STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

AMENDMENT TO FY18 ACCOUNTABLE CARE ORGANIZATION BUDGET ORDER

In re:	OneCare Vermont Accountable Care Organization, LLC Fiscal Year 2018	))))	Docket No. 17-001-A

INTRODUCTION

On December 21, 2017, the Green Mountain Care Board (Board or GMCB) approved OneCare Vermont Accountable Care Organization, LLC's (OneCare) fiscal year 2018 (FY18) budget. *In re OneCare Vt. Accountable Care Org., LLC, Fiscal Year 2018*, Doc. No 17-001-A (GMCB 2018). The Board's order included a number of conditions related to benchmarks, risk arrangements, reserves, population health investments, administrative expenses, and reporting obligations. *Id.* at Order, ¶¶ A-R.

On December 7, 2018, OneCare asked the Board to modify two conditions in its FY18 budget order. Letter from Tom Borys, Dir. of Fin., OneCare, to Kevin Mullin, Chair, GMCB, (Dec. 7, 2018) (Borys Letter I).[1] First, OneCare asked that Condition F.4 be modified to require that OneCare establish risk reserves of $1.4 million by the end of 2018, rather than $2.2 million, as set forth in the initial order. Second, OneCare asked that Condition H be modified to require that OneCare spend no less than 2.5%, of its overall budget on population health management and payment reform programs (PHM spending), rather than 3.1%, as set forth in the initial order.[2] *Id.*

On March 13, 2019, the Board unanimously approved OneCare's request for the reasons set forth below.

LEGAL FRAMEWORK

The Green Mountain Care Board is charged with reviewing, modifying, and approving the budgets of accountable care organizations (ACOs). 18 V.S.A. § 9382(b). As part of its oversight of ACO budgets, the Board may review an ACO's performance under a previously established budget and make adjustments or modifications, if appropriate. *See* GMCB Rule 5.000, §§ 5.407(a) & (b). When the Board evaluates whether and how to adjust an ACO's

[1] Materials submitted to the Board regarding OneCare's FY18 budget amendment request are available under the "OneCare Vermont's 2018 Budget Amendment Request" at the following link. https://gmcboard.vermont.gov/content/2018-aco-budget-information.

[2] This ratio does not include the spending required by the Board on the Vermont Blueprint for Health (Blueprint) and Support and Services at Home (SASH) programs. OneCare provided full funding to these programs in accordance with Condition G of the Board's order.

budget, it "consider[s] the financial condition of the ACO and any other factors it deems appropriate." *Id.* § 5.407(b). When an ACO seeks an adjustment or amendment to an established budget, it bears the burden of justifying its request. *See id.* § 5.405(a).

REVIEW PROCESS

The Board established OneCare's FY18 budget on December 21, 2017. *In re: OneCare*, Doc. No. 17-001-A. On December 7, 2018, OneCare asked that the Board amend Conditions F.4 and H of that order to require that OneCare: (1) establish risk reserves of $1.4 million, rather than $2.2 million, by December 31, 2018, and (2) spend no less than 2.5%, rather than 3.1%, of its overall budget on PHM spending. Borys Letter I. In response to a request from the Board, OneCare submitted additional information and documentation in support of the requested amendment on February 15, 2019. OneCare, ACO Quarterly Reporting Template Quarter 4 – Pre-Audit Projection (Feb. 15, 2019) (Pre-Audit Projection).

OneCare's Director of Finance Tom Borys testified about the bases for OneCare's requested amendment on February 27, 2019. He responded to questions from the Board and the public. The Board held an official public comment period from February 27, 2019 through March 6, 2019. During that time, the Board received one comment from the Office of the Health Care Advocate (HCA). Letter from the HCA Policy Team to Kevin Mullin, Chair, GMCB (Mar. 6, 2019). OneCare responded to the HCA's comments on March 11, 2019. Letter from Tom Borys, Dir. of Fin., OneCare to Kevin Mullin, Chair, GMCB (Mar. 11, 2019) (Borys Letter II).

On March 13, 2019, the Board voted to unanimously approve the amendment to OneCare's FY18 budget.

FINDINGS

1. OneCare's PHM spending, reserves, and other operations are funded by the ACO payers (Medicare, Medicaid, and commercial insurers) and the ACO member-hospitals (through ACO participation fees) on a per member, per month (PMPM) basis. *See In re: OneCare*, Doc. No. 17-001-A, Findings, ¶¶ 29-47. As discussed in greater detail below, OneCare's budget is based on its expected attribution (the number of members the ACO expects it will be accountable for) in the upcoming fiscal year. However, the amount of money OneCare receives and spends during the year is based on its *actual* attribution, which is not calculated until after the fiscal year begins. *See* OneCare PowerPoint, 4 (July 18, 2018).

2. FY18 was the first year of the Vermont All-Payer Accountable Care Organization Model Agreement (APM Agreement) and the first year the Board reviewed and approved ACO budgets. *In re: OneCare*, Doc. No. 17-001-A, 2. On December 21, 2017, the Board approved OneCare's FY18 budget. Minutes, GMCB Board Mtg. (Dec. 21, 2017); *In re: OneCare*, Doc. No. 17-001-A. The Board's approval was subject to 18 conditions imposing financial benchmarks, a delegated risk model, required population health investments, restrictions on administrative spending, and periodic reporting obligations. *Id.* at Order, ¶¶ A-R.

Request to Amend Condition F.4 to Require $1.4 Million in Reserves at the End of FY18

3. The Board ordered OneCare to "establish reserves of $1.1 million by July 1, 2018 and $2.2 million by December 31, 2018." *Id.* at Order, ¶ F.4. Though the Board did not require OneCare to obtain reinsurance to cover a portion of its risk, it did order OneCare to notify and obtain approval from the Board prior to purchasing reinsurance. *Id.* ¶ F.6. The Board's decision recognized that if OneCare were to purchase a reinsurance policy, the Board may need to reevaluate the reserve requirement. *Id.* at Conclusions, ¶ II.A.

4. OneCare now asks that the Board amend Condition F.4 of its FY18 budget order and require that OneCare establish reserves of $1.4 million by December 31, 2018, rather than the $2.2 million initially ordered by the Board. Borys Letter I, 1.

5. After the Board approved OneCare's FY18 budget, OneCare sought and received the Board's approval to purchase aggregate total cost of care protection, which acts like reinsurance and, once an attachment point is reached, covers a significant portion of the risk OneCare assumed through the Vermont Modified Next Generation Program (Medicare program). *See* OneCare PowerPoint (July 11, 2018). The total cost to OneCare for this protection was approximately $700,000 in FY18. Minutes, GMCB Board Mtg. (July 11, 2018); Transcript, GMCB Board Mtg. (Feb. 27, 2019) ("Transcript"), 10:11-12:7). At the time it sought the Board's approval to purchase aggregate total cost of care protection, OneCare did not request an amendment to the reserve requirement. *See* Minutes (July 11, 2018).

6. Additionally, OneCare's participation agreement with Medicare required OneCare to secure a financial guarantee of approximately $4.125 million to cover a portion of the risk OneCare incurred through the Medicare program. OneCare PowerPoint, 2 (July 11, 2019). This financial was not something OneCare brought to the Board's attention during the FY18 budget review process.

7. At the conclusion of FY18, OneCare had approximately $1.5 million in its designated risk reserve, the $1.4 million it has proposed and approximately $100,000 in "net income." Pre-Audit Projection, Bal Sheet Reporting Template. When OneCare's designated risk reserves of $1.5 million are combined with the $700,000 it spent to purchase total cost of care protection, its total FY18 spending/reserve for risk protection coverage amounts to approximately $2.2 million. Transcript, 10:24-11:4.

Request to Amend Condition H to Require OneCare Allocate 2.5% of its Overall Budget to Population Health and Payment Reform Initiatives

8. OneCare's approved budget for FY18 included several conditions related to OneCare's population health investments. For example, the Board ordered that OneCare fund both the Blueprint and SASH programs. *In re: OneCare,* Doc. No. 17-001-A, Order, ¶ G. At the close of FY18, OneCare had provided full funding to both programs in compliance with Condition G of the Board's order. *See* Pre-Audit Projection, P&L Reporting Template, Actual OCV Layout.

9. The Board also ordered OneCare to spend 3.1% of its budget on the following population health initiatives:

    - Value Based Incentive Fund (VBIF);
    - Basic OneCare PMPM (per member per month) Payments;
    - Complex Care Coordination Program;
    - Primary Care Provider Comprehensive Payment Reform Pilot (CPR Pilot); and
    - RiseVT.

    In re: OneCare, Doc. No. 17-001-A, Order, ¶ H.

10. Through its payer contracts, OneCare began distributing the Basic OneCare PMPM Payments to its attributing providers and expanded the Complex Care Coordination and RiseVT programs in FY18. *See id.* ¶¶ 32-33, 36. The VBIF and CPR Pilot programs were initiatives that OneCare created as part of its population health investment programs. *See id.* ¶¶ 30, 34. The funding for these programs is largely contingent on the number of patients that ultimately attribute to the ACO and is not finalized until after the start of the fiscal year. *See generally id.* ¶¶ 29-47.

