VERMONT
GREEN MOUNTAIN CARE BOARD

OneCare Vermont's FY 2020 Revised Budget

GMCB Staff Analysis

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July 29, 2020

Agenda

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1. Background
2. ACO 2020 Budget Review (Revised as of June 16th, 2020)
3. Next Steps
4. Questions/Public Comment
5. Appendices

Background

Background: ACO Oversight Statute and Process

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- Oversight of Accountable Care Organizations
- (18 V.S.A. § 9382 and Rule 5.000)

1. **Certification**: Occurs one-time following application for certification then eligibility verifications done annually
2. **Budget**: Review of ACO budget occurs annually during fall prior to start of budget/program year with payer contracts/attribution finalized by spring of the budget year.

ACO Oversight Timeline FY 2020

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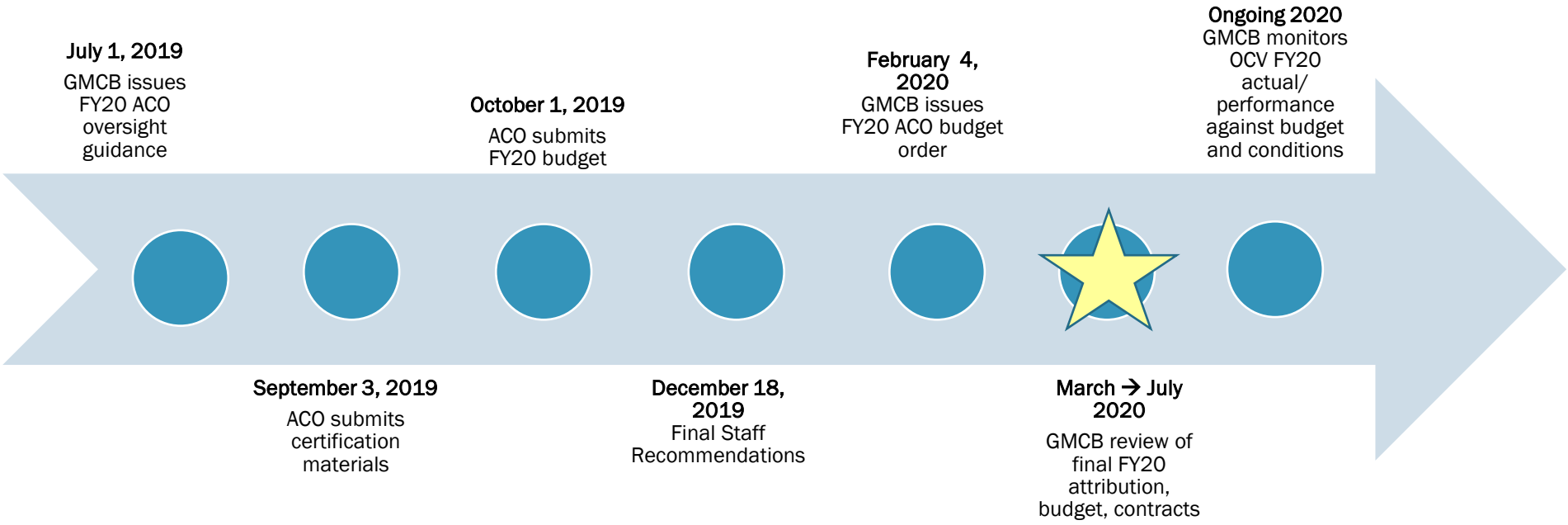

Background: ACO Oversight Timeline 2020

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- ACO 2020 Budget Guidance Issued – July 1, 2019
- OneCare Vermont's 2020 Proposed Budget Submitted – October 1, 2019
- GMCB issues OneCare Vermont's 2020 Budget Order – Early 2020
- COVID-19 State of Emergency Declared - March 13, 2020
- OneCare Vermont initially scheduled to present revised budget per 2020 Budget Order – March 30, 2020
- OneCare requests operational relief and to postpone revised budget due date – March 26, 2020
- GMCB Staff work with Chair to extend presentation deadline from June 3rd to June 24th to allow additional time to finalize payer contracts – April 1, 2020
- GMCB issues Amendment #1 to OneCare Vermont's 2020 Budget Order – May 14, 2020

Additional Context for Today

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- Staff have analyzed OneCare's June 16th revised budget in the context of the 2020 Budget Order
- Staff have not identified any necessary budget order amendments this time, but we expect additional deliverables from OneCare in the near future and will bring any relevant insights before the Board
- We must recognize that many unknowns persist related to COVID-19 over the remainder of 2020

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FY20 ACO Budget Review – Revised as of June 16, 2020

Budget Review

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1. Payer programs – Sarah Tewksbury
2. Provider network – Sarah Tewksbury
3. APM Scale – Michele Degree
4. Quality – Michele Degree
5. ACO Financials – Alena Berube
6. ACO Risk Model – Alena Berube
7. Model of care & population health – Marisa Melamed
8. Evaluation – Marisa Melamed

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Payer Programs

Payer Programs: Overview

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Payer Program	Age of Program 2020	Scale Target Qualifying?	Reasonably Aligned?
Medicare ACO Initiative	3rd year	Yes	Base
Medicaid NextGen ACO	4th year	Yes	Yes *includes expanded attribution and non-reconciled fixed payment
BCBSVT QHP	3rd year	Yes	Yes *FPP is only pilot
BCBSVT Primary 1. Risk-based 2. No risk	New	TBD	TBD
MVP QHP	New	Yes	Yes *Shared Savings only & FFS only

Relevant Budget Order Condition(s)

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2. No later than March 31, 2020, OneCare must submit a written report to the Board, using a template provided by GMCB staff, which demonstrates that OneCare's payer programs (other than the Vermont Medicare ACO Initiative) qualify as Scale Target ACO Initiatives under section 6.b. of the APM Agreement. The report must describe (a) how each program aligns with the Vermont Medicare ACO Initiative in the areas of attribution methodologies, quality measures, payment mechanisms, services included in determining shared savings and losses, patient protections, and provider reimbursement strategies; and (b) the rationale(s) for any differences in these areas. Thereafter, OneCare must update this report no later than 15 days after entering a new payer program covering any portion of 2020. If programs are not expected to qualify as a Scale Target ACO Initiatives under section 6.b. of the APM Agreement, OneCare must include in the report a justification for such an arrangement.
   - Submitted materials for executed contracts on March 31, 2020. Still outstanding: materials associated with non-risk BCBSVT program.

Relevant Budget Order Condition(s)

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3. No later than March 31, 2020, OneCare must submit a one-page document summarizing the benefits self-funded payer programs receive by participating in OneCare.
   - Submitted on March 31, 2020. Criteria met.
4. OneCare must submit the Medicaid geographic attribution implementation manual to the Board no later than 15 days after finalizing the manual with the Department of Vermont Health Access.
   - Submitted on March 9, 2020. Criteria met.
   - However, this work is evolving, and it would be helpful to understand lessons learned and challenges along the way. Staff recommend an update from OneCare/Medicaid as part of the FY 2021 ACO Budget process.

Relevant Budget Order Condition(s)

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5. OneCare must ensure that its payer contracts are consistent with the following 2020 benchmark trend rates and related conditions:
   a) Medicare: 3.5% (3.5% for A/D and 2.9% for ESRD);
   b) Medicaid: A trend within the actuarial range after completion of the Medicaid Advisory Rate Case;
   c) Commercial:
      i. The 2020 benchmark trend rates for the BCBSVT and MVP QHP programs must be based on the ACO-attributed population and the BCBSVT and MVP QHP approved rate filings; and
      ii. OneCare must provide the Board with (a) actuarial certifications for each of its commercial (including self-funded) benchmarks stating that the benchmark is adequate but not excessive; (b) an explanation of how its overall rate of growth across all payers fits within the overall APM target rate of growth and, if its overall rate of growth exceeds the APM target, how it plans to achieve the target for the term of APM Agreement (2017 to 2022); and (c) a revised budget based on the finalized benchmarks.

- OCV submitted original contracts on December 27, 2019 and renegotiated contracts on May 5, 2020. Commercial contracts are under GMCB staff review.
- **OneCare has not provided actuarial certification for commercial programs** and stated the following in their July 20th materials, *"…Actuaries for the commercial insurers who developed the targets would be a more appropriate recipient of this request."* The budget order and the way that this condition has been implemented to date is for OneCare to provide the actuarial certification.

Staff Analysis

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- Budget Order Condition
  - #2 – no changes to budget order needed
  - #3 – no changes to budget order needed
  - #4 – no budget order changes needed – but recommend an update in FY 2021 process
- Other opportunities
  - Glide path for future commercial alignment? Could address in FY 2021 budget process.

