Green Mountain Care Board

Accountable Care Organization (ACO)

Reporting Manual

Entity:	OneCare Vermont ACO, LLC
Version:	FY 2023 Updated Version (v.23.3.2)
Date:	June 27, 2023
Version Notes:	UNDER ON-GOING REVIEW – ALL CONTENT SUBJECT TO CHANGE
	Report templates, deadlines, and reporting history are under review and subject to change. The Green Mountain Care Board will publish updated versions of this manual at least annually and more often as needed.

ACO Reporting Manual Version Tracking: OneCare Vermont ACO, LLC

Date	Version*	Author(s)	Revisions
6/18/2021	FY 2021 Original Version (v.21.1.0) OCVT_FY21_GMCB_ACO_Reporting_Manual.v.21.1.0	GMCB (Marisa M; Sarah T)	N/A
5/27/2022	FY 2022 Original Version (v.22.2.0) OCVT_FY22_GMCB_ACO_Reporting_Manual.v.22.2.0	GMCB (Marisa M; Julia B)	N/A
3/20/2023	FY 2023 Original Version (v.23.3.0) OCVT_FY23_GMCB_ACO_Reporting_Manual.v.23.3.0	GMCB (Marisa M; Jennifer D; Michelle S)	N/A
6/1/2023	FY 2023 Updated Version (v.23.3.1) OCVT_FY23_GMCB_ACO_Reporting_Manual.v.23.3.1	GMCB (Michelle.S)	Updated Report 5 (Financial Reporting)
6/27/2023	FY 2023 Updated Version (v.23.3.2) OCVT_FY23_GMCB_ACO_Reporting_Manual.v.23.3.2	GMCB (Marisa M; Michelle S)	Updated Report 11 (ACO Performance Benchmarking Tool) Updated Report 16 (Quality Measures Scorecards)

General Instructions

- **File Naming Convention:** OCV_FY23- Report-Name_mm-dd-yyyy
- **Document Format:** All documents should be submitted in a machine-readable format.

* Version control key: *v=version, 23=last two digits of the year issued, 3=first year issued, 0=original version for the year; Date=date issued*

ACO Reporting Manual Index: OneCare Vermont ACO, LLC

#	Name of Report	Deadline	Frequency	Report Purpose	Report Template	Category	Statute/Rule	Budget Order Citation	GMCB teams
1	**Attribution Report**	4/28/2023; 7/31/2023; 10/31/2023; 1/31/2024	Quarterly	To report attributed lives by payer program, by month, and by quarter.	Excel	APM – Scale	5.403(a)10.; 5.501(a)	FY23 #10-12	ACO, APM, Data
2	**Scale Target Initiatives and Program Alignment Form (for each payer program)**	3/31/2023	Revised Budget	To verify that programs qualify as scale target initiatives per the APM Agreement (Section 6.b.).	FORM.docx	APM – Scale; Payer Programs	APM Agreement: Section 6	FY23 #4	ACO, APM
3	**Policies, procedures, plans checklist**	Due the last business day of each month	Monthly	GMCB Rule 5.000 requires that all certified ACOs in Vermont maintain specific standards and operational procedures. To validate that an ACO is meeting requirements laid out in Rule 5.000, the GMCB requires that policies, procedures, and plans are submitted on a monthly basis as changes are made. The GMCB verifies criteria in Rule 5.000 are being met by evaluating policies, procedures, and plans.	Excel	Certification	Rule 5.000; 5.301(c); 5.501(c)	N/A	ACO
4	**Revised budget**	3/31/2023	Revised Budget	To submit a revised budget for the current year reflecting final payer contracts, attribution, source of revenue and revised expenses, hospital dues, hospital risk, changes to the risk model, final description of population health programs, and any other reporting required by the Board.	Excel	Financial	5.403(a)	FY23 #6, 10 - 13	ACO
5	**Financial statements**	5/31/2023; 8/31/2023; 11/30/2023; 2/28/2024	Quarterly Report	To evaluate OneCare's financial performance throughout the calendar year relative to the approved budget.	Excel	Financial	5.204; 5.403(a)(3), (22); 5.501(a);	N/A	ACO, HSF
6	**Fixed prospective payment target and strategy**	3/31/2023; 7/31/2023	Semi-Annual	OneCare must work with payers to propose a target for fixed prospective payment levels, a strategy for achieving those levels, and a related timeline, with clear goals, milestones, and targets.	Reporting guidance	Financial	5.209; 5.301(c)(2)(N); 5.403(a)(8)-(10)	FY23 #7, 10 -11	ACO

7	**Comprehensive Payment Reform (CPR) Program Report**	7/31/2023	Annual	To monitor performance of the CPR program which is designed to allow greater participation from independent primary care providers and bring more providers into a capitated payment model.	Excel; Narrative elements	Financial	Certification 5.301(c)(2)(N); § 9382(a)(3)	N/A	ACO
8	**Audited financial statements**	8/31/2023 or as soon as they are available, per budget order #2.	Annual	To submit audited financial information and note disclosures for prior time periods to evaluate the audited actuals relative to the approved budget.	None	Financial	5.204; 5.403(a)(3), (22); 5.501(a), (d);	FY23 #2	ACO, HSF
9	**Settlement Reports**	11/30/2023	Annual	To ensure the ACO executed the risk model as described in their approved budget. To report financial performance and reconciliation for the performance year.	Excel	Financial	5.403(a)(3), (4), (22); 5.501; APM Agreement §6	N/A	ACO, APM
10	**ACO Return on investment analysis**	TBD 2023	Annual	Over the duration of the APM Agreement, OneCare's administrative expenses must be less than the health care savings, including an estimate of cost avoidance and the value of improved health, projected to be generated through the Model.	TBD	Financial	5.203; 5.403(2), (3)	FY23 #17	ACO, Data
11	**ACO Performance Benchmarking Tool**	3/31/2023; 9/29/2023	Semi-Annual	Data-driven monitoring to compare key quality, cost, and utilization metrics for OneCare to national benchmarks and identify best-practices based on data in key areas.	TBD	Financial; Quality/Pop. Health	5.403(a)(4), (11), (13), (16)-(22)	FY23 #1, 11	ACO, Data
12	**Beneficiary Notification Letters**	3/31/2023	Annual	To verify that OneCare is alerting individuals that are attributed to the ACO network that they are an ACO beneficiary, the GMCB requires that the ACO provides a copy of the notification letter sent to the beneficiaries.	None	Patient Protections	Certification 5.208(j)	N/A	ACO
13	**Complaint and Grievance Report ("Member & Provider Communications Report")**	7/31/2023; 1/31/2024	Semi-Annual	Per GMCB Rule 5.000, § 5.208(i) it is required that all certified ACOs submit complaint and grievance reports to the GMCB and Health Care Advocate no less than twice a year.	Excel; Narrative elements	Patient Protections	Certification 5.208(i) ; 5.403(a)(7)	N/A	ACO
14	**Signed payer contracts (for each payer program)**	3/31/2023 or within 10 business days of execution.	Revised Budget	To review ACO affiliated payer agreements.	None	Payer Programs	5.403(a)10, 5.501	FY22 #6, 10-11	ACO, APM

15	**Actuarial Certifications for Commercial Benchmarks**	8/31/2023	Annual	To verify each commercial (including self-funded) benchmark is adequate but not excessive.	Narrative	Payer Programs		FY23 #6c	ACO
16	**Quality Measures Scorecards**	11/30/2023	Annual	To report final (year-end) payer-specific quality results and score.	Per APM	Payer Programs; Quality/Pop. Health; APM	5.403(a)4; APM Agreement: Section 7	N/A	ACO, APM
17	**Hospital Maximum Risk Addenda (for each participating hospital)**	5/31/2023 or within 10 business days of execution.	Annual	To quantify hospital maximum risk on an annual basis.	None	Provider Network	5.205(a); 5.501	FY23 #11-12;	ACO
18	**Network Development Strategy**	4/28/2023	Annual	To report on provider network development and selection criteria.	Narrative	Provider Network	5.205	N/A	ACO
19	**Clinical Focus Areas (previously Clinical Priorities)**	4/28/2023	Annual	To report Clinical Focus Areas annually endorsed by the Clinical and Quality Advisory Committee and the Population Health Strategy Committee.	Narrative	Quality/Pop. Health	Certification; 5.206; § 9382(a)(2)	N/A	ACO
20	**Quality Management Improvement Work Plan**	4/28/2023	Annual	To report the work plan to monitor quality assurance, performance measurement, and performance improvement.	Narrative	Quality/Pop. Health	Certification; 5.206; 5.207(a); § 9382(a)(2); Medicaid contract	N/A	ACO
21	**Ad Hoc Reports**	Varies by Report	Ad Hoc	Reflect reports that OneCare Vermont submits to the GMCB throughout the year, on an ad hoc basis.	None	Monitoring	Certification; 5.203; 5.501;	FY23 #2	ACO

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1) Attribution Report

Report Purpose: To report attributed lives by payer program, by month, and by quarter.

