STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

FY22 ACCOUNTABLE CARE ORGANIZATION BUDGET ORDER

In re: OneCare Vermont Accountable Care Organization, LLC Fiscal Year 2022	)	Docket No. 21-001-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 2022 (FY22) is the fifth 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 FY22 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 2022, the fifth performance year of the APM Agreement, the State is expected to have 70% of All-Payer Scale Target Beneficiaries and 90% of Vermont Medicare Beneficiaries aligned to a qualifying initiative under the terms of the APM Agreement.
    - On October 12, 2021, the State of Vermont received a letter from Centers for Medicare and Medicaid Services (CMS) temporarily waiving enforcement of the ACO Scale Targets in the APM Agreement.
- **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.

FY22 REVIEW PROCESS

The review process for OneCare's FY22 budget is reflected in the following timeline:

07.01.21: The Board issued FY22 ACO budget guidance and reporting requirements to OneCare.
10.01.21: OneCare submitted its proposed FY22 budget to the Board.
10.22.21: Board staff and HCA requested additional information from OneCare regarding its proposed FY22 budget.
11.05.21: OneCare responded to Oct. 22, 2021 questions from Board staff and HCA.
11.10.21: OneCare presented its proposed FY22 budget to the Board at a public hearing.

11.19.21: Board staff and HCA sent second round of questions to OneCare regarding its proposed FY22 budget.
11.22.21: Board staff and payer representatives presented data at a public Board meeting regarding OneCare's 2020 financial settlement and quality performance under payer programs.
12.08.21: Board staff presented their analysis and preliminary recommendations regarding OneCare's proposed FY22 budget.
12.01.21: OneCare responded to Nov. 19, 2021 questions from Board staff and HCA.
12.15.21: Board staff presented additional analysis and updated recommendations regarding OneCare's proposed FY22 budget.
12.22.21: Board voted to approve OneCare's FY22 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. 2022 Certification Eligibility Verification Form for OneCare Vermont (Certification Submission), Ninth Amended and Restated Operating Agreement of OneCare Vermont (Operating Agreement), 1 (eff. October 1, 2021). OneCare was organized in 2012 by the University of Vermont Medical Center, a Vermont nonprofit corporation, and Dartmouth-Hitchcock Health, a New Hampshire nonprofit corporation. *Id*. On September 30, 2021, Dartmouth-Hitchcock Health withdrew as a member from OneCare, and the University of Vermont Medical Center transferred its membership in OneCare to the University of Vermont Health Network Inc., a Vermont nonprofit. *Id*. As a result, the University of Vermont Health Network became the sole member of OneCare.

2. OneCare is governed by a Board of Managers comprised largely of representatives of participating health care providers. Certification Submission, Operating Agreement, 5-7. In connection with the change in membership, the composition of the Board of Managers was changed; Dartmouth-Hitchcock Health no longer appoints managers to OneCare's Board of Managers, and instead the three managers previously appointed by Dartmouth-Hitchcock Health were replaced with one additional at-large manager, one manager nominated by an academic medical center in New Hampshire serving Vermonters, and one manager nominated by an academic medical center in Vermont serving Vermonters. Operating Agreement, 5-7.

[1] Written budget materials are available at https://gmcboard.vermont.gov/aco-oversight/2022. Board presentations are available at https://gmcboard.vermont.gov/board/meeting-information/2021-meetings.
[2] https://www.orcamedia.net/series/green-mountain-care-board.

FY22 Payer Programs/ACO Initiatives

3. At the time the Board reviewed and voted on the FY22 budget, OneCare was still negotiating payer contracts for FY22. OneCare Vermont FY22 Budget Submission (Budget Submission), 31. OneCare expects to continue existing programs with Medicare, Medicaid, Blue Cross and Blue Shield of Vermont (BCBSVT), and MVP Health Plan, Inc. (MVP) in FY22. OneCare PowerPoint, 25 (Nov. 10, 2021). OneCare does not anticipate any new payer programs in FY22. Budget Submission, 18.

4. In FY21, OneCare negotiated narrower risk corridors with payers in response to the financial impact of COVID-19 on OneCare's provider network. Budget submission, 47. OneCare expects to maintain the narrower risk corridors in its FY22 payer contracts. *Id*. The total "downside" risk (for shared losses) reflected in OneCare's proposed FY22 budget is just over $16.1 million. *See* Budget Submission, App. 5.1-5.2. OneCare's actual downside risk for FY22 will depend on final attribution and the terms of its payer contracts.