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Provider Network

OneCare's 2020 Provider Network

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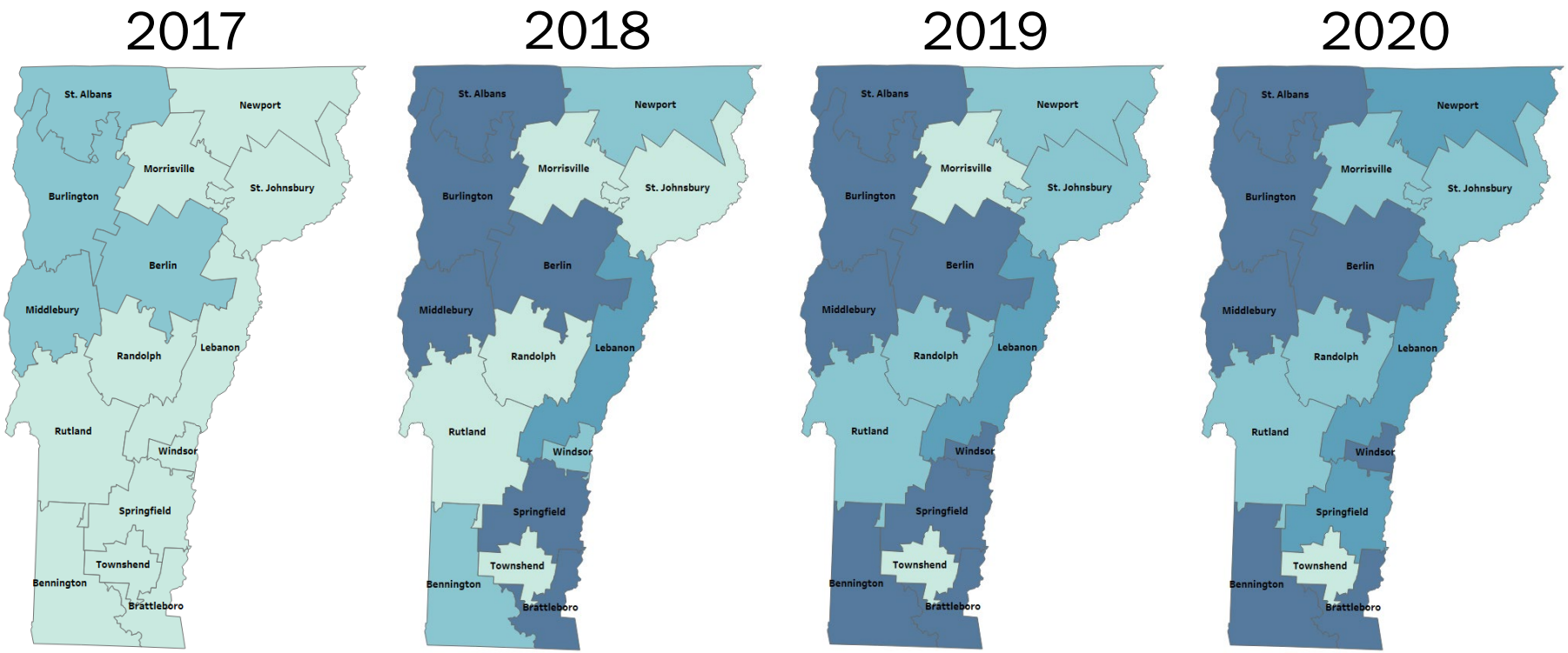
The below is from the budget submitted Oct 1 – final provider network still outstanding.

- Expanded network
  - Morrisville HSA (Copley) in for VMNG
  - Newport HSA (North Country) and CHCB added BCBSVT QHP participation
  - 1 new HSA and hospital (Copley), 3 FQHCs, 3 independent PCP practices, 1 naturopath, 3 independent specialists, 4 independent PT practices, 1 designated MH agency, 3 SNFs, 1 ASC*
- Reduced network
  - Springfield not participating in Medicare FY20 (all programs in FY19)
  - 1 PCP, 5 specialist practices**
- Challenges*
  - Expansion into Medicare program due to magnitude of downside risk and operational concerns
  - Recruitment of independent specialists due to lack of eligibility for incentives in Medicare Merit-based Incentive Payment System (MIPS)

*OneCare FY20 Budget submission, Section 2

**GMCB analysis of Sheet 2.1 Provider Network from submission, Year-Over-Year



OneCare Hospital Service Area Participation 2017-2020

Link to Tableau Public Visualization:
https://public.tableau.com/profile/state.of.vermont#!/vizhome/OCVNetworkParticipation_FY20/Dashboard1

OneCare 2020 Provider Network

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Provider Type	2019 Participation ~N of total provider type in VT	2020 Participation ~N of total provider type in VT
Hospitals and hospital providers (primary care and specialists)	**12 of 14 hospitals** Copley and Grace Cottage out **1 in NH** Dartmouth	**13 of 14 VT hospitals** Copley in **1 in NH** Dartmouth
Federally Qualified Health Centers (FQHCs)	**6 of 12 entities** including CHCB, NOTCH, SMCS, Gifford, CHCRR, Northern Counties	**9 of 12 entities** 3 new: NE Washington County (Berlin), Five Town Health Alliance (Middlebury), Copley (Morrisville)
Primary Care Practices **(~approximations)** **Hospital** **Independent** **FQHCs**	**~267 total practices** (VDH data) **~73 practices** (hosp. provider directories) **~24 of ?#** **~# out of 54 sites** (VDH data)	**~267 total practices** (VDH data) **~76 practices** (hosp. provider directories) **~29 of ?#** 5 new, incl. naturopath **~49 out of 54 sites** (VDH data)
Independent specialist	**22 of ?#**	**25 of ?#** 3 new: arthritis/rheumatology, breast surgery, urology
Home health and hospice	**9 of 9**	**9 of 9**
Skilled nursing facilities (SNFs)	**23 of 38**	**27 of 38**
Designated mental health agencies (DAs) & specialized service agencies	**9 of 16**	**10 of 16** Lamoille County new
Other (physical therapy, ambulatory surgical center)	**1 of #**	**6 of #** 4 PTs, 1 ASC

OneCare 2020 Provider Network

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Provider Type	Which Health Service Areas do not have any of these provider types listed?
Hospitals and hospital providers (primary care and specialists)	Townshend (Grace Cottage)
Federally Qualified Health Centers (FQHCs)	• Bennington (Battenkill Health) • Newport (Indian Stream) • Windsor (Little Rivers Health Care--consider Grace Cottage their home hospital) • Brattleboro (no FQHC)
Primary Care Practices **Hospital** **Independent** **FQHCs**	Hosp: Townshend Ind: Berlin, Newport, Springfield, Randolph, St. Johnsbury, Townshend
Independent specialist	Brattleboro, Windsor, Springfield, Randolph, Rutland, St. Johnsbury
Home health and hospice	N/A – all communities in network
Skilled nursing facilities (SNFs)	Lebanon, Randolph
Designated mental health agencies (DAs) & specialized service agencies	N/A – all communities have at least 1 DA in network
Other (physical therapy, ambulatory surgical center)	Windsor, Newport, Morrisville, St. Johnsbury

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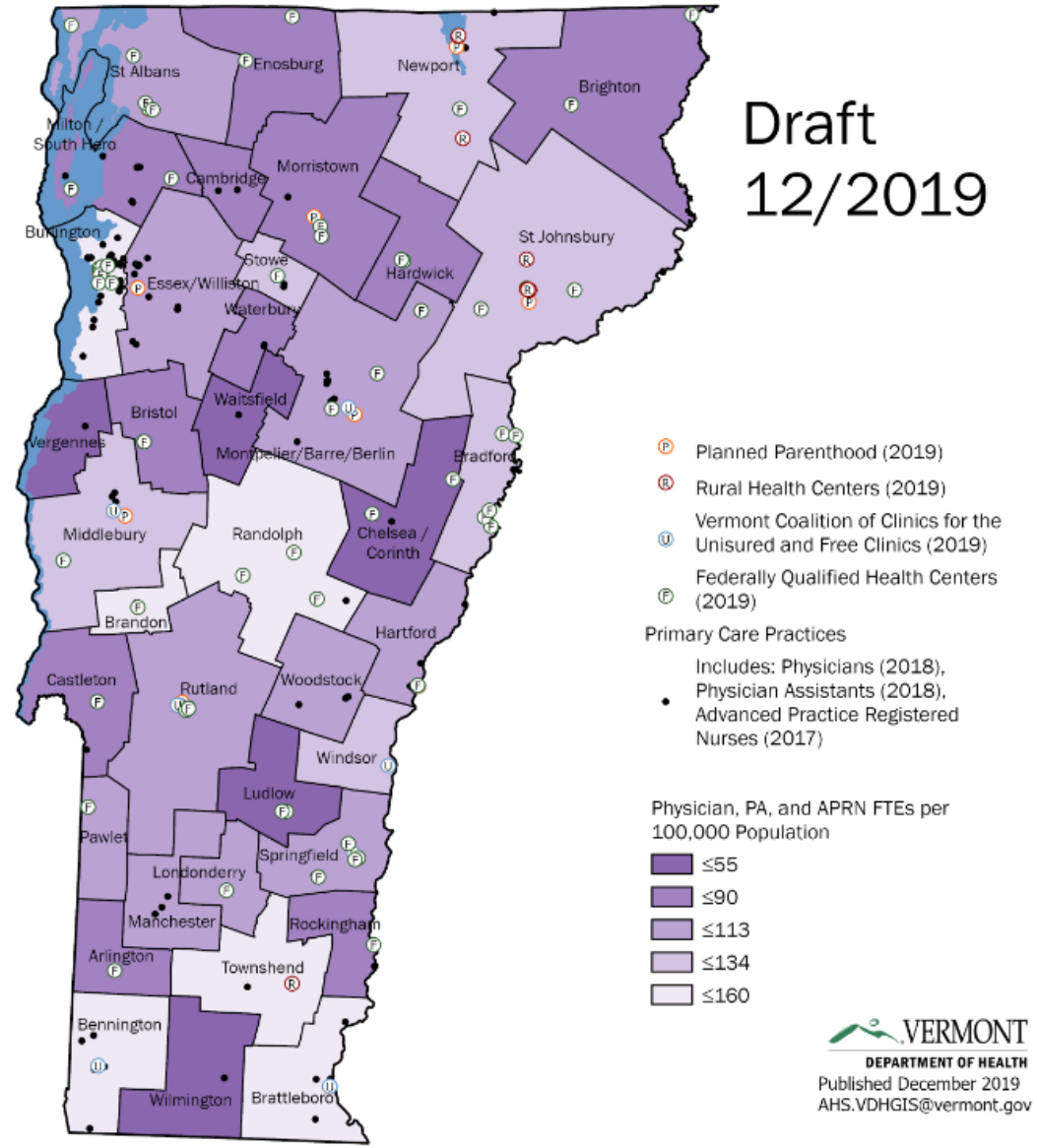
Primary Care by Rational Service Area



