Green Mountain Care Board

FY 2022 Budget Submission

OneCare Vermont Accountable Care Organization

October 1, 2021

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Section 1

ACO Information and Background

PART I. REPORTING REQUIREMENTS

Section 1: ACO Information and Background

1. **Provide an executive summary of the budget submission. In doing so, please address the following, highlighting and quantifying changes from the current performance year:**
   a. **OneCare's value proposition and business model.**

As we complete the second year of the public health emergency, it remains clear that health care reform is absolutely necessary: Vermont must change the way care is delivered and paid for to improve health outcomes while controlling costs. Making such significant change takes time, focus, and collaboration.

OneCare Vermont (OneCare), a cooperative effort of thousands of providers across the continuum of care, seeks to further these goals by taking on the accountability for cost and quality of care.

Learning from OneCare's early implementation of value-based programs, the Board of Managers (Board) undertook a strategic planning process with more than 40 stakeholders to advance payment and delivery reform for our state and Vermonters. This extensive process clarified OneCare's three core capabilities to drive success in the next few years.[1] They include:

Network Performance Management: ensuring a high quality, equitable system that continuously strives to improve health care delivery and outcomes.

Data & Analytics: delivering actionable data to providers in support of better care for patients.

Payment Reform: evolving value based care contracts to move away from fee for service (FFS).

By identifying these focus areas, OneCare's Board also drew clear distinctions among the ACO's role and the role of its' participating providers. This delineation has provided important clarity that did not previously exist. In doing so, OneCare can focus its activities and initiatives moving forward on providing the most value for its participating providers.

[1] These core capabilities align with recommendations from several national consultancies that have examined high-performing ACOs and identified key functions to realize success and align with the Agency of Human Services' APM Implementation Improvement Plan.

The strategic planning process set forth updated mission, vision, and values statements to guide OneCare's work.

> *Mission:* to partner with local health care providers to transform Vermont's health care system to one that focuses on health goals by providing actionable data and innovative payments that foster better outcomes for all.
>
> *Vision:* to be a trusted, equitable health care system where patients and providers work together to achieve optimal health and an exceptional care experience for all.
>
> *Values:* collaboration, excellence, innovation, equity, communication and integrity.

With these guiding principles and strategies in place, OneCare fills a unique niche in Vermont's health care reform efforts. Specifically, OneCare's 21-manager representational Board ensures that the main focus is on supporting the 136 organizations and 5,023 providers in OneCare's network to transition both payment and care delivery models away from volume- to value-based models. OneCare's value proposition is centered in support to health care providers and is measured by their participation in reform activities (network management), use of data and analytics (engagement with data), and participation in payment reforms (e.g. payments aligned with quality, fixed prospective payments, care coordination).

In 2022, OneCare plans to:

- evolve the care coordination program and shift prevention strategies to align with clinical and health equity focus areas and the commitment to improving the quality of care for individuals with hypertension and/or diabetes (or pre-conditions);
- support its network through increased focus on key outcomes;
- simplify programs and deepen participation in payment reform initiatives;
- monitor and/or refine key performance indicators to include publishing them bi-annually through ACO Insights; and
- continue collaboration with the Agency of Human Services (AHS), through its improvement plan, to identify areas of mutual interest and align resources.

OneCare provides additional value to the state by working with its providers to help manage cost and quality in alignment with Vermont's All Payer Accountable Care Organization Model (APM) goals and providing stability and predictability in the Medicaid budget.

In its first evaluation, NORC, an independent research organization of the University of Chicago, reported findings of OneCare's first two years (2018-2019) operating under the APM framework.[2] NORC described OneCare's work to align payments to providers with incentives that improve care and overall population health, especially for those with chronic or complex illness. They also reported the ACO programs implemented by OneCare enhance

[2] NORC at the University of Chicago. Evaluation of the Vermont All-Payer Accountable Care Organization Model. 2021.

coordination among providers, provide data to support best practices to make care more consistent, and invest in wellness and prevention through primary care. Key findings include:

- The APM achieved statistically significant Medicare gross spending reductions at both the ACO and state levels, as well as Medicare net spending reductions at the state level.
- There were statistically significant declines in acute care stays (at the ACO and state levels) and in 30-day readmissions at the state level.
- Stakeholders agree that the APM provides an important, unifying forum for providers, payers, and the state to engage in meaningful discussions about health care reform and set goals.
- The APM is also strengthening relationships among hospitals, community organizations, designated mental health agencies, primary care practices, and other providers.

Dr. Clif Gaus, president and CEO of the National Association of ACOs (NAACOS), reflected: "This evaluation of Vermont's All-Payer Model is another example of a successful ACO model. We know from other CMS models that ACOs are both lowering the cost of care and improving the quality of patient care. This report adds to the growing body of evidence that shows if you hold providers accountable for patients' total-cost-of-care and give them time to adjust practice patterns then positive results will follow."

As an output of the strategic planning process, OneCare has launched the newly-developed "ACO Insights" report to highlight key metrics being tracked across its core capabilities. Key highlights from the recently released report include: 57 provider organizations in the prior month receiving patient prioritization information to support care coordination outreach, 311 community providers trained in care coordination so far in 2021, 10 out of 14 health service areas (HSAs) demonstrating high/medium levels of data and analytic engagement to drive change in their community, and solid progression of OneCare's payment reform efforts including increasing percentages of non-reconciled fixed prospective payment (FPP) over the past two years. This report will be updated biannually and posted on our website to facilitate transparency in OneCare's focus areas and progress.

As a learning organization and in preparation for each performance year, OneCare gathers network feedback to improve programs and payment models tied to the population health and value based payments, all of which is then incorporated into OneCare's annual work plans. In addition to the strategic planning process, Performance Year (PY) 2022 planning engagement activities included provider surveys on analytics and finance; special work groups on primary care and the Comprehensive Payment Reform (CPR) program; more than 12 stakeholder meetings and listening sessions to evolve the care coordination program; OneCare/Blueprint meetings with each HSA; and new activities with Bi-State Primary Care and the Department of Vermont Health Access (DVHA) to explore a Federally Qualified Health Center (FQHC) payment reform pilot. Further, OneCare incorporated key recommendations from the state's APM Implementation Improvement Plan into its

strategic plan, thereby demonstrating the alignment in goals and resources to support areas of mutual interest and opportunity.

b. Main outcomes, objectives, opportunities and challenges faced when developing the budget, including the impact of COVID-19. Include lessons learned from the public health emergency to date that impact the 2022 budget.

It is important to recognize that OneCare's PY 2022 budget submission occurs in the midst of an unprecedented public health emergency, now in its 18th month and with no clear end in sight. During this time, health care providers of all types have endured extreme stress including, at times, lack of access to critical information and supplies, significant changes to workflows, and individuals delaying care and presenting for care later with both higher volume and acuity. Further, the public health emergency has exacerbated existing workforce challenges. It will take concerted collaboration, time, and funding to address these deep-felt trials over the years to come. During this period of uncertainty, OneCare providers receiving fixed payments and population health management investments acknowledged the importance of these ongoing and predictable revenue streams, which would have eroded under a purely volume-based reimbursement model. This proved to be a pivotal lesson that will help advance value-based care.

OneCare's PY 2022 budget aims to continue to meet the network's desire for a stabilized and value-based approach to health care payments during this difficult time, including expansion of participation in the CPR program for independent primary care, the simplification of some population health management payments, and the exploration of FPP through a new FQHC pilot program. At the same time, the loss of Delivery System Reform (DSR) and Health Information Technology (HIT) funding represents a significant ongoing budgeting challenge valued at $3.9M for PY 2022. Further, in PY 2021, OneCare utilized $2.9M of deferred revenue to maintain its investments and infrastructure; these funds are no longer available in PY 2022. Together, these total $6.8M in lost revenue – funds critical in supporting the transition to value-based care. In response, OneCare reduced expenses through discussion with stakeholders and in consultation with governance committees and hospitals agreed to shoulder lost state investment costs for their communities through increased hospital participation fees ($3.6M for PY 2022) – a particular challenge during a continued financially lean, stressful, and uncertain time.

The ongoing public health emergency presents a significant challenge when establishing many of the components of the PY 2022 budget including: total cost of care (TCOC) targets, fixed payment amounts, utilization projections relative to historical capacity, and reduction in Medicare seasonal out-migration. Additionally, OneCare awaits final decisions and outcomes regarding payer modifications to TCOC targets for PY 2021. All of these variables, including the potential mid- and long-term impact of deferred and delayed care, generates an abnormally high level of uncertainty. To mitigate this uncertainty, OneCare is actively negotiating payer contract terms to align the financial components with participants' risk tolerance in order to sustain reform efforts. In total, the PY 2022 budget is designed to keep

OneCare providers in value-based programs while responsibly recognizing these challenging times.

c. Changes to the provider network; and
d. Changes to payer programs.

OneCare's PY 2022 network development strategy remains focused on retaining current participation, managing risk and opportunity, and evolving programs to continue to advance value-based care arrangements. Strategic areas of focus for next year include: continuing investments in population health management for primary care and continuum of care, engaging with FQHCs to design a fixed payment pilot program, expanding CPR participation, unifying the network across payer programs, and ensuring providers have adequate knowledge and expectations of network participation.

OneCare anticipates continued engagement with payers including Medicaid, Medicare, Blue Cross and Blue Shield of Vermont (BCBSVT), and MVP Health Plan (MVP). In PY 2022, the budget does not contemplate the addition of any new payer programs. A goal established by the OneCare Board is to align more providers across the current programs for enhanced coordination and quality of care, as well as improved cost management. OneCare prioritized payment reform as a key component of its strategic plan and intends to pursue unreconciled fixed prospective payments for all in-network hospitals and core primary care services across all payer programs during the period of PY 2022 through 2025. Unreconciled payments move us further from a FFS structure and toward true reform. It is important to note that expansion of unreconciled fixed prospective payments, at a minimum, requires cooperation on the part of a number of external stakeholders from the public and private sectors, as well as the convergence of favorable market and regulatory conditions. OneCare will continue to be a collaborative partner and champion the concept of payment reform on behalf of its provider network.

OneCare is working to evolve provider incentive payments by adding value-based elements of accountability, while making them easier to understand, more specific, and more aligned across payers. Additionally, OneCare continues to align quality measures: 16 out of 18 quality measures currently are applicable across multiple payer programs and five are applicable to all payer programs. This standardization across programs facilitates coordinated quality improvement efforts across the network to better serve Vermonters.

OneCare's network remains strong for PY 2022 with two independent primary care practices that opted out in PY 2021 rejoining for PY 2022 and 21 organizations expanding participation in one or more commercial payer programs (three hospitals, three FQHCs, one independent primary care, four specialists, seven SNFs, two DAs, and one HHA). Two additional independent primary care practices will join CPR in PY 2022 for a total of 13 organizations. In addition, one or more FQHC(s) are anticipated to pilot a new fixed payment pilot program in collaboration with DVHA. One of the most significant indicators of

success is the continued participation of providers throughout Vermont. Cumulatively, OneCare's network has increased the number of Vermonters under value based care arrangements from 29,100 in 2017 to ~288,000 in PY 2022 (of which 257,000 are APM scale-target qualifying). This represents an addition of ~18,000 Vermonters for PY 2022 and is primarily driven by increased participation in commercial payer programs and an attribution correction with DVHA.

e. Changes to population health and preventative programs and the effect on the budget.

In preparation for PY 2022, OneCare gathered network feedback to improve its population health programs and responded by simplifying programs and setting clear value-based expectations tied to the population health. OneCare's Board and stakeholders were in agreement that while the care coordination program needs to evolve, it should remain a significant program and source of investment in population health. Over the summer of PY 2021, OneCare engaged in listening sessions that explored core model components, care team communication, accountabilities, data sources, and payments. There was unanimous agreement of the importance of care coordination and cross organizational collaboration and value was expressed for maintaining key components of the overall model (e.g. person-centered care plans, care team engagement, access to services). Simultaneously there were strong and mixed opinions about tools, including Care Navigator. It was determined that for PY 2022, care coordination payments will be paid independent of Care Navigator activity and under a simpler accountability model that provides both predictable capacity and incentive payments tied to TCOC. Further, despite significant funding constraints for PY 2022, 93% of care coordination funding was sustained across all continuum of care partners. Investments will continue in the Longitudinal Care program and DULCE, although the investments are realigned to existing scope and resources with no planned expansion in PY 2022.[3]

In alignment with OneCare's strategic plan, primary prevention activities will evolve to address opportunities for the network to address clinically-focused prevention areas, including a closer examination of opportunities to address health equity in preventive screenings and services (e.g. cancer screening, immunizations).

OneCare will continue its specific focus on diabetes, depression, developmental screening, and hypertension through the Value Based Incentive Fund (VBIF), providing quarterly reporting for each participating primary care organization and HSA and biannual financial incentives for achieving target or stretch goals in each focus area. In the most recent progress report to OneCare's Board, it was noted that 98% of primary care practices met at least one target measure goal and 84% met at least one stretch goal thus far in the year. OneCare will continue with these clinical focus areas into PY 2022; updating targets and stretch goals as needed. While the VBIF will continue in the same fashion, the total

[3] VDH Maternal and Child Health Division is contributing additional Title V funds in DULCE to maintain current levels of funding

investment is reduced by $1M for PY 2022 to directly address the budget deficit described above.

Together, OneCare's ongoing commitment to population health management investments totals $29M across the continuum of care for PY 2022.

f. Changes to staffing and other administrative operations and the effect on the budget.

OneCare has developed a highly functioning workforce to manage its value-based contracts, including experienced operations, analytics, clinical, quality, finance, contracting, and compliance departments. Staff are focused on supporting the network through effective performance management, data and analytics, and ongoing payment reforms. The current operational resources and capacity are the very minimum necessary to support the provider network in these core capabilities, in the payer program requirements, and respond to regulatory and administrative requirements. With the approval of OneCare's 9th Operating Agreement in September 2021, OneCare became a single member organization with the University of Vermont Health Network serving as the sole parent organization. OneCare will remain an independent legal entity with a statewide network of participants, including Dartmouth-Hitchcock and continues with its 21 manager representative Board of Managers.

From the operating budget perspective, the PY 2022 budget remains flat to minimize financial impact on the provider network. The most significant impacts are to software contracts where efficiencies were gained through re-evaluating the market and/or streamlining expenses. OneCare's wages and fringe, in terms of both aggregate dollars and FTEs are flat despite higher than ever resources demands. Further, OneCare is demonstrating continued efficiencies within the model, with operating costs at 1.1% of TCOC, a reduction from 1.9% in 2019.

g. Key assumptions and limitations made during budget development.

As in past budget cycles, OneCare makes key assumptions during budget development that may evolve through payer contract negotiation. OneCare relies on the best available information at the time of submission to identify reasonable attribution levels, total cost of care targets, and revenue opportunities. The goal is to provide network participants the best and most reasonable estimates of risk levels and investment opportunities. Separately, OneCare included an assumed 3.5% trend increase for the Blueprint for Health for PY 2022.

At this critical time in health care, the main objectives of OneCare's PY 2022 budget are to continue to support the provider network through the ongoing public health emergency, to balance expenses with the ongoing need to invest in value-based care transformation, and to address the loss of $6.8M of operating revenue created, in part, by the loss of state/federal investment. To accommodate this significant limitation and maintain $29M of PHM investments, the submitted budget includes $1.4M of additional payer revenue (mostly driven by attribution increases), reduces expenses by $1.8M, and balances the remainder through a $3.6M hospital participation fee increase from last year. A further

limitation is that OneCare's operations are very lean and cannot absorb additional administrative and regulatory burdens while maintaining adequate network support in the absence of additional investment. Further, OneCare's Board continues to note significant concerns that the true costs of Vermont's APM have been funded by the hospitals through their PHM investments and their ACO dues. The cumulative loss of close to $200 million in delivery system reform investment funds has strongly hindered the overall APM goal focus and achievement and must be adequately addressed for health care reform efforts to be expanded.

Throughout the years, and even during a public health emergency, OneCare's network remains dedicated to advancing health care reform in Vermont. The public health emergency has demonstrated that a reliable and resilient health care system is essential to the state's health, and that changing how we pay for, organize, and evaluate our health care system is a pressing need. OneCare is a provider-led vehicle to help this transformation take hold and grow.

2. Provide Section 1 Attachments A and B.

a. **Attachment A: 2022 OneCare ACO Network**

See Section 1, Attachment A: 2022 ACO Network enclosed.

b. **Attachment B: 2022 OneCare ACO Hospital Participation Year Over Year**

See Section 1, Attachment B: 2022 Hospital Participation enclosed.

Section 1: Attachments

Attachment A: 2022 ACO Network

Attachment B: 2022 Hospital Participation

Section 1, Attachment A: 2022 ACO Network

	Medicare, Medicaid & Commercial (BCBSVT, MVP)								Medicaid & Commercial Only (BCBSVT, MVP)				Medicaid and MVP Only	Medicare, Medicaid, BCBSVT
	Health Service Area*													
ACO Entities Within Each HSA**	**Bennington**	**Berlin**	**Brattleboro**	**Burlington**	**Lebanon**	**Middlebury**	**St. Albans**	**Rutland**	**St. Johnsbury**	**Morrisville**	**Newport**	**Springfield**	**Randolph**	**Windsor**
Hospital	Southwestern Vermont Medical Center	Central Vermont Medical Center	Brattleboro Memorial Hospital	UVM Medical Center	Dartmouth Hitchcock	Porter Medical Center	Northwestern Medical Center	Rutland Regional	Northeastern VT Regional Hospital	Copley Hospital	North Country Hospital	Springfield Hospital	Gifford Medical Center	Mt. Ascutney Hospital
FQHC	–	The Health Center	–	CHCB	–	Five Town Health Alliance	NOTCH	CHCRR	Northern Counties Health Care	Lamoille Health Partners	–	SMCS	Gifford Health Care	–
Independent Primary Care	5 Organizations	–	–	12 Organizations	2 Organizations	2 Organizations	2 Organization	–	–	1 Organization	–	–	1 Organization	–
Independent Specialist	2 Organizations	3 Organization	–	9 Organizations	1 Organization	–	1 Organizations	–	–	1 Organization	1 Organization	–	–	–
Home Health	VNA & Hospice of the SW Region[2]; Bayada[1]	Central VT Home Health & Hospice	VNA of VT & NH[3]; Bayada[1]	UVM Health Network Home Health & Hospice; Bayada[1]	VNA of VT & NH[3]	Addison County Home Health & Hospice	Franklin County Home Health Agency	VNA & Hospice of the SW Region[2]; Bayada1	Lamoille Home Health Agency[7] (Hardwick); Caledonia Home Health & Hospice[4]	Lamoille Home Health Agency[7] (Hardwick)	Orleans Essex VNA & Hospice	VNA of VT and NH[3]	VNA of VT & NH[3]	VNA of VT & NH[3]
SNF	1 SNF	2 SNFs	3 SNFs	3 SNFs	–	1 SNF	3 SNFs	3 SNFs	1 SNF	1 SNF	2 SNFs	1 SNFs	–	1 SNF
Designated Agency	United Counseling Service of Bennington County	Washington County Mental Health	Health Care & Rehab Services of SE VT[6]	Howard Center	Health Care & Rehab Services of SE VT[6]	Counseling Service of Addison County	Northwestern Counseling & Support Services	Rutland Mental Health Services	Northeast Kingdom Human Services[8]; Lamoille County Mental Health Services[5]	Lamoille County Mental Health Services[5]	Northeast Kingdom Human Services[8]	Health Care & Rehab Services of SE VT[6]	Clara Martin Center	Health Care & Rehab Services of SE VT[6]
Other	1 Special Service Agency	1 Special Service Agency	1 Other (Brattleboro Retreat)	3 Naturopath; 1 Special Service Agency; 1 Surgery Ctr; 3 Physical Therapy	1 Other (DH Clinic)	1 Naturopath	1 Physical Therapy	1 Physical Therapy	–	–	–	1 Special Service Agency	1 Naturopath	–

Notes: OneCare has Collaborator Agreements with Area Agencies on Aging (AAAs) across Vermont as well as with the Support and Services at Home (SASH) Program

[1] Bayada serves the entire State of Vermont, these are the communities where there are main offices

[2] VNA & Hospice of the Southwest Region services both the Bennington and Rutland HSAs

[3] VNA of VT and NH services the Brattleboro, Lebanon, Windsor, Springfield and Randolph HSAs

[4] Caledonia Home Health & Hospice is part of Northern Counties Health Care

[5] Lamoille County Mental Health Services covers both the Morrisville and St. Johnsbury HSAs

[6] Health Care and Rehabilitation Services of Southeastern Vermont services the Brattleboro, Lebanon, Windsor and Springfield HSAs

[7] Lamoille Home Health Agency services the Morrisville and St. Johnsbury HSAs

[8] Northeast Kingdom Human Services covers both Newport and St. Johnsbury HSAs

* The HSAs listed in Row 8 are contracted with the Payer Programs listed in Row 6.

** Not all Entities within each given HSA participate in the Payer Programs listed above. Rows 8-15 show the Entities in the given HSA.

Section 1, Attachment B: 2022 Hospital Participation

			Payer Programs by Year *(see key below)*					
#	HSA	Hospital Assigned	2017	2018	2019	2020	2021	2022
1	Burlington	UVM Medical Center	VMNG & Shared Savings	All Risk Programs	All Risk Programs & BCP	All Risk Programs, BCP & MVP	All Risk Programs, BCP & MVP	VMNG, VMAI, BCBSVT, MVP
2	Berlin	Central Vermont Medical Center	VMNG & Shared Savings	All Risk Programs	All Risk Programs & BCP	All Risk Programs, BCP & MVP	All Risk Programs, BCP & MVP	VMNG, VMAI, BCBSVT, MVP
3	Middlebury	Porter Medical Center	VMNG & Shared Savings	All Risk Programs	All Risk Programs & BCP	All Risk Programs, BCP & MVP	All Risk Programs, BCP & MVP	VMNG, VMAI, BCBSVT, MVP
4	St. Albans	Northwestern Medical Center	VMNG & Shared Savings	All Risk Programs	All Risk Programs & BCP	All Risk Programs, BCP & MVP	All Risk Programs, BCP & MVP	VMNG, VMAI, BCBSVT, MVP
5	Brattleboro	Brattleboro Memorial Hospital	Shared Savings	All Risk Programs	All Risk Programs & BCP	All Risk Programs, BCP & MVP	All Risk Programs, BCP & MVP	VMNG, VMAI, BCBSVT, MVP
6	Springfield	Springfield Hospital	No Participation	All Risk Programs	All Risk Programs	VMNG, BCBSVT QHP, BCP & MVP	VMNG, BCBSVT QHP, BCP & MVP	VMNG, BCBSVT & MVP
7	Lebanon	Dartmouth Hitchcock Hospital	Shared Savings	VMNG & BCBSVT	VMNG, BCBSVT & BCP	VMNG, BCBSVT QHP, BCP & MVP	VMNG, BCBSVT QHP, BCP & MVP	VMNG, BCBSVT & MVP
8	Bennington	Southwestern VT Medical Center	Shared Savings	VMNG Only	All Risk Programs & BCP	All Risk Programs, BCP & MVP	All Risk Programs, BCP & MVP	VMNG, VMAI, BCBSVT, MVP
9	Windsor	Mt. Ascutney Hospital	Shared Savings	VMNG Only	All Risk Programs & BCP	All Risk Programs & BCP	All Risk Programs & BCP	VMNG, VMAI, BCBSVT
10	Newport	North Country Hospital	Shared Savings	VMNG Only	VMNG Only	VMNG, BCBSVT QHP, BCP & MVP	VMNG, BCBSVT QHP, BCP & MVP	VMNG, BCBSVT & MVP
11	Rutland	Rutland Regional	BCBSVT & Shared Savings	No Participation	VMNG Only	VMNG, BCP & MVP	VMNG, VMAI, BCP & MVP	VMNG, VMAI, BCBSVT, MVP
12	St. Johnsbury	Northeastern VT Regional Hospital	No Participation	No Participation	VMNG Only	VMNG, BCP & MVP	VMNG, BCP & MVP	VMNG, BCBSVT & MVP
13	Randolph	Gifford Medical Center	No Participation	No Participation	VMNG Only	VMNG & MVP	VMNG & MVP	VMNG & MVP
14	Morrisville	Copley Hospital	Shared Savings	No Participation	No Participation	VMNG & MVP	VMNG & MVP	VMNG, BCBSVT & MVP
15	Townshend	Grace Cottage	No Participation	No Participation	No Participation	No Participation	No Participation	No Participation

All Risk Programs: VMAI, VMNG & BCBSVT QHP BCBSVT: For 2017-2021 represents QHP only; For 2022 represents QHP, BEE, Fully-Insured LG, Self-Insured LG BCP: BCBSVT Primary MVP: MVP QHP Shared Savings: Medicare and BCBSVT Shared Savings Programs VMAI: Vermont Medicare ACO Initiative VMNG: Vermont Medicaid Next Generation

Section 2

ACO Provider Network

Section 2: ACO Provider Network

1. **Provide an update on the FY22 Network Development Strategy (submitted 5/28/21). In the description, include the following:**

   OneCare's overall 2022 network development strategy remains consistent with the approach in the submission to the Green Mountain Care Board (GMCB) in May, 2021. With the ongoing public health emergency and provider organizations stretched to capacity, OneCare remains focused on retaining current participation, expanding participation in existing payer programs, managing risk and opportunity, and making modest adjustments to programs to continue to evolve value-based care arrangements. Thus, the primary network development foci for 2022 include: continuing primary care and continuum of care resource supports; engaging with FQHCs to design a fixed payment pilot program; unifying the network across payer programs; and ensuring providers have adequate knowledge and expectations of network participation.

   To support this network development strategy, OneCare has engaged in many outreach efforts to include the following:

   - Strategic Plan Development: Over the first six months of 2021, OneCare's Board developed a three year Strategic Plan focused on the ACO's core capabilities. The planning process solicited network feedback with over 40 stakeholder interviews and engaged iteratively with interested parties such as the State of Vermont (e.g. AHS, GMCB, and DVHA), health care associations and OneCare's Patient and Family Advisory Committee (PFAC). The result is a three year strategic plan: https://www.onecarevt.org/strategic-plan/
   - Care Coordination Program Evolution: An initial outcome of the 2022 Strategic Plan was the creation of stakeholder planning and listening sessions to envision the next evolution of the care coordination program, payment system, and associated tools, resources, and education. In development of the care coordination program, OneCare also sought consumer input through PFAC that informed the care coordination policies and program redesign.
   - Comprehensive Payment Reform (CPR) Engagement: To support 2022 planning for independent primary care providers, OneCare is hosting focus groups with CPR participants and other financial leaders across the network. The discussions to date have included an evaluation of the 2021 program design and input for improvements for 2022. The program is expanding to include two new practices in 2022.
   - FQHC Fixed Payment Pilot: OneCare is working with Bi-State Primary Care Association (Bi-State), their contractor HMA, and DVHA to design a fixed payment pilot for FQHCs akin to the CPR program for 2022. The initial plan is to pilot for Medicaid only and with 1-3 sites in 2022, with expansion across other payers and sites in future years.
   - Provider & Patient Surveys: During 2020, OneCare surveyed network care coordinators in an effort to elicit provider satisfaction feedback and input specific to the OneCare care coordination program. This survey provided OneCare with valuable, actionable information which informed OneCare's strategic planning process and evolution of its care coordination program. In 2021, OneCare released two additional surveys: the first was to network data contacts to invite input and feedback on how data are provided and what could be done to

better support the network. Network participants with varying needs and perspectives provided great ideas for future engagement and OneCare is formulating actions based on this feedback. The second survey was sent to finance contacts in the OneCare network in summer 2021 and similarly sought feedback on OneCare's finance functions and opportunities to provide enhanced network support. Respondents described content and delivery mechanisms for additional finance-related training on OneCare's programs and payments, and suggestions to improve monthly payment statements. Several respondents also volunteered to help create enhancements and to participate in future focus groups. Finally, in Q4 2021, OneCare will work with local care coordination staff to deploy a patient-facing survey to better understand how individuals experience the program and where there may be strengths to build upon as well as opportunities to continue to refine and improve the program.

In order to retain and grow the OneCare network, continued engagement is and will remain a focus during the current contracting period and through implementation of the programs in 2022.

a. Anticipated changes to the provider network in 2022 including areas of growth, areas of decline, and general observations as to what is driving participation decisions and how these changes affect the overall budget;

OneCare has successfully retained the majority of network providers and anticipates minimal changes to the composition for 2022. Typical changes are practices that merge, are acquired, or have retiring physicians. Of note, there are two independent primary care practices returning in 2022 due to the additional funding opportunity and program supports available through the ACO. These modest network changes are expected to have minimal impact on the budget.

Table 1: 2022 Network Changes

Organization Type	2021	2022	2022 Changes
Hospitals*	14	14	No changes
FQHCs	9	9	No changes
Independent Primary Care	25	25	2 returning; 2 terminations
In CPR Program	11	13	2 joined
Naturopaths	6	5	1 retirement
Specialists	23~	24	2 terminations; 3 joined
Continuum^	46~	47	1 termination; 2 joined

* Includes employed physicians and providers

^ SNF, Home Health and Hospice, Designated Agencies, Special Services Agencies, Ambulatory Surgery Centers

~ In 2021, after the budget was submitted, there were two changes in the network as updated above: 1) an internal reclassification of physical therapists from the continuum to the specialists category, and 2) the addition of two organizations joining. Therefore, 2021 counts differ slightly from those submitted in the FY 2021 ACO Budget submission.

For a description of network expansion across payer programs, see the response to Section 2, question 3.d.

b. Quantify the number and type of providers that have dropped out of the network 2020-2022 (prior, current, and budget years) and to the best of your knowledge, their reasons for exiting;

OneCare worked hard to retain and grow the provider network year over year and departures in 2022 are minimal. Table 2 below displays the small number of network departures and their reasons for exiting in the prior, current and budget years.

Table 2: Network Departures: 2020-2022

	# Departing Organizations		
Departure Reason	**2020**	**2021**	**2022**
Merged, Acquired or Closed	4	4	4
Lack of Specialist Program	4	2	2
COVID-19 Impacts	0	4	0
Primary Care Funding	0	2*	0
Total per Year	**8**	**12**	**6**

*These two organizations returned to the ACO network for the 2022 performance year.

c. Challenges and opportunities associated with 2022 network recruitment activities, including the continued impact of COVID-19.