5. The following is a summary of OneCare's expected risk model by payer for FY22:

	Payment Model	Budgeted Risk Corridor	Link to Quality**
Medicare	Reconciled AIPBP for eligible participants; FFS for others	Two-sided; 2% risk corridor; 100% sharing	Yes, component of settlement calculation
Medicaid - Traditional	Combination unreconciled FPP and FFS (with total reconciled to expected TCOC) for eligible participants; FFS for other	Traditional: Two-sided; 2% risk corridor; 100% sharing	Yes, component of settlement calculation; PHM payments
Medicaid - Expanded	Combination unreconciled FPP and FFS (with total reconciled to expected TCOC) for eligible participants; FFS for others	Expanded: Two-sided; 1% upside, 1% downside; 100% sharing	Yes, component of settlement calculation; PHM payments
BCBS	FPP (pilot with one hospital, reconciled) & FFS	[redacted]	Yes, component of settlement calculation
MVP	FFS	[redacted]	Yes, component of settlement calculation

*Projected by OCV as of 10/01/2021 Budget Submission, payer contracts still under negotiation.
**Source: FY22 Budget Submission Appendix 3.1 Scale Target Initiatives and Program Alignment Form. GMCB staff will review in more detail once contracts are final.

GMCB PowerPoint, 52 (Dec. 8, 2021).

Risk Management

6. OneCare plans to transfer almost all of its anticipated downside risk exposure, just over $16 million, to network providers. *See* Budget Submission, 47 and App. 5.2.

7. OneCare's risk model, which was changed in 2020, accrues shared savings and losses at the ACO level and then distributes 90% of the shared savings and losses proportionally across HSAs based on member months of attribution. *See* Budget Submission, 39-41. Of the shared savings earned at the ACO level, 10% is allocated to a performance incentive pool that the ACO distributes in accordance with its Accountability Pool settlement policy as set out in OneCare Policy F04-22-PY21 Performance Incentive Pool PY 2021. *See* Budget Submission, 49.

8. OneCare provided the following table showing actual and projected distribution of shared savings by risk-bearing entity for 2017 through 2021. Shared savings is aggregated for all payers and reflects necessary adjustments. For OneCare's actual FY2020 shared savings distribution by HSA and by payer, see OneCare Vermont 2020 Settlements (Nov. 15, 2021).[3]

Risk Bearing Entity (RBE)	HSA	Total ACO Shared Savings / (Loss) by RBE				
		Actual 2017	Actual 2018	Actual 2019	Projected 2020	Projected 2021
Southwestern VT Medical Center	Bennington	$ -	$ 247,914	$(1,740,490)	$ 2,018,229	$ 306,083
Central Vermont Medical Center	Berlin	$ 282,248	$ 277,704	$(3,616,892)	$ 1,557,836	$ 349,591
Brattleboro Memorial Hospital	Brattleboro	$ -	$ (147,239)	$ 383,751	$ 903,373	$ 195,198
The University of Vermont Medical Center	Burlington	$1,809,335	$ 1,324,565	$ 2,058,511	$ 3,831,009	$ 1,128,011
Dartmouth-Hitchcock	Lebanon	$ -	$ 314,819	$ (272,282)	$ 641,725	$ 149,443
Porter Medical Center	Middlebury	$ 158,649	$ 543,610	$ 1,035,601	$ 1,475,872	$ 200,637
Copley Hospital	Morrisville	$ -	$ -	$ -	$ 1,613,631	$ 193,615
North Country Hospital	Newport	$ -	$ 300,358	$ (411,851)	$ 590,434	$ 244,277
Gifford Medical Center	Randolph	$ -	$ -	$ (312,001)	$ 873,665	$ 185,171
Rutland Regional Medical Center	Rutland	$ -	$ -	$ (892,265)	$ 1,743,077	$ 430,311
Springfield Hospital	Springfield	$ -	$ 389,587	$ 636,267	$ 378,302	$ 235,738
Northwestern Medical Center	St. Albans	$ 114,521	$ (149,867)	$ (618,914)	$ 2,724,859	$ 396,180
Northeastern VT Regional Hospital	St. Johnsbury	$ -	$ -	$ (625,624)	$ 1,051,479	$ 331,829
Grace Cottage Hospital	Townshend	$ -	$ -	$ -	$ -	$ -
Mt. Ascutney Hospital & Health Ctr	Windsor	$ -	$ (24,233)	$ (204,793)	$ 756,251	$ 77,007
OneCare Vermont		$ -	$ 305,252	$ (447,172)	$ 125,000	
Blueprint		$ -	$ 7,776,759	$ 8,021,268	$ 8,401,660	$ 8,767,133
[Add other Risk-bearing Entity]						
TOTAL		**$ 2,364,753**	**$ 11,159,229**	**$ 2,993,112**	**$ 28,686,403**	