11. OneCare based its budget on projected attribution – the number of attributed lives it expects to be accountable for in the upcoming year. OneCare PowerPoint, 4 (July 18, 2018). OneCare does not know its actual attribution for the year until after the year has started. *Id.* Throughout the year, OneCare's attribution decreases, due in large part to attributees losing coverage. *Id.* Most of OneCare's PHM spending is distributed on a per-member basis. *See In re: OneCare*, Doc. No. 17-001-A, Findings, ¶¶ 29-47. When OneCare's attribution is lower than expected, its PHM spending necessarily will be lower. *See id.*

12. OneCare's FY18 budget was built on expected attribution of approximately 122,000 lives. OneCare PowerPoint, 4 (July 18, 2018). OneCare's actual attribution for FY18, set in January 2018, was approximately 112,000 lives. *Id.* By June 2018, OneCare's actual attribution was 106,160 lives. *Id.* Because of these decreases in attribution, OneCare received less funding for and had less money to spend on its population health programs. *See, e.g.*, Borys Letter I, 3 (noting that because attribution was "materially lower than budgeted" spending on certain programs was also lower). Additionally, OneCare did not finalize its contract with one of its payers until the second quarter of FY18 which also contributed to the lower-than-expected attribution in the first quarter of FY18. *See id.*

13. OneCare funded its CPR Pilot and Complex Care Coordination programs based on provider participation. *See* Transcript, 16:3-18:13; OneCare PowerPoint, 20 (Feb. 27, 2019). OneCare budgeted its PHM spending for these programs based on an expected number of provider participants. Transcript, 16:3-17:23.

14. For example, OneCare based its projected spending on the CPR Pilot on ten participating practices. *Id.* at 13:11-23. However, in actuality three practices joined the FY18 pilot and as a result, OneCare spent less money on the program because it had fewer practices that were eligible for payments. *Id.*

15. Similarly, OneCare funded its Complex Care Coordination program by sending eligible community organizations $15 PMPM for the patients the providers registered for the care coordination system. *In re: OneCare*, Findings, ¶ 31. Community providers receive payments after they work with each patient to develop a care coordination plan. *See id.* Only after that plan has been developed will OneCare provide the $15 per month payment to the provider. *See id.* OneCare's expected spending for this program was based on the estimated number of patients that eligible providers would enroll in FY18. *See id.* ¶ 29. Because fewer patients enrolled in the Complex Care Coordination program, OneCare's per-enrollee payments were also lower than expected. Transcript, 16:3-17:10.

16. OneCare's FY18 PHM spending was also lower than expected because several of its programs expanded in FY18 and did not have the infrastructure in place to start receiving payments at the beginning of the year. OneCare PowerPoint, 20 (Feb. 27, 2019); Transcript 19:9-20:1. OneCare faced these challenges with RiseVT. Transcript 19:9-20:1. RiseVT began in 2015 as a pilot program in Grand Isle and Franklin counties. OneCare Vermont ACO 2019 Fiscal Year Budget Submission, 6 ("FY19 Budget Submission"). The program focuses on community wellnesses and prevention through its extensive network of providers. *Id.* In FY18, OneCare worked with RiseVT to expand the program to 20 new Vermont communities and added new program managers at six Vermont hospitals. *Id.* at 60.

17. A large portion of OneCare's PHM spending for RiseVT related to the six hospitals' local program coordinators. Transcript, 19:17-20:1. Because those program coordinators were not all in place at the beginning of FY18, OneCare started payments once the respective coordinators were in place and able to use the funding. *Id.*

18. Notably, the Board did not receive any comments or complaints from the entities eligible to receive funds under OneCare's population health programs.

19. Because OneCare's funding comes from payers and hospital participation fees, OneCare would need to seek additional contributions from Vermont's 13 participating hospitals to cover increased PHM spending beyond the spending already budgeted for FY18. *See* Borys Letter II.

CONCLUSIONS

I. OneCare's Request to Amend the FY18 Budget Order to Require $1.4 Million in Risk Reserves at the Conclusion of the Fiscal Year

Following our review of OneCare's FY18 budget proposal, we ordered OneCare to establish $2.2 million in risk reserves by the end of the year. *See* Findings, ¶ 3. We did not require OneCare to obtain any other sort of risk protection, such as reinsurance, and contemplated that its total year-end risk protection would be total approximately $2.2 million. *See id.*

However, OneCare was able to obtain reinsurance-like protection at a cost of approximately $700,000. *Id.* ¶ 5. OneCare also provided a financial guarantee to cover more than $4 million of the risk it assumed through the Medicare program – covering a material portion of OneCare's overall risk in FY18. *See id.* ¶ 6.

OneCare's spending/reserving for risk in FY18 totaled approximately $2.2 million, which is the amount of reserves the Board initially ordered OneCare to maintain.[3] By spending $700,000 to purchase total cost of care protection, and by securing a $4 million financial guarantee, OneCare has mitigated its maximum risk substantially.

For the foregoing reasons, we approve OneCare's request to modify the risk reserve requirements set forth in Condition F.4 of the Board's FY18 budget order.

II. OneCare's Request to Amend the FY18 Budget Order and Require that OneCare Spend 2.5% of its Revenue on Population Health Programs

PHM spending is a tenet of Vermont's health care reform efforts and a core component to the success of ACOs and Vermont's All-Payer Model. In addition, ensuring adequate, but not excessive, reserves at the provider level is necessary to ensure solvency of Vermont's hospitals. For the reasons discussed below, the Board is confident that OneCare's request to amend its FY18 PHM spending ratio in no way lessens or changes the importance of PHM spending or provider-level solvency as Vermont moves forward with healthcare reform but provides a balanced approach for the ACO program moving forward.

OneCare's PHM spending is largely based on the number of patients that attribute to the ACO. Findings, ¶ 1. When OneCare's attribution is lower, the amount of money decreases. *Id.* ¶ 11. OneCare did not finalize its contract with one of its payers until the second quarter and that affected its PMPM payment totals for that contract. *Id.* ¶ 12. Additionally, lower than expected attribution across all its payers resulted in less funding for PHM spending than OneCare anticipated in its FY18 budget. *See id.*

Most of OneCare's programs were launching or expanding in FY18 and the budget misjudged the necessary ramp-up, and therefore the costs, of the programs. For example, during 2018 RiseVT transitioned from a pilot program in two counties to a program with a presence in 20 communities, and lead coordinators at six Vermont hospitals. *Id.* ¶ 16. It took time for RiseVT to hire staff around the state, and OneCare did not make payments to the RiseVT programs until the staff at various locations were ready to use that money. *Id.* ¶¶ 16-17. OneCare budgeted for payments starting on January 1, 2018, and the startup-related lag time resulted in reduced total spending. *Id.*

OneCare's budgeted spending on the CPR Pilot and Complex Care Coordination programs was based on the anticipated number of provider participants. *Id.* ¶¶ 13-15. OneCare initially anticipated 10 providers would participate in the CPR Pilot, but only 3 providers participated in the FY18 program. *Id.* ¶ 14. Fewer providers receiving CPR Pilot funding also contributed to the decreased PHM spending in FY18. *Id.*

[3] This $2.2 million does not include the $4 million guarantee OneCare put up for the Medicare program.

OneCare's Complex Care Coordination Program provided funding to providers based on the number of patients who completed care coordination plans. Lead care coordinators employed at community organizations (such as designated mental health agencies) were eligible for a $15 PMPM payment. *Id.* ¶ 15. To receive this payment, community providers must work with patients to develop individualized care coordination plans. *Id.* Once an individual plan has been developed, OneCare begins making the monthly payment to the provider. *Id.* OneCare estimated PHM spending based on expected participation, but only distributed funds to those providers who successfully met the milestones outlined for the program.

The start-up and roll-out delays OneCare experienced in FY18 are common when building, operationalizing, and expanding these types of programs. In addition, because attribution is completed after the performance year has begun, the approved budgets will necessarily be based on an estimate. Population health programs are dependent on attribution and, therefore, the spending projection is also an estimate. However, these operational challenges in no way diminish the importance of, or the Board's continued commitment to, population health programs moving forward.

For these reasons, we approve OneCare's request to amend Condition H of the FY18 budget order and require that OneCare's PHM spending be no less than 2.5% of its overall budget.

ORDER

Based on our findings and authority granted by 18 V.S.A § 9382(b), we amend OneCare's FY18 Budget Order, approved on December 21, 2017, as follows:

> Condition F.4: OneCare must implement the delegated risk model it described in its budget proposal, except that it must. . . establish reserves of $1.4 million by December 31, 2018.
>
> Condition H: OneCare must fund its other population health management and payment reform programs – Value-Based Incentive Fund, Basic OneCare PPM, Complex Care Coordination Program, PCP Comprehensive Payment Reform Pilot, and RiseVT – at no less than 2.5% of its overall budget.

So ordered.

Dated: April 4, 2019
Montpelier, Vermont

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

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s/ Tom Pelham)
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s/ Maureen Usifer)

Filed: April 4, 2019

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

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Attachment: FY18 Accountable Care Organization Budget Order

STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

FY18 ACCOUNTABLE CARE ORGANIZATION BUDGET ORDER

In re:	OneCare Vermont Accountable Care Organization, LLC Fiscal Year 2018	)))) Docket No. 17-001-A

INTRODUCTION

The Green Mountain Care Board (the Board) is charged with reviewing, modifying, and approving the budgets of Accountable Care Organizations (ACOs) with attributed lives in Vermont. 18 V.S.A. § 9382(b). Fiscal Year 2018 (FY18) ACO budgets are the first to be subject to Board review.

Below, we describe the relevant legal framework, provide general observations and conclusions about this initial ACO budget review, and then present specific Findings and Conclusions in support of our Order establishing the FY18 budget of OneCare Vermont Accountable Care Organization, LLC (OneCare).

