

# GMCB Regulatory Alignment White Paper

## **PART 2: OPTIONS FOR REGULATORY TIMELINE AND LOGISTICS**

August 2020

***The Green Mountain Care Board seeks to improve the health of Vermonters through a high-quality, accessible, and sustainable health care system.***

DRAFT FOR DISCUSSION



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## Introduction: Part 2, Options for GMCB Regulatory Timeline and Logistics

The Green Mountain Care Board was created as an independent board to promote the general welfare of the State by:

- (1) improving the health of the population;
- (2) reducing the per-capita rate of growth in expenditures for health services in Vermont across all payers while ensuring that access to care and quality of care are not compromised;
- (3) enhancing the patient and health care professional experience of care;
- (4) recruiting and retaining high-quality health care professionals; and
- (5) achieving administrative simplification in health care financing and delivery.

18 V.S.A. § 9372

As Vermont moves forward with health system transformation, the Board has begun reviewing its regulatory processes with the goal of aligning them more fully with each other and with the Board's statutory purpose, in particular improving the health of the population and reducing the per-capita rate of cost growth while ensuring access to and quality of health care.

This series of three white papers considers five core GMCB regulatory processes: (1) All-Payer Model (APM) Regulatory Responsibilities (Medicare ACO Program Design and Benchmark Rate Setting); (2) Accountable Care Organization (ACO) Oversight; (3) Hospital Budget Review; (4) Health Insurance Premium (Rate) Review; and (5) Certificate of Need (CON). The [first paper](#) lays out each of the regulatory processes in its current state. This second paper considers possible changes to the GMCB regulatory timeline to improve alignment. The third and final paper (to be released in early 2021) reviews four key areas for policy alignment: (1) financial measures, (2) quality measurement, (3) delivery system roles and responsibilities, and (4) risk and reserves.

### Goals

This white paper series aims to improve the Board's ability to make decisions consistently across regulatory processes and ensure appropriate assessment of regulated entities in a reformed payment and delivery system environment. Below are specific GMCB alignment goals:

- Streamline GMCB oversight to ensure regulatory processes inform one another where appropriate and achieve alignment on key policy issues (e.g., aligning health care cost growth with overall economic growth and connecting hospital budget decisions to both health insurance premium rate review and ACO oversight);
- Develop measures, where feasible, to allow for comparisons across GMCB regulatory processes; and
- Envision future GMCB regulatory structures as Vermont continues to shift from fee-for-service to population-based payment models.

### Methods

In developing this series, GMCB surveyed regulated entities and other stakeholders; held a stakeholder focus group; and gathered data about current processes, challenges, and considerations for future regulatory refinements or changes. GMCB is soliciting comment on Parts 1 and 2 of this white paper series from stakeholders and the public during Summer 2020.

### A Note on the Impact of COVID-19

The COVID-19 pandemic and public health emergency has had enormous impacts on Vermonters and Vermont's health care system. Act 91 of 2020 has offered the GMCB and GMCB-regulated entities temporary flexibility in response to the pandemic. The Board's response has included:

- Providing new guidance for emergency certificate of need applications related to the COVID-19 response
- Continuing to monitor hospital solvency and issuing new hospital budget process guidance intended to reduce the regulatory burden on hospitals, including delaying hospital budget submission due dates
- Working with federal partners at the Center for Medicare and Medicaid Innovations to request monitoring flexibility and additional funding for providers participating in Vermont's All-Payer Model
- Amending OneCare Vermont's 2020 Budget Order to allow the redirection of resources toward front-line providers and to extend the reporting timeline to allow for revisions in light of COVID-19 and account for delays in the availability of information
- Delayed GMCB's insurance rate review decisions by one week (allowable under existing authority)
- Data analysis to support the State's response

