VERMONT
GREEN MOUNTAIN CARE BOARD

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MEMORANDUM

TO: Vicki Loner, CEO; Sara Barry, COO; Joan Zipko, Operations Director; Tom Borys, Sr. Director Finance (OneCare Vermont ACO)

FROM: Alena Berube, Director of Health System Policy; Marisa Melamed, Health Care Policy Associate Director; Sarah Tewksbury, Health Policy Analyst

RE: Round 1 questions to OneCare Vermont on the FY 2021 budget submission

DATE: October 26, 2020

The Green Mountain Care Board ACO oversight team prepared the following questions in response to OneCare's FY21 budget submitted October 1, 2020. In addition, we are attaching questions for OneCare prepared by the Office of the Health Care Advocate and submitted to the Green Mountain Care Board.

Please prepare written responses to the questions by November 9, 2020. If you need more time to prepare any of the responses, please contact us to discuss the timing by October 30, 2020. We may permit questions to be submitted in more than one batch to allow us to get responses as soon as possible.

Responses are to be submitted to the GMCB ACO team, copying the Office of the Health Care Advocate, at the following email addresses:

Berube, Alena Alena.Berube@vermont.gov; Melamed, Marisa Marisa.Melamed@vermont.gov; Tewksbury, Sarah Sarah.Tewksbury@vermont.gov; Barber, Michael Michael.Barber@vermont.gov; hcapolicystaff@vtlegalaid.org

Section 1: ACO Information and Background/Executive Summary

1. The executive summary states OneCare "has expanded attribution by approximately 28,000 lives" and that "in total, OneCare anticipates 238,467 scale target qualifying attributable lives in 2021." However, attribution presented in the Excel workbook does not align with these estimates. Average attribution presented in tables 4.4, 4.5, 5.1, 5.2 is 226,432 lives (difference of 12,035).

    a. Explain the discrepancy between the summary and the data tables for 2021 projected lives.

    b. GMCB most recent scale data projects 223,158 lives for 2020, this is a difference of 15,309 lives between 2020 and projected 2021. Explain how you arrive at 28,000 additional lives for 2021.

    c. The tables report BCBSVT attributed lives as either "QHP" or "Primary." It is our understanding from the 2020 BCBS contract that the Primary program consists of several

groups, not all scale target qualifying. Please break out the attributed lives by group using the table template provided below.

d. Explain any programs for 2021 that are not scale target qualifying. What is the benefit to the ACO and to the payer or providers for programs that are not scale target qualifying?

e. Fill out the table below for questions 1.b. and 1.c. to show the number of lives by payer program from 2018 to 2021. Please include brief footnotes to describe the population of each program.

Payer Program	**Final Attributed Lives 2018**	**Final Attributed Lives 2019**	**Attributed Lives 2020**	**Estimated Attributed Lives 2021**	**Scale Target Qualifying?**
Medicare					
Medicaid Trad.					
Medicaid Expand.					
BCBSVT QHP					
BCBSVT LG					
BCBSVT SF					
BCBSVT ASO only					
MVP QHP					

Section 2: ACO Provider Network

2. In Appendix 2.1 Provider Network, explain your footnote, why are projections not available at the organization level?

3. Describe the amendments made to the provider agreement after the negotiations between OneCare and HealthFirst, as documented in the letter to Chair Mullin dated 9/10/20. Reference "Table 2: Primary Care Program Incentives" from your budget submission to describe these changes. Can these practices still get up to $4.75 PMPM? To be eligible, do they need to prove economic stress as indicated in the letter?

4. Table 1: 2021 ACO Network Participation indicates a loss of provider organizations from 2020 to 2021, specifically independent primary care, specialist, and continuum of care providers. Please explain why these providers are leaving the network. Address the following:
    a. For example, the table indicates the network dropped from 29 to 25 independent primary care practices, are these the practices that signed the letter with HealthFirst indicating they would pull out of the network? Did the agreement indicated in the follow-up letter from HealthFirst and OneCare result in retaining these providers or bringing other providers in?
    b. Do you conduct exit interviews or provider surveys to better understand provider experience with the ACO and to understand why providers join, leave, or decline participation?

5. In the "eligibility" column of Table 2: 2021 Primary Care Program Incentive, indicate which provider types are eligible to receive these payments (e.g. hospital-based or independent primary care, FQHCs, or other provider types).

6. Why do variable payment programs make sense in early stream services (i.e. primary care/prevention) if the theory of change supposes that we must maximize prevention and primary care to prevent downstream chronic care? Provide tangible examples/scenarios of the modeling OneCare does to help inform participation by provider organizations.

7. What are the areas of opportunity for expanding primary care participation in the ACO network?

Section 3: ACO Payer Program

8. Section 3, Question 2 states hospitals "use their own financial management methodology to distribute payments within their organization." How does this apply to primary care program payments described in Table 2 of the budget submission? How do the primary care incentives work if it is up to a hospital to determine what to do with the payment?

9. Why don't we see more fixed payment programs from our commercial payers? Has OneCare discussed a fixed prospective payment pilot with MVP? Why or why not?

