

**FY 2021 Budget Guidance and Reporting Requirements
for Vermont Certified Accountable Care Organization:
OneCare Vermont, ACO, LLC**

Effective July 1, 2020

Prepared by:

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TIMELINE FOR FY 2021 BUDGET SUBMISSION

(subject to change)

Budget Oversight Activity	Due Date
GMCB issues FY 2021 ACO Budget Guidance	On or before July 1, 2020
ACO submits FY 2021 Budget to GMCB	October 1, 2020
ACO FY 2021 budget hearing*	October 2020 (TBD)
ACO/Payer presentation on 2019 Performance*	November 2020 (TBD)
GMCB Staff presentation on FY 2021 Budget analysis and recommendations*	December 2020 (TBD)
Public comment period on ACO budget closes	December 2020 (TBD)
GMCB votes to est. the FY 2021 ACO Budget*	December 2020 (TBD)
GMCB est. the Medicaid Advisory Rate Case	On or before December 2020
GMCB issues written Budget order to ACO	45 days after Board vote on FY 2021 ACO Budget
ACO presents on final attribution and revised FY 2021 budget after payer contracts final*	Spring 2021
ACO submits materials required for monitoring of FY 2021 budget	2021 Ongoing

*Asterix notes board meeting

INTRODUCTION

This document, adopted by the Green Mountain Care Board (GMCB) for Budget Year 2021, serves to articulate Accountable Care Organization Budget Guidance and Reporting Requirements to the certified Vermont Accountable Care Organization: **OneCare Vermont ACO, LLC** (OneCare or ACO). *See 18 V.S.A. § 9382(b); GMCB Rule 5.000.*

A certified ACO must maintain its certification in order to receive payments from Vermont Medicaid or a commercial insurer. The GMCB will verify a certified ACO's continued eligibility for certification concurrently with its proposed budget. *See 18 V.S.A. § 9382(a); GMCB Rule 5.000, § 5.305.* Certification eligibility guidance will be sent to the ACO under separate cover.

Along with its budget submission, the ACO must submit Verifications Under Oath (forms included with the guidance) signed by the ACO's chief executive, the ACO's primary financial officer, and the head of the ACO's governing body. *See 18 V.S.A. § 9374(i).*

In accordance with 18 V.S.A. § 9382(b)(3)(A) and GMCB Rule 5.000, §§ 5.105, 5.404(b), the Office of the Health Care Advocate (HCA), which represents the interests of Vermont health care consumers, must receive ACO budget filings and other materials and will participate in the budget review process, including hearings. It is the responsibility of the ACO to ensure the HCA receives all documents pertaining to the budget.

If the ACO believes materials it provides to the GMCB during this process are exempt from public inspection and copying, the ACO must submit a written request asking the GMCB to treat the materials accordingly. The written request must specifically identify the materials the ACO claims are exempt from disclosure under 1 V.S.A. § 317(c); provide a detailed explanation citing appropriate legal authority to support the claim; and comply with all other requirements set forth in GMCB Rule 5.000, § 5.106(c). The information for which the ACO seeks confidential treatment must be submitted in separate e-mail with "Confidential" in the subject line. The document itself must include the word "Confidential" in the file name (if electronic) and on the face of the document, in a conspicuous location. The GMCB recommends that the ACO submit the confidentiality request at the same time it submits the materials it considers confidential (or at least notify the GMCB of the confidential nature of the documents), but in any event, the written request must be submitted to the GMCB no later than three (3) days after the potentially confidential information is submitted to the GMCB.

The HCA is bound to respect the GMCB's confidentiality designations and treat the submitted materials as confidential pending the GMCB's final decision on the request. *See 18 V.S.A. § 9382(b)(3)(B); Rule 5.000, § 5.106(e)-(g).*

FY 2021 BUDGET AND COVID-19

The GMCB recognizes that COVID-19 has posed significant challenges for current operations and planning for the future, and many standard questions that would otherwise be posed through this guidance may not be relevant for the present conditions. In this vein, please note, in this year's budget guidance, a number of questions or subparts of questions are "*grayed out*" and *italicized*, which indicates that these particular questions are not required to be answered for the 2021 budget year, but serve as a preview for future budget submissions. Similarly, the Board understands the challenges associated with developing estimates based on utilization and other prospective factors given COVID-

19, but still needs to understand any inputs, recognizing the uncertainty around these assumptions. In answering all questions below, where applicable, please note when changes over prior year are related to COVID-19 and how (e.g. new or uncertain trends in utilization), or whether changes are in response to other factors (e.g. changes in attributed population or efficiency gains)

PART I. REPORTING REQUIREMENTS

Section 1: ACO Information and Background

1. Provide an executive summary of the budget submission. In doing so, please address the following:
 - a. OneCare's value proposition and business model;
 - b. Main outcomes, objectives, opportunities and challenges faced when developing the budget, including the impact of COVID-19;
 - c. Changes to the provider network;
 - d. Changes to payer programs;
 - e. Changes to population health and preventative programs and the effect on the budget;
 - f. Changes to staffing and other administrative operations and the effect on the budget;
 - g. Key assumptions made during budget development.