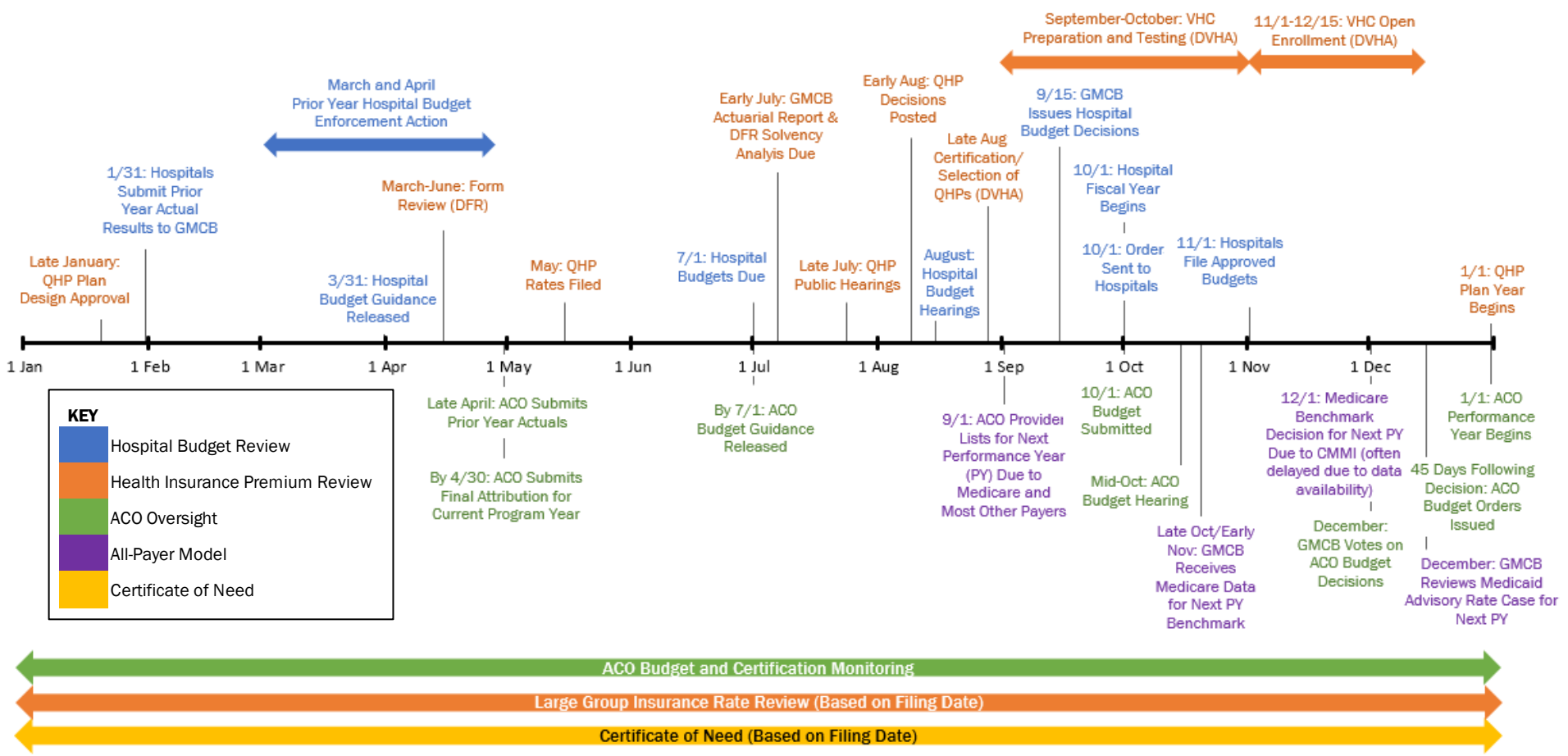
Given the uncertainty caused by COVID-19 and temporary nature of regulatory changes in response to the public health emergency, this white paper focuses on GMCB regulatory processes as they would occur in a normal year.

# GMCB Regulatory Timeline and Logistics

Part 2 of this white paper series describes the Board’s current annual regulatory timeline, timeline constraints, and options for change.

## Current State

Figure 1: GMCB Regulatory Timeline, Current State



### *Why Change the GMCB Regulatory Timeline?*

GMCB's major regulatory processes are timed based on the independent needs and constraints of each individual process. Currently, GMCB-regulated entities (hospitals, insurers, the ACO) use different fiscal years, plan years, and performance years.

- Hospital budgets are set in September, prior to the start of hospitals' fiscal year (October 1-September 30, as specified in Vermont law).
- Health insurance premium rate decisions for Vermont's merged individual and small group market are issued in August for the coming plan year (January 1-December 31, as required by federal law).
- ACO budgets and the APM Medicare benchmark are set in December for the coming performance year (generally January 1-December 31) and finalized in spring when commercial contracts and attribution are known.

GMCB has long recognized that these regulatory processes do not exist in a vacuum; they inform one another, and these interactions will only increase as the All-Payer Model (APM) continues to drive Vermont's health care system from fee-for-service (FFS) payment to value-based models.

