FY 2025 Budget Guidance and Reporting Requirements for Vermont Certified Accountable Care Organization:

OneCare Vermont, ACO, LLC

Effective May 22, 2024

Prepared by:

GREEN MOUNTAIN CARE BOARD
144 State Street
Montpelier, Vermont 05602

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TIMELINE FOR FY 2025 BUDGET SUBMISSION

(Subject to change)

Budget Oversight Activity	Due Date
GMCB issues FY 2025 ACO Budget Guidance	May 22, 2024
ACO submits FY 2025 Budget to GMCB	October 1, 2024
ACO FY 2025 Budget Hearing*	November 13, 2024
ACO/Payer presentation on 2023 Quality and Financial Performance*	November 2024 (TBD)
GMCB Staff presentation on FY 2025 Budget analysis and recommendations*	December 4, 2024
Public comment period on ACO budget closes	December 2024 (TBD)
GMCB votes to est. the FY 2025 ACO Budget*	December 2024 (TBD)
GMCB est. the Medicaid Advisory Rate Case	On or before December 31, 2024
GMCB issues written Budget order to ACO	45 days after Board vote on FY 2025 ACO Budget
ACO presents on final attribution and revised FY 2025 budget after payer contracts final*	April 2025 (TBD)
ACO submits materials required for monitoring of FY 2025 budget	2025 Ongoing

*Asterisk notes board meeting

Commented [SM1]: Add in accelerated timeline as POSSIBILITY

Commented [LR2]: Is it possible to do this earlier this year?

Commented [LR3]: If they are ready to submit most materials earlier, would this work out?

INTRODUCTION

This document, adopted by the Green Mountain Care Board (GMCB) for Budget Year 2025, serves to articulate Accountable Care Organization Budget Guidance and Reporting Requirements to the certified Vermont Accountable Care Organization: **OneCare Vermont Accountable Care Organization, LLC** (OneCare or ACO). *See* 18 V.S.A. § 9382(b); GMCB Rule 5.000.

Budget Year 2025 is the last year of the Vermont Medicare ACO Initiative, established under the Vermont All-Payer Model Agreement (APM) with the Centers for Medicare and Medicaid Innovation. At this time, the only Medicare ACO program available for BY2026 is the Medicare Shared Savings Program (MSSP). In addition, if the state enters into a subsequent State Agreement with CMMI, the model available to the state would be AHEAD (Advancing All-Payer Health Equity Approaches and Development), which includes a hospital global payment and a primary care payment. The AHEAD model does not include an ACO payment model, although it allows providers to participate in both the AHEAD payment models and Medicare's MSSP ACO program.

Recognizing that BY2025 is the final year of this ACO payment model, the GMCB is focusing the budget guidance on ensuring appropriate final year ACO costs that reflect the value to Vermonters of the ACO, ensuring sufficient oversight of the ACO, and reporting data and information that will assist in future efforts while reducing reporting that will no longer be useful. As such, the approach to the guidance is to suggest that the ACO minimize costs to support only programs shown to yield positive financial returns for Vermonters and to finish out this Model while freeing up resources to be deployed to future purposes. ~~Recognizing that BY2025 is the final year of this ACO payment model, the GMCB is focusing the budget guidance on ensuring appropriate final year ACO costs that reflect the value to Vermonters of the ACO, ensuring sufficient oversight of the ACO, and reporting data and information that will assist in future efforts while reducing reporting that will no longer be useful. As such, the approach to the guidance is to suggest that the ACO minimize costs to support programs shown to yield positive financial returns for Vermonters and to finish out this Model while freeing up resources to be deployed to future productive purposes.~~

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 on an annual basis. *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 materials 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 an 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 ACO must also submit a redacted version of any document, with the information that the ACO believes is confidential redacted so that the document may be posted publicly by GMCB. 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 must be copied on all confidentiality requests and related submissions.

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).