Section 2: ACO Provider Network

1. Explain the 2021 network development strategy and any anticipated changes to the provider network including areas of growth, areas of decline and general observations as to what is driving participation decisions and how these changes affect the overall budget. Discuss both the challenges and opportunities associated with 2021 network recruitment activities, including the impact of COVID-19.
2. Please populate **Appendix 2.1, 2021 ACO Provider Network Template, Appendix 2.2, 2021 Provider Lists**. For Appendix 2.1, utilize the drop-down box to select appropriate entries as necessary. Submit Copies of each type of provider contract, agreement, and addendum for 2021 (i.e. risk contracts, non-risk contracts, collaboration agreements, and memoranda of understanding).
3. Please describe how your provider contracts support and further the goals of reducing cost and improving quality, including reference to the following:
 - a. Provider payment strategies and methodologies.
 - b. A description of any new or expanded ACO incentives to strengthen primary care, including strategies for recruiting additional primary care providers to the model, 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.
 - c. Any strategies related to the expansion of fixed prospective payments (FPP) across the ACO provider network, recognizing provider types. Please identify any provider

- types for which FPP may not be an appropriate payment reform strategy and explain why.
- d. Any strategies related to the expansion of risk-based payment methods, whether utilizing FPP or another payment mechanism.
 - e. *Strategies for expanding provider participation across payers – how are we working toward an “all payer” model?*

Section 3: ACO Payer Programs

1. Complete **Appendix 3.1, ACO Scale Target Initiatives and Program Alignment Form**, submit copies of your 2021 proposed contractual arrangements, by payer, and explain changes made to your portfolio of payer programs for the proposed budget year, including reference to the following:
 - a. Any anticipated new payer programs and/or terminating payer programs and the overall impact on the budget model.
 - b. For continuing payer programs, explain any anticipated changes and the overall impact on the budget.
 - c. For any programs that do not generate attribution qualifying for All Payer Model scale targets, explain the rationale for entering the program and its overall impact on the budget model.
2. Please explain any strategies you are pursuing for expanding FPP offerings across payer programs, including FPP offerings that are reconciled to FFS spending and FPP offerings that are subject to risk-based methodologies. Please also explain how such FPPs are calculated for each program, how the FPP is reconciled after the performance year, the rationale for such, and what kinds of providers are eligible for participation. What mechanisms do you have to ensure that FPP is not “too high” or “too low”?
3. Please provide an update on the “expanded” or geographic attribution methodology implemented in the Medicaid ACO program in 2020.

Section 4: Total Cost of Care

1. Please complete **Appendix 4.1, TCOC Prior Year Performance by Payer, by HSA (2019)**. Please comment on variations in performance, and any lessons learned, including both challenges and opportunities statewide, and those that may exist in varying capacities across HSAs. How is the ACO helping those communities that did not meet their targets develop further insights and adapt their local strategies?
2. Please complete **Appendix 4.2, TCOC Current Year Projected Performance by Payer, by HSA (2020)**. Please recognize any relevant assumptions for projecting the remainder of the year (e.g. based on historical seasonal spend plus a particular rate of growth etc.). *How is the ACO assisting those communities that are not on target to meet their TCOC for the remainder of the year?*

3. Please populate **Appendix 4.3, the Projected and Budgeted Trend Rates by Payer Program, Appendix 4.4, TCOC Budget Year Targets by Payer, by HSA (2021), Appendix 4.5, Service Risk by Payer, by HSA** and explain the following:
 - a. All underlying assumptions for these trend rates (Appendix 4.3 Column D) and TCOC targets (Appendix 4.4), including those related to changes in utilization, service mix etc. noting any significant deviations from prior year. For programs subject to rate review by the GMCB, include details about how the Board's decision factored into the assumptions for the ACO's budgeted trend.
 - b. For each program, contrast the budgeted growth rate (Appendix 4.3, Column D) with the expected growth trend for the ACO (Appendix 4.3, Column G). Include analysis for reasons why the ACO's performance differs from the trend rates used in the budget.
 - c. How TCOC targets are distributed by HSA, including discussion of the extent to which providers have control over the risk for which they are responsible (please reference Appendix 4.5 to the extent applicable).
 - d. Recognizing that COVID-19 has resulted in unexpected utilization trends that could continue into 2021, what assumptions are you making around fluctuating utilization estimates, or any other factors that could result in material changes to these budgeted figures and what is the anticipated impact to the proposed budget.
 - e. How these growth rates and targets support the All Payer Model goal to manage overall health care cost growth to be in line with that of the Vermont economy.