One way to improve process alignment may be to adjust the Board's regulatory timeline. GMCB's current regulatory timeline creates two key challenges to holistic, system-wide regulation:

- Timing of hospital budget review and small group and individual market health insurance premium rate review: Ideally, the GMCB would work with hospitals during the budget process to set appropriate and justifiable caps on commercial charge increases. Assuming that carriers negotiate with each hospital to set actual reimbursement rates, knowledge of these caps would provide an upper limit on unit cost increases for regulated hospitals and better inform health insurance premium filings for the upcoming year. In the current system, the process is reversed: the GMCB issues small group and individual market health insurance premium decisions in July/August, prior to its review of hospital commercial rate requests during the hospital budget process in August/September. The insurers and the Board's actuary try to estimate the impact of the hospitals' submitted (but not approved) charge requests to the medical trend component of the premium rate.
- Timing of hospital budget review and ACO budget review: Hospitals would ideally develop budgets that reflect their plans for ACO participation in the coming fiscal year with the most up-to-date information on the associated costs, benefits, and risks. Tighter alignment of hospitals' budget years with the ACO performance cycle would increase the accuracy of hospital budgets and strengthen the connection between the hospital and ACO budget processes. Currently, hospitals' October-September fiscal year and summer budget approval cycle do not coincide with the January-December ACO fiscal year and ACO-payer contracts, or the late fall ACO budget approval cycle, and ACO program and incentive details are not finalized until payer contracts are executed late in the calendar year (or, in some cases, early during the performance year).

### *Timeline Constraints*

Despite the challenges caused by GMCB's current regulatory timeline, potential changes are limited by Vermont law and regulation; federal law and regulation; interaction with non-GMCB regulatory partners, particularly other State of Vermont agencies and departments; and data availability and comparability.

Figure 2: Regulatory Timeline Constraints

Regulatory Process	Regulatory Timeline Constraints	Relevant Statute
<b>All-Payer Model Regulatory Responsibilities</b>	<i>Medicare Benchmark:</i> The All-Payer ACO Model Agreement (APM Agreement) requires GMCB to submit to CMS for approval the benchmark (financial target) for the coming Medicare ACO program year by December 1 annually. Medicare data availability, driven by the final Medicare ACO provider list (available September 1), has proven a practical constraint in completing this responsibility on time; however, delays in benchmark approval also delay the finalized ACO budgets as the ACO's final budget must reflect the Medicare trend and Medicare attributed lives. Following receipt of Medicare data, GMCB staff and contractors must analyze the data to come to a growth trend and benchmark recommendation for Medicare.	APM Agreement; 18 V.S.A. § 9382(b)(1)(N) [impact of Medicaid rates on other payers]
	<i>Medicaid Advisory Rate Case:</i> GMCB is required to review any all-inclusive population-based payment arrangement between DVHA and an ACO; GMCB receives data from DVHA in mid-December for actuarial review. GMCB is required to complete its review prior to December 31 and finalization of the Medicaid ACO contract. GMCB is also required to consider the impact of Medicaid's ACO payment rates on other payer programs, including the Medicare benchmark decision.	18 V.S.A. § 9382(b)(1)(N), § 9573
<b>ACO Oversight</b>	The timeline for ACO oversight is defined by regulation in GMCB Rule 5.000; however, this timeline is dictated largely by data availability. The ACO finalizes its provider network (provider list) – a critical factor in developing its total budget – for Medicare and most other payers on September 1 for the coming January-December contract year. The ACO budget year begins on January 1, in alignment with Medicare ACO programs; however, the ACO budget is not finalized until after the start of the performance year when final patient attribution counts are available. <sup>1</sup> As the ACO approaches full scale, population volatility will decrease and early attribution and budget estimates will likely improve; however, attrition due to churn between coverage, relocation, death, and other causes mean that attribution and hence the ACO's budget will continue to be finalized in January-March for all payer programs.	18 V.S.A. § 9382
<b>Hospital Budget Review</b>	Vermont law requires that all hospitals begin their fiscal year on October 1. This aligns with federal Medicare reporting requirements for many hospital types, which are based on an October 1-September 30 fiscal year.	18 V.S.A. § 9454
<b>Insurance Premium (Rate) Review</b>	<i>Individual and Small Group Plans (Qualified Health Plans):</i> Qualified Health Plan (QHP) premiums are reviewed annually by GMCB; this review is in addition to regulatory action by DVHA and DFR. GMCB's review occurs between May, when rates for the coming plan year are filed, and August, when the Board issues its decisions. This timeline is constrained by Vermont law, which requires GMCB to issue decisions within 90 days of filing; federal law; and the needs of other Vermont agencies:	8 V.S.A. § 4062; 45 CFR § 155.410(e)(3); 45 CFR § 154