Source: Vermont Department of Health; Health Care Provider Census (2017, 2018), BiState Association; Safety Net Provider List (2019)

Rational Service Areas (RSAs) are designed based on where people receive primary care and where they live, as determined from data from Medicare, Medicaid and the Vermont Behavioral Risk Factor Surveillance System. In Vermont, primary care and dental care are divided into 38 separate RSAs.

FTE ratios only includes providers in locations open to the public. Facilities that do not offer outpatient services, do not offer on-site services, or are urgent care clinics are excluded. Locum tenens providers are excluded. Locations include independent practices, hospital owned practices, and group practices.

GMCB is working in collaboration with the VT Department of Health to quantify and map the provider landscape as part of the Health Resource Allocation Plan project.

Relevant Budget Order Condition(s)

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1. No later than April 30, 2020, or a date agreed to by OneCare and GMCB staff, OneCare must submit a 2021 Network Development Strategy that includes the following elements:
   a) A definition for ACO "network composition" necessary to maximize value-based incentives;
   b) Provider outreach strategy;
   c) Provider recruitment and acceptance criteria;
   d) Network development timeline;
   e) Providers dropping out of the network (quantify) and reasons why; and
   f) Challenges to network development.

- Submitted on April 15, 2020. Staff asked a series of follow-up questions of OneCare and determined the criteria has been met.

Staff Analysis

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- Budget Order Condition
  - #1 – no changes to budget order needed

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Scale

Scale: Payer Program x Provider

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Scale is the **% of Vermonters** attributed to a Scale Target ACO Initiative, which are ACO payer programs that meet certain requirements set forth in the APM agreement.

Scale Targets outlined in the APM agreement ensure that a **critical mass of Vermont's population is engaged in reform efforts**– and hence, that providers have a real opportunity to change their care delivery and business models to support **value-based programs**.

Scale Targets per APM Agreement	PY1 (2018)	PY2 (2019)	PY3 (2020)	PY4 (2021)	PY5 (2022)
All-Payer Scale Target	36%	50%	58%	62%	70%
Medicare Scale Target	60%	75%	79%	83%	90%

Scale & APM Populations

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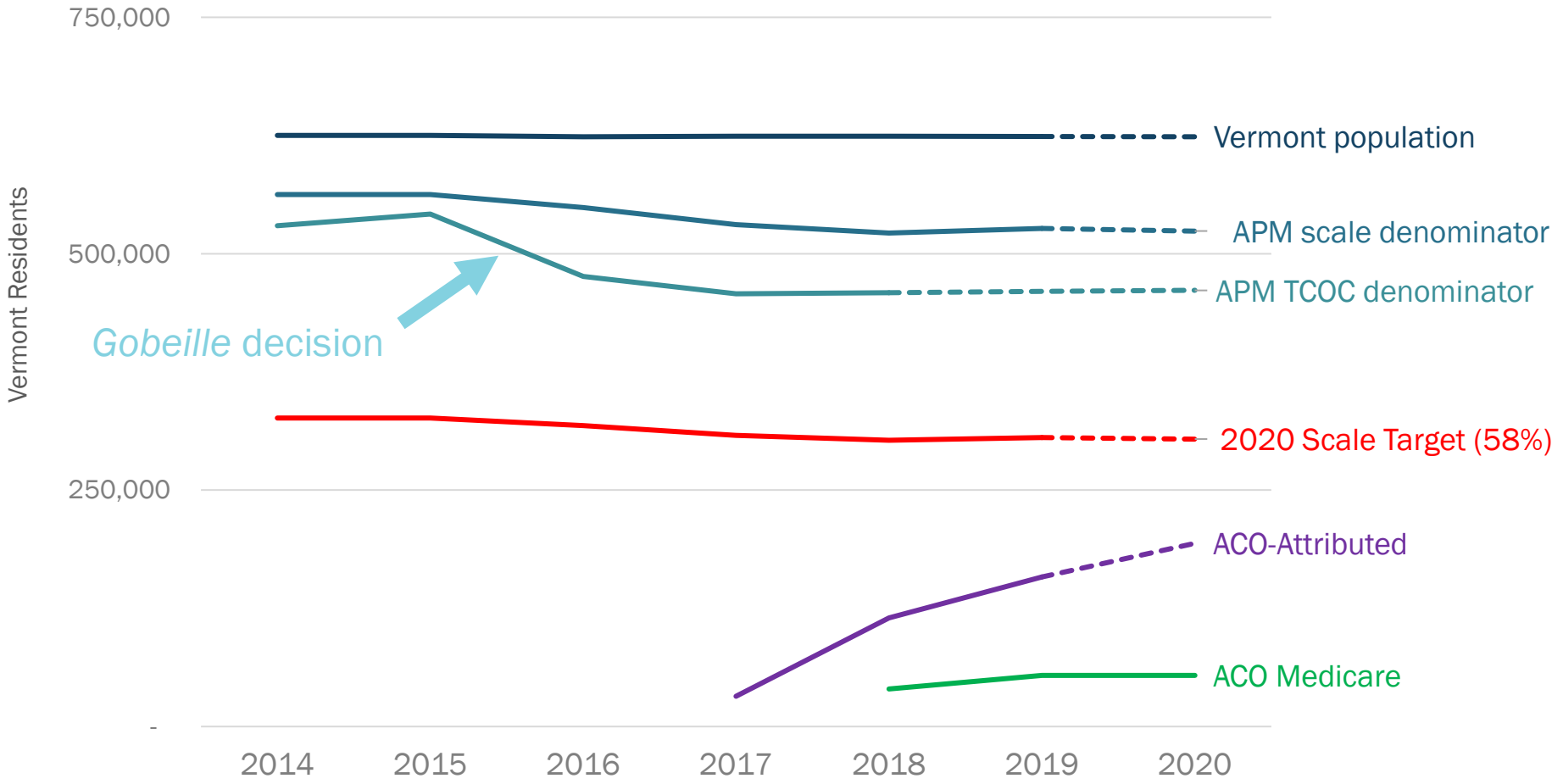

2020 Revised Attribution

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Program	Contract Status	Projected (Oct 1)	Revised (June 16)	Var (#)	Var (%)
Medicare	Executed	53,014	50,554	-2,460	-5%
Medicaid – Traditional	Executed	94,221	82,370	-11,851	-13%
Medicaid – Expanded	Executed	0	21,178	21,178	100%
BCBSVT QHP	Executed	23,538	20,221	-3,317	-14%
MVP QHP	Executed	12,304	9,944	-2,360	-19%
BCBSVT Primary	In Process	66,387	38,891	-27,496	-41%
Scale Target Qualifying		**249,464**	**223,158**	-26,306	**-11%**
BCBSVT Primary – Non-Risk	In Process	0	44,550	44,550	100%
OCV Total Attribution		**249,464**	**267,708**	18,244	7%

APM Requirements: Preliminary Scale *Estimates*

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	2018 Final		2019 Final		2020 Budget		
	Population In Scale Target Initiatives	Scale Performance (Target)	Population In Scale Target Initiatives	Scale Performance (Target)	Initial Population in Scale Target Initiatives	Revised Population In Scale Target Initiatives	Projected Scale Performance (Target)*
Medicare (Target)	**36,860**	**33% (60%)**	**53,973**	**47% (75%)**	***53,014***	**50,554**	**44% (79%)** 3% ↓
Medicaid	42,342		75,712		*94,221*	103,548	
Commercial Self-Funded	9,874		10,021		*66,387*	38,891	
Commercial Fully Insured	20,838		20,342		*35,842*	30,165	
Commercial Medicare Advantage	0		0		*0*	0	
APM Total (Target)	**112,756**	**22% (36%)**	**160,048**	**30% (50%)**	***249,464***	**223,158**	**42% (58%)** 5% ↓

- Scale Target Performance calculation based on 2019 APM population – subject to change with updated population estimates.
- *Decreases in final column relative to Oct 1 submission.

