VERMONT
GREEN MOUNTAIN CARE BOARD

ACO Oversight
FY 2023 Budget and Certification
OneCare Vermont

GMCB Deliberations

December 14, 2022

Agenda

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- Public comment received to date
- Decisions before the GMCB
- Relevant or updated analysis from 12/7
- Discussion: Staff recommendations and board proposals

FY 2023 ACO Budget Key Areas of Review

- Certification
- Budget & Financials
- Payer Programs & Risk Model
- Payment Models & FPP/CPR
- Population Health, Quality, Model of Care
- Performance Measurement & Improvement
- Results

Public Comment
Themes

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- Value of OCV's data analytics, population health initiatives, and transition to value-based care
- Value of care coordination and strengthened partnerships with local care organizations
- Concerns related to the transition of OCV data analytics to UVMHN
- Concerns related to measures of OCV's performance and overall value to Vermont's healthcare system
- On 12/13, GMCB received a letter from OCV expressing concern about the proposed new requirement to hold risk for Medicare Advanced Shared Savings at the ACO level

- In total, 23 comments were received as of 12/13.*

*All public comments are posted on GMCB website unless commenters request otherwise.

Today's Deliberation
Decisions Before the GMCB

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- **Certification Eligibility Verification discussion**

- **OneCare Vermont FY23 Budget**

Decisions before the GMCB
OneCare Vermont ACO Certification

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- **Certification Eligibility Verification**
  - OneCare remains certified unless and until its certification is limited, suspended, or revoked by the Board
  - GMCB staff recommend deferring eligibility verification discussion until after the start of the new budget year to address areas still under review
- GMCB is still reviewing
  - Executive Compensation (Rule 5.000, § 5.203(a) Guidance)
  - Review of data analytics transition

Certification
Recommended Approach/Next Steps

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- The GMCB does not need to vote in order to continue OneCare's certification.
- Action would be needed if the GMCB concludes that OneCare no longer meets the requirements to be eligible for certification. In that case, the Board would provide notice to the ACO and an opportunity to respond before requiring corrective action.

As presented 12/7
Red = Changes

Review of Data Analytics Transition
Recommended Approach/Next Steps

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- Under Rule 5.503, "The Board may use any and all powers granted to it by law to monitor an ACO's performance or operations or to investigate an ACO's compliance with the requirements of this Rule, other applicable laws or regulations, and decisions and orders of the Board."
- Reviews may be performed at any time, not limited to the FY23 budget process.
- Review outside of FY23 budget process would allow, for example, a specific hearing on the data analytics transition requested by the HCA in their comments.
- To conduct an examination of an ACO's operations, the GMCB "shall advise an ACO of the specific areas that will be reviewed and any statutory or regulatory provisions under examination." Rule 5.503(b).

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18 V.S.A. § 9382

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(b)(1) 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 10,000 or more attributed lives in Vermont. To the extent permitted under federal law, the Board shall ensure the rules anticipate and accommodate a range of ACO models and sizes, balancing oversight with support for innovation. In its review, the Board shall review and consider…

16 statutory requirements included as reference slides.

Today's Deliberation
Decisions Before the GMCB

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- Certification Eligibility Verification discussion

- **OneCare Vermont FY23 Budget**

  Approve the budget as submitted?

  OR

  Modify the budget?

OCV FY23 Budget Deliberation

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- FY23 Key Areas of Review
  - Total Cost of Care (TCOC) and Trend Rates
  - Payer Programs & Risk Model
  - Payment Models & Fixed Prospective Payments/Comprehensive Payment Reform Program
  - Population Health, Quality, and Model of Care
  - Performance Measurement and Improvement; Results to Date
  - ACO Budget & Financials

Total Cost of Care & Trend Rates
Recommended Approach

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- Require OCV to implement benchmark trend rates for payer contracts in alignment with the GMCB's decision on the Medicare ACO benchmark; the GMCB's Medicaid Advisory Rate Case; and, for commercial payer contracts, in alignment with ACO-attributed population and the GMCB approved rate filings. (Consistent with past years)
  - Require additional information from OCV to support better understanding of what commercial payer data is available to OCV during trend and benchmark negotiations. (NEW)

