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GREEN MOUNTAIN CARE BOARD

ACO Oversight
FY 2024 ACO Budget
OneCare Vermont

Staff Presentation

December 6, 2023

Agenda

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- Introduction and Background
  - Public Comment Received to Date
- FY 2024 OneCare Vermont Budget Review
  - Budget Targets
  - Financial and Performance Review
  - Options
- Board Questions and Discussion
- Public Comment

ACO Oversight Statute/Rule

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- Oversight of Accountable Care Organizations (18 V.S.A. § 9382 and Rule 5.000)
  - **Certification**: Occurs one-time following application for certification; eligibility verifications performed annually.
  - **Budget**: Review of ACO budget occurs annually, usually in the fall prior to start of budget/program year; payer contracts/attribution are finalized by spring of the budget year and the ACO submits a revised budget.

ACO Oversight: Standards of Review

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The standards and requirements by which we review the ACO submissions are set forth in:

1. 18 V.S.A., Chapter 220 (primarily 18 V.S.A. § 9382 "Oversight of Accountable Care Organizations");
2. GMCB Rule 5.000; and
3. All-Payer ACO Model Agreement.

Specifically, under Rule 5.405 the Board considers:

1. any benchmarks established under section 5.402 of this Rule;
2. the criteria listed in 18 V.S.A. § 9382(b)(1);
3. the elements of the ACO's Payer-specific programs and any applicable requirements of 18 V.S.A. § 9551 or the Vermont All-Payer Accountable Care Organization Model Agreement between the State of Vermont and CMS; and
4. any other issues at the discretion of the Board.

The ACO shall have the burden of justifying its budget to the Board.

OCV Budget and Certification Review Timeline FY 2024

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Jul 14, 2023	GMCB issues FY24 ACO oversight guidance
Sept 1, 2023	ACO submits certification materials
Oct 2, 2023	ACO submits FY24 budget
Nov 8, 2023	OneCare Vermont Budget Hearing
Nov 29, 2023	ACO 2022 Financial Settlement & Quality Performance panel
Dec 6, 2023	GMCB staff presentation: OneCare Vermont
Dec 13, 2023	GMCB deliberations on OneCare Vermont FY24 budget; FY24 Medicare Benchmark Presentation
Dec 20, 2023	GMCB potential vote on OneCare Vermont FY24 budget; GMCB potential vote on FY24 Medicare Benchmark
Ongoing 2024 - 2025	GMCB monitors FY24 actual performance against budget and conditions

Public Comment
Themes

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- Value of OCV's improved health outcomes, higher quality care, lower cost, and enhanced coordination of care
- Value of care coordination and strengthened partnerships with local care organizations
- Concerns about access to care and long wait times to see providers
- Concerns about cost of health care in Vermont
- Concerns about the effectiveness of OneCare, the loss of BlueCross BlueShield and increasing executive salaries

- In total, 12 public comments were received as of 12/06/2023

Public Comment
Themes

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From the Health Care Advocate

- Questions
  - If OneCare is providing sufficient value to Vermonter's given its cost
  - Whether OneCare's approach and place in the overall health care reform effort could achieve progress on the goals of the All-Payer Model (APM)
  - If OneCare will be able to help achieve Vermont's health care reform goals
- Concerns due to
  - Commercial insurance rate increases in Vermont now far outpace the United States average
  - Vermont's rate of underinsurance among Vermont's privately insured residents has increased from 27.3% to 44%
  - Vermont's hospital adjusted expenses per inpatient day are now growing faster than the national average
- Misrepresentation of the NORC evaluation to the Board, the HCA, and the public
- Declining population health management (PHM) expenditures while increasing expenditures on consulting and payroll
- Concerns about the purpose and benefits of Arcadia

Public Comment
Themes

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From the Health Care Advocate

Recommendations to the Board

- Request that the Board reduce OneCare's purchased services line by 50% (currently $4,327,955) and evenly reallocate these funds to non-hospital owned, independent PCPs to improve primary care. The HCA believes such a change is warranted because
  - OneCare has not provided evidence of why this amount is needed
  - There Is substantial evidence that independent PCPs provide high quality care at comparatively lower cost and
  - Vermont has historically underinvested in primary care compared to the rest of the country.
- Request that the GMCB and its staff conduct a comparative analysis of return on investment of OCV's activities to non-Chittenden County based HSAs compared to the Chittenden County HSA.
- Request that the GMCB and its staff conduct an analysis of OneCare's impact on affordability, health outcomes, and access to help inform whether OCV merits inclusion in any future APM agreement

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FY24 Budget Targets

FY24 Budget Targets

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- The FY22 and FY23 budget order conditions reflected a focus on data-driven monitoring and oversight.
  - Focus on ensuring that the ACO's management drives continuous improvement consistent with a high-performing ACOs and that it supports achieving the state's health reform goals
- This approach continues and led to the development of the Budget Targets in the FY24 OneCare Vermont Budget Guidance

FY24 Budget Targets

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- GMCB Authority to set benchmarks in Rule 5.402: The Board may establish benchmarks for any indicators to be used by ACOs in developing and preparing their proposed budgets.
- 7 budget targets and 2 place holders were included as part of the FY24 OneCare Vermont Budget Guidance.
- “If the ACO’s proposed budget varies from the budget targets, 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.”