As communicated in the network development strategy provided to the GMCB in May 2021, recruitment challenges fall into three main categories: financial, regulatory alignment, and operational. Given the unique impact of the public health emergency, this is added as a fourth category. See below:

- **Financial**
    - Reduced financial support to fund delivery system reform efforts.
    - Magnitude of risk relative to anticipated provider margins.
    - Provider organizations need time and manageable risk to facilitate their ability to recover from the public health emergency.
    - Dissatisfaction with fixed payment models that reconcile back to FFS.
    - New and evolving health care patterns as the public health emergency continues.
- **Regulatory Alignment**
    - Need for proactive regulatory support to educate and encourage national commercial insurers to participate in Vermont's All Payer Model.
    - Regulatory budgeting processes need to be aligned to promote coordination and efficiency across health care system (hospitals, payers, ACO).
- **Operational**

- Challenges with payers to deliver fixed payment models that do not reconcile back to FFS.
- Continued Medicare claims processing issues resulting in unnecessary administrative burden.
- Delays and/or inconsistent receipt of payer data constrains timely and accurate analytics and reporting to network participants.
- Lack of clarity in Critical Access Hospital cost reporting processes.
- Provider and ACO administrative burdens need to be further reduced to allow increased focus on care delivery.

- **Public Health Emergency**
  - During this prolonged public health emergency, many frontline providers and staff have endured extreme stressors, with no respite due to an outlook of increased volume and complexity of catch-up care.
  - Utilization patterns are new and evolving, therefore it will be challenging to establish fair TCOC benchmarks which results in providers requiring reduced risk to manage through the uncertainty.
  - Workforce availability is evolving and becoming more challenging as the public health emergency progresses.
  - Enhanced financial stress and uncertainty for providers.

2. Populate Appendix 2.1, 2022 ACO Provider Network Template and Appendix 2.2, 2022 Provider Lists

In accordance with the letter from the GMCB to OneCare dated September 27, 2021, OneCare will submit Appendix 2.1 and 2.2 on or before October 15, 2021.

a. Submit copies of each type of provider contract, agreement, and addendum for 2022 (i.e. risk contracts, non-risk contracts, collaboration agreements, and memoranda of understanding).

See Section 2, Attachment A: 2022 Network Agreements enclosed.

3. Describe how your provider contracts support and further the goals of reducing cost and improving quality, including reference to the following:

OneCare's network contracting approach requires a balance between serving provider needs and meeting payer-specific requirements in accordance with the All Payer Model and ACO guidance. Current provider contracting priorities are diverse and are designed to further evolve health care reform efforts statewide.

OneCare has several deliberate areas of focus which are reflected in contracting efforts for 2022. First, through the VBIF program, OneCare provides timely payments to primary care providers who meet specific quality target or stretch goals, and to continuum of care providers based on community-level quality performance at the HSA level. Further, OneCare is continuing to expand and evolve its primary care payment reform effort through the CPR program that

facilitates high value care delivery and supports providers in moving from FFS to value-based payments. Additionally, in partnership with Bi-State and several interested FQHCs, OneCare is exploring the possibility of a pilot program to test fixed payments at these critical facilities to enable the same high value and predictable payment approach as CPR. Finally, OneCare maintains its focus on population health efforts through care coordination incentive payments and facilitating network participant's ability to identify individuals who most require intervention, thereby improving the quality of their care and addressing high risk, high cost individuals.

OneCare works in a spirit of continuous improvement, which is further facilitated by its annual contracting cycle. By learning from prior year efforts, change can occur at a relatively rapid pace, which enables OneCare to respond to provider needs and concerns and to enhance high value care delivery for the benefit of all Vermonters.

a. Provider payment strategies and methodologies.

OneCare prioritized payment reform as a key component of the Strategic Plan and intends to pursue unreconciled fixed prospective payments for all in-network hospitals and core primary care services across all payer programs during the period of 2022 through 2025. Fixed monthly payments are a means to stabilize health care costs, and allow for evolved practice patterns in support of high quality patient care.

It is important to note that expansion of unreconciled fixed prospective payments, at a minimum, requires cooperation on the part of a number of external stakeholders from the public and private sectors, as well as the convergence of favorable market and regulatory conditions. OneCare will continue to be a collaborative partner and champion the concept of payment reform on behalf of its provider network.

In addition, OneCare is working to evolve provider incentive payments by adding value based elements of accountability, while making them easier to understand, more specific, and more aligned across payers. For example, care coordination payments have been decoupled from administrative burdens reported in use of Care Navigator, and tied to total cost of care (TCOC)-related or other industry accepted metrics. Additionally, the CPR program offers a payer-blended, capacity payment for primary care services across three payer programs, including Medicare and Medicaid, and will be adjusted in 2022 to be more responsive to increased service line offerings.

b. A description of new or expanded ACO incentives to strengthen primary care, including strategies for recruiting additional primary care providers to the model and providing resources to expand capacity in existing primary care practices.

The 2022 network development strategy focuses on retaining and expanding primary care participation. To succeed, OneCare needs to offer programmatic enhancements that ensure participation in value-based health care is better for individuals and their providers than operating solely in a FFS system. As defined in the Strategic Plan, offering data and analytics support, payment reform opportunities, and network performance management support are the three core strategies to strengthen a robust and high performing network of participants.

OneCare established a multi-year goal in its strategic plan to strengthen primary care by expanding CPR program participation. The CPR program supports participating independent primary care practices by providing a predictable revenue stream and additional enhanced financial resources. This program supports the transition from a FFS payment model to a value based payment model with a fixed payer-blended per member per month (PMPM) payment for core primary care services. CPR practices also receive a $5.00 PMPM primary care incentive add-on payment (in addition to the monthly PMPM payment amount for core services and separate and above other primary care incentives such as quality, population health, or care coordination payments). PMPM payments for non-core services enable practices to fund additional capacity and allow for expansion of service offerings in a more concurrent way. The submitted budget anticipates adding two additional practices joining the CPR program in 2022.

Additionally, OneCare is continuing the CPR program focus group, comprised of financial and clinical leaders from the network (both CPR participants and non-CPR participants), with the intention of deepening network leadership involvement in program design to make the model as attractive as possible. This group is also interested in exploring a number of research areas relating to primary care and collaboratively reviewing data to understand areas of strength and opportunity.

OneCare is developing a FQHC fixed payment model in partnership with Bi-State and DVHA. The specifics of the payment model will be written into policy and submitted to the OneCare Board of Managers and the GMCB once completed. This model would expand fixed payments for FQHCs in the Medicaid program for 2022 with one to three pilot sites. Further expansion to additional payers and FQHC sites is anticipated in 2023-2025.

To strengthen primary care performance under the quality measures, OneCare will continue the more focused VBIF model implemented in 2021. Under this design, primary care practices receive quarterly quality reports displaying how their specific practice performed on a subset of quality measures. Presenting these data on a regular basis will help participants understand how they perform relative to their peers and identify areas for

improvement. The financial model is designed to pay more to the participants excelling in the measures, which aligns with the underlying concept of value-based health care.

In 2022 primary care providers will receive a combination of capacity and incentive payments for care coordination services and supports.[4] In addition to a $1.50 care coordination PMPM for all attributed lives in primary care, the incentive payment to primary care providers will be tied to the risk-adjusted TCOC for the practice's attributed population. The simplification of this payment stream is intended to respond to the providers' request for reduction in administrative burdens as well as a request for ongoing flexibility in how these funds are allocated to support care coordination efforts. These efforts should contribute to improved provider satisfaction and possibly aid in recruitment and retention of the workforce.

c. Any strategies related to the expansion of fixed prospective payments (FPP) across the ACO provider network, recognizing provider types. Please identify any provider types for which FPP may not be an appropriate payment reform strategy and explain why.

OneCare recognizes that the FFS payment model is not sustainable and is committed to working with payer partners to migrate to a fixed prospective payment (FPP) methodology. An ongoing challenge with the FPP reform effort is that only Medicaid offers a true fixed payment model while all other payers offer a fixed payment option with an end of year reconciliation back to the FFS equivalent amount. This reconciled model offsets the benefits of the fixed payment conversion and impedes OneCare's ability to bring additional hospitals into the Medicare and commercial programs unless a timely path to an unreconciled fixed payment is clear. OneCare continues to explore this possibility with Medicare and commercial insurers.

To date, OneCare has not encountered any specific provider types for which FPP may not be an appropriate payment reform strategy. An ill fit with the fixed payment model is more often the result of small numbers creating unstable estimates or timing concerns related to general business changes such as practice mergers, provider turnover, or service line expansions (e.g. adding a mental health provider in a primary care practice).

Expanding fixed prospective payments for participants in the Medicare program centers heavily on CMMI moving away from reconciliation of the FPP to the FFS-equivalent value at year-end, which has been a topic of discussion at the statewide level as part of the All Payer Model Task Force. The area ripest for expansion of fixed payments within the Medicaid program would be conversion of FFS payments currently being paid to FQHCs (roughly $15M annually). A model is currently under development with one to three pilot sites and an anticipated launch in January, 2022.

Achieving all of these goals requires partnership with commercial insurers and the state. OneCare is currently participating in a series of group discussions with these parties to

[4] Continuum of Care payments are described in the response to Section 4, question 2.

identify shared goals and opportunities. Private discussions with commercial insurers are also ongoing as programs are negotiated.

For a more detailed outline of strategies related to the expansion of FPPs across the ACO provider network, see Budget Order Condition 15: FPP Target, Strategy and Timeline submitted to the GMCB on July 1, 2021.

d. Strategies for expanding provider participation across payers. How is OneCare working toward an "all-payer" model?

As a continuation of network expansion across all payers, for 2022, the OneCare Board of Managers approved a policy to require network participation in Medicaid and all commercial programs (except in approved extenuating circumstances). The Board determined not to require universal participation in Medicare until such a time as the underlying issues around reconciled fixed payments and the cost reporting issues for Critical Access Hospitals are resolved. The sheer magnitude of the financial risk in the Medicare program preclude required participant participation until these foundational issues are resolved. This policy change contributed to payer program expansion for 21 Participants and Preferred Providers in 2022. As more providers align across payer programs, there is improved opportunity for enhanced coordination and quality of care, as well as improved cost management.

OneCare's Board also noted significant concerns that the majority of costs of Vermont's All Payer Model health care delivery system reform efforts have been funded by the participating hospitals. This funding is provided by hospitals through their investments in population health management and their ACO dues in the absence of the state's ability to leverage APM investments through delivery system reform funds that could receive federal matching funds. This lack of financial support for the delivery system has hindered its ability to prepare for and move into the model.

e. Strategies for reducing the administrative burden of reporting requirements for providers while balancing the need to have sufficient measures to evaluate adequately the quality of and access to care.

OneCare engages in continuous process improvement to better serve its network. Specific areas in which OneCare is focused to decrease provider burden include advocating for reduced payer burden (e.g. prior authorizations), improving analytics and reporting based on network feedback, enhancements to payment reform programs, simplifying payment methodology, aligning quality measures and focused efforts for improvement, and evolution of the care coordination program.

One of the core capabilities in OneCare's Strategic Plan is to provide focused, actionable data and insights to the network while gathering information about changes made to succeed under value based care. By partnering closely with providers in various settings including clinical committees, HSA executive consultations, and the recent data users'

survey, OneCare works to continuously improve reporting to ensure focused and actionable data. For example, 78% of network survey respondents indicated they currently use OneCare data for organizational decision-making including to inform financial decisions, quality improvement work, workflow refinement, coordinating within and across HSAs, and to identify specific opportunities or variations in care or quality. Further, the majority of respondents indicated using a combination of static reports, self-service analytic tools, and direct support by OneCare analysts. They reported opportunities for improvement in data availability, ease of use, and a desire for more direct and customized support from OneCare analysts. These opportunities along with indications of a desire for more focus on utilization, chronic conditions, and health equity data will drive action for 2022.

In an effort to enhance the CPR program, OneCare is continuing to engage providers in a series of focus groups. To date, these focus groups have contributed to a number of improvements to the payment model for 2022 that aim to enhance overall program satisfaction and understanding. In similar fashion, as a result of feedback during OneCare's strategic planning process, OneCare has decoupled care coordination payments from the administrative burden of documentation in the system for 2022 and is aligning the payments through capacity and incentive payment formats. For more information about these payment reform simplifications, see the response to Section 2, question 3.a.

In regard to quality initiatives, the VBIF program has evolved to enhance focus on four key quality measures for improvement: Diabetes Mellitus: Hemoglobin A1C Poor Control (>9%), Hypertension: Controlling High Blood Pressure, Screening for Clinical Depression and Follow Up Plan, and Developmental Screening in First 3 Years of Life. In response to network feedback requesting more timely data to drive care delivery reform, OneCare delivers VBIF results to all network providers on a quarterly basis. Data for these efforts are collected through VITL clinical data feeds and claims data when available, and is supplemented with manual chart abstraction. These efforts are designed to emulate annual chart abstraction, which is required for quality reporting for all payer programs. The analytic and manual work is conducted by OneCare staff to reduce the burden on providers so that they can focus on patient care and systems improvement as areas of opportunity are identified.

Additionally, OneCare continues to align quality measures across payer programs to streamline work in furtherance of the APM population health goals. Of the 18 measures for performance year 2021, 16 are applicable across multiple payer programs and five are applicable to all payer programs. OneCare is eager to continue this standardization across programs to better facilitate coordinated quality improvement efforts across the network to better serve Vermonters. To do so, OneCare seeks to balance the tension between payer requests for unique and additional measures with providers' desire to focus on a subset of consistent measures where data indicate opportunity for improvement in patient care and outcomes.

Finally, OneCare continues to function as a learning health care system, gathering feedback, measuring progress, and supporting programmatic changes to achieve population health

goals. As a result of OneCare's strategic planning process, through which network participants expressed some dissatisfaction with the burden of documentation and structure of payments in the care coordination program, a decision was made to evolve the care coordination program for 2022. As part of this process, OneCare has engaged the network in listening sessions throughout the summer to better understand how to meet the needs of the network and maintain a balance of accountability and reduced burden. While the care model remains the same, there will be changes in 2022 to associated documentation and the basis of payments. Work is underway to finalize these refinements with the network and network-wide communications will take place in Q4 in order to prepare for 2022.

f. Description and results of outreach efforts to providers to evaluate the satisfaction providers have with the ACO's programs.

OneCare regularly engages in efforts to evaluate provider satisfaction with its programs and resources. Feedback through the governance structure is used to inform policy, programs, payments, and future directions. Committees include the Patient and Family Advisory Committee, Population Health Strategy Committee (and its subcommittees on quality, pediatrics, and laboratory), Audit Committee, and Finance Committee. These committees include representatives from organizations across the continuum of care.

Further, OneCare has conducted special task forces and workgroups to seek program-specific feedback. For example, a Primary Care Workgroup, comprised of network primary care providers throughout the state, convened in late 2020 and early 2021 with a goal of identifying priorities areas that would improve patient care services within the network. Priority areas identified for improvement were: transitions of care; coordination of care with the designated mental health agencies; use of the Care Navigator platform for care coordination; communication between primary care and specialty care; and access to data. Second, CPR program focus groups initiated in spring of 2021 provide input on program design with monthly meetings covering topics such as the payment model, practice variation and the development of a primary care scorecard. These meetings continue, prompting program evolution based on provider input. In addition, AHS is discussing a possible extension of the current APM Agreement for one year, with OneCare and VAHHS engaging in this process with stakeholder discussions about the financial components of the program to represent providers' needs in any extension and/or renewal of the agreement.

During 2020, OneCare released a care coordination survey to all network care coordinators to elicit provider satisfaction feedback and input specific to the care coordination program. Responses covered topics to include care coordination experience and expectations, barriers, methods, training needs, meeting frequencies, and other recommendations. OneCare received 121 responses from Area Agencies on Aging, Designated Agencies, FQHCs, home health and hospice agencies, hospital-owned and independent primary care, Support and Services at Home (SASH), and the Vermont Chronic Care Initiative. This survey provided OneCare with valuable, actionable information which informed OneCare's strategic planning process and evolution of its care coordination model.

In alignment with OneCare's Strategic Plan, in summer 2021 OneCare began more formal data gathering around the ACO's newly articulated three core capabilities. These capabilities include:

Network Performance Management: ensuring a high quality, equitable system that continuously strives to improve health care delivery and outcomes;

Data and Analytics: delivering actionable data to health care providers in support of better health care; and

Payment Reform: evolving value based care contracts to move away from FFS.

In support of the Data and Analytics core capability, OneCare distributed a survey in 2021 to network data recipients inviting feedback on what could be done to better support the network with data and analytics. Network participants with varying needs and perspectives were surveyed and many great ideas for future engagement were gathered. See the response to Section 2, question 3.e. for additional information about the survey findings.

To further develop the Payment Reform core capability, in 2021 OneCare conducted a provider survey to seek feedback related to OneCare's finance function and opportunities to provide support to the network. Overall, the results highlighted a desire for additional training on OneCare's programs and payments, to be received in the form of conversation, written documentation, or video conference(s). Additionally, respondents had suggestions on areas for improvement of OneCare's monthly payment statements including labeling, specificity, and quality of information. Through survey efforts, a number of contacts were identified as being interested in joining a focus group to assist with development of enhancements. The finance team is continuing to evaluate these results in Q4 of 2021 and seeking to begin implementation of training and knowledge tools to give providers a directory of detailed information regarding the OneCare programs and payments. Additionally, a focus group comprised of members of the network will be used to assist in development of materials, resources and future improvements.

Section 2: Attachments

Attachment A: 2022 Network Agreements

- Electronic Version – see file “Section 2 Attachment A - 2022 Network Agreements.pdf”
- Print Version – see section labeled “Section 2, Attachment A: 2022 Network Agreements”

Section 3

ACO Payer Programs

Section 3: ACO Payer Programs

1. **Complete Appendix 3.1, ACO Scale Target Initiatives and Program Alignment Form. Submit copies of your 2022 proposed contractual arrangements, by payer, and explain changes made to your portfolio of payer programs for the proposed budget year, including reference to the following:**

   In 2022, OneCare anticipates continuing with all existing payer programs in generally similar form. The budget does not reflect the addition of any new payer programs. A minor change is that OneCare is in discussion with BCBSVT to integrate the Qualified Health Plan (QHP) and Primary (Blue Edge Enterprise Group, Fully-Insured Large Group and Self-Insured Large Group) arrangements into a singular contract. While in total there are no substantial changes expected relative to the payer program offerings in 2021, the loss of Delivery System Reform (DSR) and Health Information Technology (HIT) funding that has historically been facilitated through the Medicaid contract represents a significant ongoing challenge valued at $3.9M for 2022.

   Since payer agreements are currently under negotiation, OneCare is supplying Appendix 3.1, based on knowledge obtained at date of submission. In line with the letter from the GMCB to OneCare dated September 27, 2021, OneCare will supply updates to Appendix 3.1 and accompanying payer agreements within 10 business days of execution.

   See Appendix 3.1 enclosed.

   a. **Any anticipated new payer programs and/or terminating payer programs and the overall impact on the budget model.**

      The payers for 2022 remain the same as 2021 and include Medicaid (traditional and expanded cohorts), Medicare, BCBSVT (QHP, Blue Edge Enterprise Group, Fully-Insured Large Group and Self-Insured Large Group), and MVP QHP. OneCare does not anticipate adding or removing any payer programs in 2022. As such, there is no material impact to the submitted budget as it relates to the portfolio of payer programs, with the exception of the DSR and HIT impacts noted above.

   b. **For continuing payer programs, explain any anticipated changes and the overall impact on the budget.**

      At the time of the budget submission, OneCare anticipates that the payer programs will continue in a generally similar form. Throughout the negotiation process, OneCare strives to generate consistency and alignment across program design in order to deliver a seamless program model to participating providers. A minor change is that OneCare is in discussion with BCBSVT to integrate the QHP and Primary arrangements into a singular contract. Additionally, OneCare will continue to advocate for state investment in providers' health care delivery system reform efforts, especially in the absence of DSR/HIT funding.

All of the payer contracts are in active negotiation and updates will be provided to the GMCB when concluded.

c. For any programs that do not generate attribution qualifying for All Payer Model scale targets, explain the rationale for entering the program and its overall impact on the budget model.

All budgeted programs include the ability to generate attribution that qualifies for All Payer ACO Model scale targets. Within the "Primary" component of the BCBSVT program some self-funded health plan organizations utilizing BCBSVT as their plan administrator may decline participation in the value-based model. BCBSVT provides this information to OneCare as OneCare does not have a direct relationship with employer groups. As such, the budget makes assumptions about which employer groups will elect to participate in this model for 2022.

d. If payer contracts are not finalized by the date of the budget submission, please respond as completely as possible to the applicable questions. Contracts must be submitted within 10 days of execution and the GMCB may request an update on the status of contract negotiation at any time.

OneCare's payer contract negotiation cycle occurs simultaneously with the GMCB budget progress. Payer agreements will not be executed by the date of this submission, therefore OneCare will provide completed contracts within 10 business days after execution, as agreed with the GMCB in its letter dated September 27, 2021. As with prior years, OneCare will supply the GMCB with updates on the timing of contract negotiations as they proceed.

2. Please explain any strategies you are pursuing for expanding FPP offerings across payer programs. Please also explain how FPPs are calculated for each program, the rationale for such, including how you will plan to accommodate the unusual utilization patterns associated with COVID-19, and what kinds of providers are eligible for participation. What mechanisms do you have to ensure that FPP is not "too high" or "too low"? How is OneCare working with payers to expand FPP options for providers? Discuss your strategy for expanding FPP as required by FY21 budget order condition #15 (i.e., target and strategy for expanding FPP by payer). In your answer, discuss strategy by year, with targets, for expansion of FPP. Cite national standards where applicable.

<u>Strategies for expanding FPP offerings across payer programs</u>

OneCare's strategy is to work with payers to evolve payer FPP options to be true unreconciled fixed payments like the Medicaid program, and bring additional independent primary care into fixed payments through the CPR program. Each year, OneCare discusses expansion of FPPs as a component of renegotiation with the payers. To better inform and align those discussions, the Director of Health Reform for the Vermont Agency of Human Services hosted group sessions with public and private insurers to discuss FPP evolution in Vermont. OneCare was an active participant in those discussions. In addition, OneCare is working with the payers to ensure their attribution models enable the most effective payment reform programs. The unique nature of

OneCare's statewide presence, voice of the provider network, an evaluation of available resources, and elements of value-based health care strategies determine the fixed payment approach rather than national standards.

FPP calculation and rationale for each program, accommodation of unusual utilization patterns associated with COVID-19, and types of providers eligible for participation

Hospital fixed payments are determined in aggregate by the payers and then divided between the hospitals by OneCare based on a blend of historical FFS spending and an evaluation relative to their past fixed payment amounts. This approach intends to balance responsiveness to organizational change with financial stability for participants. The methodology used to generate the payment amounts is the same for each hospital and they use their own financial management methodology to distribute payments within their organization.

CPR fixed payments are calculated in a payer-blended manner that aims to balance and enhance primary care investment. The payment to each practice is risk-adjusted to align with the composition of each panel. In 2022, the base amounts (pre-risk adjustment) were discussed and determined by a focus group of CPR participants and interested stakeholders convened to review the current program design and recommend enhancements.

As mentioned above, OneCare is developing an FQHC fixed payment model in partnership with Bi-State and DVHA. This program is intended to expand fixed payments to include one to three pilot FQHCs in the Medicaid program for 2022, with expansion to additional payers and FQHC sites anticipated for 2023-2025.

In all cases, fixed payments are designed to stabilize provider revenue, which proved effective, even during a public health emergency. OneCare does not accommodate unusual utilization patterns, to the contrary, that is precisely what fixed payments seek to avoid. Fee for service payments are sensitive to unusual patterns in utilization – a challenge that has been readily identified and is stabilized by the fixed payment programs described here.

Mechanisms to ensure FPP is not "too high" or "too low;" How OneCare works with payers to expand FPP options for providers:

OneCare actively monitors the FFS equivalent spend relative to fixed payments to ensure the FPP is appropriate (neither "too high" nor "too low"). OneCare also advises participants that receive a fixed payment to monitor their own fixed payments against the FFS-equivalent spend. The OneCare Finance Committee regularly reviews fixed payment performance and has recommended adjustments to fixed payments in the past, when appropriate.

How OneCare works with payers to expand FPP options for providers

In addition to hospitals, since 2018, OneCare has worked with payers to transition independent primary care practices from volume to value-based payment reform in the CPR program. This requires replacing payer FFS payment with a fixed monthly payment to OneCare that can then be incorporated into the CPR payments. Through contract negotiations and participant group

sessions hosted by AHS, OneCare hopes to expand the payer programs that offer payments that can be incorporated into fixed payment programs like CPR.

Strategy for expanding FPP as required by FY 2021 budget order condition #15
OneCare continues to work with payers to advocate for fixed payment models that are attractive to participants and enhance payment reform initiatives.

Movement away from the reconciled fixed payment has been a topic of discussion at the statewide level as part of the APM Task Force convened by OneCare and VAHHS. While the concept is supported by the OneCare network and is specifically endorsed by the Task Force, achievement of this target is dependent on when an unreconciled fixed payment will become an available program option. Additionally, there needs to be assurance that Critical Access Hospitals are able to cost-settle under an unreconciled fixed payment.

Further enhancement and expansion of the CPR program will continue to shift health care dollars toward fixed prospective payments for independent primary care services. OneCare is continuing a CPR program focus group, comprised of financial and clinical leaders from the network, with the intention of involving network leadership in program design as a means of increasing participation and program satisfaction. In 2022, OneCare has two new independent primary care practices interested in joining the CPR program. Over the next few years, OneCare aims to expand this program offering to hospital-employed primary care and develop a similar program concept for FQHCs.

The area ripest for expansion of fixed payments within the Medicaid program would be in-network primary care currently being reimbursed FFS ($17.8M, 8.4%). Of this amount, roughly eighty-five percent (~$15M, 7.2%) is being paid to FQHCs.

There is significant opportunity for conversion to fixed payments within commercial payer hospital services, which currently represents 55.8% of the TCOC. At present, only one OneCare network hospital participates in a pilot hospital fixed payment with a commercial plan due to the reconciled nature of the offering. The pilot has been largely successful thus far from an operational standpoint and could extend by expansion of the participants with the same commercial payer or by involving other payers in similar hospital fixed payment programs.

As is the case with Medicare and Medicaid, further enhancement of the CPR program and expansion of its network of participants will continue to shift commercial health care dollars toward fixed prospective payments for primary care services.

Achieving all of these goals requires partnership with commercial insurers and the state. OneCare is currently participating in a series of group discussions with these parties to identify shared goals and opportunities. Discussions between OneCare and commercial insurers are also ongoing as programs are negotiated.

3. Provide an update on the "expanded" or geographic attribution methodology implemented in the Medicaid ACO program in 2020, including any attribution and care management results to date and any changes to the implementation or methodology from 2021 to 2022.

In 2021, the Medicaid expanded attribution methodology resulted in an additional 27,847 lives aligned to OneCare. This population includes those who are enrolled with Medicaid as primary coverage but do not attribute in the traditional fashion though a primary care relationship. Exclusions include those who are dually eligible for Medicare, are on a limited benefit plan, and anyone who attributes naturally to a provider not in the OneCare network. Within this population, some members are new to Medicaid (and thus have no historical claims to drive attribution) and some have visits only with specialists, continuum of care providers, or hospital services.

To encourage engagement with this expanded Medicaid population in 2020 and 2021, primary care providers were offered a one-time $100 per member per year (PMPY) primary care engagement payment for conducting a qualifying visit during the contract year. In 2020, 5,295 of the 28,552 members attributed via this methodology had a visit with a primary care doctor by the end of 2020 and 3,708 (70%) became traditionally attributed in 2021.

After receiving payer data and making it available to OneCare's network, for the period of May to August 2021, the following activities were noted in support of the Medicaid expanded population:

- 111 members were actively care managed (they were engaged with a lead care coordinator and completed a shared care plan).
- 69 (62%) of these members were considered to be high or very high risk
- 87 (78%) had a care team member associated with a primary care practice
- 9 (8%) were in one of our three care coordination priority cohorts – high emergency department (ED) utilizers, high inpatient utilizers or high cost individuals.
- 25 (23%) had mental health or substance use comorbidities identified through claims
- An additional 384 members, 38% of which were high or very high risk, were engaged with at least one care team member.

Subject to the outcome of ongoing contract negotiations, OneCare plans to continue support of the Medicaid expanded population; however, in response to the loss of DSR and HIT funding, the specific PMPY revenue has been reallocated to sustaining the care coordination program for 2022.

a. What are the lessons learned from the expanded Medicaid population that could be applied to the commercial payer programs?

The Medicaid expanded population exists due to the underlying claims-based attribution logic and the fact that Medicaid does not require the member to select a primary care provider (PCP) at the time of enrollment. Some commercial insurers capture the individual's PCP and, in the absence of historical claims, the PCP on record is used to generate

attribution. For commercial insurers not utilizing this methodology, either including the PCP selection or adding in an “expanded/geographic” attribution concept may be viable. Despite the benefits of including the “expanded/geographic” lives in the program, those falling into this category often have unique health care cost dynamics which adds complexity to the risk transfer arrangement. As such, narrower risk corridors are appropriate. OneCare hoped to learn more about specific dynamics of the Medicaid expanded population in 2020/2021 to facilitate expansion into other payer programs, but the public health emergency impacts the underlying data and conclusions. Thus, ongoing evaluation will be needed over the next several years.

Section 4

Total Cost of Care

Section 4: Total Cost of Care

1. **Complete Appendix 4.1 TCOC Performance by Payer, Total ACO-Wide (2018-2022). Explain the drivers of expected vs. actual Total Cost of Care results by payer program. Provide actuals for prior year. If not available, provide projections and the timeline for when actuals will be available. Provide projections for the current year. For the budget year, provide expected TCOC. Please recognize any relevant assumptions for projections and budget figures (e.g., based on historical seasonal spend plus a particular rate of growth, etc.). Describe all adjustment factors used for calculating the settlement result (e.g., risk sharing, other fees, etc.).**

   The public health emergency presented many challenges in the target-setting process across all payers in 2021. Factors that presented large unknowns included the speed of ramp up of services across the state, regulations and restrictions that would occur during the performance year and the impact they may have on utilization, variants, and potential pent-up demand from services that were postponed in 2020. Different HSAs, age groups, and payers have all experienced these factors to varying degrees and have resulted in abnormal seasonal trends, which presents a challenge when trying to forecast total cost of care (TCOC).