*Please report Shared Savings (Loss) by Performance Year, irrespective of the timing of settlement. If settlement is not final, indicate this is a current best estimate of actual results.

See Budget Submission, App. 5.3.

9. OneCare reports that while many accountability strategies are in their first year or will begin in 2022, "early indications are that providers who see their emerging VBIF quality scores are engaged and interested in learning more. OneCare is in the process of providing enhanced organization-level transparency in VBIF quality measure performance to further facilitate information sharing and knowledge transfer." Budget Submission, 80.

10. In FY22, OneCare's budget includes a variable element for its care coordination payments to participants. *See* Budget Submission, 40. In addition to the base payment, the care coordination program will allocate 15% of its available funds to be rewarded based on performance outcomes, with metrics to be determined. *See id*.

11. OneCare's FY22 budget does not include the cost of any third-party risk protection arrangements. Budget Submission, 48. OneCare concluded that the premium for a risk protection product would be high relative to the value of any potential return. *See id*.

[3] Available at https://gmcboard.vermont.gov/sites/gmcb/files/documents/2020_Settlements_Final_2021.11.15_0.pdf.

12. The following table shows the expected allocation of risk for FY22 within OneCare's network:

	Primary Care Accountability Pool				Risk Bearing Entity (Hospital) Share	Total Risk/ Reward
	Non-Hospital Primary Care		Hospital Primary Care			
	Accountability Pool Share	Proportion of HSA Attributed through Non-Hospital PC*	Accountability Pool Share	Proportion of HSA Attributed through Hospital PC*		
Bennington	$58,210	31%	$130,050	69%	$1,226,281	**$1,414,541**
Berlin	$37,371	12%	$219,150	88%	$1,840,424	**$2,096,945**
Brattleboro	$42,504	38%	$69,570	62%	$712,189	**$824,263**
Burlington	$407,431	59%	$286,362	41%	$4,230,828	**$4,924,621**
Lebanon	$38,002	53%	$27,576	47%	$318,037	**$383,615**
Middlebury	$61,426	43%	$73,368	57%	$764,217	**$899,011**
Morrisville	$68,360	99%	$0	1%	$175,475	**$243,835**
Newport	$600	1%	$84,438	99%	$212,313	**$297,351**
Randolph	$65,188	100%	$0	0%	$156,698	**$221,885**
Rutland	$278,842	100%	$0	0%	$1,718,442	**$1,997,284**
Springfield	$86,234	99%	$0	1%	$212,343	**$298,577**
St. Albans	$123,958	55%	$104,796	45%	$1,374,330	**$1,603,084**
St. Johnsbury	$59,203	55%	$58,392	45%	$278,574	**$396,170**
Townshend	$0		$0		$0	**$0**
Windsor	$979	1%	$54,468	99%	$388,078	**$443,526**
OneCare Vermont	$0		$0		$125,000	**$125,000**
Total	**$1,328,310**		**$1,108,170**		**$13,733,228**	**$16,169,708**
	8% of total risk		**7% of total risk**		**85% of total risk**	

* Accountability Pool Share for Non-Hospital and Hospital Primary care are based on the proportion of the HSA attributed through those practice types.
SOURCE: OCV Response to Round 2 Questions, Q10.

See Budget Submission, App. 5.2; GMCB PowerPoint, 55 (Dec. 8, 2021); OneCare Responses to GMCB Round Two Questions, 7.

13. In FY22, OneCare's budget included a reserve of $5.6 million. *See* Budget Submission, App. 6.1. OneCare funds its reserves through payment of hospital dues. In FY20, OneCare decided to refund approximately $3.1 million of participation fees to risk bearing entities instead of retaining that amount as its reserves. *See* GMCB PowerPoint, 130 (Dec. 8, 2021).

