STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

FY21 ACCOUNTABLE CARE ORGANIZATION BUDGET ORDER

In re:	OneCare Vermont Accountable Care Organization, LLC Fiscal Year 2021	)))
		) Docket No. 20-001-A

INTRODUCTION

The Green Mountain Care Board (GMCB or Board) is charged with reviewing, modifying, and approving the budgets of accountable care organizations (ACOs). 18 V.S.A. § 9382(b). Fiscal Year 2021 (FY21) is the fourth year that ACO budgets are subject to Board review. Below, we describe the relevant legal framework, outline the criteria that the Board considered during its review, and present specific Findings and Conclusions in support of our Order establishing an FY21 budget for OneCare Vermont Accountable Care Organization, LLC (OneCare).

LEGAL FRAMEWORK

In its review of an ACO's budget, the Board must consider statutory factors that generally fall into the following categories:

- Historic and future expenditures and the effects of care models on utilization, including the provision of innovative services;
- The ACO's efforts to strengthen and provide resources to primary care, address social determinants of health and the impacts of childhood trauma, integrate community providers, improve care coordination, and reduce duplication of services in partnership with the Blueprint for Health;
- Health resource allocation priorities;
- Transparency of the ACO's costs;
- Effects of Medicaid reimbursement on other payers;
- Solvency and ability to assume financial risk;
- Administrative costs;
- The character, competence, fiscal responsibility and soundness of the ACO and its leaders; and
- The Office of the Health Care Advocate's (HCA) feedback and public comment.

See 18 V.S.A. § 9382(b)(1). In addition to these statutory criteria, the Board will consider the requirements of the Vermont All-Payer Accountable Care Organization Model Agreement (APM

Agreement) between the State of Vermont and the Centers for Medicare & Medicaid Services (CMS), any benchmarks established in the Board's ACO budget guidance, and the elements of the ACO's payer programs. GMCB Rule 5.000, § 5.405(b).

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

- **Total Cost of Care (TCOC) Growth Targets.** The State is responsible for limiting per person spending growth over the five performance years of the agreement.
    - The target for Medicare TCOC per Beneficiary Growth is a compounding rate that is at least 0.2% below projected national Medicare growth.
    - The target for All-Payer TCOC per Beneficiary Growth is a compounding rate of 3.5% or less over the five performance years of the APM Agreement.
- **Statewide Health Outcomes and Quality of Care Targets.** The State is responsible for meeting a series of targets tied to three overarching population health goals:
    - Improving access to primary care;
    - Reducing deaths due to suicide and drug overdose; and
    - Reducing the prevalence and morbidity of chronic disease.
- **Scale Targets.** Over the five performance years of the agreement, the State is responsible for steadily increasing the percentages of Vermont Medicare Beneficiaries and Vermont All-Payer Scale Target Beneficiaries that are aligned to a Scale Target ACO Initiative.
    - By the end of 2021, the fourth performance year of the APM Agreement, the State is expected to have 62% of All-Payer Scale Target Beneficiaries and 83% of Vermont Medicare Beneficiaries aligned to a qualifying initiative.
- **Alignment.** Scale Target ACO Initiatives offered by payers must reasonably align with the Medicare program, referred to as the Vermont Medicare ACO Initiative.

APM Agreement, §§ 6-9, Appendix 1.

FY20 REVIEW PROCESS

The review process for OneCare's FY21 budget is reflected in the following timeline:

07.01.20: The Board issues FY21 ACO budget guidance and reporting requirements to OneCare.
10.01.20: OneCare submits its proposed FY21 budget to the Board.
10.07.20: Board staff and payer representatives present data at a public Board meeting regarding OneCare's 2019 quality performance under payer programs.
10.26.20: Board staff and HCA request additional information from OneCare regarding its proposed FY21 budget.
10.28.20: OneCare presents its proposed FY21 budget to the Board at a public hearing.
11.09.20: OneCare responds to Oct. 26, 2020 questions from Board staff and HCA.

11.19.20: Vermont Agency of Human Services (AHS) releases All-Payer ACO Model Implementation Improvement Plan.
12.02.20: Board staff and payer representatives present data at a public Board meeting regarding OneCare's 2019 financial performance under payer programs and Board staff present data regarding Vermont's performance under the APM Agreement.
12.09.20: Board staff present their analysis and preliminary recommendations regarding OneCare's proposed FY21 budget.
12.11.20: The Board requests clarification regarding information in the FY21 budget submission.
12.15.20: OneCare responds to the Board's Dec. 11, 2020 request for clarification.
12.18.20: Board staff present additional analysis and updated recommendations regarding OneCare's proposed FY21 budget.
12.22.20: Board receives letter from AHS regarding OneCare's proposal to fund the Blueprint for Health.
12.23.20: Board votes to approve OneCare's FY21 budget on the terms and subject to the conditions described in this Order.

The written materials from this process are posted on the Board's website[1] and video recordings of the meetings are available from Onion River Community Access (ORCA) Media.[2]

FINDINGS

ACO Governance and Leadership

1. OneCare is a "manager-managed" limited liability company organized under Vermont law in 2012 by the University of Vermont Medical Center, a Vermont nonprofit corporation, and Dartmouth-Hitchcock Health, a New Hampshire nonprofit corporation. 2021 Certification Eligibility Verification Form for OneCare Vermont (Certification Submission), Seventh Amended and Restated Operating Agreement of OneCare Vermont (Operating Agreement), 1 (eff. April 15, 2020).

2. OneCare is governed by a Board of Managers comprised largely of representatives of participating health care providers. 2021 Certification Submission, Operating Agreement, 8 – 9. Since our last review, Claudio Forte, President and Chief Executive Officer of Rutland Regional Medical Center, replaced Jill Berry-Bowen as the representative of community prospective payment system hospitals on OneCare's Board of Managers. *Compare* 2021 Certification Submission, OneCare Vermont Board of Managers (Sept. 2020) *with* 2020 Certification Submission, OneCare Vermont Board of Managers (Sept. 2019).

3. OneCare currently has one vacancy on its executive leadership team, a Vice President and ACO Legal Counsel. *See* 2021 Certification Submission, OneCare Leadership Team (Aug. 31, 2020). Effective Oct. 19, 2020, Tom Borys was promoted to Vice President for Finance for

[1] Written budget materials are available at https://gmcboard.vermont.gov/aco-oversight/2021. Board presentations are available at https://gmcboard.vermont.gov/board/meetings.
[2] https://www.orcamedia.net/series/green-mountain-care-board.

OneCare, filling the previously vacant executive leadership spot. OneCare Responses to Round 1 Questions, 17 (Nov. 9, 2020).

FY21 Payer Programs/ACO Initiatives

4. OneCare is still negotiating payer contracts for FY21. OneCare Vermont FY21 Budget Submission (Budget Submission), 5. OneCare expects to continue existing programs with Medicare, Medicaid, Blue Cross and Blue Shield of Vermont (BCBSVT), and MVP Health Plan, Inc. (MVP) in FY21. OneCare PowerPoint, 12 (Oct. 28, 2020). OneCare does not anticipate any new payer programs in FY21. Budget Submission, 18.

5. OneCare is seeking to negotiate narrower risk corridors with payers for FY21. Given the financial impact of COVID-19 on OneCare's provider network, OneCare explained that it is seeking to balance a desire for lower risk "with the desire to stay on the value-based care path" by maintaining two-sided accountability. Testimony of Tom Borys, Hearing Transcript (Tr.), 36:4 – 23 (Oct. 28, 2020). The total "downside" risk (for shared losses) reflected in OneCare's proposed FY21 budget is just over $19 million, approximately $17.5 million less than the ACO's pre-COVID FY20 budget. OneCare PowerPoint, 15 (Oct. 28, 2020); Testimony of Tom Borys, Tr. 36:24 – 37:6. OneCare's actual downside risk for FY21 will depend on final attribution and the terms of its payer contracts.

Risk Management

6. OneCare plans to transfer the great majority of its anticipated downside risk, just over $18 million, to network providers. *See* Budget Submission, App. 5.1 - 5.2.

7. OneCare changed the way that it manages upside and downside risk in 2020. Prior to 2020, OneCare's approach was to divide its network-wide spending targets into Health Service Area (HSA) spending targets, with the home hospital within each HSA serving as a "mini ACO" that held the upside and downside risk for greater- or lower-than-expected spending on the locally attributed population. *See In re OneCare Vermont Accountable Care Organization, LLC*, FY18 Accountable Care Organization Budget Order, Findings of Fact, ¶¶ 22-23; *see also* Testimony of Tom Borys, Tr., 38:1 – 6. Under the new risk model, shared savings and losses, which accrue at the ACO level, will be distributed proportionally across HSAs based on member months of attribution. OneCare Responses to Round 1 Questions, 6 (Nov. 9, 2020).