   Medicare:
   The public health emergency triggered the exogenous clause in OneCare's Medicare contract. This led to a change in the methodology of calculating the 2021 benchmark. The new benchmark considered the growth rate in TCOC from the base year for OneCare's attributed population relative to the region as a whole. To date, there has been a rapid return to pre-pandemic spend levels, and a higher than anticipated spring and early summer expenditures. As the public health emergency lingers on, it's unclear if there will be another reduction in care, or a rise in the number and acuity of care interventions.

   When generating the forecast for the anticipated program outcome, analysis considered the following factors:

   - Inpatient hospital service utilization did not drop as sharply as other services as a result of the public health emergency (it also did not rebound as strongly, has been fairly consistent since the shutdown ended, and is still lower than 2019 levels).
   - Outpatient hospital service utilization took the hardest hit during the shutdown and has been slower to ramp back up, though it has been steadily growing, more so this spring and summer.
   - Post-acute care (PAC) is another relevant driver of total cost. While PAC did not dip all that much during the shutdown period, and held steady through 2020, it has been running high throughout 2021 (PAC is the only service area to exceed 2019 utilization levels for all months of 2021).
   - As of spring 2021, outpatient services and PAC services are both exceeding 2019 levels and forecasting suggests neither area will taper off.

- Physician service utilization declined more sharply during the shutdown than inpatient services, but started rebounding in the summer and fall of 2020, and has returned to 2019 levels since.

Medicaid:
For both the traditional and expanded cohorts, the Medicaid targets were built without specific adjustments for the public health emergency (besides the removal of some COVID-19 admissions and vaccination spend from the actual TCOC). To date, spend has had a similar increase as Medicare in early spring but appears to have begun to taper off over the summer months. This slowing over the summer may yield favorable results in the Medicaid program, but there is significant uncertainty driven by the continuing public health emergency.

BCBSVT QHP:
The BCBSVT QHP program is forecast to be close to the target. Lower spend in January ramped up quickly and exceeded expectations in March, but has slowed down over late spring and early summer. In total, this results in a forecast similar to the projected target.

BCBSVT Primary:
There are similar patterns to the other payers in the BCBSVT Primary lines of business. Monitoring will continue throughout the remainder of the performance year.

MVP QHP:
The MVP QHP target's medical trend factor includes a [redacted].
Current 2021 performance reports for this program appear to indicate that [redacted], with the target currently being [redacted] the actual expenditures.
Performance against the target for this program is [redacted].

The expected TCOC figures can be referenced in Appendix 4.1 enclosed. When developing forecast figures, OneCare aims to prepare an analysis that will replicate the expected methodology that payers will use to set the performance year target. The TCOC forecasts rely upon an attribution estimate, an assumption of the base expenditures (with an added complexity to circumvent the impacts of the public health emergency), a projection of the trend rates payers will apply, and any final adjustments as part of the accountability model established by the payers (ex. COVID-19 exclusions). In 2022, OneCare does not anticipate significant changes to the underlying attribution totals. Assumptions to trend rates are explained in more detail in the response to Section 4, Question 3.

Prior year contracts outline the way in which the payers have historically calculated the settlement results, including factors such as risk sharing and other fees. The submitted budget does not incorporate any significant changes relating to their methodology.

Year-end assumptions include the following: factors that incorporate current health care utilization relative to historical capacity as a result of the public health emergency; seasonality with normal increases anticipated in fall 2021; and a reduction in Medicare seasonal out-migration that results from travel-related concerns due to the public health emergency. Additionally, OneCare awaits final decisions regarding payer modifications to TCOC targets for 2021. Many of these factors have no historical basis and thus need to be viewed cautiously.

See Appendix 4.1 enclosed.

2. **Complete Appendix 4.2 Settlement by Payer, by HSA (2018-2022). Explain the methodology by which the ACO distributed funds by HSA, including all adjustment factors used for calculating the settlement distribution (e.g., risk sharing/mitigation, market factor adjustments, adjustments for local performance, case mix, etc.). Discuss the ACO's Total Cost of Care accountability strategy at the HSA level.**

Methodology by which the ACO distributed funds by HSA, including all adjustment factors used for calculating the settlement distribution

Prior to 2020, shared savings and losses were calculated specifically for each HSA in a manner that reconciled with the aggregate OneCare outcome. In 2020, there was a pooled distribution model where the aggregate results flowed through to HSAs and participants in an allocated manner. For a detailed explanation of the methodology, see 04-07-PY22 Program Settlement PY 2022 Policy provided to the GMCB on August 30, 2021.

The change to the pooled model was made to address the public health emergency, generate efficiency to address resource constraints at OneCare, and reinforce the notion of a singular network with shared goals. Additionally, results at the HSA level may be driven by the volatility of small numbers at the local level. With so few lives attributing to some of the HSAs, a small number of expensive cases and/or inherent variation risk can dictate the result for the HSA, even with effective population health practices in place. As a strategy to address these issues, OneCare is continuing with a pooling of ACO risk to help protect from this volatility.

One of the lessons learned from prior program performance is that operating as a statewide system is key to success. While setting local HSA targets and evaluating each community or practice may have attractive qualities, there is ordinary volatility at the local level that results in settlement at a granular level, particularly in the Medicare program. In order for OneCare's programs to yield positive results under the All Payer ACO Model, the health care landscape must be viewed as an integrated network. With this in mind, focus can shift away from dividing health care spending into "mini ACO" segments and toward network-wide areas of opportunity. OneCare provides participants with financial, utilization, and quality reporting, key insights, and regular consultation meetings to inform their local decision-making.

OneCare does not include any material adjustment factors when allocating settlement to its provider network, other than past risk mitigation arrangements where either OneCare or the Founders retained a portion of savings/losses.

ACO's Total Cost of Care accountability strategy at the HSA level

While in 2022 shared savings and losses are pooled, OneCare aims to enhance programmatic investments that increase individual provider accountability in ways that are directly related to TCOC and quality performance.

Accountability Pool: In 2021, primary care providers are directly linked to programmatic shared savings and losses outcomes. Each can either contribute throughout the year or via year-end invoice to shared losses if owed. If no losses are owed, contributions are refunded and primary care has access to the first $1.50 PMPM of shared savings. OneCare will continue the Accountability Pool in 2022. Contributions to the Accountability Pool are only required for risk-based programs.

Care Coordination: The care coordination program in 2022 incorporates a base payment for all participant types currently receiving funds through the care coordination program (e.g. primary and continuum of care). The program also offers an incentive payment for those organizations that perform well under defined incentive measures (e.g. a risk-adjusted TCOC model for primary care and a set of national quality measures for continuum providers). As an important first step, 15% of the available funding will be rewarded based on performance outcomes. While the patient benefits of care coordination must be noted, this program design helps to reinforce the links between care coordination, quality of care, and overall health care cost.

Value Based Incentive Fund: While the VBIF is a quality investment vehicle, high performance on the quality measures used to award payment have the potential to help manage health care costs. Seventy percent (70%) of the VBIF is distributed on the practice level to those practices that meet quality measure performance targets and an additional ten percent (10%) is awarded to practices that meet the stretch goal for each measure. This strategy to award VBIF payments on the practice level is another way in which accountability is spread across OneCare's network of providers. The remaining twenty percent (20%) is awarded to network specialists and collaborating agencies based on HSA-level performance against the same quality measure targets. The intended focus of the 2022 VBIF program is in alignment with the current 2021 program with respect to provider payment structures and focused quality metrics.

See Appendix 4.2 enclosed.

a. How is the ACO using TCOC and quality data at the local HSA level to identify high-value and low-value care?

OneCare deploys various means by which it uses TCOC and quality data locally to identify high-value and low-value care. Specifically, OneCare performs in-depth review and analysis of performance in the Utilization Review Committee (URC) and also provides monthly and quarterly reporting to its network and payers in support of this priority. Additionally, HSA

executive consultations are a quarterly forum in which HSA leaders can review data and determine opportunities for improvement.

The URC monitors cost, utilization, and quality with a focus on identifying and evaluating variations in key metrics, and assessing outliers for potential improvement opportunities. When unexpected findings are identified, OneCare's analytics, finance, and/or clinical teams, with guidance from the Chief Medical Officer, outreach to participants to share their findings, gather additional information, make recommendations, and monitor performance. Additionally, OneCare communicates directly with payers to investigate performance concerns or any other notable issues resulting from data review.

OneCare leadership deploys ongoing quarterly executive HSA consultations, which are another means for identifying high-value and low-value care. These meetings began in the first quarter of 2021 and provide an opportunity to review data, share best practices, and identify opportunities for improvement in care delivery at the HSA level. In the third quarter of 2021, OneCare implemented an HSA consultation "menu" of options for deep dive discussions to take place in the final consultation of the year. HSA leadership is asked to choose which of the menu items best meet their needs, so that OneCare can present actionable data in support of HSA-specific priorities.

b. How is the ACO helping hospitals and other community providers to reduce low-value care and lower their TCOC at the local HSA level?

OneCare engaged in a comprehensive strategic planning process that included over 40 stakeholders from the care continuum and represented diverse communities throughout the state. As a result of this process, OneCare identified and clearly articulated its areas of strategic focus and core capabilities: Network Performance Management, Data and Analytics, and Payment Reform.

OneCare leverages the Network Performance Management core capability by providing targeted outreach to hospitals and other community providers to reduce low-value care and appropriately seek opportunities to improve TCOC. OneCare implements its core capability of Data and Analytics by assessing network data, variation, and performance in comparison with national, local, or other benchmarks. Outreach is focused on HSAs and organizations that demonstrate gaps in care and/or opportunities for improvement. In its partnerships with provider organizations, OneCare implements core capability Network Performance Management strategies such as Plan-Do-Study-Act (PDSA), shares network best practices, and clarifies performance expectations. OneCare representatives use a collaborative engagement approach resulting in creation of specific goals and a plan for future performance monitoring. As described in the Section 4, question 2, population health investments are now linked to the TCOC or other related outcomes and are being implemented in manageable steps to maintain network engagement and participation.

Also at the local level, OneCare engages local health care providers in the role of Regional Clinical Representatives (RCRs), who serve as liaisons between providers in a HSA and

OneCare. In this critical role, RCRs work closely with OneCare's Chief Medical Officer to optimize care provided, oversee performance improvement efforts, and provide valuable feedback from frontline providers about OneCare's clinical programs and tools.

3. Complete Appendix 4.3, Projected and Budgeted Trend Rates, by Payer Program, and explain the following, refer to "Part II. ACO Budget Targets" of this guidance in your explanation:

When compiling the trend rate forecasts for the budget submission, OneCare utilizes its growing archive of historical data to estimate the trends and targets that the payers will set for the upcoming performance year. Since the payers have not set the targets at the time of this submission, it is assumed that they will utilize a similar approach and methodology to prior years. At this point in time, OneCare still expects the targets set by payers to reflect the best possible estimate of health care expenditures for the attributed population absent ACO activities.

See Appendix 4.3 enclosed.

a. All underlying assumptions for these trend rates (Appendix 4.3, Column D) including those related to changes in utilization, service mix, unit cost etc., noting any significant deviations from prior year. For programs subject to rate review by the GMCB, include details about how the Board's decision factored into the assumptions for the ACO's budgeted trend.

OneCare generates its forecast trend rates differently for each payer program and in a manner that aims to generate a result that will align with the way each payer establishes the actual target. Despite best efforts to forecast targets, the impact of the public health emergency on current health care spending patterns may result in adjustments to the underlying payer methodology and require incorporating factors to account for the expected impact of deferred disease management in 2020 and/or increased demand continuing into 2022.

At the time of the budget submission, it is unclear how the specific changes in factors such as utilization, service mix, and unit cost will be incorporated into each payer's rate development. The budget also incorporates the maximum allowable Medicare USPCC trend rate per the Vermont All Payer Model Agreement as a critical lever to offset the cost shift and as a means to support the providers committed to, and investing in, Vermont's health care reform efforts. Trend rate assumptions by payer are noted below.

Medicare: Trend rates are sourced from the United States Per Capita Cost (USPCC) forecast published by CMS as outlined in the All Payer Model. As such, a blended trend of 10.6% was applied to a forecast of 2021 spend, adjusted for network changes, to determine the estimated 2022 benchmark. This unusually high trend rate for claims-based expenditures is a direct result of the public

health emergency and a mechanism to address atypical claims-based reductions during this period.

OneCare included an assumed 3.5% trend increase for the Blueprint for Health (Blueprint) for PY 2022. This trend takes into consideration the lack of downward pressures on this fixed dollar amount in PY 2021 which is distinctly different from the depressed claims experience observed for other Medicare providers for which the USPCC trend rate for PY 2022 is attempting to correct. In alignment with AHS, OneCare recommends extending the proposed trend increase for Community Health Team and Patient Centered Medical Home funds in the same fashion as PY 2021. In planning discussions, both SASH and OneCare agreed that a portion of the proposed SASH increase for PY 2022 could be used to continue funding the mental health integration pilot that is otherwise not included in OneCare's PY 2022 budget due to existing funding constraints with the remainder at SASH's discretion.

Medicaid: Trend rates are determined by reviewing prior rate development models to determine a reasonable budget assumption to be used until Medicaid sets the actual TCOC target. Based on this analysis, a blended 2.12% trend for the traditional cohort and a blended 0.74% trend for the expanded cohort (relative to the 2021 target) have been incorporated into the forecast.

BCBSVT QHP: OneCare requests input on the medical expense trend data from the payer. BCBSVT supplied a [redacted] for the medical expense trend, derived from the GMCB-approved rate filing, to be used in the OneCare budget development. OneCare applied [redacted] (relative to the 2021 target) to the forecast.

BCBSVT Primary: OneCare requests input on the appropriate trend data from the payer. BCBSVT supplied a [redacted] for the trend estimate. OneCare applied [redacted] (relative to the 2021 target) to the forecast.

MVP QHP: OneCare requests input on the medical expense trend data from the payer. MVP supplied a [redacted] for the medical expense trend, derived from the GMCB-approved rate filing, to be used in the OneCare budget development. However, OneCare is observing the 2021 target supplied by MVP [redacted] the actual expenditures for this cohort. Accordingly, OneCare applied [redacted] to the forecast of 2021 expenditures, which aligns with the way in which the target has been previously established in this program.

b. For each program, contrast the budgeted growth rate (Appendix 4.3, Column D) with the expected growth trend for the ACO (Appendix 4.3, Column G). Include analysis for reasons why the ACO's performance differs from the trend rates used in the budget.

Forecast trend rates are projected from varying source data, as previously described in Section 4, question 3.a. The submitted budget assumes that the expected spending is appropriately set and aligns with the anticipated actual spending that will occur absent OneCare and provider ACO interventions for all payers. As a result of the public health emergency, the actual 2021 PMPM spend may be high or low relative to what OneCare anticipates the spending targets to be in 2022 due to deferred demand and catch-up care. It's unclear if this will extend into 2022. Changes in the population will also impact the trend rate change between 2021 actual and 2022 budgeted levels, but the impact is expected to be modest. In discussion with OneCare's contracted actuaries, other ACOs seem to be gravitating toward relying upon a pre-pandemic base year (i.e. 2019), advocating for models with a target that adjust with industry trends, and/or continuing with narrower risk corridors. The actuarial process the payers undertake to set the 2022 targets will aim to capture these impacts.

c. How TCOC targets are distributed by HSA, including discussion of the extent to which providers have control over the risk for which they are responsible. Describe how the ACO's TCOC accountability strategy allows providers to benefit from their ability to provide high-value care (low-cost, high-quality) and impact TCOC growth.

Aggregate ACO-level TCOC targets will not be distributed by HSA in 2022 for the purposes of avoiding small number volatility and establishing a singular network concept discussed above. Alternatively, OneCare is working to provide analytic and financial performance data to signal high and low value care, identifying opportunities to take action impacting the TCOC, hosting quarterly HSA calls focused on these opportunities, and seeking information about specific steps HSAs are taking to address areas of opportunity. This interactive approach with the network is an improvement upon historical reliance upon more granular HSA target setting.

The 2022 population health investments, particularly care coordination payment model and the VBIF, now have components that are specifically designed to reward participants that are able to demonstrate high-value through either TCOC management or performance on the quality measures. This strategy generates a strong linkage between performance and financial outcomes for any given practice.

d. Recognizing that COVID-19 has resulted in unexpected utilization trends that could continue into 2022, what assumptions are you making around fluctuating utilization estimates, or any other factors that could result in material changes to these budgeted figures and what is the anticipated impact to the proposed budget? Include a description of how you approach calculating the base experience (Appendix 4.3, Column C).

Many unknowns remain regarding both the current and future impacts of COVID-19 on health care costs. This creates a challenge for forecasting and accepting TCOC benchmarks. With an eye toward creating stability, OneCare largely based its TCOC forecasts on 2021 targets given that they are reasonably aligned with current claims expense forecasting (with the above-noted exception of MVP). Presentations from national actuarial firms speak of variables related to a second stay-at-home wave, pent up demand, and the downstream impacts of delayed care or disease management.

As the actuarial processes with the payers unfold, emerging trends and information will be considered to ensure targets are reasonable for all parties. Fluctuating utilization trends, whether due to the public health emergency or otherwise, may result in aggregate changes to the TCOC, thereby impacting the risk or reward opportunity for the provider network.

e. How these growth rates and targets support the All-Payer Model goal to manage overall health care cost growth to be in line with that of the Vermont economy.

The pivotal first step in managing overall health cost growth is to transition the health system from one rewarded by volume to one that rewards cost-effective and high-quality care. OneCare's 2022 budget anticipates another year with a significant number of attributed lives in value based care programs, indicating ongoing commitment by Vermont's providers to this transition. The trend rates themselves are a means to establish an accountability target and install a paradigm in which providers are rewarded for effective health care cost management.

From this point forward, sustaining the momentum behind the value based care transition will require expansion of unreconciled fixed payment programs, federal and State of Vermont investments in health care reform, and resolution of issues presented by Critical Access Hospitals specific to the cost reporting process. The transition of the health care system to a value-based model requires robust support to avoid a reversion back to a FFS structure.

Section 5

Risk Management

Section 5: Risk Management

1. **Complete Appendix 5.1, ACO Risk by Payer, Appendix 5.2, Risk by Payer by Risk Bearing Entity for the budget year and explain how the ACO would manage the financial liability for the risk included in the ACOs payer program agreements for the proposed budget year should the ACO's losses equal 100% of maximum downside exposure. In doing so, please discuss the following:**

   OneCare contracts with its provider network to fund shared losses. In 2022, the budget does include [redacted]. If OneCare were to suffer losses equaling [redacted] of the downside exposure, the provider network would be invoiced to fund the payer program loss in alignment with the 04-07-PY22 Program Settlement PY 2022 Policy, and [redacted]. Through the settlement policy, the first $1.50 PMPM of downside exposure is covered by attributing primary care and the hospitals cover any remaining balance. There are no risk mitigation arrangements planned for 2022 and thus none are included in the budget model.

   See Appendices 5.1 and 5.2 enclosed.

   a. **Any significant changes over prior year and the rationale for such, including changes due to COVID-19.**

      In response to both the public health emergency and the desire to continue program participation, OneCare budgeted similarly low risk corridors in 2022 as it did in 2021. This strategy responds to the financial situation of the provider community while also maintaining a reasonable level of overall accountability.

      OneCare will also continue with the Accountability Pool concept that aims to expand accountability across the network and allows provider types other than hospitals to access shared savings opportunities.

   b. **If any risk is retained by the ACO or the founders, what is this risk associated with, and how much, and how is this obligation funded (reserves, collateral, other liquid security, reinsurance, payer withholds, commitment to pay at settlement, etc.)?**

      OneCare contracts with its provider network such that the network funds 100% of any downside risk exposure, [redacted], and according to the terms of 04-07-PY22 Program Settlement PY 2022 Policy. Hospitals make a commitment to pay any necessary settlement proceeds at the time of settlement, while attributing network providers make monthly contributions to an accountability pool, to be used at year's end to settle any programmatic losses (or to be returned to the providers in the event there are no shared losses).

c. Does the ACO intend to purchase any third-party risk protection? If so:

After careful consideration, the OneCare budget does not include the cost of a third-party risk protection arrangement. The premium for a risk protection product would be much higher relative to the dollar amount of potential return. In light of this dynamic and the need to manage hospital dues, OneCare is forgoing this expense in 2022. This will be reconsidered if the risk corridor is expanded in future years.

i. Explain the nature of the arrangement.

As described above, not applicable.

ii. How does the anticipated protection compare to prior years?

As described above, not applicable.

iii. How much of the downside risk would be covered?

As described above, not applicable.

iv. Which programs would have this protection?

As described above, not applicable.

d. If applicable, explain the nature and magnitude of any solvency or financial guarantee requirements imposed through payer contract arrangements and how the ACO aims to satisfy those requirements.

OneCare expects the Medicare program to require one percent of the TCOC to be covered by a financial guarantee. OneCare intends to use a line of credit to satisfy this program requirement.

e. Explain any other risk management strategies or arrangements that affect either aggregate ACO risk or individual provider risk.

As a risk management strategy, and as a means of sharing risk and reward, OneCare attributing providers contribute $1.50 PMPM to an Accountability Pool. This approach is part of OneCare's methodology to delegate risk to the provider network. This arrangement was in effect in 2021 and will continue in 2022.

2. **Complete Appendix 5.3, Shared Savings and Losses and Appendix 5.4, Shared Savings and Losses by Risk Bearing Entity, and describe the actual or expected distribution of earned shared savings or losses, in the prior year (2020), in the current year (2021) and in the proposed budget year (2022), noting any significant changes in methodology or practice over time.**

   The distribution of actual or expected shared savings is described in the Program Settlement Policy for each performance year. OneCare expects to distribute savings/losses via ACH or invoice, consistent with the methodology utilized in prior years. See 04-07-PY22 Program Settlement PY 2022 Policy provided to the GMCB on August 30, 2021.

   See Appendices 5.3 and 5.4 enclosed.

3. **Provide any further documentation (i.e., policies) for the ACO's management of financial risk.**

   For details about how risk is handled within the ACO, see 04-07-PY22 Program Settlement PY 2022 Policy provided to the GMCB on August 30, 2021.

Section 6

ACO Budget

Section 6: ACO Budget

1. **Complete the GMCB financial statement sheets Appendices 6.1-6.3 (Balance Sheet, Income Statement with Accountability, Cash Flow). Complete Appendix 6.4, Sources and Uses and Appendix 6.5, Per Member Per Month Revenues by Payer.**

   See Appendices 6.1 through 6.5 enclosed.

2. **Revenues: Explain any line-item variations greater than 10% evident on your budgeted income statement as compared to prior year projected actuals and prior year revised budget. Please also explain:**

   For explanations of the line-item variances, see Appendix 6.1-6.3 Variance Analysis enclosed.

   a. **Any significant risks associated with the budgeted revenue sources. If substantial risk exists, explain how the ACO would respond.**

      In light of the enhanced scrutiny of Vermont's movement toward a value-based health care system, the most significant risk in the submitted 2022 budget relates to PMPM funding facilitated through payer contracts. If this PMPM funding were eliminated or reduced, it would have a significant impact on the budget model. The response would need to be determined through a careful evaluation of priorities.

   b. **Budgeted contracted payer contributions to the ACO as well as any significant changes from the prior year.**

      The budget no longer includes a total of $3.9M of state DSR or HIT funding, which was formerly facilitated through the Medicaid program contract under the All Payer Model Agreement. In consideration of this loss of funds, OneCare has made adjustments to population health management investments, has carefully reviewed operating expenses and trimmed where possible, and has increased hospital participation fees. Aside from those funding streams, the budget assumes payer contribution models that are similar to the models incorporated in 2021. Because the revenue lines are based on attribution, variation between the estimated and actual attribution levels may cause additional line item variation. Any material reduction to the nature of these payer contributions will result in the need for significant budget changes.

   c. **Budgeted provider contributions to the ACO as well as any significant changes from the prior year.**

      In addition to the loss of $2.8M DSR and $1.0M HIT funding, there is $1.6M less deferred revenue to access in 2022. These combined factors result in significantly less revenue to implement reform efforts across the state. Filling the budget gap was accomplished through expense reduction that includes a reduction in population health investments and an increase in hospital participation fees.

d. Budgeted governmental/public contributions as well as any significant changes from the prior year.

The 2022 budget does not include state/federal DSR and HIT funding. Loss of this revenue is resulting in fewer population health program investments and increased cost assigned to participating hospitals. Overall the state has not leveraged the federal dollars that were intended for APM investments in health care reforms efforts.
Ultimately, it is not sustainable for the deliverable system to fund population health investments, above what it could incur if the ACO were to maximize payer shared savings.

3. Expenditures: Explain any line-item variations greater than 10% and $100,000 evident on your budgeted income statement as compared to prior year projected actuals and prior year revised budget. Please also explain:

For explanations of the line-item variances, see Appendix 6.1-6.3 Variance Analysis enclosed.

a. Any significant changes to the population health programs and/or care model, including temporary or permanent changes due to COVID-19, and the budgeted impact on expenses.

In response to the loss of DSR and HIT revenue, all of the OneCare population health programs were reviewed to determine the reductions least detrimental to the ongoing transition to value-based care. None of the programmatic changes are solely tied to public health emergency, yet many of the budgetary decisions were made in full awareness of the financial and operational impacts of the public health emergency and the existing cost of reform placed on the provider system.

Regarding the care coordination program, OneCare hosted a combined meeting of the Finance Committee and Population Health Strategy Committee to discuss the level of funding and whether or not reductions were appropriate. This group believed sustaining the program at a similar level was essential at this juncture. Despite this guidance, it was a significant effort to maintain the bulk of the community care coordination program investments and some reductions were required. Care coordination payments being decoupled from Care Navigator for payment purposes also represented a significant change. Budgeted program funds will be apportioned separately for each provider type. For all provider categories, eighty-five percent (85%) of program funds will be distributed based on attribution or a similar allocation methodology designed to match funding with the proportion of care relationships. The remaining fifteen percent (15%) of program funds will be distributed in the form of bonus payments tied to the TCOC (primary care) or quality/outcome-based measures (Preferred Providers). The budget also reflects funding for continuation of the Longitudinal Care Program. Further, to maintain funding for the care coordination program, primary care engagement payments (i.e. $100 PMPY) have been eliminated from the 2022 budget model.

The Value Based Incentive Fund program remains in similar form, however, the budget assumes a reduction to the amount pre-funded through hospital participation fees. Through payer negotiations, OneCare aspires to migrate quality accountability to program settlement. This shift allows OneCare to charge a lower hospital participation fee amount to hospitals and separately fund a payer-blended fund to reward providers for high-quality care. While the VBIF program itself remains in a generally similar form, the total amount in the fund itself is budgeted to be $1.2M lower in 2022 due to overall reductions in state/federal investments.

Similar to the process for the care coordination program, OneCare hosted focus group sessions to examine the CPR program. Modest changes designed to accommodate practice changes in real-time resulted from this process. The program is expanding to include two additional practices in 2022. Participation from these new practices results in increased primary care investment.

As a result of OneCare's strategic planning process, the Board determined a needed shift in the primary prevention strategy to one that has more emphasis on clinical prevention activities and, to the extent possible with ACO data, examines a health equity perspective on these clinical prevention activities. As a result, the RiseVT program will be funded in its current form for the first six months of the year to transition activities and, where possible, integrate them into their current community-based work. During the first half of 2022, OneCare will engage with its network to determine the appropriate specific focus areas and goals for the clinical prevention work and will begin implementation in the second half of the year.

OneCare's contributions to the ongoing DULCE program have been reduced in the submitted 2022 budget; however, OneCare collaborated with DULCE program staff and state Maternal and Child Health leadership at the Vermont Department of Health and funding was identified through the federal Title V grant to offset this reduction and maintain current program levels for 2022.

No new expenses are budgeted for the Specialist/Innovation Fund, with all expenditures representing a continuation of previously funded initiatives.

b. How this budget is affected by any significant changes to clinical and quality priorities for the year.

The budget assumes continuation of the same clinical and quality priorities. These priorities are effectuated financially through the VBIF, which is budgeted to continue in 2022 albeit at a different aggregate level. Further, in executing OneCare's new Strategic Plan, the 2022 prevention strategy will shift to focus on clinical prevention and health equity. As a result, OneCare will evolve away from directly funding community-focused prevention activities at the mid-point of 2022 in favor of designing more clinical-focused prevention activities.

c. Any changes, including significant new investments to the ACO's infrastructure and the budgeted impact on expenses.

There are no significant changes or new investments to the ACO's infrastructure to report.

d. If applicable, how Delivery System Reform funds are being utilized in the proposed budget.

As described, there are no DSR funds to be utilized in the proposed budget.

e. Whether and how this budget supports the maintenance or improvement of the ACO's health information technology system and the drivers of these investments (provider feedback, payer contract etc.).

OneCare continues to invest in its health information technology platform and in the personnel needed to support its core capability of providing data and analytics to the ACO network. In 2022, OneCare will implement a planned reduction of VITL investments to begin to bring costs in line with a regional market assessment. Further, as an outcome of the strategic planning process, OneCare is decoupling care coordination payments from Care Navigator. This change reduces some maintenance costs of the care coordination system. OneCare is working proactively with the network to gather feedback and continue to refine data tools, reports, and supports. For example, see provider survey feedback on financial and analytics supports as described in Section 2, questions 3.e. and 3.f. Further evidence of the ongoing use of these tools is in the new performance metric tracking highlighted through the ACO Insights available on OneCare's website (https://www.onecarevt.org/aco-insights/) and in the submission to the GMCB on September 2, 2021. OneCare will continue to look for opportunities for efficiencies in providing high quality, timely, and actionable data and information to the network to facilitate success in reform efforts.

4. Balance Sheet: Explain any variations greater than 10% and $100,000 evident on your budgeted balance sheet as compared to prior year projected actuals and prior year budget and provide an analysis of the ACO's solvency, providing metrics that you use and noting any areas of concern.

