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ACO Oversight
GMCB Staff Introduction

Marisa Melamed, Associate Director of Health Systems Policy

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Goals

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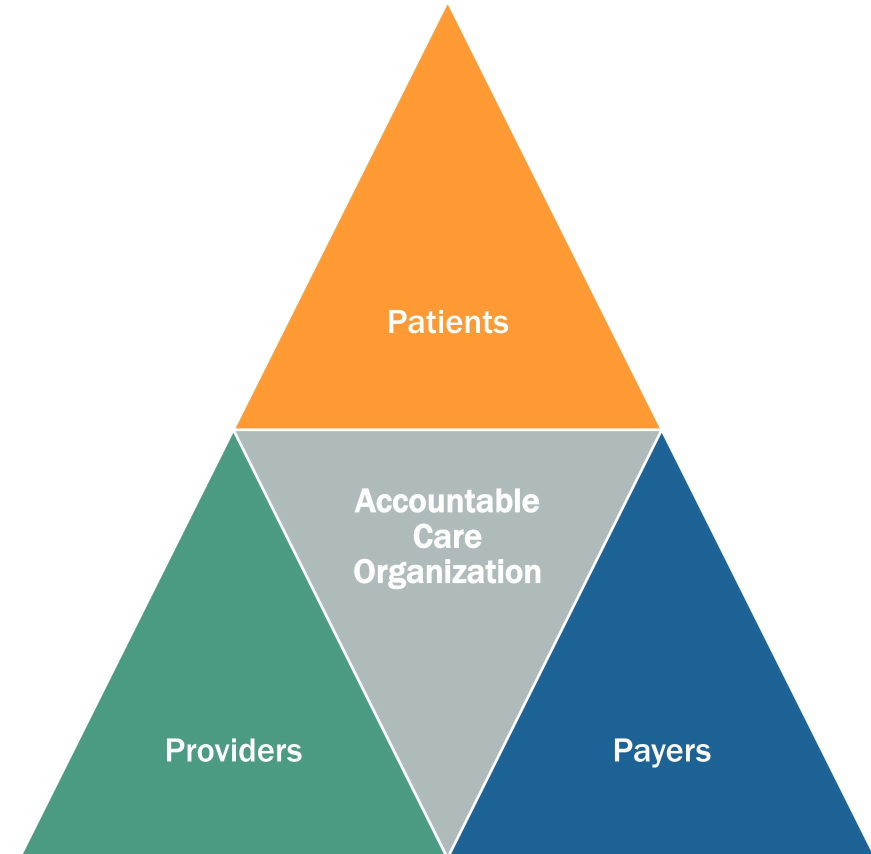
1. Give a brief background and history of ACOs and ACO regulation in Vermont
2. Introduce the ACO regulatory framework in Vermont
3. Review the process and timeline
4. Board discussion

What is an Accountable Care Organization (ACO)?

An Accountable Care Organization (ACO) is a group of health care providers who come together to be responsible for the cost and quality of a defined population of patients.

ACOs contract with payers to join *value-based payment models* that reward good financial and quality outcomes.

Value-Based Payment Models: Broad set of performance-based payment strategies that link financial incentives to providers' performance on a set of defined measures of quality and/or cost or resource use. *(Source: CHCS VBP definition)*



For more information: https://gmcboard.vermont.gov/document/aco-oversight-explainer

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Regulation of ACOs in Vermont

- In 2016, the Legislature assigned the authority to regulate ACOs to the GMCB (Act 113).
- The aim of the GMCB's ACO regulation is to provide oversight and transparency into a major component of Vermont's health care system and to ensure alignment with state health care reform goals.
- The GMCB endeavors to give a balanced view into the ACO as an entity and its impacts. Level of review is based on size and scope of the ACO.
- Vermont ACO market and regulation is unique to Vermont!

ACO Background: Patients

- Patients are "**attributed**" to an ACO based on a methodology agreed on between the ACO and the payer (insurance). Attribution means an individual is linked to the ACO, generally based on the insurance coverage they have and the care they have received in the past.
  - ACOs must notify patients if they are attributed
  - Attribution does not change insurance coverage or plan design
  - Attribution does not restrict freedom of choice to see any provider (insurance network restrictions still apply)
  - Attribution may provide enhancements, increased access to care coordination, other programs/value

ACO Background: Providers

- Providers may join an ACO in order to participate in the value-based payment arrangements and population health programs offered by the ACO.
  - Providers could be a hospital, hospital system, independent, specialist, community-based, SNF, HHH, DA, FQHC, etc.
  - Participation can allow access to ACO negotiated payment arrangements with payers which can provide more predictable payment streams or pay for care that may not be covered under traditional payment structures (i.e., FFS); can also require providers to bear risk for cost and quality of care.
  - Participation allows access to ACO resources which might include data analytics, population health management programs, enhancements, waivers, or transformation support.
  - Can promote collaboration across the continuum of care and community-based services.