<sup>1</sup> This occurs early in the performance year for Medicare and Medicaid programs, and in early spring for QHP commercial ACO programs. Federal law allows for a grace period for qualified health plan premium payment, which means the enrolled population and hence the ACO-attributed population is not finalized until February. Note that the attributed population for each payer's ACO program fluctuates (generally downward) throughout the performance year; this is taken into account at settlement following the end of the performance year.

<sup>2</sup> For a full QHP process timeline, see [2021 Qualified Health Plan Certification Timeline](#).

	<ul style="list-style-type: none"> <li>○ <i>Prior to GMCB rate decisions:</i> DFR completes form review for each health plan annually from March-June. Form review is extensive and cannot be shortened without reducing DFR's regulatory scrutiny.</li> <li>○ <i>Following GMCB rate decisions:</i> DVHA inputs plan information into its enrollment system, and there is a comprehensive testing period for both DVHA and insurers offering QHPs prior to the start of open enrollment. The federal Center for Consumer Information &amp; Insurance Oversight (CCIIO) requires state-based health insurance exchanges to begin open enrollment no later than November 1 for a plan year starting January 1.</li> </ul> <p>Federal law is the largest constraint to changing the timing of this process:</p> <ul style="list-style-type: none"> <li>○ Federal law requires plans sold in the merged individual and small group market to be on a calendar year.</li> <li>○ Rates and forms cannot be finalized by insurers and filed with DFR/GMCB until after the federal government (both CMS and IRS) issues its annual guidance, which has been shifting later into the spring. This allows QHPs to incorporate the full set of federal regulatory changes.</li> <li>○ Federal law requires an open enrollment period beginning on November 1.</li> </ul> <p>A Vermont stakeholder group convened in 2017 with the goal of condensing the QHP premium rate review timeline and concluded that it was not possible to shorten this process without reducing regulatory responsibilities and oversight.</p> <p><u>Large Group Plans:</u> GMCB reviews and approves the formulas and factors used by major medical health insurers to develop large group premium rates on a rolling basis. Currently, this process occurs relatively independently of other GMCB regulatory processes.</p>	
<b>Certificate of Need</b>	<p>Certificate of need applications are reviewed and decided on a rolling basis; GMCB is required to issue a final decision within 120 days of notifying an applicant that its application is complete, which generally occurs within 90 days of receipt of the application (excluding time spent by the applicant responding to requests for information); extensions are taken when necessary.</p>	<p>18 V.S.A. § 9440(c)</p>



## Recommendations: Regulatory Timeline and Logistics

### *Recommendation 1: Consider Changes to Hospital Budget Process to Improve Alignment, Data Availability, and Enforcement Ability*

A portion of GMCB's regulatory timeline misalignment could be solved by modifying the hospital fiscal year to allow for greater data alignment with the ACO program year and/or with the individual and small group market premium year. We describe pros and cons of two timeline options below, noting that either would likely cause significant disruption to hospital operations and financial reporting. Either option would require significant vetting with stakeholders prior to serious consideration by the Board; the Board and stakeholders would need to assess whether improved information flow is worthwhile given the operational challenges that would arise from a change in hospital fiscal year.

#### *Option 1A: Align ACO Budgets and Hospital Budgets; Move Hospital Fiscal Year to January 1*

As described in Part 1, at any given point in time, hospitals are finalizing their prior year financials and ACO performance, operating within the current budget year, and planning their next budget year, including making decisions about future ACO participation. This means hospitals are balancing prior year projected performance (including, if participating in the ACO, Medicare performance reconciliation and its potential impacts on current year financial performance), projections for current year performance, and budget planning (including risk) for the upcoming program year. Hospital budget decisions rely on a preliminary ACO provider list but the final list and attribution for the upcoming year are not available until September (provider list) and later in the fall (preliminary attribution based on provider list), after the Board's hospital budget decisions are due. In addition, hospitals do not have accurate estimates of fixed prospective payment (FPP) revenue for the following budget year at the time the Board decides their budgets because ACO-payer contracts are still in flux; this causes significant uncertainty in hospitals' budget development.