8. OneCare intends to continue its new risk model in FY21 but modify it by allocating 10% of any shared savings earned at the ACO level to a performance incentive pool that it will use to reward "exceptional performance" based on measures that are still being developed. OneCare Responses to Round 1 Questions, 7 (Nov. 9, 2020); Budget Submission, 8.

9. OneCare claims that its new network approach to allocating shared savings and losses will avoid a small number of expensive cases or inherent variation dictating an HSA's performance. OneCare also claims that the approach is simpler and more understandable for network participants and will align the financial results for OneCare and its participants with the

goals of the APM, which are measured at the state level. Budget Submission, 3, 8, 20; Testimony of Tom Borys, Tr., 38:15 – 40:4.

10. OneCare intends to assume half of Rutland Regional Medical Center's risk under the FY21 Medicare program as it is entering this program for the first time.[3] OneCare has budgeted a similar arrangement for Copley Hospital. Budget Submission, 25.

11. In FY21, OneCare also plans to implement a variable component to the base payments it makes to attributing providers. Budget Submission, 25. In past years, attributing providers, which are typically primary care providers, received a payment of $3.25 per member per month (PMPM). *Id.* at 7. In FY21, OneCare explained that providers participating in programs where the network holds risk will receive a payment of $1.75 PMPM. However, if shared savings are achieved by the ACO, the providers will receive an additional $1.50 to $3.00 PMPM, for an overall payment of between $1.75 and $4.75 PMPM. OneCare Responses to Round 1 Questions, 22 (Nov. 9, 2020); Budget Submission, 6, 58. For shared savings programs with no downside risk, the variable payments will range from $3.25 to $4.75 PMPM, and for programs where OneCare holds risk, the payments will continue at $3.25 PMPM. Budget Submission, 7, 10. Following pushback from independent primary care practices, OneCare agreed in September of 2020 to give independent primary care practices participating in risk programs the option of continuing to receive $3.25 PMPM (as opposed to $1.75) if they attest to experiencing economic stress during the pandemic, with the understanding that $1.50 PMPM will be at risk and subject to recoupment if programmatic shared savings are not earned. OneCare Responses to Round 1 Questions, 3 – 4 (Nov. 9, 2020); *see also* Letter from Vicki Loner and Susan Ridzon to Kevin Mullin (September 10, 2020).

12. OneCare's FY21 budget does not include the cost of a third-party risk protection arrangement for the Medicare program, as it has in prior years. OneCare stated that, with a narrower risk corridor, the probability of a result nearing either end of the corridor increases and the premium for a risk protection product increases relative to the amount of potential return. OneCare concluded that given this dynamic and the need to reduce hospital dues, it would forego risk protection in FY21. Budget Submission, 25 – 26.

13. The following table shows the expected allocation of risk within OneCare's network:

Risk Bearing Entity (RBE)*	HSA	Downside Risk ($1,000s)	% of Total
Southwestern VT Medical Ctr.	Bennington	$ 1,554	8.2%
Central Vermont Medical Ctr.	Berlin	$ 2,059	10.8%
Brattleboro Memorial Hospital	Brattleboro	$ 996	5.2%
University of Vermont Medical Ctr.	Burlington	$ 6,625	34.8%
Dartmouth-Hitchcock	Lebanon	$ 451	2.4%
Porter Medical Ctr.	Middlebury	$ 1,234	6.5%
Copley Hospital	Morrisville	$ 163	0.9%
North Country Hospital	Newport	$ 310	1.6%
Gifford Medical Ctr.	Randolph	$ 243	1.3%
Rutland Regional Medical Ctr.	Rutland	$ 1,499	7.9%

[3] Risk mitigation arrangements are set up so that the risk-bearing hospital bears risk up to the midpoint of its maximum risk limit or MRL and OneCare is responsible for the second half. In exchange, OneCare is entitled to 25% of any shared savings earned by the hospital. OneCare Responses to Round 1 Questions, 7 (Nov. 9, 2020).

Springfield Hospital	Springfield	$	334	1.8%
Northwestern Medical Ctr.	St. Albans	$	1,634	8.6%
Northeastern VT Regional Hospital	St. Johnsbury	$	433	2.3%
Grace Cottage Hospital	Townshend	$	-	0.0%
Mt. Ascutney Hospital & Health Ctr.	Windsor	$	506	2.7%
OneCare Vermont	Non-HSA Aligned	$	1,006	5.3%
TOTAL		**$**	**19,047**	**1.3%**

***** Figures represent HSA aggregate risk, including PHM component, which may not accrue to the RBE.

See Budget Submission, App. 5.2; GMCB PowerPoint, 46 (Dec. 9, 2020).

14. While OneCare's network providers have agreed to repay most of any shared losses that may be due to payers, as the entity with primary responsibility for repayment, OneCare still has credit risk for these losses. OneCare also has credit risk relating to prospective payment reconciliations. *See* Comments of Vicki Loner, 17:30 – 18:00 (Dec. 18, 2020).

15. OneCare reserves are generated through hospital dues and are intended to cover risk held by the ACO or to address unforeseen cash flow or business issues. OneCare Responses to Round 1 Questions, 8 (Nov. 9, 2020). OneCare's FY21 budget suggests a reserve of $5.6 million, $1.7 million more than the $3.9 million that the Board required OneCare to maintain in 2019 to fund the risk mitigation of three network hospitals and that the Board permitted OneCare to maintain in 2020 for general liquidity concerns, despite the shift of network risk mitigation obligations to the founders. OneCare does not expect any additional surplus or contribution to reserves as result of 2020 retained earnings and does not expect to build additional reserves in 2021. The $5.6 million in reserves on OneCare's balance sheet would more than cover the maximum possible downside risk carried by the ACO. Testimony of Tom Borys, Tr., 91:15 – 22. OneCare believes that maintaining the current level of reserves is appropriate and cited financial uncertainty and the amount of cash flowing through the ACO for fixed payments and other population health investments. OneCare Response to Round 2 Questions, 2 (Dec. 15, 2020).

FY19 Programmatic Performance

16. The 2019 Medicare program included a +/- 5% risk corridor and 100% risk sharing, meaning that within five percentage points of the target, OneCare would earn 100% of any savings and would be responsible for 100% of any losses. OneCare's performance in the 2019 Medicare program was within the risk corridor. Excluding money that was paid to OneCare in advance of program settlement and that the Board required OneCare to use to fund the Blueprint for Health and Support and Services at Home (SASH) programs,[4] and after accounting for the financial impact of OneCare's quality performance, OneCare earned approximately $4.8 million in shared savings under the 2019 Medicare program. *See* GMCB PowerPoint (Dec. 2, 2020), 4.

17. The 2019 Medicaid program included a +/- 4% risk corridor with 100% risk sharing, meaning that within four percentage points of the target, OneCare would earn 100% of any savings and would be responsible for 100% of any losses. GMCB PowerPoint, 11 (Dec. 2, 2020). OneCare's performance in the 2019 Medicaid program was approximately $13.5 million above

[4] Approximately $6.3 million was included in OneCare's 2019 benchmark and distributed to OneCare in advance of settlement. OneCare used this money to fund Blueprint for Health programs, including Supports and Services at Home (SASH). GMCB PowerPoint, 4 (Dec. 2, 2020).

the target and outside of the risk corridor. After application of necessary adjustments, OneCare will be required to pay approximately $6.7 million in shared losses to the Department of Vermont Health Access (DVHA). *Id.* at 12. DVHA explained that OneCare's losses under the 2019 Medicaid program were driven by higher than projected fee-for-service spending; ACO-participating providers that were paid prospectively (instead of fee-for-service) spent approximately $8.2 million less than expected. *Id.* at 14; *see also* AHS, Implementation Improvement Plan: Vermont All-Payer Accountable Care Organization Model Agreement (Implementation Improvement Plan), 11 (Nov. 19, 2020).

18. In discussing the results of the 2019 Medicaid program, DVHA noted that the ACO-attributed population nearly doubled from 2018 to 2019, which introduced relatively more uncertainty into the rate setting process compared to prior years. DVHA also noted that overall utilization trends increased for the entire Medicaid-enrolled population between 2017 (the base year used for rate development) and 2019. GMCB PowerPoint, 14 (Dec. 2, 2020).

19. Because of data challenges, BCBSVT agreed to shift its qualified health plan program from a shared risk to a shared savings program for 2019. BCBSVT stated that actual spending under the program net of member cost share exceeded the spending target by approximately $6.5 million or 6.6%. OneCare was not required to pay any of these losses. BCBSVT identified several dynamics relating to utilization and intensity of services it believes contributed to the overage, namely increased evaluation and management and professional mental health and substance use disorder visits, higher use of urgent care, and more costly and/or intense physical therapy services. GMCB PowerPoint, 25 (Dec. 2, 2020).

