VERMONT
GREEN MOUNTAIN CARE BOARD

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MEMORANDUM

TO: Vicki Loner, CEO; Sara Barry, COO; Tom Borys, VP of Finance; Joan Zipko, Director ACO Operations

FROM: Sarah Kinsler, Director of Health Systems Policy; Marisa Melamed, Associate Director Health Systems Policy

RE: Round 1 Questions to OneCare Vermont ACO on the FY 2023 Budget Submission

DATE: October 24, 2022

Green Mountain Care Board staff have prepared the following questions in collaboration with the Office of the Health Care Advocate in response to OneCare's FY 2023 budget submitted September 30, 2022. The Office of the Health Care Advocate may submit additional questions under separate cover.

Please submit written responses to the questions by November 4, 2022. If you need more time to prepare any of the responses, please contact us to discuss the timing by October 28, 2022. We may permit responses to be submitted in more than one batch to allow us to get responses as soon as possible.

Questions marked with a * may be deferred to a verbal response in OneCare's Budget Hearing on November 9, 2022.

Responses are to be submitted to the GMCB ACO oversight team, copying the Office of the Health Care Advocate, at the following email addresses: Sarah.Kinsler@vermont.gov; Marisa.Melamed@vermont.gov; Michele.Degree@vermont.gov; Michelle.Sawyer@vermont.gov; Jennifer.DaPolito@vermont.gov; Russ.McCracken@vermont.gov; Flora.Pagan@vermont.gov; Matthew.Sutter@vermont.gov; Sarah.Lindberg@vermont.gov; hcapolicystaff@vtlegalaid.org

Questions:

Section 1: ACO Budget Executive Session

1. ***Section 1, Question 1a, pg. 5**: OneCare's current strategic plan runs from 2021 through 2023. Many goals and strategies discussed in the submission are long-term. When does the ACO expect to develop its strategic plan for beyond 2023?

2. **Section 1, Question 1, pg. 5**: Is the 90% of Vermont primary care within the OneCare network a OneCare calculated figure, or are you citing a GMCB or other source for this figure? If GMCB,

that figure is inaccurate and has been updated in the most recent scale report (PY4 2021 Scale Report, p. 4). Please use the updated figure if you are using that figure in future materials.

3. ***Section 1, Question 1a, pg.6**: OneCare's narrative states that a longer-term tactic in achieving payment reform goals to evolve commercial contracts away from FFS include, "developing a roadmap to evolve the commercial payer strategy…" Developing a "roadmap" (i.e., a plan, milestones, strategies) has been in discussion for several years, including in the 2020 All-Payer Model Implementation Improvement Plan and the FY 2021 OneCare Budget Order. Why has this not been developed yet and what is the timeframe?

4. **Section 1, Question 1b, pg.7**: The total starting attribution is budgeted at 296,658 lives. Using the table below, please break out the starting attribution assumptions and the average attribution assumptions used to develop the budget, by payer program (Medicare, Medicaid traditional/expanded, BCBSVT QHP, BCBSVT Primary risk/non-risk, MVP QHP).

Payer Program	**FY23 Starting Attribution Estimated** *Used to Measure APM Scale*	**FY23 Average Attribution Estimated** *Should align with data provided in Tabs 4.1, 4.3, and 5.1*
Medicare		
Medicaid – Traditional		
Medicaid – Expanded		
BCBSVT QHP		
BCBSVT Primary – Risk		
BCBSVT Primary – Non-Risk		
MVP QHP		
TOTAL		

5. **Section 1, Question 1b, pg.7**: What do you project the impact of the growth of Medicare Advantage enrollment will have on the Medicare ACO program in areas such as acuity and utilization?

6. **Section 1, Question 1d, pg. 7**: The second sentence states, "The major difference between the two is *the entity-level budget reflects all revenue* [emphasis added], whereas the true GAAP presentation excludes all pass-through revenue for which OneCare is deemed to be acting in an agency capacity, e.g., TCOC/health care spend." The GMCB considers the GAAP presentation to be the "*entity-level*" budget presentation. The non-GAAP presentation that includes the pass-through is referred to as the "*Full-Accountability*" budget. Please clarify the italicized phrase. Do you mean "*the full-accountability budget reflects all revenue"*?

Section 2: ACO Provider Contracts

7. **Section 2, Question 4, pg. 15**: Do you have any plans to implement a fixed payment or risk model for specialists (e.g., such as a shadow bundles program)?