The ACO is also simultaneously finalizing prior year performance, operating within the current performance year, and designing and recruiting for not-yet-finalized contracts in the upcoming year.

The ACO budget, filed on October 1 annually, includes estimates of the total cost of care benchmark by payer, FPP by hospital for Medicaid and Medicare, and each hospital's risk by payer program; these estimates, based on preliminary Medicare attribution data, lack accuracy due to data availability limitations caused by significant population changes between ACO program years. Better estimates are available later in the ACO budget review period (or early in the ACO performance year for the commercial ACO/QHP population) following preliminary attribution modeling. GMCB could also alleviate some of this challenge by providing additional modeling data to the ACO regarding the entire Vermont population represented in data available to the GMCB.

In addition, the Board receives data from Medicare in late November or early December, which is used to calculate the Medicare benchmark and set a Medicare ACO program trend. The Board's decision on the Medicare trend and the analysis on the benchmark (both completed in mid-December) form the basis upon which Medicare program risk is calculated and eventually paid out to the hospitals; the Board is also required to consider the impact of Medicaid's ACO payment rates on other payer programs, including in its Medicare ACO program trend decision.<sup>3</sup>

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<sup>3</sup> The Board typically receives the Medicaid rate case in December. The Medicaid rate case provides the Board with actuarial information used by DVHA in negotiating the Medicaid ACO benchmark and Medicaid FPP to hospitals. The rate case does not currently include FPP information.

Ideally, the Board would have decided the Medicare benchmark and have accurate risk levels and FPP information prior to deciding hospital budgets in order to have a predictable and accurate projection of the non-FFS components of the hospitals’ net patient revenue. If the state were to achieve ACO scale, FPP would be a significant component of the hospitals’ budgets, which could allow for a more nuanced analysis of the appropriate price and utilization increases.

One option to improve information flow around Medicare risk levels and FPP – and with it, the accuracy of hospital budgets and the ACO budget – is moving the hospital fiscal year later to improve data availability. Moving the hospital fiscal year to *January 1* may require an earlier provider commitment to participate in the ACO in order to have the information completed in time to make hospital budget decisions by December 15.

Shift Hospital Fiscal Year to January 1: Pros	Shift Hospital Fiscal Year to January 1: Cons and Barriers
<ul style="list-style-type: none"> <li>• Hospitals have more certainty in the ACO-related portion of their budgets and more certainty about the ACO program</li> <li>• May allow risk levels and FPP amounts for Medicare and Medicaid to be known earlier and incorporated into the hospital budget process and decisions</li> </ul>	<ul style="list-style-type: none"> <li>• Hospitals would still need to submit budgets three months prior to the start of the fiscal year; this would require an October 1 submission date, based on data through August 1, and would require updating to include information based on the ACO provider list</li> <li>• Hospitals’ following year submitted commercial rates would not be available for health insurance premium rate review process</li> <li>• Budget decisions would need to occur early enough to allow hospitals to negotiate contracts with commercial payers</li> <li>• Requires statutory change in hospital fiscal year</li> <li>• Operationally challenging and administratively burdensome for hospitals, especially during the transition; would require hospitals to develop either a long (12+ month) budget or a short “bridge” budget to make this change</li> <li>• Simultaneous ACO &amp; hospital budget process would be challenging for the GMCB</li> </ul>

Alternately, GMCB could review/decide the Medicare and Medicaid trends earlier, but the feasibility of this option is limited by data availability; it would require an earlier provider commitment deadline (currently September 1) because the ACO program risk levels and FPP amounts are based on the attribution and historical claims experience of participating providers’ patients.

*Note:* This option does not improve alignment with qualified health plan premium review.