20. Within the 2019 Medicare program, OneCare earned 36.75 out of 40 points on 20 measures relating to patient/caregiver experience, care coordination/patient safety, preventive health, and at-risk populations. OneCare's overall quality score was 91.8%. OneCare's performance exceeded the national 90th percentile on three measures; was between the national 80th and 90th percentiles on five measures; was between the national 70th and 80th percentiles on three measures; was between the national 60th and 70th percentiles on one measure; was between the national 50th and 60th percentiles on one measure; and was between the national 40th and 50th percentiles on one measure. The remainder of the measures had no national benchmark. GMCB PowerPoint, 12 (Oct. 7, 2020). Of the 16 measures that were carried forward from 2018, improvement was noted in 12. *Id.* at 14.

21. Within the 2019 Medicaid program, OneCare's overall quality score was 95% based on ten pre-selected payment measures. OneCare's performance exceeded the national 90th percentile on three measures; was between the national 75th and 90th percentiles on one measure; was between the national 50th and 75th percentiles on two measures; and was between the national 25th and 50th percentiles on one measure. On one measure for which there was no 90th percentile (Developmental Screening), OneCare's performance exceeded the national 75th percentile; National benchmarks were unavailable for the remaining two payment measures, so OneCare's 2019 performance was compared to its 2018 performance. For both measures, OneCare's performance improved in 2019. For five measures, there was statistically significant improvement from 2018 to 2019. GMCB PowerPoint, 20 (Oct. 7, 2020).

22. Of the eight clinical measures in the 2019 BCBSVT QHP program, OneCare's performance improved on four measures and declined on four measures. Statistically significant improvement was observed on two measures and there were no measures with statistically significant decreases. OneCare's performance was above the national 90th percentile on three measures; was above the national 75th percentile for one measure; was above the national 50th percentile for three measures; and was above the national 25th percentile on one measure. GMCB PowerPoint, 28 (Oct. 7, 2020).

FY21 Provider Network

23. OneCare has a broad provider network for FY21 that includes all but one of Vermont's 14 community hospitals, as well as Dartmouth Hitchcock Medical Center, which is located just across the border in New Hampshire. OneCare's FY21 network will also include federally qualified health centers, skilled nursing facilities, home health agencies, designated agencies, independent primary care and specialist practices, and ambulatory surgical centers. Budget Submission, App. 2.1.

24. OneCare's FY21 network development strategy focused on maintaining the existing network composition despite challenges associated with COVID-19; increasing support for primary care; engaging organizations that take risk; working to reduce barriers to joining additional payer program; and ensuring understanding of participation expectations. Budget Submission, 10.

25. OneCare's provider network is not expected to change drastically between FY20 and FY21. Because of this, there are minimal impacts on the overall budget model due to changes in network participants. Budget Submission, 10. However, OneCare is losing four independent primary care practices (two of which were affiliated with HealthFirst), as well as several specialist practices. Budget Submission, 11; OneCare Responses to Round 1 Questions, 4 (Nov. 9, 2020).

26. Rutland Regional Medical Center and the Community Health Center of the Rutland Region are expected to join the Medicare program in FY21. Budget Submission, 10

Scale and Program Alignment

27. The APM Agreement requires Vermont to steadily increase the number of people that are attributed or aligned to an ACO over the life of the model. The APM Agreement establishes attribution targets (scale targets) for two populations—All-Payer Beneficiaries and Medicare Beneficiaries—for each of the model's five performance years. APM Agreement, § 6.a.

28. People that are attributed to an ACO only count towards the APM Agreement's scale targets if they are attributed under a "Scale Target ACO Initiative." APM Agreement, § 6.a. The APM Agreement defines a "Scale Target ACO Initiative" as an ACO arrangement that meets certain minimum standards. *Id.* The APM Agreement also requires Vermont to ensure that Scale Target ACO Initiatives offered by Medicaid and private payers reasonably align in their design with the Medicare Scale Target Initiative. *Id.* § 6.f.

29. Assuming OneCare's projections are accurate and that the payer programs OneCare is negotiating will qualify as Scale Target ACO Initiatives, and using 2019 population estimates, GMCB staff have projected that approximately 46% of Vermont All-Payer Beneficiaries and 56% of Medicare Beneficiaries could be aligned to a Scale Target ACO Initiative in 2021. While these estimates would represent a slight increase over 2020 estimates, they are below the targets set forth in the APM Agreement for 2021, the fourth performance year of the agreement. GMCB PowerPoint, 33-35 (Dec. 9, 2020); APM Agreement, 8 – 9.

30. On September 14, 2020, the State of Vermont received a warning notice from CMS that it had failed to achieve the ACO Scale Targets described in the APM Agreement for two consecutive performance years (2018 and 2019). Letter from Pierre L. Yong to Susan Barrett (Sept. 14, 2020).

31. On December 10, 2020, the State signatories to the APM Agreement responded to the warning notice and outlined strategies for improving scale performance. Letter from Philip B. Scott, Michael K. Smith, and Kevin Mullin to Pierre L. Yong (Dec. 10, 2020). CMS is currently evaluating the State's response.

Revenues

32. The following table shows the "revenues" in OneCare's proposed FY21 budget, as compared to prior budgets:

	FY18 Budget	% of Total	FY19 Budget	% of Total	FY20 Budget (Oct 1 – pre COVID)	% of Total	FY20 Budget (June 16 – post COVID)	% of Total	FY21 Budget	% of Total
Total Revenue	**639,253,005**		**898,618,967**		**1,424,634,098**		**1,255,590,792**		**1,459,027,177**	
Payer Revenues for Provider Reimbursement	599,469,290	93.8%	844,267,955	94.0%	1,362,241,283	95.6%	1,204,657,177	95.9%	1,412,335,659	96.8%
Payer Program Support (Incl. Blueprint)	17,452,793	2.7%	21,483,731	2.4%	18,999,750	1.3%	19,878,769	1.6%	20,475,699	1.4%
State Support	3,500,000	0.5%	4,250,000	0.5%	16,600,000	1.2%	11,000,000	0.9%	7,680,835	0.5%
Participation Fees (Hospital Dues)	18,459,071	2.9%	28,617,281	3.2%	24,467,227	1.7%	18,225,772	1.5%	14,935,770	1.0%
Oher (Grants & Deferred Revenue)	371,851	0.1%	-	0.0%	2,325,838	0.2%	1,829,074	0.1%	3,599,214	0.2%

GMCB PowerPoint, 22 (Dec. 9, 2020)

33. Due to the continued COVID-19 pandemic, OneCare sought to decrease hospital dues for FY21. Hospital dues for FY21 are projected to be over $9 million less than in OneCare's pre-COVID FY20 budget and approximately $3.2 million less than OneCare's revised FY20 budget. Budget Submission 31, GMCB PowerPoint, 22.

34. Informatics infrastructure support that was available in prior years ($2.8 million in the FY20 budget) will no longer be available in FY21. Budget Submission, 3, 30, App. 6.2.

35. Within the "state support" line, OneCare's FY21 budget includes $3.9 million in delivery system reform (DSR) funding. Budget Submission, App. 6.2. OneCare states that in the absence of these funds, significant budget adjustments will be required. Budget Submission, 31.

36. OneCare budgeted $861,000 in revenue related to its planned assumption of Blueprint for Health self-management programing in FY21. During the Board's review of the FY21 budget, OneCare stated that AHS was re-evaluating this initiative as part of the APM Implementation Improvement Plan. OneCare Responses to Round 2 Questions, 4 (Dec. 15, 2020).

Benchmark Trend Rates

37. A "benchmark" is a payer-specific financial target against which expenditures for ACO-aligned beneficiaries are assessed to determine whether an ACO earned savings or is responsible for losses. GMCB Rule 5.000, § 5.103(8). The APM Agreement authorizes the Board to prospectively develop the benchmark for the Medicare program, the Vermont Medicare ACO Initiative, subject to CMS approval.[5] APM Agreement, § 8.b.ii.

38. In developing its FY21 budget, OneCare assumed a 4.35% trend rate would be used in developing the 2021 benchmarks for the Medicare program, based on the Medicare USPCC. Budget Submission, 21.