Section 4: Total Cost of Care

10. Projected total cost of care appears to have increased at approximately twice the rate as attribution, year over year. Is this expansion associated with the attribution of a higher-risk/higher-cost population? If so, where do you see opportunity for savings/efficiencies?

11. In reference to the last paragraph of Section 4, Question 3a, please explain the "opportunities to more favorably balance public and private trend rates to create sustainability for both consumers and providers"—are you affecting the cost shift now? If so, please explain how? If not, what are the barriers? If removed, how could you implement such a balancing of public and private trend rates, and what results would you expect to achieve for providers and consumers?

12. Section 4, Question 3d – While there is undoubtedly uncertainty around COVID-19 and its implications for health care into the future, please explain what assumptions you have baked into this budget and the Total Cost of Care (TCOC) estimates, and explain how you arrived at these estimates.

Section 5: Risk Management

13. Please explain your revised risk model in 2020 (from calculation of risk/risk transfer through settlement). What is different and what was the impetus for that change? How does it compare to the risk model initially proposed with your October 1 submitted 2020 Budget?

14. GMCB understood that OCV's originally submitted 2020 risk sharing model combined savings/losses across all payer streams and then distributed savings/losses to HSA risk-bearing entities (RBEs). Is it accurate that the changed policy means that savings/losses will be calculated and allocated to RBEs by payer?

15. Does the change in policy modify HSA-specific maximum risk limits (MRLs)? Please address, based on the final 2020 OCV risk model, the following requests:
    a. What is the risk by payer program, the Maximum Risk Limits (MRLs) for each hospital, and any risk mitigation arrangements? Complete a revised Appendix 2.3 (FY20 Risk by Pay Program, Maximum Risk Limit, and Risk Mitigation by HSA). Alternatively, OneCare could complete the new templates Appendices 5.1 and 5.2 with revised FY20 data.

16. How does your 2021 risk model differ from the revised 2020 risk model described previously, and what was the impetus for that change?
    a. Is risk-mitigation down-side only, or does ACO (or founders) gain access to those potential savings?
    b. What is the risk you are keeping on your books? Have you considered holding the risk for the advanced shared savings or other system-wide "risk"? Why or why not?

17. Under what conditions would you dip into OCV risk reserves? Is there a scenario under which the founders would ever have to cover shared losses? Please explain.

18. In Appendix 5.1—What is "risk for non-HSA attributed lives"?

19. Appendix 5.2—Please separate risk for TCOC versus variable payment for PHM.

Section 6: ACO Budget

20. Please provide a crosswalk/reconciliation between your submitted budget financial statements to what they would be on a GAAP basis of accounting.

21. Please disclose any transfers of dollars in and out of the organization that are not part of your ordinary course of business.

22. In the 2018 OCV audit, it is noted, "UVM Medical Center bills the Organization monthly for rental expense; however, there is no formal agreement with UVM Medical Center under this arrangement." Do you have a formal agreement now? If not, what is the current arrangement and what is driving the rent increases?

23. Also, in the UVMHN 2019 audit, it notes "Additionally, UVM Medical Center provides various administrative services to OCV, including the processing of payroll and accounts payable transactions. All employees of OCV are UVM Medical Center employees and are covered under

UVM Medical Center's insurance policies and employee benefit plans. OCV reimburses UVM Medical Center for all administrative and payroll-related costs, which totaled $12,595,000 and $10,289,000 for the years ending September 30, 2019 and 2018." Even though your year ends are different, actual salary costs are only about $6.6M in 2018 and $8.2M in 2019. Please provide a breakdown of what is going into those transactions. What are you projecting for 2020 and what are you budgeting for in 2021? Please include a breakdown for those as well (I.e. $X salaries, $X rent, etc.).

24. Management compensation accounts for almost 14% of total operational expenses. What benchmarks are reviewed to ensure that OneCare's business is not "top-heavy"?

25. Please explain your proposal to level fund Blueprint, SASH, and Community Health Teams.

26. All variance analyses: Please disclose a dollar value associated with your explanations to assist in transparency/completeness in the explanations.

27. Table 5: Balance Sheet Variation. Why is retained earnings going down if the budgeted amounts are break even? Is there a projected loss missing?

28. Table 6: Cash Flow Variation. Can you be more specific on the "(Increase)/Decrease Other Changes"? The variation is significant and more disclosure of the drivers of the change would be helpful, in addition to the dollar value of the explanation (Medicare AIPBP recon).

29. Balance Sheet: Do your reserves have to be increased now that Rutland Regional Medical Center has joined the Medicare program?

30. Income statement: You appear to be adding 3 FTEs but your salary cost is increasing by almost $1.5M. What is driving this increase?

31. What is the status of the 2019 audit?

32. Please update the "Sources and Uses" in Appendix Tab 6.4 per the revised table and for any amounts listed in "other," please explain how these are funded.

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

33. Have you explored any programs to specifically benefit patients with disabilities? Where would these patients typically fall within your quadrant system (i.e. potential benefit for advanced care coordination payments, etc.)?

