STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

FY24 ACCOUNTABLE CARE ORGANIZATION BUDGET ORDER

In re: Vytalize Health 9 ACO LLC	)	
Fiscal Year 2024	)	
	)	Docket No. 23-003-A

INTRODUCTION

The Green Mountain Care Board (GMCB or Board) is charged with reviewing, modifying, and approving the budgets of accountable care organizations (ACOs). 18 V.S.A. § 9382(b). An ACO is an organization of health care providers that has a formal legal structure and agrees to be accountable for the quality, cost, and overall care of the patients assigned to it. *See* 18 V.S.A. § 9571. Below, we outline the legal framework for the Board's review of ACO budgets, identify the criteria we considered during our review of the FY24 budget of Vytalize Health 9 ACO, LLC (Vytalize), and present specific Findings and Conclusions in support of our Order approving Vytalize's FY24 budget.

LEGAL FRAMEWORK

The ACO oversight statute and GMCB Rule 5.000 state that the Board will review, modify, and approve ACO budgets. *See* 18 V.S.A. § 9382(b), GMCB Rule 5.000, § 5.405(c). The Board's review of an ACO's budget differs depending on whether the ACO is projected to have more or less than 10,000 attributed lives in Vermont. 18 V.S.A. § 9382(b)(1)-(2). For ACOs such as Vytalize that are projected to have fewer than 10,000 attributed lives, "the Board may consider as many of the factors described in [18 V.S.A. § 9382(b)(1)] as the Board deems appropriate to [the] . . . ACO's size and scope." 18 V.S.A. § 9382(b)(2); GMCB Rule 5.000, § 5.405(c)(2). Considering the size and scope of Vytalize's operations in Vermont, the Board's review of Vytalize's FY24 budget focused on the following factors from 18 V.S.A. § 9382(b)(1):

- information regarding utilization of the health care services delivered by health care providers participating in the ACO and the effects of care models on appropriate utilization, including the provision of innovative services;
- the character, competence, fiscal responsibility, and soundness of the ACO and its principals;
- any reports from professional review organizations;
- the ACO's efforts to prevent duplication of high-quality services being provided efficiently and effectively by existing community-based providers in the same geographic area, as well as its integration of efforts with the Blueprint for Health and its regional care collaboratives;

- public comment on all aspects of the ACO's costs and use and on the ACO's proposed budget;
- information gathered from meetings with the ACO to review and discuss its proposed budget for the forthcoming fiscal year;
- information on the ACO's administrative costs, as defined by the Board;
- the extent to which the ACO makes its costs transparent and easy to understand so that patients are aware of the costs of the health care services they receive; and
- the extent to which the ACO provides resources to primary care practices to ensure that care coordination and community services, such as mental health and substance use disorder counseling that are provided by community health teams, are available to patients without imposing unreasonable burdens on primary care providers or on ACO member organizations.

GMCB PowerPoint, 25-26 (Dec. 6, 2023).

The Board's review of an ACO's budget must also consider any benchmarks the Board has established, as well as the elements of the ACO's Payer-specific programs and any applicable requirements of 18 V.S.A. § 9551 or the Vermont All-Payer Accountable Care Organization Model Agreement between the State of Vermont and the Centers for Medicare and Medicaid Services (CMS). *See* GMCB Rule 5.000, § 5.405(c).

Under statute, the Board's annual ACO budget review is separate from the Board's role in certifying ACOs. Certification is required for an ACO in Vermont to be "eligible to receive payments from Medicaid or commercial insurance through any payment reform program or initiative, including an all-payer model." *See* 18 V.S.A. § 9382(a).

FY24 REVIEW PROCESS

The review process for Vytalize's FY24 budget is reflected in the following timeline:

06.28.23: The Board issued FY24 budget guidance and reporting requirements for Medicare Only Non-Certified ACOs (Medicare-Only ACO Budget Guidance).
11.01.23: Vytalize submitted its proposed FY24 budget to the Board (Vytalize Budget Submission).[1]
11.15.23: Vytalize presented its budget at a hearing before the Board (Vytalize Budget Presentation).
11.20.23: Board staff presented an analysis and preliminary recommendations regarding Vytalize's proposed FY24 budget (GMCB Staff Analysis I).
12.06.23: Board staff presented additional analysis and updated recommendations regarding Vytalize's proposed FY24 budget (GMCB Staff Analysis II), and the Board voted to approve Vytalize's FY24 budget on the terms and subject to the conditions described in this Order.