39. On December 16, 2020, Board staff presented a proposed approach to developing the 2021 benchmarks for the Medicare program. Given the uncertainty brought on by the pandemic, staff recommended that the Board approve a retrospective approach that would trend historical claims experience forward to 2021 based on the statewide changes in claims between 2020 and 2021. This retrospective approach would allow CMS to incorporate protections currently being offered in other Medicare ACO programs, such as exclusion of expenditures associated with COVID-19 episodes from total cost of care calculations. *See* GMCB PowerPoint, 11 – 13 (Dec. 16, 2020). The Board approved this approach on December 23, 2020.

40. OneCare and DVHA were still negotiating the terms of the FY21 Medicaid contract, including the appropriate trend rate, when the Board voted on OneCare's FY21 budget. Due to the state of the negotiations at that time, the Board had received insufficient data to complete the Medicaid advisory rate case required by 18 V.S.A. § 9573. In 2019, approximately 15% of All-Payer TCOC under the APM Agreement was Medicaid spending. *See* GMCB PowerPoint, 9 (Dec. 2, 2020).

41. OneCare is currently negotiating with BCBSVT and MVP regarding the trend rates that will be used to develop the financial targets for the FY21 commercial programs. OneCare used trend rates supplied by the insurers in developing its FY21 budget proposal. OneCare states that,

[5] The APM Agreement grants the Board's authority to set Medicare benchmarks; the authority is distinct from ACO budget review authority which the Board has under Vermont law.

for QHP programs, the trends were derived from the Board-approved rate filings. Budget Submission, 21.

Expenses

42. The following table categorizes the expenses in OneCare's proposed FY21 budget as compared to prior budgets:

	FY18 Budget	% of Total	FY19 Budget	% of Total	FY20 Budget (Oct 1 – pre-COVID)	% of Total	FY20 Budget (June 16 – post COVID)	% of Total	FY21 Budget	% of Total
Total Expense	**639,253,005**		**895,818,967**		**1,424,634,098**		**1,255,590,792**		**1,459,027,177**	
Provider Reimbursement	599,469,289	93.8%	842,656,459	94.1%	1,362,241,283	95.6%	1,204,657,178	95.9%	1,412,335,659	96.8%
OneCare Admin Expense	12,492,660	2.0%	15,915,189	1.8%	19,276,749	1.4%	14,916,480	1.2%	16,132,547	1.1%
Population Health Investments	27,291,056	4.3%	37,247,319	4.2%	43,116,066	3.0%	36,017,134	2.9%	30,558,970	2.1%

GMCB PowerPoint, 23 (Dec. 9, 2020).

Provider Reimbursement

43. Most of the projected provider reimbursement reflected in OneCare's FY21 budget will be paid directly by payers to providers. Prospective payments, which do flow through OneCare, are projected to account for approximately 33.6% of OneCare's budgeted total cost of care in 2021 across all payers, about the same as in 2020. GMCB PowerPoint, 51 (Dec. 9, 2020).

44. Currently, Medicaid is the only payer offering truly "fixed" prospective payments where payments made to the ACO on behalf of participating providers to care for attributed patients are not later reconciled against the amounts that would have been reimbursed to those providers had they been paid under existing payment methodologies (fee-for-service). Budget Submission, 11.

45. In the Implementation Improvement Plan, AHS notes that true fixed prospective payments offer the strongest incentive for providers to engage in delivery system transformation and emphasizes the ability of such payments to increase predictability, stability, and flexibility for providers. AHS recommends accelerating the transition to fixed prospective payments across all payers by, among other things, identifying clear milestones for including such payments in contract model design. Implementation Improvement Plan, 3, 9, 12.

46. OneCare also discussed the advantages of truly capitated payments and the importance of such payments to payment reform efforts and stated that it intends to explore the possibility of implementing such a truly capitated payment model in the Medicare and commercial programs. Testimony of Vicki Loner, Tr., 135:17 – 136:1; Budget Submission, 11, 15, 19; *see also* Testimony of Tom Borys, Tr., 134:19 – 135:13 (discussing goals for evolution of the comprehensive payment reform or CPR program).

47. When Vermont hospitals submitted their FY21 budgets to the Board, on average, they expected 14.5% of their budgeted net patient revenues would come in the form of fixed prospective payments, although there was significant variation amongst hospitals. GMCB PowerPoint, 52 (Dec. 9, 2020).

Population Health Management and Payment Reform Programs

48. OneCare uses a four-quadrant model to classify its attributed population based on relative risk. Individuals who are healthy/well are in quadrant 1 (low risk). Individuals with early onset or stable chronic conditions are in quadrant 2 (medium risk). Individuals with full onset chronic illness and rising risk are in quadrant 3 (high risk). Individuals with complex and/or high-cost acute catastrophic conditions are in quadrant 4 (very high risk). Budget Submission, 42; OneCare PowerPoint, 31 (Oct. 28, 2020). While individuals in quadrants three and four comprise just 16% of OneCare's attributed population, they account for approximately 60% of total spending. *Id.*; Budget Submission, 42 – 45.

49. OneCare has developed a variety of programs to implement its care model. *See* Budget Submission, 42 – 45. The following table details OneCare's population health management (PHM) and payment reform investments in the proposed FY21 budget and previous budgets:

	2018 Actual	2019 Actual	2020 Budget*	2020 Projected	2021 Budget
PHM/Payment Reform Programs					
Basic OneCare PMPM	$ 4,040,439	$ 6,581,843	$ 8,420,662	$ 8,778,018	$ 9,694,801
Complex Care Coordination Program	$ 5,618,420	$ 9,186,729	$ 9,672,306	$ 9,672,510	$ 7,275,652
Value-Based Incentive Fund - Total	$ 4,243,973	$ 6,224,607	$ 5,640,553	$ 5,566,458	$ 2,000,000
Comprehensive Payment Reform Program	$ 715,806	$ 1,338,005	$ 1,192,196	$ 1,192,196	$ 1,200,000
Primary Prevention	$ 620,381	$ 727,627	$ 540,000	$ 540,000	$ 950,000
Specialist Program	$ -	$ 139,240	$ 754,800	$ 754,800	$ 65,777
Innovation Fund	$ -	$ 351,818	$ 725,521	$ 725,521	$ 239,320
Regional Clinical Representatives	$ -	$ 325,000	$ -	$ -	$ -
VBIF Quality Initiatives	$ -	$ 27,000	$ 33,000	$ 33,000	$ 74,000
PCMH Payments	$ 1,830,264	$ 1,865,619	$ 1,993,092	$ 1,993,092	$ 1,993,092
Community Health Team Payments	$ 2,245,852	$ 2,321,670	$ 2,440,322	$ 2,440,322	$ 2,440,322
SASH	$ 3,704,400	$ 3,834,054	$ 3,968,246	$ 3,968,246	$ 3,968,246
Primary Care Engagement Investment	$ -	$ -	$ 636,436	$ 564,194	$ 657,760
PHM Total	**$ 23,019,535**	**$ 32,923,212**	**$ 36,017,134**	**$ 36,228,358**	**$ 30,558,970**

*Revised budget

See GMCB PowerPoint, 41 (Dec. 9, 2020).

50. The Basic OneCare PMPM provides supplemental payments to the practices of attributing providers, typically primary care providers. As explained above, OneCare plans to introduce a variable component to its Basic OneCare PMPM payments in FY21. *Supra*, Findings, ¶ 11.

51. The complex care coordination program targets patients in quadrants 3 and 4 of OneCare's care model. In July 2020 OneCare shifted the program's payment model "from a capacity model to a value-based model with higher . . . payments for implementation and documentation of key coordination interventions" such as participation in a care team conference. Budget Submission, 43 – 44, 59.

52. OneCare has implemented a value-based incentive fund (VBIF) for all payer programs except Medicare. Budget Submission, 60. OneCare explained that the VBIF has been funded with hospital dues and, as attribution has grown, the impact of the VBIF on hospital dues has become significant. Testimony of Tom Borys, Tr., 81:13 – 82:2. OneCare also explained that distributions from the fund have historically been made following program settlement, which does not occur until well after the performance year ends. OneCare described this time lag as a "disincentive" for providers. Budget Submission, 60.

53. In FY21, OneCare intends to use hospital dues to pre-fund a reduced VBIF that will be distributed to network providers during the performance year in accordance with a plan established by OneCare's Population Health Strategy Committee. *See* Budget Submission, 8, 33, 55. In addition, OneCare stated that it will negotiate with payers to move some of the accountability for quality performance to settlement (i.e., quality will affect shared savings/losses). *See* Budget Submission, 33; Testimony of Tom Borys, Tr., 82:2 – 16.