For explanations of line-item variances, see Appendix 6.1-6.3 Variance Analysis enclosed.

From a financial standpoint, OneCare functions in two primary capacities. First, OneCare operates as a fiduciary agent for many funding streams obligated to be paid to providers. For example, OneCare takes in the monthly fixed payments and then apportions those funds to participants in the network based on policy and program design. In general, these pass-through arrangements are designed to be net-neutral to OneCare, and solvency is ultimately dependent on timely receipt of the funds from the source (typically payers). Next, OneCare collects revenue that helps to support its programs, discretionary program investments, and operations. This component is largely sourced from hospital participation fees. The budget

model is designed to collect only the revenues needed to execute the operational model. At the time of this submission, there are no concerns regarding the solvency of the organization.

5. **Cash Flow: Explain any variations greater than 10% and $100,000 evident on your budgeted cash flow statement as compared to prior year projected actuals and prior year budget and provide an analysis of the ACO's current cash position, as well as expectations for the upcoming budget year, noting any potential timing challenges. Please explain the use of, or access to, any revolving debt (including maximum allowable draw) or other debt used to mitigate cash flow challenges.**

   For explanations of the line-item variances, see Appendix 6.1-6.3 Variance Analysis enclosed.

   OneCare maintains a small operating budget, but manages a significant amount of funds-flow each year for hospital fixed payments and other provider investments. This dynamic typically results in a situation where the balance sheet has a significant amount of liquid assets, and also a significant amount of offsetting liabilities. Because of the sizeable liquid assets at any given time, OneCare's cash position is comfortable and enables the organization to manage through brief timing delays in payments (with hospital fixed payments being an exception due to their magnitude). In the event OneCare liquidated or ceased operations, the remaining cash in the organization would be roughly equivalent to the current equity or reserves in the company.

   OneCare rarely has the need to invest in a capitalized asset or project, therefore, there are no budgeted or anticipated material cash outlays outside of the normal provider payments.

   OneCare does not maintain any revolving debt. The line of credit in used solely for the purpose of satisfying the Medicare financial guarantee and is not used for operational purposes.

6. **For Question 2-5, complete the Appendix 6.1-6.3 Variance Analysis in the Excel workbook.**

   See Appendix 6.1-6.3 enclosed.

7. **If the proposed budget includes a gain or a loss, please provide a rationale. Otherwise explain how to balance to a break-even budget (surplus to reserves etc.).**

   The submitted budget has a $0 gain/loss. This is achieved by floating hospital participation fees to achieve balance.

   a. **Discuss any prior or current year surplus or losses and their intended use and how they were earned. How does non-profit status affect treatment of reserves?**

      OneCare had a $0 gain/loss in 2020. The final outcome for 2021 is not expected to be significant in either direction. The 2022 budget model is designed to yield a $0 gain/loss, which means that there are no planned additions to reserves. Achievement of a 501(c)(3) tax exempt status does not have any impact on the treatment of reserves.

8. Complete Appendices 6.6, Hospital ACO Participation for the proposed budget year.

See Appendix 6.6 enclosed.

9. Complete Appendix 6.7, ACO Management Compensation with the following:

- **a. A list of all the ACO's current officers, directors and trustees, regardless of whether any compensation was paid to such individuals.**
- **b. List all positions with gross compensation (the equivalent of Box 5 on a W-2) greater than or equal to $150,000.**
- **c. List all leadership positions (VP, all C-Suite, including Chief Compliance Officer) with gross compensation (the equivalent of Box 5 on a W-2) greater than $100,000.**

See Appendix 6.7 enclosed.

10. Please provide details for any expected capital expenditures over the next three years.

OneCare does not anticipate any significant capital purchases over the next three years. The most likely expenses that would be capitalized are leasehold improvements, but there are none planned at this point in time.

Section 7

ACO Quality, Population Health, Model of Care, and Community Integration

Section 7: ACO Quality, Population Health, Model of Care, and Community Integration

1. ***Model of Care*. Please briefly explain OneCare's statewide model of care and any significant changes made in the current year, anticipated for the proposed budget year, and describe the rationale. In doing so, please include explanation for the following:**

   OneCare's population health model recognizes each individual's unique health needs and aligns programming and supports through the provider network and local communities. OneCare's four quadrant care model segments the population into Vermonter's who are healthy/well; have early onset or stable chronic conditions; have full onset chronic illness and rising risk; or have complex and/or high cost acute catastrophic conditions. The care model is supported by strong relationships among individuals, their primary care providers, and community-based care team to support appropriate identification of their health status and associated services and supports. OneCare's programs include population level strategies to protect and improve health outcomes within the four quadrant care model, as outlined below.

   Quadrant One (Healthy/Well)
   OneCare facilitates primary prevention programs to support individuals as they maintain health through preventive care and community-based wellness activities. In 2021, OneCare has continued to promote high-quality screening in the medical home, including proactive panel management to identify individuals missing these health assessments to connect them to these services. For example, OneCare has continued to support DULCE to address social determinants of health in infants, birth to six months, by connecting families with support systems to address the health disparities that often affect families of low income, of color, or of immigrant status. OneCare has also continued to invest in community programming through RiseVT in ten HSAs.

   As an outcome of OneCare's strategic planning discussions among the network, it was determined that in 2022, OneCare should enhance its focus on clinical prevention activities through a lens of health equity and develop and deploy appropriate strategies to address identified areas of opportunity in primary care settings. This type of clinical preventive care includes wellness exams, immunizations, health screenings, and social determinants of health screenings, among others. Specific strategies and programming will be explored in the first six months of 2022 with the potential for initial implementation in the second half of the year.

   Quadrant Two (Early Onset/Stable Chronic Illness)
   OneCare continues to focus on the areas outlined in Quadrant One, particularly around effective panel management and identification of populations that may be at rising risk due to changes in their health status or utilization of care. Additionally, in close partnership with the Blueprint and Vermont Department of Health, OneCare's providers work to optimize health and self-management of chronic disease. Of note, in 2021, individuals identified as "medium risk" (i.e. in quadrant two) accounted for 1,404 participants or 1.4% of the actively care managed population. This population became a focus area for providers as they worked to identify individuals with rising risk who could benefit from outreach or care coordination. It has also been seen as an opportune time to connect individuals in quadrant two with local community resources to support positive behavior change interventions.

Quadrant Three: Vermonters with Full Onset Chronic Illness and Rising Risk, and Quadrant Four: Vermonters with Complex/High Cost Acute Catastrophic Conditions)

The categories of quadrants three and four make up the majority of the population receiving support through OneCare's community team-based care coordination program. Individuals identified through risk stratification or clinician identification as falling into Quadrant Three (Rising Risk) account for 10% of the population and individuals identified as Quadrant Four (Complex/High Cost/Acute Care) make up 6% of the population. OneCare's care coordination program provides a framework, data, education and training on best practices, and network funding to engage high and very high risk individuals in supports and services to improve their health status and enhance their experience of care.

As a learning system, OneCare is evolving its overall care coordination program in 2022 based on network feedback. By creating more precise areas of focus through early identification of at risk individuals who fall into defined subpopulations and eliminating some burdensome documentation requirements, the program allows providers more time for provision of high quality care coordination for Vermonters who need it most. The 2022 care coordination program emphasizes person centered care planning, cross organizational collaboration, and timely connection to primary care and mental health services. OneCare drives these essential components through delivery of high quality workforce education, targeted regional technical assistance, and data insights including newly refined, actionable social determinants of health information. Documentation requirements in Care Navigator, as mentioned above, will become optional and alternative reporting (to and from participating organizations) will be made available. Accountabilities for care coordination will include such actions as ongoing subpopulation panel review and outreach, participation in cross organizational collaboration and shared care planning, engagement with OneCare in data driven process improvement, submission of quarterly reports, and attendance at OneCare education sessions.

During OneCare's strategic planning, OneCare's tool for care management support, Care Navigator was assessed. In 2021, the tool is used in varying degrees across the network: while some organizations appreciate the functionality and ability to communicate and coordinate care across settings, many providers expressed concerns about the system. Concerns varied and included a reported perception that Care Navigator led to "double documentation" with additional concerns about the inefficiency of the systems' design. Through stakeholder engagement, a new plan emerged for care coordination support to decouple care coordination payments from Care Navigator documentation. Instead, the payments will be tied to value-add accountabilities including panel review and outreach, and collaboration and shared care planning, among others. OneCare is currently working to finalize these network accountabilities and will communicate the specifics in Q4 2021 to prepare the network for any implementation changes in 2022. Given the inherent complexity of the program and varying degrees of change within, network education and tailored guidance during this period and ongoing is critical. Aligned with its culture of continuous improvement, OneCare will seek ongoing input and

evolve its program over time to further improve quality, efficacy, and coordination of care for Vermonters in Quadrants Three and Four.

a. What elements of the care model has OneCare eliminated or not adopted because they were not successful? What elements have been scaled up and where would OneCare like to put more resources? What is the data behind these decisions?

OneCare has not eliminated any component of the Care Model due to lack of success. In managing the 2022 budget, difficult programmatic decisions and prioritizations needed to be made, for example eliminating the $100 PMPY primary care engagement payments in order to redirect these funds to sustain care coordination efforts. Engagement payments created variability, whereas the care coordination fees will now be more predictable, a necessary component of reform efforts. OneCare works closely with its network and other stakeholders to continuously improve the care model. In 2021, OneCare focused efforts within the care coordination program on targeting specific subpopulation patient identification. This involved the proactive identification of at-risk individuals who fall into one of four subpopulations: high ED utilization, high inpatient utilization, high medical and social risk, and high cost of care. OneCare data analysis identified an opportunity for increased care management within these populations. Specifically, between 83 and 94% of individuals in these populations within OneCare's 2021 cohort do not currently meet criteria of receiving active care management. As a result of this learning, OneCare has made these patient panels available in the Workbench One platform, so that providers may use data to inform prioritization of outreach to individuals. OneCare offers training on how to best use these analytics resources and collaborates with network participants to establish care management targets for these populations.

Programs like DULCE and PUCK could be scaled, if state/federal funding were available. These programs have shown early successes and benefit to their communities. For example, DULCE served 73 families in 2020. Families are screened and offered support services and of the 75% screened, 56% accepted support. The families are also screened for mental health needs and referred for services when appropriate. The PUCK program helped children receive urgent mental health care in an appropriate setting and saw a 33% reduction in the number of kids screened in the ED during the one year period that OneCare funded the project. Over the course of the PUCK project there were 108 children served in PUCK instead of going to the ED (note that in-person services were suspended for one month during the pandemic). These kinds of innovative projects could be scaled statewide if state/federal funding were made available and would help proactively address social determinants of health and make a significant impact on the delivery of mental health care for children.

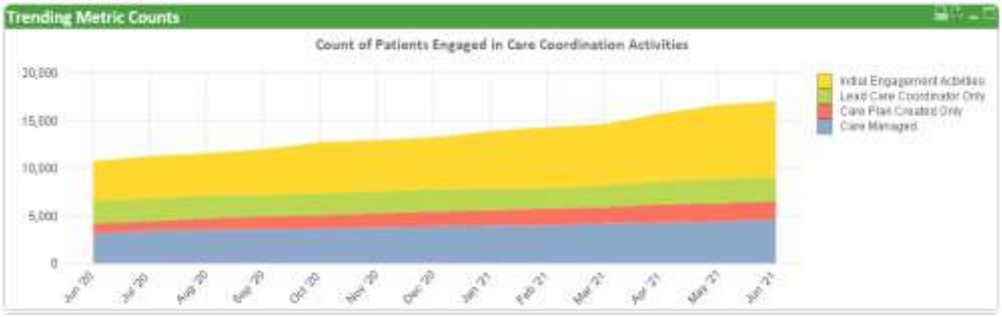
b. Progress to date in 2021 on implementing the model of care, including any quantitative evidence. Please note any lessons learned.

OneCare's model of care is designed to serve all Vermonters, with appropriate focus and attention targeted at populations who are best supported by the right interventions at the

right time. Investments in population health efforts are evaluated to ensure efficient deployment of resources. Recent population health management investments include enhanced analytics tools for network members to identify high and very high risk individuals and investments in the DULCE and RiseVT programs (see Section 7, Question 1 above).

Graph 1 below shows counts of individuals engaged in care coordination activities from June 2020 through June 2021. The trend line demonstrates a steady increase over the past 12 months, with small periods of mild correction which are attributable to payer contracting cycles which result in adjustments to OneCare patient alignment and attribution.

Graph 1: Trending Metric Counts



Further, in the month of August 2021, 57 organizations in OneCare's network were provided with care coordination prioritization tools to facilitate outreach to Vermonters who may benefit from the care coordination program (e.g. frequent users of the ED, individuals with high inpatient hospitalization utilization, or individuals identified as having high physical, mental health and/or social needs). Due to the public health emergency, normal utilization patterns have been disrupted making examination of key performance indicators for care coordination outcomes (inpatient utilization, ED utilization, and hospital readmission rates) challenging and unreliable. OneCare continues to track these indicators and looks forward to post-pandemic analysis of these potential outcomes alongside continued monitoring of care managed rates.

One lesson learned through care model implementation is the importance of ongoing care coordination skills training to ensure consistent, high quality care coordination by the network. OneCare previously sponsored care coordination training and, in response to network feedback and ongoing learning, is currently working to evolve its care coordination program. If funding allowed, ideally OneCare would offer an additional training and certification for case management in 2022; however, this is not currently budgeted due to the fiscal challenges described above.

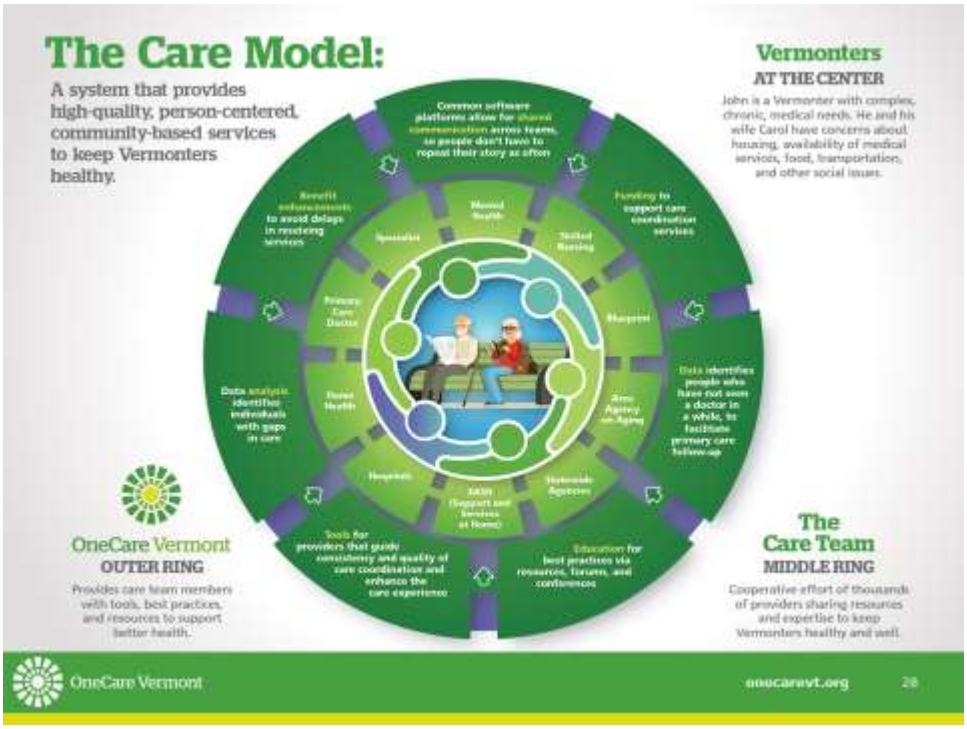
OneCare continues to devote resources toward ongoing care model education and training. Educational sessions delivered in 2021 include the following: How OneCare Vermont Prepares You for Effective Care Coordination, Sex and Gender are Core Determinants of Health, and Identifying and Managing Sub-populations. OneCare will continue to build upon its educational offerings to enhance care delivery. As of August 2021, OneCare has provided

11 care coordination education courses (synchronous and asynchronous) attended by 311 individuals. As OneCare prepares for 2022, various modes of training will be utilized including live webinar, recorded on demand sessions, and interactive dialogue at regional care coordination forums. Such education and guidance will continue as the program changes roll out to ensure thorough understanding of the evolving program and associated accountabilities.

c. Any goals or objectives associated with the model of care for the proposed budget year and the strategy for their achievement.

OneCare's care model centers on Vermonters in a system that provides high quality community based services to promote health. As described in Figure 1, OneCare provides care team members with tools, best practices, and resources so that they, as providers across the continuum of care, can engage with individuals and other professionals to promote goal identification, care planning, referrals, and resources to support individuals health and wellbeing.

Figure 1: OneCare's Care Model



As detailed in OneCare's recent strategic plan, the goal for Network Performance Management is to ensure a high quality, equitable system that continuously strives to improve health care delivery and outcomes. Over the next several years focus will be placed on evaluating the investments to align with and demonstrate success in core population health programs. A specific action for 2022 in this area includes evolving the care coordination program and shifting prevention strategies to align with clinical and health

equity focus areas, as well as a commitment to improving the quality of care for individuals with hypertension and/or diabetes (or pre-conditions). Second, OneCare is evaluating the clinical committee structure and seeking opportunities to clarify their purpose and effectiveness in alignment with Strategic Plan goals. Third, OneCare is focused on establishing key performance indicators, tracking, and publishing them bi-annually. The first edition of this report, called ACO Insights, was shared with the GMCB earlier this fall and is posted on OneCare's website. Finally, OneCare is working collaboratively with AHS, through its improvement plan, to identify areas of mutual interest and align resources. For example, OneCare and AHS are testing a model of social determinant of health data integration to better identify individuals that could benefit from enhanced services, interventions or supports. Additionally, OneCare and AHS leaders have engaged the Blueprint Administrative Entities in each HSA in listening sessions to gather information to better understand where Blueprint and OneCare activities are complementary and where there are opportunities for improvement. Data will be synthesized later this fall, with key themes identified and shared back with the communities.

d. The evidence basis for any changes made since the current year and how you intend to measure progress, including any quantitative measures, reporting, and analysis. The ACO's role in implementing this model of care as compared to other relevant stakeholders, including how the ACO collaborates with the Blueprint for Health and continues to ensure non-redundant services and investments, that are in coordination with, and not in contradiction to, state objectives (e.g. All Payer Model, Department of Mental Health's Ten Year Plan, State Health Improvement Plan).

As previously stated, the overall changes to the care model are minimal and align with the spirit of continuous quality improvement. OneCare's ACO Insights report is one key new method being used to support and measure organizational efforts as they relate to OneCare's core competencies. This document provides a snapshot of ACO implementation and includes metrics in support of OneCare's core capabilities. Key metrics include tool and educational resource utilization to enhance care coordination efforts, quality measure performance results from the VBIF program, analytics tool utilization rates, and review of total cost of care (TCOC) by payment type. These key metrics are designed to spark discussion for improvements and to serve as a way to identify specific and measureable goals. By using this data-driven approach, OneCare can measure progress and identify ongoing opportunities to further support the Strategic Plan and balance the alignment of efforts with other key stakeholders in the state.

OneCare and Blueprint have a long history of coordination and collaboration to support health reform efforts across Vermont. Over the past year, Blueprint and OneCare have explored opportunities to advance self-management work and have actively engaged with chronic disease experts at the Vermont Department of Health for input and guidance. With the movement of the Blueprint to the Office of Health Reform at AHS, renewed focus on alignment is occurring. Over the past several months, leaders from OneCare, AHS, and Blueprint have been engaging communities in collecting feedback (as described above) and

in Q4, anticipate synthesizing this information into key themes to guide strategies for alignment of efforts into 2022 and beyond.

OneCare, the Blueprint, and AHS are aligning care coordination and quality improvement efforts as well. Elements of each program including shared care planning and focus on quality measures are complimentary. As OneCare evolves its care coordination model in response to ACO network feedback and in alignment with the APM Improvement Plan, areas of opportunity will be identified and addressed. For example, OneCare is seeking ways to align provider reporting with some questions already gathered by Blueprint to create efficiencies for the provider community as well as to align feedback and key strategies in support of reform efforts. With respect to quality improvement, Blueprint QI staff are working to support alignment with core quality measures identified by OneCare (i.e. the VBIF measures) with Patient Centered Medical Home activities. This alignment creates greater value for providers and ensures focus on high priority areas of improvement.

2. ***Clinical Focus Areas.*** **Report any results on your 2020 Clinical Focus Areas (interim, if available) and progress to date on 2021 Clinical Focus Areas using Appendix 7.1 ACO Clinical Focus Areas. Provide a narrative description of the ACO's implementation strategy for its Clinical Focus Areas in the current year and in planning for the budget year. How does the ACO support providers in achieving the goals of the Clinical Focus Areas? How are results shared with providers at the HSA and/or the organization level? Does the ACO prepare a final report on Clinical Focus Areas at the close of the year?**

As outlined in Appendix 7.1, OneCare exhibited a great deal of success across all clinical priority areas in 2020. For example, for the acute inpatient admission rate for high and very high risk cohorts, OneCare targeted a 10% improvement. Results demonstrated that this 10% improvement was vastly exceeded in all payer programs, with a range of 33% to 63% improvement. Targets for improvement were largely exceeded across the majority of clinical priorities and payer programs, with few notable exceptions. Specifically, the measure "Access to Care Milestone - Medicaid Adolescents with Well-Care Visits" presented an opportunity for improvement as OneCare fell short of its target in all payer programs. Additionally, the clinical priorities of developmental screening and diabetic A1C control showed mixed results. These opportunities for improvement provided an impetus to OneCare's 2021 clinical priority strategy, as outlined below.

In response to provider feedback and resulting from a concerted effort to streamline programs, OneCare established its 2021 Clinical Focus area in alignment with the quality measures represented in its VBIF effort. This quality program provides financial incentives for high performance on four quality measures where consistent gaps were identified by OneCare's Population Health Strategy Committee. To ensure clarity of priorities and in an effort to optimize results, OneCare intends to maintain the VBIF priorities from 2021 into 2022 which are as follows: diabetes HbA1c poor control (>9.0%) (DM-2 NQF 0059, HEDIS, CDC); controlling high blood pressure (HTN-2 NQF 0018, HEDIS, CBP); early childhood developmental screening (NQF); and depression screening and follow-up (Prev-12, NQF 0418).

Aligning clinical priorities with the scope of quality measure improvement efforts in VBIF enables network participants an opportunity to leverage OneCare resources for efficient care delivery. OneCare provides targeted resources in support of network efforts related to clinical focus areas which include education, data reporting, quality improvement efforts, and financial incentives. OneCare is using a combination of electronic data feeds from the state's Health Information Exchange and manual chart abstraction to measure quality performance and share insights with network participants.

To support providers and ensure that clinical focus areas remain a high priority, OneCare is implementing an iterative program with continuous feedback cycles. OneCare's quality team provides performance feedback directly to practices following quarterly VBIF quality findings. A member of OneCare's quality team partners with organizations to review performance relative to targets, identify potential gaps in care, and determine any opportunities for improvement. OneCare also provides education and guidance with specific performance improvement methodologies, shares evidence based practice recommendations to support areas of focus chosen by participants, and connects organizations to other network partners who are successful to learn best practices. Finally, a monitoring plan is established to ensure accountability to include key timelines and expectations for ongoing data review. At year-end, OneCare will analyze results for the VBIF at practice and HSA levels to evaluate improvement and/or any further opportunities.

Results are shared at the HSA and organizational level through various means. First, OneCare shares feedback with clinical leadership during HSA consultation meetings. Performance insights are shared which inform leadership of areas for improvement and allow for comparison of HSA performance compared with OneCare's entire network. Organizations receive feedback on performance in clinical focus areas through quarterly VBIF reports posted to OneCare's portal. These reports inform practices how they compare to target and stretch goals, typically the 50th and 90th percentile nationally, respectively. OneCare is leading with transparency and timeliness of feedback as an impetus for care delivery improvement.

In a similar fashion to the quarterly reporting for clinical focus areas, OneCare will distribute year-end reports to practices and HSAs. Implementation improvements to clinical focus areas takes time for these iterative efforts to be effective. In light of this, OneCare intends to continue its clinical focus areas into 2022 without any major changes. By narrowing focus and streamlining efforts, OneCare expects to see marked improvement or identify and learn about impediments to success. As noted in Appendix 7.1, first quarter results from 2021 indicate that OneCare largely is meeting its goals, with improvements needed in hypertension management for two payer programs (Medicaid Traditional and BCBSVT QHP).

See Appendix 7.1 enclosed.

3. ***Quality Improvement.*** **Describe any changes to your quality improvement framework and your theory of change for 2022. In doing so, please include the following:**

OneCare's quality improvement program is based on *The Model for Improvement*[5] and the work of W. Edwards Deming, creator of the Plan-Do-Study-Act (PDSA) cycle of learning[6]. *The Model for Improvement* asks three guiding questions:

- What are we trying to accomplish? (the aim statement)
- How will we know the change is an improvement? (the measures); and
- What changes can we make that will result in improvement? (the changes or interventions)

The answers to these three questions then guide the exploration learning process, in small-scale, rapid tests of change.

Current quality improvement focus areas are specific and unified across the network, as determined by the 2021 Value Based Incentive program implementation. This quality program provides financial incentives for high performance on four quality measures where consistent gaps were identified by OneCare's Population Health Strategy Committee. For 2021 and 2022, focus areas include: diabetes HbA1c poor control (>9.0%) (DM-2 NQF 0059, HEDIS, CDC); controlling high blood pressure (HTN-2 NQF 0018, HEDIS, CBP); early childhood developmental screening (NQF); and depression screening and follow-up (Prev-12, NQF 0418). By narrowing down the quality measure focus to these four areas and aligning education, data reporting, supports, and incentives, network participants have a clear understanding of ACO quality priorities and how to meet them.

OneCare is using a combination of electronic data feeds and manual chart abstraction to measure quality performance for network participants on a quarterly basis. In an effort to remain transparent and provide timely feedback, quality performance is communicated directly to practices. A member of OneCare's quality team partners with organizations to review performance relative to targets, identify potential gaps in care and determine any opportunities for improvement. OneCare's support for network efforts also includes education and guidance about performance improvement methodologies, sharing researched best practices relative to chosen areas of focus, and connecting organizations to other network partners who are successful in areas of interest. Finally, a monitoring plan is established to ensure accountability to include key timelines and expectations for ongoing data review.

[5] Langley GL, Nolan KM, Nolan TW, et al. The improvement guide: a practical approach to enhancing organizational performance. San Francisco: Jossey-Bass; 1996

[6] Deming WE. The new economics for industry, government, education. Cambridge: Massachusetts Institute of Technology; 1994

a. Progress to date and quantitative or qualitative evidence at the ACO, and local (HSA) levels, including an evaluation and the supporting data for the following, over the last four years (2018, 2019, 2020, 2021), by HSA:

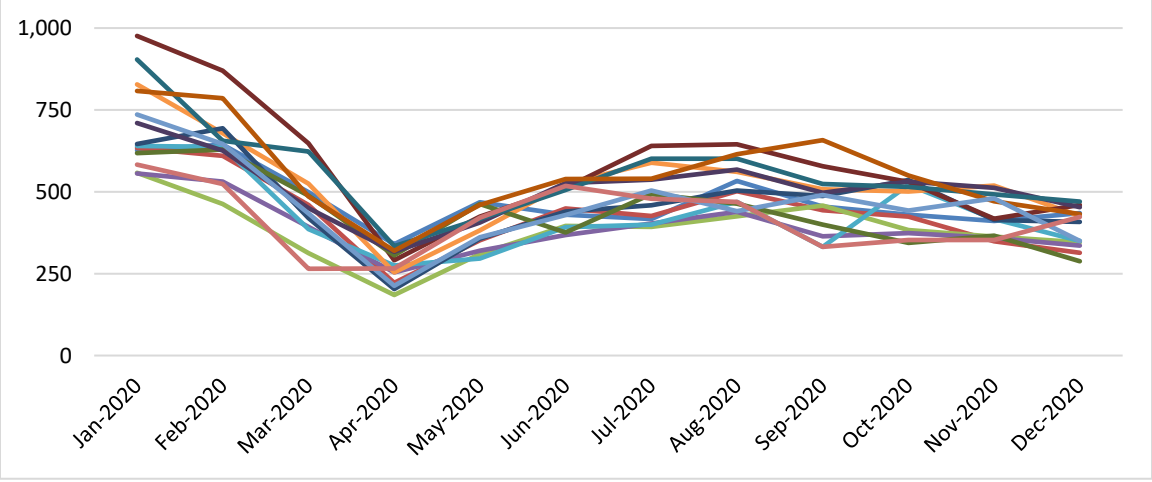
1. Variations in care (utilization measures);

OneCare tracks and reports monthly on key utilization metrics at the ACO and HSA levels through the Performance Dashboard Report and corresponding Performance Dashboard Companion Workbench One application. In addition to making this data readily available to the entire network, OneCare provides outreach through quarterly HSA consultations, which gives OneCare the ability to inform each HSA how they were performing on the key utilization metrics of inpatient admissions, ED visits, outpatient advanced imaging, primary care visits, and specialty care visits relative to their peers and the OneCare network as a whole.

OneCare actively reviews key utilization metrics monthly in the Utilization Review Committee and continues to observe and monitor variations in care among the network. OneCare routinely engages with network participants to highlight variations in care by notifying the impacted HSA through standard reporting and HSA consultations. These conversations also take place in cross-community forums such as the Clinical and Quality Advisory Committee. One outcome of this variation analysis was the identification of the four focused measures for the VBIF. It is notable that higher utilization in certain metrics were a result of outlier cases, and not a reflection on overall and consistent higher or lower utilization among certain communities. For payer-specific descriptions of key cost and utilization measure variation, see the response to Section 7, question 3.a.2.

See Graph 2 below for an example of the impact the public health emergency had on ED utilization within the Medicaid (Traditional) program by HSA.

