Medicare Only Guidance
Vytalize Health 9 ACO LLC

Section 1: ACO INFORMATION, BACKGROUND AND GOVERNANCE

1. Date of Application: **November 1, 2023**

2. Name of ACO: **Vytalize Health 9 ACO LLC**

3. Tax ID Number: **Redacted**

4. Identify and describe the ACO and its governing body, including:

a. Legal status of the ACO (e.g., corporation, partnership, not-for-profit, LLC);

Limited Liability Company

b. In which Medicare Program the ACO is participating;

Accountable Care Organization (ACO) Realizing Equity, Access, and Community Health (REACH) Model. (ACO REACH)

c. Members of the governing body and their organizational affiliation (and identifying the designated Beneficiary member of the governing body and the Consumer Advocate);

See, ACO Public Reporting – Vytalize Health REACH PCC

d. Officers of the ACO;

Faris Ghawi - President

Faris Ghawi - Secretary, Treasurer

Amer Alnajar, MD - Medical Director

John Torontow, MD, MPH - Quality Assurance and Improvement Officer

Derek Kang - Compliance Officer

e. Committee and subcommittee structure of the governing body, as applicable;

The board has three (3) committees: Finance, Compliance, and Health Equity, Quality Management and Patient Care, each with a Committee Leader and one or more Directors.

f. Description of governing body's voting rules;

Directors holding a majority of the percentage voting rights shall constitute a quorum for the transaction of business of the Board, and a majority of the total members of any committee of the Board shall constitute a quorum for the transaction of business of such committee. A quorum, once established at a meeting, shall not be broken by the subsequent withdrawal from such meeting of enough votes to leave less than a quorum.

5. Identify and describe each member of the ACO's executive leadership team, including name, title, tenure in current position, and qualifications for current position.

Please find key clinical and administrative leaders at: ACO Public Reporting – Vytalize Health REACH PCC

a. Does the ACO have any executive leadership compensation structure that is tied to reducing the amount paid for patient care?

No

6. Describe any material pending legal actions taken against the ACO or its affiliates, any members of the ACO's executive leadership team or Board of Directors related to their duties. Describe any such actions known to be contemplated by government authorities.

None

7. With respect to the ACO's executive leadership team or Board members, describe any legal, administrative, regulatory, or other findings indicating a wrongful action involving or affecting the performance of their duties, or professional fiscal irresponsibility.

None

8. If the ACO has been accredited, certified, or otherwise recognized by an external review organization (e.g., for EHNAC accreditation or payer assessments), submit the review organization's determination letter, associated assessment documents and results. If the ACO is working toward accreditation or certification, please describe.

Not Applicable

Section 2: ACO PROVIDER NETWORK

1. With respect to the ACO's provider network in Vermont, complete Appendix A-1 – ACO Provider Network Summary Template and, in the box starting on row 25, provide a brief narrative summary of each payment model that the ACO identified in Appendix A-1, column K, that the ACO utilizes in its provider network.

Providers are participating in the ACO REACH Model for 2024

2. How many other states will the ACO operate in for 2024?

For 2024, Vytalize Health 9 ACO will be participating in 36 states.

3. What percentage of the ACO's attributed lives for 2024 will be in Vermont?

For 2024, we anticipate approximately 1% of our ACO's attributed lives to be in Vermont.

4. For ACOs that were operating in Vermont prior to 2024, complete Appendix A-2 to quantify the number and type of providers that have dropped out of the network starting in either the prior calendar if the ACO was operating in Vermont during 2022, or 2023 if the ACO was operating in Vermont at this time, and to the best of your knowledge, their reasons for exiting;

Not Applicable

5. For all provider contract types for which the provider is assuming risk, describe the ACO's current contract with the provider:

a. The percentage of downside risk assumed by the provider, if any;

Our Participant Providers never assume any downside risk.

b. The cap on downside risk assumed by the provider, if any, and

Not applicable

c. What risk mitigation requirements does the ACO place on providers, if any (e.g., reinsurance, reserves).

Not applicable. All risk mitigation mechanisms are borne by the ACO.

6. Submit the template of the ACO's provider contract(s) to GMCB.

Please see attached.

7. Does the ACO have plans to expand their provider network in Vermont in future years? (yes/no)

If yes, please describe the ACO's recruitment strategies:

a. Describe the ACO's recruitment strategy and criteria for accepting providers into the network.

