STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

FY19 ACCOUNTABLE CARE ORGANIZATION BUDGET ORDER

In re: OneCare Vermont Accountable)
Care Organization, LLC)
Fiscal Year 2019)
) Docket No. 18-001-A

INTRODUCTION

The Green Mountain Care Board (GMCB or Board) is charged with reviewing, modifying, and approving the budgets of Accountable Care Organizations (ACOs). 18 V.S.A. § 9382(b). Fiscal Year 2019 (FY19) is the second year ACO budgets are subject to Board review.

Below, we describe the relevant legal framework, outline the criteria the Board considered during its review, and present specific Findings and Conclusions in support of our Order establishing the FY19 budget for OneCare Vermont Accountable Care Organization, LLC (OneCare).

LEGAL FRAMEWORK

When reviewing an ACO's budget, the Board is guided by statutory criteria enumerated in 18 V.S.A. § 9382. Those criteria generally fall into the following categories:

- Historic and future expenditures and the effects of care models on utilization and innovative services;
- The ACO's efforts to strengthen primary care, invest in social determinants of health, address the impact of childhood trauma, integrate community providers, improve care coordination, and reduce duplication of services;
- Health resource allocation and priorities;
- Transparency of costs;
- Effects of Medicaid reimbursement on other payers;
- Solvency and ability to assume financial risk;
- Administrative costs;
- Character of ACO leadership and competence to carry out their duties; and
- The Health Care Advocate's (HCA) feedback and public comment.

See 18 V.S.A § 9382(b)(1)(A)-(O).

In addition to these statutory criteria, the Board will also consider:

- Benchmarks established under Rule 5.000, Section 5.402;
- Elements of the ACO's payer-specific programs;
- The statutory requirements for the All-Payer ACO Model (the Model);
- Relevant requirements of the Vermont All-Payer Accountable Care Organization Model Agreement (APM Agreement) between the State of Vermont and the Centers for Medicare & Medicaid Services (CMS); and
- At the Board's discretion, any other relevant issues and information.

GMCB Rule 5.000 (Rule 5.000), § 5.405(b).

The APM Agreement provides for Medicare's participation in a statewide health care payment and delivery system reform effort referred to as the "All-Payer ACO Model" (hereafter "the Model"). The Model relies on private-sector health care providers voluntarily working together, as part of an ACO, to reduce health care spending and improve health care quality and outcomes for Vermonters. Relevant requirements of the APM Agreement include:

- Total Cost of Care (TCOC) Growth Rate Targets
    - The target for Medicare TCOC per Beneficiary Growth is a compounding rate that is at least 0.2% below projected national Medicare growth. APM Agreement, § 9.b.
    - The target for All-Payer TCOC per Beneficiary Growth is a compounding rate of 3.5% or less over the five performance years of the APM Agreement. *Id.* § 9.a.
- By the end of 2019, at least 75% of Vermont Medicare beneficiaries and 50% of Vermont All-Payer Scale Target[1] beneficiaries must be aligned to a Scale Target ACO Initiative.[2] *Id.* § 6.a.
- Scale Target ACO Initiatives must reasonably align with the Vermont Medicare ACO Initiative. *Id.* § 6.f.

FY19 REVIEW PROCESS

The ACO bears the burden of justifying its budget proposal. Rule 5.000, § 5.405(a). The Board issued its 2019 Budget Guidance on July 24, 2018.[3] This Guidance provided OneCare with a detailed framework for its FY19 budget submission, including benchmarks set pursuant to Rule 5.000, Section 5.402. OneCare submitted its proposed budget on October 1, 2018 and

[1] A Vermont All-Payer Scale Target Beneficiary is "a Vermont resident who is also a Vermont Medicare Beneficiary or enrolled in Vermont Medicaid, a Vermont Commercial (insurance) Plan, or a Vermont Self-Insured Plan. APM Agreement, § 1.aa.

[2] A Scale Target ACO Initiative is "an ACO arrangement offered by Vermont Medicaid, Vermont Commercial Plans, Vermont Self-insured Scale Target Plans, or Medicare FFS to a Vermont ACO" that incorporates certain features, such as the possibility for shared savings. APM Agreement, § 6.b.

[3] 2019 Budget Guidance and Reporting Requirements for Vermont Certified Accountable Care Organization: OneCare Vermont, ACO, LLC. This document and all documents submitted to the Board for OneCare's FY19 budget review and recertification are available at https://gmcboard.vermont.gov/content/aco-certification-and-budget-review.

presented it at a public meeting on October 24, 2018. *See* OneCare Vermont 2019 Fiscal Year Budget Submission (Budget Submission); OneCare PowerPoint (Oct. 24, 2018).[4]

Throughout the budget review process, OneCare responded to questions from the Board, Board staff, the Board's actuarial consultant, Lewis & Ellis, Inc. (L&E), and the Office of the Health Care Advocate (HCA).[5] On November 14, 2018, the Board's staff presented at a public Board meeting regarding OneCare's proposed FY19 budget. GMCB PowerPoint (Nov. 14, 2018).[6] On November 19, 2018, staff from the Department of Vermont Health Access (DVHA) presented at a public Board meeting, summarizing OneCare's 2017 performance under the Vermont Medicaid Next Generation program, OneCare's 2018 performance to date, and the ongoing program planning for 2019. *See* DVHA PowerPoint (Nov. 19, 2018). Board staff made recommendations regarding the approval of OneCare's FY19 budget on December 12, 2018 and December 17, 2018. *See* GMCB PowerPoint (Dec. 12, 2018); GMCB PowerPoint (Dec. 17, 2018). We accepted public comments on OneCare's FY19 proposed budget from October 8, 2018 through December 14, 2018. On December 17, 2018, we voted to establish OneCare's budget, on terms and subject to conditions described below. Minutes, Green Mountain Care Board Meeting (Dec. 17, 2018). The written materials from this process are posted on the Board's website and video recordings of the public meetings are available from Orca Media.[7]

FINDINGS

Background

1. OneCare is a manager-managed limited liability company organized under the laws of the State of Vermont. *See* Budget Submission, 5. OneCare was organized and founded in 2012 by the University of Vermont Medical Center (UVMMC), a Vermont nonprofit corporation, and Dartmouth-Hitchcock Health (DHH), a New Hampshire nonprofit corporation. *Id.*

2. OneCare is governed by a 19-member Board of Managers that is comprised largely of representatives of OneCare's participating providers.[8] *See* 2019 Certification Eligibility Verification Form for OneCare Vermont Accountable Care Organization, LLC (Verification), 4 & Attach. A. OneCare expanded its executive team from five members to six members, adding a Vice President of Revenue and Strategy during 2018. *See* Verification, 5 & Attach. C. Three members of the executive team, including the Chief Executive Officer, have worked at OneCare for more than five years. Verification, Attach. C. The other three have worked at OneCare a year or less. *Id.* Nine additional positions round out the OneCare leadership team. *Id.*

3. Overall, OneCare's proposed budget increased from approximately $600 million in FY18 to more than $850 million in FY19. OneCare PowerPoint (Oct. 24, 2018), 13. The primary reason for the budget increase is an increase in the number of lives OneCare expects will be

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[4] https://gmcboard.vermont.gov/sites/gmcb/files/OneCare%20Budget%20Presentation%20-%20GMCB%20Final.pdf.

