VERMONT
GREEN MOUNTAIN CARE BOARD

ACO Oversight
FY 2025 Budget Hearing
OneCare Vermont

GMCB Staff Introduction

November 13, 2024

Agenda

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- Staff Intro
- OneCare FY2025 Budget Presentation
- Board Questions
- Health Care Advocate Questions
- Public Comment

OneCare Budget and Certification Review Timeline FY 2025

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May 29, 2024	GMCB issues FY25 Certified ACO Budget Guidance
June 19, 2024	GMCB approves OCV's FY25 Risk Mitigation Plan
Aug 28, 2024	OCV submits certification verification materials
Oct 1, 2024	OCV submits FY25 budget
Nov 13, 2024	OneCare Vermont Budget Hearing
Dec 4, 2024	GMCB staff presentation: OneCare Vermont FY25 budget
Dec 18, 2024	GMCB deliberations on OneCare Vermont FY25 budget and potential vote
Ongoing 2025- 2026	GMCB monitors FY25 actual performance against budget and conditions

Oversight of ACOs – Legal Review

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- Oversight of Accountable Care Organizations (18 V.S.A. § 9382 and Rule 5.000)
  - **Certification**: Occurs once following application for certification; eligibility verifications performed annually.
  - **Budget**: 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.

Budget Review Process

18 V.S.A. § 9382(b)(1) and Rule 5.405(a) and (b)

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The ACO shall have the burden of justifying its proposed budget to the Board. In deciding whether to approve or modify the proposed budget of an ACO projected to have more than 10,000 attributed lives in Vermont during the next Budget Year, the Board will take into consideration:

1. any benchmarks established under section 5.402 of this Rule;
2. those 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.

Establishing Benchmarks

GMCB Rule 5.402 and FY25 Budget Guidance and Reporting Manual

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- The Board may establish benchmarks for any indicators to be used by ACOs in developing and preparing their proposed budgets. The benchmarks are included in the annual reporting and budget review manual ("FY25 Budget Guidance") and assist the Board in determining whether to approve or modify an ACO's proposed budget.
- The Board established benchmarks ("budget targets") during its meeting of May 22, 2024.
- These budget targets are included in the FY25 Budget Guidance document for OneCare, established on May 29, 2024.

FY25 OneCare Vermont Budget Targets

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1. The FY25 commercial benchmark trend rates must be consistent with the ACO-attributed population and the GMCB approved rate filings.
2. Maintain risk corridors for all public payer programs at minimum of FY23 levels or elect asymmetric risk corridor offered by Medicare.
3. Aside from waivers provided in the 2024 amendment of the APM agreement, OneCare's FY25 budget should not support new programs. Administrative expenses should be associated with 1)programs demonstrated to yield positive benefits for Vermonters and VT Providers, or 2)programs/resources necessary to support APM requirements, or 3)meeting payer contractual obligations/participation requirements
4. Ratio of operating expenses to PHM/payment reform payments (including FPP and budgeted bonus payments) must not exceed the FY24 revised budget amount

FY25 OneCare Vermont Budget Targets

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5. The ratio of population health management funding to number of attributed lives must be at a minimum of the FY24 revised budget amount; specific line items may vary based upon any internal evaluation of the effectiveness of individual PHM programs.
6. Continue efforts around the 3 metrics that the ACO has selected to address in response to the March 2023 Medicare ACO Performance Benchmarking report through the Quality Evaluation and Improvement plan. The ACO should justify its choice of tactics to improve performance in these areas.
7. Should the ACO choose to participate as an MSSP ACO in FY25 and leave the APM, OCV much submit a budget that reflects the fact that its value to the state is more limited and must provide any and all additional information as requested by the Board.
8. The ACO must account for its administrative budget by providing a breakout of the budget by function.

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REFERENCE SLIDES

18 V.S.A. § 9382

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(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.