FY 2024 Budget Guidance and Reporting Requirements for Vermont Certified Accountable Care Organization:

OneCare Vermont, ACO, LLC

Effective July 14, 2023

Prepared by:

GREEN MOUNTAIN CARE BOARD
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2023 TIMELINE FOR FY 2024 BUDGET SUBMISSION

(Subject to change)

Budget Oversight Activity	Due Date
GMCB issues FY 2024 ACO Budget Guidance	July 14, 2023
ACO submits FY 2024 Budget to GMCB	October 2, 2023
ACO FY 2024 Budget Hearing*	November 8, 2023
ACO/Payer presentation on 2022 Quality and Financial Performance*	November 2023 (TBD)
GMCB Staff presentation on FY 2024 Budget analysis and recommendations*	December 6, 2023
Public comment period on ACO budget closes	December 2023 (TBD)
GMCB votes to est. the FY 2024 ACO Budget*	December 2023 (TBD)
GMCB est. the Medicaid Advisory Rate Case	On or before December 31, 2023
GMCB issues written Budget order to ACO	45 days after Board vote on FY 2024 ACO Budget
ACO presents on final attribution and revised FY 2024 budget after payer contracts final*	May 2024 (TBD)
ACO submits materials required for monitoring of FY 2024 budget	2024 Ongoing

*Asterix notes board meeting

INTRODUCTION

This document, adopted by the Green Mountain Care Board (GMCB) for Budget Year 2024, 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 adequately explain to the GMCB how it arrived at each piece of information in its submission.

Submission Instructions

1. The ACO must be prepared to submit hard copies (published into binders) of the narrative responses and appendices formatted for printing. If an appendix or attachment cannot be formatted for printing, please indicate that it is "electronic-only." The GMCB will indicate the number of binders needed at least 30 days in advance of the submission deadline.
2. All electronic documents must be machine-readable and submitted with the following naming convention: **OCV_FY24-Budget_[name-of-document-with-dashes]_Sent-MM-DD-YYYY**.
    a. Documents must be submitted as individual, discrete files e.g., do not merge policies, contracts, or other source documents.
    b. Documents must be paginated, and pagination of the electronic submission must match the printed submission.
3. Word counts: Word counts will not be enforced but are intended to guide concise responses that convey the essential information.
4. Responses may be provided in formats other than narrative (e.g., table, figure, etc.) if the respondent believes it is the clearest way to convey the information requested. Any numerical tables should be provided as an attachment in Excel format and any graphs or charts need to be described and interpreted.
5. If the ACO identifies line items or column headers in Excel workbooks that need to be adjusted, they may do so with written permission from GMCB staff. Please add explanatory notes to Excel sheets as needed. Adaptive Sheets can only be modified by GMCB staff and can be done with written request to the GMCB from the ACO.
6. Any "Total" cell or other cell in an Excel sheet should include a formula to clarify to where the number ties within the workbook.
7. If the ACO believes they have answered a question in the response of a different question, it is acceptable to make reference to that question/response in whole or in part to reduce repetition.
8. Please see the "Introduction" paragraphs above for detailed instructions on submitting information the ACO believes to be confidential. Reminders:
    a. The ACO must request confidentiality for any material it believes to be exempt from public inspection.
    b. When making a request, "Confidential" must be in the subject line of the email, the document name, and on the face of the document or in the header.
    c. Both the Confidential and Redacted versions must be submitted at the same time.

PART I. ACO BUDGET TARGETS

FY 2024 Budget Targets

The Board may add targets to guide the development or implementation of the ACO's Budget. Budget targets are not requirements for any budget submission. If the ACO's proposed budget varies from the budget targets below, the Board will review the ACO's proposed budget and its support for varying from these targets in its FY24 budget submission using the factors and criteria set out in statute and rule. For all budget targets that are met, the ACO should expect less analysis of this area of the budget from the GMCB and staff.