[5] *See generally* https://gmcboard.vermont.gov/content/aco-certification-and-budget-review.

[6] Presentations made at 2018 GMCB meetings and meeting minutes are posted by meeting date and are available at https://gmcboard.vermont.gov/content/2018-board-meeting-information-0.

[7] https://www.orcamedia.net/series/green-mountain-care-board.

[8] OneCare added an additional member to its Board of Managers in the past year. Verification, Attach. A.

attributed to it in FY19. *See id.* at 10. OneCare's proposal anticipates more than 172,000 attributed lives in FY19—an increase of almost 60,000 people over actual FY18 attribution. *Compare* OneCare PowerPoint (Oct. 24, 2018), 10 *with* OneCare Vermont 2018 Performance Update (July 18, 2018), 4 (showing attribution as of January 2018 was slightly less than 113,000). The actual number of people attributed to OneCare in 2019 is likely to be more than the 172,000 reflected in the budget submission. *See* GMCB PowerPoint (Nov. 14, 2018), 26 (estimating FY19 attribution of over 190,000). OneCare's FY19 budget proposal also contemplates a 0.4 percentage point increase in spending related to population health management (PHM) programs and initiatives (representing 4.1% of OneCare's expected revenue) and a 0.18 percentage point decrease in administrative expenses as compared to the approved FY18 budget. *Id.* at 44.

4. Early data suggest the All-Payer Model cohort (lives attributed to the All-Payer Model) has exhibited positive shifts related to appropriate network utilization. *See, e.g.*, Budget Submission, 45; *see also* DVHA PowerPoint (Nov. 19, 2018), 10. For example, OneCare observed a decrease in the rates of acute hospital admissions and emergency department utilization for its high-risk patients. Budget Submission, 45. Additionally, data suggest Medicaid recipients who are attributed to the ACO are using their primary care providers more than Medicaid recipients who are not attributed to the ACO. DVHA PowerPoint (Nov. 19, 2018), 10.

FY19 Payer Structure

5. OneCare expects to contract with Medicare, Medicaid, BlueCross BlueShield of Vermont (BCBSVT), and several self-funded group health plans in FY19. GMCB PowerPoint (Dec. 12, 2018), 4. FY19 will be OneCare's second year participating in a Medicare program based on the Medicare Next Generation ACO Program. In 2019, this program will be known as the Vermont Medicare ACO Initiative. *See* APM Agreement, § 1.dd. FY19 will be OneCare's third consecutive year participating in the Vermont Medicaid Next Generation Program (2019 Medicaid Program). GMCB PowerPoint (Dec. 12, 2018), 4.

6. FY 2019 will be OneCare's second year participating in a shared risk program with BCBSVT's qualified health plan (QHP) business. OneCare PowerPoint (Oct. 24, 2018), 7. OneCare also expects to continue to operate a program with the UVMMC's self-funded group health plan in 2019 and to establish similar programs with other hospitals in OneCare's network. *Id.*, *see also* Budget Submission, 25.

7. OneCare hopes to reach an agreement with a third-party-administrator (TPA) to implement an ACO program in 2019 across several self-funded health plans that are currently contracted with the TPA, though the agreement is not yet finalized. *See* OneCare PowerPoint (Oct. 24, 2018), 7. Because these negotiations are ongoing and incomplete, we have received limited information regarding the details of the potential program.

FY19 Provider Network

8. OneCare has a broad provider network that includes 12 of the 14 hospitals in Vermont; DHH (New Hampshire), the largest out-of-state provider of care to Vermonters; federally

qualified health centers (FQHCs); skilled nursing facilities; home health agencies; designated agencies; and independent primary care and specialist practices. Budget Submission, 5 & Part 1, Attachs. A & B.

9. For FY19, OneCare has added three hospitals that will participate in the Vermont Medicaid Next Generation Program – Rutland Regional Medical Center, Northeastern Vermont Regional Hospital, and Gifford Medical Center. *Id.* at 5 & Part 1, Attach. B. Two hospitals – Southwestern Vermont Medical Center and Mt. Ascutney Hospital – that only participated in the Medicaid program previously, will participate in all three programs (Medicaid, Medicare, and Commercial) for the coming year. *Id.* In FY19, eight of Vermont's 14 hospitals will participate in all three programs, four additional hospitals will participate in the Medicaid program, and DHH will participate in the Medicaid and Commercial programs. *Id.* Attach. B. OneCare also added FQHCs, primary care practices, and specialty practices to its 2019 network. *Id.* at 5.

Population Health Management and Payment Reform Programs

10. OneCare plans to continue investing in several programs to support PHM activities and provide support to community providers, such as designated mental health agencies and home health providers, across the full continuum of care. *Id.* at 33. While OneCare quantified its planned investments, the actual amounts may change as the attribution changes. Board staff therefore calculated each investment as a percentage of total projected revenue:

2019 PHM/Payment Reform Budget

PHM/Payment Reform Programs	FY19 Budgeted Investment	% of Revenue
Basic OCV PMPM	$5,935,530	0.7%
Complex Care Coordination Program	$9,181,362	1.0%
Value-Based Incentive Fund	$7,537,231	0.8%
Comprehensive Payment Reform Program	$2,250,000	0.3%
Primary Prevention	$910,720	0.1%
Specialist Program Pilot	$2,000,000	0.2%
Innovation Fund	$1,000,000	0.1%
RCRs	$375,000	0.0%
PCMH Legacy Payments	$1,830,264	0.2%
CHT Block Payment	$2,411,679	0.3%
SASH	$3,815,532	0.4%
Total Investment	**$37,247,319**	**4.1%**
Total revenues	$898,618,967	
Total attributed lives[9]	172,365	

See GMCB PowerPoint (Dec. 12, 2018), 41.

[9] Budget Submission, Appendix 2.4.

11. OneCare's budgeted investments in PHM and payment reform represent a 36.5% increase over the FY18 approved budget. *See id.* (noting an almost $10 million increase in proposed spending from FY18 to FY19). FY19's proposed PHM and payment reform expenditures are 4.1% ($37,247,319) of OneCare's expected total revenue in FY19, as compared to 4.4% ($27,291,056) of OneCare's expected total revenue in FY18. *See id.*; Budget Submission, Appendix 2.4; FY18 Accountable Care Organization Budget Order, *In re: OneCare Vt. Accountable Care Org., LLC*, Doc. No. 17-001-A, Findings, ¶ 29 (Jan. 3, 2018) (FY18 ACO Budget Order).