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Payer Programs & Risk Model
Recommended Approach

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- Require OCV to 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. (Consistent with past years)
- Require OCV to work with Medicare Advantage plans operating in Vermont over the next two years – with a particular focus on Vermont-based plans offered by BCBSVT and UVMMC-MVP – to develop Scale-qualifying programs.
- Implement the ACO risk model as described in the budget, except for the new Medicare Advanced Shared Savings risk requirement; notify the GMCB of any changes. (Consistent with past years)
- Require that OCV hold risk for Medicare Advanced Shared Savings (Blueprint for Health/SASH funds) rather than delegating risk to network. (NEW –also see Population Health Management recommended approach)

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Payment Models and FPP/CPR
Recommended Approach FPP

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- Per the FY22 Budget Order and FY23 Guidance, GMCB staff recommend adopting goals for FPP in FY24 Guidance at (NEW)
  - **Medicaid 55%**
  - **Commercial 24%**
- The ACO must continue to report FPP data and progress toward the goals as specified in the ACO Reporting Manual and FY24 Guidance
- Goals reflect an aspiration, not a concrete plan. The ACO shall use best efforts to meet or exceed the goals as modified by the GMCB and identify and report specific obstacles to achieving the goals and action steps required (by OCV or others) to overcome those obstacles.
  - BCBSVT, MVP and OneCare have not identified clear milestones for including FPP in new contract model design (APM IIP, Nov 2020)
  - Medicare fixed payment model does not align with Medicaid (APM IIP, Nov 2020)

Reference: Implementation Improvement Plan (APM IIP): Vermont All-Payer Accountable Care Organization Model Agreement (Nov. 19, 2020)
https://gmcboard.vermont.gov/sites/gmcb/files/documents/APM%20Implementation%20Improvement%20Plan%20Final%2011.19.20.pdf

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Payment Models and FPP/CPR
Recommended Approach CPR

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- Report OCV-performed CPR Program Evaluation to the GMCB (NEW-Reporting Manual)
- Continue to provide CPR standard reporting (Consistent with past years and Reporting Manual)
- Provide information on impact of moving CPR to % TCOC in Revised Budget (NEW)

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Population Health, Quality, Model of Care
Key Takeaways

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- Total PHM expenditures of $29.9 million
  - All payments go to providers
- PHM investments are concentrated in Blueprint ($9.5M), PMPM Base/Bonus ($17.6M), CPR program ($1.5M)
- Evolving PHM payment model
- New care coordination reporting
- Phase out of some program support
- On-going ACO self-evaluation

Updated from 12/7

Population Health and Quality
Recommended Approach

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- Require OneCare to fund population health management and payment reform programs as detailed in the FY23 submission, and to 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. (Consistent with past years)
- VBIF/pre-funded clinical quality incentive is at least $2.24 (in guidance)
  - Describe final funding in revised budget
- Report self-evaluation results to GMCB (Reporting Manual) See next slide for evaluation requirements
- 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 (to be presented 12/14) without passing risk associated with Medicare Advanced Shared Saving Payments on to the ACO network. (Largely consistent with past years; underlined is new in FY23). (NEW –also see Payer Programs and Risk Model recommended approach)
  - OCV FY23 budget proposes 5.2% increases for both SASH and Blueprint payments.

