VERMONT
GREEN MOUNTAIN CARE BOARD

2022 Budget Guidance and Reporting Requirements for Medicare-Only Non-Certified Accountable Care Organizations

October 13, 2021

Statute and Rule Overview

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- Medicare-only ACO is not subject to the certification requirement of 18 V.S.A. § 9382(a)
  - "In order to be eligible to receive payments from Medicaid or commercial insurance through any payment reform program or initiative, including an all-payer model, each accountable care organization shall obtain and maintain certification from the Green Mountain Care Board." 18 V.S.A. § 9382(a)
- Medicare-only ACO is subject to the annual budget review and approval in 18 V.S.A. § 9382(b)(2):
  - 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 fewer than 10,000 attributed lives in Vermont. In its review, the Board may consider as many of the factors described in subdivision (1) of this subsection as the Board deems appropriate to a specific ACO's size and scope.

Statute and Rule Overview (continued)

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- GMCB Rule 5.405:

> (c) 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.

- GMCB Rule 5.404 says the Board will hold public hearing for ACO budget review "except that the Board may decline to hold a hearing concerning a proposed budget submitted by an ACO that is expected to have fewer than 10,000 attributed lives in Vermont during the next Budget Year or that will not be assuming risk during the next Budget Year."

Scope of Guidance

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- This 2022 guidance and budget process would apply only for an ACO that:
  - is not certified by the GMCB,
  - is participating only with Medicare and not Medicaid or any commercial payers, and
  - that 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

Procedural Background

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- Clover Health requested a waiver of GMCB Rule 5.400 (annual budget review and approval) and GMCB Rule 5.500 (monitoring and oversight)
- Following a presentation by Clover Health and deliberation by the Board, the Board declined the waiver requested and asked staff to prepare budget guidance and process, working with Clover Health and HCA.
- Presenting draft guidance for Board review, following discussion with both Clover and HCA on draft.

Medicare-only ACO guidance

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- Review of Draft Guidance
- Comments, questions, and discussion