Policy Number & Title:	04-20-PY23-25 Preferred Provider and Collaborator Population Health Model and Payments PY 2023-2025
Responsible Departments:	Clinical, Quality, Analytics, and Finance
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I. **Purpose:** OneCare's Population Health Model (PHM) integrates previously separate Care Coordination, Value Based Incentive Fund and Population Health Management programs into a single blended program and payment stream. This integration fosters a common vision of the ACO's population health endeavors and relies upon coordinated engagement across the continuum of care. This policy describes the PHM core concepts, obligations, and associated distribution of PHM payments to Preferred Providers and Collaborators.

II. **Scope:** This Policy is applicable to the OneCare Workforce, Board of Managers, Committees, and those Preferred Providers and Collaborators specifically named in this policy.

III. **Definitions:** Capitalized terms have the same definition as defined in OneCare's *Policy and Procedure Glossary*. For purposes of this policy, the terms below have the following meanings:

Collaborator means an individual or entity that has entered into a Collaboration Agreement with OneCare to: (i) provide for, (ii) arrange for, or (iii) manage health care services and/or social support services in the ACO service area, or to otherwise support the activities and goals of the ACO.

PHM Accountability Measures means a defined set of care coordination and quality measures and the corresponding performance goals selected by the Population Health Strategy Committee (or any successor committee) and endorsed by the Board of Managers (see Section IV.B.iv., below).

Preferred Provider means an individual or an entity that: (1) is identified by a TIN; (2) if required by ACO Payer(s), is included on the list of Preferred Providers submitted by ACO to Payer(s); (3) does not qualify to attribute lives in ACO Programs; and (4) has entered into a Risk Bearing Participant and Preferred Provider Agreement with ACO. Preferred Provider may be more particularly defined in each ACO Program.

IV. **Population Health Model Policy**

A. Population Health Model Core Concepts

i. OneCare's Population Health Model (PHM) enhances and supports a system of care in which all Vermonters have access to high-quality care. The PHM relies upon a mutual commitment to priority goal-setting and follow-through, and provides a streamlined path for Preferred Providers and Collaborators to achieve ACO goals through a mutual commitment to accountability.

ii. Patient-centered, evidence-informed Care Coordination is the foundation of the PHM, and includes shared decision-making, aligned efforts that reduce fragmentation and improve collaboration, and use of data to reduce cost and achieve measureable improvement in quality and patient outcomes. For this reason, Preferred Providers and Collaborators **must**

actively participate in Care Coordination, per the requirements set forth in this policy, in order to receive **any PHM payments** under this policy.

iii. To encourage improvement in quality and patient outcomes, **financial incentives** are being offered for meeting or exceeding the performance goals for quality measures, as further detailed in Section IV.D, PHM Payments, below.

B. Preferred Provider and Collaborator Obligations

i. Preferred Providers and Collaborators shall participate in Care Coordination, including compliance with specific criteria, actions and reporting requirements as set forth in the *2023 OneCare Care Coordination Guidance Document*, as overseen by OneCare's Population Health Strategy Committee, and which will be made available to Preferred Providers and Collaborators on the Provider Portal or upon request no later than November 1, 2022.

ii. For Program Year 2023, Care Coordination requirements for Preferred Providers and Collaborators include:

a. Tri-annual Care Coordination reporting of care managed attributed lives and associated Care Coordination data;

b. Timely response to Care Coordination Validation Audits demonstrating supportive evidence of data submitted with tri-annual reports; and

c. Preferred Providers and Collaborators shall meet with a OneCare representative at least once annually upon request, to review areas of opportunity and/or process improvement initiatives focused on reduction of avoidable healthcare service utilization.

C. OneCare Obligations

i. OneCare shall distribute PHM Base Payments and PHM Bonus Payments to Preferred Providers and Collaborators as set forth in Section IV.D, PHM Payments, below.

ii. OneCare shall engage with Preferred Providers and Collaborators to support achievement of PHM Base Payments and PHM Bonus Payments. At a minimum, OneCare will provide PHM performance reports to support ongoing monitoring of PHM Accountability Measures, measures impacting payment of PHM Bonus Payments, care coordination rates, gaps in care, and trends in utilization. Additionally, OneCare provides access to data in support of PHM efforts and other ACO activities pursuant to OneCare's *03-03 Data Use Policy*.

iii. OneCare shall provide prospective medical, financial, and social determinants of health risk information to Preferred Providers and Collaborators for the purpose of identifying and prioritizing opportunities for Care Coordination and quality improvement (when available from Payers or through other contractual relationships with external vendors).

iv. OneCare shall review trends in utilization, cost, and health outcomes and recommend refinements or enhancements of the PHM through the established governance process. OneCare shall collaborate with Network counterparts to support performance improvement efforts, data sharing, and best-practice workflows, provided such collaboration is permissible, feasible and appropriate.

v. OneCare's Population Health Strategy Committee will review PHM Accountability Measures at least annually through a process of the Committee's choosing, and will recommend changes to the Board of Managers, if any. This work will be completed in time to inform PHM policy development for Program Years 2024 and 2025.