Section 5: Risk Management

1. Populate **Appendix 5.1, ACO Risk by Payer, Appendix 5.2, Risk by Payer by Risk-bearing Entity** for the budget year and explain how the ACO would manage the financial liability for the risk included in the ACO's payer program agreements for the proposed budget year should the ACO's losses equal 100% of maximum downside exposure. In doing so, please discuss the following:
 - a. Any significant changes over prior year and the rationale for such.
 - b. If any risk is retained by the ACO or the founders, what is this risk associated with, and how much, and how is this obligation funded (reserves, collateral, other liquid security, reinsurance, payer withhold, commitment to pay at settlement etc.)?
 - c. Does the ACO intend to purchase any third-party risk protection? If so:
 - i. Explain the nature of the arrangement.
 - ii. How does the anticipated protection compare to prior years?
 - iii. How much of the downside risk would be covered?
 - iv. Which programs would have this protection?
 - d. If applicable, explain the nature and magnitude of any solvency or financial guarantee requirements imposed through payer contract arrangements and how the ACO aims to satisfy those requirements.
 - e. In addition to **Appendix 5.1**, which is used to document ACO level risk and to differentiate between risk mitigation strategies and risk transfers to provider risk-bearing entities, and **Appendix 5.2**, which details any provider-specific risk arrangements, please explain any other risk management strategies or arrangements that affect either aggregate ACO risk or individual provider risk that may not be apparent from these appendices.

2. Please complete **Appendix 5.3, Shared Savings and Losses** and describe the actual or expected distribution of earned shared savings or losses in the prior year (2019), in the current year (2020) and in the proposed budget year (2021), noting any significant changes in methodology or practice over time.
3. Have there been any changes or discussions of any changes to the risk methodology?
4. Provide any further documentation (i.e. policies) for the ACO's management of financial risk.

Section 6: ACO Budget

1. Complete the GMCB financial statement sheets in Adaptive, including Income Statement, Balance Sheet, and Cash Flow. Sheets in Adaptive: *A1a-Income Statement (All Accounts); A1b-Income Statement (Excl. Pass-Thru); A2-Balance Sheet; A3-Cash Flow*. Excel versions are **Appendices 6.1-6.3**, for reference. Please also fill out **Appendix 6.4, Sources and Uses** and **Appendix 6.5, Per Member Per Month Revenues by Payer**.
2. Revenues: Please explain any line item variations greater than 10% evident on your budgeted income statement as compared to prior year projected actuals and prior year budget. Please also explain:
 - a. Explain any significant risks associated with the budgeted revenue sources. If substantial risk exists, explain how the ACO would respond.
 - b. Explain budgeted contracted payer contributions to the ACO as well as any significant changes from the prior year.
 - c. Explain budgeted provider contributions to the ACO as well as any significant changes from the prior year.
 - d. Explain budgeted governmental/public contributions as well as any significant changes from the prior year.
3. Expenditures: Please explain any line item variations greater than 10% and \$100,000 evident on your budgeted income statement as compared to prior year projected actuals and prior year budget. Please also:
 - a. Explain any significant changes to the population health programs and/or care model and the budgeted impact on expenses.
 - b. Note how this budget is affected by any significant changes to clinical and quality priorities for the year.
 - c. Explain any changes, including significant new investments to the ACO's infrastructure and the budgeted impact on expenses.
 - d. If applicable, explain how Delivery System Reform funds are being utilized in the proposed budget.
 - e. Explain whether and how this budget supports the maintenance or improvement of the ACO's health information technology system and the drivers of these investments (provider feedback, payer contract etc.).
4. If the budget includes a gain or a loss, please provide a rationale. Otherwise please explain how to balance to a break-even budget (surplus to reserves etc.).