12. OneCare continues to invest in the PHM programs funded in last year's budget, including the Basic OCV per member, per month (PMPM) program, Complex Care Coordination, the Comprehensive Payment Reform (CPR) Program, a Value-Based Incentive Fund (VBIF), Blueprint for Health and Supports and Services at Home (SASH),[10] and RiseVermont. *See* FY18 ACO Budget Order, Order, ¶¶ G-H.

13. The FY19 budget proposes the following changes to existing PHM programs:

- OneCare plans to expand its primary care capitation model from the three-practice pilot started in FY18 to nine independent primary care practices in FY19. OneCare Vermont Comprehensive Payment Reform Pilot Status Report to Green Mountain Care Board (Dec. 2018), 3.[11]
- OneCare's FY19 budget proposes the following payer-based breakdown in VBIF withholdings:
  - Medicare: 0.5% VBIF withholding;
  - Medicaid: 2.0% VBIF withholding;
  - BCBSVT: 1.5% VBIF withholding; and
  - Self-Funded: $1.00 PMPM VBIF withholding.

  Budget Submission, 23-28.
- Testing a variable component to the existing VBIF distribution formula for potential use in 2020. *See* OneCare PowerPoint (Oct. 24, 2018), 33 (erroneously marked 8); Transcript, GMCB Meeting (Oct. 24, 2018) ("Transcript"), 44:9-19.
- RiseVT is now in 20 communities throughout Vermont, with six hospitals hiring dedicated RiseVT program managers. Budget Submission, 60.

New Population Health Initiatives

14. *DULCE*: OneCare is exploring a new partnership with the Developmental Understanding and Legal Collaboration for Everyone (DULCE) Program and the Vermont Department of Health that would start in certain communities in 2019. Budget Submission, 7-8; OneCare PowerPoint (Oct. 24, 2018), 33 (erroneously labeled 8). The DULCE program seeks to prevent Adverse Childhood Experiences (ACEs) using proactive intervention. Budget Submission, 7-8.

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[10] OneCare is continuing the support that Medicare provided to these programs as part of CMS's Multipayer Advanced Primary Care Practice Demonstration.

[11] https://gmcboard.vermont.gov/sites/gmcb/files/OneCare%20CPR%20Pilot%20Report%20to%20GMCB%20December%202018%20Final.pdf; s*ee also* Budget Submission, 7; Transcript, GMCB Meeting (Oct. 24, 2019), 44:20-25; OneCare PowerPoint (Oct. 24, 2018), 34 (erroneously numbered 8).

Through DULCE, providers at clinical sites work with families to address social determinants of health and promote healthy infant development during the first six months after a child's birth, while also providing educational and legal support to the child's parents. *Id.* A DULCE specialist meets with families at an infant's routine health care visits and offers support through home visits, telephone, e-mail, and text messaging. *Id.*

15. *Community Innovation Fund*: OneCare has set aside a $1 million fund to "support innovative[,] evidence-based (or informed) programs. . . [that] could be readily spread and sustained" by OneCare and the relevant communities. Budget Submission, 8; OneCare PowerPoint (Oct. 24, 2018), 35 (erroneously labeled 8). OneCare plans to have its Population Health Strategy Committee design the program criteria and application progress and monitor selected programs, while OneCare's Board of Managers will select the applicants that will participate. *Id.*

16. *Regional Clinical Representatives*: OneCare has engaged 13 local providers and one pediatrician (working statewide) who each dedicate six hours per week in their respective regions serving as a conduit between OneCare and local providers, disseminating local success stories and best practices, and participating in Accountable Communities for Health (ACH) meetings. Budget Submission, 61; OneCare PowerPoint (Oct. 24, 2018), 35 (erroneously labeled 8). OneCare explained that these representatives "serve as bi-directional eyes and ears for OneCare in local communities," reducing duplication of efforts and helping to integrate the ACO's work with community collaboratives. Budget Submission, 61.

17. *Pediatric Household-Derived Risk Model:* OneCare is partnering with "Algorex Health and [its] pediatric community to evaluate the reliability of augmenting risk stratification models to include social determinants of health data that could provide a more comprehensive view of the population and their needs." *Id.* at 6. This partnership supports "a pilot to create a pediatric household-derived risk model to provide a risk score for each identified member," allowing providers to identify and track members with increasing risk scores. *Id.* at 50.

18. *Network-Wide Food Insecurity Survey*: OneCare's clinical committees have "engaged in extensive discussions. . . around the current practices, opportunities for standardization, and possible methods to support an ACO-level approach to food insecurity screening." *Id.* at 49-50. OneCare has distributed a "network survey for food insecurity" and seeks to develop "a process search for food insecurity screenings for all patients selected for chart review as part of the 2018 clinical quality measure data abstraction." *Id.*

19. *St. Johnsbury Accountable Community for Health Pilot Study*: OneCare plans to work with the St. Johnsbury Accountable Community for Health (ACH) and DVHA on additional "innovations to enhance the Accountable Communities for Health model and its potential to extend OneCare's population health approach in 2019 by exploring: a) an enhanced attribution model, with a geographic focus and b) interventions and investment opportunities that address the ACH's social determinant of health priorities." *Id.* at 8.

Risk-Sharing Arrangements with Payers

20. OneCare intends to expand its potential for savings and losses under the Medicaid program (moving from a three percent to a four percent corridor), Medicare program (moving from an 80% to a 100% share), and the Self-Funded Program (moving from a shared savings to a shared risk arrangement). Budget Submission, 23-25. The following table shows the risk arrangements described in OneCare's budget:

Risk Arrangements by Payer		
Payer	**Corridor**	**OneCare's Share**
Medicaid	96% - 104%	100%
Medicare	95% - 105%	100%
Commercial	94% - 106%	50%
Self-Funded[12]	94% - 106%	30%

GMCB PowerPoint (Dec. 12, 2018), 33.

21. Under the anticipated risk-sharing arrangements, OneCare would be responsible for 100% of any losses and would realize 100% of any savings within five percentage points of the Medicare benchmark. Budget Submission, 23. Within four percentage points of the Medicaid benchmark, OneCare would be responsible for 100% of any losses and would realize 100% of any savings. *Id.* Within six percentage points of the Commercial benchmark, OneCare would be responsible for 50% of any losses and would realize 50% of any savings, with the remaining 50% of either losses or savings accruing to BCBSVT.[13] *Id.* at 24-25. Within six percentage points of the Self-Funded benchmark(s), OneCare would be responsible for 30% of the losses and would realize 30% of the gains. *Id.* All savings and losses outside of the risk corridors would accrue to the payers. *Id.* at 23-25. When the estimated TCOC targets are applied to these risk arrangements, OneCare's estimated maximum risk across its payer programs is $30,942,262. GMCB PowerPoint (Dec. 12, 2017), 34.