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Performance Measurement & Improvement/ Results to Date

Recommended Approach

- Any program evaluation reported to the GMCB must include standard study elements, e.g.:
  - Background/Rationale
  - Objective
  - Study design
  - Setting
  - Participants/Study Size
  - Variables
  - Data Source(s)
  - Measures
  - Bias
  - Results
  - Discussion
  - Limitations

NEW RECOMMENDATION

High-Level Overview
FY23 Recommendations

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- The FY22 budget order conditions reflected a focus on data-driven monitoring and oversight.
  - Focus on ensuring that the ACO's management drives continuous improvement consistent with a high-performing ACO and that it supports achieving the state's health reform goals
- This was envisioned as a multi-year approach, to be refined in 2023 through the FY23 ACO budget review and FY24 guidance development process. Staff recommend continuing to strengthen this approach over the coming year, keeping data-driven ACO performance monitoring at the center of our ACO oversight.
  - Focus on performance benchmarking, target-setting, and evaluation

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Performance Measurement & Improvement
Key Takeaways

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- Existing performance measurement does not satisfy GMCB requests for assessment of:
  - OCV patient and population outcomes at the ACO-level against **high-performance targets and trends**
  - **ROI on OCV investments**, including population health programs and administrative expenses
  - **Relationship** between OCV programs and investments and improved outcomes

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Performance Measurement & Improvement
Recommended Approach

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- Propose to require improvements to the report in the areas of comparison group, measure-specific benchmarking, and identification of high performers to support targeted quality improvement.
  - Implement through Reporting Manual
- Build on FY22 budget order by requiring improvements to benchmarking report in FY23 budget order, including:
  - Identifying best performers and best practices
  - Clarifying required methodology for comparison to best performers (per measure, rather than identifying individual high-performing ACOs and comparing across measures)
  - ROI calculation for areas of improvement
  - Larger and more transparent comparison cohort
- Require OCV to meet specific performance targets in FY24 guidance, and to indicate how benchmarking report results drive PHM spending decisions. (NEW)
  - If necessary, require performance improvement plans or corrective action based on performance against targets

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Results to Date
Recommended Approach

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- Require OneCare to complete a return on investment (ROI) analysis comparing their administrative expenses to health care savings, including an estimate of cost avoidance and the value of improved health.
  - Past budget orders have required that this be done over the duration of the APM Agreement; the Agreement's original term ends on 12/31/22
  - Staff recommend requiring OneCare to submit a methodological approach with their revised budget submission for GMCB discussion and GMCB staff approval, and to provide an analysis by 6/30; if necessary, GMCB could require corrective action to address compliance.
- In addition to the budget review process, per Rule 5.501, OneCare must comply with all GMCB data requests to aid in analysis and evaluation.

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High-Level Overview
Financial Context – Full Accountability