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

Proposed budget targets for FY24:

1. The FY24 commercial benchmark trend rates must be consistent with the ACO-attributed population and the GMCB approved rate filings.
2. The ACO must use best efforts to meet or exceed the goals for reconciled and unreconciled FPP as adopted by the GMCB as seen below and identify and report specific obstacles to achieving the goals and action steps required (by OCV or others) to overcome those obstacles:
    - Medicaid 55%
    - Commercial 24%
3. The ACO must hold 100% of the Medicare Advanced Shared Savings dollars as risk at the entity-level and not pass this risk along to the provider network.
4. Increase risk corridors for all payer programs above FY23 levels.
5. Ratio of operating expenses to PHM/payment reform payments (including FPP and budgeted bonus payments) must not exceed the 5-year average of 3.25%.
6. [Any benchmark or target regarding total executive compensation to be determined and issued]
7. [Any benchmark or target regarding the structure of the variable portion of executive compensation to be determined and issued]
8. The ratio of population health management funding to number of attributed lives must be at a minimum of the FY23 revised budget amount; specific line items may vary based upon any internal evaluation of the effectiveness of individual PHM programs. The ACO must propose a plan to increase the accountability of its provider network for quality. Examples for increased accountability could include adding in an adjustment to hospital fixed payments for quality or increasing the ratio of the PHM bonus payments to base payments for primary care and community providers.
9. March 2023 Medicare Benchmarking Report: Where OCV ranks below the 10th percentile among the national ACO cohort OR for metrics where the trend has shown a decrease in performance between the years of 2019 and 2021, choose three metrics that the ACO will address through the Quality Evaluation and Improvement plan. The ACO should use metrics on which the ACO's provider network has the most influence on the outcomes and should justify their choice of said metrics.

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 2023. Each year, the State is assessed to determine how its observed growth compares to the Agreement's targeted range (3.5% to 4.3%). Vermont residents are included in the All-Payer calculation whether or not they are attributed to an ACO Initiative.

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

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

		PREVIOUS YEAR	PERFORMANCE YEAR	PROJECTED ANNUAL GROWTH
Non-ESRD	2018	Floor	Floor	3.7%
	2019	$856.41	$891.07	4.0%
	2020	$903.21	$940.81	4.2%
	2021	$932.34	$975.06	4.6%
	2022	$929.69	$1,028.38	10.6%
	2023	$1,023.31	$1,078.63	5.4%
	2024	$1,057.70	$1,105.10	4.5%
			Compounding Growth to Date	5.3%
			Growth Target (2017 to 2024)	**5.1%**
ESRD	2018	Floor	Floor	3.7%
	2019	$7,586.28	$7,833.28	3.3%
	2020	$7,563.53	$7,795.38	3.1%
	2021	$7,910.87	$8,110.21	2.5%
	2022	$7,897.64	$8,515.64	7.8%
	2023	$8,926.41	$9,332.69	4.6%
	2024	$8,929.61	$9,544.97	6.9%

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

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

PART II. REPORTING REQUIREMENTS

Section 1: ACO Budget Executive Summary

1. Provide brief narratives to summarize the components of the budget submission and describe how the ACO's budget supports the mission, vision, and core functions for the coming budget year. Include key assumptions and limitations of the budget, including: *(Max Word Count 2,000)*
    a. An updated current mission and vision statement;
    b. Reflections on the goals, strategies, and outcomes of the strategic plan that ends with PY 2023
    c. An update on the strategic planning process and major strategies for PY2024 and beyond;
    d. Summary of the Full Accountability Budget (Non-GAAP);
    e. Summary of the Entity-Level Budget (GAAP);
    f. Summary of changes to ACO Network Programs, Population Health Programs, and Care Model; and
    g. Summary of lessons learned through programmatic evaluation and future evaluation plans. Response should include a summary of plans to integrate findings into budgeting/practice.
    h. Summary of ACO benchmarking results to date. Response should include summary of performance improvement plans to integrate findings into budgeting/practice.