Deadline: Quarterly (4/28/2023; 7/31/2023; 10/31/2023; 1/31/2024)

Instructions:

1. Provide the final number of attributed lives by payer program, by month, and by quarter.
2. Payer program and year fields and definitions are to be updated annually.
3. Provide final attribution numbers at the end of each quarter and update any changes to previously submitted data.
4. Please note updated cells by highlighting in yellow.

Definitions:

BCBS QHP – BCBSVT Qualified Health Plan attributed lives

MVP QHP – MVP Qualified Health Plan attributed lives

BCBS LG Full-Ins – BCBSVT Fully Insured Large Group

BCBS LG Self-Ins – BCBSVT Self-Insured Large Group

BCBS BEE – BCBSVT Blue Edge Enterprise Group

BCBS LG and BEE make up the "BCBSVT Primary Program"

Report Template: Excel

	2021											
	Q1			Q2			Q3			Q4		
Program	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Medicare												
Medicaid												
BCBS QHP												
MVP QHP												
BCBS LG Full-Ins												
BCBS LG Self-Ins												
BCBS BEE												

Notes:

Generally, due to timing of reporting and natural attrition, Medicare numbers reported quarterly by OneCare will not align with CMS numbers used in GMCB annual reporting.

Version	**Submitted to GMCB**
FY18 Year End Attribution Report	3/21/18
FY19 Quarterly Attribution Reports	4/30/19, 7/31/19, 10/31/19, 1/31/20
FY20 Quarterly Attribution Reports	4/30/20, 7/31/20, 10/31/20, 1/31/21
FY21 Quarterly Attribution Reports	4/30/21, 7/30/2021, 10/29/2021, 1/27/2022
FY22 Quarterly Attribution Reports	4/28/22; 7/27/22; 10/31/22, 1/31/23
FY23 Quarterly Attribution Reports	**Due 4/28/23, 7/31/2023, 10/31/2023, 1/31/2024**

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2) Scale Target Initiatives and Program Alignment

Report Purpose: To verify that programs qualify as scale target initiatives per the APM Agreement (Section 6.b.) and quality measures are aligned, to the greatest extent possible (Section 6.f.).

Deadline: 3/31/2023 (received 2/17/2023)

Instructions:

1) Complete the "ACO Scale Target Initiatives and Program Alignment Forms" for each payer program (separate forms for any groups within a payer contract that have different financial or quality arrangements). Requests must be made in writing for confidentiality for any information OneCare believes to be exempt from public record. Additionally, the GMCB will ask OneCare Vermont to review and confirm accuracy of the tables when preparing the Annual Scale Targets and Alignment Report as required by Section 6.j.i. of the Agreement, ensuring that no changes would disqualify a program.
2) Address the following (FY23 Budget Order Condition #4): For each payer program OneCare enters into that does not qualify as a Scale Target ACO Initiative, and for each program element that is not reasonably aligned across payers, OneCare must provide a detailed justification to the GMCB.

Report Template: (example image is p.2 of 7)

Payer Contract: Click or tap here to enter text. **Contract Period:** Start Date to End Date **Date Signed:** Click or tap here to enter text.
Financial Arrangement – Shared Savings and/or Shared Risk Arrangements
Are shared savings possible? * Choose an item.
Does shared savings arrangement meet minimum requirements of 30% of the difference between actual and expected spending (see Section 6.b of the All-Payer ACO Model Agreement)? * Choose an item.
Describe shared savings and shared risk arrangement(s): Click or tap here to enter text.
Contract Reference(s): Click or tap here to enter text.
Payment Mechanisms – Payer/ACO Relationship
Describe payment mechanism(s) between payer and ACO (AIPBP, FFS, etc.): Click or tap here to enter text.
Contract Reference(s): Click or tap here to enter text.
Payment Mechanisms – ACO/Provider Relationship
Describe payment mechanism(s) between ACO and ACO provider network: Click or tap here to enter text.
ACO Provider Agreement Reference(s): Click or tap here to enter text.
Services Included in Financial Targets (Total Cost of Care)
Services Included in Financial Targets: *Complete **Appendix A, Services Included in Financial Targets**, for all ACO-payer contracts. (Services must be comparable to All-Payer Financial Target Services as defined in section 1.f of the All-Payer ACO Model Agreement, to qualify as Scale Target ACO Initiative) ****
Contract Reference(s): Click or tap here to enter text.
Quality Measurement
Is financial arrangement tied to quality of care or the health of aligned beneficiaries? * Choose an item.
Describe methodology for linking payments to quality of care or health of aligned beneficiaries (e.g., withhold, gate and ladder, etc.): Click or tap here to enter text.
Quality Measures: *Complete **Appendix B, Quality Measures**, for all ACO-payer contracts.*
Contract Reference(s): Click or tap here to enter text.
Attribution Methodology
Describe attribution methodology: Click or tap here to enter text.
Contract Reference(s): Click or tap here to enter text.
Patient Protections
Describe patient protections included in ACO contracts or internal policies: Click or tap here to enter text.
Contract and Policy Reference(s): Click or tap here to enter text.

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Version	Submitted to GMCB
FY18 Scale Target Initiatives	4/2/2018
FY19 Scale Target Initiatives	4/30/2019
FY20 Scale Target Initiatives	3/31/2020
FY21 Scale Target Initiatives	3/31/2021
FY22 Scale Target Initiatives	1/10/2022; 1/24/2022; 6/10/2022
FY23 Scale Target Initiatives	**Received 2/17/2023**

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3) Policies, Procedures, Plans Checklist

Report Purpose: GMCB Rule 5.000 requires that all certified ACOs in Vermont maintain specific standards and operational procedures. To validate that an ACO is meeting requirements laid out in Rule 5.000, the GMCB requires that policies, procedures, and plans are submitted on a monthly basis as changes are made. The GMCB verifies criteria in Rule 5.000 are being met by evaluating policies, procedures, and plans.

Deadline: Due the last business day of each month

Instructions: Submit a summary of Policy Changes for the current month. Each month, add to the previous month's summary template (details below). For each new/updated policy, procedure, or plan, submit an individual PDF so each policy is a separate document.

Definitions: None.

Report Template: None

New/Updated Policies/Procedures: For new or updated policies/procedures, continue with internal OneCare format and submit as a machine-readable PDF. Each policy/procedure must be submitted in an individual PDF.

Policy/Procedure Naming Convention: note this is different from the standard convention.

> File Naming:* Policy-Number_PY##_Name-With-Dashes_Voted-Month-yyyy
> Example: 04-13_PY21_Value-Based-Incentive-Fund_Voted-Nov-2021
>
> *Note that "Voted" refers to the month and year that the Board of Managers voted on the new policy/procedure and "PY##" should be filled in only when applicable (when there is a year in the policy title).

Monthly Summary: Template for summarizing policy/procedure changes to date in excel. For each month, add changes to completed template from the previous month. In other words, each month will add to the past month's summary and contain a running list of changes for the year.

> File Naming: OCV-Policies-and-Procedures-Tracker_MonthYYYY

	A	B	C	D	E	F
1	Policy #	Policy Title	Most Recent Approval (BOM vote date)	Date Active Version Submitted to GMCB	Month of Submission to GMCB	Key Changes
2	01-02	Conflict of Interest	12/21/2021	2/28/2022	February	The policy was updated to shift responsibility for the identification and management of Conflicts of Interest from the CCPO to the Chief Legal Counsel; to reflect OneCare's non-profit status; and to include the Audit Committee and a COI Working Group into the process. Formerly numbered 07-06.
3	02-04-PY22	Community Care Coordination Program PY 2022	1/18/2022	2/28/2022	February	This policy was updated to reflect 2022 network responsibilities as they have been communicated to the Network. A statement was added to clarify that failure to fulfill Care Coordination Program responsibilities may result in delay, suspension, or termination of related payments.
4	04-16-PY22	Community Care Coordination Payments PY 2022	1/18/2022	2/28/2022	February	This policy was updated to reflect the bonus incentive payment measures for collaborating agencies, and to align with the terms negotiated with DVHA for PY 2022, e.g., the exclusion of bonus payments for Medicaid Attributed Lives.
5						
6						
7						
8						

Notes: None.

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4) Revised Budget

Report Purpose: To submit a revised budget for the current year reflecting final payer contracts, attribution, source of revenue and revised expenses, hospital dues, hospital risk, changes to the risk model, final description of population health programs, and any other reporting required by the Board.