LEGAL FRAMEWORK

In 2011, the Vermont Legislature passed Act 48 in an effort to ensure that all Vermonters could access high-quality, affordable health care. Act 48 created the Board and authorized it to develop and implement "payment and delivery system reforms designed to control the rate of growth in health care costs and maintain health care quality in Vermont." 18 V.S.A. § 9375(b)(1) (amended by 2015 Adj. Sess., No. 113, § 4). Act 48 defined "payment reform" as modifying the method of payment from a fee-for-service (FFS) basis, where providers and suppliers are paid for each service or item they deliver, to one or more alternative methods of compensation (e.g., global payments), while measuring quality and efficiency. 18 V.S.A. § 9373.

In 2016, the Vermont Legislature passed Act 113, which established a series of principles to guide the State in implementing an ACO-based, all-payer health care payment model (All-Payer ACO Model) — "a value-based health care payment model that allows participating providers to be paid by Medicaid, Medicare, and commercial insurers using a common methodology that may include population-based payments and increased financial predictability for providers." 18 V.S.A. § 9551. Subsequently, the Governor, the Chair of the Board, and the Secretary of the Vermont Agency of Human Services signed the All-Payer Accountable Care Organization Model Agreement (APM Agreement) with the Centers for Medicare & Medicaid Services (CMS), which allowed for Medicare's participation in the model.

Act 113 also charged the Board with regulating ACOs, the primary actors in this new payment model. Specifically, Act 113 required ACOs to obtain and maintain certification from

the Board in order to receive payments from Medicaid or commercial insurers under the model (or any other payment reform program or initiative). 18 V.S.A. § 9382(a). Act 113 also called on the Board to review, modify, and approve the budgets of ACOs after considering certain criteria, many of which relate to whether an ACO is making the kinds of investments and creating the kinds of incentives that will allow the model to succeed. 18 V.S.A. § 9382(b).

The All-Payer ACO Model relies on private-sector health care providers voluntarily working together, as part of an ACO, to improve health care quality and outcomes for Vermonters. Previously in Vermont, the ACO delivery model has been paired only with a payment model that has a FFS foundation. By paying for health care differently than through FFS reimbursement, under a common structure, the All-Payer ACO Model allows investment in providers that have historically been less well funded, such as primary care, mental health, home health, and other community-based providers. This flexible model can move the focus away from "sick care" and emphasize those services that keep people well without increasing total cost of care, and thus, premiums and taxes.

FY18 REVIEW PROCESS

While we were drafting an administrative rule, GMCB Rule 5.000, to regulate the ACO certification and budget review processes, we invited OneCare to submit a proposed FY18 budget using guidance and templates we created for this purpose.[1] OneCare submitted its proposed budget on June 23, 2017 and presented it at a public meeting on July 13, 2017. On October 20, 2017, at the request of our staff, OneCare submitted a revised budget, which it presented at public meetings on November 2 and 16, 2017. Throughout the 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). Board staff made recommendations regarding the approval of OneCare's budget on December 12, 2017. On December 19, 2017, staff from the Board and the Department of Vermont Health Access (DVHA) presented at a public Board meeting regarding the performance of ACOs, including OneCare, under the Medicare, Medicaid, and commercial shared savings programs from 2014 through 2016, and provided preliminary results for the 2017 Medicaid Next Generation Program. Public comments on OneCare's proposed budget were accepted through December 19, 2017. On December 21, 2017, after receiving additional recommendations from Board staff, we voted to establish OneCare's budget, on terms and subject to conditions described below. The written materials from this process are posted on the Board's website[2] and video recordings of the public meetings are available from Orca Media.[3]

We have described this first ACO budget review as a "test year" that will allow us to determine what kinds of data we will need to examine ACOs' financial health and ability to take on risk, and to evaluate ACOs' provider, payer, and community relationships and investments.

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[1] The Board also invited Community Health Accountable Care, LLC (CHAC) to submit a proposed FY18 budget, which it did. However, on October 18, 2017, CHAC's Board voted to conclude operations and CHAC withdrew its budget submission shortly thereafter.

[2] ACO Certification and Budget Review, http://gmcboard.vermont.gov/content/aco-certification-and-budget-review, and 2017 Board Meeting Materials, http://gmcboard.vermont.gov/board/meetings/minutes/2017.

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

GMCB ACO Budget Guidance and Letter (May 3, 2017), 1. However, we have the authority to establish ACO budgets prior to January 1, 2018, the effective date of the ACO budget review statute, and this Order is fully enforceable. 2015 Adj. Sess., No. 113, § 8. As the State moves into Performance Year 1 (PY1) of the APM Agreement, we will seek to refine the ACO budget review process and better align it with our other regulatory work to more effectively further the goals of health care payment and delivery system reform expressed in Act 48 and Act 113.

FINDINGS

Background

1. OneCare is a manager-managed limited liability company organized under the laws of the State of Vermont. OneCare Vermont ACO 2018 Fiscal Year Budget Resubmission (Resubmission), 8. OneCare was organized and founded in 2012 by the University of Vermont Medical Center (UVMMC), a Vermont nonprofit corporation, and Dartmouth Hitchcock Health (DH-H), a New Hampshire nonprofit corporation. *Id.* at 5 & Sec. 1, Attach. E.

2. In 2013, OneCare began participating in the Medicare Shared Savings Program (MSSP). In 2014, it began participating in a Medicaid Shared Savings Program offered by DVHA and a Commercial Exchange Shared Savings Program offered by Blue Cross Blue Shield of Vermont (BCBSVT). *Id.* at 5. OneCare did not bear risk under these programs and, except for one year under the Medicaid program, did not achieve savings. GMCB PowerPoint (Dec. 19, 2017), 17. However, OneCare showed progressive improvement in overall quality scores. *Id*. OneCare's financial performance in 2016 in the MSSP was within the norm for MSSP ACOs nationally. *See* MSSP ACO Cost vs. Quality 2016 Results (Nov. 16, 2017); *see also* Resubmission at 5-6 (describing OneCare's 2015 results). Nationally, ACOs like OneCare in Track 1 (no risk) of the MSSP had overall net costs to Medicare relative to their aggregate benchmark, while results have been more positive for ACOs in Tracks 2 and 3 and the Medicare Next Generation Program—two-sided risk programs that require ACOs to assume some level of risk. GMCB PowerPoint (Dec. 19, 2017) at 22.

3. In 2015, OneCare was selected to participate in the Medicare Next Generation Program, but chose to defer and reapply in 2017 for a January 2018 start to better align with the All-Payer ACO Model. Resubmission at 5. In 2017, OneCare entered the Vermont Medicaid Next Generation Program with DVHA, a two-sided risk program modeled on the Medicare Next Generation Program. Based on preliminary data, OneCare's actual spending in this program has been fairly consistent with expected spending. GMCB PowerPoint (Dec. 19, 2017) at 26. OneCare assumes it will continue to participate in the Medicaid Next Generation Program in 2018. OneCare also assumes it will participate in 2018 in the Medicare Next Generation Program and a two-sided risk program with BCBSVT for its exchange (Vermont Health Connect) population. Finally, OneCare assumes it will enter into a shared savings contract in 2018 with UVMMC for individuals covered under UVMMC's self-insured employee plan. Resubmission at 23-25 & Sec. 3, Attach. B; OneCare PowerPoint (Nov. 2, 2017), 29. Hereafter, these programs will be referred to as the 2018 Medicare, Medicaid, commercial, and self-insured programs.

4. OneCare has a broad provider network that includes most hospitals in Vermont; Dartmouth Hitchcock, the largest out-of-state provider of care to Vermonters; federally qualified health centers; skilled nursing facilities; home health agencies; designated agencies; and independent primary care and specialist practices. Resubmission at 5 & Sec. 2, Attach. F.

5. OneCare is governed by an 18-member Board of Managers that is comprised largely of representatives of OneCare's participating providers. *Id.* at Sec. 1, Attach. A. All five members of OneCare's executive team—its Chief Executive Officer, Vice President and Chief Operations Officer, Chief Medical Officer, and Chief Information Security Officer—have been with the ACO for four or more years and have relevant qualifications. *Id.* at 9. No legal actions have been taken against OneCare, its leadership team, or its Board of Managers. *Id.* at 10.

Benchmark Trend Rates

6. A "benchmark" or total cost of care (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. GMCB Rule 5.000, § 5.103. In building its FY18 budget, OneCare estimated a benchmark for each of the payer programs it will participate in for 2018, with the exception of the self-insured program. Resubmission at Sec. 3, Attach. A.

7. The APM Agreement authorizes the Board to prospectively develop the benchmark for the 2018 Medicare program, subject to the approval of CMS. APM Agreement at § 8(b)(ii). In exchange for this authority, Vermont is required to limit per capita spending growth for Medicare beneficiaries to at least 0.2 percentage points below projected national per capita Medicare growth over a five-year performance period, from 2018 through 2022. APM Agreement at § 9.b. The projected national per capita Medicare growth rate for 2018, PY1 of the APM Agreement, is 2.7%. GMCB PowerPoint (Dec. 12, 2017), 5.

8. The State negotiated a "floor" to protect itself from low projected national Medicare growth in PY1. Because the floor has been triggered, the Board may set the trend rate used to calculate the 2018 Medicare benchmark at no more than 3.5%. GMCB PowerPoint (Dec. 12, 2017) at 5; APM Agreement at § 8.b.ii.1.b.ii. Regardless of where the Board sets the rate, Vermont's performance in PY1 with respect to the Medicare growth target will be calculated as if national projected Medicare growth was 3.7%. GMCB PowerPoint (Dec. 12, 2017) at 6; APM Agreement at § 9.b.iv.