34. Section 7, Question 1b asks you to discuss anticipated changes to your 2021 programs (proposed budget year), but the response focuses on 2020 progress. For example, you mention expanding DULCE in 2020, are there plans to further this expansion in 2021?
    c. Please break out the funding amount for DULCE in the Income Statement. Is it rolled into the Primary Prevention line item for years 2019-2021?
    d. Please provide more detail on the inclusion of Blueprint self-management plans (SMPs) into your 2021 budget. Which SMPs? How are these programs being funded? Where in

the proposed budget is this associated cost? Are there also associated costs with adding these programs into WorkBenchOne?

e. In what areas is the Longitudinal Care Program expanding in 2021? What is the funding stream for this program?
f. You mention an investment of $500,000 for mental health services in Emergency Departments (p.44)—which hospitals are part of this investment? Which population health line item does this fall under in the budget? Do you plan to continue this program for 2021?

35. In Table 7: 2020 Supplemental Care Coordination Payments, could you show cumulative payout under each of these Roles/Interventions? If so, please provide for all Performance Years.
    g. The explanation for the expenditure variation of -25% on this Complex Care Coordination Program states, "refining program for 2021." Please explain why 2021 program changes result in 25% less investment in this program.

36. You state that the 2020 all payer blended care managed rate of 15% of high and very high-risk lives has been met (p.44). What is the goal for the 2021 Care Managed Rate? Why is the commercial care managed rate so much lower (3%)?

37. Do you have any insights on how COVID-19 may impact 2020 rates as seen in Table 8: Summary of Clinical Priority Area Results for 2018 and 2019? Given potential decreased utilization, would these goals/targets be revisited to address current state?

38. Please provide more detail on how the COVID-19 patient prioritization application was implemented.
    a. Did providers receive a list of members at risk for Covid-19 or were they given a set of criteria to use to identify which patients were at risk? How was this risk level or criteria determined? How did you distribute this to members and how do you determine how many providers used the application? OneCare noted that 80 providers used its COVID-19 prioritization tool. How many providers was this offered to? Does the 80 refer to individual providers or provider organizations?

39. Starting with Graph 4, please provide this data unblinded. It would be helpful to see who are high vs. low performers as we evaluate Population Health Management investments and programs.

40. What is the Value-Based Incentive Fund (VBIF) distributive model for 2021? Please provide the policy when it is finalized.

41. In Table 10: OneCare Population Health Investment, please confirm attribution numbers and update as necessary for 2020 contracts (under base OneCare PMPM). In addition, please quantify spending in each investment category (tie to PHM/Payment Reform Program Expenses in Income Statement).

42. What hospital houses the chronic kidney disease program? Was this through innovation funding? If so, what was the total amount awarded to fund this program?

43. Please provide a shading key and HSA key for Exhibit C to Section 7: HSA Cost and utilization Variation Tables by Payer, as you have provided with this data previously.

44. Is OneCare planning to enter into any contracts for independent evaluation of their care model? How is OneCare participating and/or planning to participate in the federal evaluation?

45. What is OneCare's approach to measuring return on investment of its population health programs? For example, how is OneCare measuring a return on investment of care coordination activities as mentioned on p. 45?

46. You reference challenges of COVID-19 and deferred care with downstream effects of limited disease management (end of question 2)—has this subsided? What will you do if there is another surge, including through the possible "twindemic"?

47. Please describe in detail the data reports that participating providers receive from OneCare, including how often providers receive the reports and a description of any relevant data lags.
    a. Please provide example reports for each provider type.

Questions for FY21 Certification Eligibility Verification

1. *Governing Body 5.202(f)2.* Do the agendas or publicly posted minutes of the OneCare Board of Managers meetings specify the topics of business to be conducted or actually conducted during executive sessions? If the topics of business discussed under executive session are not itemized in the agenda or minutes, please explain why and address how the public is supposed to know that the topics discussed in executive session are allowed under 18 V.S.A. § 9572. Please provide any policies governing the conduct of OneCare Board of Managers meetings.

2. *Governing Body 5.202(h).* Please provide the date the consumer advisory board will have its annual meeting with representatives of the Office of the Health Care Advocate (HCA). Submit any report the HCA provides to the ACO following that meeting.

3. *Leadership and Management 5.203(a).* Why has OneCare had difficulty filling the position of Chief Financial Officer?

4. *Leadership and Management 5.203(a).* The current Leadership Team Table dated August 2020 includes a vacant position of Vice President and Legal Counsel that was not included in the 2019 Leadership Team Table; the 2019 table also included a position of Chief Information and Security Officer that is not included in the current submission. Please explain these changes to the composition of OneCare's Executive Team.

1. *Solvency and Financial Stability 5.204(a).* What legal and financial vulnerabilities does OneCare routinely assess? Please provide examples. Please also provide any policies or procedures describing the process for reporting the results of any assessments of the ACO's legal and financial vulnerabilities to the ACO's Board of Managers. If no such policies or procedures exist, how do you ensure that the Board of Managers is adequately informed?