The Future of Regulation of Accountable Care Organizations in Vermont

In 2016, the Green Mountain Care Board (GMCB) was given the authority to develop rules and standards to regulate Accountable Care Organizations (ACOs) through Vermont's Act 113: *'An act relating to implementing an all-payer model and oversight of accountable care organizations.'* Multi-Payer ACOs are able to contract with multiple payers, i.e. Medicaid, Medicare, and/or commercial payers.

In 2017, the GMCB adopted Rule 5.000: Oversight of Accountable Care Organizations[1], which with 18 V.S.A § 9382 establishes standards and processes to certify ACOs that accept Medicaid and commercial payers and annually review, modify, and approve the budgets of all ACOs operating in Vermont.

The annual ACO budget review process provides an opportunity to assess the ACO's programs, which are expected to facilitate Vermont's shift toward value-based care, as well as the cost of administering these programs. With ACOs being central to Vermont's All Payer ACO Model (APM) agreement with the Center for Medicare and Medicaid Innovation (CMMI), ensuring that ACOs in Vermont are working to achieve the goals of this model has been accomplished through an intensive and detailed budget review process. All ACOs contracting with Vermont providers must submit their budget to the GMCB on an annual basis for review and approval, however the number of Vermonters attributed to the ACO dictates the scope of the budget review. For ACOs with 10,000 or more Vermont lives, the ACO is subject to a budget review against the full set of statutory criteria, while ACOs with fewer than 10,000 lives may have their budgets reviewed under a selected subset of criteria depending on the type and nature of the ACO.

Certification ensures that ACOs seeking to receive payments from Vermont Medicaid and commercial payers (including Medicare Advantage) have the systems in place to effectively do the work required of an ACO. Only ACOs with Medicaid and/or commercial payers are required to obtain certification. Once certified initially, these ACOs must have their certification eligibility verified annually.

In 2021, the GMCB developed guidance for Medicare-only ACOs for the first time. Medicare-only ACOs currently have their budgets reviewed to be modified or approved by the GMCB annually but are not required to participate in the certification process.

Necessity of Updates

There are two timely and pertinent reasons to make substantial updates to the statute and rule outlining the Board's authority to regulate ACOs operating in Vermont: 1) for multi-state Medicare-Only ACOs, the statutory framework is not generally viewed as effective, and 2) the statewide, all-

[1] Code of Vt. Rules 80 280 005 (http://www.lexisnexis.com/hottopics/codeofvtrules)

payer ACO is ceasing operations at the end of 2025 and will no longer be central to the state's future health care reform activities.

Multi-State Medicare-Only ACOs

The number of Medicare-Only ACOs contracting with Vermont providers has increased year-over-year since 2022 with no slow-down anticipated as the number of ACOs participating in Center for Medicare and Medicaid Service (CMS)'s ACO programs increases. At the time that the statute was written, no one anticipated the presence or prevalence of these types of multi-state ACOs in the state, leading to the Board's regulatory authority over these types of entities to be challenging and ill-fitting. Modifying and approving a multi-state ACO's budget, especially while that ACO has a contract with the federal government, is a limited and ineffective method of regulation for these entities because modifications made to a budget in this context are not always feasible in a way that would result in meaningfully changing the ACO's Vermont operations or model of care. Additionally, Medicare-Only ACOs do not need to be certified to operate in the state of Vermont. This is concerning to the Office of the Health Care Advocate and many Vermonters have submitted public comments expressing their desire for the GMCB to exercise this power that they do not currently have over multi-state ACOs.

Close of the Model

As the final extension year of the All-Payer ACO Model draws near in 2025, we must consider the role of ACOs within Vermont's health care reform landscape. It is highly likely that ACOs will no longer be central to future reform efforts; Medicare-Only or Multi-Payer, ACOs may no longer be tasked with achieving the goals of a federal/state agreement.

Alternative to Change

Should the current statute and rule remain in place, the regulatory process will remain largely unchanged with the remaining Medicare-Only ACOs in Vermont participating in a rigorous budget review process, though alignment with the APM will no longer be a priority. The Board will continue to be limited in its ability to effectively regulate Medicare-Only ACOs, while the number of these ACOs in Vermont is likely to increase.

Proposal for Changes

We are proposing that starting for CY2026 that all ACOs, regardless of model or size, that are contracting with one or more providers operating in Vermont and partnering with Medicare, Vermont Medicaid, and/or private Vermont payer(s) be subject to an initial, one-time certification process. In 2027 and beyond, any certified ACO will be subject to an annual eligibility verification, and any new ACOs will undergo initial certification and annual eligibility verification thereafter. This would be similar to the current ACO certification process in that both the initial and continued eligibility processes would involve the submission of requested materials from the ACO prior to the start of the program year at hand.

Certification for ACOs contracting with Vermont Medicaid and/or private Vermont payer(s) including Medicare Advantage plans requires that the ACO must meet the full set of criteria as set forth in future statute. Similar to how New York certifies Medicare-Only ACOs, expedited certification would be available for these entities due to the fact that there is some degree of oversight from CMS.

Expedited certification would allow for some flexibility as to what specific criteria are met, depending on the nature of the ACO.

Any ACO could be summoned to present at a hearing as part of the certification or eligibility verification processes at the discretion of the Board.

The Board would have the authority to approve, approve with modifications/conditionally approve, or deny the certification or continuing eligibility for certification of an ACO. If an ACO does not achieve certification or has its certification eligibility revoked, the ACO may not operate in Vermont for that program year.

All ACOs contracting with Vermont Medicaid and/or private Vermont payer(s) would be subject to an annual budget review process. The 10,000-life threshold would be removed; all ACOs of this type, regardless of size, would have their budgets reviewed against the same criteria outlined in future statute. The Board would have the authority to approve a budget or approve with modifications. The budget review process would be right sized to reflect that ACOs may no longer central to Vermont's health care reform efforts.

Future certification criteria would include many of the current requirements, but the list will be updated to simplify the statute, allowing for more detailed criteria to be outlined in rule. Likewise with the budget review criteria, the statute has been simplified with more detailed requirements to be determined during the rule-making process. See the attached draft of 18 V.S.A 9382.