Scale Target Survey

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In response to **not meeting scale targets** in the first year of the model, state partners conducted a survey in which Vermont hospitals and FQHCs identified barriers to scale and potential strategies for state, federal, ACO, and local partners to improve the model. Examples of **scale strategies** identified for **OneCare** to pursue include:

1. Design an option for primary care to join without a hospital partner
2. Offer multiple risk models based on hospital size and readiness
3. Improve clarity of contracts with FQHCs (e.g., expectations, deliverables, attribution methodology)
4. Offer or facilitate network-based telehealth opportunities to smaller providers
5. Continue to improve Care Navigator to allow use for all patients (not just ACO-attributed) and reduce burden of duplicate record-keeping by allowing uploads from existing EMR systems

Source: https://gmcboard.vermont.gov/sites/gmcb/files/documents/payment-reform/GMCB%20Scale%20Memo%208-15-2019.pdf

Relevant Budget Order Condition(s)

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7. No later than March 31, 2020, OneCare must provide a written follow-up to each item from the August 16, 2019 "Insights from Hospital/FQHC Scale Survey: Results and Reactions" for which OneCare was designed as the responsible party.
   - Submitted on March 31, 2020 but with limited information. Given failure to meet scale for two years in a row (2018 Scale Target Report, 2019 Scale Target Report), and a decline expected for 2020, Staff suggest a need to revisit the ACO's scale strategy survey and better understand next steps and timeline for completing scale strategies under the purview of the ACO.

Staff Analysis

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- Budget Order Condition
  - #7 – no changes to budget order needed
    - Could ask for more information about timeline and next steps for scale strategies identified in the scale target survey as part of FY 2021 process.
- Other opportunities
  - Scale & ACO risk model: will discuss in more detail later

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Quality

Quality

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- The All Payer Model Agreement establishes a quality framework that requires the state to maintain if not improve its performance across a variety of care and population health measures
- The ACO holds participating providers accountable to quality standards through its payer contracts; these quality frameworks though not identical, align to the APM quality framework
- Rule 5 Requirements
  - 5.205(b) Provider Network: …The ACO's Participant selection criteria must relate to the needs of the ACO and Enrollee population it serves, including access to and Quality of Care.
  - 5.206(a) Population Health Management and Care Coordination: A primary function of an ACO is to improve Enrollees' Quality of Care by enhancing coordination and management of the services Enrollees receive.
  - 5.207 (a-d) Quality Evaluation and Improvement: Requires an ACO to have a quality and evaluation improvement program that identifies problems in health care delivery and opportunities for improvement; evaluates the care delivered to patients against defined measures and standards; must utilize evaluations to provide feedback to participants to improve quality of care.

Quality

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Measure	Vermont All-Payer ACO Model	2020 Vermont Medicaid Next Gen	2020 Medicare Initiative	2020 BCBSVT Next Gen/ UVMMC	2020 MVP Next Gen
% of adults with a usual primary care provider	X				
Statewide prevalence of Chronic Obstructive Pulmonary Disease	X				
Statewide prevalence of Hypertension	X				
Statewide prevalence of Diabetes	X				
% of Medicaid adolescents with well-care visits	X	X		X	X
Initiation of alcohol and other drug dependence treatment	X	X	X	X	X
Engagement of alcohol and other drug dependence treatment	X	X	X		
30-day follow-up after discharge from emergency department for mental health	X	X	X	X	X
30-day follow-up after discharge from emergency department for alcohol or other drug dependence	X	X	X	X	X
% of Vermont residents receiving appropriate asthma medication management	X				
Screening for clinical depression and follow-up plan (ACO-18)	X	X	X	X	
Tobacco use assessment and cessation intervention (ACO-17)	X	X	X		
Deaths related to suicide	X				
Deaths related to drug overdose	X				

Quality

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Measure	Vermont All-Payer ACO Model	2020 Vermont Medicaid Next Gen	2020 Medicare Initiative	2020 BCBSVT Next Gen/ UVMMC	2020 MVP Next Gen
% of Medicaid enrollees aligned with the ACO	X				
# per 10,000 population ages 18-64 receiving Medication Assisted Treatment for opioid dependence					
Rate of growth in mental health or substance abuse-related emergency department visits	X				
# of queries of Vermont Prescription Monitoring System by Vermont providers (or their delegates) divided by # of patients for whom a prescriber writes prescription for opioids	X				
Hypertension: Controlling high blood pressure	X	X	X	X	X
Diabetes Mellitus: HbA1c poor control	X	X	X	X	X
All-Cause unplanned admissions for patients with multiple chronic conditions	X	X	X		
Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient experience surveys	X	X	X	X	X
ACO all-cause readmissions (HEDIS measure for commercial plans)				X	X
Risk-standardized, all-condition readmission (ACO-8)			X		
Influenza immunization (ACO-14)			X		
Colorectal cancer screening (ACO-19)			X		
Developmental screening in the first 3 years of life		X		X	
Follow-up after hospitalization for mental Illness (7-Day Rate)		X		X	X

Quality

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1. ACO 2018 payer program results (11/20/2019); will continue annually
2. APM 2018 Results (10/30/2019)
3. Proposed Technical Changes to the APM Agreement (2/26/2020)
4. Letters on Quality and COVID-19
    - Letter (re: COVID-19) from State of Vermont to CMS, CMMI (4/27/2020)
    - Letter (re: Risk Corridor) from the Executive Director of GMCB to CMS, CMMI (5/27/2020)
    - CMS Response to the GMCB Request (re: COVID-19) (6/24/2020)
5. APM Annual Health Outcomes and Quality of Care Report Performance Year 1—2018

Relevant Budget Order Condition(s)

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16. OneCare must use its community-specific quality health investments (e.g., VBIF, future variable value-based payments) to address cost and quality differences across Health Service Areas as identified in OneCare's variations-in-care analysis. These programs must be evidence-informed, assessed by OneCare for return on investment, and tracked by the ACO.
    - Determination for compliance with this condition will be assessed by staff analysis of deliverables associated with Budget Order condition #18. Currently under Staff review.

Staff Analysis

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- Budget Order Item
  - #13 – no changes to budget order needed
- Other Considerations
  - Is there a recommendation to be had related to COVID-19? Should we add measures to look at new care patterns? Telehealth? Perhaps a question for FY 2021.

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ACO Financials

Budget Components

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($ millions)	FY20 Budget (Oct 1)	% of Total	FY20 Budget (Jun 16)	% of Total	Var (%)	Weighted Ave Var (%)
TOTAL REVENUE	**$1,424.6**		**$1,255.6**		**-11.9%**	
Payer Revenues for Provider Reimbursement	$1,362.2	95.6%	$1,204.7	95.9%	-11.6%	-11.1%
Payer Program Support (Incl. Blueprint)	$19.0	1.3%	$19.9	1.6%	4.6%	0.1%
State Support	$16.6	1.2%	$11.0	0.9%	-33.7%	-0.4%
Participation Fees (Hospital Dues)	$24.5	1.7%	$18.2	1.5%	-25.5%	-0.4%
Other (Grants & Deferred Revenue)	$2.3	0.2%	$1.8	0.1%	-21.4%	0.0%
TOTAL EXPENSE	**$1,424.6**		**$1,255.6**		**-11.9%**	
Provider Reimbursement	$1,362.2	95.6%	$1,204.7	95.9%	-11.6%	-11.1%
OneCare Admin Expense	$19.3	1.4%	$14.9	1.2%	-22.6%	-0.3%
Population Health Investments	$43.1	3.0%	$36.0	2.9%	-16.5%	-0.5%
Gain/Loss	*$0*	*0%*	*$0*	*0%*	*0%*	*0%*

Provider Payments

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Provider Reimbursement Source	$ FFS	$ FPP	% FPP
Medicare			
Medicaid			
Commercial QHP			
Commercial Self-Funded			
Commercial Self-Funded * No Risk			
Total			100%

All provider payments flowing through OneCare are "value-based", meaning that providers are held accountable for their attributed lives regardless of whether the provider opts to receive fee-for-service or a fixed prospective payment; Although, many of the financial penalties associated with quality performance have been waived in 2020 due to COVID-19.