2. Provide Section 1 Attachments A and B.
    a. **Attachment A: 2024 OneCare ACO Network**
    b. **Attachment B: 2024 OneCare ACO Hospital Participation Year Over Year**

Section 2: ACO Provider Contracts

1. Submit **Appendix 2.1, 2024 ACO Organizations List** and **Appendix 2.2, 2024 ACO Provider Lists** as soon as they are final and no later than October 13, 2023.[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

2. Submit copies of each type of **provider contract, agreement, and addendum** for 2024 and explain how and why these contracts changed from the previous year (i.e., risk contracts, non-risk contracts, collaboration agreements, and memoranda of understanding). Please include any provider agreements with any ambulatory surgical centers in Vermont. Please explain how each contract aligns the provider incentives with the ACO's mission, vision, and the payers value-based payment model. *(Max Word Count 500)*

3. Provide an update on the **FY24 Network Development Strategy** (submitted 6/30/23). In your response, discuss any new provider programs or pilots and progress in 2024 provider network goals, challenges, and opportunities. Describe rationale for any changes and include what data and/or information led to these decisions. *(Max Word Count 500)*

[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 FY24 Budget.

4. Quantify the number and type of providers (i.e., primary care, specialty care, SNF…) that have dropped out of the network 2022-2024 (prior, current, and budget years) and to the best of your knowledge, their reasons for exiting. If applicable, explain any actions taken in response by the ACO to address the providers' concerns.

Table 2: ACO Provider Departures (2022 – 2024)

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

Section 3: ACO Payer Contracts

1. Complete **Appendix 3.1, ACO Scale Target Initiatives and Program Alignment Forms** and **submit copies of each 2024 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 guidance 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 ten (10) days of execution and the GMCB may request an update on the status of contract negotiation at any time.** *(Max Word Count: 1000)*

    a. For any new payer program in 2024, 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. Specifically, include discussion of the anticipated effect of Medicaid redeterminations, as well as the impact of the growth of Medicare Advantage enrollment on the Medicare ACO program in areas such as acuity and utilization.
    c. For any terminated payer programs, please explain the specific reasons for the change and any steps being taken to mitigate the impact of the terminated contract.
    d. Discuss payer contracting goals, strategies, opportunities, and limitations for creating and maintaining Scale Qualifying lives and alignment with the ACO's mission, vision, and value-based payment plan.

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 2024 and beyond, consistent with the template in the ACO Reporting Manual: (Max 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 2024-2027. Total Fixed Payments include both reconciled and unreconciled fixed payment arrangements. Include the numerator and the denominator for the Budget Year 2024. 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 and specific measurable goals, and milestones. Discuss barriers, limitations, or other factors, by payer. See **Part I – Budget Targets**.

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. *(Max Word Count: 250)*

5. Provide an update on OneCare's work to execute risk-bearing commercial payer contracts for FY24 and beyond. *(Max Word Count: 250)*

6. Provide an update regarding the unattributed population pilot/fixed payment expansion with DVHA as mentioned in the revised FY23 budget narrative. *(Max Word Count: 250)*

Section 4: Total Cost of Care

1. Complete **Appendix 4.1 TCOC Performance by Payer, Total ACO-Wide (2018-2024)**. Instructions:
    a. Verify actuals for past years 2018-2021.
    b. Provide projections for the current and prior year (2022-2023) and the timeline for when actuals will be available.
    c. For the budget year (2024), provide expected TCOC.

2. Discuss drivers and assumptions for Total Cost of Care targets and results by payer program. *(Max Word Count: 1000)*
    a. Explain the drivers of expected vs. actual Total Cost of Care results by payer program and discuss any significant changes and 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.).

3. Describe the adjustment factors, by payer program if necessary, used for calculating the final settlement result, i.e., explain the difference between the "Amount Over/(Under) Target" and the "Settlement" cells in Appendix 4.1. (*Max Word Count: 250)*

4. Complete **Appendix 4.2, Projected and Budgeted Trend Rates by Payer Program**, and explain the following, refer to **Part I – Budget Targets** of this guidance in your explanation: (*Max Word Count:1000)*
    a. All underlying assumptions for these trend rates (Appendix 4.2, Column D) including those related to changes in utilization, service mix, unit cost, etc., noting any significant deviations from prior year. For programs subject to health insurance premium rate review by the GMCB, the 2024 benchmark trend rates must be consistent with the ACO-attributed population and the GMCB approved rate filings, if any.
    b. For each program, contrast the budgeted growth rate (Appendix 4.2, Column D) with the expected growth trend for the ACO (Appendix 4.2, Column G). Include analysis for reasons why the ACO's performance differs from the trend rates used in the budget.
    c. Include a description of how the ACO approaches calculating the base experience (Appendix 4.2, Column C).
    d. How have these growth rates and targets supported the All-Payer Model goal to manage overall health care cost growth to be in line with that of the Vermont economy and align incentives offered by the ACO to attain these goals?

