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GREEN MOUNTAIN CARE BOARD

FY 2023 ACO Guidance Overview and Medicare-Only Guidance Draft

June 8, 2022

Agenda for Today

1. ACO Guidance Process Overview
   - Statutory Authority
   - Approach for FY23
   - Timeline
2. Certified ACO Guidance Outline Preview
3. Medicare-Only ACO Draft Guidance Review

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ACO GUIDANCE PROCESS OVERVIEW

ACO Guidance Process Overview
ACO Certification and Budget Review

- ACO Budget Review
  - All ACOs operating in Vermont are subject to budget review
  - Threshold of 10,000 lives defines scope of review
  - *GMCB Guidance: Annual Budget Review Manual ("ACO Budget Guidance")*
- ACO Certification
  - ACOs that want to accept payments from **Medicaid or Commercial** insurance must be **certified**
  - ACOs that plan to accept payments from **Medicare only** are not required to be certified
  - *GMCB Guidance: Annual Eligibility Verification ("Certification Form")*
- Authority
  - 18 V.S.A. § 9382 and GMCB Rule 5.000

ACO Guidance Process Overview

Certified ACO vs Medicare-Only ACO

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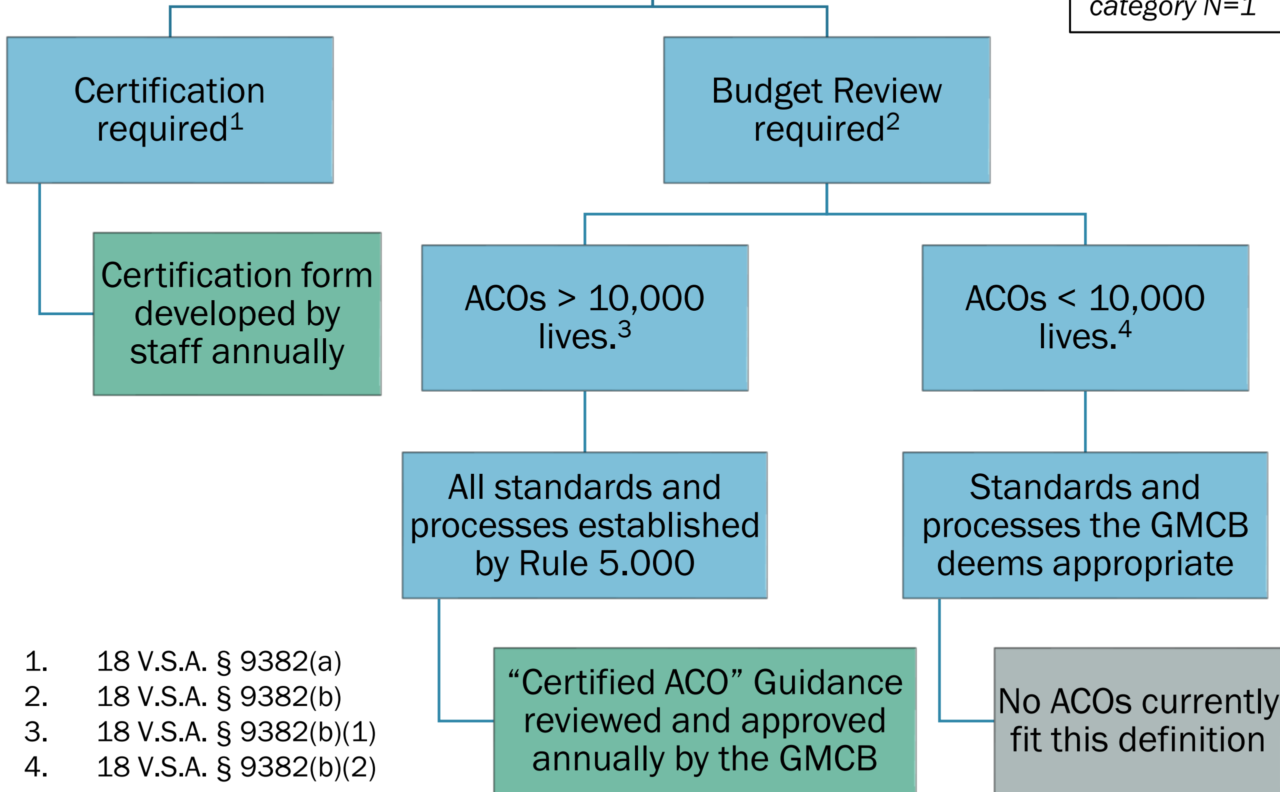