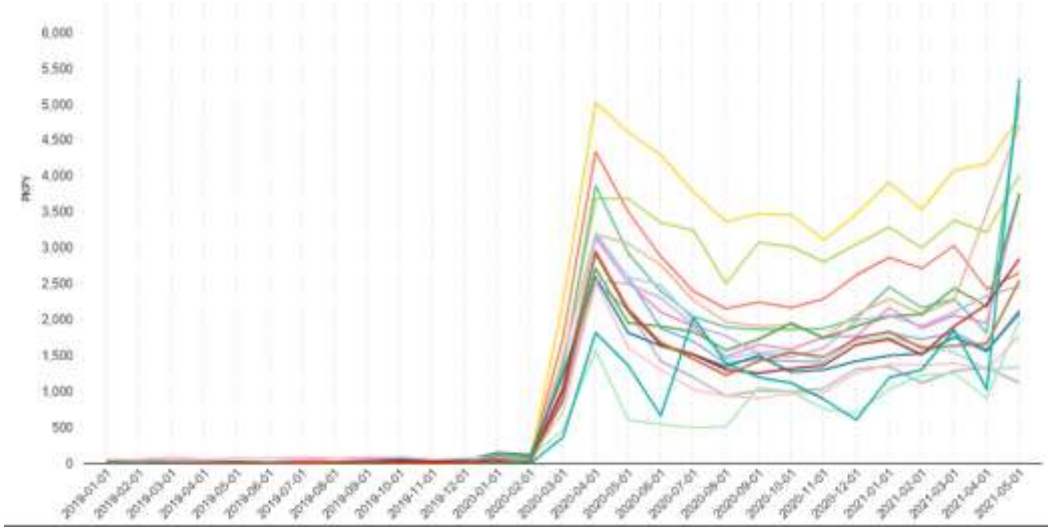
Graph 2: Emergency Department Visits Per-Thousand, Per-Year for Medicaid (Traditional) 2020 Cohort by Health Service Area



In response to the impact of the public health emergency on the way health care was delivered across Vermont, OneCare's Utilization Management Workgroup monitored the telehealth services provided by HSA. OneCare observed significant variation in the delivery of telehealth services across HSAs and this finding was shared with the Population Health Strategy Committee, which includes member representation from across OneCare's network.

As noted in Graph 3 below, which demonstrates HSA telehealth utilization, OneCare observed a substantial increase in telehealth activity at the height of the public health emergency and is currently seeing increased rates of telehealth utilization as of May, 2021.

Graph 3: Telehealth Utilization by HSA



2. Variations in outcomes (outcome measures);

Exhibit A to Section 7: HSA Cost and Utilization Variation by Payer highlights variation in key cost and utilization metrics across the OneCare network for services included in the financial risk model. This includes Variation Analysis reports for 2018, 2019, 2020, and Q1 2021 for Medicare (Tables 4, 5, 6, and 7), MVP QHP (Tables 8 and 9), BCBSVT QHP (Tables 10, 11, 12, and 13), BCBSVT Primary (Tables 14 and 15), Medicaid (Traditional) (Tables 16, 17, 18, and 19), and Medicaid (Expanded) (Tables 20 and 21) programs. The lowest two data points in each metric are highlighted in blue. The highest two data points in each metric are highlighted in yellow. Note HSA labels are varied, thus HSA "A" cannot be compared across tables.

In reviewing performance, OneCare notes that HSAs with overall higher PMPM spend can largely be attributed to greater utilization of inpatient and specialty provider services. While other cost and utilization categories may be the key cost driver for a particular HSA, there was not a pattern exhibited network wide.

Medicare: When reviewing key cost and utilization metrics for the periods 2018 through 2021-Q1 for Medicare, there are some notable differences when comparing HSAs, and when comparing years. Notably, the range of FFS equivalent PMPM spend across HSAs fluctuates throughout that period, with 2019 having the narrowest difference between minimum and maximum FFS equivalent PMPM spend. The data further demonstrate that, across years, there are differences in observable performance metrics which are not entirely consistent from year to year. In 2018, the highest and lowest FFS equivalent PMPM spend at the HSA level was driven by inpatient, ED, and primary care spend. In 2019, the data show that the HSA with the highest level of spend was driven by primary care and specialty care spending whereas the lowest HSA spending appears attributable to low inpatient spending. In 2020, Exhibit A shows that highest HSA spending was driven by relatively high spending in all key metrics except specialty care.

OneCare observes promising findings in utilization metrics across this period as well. First, a notable decrease in inpatient admissions from 2018 to 2021, with HSA level maximum inpatient admissions per thousand patient per year (PKPY) moving from 294.7 to 259.8 to 207.9 from 2018 to 2020. Additionally, minimum HSA-level inpatient admissions decreased throughout that period, from 203.8 PKPY in 2018 to 125.3 and 134.5 in 2020 and the first quarter of 2021, respectively. Reviewing minimum and maximum HSA-level performance in ED utilization across this timeframe also yields promising results: maximum and minimum PKPY rates moved with consistent improvement from 612 and 1600 in 2018 to 426 and 920 in 2021. Review of these key metrics demonstrate promising initial results in the Medicare population.

Medicaid (Traditional): Three new HSAs joined the OneCare Medicaid (Traditional) program in 2019, which adds difficulty reviewing time trends or comparing across performance years. In 2020 this program saw an overall decrease in the FFS equivalent spend PMPM from 2019, possibly as a result of the public health emergency. While 2021 data are immature and thus only limited insights are observable, there is a notable pattern across performance years when reviewing the data in Exhibit A. Interestingly, the highlighted HSAs with high and low spending relative to the group show that often times, relatively high or low spending and utilization is noted in many of the key metrics displayed. Using the color-coded display, it is apparent that the HSAs highlighted for low (blue) or high (yellow) spending are also relatively high or low performers on many of the key metrics. 2018 most prominently displays this pattern, where the reader can see clearly the yellow indicators across metrics, beginning with FFS equivalent spending. Generally, the pattern holds across years which indicates that for the Medicaid (Traditional) cohort, the key metrics presented are primary drivers of overall cost of care at the HSA level.

Medicaid (Expanded): This program began in 2020 during the public health emergency and thus, OneCare does not note any significant variations in care. However, one useful comparison for 2020 Medicaid (Expanded) is to the Medicaid (Traditional) population.

The data presented indicate that generally, both spending and utilization metrics for Medicaid (Expanded) are lower than those of the Medicaid (Traditional) program with two exceptions: ED and outpatient advanced imaging utilization rates. These data suggest a pattern: lower cost, higher frequency utilization of ED and imaging services may indicate an opportunity area for improvement within the Medicaid (Expanded) population.

BCBSVT Primary: The BCBSVT Primary program began in 2020 during the public health emergency and therefore trends are not observable. However, data show that the two HSAs with highest FFS equivalent PMPM spending in 2020 were driven by relatively high inpatient spending, outpatient advanced imaging at both HSAs and high primary care spending and specialty care spending observed in HSA J and K, respectively.

BCBSVT QHP: Two new HSAs joined the OneCare BCBSVT QHP program in 2019. As noted above, shifts in patient populations due to increased participation of new HSAs creates additional challenges to reviewing data. The 2020 BCBSVT QHP program saw an overall decrease in the FFS equivalent spend PMPM from 2019, possibly as a result of the public health emergency.

Results for 2021 are relatively immature, given that only one quarter of data are present. In 2020, the two HSAs with lowest overall spending demonstrated difference in contributing factors. For HSA D, low levels of ED, outpatient advanced imaging, primary care, and specialty care spending contributed to overall low spending whereas for HSA I, the primary driver of low FFS equivalent PMPM spending was low inpatient spending. Similarly, the two HSAs with highest spending in 2020 showed a difference in contributing factors. For HSA J, the highest spending HSA, ED and outpatient advanced imaging spending and inpatient and ED utilization appear to be the primary contributors to overall spend. For HSA H, the primary driver was high inpatient spending. Performance year 2019 shows similar patterns to 2020: high and low spending HSAs have varying contributors to overall FFS equivalent spending.

MVP QHP: The MVP QHP program began in 2020 during the public health emergency. The data OneCare receives do not allow for a complete evaluation to determine whether or not there are any significant variations in care at this time.

3. Five most prevalent chronic conditions; and

OneCare monitors the top prevalent conditions by HSA and payer programs. The top prevalent conditions affecting the 2021 patient population have been identified with Johns Hopkins ACG algorithm using the most recent 12 months of historical claims data. Data for each payer are provided in Exhibit B to Section 7: Most Prevalent Conditions by Payer, and briefly summarized below. With the exception of Medicare, anxiety and depression has been identified among the top five prevalent conditions in all payer programs. While a direct comparison between the prevalent conditions identified last

year and this year is not possible due to the change in the payer programs, OneCare did observe an overall increase in the ranking of mental health conditions identified in the top prevalent conditions for the commercial and Medicaid programs (see Table 3), which is hypothesized to be related to the public health emergency, both in terms of an increase in anxiety and depression and the result of delayed care for other conditions.

Table 3: Change in ranking of anxiety and depression among the top prevalent conditions for Commercial (BCBSVT Primary, BCBSVT QHP, and MVP QHP) and Medicaid programs

	Anxiety Ranking		Depression Ranking	
	2020 Population	**2021 Population**	**2020 Population**	**2021 Population**
Medicaid (Traditional)	2nd	1st	3rd	3rd
Medicaid (Expanded)	2nd	1st	4th	2nd
BCBSVT Primary	Not available	1st	Not available	4th
BCBSVT QHP	4th	2nd	Not in top 5	4th
MVP QHP	Not available	2nd	Not available	4th

Medicare: Hypertension is the top prevalent condition for all HSAs, affecting the Medicare population with an overall prevalence of 54.8%. While the prevalent condition ranking differs slightly among the HSAs, all nine HSAs participating in the Medicare program have disorders of lipid metabolism ranked among the top five conditions, and eight out of nine HSAs have cataract aphakia and coronary artery disease ranked among the top prevalent conditions.

Medicaid (Traditional): Anxiety is the top prevalent condition for nine of the fourteen HSAs participating in the Medicaid (Traditional) program, affecting 15.6% of the Medicaid (Traditional) population. The five HSAs that did not have anxiety as the top prevalent condition, did have anxiety identified as either the second or third most prevalent condition within their community. Other prevalent conditions impacting the Medicaid (Traditional) population include acute respiratory tract infection, refractive errors, depression, and adjustment disorder.

Medicaid (Expanded): The Medicaid (Expanded) population had a similar list of top prevalent conditions as the Medicaid (Traditional) population. Anxiety is the top prevalent condition, impacting 7.7% of the population, with the other top conditions being depression, refractive errors, tobacco, and adjustment disorder.

BCBSVT Primary: Anxiety and hypertension are the top two prevalent conditions impacting the BCBSVT Primary population, with an overall prevalence of 14.6% and 12.5% respectfully. The other top conditions for the overall BCBSVT Primary population are acute upper respiratory tract infection, depression, and adjustment disorder. Eight of the HSAs have either obesity or disorders of lipid metabolism also identified among the top five prevalent conditions for their community.

BCBSVT QHP: Hypertension and anxiety are the top two prevalent conditions impacting the BCBSVT QHP population, with an overall prevalence of 14.8% and 13.6% respectfully. The other top conditions for the overall BCBSVT QHP population are disorders of lipid metabolism, depression, and benign and unspecified neoplasm.

MVP QHP: Hypertension and anxiety are the top two prevalent conditions impacting the MVP QHP population, with an overall prevalence of 15.5% and 11.8% respectfully. The other top conditions for the overall MVP QHP population are disorders of lipid metabolism, depression, and benign and unspecified neoplasm.

4. Five most prevalent high cost chronic conditions

"Exhibit C to Section 7: Most Prevalent High Cost Conditions by Payer" details the top prevalent conditions for the high cost population. Individuals are identified as high cost if they incurred $15,000 or more in claims expense in the last 12 months. The high cost populations exhibited similar top prevalent conditions to the general populations within their payer programs. The commercial and Medicaid programs' high cost individuals exhibit high prevalence in hypertension and anxiety and the Medicare program's high cost individuals exhibit high prevalence in hypertension, coronary artery disease, and disorders of lipid metabolism. There are no discernable patterns or changes noted over time in these conditions across payers.

b. Discuss how results and progress to date are used to support ACO network providers in quality improvement and implementation of the care model.

OneCare uses cost, utilization, and quality measures to assess performance, evaluate variation in care, and identify opportunities for improvement across the ACO. Data collection efforts provide quality performance indicators throughout the year and ensure opportunities for improvement. A combination of data sources including claims, clinical, and manually abstracted information are reviewed and analyzed for time trends and to compare performance that identifies specific, measurable and realistic goals for improvement. When providers perform below expectations, OneCare will directly communicate to these participants to ensure data-driven solutions lead to clear and concise improvement plans. These plans will include time-bound, realistic and specific goals. As part of ongoing improvement efforts, there are quarterly performance updates to evaluate improvement efforts to determine if additional efforts are required. OneCare's goal is to empower providers with support such that organizations exceed targets and receive quality-based incentive payments. As OneCare moves deeper into its accountability model and

expectations, it will develop policies and procedures to address under-performance which may include written action plans, adjusting incentives, additional focused supports, or other techniques to be determined by OneCare's Board.

As an example, OneCare is using the 2021 VBIF Program as a focus area for process improvement. Previously quality measure incentives were based on network-wide aggregate performance annually, determined by randomly sampled members. This sample methodology, due to random selection, did not include all network providers. In response to network feedback, OneCare is reporting quality measure performance on a quarterly basis for all attributing practices. This timely and specific feedback will ensure providers have the ability to respond and engage in improvement efforts prior to the end of the performance year. Additionally, to connect quality-based incentive payments more directly with performance in 2021, incentive payments will be distributed following quarters two and four rather than after the entire performance year as was previous practice.

OneCare's initial performance evaluation of key quality measures occurred following the first quarter of 2021. At that time, OneCare evaluated every primary care organization within the network. Adult practices, measured in hypertension and diabetes control measures showed mixed results. For diabetes management, 95% of practices evaluated met a target for at least one payer group and 62% of practices met at least one stretch goal. Hypertension performance presented a greater opportunity for improvement, with 86% of practices meeting at least one target and just 34% of practices meeting at least one stretch goal. For pediatric practices, OneCare identified opportunity for improvement within the depression screening measure with 84% of practices meeting target and just 5% of practices meeting at least one stretch goal. Developmental screening results were positive, with 89% of practices meeting a stretch goal. OneCare is using these findings as an impetus for targeted quality improvement efforts. OneCare's quality team is actively engaging with practices to share best practices, identify shortcomings, and develop an action plan for improvement.

c. Discuss your quality program in the context of COVID-19. Do you believe any additional metrics should be tracked due to COVID-19? Discuss lessons learned from the pandemic in the quality improvement program from 2020 to 2021. How do these lessons inform your planning for 2022?

OneCare's infrastructure enables flexible and dynamic solutions, as evidenced by work performed during the public health emergency. Given the rapid rate of change and evolving crisis, OneCare responded by focusing support efforts to meet the needs of providers during the public health emergency. Specifically, OneCare refined support for high risk individuals and developed a custom application to enable providers to identify individuals at risk of adverse outcomes due to COVID-19, OneCare also negotiated on behalf of its network providers to ensure quality performance impacts remained reasonable given the obvious constraints of the public health emergency, and continued its alignment with Blueprint for Health efforts.

OneCare analyzed member data to identify those most at risk for poor outcomes due to COVID-19 and provided member lists to network participants enabling care teams to proactively outreach to individuals in an effort to mitigate any potential adverse quality or financial outcomes. Provider organizations reported changes to their outreach strategies (e.g. safety calls to vulnerable Vermonters), prioritization of individuals in need of support, and new workflows associated with advancing telehealth services.

During the public health emergency, OneCare successfully negotiated on behalf of its providers to establish reporting-only basis for quality measurement as opposed to performance-based payment for the majority of quality programs. This critical move enabled OneCare's providers to maintain focus on remaining open for business and, most importantly, responsive to individuals during a time of tremendous uncertainty. While there may be a necessity to continue reporting-only evaluation of quality measures, there could be other opportunities to identify areas of success and opportunities for improvement in 2022 and beyond. OneCare is currently awaiting 2020 quality measure results from several payers and anticipates seeing reductions in quality associated with known delayed care due to the public health emergency. Due to the ongoing nature of the public health emergency and recent increases in COVID-19 cases in Vermont, there continues to be uncertainty about what utilization patterns will look like over the fall and winter. This again could impact quality of care metrics for 2021 and 2022. OneCare has ongoing conversations with payers to explore the best approaches to quality measurement and evaluation during these uncertain times.

Building upon the lessons learned during the public health emergency thus far, OneCare will deploy targeted quality improvement work in 2022, consistent with the VBIF program of 2021. Further, quality measure benchmarks are largely unavailable for 2020 and the future into 2021 remains uncertain. Despite these challenges, OneCare intends to remain focused on aligned quality measures across payers and with the APM population health goals.

4. ***Population Health and Payment Reform*. Complete Appendix 7.2, Population Health and Payment Reform Details and explain your strategy for making investments in population health and developing payment reform programs across the continuum of care.**

OneCare's population health management investments are intended to facilitate care delivery transformation supported by unique payment reforms, as well as opportunities for innovation and incentives that encourage the transition to value. Each investment is evaluated for its ongoing alignment with ACO strategy, its ability to drive performance, its impact, and its ongoing affordability. As part of a learning system, adjustments and refinements are made regularly in response to network feedback, evaluation data, or other factors to improve the success of the population health program or investment strategy.

See Appendix 7.2 enclosed.

5. ***Care Coordination and Care Navigator*. Complete Appendices 7.3, 7.4, and 7.5 for the proposed budget year and explain any opportunities or challenges you have experienced in**

your continued implementation of care coordination and the use of Care Navigator. In doing so, please discuss the following:

OneCare's care coordination program has grown along with its network and the number of Vermonters served. In 2021, OneCare began providing specific sub-population lists to drive attention and action on specific individuals with changing utilization or cost metrics. In addition, OneCare's team began focusing more on improving compliance with minimum outreach to achieve consistency and continuity in all HSAs by providing access to education, technical assistance, and care coordination supplemental payments based on documentation in Care Navigator. By August 2021, OneCare had 4,249 individuals who were actively care managed by approximately 730 care managers[7]. Despite significant advancements in organizing care teams, improving knowledge and competence of the workforce, and maintaining a high number of individuals in active care management, the public health emergency has had an impact on the care coordination program in over the past 18 months. It has caused prolonged interruptions of normal care delivery processes with corresponding shifts in workforce focus to educating, screening, and treating individuals with COVID-19. Similarly it has raised concerns of individuals for their safety in seeking care, with too many individuals waiting longer than prudent to seek care for chronic and acute needs. This has caused increase strain on the workforce, particularly in 2021, as providers now care for individuals who are sicker than pre-pandemic.

In this environment, network participants have expressed ongoing challenges with the use of Care Navigator, including the documentation burden and lack of interoperability between providers' primary electronic medical records and Care Navigator. Further, uptake and utilization continues to vary widely from one community to another with consistent proactive utilization of some partner types in one community but not in another. Responding to these challenges as part of the learning health care system, OneCare sought feedback from more than 40 stakeholders during the early stages of OneCare's Board strategic planning process to inform future state for the care coordination program (e.g. care model, tools, resources, payments). The output from this process included:

a. confirmation of the value of ACO supports for a complex care coordination;
b. recognition that additional time is needed to allow the care coordination program to mature and to achieve outcomes;
c. direction to decouple care coordination payments and Care Navigator utilization;
d. recommendations for a stakeholder engagement process to gather feedback on the care coordination approach, payments, barriers and tools to collect data; and
e. network accountabilities for care coordination need to be tighter and more clearly delineated.

To address the recommendations from OneCare's strategic planning process, OneCare has deployed a robust stakeholder engagement process consisting of twelve sessions covering four topic areas: evolving the care coordination model, payment system, and associated tools, resources, and education. Through these discussions, the core care coordination program components have been affirmed: cross organizational collaboration, patient centered care, and

[7] The number of care managers is a reduction from 2020 due to workforce challenges during the public health emergency.

shared care planning, among others. In 2022, data collection may occur through Care Navigator or through alternate reporting that will be aligned with key program metrics while focusing on reducing the identified burdens. Further, payments will be decoupled from Care Navigator activity. A portion of payments (85%) will be capacity payments; a portion, incentive payments (15%) based on mutually agreed upon quality, cost or utilization metrics. OneCare will prepare the network for these latest evolutions through proactive communications and trainings in Q4 2021.

See Appendices 7.3, 7.4, and 7.5 enclosed.

a. An update on your Care Coordination Effectiveness and Outcomes Analysis Framework using data.

OneCare monitors the care coordination program through a robust set of process metrics including number of individuals with shared care plans, number of individuals engaged, and number of providers participating in care coordination as evidenced by Care Navigator activity. These metrics reflect the network's overall engagement in the care coordination program. OneCare supports the network in these efforts through provision of high quality education, actionable data, and targeted technical assistance.

In 2020, given the impacts of the public health emergency on providers and their available resources for care coordination, OneCare shifted its focus to providing supports for identification, outreach and engagement of individuals most at risk for complications related to COVID-19. In August 2021, given a rise in COVID-19 cases, a refresher seminar was conducted highlighting enhanced data analytic tools that generate lists for outreach to individuals at greatest risk for COVID-19 complications, an updated script for outreach calls, and patient engagement techniques. Despite the impact of the public health emergency and waves of care coordinator availability, OneCare demonstrated improvements in all of the aforementioned process metrics. Specifically, individuals with shared care plans increased from 5,625 in 2020 to 6,284 in 2021; individuals with status of engaged increased from 6,851 in 2020 to 8,805 in 2021; and number of providers engaging in care coordination as evidenced by activity in Care Navigator, increased from 723 in 2020 to 790 in 2021. These are all positive signs of program evolution and network engagement. For additional Care Navigator metrics, see Appendix 7.4 enclosed.

In addition to program evaluation through process metrics, OneCare evaluates its impact on outcome metrics. In 2021, OneCare developed an evaluation methodology that can be used in future years and applied to areas beyond the Care Coordination program. The methodology evaluates the effect of care coordination on inpatient admissions, emergency room utilization, and TCOC. Initial findings, in light of the public health emergency, show that ongoing work is needed to positively impact these outcome measures. In response to these initial findings, OneCare has refined its approach to care coordination by focusing on care coordination of individuals within defined subpopulations including those with high emergency room and inpatient utilization, those with high social and medical risk, and those

who have a high total cost of care. The evaluation framework built can be applied in future years to assess the impact of these more refined efforts.

b. An overview of your risk stratification methodology, and rationale for its selection/continued use, among others.

OneCare uses the John Hopkins Adjusted Clinical Grouper (ACG) algorithm to assign a risk score based on the 12 months of claims data prior to the contract year for each member. The score predicts the cost of the service for that member in the coming 12 months. Risk scores are calculated separately for each payer program and for the pediatric and adult age groups and then assigned one of four risk levels: the top 6% are very high risk, the next 10% are high risk, the next 40% are medium risk and the lowest 44% are low risk. Separation of the pediatric population (0-18 year olds) from the adult population (over 18) was initiated in 2020 based on feedback from the pediatric workgroup. The rationale was that the pediatric high and very high risk population may be underrepresented in the top 16% when blended with adults who have more robust claims histories. This separation has increased awareness of high risk children and adolescents for care team members.

It is important to recognize that a claims-based risk stratification algorithm is an important tool to aid in the identification and prioritization of individuals for outreach, and that it is most effective when combined with a provider's timely, proximate knowledge of each individual's clinical and social needs. OneCare makes available many claims based indicators beyond the predictive risk scores to allow providers and coordinators more flexibility in how they are organizing outreach and interventions.

Social indicators of risk become available and are used in conjunction with the medical risk scores to create a more focused group for outreach through care coordination. Efforts to enhance and refine the ability to comment on social risk are continuing through work with the network and state partners. Advancements were made this past year in data sharing agreements between state agencies and OneCare via the Health Information Exchange that would provide indicators of social risk available from those agencies. Work continues to review this data and make recommendations for how it can be used at the point of care.

c. How is the ACO incorporating provider and patient input on the use of these software tools? Please share any relevant lessons learned.

OneCare seeks ongoing input into software tools through a variety of methods. For example, in Q4 2020, OneCare sought provider input on its software tools through a care coordination program survey. Additionally, as referenced above in Question 5, OneCare is currently working to evolve its care coordination implementation and related tools in a manner which reflects input from network participants. Information gathering yielded several insights to guide the redesign anticipated to be finalized and communicated broadly in late 2021 or early 2022.

Providers also shared feedback for enhancements to Care Navigator and Workbench One self-service tools through OneCare committees, training sessions, monthly user group sessions, and informal discussions with clinical and analytics staff in the field. As a result of feedback, OneCare has strengthened the Care Coordination Process Metrics Application to easily identify patient panels that meet the criteria for the four at risk subpopulations. These subpopulations of focus for 2021 include high ED utilizers, high inpatient utilizer, high medical and social risk, and individuals with a high cost of care.

Lessons learned from provider and patient input through use of OneCare's software tools aren't always consistent. Due to OneCare's diverse network, needs and goals for software and tool utilization can vary widely. During quarterly HSA consultation meetings, committee efforts, and other communications, OneCare learns of these varied perspectives. For example, some providers prefer to utilize self-service tools in Workbench One, while others state a strong preference for static reports to guide their efforts. Additionally, some of OneCare's participants with greater internal resources are interested in accessing raw data for utilization by their own analytics staff. Striking a balance to meet these needs is a challenge that OneCare welcomes and intends to refine as the needs of the network evolve.

OneCare also engages directly with patients through the representational Board of Managers, where four seats are held by consumers. In 2021, in accordance with Rule 5, OneCare designated an At Large seat to an additional Consumer Member to meet the requirement for a commercial seat for any contracted commercial insurer that has a Vermont market share of greater than 5%. These consumer Board members participate in subcommittees of the Board, and through a very active and engaged PFAC. PFAC meets on a monthly basis and provides input on a wide variety of topics that OneCare staff or consumers bring to the table. Topics covered by PFAC over the last year include Patient & Family Advisors Training, Developmental Understanding and Legal Collaboration for Everyone (DULCE), Office of the Health Care Advocate feedback session, Diversity, Equity, and Inclusion, OneCare Strategic Planning Updates, Care Coordination Policy, Care Coordination Program Re-Design, Analytics Data Needs, and OneCare Vermont Tagline/Elevator Speech.

d. How does the ACO's care coordination align with other payer care coordination programs?

OneCare aligns with each of the payers' care coordination programs by creating contractual elements for care coordination that, together, drive network-wide alignment and integration. OneCare and payers work collaboratively to align strengths, share best practices, and successfully transition ongoing care coordination supports to the local care teams. OneCare staff meet regularly with Medicaid and commercial payer analytics, quality, and care management teams to discuss and evaluate workflows to facilitate patient hand-offs, ensure appropriate coordination of care, share data, and discuss advancements in care coordination.

e. How is the ACO expanding access and usage of care navigator to non-participating providers?

In early 2020, OneCare added new functionality in Care Navigator that enabled users to add information about non-ACO participating care team members to patient care teams. This resulted in non-ACO team member information being reflected on Shared Care Plans, and visible to all care team members regardless of participation barriers. Non-ACO care team member data entered in this way enables care coordinators to conduct outreach to non-participating providers and organizations to encourage collaboration and discuss joining the ACO. This optimization has led to an increase in care team information throughout 2021.

OneCare follows strict federal privacy regulations specific to information sharing. Non-ACO care team member information entered into the Care Navigator system by ACO participants is informational and does not convey access to the software system or visibility into it for the non-ACO care team member. As a result of the strategic planning process, OneCare does not envision dedicating new resources toward further expansion of Care Navigator usage; instead, efforts will focus on outreaching to all continuum of care providers in OneCare's network to strengthen their focus on care coordination by providing them with clear accountabilities, new payment mechanisms, and resources and training to support their ongoing adoption of the program.

6. *Integration of Social Services*. Please explain how the ACO integrated or facilitated the integration of healthcare and social services in FY21 and give a detailed description of how the ACO plans to further integrate healthcare and social services in FY22. How did the ACO provide incentives for investments to address social determinants of health in FY21 and how does the ACO plan to further do so in FY22?

OneCare continues to deepen collaborations with and facilitate integration of health care and social services through the care coordination model. By actively engaging with providers across the continuum of care, OneCare can determine how to best integrate their work into the care model and incentive structure. As part of this effort, OneCare identified four subpopulations of focus during 2021: individuals with high ED utilization, high inpatient utilization, high medical and social risk, and also those with a relatively high cost of care. Currently, OneCare has invested in a partnership with a vendor to provide social determinants of health data at the point-of-care to coordinators. Within the Care Navigator tool, fields to identify social risk and the ability to include diverse care team members outside of OneCare participants support this goal and enhance human service participation and integration into care teams.

OneCare continues to explore the legal and compliance frameworks necessary to share data and information across health and human services providers in support of person-centered care. Over the past year, through the *Advancing Integrated Models* (AIM) grant from the Robert Wood Johnson Foundation, OneCare and the AHS have developed a data and systems-driven collaboration to determine the legal and operational pathways to integrate social needs data within OneCare that will enhance the risk stratification process. This will allow providers to better identify individuals that could benefit from enhanced services and supports, reduce

duplication, improve individual's experience of care, and align and integrate health and human services supports in local communities. An initial data use agreement was signed in 2021 and pilot data will be shared by year-end. The relationship built between OneCare and AHS through this work will support advancements in this integration in the years ahead.

7. ***ACO Self-Evaluation*. How is the ACO evaluating its accountability strategy and risk model as at the local HSA and provider level, as described in Sections 4 and 5 of this guidance? In your response, discuss:**

Evaluation of OneCare strategies, whether accountability, risk, or clinical models, is facilitated through both structured and unstructured dialogue with provider participants. Structured forums for provider input include the Board of Managers meetings, committee meetings (for example, Finance Committee and Population Health Strategy Committee), HSA Consultation meetings, provider surveys, and topical focus groups (for example, CPR focus group). OneCare also collects provider feedback in unstructured ways when answering questions, or responding to data requests.

d. What evidence do you have that the local accountability strategy as described in Section 4, Question 2 and Appendix 4.2 is working? If data is not yet available, how does the ACO plan to evaluate if the local accountability strategy is working, including what evidence you will examine and the timeline for evaluation?