9. In addition to limiting Medicare spending growth, the APM Agreement requires Vermont to limit per capita spending growth for "all-payer beneficiaries"—Vermont residents who are Medicare beneficiaries or enrolled in Medicaid or a commercial or self-insured plan—to a compound annual growth rate (CAGR) of 3.5% over the five-year performance period. APM Agreement at § 9.a.

10. OneCare used a rate of 3.5% to estimate the 2018 Medicare benchmark. Resubmission at 24. L&E and Board staff recommended that the Board set the Medicare rate at 3.5%. GMCB PowerPoint (Dec. 12, 2017) at 20, 24. Since all-payer growth is calculated over a five-year period, Vermont can create "room" by staying below 3.5% in PY1, which would provide

flexibility in later years. *Id.* at 6-7. Setting the rate at 3.5%, however, will allow OneCare to make investments in PY1 that may be essential to achieving savings in later years. *Id.* at 24. Also, preliminary data for the Medicare beneficiaries expected to be attributed to or aligned with OneCare in 2018 suggest the trend for this population could be much higher than the projected national trend of 2.7%. *Id*. The Board voted on December 21, 2017 to set the rate at 3.5%.

11. DVHA engaged Wakely Consulting Group (Wakely), an actuarial consulting firm, to develop and certify the capitation rates DVHA will pay to OneCare under the 2018 Medicaid program. Wakely provided DVHA with a range of rates it would certify. As part of the "Medicaid rate case," the Board had L&E review the proposed payment arrangement between DVHA and OneCare for 2018, including the capitation rates. Testimony of Jackie Lee (Nov. 16, 2017) at 11:50-13:45; 2017, No. 3, § 80 (amending 2015 Adj. Sess., No. 113, § 8).

12. OneCare used a trend rate of 6.1% to estimate the 2018 Medicaid benchmark. Resubmission at 23; *see also*, GMCB PowerPoint (Dec. 12, 2017) at 27. OneCare confirmed that this rate falls within the ranges recommended by Wakely and L&E. Testimony of Jackie Lee (Dec. 12, 2017) at 63:42-63:54. The 6.1% rate includes adjustments for increases in Medicaid reimbursement, which can be excluded from the calculation used to assess Vermont's success in constraining all-payer TCOC per beneficiary growth under the APM Agreement. DVHA PowerPoint (Dec. 12, 2017), 9-11; Testimony of Michael Costa (Dec. 12, 2017) at 83:50-86:00; APM Agreement at § 10.d. The annualized Medicaid trend, excluding the pricing adjustments, is 1.5%. DVHA PowerPoint (Dec. 12, 2017) at 10; GMCB PowerPoint (Dec. 21, 2017) at 6-7.

13. OneCare used a 3.8% trend to estimate the 2018 commercial benchmark. Resubmission at 25. The rate is still being negotiated, but the combined annual trend is projected to be between 3.5% and 3.7%. Testimony of Jackie Lee (Dec. 12, 2017) at 62:05. The Board approved a medical trend of 3.7% in the 2018 BCBSVT qualified health plan (QHP) premium rate decision. Decision & Order, Docket No. GMCB-008-17rr, 11.

14. On behalf of the Board, L&E reviewed the methodology being used to develop the commercial rate. The parties are using the same data BCBSVT used to develop its 2018 QHP premium rates, except limited to members expected to be aligned with OneCare in 2018. For the unit cost trend, adjustments were made to the trend extracted from the 2018 QHP rate filing to reflect approved hospital budgets. For the utilization trend, the parties used the 0.9% trend ordered by the Board in the QHP premium rate decision. *See* Testimony of Jackie Lee (Dec. 12, 2017) at 60:40-61:40. L&E recommended that the Board condition approval of OneCare's budget on the commercial trend being within the range of 3.5% to 3.7%, which L&E believed is within the range of what would be reasonable. GMCB PowerPoint (Dec. 12, 2017) at 27; Testimony of Jackie Lee (Dec. 12, 2017) at 62:00-62:22.

Risk-Sharing Arrangements with Payers / Maximum Potential Losses

15. OneCare assumed that it will select a 5% risk corridor and an 80/20 risk-sharing arrangement for the 2018 Medicare program. OneCare assumed that the 2018 Medicaid program, like the 2017 Medicaid program, will include a 3% risk corridor and no risk sharing within the corridor. Finally, OneCare assumed that the 2018 commercial program will include a 6% risk

corridor and a 50/50 risk-sharing arrangement. Resubmission at 24-25. The following table shows the risk contracts described in OneCare's budget:

Risk Arrangements by Payer		
Payer	**Corridor**	**OneCare's Share**
Medicaid	97% - 103%	100%
Medicare	95% - 105%	80%
Commercial	94% - 106%	50%

GMCB PowerPoint (Dec. 12, 2017) at 31.

16. Under the anticipated risk-sharing arrangements, OneCare would be responsible for 80% of any losses and would realize 80% of any savings within five percentage points of the Medicare benchmark, with the remaining 20% of either losses or savings accruing to CMS. Within three percentage points of the Medicaid benchmark, OneCare would be responsible for 100% of any losses and would realize 100% of any savings. Finally, 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.[4] All savings and losses outside of the corridors would accrue to the payers. OneCare's maximum potential losses and savings would be 4% of the Medicare benchmark, 3% of Medicaid benchmark, and 3% of the commercial benchmark. Resubmission at 24-25.

17. The self-insured program is still being developed, but OneCare intends for it to align with the other 2018 payer programs. Testimony of Todd Moore (Nov. 2, 2017) at 101:05-101:09. The self-insured program will be a shared savings only program and will present no additional risk to OneCare. As the program is currently envisioned, UVMMC would pay OneCare $9.00 per-member, per-month (PMPM). OneCare would take some of this money ($3.25 PMPM) to fund its infrastructure; the rest would be paid out under OneCare's programs or used to fund its Value-Based Incentive Fund. OneCare would receive 30% of any savings after the first $9.00 PMPM is saved, up to 10% of the benchmark, which will be set by UVMMC. OneCare PowerPoint (Nov. 2, 2017) at 29; Testimony of Todd Moore (Nov. 2, 2017) at 101:15-104:00. OneCare is interested in growing its self-insured line of business beyond UVMMC in the 2019 plan year and intends for this program to serve as a pilot for building its capabilities and value proposition for self-insured plans. Questions and Answers re: Resubmission (Nov. 2, 2017), ¶ 7.

18. The Medicaid, commercial, and self-insured contracts have not been finalized. However, DVHA has sought to align the Medicaid program as much as possible with the Medicare and commercial programs. DVHA PowerPoint (Dec. 12, 2017) at 7.

Hospital Payments and ACO Risk Mitigation

19. OneCare has assumed that the All-Inclusive, Population-Based-Payment (AIPBP) model available in the 2018 Medicare program will be available in the Medicaid and commercial

[4] 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.

programs as well. In this model, ACO-contracted participant providers (identified at the level of the Tax Identification Number) can agree to forego their payer-administered FFS payments and receive payments from an ACO instead; the payer pays the ACO and the ACO is responsible for paying the providers. OneCare assumes hospitals will be the primary participants in the AIPBP model in 2018.[5] Resubmission at 35; Testimony of Todd Moore (Nov. 2, 2017) at 73:26-74:40.

20. OneCare plans to use the AIPBP payments it will receive from payers to fund its operations and its population health management and payment reform programs. OneCare PowerPoint (Nov. 2, 2017) at 24. It will use the remainder to pay hospitals fixed prospective payments based on historical utilization and expected spending for OneCare-attributed beneficiaries. *Id.*; Questions and Answers re: Resubmission (Nov. 2, 2017) at ¶ 2. These fixed payments will function as "pre-payments" for services the hospitals will deliver to OneCare-attributed beneficiaries.[6] Resubmission at 35. All other providers, except for three independent primary care practices participating in OneCare's Comprehensive Payment Reform Pilot, will receive regular, payer-administered, FFS payments. *Id.* While OneCare will not be making these FFS payments, the payments will be counted against OneCare's TCOC targets. *See id.* at 36.

21. Each hospital participating in the AIPBP model in 2018 will bear what OneCare refers to as "fixed revenue risk" with respect to care they provide to their "locally-attributed population" (i.e., patients attributed to OneCare by providers in the hospital's Health Service Area or HSA). If a hospital's cost of providing care to this population exceeds the fixed payments it receives from OneCare, the hospital will have to absorb the cost of delivering the care. *Id*. at 36-37; OneCare PowerPoint (Nov. 2, 2017) at 18. OneCare expects the fixed payments it will make to hospitals will represent approximately 68% of its overall TCOC target, with the remainder being FFS. The fixed prospective hospital payments do not decrease OneCare's maximum risk, but make it less likely that OneCare will experience this worst-case scenario by shielding OneCare from losses on the majority of its expected spending. Based on OneCare's projections, it would take a 7.5% overrun on FFS spending to hit 75% of its maximum risk, and a 9.5% overrun to reach 100%. While OneCare believes it is unlikely to experience losses in this range, it must be able to cover them should they accrue due to poor performance in all payer programs. To repay losses, OneCare plans to rely on funds committed by hospitals. Resubmission at 36.

22. Under OneCare's "delegated risk model," OneCare will establish a TCOC target for each HSA in its network. The hospital in each HSA will assume responsibility for the FFS spending[7] on its locally-attributed population that exceeds the HSA's TCOC target, up to a maximum risk level or MRL. *Id.*; OneCare PowerPoint (Nov. 2, 2017) at 18-19. The MRL will serve as a cap on a hospital's potential payment obligation to OneCare. OneCare Responses to GMCB Questions (Nov. 14, 2017) at ¶ 12. A hospital's MRL will be calculated for each payer program

[5] Three independent primary care practices participating in OneCare's Comprehensive Payment Reform Pilot will also participate in the AIPBP model in 2018 for Medicare and Medicaid. Testimony of Todd Moore (Nov. 2, 2017) at 98:15-99:43; OneCare PowerPoint (Nov. 2, 2017) at 28.