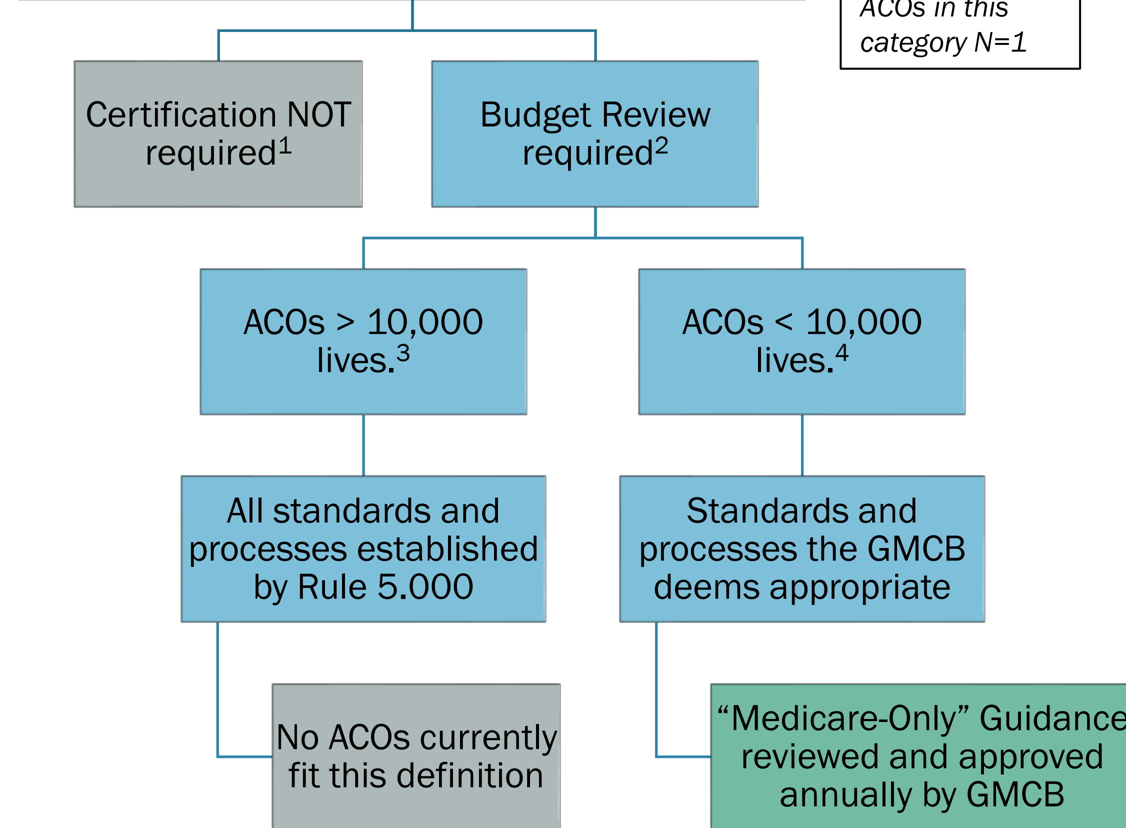

1. 18 V.S.A. § 9382(a)
2. 18 V.S.A. § 9382(b)
3. 18 V.S.A. § 9382(b)(1)
4. 18 V.S.A. § 9382(b)(2)

ACO Guidance Process Overview
Standards of Review

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:

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.