We are currently in the midst of our planning cycle for the 2025 Performance Year, and we have not yet finalized any plans to recruit additional Vermont providers at this time.

b. Describe the ACO's outreach strategy and contact methods (phone calls, mailings, in-person outreach, etc.).

We focus primarily on in-person outreach with a goal of building a relationship with each practice. These efforts are augmented by email and telephonic outreach, but the primary mode of engagement is in-person.

c. Are there any differences in your approach to independent versus hospital-owned practices?

At Vytalize, we focus more on independent practices but in some cases, we will partner with hospitals.

d. What is the ACO's network development timeline and contracting deadline?

Our annual network development cycle is built on an August 1st deadline to coincide with the ACO REACH deadline.

e. Are there any challenges to network development?

Our goal with network development is to establish a strong primary care base within a given geography that represents sufficient density to support effective care coordination within a network of specialists, ancillary and post-acute providers. The challenge is in creating that density.

If no (the ACO is not planning to expand in future years in Vermont), explain why.

Section 3: ACO PAYER PROGRAMS GARY

1. Provide copies of existing agreements or contracts with Medicare governing the ACOs in the applicable Medicare program, including the participation agreement and any amendments. If 2024 contract is not available, please submit as an addendum when signed.

Please see attached CMS Participation Agreement

2. Provide a completed Appendix B – 2024 ACO Program Arrangements and Elements

Completed – see attached.

3. Describe proposed categories of services included for determination of the ACO's savings or losses, if applicable, and if possible, projected revenues by category of service and type of payment model (e.g., FFS, capitation, or AIPBP).

All Medicare Part A and Part B medical expenditures are included under the ACO REACH Model.

4. Describe how the proposed ACO benchmark, capitation payment, AIPBP, shared savings and losses, or any other financial incentive program are tied to quality of care or health of aligned beneficiaries.

Subject to the ACO REACH Program design and requirements.

5. Provide the most recent annual ACO quality reports for all measures included in agreements with CMS. To the extent practicable, please provide segmented reports for Vermont operations.

PY 2023 is our first Performance Year for Vytalize Health 9 ACO and, therefore, we have not received any ACO quality reports.

6. Describe the current or proposed methodology used for beneficiary/member alignment (also known as attribution). Include how attributed lives are calculated for budgetary purposes (i.e. starting attribution, average attribution, etc.)

We will utilize the CMS Provider Alignment report to identify beneficiary alignment to their providers. We anticipate receiving our initial report for PY 2024 in January.

Section 4: ACO BUDGET AND FINANCIAL PLAN

1. Submit most recent audited financial statements and the most recent publicly available quarterly financial reports or incorporate by reference to public filings with the Securities and Exchange Commission. Responses to this question do not need to be specific to Vermont operations.

Vytalize Health 9 ACO LLC is a subsidiary of Vytalize Health LLC (formerly Vytalize Health, Inc.). As such, the subsidiaries do not have individually audited financial statements and there are no publicly available financial reports. Vytalize Health 9 ACO LLC had no prior operations in Vermont.

2. Provide a description of the flow of funds between payer, ACO, provider, and patients using the below chart, include narrative descriptions in the "Notes" column for each row. Please also describe the ACO's

business model. The description should indicate how the ACO expects to realize savings and should demonstrate the ability of the ACO to maintain sufficient funds to support its administrative operations and meet provider payment obligations.

Funds Flow

From	To	Payment Type (Funds)	Notes
CMS	Vytalize	Capitation payments	CMS estimates claims to be paid by Vytalize and funds with weighting early in the calendar year.
Vytalize	Providers	Capitation payment funds for Claims	Claims processed are paid monthly out of the Capitation Payments received. Balance is reconciled at Final Settlement.
Vytalize	PCPs	Portion of Savings Earned	Vytalize has established incentives for PCPs to be paid during the performance year with a settlement following Final Settlement.
Patients	Vytalize	Co-pays	Where required, co-pays are collected according to regulatory guidance.

Vytalize partners with PCPs to enable their success in Value Based Care, resulting in improved outcomes and substantial savings through reduced hospital admissions, readmissions and ER usage, among many other methods. The company is well capitalized and will be cash flow positive for calendar year 2024.

