FY 2023 Budget Guidance and Reporting Requirements for Vermont Certified Accountable Care Organization:

OneCare Vermont, ACO, LLC

Effective July 1, 2022

Prepared by:

GREEN MOUNTAIN CARE BOARD
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2022 TIMELINE FOR FY 2023 BUDGET SUBMISSION

(Subject to change)

Budget Oversight Activity	Due Date
GMCB issues FY 2022 ACO Budget Guidance	On or before July 1, 2022
ACO submits FY 2022 Budget to GMCB	October 1, 2022
ACO FY 2022 budget hearing*	November 9, 2022
ACO/Payer presentation on 2021 Quality and Financial Performance*	November 2021 (TBD)
GMCB Staff presentation on FY 2022 Budget analysis and recommendations*	December 7, 2022
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 2023 ACO Budget
ACO presents on final attribution and revised FY 2023 budget after payer contracts final*	May 2022 (TBD)
ACO submits materials required for monitoring of FY 2023 budget	2022 Ongoing

*Asterix notes board meeting

INTRODUCTION

This document, adopted by the Green Mountain Care Board (GMCB) for Budget Year 2023, 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 an e-mail with "Confidential" in the subject line. The document itself must include the word "Confidential" in the file name (if electronic) and on the face of the document, in a conspicuous location. The ACO must also submit a redacted version of any document, with the information that the ACO believes is confidential redacted so that the document may be posted publicly by GMCB. The GMCB recommends that the ACO submit the confidentiality request at the same time it submits the materials it considers confidential (or at least notify the GMCB of the confidential nature of the documents), but in any event, the written request must be submitted to the GMCB no later than three (3) days after the potentially confidential information is submitted to the GMCB. The HCA must be copied on all confidentiality requests and related submissions.

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

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

Submission Instructions

1. The ACO must be prepared to submit hard copies (published into binders) of the narrative responses and appendices formatted for printing. If an appendix or attachment cannot be formatted for printing, please indicate that it is "electronic-only." The GMCB will indicate the

number of binders needed at least 30 days in advance of the submission deadline. For FY22, the number was fifteen (15).

2. All electronic documents must be machine-readable and submitted with the following naming convention: **OCV_FY23-Budget_[name-of-document-with-dashes]_Sent-MM-DD-YYYY**.
    a. Documents must be submitted as individual, discrete files e.g., do not merge policies, contracts, or other source documents.
    b. Documents must be paginated, and pagination of the electronic submission must match the printed submission.
3. Word counts: The GMCB is introducing word count guidelines into the FY23 Guidance. Word counts will not be enforced but are intended to guide concise responses that convey the essential information.
4. Responses may be provided in formats other than narrative (e.g., table, figure, etc.) if the respondent believes it is the clearest way to convey the information requested. Please describe and interpret any graphs or charts.
5. If the ACO identifies line items or column headers in Excel workbooks that need to be adjusted, they may do so with written permission from GMCB staff. Please add explanatory notes to Excel sheets as needed. Adaptive Sheets can only be modified by GMCB staff.
6. If the ACO believes they have answered a question in the response of a different question, it is acceptable to make reference to that question/response in whole or in part to reduce repetition.
7. Please see the "Introduction" paragraphs above for detailed instructions on submitting information the ACO believes to be confidential. Reminders:
    a. The ACO must request confidentiality for any material it believes to be exempt from public inspection.
    b. When making a request, "Confidential" must be in the subject line of the email, the document name, and on the face of the document or in the header.
    c. Both the Confidential and Redacted versions must be submitted at the same time.

FY 2023 BUDGET AND COVID-19

The GMCB recognizes that the COVID-19 public health emergency has posed significant challenges for Vermont's health care providers since March 2020. In its role as an ACO managing network participants to achieve cost and quality goals, the GMCB recognizes that COVID-19 has created challenges related to developing estimates based on utilization and other prospective factors, and that OneCare has had to adjust ACO operations and implementation of programs and planning for the future. In answering all questions below, where applicable, please note when changes over prior years 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.), to help the Board understand any inputs, recognizing the uncertainty around these assumptions.