ACO Guidance Process Overview

FY23 ACO Oversight Approach

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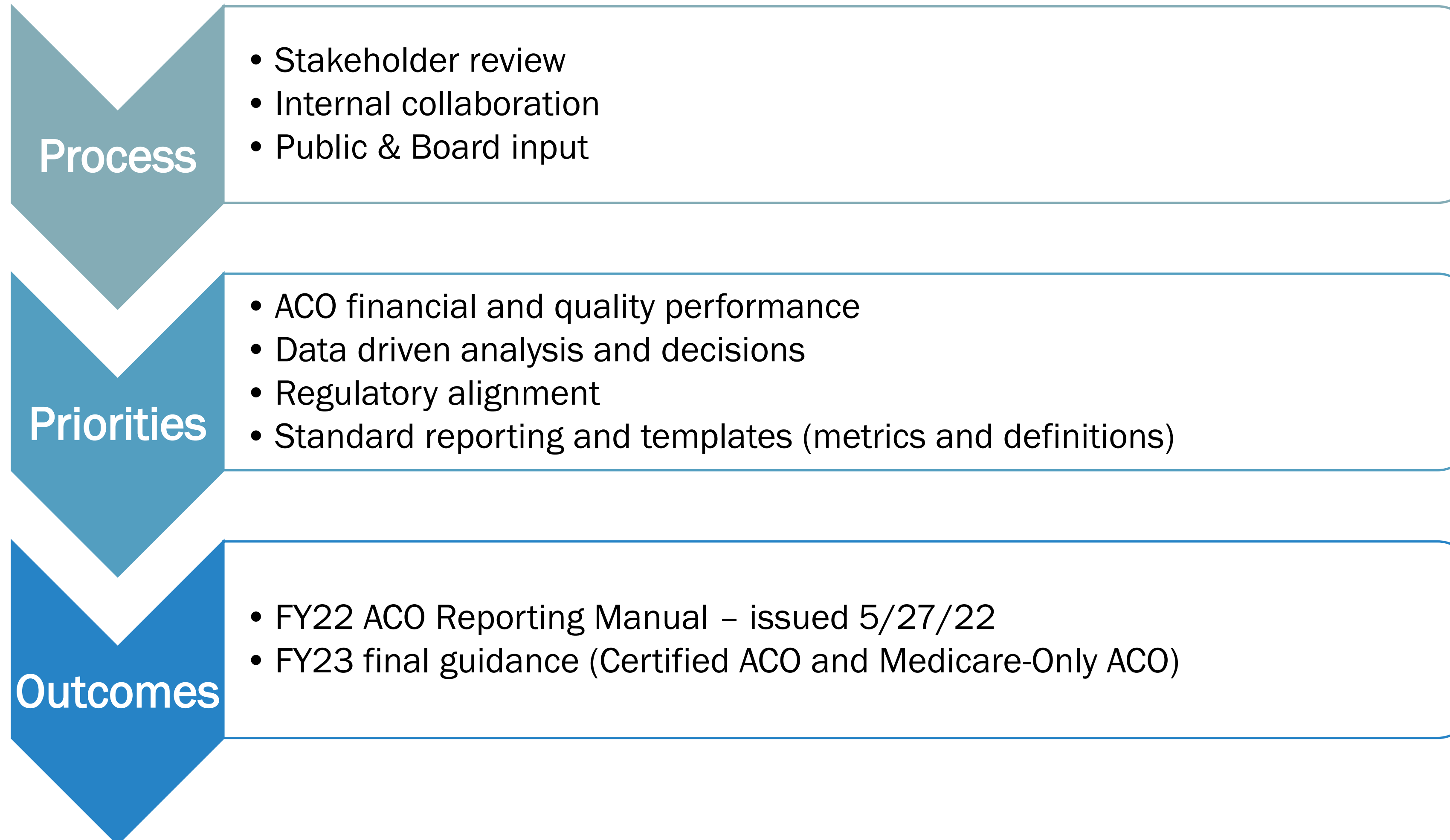

