VERMONT
GREEN MOUNTAIN CARE BOARD

ACO Oversight
FY 2024 Medicare Only ACO Budget Review
Lore Health ACO and Vytalize Health 9 ACO

Staff Recommendations and Potential Vote

December 6, 2023

Agenda

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1. Scope of Review
2. FY24 Lore Health Budget
    1. Public Comment
    2. Staff Recommendations
    3. Discussion and potential vote
3. FY24 Vytalize Health 9 Budget
    1. Public Comment
    2. Staff Recommendations
    3. Discussion and potential vote

Scope for Medicare-Only Review

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- Medicare-Only ACOs are not subject to certification
- Smaller ACOs are under a different section of the statute (Lore Health and Vytalize Health 9 have less than 10,000 lives in Vermont)
- Both are participating in standard Medicare models, with terms established under federal rule
- Both are multi-state ACOs

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LORE HEALTH ACO

FY24 Budget

Public Comment – Lore Health

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Office of the Health Care Advocate

Concerns:

- Lack of evidence regarding efficacy of model of care
- Lack of transparency
- Profit-priority motive

Recommendations:

- Lore to submit financial and quality reporting to GMCB annually
- Establish deadline for confidentiality requests in budget guidance
- GMCB should expand the scope of authority over Medicare-Only ACOs

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UPDATED STAFF RECOMMENDATIONS

Recommendations Summary

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- **Recommendation 1:** Lore Health provides to GMCB its shared savings/losses, segmented for Vermont.
- **Recommendation 2:** Lore Health provides an updated version of their Vermont financial summary. GMCB staff to develop template and set deadline.
- **Recommendation 3:** Lore Health provides to GMCB its MSSP quality reporting, segmented for Vermont if possible, with appropriate restrictions to protect patient confidentiality.
- **Recommendation 4:** Following three performance years in Vermont, Lore Health provides reporting for those years on GMCB-specified metrics which may include the categories of inpatient medical, inpatient surgical, emergency department, professional office visits, ambulatory care sensitive admissions, and any additional metrics. GMCB staff to develop template and metrics and set deadline.
- **Recommendation 5:** Lore Health provides a semi-annual update (first report submitted with FY25 budget submission on October 1, 2024) about how Vytalize Health's care model is working in Vermont including any consumer complains received from attributed Vermont beneficiaries. GMCB staff to develop template.
- **Recommendation 6:** A representative from Lore Health must engage in an orientation led by Blueprint for Health within the first quarter of 2024.

Suggested Motion Language

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- Motion language:

Move that the GMCB approve Lore Health ACO's FY24 budget as submitted to the Board subject to the conditions reviewed by the Board today.

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VYTALIZE HEALTH 9 ACO

FY24 Budget

Public Comment – Vytalize Health 9

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58 public comments received as of December 5th at noon

Themes

- Private equity firms/for-profit motive
- Privatization of Medicare
- Potential effects on health care delivery
- Public comment period too short
- Board should reject Vytalize's budget or delay vote

From Little Rivers FQHC:

- Wishes to engage with value-based care arrangements and explored several ACOs
- ACO agreement allows for disengagement at any time
- Financial health of the practice

Public Comment – Vytalize Health 9

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Office of the Health Care Advocate

Concerns:

- Motives of private equity firms (profit)
- Claims that Medicare-Only ACOs create savings or reduce spending
- Efficacy of model of care
- Competitor to OneCare Vermont

Recommendations:

- Vytalize Health 9 to submit financial and quality reporting to GMCB annually
- Establish deadline for confidentiality requests in budget guidance
- GMCB should expand the scope of authority over Medicare-Only ACOs

