

**FY 2022 Budget Guidance and Reporting Requirements
for Vermont Certified Accountable Care Organization:
OneCare Vermont, ACO, LLC**

Effective July 1, 2021

Draft for review and discussion 6/9/2021

Prepared by:

**GREEN MOUNTAIN CARE BOARD
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Commented [MM1]: Data no longer relevant to the ACO risk model

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Commented [MM2]: Under review

Commented [MM3]: Financial sheets require final formatting. See separate Financial Workbook (Excel).

2021 TIMELINE FOR FY 2022 BUDGET SUBMISSION

(subject to change)

Budget Oversight Activity	Due Date
GMCB issues FY 2022 ACO Budget Guidance	On or before July 1, 2021
ACO submits FY 2022 Budget to GMCB	October 1, 2021
ACO FY 2022 budget hearing*	November 10, 2021
ACO/Payer presentation on 2020 Quality and Financial Performance*	November 2021 (TBD)
GMCB Staff presentation on FY 2022 Budget analysis and recommendations*	December 8, 2021
Public comment period on ACO budget closes	December 2021 (TBD)
GMCB votes to est. the FY 2022 ACO Budget*	December 2021 (TBD)
GMCB est. the Medicaid Advisory Rate Case	On or before December 31, 2021
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 2022 budget after payer contracts final*	Spring 2022 (TBD)
ACO submits materials required for monitoring of FY 2022 budget	2022 Ongoing

*Asterix notes board meeting

INTRODUCTION

This document, adopted by the Green Mountain Care Board (GMCB) for Budget Year 2022, 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.

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 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 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 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 demonstrate and explain how it arrives at each piece of information in its submission.

FY 2022 BUDGET AND COVID-19

The GMCB recognizes that COVID-19 has posed significant challenges for [Vermont's health care providers since March 2020 through 2021 to date. In its role as an ACO managing network participants to achieve cost and quality goals, the GMCB recognizes that OneCare has had to adjust ACO operations and implementation of programs and planning for the future. Last year, GMCB guidance waived certain questions that may not have been relevant under the circumstances. For this year's guidance, the](#)

~~GMCB reviewed those questions and incorporated the relevant questions into this guidance as required. While there is still uncertainty about the pandemic's impacts on utilization and outcomes, the GMCB expects OneCare will have adjusted its operations for 2022 and can fulfill all reporting requirements, current ACO 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 budget year but serve as a preview for future budget submissions. Similarly, the The Board understands the challenges associated with developing estimates based on utilization and other prospective factors given COVID-19, but 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, efficiency gains etc.)~~

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, highlighting and quantifying changes from the current performance year:
 - 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. Include lessons learned from the public health emergency to date that impact the 2022 budget;
 - 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 and limitations made during budget development.
2. Explain what changes OneCare is making to its organizational structure, corporate form, governance, tax reporting, or other areas now that the company has received 501(c)(3) status.
 - a. Confirm that the GMCB has the most recent version of the Operating Agreement with a description of any changes.
3. Provide Section 1 Attachments A and B.
 - a. Attachment A: 2022 OneCare ACO Network
 - a-b. Attachment B: 2022 OneCare ACO Hospital Participation Year Over Year

Commented [MM4]: This new question about OneCare's change in tax status will be in the FY22 Certification Form because it applies to §5.305(a)2. "Annual Eligibility Verification."

Commented [MM5]: These attachments were waived for FY21 submission. Staff recommend including them again. They are a visual analysis of the provider network and payer programs.

Section 2: ACO Provider Network

1. Provide an update on the FY22 Network Development Strategy (submitted 5/28/21). In the description, include the following:
 - a. 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; and
 - b. Challenges and opportunities associated with 2022 network recruitment activities, including the continued impact of COVID-19.

2. Populate **Appendix 2.1, 2022 ACO Provider Network Template and Appendix 2.2, 2022 Provider Lists**
 - a. Submit copies of each type of provider contract, agreement, and addendum for 2022 (i.e. risk contracts, non-risk contracts, collaboration agreements, and memoranda of understanding).
3. 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 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. Strategies for expanding provider participation across payers. How is OneCare 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 2022 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.
 - e.d. If payer contracts are not finalized by the date of the budget submission, please respond as completely as possible to the applicable questions. Contracts must be submitted within 10 days of execution and the GMCB may request an update on the status of contract negotiation at any time.
2. Please explain any strategies you are pursuing for expanding FPP offerings across payer programs. Please also explain how FPPs are calculated for each program, the rationale for such, including how you will plan to accommodate the unusual utilization patterns associated with COVID-19, 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”? How is OneCare working with payers to expand FPP options for providers? Discuss your strategy for expanding FPP as required by FY21 budget order condition #15 (i.e., target and strategy for expanding FPP by payer). In your answer, discuss strategy by year, with targets, for expansion of FPP. Cite national standards where applicable.