ACO Guidance Process Overview
2022 Development Timeline for FY23

- May: GMCB staff worked with stakeholders (ACOs and HCA)
- June 8: Medicare-Only ACO Guidance
- June 15: Certification Form and Certified ACO Budget Guidance
- June 22: Potential Vote

Special public comment period: June 8-June 20

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CERTIFIED ACO GUIDANCE OUTLINE PREVIEW

Certified ACO Guidance Preview
FY23 Staff Goals

Continued FY22 Goals and Considerations (current year)

- Streamline information requests across regulated entities (ACO & hospitals)
- Break out information requests across processes categorically to ensure Rule 5.000 regulatory requirements
- Emphasis on data over narrative where appropriate
- Reconsider timing of information requests (e.g., Budget cycle vs. on-going monitoring)
- Impact of Covid-19
- 2022 is final year of current APM Agreement
- Consider how to operationalize core-competencies into review (see 5/12/21 Bailit presentation)

New FY23 Goals and Considerations (budget year)

- Crosswalk to Rule 5.000
- Remove areas of identified duplication and streamline questions
- Incorporate performance benchmarks and prescriptive guidance as allowed in § 5.402
- 2023 is extension year of APM Agreement

Certified ACO Guidance Preview
Reporting Requirements Sections

1. Budget Executive Summary **(name change)**
2. Provider Contracts **(name change)**
3. Payer Contracts **(name change)**
4. Total Cost of Care
5. **Network Program and Risk Arrangement Policies**
6. Budget and Financials
7. Quality, Population Health, Model of Care, and Community Integration
8. **Evaluation and Performance Benchmarks**
9. Vermont All-Payer ACO Model Alignment

Changes: bolded blue

Certified ACO Guidance Preview
Example: Reporting Requirements Outline

Section 1: Budget Executive Summary. Provide brief narratives to summarize the components of the budget submission; describe the ACO's vision for the coming budget year including:

a) Strategic Plan 2021-2023 update
b) Provider network
c) Payer Programs
d) Attribution estimates
e) Full Accountability and Entity-Level budget summaries
f) Network programs and population health/care model changes for 2023
g) Evaluation – lessons learned and plans for 2023, including a summary of ACO performance benchmarking results to date

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MEDICARE-ONLY GUIDANCE DRAFT REVIEW

Medicare-Only Guidance
Background

- This Medicare-Only guidance applies if ACO:
  - Does not participate with Medicaid or commercial payers, meaning certification is not required,
  - Has less than 10,000 attributed lives in the State of Vermont.
- Guidance is not specific to a particular ACO, but would apply to any ACO that fits the criteria above
- As of now, there is only one Medicare-Only ACO in Vermont that fits this criteria