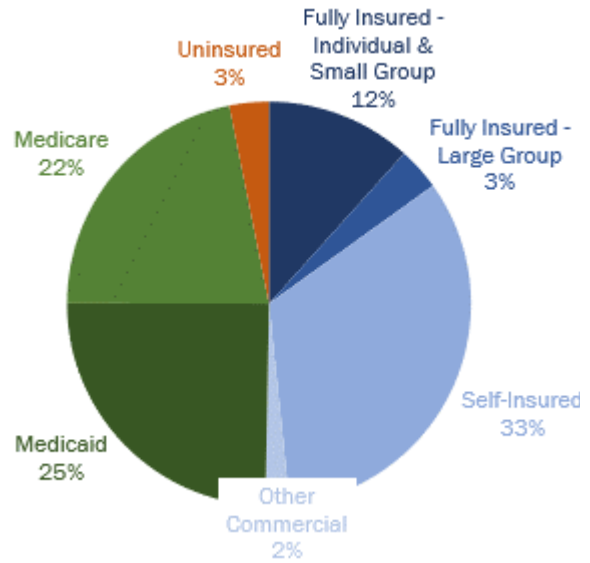
*Option 1B: Shift Hospital Fiscal Year to July 1 to Improve Data Availability in Hospital Budget, QHP, and ACO Oversight Processes*

To improve information flow between hospital budgets, QHP premium rate review, and the ACO process, a July 1 hospital fiscal year might be considered. This would allow the hospital budgets to be known prior to insurance premium rate review decisions in August. With a July 1 hospital fiscal year, 6 months of hospital revenue projections could be incorporated into the QHP filings.

Moving the hospital fiscal year is more feasible than adjusting the QHP timeline. As noted earlier, moving premium review for individual and small group insurance plans is very difficult due to the federal constraints and the roles of other state agencies in the QHP process. In the best-case scenario, GMCB may be able to move its portion of the QHP process by a week earlier or later, neither of which improves alignment in a significant way.

It is important to understand that the impact of moving the hospital fiscal year to better align the hospital budget process with the QHP process may also be minimal. Only about 73,000 people are insured by these plans (12% of the VT population and 23% of the privately insured population),<sup>4</sup> so, as noted in the first white paper, this market has a small impact on APM TCOC and on hospital budgets. Furthermore, the impact of the uncertainty created by the misalignment may be relatively small in terms of carriers' overall rate requests. For example, the FY2020 budgets submitted by hospitals, if approved by the Board as filed, would have increased the 2020 premium rates filed by the carriers by approximately 0.5%.<sup>5</sup>

Figure 3: Vermont Health Insurance Enrollment



Despite limited alignment improvements between the hospital budget and QHP process, a July 1 hospital fiscal year could improve data availability between the hospital budget and ACO oversight process for half the year. Moving the hospital fiscal year to July 1 would allow for the hospital budgets to reflect actual ACO attribution and FPP for the remaining six months of the calendar year (July-December). This would require an earlier estimate of the ACO budget for the second half of the new hospital fiscal year (January-June); however, hospitals could likely use prior year budget data to estimate this, since Medicare FPP is reconciled to FFS spend.

Shift Hospital Fiscal Year to July 1: Pros	Shift Hospital Fiscal Year to July 1: Cons and Barriers
<ul style="list-style-type: none"> <li>Hospital budgets could reflect 6 months of final ACO FPP, known in February/March based on final attribution</li> <li>Data from two quarters of approved hospital budgets could be incorporated into QHP filings</li> </ul>	<ul style="list-style-type: none"> <li>Hospitals would still need to submit budgets three months prior to the start of the fiscal year; this would require an April 1 submission date, based on data through February 1, when commercial ACO contracts and attribution may not yet be final, and would require updating to include this information</li> <li>Requires statutory change in hospital fiscal year</li> <li>Operationally challenging and administratively burdensome for hospitals, especially during the transition; would require hospitals to develop either a long (12+ month) budget or a short “bridge” budget to make this change</li> <li>Final ACO attribution would not be known in advance of budget decision for the following calendar year</li> </ul>

*Recommendation 2: Consider Using Statewide Data for Medicare Benchmark to Reduce Data Availability Challenges*

GMCB currently faces significant data availability challenges in the Medicare benchmark calculation, which impacts both the Medicare benchmark approval process as well as the Board’s annual decision on the Medicare ACO trend rate. Currently, both are contingent on the Medicare ACO provider list, received on September 1; this allows only a short period for staff and contractors to

<sup>4</sup> See [2018 Vermont Expenditure Analysis](#) (Health Insurance Coverage Profile, Vermont Residents, pg. 43)

<sup>5</sup> See [Blue Cross and Blue Shield of Vermont 2020 Individual and Small Group Rate Filing Decision](#) (August 8, 2019), Findings, ¶33; [MVP Health Plan Inc. 2020 Individual and Small Group Rate Filing Decision](#) (August 8, 2019), Findings, ¶52.

perform necessary analysis – including identifying a preliminary beneficiary cohort and analyzing historical spending among this cohort – and for the Board to make its decisions.