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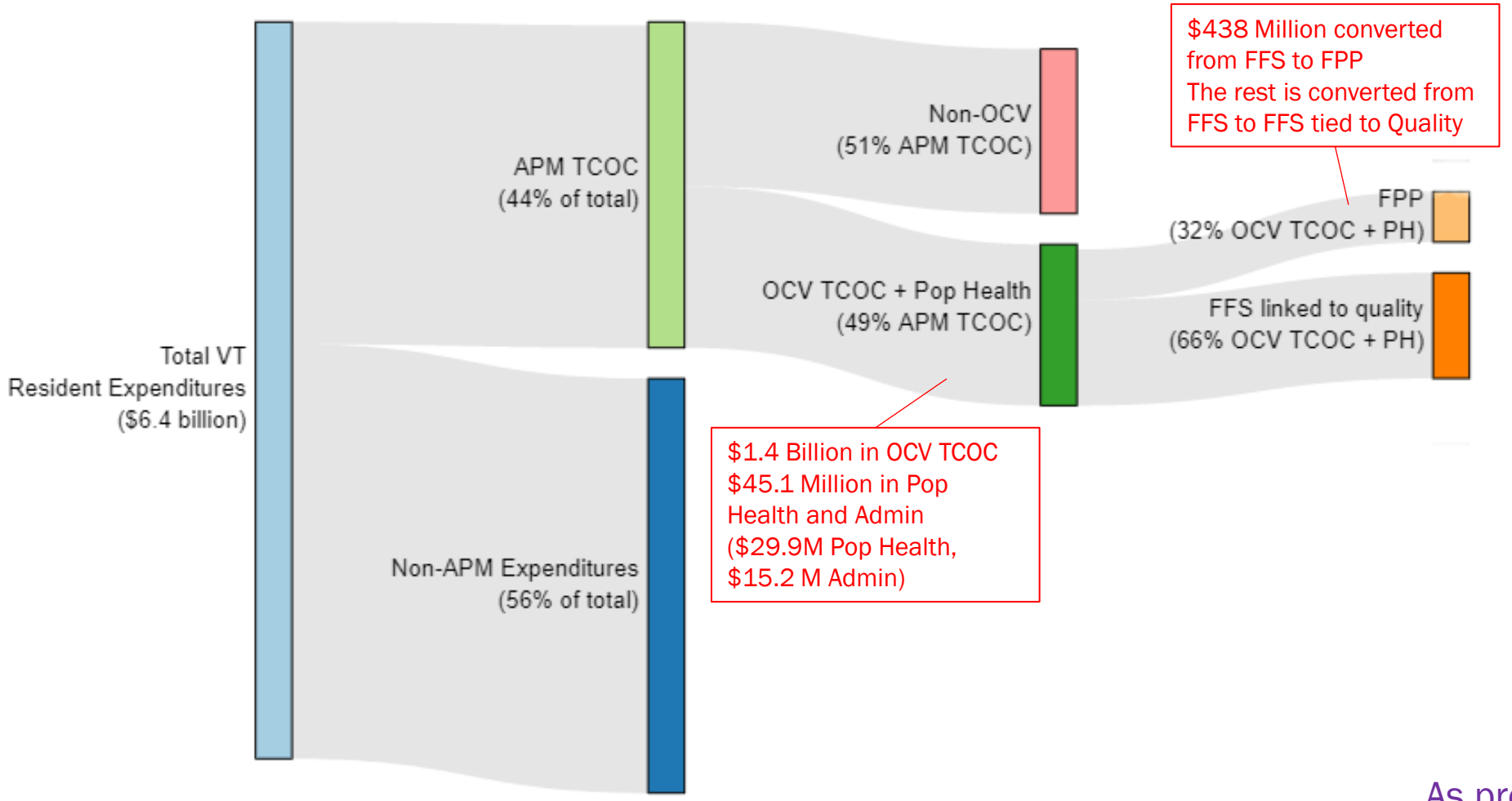

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High-Level Overview
Administrative Costs

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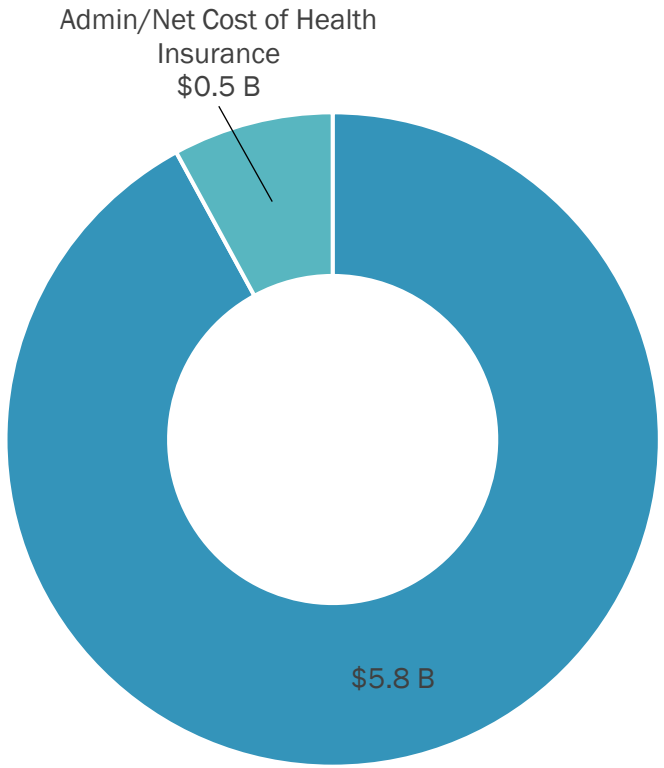
Administrative costs associated with insurance were **8.3%** of total Vermont resident expenditures in 2020.