During the budget review process the ACO must be prepared to answer all questions and adequately explain to the GMCB how it arrived at each piece of information in its submission.

Submission Instructions

1. The ACO must be prepared to submit hard copies (published into binders) of the narrative responses and appendices formatted for printing. If an appendix or attachment cannot be formatted for printing, please indicate that it is "electronic-only." The GMCB will indicate the number of binders needed at least 30 days in advance of the submission deadline.
2. All electronic documents must be machine-readable and submitted with the following naming convention: **OCV_FY25-Budget_[name-of-document-with-dashes]_Sent-MM-DD-YYYY**.
    a. Documents must be submitted as individual, discrete files e.g., do not merge policies, contracts, or other source documents.
    b. Documents must be paginated, and pagination of the electronic submission must match the printed submission.
3. Word counts: Word counts will not be enforced but are intended to guide concise responses that convey the essential information.
4. Responses may be provided in formats other than narrative (e.g., table, figure, etc.) if the respondent believes it is the clearest way to convey the information requested. Any numerical tables should be provided as an attachment in Excel format and any graphs or charts need to be described and interpreted.
5. If the ACO identifies line items or column headers in Excel workbooks that need to be adjusted, they may do so with written permission from GMCB staff. Please add explanatory notes to Excel sheets as needed. Adaptive Sheets can only be modified by GMCB staff and can be done with written request to the GMCB from the ACO.
6. Any "Total" cell or other cell in an Excel sheet should include a formula to clarify to where the number ties within the workbook.
7. If the ACO believes they have answered a question in the response of a different question, it is acceptable to refer to that question/response in whole or in part to reduce repetition.
8. Please see the "Introduction" paragraphs above for detailed instructions on submitting information the ACO believes to be confidential. Reminders:
    a. The ACO must request confidentiality for any material it believes to be exempt from public inspection.
    b. When making a request, "Confidential" must be in the subject line of the email, the document name, and on the face of the document or in the header.
    c. Both the Confidential and Redacted versions must be submitted at the same time.

PART I. ACO BUDGET TARGETS

FY 2025 Budget Targets

The Board may add targets to guide the development or implementation of the ACO's Budget. Budget targets are not requirements for any budget submission. If the ACO's proposed budget varies from the budget targets below, the Board will review the ACO's proposed budget and its support for varying from these targets in its FY25 budget submission using the factors and criteria set out in statute and rule. For all budget targets that are met, the ACO should expect less analysis of this area of the budget from the GMCB and staff.

Budget targets set in the past have included an administrative expense ratio and a population health investment ratio, among others. Please see prior years' Budget Orders for examples.

Proposed budget targets for FY25:

1. The FY25 commercial benchmark trend rates must be consistent with the ACO-attributed population and the GMCB approved rate filings.
2. Maintain risk corridors for all payer programs at a minimum of FY23 levels or elect the new asymmetric risk corridor offered by Medicare. Downside risk for shared losses may be held centrally at the ACO level or dispersed to the network; this decision will be at the discretion of the ACO. If the ACO elects the asymmetric risk corridor, the ACO must maintain risk for the Medicare hospital AIPBP payment reconciliation at the ACO level consistent with the First Amended and Restated Vermont All-Payer Accountable Care Organization Model Agreement (2024 Amendment No.1). The ACO may propose a payment withhold consistent with the Medicare Participation Agreement.
3. The ACO's administrative budget should not include expenses associated with programs not demonstrated to yield positive results for Vermonters; it should include only programs necessary and resources necessary for it to satisfy All-Payer Model requirements.
4. Ratio of operating expenses to PHM/payment reform payments (including FPP and budgeted bonus payments) must not exceed the FY24 amount of X.XX%.
5. The ratio of population health management funding to number of attributed lives must be at a minimum of the FY24 revised budget amount; specific line items may vary based upon any internal evaluation of the effectiveness of individual PHM programs.
6. Continue efforts around the three metrics that the ACO has selected to address in response to the March 2023 Medicare ACO Performance Benchmarking report through the Quality Evaluation and Improvement plan. The ACO should justify its choice of tactics to improve performance in these areas.
7. Should the ACO choose to participate as a Medicare Shared Savings Program ACO in FY25 and leave Vermont's All-Payer Accountable Care Organizational Model Agreement, OCV must submit a new budget that reflects the fact that its value to the state is far more limited. Whether under the APM or MSSP, the ACO must account for its administrative budget by providing a breakout of the budget by function and must provide any and allall additional information as requested by the Board.
~~7.~~

