VERMONT
GREEN MOUNTAIN CARE BOARD

FY2023 ACO Budget Guidance and Certification Form

June 22, 2022

Agenda for Today

- Public Comment
- Updates to Medicare-Only Guidance since 6/15
- Updates to Certified ACO Guidance since 6/15
- Questions
- Public Comment
- Potential vote

FY23 ACO Guidance Public Comment
Summary of Comments

- Medicare-Only Guidance
  - **Concerns about beneficiary impact**
    As described in the staff analysis, being attributed to an ACO in the ACO REACH or DCE models will not change or limit the beneficiary's Traditional Medicare benefits, access to Medicare providers, or costs.
  - **Concerns about private companies in Medicare**
    Under statute and rule, the Board's authority is to review and approve or modify an ACO's proposed budget, and the Board must work with the parameters of Medicare programs set by CMS. The guidance covers elements of the budget review in 18 V.S.A. 9382(b), but wouldn't cover other statutory requirements.

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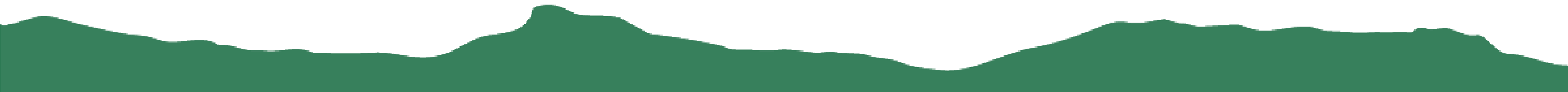
FY 2023 MEDICARE-ONLY GUIDANCE



FY23 Medicare-Only Guidance
Updates Since June 8 Presentation

- Edit to Health Equity question to keep language broad (Section 5, question 3)
- Previous question:
  - *How is the ACO addressing health equity concerns such as access to care and racial disparities in care? If the ACO has specific goals in these areas, describe any specific actions the ACO is taking to achieve these goals.*
- New edit:
  - **How is the ACO addressing health equity concerns? If the ACO has specific goals in this area, describe any specific actions the ACO is taking to achieve these goals.**

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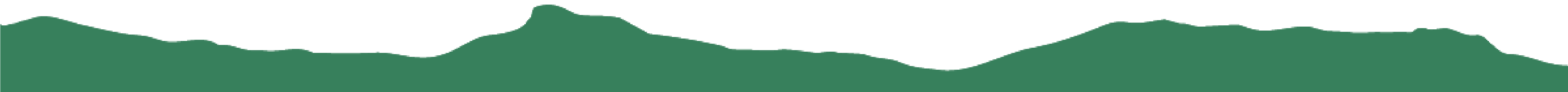
FY 2023 CERTIFIED ACO BUDGET GUIDANCE



FY23 Medicare-Only Guidance
Updates Since June 15 Presentation

- Edit to TCOC accountability strategy by HSA question (Section 5, Question 6)
- Edited question:
- Discuss the ACO's Total Cost of Care accountability strategy at the HSA level. (Word Count: 500)
    a) How is the ACO using TCOC and quality data at the local HSA level to identify high-value and low-value care? **Specifically,** how is the ACO helping hospitals and other community providers to reduce **avoidable utilization**, low-value care, and lower their TCOC at the local HSA level? **Cite specific examples and where possible, quantify the ACO's direct impact on reducing avoidable utilization and/or low-value care and lowering TCOC in specific HSAs.**
    b) Discuss the extent to which providers have control over the risk for which they are responsible. Describe how the ACO's TCOC accountability strategy allows providers to benefit from their ability to provide high-value care (low-cost, high-quality) and impact TCOC growth.

FY23 Certified ACO Budget Guidance
Updates Since June 15 Presentation

- Edit to Health Equity question to keep language broad (Section 7, Question 1h)
- Previous Question:
  - *"...please address the following ...Whether and how race and ethnicity data are collected and how they are incorporated into the model of care;"*
- New edit:
  - **"...please address the following... Whether and how social determinant of health-related data is collected and how it is incorporated into the model of care"**

FY23 Certified ACO Budget Guidance

Updates Since June 15 Presentation

- Edit to Health Equity question to keep language broad (Section 7, Question 1h)
- Previous Question:
  - *"...please address the following ...Whether and how race and ethnicity data are collected and how they are incorporated into the model of care;"*
- New edit:
  - **"...please address the following... Whether and how social determinant of health-related data is collected and how it is incorporated into the model of care"**

FY23 Certified ACO Budget Guidance
Updates Since June 15 Presentation

- Edit to evaluation of Quality Improvement Program to ask for examples (Section 8, Question4)
- Edited Question:
- Discuss the ACO's approach to evaluation of its Quality Improvement Program **and provide a couple of examples of how it has improved quality**.