ACO Background: Payers

- Payers contract with an ACO in order to bring more providers into a value-based payment arrangement.
  - Shifts some accountability for cost and quality outcomes to the ACO; can lessen payers’ risk.
  - If successful, this would improve the health of the insurer's covered population and over time, reduce overall costs (e.g., from chronic disease).

ACO Oversight: Brief national history

- **2006:** Term Accountable Care Organization was coined
- **2008:** Concept was scored favorably by the Congressional Budget Office
- **2010:** ACO model was included in the Medicare program through the Affordable Care Act
- **2012:** CMS launched the Medicare Shared Savings Program and Pioneer ACO Program
- **Present:** ACO implementation continues to grow through both public and private payers and different provider organizations

ACO Oversight: Brief Vermont history

- **2014 - 2017:** Vermont had shared-savings ACO programs for three payers – Medicare's national program, and similar programs for Medicaid and BCBSVT – with three ACOs.
- **2016:** Act 113 charged the GMCB with oversight of ACOs.
- **2017:** GMCB adopted Rule 5.000, which established standards and processes to certify ACOs and annually review, modify, and approve their budgets.
- **2018:** GMCB certified one ACO, OneCare Vermont, and completed the first budget review. This was also Performance Year 1 of Vermont's All-Payer Model.
- **2021:** Program improvements
  - GMCB adopted guidance for Medicare-only ACOs.
  - GMCB reviewed core competencies of high-performing ACOs which led to recommendations to enhance the Board's regulatory framework.
- **2022:** GMCB reviewed a Medicare-only ACO operating under Medicare's Direct Contracting model (Clover Health) and will review a Medicare-only ACO in the Shared Savings program for 2023 (Gather Health).

ACO Oversight: 2022 and beyond

- Continue work to include ACO core competencies and ACO performance benchmarking into the regulatory framework
- Oversight will evolve with any future All-Payer Model Agreement
- Standardize guidance for Medicare-Only ACOs to accommodate new entrants under Medicare models
- Continue transition to Adaptive database for ACO financial reporting (same system used for hospital budgets)

ACO Oversight: Overview

- The Green Mountain Care Board's (GMCB) oversight of Accountable Care Organizations (ACOs) consists of:
  1) Certification
  2) Budget Review
- These regulatory processes include a review of:
  - Programs and investments to facilitate the shift to value-based care
  - Investments in health improvement activities
  - Tools and analytics to support providers and improve health care quality and reduce unnecessary costs
  - ACO administrative costs
  - Alignment of ACO strategies with Vermont's All-Payer Model goals.

ACO Oversight: Certification

- Occurs one-time following application for certification; eligibility verifications performed annually.
- Certification applies only to ACOs seeking Medicaid or commercial contracts.
  - Medicare-only ACOs are not required to be certified
- Certification ensures that ACOs seeking to receive payments from Vermont Medicaid and commercial payers have the systems in place to do the work required of an ACO.

ACO Oversight: Budget Review

- All ACOs operating in Vermont are subject to budget review.
- Threshold of 10,000 lives defines scope of review.
- Review of ACO budget occurs annually, usually in the fall prior to start of budget/program year; payer contracts/attribution are finalized by spring of the budget year and the ACO submits a revised budget.
- The Board monitors ACO activities and performance throughout the year to ensure compliance with the requirements of budget approval ("conditions") and to ensure that the ACO is operating as required by Vermont's All-Payer Model Agreement (APM).

ACO Oversight: Standards of Review

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The standards and requirements by which we review the ACO submissions are set forth in:

1. 18 V.S.A., Chapter 220 (primarily 18 V.S.A. § 9382 "Oversight of Accountable Care Organizations");
2. GMCB Rule 5.000; and
3. All-Payer ACO Model Agreement.

Specifically, under Rule 5.405 the Board considers:

1. any benchmarks established under section 5.402 of this Rule;
2. the criteria listed in 18 V.S.A. § 9382(b)(1);
3. 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 CMS; and
4. any other issues at the discretion of the Board.

The ACO shall have the burden of justifying its budget to the Board.