Targets		Target met?	Notes
1	The FY24 commercial benchmark trend rates must be consistent with the ACO-attributed population and the GMCB approved rate filings.	TBD	MVP target met, self-funded TBD
2	ACO must use best efforts to meet or exceed the goals for reconciled and unreconciled FPP and identify and report specific obstacles to achieving the goals; Medicaid 55%, Commercial 24%	Yes	Medicaid FY23 is 57.5%, Commercial is 0%. Best efforts and obstacles reported
3	ACO must hold 100% of the Medicare Advanced Shared Savings dollars at risk at the entity-level and not pass the risk along to the provider networks	No	Holding 8.8% of the risk
4	Increase risk corridors for all payer programs above FY23 levels	No	Risk corridors static
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%	Yes	3.1%
6	[Any benchmark or target regarding total executive compensation to be determined and issued]	N/A	
7	[Any benchmark or target regarding the structure of the variable portion of executive compensation to be determined and issued]	N/A	
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.	Yes	Population health management funding per attributed life at $166 per life. Accountability increased through increasing ratio of PHM bonus payments to base payments and the addition of network provider accountabilities to contracts
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.	Yes	Three metrics chosen: ED Utilization Annual Wellness Visits Number of beneficiaries with a primary care visit

Target 1: Commercial Trend Rates

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- The FY24 commercial benchmark trend rates must be consistent with the ACO-attributed population and the GMCB approved rate filings.
- Target Met?
  - MVP target met, self-funded TBD

Target 1: Commercial Trend Rates
Setting Trends and Benchmarks

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How is the trend and benchmark (ACO Total Cost of Care spending target) set?	
Medicare	GMCB-calculated and proposed Medicare ACO Benchmark
Medicaid	Medicaid and ACO negotiation; GMCB reviews in Medicaid advisory rate case
MVP QHP	MVP and ACO negotiation; GMBC rate review decision on medical trend is an input
Self-Funded	Submitted budget does not describe benchmark-setting methodology; submission states, “OCV will analyze cost trends in more depth over the next few months. Insights after this process can be shared as needed.”

Target 1: Commercial Trend Rates

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	FY2023 Expected TCOC	FY2024 Benchmark (Expected TCOC)	Budgeted Trend from Base Experience
Medicaid Blended	$342,972,529	$259,971,659	7.1%
Medicare	$541,014,988	$573,603,715	4.5%
MVP - QHP	REDACTED	$67,482,473	17.3%
UVMHN – self-funded	REDACTED	$72,726,909	5.0%

Target 2: Fixed Prospective Payments

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- ACO must use best efforts to meet or exceed the goals for reconciled and unreconciled FPP and identify and report specific obstacles to achieving the goals; Medicaid 55%, Commercial 24%
- Target Met?
  - Yes. Medicaid FY23 is 55%, Commercial is 0%. Best efforts and obstacles reported

Target 2: Fixed Prospective Payments 2018-2024

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Target 2: FPP Targets

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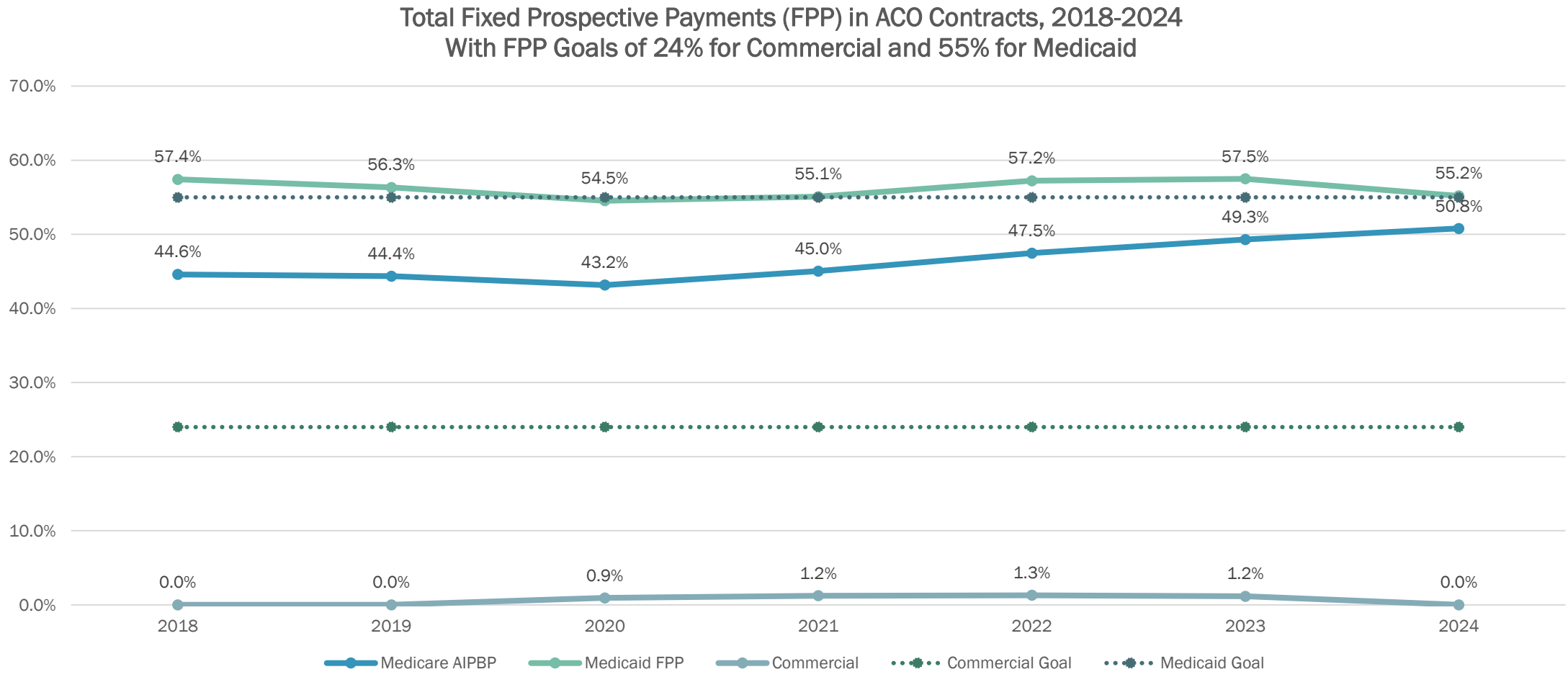

