ACO Oversight

VERMONT
GREEN MOUNTAIN CARE BOARD

Summary

The Green Mountain Care Board's (GMCB) oversight of Accountable Care Organizations (ACOs) consists of 1) certification and 2) annual 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; and the alignment of ACO strategies with Vermont's All-Payer Model goals.

18 V.S.A. § 9382; GMCB Rule 5.000

Background Information

An **Accountable Care Organization (ACO)** is a group of health care providers who agree to be accountable for the care and cost of a defined population of patients. The Affordable Care Act (ACA) included incentives for creating ACOs for people with Medicare because this model was identified as a promising way to reduce the ever-rising cost of health care nationwide. Vermont law requires the GMCB to oversee ACOs through two key ACO regulatory processes:

(1) *Certification*. 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.
(2) *Budget Review*. The annual ACO budget review process provides an opportunity to assess the ACO's programs, which are expected to facilitate Vermont's shift toward value-based care, as well as the cost of administering these programs.

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) with the federal government.

Green Mountain Care Board

The purpose of the Green Mountain Care Board is to promote the general good of the State by:

1. Improving the health of the population;
2. Reducing the per-capita rate of growth in expenditures for health services in Vermont across all payers while ensuring that access to care and quality of care are not compromised;
3. Enhancing the patient and health care professional experience of care;
4. Recruiting and retaining high-quality health care professionals; and
5. Achieving administrative simplification in health care financing and delivery.

18 V.S.A. § 9372

ACO Certification and Budget Review Timeline

January 1: Start of ACO Performance Year

June-July	September	October-November	December	~March-April
• ACO certification and budget review guidance released by July 1 • Enforcement review of previous year's budget order	• ACO certification materials submitted by September 1 • GMCB reviews certification materials	• ACO budget submitted by October 1 • GMCB reviews submissions • ACO presents proposed budget at public hearings • ACO and payers present prior year results	• Board publicly deliberates to approve, modify, or deny budgets • ACO program year begins January 1	• ACO submits prior year actuals • ACO submits final contracts and attribution for current program year; total ACO budget is updated

Ongoing: ACO Budget and Certification Monitoring

Shifting How We Pay for Health Care

Vermont is working to shift health care payment from a fee-for-service system, where hospitals and clinician offices get paid for each service they provide, to a system of **Value-Based Care**, which rewards high quality and improved health outcomes. This change in incentives helps Vermonters connect to the right care, at the right place, at the right time. By shifting the focus to preventive care, the APM urges providers to catch and treat small health problems before they turn into big issues. The APM also encourages increased communication and coordination between health care and social service providers, especially those who are caring for the sickest or highest-risk patients, to drive better health outcomes and enhance the quality of care. By working with providers and payers (including insurance companies, employers, and Medicare and Medicaid) to align quality measures, models of delivery, payments, and more, we can help improve care for all Vermonters.

Paying for Health Care Services: Vermont health care providers, including but not limited to hospitals and clinician offices, get paid for patient services in two primary ways:

1. **Fee-for-service (FFS):** FFS is still the most common way of paying for health care and makes up about 86% of Vermont hospitals' budgeted net revenues in FY2022. Under FFS, providers make more money for providing more services (known as **volume** or **utilization**). There are also other ways of paying providers that tie payment to the volume of services provided (e.g., bundled payments) that are not discussed here. Some providers participate in value-based programs that include financial incentives tied to quality or health care costs but may still choose to continue receiving FFS payments.

2. **Fixed prospective payments (FPP):** In Vermont, providers who participate in the ACO can receive fixed payments and, in exchange, assume accountability for the care of a group of "attributed" patients (see pg. 3). FPP are a lump sum payment, paid on a periodic basis (often monthly). Instead of paying for each service rendered, providers receive a predetermined amount for care in advance to care for a particular population. This payment model gives providers the flexibility to invest in services that may be otherwise non-reimbursable under FFS, allowing them to focus on giving patients the best care possible, rather than worrying about how and when they can expect to be paid. Right now, FPP accounts for a minority of Vermont providers' budgets, but as hospitals and provider practices receive fixed payments for a greater proportion of their business, they will have more discretion to adjust their business models to prioritize preventative services, technology, and new staffing that will help keep patients healthy.

Investing in Improving Health and Transforming Health Care: Providers may also receive regular payments for certain groups of patients – sometimes in the form of "per-member per-month" payments – to support specific health improvement activities or investments in infrastructure to help enhance care and support improved outcomes. This could take the form of monthly payments on behalf of each patient who gets help coordinating their care. Providers might also receive lump-sum payments to support new health improvement activities or programs. ACOs and providers can work together to design payment models that work for them, using some combination of the payment types described here or another model.

Which Patients are in an ACO?

The process of figuring out which patients are part of an ACO is called **attribution**. In Vermont, while the exact method varies depending on which insurance each individual has, attribution generally starts with a person's primary care provider. Patients whose primary care provider is an ACO member and whose insurance carrier has a contract with an ACO are "attributed" to the ACO. This might not mean a lot to attributed patients; Vermonters' health care should look largely the same, except hopefully more coordinated, and attributed patients may gain access to some additional benefits. Fundamentally, being attributed means that the ACO and its providers are now being held accountable for the cost and quality of care.