Section 3: ACO Payer Contracts

8. **Section 3, Question 2d, pg. 21**: OneCare states that it "remains focused on health equity and coordination of care, prevention and chronic condition management, and the use of data to identify opportunities for improved care. These competing priorities and the ensuing provider-payer tensions make it challenging to negotiate annual contracts formulated to grow scale." Please elaborate on why these priorities appear to be "competing."

9. ***Section 3, Question 2e, pg. 21**: Narrative states that OneCare views the BCBSVT Primary Non-Risk cohort as an "on-ramp" to move employer groups to risk-based arrangements. Has this effort been successful? How many employer groups have transitioned from non-risk to risk?

10. **Section 3, Question 3b, pg. 22**: OneCare describes upcoming Medicaid redeterminations as a challenge in managing the DVHA contract and fixed payments in FY23. What is your assumption about average attribution in FY23 for the purpose of the submitted budget and how did you arrive at your assumption? If there are financial risks associated with likely redeterminations, what strategies will OneCare employ to mitigate this challenge and associated risk?

Section 4: Total Cost of Care

11. **Section 4, Question 2b, pg. 27 and Appendix 4.1**: Describe the adjustment factors, by payer program if necessary, used for calculating the final settlement result, i.e., what is the difference between the "Amount Over/(Under) Target" and the "Settlement" cells in Appendix 4.1.

Section 5: ACO Network Programs and Risk Arrangement Policies

12. **Section 5, Question 2a, pg. 33**: Narrative states, "OneCare has faced longstanding challenges in the commercial target-setting space. A reasonable, industry-standard, actuarially-sound process for modeling fair total cost of care targets is a non-negotiable prerequisite for taking more downside risk with commercial payers." OneCare's current commercial targets are actuarially certified; if there is disagreement between the parties about the reasonableness of these targets, please describe. In addition, commercial ACO programs are fairly common nationally. What can we learn from the national experience about setting fair targets? Has OneCare explored industry standard for how this is done?

13. **Section 5**: What are the potential advantages and challenges OneCare sees in extending a model like the Comprehensive Payment Reform (CPR) program to hospitals (i.e., unreconciled, multi-payer fixed payments)?

14. **Section 5, Question 2c, pg. 33**: What feedback have CPR practices offered on potential methodology change to tie CPR payments to total cost of care rather than FFS equivalent?

15. **Section 5**: Is the new PHM payment model described in Section 5 expected to result in different payment amounts for some practices or provider types compared to the previous PHM payment streams?

Section 6: ACO Budget

16. **Section 6, pg. 44**: How does OneCare plan to appropriately protect network data in the new PHM Platform arrangement with UVMHN? Please provide OneCare's final agreement with UVMHN regarding these shared services within 5 business days of execution.

17. **Section 6, Appendix 6.2 Income Statement with Accountability (Adaptive A2)**: Lines 102, 107-110 represent the FY23 budgeted Blueprint for Health and SASH funding that comes through OneCare from Medicare. Are the CHT and SASH funding lines meant to be broken out by risk communities and non-risk communities?

18. **Section 6**: Are there any updates or changes to information on actions, investigations, or findings involving the ACO or its agents or employees (Rule 5.403(a)(6)) from what has been previously provided to the GMCB?

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

19. **Section 7, Question 1a, pg. 49**: There appear to be several programs that have been eliminated between 2022 and 2023 or are expected to be discontinued in 2023. Please explain the rationale for the following changes in the model: reduction of DULCE funding/elimination of the program; reduction of Innovation Grant funding/lack of new initiatives; elimination of Chronic Kidney Disease program; and the elimination of the Mental Health Initiatives program.

20. **Section 7, Question 1a, pg. 49**: In the FY22 budget narrative, it was explained that the RiseVT program would be funded through the first half of 2022. The organizational chart provided to the GMCB staff in August 2022 shows the elimination of the Director position for this program, but two RiseVT positions remain under the Director of Public Affairs. What is the plan for these positions in FY23?

21. **Section 7, Question 2, pg. 58**: How are target rates set, by clinical committee? Why do the rates differ from what is set in the APM agreement for measures that are consistent?

22. **Section 7, Question 3, pg. 61**: Can you provide a specific description of the HSA coaching/consulting program? Who is involved in this effort at the HSA level, and how are participants selected?