[1] The deadline for ACO budget submissions was October 1, 2023. Vytalize's late filing was due to a misunderstanding regarding the scope of the required budget submission.

The written materials from this process are posted on the Board's website[2] and video recordings of the meetings are available on the Board's YouTube channel.[3]

FINDINGS

Overview

1. Vytalize Health 9 ACO LLC ("Vytalize") is a New Jersey limited liability company. Vytalize is a subsidiary of Vytalize Health LLC, a Delaware limited liability company that owns several ACOs. *See* Vytalize Budget Submission, 4; GMCB Staff Analysis I, 36, GMCB Staff Analysis II, 12.

2. 2024 will be Vytalize's second year participating in the Accountable Care Organization Realizing Equity, Access, and Community Health (ACO REACH) Model, which is run by the Centers for Medicare and Medicaid Services (CMS).[4] *See* Vytalize Budget Submission, 4; Vytalize Budget Presentation, 2; GMCB Staff Analysis I, 7.

3. The ACO REACH Model is the only Payer program that Vytalize participates in. *See* Vytalize Budget Submission, App. B. The specific requirements for attribution to the model, which can be claims-based or voluntary, as well as the other parameters for participation, are set by CMS. *See* GMCB Staff Analysis II, 3.

4. 2024 is Vytalize's first year operating in Vermont. *See* Vytalize Budget Submission, 4.

5. Vytalize's provider network spans 36 states, including Vermont. *See* GMCB Staff Analysis I, 7; Vytalize Budget Submission, 3.

6. Vytalize will have two Vermont organizations in its network in 2024, Little Rivers Health Care and Mountain Community Health. Little Rivers Health Care and Mountain Community Health are Federally Qualified Health Centers (FQHCs) that provide a range of services, including primary care, mental health, and dental. Vytalize Budget Presentation, 2; GMCB Staff Analysis I, 37-38; *see also* GMCB Staff Analysis II, 14.

7. Vytalize anticipates having just over 2,000 aligned Medicare beneficiaries in Vermont in FY24, slightly more than 1.0% of its total number of aligned beneficiaries (180,000). *See* Vytalize Budget Submission, 2, App. B; Vytalize Budget Presentation, 2.

8. At the time of the Board's review of Vytalize's FY24 budget, Vytalize was in the midst of planning for the 2025 performance year and had not finalized any plans to recruit additional