PART I. REPORTING REQUIREMENTS

Section 1: ACO Budget Executive Summary

1. Provide brief narratives to summarize the components of the budget submission and describe the ACO's vision for the coming budget year. Include key assumptions and limitations of the budget, including: *(Word Count 2,000)*
    a. An update on the goals and strategies of the current organization-wide strategic plan and future strategic planning process;
    b. Total projected attributed lives and projected attribution by payer program;

c. Summary of the Full Accountability Budget (Non-GAAP);
d. Summary of the Entity-Level Budget (GAAP);
e. Summary of changes to ACO Network Programs, Population Health Programs, and Care Model; and
f. Summary of lessons learned through evaluation and future evaluation plans. Include a summary of ACO benchmarking results to date.

2. Provide Section 1 Attachments A and B.
    a. Attachment A: 2023 OneCare ACO Network
    b. Attachment B: 2023 OneCare ACO Hospital Participation Year Over Year

Section 2: ACO Provider Contracts

3. Submit Appendix 2.1, **2023 ACO Organizations List** and **Appendix 2.2, 2023 ACO Provider List** as soon as they are final and no later than October 15, 2022.[1] Additionally, complete the following summary tables in the Excel Workbook:
    a. 2.2.1 Count of Individual Practitioners Contracted with the ACO
    b. 2.2.2 Count of Entities by Contract Types
    c. 2.2.3 Count of Entities by Organization Type

4. Submit copies of each type of **provider contract, agreement, and addendum** for 2023 (i.e. risk contracts, non-risk contracts, collaboration agreements, and memoranda of understanding).

5. Provide an update on the **FY23 Network Development Strategy** (submitted 4/28/22). In your response, discuss any new provider programs or pilots and progress on 2023 provider network goals, challenges, and opportunities. *(Word Count 500)*

6. Quantify the number and type of providers that have dropped out of the network 2021-2023 (prior, current, and budget years) and to the best of your knowledge, their reasons for exiting.

	# Departing Organizations		
Departure Reason	**2021**	**2022**	**2023**

7. Describe changes to the base Provider Agreements for 2023, if any. Discuss any differences in the base agreement by provider type where applicable. (*Word Count 500*)
    a. In your response, compare the 2022 Program of Payments to 2023 (Reference Attachment Provider Agreements and Addenda Provider Agreement Performance Year Program of Payments, Participant and Preferred Providers).

[1] The ACO Provider List is due to CMS on September 30. Preparing the list for the GMCB customized format required an extension in previous years, so GMCB is allowing the extension upfront for the FY23 Budget.

Section 3: ACO Payer Contracts

1. Complete **Appendix 3.1, ACO Scale Target Initiatives and Program Alignment Forms** and **submit copies of each 2023 payer program contract**, within ten (10) days of execution.
    a. An **ACO Scale Target Initiative and Program Alignment Form** must be completed for EACH sub-group within a payer contract (i.e., risk/non-risk programs under the same contract).

2. Explain changes made to your portfolio of payer programs for the proposed budget year using the below table and relevant narrative as described below. For new and continuing payer programs discussion of anticipated changes should include changes to specific groups covered under payer contracts such as the traditional and expanded Medicaid cohort, QHP, insured, or self-insured groups within commercial contracts. **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.** *(Word Count: 500)*

Payer Program	Program Start Year	Anticipated Changes?	Scale Qualifying?

    a. For any new payer program in 2023, describe the anticipated size and scope of the program and the impact on the budget model.
    b. For continuing payer programs that have Anticipated Changes, explain the anticipated changes and the overall impact on the budget.
    c. For any terminated payer programs, please explain.
    d. Discuss payer contracting goals, strategies, opportunities, and limitations for creating and maintaining Scale Qualifying lives.
    e. For any payer programs or groups covered by payer programs that do not generate attribution qualifying for All Payer Model scale targets (not Scale Qualifying), explain the rationale for entering the program and its overall impact on the budget model.