3. If the ACO is taking risk of loss, provide a narrative explaining how the ACO would manage the financial liability for 2024 through the risk programs included in Part 3 should the ACO's losses equal

i) 75% of maximum downside exposure, and ii) 100% of maximum downside exposure. As part of the narrative response, describe your full risk mitigation plan to cover this liability and the mitigation plan for any contracted providers to which risk is being delegated or with which risk is being shared. This response is to include, but is not limited to:

a. Portion of the risk covered by reserves, collateral, or other liquid security whether established as a program contractual requirement or as part of the ACO's risk management plan;

Vytalize typically satisfies its Financial Guarantee obligations to CMS through Surety Bonds, each of which requires some level of collateral held in escrow.

b. Portion of the risk delegated through fixed payment models to ACO-contracted providers;

Vytalize does not pass risk to providers.

c. Portion of the risk covered by ACO providers through mechanisms other than fixed payment models (e.g., withholds, commitment to fund losses at annual settlement, etc.);

Practices with significant losses in a Performance Year may be subject the following year to certain clawbacks of funds advanced during the Performance Year.

d. Portion of the risk covered by reinsurance or through any other mechanism (please specify);

Vytalize has historically used and expects to continue to use Aggregate Stop Loss insurance to cover large losses.

e. Any risk management or financial solvency requirements imposed on the ACO by third-party health care payers under ACO program contracts appearing in Section 3; and

None

f. Whether any liability of the ACO could be passed along to providers in its network if the ACO failed to pay any obligation related to its assumed risk.

None

4. Provide any further documentation (i.e. policies) for the ACO's management of financial risk that provide additional context or support of the narrative response to question 3 above.

None

5. Complete Appendix C – Financials for 2024 and all past years the ACO has operated in Vermont as actuals or estimates as necessary. In addition to the Appendix, describe:

a. The proportion of shared savings invested in infrastructure, redesigned care processes, and other resources necessary to improve outcomes and reduce Medicare costs for beneficiaries on a total ACO-wide basis; and

Vytalize has invested heavily in technology, infrastructure, and staff to enable success in Value Based Care. As the company believes it will achieve profitability in 2024, it has been investing 100% of savings achieved into these initiatives historically.

b. The proportion of shared savings distributed to providers on a total ACO-wide basis, with breakouts for different provider types if applicable

Vytalize distributed approximately 50% of Shared Savings with providers each year.

Section 5: ACO MODEL OF CARE AND COMMUNITY INTEGRATION

1. Describe the ACO's model of care, including the philosophy and evidence (such as peer reviewed studies, past performance, etc.) that informs the ACO's model, programs, and processes.

Redacted

2. Describe how the ACO's model of care may incorporate each of the following efforts. Describe any other applicable efforts not listed:

a. Any and all population health initiatives;
i. Describe the methods for prioritizing the initiatives;
ii. List the major objectives for each initiative;
iii. List the outcome measures and key performance indicators for each initiative;

Redacted

b. Benefit enhancements or payment waivers offered;

Redacted

c. How the ACO supports appropriate utilization of health care services by providers and patients;

Redacted

d. How the ACO supports, assesses, and monitors coordination of care across the care continuum, including primary care, hospital inpatient and outpatient care, specialty medical care, post-acute care, mental health and substance abuse care, and disability and long-term services and supports, especially during care transitions;

Redacted

e. Participation and role of community-based providers (e.g., designated mental health agencies, specialized services agencies, area agencies on aging, home health services, and others) that are included in the ACO, including any proposed investments to expand community-based provider capacity and efforts to avoid duplication of existing resources;

Redacted

f. Integration efforts with the Vermont Blueprint for Health, regional care collaboratives and other state care coordination initiatives;

Redacted

g. Efforts that incentivize systemic health care investments in social determinants of health; and

Redacted

h. Efforts that incentivize addressing the impacts of adverse childhood experiences and other traumas.

Redacted

3. Describe any strategies for expanding capacity in existing primary care practices, including but not limited to reducing administrative burden on such practices.

Redacted

4. Describe how the ACO is addressing health equity? If the ACO has specific goals in this area, describe any specific actions the ACO is taking to achieve these goals.

Redacted

5. Describe the ACO initiatives addressing the items below. Specify objectives and include how the ACO will measure its performance over time.

Redacted

a. Substance Use Disorder: reducing deaths from drug overdoses, increasing initiation and engagement of alcohol and drug dependence treatment, increase follow-up after discharge from the emergency department for alcohol or other drug dependence, reduce rate of growth of emergency department visits with a primary diagnosis of substance abuse condition, increase the utilization of Vermont's prescription drug monitoring program, and increase the number of Vermont residents receiving medication-assisted treatment (MAT) for substance use.

Redacted

b. Suicide: reduce the number of deaths due to suicide.