Targets 3-4: ACO Risk Model

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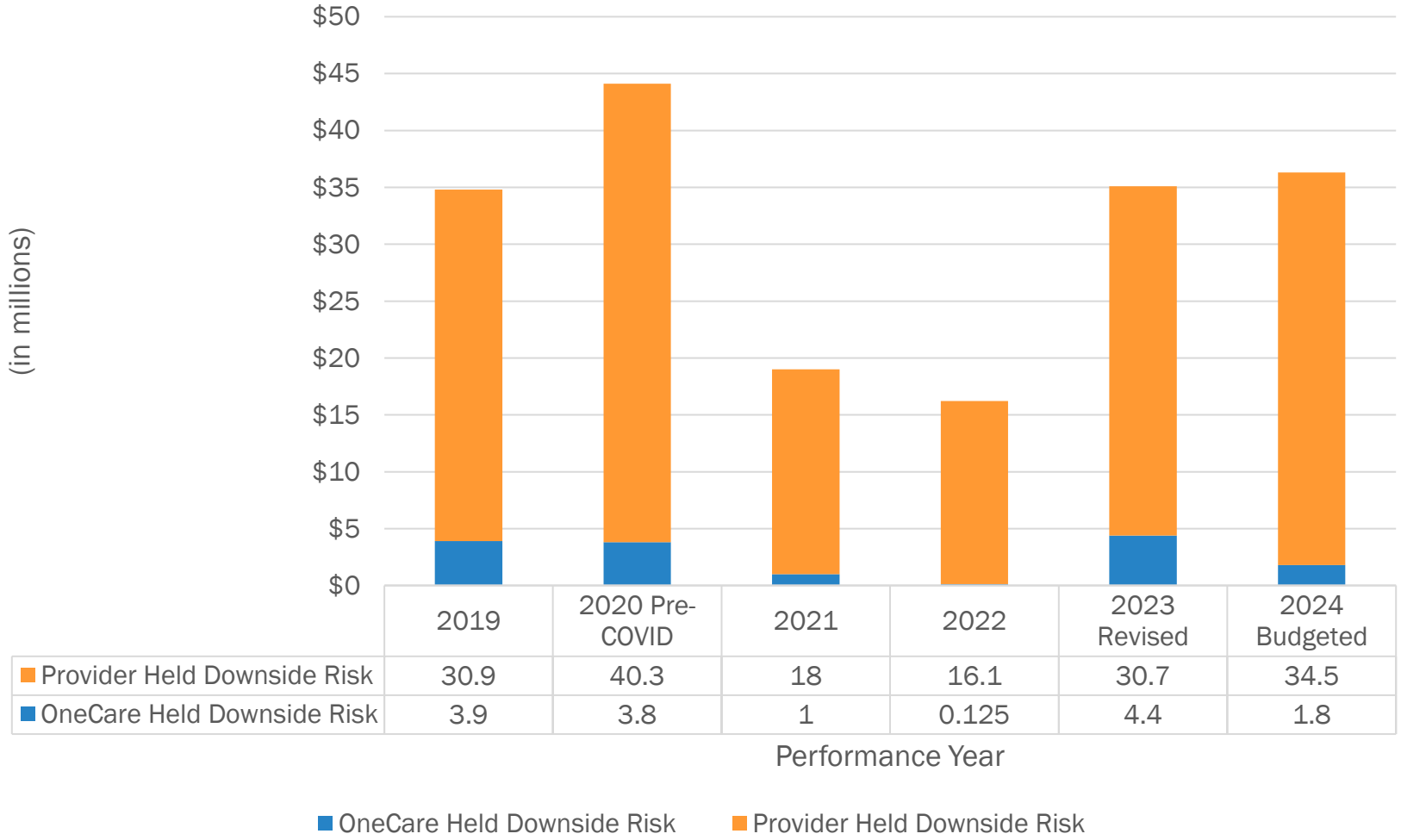
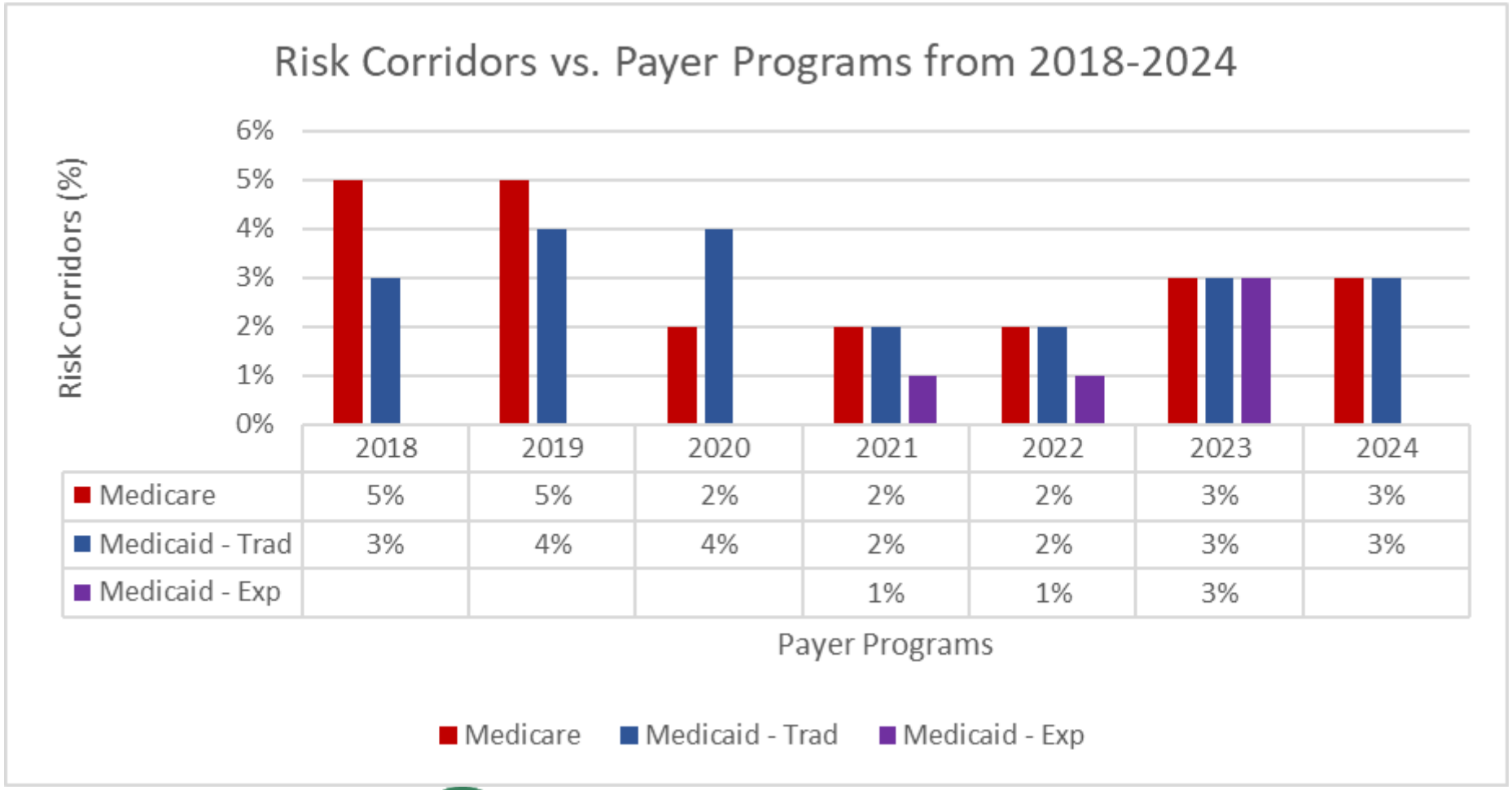
- ACO must hold 100% of the Medicare Advanced Shared Savings dollars at risk at the entity-level and not pass the risk along to the provider networks
  - Target Met? No. Holding 8.8% of the risk.
- Increase risk corridors for all payer programs above FY23 levels
  - Target Met? No. Risk corridors static.