54. OneCare's comprehensive payment reform (CPR) program is designed to transition independent primary care practices from fee-for-service reimbursement to a PMPM payment model and facilitate innovation within practices. *See* Budget Submission, 62. In FY21, OneCare plans to provide a $5 PMPM supplemental payment and to shift the Basic OneCare PMPM and care coordination payments outside of the CPR payment model. Budget Submission, 62; OneCare Responses to Round 2 Questions, 4 – 5 (Dec. 15, 2020). OneCare expects participation in the CPR program to grow from seven organizations with 10 practice sites in FY20 to 11 organizations with 17 practice sites in FY21. Budget Submission, 62.

55. Included in the budgeted primary prevention investments for FY21 is a transfer of Blueprint for Health self-management programs to OneCare and revisions to these programs developed by OneCare in partnership with the Blueprint and the Vermont Department of Health. Budget Submission, 61. Specifically, OneCare anticipated contracting with the Blueprint for Health in January 2021 to administer self-management programs for individuals who have or are at risk for hypertension and type 2 diabetes. However, during the Board's review, OneCare indicated that this contract may not come to fruition. Budget Submission, 9; Testimony of Sara Barry, Tr., 58:3 – 59:2. OneCare states that its initial focus would be on developing programs to support Vermonters who experience hypertension or diabetes and that it would also look at new ways to identify individuals at risk for these diseases and support early intervention. Testimony of Sara Barry, Tr. 58:3 – 59:2; Budget Submission, 33 – 34; OneCare Responses to Round 1 Questions, 24 (Nov. 9, 2020).

56. The primary prevention investments included in OneCare's proposed FY21 budget also include investments in the RiseVT program and the Developmental Understanding and Legal Collaborations for Everyone (DULCE) program, which provides interventions within a pediatric

care office setting designed to address social determinants of health in infants age zero to six months and offers social and legal support for their parents. Budget Submission, 61.

57. OneCare's FY21 budget does not include new investments in the specialist program. Despite no new investments, OneCare will fulfill prior commitments, including funding for projects related to chronic kidney disease and mental health. *See* Budget Submission, 33, 63.

58. In light of the financial circumstances of participating providers brought about by COVID-19, OneCare will not fund new innovation projects in FY21. Despite not making new investments, OneCare will fulfill prior commitments. *See* Budget Submission, 33.

59. As in past years, Board staff recommended that the Board propose an adjustment to the Medicare benchmark calculation to fund the Blueprint for Health and SASH programs in 2021. GMCB PowerPoint, 14 – 18 (Dec. 16, 2020). This benchmark adjustment allows Medicare funding to continue to be directed to these programs through the ACO. Evaluations of the Blueprint for Health and SASH programs suggest that they generate savings. *See* GMCB PowerPoint, 13 (Dec. 18, 2020); Board Meeting Materials (Oct. 14, 2020).

60. OneCare's proposed FY21 budget would level fund the Blueprint for Health Patient-Centered Medical Home (PCMH) and Community Health Team (CHT) payments, as well as the SASH program at 2020 dollar levels. Budget Submission, 34; OneCare PowerPoint, 21 (Oct. 28, 2020). The following table shows investments in the Blueprint for Health and SASH programs compared to total projected revenue and total PHM and payment reform spending over time:

	2018 Actual	2019 Actual	2020 Budget*	2020 Projected	2021 Budget
Total Revenue	**$ 634,311,450**	**$ 911,202,326**	**$ 1,255,590,792**	**$ 1,184,638,872**	**$ 1,459,027,177**
Population Health Management (PHM) Total	$ 23,019,535	$ 32,923,212	$ 36,017,134	$ 36,228,358	$ 30,558,970
Blueprint (PCMH,CHT,SASH)	$ 7,780,516	$ 8,021,343	$ 8,401,660	$ 8,401,660	$ 8,401,660
(PHM LESS Blueprint)/Revenue	2.4%	2.7%	2.2%	2.3%	1.5%
PHM/Total Revenue	3.6%	3.6%	2.9%	3.1%	2.1%

*Revised budget

GMCB PowerPoint, 41 (Dec. 9, 2020).

61. While OneCare proposed funding the Blueprint for Health and SASH programs at 2020 dollar levels in FY21, OneCare assumed that the Medicare benchmark will include a 4.35% trend on this funding. OneCare states that it pursued this approach because these additional funds create asymmetric risk for hospitals participating in the Medicare program. *See* Cover Letter for OneCare Responses to Round 2 Questions, 1 – 2 (Dec. 15, 2020).

62. As part of its FY21 budget submission, OneCare described progress and opportunities for improvement on various clinical and quality improvement initiatives. For example, OneCare

stated that it met its goals of reducing acute inpatient admission and emergency department utilization rates for its high-risk and very high-risk cohorts by 5% in all programs in 2019. However, OneCare explained that it had not met its goal of reducing ambulatory sensitive condition admissions for COPD or heart failure in 2019 for the Medicare program or its goal of achieving a payer blended 15% managed care rate in 2019 (although OneCare stated that it continued its efforts into 2020 and has achieved this goal). Budget Submission, 49 – 53.

Administrative Expenses

63. The following table shows the administrative expenses in OneCare's proposed FY21 budget and in prior budgets in comparison to total revenue and PHM and payment reform investments:

Expense/Metric ***($ in millions)***	**2018 Actual**	**2019 Actual***	**2020 Projection**	**2021 Budget**
Admin	$11.7	$15.4	$14.4	$16.1
Pop Health Mgt/Pmt Reform Invest (PHM)	$23.0	$32.9	$36.2	$30.6
Total Revenue	$634.3	$911.2	$1,184.6	$1,459.0
Admin Ratio (Admin/Total Revenue)	1.8%	1.7%	1.2%	1.1%
PHM Ratio (PHM/Total Revenue)	3.6%	3.6%	3.1%	2.1%

*pre-audit estimates

GMCB PowerPoint, 67 (Dec. 9, 2020).

64. The following table breaks down the administrative expenses in OneCare's proposed FY21 budget and prior budgets

Expense (in *millions*)	**Actuals 2018**	**Actuals 2019***	**Budget 2020 (Oct 1)**	**Budget 2020 (Jun 16)**	**Projected 2020**	**Budget 2021**	**Budget 2021 % Total**
Salaries & Benefits	$6.6	$8.2	$11.8	$8.3	$8.3	$9.8	61%
Software	$-	$2.6	$3.7	$3.6	$3.5	$3.5	22%
Contract Services	$1.3	$2.2	$1.2	$1.5	$1.2	$0.9	5%
Other (incl. travel, rounding)	$3.0	$0.7	$0.7	$0.8	$0.7	$1.0	6%
Occupancy	$-	$0.4	$0.5	$0.4	$0.5	$0.5	3%
Supplies	$-	$0.3	$0.2	$0.2	$0.1	$0.3	2%
Risk Protection	$0.8	$1.0	$1.2	$0.1	$0.1	$0.1	1%
Total	**$11.7**	**$15.4**	**$19.3**	**$14.9**	**$14.4**	**$16.1**	**100%**

GMCB PowerPoint, 54 (Dec. 9, 2020).

65. OneCare overestimated the amount of the Board's billback by approximately $170,000. GMCB PowerPoint, 68 (Dec. 9, 2020); *see also* GMCB PowerPoint, 9 (Dec. 18, 2020).

66. While administrative expenses in OneCare's proposed FY21 budget are approximately $3.2 million less than in the pre-COVID FY20 budget, they are approximately $1.2 million greater than in the revised FY20 budget. This is driven in large part by an increase of $1.5 million in salaries and benefits compared to the revised FY20 budget:

#	Type	Amount $	% Increase Over Prior Year	Driver/Reason/Value of Investment
1	Net impact of vacancy reinstatements and other positional changes in 2021	$666k	8%	Reinstatements of positions and other changes necessary to fulfill the expectations set by the OneCare Board of Managers
2	Reinstatement of leadership compensation	$595k	7%	Restoration of temporary COVID-related salary and benefit reductions
3	2% Salary Increase	$209k	3%	Annual increase for continuing staff
Total	Increase over revised 2020 Budget	$1,470k	18%	

OneCare Responses to Round 2 Question (Dec. 15, 2020); GMCB PowerPoint, 7 (Dec. 18, 2020).

67. The reinstatement of leadership compensation reflects the reinstatement of temporary reductions for leadership at the level of Director and above that OneCare implemented in FY20 and does not include any back pay or salary increases. OneCare Responses to Round 2 Questions (Dec. 15, 2020).

68. When asked about the benchmarks OneCare uses in setting management compensation, OneCare responded that it targets the market median (50th percentile) rate when setting base pay for executives, and that it targets the market 65th percentile when setting total direct compensation (base pay plus variable pay) for executives. It stated that a third-party consultant is occasionally used to benchmark director level roles, but the rest are benchmarked in-house using market surveys and software which aggregates the survey data. For non-executive pay, OneCare stated that it targets the market median (50th percentile). OneCare Responses to Round 1 Questions, 9 (Nov. 9, 2020).