Commented [MS4]: Board: Any interest in a target around primary care spend?

Commented [MH5]: Just want to triple-check that we're okay with the 3% risk corridor for Medicare for FY25, rather than the 4% under the FY24 budget order.

Commented [MH6]: I will defer to anyone else's math, but I think the budget order reduced OCV to 2.92%. It's an opex difference of like $300K.

Commented [MS7R6]: We will have to see what their "actual" revised budget looks like before we can calculate this.

Commented [MS8]: Same- we will need to see their corrected revised budget to determine this amount.

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All-Payer Model Agreement Growth and ACO Financial Targets

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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).

The All-Payer Total Cost of Care (TCOC) per Beneficiary Growth target is a compounding annual growth rate comparing the per person costs in 2017 to those in 2023. Each year, the State is assessed to determine how its observed growth compares to the Agreement's targeted range (3.5% to 4.3%). Vermont residents are included in the All-Payer calculation whether or not they are attributed to an ACO Initiative.

The Medicare TCOC per Beneficiary Growth target measures compounding annual growth for a subset of the Vermont residents included in the All-Payer TCOC calculation. However, instead of a target that is fixed in the Agreement, targets are based on projected growth for Medicare beneficiaries nationally (see Table 1 for the projections and targets to date). For the remainder of the Agreement, all Vermont Medicare beneficiaries are included in the calculation whether or not they are attributed to an ACO Initiative.

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

		PREVIOUS YEAR	PERFORMANCE YEAR	PROJECTED ANNUAL GROWTH
Non-ESRD	2018	Floor	Floor	3.7%
	2019	$856.41	$891.07	4.0%
	2020	$903.21	$940.81	4.2%
	2021	$932.34	$975.06	4.6%
	2022	$929.69	$1,028.38	10.6%
	2023	$1,023.31	$1,078.63	5.4%
	2024	$1,057.70	$1,105.10	4.5%
			Compounding Growth to Date	5.3%
			Growth Target (2017 to 2024)	**5.1%**
ESRD	2018	Floor	Floor	3.7%
	2019	$7,586.28	$7,833.28	3.3%
	2020	$7,563.53	$7,795.38	3.1%
	2021	$7,910.87	$8,110.21	2.5%
	2022	$7,897.64	$8,515.64	7.8%
	2023	$8,926.41	$9,332.69	4.6%

	2024	$8,929.61	$9,544.97	6.9%
			Compounding Growth to Date	4.5%
			Growth Target (2017 to 2024)	**4.3%**
Blended (0.36% ESRD)	2018	Floor	Floor	3.7%
	2019	$880.64	$916.06	4.0%
	2020	$927.19	$965.49	4.1%
	2021	$957.46	$1,000.75	4.5%
	2022	$946.80	$1,055.33	11.5%
	2023	$1,051.76	$1,108.34	5.4%
	2024	$1,086.04	$1,135.48	4.6%
			Compounding Growth to Date	5.4%
			Growth Target (2017 to 2024)	**5.2%**

Calculation:
Blended Compounding Projection= (1.037*1.0402*1.0413*1.0452*1.1146*1.0538*1.046)^(1/7)-1=5.4%
Blended Target to Date= 5.4% - 0.2% = 5.2%