Payer Programs & Risk Model
Budgeted Risk Over Time



Payer Programs & Risk Model

Risk Corridors– Pre-COVID to Current



Target 5: OpEx to PHM Payment Ratio

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- 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%
  - Target Met? Yes. 3.1%

	FY2018A	FY2019A	FY2020A	FY2021A	FY2022A	FY2023P	FY2024B
Total PHM/Payment Reform Program less Settlement Expenses	260,027,734	375,802,982	435,107,902	436,367,075	473,336,001	499,317,118	455,781,789
Total Operating Expenses	13,739,102	15,341,451	14,044,262	13,608,546	13,613,662	14,108,861	14,285,361
	5.28%	4.08%	3.23%	3.12%	2.88%	2.83%	3.13%
					5-year AVG	**3.23%**	

Targets 6-7

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- 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]

Target 8: PHM Payment to Attribution Ratio

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- 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.
- Target Met? Yes.
  - Population health management funding per attributed life at $166 per life.
  - Accountability increased through increasing ratio of PHM bonus payments to base payments and the addition of network provider accountabilities to contracts.

ACO Budget & Financials

Spending per Life

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	2018A	2019A	2020A	2021A	2022A	2023P	2024B
Average Attributed Lives	91,651	137,012	203,794	214,040	224,763	189,175	154,665
Pop Health Spending ($M)	$22.64	$29.46	$32.70	$28.21	$28.42	$25.30	$25.70
Pop Health Expenditures per Attributed Life	$247	$215	$160	$132	$126	$134	$166
Operating Expenses ($M)	$13.74	$15.34	$14.04	$13.61	$13.61	$14.11	$14.29
Operating per Attributed Life	$150	$112	$69	$64	$61	$75	$92

PHM Base/Bonus Payments

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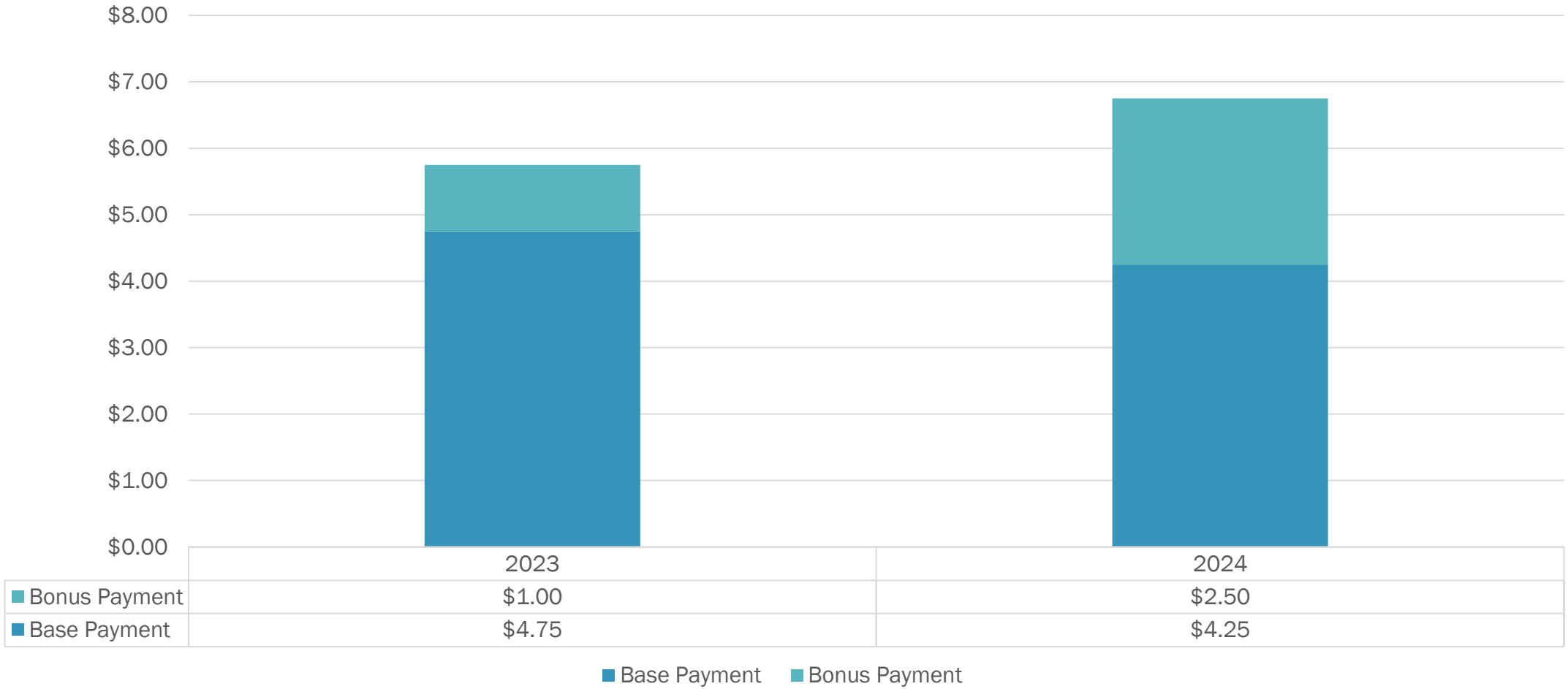