22. OneCare's FY19 budget includes a continuation of the Medicare program's 2018 risk protection arrangement. Budget Submission, 16-17. Under this arrangement, if the ACO's aggregate spend on the Medicare program reaches the mid-point of the maximum risk, a third party will pay 90% of any spend thereafter. *Id.*

Hospital Payments and ACO Risk Mitigation

23. OneCare has a delegated risk model whereby it passes most of its risk onto the hospitals in its network. Budget Submission, 16-18; OneCare PowerPoint (Oct. 24, 2018), 42. OneCare will establish TCOC targets for each health service area (HSA) in its network. Budget Submission, 16. Each HSA's TCOC target is set "based on historical cost of care derived from modeling and/or historical experience data." *Id.* Each participating hospital bears risk of losses and is eligible to receive savings on spending for the lives attributed to providers (including

[12] The potential TPA-level program will likely be a shared savings program (i.e., no risk).
[13] Savings or losses accruing to BCBSVT under the Commercial program will need to be examined by the Board when it reviews BCBSVT's proposed premium rates for QHPs offered on Vermont Health Connect.

themselves) in the hospital's HSA, up to a maximum risk limit (MRL). If losses exceed a hospital's MRL, other network hospitals will cover the excess, up to their respective MRLs. Budget Submission, Part 4, Attach. I. In addition to the protection offered by this hospital cross-coverage, OneCare plans to offer risk mitigation to qualifying hospitals. *Id.* at 16. The chart below outlines each HSA's risk for each payer program, the estimated MRL each hospital in the HSA is expected to assume, and any risk mitigation OneCare has offered:

HAS (Hospital)	Medicare Risk	Medicaid Risk	BCBSVT QHP Risk	MRL	Risk Mitigation	Est. MRL
Bennington (SVMC)	$3,207,210	$617,582	$447,389	$4,272,180	$2,000,000	$2,272,180
Berlin (CVMC)	$2,675,188	$580,193	$438,350	$3,693,731	-	$3,693,731
Brattleboro (BMH)	$1,221,777	$318,183	$120,235	$1,660,196	$900,000	$760,196
Burlington (UVMMC)	$8,794,030	$2,085,398	$1,497,348	$12,376,776	-	$12,376,776
Lebanon (DH)	$0	$242,223	$244,954	$487,176	-	$487,176
Middlebury (Porter)	$1,898,569	$499,080	$266,110	$2,663,760	-	$2,663,760
Morrisville (Copley)	$0	$0	$0	$0	-	$0
Newport (North Country)	$0	$452,664	$0	$452,664	-	$452,664
Randolph (Gifford)	$0	$362,194	$0	$362,194	-	$362,194
Rutland (RRMC)	$0	$706,548	$0	$706,548	-	$706,548
Springfield (Springfield)	$2,422,080	$326,207	$243,927	$2,992,214	$1,000,000	$1,992,214
St. Albans (NMC)	$1,879,252	$848,832	$245,421	$2,973,505	-	$2,973,505
St. Johnsbury (NVRH)	$0	$560,735	$0	$560,735	-	$560,735
Townshend (Grace Cottage)	$0	$0	$0	$0	-	$0
Windsor (Mt. Ascutney)	$1,267,514	$133,260	$239,809	$1,640,583	-	$1,640,583
TOTAL	**$23,365,621**	**$7,733,097**	**$3,743,543**	**$34,842,262**	**$3,900,000**	**$30,942,262**

See Budget Submission, 17-18.

24. For FY19, OneCare has offered risk mitigation to three hospitals: Bennington, Brattleboro, and Springfield. *Id.* at 16. The Board expressed concern during the hospital budget process in 2018 about the financial situation of both Brattleboro and Springfield.[14] *See* FY19 Hosp. Budget Decision & Order, *In re: Brattleboro Mem'l Hosp. Fiscal Year 2019*, Doc. No. 18-001-H, 5 (Sept. 28, 2018); FY19 Hosp. Budget Decision & Order, *In re: Springfield Hosp. Fiscal Year 2019*, Doc. No. 18-014-H, 4 (Sept. 28, 2018).

25. Board staff have analyzed the HSA MRLs as compared to the days cash on hand approved for each hospital in their respective 2019 budgets. GMCB PowerPoint (Dec. 12, 2018), 35. The results of that analysis are outlined in the table below:

[14] The Board is tasked with reviewing and approving the budgets of all hospitals operating in Vermont. 18 V.S.A. § 9375(b)(7).

HSA	Hospital	Estimated MRL	Days Cash on Hand	MRL as Days Cash on Hand*	MRL as % of Days Cash on Hand
Bennington	**SVMC**	$2,272,180	46.3	2.59	1.4%
Berlin	**CVMC**	$3,693,731	112.7	1.96	1.7%
Brattleboro	**BMH**	$760,196	196.2	1.81	0.9%
Burlington	**UVMMC**	$12,376,776	192.4	1.85	1.0%
Lebanon	**DH**	$487,176	Information Not Available – Not a regulated hospital		
Middlebury	**Porter**	$2,663,760	134.9	4.32	3.2%
Morrisville	**Copley**	-	66.4	N/A	N/A
Newport	**North Country**	$452,664	196.3	1.08	0.6%
Randolph	**Gifford**	$362,194	177.5	1.22	0.7%
Rutland	**RRMC**	$706,458	205.7	0.57	0.3%
Springfield	**Springfield**[15]	$1,992,214	106.8	3.61	3.4%
St. Albans	**NMC**	$2,973,505	306.5	8.28	2.7%
Townshend	**Grace Cottage**	-	92.5	N/A	N/A
Windsor	**Mt. Ascutney**	$1,640,583	176.4	5.50	3.1%

*per approved 2019 hospital budgets

See id.

<u>*Operating/Administrative Budget*</u>

26. OneCare budgeted $15,915,189 for operating expenses in FY19, as compared to the $12,492,660 the Board approved for OneCare's FY18 budget. Budget Submission, 34 & Sect. 4, Append. 4.2. OneCare's operating expense budget includes salaries and benefits (including those of the RiseVt team), contracted services, insurance, supplies, office expenses, and other administrative expenses. *See id.*

27. Though the FY19 budget represents a 27.4% increase in overall operating expenses compared to the FY18 Board-approved budget, the overall administrative expense ratio decreased from 1.95% approved in the FY18 budget to 1.77% for FY19. *Id.* Sect. 4, Append. 4.2; GMCB PowerPoint (Dec. 12, 2018), 38. OneCare's administrative costs amount to a per member per year range of $95.19-$115.21, depending on whether OneCare implements all of its budgeted programs or only its core budgeted programs. Responses to GMCB's Second Q&A, Q.8.

<u>*Benchmark Trend Rates*</u>

28. A "benchmark" or TCOC target is a payer-specific financial target against which expenditures for ACO-aligned beneficiaries are assessed to determine whether an ACO has earned savings or is responsible for losses. Rule 5.000, § 5.103(8). In building its FY19 budget, OneCare provided benchmark estimations for each of its payer programs. Budget Submission, 23-26. As discussed in greater detail below, we have approved OneCare's FY19 budget with some modifications to payer trend rates. *See infra* Conclusions, II.A.; Order, ¶¶ C-D.