69. Uncertainties in OneCare's administrative budget include the availability of $3.9 million in delivery system reform (DSR) funding, as well as approximately $261,000 in administrative funding for the Blueprint for Health self-management programs. GMCB PowerPoint, 9 (Dec. 18, 2020).

Public Comments

70. The Board accept public comments on OneCare's proposed budget from October 1, 2020 through December 21, 2020. These comments are available on the Board's website.[6] The Board received 18 public comments regarding the OneCare's FY21 budget and the Board's review. Generally, the themes from public comments reflect:

- A desire for increased transparency with the public and regulators.
- Generally, a positive reaction about care navigation platform, data analytics, and support for providers in network.
- A desire for concentration on expanding health care access to all Vermonters.
- Pleasure with population health initiatives overall but a desire for an increase in funding to further the programs.
- Continuation of value-based care.
- Questions about what the disruptions from COVID-19 mean for the evaluation of the APM and OneCare's performance.
- Questions about the ability of OneCare to achieve widespread participation in the APM and criticism of its financial and quality performance, its approach to primary care, and its administrative expenses and leadership salaries.
- Support for including an inflationary factor to OneCare's SASH funding for FY21.

See GMCB PowerPoint, 17 (Dec. 9, 2020); GMCB PowerPoint, 5 (Dec. 23, 2020).

Key concerns raised by the HCA in its comments include:

- Proposed changes to the risk model to remove HSA performance accountability may reduce incentives for cost reduction and return to a focus on generating volume.
- OneCare's investments in care management may not be sufficient to bend the cost curve, nor do they provide sufficient support to highest risk patients.
- The impact of OneCare's population health investments should be clear and measurable and, at this time, there is neither an empirical nor conceptual model through which to evaluate these efforts.
- Disruptions associated with COVID-19 will have a profound impact on our ability to empirically evaluate OneCare Vermont's quality and financial performance and its impact on the All-Payer Model goals.
- Recognition of technological disruptions impeding OneCare's ability to submit timely responses throughout the Budget review process this year

Letter from the HCA Policy Team to Kevin Mullin (Dec. 2, 2020).

71. Board staff considered the public comments and HCA comments in developing their recommendations regarding OneCare's proposed FY21 budget. *See* GMCB PowerPoint, 17 (Dec. 9, 2020); GMCB PowerPoint, 5 (Dec. 23, 2020).

[6] https://gmcboard.vermont.gov/aco-oversight/2021.

CONCLUSIONS

Statutory Criteria

A. Historic and future expenditures and the effects of care models on utilization, including the provision of innovative services;

OneCare's budget is driven primarily by its benchmarks or TCOC targets, which are developed by trending past claims experience forward to estimate future expenditures for the people who will be attributed or aligned to the ACO in the performance period. In 2019, the most recent year for which data are available, OneCare's performance against these targets was mixed. *See* Findings, ¶¶ 16 – 19. OneCare also described mixed results on its internal clinical and quality improvement priorities. *See* Findings, ¶ 62.

Payers are responsible for evaluating whether OneCare is positively impacting the cost and quality of care provided to their beneficiaries or members. BCBSVT noted some concerning utilization trends within its QHP program in 2019. *See* Findings, ¶ 19. However, BCBSVT, MVP, DVHA, and CMS are expected to continue their existing programs with OneCare in 2021, indicating that they see continued promise in an ACO to deliver value for their members or beneficiaries. *See* Findings, ¶ 4.

B. The ACO's efforts to strengthen and provide resources to primary care, address social determinants of health and the impacts of childhood trauma, integrate community providers, improve care coordination, and reduce duplication of services in partnership with the Blueprint for Health.

OneCare's FY21 budget continues investments designed to strengthen and provide resources to primary care practices, address social determinants of health and the impacts of childhood trauma, integrate community providers, improve care coordination for patients, and reduce duplication of services in partnership with the Blueprint for Health. *See* Findings, ¶¶ 48 – 60. The total amount of money being invested in these programs is lower than in prior years due in large part to OneCare's desire to reduce hospital dues. *See* Findings, ¶¶ 33, 60. This desire is understandable in light of the strain that COVID-19 has had on hospital finances and the uncertainty it creates for FY21.

Despite a budget review process that lasted several months, OneCare's approach to funding the Blueprint for Health and SASH programs was never clearly articulated. Towards the very end of the process, we came to understand that OneCare proposed to increase payments for those Blueprint for Health practices participating in the Medicare program in 2021 but continue to pay practices not participating in the Medicare program at 2020 levels. AHS informed the Board that it supported this approach as consistent with the APM Implementation Improvement Plan. AHS stated that it would work to amend its contract with OneCare to incorporate this approach. Letter from Michael K. Smith to Kevin Mullin (Dec. 22, 2020). OneCare's approach to SASH funding was not similarly supported; OneCare failed to justify taking the additional money generated by trending 2020 funding out of the program. We will therefore require that OneCare fund this program with the inflationary factor it proposed in the budget. We will request

that the necessary funding be added to OneCare's 20201 benchmarks for the Medicare ACO Initiative.

C. The Goals and Recommendations of HRAP

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

D. Transparency of ACO's Costs

As noted in the Implementation Improvement Plan, it is important that OneCare be transparent and responsive to its payer partners and regulators, who are collectively gauging the progress of payment and delivery system reforms. At times during our review of OneCare's proposed FY21 budget we had difficulty getting clear answers to our questions. We expect this to improve going forward. With respect to the transparency of OneCare's costs, however, they are described in detail in OneCare's budget submission and this order.

E. Effects of Medicaid Reimbursement on Other Payers

OneCare's FY21 budget includes trend rates for the MVP and BCBSVT QHP programs that are based on Board-approved rate increases for 2021 QHPs. Findings, ¶ 41. These health insurance rate increases are significantly affected by the cost shift. *See* GMCB Annual Report for 2019, 27 (calculating the impact of the cost shift, as defined elsewhere in the report, on QHP rate increases to be approximately 14.7%). Thus, as we noted last year, through the cost shift, Medicaid reimbursement levels impact the benchmark rates negotiated by OneCare and commercial insurers.

The payer differential report we just issued describes a significant difference between risk-adjusted ACO benchmarks for Medicaid and other payers. The report suggests, however, that this differential reflects underlying reimbursement differentials between Medicaid and other payers and that the Medicaid benchmarking process is not exacerbating this differential. *See* Payer Differential Reporting for the OneCare ACO, Executive Summary (Dec. 31, 2020).

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

OneCare seeks to negotiate narrower risk corridors with payers for FY21. The total "downside" risk reflected in OneCare's proposed FY21 budget is just over $19 million, approximately $17.5 million less than its pre-COVID FY20 budget. Findings, ¶ 5. OneCare plans to transfer the great majority of its anticipated downside risk, just over $18 million, to network providers, primarily hospitals, although OneCare is also putting some of its supplemental PMPM payments to attributing providers at risk in FY21. Findings, ¶¶ 6, 11. OneCare does not plan to

purchase third-party risk protection for the Medicare program, as it has done in past years. Findings, ¶ 12.

The $5.6 million in reserves on OneCare's balance sheet more than covers the maximum possible downside risk carried by the ACO and will be available to the ACO to address unforeseen cash flow or business issues that may arise. *See* Findings, ¶ 15.

We impose conditions on our approval of OneCare's FY21 budget designed to ensure that OneCare's delegated risk model is implemented as described in the budget submission and that OneCare does not materially change the model without Board approval.

G. ACO's Administrative Costs

OneCare proposes FY21 administrative expenses of just over $16.1 million. This represents a 16% reduction relative to OneCare's originally approved FY20 Budget submitted on October 1, 2019, an 8% increase relative to its revised FY20 budget submitted after the onset of COVID-19 on June 16, 2020, and a 12% increase relative to its projected 2020 actuals as of Oct 1, 2020. *See* Findings, ¶ 64. OneCare stated that this level of administrative expenses will allow the organization to return to a pre-COVID level of operations, while still minimizing hospital dues. Correcting for the overstated billback expense, the administrative budget would total approximately $15.9 million. *See* Findings, ¶¶ 64 – 65. We will therefore require that OneCare's administrative expenses not exceed $15.9 million. We will also require that OneCare submit additional benchmark information on salaries and benefits, which comprise the majority of the organization's administrative expenses. *See* Findings, ¶ 64.

H. The character, competence, fiscal responsibility and soundness of the ACO and its leaders.

OneCare did not make major changes to its Board of Managers or executive leadership teams in FY20. *See* Findings, ¶¶ 2 – 3. Consistent with AHS's Implementation Improvement Plan, we will consider making changes to our ACO oversight rule in the coming year to require a meaningful connection between ACO executive compensation and performance measures that align with broader health reform and value-based care strategies.