	2023	2024
Bonus Payment	$1.00	$2.50
Base Payment	$4.75	$4.25

Network Accountabilities

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New in 2024, OneCare established a set of six network accountabilities.

- **Technology:** implement and utilize an Electric Health Record that is compatible with CMD 2015 CERHT certification standards on or before January 1st, 2025
- **Care model:** maintain alignment with OneCare's care model and actively pursue attaining 75th percentile or more in 50% or more of PHM quality metrics in 2024 and 85th percentile in 75% or more in 2025
- **Health equity:** incorporate social determinants of health (SDOH) screening into yearly patient visits, beginning July 1st, 2024, electronically report SDOH screening rates to OneCare, and develop a plan to collaborate to systematically address gaps in care by July 1st, 2024
- **Engagement:** participate in 50% or more of OneCare value-based care related meetings annually
- **Citizenship:** commit to OneCare's organizational values, which include collaboration, excellence, innovation, equity, and communication
- **Cost and quality performance:** perform at or above the OneCare target performance level on follow up after emergency department visits for individuals with high-risk multiple chronic conditions (HEDIS FMC)

Target 9: Medicare Benchmarking Report

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- 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.
- Target Met? Yes.
  - Three metrics chosen: ED Utilization, Annual Wellness Visits, Number of beneficiaries with a primary care visit.

Medicare Benchmarking Report

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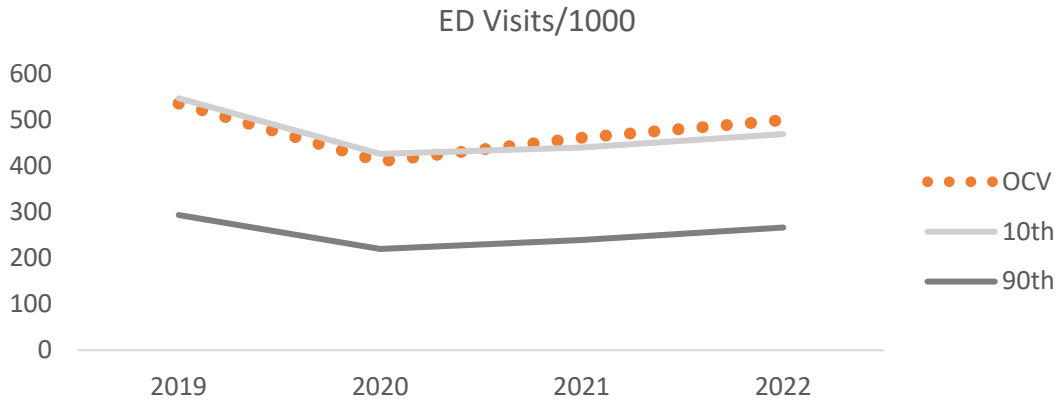
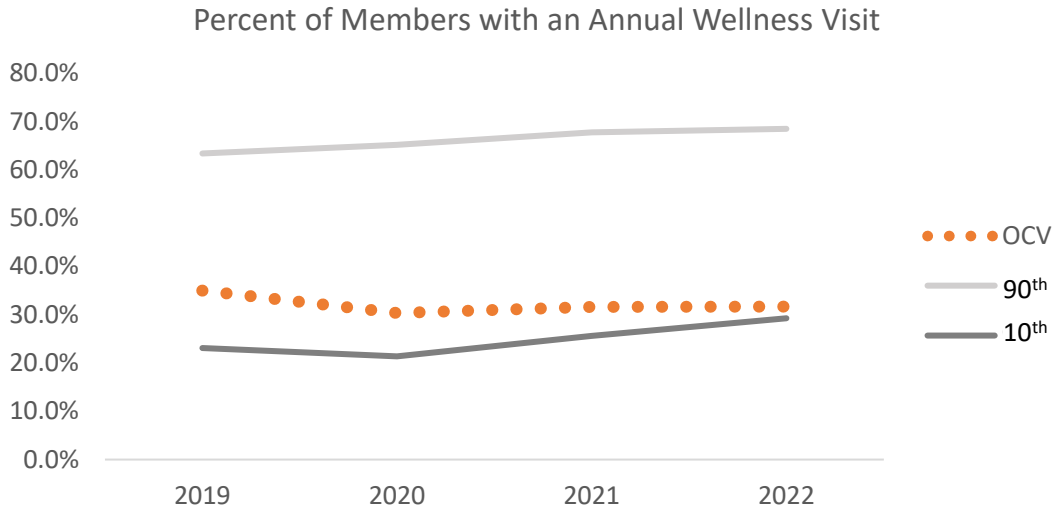
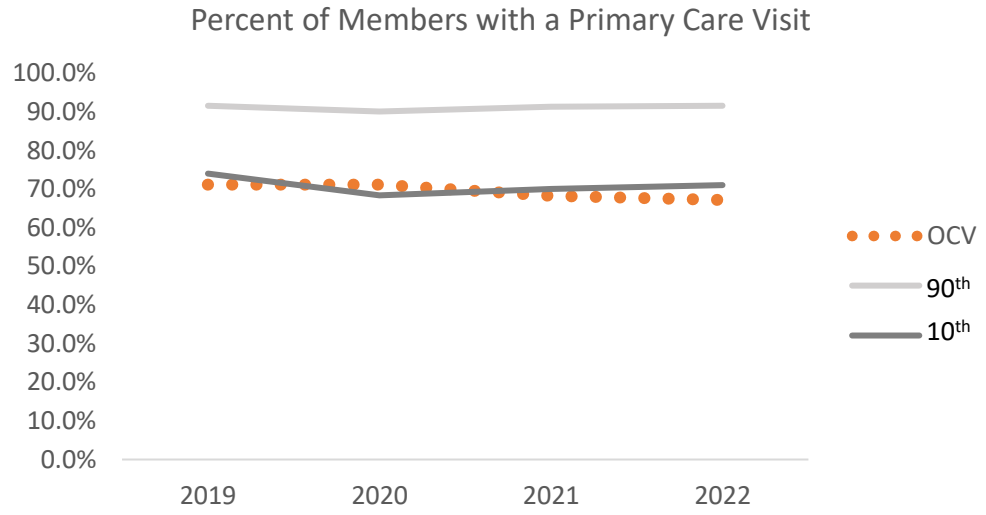