D. PHM Payments (Program Year 2023): OneCare shall distribute PHM payments to these Preferred Providers and Collaborators as follows:

i. Preferred Providers and Collaborators must participate in Care Coordination in order to receive **any PHM payments** under this policy, as determined solely by OneCare per the terms set forth in Section IV.A-B, above. OneCare will evaluate Care Coordination activity on an ongoing basis to determine eligibility for PHM payments. OneCare reserves the right to adjust PHM payments in the event of unforeseen circumstances that create unfair results. For guidance regarding the consequences for non-compliance, please see Section V, below.

ii. For Performance Year 2023, OneCare shall apportion eighty-five percent (85%) of PHM funds allocated in OneCare's approved budget for Preferred Providers and Collaborators ("Budgeted PHM Funds"), and distribute those Budgeted PHM Funds as **monthly PHM Base Payments** to those Preferred Providers and Collaborators specified in this policy, subject to the obligations and conditions set forth herein. Monthly PHM Base Payments are explicitly made as consideration for Care Coordination of Attributed Lives.

iii. For Performance Year 2023, OneCare shall distribute eighty-five percent (85%) of Budgeted PHM Funds to Preferred Providers and Collaborators as follows:

a. Monthly PHM Base Payments will be distributed to Home Health Agencies based on each Agency's proportional share of the total dollar value of claims for care provided by Home Health Agencies to Attributed Lives for all ACO Programs for the period July 1, 2021 to June 30, 2022.

b. Monthly PHM Base Payments will be distributed to Designated Agencies ("DAs") based on each DA's proportional share of the total dollar value of claims for care provided by DAs to Attributed Lives for all ACO Programs for the period July 1, 2021 to June 30, 2022.

c. Monthly PHM Base Payments will be distributed to Area Agencies on Aging ("AAAs") based on each AAA's proportional share of Attributed Lives being actively care managed (as reflected in tri-annual Care Coordination reporting).

iv. The remaining fifteen percent (15%) of Budgeted PHM Funds are available for distribution as **annual PHM Bonus Payments** to the following Preferred Providers and Collaborators for meeting or exceeding the performance goal(s) for the following quality measures:

a. Annual PHM Bonus Payments to Home Health Agencies tied to each Home Health Agency's rate of inpatient admissions following a home health visit for Attributed Lives with at least one claim for services within the Performance Year.

b. Annual PHM Bonus Payments to DAs tied to each DA's Primary Care Provider engagement rate for Attributed Lives being actively care managed (as reflected in tri-annual Care Coordination reporting).

c. Annual PHM Bonus Payments to AAAs tied to each AAA's Primary Care Provider engagement rate for Attributed Lives being actively care managed (as reflected in tri-annual Care Coordination reporting)

v. Annual PHM bonus payments will be based on meeting or exceeding the performance goal(s) for the Performance Year, to be measured after sufficient claims runout following the end of the Performance Year.

V. Future PHM Program and Payments for Preferred Providers and Collaborators (Program Years 2024-2025)

A. For Program Years 2024 and 2025, PHM base payments to Preferred Providers and Collaborators could be gradually phased out in favor of more provider-specific programs. **Examples** of future focus areas include access to mental health services, reduction of avoidable healthcare service utilization, and a focus on wellness visits.

B. For Program Years 2024 and 2025, Preferred Providers and Collaborators will be asked to further support the Network's goal to meet or exceed benchmarks for PHM Accountability Measures. For Program Year 2023 the PHM Accountability Measures are applicable to Participants only, and not Preferred Providers or Collaborators. Program Year 2023 Accountability Measures include: Medicare annual wellness visits, diabetes – poor control (A1c > 9), child and adolescent well visits, developmental screening, and two Care Coordination metrics, to be determined. In future years, performance goals for and PHM Accountability Measures by ACO Program will be selected by the Population Health Strategy Committee (or any successor committee), approved by the Board of Managers, and communicated to the Network no later than September 1st of the prior Performance Year. See OneCare's *04-19-PY23-25 Participant Population Health Model and Payments Policy.*

VI. Non-Compliance

A. Failure to fulfill PHM and/or Care Coordination responsibilities as set forth in this policy may result in delay, suspension, termination, or recoupment of PHM payments.

B. OneCare shall provide written notice of non-compliance with sufficient specificity to allow the Preferred Provider or Collaborator the opportunity to cure the non-compliance. The written notice will offer the opportunity to meet with OneCare to develop an action plan, where applicable. Absent a specific action plan and/or material improvement within ninety days of written notice of non-compliance, OneCare may proceed with the delay, suspension, termination, or recoupment of PHM payments.

C. Preferred Providers may appeal the delay, suspension, termination, or recoupment of PHM payments by engaging in the process described in OneCare's *05-02 Participant and Preferred Provider Appeals Policy*.

VII. Review Process:

This policy shall be reviewed annually and updated to be consistent with requirements set forth by OneCare Board of Managers, OneCare Leadership and regulatory bodies.

VIII. References:

- OneCare Risk Bearing Participant and Preferred Provider Agreement
  - Exhibit A Performance Year 2023 Program of Payment
- OneCare ACO Program Agreement with CMS (Medicare ACO Program)
- OneCare ACO Program Agreement with Department of Vermont Health Access (Medicaid ACO Program)

- OneCare ACO Program Agreement with Blue Cross Blue Shield of Vermont
- OneCare ACO Program Agreement with MVP
- OneCare 2023 Care Coordination Guidance Document
- OneCare Policy and Procedure Glossary

IX. Related Policies/Procedures:

- 03-03 Data Use Policy
- 03-06 Assignment of Attributed Lives Policy
- C02-15 Care Coordination Validation Audit Procedure
- 05-02 Participant, Preferred Provider and Collaborator Appeals Policy

Management Approval:

Derek Raynes	May 18, 2022
Director, Payment Reform	Date
	6/7/2022
Vice President, Finance	Date
Carrie Wulfman, M.D.	06/17/2022
Chief Medical Officer	Date
Sara E Barry	06/17/2022
Chief Operating Officer	Date