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? *(Max Word Count: 750)*
    a. Participant vs. Preferred Providers
    b. Risk-bearing participants
    c. Primary care (non-hospital versus hospital)
    d. Specialty care (non-hospital versus hospital)
    e. Continuum of care (i.e., HHH, DAs, SNFs)

2. Discuss ACO program goals, strategies, opportunities, and limitations for the following: *(Max Word Count: 1400)*
    a. The ACO's strategy for increasing the opportunity for upside/downside risk;
    b. The ACO's strategy for better aligning provider risk and provider payment models with ACO risk;
    c. Strengthening primary care, including access and utilization;
    d. Reducing administrative burden of reporting requirements for providers;
    e. Providing incentives for preventing and addressing the impacts of adverse childhood experiences and other traumas;
    f. Expanding Fixed Prospective Payment arrangements;
    g. Expanding payer program participation across the network; and
    h. Monitoring and providing incentives for reducing potentially avoidable utilization.
    i. Improving access to behavioral health services.

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 and stratification methodology. 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. *(Max 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: *(Max Word Count: 500)*
    a. In order to manage the maximum downside risk retained by the ACO or its founders, explain with what the risk is associated, how much, and how is this obligation funded (reserves, collateral, other liquid security, reinsurance, payer and provider withholds, commitment to pay at settlement, etc.)? See **Part I – Budget Targets**.
    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 (2022), in the current year (2023) and in the proposed budget year (2024), noting any significant changes in methodology or practice over time. *(Max Word Count: 250)*

6. Discuss the ACO's Total Cost of Care accountability strategy at the HSA level. *(Max Word Count: 750)*
    a. How is the ACO using TCOC and quality data at the local HSA level to identify high-value and low-value care? How will these actions and tactics improve for FY24?
    b. 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.
    c. Specifically, how is the ACO helping hospitals and other community providers to reduce avoidable utilization, low-value care, and lower their TCOC at the local HSA level? What concrete changes have been observed as a result of these efforts? Cite specific examples, including actions taken by the ACO, and where possible, quantify the ACO's direct impact on reducing avoidable utilization and/or low-value care and lowering TCOC in specific HSAs.

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

Section 6: ACO Budget

1. Complete the GMCB financial statements **A1, A2, A3, and A4 (Income Statement, Balance Sheet, Cash Flow, Staffing) in the Adaptive Database**.

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

3. For Questions 4-9, 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: *(Max 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: *(Max Word Count: 600)*
    a. Any significant changes to the population health programs and/or care model and the budgeted impact on expenses.
    b. How this budget is affected by any significant changes to enrollment or clinical and quality improvement priorities for the year.
    c. Any changes, including significant new investments to the ACO's infrastructure and the budgeted impact on expenses.

6. Explain what proportion of the ACO's operating expenses are fixed versus variable and explain why. *(Max Word Count: 300)*

7. What ACO services are outsourced to UVMHN as the sole member or any of its subsidiaries? Please specify the dollar amounts for each service provided if not designated under Expenditures and how the ACO determined that these services are at fair market value. *(Max Word Count: 700)*

8. Explain the expected outcomes of the data analytics transition. How will these outcomes impact the operations of the ACO, the provider network, and Vermonters in comparison to the impact of the previous data analytics services? *(Max Word Count: 400)*

9. Administrative Expenses: Describe the administrative expenses incurred in connection with implementing each of population health and payment reform programs as well as data and analytics work. *(Max Word Count: 300)*

10. 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. *(Max Word Count: 250)*

11. 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. *(Max Word Count: 250)*