OCV is incentivizing their network to improve these metrics via the PHM measures which closely align:

- Potentially avoidable ED visits
- 40+ wellness visits

Performance Incentive Pool also rewards HSAs with lower ED utilization



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Financial and Performance Review

High-Level Overview
Summary Income Statement

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Full-Accountability (Total Cost of Care) Budget

- Submitted budget is the result of provider network participation, negotiated payer program terms, and OneCare strategies to develop their network and payer programs

Summary - Full Accountability Budget (Non-GAAP)	
Budgeted FY2024 Revenue	$1,003,817,217
Budgeted FY2024 Expense	$1,003,817,217
Budgeted Net Income (Full Accountability)	$0

Entity-Level (Organization-Level) Budget

- Submitted budget is elements that are not contractually obligated and are at the discretion of OneCare governance and leadership

Summary - OCV Entity-Level Budget (GAAP)	
Budgeted FY2023 Revenue	$22,382,654
Budgeted FY2023 Expense	$22,382,654
Budgeted Net Income (Entity-Level)	$0

Full-Accountability Budget includes…

- Health care spending for OneCare attributed lives for TCOC services processed externally to OneCare (96%)
- Population health expenses (2.5%)
- Administrative expenses (1.5%)

Entity-Level Budget includes…

Revenues and expenses that are not contractually obligated as pass-through to providers, e.g.,

- Revenues: Participation fees; shared savings distribution (if any)
- Expenses: Shared losses distribution (if any); PHM investments; Admin expenses

ACO Budget & Financials

Summary Income Statement

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	2018 Actual	2023 Projected	2024 Budget	FY23-FY24 Δ		FY18-FY24 Δ	
Total Cost of Care Target Components (External)	605,433,215	539,337,038	543,704,548	4,367,510	0.8%	(61,728,667)	-10.2%
Fixed Prospective Payment Funding (FPP)	-	474,019,206	430,080,208	(43,938,998)	-9.3%	430,080,208	
Other Contract Revenue	4,326,298	7,920,095	7,649,807	(270,288)	-3.4%	3,323,509	76.8%
State Support	3,500,000	-	-	-		(3,500,000)	-100.0%
Participation Fees	17,397,929	18,054,633	17,643,487	(411,146)	-2.3%	245,558	1.4%
Administrative Revenue	3,086,492	-	-	-		(3,086,492)	-100.0%
Consulting Revenue	309,407	-	-	-		(309,407)	-100.0%
Other Revenue	1,393,945	21,075,698	4,739,167	(16,336,531)	-77.5%	3,345,222	240.0%
Income and Other Total Cost of Care Components	**635,447,286**	**1,060,406,670**	**1,003,817,217**	**(56,589,453)**	**-5.3%**	**368,369,931**	**58.0%**
Total Health Care Spend Components (External)	360,711,323	529,658,426	533,750,067	4,091,641	0.8%	173,038,744	48.0%
Fixed Prospective Payments (FPP)	237,390,466	474,019,206	430,080,208	(43,938,998)	-9.3%	192,689,742	81.2%
Population Health Management (PHM)	22,637,268	42,025,323	25,701,581	(16,323,742)	-38.8%	3,064,313	13.5%
				-		-	
Salaries and Benefits	7,344,815	7,538,119	8,191,655	653,536	8.7%	846,840	11.5%
Contracted / Purchased Services	1,746,953	3,723,145	4,327,955	604,810	16.2%	2,581,002	147.7%
Software	2,795,193	1,746,660	494,951	(1,251,709)	-71.7%	(2,300,242)	-82.3%
Other Operating Expenses	1,852,142	1,100,937	1,270,800	169,863	15.4%	(581,342)	-31.4%
Subtotal Operating Expenses	**13,739,102**	**14,108,861**	**14,285,361**	**176,500**	**1.3%**	**546,259**	**4.0%**
Expenses and Health Care Spend Components	**634,478,160**	**1,059,811,816**	**1,003,817,217**	**(55,994,599)**	**-5.3%**	**369,339,057**	**58.2%**
Net Income	**969,126**	**594,854**	**-**	**(594,854)**	**-100.0%**	**(969,126)**	**-100.0%**
Administrative Ratio	2.17%	1.33%	1.42%				
PHM Ratio with Blueprint	3.57%	3.97%	2.56%				
PHM Ratio without Blueprint	2.34%	3.34%	1.57%				

