Oregon. 414.625 *Coordinated Care Organizations rules*. http://www.oregonlaws.org/ors/414.625, accessed 9/27/2016.

[10]Oregon Coordinated Care Organization *Request for Application, E – Financial Reporting and Solvency Questionnaire.* https://cco.health.oregon.gov/RFA/Documents/RFA%203402-Addendum12%20tlh%20final.pdf, accessed 9/27/2016.

[11]State of Oregon, *CCO Contract Forms, 2016 Exhibit L Financial Reporting Template*. http://www.oregon.gov/oha/healthplan/Pages/cco-contract-forms.aspx, accessed 11/10/2016.

[12]State Of Illinois. *Solicitation for Accountable Care Entities,* https://www.illinois.gov/hfs/SiteCollectionDocuments/HFS%20ACESolicitation_080113.pdf, accessed 11/10/2016.

[13]Lewis, Valerie, et al. *ACO Contracting With Private and Public Payers: A Baseline Comparative Analysis.* Journal of Managed Care, December 2014, pp. 1008-1014.

[14]Seidman, Josh., Kelly, Cara., Ganesan, Nelly, Gray, Ashley. *Payment Reform on the Ground: Lessons from the Blue Cross Blue Shield of Massachusetts Alternative Quality Contract.* Avalere Health LLC. March 2015.

[15]The Vermont All-Payer Accountable Care Organization Agreement.