Deadline: 3/31/2023

Instructions: Submit a revised budget that is based on final attribution. Specifically note all changes from the initial submission. OneCare is also required to present the revised budget to the GMCB at a public meeting. All of the following topics and supporting documents are required to be submitted:

a. Final payer contracts;
b. Attribution by payer;
c. A revised budget, using a template provided by GMCB staff;
d. Final descriptions of OneCare's population health initiatives, including final care coordination payment model;
e. Hospital dues for 2023 by hospital;
f. Hospital risk for 2023 by hospital and payer;
g. Documentation of increasing the OneCare held risk in the amount ordered by the GMCB and any changes to the overall risk model for 2023;
h. Source of funds for its 2023 population health management programs;
i. Revised benchmarking report pursuant to Condition 1;
j. A report to the Board on OneCare's progress relative to its targets for commercial payer FPP levels; and
k. Any other information the GMCB deems relevant to ensuring compliance with FY23 Budget Order.

Definitions: None

Report Template: See "OCV_FY23_revised-budget-workbook-CONFIDENTIAL", and Adaptive sheets A1, A2, and A3, as instructed in email sent 2/28/2023

Notes: None

Version	**Submitted to GMCB**
FY20 Revised Budget	7/20/20; 7/24/20 presentation
FY21 Revised Budget	5/24/21; 5/26/21 presentation
FY22 Revised Budget	3/31/22; 5/4/22 presentation
FY23 Revised Budget	**3/31/23; 5/5/23 presentation**

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5) Financial Statements

Report Purpose: To evaluate OneCare's financial performance throughout the calendar year relative to the approved/revised budget.

Deadline: Quarterly (5/31/2023; 8/31/2023; 11/30/2023; 2/28/2024)

Instructions: Please complete and submit the following financial templates on a quarterly basis through the GMCB Adaptive Database and/or Excel, upon approval of OneCare's Board of Managers. Variance analysis should explain any line-item variations greater than 10% within revenues, and greater than 10% *and* $100,000 within expenses.

- A1-Income Statement (Adaptive)
- A2-Balance Sheet (Adaptive)
- Variance Analysis (Adaptive)
- Staffing Sheet (Adaptive)
- Network Accountability Report (Excel)
- Sources/Uses (Excel)
- PHM Expense Breakout (Excel)

Financial templates must be submitted following approval from OneCare's Board of Managers according to the schedule established by OneCare and the GMCB.

Definitions: None

Report Template: See financial workbook "OCV_FY23_Q1_Quarterly-Financials_sent-mm-dd-yyyy" or in Adaptive database.

Notes: None

Version	**Submitted to GMCB**
FY19 Quarterly Financial Statements	5/31/19, 8/31/19, 11/30/19, 2/28/20
FY20 Quarterly Financial Statements	5/31/20, 8/31/20, 11/30/20, 2/28/21
FY21 Quarterly Financial Statements	5/31/21, 8/30/21, 11/30/21, 2/28/22
FY22 Quarterly Financial Statements	5/31/2022, 8/31/2022, 11/29/2022, 2/27/2023
FY23 Quarterly Financial Statements	**Received 5/30/2023; Due: 8/31/2023, 11/30/2023, 2/28/2024**

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6) Fixed Prospective Payment Target and Strategy

Report Purpose: To monitor proposed targets for fixed prospective payment levels, strategies for achieving those levels, and a timeline, with clear goals, milestones, and targets.

Deadline: 3/31/2023; 7/31/2023

Instructions:

OneCare must submit a report to the GMCB in compliance with FY23 Budget Order Conditions #10 and 11. The report must include the following:

1. Total Fixed Payment (FPP+CPR) as a percent of Expected (or Actual) Total Cost of Care, by payer program for 2021 - 2023. Break out Total Fixed Payments into both reconciled and unreconciled fixed payment arrangements. Include the numerator and the denominator. See table below. **(March and July)**
2. Provide a one-line description of the payment arrangements in each OneCare payer contract or program for FY23 (e.g., FPP reconciled or unreconciled to FFS; FFS with shared savings/loss; foundational PMPM payments to support infrastructure or care coordination; or any other). **(March and July)**
3. Targets for contract revenue in FPP arrangements (Total Fixed Payment as % of Expected TCOC, by payer, as in #1 above) by year, 2023-2026. Indicate if targets are for reconciled or unreconciled fixed payments, or unreconciled fixed payments only. **(March and July)**
4. OneCare's strategy for achieving the targets, by payer, with timelines, clear goals, and milestones. Discuss barriers, limitations, or other factors by payer. **(July only)**
5. The report from OneCare may also include discussion of OneCare's work to reduce reliance on fee-for-service and achieve the goals of value-based care to reduce costs and improve quality of care via non-FPP payment models. Discussion may include:
    a. What types of payments work best for different provider types?
    b. What other provider types does it make sense to evolve the payment models to, e.g., FQHCs?
    c. What other payment types exist which could support Vermont providers in improving performance on cost and quality? **(July only)**

To illustrate 1 and 3, data collected from this report should allow us to replicate the tables below.

	Attribution	Expected TCOC	Reconciled & Un-Reconciled FPP Total $	Total FPP %	Un-Reconciled FPP Only $	Un-Reconciled FPP %
Medicare						
Medicaid						
Medicaid						
BCBSVT						
MVP QHP						
TOTAL						

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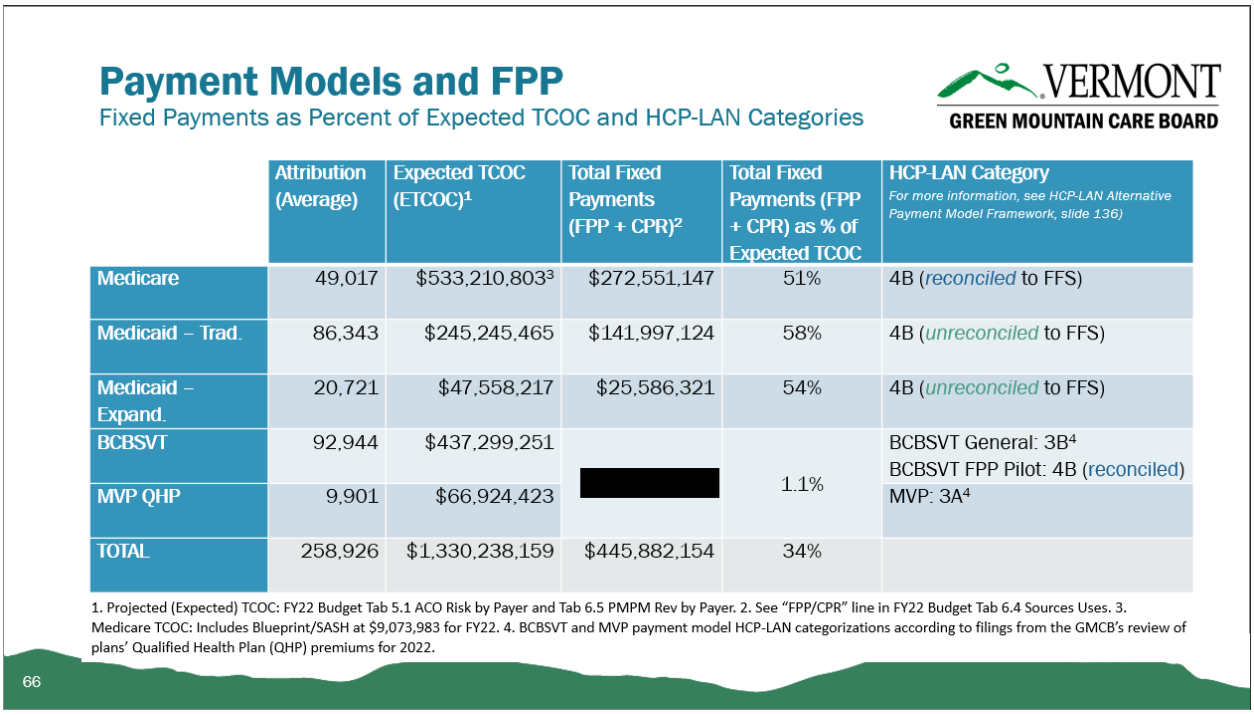
Program	Baseline	PY22	PY23	PY24	PY25	PY26
Medicare						
Medicaid						
Commercial						



Payment Models and FPP

Fixed Payments as Percent of Expected TCOC and HCP-LAN Categories

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GREEN MOUNTAIN CARE BOARD

	Attribution (Average)	Expected TCOC (ETCOC)[1]	Total Fixed Payments (FPP + CPR)[2]	Total Fixed Payments (FPP + CPR) as % of Expected TCOC	HCP-LAN Category *For more information, see HCP-LAN Alternative Payment Model Framework, slide 136)*
Medicare	49,017	$533,210,803[3]	$272,551,147	51%	4B (*reconciled* to FFS)
Medicaid – Trad.	86,343	$245,245,465	$141,997,124	58%	4B (*unreconciled* to FFS)
Medicaid – Expand.	20,721	$47,558,217	$25,586,321	54%	4B (*unreconciled* to FFS)
BCBSVT	92,944	$437,299,251	[redacted]	1.1%	BCBSVT General: 3B[4] BCBSVT FPP Pilot: 4B (reconciled)
MVP QHP	9,901	$66,924,423			MVP: 3A[4]
TOTAL	258,926	$1,330,238,159	$445,882,154	34%	

1. Projected (Expected) TCOC: FY22 Budget Tab 5.1 ACO Risk by Payer and Tab 6.5 PMPM Rev by Payer. 2. See "FPP/CPR" line in FY22 Budget Tab 6.4 Sources Uses. 3. Medicare TCOC: Includes Blueprint/SASH at $9,073,983 for FY22. 4. BCBSVT and MVP payment model HCP-LAN categorizations according to filings from the GMCB's review of plans' Qualified Health Plan (QHP) premiums for 2022.