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State Support

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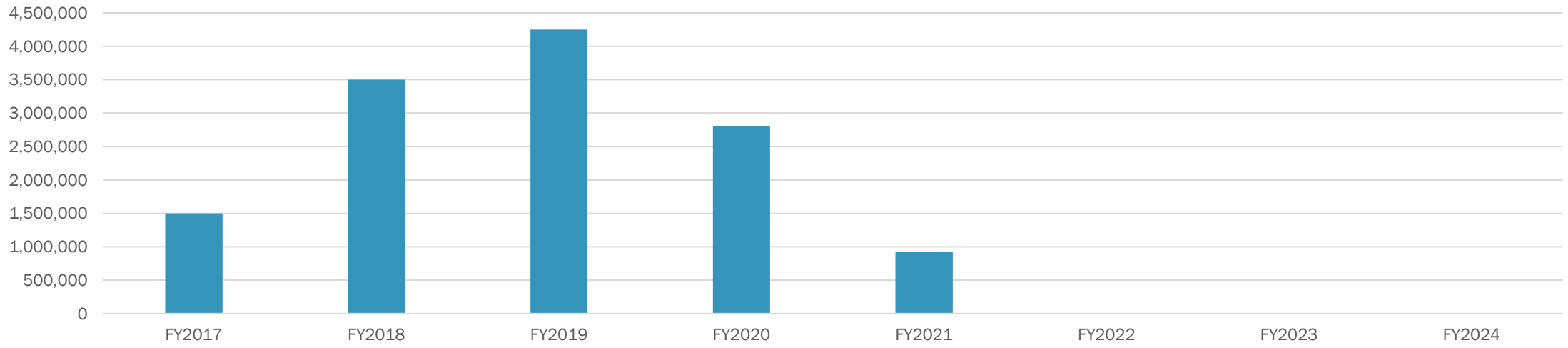
	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024
Informatics Infrastructure Support	1,500,000	3,500,000	4,250,000	2,800,000	924,617	0	0	0



Performance Measurement
Available Data

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What data do we use to measure success?

- Quality and Financial Results (annual payer contract scorecards)
- Medicare FFS Benchmarking Report
- OCV PHM measures
- OCV KPIs

Performance Measurement
2022 OCV Payer Program Results (Quality)

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	PY1 (2018)	PY2 (2019)	PY3 (2020)	PY4 (2021)	PY5 (2022)
Medicare	100% (reporting only)	91.8%	100% (reporting only)	100% (reporting only)	65.63%
Medicaid	85%	95%	100% (reporting only)	68.75%	65%
BCBSVT	86%	81%	N/A (reporting only)	N/A (reporting only)	N/A (reporting only)
MVP	-	-	50%	85%	45%

Performance Measurement
2018-2023 Financial Results

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2018-2023 Totals

Payer	Over/Under	Settlement
Medicare	($108,426,030)	($69,828,369)
Medicaid	($40,342,645)	($12,236,839)
Commercial	($998,029)	($497,269)
TOTAL	($149,766,704)	($82,562,477)

Totals without 2020

Payer	Over/Under	Settlement
Medicare	($81,423,408)	($53,513,898)
Medicaid	($23,510,610)	($658,851)
Commercial	$43,500,206	$690,913
TOTAL	($61,433,812)	($53,481,836)

Performance Measurement
Fall 2023 Medicare Benchmarking Report

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Metric	2019	2020	2021	2022	Trend
Percent of Members with an Annual Wellness Visit	35.0%	30.3%	31.6%	31.6%	
Percent of Inpatient Admissions with Readmission within 90 Days	17.0%	15.4%	16.0%	15.9%	
Percent of Members with a Primary Care Visit	71.1%	71.1%	68.2%	67.1%	
Prevention Quality Overall Composite	36.1	27.9	26.9	27.4	
Prevention Quality Acute Composite	11.3	8.1	7.0	6.4	
Prevention Quality Chronic Composite	24.8	19.8	19.9	21.1	
Prevention Quality Diabetes Composite	4.5	3.4	3.1	3.4	
Congestive Heart Failure (CHF)	13.1	11.4	11.2	12.5	
Community-Acquired Pneumonia	7.4	4.7	3.4	3.5	
Urinary Tract Infection	3.9	3.4	3.6	2.9	
Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults	6.5	4.3	4.9	4.7	
Diabetes Long-Term Complications	2.3	1.8	1.9	1.9	
Hypertension	0.6	0.6	0.7	0.4	
Lower-Extremity Amputation Among Patients with Diabetes	0.2	0.2	0.1	0.2	
Diabetes Short-Term Complications	1.1	0.7	0.7	0.8	
Uncontrolled Diabetes	0.9	0.7	0.3	0.5	
Asthma in Younger Adults	0.0	0.0	0.0	0.0	
Total Cost of Care PBPM	$926.08	$832.37	$916.78	$1,002.58	
Total Inpatient Cost of Care PBPM - Medical	$151.52	$136.97	$149.62	$167.89	
Total Inpatient Cost of Care PBPM - Surgical	$129.09	$113.54	$117.86	$127.68	
ED Cost of Care PBPM	$23.74	$18.99	$20.70	$22.55	
Primary Care Cost of Care PBPM	$26.86	$25.22	$23.87	23.0	
Admissions/1000 Inpatient Facility	170.5	142.1	151.1	156.8	
Hospital Days/1000 Inpatient Facility	853.7	728.7	786.0	855.9	
ED Visits/1000	535.9	410.1	461.8	500.2	
Primary Care Visits/1000	3,136.5	2,911.4	2,823.8	2,739.9	