GMCB could accelerate the Medicare benchmark and Medicare ACO program trend decisions by using the statewide Medicare population in both calculations. Utilizing historical spending data for all Vermont Medicare beneficiaries in the benchmark calculations (rather than historical spending for a preliminary attributed population) would tie the benchmark to statewide Medicare spending and allow for a more stable and predictable benchmark prior to achieving ACO scale (the Medicare ACO population has historically changed significantly from year to year). Once scale is achieved, the ACO-attributed Vermont Medicare population will be very close to the full Vermont Medicare population.

Use Full Vermont Medicare Population to Calculate Benchmark: Pros	Use Full Vermont Medicare Population to Calculate Benchmark: Cons and Barriers
<ul style="list-style-type: none"> <li>• Increased stability and predictability</li> <li>• More timely benchmark calculation</li> <li>• Aligns with Medicare TCOC population in PY4-5</li> </ul>	<ul style="list-style-type: none"> <li>• May not accurately reflect the risk of the ACO-attributed Medicare population</li> </ul>

### *Recommendation 3: Continue to Improve Communication of Hospital Budget Impacts on QHP Filings*

In the past two years, the Board has included the impacts of hospital budgets in its rate review decisions. The decisions are legal documents which are not easily understood by the public. The Board will continue to work on improving the way we communicate how these processes overlap.

### Additional Options: Not Recommended

The Board also considered the following options, but determined that these options should not be considered further:

#### Implement a 2-Year Hospital Budget Review Process

Implementing a 2-year hospital budget review process would provide hospitals with increased regulatory certainty due to known NPR and commercial rate increases for a two-year period. However, utility is questionable at this time given the limited data on which the 2-year budget submissions would be based; 2-year budgets would likely require continued adjustments throughout the budget period. The Board issued guidance with NPR targets for two years in 2019, but has maintained the same annual process to review budgets. This guidance did not include a target for commercial rate increases. This option may be feasible to reconsider if we achieve greater stability in the ACO population and more stability in the growth rates.

#### Shift QHP Approval Process to After Hospital Budget Approval to Better Integrate Hospital Commercial Charge Increases into QHP Premiums

While GMCB would ideally set commercial charge increases and then integrate them into QHP premium filings for the upcoming plan year, state and federal constraints in the QHP approval timeline preclude a later GMCB QHP rate review process.

#### Align Large Group Insurance Premium Years and Hospital Fiscal Years; Require Large Group Plans to Operate on a January 1 Plan Year

While this option would more clearly crosswalk hospital commercial charge increases with large group premium rate review, it would be extremely burdensome and provide minimal improvements over the current process. The transition period where large group plans were moved from current plan years (throughout the year) to a January 1 plan year would cause significant consumer confusion regarding deductibles, due to either a partial year plan or a plan for over 12 months;

insurers would face operational costs from a short interim plan year or premium estimation challenges for a plan that longer than year.

In addition, alignment would have a small impact: large group plans currently cover ~18,000 people, and, to the fullest extent possible, actuaries already incorporate prior year hospital budget orders and review the most up-to-date budget submissions for consideration in the premium review process (see pg. 5).

#### Shift Hospital Fiscal Year to April 1

Under this option, hospital accounting would shift to an April 1-March 31 fiscal year; budgets would be submitted early in the calendar year, for approval by March 15. In theory, this would allow hospital budgets to take into account the ACO's approved budget and final FPP, which is known in February/March; however, final ACO would still not be known in advance of hospitals' initial budget submissions, so budgets would need to be updated mid-process to reflect final attribution.

### Next Steps: Regulatory Timeline and Logistics

**Engage stakeholders to discuss changing hospital fiscal year and budget process.** All options included in recommendation 1 would require significant effort on the part of hospitals and would impact numerous other stakeholders, including the ACO, insurers, and State entities. It would also require a statutory change. Prior to pursuing any changes, GMCB should engage a broad group of stakeholders to consider these changes and assess whether the benefits outweigh the costs and to assess how implementation could impact the full health system.

**Perform modeling on using statewide data to set ACO Medicare benchmark.** GMCB staff, potentially with support from contractors, should model how this change would have impacted the benchmark in past years, and model how it could impact future benchmarks under different scenarios. GMCB should also gather input from CMMI and the ACO as it considers this option.