FY20 Programmatic Performance

14. The 2020 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. *See* GMCB PowerPoint, 10 (Nov. 22, 2021), 10 OneCare's performance in the 2020 Medicare program was outside of the risk corridor. *See id.* 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 $7.9 million in shared savings under the 2020 Medicare program. *See id.* OneCare's projected distribution of all FY20 shared savings is set out above in Findings ¶ 8 above; for OneCare's actual FY20 distribution of Medicare shared savings by HSA, see OneCare Vermont 2020 Settlements (Nov. 15, 2021) in footnote 3, above.

[4] Approximately $8.4 million was included in OneCare's 2020 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 (Nov. 22, 2021).

15. The 2020 Medicaid program included a +/- 4% risk corridor with 100% risk sharing for the traditional attribution cohort, meaning that for that cohort, within four percentage points of the target, OneCare would earn 100% of any savings and would be responsible for 100% of any losses. For the first time, the 2020 Medicaid program also included a +/- 2% risk corridor with 100% risk sharing for an expanded attribution cohort, meaning that for that cohort, within one percentage point above or two percentage points below the target, OneCare would earn 100% of any savings and would be responsible for 100% of any losses. GMCB PowerPoint, 25-26 (Nov. 22, 2021). In alignment with federal program changes, the Department of Vermont Health Access (DVHA) modified the Medicaid contract with OneCare to, among other things, reduce the downside risk corridor proportionally to the number of months in 2020 that were in the Public Health Emergency, which effectively reduced the downside risk to 0%. *See* GMCB PowerPoint, 21 (Nov. 22, 2021). GMCB PowerPoint, 25-26 (Nov. 22, 2021). OneCare's performance in the 2020 Medicaid program was approximately $11.6 million below the target, and outside of the risk corridor, for the traditional attribution cohort, and approximately $5.2 million below the target, and outside of the risk corridor, for the expanded attribution cohort. After application of necessary adjustments, DVHA will issue OneCare a reconciliation payment of approximately $15.4 million in shared savings. *Id.* at 25. OneCare's projected distribution of all FY20 shared savings is set out above in Findings ¶ 8 above; for OneCare's actual FY20 distribution of Medicaid shared savings by HSA, see OneCare Vermont 2020 Settlements (Nov. 15, 2021) in footnote 3, above.

16. BCBSVT reduced its risk corridors for its 2020 OneCare contract in light of the COVID-19 pandemic. *See* GMCB PowerPoint, 36 (Nov. 22, 2021). The final shared savings for OneCare under the BCBSVT program was $125,000. *See* GMCB PowerPoint, 60 (Dec. 8, 2021). The effect of COVID-19 on utilization impacted performance relative to the TCOC target; BCBSVT stated that the effect of deferring non-urgent procedures in 2020 "renders meaningless" claims experience results related to target or year-over-year comparisons. *See* GMCB PowerPoint, 36 (Nov. 22, 2021).

17. 2020 was the first year of MVP's contract with OneCare. *See* GMCB PowerPoint, 45 (Nov. 22, 2021). MVP's arrangement with OneCare offered a shared savings and fee-for-service program. *See id*. In 2020, actual per-member-per-month spending was lower than had been budgeted, resulting in $1.062 million in savings to OneCare. GMCB PowerPoint, 47 (Nov. 22, 2021).

18. Within the 2020 Medicare program, OneCare earned a 100% score on 20 measures relating to patient/caregiver experience, care coordination/patient safety, preventive health, and at-risk populations. Due to the Public Health Emergency, all measures were reverted to pay-for-reporting in 2020. OneCare's score was also calculated using the pre-COVID rubric based on the raw score for each of the 20 measures, using this rubric, OneCare would have scored 96.25%. GMCB PowerPoint, 14 (Nov. 22, 2021).

19. Within the 2020 Medicaid program, OneCare's overall quality score was 100% based on ten pre-selected payment measures. Due to the COVID-19 pandemic, all measures were reverted to pay for reporting and no overall score was issued. GMCB PowerPoint, 29 (Nov. 22, 2021).

20. No quality score was generated for 2020 ACO performance, all measures were reporting only due to the Public Health Emergency and the base year performance of the Large Group population. GMCB PowerPoint, 38 (Nov. 22, 2021).