Many of the local accountability strategies, such as the Accountability Pool, practice-specific VBIF payments, and new care coordination payment model, are in their first year of implementation, or are slated to begin in 2022. However, early indications are that providers who see their emerging VBIF quality scores are engaged and interested in learning more. OneCare is in the process of providing enhanced organization-level transparency in VBIF quality measure performance to further facilitate information sharing and knowledge transfer.

Downstream, evidence that the accountability model is working will be facilitated through success in OneCare's population health programs. In alignment with the core concept of value-based health care, providers generating the best health care outcomes should be those receiving the most funding relative to their peers. Whether or not this is occurring can be evaluated over the upcoming three to five years.

e. How do the risk management arrangements described in Section 5 of this guidance support the overall ACO accountability strategy to increase high-value care and eliminate low-value care (please discuss both)?

Network hospitals are the primary risk bearing entities in the network as the fiscal guarantors for the vast majority of the network's risk exposure. Hospital financial leaders are therefore acutely aware of the upside opportunities and downside risk of the programs they participate in, which are centered on TCOC targets. As such, hospitals are becoming more engaged with the community of providers in an attempt to manage to these cost

targets. Together, they are examining opportunities to support increased preventive care and chronic disease management and coordination across organizations to improve services and reduce fragmentation for individuals with complex needs (e.g. high cost/high utilizers). These are all examples of high value care opportunities. Low value care is identified through the ACO Performance Dashboard analytics and accompanying discussions with local leaders in HSA Consultation meetings.

Attributing providers are also aware of the Accountability Pool contributions reflected on their monthly statements, and have sought a better understanding of the program as a result of the impact the pool contributions have on their practice finances, and their desire to recover the pool contributions and share in savings. For example, Preferred Providers recently reached out to request interim quality reporting data for their HSA so that they understand how local performance may impact their risks/rewards.

To further increase focus on TCOC targets, care coordination performance incentives are also being tied to TCOC performance.

f. How is the ACO using prior performance to improve program development?

As outlined above, OneCare's Strategic Plan development process is gleaning important insights into the path ahead. OneCare identified its core competencies of Network Performance Management, Data and Analytics, and Payment Reform and through this process learned that efforts aligned with these competencies will best serve network health care reform efforts. Goals outlined in OneCare's Strategic Plan include regular feedback from network participants in an effort to guide prioritization of work. OneCare has been addressing this goal by collecting network feedback through structured surveys, formal committee meetings, and informal discussions. This feedback continues to inform ACO operational efforts.

In preparation for the 2022 performance year, OneCare continues to gather network feedback to improve its population health programs, payment models, and incentives. Strategically, it is important to simplify and set clear value-based expectations tied to the population health, care coordination and value based payments. It is also imperative to respond to feedback from the network and Board of Managers regarding operational improvements such as the delivery of data and care coordination panel management activities.

Through its Utilization Review Committee, as well as monthly and quarterly reporting to its network and payers, OneCare ensures services are delivered; identifies and evaluates variations in utilization, cost, and quality; and assesses outliers for potential improvement opportunities. When unexpected findings are identified, OneCare's analytics, finance, and/or clinical team with guidance from the CMO, outreach to participants to share their findings, gather additional information, make recommendations, and monitor performance. As appropriate, OneCare also reaches out to payers to understand root causes of variation,

such as changes in coding definitions or practices that might result in new patterns of care emerging.

In summary, OneCare is addressing the evolving health care reform landscape in a number of ways. The ACO Insights report outlined above will identify performance in key metrics and support ongoing improvement efforts. OneCare will continue ongoing monthly performance monitoring of cost, utilization and quality and will escalate any relevant issues as required. Additionally, OneCare is eager to continue addressing health equity and is actively engaging resources to identify pilot programs which utilize existing infrastructure to close gaps or other inequities in care delivery. Finally, as outlined in its Strategic Plan OneCare is working to enhance key performance indicator metrics which serve to measure ongoing performance and inform future decision making.

Section 7: Exhibits

Exhibit A: HSA Cost and Utilization Variation by Payer

Exhibit B: Most Prevalent Conditions by Payer

Exhibit C: Most Prevalent High Cost Conditions by Payer

Exhibit A to Section 7: HSA Cost and Utilization Variation by Payer

The Variation Analysis highlights variation in key cost and utilization metrics across the OneCare network for services included in the financial risk model.

- The lowest two data points in each metric are highlighted in BLUE.
- The highest two data points in each metric are highlighted in YELLOW.

Program: Medicare

Table 4: Medicare Variational Analysis

2018 Cohort, Reporting Period: Jan 2018 – Dec 2018

Blinded HSA	Fee-for-Service Equivalent Spend PMPM	Inpatient Spend PMPM	Emergency Department Spend PMPM	Outpatient Advanced Imaging Spend PMPM	Primary Care Spend PMPM	Specialty Care Spend PMPM	Inpatient Admissions PKPY	Emergency Department Visits PKPY	Outpatient Advanced Imaging PKPY	Primary Care Visits PKPY	Specialty Care Visits PKPY
Total	$794.35	$282.52	$42.21	$7.39	$72.53	$58.89	228.7	841.6	524.3	4,890.2	3,041.4
HSA A	$775.23	$245.09	$56.45	$10.71	$82.07	$44.68	202.3	1,258.4	518.7	6,334.3	2,081.0
HSA B	$845.78	$313.20	$46.96	$8.50	$64.51	$72.80	246.9	929.0	705.9	4,617.3	3,812.0
HSA C	$798.44	$288.26	$39.14	$6.46	$80.54	$56.21	231.3	683.1	509.9	4,700.7	2,867.3
HSA D	$920.70	$357.09	$66.45	$7.99	$86.72	$44.78	294.7	1,600.3	456.9	6,159.7	2,658.4
HSA E	$855.78	$324.03	$43.12	$6.70	$56.02	$63.72	241.0	689.0	467.6	4,128.8	3,677.1
HSA F	$708.14	$241.83	$59.21	$6.06	$57.24	$58.13	245.5	1,002.1	428.7	4,072.7	4,156.9
HSA G	$752.49	$261.33	$32.54	$6.80	$68.27	$63.85	212.1	612.9	533.4	4,488.5	3,167.7

Table 5: Medicare Variational Analysis

2019 Cohort, Reporting Period: Jan 2019 – Dec 2019

Blinded HSA	Fee-for-Service Equivalent Spend PMPM	Inpatient Spend PMPM	Emergency Department Spend PMPM	Outpatient Advanced Imaging Spend PMPM	Primary Care Spend PMPM	Specialty Care Spend PMPM	Inpatient Admissions PKPY	Emergency Department Visits PKPY	Outpatient Advanced Imaging PKPY	Primary Care Visits PKPY	Specialty Care Visits PKPY
Total	$805.33	$281.41	$42.94	$7.68	$73.03	$60.74	223.8	780.0	531.8	4,679.8	3,083.3
HSA A	$839.71	$306.93	$56.55	$7.99	$79.03	$45.91	240.9	989.9	483.6	5,303.0	2,793.2
HSA B	$756.50	$238.78	$57.78	$10.70	$79.76	$46.29	208.1	1,186.5	496.0	5,708.5	2,022.1
HSA C	$876.82	$335.31	$39.99	$6.76	$88.61	$65.49	244.3	676.9	549.7	4,586.3	2,920.4
HSA D	$865.20	$300.39	$37.01	$9.17	$64.77	$69.81	236.4	689.3	480.1	2,785.8	2,629.6
HSA E	$745.17	$251.62	$32.99	$6.89	$65.46	$59.91	205.1	616.7	530.0	4,567.2	3,218.0
HSA F	$822.17	$269.54	$58.25	$11.88	$77.73	$41.31	203.8	1,012.4	477.2	5,287.9	2,358.1
HSA G	$825.44	$296.28	$46.54	$7.81	$60.55	$67.89	216.2	699.9	537.3	4,417.1	3,679.0
HSA H	$857.45	$323.72	$48.06	$7.75	$62.52	$63.07	247.0	948.5	625.4	4,717.8	3,168.4
HSA I	$882.46	$300.14	$47.39	$6.66	$89.50	$84.21	259.8	810.5	528.9	3,984.5	3,808.4

Table 6: Medicare Variational Analysis

2020 Cohort, Reporting Period: Jan 2020 – Dec 2020

Blinded HSA	Fee-for-Service Equivalent Spend PMPM	Inpatient Spend PMPM	Emergency Department Spend PMPM	Outpatient Advanced Imaging Spend PMPM	Primary Care Spend PMPM	Specialty Care Spend PMPM	Inpatient Admissions PKPY	Emergency Department Visits PKPY	Outpatient Advanced Imaging PKPY	Primary Care Visits PKPY	Specialty Care Visits PKPY
Total	$722.88	$248.90	$35.27	$6.60	$57.78	$53.71	183.7	611.2	447.9	4,109.0	2,720.2
HSA A	$862.05	$303.72	$57.11	$17.25	$72.87	$32.17	200.3	1,059.8	469.9	5,054.5	1,926.5
HSA B	$775.97	$258.78	$29.04	$8.91	$62.46	$68.28	170.5	495.5	550.3	2,377.7	2,389.6
HSA C	$693.57	$223.40	$54.91	$10.81	$66.05	$41.52	189.5	969.4	444.5	5,026.6	1,911.1
HSA D	$779.00	$295.49	$41.16	$6.94	$45.85	$55.36	187.8	553.2	482.7	3,872.7	3,122.3
HSA E	$708.85	$238.76	$31.53	$10.03	$62.39	$46.35	125.3	452.3	378.1	4,625.3	2,524.7
HSA F	$789.78	$291.04	$42.63	$5.94	$53.65	$64.83	207.9	798.6	488.4	4,529.3	2,714.3
HSA G	$668.24	$225.71	$28.31	$5.13	$48.63	$51.87	168.6	500.8	410.0	3,912.1	2,867.8
HSA H	$758.05	$278.77	$33.21	$5.76	$68.63	$52.24	203.9	574.0	473.0	4,373.7	2,449.9
HSA I	$782.89	$241.34	$36.84	$6.39	$81.31	$68.04	202.0	621.1	507.6	3,559.3	3,228.3

Table 7: Medicare Variational Analysis

2021 Cohort, Reporting Period: Jan 2021 – Dec 2021

Blinded HSA	Fee-for-Service Equivalent Spend PMPM	Inpatient Spend PMPM	Emergency Department Spend PMPM	Outpatient Advanced Imaging Spend PMPM	Primary Care Spend PMPM	Specialty Care Spend PMPM	Inpatient Admissions PKPY	Emergency Department Visits PKPY	Outpatient Advanced Imaging PKPY	Primary Care Visits PKPY	Specialty Care Visits PKPY
Total	**$774.92**	**$267.64**	**$35.69**	**$6.85**	**$55.06**	**$53.97**	**192.8**	**595.9**	**556.9**	**4,228.6**	**2,930.2**
HSA A	$715.72	$241.43	$28.66	$6.28	$43.89	$51.91	189.0	509.6	572.7	3,980.8	3,165.4
HSA B	$664.37	$218.81	$24.47	$5.51	$39.92	$66.34	162.4	495.6	450.8	2,217.5	2,385.4
HSA C	$735.74	$270.58	$32.17	$6.61	$57.95	$47.94	190.8	552.9	623.8	4,272.4	2,587.2
HSA D	$722.02	$239.76	$28.45	$11.10	$65.39	$39.03	134.5	426.6	422.8	4,501.0	2,621.4
HSA E	$804.40	$277.36	$35.04	$6.49	$64.71	$62.22	200.4	572.0	588.7	3,391.8	3,238.9
HSA F	$909.45	$307.08	$37.20	$5.10	$62.57	$55.20	212.4	639.5	479.1	4,860.6	3,106.5
HSA G	$808.90	$301.45	$40.85	$5.75	$54.03	$56.21	208.7	704.9	589.8	4,581.6	2,960.1
HSA H	$729.70	$261.56	$41.68	$6.92	$50.27	$64.44	170.8	584.5	552.1	4,007.1	3,213.6
HSA I	$1,064.26	$346.98	$67.10	$16.03	$89.41	$54.83	207.5	920.5	450.7	5,282.2	1,914.9
HSA J	$742.37	$233.39	$57.01	$11.19	$66.89	$49.88	180.4	868.2	519.1	5,277.0	2,229.2

Program: MVP QHP

Table 8: MVP QHP Variational Analysis
2020 Cohort, Reporting Period: Jan 2020 – Dec 2020

Blinded HSA	Fee-for-Service Equivalent Spend PMPM	Inpatient Spend PMPM	Emergency Department Spend PMPM	Outpatient Advanced Imaging Spend PMPM	Primary Care Spend PMPM	Specialty Care Spend PMPM	Inpatient Admissions PKPY	Emergency Department Visits PKPY	Outpatient Advanced Imaging PKPY	Primary Care Visits PKPY	Specialty Care Visits PKPY
Total	$409.52	$81.25	$35.58	$18.82	$32.96	$62.53	28.1	152.1	89.8	1,700.0	1,295.0
HSA A	$409.59	$66.25	$25.66	$23.02	$32.83	$96.19	25.0	122.1	92.7	1,461.2	1,239.0
HSA B	$394.81	$108.00	$36.34	$19.32	$30.97	$43.65	42.6	227.5	102.5	1,952.1	1,403.9
HSA C	$561.57	$152.20	$41.44	$27.04	$29.21	$69.96	43.0	205.1	144.3	1,820.3	1,379.7
HSA D	$276.68	$41.55	$22.52	$11.87	$30.61	$41.28	24.4	177.3	84.2	1,741.5	1,413.6
HSA E	$359.84	$28.47	$35.41	$19.22	$41.45	$46.79	20.0	129.0	102.3	1,672.0	1,227.3
HSA F	$330.09	$61.03	$31.74	$14.26	$27.51	$47.32	23.6	105.7	58.9	1,617.3	1,155.1
HSA G	$546.17	$146.62	$41.78	$18.98	$48.67	$78.34	46.9	184.4	124.8	1,707.3	1,682.1
HSA H	$666.54	$64.24	$31.59	$38.67	$34.12	$76.20	24.8	124.2	223.6	1,068.3	1,416.1
HSA I	$365.88	$60.71	$35.27	$15.22	$28.03	$61.98	21.2	153.1	76.5	1,688.7	1,120.4
HSA J	$620.03	$146.17	$48.20	$27.92	$41.76	$116.32	20.6	177.4	104.1	2,079.5	1,448.4
HSA K	$441.49	$51.32	$35.63	$16.31	$24.27	$85.43	32.5	184.7	77.4	1,625.1	1,218.2
HSA L	$339.99	$62.06	$35.55	$25.69	$25.43	$34.75	24.9	164.6	102.5	1,537.7	1,087.2
HSA M	$395.20	$18.54	$28.97	$21.40	$39.52	$51.85	11.1	151.1	99.5	1,606.9	1,267.8
HSA N	$516.51	$111.17	$75.02	$31.74	$49.44	$54.73	37.5	243.5	173.2	1,746.4	1,657.4

Table 9: MVP QHP Variational Analysis

2021 Cohort, Reporting Period: Jan 2021 – Dec 2021

Blinded HSA	Fee-for-Service Equivalent Spend PMPM	Inpatient Spend PMPM	Emergency Department Spend PMPM	Outpatient Advanced Imaging Spend PMPM	Primary Care Spend PMPM	Specialty Care Spend PMPM	Inpatient Admissions PKPY	Emergency Department Visits PKPY	Outpatient Advanced Imaging PKPY	Primary Care Visits PKPY	Specialty Care Visits PKPY
Total	**$496.84**	**$86.70**	**$36.85**	**$28.15**	**$41.45**	**$70.94**	**32.6**	**154.6**	**124.3**	**2,051.3**	**1,673.7**
HSA A	$611.35	$72.20	$51.75	$51.06	$52.15	$75.75	37.3	195.0	186.7	2,472.2	1,874.9
HSA B	$558.32	$94.19	$47.56	$23.62	$38.44	$63.42	46.7	233.6	121.5	2,303.7	1,813.1
HSA C	$443.11	$88.51	$26.86	$27.48	$38.51	$67.14	26.3	114.4	101.3	2,011.0	1,590.1
HSA D	$413.10	$57.69	$18.02	$18.28	$49.92	$77.39	13.0	39.1	104.3	2,034.8	1,317.4
HSA E	$486.86	$91.91	$22.14	$33.95	$36.93	$92.24	57.4	157.9	119.6	1,717.7	1,526.3
HSA F	$405.56	$0.00	$70.64	$12.24	$45.62	$68.64	0.0	112.9	56.5	1,797.6	1,552.9
HSA G	$391.79	$0.00	$33.74	$36.28	$53.62	$67.89	0.0	118.4	192.4	1,967.9	1,642.4
HSA H	$556.57	$187.48	$26.72	$22.15	$37.06	$52.38	26.7	115.9	107.0	2,112.9	1,622.6
HSA I	$640.48	$153.07	$60.24	$28.40	$50.81	$89.43	58.6	231.0	182.8	1,989.7	1,965.5
HSA J	$386.51	$28.76	$29.66	$20.29	$27.49	$50.88	30.6	173.3	91.8	1,988.1	1,600.7
HSA K	$425.17	$61.46	$46.04	$30.50	$34.01	$45.84	18.7	143.5	118.5	2,151.8	1,359.7
HSA L	$568.05	$92.71	$15.32	$22.62	$44.42	$70.68	26.1	91.5	104.6	1,843.1	1,856.2
HSA M	$450.94	$51.94	$22.15	$13.31	$37.19	$83.27	23.1	200.0	115.4	2,023.1	1,853.8

Program: BCBSVT QHP

Table 10: BCBSVT QHP Variational Analysis
2018 Cohort, Reporting Period: Jan 2018 – Dec 2018

Blinded HSA	Fee-for-Service Equivalent Spend PMPM	Inpatient Spend PMPM	Emergency Department Spend PMPM	Outpatient Advanced Imaging Spend PMPM	Primary Care Spend PMPM	Specialty Care Spend PMPM	Inpatient Admissions PKPY	Emergency Department Visits PKPY	Outpatient Advanced Imaging PKPY	Primary Care Visits PKPY	Specialty Care Visits PKPY
Total	**$477.10**	**$102.34**	**$32.23**	**$27.25**	**$39.57**	**$47.67**	**34.0**	**172.4**	**127.8**	**1,901.6**	**1,505.9**
HSA A	$438.42	$95.22	$29.68	$26.56	$34.04	$50.73	30.6	198.3	146.9	1,995.6	1,572.9
HSA B	$815.79	$117.97	$25.57	$35.25	$230.93	$59.78	32.5	154.2	211.0	2,677.5	2,547.7
HSA C	$410.79	$85.55	$27.90	$22.29	$36.31	$41.78	29.4	171.6	106.4	1,862.2	1,314.3
HSA D	$414.67	$68.58	$36.79	$23.05	$36.34	$43.78	37.3	184.5	118.0	1,936.0	1,398.5
HSA E	$440.91	$101.36	$48.00	$26.28	$34.44	$48.32	41.4	238.2	154.7	1,726.9	1,741.4
HSA F	$663.70	$176.17	$34.02	$36.18	$67.16	$57.35	47.9	209.5	183.0	2,005.8	1,489.4
HSA G	$487.86	$105.41	$30.32	$28.22	$34.87	$49.06	32.3	152.8	115.9	1,904.4	1,524.6
HSA H	$450.82	$88.88	$31.84	$25.64	$42.25	$42.90	33.2	172.7	133.5	1,883.1	1,427.1

Table 11: BCBSVT QHP Variational Analysis

2019 Cohort, Reporting Period: Jan 2019 – Dec 2019

Blinded HSA	Fee-for-Service Equivalent Spend PMPM	Inpatient Spend PMPM	Emergency Department Spend PMPM	Outpatient Advanced Imaging Spend PMPM	Primary Care Spend PMPM	Specialty Care Spend PMPM	Inpatient Admissions PKPY	Emergency Department Visits PKPY	Outpatient Advanced Imaging PKPY	Primary Care Visits PKPY	Specialty Care Visits PKPY
Total	**$556.59**	**$120.78**	**$40.27**	**$28.76**	**$46.91**	**$63.71**	**43.1**	**198.2**	**137.9**	**2,172.8**	**1,850.8**
HSA A	$535.44	$126.10	$48.95	$28.29	$37.57	$67.80	55.6	277.4	145.3	2,159.3	2,122.8
HSA B	$507.14	$108.57	$39.09	$22.20	$42.71	$73.29	42.5	210.5	105.9	2,293.2	1,631.3
HSA C	$459.75	$97.68	$51.50	$23.31	$34.68	$52.76	42.3	258.3	141.0	1,881.9	1,957.7
HSA D	$625.86	$155.92	$44.89	$30.91	$60.20	$67.16	43.9	205.2	157.6	2,135.0	1,992.8
HSA E	$540.68	$142.12	$40.38	$28.34	$38.06	$53.53	59.9	162.4	145.2	2,101.4	1,971.2
HSA F	$692.00	$135.72	$46.42	$39.65	$73.37	$79.90	46.1	230.7	196.1	2,069.2	1,798.6
HSA G	$472.80	$96.44	$32.23	$25.41	$44.14	$56.19	31.5	179.5	134.7	2,084.1	1,709.6
HSA H	$604.91	$169.22	$45.59	$29.40	$44.51	$56.23	53.1	242.2	149.8	1,915.8	1,759.8
HSA I	$490.49	$96.23	$26.50	$21.60	$44.22	$36.17	63.3	165.7	144.6	2,265.6	1,563.6
HSA J	$577.87	$114.34	$37.86	$30.66	$46.88	$66.04	40.0	171.3	128.1	2,298.7	1,870.3

Table 12: BCBSVT QHP Variational Analysis

2020 Cohort, Reporting Period: Jan 2020 – Dec 2020

Blinded HSA	Fee-for-Service Equivalent Spend PMPM	Inpatient Spend PMPM	Emergency Department Spend PMPM	Outpatient Advanced Imaging Spend PMPM	Primary Care Spend PMPM	Specialty Care Spend PMPM	Inpatient Admissions PKPY	Emergency Department Visits PKPY	Outpatient Advanced Imaging PKPY	Primary Care Visits PKPY	Specialty Care Visits PKPY
Total	**$503.03**	**$98.21**	**$38.85**	**$26.49**	**$38.99**	**$51.40**	**35.0**	**163.8**	**121.0**	**1,896.5**	**1,629.7**
HSA A	$496.84	$104.80	$45.15	$23.29	$35.16	$59.02	43.4	191.5	127.0	2,089.9	1,768.3
HSA B	$419.31	$54.83	$42.50	$25.77	$31.55	$61.65	21.1	175.7	115.5	1,574.6	1,467.3
HSA C	$485.82	$115.78	$49.70	$29.92	$30.06	$44.59	38.9	236.3	164.5	1,522.6	1,879.5
HSA D	$415.99	$91.71	$33.66	$22.53	$31.23	$37.30	30.3	163.3	112.0	1,984.3	1,431.1
HSA E	$481.00	$67.49	$42.15	$27.19	$50.22	$41.65	29.4	172.6	125.8	1,748.5	1,731.7
HSA F	$532.03	$110.77	$35.22	$25.79	$41.00	$56.45	36.0	137.2	104.5	2,037.9	1,660.3
HSA G	$487.65	$86.21	$37.63	$33.61	$45.79	$59.07	35.8	155.8	155.0	1,828.1	1,453.5
HSA H	$459.88	$79.90	$36.89	$23.41	$36.49	$43.30	35.3	181.7	116.9	1,797.7	1,578.7
HSA I	$617.17	$137.47	$43.47	$30.53	$33.20	$57.27	38.4	165.4	157.5	1,774.8	1,621.3
HSA J	$639.87	$109.19	$58.72	$35.36	$35.47	$53.37	39.7	217.7	143.4	1,783.4	1,615.8

Table 13: BCBSVT QHP Variational Analysis

2021 Cohort, Reporting Period: Jan 2021 – Dec 2021

Blinded HSA	Fee-for-Service Equivalent Spend PMPM	Inpatient Spend PMPM	Emergency Department Spend PMPM	Outpatient Advanced Imaging Spend PMPM	Primary Care Spend PMPM	Specialty Care Spend PMPM	Inpatient Admissions PKPY	Emergency Department Visits PKPY	Outpatient Advanced Imaging PKPY	Primary Care Visits PKPY	Specialty Care Visits PKPY
Total	**$619.79**	**$126.91**	**$41.78**	**$33.41**	**$46.78**	**$64.27**	**38.8**	**172.9**	**146.9**	**2,022.7**	**1,866.9**
HSA A	$659.09	$144.62	$41.39	$33.58	$48.42	$70.85	36.8	155.3	132.9	2,174.6	1,890.3
HSA B	$832.61	$186.36	$58.58	$34.85	$39.41	$65.15	44.3	228.9	140.3	1,779.7	1,572.9
HSA C	$614.91	$113.63	$33.94	$53.89	$72.03	$74.24	43.0	156.3	273.5	2,246.8	1,945.9
HSA D	$530.61	$76.75	$64.36	$21.99	$30.51	$62.39	38.4	261.0	115.1	1,711.5	2,060.8
HSA E	$381.96	$12.88	$45.24	$34.22	$31.70	$50.04	6.1	175.7	139.3	1,508.3	1,562.8
HSA F	$606.59	$160.76	$35.41	$30.43	$48.58	$42.60	54.4	187.8	141.5	2,240.0	1,671.1
HSA G	$849.48	$275.36	$60.77	$35.95	$44.14	$61.92	71.2	280.5	155.8	2,466.8	1,892.4
HSA H	$586.63	$52.74	$40.73	$25.83	$37.04	$64.00	39.6	151.8	125.4	1,894.4	1,742.6
HSA I	$551.38	$88.63	$39.24	$35.31	$48.70	$57.78	39.0	135.3	153.5	1,709.5	1,930.6
HSA J	$558.25	$97.19	$31.21	$30.50	$45.92	$66.14	29.0	154.4	146.7	1,826.5	1,935.0

Program: BCBSVT Primary

Table 14: BCBSVT Primary Variational Analysis
2020 Cohort, Reporting Period: Jan 2020 – Dec 2020

Blinded HSA	Fee-for-Service Equivalent Spend PMPM	Inpatient Spend PMPM	Emergency Department Spend PMPM	Outpatient Advanced Imaging Spend PMPM	Primary Care Spend PMPM	Specialty Care Spend PMPM	Inpatient Admissions PKPY	Emergency Department Visits PKPY	Outpatient Advanced Imaging PKPY	Primary Care Visits PKPY	Specialty Care Visits PKPY
Total	**$430.20**	**$88.95**	**$34.07**	**$20.94**	**$30.71**	**$46.09**	**38.6**	**168.0**	**94.2**	**1,956.7**	**1,618.6**
HSA A	$443.89	$85.33	$32.36	$23.20	$36.42	$40.22	41.0	193.2	122.5	1,881.3	1,568.4
HSA B	$404.59	$91.58	$38.42	$17.54	$30.08	$36.17	43.8	215.6	86.7	2,066.6	1,629.2
HSA C	$912.22	$513.51	$40.00	$44.72	$47.02	$43.07	87.2	150.2	188.9	1,933.0	1,356.5
HSA D	$528.39	$146.97	$29.79	$16.39	$36.99	$59.94	57.3	193.6	79.0	1,974.7	1,384.6
HSA E	$421.96	$88.16	$36.65	$18.19	$30.97	$31.53	48.0	183.1	86.4	1,995.2	1,514.6
HSA F	$361.41	$130.25	$45.23	$12.32	$26.71	$23.18	84.7	277.1	46.2	1,239.3	1,046.8
HSA G	$556.60	$126.53	$44.75	$22.52	$32.83	$76.65	52.6	272.7	107.4	1,727.5	2,011.6
HSA H	$521.93	$136.91	$22.03	$21.28	$50.96	$37.82	41.5	152.1	89.9	1,856.0	1,621.0
HSA I	$403.01	$77.78	$31.56	$20.77	$28.78	$43.48	34.4	142.5	88.7	2,004.0	1,609.4
HSA J	$578.33	$90.97	$76.65	$27.17	$43.84	$78.28	36.4	257.8	121.3	1,810.5	1,325.2
HSA K	$492.63	$76.79	$52.33	$19.93	$28.74	$31.76	34.6	181.8	101.0	1,737.4	1,324.7
HSA L	$268.59	$37.16	$43.51	$6.71	$21.63	$43.62	5.9	229.2	41.1	1,363.4	2,333.0
HSA M	$684.98	$162.69	$42.38	$32.40	$36.71	$209.64	52.3	235.4	130.8	1,443.8	1,218.8

Table 15: BCBSVT Primary Variational Analysis

2021 Cohort, Reporting Period: Jan 2021 – Dec 2021

Blinded HSA	Fee-for-Service Equivalent Spend PMPM	Inpatient Spend PMPM	Emergency Department Spend PMPM	Outpatient Advanced Imaging Spend PMPM	Primary Care Spend PMPM	Specialty Care Spend PMPM	Inpatient Admissions PKPY	Emergency Department Visits PKPY	Outpatient Advanced Imaging PKPY	Primary Care Visits PKPY	Specialty Care Visits PKPY
Total	**$561.53**	**$93.06**	**$42.95**	**$31.10**	**$45.66**	**$57.52**	**39.7**	**181.2**	**133.2**	**2,110.2**	**1,947.4**
HSA A	$1,010.17	$143.36	$77.47	$38.38	$303.62	$60.78	62.9	276.9	182.5	2,045.1	2,284.2
HSA B	$474.17	$60.16	$42.51	$25.17	$37.89	$45.16	35.1	210.7	108.0	2,257.9	1,982.4
HSA C	$627.11	$100.83	$54.08	$27.68	$44.54	$86.94	52.7	271.0	137.8	1,849.3	2,411.5
HSA D	$519.67	$86.86	$35.72	$30.92	$34.06	$52.20	35.4	137.8	122.4	2,136.4	1,902.7
HSA E	$649.39	$110.92	$60.37	$30.11	$78.69	$44.97	64.5	243.3	129.0	2,283.3	1,618.0
HSA F	$529.40	$139.37	$31.92	$26.77	$48.67	$70.40	34.4	163.6	120.5	2,083.2	1,670.0
HSA G	$916.69	$411.12	$103.86	$35.77	$37.64	$59.55	136.2	272.3	136.2	2,115.0	1,960.7
HSA H	$667.57	$107.29	$143.01	$41.35	$57.11	$91.49	38.1	449.8	175.3	1,707.8	2,485.4
HSA I	$594.03	$91.36	$41.22	$33.12	$52.91	$63.85	40.2	204.5	161.2	2,060.2	1,987.8
HSA J	$609.16	$33.78	$54.66	$39.82	$59.29	$62.95	19.0	227.9	166.2	1,856.7	1,638.3
HSA K	$582.28	$95.42	$47.09	$29.35	$42.05	$57.50	39.7	222.1	133.6	2,379.4	1,915.5
HSA L	$415.95	$85.94	$56.30	$14.20	$43.41	$50.30	22.8	330.8	79.8	1,825.1	1,482.9