5. Balance Sheet: Please explain any variations greater than 10% and \$100,000 evident on your budgeted balance sheet as compared to prior year projected actuals and prior year budget and provide an analysis of the ACO's solvency, providing metrics that you use and noting any areas of concern.
6. Cash Flow: Please explain any variations greater than 10% and \$100,000 evident on your budgeted cash flow statement as compared to prior year projected actuals and prior year budget and provide an analysis of the ACO's current cash position, as well as expectations for the upcoming budget year, noting any potential timing challenges. Please explain the use of any revolvers or other debt used to mitigate cash flow challenges.
7. Complete **Appendices 6.6, Hospital Participation** for the proposed budget year.
8. Please complete **Appendix 6.7, ACO Management Compensation** with the following:
 1. A list of all the ACO's current officers, directors and trustees, regardless of whether any compensation was paid to such individuals.
 2. List all positions with gross compensation (the equivalent of Box 5 on a W-2) greater than or equal to \$150,000.
 3. List all leadership positions (VP, all C-Suite, including Chief Compliance Officer) with gross compensation (the equivalent of Box 5 on a W-2) greater than \$100,000.
9. Please provide a description of how salaries are calculated. What benchmarks are used for the salary ranges?
10. Please provide details for any expected capital expenditures over the next three years.

Section 7: ACO Quality, Population Health, Model of Care, and Community Integration

1. *Model of Care.* Please briefly explain your statewide model of care and any significant changes made in the current year or anticipated for the proposed budget year. In doing so, please include explanation for the following:
 - a. Progress to date on implementing your model of care, including any quantitative evidence. Please note any lessons learned.
 - b. Any goals or objectives associated with your model of care for the proposed budget year and your strategy for their achievement.
 - c. The evidence base for any changes made since the current year and how you intend to measure progress, including any quantitative measures, reporting, and analysis.
 - d. The ACO's role in implementing this model of care as compared to other relevant stakeholders, including how the ACO collaborates with the Blueprint for Health and continues to ensure non-redundant services and investments, that are in coordination with, and not in contradiction to, state objectives.
2. *Quality Improvement and Clinical Priorities.* Please complete **Appendix 7.1, ACO Clinical Priorities** and describe your quality improvement framework and your theory of change,

including your clinical priorities for the proposed budget year. In doing so, please include an explanation for the following:

- a. Progress to date and quantitative or qualitative evidence at the ACO, and local (HSA) levels, including an evaluation and the supporting data for the following, over the last three years (2018, 2019, 2020), by HSA:
 1. Variations in care;
 2. Most prevalent conditions; and
 3. Variations in outcomes.
 - b. Method for establishing the clinical priorities for the proposed budget year at the ACO and local (HSA) levels.
 - c. How does the ACO support HSAs in driving change? How is data used to drive change? Whether and how is there an accountability or incentive structure for driving change?
3. *Population Health and Payment Reform.* Please complete **Appendix 7.2, Population Health and Payment Reform Details** and explain your strategy for making investments in population health and developing payment reform programs across the continuum of care, including reference to the following:
- a. Progress to date, including quantitative or qualitative evidence at the ACO, and local (HSA) levels.
 - b. Methods for establishing new or continued investment in such initiatives/programs.
 - c. Measures and methods used to track progress and identify challenges and opportunities.
 - d. Whether and how is there an accountability or incentive structure to drive change?
4. *Care Coordination and Care Navigator.* Please complete **Appendices 7.3, 7.4, 7.5, and 7.6** for the proposed budget year and explain any opportunities or challenges you have experienced in your continued implementation of care coordination and the use of Care Navigator. In doing so, please discuss the following:
- a. An update on your Care Coordination Effectiveness and Outcomes Analysis Framework using data.
 - b. An overview of your risk stratification methodology, and rationale for its selection/continued use possible methodologies.
 - c. How is the ACO incorporating provider and patient input on the use of these software tools? Please share any relevant lessons learned.
 - d. How does the ACO's care coordination align with other payer care coordination programs?
 - e. How is the ACO expanding access and usage of Care Navigator to non-participating providers?
5. *Integration of Social Services.* Please explain how the ACO integrates or facilitates the integration of healthcare and social services.
6. *All Payer Model Quality and Population Health Goals.* Please complete **Appendix 7.7, ACO Activities related to the Vermont All-Payer Model ACO Agreement Population Health and**

Quality Goals to describe results to date and explain your strategies for assisting the State achieve its quality and population health goals as specified in the APM. *In particular, please rank HSAs in their contribution to the State's performance on the quality goals of the APM and explain how you are supporting their continuous improvement on these goals.* Please discuss the expected impact of COVID-19 on 2020 performance, sharing any early indicators or relevant insights.