[6] The payments cover all services the hospitals bill under their TINs. Testimony of Todd Moore (Nov. 2, 2017) at 79:02-79:21.

[7] While services provided by Vermont risk-bearing hospitals to non-locally-attributed patients are included in their fixed prospective payments, the "home hospital" will be responsible for the FFS value of services provided by risk-bearing hospitals to its locally-attributed population. *See* OneCare PowerPoint (Nov. 2, 2017) at 18, 23; Testimony of Todd Moore (Nov. 2, 2017) at 75:01-75:59.

the hospital is participating in by applying the risk corridor for the program to the relevant HSA TCOC target. Resubmission at 37; OneCare PowerPoint (Nov. 2, 2017) at 19. The sum of the MRLs will cover OneCare's total maximum risk. Questions and Answers re: Resubmission (Nov. 2, 2017) at ¶ 3; OneCare PowerPoint (Nov. 2, 2017) at 19-20.

23. If OneCare is responsible for repayment of losses, those losses will be assigned to the hospitals that exceeded their HSA TCOC target. Hospitals whose calculated payback to OneCare exceeds their MRL will be charged their full MRL; the liability in excess of the MRLs will be pooled and shared proportionally by other risk-bearing hospitals based on their MRLs. OneCare PowerPoint (Nov. 2, 2017) at 20; Testimony of Tom Borys (Nov. 2, 2017) at 61:27-62:39; OneCare Responses to GMCB Questions (Nov. 14, 2017) at ¶ 12. This spreading of risk will help protect hospitals from unaffordable overruns, but may require a hospital to help cover losses generated by another HSA. OneCare Responses to GMCB Questions (Nov. 14, 2017) at ¶ 12. UVMMC and DH-H have agreed to limit the risk for Brattleboro Memorial Hospital and Springfield Hospital to 50% of what it otherwise would be for 2018. Testimony of Todd Moore (Nov. 2, 2017) at 57:13-57:29, 60:25-60:39.

24. Because the losses hospitals could experience under OneCare's delegated risk model are similar in magnitude to other effects they occasionally experience (e.g., cost report settlements, DSH payment changes, and reimbursement changes), OneCare did not independently analyze hospitals' ability to cover their MRLs by, for example, comparing hospitals' MRLs to their days cash on hand. OneCare provided each risk-bearing hospital with an estimate of its MRL, entrusting the hospital to determine whether participation would jeopardize its solvency. Questions and Answers re: Resubmission (Nov. 2, 2017) at ¶ 3; Testimony of Todd Moore (Nov. 2, 2017) at 69:55-70:50.

25. Board staff have confirmed that each risk-bearing hospital understands its level of risk under OneCare's delegated risk model and that the hospitals currently have sufficient cash on hand to cover their potential 2018 losses. Testimony of Kelly Theroux (Nov. 2, 2017) at 171:23-171:41. Staff also confirmed that OneCare will work with hospitals to help them monitor utilization and spending, so they can understand and improve their performance. Questions and Answers re: Resubmission (Nov. 2, 2017) at ¶ 16.

26. OneCare expressed interest in purchasing reinsurance to protect against broad-based overruns driven by FFS spending and included a reinsurance premium expense of $1.5 million in its administrative budget. Resubmission at Sec. 4, Attach E. However, the details of a potential policy are still being explored, and no formal or binding proposal has been made. If OneCare can purchase reinsurance, a contract could not be executed until sometime in 2018, after attribution is finally determined and the benchmarks are calculated. Testimony of Tom Borys (Nov. 2, 2017) at 69:00-69:42.

Operating/Administrative Budget

27. OneCare budgeted $12,492,660 for operating expenses, including personnel, office space, utilities, supplies, information systems and security, and contracted services (e.g., finance, auditing, accounting, actuarial and legal services), as well as a commercial reinsurance premium.

Resubmission at Sec. 4, Attach. C-5. Excluding the $1.5 million reinsurance premium expense, OneCare's administrative expense PMPM is $7.47. *Id.* at 32.

28. While no ACO-specific administrative expense benchmarks currently exist, OneCare compared its projected administrative expenses to managed care operations benchmarks developed by the Sherlock Company, the national leader in such benchmarking. Based on ACO-applicable categories for medical management, provider network management, and administration, including finance and information systems, OneCare's expected range is from $6.00 PMPM to $8.00 PMPM. As a second benchmark exercise, OneCare applied a percent of premium approach by dividing its projected administrative expenses into the total of its payer risk targets plus those administrative expenses. OneCare calculated that the percent of premium for its administrative expenses is 1.8%, which it concluded is well within an expected range for a risk-bearing ACO of its size. *Id.* at 32.

Population Health Management and Payment Reform Programs

29. OneCare plans to invest in several programs to support population health management 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 benchmarks change. Board staff therefore calculated each investment as a percentage of total projected revenue:

Population Health Management / Payment Reform Program	**Investment Amount**	**Percentage of Budget**
Value-Based Incentive Fund	$4,305,223	0.7%
Basic OneCare PMPM	$4,781,010	0.8%
Complex Care Coordination Program	$7,064,722	1.1%
PCP Comprehensive Payment Reform Pilot	$1,800,000	0.3%
RiseVT	$1,577,600	0.2%
CHT/SASH/PCP (Risk & Non-Risk Communities)	$7,762,501	1.3%
Total	**$27,291,056 ($18.55 PMPM)**	**4.4%**

GMCB PowerPoint (Dec. 12, 2017) at 29.

Value-Based Incentive Fund

30. OneCare established a Value-Based Incentive Fund (VBIF) as part of the 2017 Medicaid program that it plans to expand in 2018 to all payer programs. Resubmission at 59. If OneCare can distribute money from the VBIF based on its performance against payer program quality measures, 70% will go to primary care practices based on attribution and the remainder will go to other providers based on their percentage of total eligible expenditures. *Id.* at Sec. 3, Attach. C. OneCare states that this distribution recognizes that the preponderance of quality measures rely on primary care and that primary care providers are the cornerstone to its population health management strategy. *Id.* at 59. By 2019, OneCare intends to add a variable component to the

distribution formula to account for performance at a provider organization level. *Id.*; OneCare PowerPoint (July 13, 2017) at 38.

Basic OneCare PMPM Payments

31. OneCare plans to make basic payments of $3.25 PMPM to the practices of attributing providers, typically primary care providers, for each of their patients attributed to any OneCare program. The payments are intended to support OneCare's overall population health management and quality model by providing financial support for engaging in quality measurement, participating in quality improvement activities, working with Community Collaboratives, and undertaking similar activities. The payments will be in addition to any Blueprint for Health (Blueprint) payments a provider may receive. Resubmission at Sec. 4, Attach. D; Testimony of Todd Moore (July 13, 2017) at 149:24-150:15.

Complex Care Coordination Program Payments

32. OneCare implemented a complex care coordination program under the 2017 Medicare program that targets high- and very high-risk Medicaid patients. The program aims to mitigate spending on these populations through the delivery of more proactive and preventive care. Resubmission at 43. OneCare plans to expand this program in 2018 to include patients attributed under other payer programs. *Id.* at 44; Questions and Answers re: Resubmission at ¶ 18.

33. OneCare plans to make payments of $15.00 PMPM to primary care practices for the practices' attributed patients in the complex care coordination program, as well as to designated agencies, home health agencies, and area agencies on aging involved in these patients' care. Resubmission at Sec. 4, Attach. D. OneCare plans to make additional payments of $10.00 PMPM, as well as a one-time payment (expected to be $150), to the organization of whichever care team member is selected by a patient to be the "lead care coordinator," responsible for tasks such as leading the development of a shared care plan, coordinating communication amongst team members, planning care conferences, facilitating patient education and referrals, and monitoring milestones. *Id.*; OneCare PowerPoint (July 13, 2017) at 24. Finally, OneCare will make payments (expected to be $25,000 per year) to community program organizing entities to provide support for their work. Resubmission at Sec. 4, Attach. D.

Comprehensive Payment Reform (CPR) Pilot for Independent Primary Care

34. OneCare will implement a blended capitation pilot for primary care services in 2018. OneCare offered the program to independent practices with at least 500 attributed lives across all payer programs. The three practices that agreed to participate will receive monthly prospective payments to cover primary care services delivered to patients attributed by the practice. *Id.*; OneCare PowerPoint (Nov. 2, 2017) at 28.

Blueprint and SASH Funding

35. OneCare plans to continue Medicare SASH and Blueprint payments (CHT and primary care practice-level) statewide, in both "risk" and "non-risk" communities. In PY1 of the APM

Agreement, it will fund these payments at the 2017 Medicare levels plus an inflationary rate of 3.5%. Resubmission at Sec. 4, Attach. D. DVHA and BCBSVT will also continue to make payments, but not through OneCare.