3. Report the following information on the ACO's budgeted and target fixed prospective payment arrangements for 2023 and beyond, consistent with the template in the ACO Reporting Manual: (*Word Count:750)*
    a. Budgeted and Target Total Fixed Payment (FPP+CPR) as a percent of Expected Total Cost of Care, by payer program for 2023-2026. Total Fixed Payments include both reconciled and unreconciled fixed payment arrangements. Include the numerator and the denominator for the Budget Year 2023. Indicate if targets are for reconciled or unreconciled fixed payments, or unreconciled fixed payments only.
    b. The ACO's strategy for achieving the targets, by payer, with timelines, clear goals, and milestones. Discuss barriers, limitations, or other factors, by payer.

4. Provide an update on OneCare's work to develop scale target qualifying programs with Medicare Advantage plans operating in Vermont, with a special focus on Vermont-based plans offered by BCBSVT and UVMMC-MVP. *(Word Count: 300)*

Section 4: Total Cost of Care

1. Complete **Appendix 4.1 TCOC Performance by Payer, Total ACO-Wide (2018-2023)**. Instructions:
    a. Verify actuals for past years 2018-2020.
    b. Provide projections for the current and prior year (2021-2022) and the timeline for when actuals will be available.
    c. For the budget year (2023), provide expected TCOC.

2. Discuss drivers and assumptions for Total Cost of Care targets and results by payer program.
    a. Explain the drivers of expected vs. actual Total Cost of Care results by payer program and discuss any significant trends over time.
    b. Discuss 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.). *(Word Count: 800)*

3. Complete **Appendix 4.2, Projected and Budgeted Trend Rates, by Payer Program**, and explain the following, refer to "Part II. ACO Budget Targets" of this guidance in your explanation: (*Word Count:1,000)*
    a. All underlying assumptions for these trend rates (Appendix 4.3, Column D) 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, the 2023 benchmark trend rates must be consistent with the ACO-attributed population and the GMCB approved rate filings, if any. See Other Targets/Benchmarks section below (p.16).
    b. For each program, contrast the budgeted growth rate (Appendix 4.3, Column D) with the expected growth trend for the ACO (Appendix 4.3, Column G). Include analysis for reasons why the ACO's performance differs from the trend rates used in the budget.
    c. Recognizing that COVID-19 has resulted in unexpected utilization trends that could continue into 2023, 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).
    d. 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: ACO Network Programs and Risk Arrangement Policies

1. Describe provider payment strategies, methodologies, and rationale. Reference relevant contract terms or policies. Include in your response, which provider types are eligible for which types of payments? Why? *(Word Count: 500)*
    a. Participant vs. Preferred Providers
    b. Risk-bearing participants
    c. Primary care
    d. Specialty care
    e. Continuum of care (i.e., HHH, DAs, SNFs)

2. Discuss ACO program goals, strategies, opportunities, and limitations for the following: *(Word Count: 1,000)*
    a. The ACO's strategy for increasing the opportunity for upside/downside risk;
    b. The ACO's strategy for better aligning provider risk with ACO risk;

c. Strengthening primary care;
d. Reducing administrative burden;
e. Expanding Fixed Prospective Payment arrangements; and
f. Expanding payer program participation across the network.

3. Complete **Appendix 5.1, ACO Risk by Payer and by Risk Bearing Entity** for the budget year.
    a. Describe the ACO's risk model. How is risk delegated and how does the risk delegation support the goals of the ACO? Include discussion of any significant changes over the prior year and the rationale for such changes. *(Word Count: 500)*

4. 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: *(Word Count: 500)*
    a. 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.)?
    b. Does the ACO intend to purchase any third-party risk protection? If so:
        i. Explain the nature of the arrangement.
        ii. How does the anticipated protection compare to prior years?
        iii. How much of the downside risk would be covered?
        iv. Which programs would have this protection?
    c. If applicable, explain the nature and magnitude of any solvency or financial guarantee requirements imposed through payer contract arrangements and how the ACO aims to satisfy those requirements.
    d. Explain any other risk management strategies or arrangements that affect either aggregate ACO risk or individual provider risk.