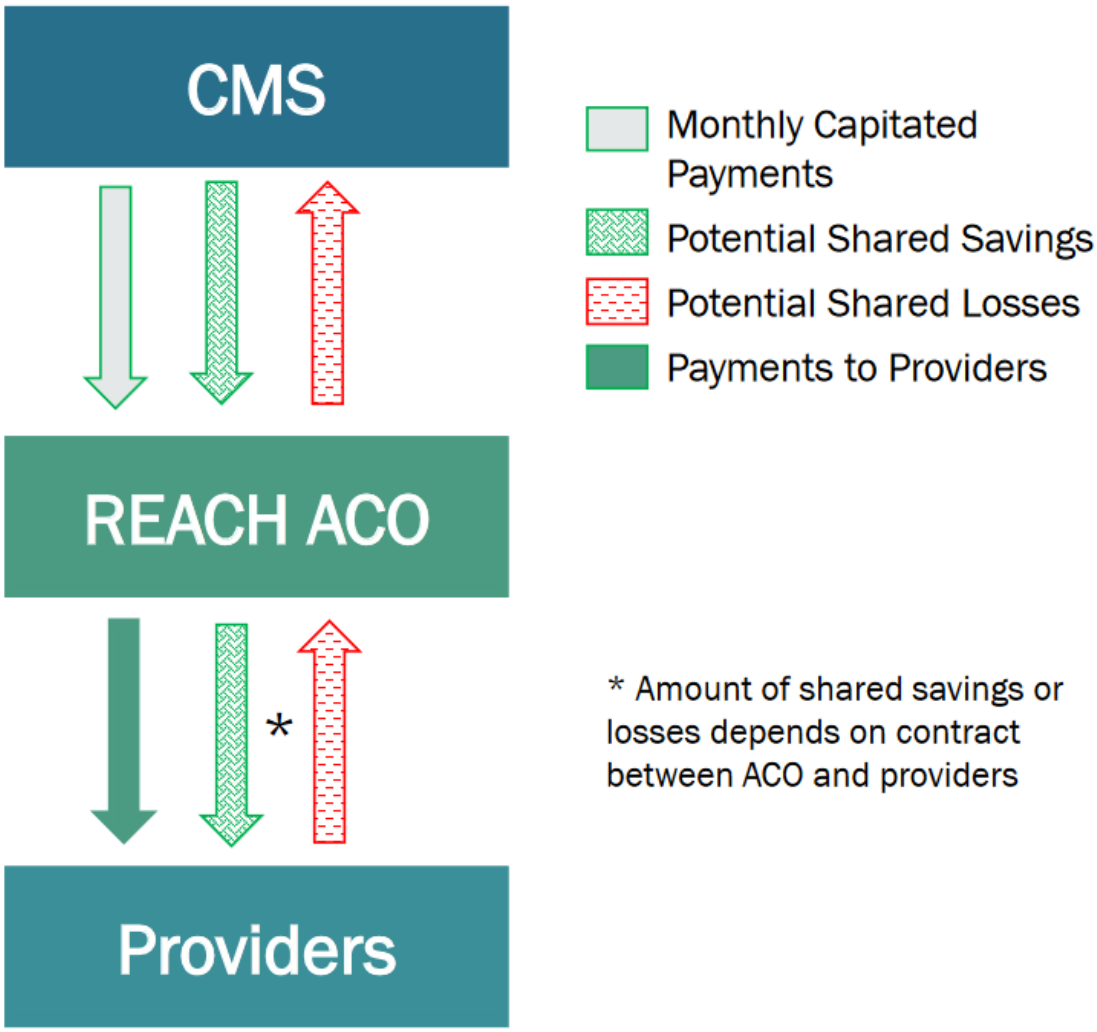
[2] Written budget materials are available at https://gmcboard.vermont.gov/aco-oversight/FY24MedicareOnly. Board presentations are available at https://gmcboard.vermont.gov/2023-meetings.
[3] https://www.youtube.com/@GreenMountainCareBoard/videos.
[4] CMS redesigned its Global and Professional Direct Contracting (GPDC) Model in performance year 2023 and changed its name to the ACO REACH Model. *See* GMCB Staff Analysis II, 16; *see also* CMS, Fact Sheet, Accountable Care Organization (ACO) Realizing Equity, Access, and Community Health (REACH) Model (Feb. 24, 2022), https://www.cms.gov/newsroom/fact-sheets/accountable-care-organization-aco-realizing-equity-access-and-community-health-reach-model.

Vermont providers. Vytalize states that its recruitment efforts focus more on "independent" or non-hospital-owned practices, but that it will partner with hospitals. *See* Vytalize Budget Submission, 3.

Payer Program and Risk Model

9. The ACO REACH Model is a capitated payment model. Vytalize has selected the ACO REACH Model's primary care capitation (PCC) option, which allows participating primary care providers to forgo some or all of their Medicare fee-for-service claims payments aligned beneficiaries in exchange for compensation from Vytalize. *See* Vytalize Budget Submission, App. B; Vytalize Budget Presentation, 2. There is a potential for shared savings or shared losses based on Vytalize's performance in relation to the total cost of care benchmark or financial target, which would be paid between CMS and Vytalize. *See id.* Vytalize pays providers according to the terms of its network agreements. *See id.*

10. The general flow of payments in the ACO REACH Model is outlined below:



11. The specific requirements for attribution to the ACO REACH Model, which can be claims-based or voluntary, as well as the other parameters for participation in the program, are set by CMS. *See* GMCB Staff Analysis I, 40; GMCB Staff Analysis II, 3.

12. Total cost of care benchmarks for ACOs in the ACO REACH Model are set by CMS using trended, risk-adjusted historic spending. *See* Center for Medicare & Medicaid Services, Fact Sheet, Accountable Care Organization (ACO) Realizing Equity, Access, and Community Health (REACH) Model – How do risk adjusted benchmarks and payments work in the model?[5]. The benchmarks are set prospectively and cover all Medicare Part A and Part B expenditures. *See* Center for Medicare & Medicaid Services, Request for Applications, Organization (ACO) Realizing Equity, Access, and Community Health (REACH) Model (Feb. 24, 2022), 89. [6] .

13. Vytalize has selected the ACO REACH Model's global risk-sharing arrangement, which offers the highest levels of risk. *See* Vytalize Budget Submission, 14; Vytalize Budget Presentation, 2.