Provider Dues

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Hospital	2020 Budget (Oct 1)	2020 Budget (Jun 16)	Var ($)	Var (%)	% Total
Brattleboro Memorial Hospital	1,152,539	815,747	(336,792)	-29%	4%
Central Vermont Medical Center	3,247,717	2,403,718	(843,999)	-26%	13%
Copley Hospital	204,388	137,162	(67,226)	-33%	1%
Gifford Medical Center	245,459	102,142	(143,317)	-58%	1%
Mt. Ascutney Hospital and Health Center	772,047	407,268	(364,779)	-47%	2%
North Country Hospital	1,062,570	824,845	(237,725)	-22%	5%
Northeastern VT Regional Hospital	749,945	525,519	(224,426)	-30%	3%
Northwestern Medical Center	1,571,870	1,174,600	(397,270)	-25%	6%
Porter Medical Center	1,259,947	782,832	(477,115)	-38%	4%
Rutland Regional Medical Center	1,430,792	1,031,701	(399,091)	-28%	6%
Southwestern VT Medical Center	1,900,307	1,519,831	(380,476)	-20%	8%
Springfield Hospital	160,983	116,153	(44,830)	-28%	1%
The University of Vermont Medical Center	9,555,250	7,340,106	(2,215,144)	-23%	40%
Dartmouth-Hitchcock	1,153,414	1,044,146	(109,268)	-9%	6%
Total	**24,467,228**	**18,225,770**	**(6,241,458)**	**-26%**	**100%**

Hospital-ACO participation FPP%

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	FY18	FY19	FY20
	Actuals	Actuals	Budget
Brattleboro Memorial Hospital	9.7%	12.9%	12.5%
Central Vermont Medical Center	14.7%	19.2%	21.8%
Copley Hospital	0.0%	0.0%	0.0%
Gifford Medical Center	0.0%	3.9%	5.3%
Grace Cottage Hospital	0.0%	0.0%	0.0%
Mt. Ascutney Hospital & Health Ctr	1.4%	12.6%	17.9%
North Country Hospital	5.2%	7.6%	6.3%
Northeastern VT Regional Hospital	0.0%	0.0%	5.9%
Northwestern Medical Center	14.9%	17.5%	21.0%
Porter Medical Center	14.3%	18.1%	23.6%
Rutland Regional Medical Center	0.0%	0.0%	4.6%
Southwestern VT Medical Center	3.3%	14.5%	21.2%
Springfield Hospital*	0.0%	0.0%	0.0%
The University of Vermont Medical Center	9.3%	11.0%	16.9%
System Total	7.5%	10.2%	14.8%

Table displays FPP as a percentage of total NPR/FPP
*Springfield Hospital not reported accurately; FPP>0%

Administrative Expense Ratio

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Administrative Expense Ratio Calculation:

$$\frac{ACO\ Operational\ Expenses}{ACO\ Total\ Revenue}$$

Operational Expenses: includes salary, benefits, contracts, supplies etc.; does not include population health investments, provider reimbursements ("existing health care spending")

Administrative Expense Ratio

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	FY2018 Actual	FY2019 Budget	FY2019 Actuals	FY2020 Budget (10/01/19)	FY2020 Budget (06/16/20)	Var (%)
Total Revenue	$634 M	$899 M	$889 M	$1,425 M	$1,256 M	-12%
Admin Expense	$11.7 M	$15.9 M	$15.1 M	$19.3 M	$14.9 M	-23%
Admin Expense Ratio	**1.84%**	**1.77%**	**1.70%**	**1.35%**	**1.19%**	**-0.16%**

Relevant Budget Order Condition(s)

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10. If total revenues are projected to increase, the administrative expense ratio must not exceed 1.35%, and if total revenues are projected to decrease, the administrative expenses ratio must not exceed 1.60%, unless otherwise approved by the Board. The Board will review this condition based on final attribution.
    - Submitted documentation on June 19, 2020. Staff determined this criteria was met since the current admin expense ratio of 1.19% is less than the "not to exceed value" of 1.35%.

Staff Analysis

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- Budget Order Condition
  - #10 – no changes to budget order needed

Financial Statements

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Detailed financial statements submitted to GMCB July 27th at 7:52 PM.

Under staff review, but we would expect these to tie in total to the revised budget materials submitted as of June 16th.

Relevant Budget Order Condition(s)

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12. If OneCare uses its $4 million reserve, it must notify the Board within 15 days of such use. Notification must include the reason for drawing down the reserve and, for any use authorized under Condition 11(c), a corresponding cash flow analysis. The use of this reserve shall be limited to:
    a) Additional funding for population health investments;
    b) Financial backing for risk incurred by hospitals **engaging in sustainability planning**;
    c) Temporary cash flow issues associated with payer revenue delays; and
    d) Other uses pre-approved by the Board

- OneCare has not indicated that they intend to use this reserve.

Staff Analysis

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- Budget Order Condition
  - #12 – no changes to budget order needed
    - Could remove “sustainability planning” language from item “b” to broaden pool of applicable risk bearing entities.

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ACO Risk Model

Transferring Performance Risk to Providers

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Insurance Risk: Financial risk that is based on the prevalence, severity, and types of health conditions that occur in a population

Performance Risk: Financial risk based on what is done to mitigate health conditions, which is a function of the number and type of treatments that are applied

Key Takeaway: While there is overlap of performance risk with insurance risk, performance risk can be measured and transferred to providers.

Transferring Performance Risk to Providers

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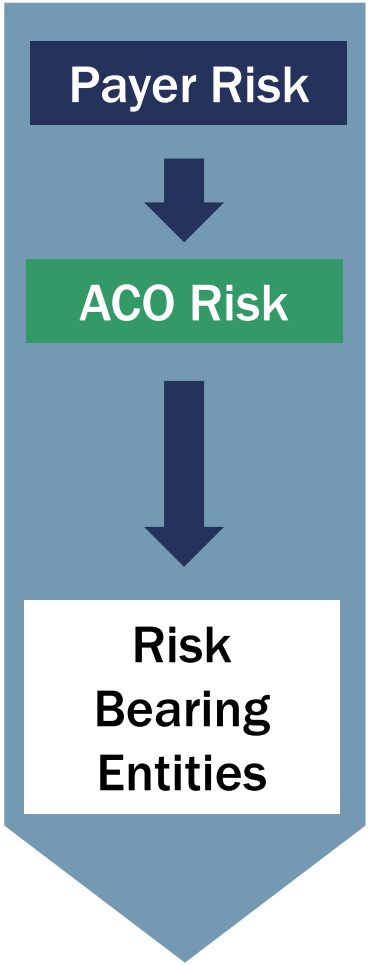

Medicare
Medicaid
Commercial
Self Insured

OneCare Vermont

ACO Network Participation contracts

- Southwestern VT Medical Center
- Central Vermont Medical Center
- Brattleboro Memorial Hospital
- The University of Vermont Medical Center
- Dartmouth-Hitchcock
- Porter Medical Center
- Copley Hospital
- North Country Hospital
- Gifford Medical Center
- Rutland Regional Medical Center
- Springfield Hospital
- Northwestern Medical Center
- Northeastern VT Regional Hospital
- Mt. Ascutney Hospital & Health Ctr

Key Takeaway: Vermont payers transfer a percentage of financial risk onto OneCare Vermont, which then transfers this risk onto hospitals participating in the OneCare network.

OneCare Vermont's Risk Model

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- While the risk negotiated with payers must be accounted for at a system-level, it is up to the ACO to decide whether and how that risk is distributed across risk bearing entities (RBEs)
- There have been no changes to OneCare's risk model to date
  - Passes performance risk uniformly to hospitals, the primary risk-bearing entities
  - Founders may agree to backstop a hospital's performance risk on case-by-case basis
- Risk has been cited by some providers as a barrier to participation (scale)

Hospital Maximum Risk Limits

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Hospital	Total Risk (MRL)	Risk Mitigation	Est. Max Risk Limit (MRL) - CY20	Days Cash on Hand	MRL as % of Days Cash on Hand	Percent of System MRL
Brattleboro Memorial Hospital	$ 2,368,265	$ 1,184,133	$ 1,184,133	121.6	1.4%	2.9%
Central Vermont Medical Center	$ 4,971,384		$ 4,971,384	75.0	2.2%	12.3%
Copley Hospital	$ 475,334	$ 237,667	$ 237,667	72.1	0.3%	0.6%
Gifford Medical Center	$ 457,211		$ 457,211	241.4	0.9%	1.1%
Grace Cottage Hospital	$ -		$ -	87.7	N/A	0.0%
Mt. Ascutney Hospital & Health Ctr	$ 2,196,835		$ 2,196,835	134.1	4.0%	5.4%
North Country Hospital	$ 785,616		$ 785,616	201.8	0.9%	1.9%
Northeastern VT Regional Hospital	$ 822,304		$ 822,304	114.3	1.0%	2.0%
Northwestern Medical Center	$ 4,303,405		$ 4,303,405	279.2	3.7%	10.7%
Porter Medical Center	$ 3,447,724		$ 3,447,724	125.3	4.0%	8.5%
Rutland Regional Medical Center	$ 1,297,409		$ 1,297,409	204.6	0.5%	3.2%
Southwestern VT Medical Center	$ 4,696,716	$ 2,348,358	$ 2,348,358	35.7	1.4%	5.8%
Springfield Hospital	$ 825,283		$ 825,283	3.7	1.7%	2.0%
The University of Vermont Medical Center	$ 16,830,645		$ 16,830,645	192.7	1.2%	41.7%
DHMC	$ 640,310		$ 640,310	N/A	N/A	1.6%
Total	$ 44,118,441		$ 40,348,284			