12. Provide details of any expected capital expenditure over the next three years. *(Max Word Count: 200)*

13. 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.). Discuss any prior or current year surplus or losses and their intended use and how they were earned. *(Max Word Count: 200)*

14. Complete **Appendix 6.6, Hospital ACO Participation-All Hospitals** for the proposed budget year.

15. Submit the ACO's most recent (2022) **IRS Form 990.**

16. Please refer to **Part I – Budget Targets** for guidance regarding executive compensation. Complete **Appendix 6.7, ACO Management Compensation.** Additionally, please describe: *(Max Word Count: 750)*
    a. All factors considered when awarding variable pay for FY24, as well as any ACO-wide goals- the achievement of which affect executive compensation bonuses. Provide a description of how the achievement of those goals are determined. If this process changed from FY23, please provide an overview of these changes.
    b. For each position, explain how salary benchmarks were determined and utilized when budgeting the base and total executive compensation. Justification for executive compensation shall include reference to and analysis of the ACO's performance.
    c. A year-to-date update on the achievement of any ACO-wide goals, on which executive compensation is based, for FY23.

17. 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.

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

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: *(Max Word Count: 3,000)*

a. Any elements of the care model or programs that OneCare has either eliminated or scaled up for FY24 including rationale for changes;
b. Any areas in which OneCare would like to put more resources if available;
c. All goals or objectives in PY23 related to the model of care and the status of the achievement of those goals;
d. All goals or objectives associated with the model of care for the proposed budget year and the strategies for their achievement;
e. How the ACO intends to measure progress for the proposed budget year, including any quantitative measures, reporting, and analysis; and
f. 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).
g. Consistencies and inconsistencies of care delivery and care coordination across HSAs;
h. Whether and how social determinant of health-related data is collected and how it is incorporated into the model of care;
i. How health equity is being addressed in the model of care;
j. Any benefit enhancements being offered.

2. *Clinical Focus Areas.* Report any results on your 2022 Clinical Focus Areas (interim, if available) and progress to date on 2023 Clinical Focus Areas using **Appendix 7.1 ACO Clinical Focus Areas**. 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)) *(Max Word Count: 400)*

3. *Quality Improvement.* Describe any changes to your quality improvement framework and your theory of change for 2024. See **Part I – Budget Targets** for additional guidance. (*See* § 5.403(a)(12)) In addition, please include the following: *(Max Word Count: 800)*
    a. Discuss how areas for quality improvement are identified and cite specific strategies utilized to address root causes and improve results;
    b. Discuss how results and progress to date are used to support ACO network providers in quality improvement and implementation of the care model.

4. *Population Health and Payment Reform*. Complete **Appendix 7.2, Population Health and Payment Reform Details**. (*See* § 5.403(a)(11)) In addition, describe the following: *(Max Word Count: 500)*
    a. the ACO's methods for prioritizing population health initiatives and developing payment reform programs across the continuum of care, including the rationale/evidence base for the methods.
    b. the impact of each population health program on containing costs, improving access to care, and/or improving quality of care, citing specific and measurable changes observed in these areas.

5. *Care Coordination*. Complete **Appendix 7.3 Care Coordination and Appendix 7.4 Care Coordination Payments.** Explain any opportunities or challenges experienced with the implementation of the PHM model in FY2023, and any changes planned for FY2024. (*See* § 5.403(a)(18)) In doing so, please discuss the following: *(Max Word Count: 750)*

a. Any changes made to 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 observed and measurable clinical outcomes related to the shift to the PHM model.

6. *Integration of Social Services*. Please explain how the ACO integrated or facilitated the integration of healthcare and social services in FY23 and give a detailed description of how the ACO plans to further integrate healthcare and social services in FY24. (*See* § 5.403(a)(18); § 5.403(a)(19); § 5.403(a)(20)) In doing so, please discuss: *(Max 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 FY23 and how the ACO plans to further do so in FY24.