New Information

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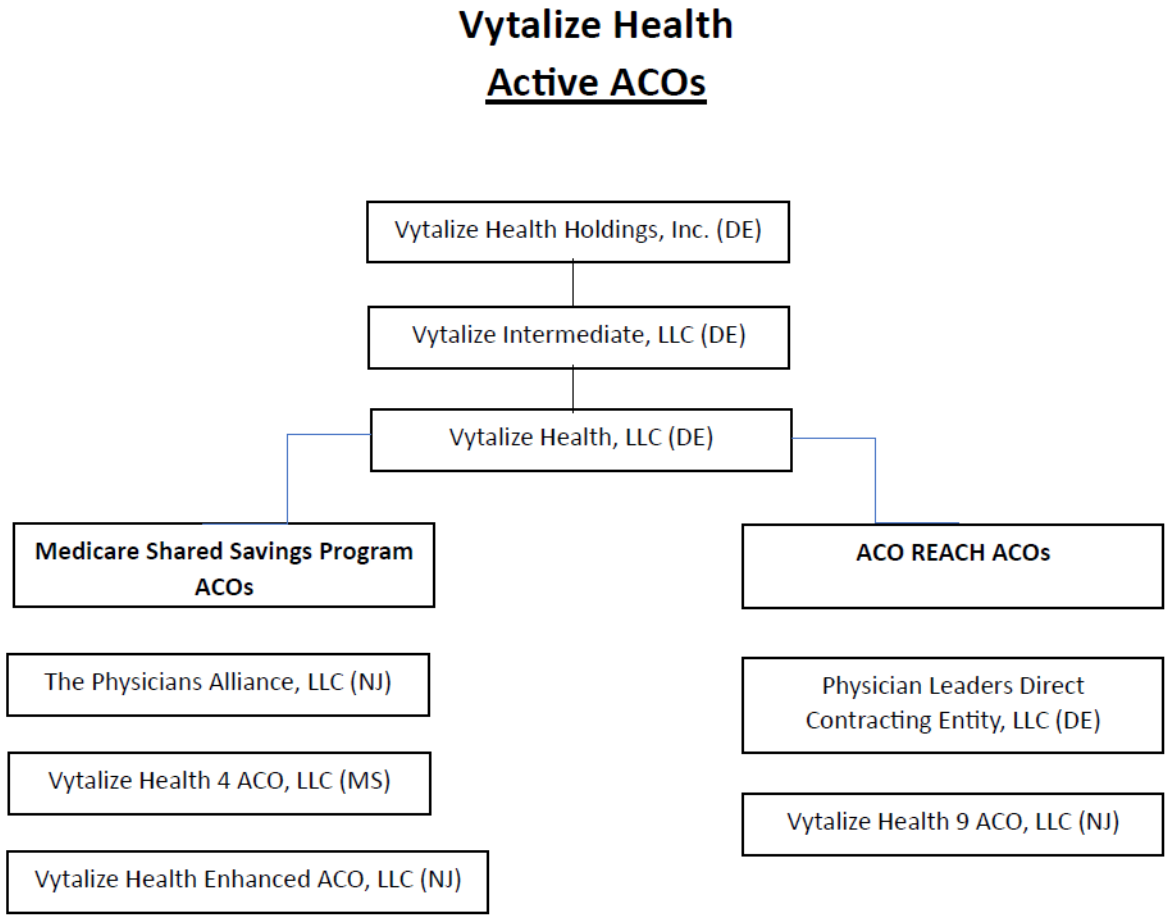

- All ACOS on the chart are owned in full by Vytalize Health LLC except for Physician Leaders, which is an ACO which Vytalize Health has an investment and operate under a management services agreement.

New Information
Health Equity Plan

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- During the hearing, it was stated that Vytalize Health 9's health equity plan would roll out nation-wide in 2024.
- The ACO provide an update stating that while CMS has approved the plan, in the start of 2024, the initiative will be implemented in a single zip code in Mississippi. If the program is deemed successful, it may be expanded into additional regions.
- Example goals for this initiative include no increase in ED visits and inpatient admissions related to complications from food-related chronic illnesses.

New Information
Provider Network

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- The 52 providers listed in the Vermont network include the following types:
  - Primary Care Physicians
  - Nurse Practitioners
  - Physician Assistants
  - Obstetricians/Gynecologists
  - Certified Nurse Midwives
  - Clinical Social Workers
  - Psychiatrists
  - Dentists

New Information
Provider Payments

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- The quality withhold that exists as part of the ACO REACH model is not considered until the final shared savings numbers are received; they are not baked into the PMPM payments going to providers.
- Of all the support payments made to providers, the priority care program support payments are the only ones not considered an advance in shared savings.

