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GREEN MOUNTAIN CARE BOARD

ACO Oversight
FY 2025 ACO Budget
OneCare Vermont

GMCB Deliberations and Potential Vote

December 18, 2024

Agenda

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- Review of Public Comment
- FY 2025 OneCare Vermont Budget: Options for Budget Modification and Approval
- Board Questions and Discussion
- Public Comment

Public Comment
Themes

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- Providers in favor of OCV's Regional Care Representative (RCR) program
- Providers offered ideas for uses of additional funding
- Office of the HCA: Reduce OCV's purchased services and labor costs by 30% of its current proposed budget and reallocate these funds to non-hospital owned, independent primary care providers (PCPs)
  - Redistribute all costs associated with advertising, lobbying, public relations, and travel to independent PCPs
- OCV: True winddown year is 2026; all programs will run as planned in 2025. RCR program is essential for success in 2025 and beyond. Requested that administrative cuts not surpass the amount of $957k presented by GMCB staff on 12/4.
- In total, 7 public comments were received as of 12/16/2024

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Budget Modifications and Approval Options

Budget Conditions
Consistent with previous years

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- Must submit reports and information in accordance with the GMCB Reporting Manual, with authority delegated to the GMCB Health Policy Project Director to develop and modify the reporting requirements.
- Notify GMCB of any material changes to their budget and explain variance.
- Notify GMCB of any use of reserves or line of credit or any adjustment to participation fees, with standard limitations for use of these funds.
- Over the duration of the APM Agreement, OneCare's administrative expenses must be less than the health care savings, including an estimate of cost avoidance and the value of improved health, projected to be generated through the Model.

Budget Conditions
Consistent with previous years

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- Implement benchmark trend rates for payer contracts in alignment with the GMCB's decision on the Medicare ACO benchmark (Presentation 12/11, vote 12/18); the GMCB's Medicaid Advisory Rate Case; and, for commercial payer contracts, in alignment with ACO-attributed population and the GMCB approved rate filings.
- Engage in payer programs that qualify for APM Scale to the greatest extent possible and align payer programs in key areas to the extent reasonable; explain non-Scale qualifying programs and areas of misalignment. Require continued reporting on payer programs.

Budget Conditions
Consistent with previous years

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- Fund population health management and payment reform programs as detailed in the FY25 submission, as modified by this order, and notify GMCB of any changes, including funding shortfalls, changes in program scope, and an analysis for each program line item as to whether and why the funding is appropriately scaled by attribution, or some other factor.
- Fund the Support and Services at Home (SASH) program and Blueprint for Health payments to primary care practices and community health teams consistent with the amount approved by the GMCB in the Medicare ACO Benchmark process (vote scheduled for 12/18).

Budget Modification and Approval Options

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1. Reduce OneCare's administrative budget by $1,457,713 and reallocate these funds to independent primary care practices, Federally Qualified Health Centers, Designated Agencies, home health agencies, and area agencies on aging. The method of distribution of these funds shall be at the discretion of the ACO.
2. Require that hospital participation fees be adjusted at least once during 2025 to minimize hospital credits that are accumulated should revenues be outpacing expenditures.

Budget Modification and Approval Options

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Options for reducing administrative expenses:

- Level-fund salary and benefit expenses from FY24 projected ($634,771)
- Eliminate expense of CFO position ($322,604)
- Eliminate expense of benchmarking report and evaluation contract ($468,638)
- Eliminate expense on lobbying contract ($26,700)
- Eliminate expense of Board of Managers recruitment ($5,000)

Total reduction: $1,457,713

Resulting administrative budget: $11,294,649

	2024 Approved Budget	2025 Requested Budget	2025 Potential Modified
TOTAL PHM* payments for non-hospital providers	$8,955,742	$8,471,617	$9,929,330

*Inclusive only of Population Health Management program base and bonus pools (no CPR, Longitudinal Care, etc)

Template Motion Language

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Approve Budget with Modifications (modify as needed):

Incorporating this Board's FY25 Risk Mitigation Decision and Order, move to approve OneCare's FY25 budget with the following modifications:

1. With a $1,457,713 reduction to OneCare's administrative budget. This sum shall be reallocated to the following types of providers in OneCare's existing network:
    1. Independent Primary Care Practices
    2. Federally Qualified Health Centers
    3. Designated Agencies
    4. Home Health Agencies
    5. Area Agencies on Aging

    The method of distribution of these funds shall be at the discretion of the ACO.
2. With a requirement that hospital participation fees be adjusted at least once during 2025 to align with updates to OneCare's projected FY25 expenditures.
3. Subject to the budget conditions presented today by GMCB staff.

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Board Discussion

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Public Comment

ACO Oversight Statute/Rule

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- Oversight of Accountable Care Organizations (18 V.S.A. § 9382 and Rule 5.000)
  - **Certification**: Occurs one-time 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.

ACO Oversight: Standards of Review

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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 the Board considers:

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.