Payer: Medicaid (Traditional)

Table 16: Medicaid (Traditional) Variational Analysis
2018 Cohort, Reporting Period: Jan 2018 – Dec 2018

Blinded HSA	Fee-for-Service Equivalent Spend PMPM	Inpatient Spend PMPM	Emergency Department Spend PMPM	Outpatient Advanced Imaging Spend PMPM	Primary Care Spend PMPM	Specialty Care Spend PMPM	Inpatient Admissions PKPY	Emergency Department Visits PKPY	Outpatient Advanced Imaging PKPY	Primary Care Visits PKPY	Specialty Care Visits PKPY
Total	$207.40	$55.64	$24.98	$0.43	$34.86	$13.34	50.0	584.8	86.8	3,180.2	957.3
HSA A	$186.40	$48.60	$17.54	$0.36	$32.49	$10.07	39.4	404.7	70.9	3,153.4	832.9
HSA B	$278.28	$78.68	$45.68	$0.59	$49.95	$20.24	73.6	801.7	123.4	3,056.4	1,476.3
HSA C	$184.37	$42.99	$26.86	$0.34	$35.69	$11.16	45.3	752.5	66.5	3,274.4	876.4
HSA D	$311.51	$84.95	$41.91	$0.91	$43.44	$29.92	77.4	882.9	183.6	3,256.8	1,742.6
HSA E	$186.10	$67.69	$20.33	$0.27	$28.77	$9.69	48.0	471.3	59.6	3,022.8	862.8
HSA F	$206.55	$51.23	$25.77	$0.66	$31.78	$13.45	64.6	624.4	130.2	2,750.9	1,126.4
HSA G	$203.00	$55.62	$23.12	$0.36	$29.59	$13.72	48.3	558.4	73.6	3,066.2	862.0
HSA H	$211.74	$53.31	$28.01	$0.48	$35.65	$14.73	56.4	607.5	97.6	3,725.2	933.5
HSA I	$223.55	$59.11	$29.52	$0.44	$42.47	$12.86	56.7	836.4	86.2	3,019.7	874.2
HSA J	$166.54	$36.97	$22.79	$0.50	$29.05	$11.72	31.2	526.4	102.7	2,757.7	877.6

Table 17: Medicaid (Traditional) Variational Analysis

2019 Cohort, Reporting Period: Jan 2019 – Dec 2019

Blinded HSA	Fee-for-Service Equivalent Spend PMPM	Inpatient Spend PMPM	Emergency Department Spend PMPM	Outpatient Advanced Imaging Spend PMPM	Primary Care Spend PMPM	Specialty Care Spend PMPM	Inpatient Admissions PKPY	Emergency Department Visits PKPY	Outpatient Advanced Imaging PKPY	Primary Care Visits PKPY	Specialty Care Visits PKPY
Total	**$222.62**	**$56.03**	**$25.97**	**$0.45**	**$39.97**	**$15.45**	**50.3**	**620.2**	**91.0**	**3,183.4**	**1,048.0**
HSA A	$194.41	$40.58	$20.25	$0.61	$33.17	$10.86	34.4	505.1	119.3	2,986.4	927.2
HSA B	$232.30	$55.26	$31.87	$0.51	$43.39	$12.96	43.0	715.6	106.1	2,981.5	889.5
HSA C	$227.58	$67.23	$21.70	$0.45	$34.82	$12.35	62.3	523.2	84.5	3,194.9	993.0
HSA D	$190.19	$51.98	$22.11	$0.41	$28.94	$11.46	46.1	496.7	81.1	3,073.2	996.2
HSA E	$229.87	$56.50	$35.63	$0.46	$46.63	$21.74	45.1	739.3	90.5	3,043.7	1,566.4
HSA F	$218.43	$46.34	$30.35	$0.47	$36.23	$19.55	48.6	735.2	96.8	3,138.0	1,108.6
HSA G	$197.77	$52.74	$22.26	$0.39	$28.68	$12.37	47.1	549.4	78.1	3,049.7	847.1
HSA H	$235.74	$73.14	$24.81	$0.55	$36.50	$14.02	64.0	601.1	111.6	3,578.7	928.1
HSA I	$239.11	$61.04	$25.27	$0.41	$52.49	$18.88	59.8	622.7	80.2	3,490.2	1,282.1
HSA J	$245.41	$59.54	$26.60	$0.67	$46.74	$21.47	54.1	655.1	137.3	3,242.6	1,253.7
HSA K	$211.82	$53.66	$29.96	$0.44	$41.24	$13.32	47.2	812.6	90.0	3,313.2	871.8
HSA L	$217.10	$52.48	$21.83	$0.37	$38.63	$14.90	47.3	504.7	79.1	3,149.6	1,025.5
HSA M	$251.94	$65.76	$32.38	$0.51	$47.38	$12.87	54.9	845.5	98.2	2,894.2	913.5

Table 18: Medicaid (Traditional) Variational Analysis

2020 Cohort, Reporting Period: Jan 2020 – Dec 2020

Blinded HSA	Fee-for-Service Equivalent Spend PMPM	Inpatient Spend PMPM	Emergency Department Spend PMPM	Outpatient Advanced Imaging Spend PMPM	Primary Care Spend PMPM	Specialty Care Spend PMPM	Inpatient Admissions PKPY	Emergency Department Visits PKPY	Outpatient Advanced Imaging PKPY	Primary Care Visits PKPY	Specialty Care Visits PKPY
Total	**$198.50**	**$53.14**	**$20.86**	**$0.39**	**$32.41**	**$17.20**	**45.4**	**465.7**	**79.7**	**2,681.6**	**1,158.9**
HSA A	$181.09	$56.04	$18.00	$0.37	$21.94	$11.18	40.5	383.3	71.1	2,378.0	985.7
HSA B	$209.03	$40.30	$22.81	$0.49	$38.99	$17.29	41.6	461.8	97.1	2,623.3	999.2
HSA C	$216.05	$46.71	$20.38	$0.41	$28.38	$13.35	35.8	416.0	78.2	2,496.2	1,034.8
HSA D	$203.67	$63.44	$18.39	$0.51	$38.84	$14.17	46.9	437.5	102.1	2,653.0	1,034.9
HSA E	$215.87	$63.79	$21.68	$0.38	$40.19	$23.46	55.8	512.0	72.3	2,901.9	1,705.7
HSA F	$193.31	$54.78	$19.87	$0.36	$26.63	$15.87	42.9	433.2	74.1	2,666.9	1,015.1
HSA G	$221.42	$58.06	$19.36	$0.55	$30.59	$13.38	48.2	427.2	106.8	2,788.2	1,029.1
HSA H	$175.03	$25.87	$20.90	$0.29	$34.12	$28.74	29.9	464.9	62.8	2,450.0	2,007.8
HSA I	$202.85	$53.08	$27.35	$0.41	$35.49	$22.01	45.0	554.9	87.4	2,380.1	1,623.2
HSA J	$188.14	$48.94	$20.92	$0.49	$27.67	$15.51	48.0	474.8	101.7	2,875.5	904.1
HSA K	$242.33	$60.49	$25.28	$0.54	$42.14	$18.73	53.5	584.4	99.5	2,552.0	1,079.5
HSA L	$177.14	$50.74	$21.87	$0.34	$27.74	$14.58	46.5	526.0	68.7	2,687.3	889.7
HSA M	$189.40	$55.06	$17.53	$0.30	$30.56	$14.66	44.2	392.2	65.4	2,794.8	1,042.9
HSA N	$195.08	$51.39	$24.19	$0.41	$28.76	$17.69	44.0	556.3	82.5	2,551.8	990.8

Table 19: Medicaid (Traditional) Variational Analysis

2021 Cohort, Reporting Period: Jan 2021 – Dec 2021

Blinded HSA	Fee-for-Service Equivalent Spend PMPM	Inpatient Spend PMPM	Emergency Department Spend PMPM	Outpatient Advanced Imaging Spend PMPM	Primary Care Spend PMPM	Specialty Care Spend PMPM	Inpatient Admissions PKPY	Emergency Department Visits PKPY	Outpatient Advanced Imaging PKPY	Primary Care Visits PKPY	Specialty Care Visits PKPY
Total	**$192.50**	**$43.40**	**$19.94**	**$0.47**	**$34.10**	**$15.66**	**41.0**	**409.7**	**100.8**	**2,838.5**	**1,095.7**
HSA A	$199.70	$49.09	$20.64	$0.50	$34.15	$15.05	46.2	448.6	108.0	3,233.6	1,042.8
HSA B	$180.44	$32.09	$18.81	$0.42	$34.35	$19.82	35.3	395.8	88.3	2,580.7	1,219.1
HSA C	$200.08	$32.41	$26.06	$0.64	$22.24	$19.06	32.7	414.2	119.9	2,395.1	1,373.3
HSA D	$219.39	$59.10	$19.62	$0.56	$29.85	$17.28	47.8	388.6	122.6	2,817.6	1,157.0
HSA E	$155.08	$37.65	$17.17	$0.41	$22.56	$9.88	26.6	404.1	83.1	2,337.9	957.1
HSA F	$199.07	$48.27	$18.21	$0.58	$40.67	$18.35	49.0	383.9	113.9	2,795.8	1,020.8
HSA G	$216.63	$52.66	$21.39	$0.43	$48.72	$17.70	47.3	492.2	92.5	3,118.3	1,356.6
HSA H	$196.47	$40.72	$21.08	$0.51	$38.32	$13.84	38.5	418.4	113.0	2,683.8	875.9
HSA I	$183.17	$46.90	$18.62	$0.57	$26.77	$14.59	47.4	392.5	117.9	2,837.7	879.1
HSA J	$218.95	$53.00	$23.34	$0.52	$34.93	$15.74	46.9	481.2	115.3	2,403.1	945.2
HSA K	$174.79	$35.21	$21.66	$0.42	$28.88	$16.83	36.9	439.1	94.2	2,678.3	1,183.6
HSA L	$170.28	$7.55	$25.85	$0.68	$43.55	$14.37	6.6	459.0	124.6	3,750.8	1,075.4
HSA M	$184.73	$30.34	$23.59	$0.40	$39.22	$20.66	37.0	439.5	87.9	2,622.5	1,442.6
HSA N	$189.67	$42.73	$17.45	$0.43	$32.51	$14.57	39.4	331.8	94.4	2,965.2	1,068.5
HSA O	$178.76	$43.11	$20.46	$0.44	$28.33	$12.25	40.6	486.7	90.7	2,826.5	1,068.5

Payer: Medicaid (Expanded)

Table 20: Medicaid (Expanded) Variational Analysis
2020 Cohort, Reporting Period: Jan 2020 – Dec 2020

Blinded HSA	Fee-for-Service Equivalent Spend PMPM	Inpatient Spend PMPM	Emergency Department Spend PMPM	Outpatient Advanced Imaging Spend PMPM	Primary Care Spend PMPM	Specialty Care Spend PMPM	Inpatient Admissions PKPY	Emergency Department Visits PKPY	Outpatient Advanced Imaging PKPY	Primary Care Visits PKPY	Specialty Care Visits PKPY
Total	**$154.35**	**$50.51**	**$17.66**	**$0.28**	**$20.66**	**$12.35**	**46.6**	**407.6**	**57.5**	**1,719.8**	**839.0**
HSA A	$169.14	$61.31	$18.20	$0.29	$26.21	$14.20	60.1	444.8	64.0	1,869.1	990.4
HSA B	$136.94	$46.25	$13.59	$0.26	$22.99	$16.34	51.9	361.4	55.2	1,786.7	967.0
HSA C	$133.21	$34.63	$18.77	$0.42	$16.64	$12.23	34.6	407.1	82.3	1,450.7	991.7
HSA D	$154.84	$48.53	$17.06	$0.22	$19.31	$12.49	44.7	430.7	47.2	1,728.3	802.7
HSA E	$175.67	$60.63	$23.41	$0.28	$23.06	$19.50	61.5	466.6	60.5	1,610.2	1,169.7
HSA F	$175.29	$75.06	$18.79	$0.32	$19.77	$10.61	53.4	469.3	59.6	1,400.8	707.1
HSA G	$145.65	$46.38	$19.74	$0.39	$17.34	$15.90	47.8	441.0	71.6	1,472.7	829.5
HSA H	$161.98	$24.92	$20.45	$0.32	$26.38	$10.50	30.1	449.8	70.3	1,811.1	610.4
HSA I	$182.86	$85.56	$15.79	$0.24	$18.96	$18.72	46.3	388.2	54.4	1,486.5	1,023.1
HSA J	$162.80	$64.98	$17.43	$0.27	$14.86	$9.35	52.7	364.0	54.7	1,543.4	955.7
HSA K	$133.70	$36.75	$18.28	$0.36	$18.61	$13.60	50.7	415.2	72.6	1,692.5	727.0
HSA L	$135.18	$46.38	$20.84	$0.26	$21.07	$6.28	43.4	546.3	56.9	1,904.7	562.6
HSA M	$139.19	$38.08	$14.66	$0.20	$20.37	$9.81	38.4	313.6	46.5	1,869.8	833.4
HSA N	$119.49	$14.59	$20.20	$0.25	$16.80	$7.49	27.8	500.2	39.7	1,706.9	758.2
HSA O	$176.35	$55.36	$15.21	$0.32	$22.26	$13.26	38.5	339.8	64.1	1,723.4	720.7
HSA P	$147.98	$51.89	$19.11	$0.29	$18.54	$10.43	47.8	435.6	56.4	1,731.9	784.2

Table 21: Medicaid (Expanded) Variational Analysis

2021 Cohort, Reporting Period: Jan 2021 – Dec 2021

Blinded HSA	Fee-for-Service Equivalent Spend PMPM	Inpatient Spend PMPM	Emergency Department Spend PMPM	Outpatient Advanced Imaging Spend PMPM	Primary Care Spend PMPM	Specialty Care Spend PMPM	Inpatient Admissions PKPY	Emergency Department Visits PKPY	Outpatient Advanced Imaging PKPY	Primary Care Visits PKPY	Specialty Care Visits PKPY
Total	**$138.13**	**$43.38**	**$12.90**	**$0.27**	**$18.66**	**$11.93**	**40.1**	**285.2**	**56.2**	**1,491.2**	**738.2**
HSA A	$95.21	$35.27	$11.03	$0.28	$19.11	$5.00	42.4	275.5	68.9	1,377.5	429.1
HSA B	$128.35	$32.60	$13.85	$0.16	$16.92	$10.99	35.6	331.8	38.4	1,623.4	718.5
HSA C	$117.11	$27.81	$19.65	$0.34	$15.58	$10.43	33.7	401.3	64.1	1,173.7	573.4
HSA D	$108.36	$32.48	$10.99	$0.24	$13.94	$8.29	37.3	285.0	53.3	1,233.0	537.9
HSA E	$140.69	$48.73	$12.98	$0.25	$15.51	$10.19	49.4	285.9	63.5	1,362.4	903.5
HSA F	$96.72	$19.18	$19.03	$0.31	$12.37	$7.74	45.1	451.1	45.1	1,188.0	571.4
HSA G	$153.28	$61.14	$8.78	$0.28	$19.97	$11.89	52.8	234.4	62.7	1,333.7	706.5
HSA H	$166.64	$49.40	$14.34	$0.32	$20.28	$28.64	39.9	308.6	69.0	1,441.5	1,078.4
HSA I	$138.60	$35.51	$11.24	$0.22	$19.19	$9.85	31.3	225.5	50.6	1,650.9	789.6
HSA J	$127.06	$14.44	$13.13	$0.48	$13.89	$17.46	28.6	286.3	95.4	1,364.6	768.2
HSA K	$121.28	$27.72	$14.22	$0.18	$21.84	$9.08	30.6	283.3	34.4	1,523.4	627.8
HSA L	$176.34	$84.79	$12.11	$0.30	$19.17	$14.70	35.1	245.7	57.0	1,511.5	739.3
HSA M	$137.07	$26.63	$13.04	$0.29	$21.91	$12.47	43.3	295.7	72.1	1,730.8	865.4
HSA N	$89.26	$30.81	$5.19	$0.21	$13.14	$9.97	51.9	121.2	51.9	1,281.4	952.4
HSA O	$121.63	$35.60	$10.55	$0.18	$14.87	$21.56	56.6	283.0	37.7	1,163.5	641.5
HSA P	$163.57	$65.46	$16.25	$0.35	$25.51	$9.40	60.4	362.5	56.5	1,781.1	779.5

Exhibit B to Section 7: Most Prevalent Conditions by Payer

Table 22: BCBSVT Primary Prevalent Conditions, 2021

Health Service Area	#1 Prevalent Condition	#2 Prevalent Condition	#3 Prevalent Condition	#4 Prevalent Condition	#5 Prevalent Condition
Bennington	Anxiety	Hypertension	Acute upper respiratory tract infection	Obesity	Depression
	18.0%	*17.8%*	*14.2%*	*12.4%*	*10.3%*
Berlin	Anxiety	Hypertension	Refractive errors	Depression	Disorders of lipid metabolism
	14.6%	*14.2%*	*11.9%*	*11.6%*	*11.3%*
Brattleboro	Hypertension	Anxiety	Acute upper respiratory tract infection	Refractive errors	Depression
	14.6%	*13.2%*	*12.4%*	*11.9%*	*11.3%*
Burlington	Anxiety	Acute upper respiratory tract infection	Adjustment disorder	Hypertension	Depression
	14.6%	*12.5%*	*10.8%*	*10.0%*	*9.6%*
Lebanon	Anxiety	Hypertension	Refractive errors	Obesity	Benign and unspecified neoplasm
	14.8%	*14.7%*	*13.4%*	*10.0%*	*9.7%*
Middlebury	Hypertension	Anxiety	Acute upper respiratory tract infection	Refractive errors	Disorders of lipid metabolism
	15.7%	*14.8%*	*12.6%*	*11.8%*	*10.0%*
Newport	Hypertension	Disorders of lipid metabolism	Anxiety	Refractive errors	Depression
	18.8%	*16.2%*	*15.0%*	*14.3%*	*11.5%*
Rutland	Hypertension	Acute upper respiratory tract infection	Anxiety	Disorders of lipid metabolism	Depression
	15.8%	*14.6%*	*13.1%*	*11.1%*	*10.0%*
Springfield	Anxiety	Obesity	Hypertension	Acute upper respiratory tract infection	Depression
	19.1%	*16.9%*	*13.4%*	*12.8%*	*12.2%*

Health Service Area	#1 Prevalent Condition	#2 Prevalent Condition	#3 Prevalent Condition	#4 Prevalent Condition	#5 Prevalent Condition
St. Albans	Hypertension	Anxiety	Acute upper respiratory tract infection	Disorders of lipid metabolism	Ophthalmic signs and symptoms
	17.5%	*13.6%*	*12.1%*	*10.4%*	*9.9%*
St. Johnsbury	Hypertension	Refractive errors	Anxiety	Acute upper respiratory tract infection	Disorders of lipid metabolism
	17.2%	*16.3%*	*14.8%*	*11.7%*	*10.3%*
Windsor	Hypertension	Anxiety	Adjustment disorder	Acute upper respiratory tract infection	Depression
	12.7%	*12.6%*	*11.2%*	*10.4%*	*10.0%*
OneCare	**Anxiety**	**Hypertension**	**Acute upper respiratory tract infection**	**Depression**	**Adjustment disorder**
	14.6%	***12.5%***	***12.1%***	***10.1%***	***9.6%***

Table 23: BCBSVT QHP Prevalent Conditions, 2021

Health Service Area	#1 Prevalent Condition	#2 Prevalent Condition	#3 Prevalent Condition	#4 Prevalent Condition	#5 Prevalent Condition
Bennington	Hypertension	Anxiety	Disorders of lipid metabolism	Benign neoplasm of skin and subcutaneous tissues	Benign and unspecified neoplasm
	15.7%	*13.5%*	*11.2%*	*10.7%*	*10.3%*
Berlin	Hypertension	Anxiety	Disorders of lipid metabolism	Depression	Adjustment disorder
	14.6%	*13.6%*	*13.1%*	*10.2%*	*8.2%*
Brattleboro	Hypertension	Anxiety	Depression	Disorders of lipid metabolism	Adjustment disorder
	15.4%	*15.2%*	*12.5%*	*10.2%*	*8.9%*
Burlington	Anxiety	Hypertension	Adjustment disorder	Depression	Benign neoplasm of skin and subcutaneous tissues
	14.6%	*11.9%*	*9.8%*	*9.7%*	*9.6%*
Lebanon	Anxiety	Skin keratoses	Hypertension	Depression	Benign neoplasm of skin and subcutaneous tissues
	14.3%	*12.8%*	*12.7%*	*11.9%*	*10.3%*
Middlebury	Hypertension	Anxiety	Disorders of lipid metabolism	Refractive errors	Benign and unspecified neoplasm
	17.6%	*12.0%*	*10.2%*	*9.5%*	*8.6%*
Newport	Hypertension	Disorders of lipid metabolism	Anxiety	Refractive errors	Urinary symptoms
	23.6%	*18.5%*	*10.9%*	*10.0%*	*8.3%*

Health Service Area	#1 Prevalent Condition	#2 Prevalent Condition	#3 Prevalent Condition	#4 Prevalent Condition	#5 Prevalent Condition
Springfield	Hypertension	Obesity	Disorders of lipid metabolism	Anxiety	Benign neoplasm of skin and subcutaneous tissues
	18.1%	*17.3%*	*16.7%*	*12.7%*	*8.1%*
St. Albans	Hypertension	Disorders of lipid metabolism	Anxiety	Benign and unspecified neoplasm	Cataract, aphakia
	24.2%	*15.6%*	*13.4%*	*11.7%*	*11.2%*
Windsor	Hypertension	Anxiety	Refractive errors	Benign and unspecified neoplasm	Skin keratoses
	12.8%	*9.5%*	*9.4%*	*8.9%*	*8.6%*
OneCare	**Hypertension**	**Anxiety**	**Disorders of lipid metabolism**	**Depression**	**Benign and unspecified neoplasm**
	14.8%	***13.6%***	***11.1%***	***9.5%***	***8.9%***

Table 24: MVP QHP Prevalent Conditions, 2021

Health Service Area	#1 Prevalent Condition	#2 Prevalent Condition	#3 Prevalent Condition	#4 Prevalent Condition	#5 Prevalent Condition
Bennington	Hypertension	Anxiety	Benign neoplasm of skin and subcutaneous tissues	Disorders of lipid metabolism	Benign and unspecified neoplasm
	17.6%	*13.2%*	*10.5%*	*10.3%*	*8.8%*
Berlin	Anxiety	Disorders of lipid metabolism	Hypertension	Depression	Benign and unspecified neoplasm
	13.6%	*13.6%*	*12.3%*	*8.3%*	*6.2%*
Brattleboro	Anxiety	Hypertension	Disorders of lipid metabolism	Depression	Benign and unspecified neoplasm
	15.5%	*11.9%*	*8.7%*	*8.3%*	*7.5%*
Burlington	Anxiety	Hypertension	Disorders of lipid metabolism	Adjustment disorder	Depression
	11.6%	*10.1%*	*8.1%*	*7.4%*	*7.4%*
Lebanon	Hypertension	Anxiety	Refractive errors	Depression	Disorders of lipid metabolism
	12.9%	*12.4%*	*10.0%*	*9.4%*	*9.4%*
Middlebury	Hypertension	Disorders of lipid metabolism	Refractive errors	Anxiety	Benign and unspecified neoplasm
	17.8%	*12.6%*	*11.8%*	*10.3%*	*7.5%*
Morrisville	Hypertension	Obesity	Refractive errors	Disorders of lipid metabolism	Anxiety
	13.6%	*13.2%*	*11.3%*	*10.9%*	*8.1%*
Newport	Hypertension	Disorders of lipid metabolism	Refractive errors	Anxiety	Benign and unspecified neoplasm
	20.5%	*19.1%*	*10.8%*	*10.5%*	*9.4%*
Randolph	Hypertension	Disorders of lipid metabolism	Anxiety	Depression	Gastroesophageal reflux
	22.8%	*10.6%*	*9.5%*	*9.3%*	*6.8%*

Health Service Area	#1 Prevalent Condition	#2 Prevalent Condition	#3 Prevalent Condition	#4 Prevalent Condition	#5 Prevalent Condition
Rutland	Hypertension	Disorders of lipid metabolism	Anxiety	Acute upper respiratory tract infection	Gastroesophageal reflux
	22.6%	*18.7%*	*12.6%*	*9.9%*	*9.6%*
Springfield	Hypertension	Disorders of lipid metabolism	Anxiety	Obesity	Depression
	19.5%	*14.6%*	*14.4%*	*13.9%*	*8.6%*
St. Albans	Hypertension	Disorders of lipid metabolism	Anxiety	Tobacco	Ophthalmic signs and symptoms
	22.1%	*12.6%*	*10.2%*	*9.7%*	*8.6%*
St. Johnsbury	Hypertension	Refractive errors	Disorders of lipid metabolism	Anxiety	Depression
	19.3%	*15.2%*	*12.1%*	*9.1%*	*8.3%*
OneCare	**Hypertension**	**Anxiety**	**Disorders of lipid metabolism**	**Depression**	**Benign and unspecified neoplasm**
	15.5%	***11.8%***	***11.5%***	***7.8%***	***7.4%***

Table 25: Medicaid (Traditional) Prevalent Conditions, 2021

Health Service Area	#1 Prevalent Condition	#2 Prevalent Condition	#3 Prevalent Condition	#4 Prevalent Condition	#5 Prevalent Condition
Bennington	Anxiety	Acute upper respiratory tract infection	Depression	Attention deficit disorder	Hypertension
	16.7%	*12.6%*	*10.5%*	*9.8%*	*8.1%*
Berlin	Anxiety	Depression	Adjustment disorder	Refractive errors	Acute upper respiratory tract infection
	16.9%	*13.1%*	*11.1%*	*11.0%*	*9.1%*
Brattleboro	Anxiety	Depression	Attention deficit disorder	Acute upper respiratory tract infection	Refractive errors
	18.1%	*11.8%*	*9.6%*	*9.6%*	*7.8%*
Burlington	Anxiety	Depression	Acute upper respiratory tract infection	Adjustment disorder	Refractive errors
	16.1%	*11.5%*	*10.8%*	*9.6%*	*8.5%*
Lebanon	Anxiety	Depression	Refractive errors	Ophthalmic signs and symptoms	Attention deficit disorder
	18.4%	*13.9%*	*12.5%*	*11.0%*	*10.1%*
Middlebury	Anxiety	Depression	Acute upper respiratory tract infection	Refractive errors	Hypertension
	16.6%	*11.8%*	*10.8%*	*9.1%*	*9.0%*
Morrisville	Refractive errors	Acute upper respiratory tract infection	Anxiety	Adjustment disorder	Tobacco
	14.6%	*12.4%*	*12.0%*	*9.6%*	*7.1%*
Newport	Refractive errors	Anxiety	Depression	Acute upper respiratory tract infection	Hypertension
	18.6%	*15.7%*	*11.4%*	*10.7%*	*9.9%*

Health Service Area	#1 Prevalent Condition	#2 Prevalent Condition	#3 Prevalent Condition	#4 Prevalent Condition	#5 Prevalent Condition
Randolph	Ophthalmic signs and symptoms	Anxiety	Depression	Asthma	Acute upper respiratory tract infection
	13.9%	*13.5%*	*11.7%*	*8.6%*	*8.4%*
Rutland	Acute upper respiratory tract infection	Anxiety	Obesity	Depression	Refractive errors
	14.3%	*13.4%*	*10.2%*	*10.2%*	*10.0%*
Springfield	Anxiety	Acute upper respiratory tract infection	Depression	Obesity	Tobacco
	16.5%	*12.1%*	*11.0%*	*9.7%*	*9.6%*
St. Albans	Anxiety	Tobacco	Toxic effects of nonmedicinal agents	Acute upper respiratory tract infection	Depression
	14.5%	*13.8%*	*13.2%*	*12.9%*	*11.2%*
St. Johnsbury	Refractive errors	Anxiety	Acute upper respiratory tract infection	Depression	Hypertension
	16.4%	*14.9%*	*10.9%*	*9.8%*	*9.5%*
Windsor	Anxiety	Refractive errors	Depression	Adjustment disorder	Ophthalmic signs and symptoms
	15.2%	*10.5%*	*9.9%*	*9.9%*	*8.0%*
OneCare	**Anxiety**	**Acute upper respiratory tract infection**	**Depression**	**Refractive errors**	**Adjustment disorder**
	15.6%	***11.2%***	***11.1%***	***10.2%***	***8.3%***