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Definitions:

Health Care Payment Models:

Definitions adapted from the Health Care Payment Learning & Action Network's Alternative Payment Model Framework.

Fee-for-service (FFS) – Traditional, no link to Quality/Value: payments are made to providers to deliver a service without providing an incentive to improve quality or reduce costs.

Fee-for-service (FFS) – link to Quality/Value: uses traditional FFS payment but adds incremental incentives or disincentives for performance on quality, patient satisfaction, efficiency, or for participation in activities that could improve care. Examples include FFS supplemented with care coordination/HIT payments, pay for reporting, and pay for performance.

Alternative Payment Models (APM)

> *FFS with Shared Savings:* uses traditional FFS payment but holds savings "at risk" for performance on quality and total cost of care
>
> *FFS with Shared Savings and Losses:* uses traditional FFS payment but holds provider "at risk" for savings as well as losses associated with the total cost of care versus the established budget, as well as for performance on quality.

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Fixed prospective payment (FPP) with FFS reconciliation and Shared Savings and Losses: pays a fixed prospective payment, often monthly, with a year-end reconciliation against the FFS equivalent, and holds the provider "at risk" for savings as well as losses associated with the total cost of care versus the established budget, as well as for performance on quality (e.g. Vermont Medicare ACO Initiative)

FPP with Shared Savings and Losses: pays a fixed prospective payment, and holds the provider "at risk" for savings as well as losses associated with the total cost of care versus the established budget, as well as for performance on quality (e.g. Vermont Medicaid Next Generation)

Population-Based Payment: prospective payment to providers for "all care", with quality incentives playing a central role.

Other Population Health or Health Care Reform Payments:

Care Coordination Payment: Payments for the organization of patient care activities, including information sharing among a patient's care team, in order to achieve safer and more effective care with the goal of improving a patient's health outcomes.

ACO Population Health Management (PHM): PHM payments delivered through the ACO are intended to maximize health outcomes, and support value-based care objectives. PHM payments can be fixed or variable, depending on whether a recipient assumes risk during participation. OneCare has a variable population health management payment program for risk-based programs.

Blueprint for Health: OneCare administers payments to Blueprint for Health participating providers for two key programs: Primary Care Medical Home (PCMH) and Community Health Teams (CHT). The only program that receives PCMH payments is Medicare and eligibility is based on attribution.

ACO Shared Savings/Losses: Shared savings and losses is a payment strategy that incentivizes providers to reduce health care costs for their patient population in which the ACO offers providers a portion of net savings for their efforts to reduce spending for their population, or losses if spending ends up being more than expected. This payment methodology is designed to tie payment to ACO or provider performance.

Other Value Based Infrastructure Payments: Payments or incentives to providers to invest in infrastructure expected to improve patient care (e.g., EMR/HIT investments).

Report Template: Report format is at the discretion of OneCare provided that all elements of the instructions are included.

Notes: None

Version	**Submitted to GMCB**
FY21 FPP Target and Strategy	7/1/2021
FY22 FPP Target and Strategy	7/27/2022
FY23 FPP Target and Strategy	**Due 3/31/2023; 7/31/2023**

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7) Comprehensive Payment Reform (CPR) Program

Report Purpose: To monitor performance of the CPR program which is designed to allow greater participation from independent primary care providers and bring more providers into a capitated payment model.

Deadline: 7/31/2023

Instructions: Submit a report including final financial and quality information for the CPR program's performance in the prior year (FY22 reported in 2023). The report must include the following elements:

a) Description of the CPR program
b) Description of any changes made in the prior year (FY22) to the financial and quality models of the program
c) Any evaluation results for the CPR program
d) Financial tables that include:
    a. Source of funds for the CPR program, including the allocation of fixed payments from payer contracts between the hospitals and CPR practices.
    b. Total CPR program revenue and expenses, by payer or other (e.g., hospital investments).
    c. Comparison of capitated payment amounts made to CPR participants to payments made by hospitals to non-CPR primary care practices.
e) Table of participating practices by HSA, and the number of associated attributed lives by payer. Indicate change in number of participating practices and associated lives. Discuss reasons for practices joining/leaving the program, limitations, and recruitment strategies.
f) Describe the evolution of the CPR program, including any changes and a description of practices' experiences with the program (e.g. quality component, impacts on administrative burden and any clinical innovations allowed by increased flexibility and/or resources; challenges practices have faced in implementing this model).

Definitions: From the report dated 1/28/2022, "The Comprehensive Payment Reform (CPR) program is OneCare's payer-blended fixed payment model for independent primary care practices. Currently, fixed payments replace fee-for-service (FFS) for the Medicaid, Medicare, and [participating commercial] programs."

Report Template: Report format is at the discretion of OneCare provided that all elements of the instructions are included. Financial tables should be submitted in Excel.

Notes: None

Version	**Submitted to GMCB**
2018 CPR Report	6/30/18, 1/3/19
2019 CPR Report	8/1/19
2020 CPR Report	7/31/21, 1/31/22
2021 CPR Report	7/27/22
2022 CPR Report	**Due 7/31/2023**

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8) Audited Financial Statements

Report Purpose: To submit audited financial information and note disclosures for prior time periods to evaluate the audited actuals relative to the approved budget.

Deadline: 8/31/2023 or as soon as available, per FY23 Budget Order Condition #2.

Instructions: Submit audited financial statements as soon as they are available. OneCare must crosswalk submitted actuals per its budget submission to audited financial statements.

Definitions: None

Report Template: Audited financials must be submitted per financial audit standards.

Notes: None

Version	**Submitted to GMCB**
FY17-18 Audited Financials	12/23/2019
FY19-20 Audited Financials	8/10/2021
FY21 Audited Financials	9/29/2022
FY22 Audited Financials	**Expected by 8/31/2023**

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9) Settlement Reports

Report Purpose: To ensure the ACO executed the risk model as described in their approved budget. To report financial performance and reconciliation for the performance year.

Deadline: 11/30/2023

Instructions: Complete the settlement report template broken out by payer and HSA. This report must be submitted on an annual basis.

Definitions: None

Report Template:

OneCare Vermont
2020 Settlements
11/15/2021

	Medicare		Medicare	Medicaid Traditional		Medicaid Expanded		Medicaid Elsewhere FPP Recon		Medicaid MEG Class Recon		BCBS QHP	BCBS QHP	MVP QHP		Primary ASO	Primary LG	Primary BEE	Total
	Attrib	Shared Savings (Loss)	AIPBP Recon	Attrib	Shared Savings (Loss)	Attrib	Shared Savings (Loss)	Traditional	Expanded	Traditional	Expanded	Shared Savings (Loss)	AIPBP Recon	Attrib	Shared Savings (Loss)	Shared Savings (Loss)	Shared Savings (Loss)	Shared Savings (Loss)	Shared Savings (Loss)
Bennington	9%	$ 746,661	$ (4,737,890)	7%	$ 680,649	8%	$ 102,430	$ 279,957	$ 181,004	$ 112,525	$ 219,372	$ -	$ (1,346,064)	9%	$ 100,442	$ -	$ -	$ -	$ (3,660,914)
Berlin	14%	$ 1,123,233	$ (8,202,153)	8%	$ 807,496	10%	$ 127,805	$ (85,961)	$ (527,975)	$ 251,358	$ 131,212	$ -	$ -	7%	$ 77,803	$ -	$ -	$ -	$ (6,297,182)
Brattleboro	6%	$ 480,892	$ (2,395,128)	4%	$ 437,372	5%	$ 64,346	$ (198,188)	$ 102,326	$ 125,858	$ 38,722	$ -	$ -	3%	$ 36,855	$ -	$ -	$ -	$ (1,306,944)
Burlington	46%	$ 3,641,345	$ (19,381,471)	25%	$ 2,556,203	21%	$ 253,068	$ (2,523,183)	$ (377,180)	$ 944,882	$ 1,012,021	$ -	$ -	33%	$ 351,892	$ -	$ -	$ -	$ (13,522,422)
Lebanon	2%	$ 165,263	$ -	4%	$ 394,225	4%	$ 49,678	$ -	$ -	$ -	$ -	$ -	$ -	5%	$ 51,490	$ -	$ -	$ -	$ 660,657
Middlebury	8%	$ 663,398	$ (349,659)	5%	$ 558,967	4%	$ 47,183	$ 15,911	$ 149,563	$ 91,900	$ 61,538	$ -	$ -	7%	$ 70,418	$ -	$ -	$ -	$ 1,309,220
Morrisville	N/A	$ -	$ -	4%	$ 454,388	6%	$ 70,488	$ 1,036,467	$ 57,787	$ 97,018	$ 89,226	$ -	$ -	5%	$ 51,671	$ -	$ -	$ -	$ 1,857,046
Newport	N/A	$ -	$ -	5%	$ 541,832	7%	$ 81,493	$ 141,861	$ (178,802)	$ 66,197	$ 57,851	$ -	$ -	3%	$ 31,064	$ -	$ -	$ -	$ 741,495
Randolph	N/A	$ -	$ -	4%	$ 440,595	3%	$ 40,202	$ 259,856	$ 143,886	$ 98,364	$ 41,983	$ -	$ -	2%	$ 24,452	$ -	$ -	$ -	$ 1,049,338
Rutland	N/A	$ -	$ 59,760	10%	$ 1,081,732	11%	$ 133,985	$ 320,688	$ 182,889	$ 309,109	$ 146,589	$ -	$ -	8%	$ 89,290	$ -	$ -	$ -	$ 2,324,043
Springfield	N/A	$ -	$ -	6%	$ 596,124	6%	$ 68,465	$ (199,203)	$ (118,362)	$ 133,720	$ 108,188	$ -	$ -	4%	$ 45,222	$ -	$ -	$ -	$ 634,154
St. Albans	10%	$ 795,467	$ (1,577,269)	9%	$ 888,830	8%	$ 104,299	$ 774,725	$ 141,629	$ 158,952	$ 92,380	$ -	$ -	8%	$ 86,265	$ -	$ -	$ -	$ 1,465,278
St. Johnsbury	N/A	$ -	$ -	8%	$ 792,260	6%	$ 69,925	$ 140,247	$ 28,863	$ 146,705	$ (41,760)	$ -	$ -	4%	$ 46,090	$ -	$ -	$ -	$ 1,182,330
Windsor	4%	$ 295,551	$ -	2%	$ 161,085	1%	$ 16,112	$ 36,822	$ 214,373	$ 42,841	$ 27,011	$ -	$ -	N/A	$ -	$ -	$ -	$ -	$ 793,795
OCV	N/A	$ -	$ -	N/A	$ -	N/A	$ -	$ -	$ -	$ -	$ -	$ 50,000	$ 11,097	N/A	$ -	$ 50,000	$ 17,500	$ 7,500	$ 136,097
Total		$ 7,911,811	$ (36,583,810)		$ 10,391,757		$ 1,229,479	$ 0	$ (0)	$ 2,579,432	$ 1,984,333	$ 50,000	$ (1,334,967)		$ 1,062,955	$ 50,000	$ 17,500	$ 7,500	$ (12,634,010)

Notes: None

Version	Submitted to GMCB
FY19 Settlement Report	11/11/2020
FY20 Settlement Report	11/30/2021
FY21 Settlement Report	11/29/2022
FY22 Settlement Report	**Due 11/30/2023**

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10) ACO Return on Investment Analysis

Report purpose: Over the duration of the APM Agreement, OneCare's administrative expenses must be less than the health care savings, including an estimate of cost avoidance and the value of improved health, projected to be generated through the Model.

Deadline: TBD 2023

Instructions: UNDER DEVELOPMENT

Definitions:

Report Template:

Notes:

Version	**Submitted to GMCB**
One-time submission of ACO Return on Investment Analysis	**Due xx/xx/2023**

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11) ACO Performance Dashboard

Report Purpose: Data-driven monitoring to compare key quality, cost, and utilization metrics for OneCare to national benchmarks and identify best-practices based on data in key areas.

Deadline: 3/31/2023; 9/29/2023

Background: Per FY23 Budget Order Condition #1, OneCare must continue to support an ACO performance benchmarking tool that compares key quality, cost, and utilization metrics to national ACO metrics in accordance with its FY22 Budget Order and further defined by FY23 Budget Order. The ACO performance benchmarking tool must:

a) Allow the ACO and GMCB to assess OneCare's performance against peer ACO's or integrated health systems by comparing OneCare ACO-level performance metrics to a broad national cohort of ACOs in five key areas, as available and appropriate:
    i. Utilization
    ii. Cost per capita
    iii. Patient satisfaction/engagement
    iv. Quality
    v. Evidence-based clinical appropriateness
b) Compare ACO performance metrics to at least the 50th and 90th percentiles, though comparison by quartile or decile is preferred, by each metric to allow for identification of top performers by measure in each key area.
c) Enhance OneCare's ACO-level performance management strategy, including integration of best practices and priority opportunities identified through benchmarking and peer networking in the OneCare Quality Evaluation and Improvement Program.
d) Improve regulatory reporting and performance assessment by providing the benchmarking comparisons to targets at least semiannually to the GMCB.
    i. FY23 Guidance laid out future expectations for setting targets for performance benchmarks at or above the 50th percentile and that any Performance Improvement Plans should include best practices identified through top-performers (90th percentile).
e) Meet the standards and methods for the report as specified by FY23 Budget Order and the ACO Reporting Manual. The GMCB Board Chair is authorized to delegate authority to one or two GMCB Board Members and the GMCB Director of Health Systems Policy to review and approve proposed revisions to the report.

Instructions (updated June 2023): As discussed with OneCare and their vendor, and then presented during the FY23 revised budget process May 2023, the 9/29/23 report submission must include the following updates:

1. Description of comparison cohorts and exclusion criteria
2. Description of benchmarking methodology (i.e., how metrics and benchmarks are calculated)
3. Data source(s) and data dictionary
4. Limitations/caveats/interpretation notes
5. Executive summary of analysis results
6. Year over year trend report for the following selected metrics with "favorable" and "unfavorable" trends indicated.

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Topic	Metric
Cost	Total Cost of Care PBPM
Inpatient Facility - Medical	Admissions/1000
Inpatient Facility - Medical	Hospital Days/1000
Inpatient Facility - Medical	Total Inpatient Cost of Care PBPM
Inpatient Facility - Surgical	Total Inpatient Cost of Care PBPM
Emergency Department	ED Visits/1000
Emergency Department	ED Cost of Care PBPM
Professional Office Visits	Primary Care Visits/1000
Professional Office Visits	Primary Care Cost of Care PBPM
Ambulatory Care Sensitive Admissions/1000	Prevention Quality Overall Composite
Ambulatory Care Sensitive Admissions/1000	Prevention Quality Acute Composite
Ambulatory Care Sensitive Admissions/1000	Prevention Quality Chronic Composite
Ambulatory Care Sensitive Admissions/1000	Prevention Quality Diabetes Composite
Ambulatory Care Sensitive Admissions/1000	Congestive Heart Failure (CHF)
Ambulatory Care Sensitive Admissions/1000	Community-Acquired Pneumonia
Ambulatory Care Sensitive Admissions/1000	Urinary Tract Infection
Ambulatory Care Sensitive Admissions/1000	Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults
Ambulatory Care Sensitive Admissions/1000	Diabetes Long-Term Complications
Ambulatory Care Sensitive Admissions/1000	Hypertension
Ambulatory Care Sensitive Admissions/1000	Lower-Extremity Amputation Among Patients with Diabetes
Ambulatory Care Sensitive Admissions/1000	Diabetes Short-Term Complications
Ambulatory Care Sensitive Admissions/1000	Uncontrolled Diabetes
Ambulatory Care Sensitive Admissions/1000	Asthma in Younger Adults
Additional Metrics	Percent of Members with an Annual Wellness Visit
Additional Metrics	Percent of Inpatient Admissions with Readmission within 90 Days
Additional Metrics	Percent of Members with a Primary Care Visit

Definitions: Provided in the report.

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Report Template: Report format is subject to approval by the GMCB. Required changes to the template and format for 9/29/23 are provided in the instructions above and were discussed during a public meeting of the GMCB on May 17, 2023.

Version	Submitted to GMCB
FY19 ACO Performance Dashboard	1/14/2021
FY20 ACO Performance Dashboard ("ACO Insights")	12/31/2021
FY21 ACO Performance Dashboard	10/31/2022
FY22 ACO Performance Dashboard	**Due 3/31/2023; 9/29/2023**

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12) Beneficiary Notification Letters

Report Purpose: Per GMCB Rule 5.000, § 5.208(j) it is required that all certified ACOs alert individuals that are attributed to the ACO network that they are an ACO beneficiary. The GMCB requires that a copy of the notification letters from each payer sent to the beneficiaries be provided.

Deadline: 3/31/2023

Instructions: OneCare must submit beneficiary notification letters on an annual basis. The GMCB must be notified of any changes be made to letters. Revised copies must be submitted within 15 days of revisions.