I. HCA Participation and Public Comment

The Board took public comments on OneCare's proposed budget and the budget review process from October 1, 2020 through December 21, 2020. During that time, the Board received 18 public comments regarding the OneCare's FY21 budget and the Board's review. Findings, ¶ 70. The Board's staff considered these comments in their analysis and recommendations and we have reviewed and considered them as well. *See* Findings, ¶ 71.

APM Agreement

J. TCOC Growth Rates

The total cost of care per person across all payers grew 4.2% from 2017 through 2019 for services covered by the APM Agreement. GMCB PowerPoint, 10 (Dec. 2, 2020). This growth rate is above the APM Agreement's target of 3.5% but below the corrective action trigger of 4.3%. Due to COVID-19, compounding growth in expenditures from 2017 through 2020 is also expected to be within the range allowed for by the APM Agreement. GMCB PowerPoint, 10 (Dec. 2, 2020); GMCB PowerPoint, 11 (Dec. 16, 2020). On December 23, 2020, the Board voted to propose that retrospective trend factors be used to develop the 2021 benchmarks for the Medicare program. *See* Findings, ¶ 39.

At the time the Board approved OneCare's budget, OneCare was still negotiating with DVHA on the terms of the 2021 contract, including the appropriate trend rate(s). Furthermore, give the state of these negotiations, the Board had not finalized the Medicaid Advisory Rate Case required by 18 V.S.A. § 9573. Findings, ¶ 40. However, since only around 15% of (2019) All-Payer TCOC under the APM Agreement is Medicaid spending, we do not expect OneCare's Medicaid rate to have a dramatic impact the State's ability to meet its financial targets for 2021. *See* Findings, ¶ 40. We will require that OneCare ensure the Medicaid trend rates are consistent with the Board's recommendations in the Medicaid advisory rate case.

At the time the Board approved OneCare's budget, OneCare was still negotiating final trend rates with commercial payers as well. While it is not ideal to move forward with the budget without more information about the 2021 commercial contracts, this uncertainty is not new. Similar to last year, we believe the appropriate course of action is to allow OneCare and commercial payers to negotiate rates for their programs that are tied to the Board-approved rates, are actuarially sound for the attributed populations, and that align with the All-Payer TCOC target growth.

K. Scale and Program Alignment

The State is currently below the scale targets in the APM Agreement. It is therefore disappointing that OneCare does not expect to negotiate any new payer programs for FY21. *See* Findings, ¶ 4. However, given the strain that the pandemic has placed on providers' finances, it was also an achievement for the ACO to not lose ground in FY21. *See id*.

To maximize scale and the consistency of provider incentives, we will require that, to the greatest extent possible, OneCare negotiate payer programs that qualify as Scale Target ACO Initiatives and that align in key areas (e.g., attribution methodologies, quality measures, payment mechanisms, included services, etc.). We will also require that OneCare work with payer partners to establish a target for fixed prospective payment levels and a strategy for achieving those levels, including a timeline with clear goals and milestones. OneCare and AHS have discussed the benefits of fixed prospective payments and have identified the increased

availability of such payments as important to getting more providers to participate in the All-Payer ACO Model. *See* Findings, ¶¶ 45 – 46.

ORDER

Based on our Findings and Conclusions above, and pursuant to 18 V.S.A. § 9382, we hereby approve OneCare's FY21 budget on the terms, and subject to the conditions, set forth below:

1. The GMCB expects to issue reporting requirements in the coming months pursuant to GMCB Rule 5.501. Reporting may be required on network development; attribution; payer programs and their alignment; finances, including dues and administrative expenses; risk; population health programs and investments; quality; and variations in cost and quality, all of which have been the subject of reporting requirements imposed by the Board in prior budget orders. However, reporting may also be required on any other subjects or issues relating to the ACO, ACO activities, or ACO providers or participants. These reporting requirements will be in addition to information required in the Annual Budget Review Guidance and Certification Eligibility Review Form released by the GMCB each summer. Under GMCB Rule 5.501, and as a condition of this budget order, OneCare must consult with GMCB staff as needed in the development of the reporting requirements, including the development of required data templates and formats, and must completely, timely, and accurately report all data and analyses specified therein.

2. To the greatest extent possible, OneCare must design payer programs to qualify as Scale Target ACO Initiatives (as defined by the All-Payer Accountable Care Organization Model Agreement) and to reasonably align in key areas, including beneficiary alignment methodology, ACO quality measures, payment mechanisms, risk arrangements, and services included for determination of any shared losses and shared savings. For each payer program OneCare enters into that does not qualify as a Scale Target ACO Initiative, and for each program element that is not reasonably aligned across payers, OneCare must provide a detailed justification to the GMCB. OneCare must report to the GMCB on its payer programs as specified in the reporting manual.

3. OneCare must ensure that its payer contracts are consistent with the following 2021 benchmark trend rates and related conditions:
    a. Vermont Medicare ACO Initiative: the trend factors proposed by the Board and approved by CMS;
    b. Medicaid Next Generation ACO Program: the trend factors that are consistent with the Board's recommendations in the Medicaid advisory rate case.
    c. Commercial:
        i. The 2021 benchmark trend rates for commercial programs must be consistent with the ACO-attributed population and the GMCB approved rate filings, if any; and
        ii. OneCare must provide the Board with (a) actuarial certifications for each of its commercial (including self-funded) benchmarks stating that the benchmark is adequate but not excessive; (b) an explanation of how its overall rate of growth across all payers fits within the overall APM target rate of growth and,

if its overall rate of growth exceeds the APM target, how it plans to achieve the target for the term of APM Agreement (2017 to 2022); and (c) a revised budget based on the finalized benchmarks.

4. The maximum amount of risk OneCare may assume for 2021 is the sum of the following: 2% of the Medicare benchmark; 2% of the Medicaid benchmark for the traditional attribution cohort and 1% of the Medicaid benchmark for the expanded attribution cohort; and the amounts of commercial risk as described in OneCare's FY2021 budget submission. OneCare must request and receive an adjustment to its budget prior to executing a contract that would cause it to exceed these risk levels.

5. OneCare must implement the risk model that it described in its budget proposal and must request and receive approval from the Board prior to making any material changes thereto. OneCare must:
    a. Submit to the Board copies of the contracts that bind each of the risk bearing hospitals to OneCare's risk sharing policy no later than 10 days after all contracts have been executed;
    b. Notify and seek approval from the Board as early as possible of any proposed changes to the risk model and, for any proposed changes determined by Board staff to be material, provide the Board with detailed information, including effects by hospital and by founder; and
    c. Submit underlying risk model methodologies for distribution of shared savings or losses (SS/SL), including mechanics of the 10% performance incentive pool, any market factor adjustments, or any other potential adjustments to SS/SL on or before March 31, 2021.

    The Board may require OneCare to come before the Board in a public meeting to explain the details of the risk model and its impact on incentive structures to the Board on or before April 15, 2021.

6. No later than April 15, 2020, OneCare must present to the Board on the following topics:
    a. 2021 attribution and payer contracts;
    b. Revised budget, based on final attribution;
    c. Final description of population health initiatives;
    d. Expected hospital dues for 2021 by hospital;
    e. Expected hospital risk for 2021 by hospital and by payer;
    f. Any changes to the overall risk model for 2021;
    g. Source(s) of funds for OneCare's 2021 population health management programs;
    h. Any other information the Board deems relevant to ensuring compliance with this order.

7. No later than March 31, 2021, OneCare must provide GMCB staff with the supporting documentation relevant to the topics identified in Condition 6. Among the supporting documentation, OneCare must submit:
    a. Final payer contracts;
    b. Attribution by payer;

c. A revised budget, using a template provided by GMCB staff;
d. Final descriptions of OneCare's population health initiatives;
e. Hospital dues for 2021 by hospital;
f. Hospital risk for 2021 by hospital and payer;
g. Documentation of any changes to the overall risk model for 2021;
h. Source of funds for its 2021 population health management programs;
i. OneCare must quantify the proportion of the VBIF that is now operationalized at settlement, versus distributed throughout the performance year; explaining and quantifying any and all other mechanisms that tie financial incentives to quality performance;
j. OneCare's most recent strategic plan; and
k. Any other information the Board deems relevant to ensuring compliance with this order.

8. In 2021, OneCare's Administrative Expenses must not exceed $15.9 million. If OneCare does not secure Delivery System Reform funding and the Blueprint Self-Management contract in the amounts reflected in the October 1 Budget submission, then a revised administrative budget must be submitted consistent with Conditions 6 and 7. By March 31, 2021, OneCare shall submit benchmark information on salaries and benefits.