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[15] The information contained in this table regarding Springfield Memorial Hospital represents the information available to the Board at the time we approved OneCare's FY19 budget but is not indicative Springfield's current financial status. The Board is actively monitoring Springfield's financial health indicators and approves and monitors all hospital budgets pursuant to its statutory mandate. *See, e.g.*, 18 V.S.A. §§ 9375(b)(7).

29. The APM Agreement authorizes the Board to prospectively develop the benchmark for the 2019 Vermont Medicare ACO Initiative, subject to the approval of CMS.[16] APM Agreement, § 8.b.ii. In exchange for this authority, Vermont must maintain a compound annual growth rate (CAGR) for Medicare beneficiaries that is at least 0.2 percentage points below national projections. APM Agreement, § 9.b. The projected national per capita Medicare growth rates for 2019 are 3.3% for the end-stage renal disease (ESRD) population and 4.0% for the aged and disabled (A/D) population. GMCB PowerPoint (Dec. 12, 2018), 17.

30. In accordance with the terms of the APM Agreement, we set Medicare trend rates of 3.1% for the ESRD Medicare population and 3.8% for the A/D Medicare population. *See* GMCB PowerPoint (Dec. 12, 2017), 18; Conclusions, § II.A.

31. In addition to limiting per capita Medicare spending growth, the APM Agreement requires Vermont to limit per capita spending growth for "all-payer beneficiaries"[17] to a CAGR of 3.5%. APM Agreement, § 9.a. Both the Medicare and all-payer CAGRs are calculated over the five-year performance period, from 2018 through 2022. APM Agreement, § 9.b.

32. As of the time the Board approved OneCare's FY19 budget, OneCare and DVHA were still negotiating the terms of their FY19 Medicaid contract, including the benchmark trend growth rate that would be used in their agreement. *See* GMCB PowerPoint (Dec. 12, 2018), 31.

33. DVHA's actuary, Wakely, has advised L&E regarding the expected range for the FY19 Medicaid benchmark.[18] *Id.* at 29. Using this information, L&E has prepared the Medicaid advisory rate case and the Board's non-binding recommendation has been submitted to DVHA. *See* 18 V.S.A. § 9573(a). Based on the Medicaid advisory rate case and its discussions with Wakely, L&E recommended that the Board approve a Medicaid benchmark growth rate that fell in the range Wakely proposed. GMCB PowerPoint (Dec. 12, 2018), 29.

34. OneCare is also involved in ongoing negotiations with BCBSVT regarding the final benchmark rates for FY18 and FY19. *Id.* at 30.

Scale Target ACO Initiative Programs

35. The APM Agreement requires Vermont to steadily increase the number of lives attributed to the Model. *See* APM Agreement, § 6.a. According to scale projections for the conclusion of FY18, an estimated 112,756 (20%) of All-Payer Target Beneficiaries will be attributed to the Model. GMCB PowerPoint (Nov. 14, 2018), 26. Of those 112,756 All-Payer Beneficiaries, an estimated 39,702 (36%) are Medicare enrollees. *Id.* By the end of FY19, estimates show approximately 196,418 (35%) All-Payer Target Beneficiaries will be attributed to the Model, and of those, 58,782 (50%) are Medicare enrollees. *Id.*

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[16] The APM Agreement grants the Board's authority to set Medicare benchmarks; the authority is distinct from ACO budget review authority which the Board has via statutory mandate. *Compare* APM Agreement, 8.b.ii *with* 18 V.S.A. § 9382.

[17] Vermont All-Payer Beneficiaries are Vermont residents who are Medicare beneficiaries or enrolled in Medicaid or a commercial or self-insured plan. APM Agreement, § 1.z.

[18] This information was provided confidentially. 18 V.S.A. § 9573(c); *see also* 18 V.S.A. § 317(c)(15).

36. Only those lives attributed to a "Scale Target ACO Initiative" (Scale Initiative) program are included in scale target calculations. *See* APM Agreement, § 6.b.

37. A program must meet four requirements to qualify as Scale Initiative:

- The program must have a possibility of shared savings based on achieving quality of care and utilization goals;
- The ACO's shared savings, as a percentage of its expenditures less than the target, must be at least 30%; and the ACO's shared loses (if applicable), as a percentage of its expenditures in excess of the target, must be at least 30%;
- Services comparable to the All-Payer Financial Target Services and their associated expenditures must be included in the ACO's shared losses and shared savings calculations;
- The ACO Benchmark, Shared Savings, and/or Shared Losses must be tied to the quality of care the ACO delivers and/or the health of its aligned beneficiaries.

Id. § 6.b. Subject to CMS's agreement, the Board reviews the proposed programs and determines whether OneCare's programs qualify as Scale Initiative programs. *Id.* § 6.j.i.

38. OneCare identified the following potential changes to its existing programs for FY19:

- Medicare
  - Increasing OneCare's risk share from 80% to 100% (Budget Submission, 23);
  - Including a VBIF quality framework to more closely align with other payers (*Id.* at 29);
- Medicaid
  - Increasing the VBIF withhold as a percentage of the benchmark (*Id.* at 29; *compare* Contract #32318, Amendment #2, 80 (1.5%)[19]);
  - Increasing the risk corridor from 3% to 4% (Budget Submission, 23; *compare* Contract #32318, Amendment #2, 78 (3%));
- BCBSVT QHP
  - Removing non-specialty pharmacy costs from its FY19 savings/loss calculations (GMCB PowerPoint (Dec. 12, 2017), 7); and
- Self-Funded
  - Moving from shared savings structure to shared risk, with OneCare's risk capped at 30% within a 6% risk corridor (Budget Submission, 25).

39. Because the new TPA self-funded program remains in the negotiation phase, the Board has insufficient information to evaluate whether the program would qualify as a Scale Initiative. GMCB PowerPoint (Dec. 12, 2018), 7. However, OneCare intends that the new TPA program will be an additional Scale Initiative program. Budget Submission, 6.

[19] http://dvha.vermont.gov/administration/onecare-32318-am2-final-signed.pdf.

Program Alignment

40. The APM Agreement requires that OneCare's non-Medicare payer programs "reasonably" align with the Medicare payer program with respect to beneficiary alignment methodology, quality measures, payment mechanisms, risk arrangements, and services used to calculate shared savings and losses. APM Agreement, § 6.f. In consultation with the Vermont Agency of Human Services, we must report to CMS on program alignment and justify material differences in the programs. *Id.* § 6.j.