Definitions: None

Report Template/File Format: Machine readable PDF.

Notes: None

Version	Submitted to GMCB
FY21 Beneficiary Notification Letters	4/29/21
FY22 Beneficiary Notification Letters	3/25/22
FY23 Beneficiary Notification Letters	**Due 3/31/2023**

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13) Complaint and Grievance Report

Report Purpose: Per GMCB Rule 5.000, § 5.208(i) it is required that all certified ACOs submit complaint and grievance reports to the GMCB and Health Care Advocate no less than twice a year.

Deadline: 7/31/2023; 1/31/2024

Instructions:

1. Complete and submit the Excel template.
2. Provide notes on the following:
    a. Tracking, monitoring, and reporting (summarize policy/procedure)
    b. Primary drivers for patient/provider customer service
    c. Count of inquiries, complaints, grievances
    d. Escalation

Definitions:

Complaint – A routine communication from a patient or provider that requires the ACO to take an action to resolve concerns.

Grievance – an Attributed Individual(s)'s expression of dissatisfaction about actions taken by OneCare or its Providers that relate to Attributed Lives such as dissatisfaction with an ACO Program, an ACO Program policy, or a Provider affiliated with a Payer, which may include the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a Provider or employee, or failure to respect the Attributed Individual's "Member Rights", as that term is defined in this Policy, regardless of whether remedial action is requested. Grievances related to clinical decision-making or an Adverse Benefit Determination are resolved with the Payer(s).

Template Updated July 2021:

OneCare Complaints, Grievances and Appeals Report
July-December 2021

Providers

Payer Program	July				August				September				October				November				December			
	Complaints	Grievances	Appeals	Total	Complaints	Grievances	Appeals	Total	Complaints	Grievances	Appeals	Total	Complaints	Grievances	Appeals	Total	Complaints	Grievances	Appeals	Total	Complaints	Grievances	Appeals	Total
Medicaid	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Medicare	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
BCBSVT	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
MVP	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Beneficiaries

Payer Program	July				August				September				October				November				December			
	Complaints	Grievances	Appeals	Total	Complaints	Grievances	Appeals	Total	Complaints	Grievances	Appeals	Total	Complaints	Grievances	Appeals	Total	Complaints	Grievances	Appeals	Total	Complaints	Grievances	Appeals	Total
Medicaid	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Medicare	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
BCBSVT	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
MVP	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Detail (if applicable)
No Complaints, Grievances or Appeals recorded from July-December 2021

Definitions
Complaint: A routine communication from a patient or provider that requires the ACO to take an action to resolve concerns.
Grievance: A complaint that is not resolved through discussion with the ACO when first presented, and is escalated to senior leadership of the ACO, the payer, and/or the Health Care Advocate.
Appeal: Written and formal method a Participant or Preferred Provider may invoke to address a determination, decision or action made by the ACO

OneCare Vermont Update for PY 2018

Notes: This report was known as the "Member & Provider Communications Report" by OneCare until 2020 and called a "complaint and grievance report" in the Rule.

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Version	Submitted to GMCB
FY20 Complaint and Grievance	7/31/2020, 1/31/2021
FY21 Complaint and Grievance	7/30/2021, 1/27/2022
FY22 Complaint and Grievance	7/27/2022, 1/27/2023
FY23 Complaint and Grievance	**Due 7/31/2023, 1/31/2024**

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14) Signed Payer Contracts

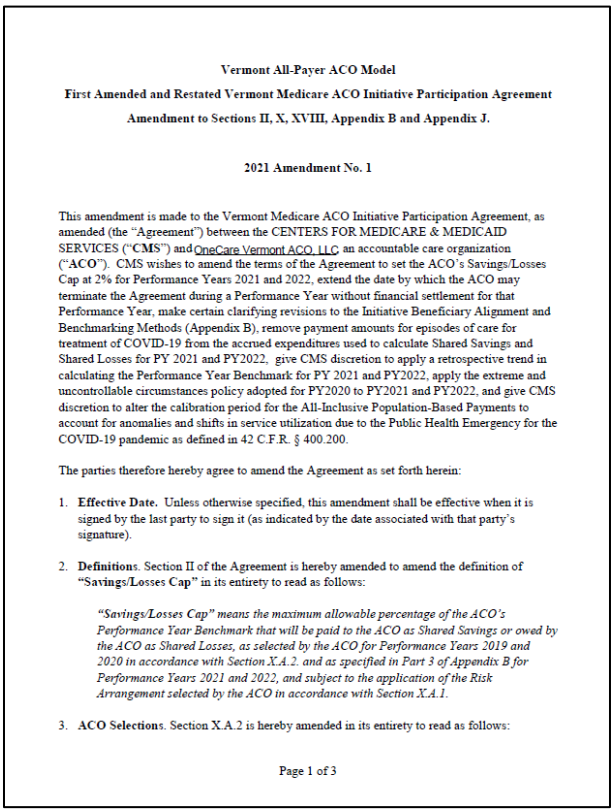
Report Purpose: To review ACO affiliated payer agreements.

Deadline: Submit within 10 business days of execution and provide on or before 3/31/2023 as part of the revised budget material submission (FY23 Budget Order Condition #11- 12).

Instructions: Submit copies of each type of provider contract, agreement, and addendum for the fiscal year (i.e. risk contracts, non-risk contracts, collaboration agreements, and memoranda of understanding).

Definitions: None

Report Template: Machine-readable PDF.



Vermont All-Payer ACO Model

First Amended and Restated Vermont Medicare ACO Initiative Participation Agreement

Amendment to Sections II, X, XVIII, Appendix B and Appendix J.

2021 Amendment No. 1

This amendment is made to the Vermont Medicare ACO Initiative Participation Agreement, as amended (the "Agreement") between the CENTERS FOR MEDICARE & MEDICAID SERVICES ("**CMS**") and OneCare Vermont ACO, LLC an accountable care organization ("**ACO**"). CMS wishes to amend the terms of the Agreement to set the ACO's Savings/Losses Cap at 2% for Performance Years 2021 and 2022, extend the date by which the ACO may terminate the Agreement during a Performance Year without financial settlement for that Performance Year, make certain clarifying revisions to the Initiative Beneficiary Alignment and Benchmarking Methods (Appendix B), remove payment amounts for episodes of care for treatment of COVID-19 from the accrued expenditures used to calculate Shared Savings and Shared Losses for PY 2021 and PY2022, give CMS discretion to apply a retrospective trend in calculating the Performance Year Benchmark for PY 2021 and PY2022, apply the extreme and uncontrollable circumstances policy adopted for PY2020 to PY2021 and PY2022, and give CMS discretion to alter the calibration period for the All-Inclusive Population-Based Payments to account for anomalies and shifts in service utilization due to the Public Health Emergency for the COVID-19 pandemic as defined in 42 C.F.R. § 400.200.

The parties therefore hereby agree to amend the Agreement as set forth herein:

1. **Effective Date.** Unless otherwise specified, this amendment shall be effective when it is signed by the last party to sign it (as indicated by the date associated with that party's signature).

2. **Definitions**. Section II of the Agreement is hereby amended to amend the definition of **"Savings/Losses Cap"** in its entirety to read as follows:

   "Savings/Losses Cap" means the maximum allowable percentage of the ACO's Performance Year Benchmark that will be paid to the ACO as Shared Savings or owed by the ACO as Shared Losses, as selected by the ACO for Performance Years 2019 and 2020 in accordance with Section X.A.2. and as specified in Part 3 of Appendix B for Performance Years 2021 and 2022, and subject to the application of the Risk Arrangement selected by the ACO in accordance with Section X.A.1.

3. **ACO Selections**. Section X.A.2 is hereby amended in its entirety to read as follows:

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Notes: None

Version	Submitted to GMCB
FY18 Payer Contracts (Medicaid, UVMMC Self-funded, BCBSVT, Medicare)	2/6/2018, 5/23/2018, 5/23/2018, 6/26/2018 (respectively)
FY19 Payer Contracts	5/30/2019
FY20 Payer Contracts	5/5/2020
FY21 Payer Contracts	5/21/2021
FY22 Payer Contracts	3/31/2022
FY23 Payer Contracts	**Due 3/31/2023**

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15) Actuarial Certifications for Commercial Benchmarks and All Payer Growth Rate

Report Purpose: Satisfy FY23 Budget Order Condition #6c:

1) **Actuarial certifications** for each commercial (including self-funded) benchmark stating that the benchmark is adequate but not excessive. Actuarial certifications are required because the financial targets for commercial ACO programs are typically not finalized until after the Board issues the budget order. For FY19 and FY20, the GMCB approved budgets reflecting yet-to-be negotiated commercial targets, provided targets met certain requirements, including that the targets be certified by an actuary as "adequate" but "not excessive."
2) **All Payer Growth Rate:** Provide an explanation of how its overall rate of growth across all payers fits within the overall APM target rate of growth and, if its overall rate of growth exceeds the APM target.