Performance Measurements
2023 PHM Measure and KPI Performance

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PHM Measures/KPI	2023 Target	Progress through March 2023	Target Met?
Child and Adolescent Well-Care Visits	57.5%	57.2% network wide 40% practices met target	No
Developmental Screening	57.4%	60.4% 40% practices met target	Yes
Diabetes A1c Poor Control	39.9%	97% practices met target	TBD
Initial Hypertension	10% improvement	1/14 HSAs met target	HSA specific
Routine Hypertension	10% improvement	5/14 HSAs met target	HSA specific
Annual Wellness Visit 40+	10% improvement	0/10 HSAs and 19% practices met target	HSA specific
Potentially Avoidable ED Visits (KPI Only)	10% improvement	33% network wide	HSA specific

Population Health and Quality
Support for Primary Care

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Budgeted non-FPP/FFS funding for Primary Care through programs such as the PHM program, CPR, VBIF, Mental Health Screening Initiative, Primary Prevention, has increased.

	2022			2023 (rev)*			2024		
	Hospital-Owned	Independent	FQHC	Hospital-Owned	Independent	FQHC	Hospital-Owned	Independent	FQHC
Total by Type	$6,570,743	$5,851,376	$3,687,099	$5,131,970	$4,575,545	$4,112,999	$5,077,536	$4,063,926	$3,646,576
TOTAL non FPP/FFS Primary Care	$16,109,218			$13,820,514			$12,788,038		
Average Attribution	228,459			190,642			154,665		
Amount per Life	$71			$72			$83		

*non-inclusive of DVHA funds

Budget Modification and Approval Options

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1. Fund OneCare's Budget as submitted with any or all reporting conditions as outlined in following slides
2. Same as #1 plus the new condition that OCV must hold the Medicare Advanced Shared Savings dollars as risk at the entity level unless they increase the Medicare risk corridor for FY24.
3. Reduce OneCare's salary and purchased services from $12.5M to the 2018 level of $7.4M, and evenly reallocate these funds to non-hospital owned, independent PCPs to improve primary care (additional conditions re: reporting/with or without risk option)
4. Reduce OneCare's administrative expenses from $14.3M to the 2018 level of $13.7M and evenly reallocate these funds to non-hospital owned, independent PCPs to improve primary care (additional conditions re: reporting/with or without risk option)
5. Reduce OneCare's administrative expenses from $14.3M to $11.6M in order to maintain the ratio of administrative expenses to attributed lives at the 2023 level of $75 per life
6. HCA's recommendation: Reduce OneCare's purchased services line by 50% (currently $4.3M) and evenly reallocate these funds to non-hospital owned, independent PCPs to improve primary care (additional conditions re: reporting/with or without risk option)

Potential Conditions
Consistent with previous years

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- Notify GMCB of any material changes to their budget and explain variance.
- Submit a revised budget by March 31, 2024 , and present on the revised budget in April 2024, including final payer contracts, attribution by payer, a revised budget, hospital dues and risk, any changes to the risk model, source of funds for population health programs.
- Notify GMCB of any use of reserves or line of credit or any adjustment to participation fees.

Potential Conditions
Consistent with previous years

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- Implement benchmark trend rates for payer contracts in alignment with the GMCB's decision on the Medicare ACO benchmark (Presentation 12/13, vote 12/20); the GMCB's Medicaid Advisory Rate Case; and, for commercial payer contracts, in alignment with ACO-attributed population and the GMCB approved rate filings.
- Engage in payer programs that qualify for APM Scale to the greatest extent possible and align payer programs in key areas to the extent reasonable; explain non-Scale qualifying programs and areas of misalignment. Require continued reporting on payer programs.

Potential Conditions
Consistent with Previous Years

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- Fund population health management and payment reform programs as detailed in the FY24 submission, and to notify GMCB of any changes, including funding shortfalls, changes in program scope, and an analysis for each program line item as to whether and why the funding is appropriately scaled by attribution, or some other factor.
- Report evaluation results and evaluation focus areas for 2024 to GMCB
- Fund the Support and Services at Home (SASH) program and Blueprint for Health payments to primary care practices and community health teams consistent with the amount approved by the GMCB in the Medicare ACO Benchmark process (to be presented 12/13).

Potential Conditions
Updated Deliverables

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- Work with Medicare Advantage plans operating in Vermont ~~over the next two years~~ – with a particular focus on Vermont-based plans offered by BCBSVT and UVMMC-MVP – to develop Scale-qualifying programs.
- Report FPP data and progress toward the goals as specified in the ACO Reporting Manual and FY24 Guidance
- Report on the CPR program
- Make improvements to benchmarking report
  - Statistical significance analysis (NEW)
  - Risk of all cohorts for each year (NEW)

Potential Conditions
New for FY24

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- Hold risk for all Medicare Advanced Shared Savings dollars unless the Medicare risk corridor is increased above 3%.

OCV Budget and Certification Review Timeline FY 2024

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Jul 14, 2023	GMCB issues FY24 ACO oversight guidance
Sept 1, 2023	ACO submits certification materials
Oct 2, 2023	ACO submits FY24 budget
Nov 8, 2023	OneCare Vermont Budget Hearing
Nov 29, 2023	ACO 2022 Financial Settlement & Quality Performance panel
Dec 6, 2023	GMCB staff presentation: OneCare Vermont
Dec 13, 2023	GMCB deliberations on OneCare Vermont FY24 budget; FY24 Medicare Benchmark Presentation
Dec 20, 2023	GMCB potential vote on OneCare Vermont FY24 budget; GMCB potential vote on FY24 Medicare Benchmark
Ongoing 2024 - 2025	GMCB monitors FY24 actual performance against budget and conditions

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Board Discussion

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Public Comment