Table 26: Medicaid (Expanded) Prevalent Conditions, 2021

Health Service Area	#1 Prevalent Condition	#2 Prevalent Condition	#3 Prevalent Condition	#4 Prevalent Condition	#5 Prevalent Condition
Bennington	Anxiety	Depression	Acute upper respiratory tract infection	Tobacco	Adjustment disorder
	7.3%	*5.3%*	*4.7%*	*4.0%*	*3.6%*
Berlin	Anxiety	Depression	Adjustment disorder	Refractive errors	Tobacco
	8.4%	*6.4%*	*6.4%*	*6.2%*	*4.8%*
Brattleboro	Anxiety	Depression	Tobacco	Adjustment disorder	Refractive errors
	9.3%	*9.0%*	*5.7%*	*4.6%*	*4.6%*
Burlington	Anxiety	Depression	Adjustment disorder	Refractive errors	Acute upper respiratory tract infection
	8.3%	*6.0%*	*5.5%*	*5.2%*	*3.5%*
Lebanon	Anxiety	Depression	Ophthalmic signs and symptoms	Refractive errors	Adjustment disorder
	8.4%	*6.5%*	*5.6%*	*5.5%*	*4.7%*
Middlebury	Anxiety	Depression	Acute upper respiratory tract infection	Refractive errors	Tobacco
	7.4%	*5.0%*	*4.3%*	*4.3%*	*4.2%*
Morrisville	Refractive errors	Anxiety	Adjustment disorder	Tobacco	Acute upper respiratory tract infection
	7.7%	*6.0%*	*4.9%*	*4.4%*	*3.8%*
Newport	Refractive errors	Anxiety	Tobacco	Adjustment disorder	Lacerations
	8.5%	*6.2%*	*5.4%*	*4.2%*	*3.8%*
Out of State	Refractive errors	Anxiety	Depression	Tobacco	Acute upper respiratory tract infection
	7.6%	*7.3%*	*7.1%*	*5.7%*	*4.5%*
Randolph	Anxiety	Ophthalmic signs and symptoms	Tobacco	Depression	Pregnancy and delivery, uncomplicated
	6.2%	*6.2%*	*4.8%*	*4.2%*	*3.7%*

Health Service Area	#1 Prevalent Condition	#2 Prevalent Condition	#3 Prevalent Condition	#4 Prevalent Condition	#5 Prevalent Condition
Rutland	Anxiety	Depression	Acute upper respiratory tract infection	Refractive errors	Adjustment disorder
	7.6%	*6.4%*	*5.0%*	*4.8%*	*4.5%*
Springfield	Anxiety	Tobacco	Depression	Refractive errors	Pregnancy and delivery, uncomplicated
	8.8%	*7.5%*	*6.3%*	*5.0%*	*4.8%*
St. Albans	Tobacco	Anxiety	Depression	Acute upper respiratory tract infection	Refractive errors
	9.8%	*7.4%*	*4.7%*	*4.5%*	*4.4%*
St. Johnsbury	Refractive errors	Anxiety	Adjustment disorder	Depression	Tobacco
	9.7%	*7.3%*	*4.6%*	*4.6%*	*4.1%*
Townshend	Anxiety	Depression	Attention deficit disorder	Acute sprains and strains	Refractive errors
	8.3%	*7.3%*	*4.2%*	*3.8%*	*3.7%*
Windsor	Anxiety	Depression	Refractive errors	Tobacco	Ophthalmic signs and symptoms
	7.6%	*7.2%*	*6.3%*	*5.9%*	*5.7%*
OneCare	**Anxiety**	**Depression**	**Refractive errors**	**Tobacco**	**Adjustment disorder**
	7.7%	***5.7%***	***5.5%***	***4.8%***	***4.5%***

Table 27: Medicare Prevalent Conditions, 2021

Health Service Area	#1 Prevalent Condition	#2 Prevalent Condition	#3 Prevalent Condition	#4 Prevalent Condition	#5 Prevalent Condition
Bennington	Hypertension	Disorders of lipid metabolism	Coronary artery disease	Benign neoplasm of skin and subcutaneous tissues	Cataract, aphakia
	54.5%	*41.8%*	*35.4%*	*24.5%*	*23.6%*
Berlin	Hypertension	Disorders of lipid metabolism	Coronary artery disease	Cataract, aphakia	Diabetes
	54.2%	*47.9%*	*29.6%*	*27.8%*	*20.6%*
Brattleboro	Hypertension	Disorders of lipid metabolism	Coronary artery disease	Cataract, aphakia	Refractive errors
	51.9%	*38.4%*	*30.0%*	*24.5%*	*20.0%*
Burlington	Hypertension	Disorders of lipid metabolism	Coronary artery disease	Cataract, aphakia	Skin keratoses
	51.8%	*39.6%*	*28.2%*	*23.3%*	*22.1%*
Lebanon	Hypertension	Disorders of lipid metabolism	Skin keratoses	Refractive errors	Benign and unspecified neoplasm
	48.8%	*36.2%*	*34.8%*	*30.6%*	*27.7%*
Middlebury	Hypertension	Disorders of lipid metabolism	Coronary artery disease	Cataract, aphakia	Skin keratoses
	57.6%	*45.2%*	*33.9%*	*30.8%*	*22.1%*
Rutland	Hypertension	Disorders of lipid metabolism	Coronary artery disease	Cataract, aphakia	Diabetes
	59.3%	*48.5%*	*32.9%*	*29.8%*	*24.0%*
St. Albans	Hypertension	Disorders of lipid metabolism	Coronary artery disease	Cataract, aphakia	Diabetes
	66.5%	*51.8%*	*33.0%*	*30.4%*	*25.9%*
Windsor	Hypertension	Disorders of lipid metabolism	Coronary artery disease	Skin keratoses	Cataract, aphakia
	54.8%	*32.4%*	*29.4%*	*27.7%*	*26.6%*

Health Service Area	#1 Prevalent Condition	#2 Prevalent Condition	#3 Prevalent Condition	#4 Prevalent Condition	#5 Prevalent Condition
OneCare	**Hypertension**	**Disorders of lipid metabolism**	**Coronary artery disease**	**Cataract, aphakia**	**Diabetes**
	54.8%	***43.1%***	***30.7%***	***26.2%***	***20.5%***

Exhibit C to Section 7: Most Prevalent High Cost Conditions by Payer

Table 28: BCBSVT Primary Prevalent Conditions (High Cost Individuals $15K+), 2021

Health Service Area	#1 Prevalent Condition	#2 Prevalent Condition	#3 Prevalent Condition	#4 Prevalent Condition	#5 Prevalent Condition
Bennington	Hypertension	Anxiety	Coronary artery disease	Degenerative joint disease	Obesity
	40.5%	*28.2%*	*23.6%*	*22.3%*	*21.9%*
Berlin	Hypertension	Disorders of lipid metabolism	Anxiety	Depression	Benign and unspecified neoplasm
	31.2%	*24.3%*	*24.3%*	*20.6%*	*17.7%*
Brattleboro	Hypertension	Bursitis, synovitis, tenosynovitis	Urinary symptoms	Benign and unspecified neoplasm	Refractive errors
	31.9%	*25.5%*	*23.4%*	*21.3%*	*21.3%*
Burlington	Anxiety	Hypertension	Depression	Benign and unspecified neoplasm	Adjustment disorder
	25.1%	*22.8%*	*20.6%*	*18.1%*	*17.4%*
Lebanon	Hypertension	Obesity	Benign and unspecified neoplasm	Acute sprains and strains	Gastroesoph ageal reflux
	35.3%	*25.5%*	*22.9%*	*21.6%*	*19.6%*
Middlebury	Hypertension	Degenerative joint disease	Acute sprains and strains	Anxiety	Disorders of lipid metabolism
	34.1%	*21.8%*	*21.0%*	*20.8%*	*19.6%*
Newport	Hypertension	Disorders of lipid metabolism	Gastroesoph ageal reflux	Anxiety	Depression
	37.5%	*31.4%*	*22.5%*	*22.2%*	*21.8%*
Rutland	Hypertension	Gastroesoph ageal reflux	Obesity	Anxiety	Depression
	37.7%	*27.7%*	*25.8%*	*22.0%*	*20.7%*
Springfield	Hypertension	Obesity	Gastroesoph ageal reflux	Anxiety	Depression
	39.2%	*33.0%*	*30.9%*	*24.1%*	*22.0%*

Health Service Area	#1 Prevalent Condition	#2 Prevalent Condition	#3 Prevalent Condition	#4 Prevalent Condition	#5 Prevalent Condition
St. Albans	Hypertension	Anxiety	Acute upper respiratory tract infection	Benign and unspecified neoplasm	Disorders of lipid metabolism
	31.9%	*21.8%*	*19.2%*	*18.3%*	*18.2%*
St. Johnsbury	Hypertension	Refractive errors	Acute sprains and strains	Anxiety	Bursitis, synovitis, tenosynovitis
	38.8%	*32.7%*	*24.5%*	*22.2%*	*19.8%*
Windsor	Hypertension	Anxiety	Benign and unspecified neoplasm	Refractive errors	Urinary symptoms
	42.0%	*28.0%*	*23.3%*	*23.3%*	*23.3%*
OneCare	**Hypertension**	**Anxiety**	**Depression**	**Disorders of lipid metabolism**	**Benign and unspecified neoplasm**
	28.7%	***23.8%***	***19.9%***	***18.7%***	***18.0%***

Table 29: BCBSVT QHP Prevalent Conditions (High Cost Individuals $15K+), 2021

Health Service Area	#1 Prevalent Condition	#2 Prevalent Condition	#3 Prevalent Condition	#4 Prevalent Condition	#5 Prevalent Condition
Bennington	Hypertension	Benign and unspecified neoplasm	Obesity	Disorders of lipid metabolism	Depression
	28.8%	*23.1%*	*23.1%*	*23.0%*	*22.1%*
Berlin	Hypertension	Disorders of lipid metabolism	Anxiety	Gastroesoph ageal reflux	Bursitis, synovitis, tenosynovitis
	29.0%	*25.4%*	*24.8%*	*22.7%*	*22.6%*
Brattleboro	Hypertension	Anxiety	Benign and unspecified neoplasm	Depression	Bursitis, synovitis, tenosynovitis
	39.6%	*30.9%*	*28.3%*	*28.1%*	*25.2%*
Burlington	Hypertension	Anxiety	Benign and unspecified neoplasm	Acute sprains and strains	Disorders of lipid metabolism
	27.6%	*25.4%*	*22.2%*	*18.2%*	*17.8%*
Lebanon	Hypertension	Depression	Skin keratoses	Acute sprains and strains	Anxiety
	32.3%	*21.7%*	*21.1%*	*21.1%*	*20.8%*
Middlebury	Hypertension	Anxiety	Bursitis, synovitis, tenosynovitis	Benign and unspecified neoplasm	Acute sprains and strains
	36.2%	*26.1%*	*25.4%*	*22.5%*	*20.4%*
Newport	Hypertension	Disorders of lipid metabolism	Urinary symptoms	Benign and unspecified neoplasm	Obesity
	38.8%	*27.6%*	*24.8%*	*23.7%*	*18.3%*
Springfield	Hypertension	Disorders of lipid metabolism	Obesity	Coronary artery disease	Anxiety
	41.3%	*35.9%*	*27.5%*	*25.9%*	*21.0%*
St. Albans	Hypertension	Disorders of lipid metabolism	Gastroesoph ageal reflux	Benign and unspecified neoplasm	Cataract, aphakia
	46.5%	*27.9%*	*24.1%*	*23.6%*	*23.0%*

Health Service Area	#1 Prevalent Condition	#2 Prevalent Condition	#3 Prevalent Condition	#4 Prevalent Condition	#5 Prevalent Condition
Windsor	Benign and unspecified neoplasm	Hypertension	Disorders of lipid metabolism	Degenerative joint disease	Anxiety
	29.0%	*24.3%*	*20.9%*	*18.5%*	*18.2%*
OneCare	**Hypertension**	**Anxiety**	**Disorders of lipid metabolism**	**Benign and unspecified neoplasm**	**Gastroesophageal reflux**
	32.0%	***23.5%***	***22.2%***	***21.3%***	***18.4%***

Table 30: MVP QHP Prevalent Conditions (High Cost Individuals $15K+), 2021

Health Service Area	#1 Prevalent Condition	#2 Prevalent Condition	#3 Prevalent Condition	#4 Prevalent Condition	#5 Prevalent Condition
Bennington	Hypertension	Coronary artery disease	Bursitis, synovitis, tenosynovitis	Benign neoplasm of skin and subcutaneous tissues	Acute sprains and strains
	33.7%	*18.9%*	*18.6%*	*17.4%*	*17.1%*
Berlin	Disorders of lipid metabolism	Hypertension	Anxiety	Gastroesophageal reflux	Benign and unspecified neoplasm
	34.0%	*31.5%*	*26.4%*	*25.5%*	*18.8%*
Brattleboro	*Suppressed due to small numbers*				
Burlington	Hypertension	Disorders of lipid metabolism	Anxiety	Benign and unspecified neoplasm	Bursitis, synovitis, tenosynovitis
	29.2%	*23.7%*	*20.5%*	*19.9%*	*17.1%*
Lebanon	Benign and unspecified neoplasm	Hypertension	Skin keratoses	Disorders of lipid metabolism	Diabetes
	31.5%	*24.5%*	*21.0%*	*17.5%*	*17.5%*
Middlebury	Hypertension	Obesity	Disorders of lipid metabolism	Diabetes	Benign and unspecified neoplasm
	38.9%	*33.8%*	*22.7%*	*22.2%*	*22.2%*
Morrisville	Bursitis, synovitis, tenosynovitis	Hypertension	Benign and unspecified neoplasm	Obesity	Anxiety
	21.8%	*19.6%*	*18.9%*	*18.9%*	*18.2%*
Newport	Disorders of lipid metabolism	Hypertension	Coronary artery disease	Benign and unspecified neoplasm	Urinary symptoms
	33.1%	*29.4%*	*25.8%*	*25.8%*	*25.8%*
Randolph	Hypertension	Coronary artery disease	Disorders of lipid metabolism	Gastroesophageal reflux	Adjustment disorder
	50.0%	*28.6%*	*23.2%*	*22.3%*	*21.4%*

Health Service Area	#1 Prevalent Condition	#2 Prevalent Condition	#3 Prevalent Condition	#4 Prevalent Condition	#5 Prevalent Condition
Rutland	Hypertension	Disorders of lipid metabolism	Anxiety	Degenerative joint disease	Benign and unspecified neoplasm
	39.1%	*33.7%*	*24.2%*	*19.5%*	*19.4%*
Springfield	Hypertension	Coronary artery disease	Degenerative joint disease	Diabetes	Disorders of lipid metabolism
	53.3%	*36.1%*	*31.4%*	*28.4%*	*26.0%*
St. Albans	Hypertension	Benign and unspecified neoplasm	Cataract, aphakia	Disorders of lipid metabolism	Bursitis, synovitis, tenosynovitis
	49.5%	*25.9%*	*23.9%*	*23.3%*	*21.0%*
St. Johnsbury	Refractive errors	Degenerative joint disease	Disorders of lipid metabolism	Coronary artery disease	Benign and unspecified neoplasm
	37.8%	*25.2%*	*22.0%*	*22.0%*	*22.0%*
OneCare	**Hypertension**	**Disorders of lipid metabolism**	**Benign and unspecified neoplasm**	**Anxiety**	**Degenerative joint disease**
	34.1%	***24.0%***	***20.4%***	***20.3%***	***17.6%***

Table 31: Medicaid (Traditional) Prevalent Conditions (High Cost Individuals $15K+), 2021

Health Service Area	#1 Prevalent Condition	#2 Prevalent Condition	#3 Prevalent Condition	#4 Prevalent Condition	#5 Prevalent Condition
Bennington	Hypertension	Anxiety	Depression	Deficiency anemias	Obesity
	39.0%	*37.2%*	*31.8%*	*31.0%*	*27.0%*
Berlin	Depression	Anxiety	Hypertension	Tobacco	Coronary artery disease
	37.0%	*36.7%*	*34.7%*	*27.3%*	*25.7%*
Brattleboro	Depression	Anxiety	Tobacco	Urinary symptoms	Attention deficit disorder
	49.8%	*45.2%*	*28.3%*	*26.6%*	*25.8%*
Burlington	Anxiety	Depression	Hypertension	Adjustment disorder	Fluid/electrolyte disturbances
	39.7%	*35.7%*	*32.8%*	*24.6%*	*24.2%*
Lebanon	Anxiety	Depression	Hypertension	Obesity	Acute sprains and strains
	38.2%	*38.0%*	*29.4%*	*26.7%*	*24.8%*
Middlebury	Hypertension	Anxiety	Depression	Bursitis, synovitis, tenosynovitis	Obesity
	39.9%	*33.0%*	*31.9%*	*30.2%*	*26.9%*
Morrisville	Hypertension	Tobacco	Asthma	Anxiety	Acute sprains and strains
	35.6%	*32.2%*	*27.9%*	*26.0%*	*22.8%*
Newport	Hypertension	Depression	Anxiety	Tobacco	Urinary symptoms
	43.4%	*34.7%*	*30.8%*	*29.9%*	*26.8%*
Randolph	Anxiety	Depression	Hypertension	Ophthalmic signs and symptoms	Tobacco
	42.8%	*41.3%*	*34.5%*	*31.2%*	*30.7%*
Rutland	Depression	Hypertension	Anxiety	Tobacco	Deficiency anemias
	39.6%	*37.4%*	*35.8%*	*29.0%*	*26.5%*
Springfield	Anxiety	Hypertension	Depression	Fluid/electrolyte disturbances	Obesity
	45.7%	*40.7%*	*36.5%*	*25.2%*	*24.3%*
St. Albans	Depression	Hypertension	Anxiety	Tobacco	Gastroesophageal reflux
	39.3%	*38.6%*	*34.5%*	*31.4%*	*30.6%*

Health Service Area	#1 Prevalent Condition	#2 Prevalent Condition	#3 Prevalent Condition	#4 Prevalent Condition	#5 Prevalent Condition
St. Johnsbury	Tobacco	Hypertension	Anxiety	Depression	Bursitis, synovitis, tenosynovitis
	32.4%	*32.2%*	*31.8%*	*29.6%*	*29.1%*
Windsor	Anxiety	Tobacco	Depression	Acute sprains and strains	Gastroesophageal reflux
	44.7%	*27.9%*	*25.5%*	*23.7%*	*23.1%*
OneCare	**Anxiety**	**Depression**	**Hypertension**	**Tobacco**	**Coronary artery disease**
	36.9%	***36.0%***	***34.9%***	***27.4%***	***23.6%***

Table 32: Medicaid (Expanded) Prevalent Conditions (High Cost Individuals $15K+), 2021

Health Service Area	#1 Prevalent Condition	#2 Prevalent Condition	#3 Prevalent Condition	#4 Prevalent Condition	#5 Prevalent Condition
Bennington	Hypertension	Tobacco	Depression	Coronary artery disease	Newborn status, uncomplicated
	38.7%	*33.3%*	*22.6%*	*18.9%*	*18.9%*
Berlin	Adjustment disorder	Anxiety	Obesity	Depression	Adverse events from medical/surgical procedures
	33.5%	*33.1%*	*31.8%*	*28.4%*	*24.2%*
Brattleboro	Depression	Anxiety	Coronary artery disease	Peripheral neuropathy, neuritis	Gastroesophageal reflux
	42.3%	*37.7%*	*27.7%*	*26.8%*	*24.5%*
Burlington	Anxiety	Adjustment disorder	Hypertension	Urinary symptoms	Coronary artery disease
	24.4%	*20.4%*	*20.4%*	*16.5%*	*15.6%*
Lebanon	*Suppressed due to small numbers*				
Middlebury	*Suppressed due to small numbers*				
Morrisville	Hypertension	Anxiety	Fluid/electrolyte disturbances	Depression	Coronary artery disease
	37.5%	*34.9%*	*34.3%*	*32.3%*	*27.9%*
Newport	*Suppressed due to small numbers*				
Out of State	*Suppressed due to small numbers*				
Randolph	*Suppressed due to small numbers*				
Rutland	Disorders of lipid metabolism	Cerebrovascular disease	Head injury	Ophthalmic signs and symptoms	Autism Spectrum Disorder
	20.3%	*20.3%*	*17.8%*	*16.1%*	*15.3%*

Health Service Area	#1 Prevalent Condition	#2 Prevalent Condition	#3 Prevalent Condition	#4 Prevalent Condition	#5 Prevalent Condition
Springfield	*Suppressed due to small numbers*				
St. Albans	Tobacco	Refractive errors	High Risk Pregnancy	Fungal infections	Obesity
	45.5%	*38.6%*	*31.8%*	*26.1%*	*26.1%*
St. Johnsbury	*Suppressed due to small numbers*				
Townshend	*Suppressed due to small numbers*				
Windsor	*Suppressed due to small numbers*				
OneCare	**Anxiety**	**Hypertension**	**Depression**	**Tobacco**	**Adjustment disorder**
	24.8%	***24.6%***	***23.1%***	***21.1%***	***18.5%***

Table 33: Medicare Prevalent Conditions (High Cost Individuals $15K+), 2021

Health Service Area	#1 Prevalent Condition	#2 Prevalent Condition	#3 Prevalent Condition	#4 Prevalent Condition	#5 Prevalent Condition
Bennington	Hypertension	Coronary artery disease	Disorders of lipid metabolism	Deficiency anemias	Benign and unspecified neoplasm
	73.9%	*63.8%*	*47.5%*	*37.6%*	*32.9%*
Berlin	Hypertension	Coronary artery disease	Disorders of lipid metabolism	Diabetes	Deficiency anemias
	72.6%	*55.9%*	*54.1%*	*33.7%*	*33.5%*
Brattleboro	Hypertension	Coronary artery disease	Disorders of lipid metabolism	Degenerative joint disease	Deficiency anemias
	69.6%	*58.9%*	*49.0%*	*33.0%*	*32.2%*
Burlington	Hypertension	Coronary artery disease	Disorders of lipid metabolism	Diabetes	Degenerative joint disease
	69.5%	*55.3%*	*44.6%*	*29.7%*	*29.4%*
Lebanon	Hypertension	Coronary artery disease	Disorders of lipid metabolism	Degenerative joint disease	Skin keratoses
	72.3%	*56.3%*	*52.8%*	*41.8%*	*31.7%*
Middlebury	Hypertension	Coronary artery disease	Disorders of lipid metabolism	Diabetes	Deficiency anemias
	73.9%	*62.0%*	*51.6%*	*31.8%*	*31.7%*
Rutland	Hypertension	Coronary artery disease	Disorders of lipid metabolism	Deficiency anemias	Fluid/electrolyte disturbances
	72.0%	*58.0%*	*51.6%*	*38.5%*	*37.3%*
St. Albans	Hypertension	Coronary artery disease	Disorders of lipid metabolism	Diabetes	Benign and unspecified neoplasm
	82.4%	*62.0%*	*55.4%*	*36.9%*	*36.6%*
Windsor	Hypertension	Coronary artery disease	Degenerative joint disease	Disorders of lipid metabolism	Fluid/electrolyte disturbances
	71.7%	*52.7%*	*35.8%*	*35.6%*	*33.0%*

Health Service Area	#1 Prevalent Condition	#2 Prevalent Condition	#3 Prevalent Condition	#4 Prevalent Condition	#5 Prevalent Condition
OneCare	**Hypertension**	**Coronary artery disease**	**Disorders of lipid metabolism**	**Deficiency anemias**	**Diabetes**
	72.2%	***57.6%***	***48.8%***	***32.9%***	***31.5%***

Section 8

Other Vermont All Payer ACO Model Questions

Section 8: Other Vermont All-Payer ACO Model Questions

1. How are you ensuring that your portfolio of programs are coordinated in such a way that allocates resources most efficiently for supporting the goals (scale, cost, quality) under the Vermont All-Payer ACO Model?

In many ways, the goals of an ACO are naturally aligned with the goals of the Vermont All-Payer ACO Model. To succeed, enough lives need to be included to incentivize holistic change, and financial outcomes are directly linked to cost and quality performance outcomes. Through this lens, if OneCare's providers succeed, the success will benefit Vermonters.

To support continued success, in late 2020 and into 2021, OneCare engaged in a comprehensive strategic planning process with internal and external stakeholders across the state. This process yielded numerous valuable insights, and enabled OneCare to further focus its attention on the issues most critical to its mission and providers. As such, OneCare identified three strategic foci on which to work with its health care provider partners, including: work to continuously improve health outcomes, elevate data and analytics capabilities to support health care provider partners, and work toward a system that pays for value. OneCare also identified the following core capabilities of the organization to support these areas of focus: Network Performance Management, Data and Analytics, and Payment Reform. OneCare deploys a balanced approach in engaging key stakeholders through its committee structure and receives guidance and strategic direction from its Board of Managers. Through thoughtful integration of the above, OneCare works to support its goals of scale, cost reduction, and quality improvement under the Vermont All-Payer ACO Model.

Through OneCare's governance structures, network participants can provide input on programmatic decisions, strategic direction of quality improvement efforts, care model implementation, and other critical components of operations. OneCare's HSA structure creates an additional opportunity for collaboration. Each HSA has its own composition and identity, and OneCare works to build resources and tools which facilitate this diversity across the state. By incorporating the larger perspective of statewide health care reform, OneCare delivers insights which can be tailored to the needs of any given audience. Starting in 2021, OneCare began quarterly HSA executive consultation with hospital and community provider leadership. These meetings offer an opportunity to review data and identify areas for improvement efforts. OneCare works with these teams to ensure data delivered is actionable and meets the team's specific needs. These HSA consultations provide an opportunity to align clinical priority areas with OneCare's larger mission and enable HSA leadership to understand key performance issues and how OneCare's analytics tools can support their work.

Quality and care coordination teams at OneCare perform proactive and systematic network outreach and engagement to optimize efforts in the community. Examples include:

- Care Coordination Core Team meetings where OneCare provides updates to and seeks feedback from HSA care coordination representatives, including the Blueprint Quality Improvement Specialist(s);

- Care coordination education sessions to provide the structure, best practices, and expectations of OneCare's care model implementation;
- In 2020, OneCare sponsored a national Commission on Care Management (CCMC) training and certification for member organizations for enhanced care coordination competencies and improved consistency of statewide care coordination efforts; and
- Quality and care coordination education via the online learning platform Vermont Health Learn, offering the convenience of on-demand education.

OneCare thrives in a culture of continuous improvement and regularly seeks to improve existing processes to deliver innovative health care delivery solutions to Vermonters. The dynamic and evolving health care reform environment demands this approach, and OneCare regularly works to build its team and organizational structures in support of these efforts.

2. What other actions can healthcare stakeholder be taking to support the goals of the Vermont All-Payer ACO Model?

Evolving the Vermont health care system away from one that rewards volume to one that reflects the value of care delivered and results achieved is the work of generations. It is also the direction that health care is moving in nationally and Vermont continues to be an early adopter and innovator in this space. This willingness to take on intractable challenges is not new to Vermont but it does require all stakeholders to work together toward a common vision. Vermont's All Payer Model is an important next step in this long-term goal. In order to enhance the state's ability to achieve the APM goals, stakeholders could be further encouraged to share their experiences and to facilitate public understanding of and engagement in this work. As part of this effort, common and easily understandable vocabularies could be created, agreed upon, and used consistently. New mechanisms for local story telling could be imagined, and expectations could be appropriately calibrated as to the timeline and milestones to be achieved over the next 2, 5, and 10 years.

Included in these goals, should be an explicit commitment to achieve the recommendations Vermont's health care providers (through the OneCare/VAHHS APM Extension Task Force) are requesting for the extension of the APM Agreement. These include achieving an unreconciled Medicare fixed payment model; maximizing the annual Medicare trend rate to facilitate increased scale and reduce the cost shift; moderating risk-sharing levels until the delivery system re-stabilizes from the public health emergency; clarifying the settlement issues for Critical Access Hospitals in the Medicare program; addressing the known deficiencies in the scale target methodology calculations; addressing the Medicare Blueprint methodology; and providing investments in shifting the delivery system to a new and sustainable model.

3. ***All Payer Model Quality and Population Health Goals*. Please complete Appendix 8.1, ACO Activities related to the Vermont All-Payer Model ACO Agreement Population Health and Quality Goals to describe results to date and explain your strategies for assisting the state to achieve its quality and population health goals as specified in the APM. In doing so, please also discuss the expected impact of COVID-19 on 2021 performance, sharing any early indicators or relevant insights.**

Vermont's provider community remains committed to providing high quality care with corresponding outcomes. While the public health emergency may have redirected some of those efforts, the overarching goal of reforming health care delivery in Vermont remains. In the past year, OneCare focused its efforts on refining its approach while also setting clear and concise short, medium and long term strategic goals. These directives will serve as a guide to organizational priorities in an effort to best serve the goals specified in the APM. As noted in Appendix 8.1, OneCare observed mixed results with respect to raw measure scores and was unable to identify percentile performance due to the lack of benchmark availability resulting from the public health emergency.

OneCare clearly observed a large uptick in utilization of telehealth services during the height of the public health emergency, and continues to see greater utilization of these services relative to baseline. In an effort to support provider's efforts during the past year, OneCare developed a new Workbench One application to address diabetes and hypertension patient management. The application enables providers to identify individuals both diabetic and pre-diabetic or hypertensive and pre-hypertensive based on recent lab or vital signs data, so that they can proactively engage these individuals. This is an example of how OneCare's core capability of data analytics is responsive in serving the network and supporting those at risk for adverse health outcomes throughout Vermont.

As detailed in Appendix 8.1, OneCare does not yet have all final quality results for Program Year 2020 and does not have benchmarks to which scores can be measured. Therefore, comparing raw measure scores or rates is the best available method for identifying changes to quality performance. In the programs which OneCare did receive final quality reports, results were varied. Likely a direct result of the public health emergency, the Medicaid (Traditional) population noted a lower/worse score for all measures except Initiation of Alcohol and Other Drug Abuse or Dependence Treatment (IET) and Follow-Up after Hospitalization for Mental Illness (7 days) (FUM). For BCBSVT Primary and Medicaid expanded populations, 2020 was the first year in which OneCare contracted to provide ACO services. Therefore, there is no prior year of data for direct comparison for these populations. Additionally, Medicare and MVP quality results are not yet available.

As previously outlined, OneCare assisted providers in identifying those at highest risk of serious illness using guidance from the Center for Disease Control, World Health Organization, and Johns Hopkins University. The COVID-19 Patient Prioritization Application was deployed to the network in April 2020 to support providers in their efforts to continue to care for high risk individuals during the global public health emergency. This tool identifies those individuals most at risk of contracting or having negative impacts from COVID-19 by accessing condition and utilization information for those individuals. Providers are able to outreach to high risk individuals to help them manage their

chronic conditions and to assure they can receive their prescriptions in order to remain safe in an uncertain time. This tool can be regularly accessed by participants to gain understanding about their patient panel and support outreach as the public health emergency continues. With the immediate future of COVID-19 in Vermont not yet known, it is comforting to know that this tool remains readily available if needed.

See Appendix 8.1 enclosed.