Deadline: 8/31/2023

Actuarial Certification Instructions

1. Submit documentation signed by an actuary retained by the ACO attesting that the actuary has reviewed the financial targets proposed for each commercial ACO program for the budget year and certifies, to the best of their knowledge, that the financial targets are representative of expected budget year experience and are adequate but not excessive.
2. Documentation should include a brief response to the following questions. What data does the consulting actuary receive and explain why it is (or is not) sufficient to provide an actuarial certification? Has the ACO reviewed that budget order requirement and actuarial review with commercial insurers?

All Payer Growth Rate Instructions

1. Provide an explanation of how its overall rate of growth across all payers fits within the overall APM target rate of growth and, if its overall rate of growth exceeds the APM target.

Definitions:

Adequate – A certification that the financial targets are "adequate" provides the Board with some assurance that the ACO is not taking on inappropriate risk and that the financial targets the ACO is agreeing to do not threaten the solvency of the ACO or the Vermont hospitals that ultimately bear the risk under OneCare's delegated risk model.

Not Excessive – An ACO is a legal structure that allows health care providers to jointly negotiate with health insurers. A certification that a commercial program's financial target is "not excessive" provides the Board with some assurance that the product of these negotiations is based on the application of actuarial science to data, not providers' bargaining power.

Report Template:

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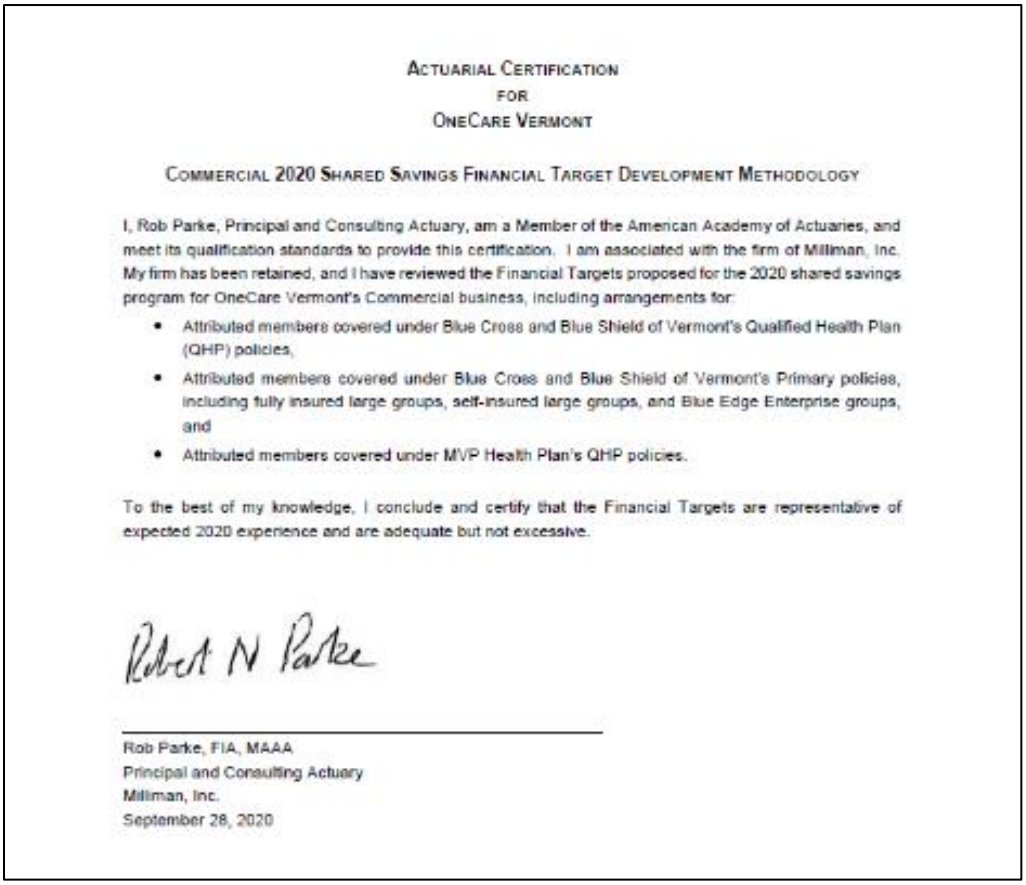

ACTUARIAL CERTIFICATION
FOR
ONECARE VERMONT

COMMERCIAL 2020 SHARED SAVINGS FINANCIAL TARGET DEVELOPMENT METHODOLOGY

I, Rob Parke, Principal and Consulting Actuary, am a Member of the American Academy of Actuaries, and meet its qualification standards to provide this certification. I am associated with the firm of Milliman, Inc. My firm has been retained, and I have reviewed the Financial Targets proposed for the 2020 shared savings program for OneCare Vermont's Commercial business, including arrangements for:

- Attributed members covered under Blue Cross and Blue Shield of Vermont's Qualified Health Plan (QHP) policies,
- Attributed members covered under Blue Cross and Blue Shield of Vermont's Primary policies, including fully insured large groups, self-insured large groups, and Blue Edge Enterprise groups, and
- Attributed members covered under MVP Health Plan's QHP policies.

To the best of my knowledge, I conclude and certify that the Financial Targets are representative of expected 2020 experience and are adequate but not excessive.

Robert N Parke

Rob Parke, FIA, MAAA
Principal and Consulting Actuary
Milliman, Inc.
September 28, 2020

Version	Submitted to GMCB
FY19 Actuarial Certification	1/28/2019
FY20 Actuarial Certification	9/28/2020
FY21 Actuarial Certification	10/29/2021
FY22 Actuarial Certification	8/31/2022
FY23 Actuarial Certification	**Due 8/31/2023**

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16) Quality Measure Scorecards

Report Purpose: To report final (year-end) payer-specific quality results and score.

Deadline: 11/30/2023

Instructions: Use existing reporting format (example image below) and submit to GMCB for each allowable scale-qualifying payer program.

Report Template:

OneCare Vermont

Vermont Medicaid Next Generation Program
2019 Quality Measure Scores: Medicaid
Performance Year 3: Reporting and Performance Measures

Measure	Y1 2017	Y2 2018	Y3 2019	Quality Compass 2018 National Medicaid Benchmarks 25th (0.5 point)	50th (1 point)	75th (1.5 points)	90th (2 points)	Rate 2017	Rate 2018	Rate 2019	Num	Den	Bonus Points	Quality Points
30 Day Follow-Up after Discharge from the ED for Alcohol and Other Drug Dependence	P	P	P	10.07	16.26	24.48	32.15	30.25	29.15	37.15	227	611	1.00	2.00
30 Day Follow-Up after Discharge from the ED for Mental Health	P	P	P	45.58	52.79	66.25	74.47	80.93	81.74	85.53	532	622	0.00	2.00
Adolescent Well-Care Visits	P	P	P	45.74	54.57	61.99	66.80	57.50	56.40	57.35	8,789	15,326	0.00	1.00
All Cause Unplanned Admissions for Patients with Multiple Chronic Conditions	P	P	P	-	-	-	-	1.48	1.02	0.88	17	1,940	N/A	1.00
Developmental Screening in First 3 Years of Life	P	P	P	17.80	39.80	53.90	N/A	59.74	59.27	62.10	3,107	5,003	1.00	2.00
Diabetes Mellitus: Hemoglobin A1c Poor Control (>9%)*	P	P	P	46.96	38.20	33.09	29.68	31.52	33.33	25.61	95	371	1.00	2.00
Hypertension: Controlling High Blood Pressure	P	P	P	49.27	58.68	65.75	71.04	64.61	63.90	62.63	233	372	0.00	1.00
Initiation of Alcohol and Other Drug Dependence Treatment	P	P	P	38.62	42.22	46.40	50.20	35.39	38.87	40.77	806	1,977	0.00	0.50
Engagement of Alcohol and Other Drug Dependence Treatment	P	P	P	9.11	13.69	17.74	21.40	17.63	16.21	20.23	400	1,977	1.00	1.50
Screening for Clinical Depression and Follow-Up Plan	P	P	P	-	-	-	-	47.37	43.43	51.96	159	306	N/A	2.00
Follow-Up after Hospitalization for Mental Illness (7 Day Rate)	R	R	R	29.61	36.54	45.79	54.13	37.02	37.50	40.85	306	749	N/A	-
Tobacco Use Assessment and Tobacco Cessation Intervention	R	R	R	-	-	-	-	N/A	60.76	83.87	312	372	N/A	-

* Inverse rate measure

Points Earned: 19.00
Total Possible Points: 20.00
2019 Final Score: 95.00%

Notes: None

Version	Submitted to GMCB
FY18 Quality Measure Scorecards	10/2/2019
FY19 Quality Measure Scorecards	10/1/2020
FY20 Quality Measure Scorecards	11/30/2021
FY21 Quality Measure Scorecards	10/31/2022
FY22 Quality Measure Scorecards	**Due 11/30/2023**

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17) Hospital Maximum Risk Addenda

Report purpose: To quantify hospital maximum risk on an annual basis.