14. The global risk-sharing arrangement utilizes symmetrical savings and losses rates within four different risk bands, as reflected in the following table:

Savings/Losses as % of Benchmark	Savings/Losses Rate
Less than 25%	100%
25-35%	50%
35-50%	25%
More than 50%	10%

See GMCB Staff Analysis I, 42.

15. The ACO REACH Model is considered an Advanced Alternative Payment Model (APM) under CMS's Quality Payment Program, allowing participating providers to seek Qualifying APM Participant (QP) status based on their levels of payments or patients through the Advanced APM. *See* Vytalize Budget Submission, 11; *see also* Alternative Payment Models in the Quality Payment Program as of December 2022.[7]

16. Vytalize holds surety bonds to comply with the financial guarantee required by CMS for participation in the ACO REACH Model. *See* Vytalize Budget Submission, 5. Vytalize also has historically used and expects to continue using aggregate stop-loss insurance to mitigate its risk for large losses. *Id.* at 6. Provider organizations participating in Vytalize are not liable for downside risk. *Id.*; *see also* GMCB Staff Analysis I, 42.

[5] Available at: https://www.cms.gov/newsroom/fact-sheets/accountable-care-organization-aco-realizing-equity-access-and-community-health-reach-model.
[6] Available at: https://www.cms.gov/priorities/innovation/media/document/aco-reach-rfa.
[7] https://qpp-cm-prod-content.s3.amazonaws.com/uploads/2180/2022%20and%202023%20Comprehensive%20List%20of%20APMs.pdf.

17. Medicare beneficiaries that are aligned to Vytalize will remain enrolled in traditional Medicare (not Medicare Advantage) and will have access to the same network of providers they would have access to if they were not aligned. GMCB Staff Analysis I, 33; *see also* CMS, ACO REACH Model FAQ, Version 1, 6 (April 2022).[8] Alignment to an ACO like Vytalize also does not increase a beneficiary's out-of-pocket costs or premiums. *See* GMCB Staff Analysis I, 33.

18. CMS engages in various vetting, monitoring, and auditing activities aimed at protecting Medicare beneficiaries and health care providers in the ACO REACH Model. For example, CMS monitors claims to identify ACOs that may be "stinting" on beneficiary care. CMS also conducts compliance audits throughout the year, investigates beneficiary complaints, and conducts beneficiary experience of care surveys (CAHPS) annually to measure changes in beneficiary satisfaction. *See* GMCB Staff Analysis II, 18.

Financials (Revenues and Expenses)

19. In 2022, Vytalize was one of five Direct Contracting Entities in the Global and Professional Direct Contracting (GPDC) Model to perform in the top quartile for cost and quality. *See* Vytalize Budget Presentation, 3; Testimony of Amer Alnajar, Hearing Transcript, 12:2-12:7 (Nov. 15, 2023); GMCB Staff Analysis I, 45.

20. Vytalize's 2023 performance under the ACO REACH Model will not be known until October of 2024. *See* GMCB Staff Analysis I, 46; Testimony of Amer Alnajar, Hearing Transcript, 9:1-9:14 (Nov. 15, 2023).

21. Vytalize provided projected financials for its Vermont operations as part of its FY24 budget submission, which are summarized in the following table:

FY24 Budget Projections – Vermont Only	Amount	Notes
Projected Vermont Benchmark	$31M	Based on 2,005 beneficiaries $15,500 spending per beneficiary
Projected Shared Savings	$1.9M	6% estimate
Projected Vermont Provider portion of SS	$745,860	40% of estimated shared savings
Medicare Payments to Vermont Providers	$29.2M	Claims-based

22. Vytalize has a program whereby it pays providers a portion of estimated shared savings in advance and trues up these advances at the time of final program settlement with CMS. *See* Testimony of Kevin Murphy, Vytalize Budget Hearing Transcript, 21:23 – 22:6. Vytalize testified that its provider contracts allow it to "claw back" advances of shared savings against payments in future years in certain circumstances, but that Vytalize has not exercised that ability to date. *See* Testimony of Kevin Murphy, Vytalize Budget Hearing Transcript, 25:5 - 19; GMCB Staff Analysis I, 46; Vytalize Budget Submission, 5-6.

[8] https://www.cms.gov/priorities/innovation/media/document/aco-reach-genfaqs.

Model of Care

23. Vytalize focuses on supporting primary care practices in value-based care through incentivizing care coordination and implementing population health initiatives. *See* GMCB Staff Analysis I, 49; Vytalize Budget Submission, 7.

24. Vytalize has population health initiatives related to annual wellness visits, post-discharge follow-up, and healthy holidays. GMCB Staff Analysis I, 49.