PART II. REPORTING REQUIREMENTS

Section 1: ACO Budget Executive Summary

1. Focusing on changes proposed for PY25, provide brief narratives to summarize the components of the budget submission and describe how the ACO's budget supports the efforts of the ACO, including: *(Max Word Count 2,000)*
   a. Summary of the Full Accountability Budget (Non-GAAP);
   b. Summary of the Entity-Level Budget (GAAP);
   c. Summary of changes to ACO Network Programs, Population Health Programs, and Care Model; and
   d. Summary of lessons learned through programmatic evaluation. Response should include how these lessons will influence the ACO's programs in the budget year and beyond.

Section 2: ACO Provider Contracts

1. Describe any anticipated changes to the provider network for PY2025. Submit **Appendix 2.1, 2025 ACO Organizations List** and **Appendix 2.2, 2025 ACO Provider Lists**, provider contract, agreement, and any addenda **as soon as they are final.** Additionally, complete the following summary tables in the Excel Workbook. (*See* § 5.403 (a)8, (a)9)
   a. 2.2.1 Count of Individual Practitioners Contracted with the ACO
   b. 2.2.2 Count of Entities by Contract Types

2. Quantify the number and type of providers (i.e., primary care, specialty care, SNF…) that have left or who are likely to leave the network 2023-2025 (prior, current, and budget years) and to the best of your knowledge, their reasons for exiting. If applicable, explain any actions taken in response by the ACO to address the providers' concerns. (*See* § 5.403 (a)8; 18 V.S.A. § 9382 (b)(1)(D).)

Table 2: ACO Provider Departures (2022 – 2025)

Departing provider type and count	PY of departure	Reason for departure	ACO Response (if any)

Section 3: ACO Payer Contracts

1. For any new payer contracts, complete **Appendix 3.1, ACO Scale Target Initiatives and Program Alignment Forms** for each sub-group that may exist within a payer contract**.** For all payer contracts, **submit copies of each 2025 payer program contract**, within ten (10) days of execution. (*See* § 5.403 (a)10.)

2. Explain changes made to your portfolio of payer programs for the proposed budget year using the guidance below. For new and continuing payer programs discussion of anticipated changes should include changes to specific groups covered under payer contracts such QHP or self-insured groups within commercial contracts. (*See* § 5.403 (a)10.) *(Max Word Count: 1000)*

    a. For any new payer program in 2025, describe the anticipated size and scope of the program and the impact on the budget model.
    b. For continuing payer programs that have Anticipated Changes, explain the anticipated changes and the overall impact on the budget.
    c. For any terminated payer programs, please explain the specific reasons for the change and any steps being taken to mitigate the impact of the terminated contract.

Section 4: Total Cost of Care

1. Complete **Appendix 4.1 TCOC Performance by Payer, Total ACO-Wide (2018-2025)**. (*See* § 5.403 (a)4, (a)10.) Instructions:
    a. Verify actuals for past years 2018-2022.
    b. Provide projections for the current and prior year (2023-2024) and the timeline for when actuals will be available.
    c. For the budget year (2025), provide expected TCOC.

2. Complete **Appendix 4.2, Projected and Budgeted Trend Rates by Payer Program** and explain the following: (*See* § 5.402, § 5.403 (a)4, (a)10) (*Max Word Count:1000)*
    a. All underlying assumptions for these trend rates (Appendix 4.2, Column D) including those related to changes in utilization, service mix, unit cost, etc., noting any significant deviations from ~~prior~~the prior year. For programs subject to health insurance premium rate review by the GMCB, the 2025 benchmark trend rates must be consistent with the ACO-attributed population and the GMCB approved rate filings, if any.