For small group and individual commercial plans review by the GMCB In 2020, the administrative expenses were **~7.5%** of premium.

The administrative tasks for commercial plans are much broader than an ACO, but the premiums include contributions to support these tasks.

Actual administrative PMPMs in 2020 were approximately **$44 for QHPs** and **$6 for OCVT**.

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ACO Budget & Financials

Full Accountability Summary Income Statement

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Full Accountability (Non-GAAP)	2018 Actual	2019 Actual	2020 Actual	2021 Actual	2022 Revised	2023 Budget
Total Cost of Care Target Components (External)	$ 605,433,215	$ 294,018,591	$ 677,948,979	$ 1,188,108,529	$ 882,713,433	$ 974,663,796
Fixed Prospective Payment Funding (FPP)	$ -	$ 346,341,673	$ 402,406,905	$ 408,150,868	$ 435,607,649	$ 438,664,506
Other Contract Revenue	$ 7,826,298	$ 13,090,261	$ 15,155,666	$ 9,959,641	$ 10,460,595	$ 10,074,567
Participation Fees	$ 17,397,929	$ 25,842,028	$ 15,273,570	$ 16,838,987	$ 20,415,985	$ 19,898,111
Administrative Revenue	$ 3,086,492	$ 5,395,629	$ 7,432,261	$ 7,558,032	$ -	$ -
Consulting Revenue	$ 309,407	$ 355,289	$ 193,289	$ 18,000	$ -	$ -
Other Revenue	$ 1,393,945	$ 777,624	$ 288,816	$ 16,460,005	$ 4,601,560	$ 5,593,389
Income and Other Total Cost of Care Components	**$ 635,447,286**	**$ 685,821,095**	**$ 1,118,699,486**	**$ 1,647,094,062**	**$ 1,353,799,222**	**$ 1,448,894,369**
Total Health Care Spend Components (External)	$ 360,711,323	$ 289,987,490	$ 669,547,321	$ 1,195,825,023	$ 873,639,451	$ 965,117,880
Fixed Prospective Payments (FPP)	$ 237,390,466	$ 346,341,673	$ 402,406,905	$ 408,156,421	$ 435,607,649	$ 438,664,506
Population Health Management (PHM)	$ 22,637,268	$ 29,461,309	$ 32,700,997	$ 28,210,654	$ 29,114,584	$ 29,922,012
Salaries & Benefits	$ 7,344,815	$ 7,721,134	$ 8,346,024	$ 8,225,855	$ 9,368,623	$ 8,704,465
Contracted / Purchase Services	$ 1,746,953	$ 2,622,296	$ 1,637,954	$ 1,565,413	$ 1,366,121	$ 3,369,471
Software	$ 2,795,193	$ 2,600,557	$ 2,806,528	$ 2,594,036	$ 2,683,279	$ 1,871,810
Other Operating Expenses	$ 1,852,142	$ 2,397,464	$ 1,253,756	$ 1,223,242	$ 2,019,515	$ 1,244,225
Subtotal Operating Expenses	$ 13,739,102	$ 15,341,451	$ 14,044,262	$ 13,608,546	$ 15,437,538	$ 15,189,971
Total Expenses and Health Care Spend Components	**$ 634,478,160**	**$ 681,131,922**	**$ 1,118,699,485**	**$ 1,645,800,644**	**$ 1,353,799,222**	**$ 1,448,894,369**
Net Income	**$ 969,126**	**$ 4,689,173**	**$ 1**	**$ 1,293,418**	**$ (0)**	$ -
Administrative Ratio	2.17%	2.25%	1.26%	0.83%	1.14%	1.05%
PHM Ratio with Blueprint	3.57%	4.33%	2.92%	1.71%	2.15%	2.07%
PHM Ratio without Blueprint	2.34%	3.63%	2.17%	1.18%	1.48%	1.41%
Total Margin	0.15%	0.68%	0.00%	0.08%	0.00%	0.00%