Certification Eligibility: Verification

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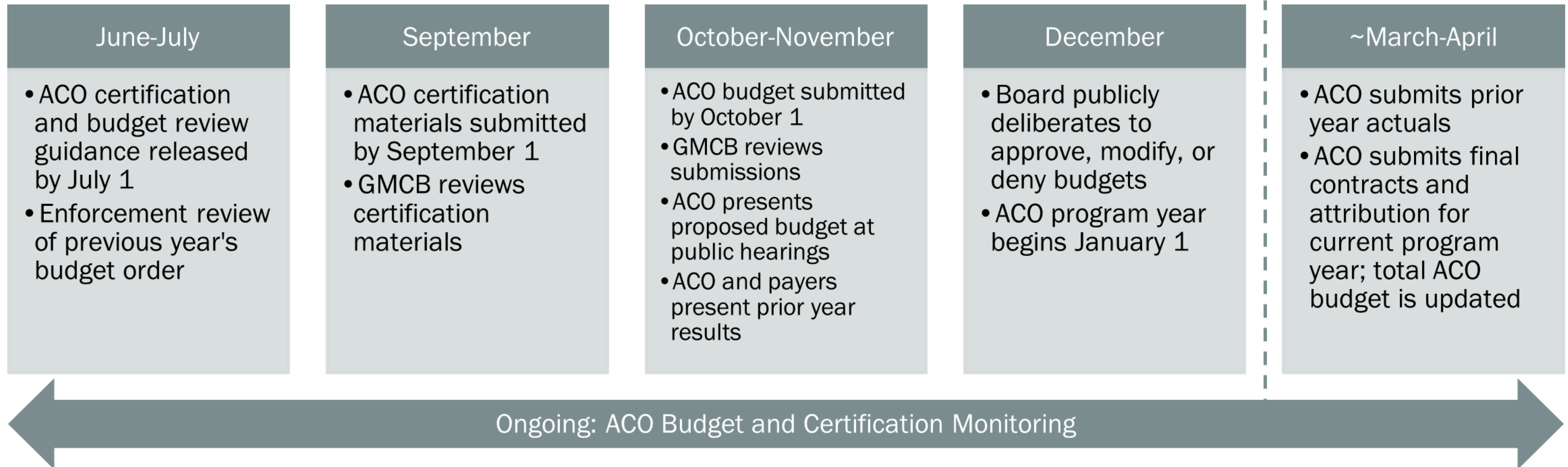
Once certified, an ACO must annually submit a form to the GMCB (1) verifying that the ACO continues to meet the requirements of 18 V.S.A. §9382 and Rule 5.000; and (2) describing in detail any material changes to the ACO's policies, procedures, programs, organizational structures, provider network, health information infrastructure, or other matters addressed in the certification sections of Rule 5.000.

- 5.201 Legal Entity
- 5.202 Governing Body
- 5.203 Leadership and Management
- 5.204 Solvency and Financial Stability
- 5.205 Provider Network
- 5.206 Population Health Management and Care Coordination
- 5.207 Performance Evaluation and Improvement
- 5.208 Patient Protections and Support
- 5.209 Provider Payment
- 5.210 Health Information Technology

ACO Oversight: Timeline



ACO Oversight: FY23 Timeline

Date	Milestone
Jul 1, 2022	GMCB issues FY23 ACO oversight guidance
Sept 1, 2022	ACO submits certification materials
Oct 1, 2022	ACO submits FY23 budget
Oct 12, 2022	GMCB staff ACO Oversight Background presentation
Oct 24, 2022	Gather Health Budget Hearing
Nov 2, 2022	GMCB staff analysis presentation: Gather Health
Nov 9, 2022	OneCare Vermont Budget Hearing
Nov 16, 2022	GMCB staff ACO Certification presentation; GMCB potential vote on Gather Health FY23 Budget
Dec 7, 2022	GMCB staff analysis presentation: OneCare Vermont
Dec 21, 2022	GMCB potential vote on OneCare Vermont FY23 budget
Ongoing 2022 - 2023	GMCB monitors FY23 actual performance against budget and conditions