41. OneCare's budget contemplates the following changes to its existing programs:

- Alignment/Attribution Methodologies: OneCare proposes potential changes to the Medicaid methodology in 2019. No changes anticipated for other payers;
- Quality Measures: Proposed changes to Medicare measures will increase cross-program alignment;
- Payment Mechanisms: No changes from FY18 payment structures;
- Risk Arrangements: Symmetrical shared risk arrangements; increased alignment with risk arrangements for Medicare and Medicaid (e.g., 3%→4% and 80%→100%); and
- Services Included in Determining Savings and Losses: OneCare suggests its commercial program with BCBSVT may not include non-specialty pharmacy costs in its FY19 savings and loss calculations, which will align with the Medicare program.

GMCB PowerPoint (Dec. 12, 2018), 7.

Public Comments

42. The Board took public comments on OneCare's proposed budget and the budget review process from October 1, 2018 through December 14, 2018.[20] During that time, the Board received 33 public comments regarding the OneCare's FY19 budget and the Board's review. *Id.* Generally, the themes from public comments included:

- Public support for OneCare's continued investments in disease prevention, primary care, home health, mental health, and other community-level services;
- Interest in considering alternatives to the Model (e.g., single payer) and criticisms of ACO programs;
- Requests for continued monitoring of ACO programs, expenses (including administrative costs), tools (e.g., Care Navigator), quality measures, and TCOC;
- Suggestions for further evaluation of ACO programs and the Model;
- Recommendations for modifications to specific payer programs (e.g., the Medicaid ACO program);
- Consideration of the relationship between the QHP filing and the ACO commercial program trend rate; and
- Desire to ensure OneCare's operational transparency.

[20] https://gmcboard.vermont.gov/board/comment.

GMCB PowerPoint (Dec. 17, 2018), 7.[21]

CONCLUSIONS

OneCare bears the burden of justifying its proposed FY19 budget. Rule 5.000, § 5.405(a). In deciding whether to approve or modify the budget, the Board must consider the criteria of 18 V.S.A. § 9382(b) and the requirements of the APM Agreement. Rule 5.000, § 5.405(b).

I. Statutory Criteria

A. Historic and future expenditures and the effects of care models on utilization and innovative services

OneCare's budget and financial targets are based on historical experience, trended forward to the current performance period (FY19). *E.g.*, *supra* Findings, ¶ 23. OneCare's provider network for FYI9 has expanded, with additions that include three hospitals and four FQHCs. *Id.* ¶ 3. OneCare also anticipates it will add almost 60,000 attributed lives in FY19. *Id.* The expanding network and increasing number of attributed members make predicting material changes in services utilization difficult. However, OneCare has monitored effects of its care model on *appropriate* utilization. *Id.* ¶ 4. For example, OneCare saw a decrease in acute hospital admissions and emergency department utilization from its high-risk patients. *Id.* Though it is still early in the process and only a small portion of 2018 data are available, we are also encouraged to see that OneCare-attributed Medicaid patients seem to be utilizing their primary care providers more than a comparison cohort of Medicaid patients who are not attributed. *Id.* We are also encouraged to see the OneCare cohort is utilizing other services (such as in-patient hospital services) less frequently. *Id.*

Based on information currently available about our early experience with the All-Payer Model and OneCare's use of historic expenditures and utilization, and its understanding about future trends in expenditure and utilization, we will approve the FY19 OneCare budget subject to the trend-rate requirements discussed in the Order, below. *See supra* Order, ¶ C-D.

B. The ACO's Efforts to Strengthen Primary Care, Invest in Social Determinants of Health, Address the Impact of Childhood Trauma, Integrate Community Providers, Improve Care Coordination, and Reduce Duplication of Services

OneCare's FY19 budget includes continued investments in ongoing programs, as well as investments in new programs aimed at primary care, social determinants of health, the impact of childhood traumas, integrating community providers, improving care coordination, and reducing duplication of services. Findings, ¶¶ 10-19. In total, OneCare plans to invest more than $37 million (4.1% of its expected revenues) in these programs, which, in many instances, meet more than one of the PHM focuses. *Id.* ¶ 11. OneCare's budget shows its continued interest and investment in programs supporting overall population health, community providers, and the other goals of the Model.

[21] *See also* https://gmcboard.vermont.gov/board/comment.

C. The Goals and Recommendations of HRAP

The Health Resource Allocation Plan (HRAP) was last updated in 2009 and the recommendations in the HRAP were not relevant in OneCare's budget planning. In accordance with Act 167 of 2018, we are currently working to update the HRAP and will review how it can best be utilized in the ACO budget process in the future. *See* 2018 Sess., No. 167. However, we did not find it relevant to our review.

D. Transparency of ACO's Costs

OneCare has been transparent about the expected costs of its programs and the administration thereof. It has estimated the amounts each hospital will receive under its fixed prospective payment model, as well as each hospital's projected MRL. Findings, ¶ 23. It has also described the payments it plans to make under its population health management programs. *Id.* ¶ 10. Finally, it has provided a detailed breakdown of its proposed administrative budget. *Id.* ¶ 26-27. It has responded to questions from the GMCB staff and the HCA. FY19 Review Process, 2-3. We would like additional details on several of its programs in development, including the specialist payment program and the innovation fund. Accordingly, we have asked OneCare to provide a report on these investments. Order, ¶¶ L-P.

E. Effects of Medicaid Reimbursement on Other Payers

In FY18, the Medicaid benchmark trend rate was the highest of OneCare's payers at 6.1%, largely as a result of Medicaid reimbursement increases to DHH. FY18 ACO Budget Order, § II.F.; *see* DVHA PowerPoint (Dec. 12, 2017), 10-11[22]. Under the APM Agreement, Vermont may request that TCOC growth associated with increases in Medicaid reimbursement rates intended to address existing payer differentials or ensure greater access, such as the DHH increases, be excluded from the all-payer TCOC calculation, discussed in Findings, ¶ 31. *See* APM Agreement, § 10.d. Though OneCare proposed a considerably lower rate increase for FY19, we approve OneCare's budget to the extent the actual rate increase falls within the range recommended by DVHA's actuary, Wakely, which will account for reimbursement changes between the base and performance periods. Findings, ¶ 32-33.

In FY19, the Board must submit several reports to CMS related to differences in the approved benchmarks between the Model payers, and what impact, if any, rate differentials have on OneCare's profits, the rates other payers pay, and potential options to reduce payer differential. *See* APM Agreement, § 10. To that end, we ask OneCare to submit periodic reports with this information as outlined below. Order, ¶ B.

F. ACO's Solvency and Ability to Assume Financial Risk

We are responsible for ensuring an ACO has a sufficient financial guarantee to cover the risk it will assume. Rule 5.000, § 5.403(b); 18 V.S.A. § 9382(a)(16). OneCare's risk arrangements with each of its payers make OneCare responsible for losses incurred (up to a certain amount), but also allow OneCare to realize gains the programs yield (up to a certain amount). Findings, ¶¶

[22] https://gmcboard.vermont.gov/sites/gmcb/files/GMCB_VMNG_12-12-2017.pdf.