Section 8: Other Vermont All-Payer ACO Model Questions

1. How are you ensuring that your programs are coordinated in a way that allocates resources most efficiently for supporting the goals of the APM?
2. What other actions can healthcare stakeholder be taking to support the goals of the APM?

PART II. ACO BUDGET TARGETS

Medicare Benchmark

In deciding whether to approve or modify an ACO's proposed budget, the Board will take into consideration the requirements of the Vermont All-Payer Accountable Care Organization Model Agreement (the Agreement), including the All-Payer Total Cost of Care per Beneficiary Growth Target, the Medicare Total Cost of Care per Beneficiary Growth Target, the ACO Scale Targets, and the Statewide Health Outcomes and Quality of Care Targets. GMCB Rule 5.000, § 5.405(b), (c). As described in more detail below, the Agreement also limits the Board's discretion to prospectively establishing benchmarks for the Vermont Medicare ACO Initiative (i.e., the financial targets against which expenditures for services furnished to ACO-aligned Medicare beneficiaries will be assessed).

Under the Agreement, the Board will prospectively develop, in accordance with the requirements of the Agreement and subject to CMS approval, a benchmark for each ACO participating in the initiative.¹ To guide ACOs in developing their 2021 budgets, this section outlines the factors the Board considers when setting the Initiative benchmarks.

Under the terms of the Agreement, the Vermont Medicare ACO Initiative Benchmarks for 2021, Performance Year 4 of the Agreement, must be established so that either:

- 1) The annual growth rate is at least 0.2 percentage points below the projected annual growth from 2020 to 2021 for Medicare nationally; or
- 2) The compounded annualized growth rate (CAGR) is less than 0.1 percentage points above the projected CAGR from 2017 to 2021 for Medicare nationally.

See Agreement, §§ 8(b)(ii)(1)(c)(i) & (iii).

¹ Underneath the overall benchmark, separate benchmarks will be established for two Medicare fee-for-service populations, the End-Stage Renal Disease (ESRD) population and the Aged and Disabled (A/D or non-ESRD) population.

Table 1: Medicare Advantage United States Per Capita Fee-For-Service Projections

	Aged and Disabled		ESRD		Blended (0.36% ESRD)	
2017 to 2018	Floor	3.70%	Floor	3.70%	Floor	3.70%
2018 to 2019	\$891.07 \$856.41	4.05%	\$7,833.28 \$7,586.28	3.26%	\$916.06 \$880.64	4.02%
2019 to 2020	\$940.81 \$903.21	4.16%	\$7,795.38 \$7,563.53	3.07%	\$965.49 \$927.19	4.13%
2020 to 2021						
Compounding Projection to Date		3.97%		3.34%		3.95%
Compounding Target to Date		3.77%		3.14%		3.75%

Calculation:
Blended Compounding Projection = $(1.037 * 1.0402 * 1.0413) ^ {(1/3)} - 1 = 3.95\%$
Blended Target to date = $3.95\% - 0.2\% = 3.75\%$
Source:
<https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents.html>

Additionally, the benchmarks must enable achievement of the financial targets in the Agreement.

See id. § 8(b)(ii)(1)(e).

Other Targets/Benchmarks and Budget Conditions

The Board may add other budget conditions to guide the implementation of the ACO's Budget after the initial submission. Such budget conditions set in the past have included an administrative expense ratio and a population health investment ratio, among others. Overtime it is the goal of Board to establish standard budget conditions as targets or benchmarks up front to the extent possible.

PART III. MONITORING

GMCB staff are currently working on developing a monitoring plan that will outline standard reporting and other deliverables to be provided by the ACO to the GMCB, along with a timeline for their submission. This monitoring plan will include (but is not limited to):

1. Presentation of prior year performance, before Board vote on proposed budget.
2. Revised Budget Deliverables due Spring 2021, upon execution of payer contracts:
 - a. Final attribution by payer;
 - b. Provider copies of all payer contracts; and
 - c. Provide an actuarial opinion that the risk-bearing arrangements between the ACO and payers are not expected to threaten the financial solvency of the ACO.
3. Tables submitted through the budget process for which reporting on actuals is required (e.g. Quarterly Financial Statements).
4. Data on HSA-level performance (financial, quality, utilization) at least quarterly.
5. All-Payer Total Cost of Care, Per Member Per Month, 5-Year Compounding Growth Rate, comparative analysis of state-wide performance to ACO-specific performance.

This monitoring plan will also discuss confidentiality and will specify when certain deliverables warrant presentation to the Board in a public forum as opposed to conditions under which staff review and analysis is sufficient.