21. 2020 was the first year of the MPV contract with OneCare. *See* GMCB PowerPoint, 45 (Nov. 22, 2021). Eight measures were selected to be in alignment with the State's All-Payer ACO Model Agreement, with a total of 100 available performance points. OneCare earned 50 points, or 50%, resulting in a 30% eligible payout under the programs terms. *See* GMCB PowerPoint, 50 (Nov. 22, 2021).

FY22 Provider Network

22. OneCare has a broad provider network for FY22 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 FY22 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. *See* Budget Submission, App. 2.1; GMCB PowerPoint, 10 (Dec. 8, 2021).

23. OneCare's FY22 network development strategy focused on maintaining the existing network composition despite challenges associated with COVID-19; managing risk and opportunity, and evolving programs to continue to advance value-based care arrangements. Budget Submission, 9.

24. OneCare's provider network is not expected to change drastically between FY21 and FY22. Two primary care practices are returning to the OneCare network for FY22, but OneCare is losing two other primary care practices so there is no net change from FY21 to FY22 in number of primary care practices participating. *See* Budget Submission, App. 2.1; GMCB PowerPoint, 10 (Dec. 8, 2021).

25. OneCare plans to work with FQHCs, Bi-State Primary Care Association, and DVHA to design a fixed payment pilot program, similar to OneCare's CPR program. *See* Budget Submission, 17. OneCare plans the pilot for Medicaid only and with 1-3 sites, which is likely to launch in 2023, with expansion across other payers and sites in future years. *See* Testimony of Tom Borys, Hearing Transcript, 65:1-65:6.

Scale and Program Alignment

26. 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.

27. 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.

28. Assuming OneCare's projections are accurate and that the payer programs OneCare is negotiating will qualify as Scale Target ACO Initiatives, and using 2020 population estimates, GMCB staff have projected that approximately 52% of Vermont All-Payer Beneficiaries and 54% of Medicare Beneficiaries could be aligned to a Scale Target ACO Initiative in 2022. While these estimates would represent a slight increase over 2021 estimates, they are below the targets set forth in the APM Agreement for 2021, the fourth performance year of the agreement. GMCB PowerPoint, 89-90 (Dec. 8, 2021); APM Agreement, 8 – 9.

		PY1 (2018) Final	PY2 (2019) Final	PY3 (2020) Final	PY4 (2021) Preliminary*	PY5 (2022) Projected**
All-Payer Scale Target	*Target*	*36%*	*50%*	*58%*	*62%*	*70%*
	Actual	22%	31%	45%	47%	52%
	Attributed Lives	112,756	160,048	230,785	242,298	266,920
Medicare Scale Target	*Target*	*60%*	*75%*	*79%*	*83%*	*90%*
	Actual	34%	47%	47%	54%	54%
	Attributed Lives	39,702	53,973	53,842	59,571	62,707

*Preliminary 2021 results utilize 2020 population estimates; these results are subject to change.
**Projected 2022 estimates are calculated using scale estimates from CMMI, DVHA, and the budget submission and utilize 2020 population estimates; these results are subject to change.

GMCB PowerPoint, 89-90 (Dec. 8, 2021)

29. On October 12, 2021, the State of Vermont received a letter from Centers for Medicare and Medicaid Services (CMS) temporarily waiving enforcement of the ACO Scale Targets in the APM Agreement. See Letter from Amy Bassano to Michael Smith, Ena Backus, and Kevin Mullin, *Temporary Waiver of Enforcement of the Vermont All-Payer Accountable Care Organization Model State Agreement ACO Scale Targets* (Oct. 12, 2021).

Financials (Revenues and Expenses)

30. GMCB considered both full accountability and entity-level perspective on OneCare's FY22 budget. See GMCB PowerPoint, 21 (Dec. 8, 2021). Full accountability is an "all-in" financial perspective which captures Expected TCOC pass-through, Contract revenues (incl. FPP), and organizational revenues and expenses. The Full Accountability budget is not in line with US GAAP as most of the revenues are the responsibility of third-party fiduciaries. The entity-level budget captures only the revenues and expenses derived from and incurred by the organization's operating activity in line with US Generally Accepted Accounting Principles (GAAP). *Id.*

31. The following table shows the full accountability (Non-GAAP) and entity level (GAAP) summary income statements for OneCare's proposed FY22 budget, as compared to prior budgets:

Full Accountability (Non-GAAP)	**2018 Actual**	**2019 Actual**	**2020 Actual**	**2021 Revised**	***2021 Projection****	**2022 Budget**
Expected Total Cost of Care Target (External)	605,433,215	294,018,591	677,948,979	792,975,361	*766,163,732*	884,356,005
Fixed Prospective Payment/Funded CPR	-	346,341,673	402,406,905	407,254,322	*403,900,213*	445,882,154
Other Contract Revenue	7,826,298	13,090,261	15,155,666	10,748,878	*10,704,617*	7,371,394
Participation Fees	17,397,929	25,842,028	15,273,570	18,917,509	*16,595,361*	19,231,028
Administrative Revenue	3,086,492	5,395,629	7,432,261	7,428,852	*7,560,687*	7,978,014
Consulting Revenue	309,407	355,289	193,289	18,000	*18,000*	-
Other Revenues (incl. Settlement)	1,393,945	777,624	288,816	115,000	*14,186,141*	527,247
Total Revenues	635,447,286	685,821,095	1,118,699,486	1,237,457,922	*1,219,128,751*	1,365,345,843
Expected Health Care Spend (External)	360,265,990	289,261,914	669,547,321	784,208,228	*761,927,779*	875,282,023
Fixed Prospective Payments	237,390,466	346,341,673	402,406,905	407,254,322	*403,900,213*	445,882,154
Population Health Management (incl. Settlement)	23,082,601	30,186,885	32,700,998	30,089,714	*37,439,346*	28,894,128
Operational Expenses	13,739,102	15,341,451	14,044,262	15,905,658	*13,464,440*	15,287,538
Total Expenses	634,478,160	681,131,922	1,118,699,486	1,237,457,922	*1,216,731,778*	1,365,345,843
Net Income	969,127	4,689,173	(0)	-	*2,396,973*	-
Administrative Ratio	**2.16%**	**2.24%**	**1.26%**	**1.29%**	***1.10%***	**1.12%**
PHM Ratio with Blueprint	**3.56%**	**4.30%**	**2.92%**	**2.43%**	***3.07%***	**2.12%**
PHM Ratio without Blueprint	**2.34%**	**3.60%**	**2.17%**	**1.72%**	***2.35%***	**1.45%**
Operating Margin	**0.15%**	**0.68%**	**0.00%**	**0.00%**	***0.20%***	**0.00%**
Total Margin	**0.15%**	**0.68%**	**0.00%**	**0.00%**	***0.20%***	**0.00%**
FTEs - Fiscal Year (budgeted)	**46.05**	**49.15**	**60.00**	**61.37**	***N/A***	**61.40**
***Includes $14,071,141 in settlement revenue and $9,638,875 in settlement expense**						

GMCB PowerPoint, 24 (Dec. 8, 2021)

Entity Level (GAAP)	**2018 Actual**	**2019 Actual**	**2020 Actual**	**2021 Revised/Projection**	**2022 Budget**
Expected Total Cost of Care Target (External)	-	0	-	-	-
Fixed Prospective Payment/Funded CPR	-	-	-	-	-
Other Contract Revenue	3,771,184	10,771,692	11,194,712	7,254,110	3,360,439
Participation Fees	17,397,929	25,842,028	15,273,570	18,917,509	19,231,028
Administrative Revenue	1,543,246	2,697,815	3,897,306	3,893,058	4,175,496
Consulting Revenue	309,407	355,289	193,289	18,000	-
Other Revenues (incl. Settlement)	1,393,945	777,624	288,816	115,000	527,247
Total Revenues	24,415,710	40,444,448	30,847,693	30,197,677	27,294,211
Expected Health Care Spend (External)	-	-	-	-	-
Fixed Prospective Payments	-	-	-	-	-
Population Health Management (incl. Settlement)	9,711,238	20,413,825	16,803,432	14,292,018	12,006,673
Operational Expenses	13,735,346	15,341,450	14,044,262	15,905,658	15,287,538
Total Expenses	23,446,583	35,755,274	30,847,693	30,197,677	27,294,211
Net Income	969,127	4,689,173	(0)	-	-
Administrative Ratio	**56.26%**	**37.93%**	**45.53%**	**52.67%**	**56.01%**
PHM Ratio with Blueprint	**37.95%**	**48.68%**	**54.47%**	**47.33%**	**43.99%**
PHM Ratio without Blueprint	**37.92%**	**48.68%**	**54.47%**	**47.33%**	**43.99%**
Operating Margin	**3.97%**	**11.59%**	**0.00%**	**0.00%**	**0.00%**
Total Margin	**3.97%**	**11.59%**	**0.00%**	**0.00%**	**0.00%**
FTEs - Fiscal Year (budgeted)	**46.05**	**49.15**	**60.00**	**61.37**	**61.40**

