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GREEN MOUNTAIN CARE BOARD

OneCare Vermont ACO
FY 2022 Budget
GMCB Staff Introduction

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November 10, 2021

ACO Oversight Statute/Rule

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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. Certification applies only to ACOs seeking Medicaid or commercial contracts.
2. **Budget:** Review of ACO budget generally 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

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Jul 1, 2021	GMCB issues FY22 ACO oversight guidance
Sept 1, 2021	ACO submits certification materials
Oct 1, 2021	ACO submits FY22 budget
Nov 10, 2021	**ACO FY22 Budget Hearing**
December 1, 2021	Public comment should be submitted to be considered in staff analysis
Dec 8, 2021	GMCB staff analysis presentation
December 2021	Medicare Benchmark and Medicaid Advisory Rate Case
By Dec 31, 2021	Board vote on budget
Jan/Feb 2022	GMCB issues FY22 ACO budget order
Spring 2022	GMCB review of final FY22 attribution, budget, contracts
Spring 2022	Development of FY23 Guidance
Ongoing 2022	GMCB monitors FY22 actual/ performance against budget and conditions

The Board will consider…

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- 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

APM Targets

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- **Total Cost of Care.** In line with Vermont's historical economic growth: 3.5%, no higher than 4.3% (compound average growth rate).

- **Quality and Population Health Outcomes.** Three high-level goals:
  - Increase access to primary care
  - Reduce deaths due to suicide and drug overdose
  - Lower prevalence of chronic disease

- **Scale.** Vermont received a letter from CMMI on 10/12/21 recognizing that the Agreement scale targets are unattainable based on information that was not available when the Agreement was signed, and waiving scale enforcement for the remainder of the current Agreement.
  - GMCB will continue to produce reports on scale performance.

ACO 2022 Budget Guidance Summary

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1. FY22 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

Agenda for Today

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1. GMCB Staff Intro
2. OneCare FY2022 Budget Presentation
3. GMCB Staff Questions
4. Board Questions (Possible Executive Session)

Break for Lunch (30-minutes)

5. Continued Board Questions (if needed)
6. Health Care Advocate Questions
7. Public Comment

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Reference Slides

Resources

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FY22 Materials on the GMCB Website:
https://gmcboard.vermont.gov/aco-oversight/2022

1. ACO Budget Guidance
2. OCV Budget Submission
3. Public Comments

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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.