RiseVT

36. RiseVT is a community-based primary prevention program. Piloted in St. Albans, the program emphasizes healthy lifestyles in, for example, schools and businesses, and is a major feature in OneCare's population health management model. OneCare plans to expand the program to other communities in 2018. *Id.*

Model of Care and Integration with the Blueprint for Health

37. OneCare employs a population health model that segments the attributed population into four quadrants based on their health status. OneCare runs claims and clinical data through a risk stratification algorithm, the John's Hopkins Adjusted Clinical Grouper, to evaluate the prospective risk of each patient. For patients that fall into the first two quadrants of risk, OneCare's focus is on maintaining health through preventive care and community-based wellness activities and optimizing health and self-management of chronic disease. While a relatively small percentage of the attributed population, patients that fall into the third and fourth quadrants often have one or more chronic conditions or mental health conditions and account for the majority of spending. OneCare seeks to better manage the health of this population through its complex care coordination program. *Id.* at 57-58; OneCare PowerPoint (July 13, 2017) at 20; Testimony of Sara Barry (July 13, 2017) at 157:20-160:31.

38. OneCare's complex care coordination program enables providers to work with patients to develop shared care plans. OneCare has included tools in the care plan development process to help providers identify social determinants of health that may be affecting a patient's health. For example, OneCare described how "Camden Cards" are used to help identify patients' goals and priorities, as well as obstacles to achieving these goals and potential areas for intervention or support (e.g., lack of transportation or housing, or substance use). OneCare PowerPoint (July 13, 2017) at 22; Testimony of Sara Barry (July 13, 2017) at 166:47-168:05.

39. OneCare uses Care Navigator, its care coordination software platform, to support cross-organization communication and coordination of care. ACO participants and collaborators can use Care Navigator to access patient-level information. OneCare plans to expand Care Navigator's functionality to incorporate event notification so that members of a patient's care team can receive timely notice of the patient's admissions and discharges and can then conduct outreach to the patient to ensure effective care transitions. Resubmission at 62. Care Navigator can also be customized to deliver reminders and trigger specific tasks for care team members and patients (e.g., sending a patient a reminder that it is time to fill a prescription). *Id.*

40. Over the past year, OneCare has worked with the Blueprint to coordinate activities and build on pre-existing Blueprint infrastructure. Examples of this coordination include evolution of Community Collaboratives in each HSA, co-leadership of statewide training sessions, and alignment of OneCare priorities and Blueprint HSA project management contracts. *Id.* at 62-63.

OneCare has also actively worked with the Blueprint and the Vermont Health Care Innovation Project to implement the Integrated Communities Care Management Learning Collaborative (ICCMLC). *Id.* at 57. The ICCMLC framework has evolved into OneCare's complex care coordination model. *Id.* at 63. The Blueprint and OneCare continue to collaborate on co-sponsoring care coordination trainings, facilitating community dialogue at "All Field Team" meetings, and developing plans to monitor and adjust the model and associated payment methodology. *Id.*

41. OneCare is promoting the use of registered nurses to expand the primary care workforce by involving them in the performance of the Medicare Wellness Visit, which frees up physicians and APP-level clinicians to manage other acute and chronically ill patients. *Id.* at 65.

42. OneCare has recently focused on a number of initiatives, including: 1) developing and implementing a controlling hypertension project in partnership with the Blueprint, the Vermont Department of Health, and other community partners; 2) collaborating with the Vermont Child Health Improvement Project to support 22 pediatric and family practices in improving pediatric quality measure results related to developmental screening and adolescent well care visits; 3) partnering with The Permanent Fund for Vermont's Children to explore opportunities to promote health for children and families through early care and education settings; 4) developing partnerships to investigate social determinants of health screening in primary care settings (e.g., adverse childhood events (ACES), food insecurity, and maternal depression); 5) providing training for primary care medical homes on effective panel management to identify sub-populations that could benefit from enhanced care planning; 6) organizing, evaluating, and obtaining feedback on current and proposed ACO quality measures to identify efficiencies and align priorities with gaps in care; and 7) facilitating the development and deployment of best practices for caring for people with congestive heart failure, reducing readmission rates, and reducing high emergency room utilization. *Id.* at 52.

43. OneCare implemented a waiver of prior authorization for a specific set of services under the 2017 Medicaid contract to reduce administrative burden on providers, while developing an analytic application to monitor utilization and identify any unwarranted variation in services. *Id.*

Initiatives to Address APM Agreement Population Health Goals

44. The APM Agreement establishes three overarching population health goals for the State: 1) increasing access to primary care, 2) reducing deaths caused by suicide and drug overdose, and 3) reducing the prevalence and morbidity of chronic disease. To support achievement of the goals, the APM Agreement also establishes a number of specific measures. APM Agreement at App. 1. OneCare described a current or planned strategy for each of these measures. Resubmission at Sec. 5, Attach. B.

45. Regarding the first goal, OneCare has worked under the 2017 Medicaid program to ensure each Medicaid beneficiary attributed to a specialist has an identified primary care provider. It plans to undertake similar efforts for other attributed populations as it expands to more risk-based contracts with specialist attribution in 2018. OneCare also identified Medicaid adolescents with well-care visits as a clinical priority area and is partnering with the VCHIP on a

quality improvement project to improve this pediatric measure. *Id.* As noted above, OneCare is piloting a capitated payment model for primary care services in 2018 that it hopes will enhance recruitment of primary care providers. Finally, OneCare's complex care coordination program and the payments that come with it should help primary care providers identify high- and very-high risk patients and allow them to provide these patients the extra time and attention they need.

46. Regarding the second goal, several HSAs within OneCare's network are exploring best practices to embed mental health and substance abuse services into primary care practices. OneCare plans to look into opportunities for data sharing with designated agencies and other community providers so it can incorporate social determinants of health data into its risk stratification process and improve its ability to identify high-risk/high-needs individuals. OneCare plans to continue discussions with State leadership on dissemination strategies for Screening, Brief Intervention, and Referral to Treatment, and is planning a "Grand Rounds" on mental health/suicide prevention that will be available to anyone in the OneCare network. Finally, OneCare is striving to educate providers on prescription drug monitoring rules and medication-assisted treatment (MAT) resources, and is promoting training to allow providers to become MAT providers. *Id.*; Testimony of Sara Barry (July 13, 2017) at 162:20-164:35.

47. Regarding the third goal, OneCare provides analytic tools through Care Navigator that enable providers to identify patients that have certain disease states, such as hypertension or COPD, and identify potential gaps in their care. OneCare is researching evidence-based tools and resources for patients with the goal of building a patient resource library on hypertension within Care Navigator. OneCare has been and will continue to work in partnership with the Vermont Department of Health to support the 3-4-50 campaign and is also supporting the expansion of RiseVT. Finally, OneCare plans to explore future education and quality improvement initiatives on pre-diabetes as part of its overall population health management strategy. Resubmission at Sec. 5, Attach. B; Testimony of Sara Barry (July 13, 2017) at 164:35-166:35.

Comments

48. The Board received four public comments on OneCare's FY18 budget. The Board also received comments from the HCA. Commenters generally expressed concern about the lack of finalized payer contracts, the addition of expenses to the system, the sufficiency of OneCare's investments in community-based services and primary care, and the shifting of risk to hospitals, as well as concerns about properly monitoring quality, access to care, and utilization of health care services. Some commenters were concerned that OneCare's performance in shared savings programs were indicative of future poor performance in programs modeled on the Medicare Next Generation ACO program.

CONCLUSIONS

OneCare bears the burden of justifying its proposed FY18 budget. 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. GMCB Rule 5.000, § 5.405(a), (b).

I. APM Agreement

A. Rates

We set the trend rate that will be used to calculate the benchmark for the 2018 Medicare program at 3.5%. Findings at ¶ 10. This should permit OneCare to make investments in PY1 of the APM Agreement that may be essential to achieving savings in later years. Furthermore, while 3.5% is higher than the projected national Medicare growth rate for 2018, it is lower than preliminary data suggests may be the true rate of growth for OneCare-aligned beneficiaries in 2018. *Id.* Thus, 3.5% may represent an aggressive spending target for OneCare.

We approve a 1.5% Medicaid trend rate, excluding Medicaid pricing changes, or a 6.1% rate including those changes. The rate falls within the range Wakely will certify, which has been reviewed by L&E and found to be reasonable. Because pricing changes can be excluded from the calculation of all-payer TCOC per beneficiary growth, the rate is below the APM Agreement's all-payer CAGR target of 3.5%. *Id.* at ¶ 12.

Finally, we approve a combined annual trend rate for the 2018 commercial program of between 3.5% and 3.7%, consistent with the approved FY18 hospital budgets and the utilization trend we established in BCBSVT's 2018 QHP premium rate case. *Id.* at ¶¶ 13-14. We do not believe a rate in this range will cause the overall rate for Medicare, Medicaid, and commercial to exceed the all-payer CAGR target of 3.5%. *See id.* at ¶ 9.

B. Alignment and Scale

Vermont must ensure that the programs offered in 2018 by Medicaid and by commercial and self-insured plans reasonably align with the 2018 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. APM Agreement at § 6.f. DVHA has sought to align the 2018 Medicaid program with the Medicare and commercial programs. Findings at ¶ 18. Because the commercial and self-insured programs are new and their terms are not yet final, we will require OneCare to report to the Board on how these programs align with the Medicare program and explain the rationale for any differences.

The APM Agreement also includes targets for the percentage of Medicare and all-payer beneficiaries aligned to a "Scale Target ACO Initiative." APM Agreement at § 6.a. As described in its budget filings, the 2018 payer programs appear to qualify as Scale Target ACO Initiatives. However, we will require OneCare to demonstrate that this is indeed the case no later than the end of the first quarter of 2018, after the programs are finalized and the contracts executed.