Redacted

c. Mental Health: increase follow-up care within 30 calendar days after discharge from a hospital emergency department for mental health, reduce rate of growth of emergency department visits with a primary diagnosis of mental health, increase screening for clinical depression (and if depression was detected, include a follow-up plan).

Redacted

d. Chronic Conditions: decrease the prevalence of COPD, diabetes, and hypertension for residents, reduce composite measure comprising of diabetes, hypertension, and multiple chronic condition morbidity.

Redacted

e. Access to Care: increase number of Vermont residents reporting that they have a personal doctor or care provider, and increase percent of Vermont residents who say they are getting timely care, appointments, and information.

Redacted

f. Tobacco Use and Cessation: increase percent of Vermont residents who are screened for tobacco use and who receive cessation counseling intervention.

Redacted

g. Asthma: increase percent of Vermont residents who receive appropriate asthma medication management.

Redacted

6. Please describe any referral program that the ACO employs to coordinate patient care, including home-based care providers and community-based providers.

Redacted

7. Does the ACO benchmark performance measures against similar entities? If no, explain why not. If yes, what specific metrics does the ACO track and benchmark, what peer group(s) does the ACO use, and how does the ACO use the results?

Redacted

8. The GMCB expects to require FY24 reporting of Vermont performance data from the ACO as part of a FY24 budget approval. The reporting requirements will be finalized in the ACO's budget approval.

Section 6: VERMONT ALL-PAYER ACCOUNTABLE CARE ORGANIZATION MODEL AGREEMENT SCALE TARGET ACO INITIATIVE

1. These tables seek to assist the GMCB in determining whether the ACO's payer contract meet the requirements of a Scale Target ACO Initiative (defined in Section 6.b of the All-Payer ACO Model Agreement). The GMCB may require additional information if required to satisfy the State of Vermont's reporting obligations under the All-Payer ACO Model Agreement.

Payer Contract: **ACO REACH** **Contract Period**: **January 1, 2023 to December 31, 2026** **Date Signed**: **December 5, 2022**
Financial Arrangement – Shared Savings and/or Shared Risk Arrangements
Are shared savings possible? * **Yes**
Does shared savings arrangement meet minimum requirements of 30% of the difference between actual and expected spending (see Section 6.b of the All-Payer ACO Model Agreement)? * **We believe so.**
Describe shared savings and shared risk arrangement(s): **ACO REACH Global Risk**
Contract Reference(s): **ACO REACH Participation Agreement, Section VI, F**

Payment Mechanisms – Payer/ACO Relationship
Describe payment mechanism(s) between payer and ACO (AIPBP, FFS, etc.): **Enhanced Primary Care Capitation with FFS and Risk Share Settlement**
Contract Reference(s): **ACO REACH Participation Agreement, Article II**
Payment Mechanisms – ACO/Provider Relationship
Describe payment mechanism(s) between ACO and ACO provider network: **For Primary Care Providers, fee-for-service at 100% of the Medicare Fee schedule with Monthly Bonuses based on performance on key metrics (Annual Wellness Visits, Post-Discharge Follow-up, Chronic Patient Visit Rate, Coding Accuracy, etc.)**
ACO Provider Agreement Reference(s): **Vytalize Health 9 ACO LLC Participant Agreement, Exhibit 2A**
For payments to providers, please complete the table below, identifying the applicable category of the payments (or percentage of payments in each category) based on HCP-LAN categories: **N/A**

HCP-LAN Category	**ACO / provider arrangements**	**$ value**
Category 1: FFS-No link to Quality and Value		
1: FFS-No link to Quality & Value		
Category 2: FFS-Link to Quality and Value		
2A: Foundational payments for infrastructure & operations		
2B: Pay for reporting		
2C: Pay for performance		
Category 3: APMs Built on FFS Architecture		
3A: APMs with shared savings		
3B: APMs with shared savings and downside risk		
3N: Risk based payments NOT linked to quality		
Category 4: Population-Based Payment		
4A: Condition-specific population-based payment		
4B: Comprehensive population-based payment		

4B with reconciliation to FFS and ultimate accountability for TCOC	**Medicare AIPBP (Per CMMI and LAN)**: *CMMI actually includes VT All payer in the Annual LAN APM measurement effort and currently categorizes VT All payer as Category 4B (See definition from the LAN's APM Framework):* *"Payments in Category 4B are prospective and population-based, and they cover all an individual's health care needs. Category 4B encompasses a broad range of financing and delivery system arrangements, in which payers and providers are organizationally distinct."*	
4B with NO reconciliation to FFS	**Medicaid**	
4C: Integrated finance & delivery system		
4N: Capitated payments NOT linked to quality		