Key Points

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- Medicare ACOs vs Medicare Advantage
  - Patient is still a traditional Medicare beneficiary, not Medicare Advantage enrollee
  - According to CMS, beneficiaries included in the model keep all of their rights, coverage, and benefits, including the freedom to see any Medicare-enrolled provider they want. Even if a beneficiary is aligned to a REACH ACO, they always have the freedom to see any Medicare-enrolled provider or supplier. CMS expects that beneficiaries whose primary care provider is part of a REACH ACO will see and feel improvements in the quality and experience of care they are getting because of the ACO REACH Model
- ACO REACH program replaced Global and Professional Direct Contracting Model, with several improvements
  - 75% of governing body made up of participating providers
  - Consumer advocate and Medicare beneficiary seats w/voting rights
  - Update to risk score growth in response to concerns about risk coding abuse
  - Increased vetting of applicants and monitoring of participating entities

Key Points

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- Beneficiaries can opt out of data sharing
  - Can maintain traditional benefits through Medicare and access their provider without engaging in ACO-specific programs
- ACO enters a market through a contract with providers, which providers enter voluntarily
- GMCB budget review
  - ACOs that only have Medicare contracts are not required to be certified by GMCB. 18 V.S.A. § 9382(a)
  - For budget review, GMCB is tasked with "reviewing, modifying, and approving" budgets, unlike certification where the GMCB may "either approve, provisionally approve with conditions, or deny" a certification application. GMCB Rule §5.303, §5.405, 18 V.S.A. § 9382(b)
  - Under current statute and rule, GMCB does not have the authority to prevent a Medicare-only ACO from entering into the state
  - Programmatic elements of REACH are set by CMS

Program Safeguards

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- CMS monitors levels of care to determine if REACH ACOs are stinting on beneficiary care.
- CMS conducts compliance audits throughout the year, investigates beneficiary complaints, and conducts beneficiary experience of care surveys (CAHPS) annually to measure changes in beneficiary satisfaction
- CMS will monitor whether beneficiaries aligned to the model are being shifted into or out of Medicare Advantage.

See: https://www.cms.gov/priorities/innovation/media/document/aco-reach-mont-comp-ovw

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- **Recommendation 2:** Vytalize Health 9 provides an updated version of their Vermont financial summary. GMCB staff to develop template and set deadline.
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Suggested Motion Language

VERMONT
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- Motion language:

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REFERENCE SLIDES

ACO Oversight Statute/Rule

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- What is the Board approving?
  - Certification is not required under 18 V.S.A. § 9382(a)
  - Under 18 V.S.A. § 9382(b)(2) and Rule 5.405, GMCB shall **review and approve or modify** an ACO's budget.
    - Guidance approved by the Board earlier this year for Medicare-only ACOs with fewer than 10,000 attributed lives
  - Scope of Board's jurisdiction
- Reporting obligations under Rule 5.501

Budget Review Process

18 V.S.A. § 9382(b)(2) and Rule 5.405(c)

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In deciding whether to approve or modify the proposed budget of an ACO projected to have fewer 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) ***that the Board deems appropriate to the ACO's size and scope***;
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.

Board Review Scope

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- Staff recommend Board consider the following factors from 18 V.S.A. § 9382(b)(1):
  - 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;
  - the character, competence, fiscal responsibility, and soundness of the ACO and its principals;
  - any reports from professional review organizations;
  - 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;

Board Review Scope (cont.)

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- Recommended factors from 18 V.S.A. § 9382(b)(1) continued:
  - public comment on all aspects of the ACO's costs and use and on the ACO's proposed budget;
  - information gathered from meetings with the ACO to review and discuss its proposed budget for the forthcoming fiscal year;
  - information on the ACO's administrative costs, as defined by the Board;
  - 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
  - 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.

Acronym List

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- ACO — Accountable Care Organization
- APM — All-Payer Model
- CMS — Centers for Medicare & Medicaid Services
- FFS — Fee-for-Service
- FY – Fiscal Year
- GPDC – Global and Professional Direct Contracting
- GMCB — Green Mountain Care Board
- HCP-LAN – Health Care Payment Learning & Action Network
- HCA — Health Care Advocate
- HSA — Health Service Area
- MSSP — Medicare Shared Savings Program
- PCP — Primary Care Provider
- PMPM — Per-Member Per-Month
- PY — Performance Year
- ACO REACH – Realizing Equity, Access, and Community Health ACO program
- SNF — Skilled Nursing Facility
- SS/SL — Shared Savings/Shared Losses
- TCOC — Total Cost of Care