Overall, OneCare's payment model has a strong emphasis on redirecting dollars from hospitals to primary care providers, which should act as a financial incentive for these providers to join OneCare's network. Findings at ¶¶ 20, 29-36. Because scale is calculated based on attribution, which is done largely through attracting primary care providers into the program, this emphasis should build scale over time. It is important, however, to ensure that OneCare can accommodate and manage the growth; otherwise, the care management model discussed below is less likely to be successful.

C. Population Health Goals

The APM Agreement establishes three statewide population health goals and, to support achievement of these goals, a number of measures. *Id.* at ¶ 44. OneCare described a current or planned strategy for each of these measures. *Id.* at ¶¶ 45-47. We note that OneCare will also be accountable for meeting quality measures under each of its payer contracts and these measures should reasonably align with the APM measures. We also note that OneCare has a solid track record in the shared savings programs of meeting these payer measures. *Id.* at ¶ 2. As part of our ongoing monitoring, we will require OneCare to continue to provide us with information on its current or planned initiatives to address the APM measures and will review payer-ACO and ACO-provider quality measures for alignment and consistency with the APM measures.

While we commend OneCare for the work it has done and plans to do on the APM measures, we believe OneCare should work to better understand its network's capacity for providing substance use disorder treatment. We will therefore require OneCare to report on the number of MAT providers in its network and its network's capacity for substance use disorder treatment at all levels of care.

II. Statutory Criteria

A. Ability to Assume Financial Risk

We must approve a maximum amount of risk that OneCare can assume for 2018 and ensure that OneCare has in place a financial guarantee sufficient to cover these potential losses. GMCB Rule 5.000, § 5.403(b); 18 V.S.A. § 9382(a)(16). We cannot approve an actual dollar amount because the benchmarks will not be calculated until after this Order is issued and will shift over the course of year as attribution changes.[8] Therefore, we approve the risk-sharing arrangements OneCare proposed in its budget, which means that OneCare's maximum risk will be the sum of 4% of the Medicare benchmark, 3% of the Medicaid benchmark, and 3% of the commercial benchmark. Findings at ¶ 16.

If OneCare implements the "delegated risk model" described in its filings and presentations, it should be able cover its maximum potential losses, so long as hospitals cover their MRLs. *Id.* at ¶ 22. The fixed prospective payment system for hospitals will reduce the likelihood that OneCare will be responsible for losses approaching its maximum risk because it will essentially lock in the majority of OneCare's overall expected spending. If FFS spending exceeds expectations and OneCare is responsible for repaying losses, hospitals will be obligated to contribute funds to cover those losses, up to their MRLs. *Id.* at ¶¶ 21-23.

OneCare did not independently analyze whether hospitals can afford the potential losses they will assume under the delegated risk model. However, it provided each risk-bearing hospital with an estimate of their MRL so each hospital could determine whether participation would jeopardize its solvency. *Id.* at ¶ 24. Board staff have confirmed that these risk-bearing hospitals

[8] For example, under the 2017 Medicaid program, the number of attributed lives has dropped from 29,102 to 24,038 (82.6%). GMCB PowerPoint (Dec. 14, 2017) at 25.

understand their level of risk and have sufficient cash on hand to cover their maximum risk for 2018. *Id.* at ¶ 25. Through the hospital budget process, we will monitor the ability of these hospitals, on an ongoing basis, to take on this level of risk long-term.

We will require OneCare to provide documentation for some of the representations it has made in its filings. For example, OneCare must provide letters of credit from its founders evidencing their commitment to cover the top half of the risk being delegated to Brattleboro Memorial Hospital and Springfield Hospital in 2018 and must provide us with contracts that obligate each of the risk-bearing hospitals to share risk in the manner described in the budget filings. To help mitigate risk, OneCare must also establish reserves of $1.1 million by the midpoint of FY18 and $2.2 million by the end of FY18.

While OneCare expressed interest in purchasing reinsurance at the ACO level and budgeted $1.5 million for a reinsurance premium expense, it has been unable to provide us with a quote and discussions on the availability and potential parameters of a policy are still ongoing. *Id.* at ¶ 26. We will not require OneCare to purchase reinsurance for 2018. However, if OneCare can purchase a policy and decides to do so, we need to reevaluate the reserve requirement we are imposing.[9] We will therefore require OneCare to promptly notify us regarding its intent with respect to reinsurance and obtain our approval prior to purchasing a policy.

B. Information regarding utilization of services and the effects of care models on appropriate utilization, the ACO's efforts to prevent duplication of services, and the ACO's integration of efforts with the Blueprint for Health and its regional care collaboratives.

We have reviewed and considered OneCare's performance in the Medicare, Medicaid, and commercial shared savings programs in relation to state and national performance. *See id.* at ¶ 2. While OneCare shared in savings in only one year of one program, this is not necessarily indicative of what its performance will be in 2018. The design of the Commercial Exchange Shared Savings Program was flawed and its results are confounded by the program coinciding with the first year of the merged individual and small group markets in Vermont and an influx of previously uninsured as a result of the Affordable Care Act. OneCare's financial performance in the Medicare Shared Savings was within the norm for most shared savings programs across the country. Given the national results, it is feasible that OneCare's failure to achieve savings is due in part to the weak financial incentives provided for in shared savings programs. *See id.* Nationally, performance has been better in two-sided risk programs and preliminary data for 2017 suggest that OneCare's actual spending in the 2017 Medicaid program, a two-sided risk program, has been fairly consistent with expected spending. *Id.* at ¶¶ 2-3.

OneCare has developed a comprehensive model of care designed to achieve quality, patient experience, and cost goals through increased coordination and collaboration across the care spectrum. OneCare also described a history of close collaboration and integration with the Blueprint and existing Community Collaboratives, which can be expected to prevent duplication with the existing Blueprint networks. *Id.* at ¶ 40.

[9] If OneCare decides not to purchase reinsurance, our expectation is that it would use the budgeted reinsurance premium to partially fund the reserves, and the remaining $700,000 would be funded by hospitals.

OneCare plans to expand the complex care coordination program it developed for the 2017 Medicaid program to all payers in 2018. Findings at ¶ 32. This robust program uses risk stratification to identify the most complex patients and meet their needs through coordinated efforts at the primary care and community-based provider levels. Increased coordination among local providers under this program, enabled by web-based care coordination software, should help prevent duplication of services.

We note that OneCare's approach to care management and clinical prioritization is decentralized and relies heavily on the Blueprint Community Collaboratives. If this decentralized model is ineffective in supporting the achievement of TCOC and quality targets, OneCare may need to consider refining the approach or seeking a different approach in the future.

C. The extent to which the ACO provides incentives for systemic health care investments to strengthen primary care (e.g., recruiting additional primary care providers, providing resources to expand capacity in existing practices, and reducing the administrative burden of reporting requirements for providers while balancing the need to have sufficient measures).

OneCare plans to redirect money from AIPBP hospital payments to primary care practices. It will offer a basic payment of $3.25 PMPM to all "attributing providers," which are typically primary care providers, and payments of $15.00 PMPM to primary care providers for OneCare attributed patients in the complex care coordination program. *Id.* at ¶¶ 20, 31, 33. These payments, which will augment existing Blueprint payments, appear likely to attract new primary care providers to OneCare's network and will provide new financial support to primary care practices. OneCare is also offering certain independent primary care practices a capitation payment model for primary care services, which may appeal to some larger practices. *Id.* at ¶ 34. Finally, for the 2018 performance year, primary care providers will receive 70% of any distributions OneCare is able to make from the VBIF. *Id.* at ¶ 30.

OneCare described several strategies to expand capacity in existing primary care practices. First, it noted that because hospital-owned primary care practices will be capitated for their attributed lives, they will have more flexibility to use non-face-to-face visit models, including telehealth, patient portal, and phone calls. *Id.* at ¶ 20. It also noted the availability of clinical tools like Care Navigator. *Id.* at ¶ 39. Finally, it explained that it is promoting the use of registered nurses to expand the primary care workforce by involving them in the performance of the Medicare Wellness Visit, which frees up physicians and APP-level clinicians to manage other acute and chronically ill patients. *Id.* at ¶ 41.

OneCare also described actions that can be expected to reduce administrative burdens on primary care providers, including the waiver of some prior authorization and utilization management requirements under the 2017 Medicaid Program. *Id.* at ¶ 43. In addition, OneCare stated that it has prioritized reducing the burdens of quality measure reporting by emphasizing claims-based measures that do not require labor-intensive data gathering from medical records.

D. The extent to which the ACO provides incentives for systemic integration of community-based providers in its care model or investments to expand capacity in existing community-based providers, in order to promote seamless coordination of care across the care continuum.

As explained above, OneCare has developed a complex care coordination program to treat its most complex patients through a coordinated effort at the primary care and community-based provider levels, including a web-based platform for care coordination and analytics. *Id.* at ¶¶ 32, 37-39. The program includes financial support to community-based providers for their work in caring for these high-needs patients. *Id.* at ¶ 33. The program and the payments that come with it appear to have a strong potential to engage and integrate community-based providers in OneCare's model of care and appears to rely on attracting existing community-based providers into the model, rather than providing an incentive for hospitals to hire their own providers. Again, the funding for this financial support is redirected from hospitals to community-based providers. *Id.* at ¶ 20.

E. The extent to which the ACO provides incentives for preventing and addressing impacts of trauma and for investments in social determinants of health (e.g., developing support capacities that prevent hospital admissions and readmissions, reduce length of hospital stays, improve population health outcomes, reward healthy lifestyle choices, and improve the solvency of and address the financial risk to community-based providers).