Board Discussion

ACO Certification and Budget Review

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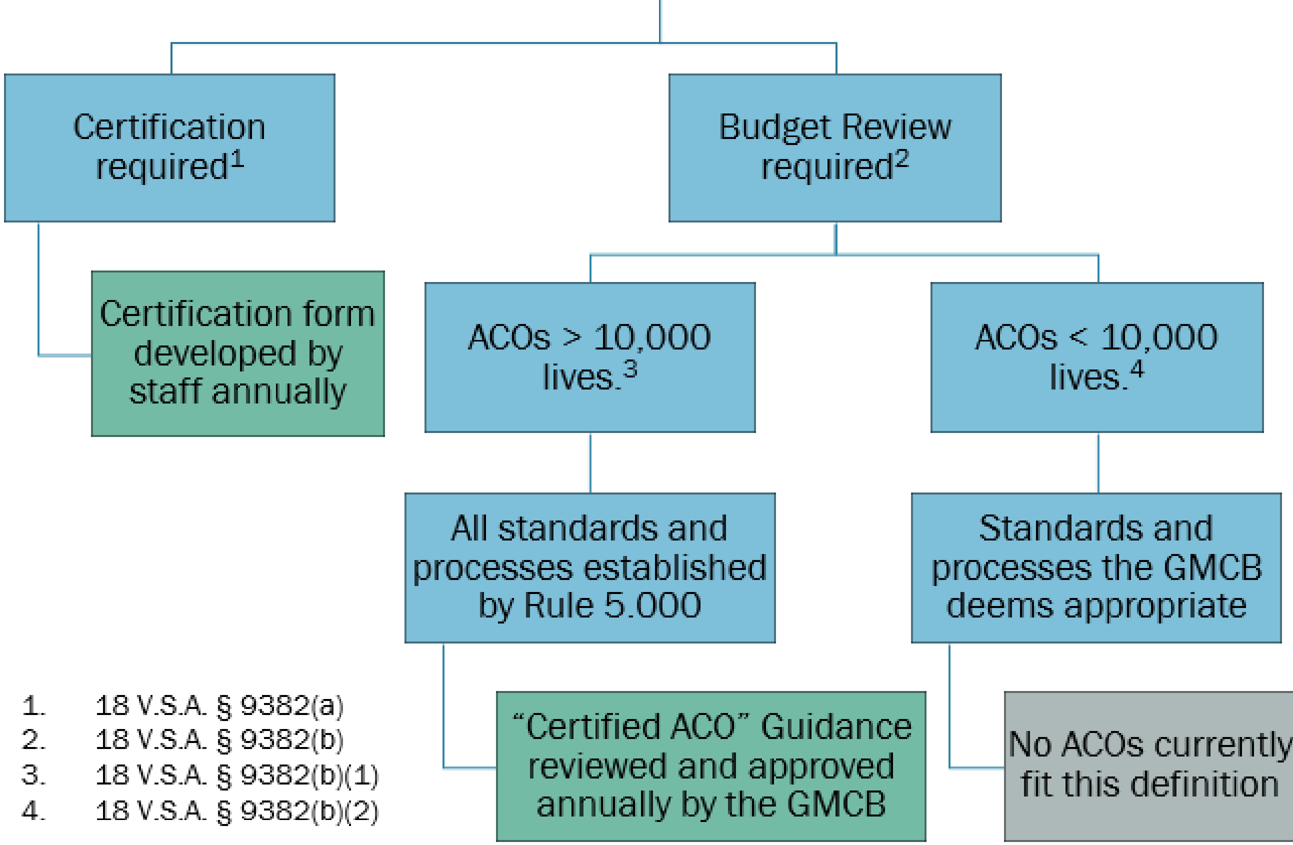