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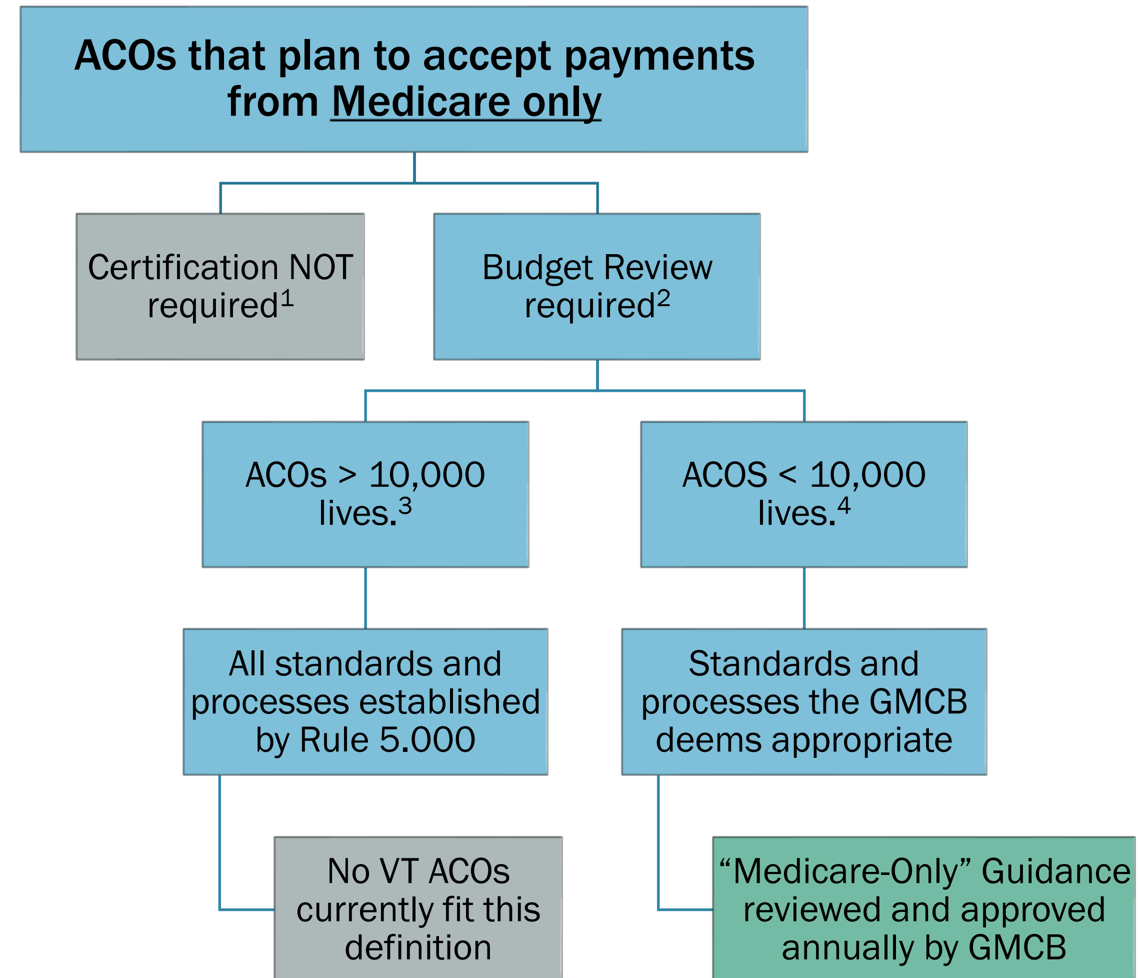

Medicare-Only Guidance
Background

- This is the second year that Medicare-Only Guidance is coming before the Board.
- In FY22, one Medicare-Only ACO (Clover Health Partners) was operating in Vermont and went through the budget review process.
- Medicare-Only ACOs have a participation agreement with CMS that dictates many elements of their operations.
  - The Direct Contracting (DC) Model is sunsetting at the end of 2022 and being replaced with the REACH Model (Realizing Equity, Access, and Community Health).
  - The REACH Model has new requirements around ACO governance and health equity.
  - More information on the ACO REACH Model: https://innovation.cms.gov/media/document/aco-reach-graphic

Medicare-Only Guidance
Background

- The ACO REACH Model is an agreement between CMS, the REACH ACO, and providers who contract with the REACH ACO.
- Beneficiaries aligned to REACH ACOs are still in Traditional Medicare:
  - Access to the entire Traditional Medicare network
  - Alignment to REACH ACO does not affect out-of-pocket costs and premiums
  - Does not affect use of supplemental insurance (Medigap)
- Beneficiaries may have access to enhanced benefits through the REACH Model.