GMCB PowerPoint, 31 (Dec. 8, 2021)

32. OneCare cited the loss of Delivery System Reform and Health Information Technology funding, in the total amount of $3.9 million, as its main budget challenge for FY22. *See* Budget Submission, 8; OneCare Presentation, 36 (Nov. 10, 2021). To balance its revenue and expenses, OneCare increased hospital participation fees by $3.6 million for FY22.[5] *See id*.

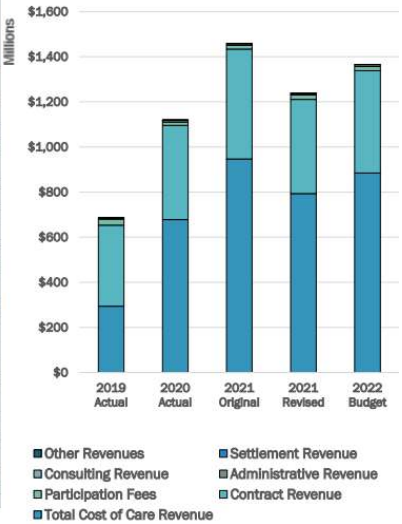
[5] OneCare's treatment of its participation fees is not apparent from its income statement alone. OneCare's participation fees collected annually from hospitals is increasing from $15 million to $18.6 million. Additionally,

33. The following table shows the full accountability (Non-GAAP) and entity level (GAAP) "revenues" in OneCare's proposed FY22 budget, as compared to prior budgets:

Full accountability:

	FY19 Actual *% of Total*	FY20 Actual *% of Total*	FY21 Budget (Oct 1 - Approved) *% of Total*	FY21 Budget (May 24) *% of Total*	FY22 Budget *% of Total*
Total Revenue	**685,821,095**	**1,118,699,486**	**1,459,165,761**	**1,237,457,922**	**1,365,345,843**
Expected Total Cost of Care Revenue	294,018,591 *42.9%*	677,948,979 *60.6%*	946,683,974 *64.9%*	792,975,361 *64.1%*	884,356,005 *64.8%*
Contract Revenue	359,431,934 *52.4%*	417,562,571 *37.3%*	486,722,289 *33.4%*	418,003,200 *33.8%*	453,253,548 *33.2%*
Participation Fees	25,842,028 *3.8%*	15,273,570 *1.4%*	17,108,917 *1.2%*	18,917,509 *1.5%*	19,231,028 *1.4%*
Administrative Revenue	5,395,629 *0.8%*	7,432,261 *0.7%*	7,451,403 *0.5%*	7,428,852 *0.6%*	7,978,014 *0.6%*
Consulting Revenue	355,289 *0.1%*	193,289 *0.0%*	149,178 *0.0%*	18,000 *0.0%*	- *0.0%*
Settlement Revenue	415,240 *0.1%*	32,986 *0.0%*	- *0.0%*	- *0.0%*	- *0.0%*
Other Revenues	362,384 *0.1%*	255,830 *0.0%*	1,050,000 *0.1%*	115,000 *0.0%*	527,247 *0.0%*

Presentation slightly different due to template changes

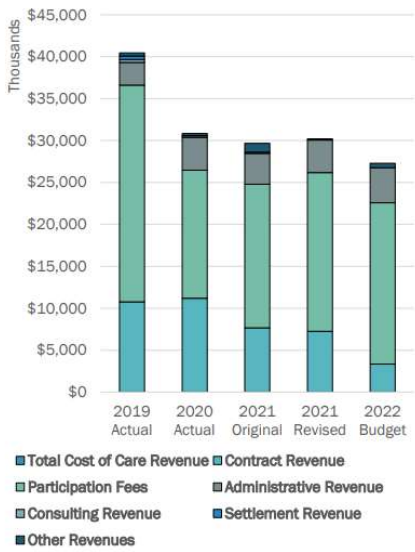


GMCB PowerPoint, 25 (Dec. 8, 2021)