20-21. Under these payer models, the maximum amount of risk OneCare is responsible for is 5% of the Medicare benchmark; 4% of the Medicaid benchmark; 3% of the commercial BCBSVT QHP benchmark; and 1.8% of the commercial self-funded programs benchmark. *See id*. When the estimated TCOC targets are applied to these risk arrangements, OneCare's estimated maximum risk across its payer programs is $30,942,262. Findings, ¶ 21.

Under OneCare's delegated risk model, OneCare passes most of its risk to the participating hospitals. *Id.* ¶¶ 23-25. Each hospital's MRL is based on the payers' approved risk arrangements and the TCOC estimates for each hospital's HSA. *Id*. If an HSA and its risk-bearing hospital exceed their MRL on losses, the excess liability will be covered collectively by the other participating hospitals proportional to their own maximum risk level. *See id.* ¶¶ 23-25. This gives the HSAs a capped amount on the money they would owe into the program. *Id.*

Finally, OneCare's FY19 budget includes a continuation of the FY18 Medicare program risk protection arrangement. *Id.* ¶ 22. Under this arrangement, in the event the aggregate ACO spend in the Medicare program reaches the mid-point of the maximum risk, a third party will pay 90% of any spend thereafter. *Id*.

Accordingly, subject to the following conditions outlined in the Order below, we approve OneCare's financial structure and risk arrangements proposed in its FY19 budget. Order, ¶¶ E-H.

G. ACO's Administrative Costs

OneCare's projected administrative expenses are reasonable and consistent with available benchmarks. Findings, ¶¶ 26-27. Though OneCare's FY19 administrative costs have increased 27.4% (approximately $3.5 million) from FY18, administrative expenses represent 1.77% of the overall budget for FY19, a decrease of 0.18 percentage points from FY18. *Id.* ¶ 27. OneCare's increased operating expenses for FY19 appear largely related to its projected increase in budgeted attributed lives from adding several communities to its 2019 network. Additional people and providers in the network require an expansion of OneCare's complex care coordination programs and the new employees to support its expanding programs. In addition, RiseVT has been integrated into OneCare's operations, which adds employees and programmatic spending that existed separately in 2018. *See id.* ¶ 26. Accordingly, we believe OneCare's increase in its budgeted administrative expenses are reasonable and in line with OneCare's expansion and the expansion of the Model.

As outlined in the conditions enumerated below, we will monitor OneCare's administrative expenses throughout the year to ensure they remain close to the budgeted amounts and to ensure expenses are appropriately allocated by state. Order, ¶¶ I.-J., Q.

H. Character of the ACO and its Leadership and Competence to Carry out its Duties

OneCare has made some minor changes to its Board of Managers and executive leadership team in the past year. Findings, ¶ 2. OneCare expanded its board to 19 members (last year it had 18 members) and added a position to its executive leadership team (Vice President of Revenue and Strategy and Chief Compliance and Strategy Officer). Findings, ¶ 2. Our interactions with

OneCare, its board, and its management team have raised no concerns regarding their competence, character, fiscal responsibility, or their professionalism.

I. HCA Participation and Public Comment

We have sought to address some of the concerns raised by the public and the HCA through conditions we are imposing on our approval of OneCare's budget. For example, the public has raised concerns about the administrative expense associated with OneCare and asked whether the additional administrative costs might exceed the intended savings the All-Payer Model was designed to create. Findings, ¶ 42. As discussed above in section G., our Order includes provisions that address administrative expenses and allow us to proactively review potential increases in that spending during FY19. Order, ¶¶ I.-J., Q.

Some comments expressed frustration that payment and delivery system reform were not moving quickly enough or that these efforts did not solve all health care issues in Vermont. Fundamental change of a system which is a quarter of the state's economy takes time and requires patience to be successful. It may take years before we see significant quality and financial results, as well as scale. This is appropriate for the size of the system and the importance of health care in Vermonters' lives. Innovation requires a willingness to take risks, constant iteration, testing and pivoting as well as patience. The entities we regulate must transform their business models and reengineer their operations if this reform is to be successful, which takes time.

Additionally, we received numerous comments related to the importance of OneCare's investments in PHM and coordination of care with community providers and programs. Findings, ¶ 42. We focused heavily on OneCare's proposals related to these areas during this budget review. OneCare continues to provide the Medicare investments in the Blueprint for Health, continues initial investments in PHM, and has added new programs and investments for 2019. However, the care model and investments are relatively new, some are pilots, and have not been fully implemented, so it is important to continue monitoring in the interim. Accordingly, we will receive updated reports on these projects during the coming year. *See* Order, ¶¶ L-P.

II. APM Agreement

A. TCOC Growth Rates

We set the trend rate that will be used to calculate the benchmark for the 2019 Medicare program at 3.8% for the A/D population and 3.1% for the ESRD population. Findings, ¶ 30. These recommendations are within APM Agreement parameters. *Id.* ¶ 29. Further, based on the Board's best estimates, these rates would not cause Vermont to exceed the Medicare compounded growth rate target to date under the APM Agreement.

At the time the Board approved OneCare's budget, OneCare had not yet finalized its 2019 contract with DVHA and, therefore, has not agreed to a trend rate. *Id.* ¶ 32. As part of the Board's Advisory Medicaid Rate Case, DVHA's actuary (Wakely) has communicated with our actuary (L&E) regarding the range in which the final rate will likely fall. *Id.* ¶ 33. Because that

range is almost completely within L&E's recommended range, we accept L&E's recommendation to approve a Medicaid rate that falls within Wakely's range. *Id.* Our Advisory Medicaid Rate Case will become public after the Medicaid contract is finalized. *See* 18 V.S.A. § 9573(c).

Finally, OneCare is still negotiating final trend rates with commercial payers. Findings, ¶ 34. While it is not ideal to move forward with the budget without more information about the 2019 commercial contracts, there is a significant amount of uncertainty built into the current ACO budget process. For example, attribution is one of the primary drivers of an ACO's budget and actual attribution numbers will not be available until well into 2019. Given the number of lives currently attributed to the commercial programs, we believe the contribution of these programs to All-Payer TCOC per Beneficiary growth will be small. This year, we believe the appropriate course of action is to allow OneCare and commercial payers to negotiate trends that are actuarially sound for their attributed populations and, to the extent possible, align cost growth across OneCare's various payer programs with the all-payer target of 3.5% or less. Therefore, we approve OneCare's 2019 commercial trend rates, subject to the following requirements. OneCare must provide the Board with (a) actuarial certifications for each of its commercial (including self-funded) benchmarks stating that the benchmark is adequate but not excessive; (b) an explanation of how its overall rate of growth across all payers fits within the overall all-payer target rate of growth and, if its overall rate of growth exceeds the target, how it plans to achieve the target for the term of the APM Agreement (2017 to 2022); and (c) a revised budget based on the finalized benchmarks.