OneCare's investment strategy for addressing social determinants of health and the impacts of trauma were not clearly articulated, although it did describe a number of activities that could address these issues. For example, OneCare is making substantial investments in its complex care coordination program. *Id.* at ¶ 33. Under this program, providers work with complex patients to develop and execute a shared care plan, which may address non-medical barriers to health like lack of housing or transportation. *Id.* at ¶ 38. OneCare is also making investments to expand RiseVT as part of its strategy to support prevention and healthy living. *Id.* at ¶ 36. Finally, OneCare is developing partnerships to investigate social determinants of health screenings in primary care settings (e.g., ACES, food insecurity, and maternal depression) and is partnering with The Permanent Fund for Vermont's Children to investigate opportunities to promote health for children and families through early care and education settings. *Id.* at ¶ 42.

With respect to developing support capacities that address the financial risk to community-based providers, we note that hospitals bear all the risk under OneCare's delegated risk model and that community-based providers will receive payments for engaging in quality measurement, participating in quality improvement activities, working with their Community Collaboratives, and engaging in care coordination activities. *Id.* at ¶¶ 21-22, 31, 33. OneCare will also continue to fund Medicare SASH and Blueprint payments in risk and non-risk communities statewide. *Id.* at ¶ 35. Finally, OneCare described a primary care capitation pilot that it hopes can serve as an attractive funding model for independent primary care practices. *Id.* at ¶ 34.

F. The effect, if any, of Medicaid reimbursement rates on other payers' rates.

Increased Medicaid reimbursement rates account for much of the 6.1% Medicaid trend. After adjusting for these rate increases, which may be excluded from the calculation of all-payer TCOC per beneficiary growth under the APM Agreement, the rate is 1.5%. *Id.* at ¶ 12. We will seek to examine the degree to which the Medicaid rate provided to OneCare maintains, lessens, or widens the differential with other payers participating in the All-Payer ACO Model for the same services.

G. Information on the ACO's administrative costs.

OneCare's projected administrative expenses are reasonable and consistent with available benchmarks. *Id.* at ¶ 28. We will monitor OneCare's administrative expenses throughout the year to ensure they remain close to the budgeted amounts. We will also monitor the administrative expense ratio year-over-year and compared to national data. Finally, we will require that administrative expenses be appropriately allocated between Vermont and other states.

While we believe the All-Payer ACO Model holds great promise for controlling health care cost growth and improving quality of care in Vermont, we understand the concern expressed by some that ACOs add another layer of complexity and expense to an already complicated and expensive health care payment system. ACOs should provide a net benefit to the system and we will monitor OneCare's administrative expenses to ensure they are less than the total health care savings generated through the All-Payer ACO Model.

H. The extent to which the ACO makes its costs transparent and understandable.

OneCare has been transparent about the expected costs of its programs and the administration thereof. OneCare has estimated the amounts each hospital will receive under its fixed prospective payment model, as well as each hospital's projected MRL. It has also described the payments it plans to make under its population health management program. Finally, it has provided a detailed breakdown of its proposed administrative budget. Representatives from OneCare have answered questions in several public meetings regarding this information and the Board has posted all submissions on its website. We note, however, that OneCare has not described its primary care capitation pilot in as much detail as its other programs. We will require OneCare to submit more information regarding this pilot program, including a description of how the capitated payments for primary care services under the pilot compare to payments hospitals make to primary care providers not participating in the pilot.

I. Public comment on all aspects of the ACO's costs and use and on the ACO's proposed budget.

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 HCA expressed concern about the adequacy of OneCare's grievance policy and the fact that it is currently limited to Medicaid beneficiaries. To address this concern, we will require OneCare to consult with the HCA in establishing a process that is consistent with Rule 5.000 and to submit a

final policy that applies to all aligned beneficiaries. Another commenter noted the need for a plan to address the provider pay disparity. As explained above, we will require OneCare to provide a report that describes how the capitated payments under its primary care capitation pilot compare to payments hospitals make to primary care providers not participating in the pilot. We will also require that OneCare include in the report a discussion of the degree to which the pilot reduces administrative burdens for primary care providers. Other issues raised by commenters can be addressed through the certification process, through ongoing monitoring and reporting, or were identified as considerations for future ACO budget reviews.

J. The goals and recommendations of the Health Resource Allocation Plan and the expenditure analyses for the previous year and the year under review.

The Health Resource Allocation Plan or HRAP was last updated in 2009 and the recommendations in the HRAP were not relevant in OneCare's budget planning. We are currently reviewing the HRAP and how it can be used more effectively in our regulatory processes. In the future, we may want to better understand how ACOs are using the HRAP in their planning, but for this review we did not find it relevant.

K. The character, competence, fiscal responsibility, and soundness of the ACO and its principals, and any reports from professional review organizations.

We believe this consideration weighs in favor of approving OneCare's budget. OneCare is governed by an 18-member Board that includes experienced executives and clinicians selected by participating providers. Each member of OneCare's executive team has been at the ACO for at least four years and has relevant qualifications. *Id.* at ¶ 5. No legal actions have been taken against OneCare, its leadership team, or its Board of Managers. *Id.* There are no reports from professional review organizations for us to consider.

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 FY18 budget on the terms, and subject to the conditions, set forth below:

A. The trend rates used to calculate OneCare's 2018 benchmarks are approved at 3.5% for Medicare; 3.5% - 3.7% for commercial; and 6.1% for Medicaid (1.5% after All-payer TCOC calculation exclusions). OneCare must submit to the Board an updated P&L after attribution has been finalized and the benchmarks for all payer programs have been calculated.

B. The maximum amount of risk OneCare may assume for 2018 is the sum of the following: 4% of the Medicare benchmark, 3% of the Medicaid benchmark, and 3% of the commercial benchmark. OneCare must request and receive from the Board an adjustment to its budget prior to executing a contract that would cause it to exceed these risk levels.

C. OneCare must submit each payer contract, Medicare, Medicaid, commercial, to the Board promptly after it is executed.

D. No later than the end of the first quarter of 2018, OneCare must submit a written report to the Board demonstrating to the Board's satisfaction that the BCBSVT and UVMMC programs qualify as Scale Target ACO Initiatives under section 6.b. of the APM Agreement.

E. No later than the end of the first quarter of 2018, OneCare must submit a report to the Board that describes how its contracts with BCBSVT and UVMMC align with the Medicare contract in the areas of total cost of care, attribution and payment mechanisms, patient protections, provider reimbursement strategies, and quality measures, and that explains the rationale for any differences in these areas.

F. OneCare must implement the delegated risk model it described in its budget proposal, except that it must:

1. provide the Board by January 15, 2018, contracts that obligate each of the risk-bearing hospitals to OneCare's risk sharing policy;
2. provide the Board by January 15, 2018, a policy approved by OneCare's Board of Managers which delegates risk to the risk-bearing hospitals in the manner described in OneCare's budget filings;
3. provide the Board with irrevocable letters of credit from UVMMC and DH-H committing to cover risk-share for Brattleboro Memorial Hospital and Springfield Hospital;
4. establish reserves of $1.1 million by July 1, 2018 and $2.2 million by December 31, 2018;
5. seek and obtain approval from the Board prior to using reserves; and
6. notify the Board promptly regarding its intent to purchase aggregate total cost of care reinsurance for 2018 and obtain the Board's approval prior to purchasing a policy.

G. OneCare must fund SASH and Blueprint for Health payments (CHT and PCP) at 2017 Medicare levels plus an inflationary rate of 3.5% in both risk and non-risk communities, as described in the proposed budget.

H. OneCare must fund its other population health management and payment reform programs—Value-Based Incentive Fund, Basic OneCare PPM, Complex Care Coordination Program, PCP Comprehensive Payment Reform Pilot, and RiseVT—at no less than 3.1% of its overall budget. The Board will monitor this ratio throughout the year to ensure it does not decrease below 3.1%. If the percentage decreases, OneCare must promptly alert the Board.

I. No later than the end of the second quarter of 2018, OneCare must submit a payment differential report that describes its Comprehensive Payment Reform Pilot's payment methodology and analyzes how the capitated payments for primary care services under its program compare to the payments hospitals make to primary care providers that are not participating in the pilot. The report must also address how the Comprehensive Payment Reform pilot reduces administrative burden for primary care providers. At the end of the fourth quarter of 2018, OneCare must submit a quality report that includes a description of the measurement process and preliminary quality results comparing the outcomes of the Comprehensive Payment Reform Pilot cohort with the non-pilot cohort. A final report of

quality results must be submitted in 2019 at a time to be determined by Board staff in consultation with OneCare.

J. No later than the end of the second quarter of 2018, OneCare must report to the Board on the number of Medication Assisted Treatment providers in its network and update the Board on its network's capacity for substance use disorder treatment at all levels of care (including preventive care).

K. OneCare must ensure that its administrative expenses are appropriately allocated by state (i.e., between VT and NY).

L. OneCare's administrative expense ratio must be consistent with its proposed budget, as modified by this Order. If the expense ratio increases by more than one percent (1%), OneCare must promptly notify the Board.

M. OneCare's administrative expenses should be less than the health care savings generated through the All-Payer Accountable Care Organization Model.

N. OneCare must consult with the Office of the Health Care Advocate to establish a grievance and appeals process consistent with Rule 5.000 and submit to the Board a final policy that applies to all aligned beneficiaries.

O. In consultation with GMCB staff, OneCare must identify a pathway by which potential savings from this model will be returned to participating commercial premium rate payers, initially focusing on those individuals with qualified health plan (QHP) coverage through Vermont Health Connect.

P. 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.

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

R. 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: January 3, 2018 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: January 3, 2018

Attest: s/ Erin Collier
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).