***Note**: These data are as of the Oct 1 submission; Days cash on hand, reported as of May (GMCB's most recent data) are over inflated and may give a false sense of risk across the system; Staff will recalculate once we receive more information on how COVID-related grants and loans to hospitals should be accounted for.*

Relevant Budget Order Condition(s)

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6. The maximum amount of risk OneCare may assume for 2020 is the sum of the following: 5% of the Medicare benchmark; 4% of the Medicaid benchmark; and a percentage of the commercial benchmarks in the ranges set forth in the relevant contracts. OneCare must request and receive an adjustment to its budget prior to executing a contract that would cause it to exceed these risk levels.
   - Currently under review but must consider additional information.
     - Awaiting final commercial contracts and actuarial certification.
     - Due to dramatic declines in Medicare expenditures, CMS will request a recalculation of the Medicare Benchmark. The process and parameters for this recalculation are currently being developed. Once established, staff will return to the Board with the details and its estimated budgetary impact. Since the associated risk will likely decrease, staff do not see this jeopardizing compliance with the Budget Order.

Relevant Budget Order Condition(s)

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11. OneCare must implement the delegated risk model it described in its budget proposal, except that it must:
    a) Submit to the Board copies of the contracts that bind each of the risk-bearing hospitals to OneCare's risk sharing policy;
    b) For the hospitals that are not covering 100% of their assumed risk, provide the Board with irrevocable letters of credit or other documentation specifying how UVMMC and/or DH-H will back the uncovered portion(s) of risk;
    c) Inform the Board whether it has secured aggregate Total Cost of Care protection for Medicare or any other payer programs in 2020; and
    d) Notify the Board staff within 15 days of any changes to OneCare's risk model outlining effects by hospital and by founder.

- Submitted 11(c) on June 29, 2020; however, other items are outstanding. Staff recommends OneCare submit 11(a), 11(b), and provide an update on 11(d). Staff were verbally notified that a memo was coming in the near future on potential changes to the risk model for 2020. Once the details of those changes are known, we will bring it before the Board.

Staff Analysis

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- Budget Order Condition
  - #6 - no changes to budget order needed at this time
  - #11 - no changes to budget order needed at this time
- Other considerations
  - OneCare could report on whether and how the OCV risk model supports APM scale, since it has been seen by some providers as a barrier to participation.

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Model of Care and Population Health Investments

Vermont's 2017 Population Health Plan

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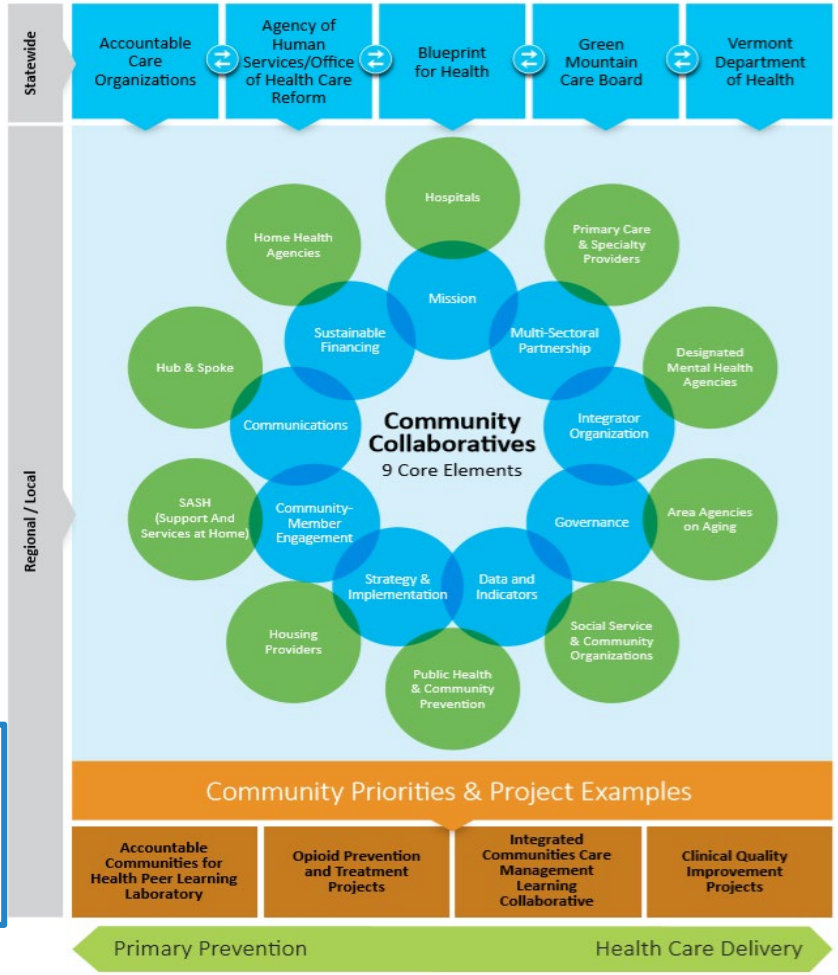
FIG. 5: Vermont Health Care Delivery System Evolution

1.0 Acute Care System	2.0 Coordinated Seamless Health Care System	3.0 Community Integrated Health Care System
Episodic Non-Integrated Care	**Outcome Accountable Care**	**Community Integrated Health Care**
• Episodic health care • Lack integrated care networks • Lack quality & cost performance transparency • Poorly coordinated chronic care management	• Person-centered • Transparent cost and quality performance • Accountable provider networks designed around the patient • Shared financial risk • HIT integrated • Focus on care management and preventative care	• Healthy population-centered • Population health-focused strategies • Integrated networks linked to community resources capable of addressing psychosocial/ economic needs • Population-based reimbursement • Learning organization that is capable of rapid deployment of best practices • Community health integrated • E-health and telehealth capable



ACO's Role in Vermont Population Health

See Figures 3 and 5, page 19: https://healthcareinnovation.vermont.gov/sites/vhcip/files/documents/SIM-PopulationHealthPlan-Final-Web.pdf

Population Health Investments

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Category of Investment	Budget Line Item	2020 Budget (Oct 1, 2019)	2020 Budget (June 16, 2020)	Variance
Primary Care	Basic OCV Per Member Per Month	$8,569,920	$8,420,662	($149,258)
Primary Care	Comprehensive Payment Reform Program	$1,606,613	$1,192,196	($414,417)
Primary Care	Primary Care Engagement Investment	$375,000	$636,436	$261,436
Quality	Value-Based Incentive Fund (VBIF) for 2020	$8,387,232	$5,640,553	($2,746,679)
Quality	VBIF Quality Initiatives	$167,505	$33,000	($134,505)
Care Coordination	Complex Care Coordination Program	$9,423,590	$9,672,306	$248,716
Care Coordination	DULCE	$800,000	*Incl. in Complex Care Coordination*	*($800,000)*
Primary Prevention	RiseVT	$1,031,752	$540,000	($491,752)
Blueprint for Health funding	Patient Centered Medical Home (PCMH) Pmts	$1,894,417	$1,993,092	$98,675
Blueprint for Health funding	Community Health Teams Block Payment	$2,379,711	$2,440,322	$60,611
Blueprint for Health funding	Supports and Services at Home (SASH)	$3,968,246	$3,968,246	$0
Specialty Care	Specialist Program Pilots (Incl. Mental Health)	$3,144,500	$754,800	($2,389,700)
Innovation	Innovation Funds	$1,367,580	$725,521	($642,059)
Total		**$43,116,066**	**$36,017,134**	**($7,098,932)**