How are ACO-Participating Providers Held Accountable?

Accountability for Cost: Before the start of the year, an ACO and each payer it contracts with set a **spending target** for the coming year, sometimes called a **benchmark**, based on past spending. If providers can spend less than that target while meeting quality thresholds – for example by finding ways to make the care they provide more efficient, and by keeping patients healthy and out of the hospital – then they are rewarded by earning back "shared savings." There are two major types of savings arrangements between payers and ACOs:

- **Shared Savings Only**: If an ACO spends less than the target – and meets quality and performance targets – it can receive incentive payments. This is sometimes called an "upside only" model.
- **Shared Savings and Shared Risk** (sometimes called Shared Losses): If an ACO spends less than the target, it can receive incentive payments, but if it spends more than the target, the ACO has to pay money back. This is sometimes called a "two-sided" or "upside/downside" model.

Vermont ACO Oversight History

From 2014 to 2017, the State tested a shared-savings ACO program with three ACOs.

In 2016, Act 113 charged the GMCB with oversight of ACOs.

In 2017, the GMCB adopted Rule 5.000, which established standards and processes to certify ACOs and annually review, modify, and approve their budgets.

In 2018, GMCB certified one ACO, One Care Vermont. This was also Performance Year 1 of Vermont's All-Payer Model.

In 2021, GMCB is developing guidance for Medicare-only ACOs and expects to review the budget of a small Medicare-only ACO operating under Medicare's Direct Contracting model in 2022.

Exactly how this works varies depending on the contract between the payer and the ACO, and exactly how earned savings or losses are distributed from an ACO to providers depends on contracts between the ACO and participating providers.

Accountability for Quality: Each ACO-payer contract includes a set of metrics which are designed to assess whether the ACO and its providers are delivering high quality care to patients. In Vermont, these "measure sets" are expected to align to the quality and population health goals established under Vermont's All-Payer Model Agreement with the federal government, though they do vary somewhat by payer (for example, based on population: Medicare includes mostly older members, while Medicaid covers many children). Quality measures are selected to make sure providers are following clinical guidelines, that patients can get the care they need, and that outcomes are acceptable (for example, providers are successfully managing care for patients with diabetes).

Quality performance also affects accountability for cost: providers that do not perform at a certain threshold on quality are not eligible to share in savings. For more information on the quality measure sets used in Vermont's ACO programs, click here.

GMCB Oversight: ACO Certification

An ACO in Vermont is required to be legally certified by the GMCB in order to receive payments from Medicaid or commercial insurers. Certification ensures that an ACO meets State standards for appropriate governance, policies, and procedures to make sure it is capable of doing the work of an ACO: to facilitate provider-led delivery system reform in a way that represents the interests of the ACO's participating providers and attributed patients. ACOs apply for initial certification and if certified, eligibility is verified annually with ongoing monitoring throughout the performance year. Certification criteria include information on the legal entity, population health management and care coordination, governing body, performance evaluation and improvement, leadership and management, patient protections and support, solvency and financial stability, provider payment infrastructure, provider network, and health information technology. GMCB staff review deliverables rigorously and through a public process prior to approval of initial certification and annual certification verification.

GMCB Oversight: ACO Budget Review

Over 96% of the money associated with OneCare Vermont's budget is money that is already being paid to providers for caring for patients; it is not new health care spending. In fact, much of this money will continue to flow directly from insurers to providers, even though the ACO is accountable for how much is spent.

GMCB reviews each ACO's budget annually, with a Board decision on the proposed budget before the ACO performance year begins (usually on January 1). The annual ACO budget review process provides an opportunity to assess the ACO's programs, which are expected to facilitate Vermont's shift toward value-based care, as well as the cost of administering these programs. This includes, but is not limited to, a review of ACO financial and quality performance to date, the ACO's investments in infrastructure and direct programming for health improvement and payment reform, the ACO's administrative and operational costs, the ACO's contractual relationships with payers and providers, and the alignment of ACO activities and strategies with the state's objectives as stated under the Vermont's All-Payer Model Agreement with the federal government. The Board monitors ACO activities and performance throughout the year to ensure compliance with the requirements of budget approval conditions.

Transparency and Public Engagement

During the ACO certification and budget review process, the Green Mountain Care Board gives public notice of board meetings and invites the public to comment and attend these public meetings. The Board deliberates in a public setting and posts budget information to its website. The Board is subject to Vermont's Open Meeting Law (1 V.S.A. § 310-314), which means that all meetings and deliberations about ACO oversight are open to the public, with meeting information and an agenda shared in advance on GMCB's website.

By statute, the Office of Health Care Advocate, a division of Vermont Legal Aid, receives ACO oversight materials and other pertinent information, and participates in the certification process and budget hearings.

Additional Resources

- GMCB Website – ACO Oversight
- GMCB Rule 5.000
- 18 V.S.A. § 9382: Oversight of ACOs
- GMCB Website – All-Payer Model

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