5. Complete **Appendix 5.2, Shared Savings and Losses by Payer, HSA, Primary Care/Risk Bearing Entity**, and describe the actual or expected distribution of earned shared savings or losses, in the prior year (2021), in the current year (2022) and in the proposed budget year (2023), noting any significant changes in methodology or practice over time. *(Word Count: 250)*

6. Discuss the ACO's Total Cost of Care accountability strategy at the HSA level. *(Word Count: 500)*
    a. How is the ACO using TCOC and quality 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. Discuss 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.

7. Provide any further documentation (i.e., policies) for the ACO's management of financial risk.

Section 6: ACO Budget

1. Complete the GMCB financial statements **A1, A2, and A3 (Income Statement, Balance Sheet, Cash Flow) in the Adaptive Database**.

2. Complete **Appendix 6.4, Sources and Uses** in the Budget Guidance Workbook (Excel).

3. For Questions 4-7, complete the **Variance Analysis Report** through the **Adaptive Database**.

4. Revenues: Explain any line-item variations greater than 10% evident on your budgeted income statement as compared to prior year projected actuals and prior year revised budget. Please also explain: *(Word Count: 500)*
    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.

5. Expenditures: Explain any line-item variations greater than 10% and $100,000 evident on your budgeted income statement as compared to prior year projected actuals and prior year revised budget. Please also explain: *(Word Count: 600)*
    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.).

6. Balance Sheet: Explain any variations greater than 10% and $100,000 evident on your budgeted balance sheet as compared to prior year projected actuals and prior year budget and provide an analysis of the ACO's solvency, providing metrics that you use and noting any areas of concern. *(Word Count: 200)*

7. Cash Flow: Explain any variations greater than 10% and $100,000 evident on your budgeted cash flow statement as compared to prior year projected actuals and prior year budget and provide an analysis of the ACO's current cash position, as well as expectations for the upcoming budget year, noting any potential timing challenges. Please explain the use of, or access to, any revolving debt (including maximum allowable draw) or other debt used to mitigate cash flow challenges. *(Word Count: 200)*

8. If the proposed budget includes a gain or a loss, please provide a rationale. Otherwise explain how you arrived at a break-even budget (surplus to reserves, etc.). *(Word Count: 200)*
    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?

9. Complete Appendix **6.5, Hospital ACO Participation-All Hospitals** for the proposed budget year.

10. Submit the ACO's most recent (2021) **IRS Form 990 (Appendix 6.6)**.

11. Complete **Appendix 6.7, ACO Management Compensation** (projected for the current year, 2022) with the following:
    a. A list of all the ACO's current officers, directors and trustees, regardless of whether any compensation was paid to such individuals.
    b. List all positions with gross compensation (the equivalent of Box 5 on a W-2 and any other compensation as reported on IRS Form 990) greater than or equal to $150,000.
    c. List all leadership positions (VP, all C-Suite, including Chief Compliance Officer) with gross compensation (the equivalent of Box 5 on a W-2 and any other compensation as reported on IRS Form 990) greater than $100,000.

12. Complete **Appendix 6.8, Population Health Management Expense Breakout**.
    a. Identify bonus payments where the ACO will budget the dollar amount, but not the actual distribution across provider types.
    b. Identify blank cells where provider types are ineligible for payments.

13. Please provide details for any expected capital expenditures over the next three years. *(Word Count: 200)*

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

1. *Model of Care*. Please briefly explain progress to date on implementing the Model of Care, including significant changes made during the current year. Include what changes will be anticipated for the proposed budget year, and describe any lessons learned and the rationale for the(se) change(s). (*See* § 5.403(a)(11); § 5.403(a)(16)) In doing so, please discuss the following: *(Word Count 2,500)*
    a. Any elements of the care model that OneCare has either eliminated or scaled up for FY23 including rationale for changes;
    Any areas in which OneCare would like to put more resources if available;
    b. All goals or objectives in PY22 related to the model of care and the status of the achievement of those goals;
    c. All goals or objectives associated with the model of care for the proposed budget year and the strategy for their achievement;
    d. How the ACO intends to measure progress for the proposed budget year, including any quantitative measures, reporting, and analysis; and
    e. 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).