B. Scale Target ACO Initiatives

We have reviewed OneCare's proposed changes to its existing programs and believe those changes are unlikely to affect the programs' status as Scale Target Initiative programs. In fact, the anticipated changes, including increased risk sharing and increased program alignment, generally increase OneCare's accountability for the costs and quality of services provided to members. *See* Findings, ¶¶ 35-39. We have insufficient information at this time to assess whether the proposed TPA arrangement will qualify as a Scale Target Initiative program. *Id.* ¶ 39. Accordingly, we require the follow-up outlined below to ensure the existing programs continue to meet Scale Initiative requirements and evaluate whether the new TPA program will qualify. Order, ¶ A.

C. Program Alignment

Vermont must ensure that the programs offered in 2019 by Medicaid and by commercial and self-insured plans "reasonably" align with the 2019 Medicare program in the areas of beneficiary alignment, quality measures, payment mechanisms, risk arrangements, and services included in the calculation of shared savings and shared losses. Findings, ¶¶ 40-41. As previously discussed, OneCare's budget contemplates changes to existing payer programs. *Id.* ¶ 41. Despite these potential changes, we expect OneCare's payer programs will reasonably align with the Medicare program to the extent possible, and we require OneCare to report on this topic and provide a justification for any areas of misalignment. Order, ¶ A.

ORDER

Based on our Findings and Conclusions above, and pursuant to 18 V.S.A. § 9382 and Act 113, § 8, we hereby approve OneCare's FY19 budget on the terms, and subject to the conditions, set forth below:

A. No later than 30 days after end of Q1 2019, OneCare must submit a written report to the Board which demonstrates to the Board's satisfaction that its payer programs (other than the Vermont Medicare ACO Initiative) qualify as Scale Target ACO Initiatives under section 6.b. of the APM Agreement, and which describes (a) how these programs align with the Vermont Medicare ACO Initiative in the areas of attribution methodologies, quality measures, payment mechanisms, services included in determining shared savings and losses, patient protections, and provider reimbursement strategies, and (b) the rationale(s) for any differences in these areas. Thereafter, OneCare must update this report no later than 15 days after entering a new payer program covering any portion of 2019.

B. At times specified by the Board, OneCare must submit documents or summary information needed to prepare reports required by the APM Agreement (e.g., the Payer Differential Report).

C. Approve the following 2019 benchmark trend rates:

   1. **Medicare:** 3.8% (3.8% for A/D and 3.1% for ESRD);
   2. **Medicaid:** Within the Wakely range.
   3. **Commercial:** OneCare must provide the Board with (a) actuarial certifications for each of its commercial (including self-funded) benchmarks stating that the benchmark is adequate but not excessive; (b) an explanation of how its overall rate of growth across all payers fits within the overall all-payer target rate of growth and, if its overall rate of growth exceeds the target, how it plans to achieve the target for the term of APM Agreement (2017 to 2022); and (c) a revised budget based on the finalized benchmarks.

D. In developing the 2019 benchmark for the BCBSVT QHP program, OneCare must base its trend figures on the ACO-attributed population and, if it is relying on the BCBSVT QHP filing, data supporting the trend should be drawn from BCBSVT's final, ordered filing.

E. The maximum amount of risk OneCare may assume for 2019 is the sum of the following: 5% of the Medicare benchmark; 4% of the Medicaid benchmark; 3% of the commercial BCBS QHP benchmark; and 1.8% of the commercial self-funded program benchmark(s). OneCare must request and receive an adjustment to its budget prior to executing a contract that would cause it to exceed these risk levels.

F. OneCare must provide the Board contracts that bind each of the risk-bearing hospitals to OneCare's risk sharing policy.

G. OneCare must hold at least $3.9 million in reserves by the end of 2019.

H. OneCare must inform the Board whether it has secured aggregate TCOC protection for Medicare or any other payer programs in 2019.

I. If total revenues are projected to increase, the expense ratio may remain at 1.77% unless otherwise approved by the Board. If total revenues are projected to decrease, the administrative expenses shall not exceed $16,000,000. If total revenues stay the same, OneCare must promptly inform the Board if total administrative expenses increase by more than 10% or to $17,600,000.

J. OneCare must ensure that its administrative expenses are appropriately allocated by state.

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

L. OneCare must fund the PHM and payment reform programs/investments described in its submission at no less than 3.6% of its overall budget (i.e., within 0.5 percentage points of the targeted ratio of 4.1%) and must fund the SASH and Blueprint for Health (PCMH and CHT) investments at 2018 Medicare levels plus an inflationary rate of 3.8% in risk and non-risk communities. If the percentages are projected to be less than those required by this order by the end of 2019, OneCare must promptly alert the Board.

M. No later than 30 days after the end of Q3 2019, OneCare must submit a final report on its 2018 CPR Pilot that (a) compares the 2018 quality outcomes of the pilot cohort with the non-pilot cohort; (b) analyzes how the capitated payments received by primary care practices in 2018 under the pilot compared to payments hospitals made to primary care providers that did not participate in the pilot; and (c) describes practices' experiences with the pilot (e.g., impacts on administrative burden and any clinical innovations allowed by increased flexibility and/or resources).

N. No later than 30 days after the end of Q2 2019, OneCare must submit an interim financial report on the 2019 CPR program that describes changes made to the program in 2019 and analyzes how the capitated payments received by primary care practices under the program compared to payments hospitals made to primary care providers not participating in the pilot.

O. No later than 30 days after the end of Q3 2019, OneCare must submit a written report describing its progress in testing and implementing a variable component to the VBIF distribution methodology for 2020.

P. No later than 30 days after the end of Q3 2019, OneCare must submit implementation and evaluation reports for the specialist payment pilot and the community innovation fund. OneCare must work with GMCB staff regarding the subjects to be covered by the reports, which may include, for example, how the innovation fund investments balance a state-wide approach that considers regional innovation and community needs, and how the specialist pilot relates to OneCare's care model and clinical priorities.

Q. Over the duration of the agreement, OneCare's administrative expenses should be less than the health care savings, including cost avoidance and the value of improved health, projected to be generated through the Model.

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

S. All materials required under this Order shall be provided electronically, unless doing so is not practicable.

The findings and orders contained in this decision do not constrain the Board's decisions in future ACO budget reviews, hospital budget reviews, certificate of need reviews, insurance rate reviews, or in any other future regulatory or policy decisions.

So ordered.

Dated: February 5, 2019 at Montpelier, Vermont

s/ Kevin Mullin, Chair)
)
s/ Jessica Holmes) GREEN MOUNTAIN
) CARE BOARD
s/ Robin Lunge) OF VERMONT
)
s/ Maureen Usifer)
)
s/ Tom Pelham)

Filed: February 5, 2019

Attest: */s/ Jean Stetter*
Green Mountain Care Board
Administrative Services Coordinator

NOTICE TO READERS: This document is subject to revision of technical errors. Readers are requested to notify the Board (by e-mail, telephone, or in writing) of any apparent errors, so that any necessary corrections may be made. (Email address: Janeen.Morrison@vermont.gov).