3. Provide an update on the “expanded” or geographic attribution methodology implemented in the Medicaid ACO program in 2020, including any attribution and care management results to date and any ~~plans to changes to~~ the implementation or methodology for 2024 from 2021 to 2022.
 - a. What are the lessons learned from the expanded Medicaid population that could be applied to the commercial payer programs?

Section 4: Total Cost of Care

1. ~~Complete Appendix 4.1, TCOC Prior Year Performance by Payer, by HSA (2020). 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?~~ Complete Appendix 4.1 TCOC Performance by Payer, Total ACO-Wide (2018-2022). Explain the drivers of expected vs. actual Total Cost of Care results by payer program. Provide actuals for prior year. If not available, provide projections and the timeline for when actuals will be available. Provide projections for the current year. For the budget year, provide expected TCOC. Please recognize any relevant assumptions for projections and budget figures (e.g., based on historical seasonal spend plus a particular rate of growth, etc.). Describe all adjustment factors used for calculating the settlement result (e.g., risk sharing, other fees, etc.).
2. ~~Complete Appendix 4.2, TCOC Current Year Projected Performance by Payer, by HSA. 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?~~ Complete Appendix 4.2 Settlement by Payer, by HSA (2018-2022). Explain the methodology by which the ACO distributed funds by HSA, including all adjustment factors used for calculating the settlement distribution (e.g., risk sharing/mitigation, market factor adjustments, adjustments for local performance, case mix, etc.). Discuss the ACO’s Total Cost of Care accountability strategy at the HSA level.
 - a. How is the ACO using TCOC data at the local HSA level to identify high-value and low-value care?
 - b. How is the ACO helping hospitals and other community providers to reduce low-value care and lower their TCOC at the local HSA level?
 - c. What evidence do you have that the ACO local accountability strategy is working?
3. Complete **Appendix 4.3, Projected and Budgeted Trend Rates, by Payer Program, Appendix 4.4, TCOC Budget Year Targets by Payer, by HSA (), Appendix 4.5, Service Risk by Payer, by HSA** and explain the following, refer to “Part II. ACO Budget Targets” of this guidance in your explanation:
 - 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, unit cost 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.

Commented [MM6]: 4.4 and 4.5 data no longer relevant to the ACO risk model.

- 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. Describe how the ACO's TCOC accountability strategy allows providers to benefit from their ability to provide high-value care (low-cost, high-quality) and impact TCOC growth. ~~(please reference Appendix 4.5 to the extent applicable).~~
- d. Recognizing that COVID-19 has resulted in unexpected utilization trends that could continue into 2022, 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? Include a description of how you approach calculating the base experience (Appendix 4.3, Column C).
- 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. Complete **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 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:
 - a. Any significant changes over prior year and the rationale for such, including changes due to COVID-19.
 - 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 withholds, 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. Explain any other risk management strategies or arrangements that affect either aggregate ACO risk or individual provider risk.
2. Complete **Appendix 5.3, Shared Savings and Losses** and **Appendix 5.4, Shared Savings and Losses by Risk Bearing Entity**, and describe the actual or expected distribution of earned shared savings or losses, in the prior year (2020), in the current year (2021) and in the proposed budget year (2022), noting any significant changes in methodology or practice over time.
3. 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 (Balance Sheet, Income Statement with Accountability, Cash Flow), for~~

Commented [MM7]: See new financial reporting templates 6.1-6.4 revised in collaboration with OCV.

~~reference.~~ Complete **Appendix 6.4, Sources and Uses** and **Appendix 6.5, Per Member Per Month Revenues by Payer**.

2. 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. Please also explain:
 - a. Any significant risks associated with the budgeted revenue sources. If substantial risk exists, explain how the ACO would respond.
 - b. Budgeted contracted payer contributions to the ACO as well as any significant changes from the prior year.
 - c. Budgeted provider contributions to the ACO as well as any significant changes from the prior year.
 - d. Budgeted governmental/public contributions as well as any significant changes from the prior year.
3. 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:
 - a. Any significant changes to the population health programs and/or care model, including temporary or permanent changes due to COVID-19, and the budgeted impact on expenses.
 - b. How this budget is affected by any significant changes to clinical and quality priorities for the year.
 - c. Any changes, including significant new investments to the ACO's infrastructure and the budgeted impact on expenses.
 - d. If applicable, how Delivery System Reform funds are being utilized in the proposed budget.
 - e. 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. 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.
5. 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, or any revolving debt (including maximum allowable draw) or other debt used to mitigate cash flow challenges.
6. For Question 2-5, complete the **Appendix 6.1-6.3 Variance Analysis** in the Excel workbook.
7. If the proposed budget includes a gain or a loss, please provide a rationale. Otherwise explain how to balance to a break-even budget (surplus to reserves etc.).
 - a. Discuss any prior or current year surplus or losses and their intended use and how they were earned. How does non-profit status affect treatment of reserves?