Population Health Areas of Investments

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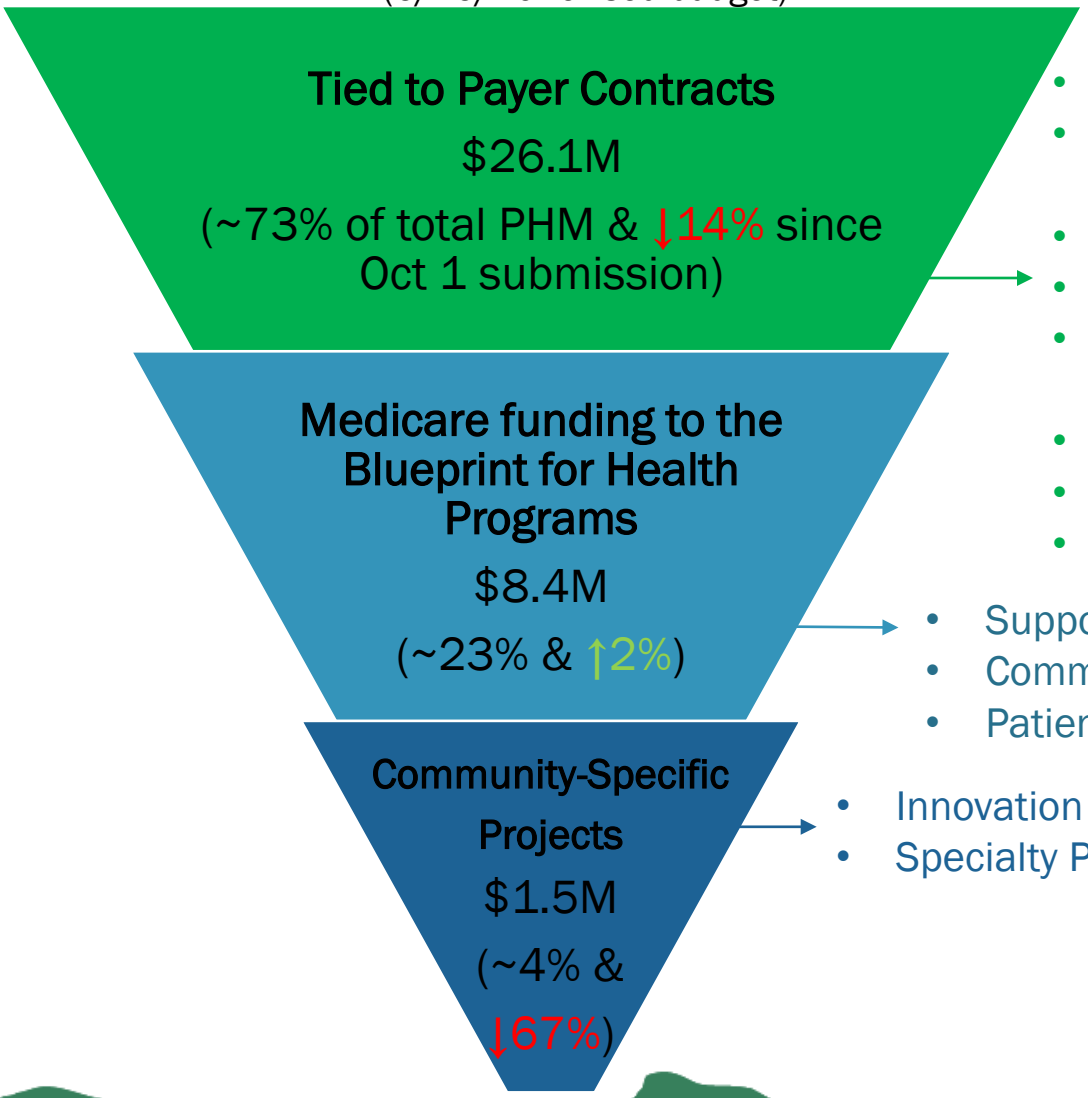
(6/16/20 revised budget)



- RiseVT ($540K)
- Per member per month payments for primary care providers ($8.4M)
- Comprehensive payment
- reform program ($1.2M)
- Complex care coordination program, including DULCE ($9.7M)
- Value-based incentive fund &
- quality initiatives ($5.7M)
- BCBS primary care engagement ($636K)

- Supports and Services at Home (SASH) ($4.0M)
- Community Health Teams (CHT) ($2.4M)
- Patient Centered Medical Home payments ($2.0M)

- Innovation Fund ($725K)
- Specialty Pilots ($754K)

Population Health Ratio (PHM Ratio)

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Metric	2018 Budget	2018 Actual	2019 Budget	2019 Actuals	2020 Budget (10/1/19)	2020 Budget (6/16/20)
Total Revenue	$639 M	$634 M	$899 M	$889 M	$1,425 M	$1,256 M
Pop Health Mgt (PHM) Total	$27 M	$23 M	$37 M	$35 M	$43 M	$36 M
Blueprint	$7.8 M	$7.8 M	$8.1 M	$8.0 M	$8.2 M	$8.4M
(PHM LESS Blueprint)/Revenues	3.05%	2.40%	3.25%	3.00%	2.45%	2.20%
PHM/Total Revenues	4.27%	3.63%	4.14%	3.90%	3.03%	2.87%

PHM Ratio & COVID-19

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- Historically the Board has set a PHM Ratio to ensure that OneCare maintains a certain level of population health investments relative to scale and their overall budget.
- During the initial 2020 Budget review, staff postponed the PHM recommendation to collect more information and rethink the methodology for calculating the PHM ratio.
- However, COVID-19 has significantly altered the context for population health investment.
  - Providers financial challenges inhibit their ability to pay dues to the ACO, which have historically funded population health investments.
  - CRF funding was made available to providers on the condition that population health investments continue (Act 136 of 2020); Staff will update the board when grant details become available.

Relevant Budget Order Condition(s)

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13. If population health management programs are not fully funded as detailed in OneCare's 2020 budget submission, OneCare must submit a revised proposal no later than March 31, 2020 to the Board. This should include any requests for budget revisions, for changes to OneCare programs, including any 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.
    - Submitted on June 19, 2020 and July 20, 2020. Criteria met, but staff have follow-up questions.

Relevant Budget Order Condition(s)

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14. In 2020, OneCare must fund the SASH and Blueprint for Health (PCMH and CHT) investments in the amount of $8,401,660, at a minimum.
    - Submitted documentation on June 19, 2020. OneCare indicated this amount will be met. Staff will confirm at year end that these funds were invested by OneCare according to their intended use.

17. No later than April 30, 2020, OneCare must provide a report on how its population health investments address cost and quality differences across Health Service Areas as identified in OneCare's variations-in-care analysis.
    - GMCB amended the Budget Order so the new due date of this report is September 30, 2020.

Relevant Budget Order Condition(s)

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18. No later than June 30, 2020, or a date agreed to by OneCare and GMCB staff, OneCare must develop a workplan to evaluate the effectiveness of its population health investments including analysis of how to scale those that are successful, sunset those that are not, and report on opportunities for sustainability. This plan must include the identity of each entity receiving funding, the funding amount, any evidence supporting the purpose(s) of the corresponding project, a distribution plan for the funding, the scope of project, relevant timeframe(s) for implementation and evaluation, any measurable outcomes, and any risks, issues, or challenges. This workplan may exclude the Blueprint for Health investments (SASH, CHT, and PCMH). For competitive grants, OneCare should provide and explanation of the criteria by which it evaluates proposals for funding.
    - Submitted on June 29, 2020. Criteria met, but staff have follow-up questions.

Staff Analysis

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- Budget Order Conditions
  - #13 – TBD – under staff review
  - #14 – no changes needed
  - #17 – no changes needed at this time
  - #18 – TBD – under staff review
- Other Considerations
  - Historically the Board has made a determination that OCV must fund population health investments at a certain level. With COVID-19 the context has changed
  - Whether/how to consider CRF funding