25. The goal of Vytalize's annual wellness visit initiative is to ensure patients are scheduled for annual wellness visits and that these visits are completed. The key outcome measured is the annual wellness visit completion rate. When done properly, annual wellness visits help ensure that patients' gaps in care are closed, that the provider understands patient health risks and functional ability, and that patients and providers have advanced care planning discussions. Vytalize Budget Submission, 7.

26. The goal of Vytalize's post-discharge follow-up initiative is to increase follow-up after hospitalization and emergency department (ED) utilization. The initiative includes investing in ADT (admission, discharge, transfer) alert systems to provide real-time notifications to patients' primary care providers. Key outcomes measured for this initiative include hospital follow-up and ED follow-up. Vytalize Budget Submission, 8.

27. The goal of Vytalize's healthy holidays initiative is to decrease ED utilization among patients who use the ED frequently. Those who utilize the ED frequently will receive outreach post cards with holiday practice hours of operation and other tips to stay healthy for the holidays. Key outcomes measured for this initiative include the reduction in ED costs for this segment of the population. *See* Vytalize Budget Submission, 8.

28. Vytalize has a team with clinical and analytics expertise that reviews the literature and other sources to continue to reassess organizational prioritization of population health goals and outcomes measurement. Once goals are identified, efforts are made to monitor progress to the goal and identify areas where new initiatives may be needed at an organizational level, or more focused at a regional or practice level. Vytalize Budget Submission, 8.

29. Vytalize states that its current evaluation of the Vermont Blueprint for Health ("the Blueprint") suggests that the goals of the Blueprint are aligned with the goals of Vytalize, and there is much room for integration and collaboration. Vytalize also states that it intends to participate in a Blueprint orientation to pursue future collaborative work. Vytalize Budget Submission, 9-10.

30. As part of the ACO REACH Model, Vytalize has proposed, and CMS has approved, a Health Equity Plan (i.e., a plan for reducing one or more health disparities experienced by underserved communities within Vytalize's beneficiary population). *See* Vytalize Budget Submission, 10; GMCB Staff Analysis II, 13; ACO REACH Model Participation

Agreement, Section 5.10.[9] Vytalize's Health Equity Plan focuses on addressing food insecurity. It will be implemented in a single zip code in Mississippi in 2024. However, if the program is deemed successful, it may be expanded into additional regions. Example goals for this initiative include no increase in ED visits and inpatient admissions related to complications from food-related chronic illnesses. *See* Vytalize Budget Submission, 10-11; GMCB Staff Analysis II, 13.

Integration with Vermont All-Payer Model Initiative

31. Providers that participate in the ACO REACH Model cannot participate in other Medicare ACO initiatives, which means they cannot participate in Vermont's Medicare ACO Initiative. *See* ACO REACH Model Participation Agreement, Section 4.02(C)(2), (J).

Public Comments

32. The Board received approximately 58 comments regarding Vytalize's proposed budget. The comments generally expressed concern about private equity firms and profit motive in Vermont's health care system, as well as concerns about privatization of Medicare, potential effects on health care delivery, and the length of the Board's public comment period. Many commenters urged the Board to reject Vytalize's budget or delay its vote. *See* GMCB Staff Analysis II, 10.

33. Little Rivers FQHC commented on Vytalize's proposed budget. Little Rivers explained its desire to engage in value-based care arrangements and described its efforts to find an ACO to participate in, selecting Vytalize because of the financial arrangement it offered providers, with shared savings payments made to providers throughout the performance year instead of the in the subsequent year, and because of the provider programming, engagement and education, and potential savings offered by Vytalize. See Public Comment, Andy Barter, CEO of Little Rivers Health Care (Dec. 1, 2024).

34. The Board received comments and recommendations on Vytalize's proposed budget from the Office of the Health Care Advocate (HCA) pursuant to 18 V.S.A. § 9382(b)(3)(A). In its comments, the HCA expressed concern about Vytalize's profit motive, Vytalize's claims that Medicare-only ACOs create savings or reduce spending, the efficacy of Vytalize's model of care, and the potential for Vytalize to stand as a large, well-funded competitor to OneCare Vermont, Vermont's primary ACO whose non-profit model has a multi-year track record within the state and their provider network. The HCA recommended that the Board require Vytalize to submit financial and quality reporting to the Board annually, establish a deadline for confidentiality requests in budget guidance, and expand the scope of its authority over Medicare-only ACOs. *See* GMCB Staff Analysis II, 11.