9. If OneCare uses its reserve, it must notify the Board within 15 days of such use. Notification must include the reason for drawing down the reserve and, for any use authorized under this condition, a corresponding cash flow analysis. The use of this reserve shall be limited to:
    a. Additional funding for population health investments;
    b. Financial backing for risk incurred by participating providers;
    c. Maintaining ACO-wide risk on behalf of participating providers;
    d. Temporary cash flow issues associated with payer revenue delays; and
    e. Other uses pre-approved by the Board.

10. If population health management and payment reform programs are not fully funded as detailed in OneCare's 2021 budget submission, OneCare must submit a revised proposal no later than March 31, 2021 to the Board. This should include any requests for budget revisions, for changes to OneCare programs, including any funding shortfalls, changes in program scope, and an analysis for each program line item as to whether and why the funding is appropriately scaled by attribution, or some other factor.

11. In 2021, OneCare must fund SASH in the amount of $4,140,865, equivalent to the 2020 budgeted amount of $3,968,246 plus an inflationary factor of 4.35%, contingent on the increase in funding being used to enhance programs or expand access to Medicare beneficiaries. In 2021 OneCare must fund the Blueprint for Health (PCMH and CHT) investments in the amount of $4,626,268, equivalent to the 2020 budgeted amount of $4,433,414 plus an inflationary factor of 4.35%, consistent with the medical home and community health team program payment design approved by the Agency of Human Services.

12. Over the duration of the APM Agreement, OneCare's administrative expenses must be less than the health care savings, including an estimate of cost avoidance and the value of improved health, projected to be generated through the Model.

13. OneCare must submit its audited financial statements as soon as they are available and must submit information as required by the Board to monitor OneCare's performance. OneCare must crosswalk submitted actuals per its budget submission to audited financial statements for fiscal years 2018-2021.

14. OneCare must provide GMCB staff with a demonstration of data, analytics, and tools available to its network participants (including Care Navigator, Workbench One etc.).

15. OneCare must work with payers to propose a target for fixed prospective payment levels, a strategy for achieving those levels, and a related timeline, with clear goals, milestones, and targets.

16. The Board's Director of Health Systems Policy may adjust the dates in this order after consulting OneCare.

17. 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 18 V.S.A. § 9382.

So ordered.

Dated: January 15, 2021 at Montpelier, Vermont

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

* Board Member Usifer was not present for the Board's December 23, 2020 vote approving OneCare's FY21 budget, but joins in this decision.

Pelham, dissenting

The ACO has yet to become a permanent institution and force in Vermont's health care landscape. The ACO is, as of now, still a temporary entity assigned aspirational expectations of reforming relationships among Vermont's healthcare institutions after the failure to transition to a single payer system pursuant to Act 48 of 2011. Both Vermonters and policymakers across the nation are watching carefully to see if Vermont's ACO can achieve reforms that enhance the affordability of health care while also enhancing the health and wellness of the citizens served by Vermont's healthcare institutions. I dissent from the decision of the majority not because I oppose the ACO. To the contrary, I wish the ACO success.

As noted under the "Introduction" and "Legal Framework" sections of the majority opinion above, the budget now before the Board is the ACO's fourth and the statutory factors under consideration are sweeping. Over the past three years, the mechanics of the ACO have been largely put in place, from its governance structure to methods of transitioning from fee-for-service to fixed prospective payments to an infrastructure and goals supporting population health investments. Some fine tuning is still underway, but it cannot be said that the ACO is in its infancy anymore. Yet, with three years of start-up in the rear-view mirror, there are still significant structural concerns that lack focus and effort.

FPP: Findings 43 through 47 above profile the importance and standing of the transition to fixed prospective payments (FPP). Of note is that Vermont's FY 2021 hospital budgets assigned only 14.5% of budgeted net patient revenues (NPR) to fixed prospective payments. This compares to a FY 2020 budgeted FPP level across hospitals of 14.8%. In 2020, UVMMC, a 50% owner of the ACO, budgeted 16.8% of NPR as FPPs but only 15.9% in 2021. GMCB Health System Finance Team, Fiscal Year 2020 Vermont Hospital Budget Submissions, 37 (July 31, 2019), https://gmcboard.vermont.gov/sites/gmcb/files/documents/FY%202020%20Vermont%20Hospital%20Budget%20Submissions%20-%20Preliminary%20Review%20-%20revised%208.20.19.pdf.

Given that FPPs provide "the strongest incentive for providers to engage in delivery system transformation" and are cited as significant leveraging points for improvements in population health, it is concerning that the Board must order (Condition #15) in 2021, its fourth year, the ACO to establish targets and timelines for this important and central component of Vermont's health care reform strategy.

ACA Benchmark Plan: Another example where the ACO will hopefully become more aggressive is in relation to Vermont's Essential Health Benefits Benchmark Plan. The Affordable Care Act required all non-grandfathered plans in the individual and small group markets to cover a set of 10 essential health benefits (EHB). Federal regulations define EHB based on a state-selected benchmark plan. *See* CMS, Information on Essential Health Benefits (EHB) Benchmark Plans, https://www.cms.gov/CCIIO/Resources/Data-Resources/ehb.

Vermont's Benchmark Plan on file with CMS predates the establishment of the ACO and the All-Payer Model (APM) agreement with the federal government. However, an alignment analysis between Vermont's Benchmark plan and the population health goals embedded in the

APM and the ACO's budget has yet to be conducted, even though over 24,000 Vermonters with Vermont Health Connect plans are expected to be attributed to the ACO in 2021. What is known, for example, is Vermont's plan does not cover participation in the Blueprint for Health's CDC recommended plan or any other provider sponsored diabetes prevention program. Given that diabetes treatment is expensive, and mitigation of this chronic disease is central to the population health goals of the APM and ACO, alignment around prevention among the APM, ACO and the Benchmark Plan should be a top priority. Further, given the expected 2021 premiums paid to BCBSVT and MVP for Vermont Health Connect plans are projected at $540 million and the ACO is strengthening its partnership with the Blueprint for Health's self-management programs, there may be financial efficiencies in addition to wellness benefits with improved alignment of the Benchmark Plan with ACO efforts.

The Cost-Shift Siphon: A fundamental premise of Vermont's healthcare reform effort is that the capitation of payments to providers via FPPs be a strong incentive for providers to emphasize population health over disease mitigation to generate/preserve provider income. A healthy population is less costly than a sick population, allowing providers to keep a larger share of reimbursements is the concept. However, this premise is in direct conflict with the Medicaid cost-shift when Medicaid reimbursement rates are flatlined or increased at less than background inflation over time. Assuming investments in population health and the FPP infrastructure do generate financial efficiencies and savings, the Medicaid cost-shift siphons away such value, thus diminishing or even negating provider incentive to participate or assume risk in alignment with the ACO.

For example, in its 2021 budget submission to the Legislature, DHVA states the following: "In 2021, DVHA will be level funding rates that do not have a federally mandated rule for increase such as FQHC services." DVHA Budget Considerations – State Fiscal Year 2021 Restatement, 2 (Aug. 19, 2020), https://ljfo.vermont.gov/assets/Uploads/62ff558a10/DVHA_2021-Budget-Restatement-Narrative_FINAL-08.19.20.pdf.

Given this context, the incentive is diminished for providers to align themselves with the ACO when the Medicaid portion of the FPP is nominally stagnant and effectively regressive. If the ACO is going to proceed by continuing the practice of embedding the Medicaid cost-shift in the rates of commercial participants, the principles underpinning the concept of FPPs will be severely compromised. The ACO, and the GMCB, need to address and unwind the cost-shift deliberately and incrementally in the name of affordability and transparency and to keep faith with providers and rate payers who align themselves with the ACO.

Fiscal years 2021 and 2022 will prove important relative to the ACO demonstrating effectiveness as the catalyst bringing greater affordability and improved population health to Vermonters. By the end of 2022, the ACO will have existed for 5 years, thus allowing enough time for Vermonters to experience through and with their providers improvements in wellness and the stabilization of health care costs as FPPs supplant the current fee-for-service system. Some say that the ACO is a "coalition of the willing" and I applaud those who have actively embraced the challenges confronting the ACO. But I fear the 2021 ACO budget as proposed is too reflective of the status quo in important areas like FPP participation, alignment with QHP benefit plans, and

mitigation of the cost-shift, among others. Should such be true, the ACO likely cannot demonstrate to Vermonters by 2022 that the ACO is an effective agent of change relative to Vermont's healthcare system. My dissent is to encourage the ACO to adopt a more aggressive posture over the 2021 and 2022 period.

Filed: January 15, 2021

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

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