23. **Section 7, Appendix 7.3**: Is the "Specialist Program" described on row 14 of Tab 7.3 the same as the "Specialist Funding" on row 123 of tab A2 of the Adaptive sheets? If not, please describe the Specialist Funding.

24. **Section 7, Appendix 7.5**: Please give examples of types of providers that might be included in the "Other" column. Break out these types into additional columns if possible.

Section 8: Evaluation and Performance Benchmarking

25. ***Section 8, Question 1, pg. 70**: What actions are planned in 2023 to address the top 2-3 concerns voiced in the provider survey?

26. **Section 8, Question 5, pg. 74-75**: Is OneCare able to discuss the ACO specific KPI measures identified by the UVM College of Medicine? What are the identified KPIs?

27. **Section 8**: When analyzing outcomes of OneCare's programs, do you have a method of determining causality? For example, if a specific quality measure in the PHM program improves, how are you able to determine if the program is the reason for this improvement? Do you use

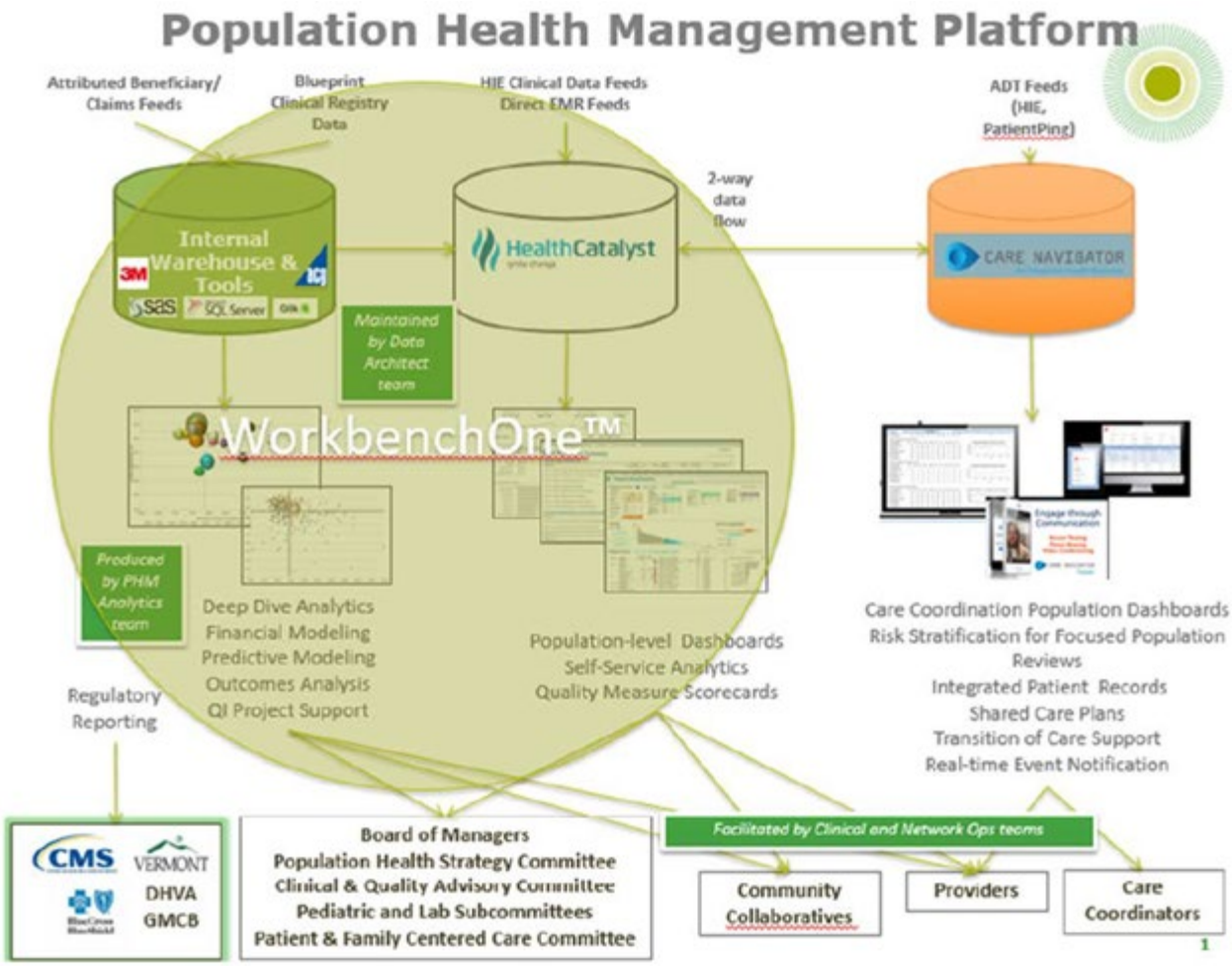
methods such as difference-in-difference modeling, causal regression models, natural experiment, etc.?