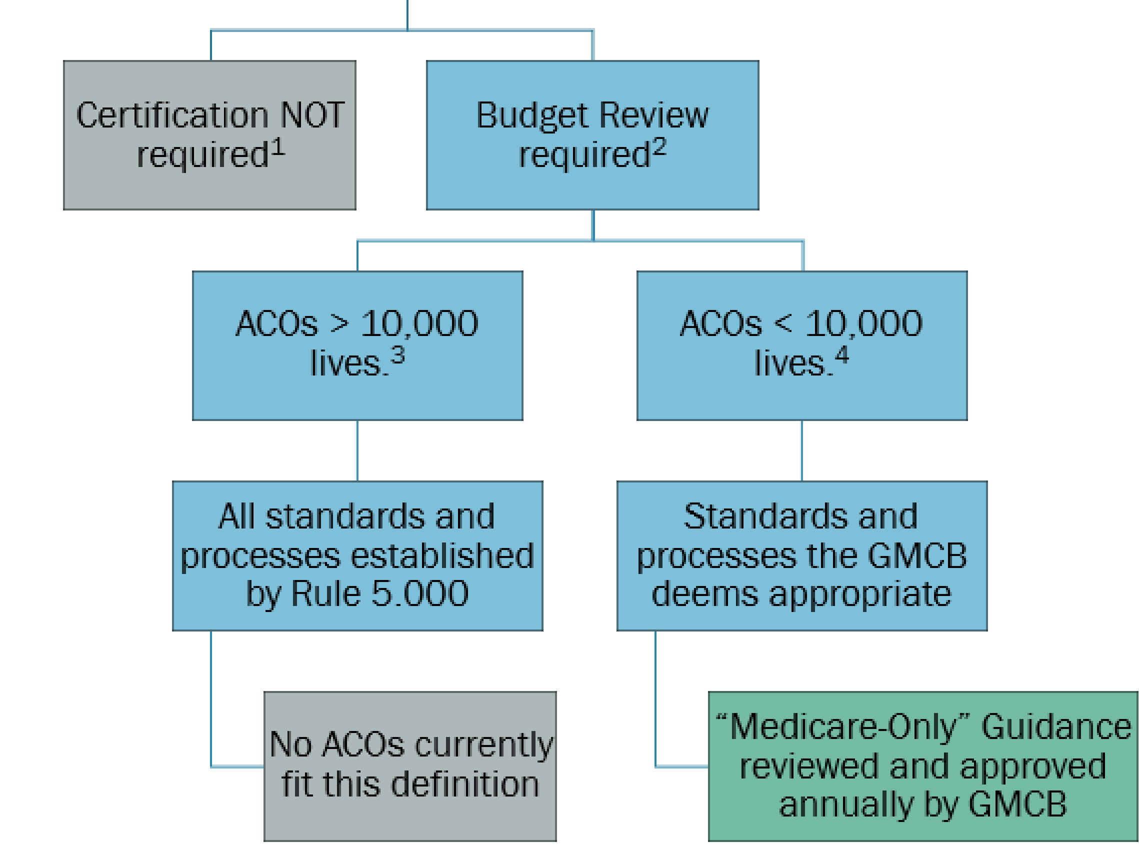

1. 18 V.S.A. § 9382(a)
2. 18 V.S.A. § 9382(b)
3. 18 V.S.A. § 9382(b)(1)
4. 18 V.S.A. § 9382(b)(2)

18 V.S.A. § 9382

(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. In its review, the Board shall review and consider:

(A) 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;

(B) the Health Resource Allocation Plan identifying Vermont's critical health needs, goods, services, and resources as identified pursuant to section 9405 of this title;

(C) the expenditure analysis for the previous year and the proposed expenditure analysis for the year under review by payer;

(D) the character, competence, fiscal responsibility, and soundness of the ACO and its principals;

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(E) any reports from professional review organizations;

(F) 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;

(G) the extent to which the ACO provides incentives for systemic health care investments to strengthen primary care, including strategies for recruiting additional primary care providers, providing resources to expand capacity in existing primary care practices, and reducing the administrative burden of reporting requirements for providers while balancing the need to have sufficient measures to evaluate adequately the quality of and access to care;

(H) the extent to which the ACO provides incentives for systemic integration of community-based providers in its care model or investments to expand capacity in existing community-based providers, in order to promote seamless coordination of care across the care continuum;

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(I) the extent to which the ACO provides incentives for systemic health care investments in social determinants of health, such as developing support capacities that prevent hospital admissions and readmissions, reduce length of hospital stays, improve population health outcomes, reward healthy lifestyle choices, and improve the solvency of and address the financial risk to community-based providers that are participating providers of an accountable care organization;

(J) the extent to which the ACO provides incentives for preventing and addressing the impacts of adverse childhood experiences (ACEs) and other traumas, such as developing quality outcome measures for use by primary care providers working with children and families, developing partnerships between nurses and families, providing opportunities for home visits, and including parent-child centers and designated agencies as participating providers in the ACO;

(K) public comment on all aspects of the ACO's costs and use and on the ACO's proposed budget;

(L) information gathered from meetings with the ACO to review and discuss its proposed budget for the forthcoming fiscal year;

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(M) information on the ACO's administrative costs, as defined by the Board;

(N) the effect, if any, of Medicaid reimbursement rates on the rates for other payers;

(O) 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

(P) 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.

Acronym List

- ACO—Accountable Care Organization
- APM—All-Payer Model
- CMS—Centers for Medicare & Medicaid Services
- CPR—Comprehensive Payment Reform Program
- DA—Designated Agency
- FFS—Fee-for-Service
- FPP—Fixed Prospective Payment
- FQHC—Federally Qualified Health Center
- FY—Fiscal Year
- GMCB—Green Mountain Care Board
- HHH—Home Health and Hospice
- OCV—OneCare Vermont
- SNF—Skilled Nursing Facility
- SS/SL—Shared Savings/Shared Losses