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ACO Budget & Financials
Recommended Approach

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- Require OCV to notify GMCB of any material changes to their budget and explain variance. (Consistent with past years)
- Require OCV to submit a revised budget by March 31, 2023, and present on the revised budget in April/May 2023, including final payer contracts, attribution by payer, a revised budget, hospital dues and risk, any changes to the risk model, source of funds for population health programs. (Consistent with past years)
- Require that Operating Expenses must not exceed $15.2M, including the cost of all required evaluation and reporting activities. (Consistent with past years, with additional language regarding evaluation and reporting costs)
- Require OCV to notify GMCB of any use of reserves or line of credit or any adjustment to participation fees. (Consistent with FY22)
- NOTE: Audited Financials and Form 990 will be collected through ACO Reporting Manual. (Consistent with past years)

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OCV Budget and Certification Review Timeline FY 2023

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Jul 1, 2022	GMCB issues FY23 ACO oversight guidance
Sept 1, 2022	ACO submits certification materials
Oct 1, 2022	ACO submits FY23 budget
Oct 12, 2022	GMCB staff ACO Oversight Background presentation
Nov 9, 2022	OneCare Vermont Budget Hearing
Nov 21, 2022	ACO 2021 Financial Settlement & Quality Performance panel
Dec 7, 2022	GMCB staff analysis presentation: OneCare Vermont
Dec 14, 2022	GMCB deliberations on OneCare Vermont FY23 budget
Dec 21, 2022	GMCB potential vote on OneCare Vermont FY23 budget
Ongoing 2022 - 2023	GMCB monitors FY23 actual performance against budget and conditions

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REFERENCE SLIDES

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.

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(b)(1) 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 10,000 or more attributed lives in Vermont. To the extent permitted under federal law, the Board shall ensure the rules anticipate and accommodate a range of ACO models and sizes, balancing oversight with support for innovation. In its review, the Board shall review and consider:

(A) 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;

(B) the Health Resource Allocation Plan identifying Vermont's critical health needs, goods, services, and resources as identified pursuant to section 9405 of this title;

(C) the expenditure analysis for the previous year and the proposed expenditure analysis for the year under review by payer;

(D) the character, competence, fiscal responsibility, and soundness of the ACO and its principals;

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(E) any reports from professional review organizations;

(F) 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;

(G) the extent to which the ACO provides incentives for systemic health care investments to strengthen primary care, including strategies for recruiting additional primary care providers, providing resources to expand capacity in existing primary care practices, and reducing the administrative burden of reporting requirements for providers while balancing the need to have sufficient measures to evaluate adequately the quality of and access to care;

(H) the extent to which the ACO provides incentives for systemic integration of community-based providers in its care model or investments to expand capacity in existing community-based providers, in order to promote seamless coordination of care across the care continuum;

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(I) the extent to which the ACO provides incentives for systemic health care investments in social determinants of health, such as developing support capacities that prevent hospital admissions and readmissions, reduce length of hospital stays, improve population health outcomes, reward healthy lifestyle choices, and improve the solvency of and address the financial risk to community-based providers that are participating providers of an accountable care organization;

(J) the extent to which the ACO provides incentives for preventing and addressing the impacts of adverse childhood experiences (ACEs) and other traumas, such as developing quality outcome measures for use by primary care providers working with children and families, developing partnerships between nurses and families, providing opportunities for home visits, and including parent-child centers and designated agencies as participating providers in the ACO;

(K) public comment on all aspects of the ACO's costs and use and on the ACO's proposed budget;

(L) information gathered from meetings with the ACO to review and discuss its proposed budget for the forthcoming fiscal year;

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(M) information on the ACO's administrative costs, as defined by the Board;

(N) the effect, if any, of Medicaid reimbursement rates on the rates for other payers;

(O) 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

(P) 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.