Medicare-Only Guidance
FY23 Goals and Focus

- Transparency and a focus on areas of GMCB jurisdiction
- Approach to edits in FY23 Draft:
  - Narrow guidance to focus on budget-specific requirements; removal of questions that would be more appropriate for certification and that Board and staff did not rely on during last year's budget review
  - Update questions and appendices to reflect understanding of Medicare-Only arrangements, including what CMS programs require vs. what the ACO has flexibility to change

Medicare-Only Guidance
Guidance and Appendix

- Medicare-Only Draft Guidance and Appendices can be found on the GMCB website:
  - Redline Copy
  - Clean Copy
  - Appendices
- Public Comment Period: June 8 - June 20

- Key: **Throughout this presentation, text in bolded blue indicates changes from last year**

Medicare-Only Section 1

ACO Information, Background and Governance

- Main change: removing submissions that fall under certification and that Board and staff did not rely on during last year's budget review.
  - Q4: Identify and describe the ACO and its governing body
    - **Removed submission of "bylaws, operation agreement, or equivalent document"**
  - Q5: Identify and describe each member of the ACO's executive leadership team
    - **Removed submission of the conflict of interest policy**
    - **Clarified that Q5a is referring to "executive leadership" compensation**

Medicare-Only Section 2
ACO Provider Network

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- Main change: added Appendix A-2
- Q1-2 about Appendix A
  - Duplicative text removed in narrative, already covered in Appendix A
- Provider network changes
  - Added Appendix A-2 to summarize provider network changes and reasons for provider departures
  - Based on FY22 follow up questions, clarified question (Q4 in FY23 draft) about whether ACO has plans to expand network in Vermont and related recruitment / network development strategies

Medicare-Only Section 3
ACO Payer Programs

- No major content changes
- Q2 (and FY22 Q3) about Appendix B
  - **Removed duplicative narrative text that was already covered in Appendix B**
  - **Changed layout of Appendix B (horizontal to vertical)**
- Q5: Provide the most recent annual ACO quality reports…
  - **Added "for all measures" and removed list of measures**
  - **Duplicative text removed in first half of question about listing measures because this content is covered in section 6**

Medicare-Only Section 4
ACO Budget and Financial Plan

- No major content changes
- Q2: Funds flow description
  - Added a funds flow chart to summarize types of funds (chart originally created by Clover in FY22 submission)
  - Dollar value question removed because duplicative of Q5
- Other questions
  - Small text edits to update year to 2023 and one clarifying edit (Q3d)

Medicare-Only Section 5

ACO Model of Care and Community Integration

- Main Change: updated questions to align with budget-specific requirements
- Q1: ACO Model of Care & Q2: primary care capacity
  - **Question updated to align with budget section of Rule 5, removed certification-specific elements**
- Q3: Health equity
  - **Added question about the ACO's health equity goals**
- Q5: Evidence used for ACO programs & Q6: ACO referral programs
  - **Updated questions for simplicity and clarity, based on follow up questions last year**
- Q7: Benchmarking question
  - **Added question to guidance that was asked in follow up last year**

Medicare-Only Section 6
Vermont All-Payer ACO Model Agreement
Scale Target ACO Initiative

- No changes to this section
- Section contains three tables: scale and financial arrangements, services included in financial targets, and quality measures

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QUESTIONS

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REFERENCE

Acronym List

- ACO—Accountable Care Organization
- APM—All-Payer Model
- CHP—Clover Health Partners, LLC
- CMS—Centers for Medicare & Medicaid Services
- FFS—Fee-for-Service
- FY—Fiscal Year
- GMCB—Green Mountain Care Board
- HCA—Health Care Advocate
- HSA—Hospital Service Area
- PCP—Primary Care Provider
- PMPM—Per-Member Per-Month
- PY—Performance Year
- SNF—Skilled Nursing Facility
- SS/SL—Shared Savings/Shared Losses
- TCOC—Total Cost of Care