~~7.8. Complete Appendices 6.6, Hospital ACO Participation for the proposed budget year.~~

Commented [MM8]: Under review

- ~~8-9~~ Complete **Appendix 6.7, ACO Management Compensation** with the following:
- A list of all the ACO's current officers, directors and trustees, regardless of whether any compensation was paid to such individuals.
 - List all positions with gross compensation (the equivalent of Box 5 on a W-2) greater than or equal to \$150,000.
 - 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.
- ~~9-10~~ 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

- Model of Care.* Please briefly explain ~~your~~ OneCare's statewide model of care and any significant changes made in the current year, ~~or~~ anticipated for the proposed budget year, and describe the rationale. In doing so, please include explanation for the following:
 - What elements of the care model has OneCare eliminated or not adopted because they were not successful? What elements have been scaled up and where would OneCare like to put more resources? What is the data behind these decisions?
 - ~~a.b~~ Progress to date in 2021 on implementing the model of care, including any quantitative evidence. Please note any lessons learned.
 - ~~b.c~~ Any goals or objectives associated with the model of care for the proposed budget year and the strategy for their achievement.
 - ~~e.d~~ The evidence basis for any changes made since the current year and how you intend to measure progress, including any quantitative measures, reporting, and analysis. 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 (e.g. All Payer Model, Department of Mental Health's Ten Year Plan, State Health Improvement Plan).
- Clinical Focus Areas.* Report any results on your 2020 Clinical Focus Areas (interim, if available) and progress to date on 2021 Clinical Focus Areas using Appendix 7.1 ACO Clinical Focus Areas. Provide a narrative description of the ACO's implementation strategy for its Clinical Focus Areas in the current year and in planning for the budget year. How does the ACO support providers in achieving the goals of the Clinical Focus Areas? How are results shared with providers at the HSA and/or the organization level? Does the ACO prepare a final report on Clinical Focus Areas at the close of the year?
- Quality Improvement and Clinical Priorities.* ~~Please complete Appendix 7.1, ACO Clinical Priorities (current year 2021) and~~ Describe any changes to your quality improvement framework and your theory of change for 2022, including your clinical priorities for the proposed budget year. In doing so, please ~~include an explanation discuss for~~ include the following:
 - 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-four~~ years (2018, 2019, 2020, 2021), by HSA:
 - Variations in care (utilization measures);
 - Variations in outcomes (outcome measures);
 - Five mMost prevalent chronic conditions; and

~~4. Five most prevalent high-cost conditions, and~~

~~4.7~~

~~b. Discuss how results and progress to date are used to support ACO network providers in quality improvement and implementation of the care model.~~

~~b.~~

~~a. Method for establishing the clinical priorities for the proposed budget year at the ACO and local (HSA) levels.~~

~~4. How does the ACO support HSAs in driving change? How is data used to drive change? Is there an accountability or incentive structure for driving change? If so, how does it work?~~

~~5.4. Please Discuss your quality program in the context of COVID-19. Do you believe any additional metrics should be tracked due to COVID-19? Discuss lessons learned from the pandemic in the quality improvement program from 2020 to 2021. How do these lessons inform your planning for 2022?~~

~~5. 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:~~

~~Progress to date, including quantitative or qualitative evidence at the ACO, and local (HSA) levels.~~

~~Methods for establishing new or continued investment in such initiatives/programs.~~

~~Measures and methods used to track progress and identify challenges and opportunities.~~

~~Whether and how is there an accountability or incentive structure to drive change?~~

~~3.4. Care Coordination and Care Navigator. Please complete Appendices 7.3, 7.4, and 7.5 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, among others.~~
- ~~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 and provides incentives for investments to address social determinants of health. Please explain how the ACO integrated or facilitated the integration of healthcare and social services in FY21 and give a detailed description of how the ACO plans to further integrate healthcare and social services in FY22. How did the ACO provide incentives for investments to address social determinants of health in FY21 and how does the ACO plan to further do so in FY22?~~

Commented [MM9]: In Reporting Manual under Clinical Focus Areas.