Section 5: ACO Network Programs and Risk Arrangement Policies

1. Discuss ACO program goals, strategies, opportunities, and limitations for the following: *(Max Word Count: 1400)*
    a. Strengthening primary care, including access and utilization; (*See* § 5.403 (a)13, (a)17; 18 V.S.A. § 9382 (b)(1)(A), (b)(1)(G))
    b. Reducing administrative burden of reporting requirements for providers;(*See* § 5.403 (a)17; 18 V.S.A. § 9382 (b)(1)(G))
    c. Providing incentives for preventing and addressing the impacts of adverse childhood experiences and other traumas; (*See* § 5.403 (a)20; 18 V.S.A. § 9382 (b)(1)(J))
    d. Expanding Fixed Prospective Payment arrangements; (*See* § 5.403 (a)17; 18 V.S.A. § 9382(b)(1)(G))

e. Monitoring and providing incentives for reducing potentially avoidable utilization; (*See* § 5.403 (a)13; 18 V.S.A. § 9382 (b)(1)(A))
f. Improving access to behavioral health services.(*See* § 5.403 (a)18-20; 18 V.S.A. § 9382 (b)(1)H-J), (b)(1)(P))

2. Complete **Appendix 5.1, ACO Risk by Payer** for the budget year. See Budget Target 2 in **Part I – Budget Targets.**
    a. Describe changes, if any, to the ACO's risk model and stratification methodology and rationale for these changes. (*See* § 5.403 (b)1-2) *(Max Word Count: 500)*

3. Explain how the ACO would manage the financial liability for the risk included in the ACOs 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: (*See* § 5.403 (b)1-2) *(Max Word Count: 500)*
    a. In order to manage the maximum downside risk retained by the ACO or its founders, explain with what the risk is associated, how much, and how is this obligation funded (reserves, collateral, other liquid security, reinsurance, payer and provider withholds, commitment to pay at settlement, etc.)?
    b. 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?
    c. 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.
    d. Explain any other risk management strategies or arrangements that affect either aggregate ACO risk or individual provider risk.

4. Complete **Appendix 5.2 Projected 2024 Accountability Pool Distribution and Network Settlement** and provide any additional context as needed. (*See* § 5.403 (b)2) *(Max Word Count: 250)*

Section 6: ACO Budget

1. Complete the GMCB financial statements **A1, A2, A3, and A4 (Income Statement, Balance Sheet, Cash Flow, Staffing) in the Adaptive Database**. (*See* § 5.403 (a)2-3)

2. Complete **Appendix 6.5, Sources and Uses** in the Budget Guidance Workbook (Excel). In addition, please provide a definition for each funding source in Row 4. (*See* § 5.403 (a)2-3)

3. Complete the Complete **Appendix 6.6 Variance Analysis Report** ~~through the **Adaptive Database**.~~.in the Budget Guidance Workbook (Excel). (*See* § 5.403 (a)2-3)

Commented [MS10]: @Sawyer, Michelle let's move away from adaptive for the variance analysis—think we may want to just include a table in the workbook for them to fill out like in the past

4. Revenues: Explain any line-item variations greater than 10% evident on your budgeted income statement as compared to prior year projected actuals and prior year revised budget. (*See* § 5.403 (a)2-3) *(Max Word Count: 500)*

5. Expenditures: 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 revised budget. Please also explain: (*See* § 5.403 (a)2-3) *(Max Word Count: 600)*
    a. Any changes, including significant new investments to the ACO's infrastructure and the budgeted impact on expenses.

6. Balance Sheet: 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. (*See* § 5.403 (a)2-3) *(Max Word Count: 250)*

7. Cash Flow: 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, or access to, any revolving debt (including maximum allowable draw) or other debt used to mitigate cash flow challenges. (*See* § 5.403 (a)2-3) *(Max Word Count: 250)*

8. Provide details of any expected capital expenditure over the next three years. (*See* § 5.403 (a)14) *(Max Word Count: 200)*

9. Complete **Appendix 6.7, Hospital ACO Participation-All Hospitals** for the proposed budget year. (*See* § 5.403 (a)2-3, (a)8)

10. Complete **Appendix 6.8, ACO Management Compensation.** (*See* § 5.403 (a)3; 18 V.S.A. § 9382 (b)(1)(M~~)) Additionally~~)) Additionally, please describe: *(Max Word Count: 750)*
    a. Any changes to the factors considered when awarding variable pay since the last budget submission.