General

28. Beginning with the 2018 Participation Agreement, OneCare elected to utilize several Medicare waivers – notably the SNF 3-day and Telehealth waivers. Does OneCare track or trend rates of utilization of these waivers over time? If yes, please share those results.

Follow-up Certification Question

29. **5.210**: Given that the ACO is undergoing significant changes in its health information technology infrastructure in 2023, please provide verification that the planned information systems fulfill the requirements of GMCB Rule 5.000 § 5.210. If available, please provide an updated version of the 2019 visual below, or another illustrative diagram describing OneCare's PHM platform. If necessary, include a narrative description.



Source: OCV FY2019 Budget Submission, pg. 32

Questions regarding confidential material:

1. **Section 3, Question 2, pg. 19**: [redacted]
2. **Section 5, Appendix 5.1 Risk Payer RBE**: [redacted]
3. **Appendix 3.1**: [redacted]

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HCA Pre-Hearing Questions re: OneCare Vermont FY2023 Budget Submission

1. OneCare states that "the most significant change for 2023 is the integration of the previous population health management, care coordination, and VBIF payments into one stream of payments consisting of base plus incentive components that are tied to specific accountabilities." After this statement, OneCare elaborates on the base expectation for care coordination and that accountability measures were researched and discussed by stakeholders and committees to ensure buy-in and focus on areas of need. Please describe the meaning of the statement of the "base expectation" for care coordination and detail the "specific accountabilities" that incentive programs are tied to. (Narrative, 8).
2. OneCare states that "SVHC shared data and improvements on four quality measures, including increasing hypertension management rates from 70% to 76% within Q1 2022 and improving diabetes A1c>9, from 50% to 35% (lower better) between January to April 2022 due to the activities spurred by OneCare's programs." How are these quality measures reported/captured? What steps, if any, were taken to connect specific interventions and/or provider efforts to observed changes in the measures? (Narrative, 38).
3. OneCare observed that the "Burlington HSA has a consistently lower TCOC than the payer-adjusted network comparison, and improvement in inpatient admissions in relation to the network, adjusted by payer mix. The predicted increase in inpatient admissions rate from May 2021 to May 2022 was 7.94% and the Burlington HSA successfully limited it to 1.21%." Please provide evidence to support the implied assertion that OneCare's activities in the HSA caused the observed lower TCOC. (Narrative, 39).
4. It appears that Care Navigator continues to be phased out of OneCare's care coordination activities. Please provide one or more years of Care Navigator usage statistics from when the platform was in operation. Please provide the amount spent on CareNavigator related to its design, implementation, usage, and maintenance. If OneCare is unable to provide an exact figure, please provide an estimate. (Narrative, 66).
5. OneCare states that decommissioning Care Navigator "will result in more clearly focused population interventions and effective panel management which will, in turn, result in improved outcomes within the quadruple aim." Describe how moving away from Care Navigator results in more focused population intervention and effective panel management. (Narrative, 66).
6. "OneCare's goal for 2023 is to demonstrate statistically significant improvement (at the ACO-level) for all measures included in its PHM accountability policies and to ensure health equity permeates throughout organizational efforts." What methods will be used to assess potential causality, if any? (e.g., Difference-in-difference modeling, causal regression models, natural experiment, etc.) (Narrative, 52).

7. Please further describe what OneCare's collaboration with the Blueprint entails. The collaboration is referenced, in general terms, on page 55 of the Narrative.
8. Please detail the method used to create "social risk heat maps" and provide an example "heat map." (Narrative, 57).
9. OneCare states it advances its focus on health equity through "robust measurement" and "thoughtful design and evaluation." Please further describe what such measurement and design and evaluation entails including the various elements and weightings used to construct indices for the five domains. (Narrative, 57).