Deadline: 5/31/2023 or within 10 business days of execution.

Instructions: Submit hospital maximum risk addenda to provider contracts for the fiscal year.

Report Template: Report format is at the discretion of OneCare provided that all elements of the instructions are included.

Notes: None

Version	**Submitted to GMCB**
FY19 Hospital Maximum Risk Addenda	9/25/2019
FY20 Hospital Maximum Risk Addenda	Received 2020
FY21 Hospital Maximum Risk Addenda	8/31/2021
FY22 Hospital Maximum Risk Addenda	8/19/2022
FY23 Hospital Maximum Risk Addenda	**Due 5/31/2023**

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18) Network Development Strategy

Report Purpose: To report on provider network development strategy and selection criteria.

Deadline: 4/28/2023

Instructions: In narrative format, describe the network development strategy for the upcoming year 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 network recruitment activities. Report to include:

a. A definition for ACO "network composition" necessary to maximize value-based incentives;
b. Provider outreach strategy;
c. Provider recruitment and acceptance criteria;
d. Network development timeline;
e. Providers dropping out of the network (quantify) and reasons why; and
f. Challenges to network development.

Definitions:

A definition for ACO "network composition" is necessary to maximize value-based incentives (provided 4/5/20): *The network of providers participating in an ACO that voluntarily come together to share resources and expertise to promote health. Network providers agree to be collectively accountable (clinically and financially) for the quality, cost, and access of the populations they serve and actively engage in appropriate systems transformation efforts.*

Report Template: Machine readable PDF. Report format is at the discretion of OneCare provided that all elements of the instructions are included.

Notes: None

Version	**Submitted to GMCB**
2021 Network Development Strategy	4/5/2020
2022 Network Development Strategy	5/28/2021
2023 Network Development Strategy	4/28/2022
2024 Network Development Strategy	**Due 4/28/2023; Extension Granted for 6/30/23**

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19) Clinical Focus Areas

Report purpose: To report Clinical Focus Areas[1] annually endorsed by the Population Health Strategy Committee and approved by its Board of Managers.

Deadline: 4/28/2023

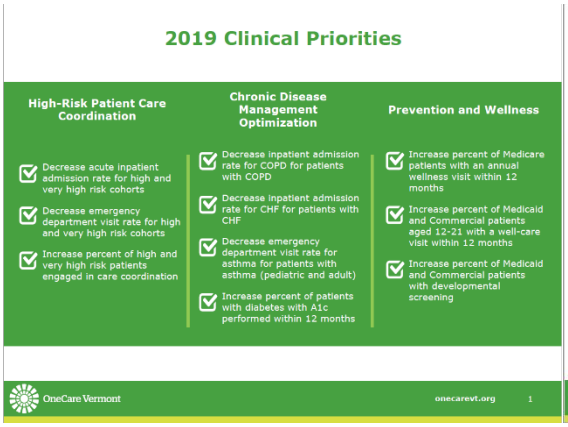
Instructions:

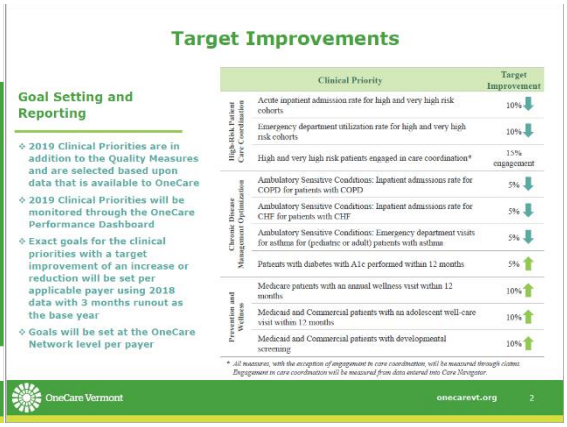
1. In narrative format describe:
    a. the process for development and approval of Clinical Focus Areas,
    b. the criteria for selecting Clinical Focus Areas,
    c. how Clinical Focus Areas fit into OneCare's overall Model of Care,
    d. changes to Clinical Focus Areas from the prior year and why those changes were made,
    e. how progress on Clinical Focus Areas is measured and reported; and
    f. the targets for improvement

Definitions:

Report template:

Report format is at the discretion of OneCare provided that all elements of the instructions are included. Example graphic is from 2019. 2020 Focus Areas were provided in narrative format without a graphic, which is also acceptable.





Notes: None

Version	Submitted to GMCB
2019 Clinical Priorities	4/30/2019
2020 Clinical Focus Areas	3/31/2020
2021 Clinical Focus Areas	4/30/2021
2022 Clinical Focus Areas	4/28/2022
2023 Clinical Focus Areas	**Due 4/28/2023**

20) Quality Management Improvement Work Plan

[1] Clinical Focus Areas were called Clinical Priorities in prior years (2019).

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Report Purpose: To report the work plan to monitor quality assurance, performance measurement, and performance improvement.

Deadline: 4/28/2023

Instructions: Please submit a work plan that details the ACO's quality assurance activities and performance management tasks. For each measure, please define and submit the aim, goal, measure, and key strategies. Additionally, please include the scope and population of each activity, the functional area, the person responsible, the planned activity name, data source, data collection methodology, reporting frequency, and status.

Definitions:

Quality Evaluation and Improvement Program- "A set of policies, procedures, and activities designed to improve the Quality of Care and the quality of the ACO's services to Enrollees and Participants by assessing the Quality of Care or service against a set of established standards and taking action to improve it" (5.207(a))

Report Template:

OneCare Vermont

2021 Quality Improvement Plan

BACKGROUND:

OneCare's Quality team is committed to designing and implementing quality improvement activities within the OneCare Vermont network. The aim is to promote a high value health care delivery system that improves population health by enhancing access to Primary Care, reducing death due to suicide and drug overdose, and reducing prevalence and morbidity of chronic disease. Improvements in population health and best practice protocols are reflected within performance rates of nationally recognized quality measures. Quality measures are an integral component of OneCare's payer programs and regulatory commitments. OneCare's Quality team members serve as subject matter experts on all ACO quality measures, data collection, and evidence based Process Improvement (PI) techniques that facilitate continuous improvement. OneCare provides financial incentives to its network for high quality measure performance through the Value Based Incentive Fund (VBIF).

Notes: OneCare calls this document the "Quality Improvement Plan" while the rule refers to it as a "Quality Evaluation and Improvement Program"

Version	**Submitted to GMCB**
2019 Quality Improvement Plan	4/30/2019
2020 Quality Improvement Plan	7/27/2020
2021 Quality Improvement Plan	4/29/2021
2022 Quality Improvement Plan	4/28/2022
2023 Quality Improvement Plan	**Due 4/28/2023**

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21) Ad Hoc Reports

Report Purpose: Reflect reports that OneCare Vermont submits to the GMCB throughout the year, on an ad hoc basis per FY23 Budget Order #2:

> OneCare must submit reports and information in accordance with the GMCB Reporting Manual. The content of the GMCB Reporting Manual shall be developed, maintained, and revised by GMCB staff, with authority delegated to GMCB's Director of Health Systems Policy, within the scope of GMCB Rules 5.501 and 5.503. OneCare must consult with GMCB staff as needed in the development of the reporting requirements. The GMCB Reporting Manual shall be in addition to, and without limitation of, other Information, data, and analysis that GMCB or GMCB staff may require OneCare to report, including under GMCB Rules 5.501 and 5.503 and in the GMCB's Annual Budget Review Guidance and Certification Eligibility Review Form.
>
> a. The GMCB Reporting Manual will include, without limitation, submission of audited financial statements, an explanation of any discrepancies from audited financials to GAAP financials, a crosswalk of is actual performance to its submitted budget, IRS Form 990, full time equivalents by ACO functional category, and FPP reporting.

Rule 5.501(c): "In addition to the reports an ACO may be required to submit to the Board under subsection (a) of this section, an ACO must report the following to the Board within fifteen (15) days of their occurrence:

1. changes to the ACO's bylaws, operating agreement, or similar documents;
2. changes to the ACO's senior management team;
3. changes to the ACO's provider selection criteria;
4. changes to the ACO's Enrollee grievance and complaint process; and
5. any notice to or discussion within the ACO's governing body of the ACO's potential dissolution or bankruptcy, the potential termination of a Payer program, or a potential new Payer program."

Ad hoc reports also include, but are not limited to:

- Board of Managers Updates
- Committee Charters

Deadline: Submit materials as required in Rules 5.501 and 5.503 and FY23 Budget Order

Instructions:

Definitions: N/A

Report Template: N/A

Notes: None