Additionally, please address the following:

f. An overview of your risk stratification methodology, and rationale for its selection/continued use;
g. Consistencies and inconsistencies of care delivery and care coordination across HSAs;
h. Whether and how race and ethnicity data are collected and how they are incorporated into the model of care;
i. How health equity is being addressed in the model of care.

2. *Clinical Focus Areas.* Report any results on your 2021 Clinical Focus Areas (interim, if available) and progress to date on 2022 Clinical Focus Areas using **Appendix 7.1 ACO Clinical Focus Areas**. Briefly explain how and why these criteria were selected. If any changes in the area of focus have been made during the current program year, please explain the changes and the reasoning behind the changes. (*See* § 5.403(a)(12)) *(Word Count 400)*

3. *Quality Improvement.* Describe any changes to your quality improvement framework and your theory of change for 2023. (*See* § 5.403(a)(12)) In addition, please include the following:
    a. Complete **Appendix 7.2 High-Cost Conditions;**
    b. Discuss how areas for quality improvement are identified;
    c. Discuss how results and progress to date are used to support ACO network providers in quality improvement and implementation of the care model. *(Word Count 800)*

4. *Population Health and Payment Reform*. Complete **Appendix 7.3, Population Health and Payment Reform Details**. (*See* § 5.403(a)(11)) In addition, please discuss the ACO's strategy for making investments in population health and developing payment reform programs across the continuum of care, including the rationale/evidence base for the strategy. *(Word Count 200)*

5. *Care Coordination*. Complete **Appendix 7.4 Care Coordination and Appendix 7.5 Care Coordination Payments.** Explain any opportunities or challenges experienced in the transition away from Care Navigator-based payments and risk-level focused care coordination, and the implementation of the revised care coordination model in FY2022. (*See* § 5.403(a)(18)) In doing so, please discuss the following: *(Word Count 1,000)*
    a. The selection of at-risk populations for care coordination, and the detailed criteria applied to these populations, including any factors of health equity and social determinants of health.
    b. Any outcomes related to the shift from focusing on high/very high-risk individuals to at-risk subpopulations.
    c. Discuss the approach to Care Coordination by payer program. Does the ACO track Care Coordination rates by payer program? If so, please provide. How does the ACO prevent duplication of efforts and collaborate with the payers?
    d. The plan for Care Navigator in the budgeted year.

6. *Integration of Social Services*. Please explain how the ACO integrated or facilitated the integration of healthcare and social services in FY22 and give a detailed description of how the ACO plans to further integrate healthcare and social services in FY23. (*See* § 5.403(a)(18); § 5.403(a)(19); § 5.403(a)(20)) In doing so, please discuss: *(Word Count 500)*
    a. Whether or not the ACO has measured the effectiveness of integrating social services and if so, please share the results;
    b. How the ACO provided incentives for investments to address social determinants of health in FY22 and how the ACO plans to further do so in FY23.

Section 8: Evaluation and Performance Benchmarking

1. Discuss the ACO's approach to evaluating provider satisfaction with ACO participation, including results of any provider satisfaction surveys, and actions the ACO is taking to address areas of provider feedback. *(Word Count: 500)*

2. Discuss the ACO's approach to evaluating its risk and financial accountability model. Explain how the ACO's risk management arrangements support the ACO accountability strategy and evidence that the local accountability strategy is working.

3. Discuss the ACO's approach to evaluating its Population Health Management programs. Narrative must include, but is not limited to:
    a. Evaluation of Clinical Focus Areas and their outcomes.
    b. The results of any evaluations done on the revised care coordination model to date and plans for further evaluation (include how TCOC, ED utilization, and inpatient admission rates have changed as a result of the revised care coordination model and whether or not these results are meeting expectations). Discuss how the ACO is incorporating provider and patient input on the new care coordination model. Please share any relevant lessons learned.