11. Complete ~~**Appendix 6.9,**~~ **Population Health Management Expense Breakout** in the Adaptive database. (*See* § 5.403 (a)2, (a)17-20; 18 V.S.A. § 9382 (b)(1)(G-J), (b)(1)(P))
    a. Identify bonus payments where the ACO will budget the dollar amount, but not the actual distribution across provider types.
    b. Identify blank cells where provider types are ineligible for payments.

12. Complete **Appendix 6.9~~10~~ Net Assets.** Provide narrative context as necessary. (*See* § 5.403 (a)3)

13. Complete **Appendix 6.101~~1~~ Admin Budget by Function/Program.** See Budget Target 7 in **Part I – Budget Targets**. Provide narrative context as necessary (*See* § 5.403 (a)3)

14. Are there any actions, investigations, or findings involving the ACO or its agents or ~~employees ?~~employees? If so, please provide any updates or additional information not previously provided to the GMCB. (*See* § 5.403 (a)6)

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

1. *Model of Care*. Please briefly explain progress to date on implementing the Model of Care, including significant changes made during the current year. Include what changes will be anticipated for the proposed budget year, and describe any lessons learned and the rationale for the(se) change(s). (*See* § 5.403 (a)11, (a)16, (a)22; 18 V.S.A. § 9382 (b)(1)(F)) In doing so, please discuss the following: *(Max Word Count: 3,000)*
    a. Any elements of the care model or population health programs that OneCare has either eliminated or scaled up for FY25 including rationale for changes;
    b. All internal goals and strategies associated with the model of care for the proposed budget year and the strategies for their achievement;
    c. Any changes to 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 (e.g. All Payer Model, Department of Mental Health's Ten Year Plan, State Health Improvement Plan).
    d. Any changes to how social determinant of health-related data is collected and how it is incorporated into the model of care;
    e. Any changes to how health equity is being addressed in the model of care;
    f. Any waivers/benefit enhancements being offered in the proposed budget year.

2. *Quality Improvement.* Report all results on Key Performance Indicator performance for FY23 and progress made to date using **Appendix 7.1 KPI Performance**. If any changes in measures, provider incentives, quality improvement framework or theory of change are being made for the budget year, please explain the changes and the reasoning behind the changes. (*See* § 5.403 (a)(11)) *(Max Word Count: 400)*

3. *Population Health and Payment Reform*. Complete **Appendix 7.2, Population Health and Payment Reform Details**. Please be sure to include: (*See* § 5.403(a)(11), (a)(17-20); 18 V.S.A. § 9382 (b)(1)(G-J))
    a. information on 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;
    b. information on 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;
    c. information on 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

Commented [SM11]: I wonder if payer panel presentation is enough, but it would be dependent on the timing of everything.

Commented [MS12R11]: We can pull PHM performance from their BoM meetings too generally; staff can send this info to Board instead of having ACO retype this into the workbook. We would not have information on KPI performance

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of and address the financial risk to community-based providers that are participating providers of an accountable care organization; and

d. information on the extent to which the ACO provides incentives for preventing and addressing the impacts of adverse childhood experiences 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;

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Section 8: Performance Benchmarking

1. Complete **Appendix 8.1 2023 and 2024 ACO Network Surveys**. Provide an update to the 2023 survey that was in the field when the FY24 Budget was submitted. For each survey conducted, please describe the results, how the ACO responded to the results, and the outcome of the ACO's response(s). *(Max Word Count: 500)*

2. Discuss any evaluation of the ACO's approach to conducting surveys, any improvements in surveying practices, and any plans for surveying stakeholders in FY25. *(Max Word Count: 250)*

