

OneCare Vermont ACO FY 2021 Budget GMCB Staff Introduction

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Agenda for the day



1. GMCB Staff Intro
2. OneCare FY2021 Budget Presentation
3. Board Questions
4. Health Care Advocate Questions
5. Public Comment

ACO Oversight Statute/Rule



Oversight of Accountable Care Organizations

([18 V.S.A. § 9382](#) and [Rule 5.000](#))

- 1. Certification:** Occurs one-time following application for certification then eligibility verifications done annually
- 2. Budget:** Review of ACO budget occurs annually during fall prior to start of budget/program year with payer contracts/attribution finalized by spring of the budget year.

ACO Oversight Timeline FY 2021

Jul 1, 2020
GMCB issues
FY21 ACO
oversight
guidance

Oct 1, 2020
ACO submits
FY21 budget

Dec 9, 2020
GMCB Staff
Analysis
Presentation

**Jan/Feb
2021**
GMCB issues
FY21 ACO
budget order

**Ongoing
2021**
GMCB
monitors
OCV FY20
actual/
performance
against
budget and
conditions



Sept 1, 2020
ACO submits
certification
materials

**Oct 28,
2020**
ACO FY21
Budget
Hearing

**By Dec 31,
2020**
Board vote
on budget

**Mar → Jul
2021**
GMCB
review of
final FY21
attribution,
budget,
contracts

Public comment accepted throughout - comment should be submitted by December 2 to be considered in staff analysis and by December 21 to be considered in final Board deliberation/vote

FY2021 ACO budget and certification materials are available here: <https://gmcboard.vermont.gov/aco-oversight/2021>

The Board will consider...



GMCB Rule 5.405

(b) In deciding whether to approve or modify the proposed budget of an ACO projected to have 10,000 or more 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. the [16] 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
- Public Hearing/Comments
 - Participation by the Health Care Advocate

[16] Statutory Criteria for ACO Budgets: 18 V.S.A. § 9382(b)(1)

Examples of [FY20 budget order](#) conditions tied to statutory criteria:

1. Network development strategy
2. Scale target initiative – program alignment
3. Effectiveness of population investments – when to scale/sunset etc.
4. ACO Dashboard
 - Variation in cost and quality
 - Trends and impact of care model on utilization
5. Measuring the value of ACO investments over the term of the APM
6. OCV to fund the SASH and Blueprint for Health (PCMH and CHT) investments in the amount of \$X, at a minimum
7. Others... (22 conditions in FY20)

ACO 2021 Budget Guidance Summary

1. FY21 Budget and COVID-19
2. Reporting Requirements
 - Section 1: Information and Background
 - Section 2: Provider Network
 - Section 3: Payer Programs
 - Section 4: Total Cost of Care
 - Section 5: Risk Management
 - Section 6: Budget
 - Section 7: Quality/Pop. Health/Model of Care/Community Integration
 - Section 8: Other All-Payer ACO Model Question
3. ACO Budget Targets
4. Revised Budget
5. Monitoring
6. Appendices

APM: Requirements and Goals



Total Cost of Care 5-year growth targets

- In line with VT economic growth: 3.5%, no higher than 4.3%
- 2018 through 2022

Quality and Population Health Outcomes

1. Increase access to primary care
2. Reduce deaths due to suicide and drug overdose
3. Lower prevalence of chronic disease

Scale

- Received [warning letter from CMMI](#) for not meeting scale targets for two years in a row (also unlikely for 2020)
- Co-signatories drafting response due back early December

Next Steps

1. ACO Budget Hearing (today)
2. Second round of Questions to ACO (Nov 2020)
3. AHS to release APM Improvement Plan/“Reboot”
4. GMCB Staff Presentation and preliminary recommendations (Dec 9th, 2020)
5. Establish 2021 Medicare Benchmark Methodology (Dec 2020)
6. Medicaid Advisory Rate Case (Dec 2020)
7. Tentative Board Vote (Dec 2020)

Reference Slides

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;

18 V.S.A. § 9382

(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.