7. *Primary Care Incentive Funds*. Please explain how the ACO ensures that primary care-earned incentive dollars are flowing to these providers and/or are being invested into primary care transformation efforts. *(Max Word Count: 400)*

8. *Public Health Emergency.* What are the expected consequences, if any, to care delivery resulting from the end of the Public Health Emergency such as the rolling back of certain waivers? *(Max Word Count: 250)*

Section 8: Evaluation and Performance Benchmarking

1. Complete **Appendix 8.1 ACO Network Surveys**. For each survey conducted, please describe the results, how the ACO responded to the results, and the outcome of the ACO's response(s). *(Max Word Count: 500)*

2. Discuss any evaluation of the ACO's approach to conducting surveys, any improvements in surveying practices, and any plans for surveying stakeholders in FY24. *(Max Word Count: 250)*

3. 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. *(Max Word Count: 300)*

4. Discuss the ACO's approach to evaluating its Population Health Management programs. Narrative must include, but is not limited to: *(Max Word Count: 1000)*
    a. Evaluation of Clinical Focus Areas and the measurable outcomes;
    b. Evaluation of the CPR program and the outcomes;
    c. Evaluation of the 2022 care coordination program;
    d. The results of any evaluations completed on the PHM model to date and plans for further evaluation (include how TCOC, ED utilization, and inpatient admission rates have changed as a result of the revised care coordination model and whether or not these results are meeting expectations);
    e. Process for monitoring and reporting the effectiveness of the Mental Health Screening and Follow-up Initiative and explain if and how OneCare plans to develop and implement mechanisms to improve coordination and continuity of care based on such monitoring and reporting.

f. How the ACO is incorporating provider and patient input on the model. Please share any relevant lessons learned.

5. Discuss the ACO's approach to evaluation of its Quality Improvement Program and provide examples of how it has improved quality. *(Max Word Count: 300)*

6. Describe the ACO's progress to date on the ROI analysis as described during the FY2023 revised budget hearing. What data and methodology are used when calculating the return on investment? *(Max Word Count: 300)*

7. Discuss progress on developing Key Performance Indicators to measure ACO-wide progress and performance. Share the status of attainment of the 2023 KPIs, and if the KPIs for FY24 differ, please explain. *(Max Word Count: 300)*

March 2023 Benchmarking Report:

8. Please describe how OneCare is specifically funding improvements in the metrics chosen for Budget Target #9 for FY24 (or note if this target was not met as prescribed). If these funding streams are unchanged from previous years, speak to how this funding has or has not made an impact on the ACO's performance in these areas. Have best-practices been gleaned from top-performing ACOs for the metrics in focus? *(Max Word Count: 300)*

9. Discuss the results from the 2021 OneCare vs. National ACO Peer Cohort Comparison results that show low specialty care visits and spend, as well as high utilization, length of stay, and costs in skilled nursing facilities. Has the ACO been able to determine the causality behind these trends, and if so, please describe the findings. *(Max Word Count: 300)*

10. Discuss specific metrics where the ACO feels that the organization has the most influence on outcomes. For metrics that may have external factors, describe these factors and how the ACO envisions progress being made in these areas for Vermont. *(Max Word Count: 500)*

Section 9: Other Vermont All-Payer ACO Model Questions

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

2. What other actions can healthcare stakeholders be taking to support the ACO in achieving the goals of the Vermont All-Payer ACO Model? *(Max 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. *(Max Word Count: 500)*

PART III. REVISED BUDGET

Revised Budget Deliverables due Spring 2024, 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. Medicare ACO Performance benchmarking report;
i. Results of evaluations as discussed during budget review;
j. A copy of Form 990 as filed with the IRS.
k. Any requests for amendments to the budget order; and
l. Any other information the board deems relevant to ensuring compliance with the budget order.

PART IV. MONITORING

GMCB staff published the FY23 OneCare Vermont ACO Reporting Manual ("Reporting Manual") as described in the FY23 budget order, condition #2. The Reporting Manual outlines standard reporting and other deliverables to be provided by the ACO to the GMCB, along with the deadlines for their submission. The objective of the Reporting Manual is to collect reports throughout the current year to enable the GMCB to monitor performance against the budget. The Reporting Manual FY 2023 Updated Version (v.23.3.1) 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.