Commented [MM10]: All elements now incorporated into Appendix 7.2.

Commented [MM11]: Assessment as part of ACO improvement plan. Evaluate efficacy of care navigator platform (2021-2022). AHS APM IIP (p.21)

4.6. Childhood Adversity. ~~How is the ACO providing incentives for preventing and addressing the impacts of adverse childhood experiences and other traumas? Please identify any significant changes in this work over prior year.~~

Commented [MM12]: Moved to Certification Form. 18 V.S.A. §9382(17) and § 5.403(a)(20).

Section 8: Other Vermont All-Payer ACO Model Questions

1. How are you ensuring that your portfolio of programs are coordinated in such a way that allocates resources most efficiently for supporting the goals (scale, cost, quality) under the Vermont All-Payer ACO Model?
2. What other actions can healthcare stakeholder be taking to support the goals of the Vermont All-Payer ACO Model?
3. All Payer Model Quality and Population Health Goals. Please complete **Appendix 8.1, 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. In doing so, please also discuss the expected impact of COVID-19 on 2021 performance, sharing any early indicators or relevant insights.

PART II. ACO BUDGET TARGETS

All-Payer Model Agreement Growth and ACO Financial Targets

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 2022. 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

	Aged and Disabled		ESRD		Blended (0.36% ESRD)	
	Floor	3.70%	Floor	3.70%	Floor	3.70%
2017 to 2018						
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	4.16%	\$7,795.38	3.07%	\$965.49	4.13%

	\$903.21		\$7,563.53		\$927.19	
2020 to 2021	<u>\$975.06</u> <u>\$932.34</u>	4.58%	<u>\$8,110.21</u> <u>\$7,910.87</u>	2.52%	<u>\$1,000.75</u> <u>\$957.46</u>	4.52%
2021 to 2022	<u>\$1,028.38</u> <u>\$929.69</u>	10.62%	<u>\$8,515.64</u> <u>\$7,897.64</u>	7.83%	<u>\$1,055.33</u> <u>\$946.80</u>	11.46%
Compounding Projection to Date		5.39%		4.06%		5.53%
Compounding Target to Date		5.19%		.86%		5.33%
<p>Calculation: Blended Compounding Projection = $(1.037*1.0402*1.0413*1.0452*1.1146)^{(1/5)} - 1 = 5.53\%$ Blended Target to date = 5.53% - 0.2% = 5.33%</p> <p>Source: https://www.cms.gov/files/document/2022-announcement.pdf</p>						

Other Targets/Benchmarks

The Board may add other targets or benchmarks to guide the development or implementation of the ACOs Budget. Such benchmarks set in the past have included an administrative expense ratio and a population health investment ratio, among others. Please see prior year Budget Orders for examples.

PART III. REVISED BUDGET

1. Revised Budget Deliverables due Spring-May 2022, or TBD upon execution of payer contracts (date set at the discretion of the Board):
 - a. Final attribution by payer;
 - b. ~~Provider e~~Copies of all payer contracts;
 - c. Final descriptions of population health initiatives and sources of funds;
 - d. ~~Expected hospital dues by hospital;~~
 - e. ~~Expected hospital risk by hospital and by payer;~~
 - e. ~~Any changes to the overall risk model;~~
 - f. ~~_____~~
 - d. ~~Details of expansion of fixed prospective payments (FPP) across payer programs, payment calculation methodologies, and adoption rates by providers; and~~
 - g. ~~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; and~~
 - h. ~~Provide a copy of Form 990 as filed with the IRS;~~
 - i. Any requests for amendments to the budget order; and
 - e.j. Any other information the board deems relevant to ensuring compliance with the budget order.

Commented [MM13]: Required in reporting manual.

Commented [MM14]: Required in reporting manual.

Commented [MM15]: Required in reporting manual.

PART IV. MONITORING

GMCB staff developed a first draft version of the FY21 OneCare Vermont ACO Reporting Manual (“Reporting Manual”) as described in the FY21 budget order, condition #1. 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 Reporting Manual Version 1 is a work in progress and includes (but is not limited to): 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 ~~current or~~ prior year performance, ~~before Board vote on proposed budget.~~
2. Tables submitted through the budget process for which reporting on actuals is required (e.g. Quarterly Financial Statements).
3. Workplans, strategic planning, and evaluations related to provider network and payer program development, utilization management and quality improvement, clinical focus areas, care model and population health investments, and overall ACO strategy.
- ~~3.4~~ Data on HSA level performance (financial, quality, utilization) ~~at least quarterly.~~
- ~~4.5~~ 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.
6. 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.

Commented [MM16]: OCV: OneCare does not monitor statewide performance.