[9] https://vytalizehealthreachpcc.com/wp-content/uploads/2023/01/ACO_REACH_2023StartersPYPA_508-ACO-REACH-Elm.pdf.

CONCLUSIONS

Under 18 V.S.A. § 9382, the GMCB's regulatory role for an ACO like Vytalize that only participates in a Medicare program is not to approve or deny the ACO's operation in Vermont; the GMCB's role is to approve or modify a proposed budget for the ACO for each year the ACO elects to operate in Vermont. Vytalize bears the burden of justifying its proposed budget. Rule 5.000, § 5.405(a). In deciding whether to approve or modify the budget, the Board may consider as many of the criteria of 18 V.S.A. § 9382(b) as the Board deems appropriate to Vytalize's size and scope. Because of Vytalize's limited size in Vermont, with only around 2,000 Vermont beneficiaries projected to be aligned in 2024, because Vytalize is a new entrant in Vermont with no specific plans to expand its footprint, and because the programmatic elements of much of Vytalize's model are established by CMS, the Board focused its review on the factors set out in the Legal Framework. *See* Findings of Fact (Findings), ¶¶ 2-8, 11. In approving Vytalize's FY24 budget, we are not making a judgment about the ACO REACH program more broadly; we are reviewing an ACO's proposed budget for operations in Vermont in accordance with our statutory mandate.

Beneficiaries aligned to Vytalize will remain enrolled in traditional Medicare and will have access to the same network of providers they would have access to if they were not aligned. Findings, ¶ 17. Alignment will not increase beneficiaries' out-of-pocket costs or premiums. *Id.* CMS engages in various vetting, monitoring, and auditing activities aimed at protecting Medicare beneficiaries and health care providers in the ACO REACH Model. Findings, ¶ 18.

2024 is Vytalize's first year operating in Vermont. *See* Findings, ¶ 4. We conclude that it is appropriate to focus on collecting information about Vytralize's quality and financial performance to help establish a baseline for its operations in the state. All reporting will be done in a way that ensures patient confidentiality is protected, in light of the small number of aligned beneficiaries. To that end, we include conditions for Vytalize to report its shared savings or losses and its quality results for Vermont, as well as an updated financial summary using a template that GMCB staff design for that purpose. We also require Vytalize to provide a semi-annual update regarding how its model of care is working in Vermont, including any consumer complaints. Finally, we require Vytalize to engage in an orientation of the Blueprint for Health to prevent duplication of efforts with that program or promote possible integration.

ORDER

Based on our Findings and Conclusions above, and pursuant to 18 V.S.A. § 9382, we hereby approve Vytalize's FY24 budget as submitted and subject to the conditions set forth below:

1. Vytalize shall provide to GMCB Vytalize's FY24 shared savings/losses, segmented for Vermont.

2. Vytalize shall provide to GMCB an updated version of its Vermont financial summary. GMCB staff is delegated responsibility to develop an appropriate template and set the submission deadline.

3. Vytalize shall provide to GMCB Vytalize's ACO REACH quality reporting, segmented for Vermont if possible, with appropriate restrictions to protect patient confidentiality.

4. Following three performance years in Vermont, Vytalize shall provide to GMCB reporting for those years on GMCB-specified metrics, which may include the categories of inpatient medical, inpatient surgical, emergency department, professional office visits, ambulatory sensitive admissions, and any additional metrics. GMCB staff is delegated responsibility to develop templates and metrics and set deadlines for this reporting.

5. Vytalize shall provide a semi-annual update about how Vytalize's care model is working in Vermont, (first report submitted with FY25 budget submission on October 1, 2024) including any consumer complaints (not limited to Vermont beneficiaries). The development of the report template and the deadlines for submission are delegated to GMCB staff.

6. A representative from Vytalize must engage in an orientation led by Blueprint for Health within the first quarter of 2024.

7. After notice and an opportunity to be heard, the GMCB may make such further orders as are necessary to carry out the purposes of this Order and 18 V.S.A. § 9382.

So ordered.

Dated: January 18, 2024 at Montpelier, Vermont

s/ Owen Foster, Chair)
)
s/ Jessica Holmes) GREEN MOUNTAIN
) CARE BOARD
s/ Robin Lunge) OF VERMONT
)
s/ David Murman)
)
s/ Thom Walsh)

Filed: January 18, 2024

Attest: s/ Jean Stetter
Green Mountain Care Board
Administrative Services Director

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