FY23 Certified ACO Budget Guidance

Part II: ACO Budget Targets

- Other Targets/Benchmarks
  - *“The Board may add other targets or benchmarks to guide the development or implementation of the ACOs Budget. Such benchmarks set in the past have included an administrative expense ratio and a population health investment ratio, among others. Please see prior year Budget Orders for examples.”*
- Proposed Budget Targets for FY23 **(NEW):**
  1. Fund the VBIF or other pre-funded clinical quality incentive programs at a minimum of the FY22 revised budget amount.
  2. The FY23 commercial benchmark trend rates must be consistent with the ACO-attributed population and the GMCB approved rate filings.
  3. **The ACO shall endeavor to meet or exceed the target proposed by the ACO and approved or modified by GMCB staff in accordance with OneCare Vermont’s FY22 Budget Order, Condition #3.a, for the portion of FY23 commercial payer contract revenue in the form Fixed Prospective Payment.**

FY23 Certified ACO Budget Guidance
Part II: ACO Budget Targets - FY22 #3.a.

- OneCare is required to submit updated reporting on % Fixed Prospective Payments at the end of July
  - Transparent calculation
  - Report both reconciled and unreconciled FPP
- *"Based on the additional reporting about ACO FPP levels and targets that GMCB staff will specify in the ACO Reporting Manual, GMCB Director of Health Systems Policy will approve, or modify and approve, a commercial FPP target and seek twice annual reporting from OneCare on progress toward this target."*

Suggested Motion Language

FY23 Medicare-Only Guidance

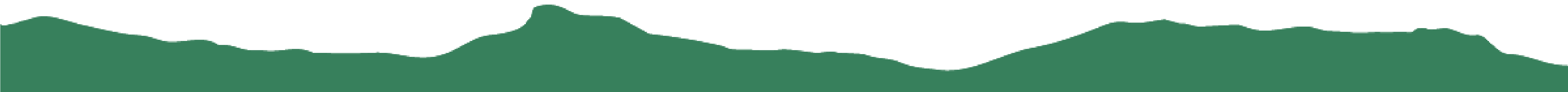
Move that the GMCB adopt the FY23 Budget Guidance and Reporting Requirements for Medicare-only Non-Certified ACOs, as presented by GMCB staff [and with the additional changes discussed during the meeting today].

FY23 Certified ACO Guidance

Move that the GMCB adopt the FY23 Budget Guidance and Reporting Requirements for Vermont Certified ACOs, as presented by GMCB staff [and with the additional changes discussed during the meeting today], specifically including the FY23 proposed budget targets presented by GMCB staff for:

- *minimum funding of the VBIF (or other pre-funded clinical quality incentive programs),*
- *commercial benchmark trend rate consistent with the ACO-attributed population and the GMCB approved rate filings, and*
- *percentage of payments in the form of FPP set in accordance with the FY22 OneCare Vermont budget order.*

QUESTIONS



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Reference Slides

ACO Guidance Process Overview
ACO Certification and Budget Review

- ACO Budget Review
  - All ACOs operating in Vermont are subject to budget review
  - Threshold of 10,000 lives defines scope of review
  - *GMCB Guidance: Annual Budget Review Manual ("ACO Budget Guidance")*
- ACO Certification
  - ACOs that want to accept payments from **Medicaid or Commercial** insurance must be **certified**
  - ACOs that plan to accept payments from **Medicare only** are not required to be certified
  - *GMCB Guidance: Annual Eligibility Verification ("Certification Form")*
- Authority
  - 18 V.S.A. § 9382 and GMCB Rule 5.000

ACO Guidance Process Overview
Certified ACO vs Medicare-Only ACO

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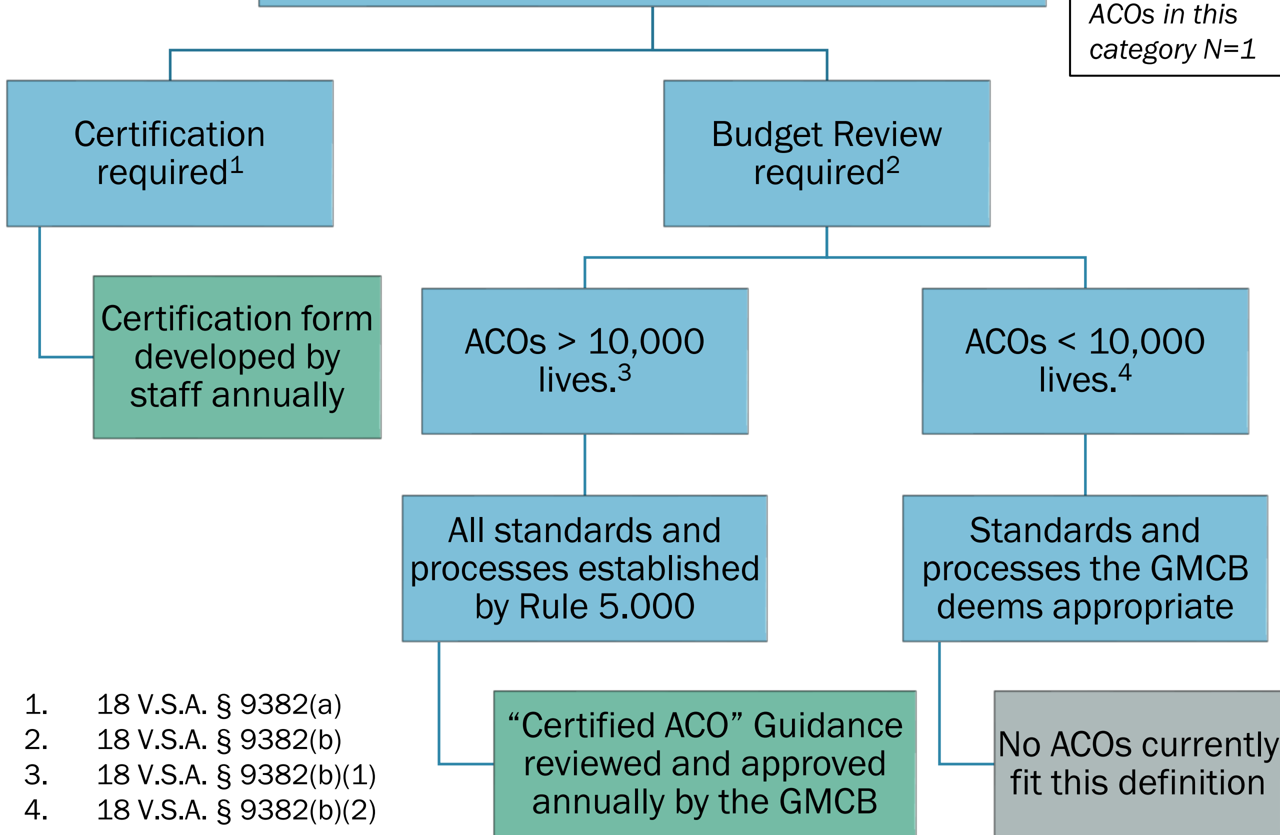