3. Discuss the ACO's approach to evaluating its Population Health Management programs. Narrative must include, but is not limited to: *(Max Word Count: 1000)*
   a. Evaluation of the CPR program and the outcomes;
   b. The results of any evaluations completed on the PHM model to date and plans for further evaluation (include how TCOC, ED utilization, and inpatient admission rates have changed as a result of the revised care coordination model and whether or not these results are meeting expectations);
   c. Process for monitoring and reporting the effectiveness of the Mental Health Screening and Follow-up Initiative
   d. How the ACO is incorporating provider and patient input on the model. Please share any relevant lessons learned.

Medicare ACO Performance Benchmarking Report:

4. Please describe any changes to how OneCare is funding improvements in the metrics chosen for Budget Target ~~#6~~5 for FY25 (or note if this target was not met as prescribed). If these funding streams are unchanged from previous years, speak to how this funding has or has not made an impact on the ACO's performance in these areas. Have additional best-practices been gleaned from top-performing ACOs for the metrics in focus? (Max Word Count: 300)

Section 9: Other Vermont All-Payer ACO Model Questions

1. How are you ensuring that your portfolio of payer programs is aligned to support the goals (scale, cost, quality) of the Vermont All-Payer ACO Model? *(Max Word Count: 500)*

Commented [MS13]: Board- we eliminated "**Appendix 9.1, ACO Activities related to the Vermont All-Payer Model ACO Agreement Population Health and Quality Goals**" as we didn't feel it informed the Board's decision-making process. If you want it added back in, please let us know.

1. ~~*All Payer Model Quality and Population Health Goals*. Please complete **Appendix 9.1, 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 to achieve its quality and population health goals as specified in the APM. *(Max Word Count: 500)*~~

Commented [MS14]: Do we need this for reporting purposes? I don't get the sense that this is useful when reviewing their budget.

Commented [LR15R14]: I don't think we need it for reporting, but let's check with MD

PART III. REVISED BUDGET

Revised Budget Deliverables due Spring 2025, or TBD upon execution of payer contracts (date set at the discretion of the Board):

a. Final attribution by payer;
b. Copies of all payer contracts;
~~b.~~c. Revised budget reflecting final attribution and payer contract terms
~~c.~~d. Final descriptions of population health initiatives and sources of funds;
~~d.~~e. Expected hospital dues by hospital;
~~e.~~f. Expected hospital risk by hospital and by payer;
~~f.~~g. Any changes to the overall risk model;
~~g. Details of expansion of fixed prospective payments (FPP) across payer programs, payment calculation methodologies, and adoption rates by providers;~~
h. Medicare ACO Performance benchmarking report;
i. Results of evaluations as discussed during budget review;
j. A copy of Form 990 as filed with the IRS.
k. Any requests for amendments to the budget order; and
l. Any other information the board deems relevant to ensuring compliance with the budget order.

PART IV. MONITORING

GMCB staff published the FY24 OneCare Vermont ACO Reporting Manual ("Reporting Manual") as described in the FY24 budget order, condition #2. The Reporting Manual outlines standard reporting and other deliverables to be provided by the ACO to the GMCB, along with the deadlines for their submission. The objective of the Reporting Manual is to collect reports throughout the current year to enable the GMCB to monitor performance against the budget. The FY2024 Reporting Manual includes (but is not limited to):

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1. Presentation of current or prior year performance.
2. Tables submitted through the budget process for which reporting on actuals is required (e.g. Quarterly Financial Statements).
3. ACO performance dashboard to compare key quality, cost, and utilization metrics to national benchmarks and identify best-practices based on data in key areas.
4. ACO strategy, workplans and evaluations related to programs, including updates to the ACO's Network Development Strategy and Clinical Focus Areas.
5. Information on ACO's complaints, grievances, and appeals processes for enrollees and providers.

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.