Services Included in Financial Targets (Total Cost of Care)
Services Included in Financial Targets: *Complete **Appendix A, Services Included in Financial Targets**, for all ACO-payer contracts. (Services must be comparable to All-Payer Financial Target Services as defined in section 1.f of the All-Payer ACO Model Agreement, to qualify as Scale Target ACO Initiative) ****
Contract Reference(s): **N/A**
Quality Measurement
Is financial arrangement tied to quality of care or the health of aligned beneficiaries? * Choose an item.
Describe methodology for linking payments to quality of care or health of aligned beneficiaries (e.g., withhold, gate and ladder, etc.): Click or tap here to enter text.
Quality Measures: *Complete **Appendix B, Quality Measures**, for all ACO-payer contracts.*
Contract Reference(s): **N/A**
Attribution Methodology
Describe attribution methodology: **Prospective Plus Alignment -** Beneficiaries are aligned to the ACO prospectively prior to the start of a Performance Year, based on both Claims-Based Alignment and Voluntary Alignment, and aligned prospectively prior to the start of the second through fourth calendar quarters of a Performance Year, to align additional Beneficiaries based only on Voluntary Alignment.
Contract Reference(s): **ACO REACH Participation Agreement, Article II**
Patient Protections

Describe patient protections included in ACO contracts or internal policies: **Business Associates Agreement for the Protection of Electronic Protected Health Information, and Beneficiary Freedom of Choice**
Contract and Policy Reference(s): **Vytalize Health 9 ACO LLC Participant Agreement, Exhibit 3 and ACO REACH Participation Agreement, Section 5.07**

Table 2: Services Included in Financial Targets

Indicate with "x" if category is included in the ACO's Medicare Program:

Category of Service or Expenditure Reporting Category	**Included in Financial Targets?** ***(X or blank)***
Hospital Inpatient	X
Mental Health/Substance Abuse - Inpatient	X
Maternity-Related and Newborns	X (Disabled Beneficiaries)
Surgical	X
Medical	X
Hospital Outpatient	X
Hospital Mental Health / Substance Abuse	X
Observation Room	X
Emergency Room	X
Outpatient Surgery	X
Outpatient Radiology	X
Outpatient Lab	X
Outpatient Physical Therapy	X
Outpatient Other Therapy	X
Other Outpatient Hospital	X
Professional	X
Physician Services	X
Physician Inpatient Setting	X
Physician Outpatient Setting	X
Physician Office Setting	X
Professional Non-physician	X
Professional Mental Health Provider	X
Post-Acute Care	X
DME	X
Dental	X
Pharmacy	X

Table 3: Quality Measures

Indicate with "x" if category is included in the ACO's Medicare Program:

Quality Measure	**Included in Quality Measures?** ***(X or blank)***
Screening for clinical depression and follow-up plan	
Tobacco use assessment and cessation intervention	
Hypertension: Controlling high blood pressure (ACO composite)	
Diabetes Mellitus: HbA1c poor control (ACO composite)	

All-Cause unplanned admissions for patients with multiple chronic conditions (ACO composite)	**X**
Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient experience surveys*	**X**
% of Medicaid adolescents with well-care visits	
30-day follow-up after discharge from emergency department for mental health	
30-day follow-up after discharge from emergency department for alcohol or other drug dependence	
Initiation of alcohol and other drug dependence treatment	
Engagement of alcohol and other drug dependence treatment	
Risk-standardized, all-condition readmission	**X**
Skilled nursing facility 30-day all-cause readmission	
Influenza immunization	
Pneumonia vaccination status for older adults	
Colorectal cancer screening	
Number of asthma-related ED visits, stratified by age	
HEDIS: All-Cause Readmissions	
Developmental screening in the first 3 years of life	
Follow-up after hospitalization for mental illness (7-Day Rate)	
Falls: Screening for future fall risk	
Body mass index screening and follow-up	
All-cause unplanned admissions for patients with Diabetes	**X**
All-cause unplanned admissions for patients with Heart Failure	**X**
Breast cancer screening	
Statin therapy for prevention and treatment of Cardiovascular Disease	
Depression remission at 12 months	
Diabetes: Eye exam	
Ischemic Vascular Disease: Use of aspirin or another antithrombotic	
Acute ambulatory care-sensitive condition composite	
Medication reconciliation post-discharge	
Use of imaging studies for low back pain	
Add Additional Measures as Needed	**Follow-up for Acute Exacerbations**