4. Discuss the ACO's approach to evaluation of its Quality Improvement Program.

5. Discuss progress on developing Key Performance Indicators to measure ACO-wide progress and performance.

6. Provide the current status of the implementation or use of a benchmarking system or datasets as a tool for assessing ACO performance. Provide available comparisons against regional or national benchmarks of peer ACOs that can be used by GMCB to establish a baseline for data-driven targets and monitoring.
    a. NOTE: Any performance targets for FY23 or future years will be determined by GMCB, taking into consideration the implementation status of the benchmarking system, and may include, e.g:
        i. Performance targets (e.g., at or above 50^{th} percentile)
        ii. Enforcement (e.g., range for requiring a Performance Improvement Plan (PIP)
        iii. Performance Improvement Plan requirements (e.g., PIPs should include best practices used by ACOs in 90^{th} percentile)

Section 9: Other Vermont All-Payer ACO Model Questions

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

2. What other actions can healthcare stakeholders be taking to support the ACO in achieving the goals of the Vermont All-Payer ACO Model? *(Word Count: 250)*

3. *All Payer Model Quality and Population Health Goals*. Please complete **Appendix 9.1, ACO Activities related to the Vermont All-Payer Model ACO Agreement Population Health and Quality Goals** to describe results to date and explain your strategies for assisting the state to achieve its quality and population health goals as specified in the APM. In doing so, please also discuss the expected impact of COVID-19 on 2022 performance, sharing any early indicators or relevant insights. *(Word Count: 500)*

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)	
2017 to 2018	Floor	3.70%	Floor	3.70%	Floor	3.70%
2018 to 2019	$891.07 $856.41	4.05%	$7,833.28 $7,586.28	3.26%	$916.06 $880.64	4.02%
2019 to 2020	$940.81 $903.21	4.16%	$7,795.38 $7,563.53	3.07%	$965.49 $927.19	4.13%
2020 to 2021	$975.06 $932.34	4.58%	$8,110.21 $7,910.87	2.52%	$1,000.75 $957.46	4.52%
2021 to 2022	$1,028.38 $929.69	10.62%	$8,515.64 $7,897.64	7.83%	$1,055.33 $946.80	11.46%
2022 to 2023	$1,078.63 $1,023.31	5.41%	$9,332.69 $8,926.41	4.55%	$1,108.34 $1,051.76	5.38%
Compounding Projection to Date		5.39%		4.14%		5.36%
Compounding Target to Date		**5.19%**		**3.94%**		**5.16%**

Calculation:
Blended Compounding Projection = (1.037*1.0402*1.0413*1.0452*1.1146*1.0538) ^ (1/6) -1 = 5.36%
Blended Target to date = 5.36% - 0.2% = 5.16%
Source:
https://www.cms.gov/files/document/2023-announcement.pdf

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.

Proposed budget targets for FY23:

1. Fund the VBIF or other pre-funded clinical quality incentive programs at a minimum of the FY22 revised budget amount.
2. The FY23 commercial benchmark trend rates must be consistent with the ACO-attributed population and the GMCB approved rate filings.

PART III. REVISED BUDGET

Revised Budget Deliverables due Spring 2023, or TBD upon execution of payer contracts (date set at the discretion of the Board):

a. Final attribution by payer;
b. Copies of all payer contracts;
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;
f. Any changes to the overall risk model;
g. Details of expansion of fixed prospective payments (FPP) across payer programs, payment calculation methodologies, and adoption rates by providers;
h. A copy of Form 990 as filed with the IRS.
i. Any requests for amendments to the budget order; and
j. Any other information the board deems relevant to ensuring compliance with the budget order.

PART IV. MONITORING

GMCB staff published the FY22 OneCare Vermont ACO Reporting Manual ("Reporting Manual") as described in the FY22 budget order, condition #3. 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 FY 2022 Original Version (v.22.2.0) includes (but is not limited to):

1. Presentation of current or prior year performance.
2. Tables submitted through the budget process for which reporting on actuals is required (e.g. Quarterly Financial Statements).

3. ACO performance dashboard to compare key quality, cost, and utilization metrics to national benchmarks and identify best-practices based on data in key areas.
4. ACO strategy, workplans and evaluations related to programs, including updates to the ACO's Network Development Strategy and Clinical Focus Areas.
5. Information on ACO's complaints, grievances, and appeals processes for enrollees and providers.

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