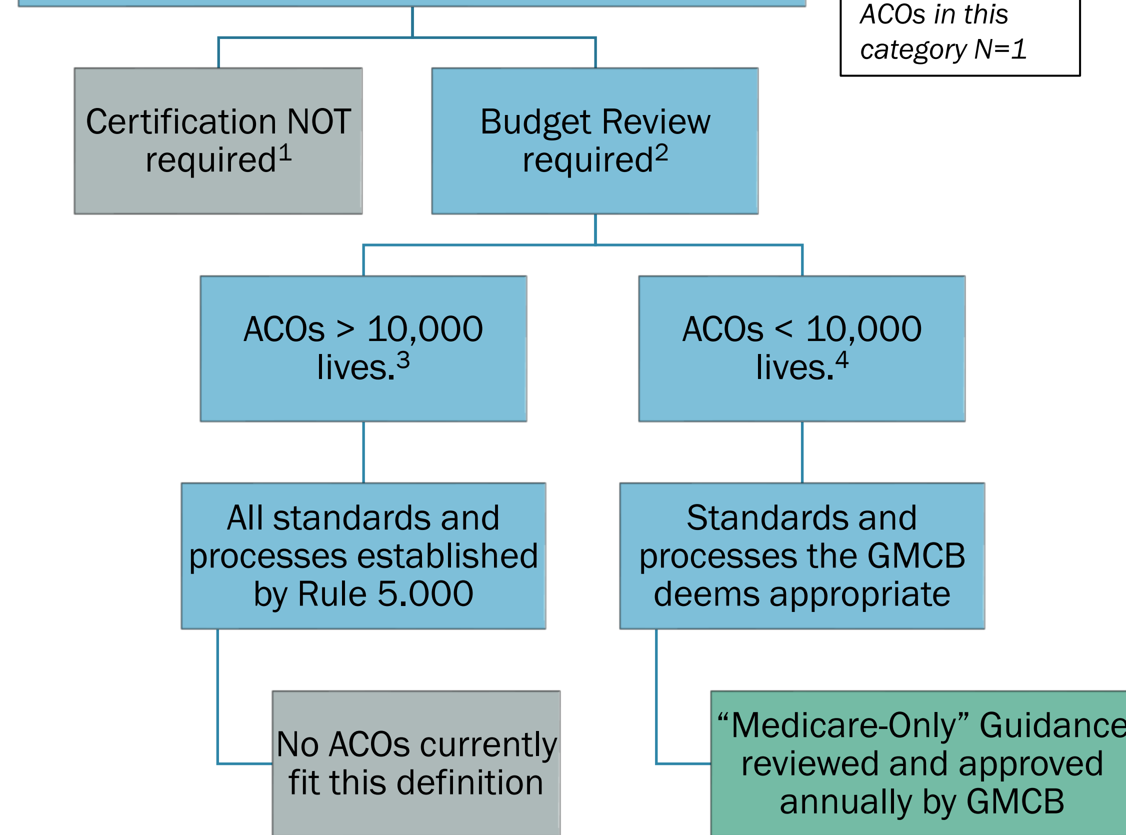

1. 18 V.S.A. § 9382(a)
2. 18 V.S.A. § 9382(b)
3. 18 V.S.A. § 9382(b)(1)
4. 18 V.S.A. § 9382(b)(2)

ACO Guidance Process Overview
Standards of Review

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:

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.