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Evaluation

Evaluating the APM and the ACO

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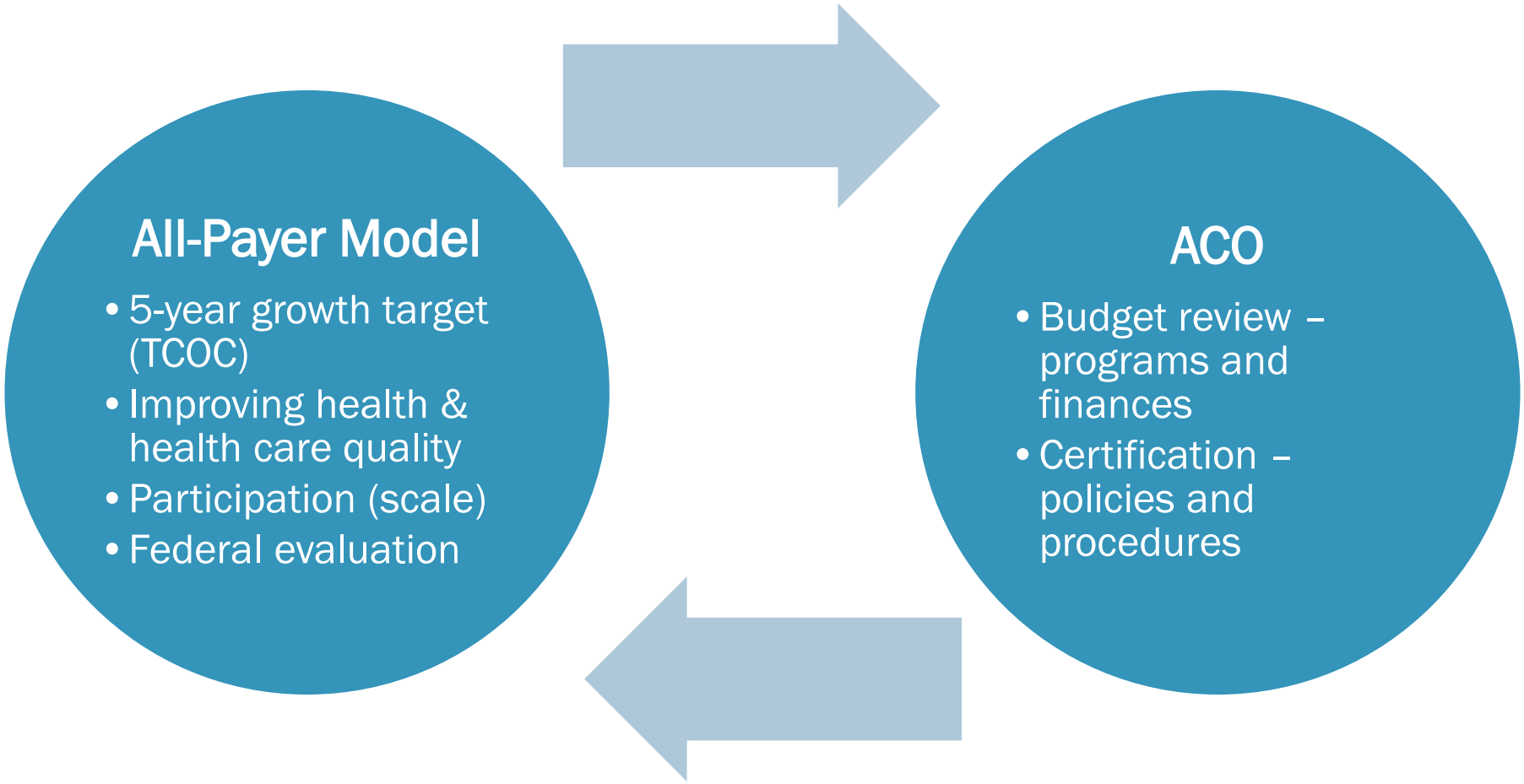

Evaluating the APM and the ACO

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1. **How we are monitoring APM progress?** Under the APM Agreement the GMCB monitors and reports on scale, cost, and quality.
    - TCOC Annual Report (2018)
    - All-Payer Model Results to Date: PY1 (2018) Summary
    - Federal Evaluation by NORC at the Univ. of Chicago
    - APM TCOC Visualization with historical data
2. **How we are monitoring ACO progress?** Through the budget and certification process the GMCB monitors and reports on ACO programs, finances, policies & procedures
    - Scale – provider and payer participation and attribution
    - Payer program results – financial and quality
    - Budget Order
        - ACO FY2020 Budget Order Dashboard – September 30, 2020
        - Budget Order Condition #20 – Duration of Agreement
            - Assessment of value generated as result of population health investments and improved care integration
            - Economies of scale through centralizing shared data infrastructure, analytics, and care coordination

Evaluating the APM and the ACO

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Budget Order Condition #20: "Over the duration of the APM Agreement, OneCare's administrative expenses must be less than the health care savings, including an estimate of cost avoidance and the value of improved health, projected to be generated through the Model."

$$\sum_{0}^{5} \frac{\text{OCV Value Created}}{\text{OCV Admin Expense}} > 1$$

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Remaining FY 2020 Budget Order Conditions

Remaining Budget Order Condition(s)

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8. No later than April 15, 2020, OneCare must present to the Board on the following topics:
   a) 2020 attribution and payer contracts;
   b) Revised budget, based on final attribution;
   c) Final description of population health initiatives;
   d) Expected hospital dues for 2020 by hospital;
   e) Expected hospital risk for 2020 by hospital and payer;
   f) Any changes to the overall risk model for 2020;
   g) Source of funds for its 2020 population health management programs; and
   h) Any other information the Board deems relevant to ensuring compliance with this order.
   - Due to COVID-19 and contracting delays, OneCare's presentation occurred on June 24, 2020.

Source: https://gmcboard.vermont.gov/sites/gmcb/files/documents/payment-reform/GMCB%20Scale%20Memo%208-15-2019.pdf

Remaining Budget Order Condition(s)

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9. No later than March 31, 2020, OneCare must provide GMCB staff with the supporting documentation relevant to these topics identified in Condition 8. Among supporting documentation, OneCare must submit:
    a) Final payer contracts;
    b) Attribution by payer;
    c) A revised budget, using a template provided by GMCB staff;
    d) Final descriptions of OneCare's population health initiatives;
    e) Hospital dues for 2020 by hospital;
    f) Hospital risk for 2020 by hospital and payer;
    g) Documentation of any changes to the overall risk model for 2020;
    h) Source of funds for its 2020 population health management programs; and
    i) Any other information the Board deems relevant to ensuring compliance with this order.

- Some deliverables were submitted on June 19, 2020, however there was missing information. Additional materials were submitted on July 27th and are currently under staff review.

15. OneCare must report quarterly on information required by the Board. This Quarterly reporting will include:
    a) Financial statements to include cash flows, income statement, and balance sheet;
    b) Information on population health investments by Health Service Area, program, and by provider type;
    c) Information on the 2020 complex care coordination program implementation, enrollment, payments, patient satisfaction, and, as they arise, relevant challenges and learning opportunities; and
    d) Any other information the Board deems relevant to ensuring compliance with this order.

- Q1 Financials were submitted, Q2 will be submitted in August. To date, OneCare has met the criteria of this Budget Order item.

Remaining Budget Order Condition(s)

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19. No later than July 31, 2020, OneCare must submit to the Board a prototype for an ACO performance dashboard and a proposed plan to implement the performance dashboard by December 31, 2020. GMCB staff will work with OneCare to determine the required form and content for the submission and to establish appropriate methodologies for reporting quality results in such a way to allow for valid comparisons where feasible. At a minimum the dashboard shall profile population health and financial data by HSA and payer in a way that promotes variational analysis across HSAs and readily reconciles to Board approved and projected fiscal year budgets and population health performance targets. The Board will also provide an opportunity for the Health Care Advocate to provide input into the dashboard, including methodologies for quality reporting.
    - GMCB amended the Budget Order so the new due date of this report is September 30, 2020.

21. OneCare must submit its audited financial statements as soon as they are available and must submit information as required by the Board to monitor OneCare's performance.
    - Upcoming.

22. After notice and an opportunity to be heard, the Board may make such further orders as are necessary to carry out the purposes of this Order and 18 V.S.A. § 9382.

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Next Steps

Next Steps

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1. OneCare to submit outstanding budget order deliverables
2. Staff to finalize 2020 revised budget analysis – (conditional on #1)
3. Public Comment Period Closes – 2 weeks (beginning after #2 above)
4. Potential Board vote on OneCare's 2020 Revised Budget – TBD
5. Board presentation on recalculation of 2020 Benchmark – TBD
6. FY 2021 Budget coming soon…

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Questions/ Public Comment

Appendix I
Acronym List

VERMONT
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- ACO—Accountable Care Organization
- APM—All-Payer Model
- ASO—Administrative Services Only
- BCBS—Blue Cross Blue Shield
- CMMI—Centers for Medicare & Medicaid Innovation
- CMS—Centers for Medicare & Medicaid Services
- FFS—Fee-for-service
- FPP—Fixed Prospective Payment
- FQHC—Federally Qualified Health Center
- GMCB—Green Mountain Care Board
- HCA—Health Care Advocate
- HSA—Health Service Area
- OCV—OneCare Vermont
- QHP—Qualified Health Plan
- PCMH—Patient-Centered Medical Home
- PCP—Primary Care Provider
- PHM—Population Health Management
- PMPM—Per Member Per Month
- PY—Performance Year
- SNF—Skilled Nursing Facility

Appendix II
Payer Programs: APM & Scale

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To qualify as a Scale Target ACO Initiative under the APM a program must meet the following requirements in regard to their risk model:

1. Possibility of Shared Savings for the ACO if it achieves goals related to quality of care or utilization.
2. The ACO's Shared savings, as a percentage of its expenditures less than the benchmark, is at minimum 30%; if the ACO is also at risk for Shared Losses, its Shared Losses, as a percentage of its expenditures in excess of the benchmark, is at minimum 30%.
3. Services comparable to, but not limited to, the All-Payer Financial Target Services and their associated expenditures are included for determination of the ACO's Shared Losses and Shared Savings;
4. The ACO Benchmark, Shared Savings, Shared Losses, or a combination is tied to the quality of care the ACO delivers, the health of its aligned beneficiaries, or both.

Appendix III
Payer Programs: APM & Alignment

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The APM Agreement requires that program design across payers **reasonably align** with the Vermont Medicare Next Generation Initiative in the areas of…

1. Alignment/attribution methodologies
2. Quality measures
3. Payment mechanisms
4. Services included in determining shared savings and losses