Entity-level:

OneCare has "deferred participation fees", which OneCare has said that it reports in accordance with Accounting Standards Codification (ASC) 606. OneCare advised the Board staff that deferred funds fall into two categories: first, funds that through programmatic agreements are required to be utilized for a specific future purpose (dictated by the agreement), and second, unspent participation fees. OneCare further informed Board staff that "funds deferred in 2020 are being used in 2021 in alignment with the nature of their initial purpose or, where discretion exists, through Board of Manager designation." Those funds offset some need for additional participation fees in 2021, according to OneCare, but the funds will be used and not available in 2022.

	FY19 Actual *% of Total*	FY20 Actual *% of Total*	FY21 Budget (Oct 1 - Approved) *% of Total*	FY21 Budget (May 24) *% of Total*	FY22 Budget *% of Total*
Total Revenue	**40,444,448**	**30,847,693**	**29,668,631**	**30,197,677**	**27,294,211**
Expected Total Cost of Care Revenue	- *0.0%*	- *0.0%*	- *0.0%*	- *0.0%*	- *0.0%*
Contract Revenue	10,771,692 *26.6%*	11,194,712 *36.3%*	7,680,835 *25.9%*	7,254,110 *24.0%*	3,360,439 *12.3%*
Participation Fees	25,842,028 *63.9%*	15,273,570 *49.5%*	17,108,917 *57.7%*	18,917,509 *62.6%*	19,231,028 *70.5%*
Administrative Revenue	2,697,815 *6.7%*	3,897,306 *12.6%*	3,679,701 *12.4%*	3,893,058 *12.9%*	4,175,496 *15.3%*
Consulting Revenue	355,289 *0.9%*	193,289 *0.6%*	149,178 *0.5%*	18,000 *0.1%*	- *0.0%*
Settlement Revenue	415,240 *1.0%*	32,986 *0.1%*	- *0.0%*	- *0.0%*	- *0.0%*
Other Revenues	362,384 *0.9%*	255,830 *0.8%*	1,050,000 *3.5%*	115,000 *0.4%*	527,247 *1.9%*



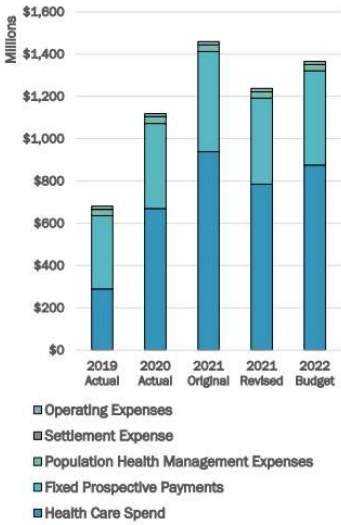
GMCB PowerPoint, 32 (Dec. 8, 2021)

34. The increase in full accountability revenue from FY21 (revised budget) to FY22 budget is driven mostly by increases in contract revenues ($35 million) and expected total cost of care ($91 million). *See* GMCB PowerPoint, 27 (Dec. 8, 2021). The decrease in entity-level revenue from FY21 (revised budget) to FY22 budget is driven by a decrease of approximately $3.9 million in contract revenues, which is partially offset by small increases in administrative revenue, participation fees, and other revenues. *See* GMCB PowerPoint, 34 (Dec. 8, 2021).

35. The following table shows the full accountability (Non-GAAP) and entity level (GAAP) "expenses" in OneCare's proposed FY22 budget, as compared to prior budgets:

Full accountability:

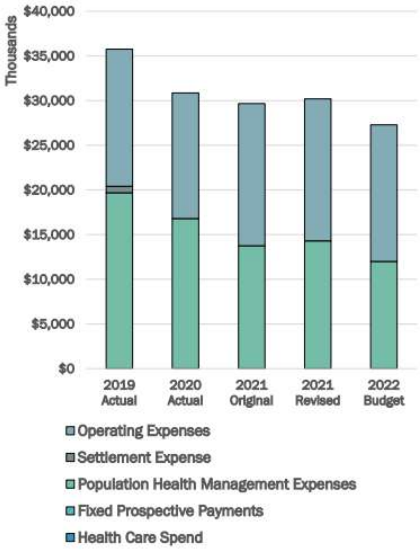
	FY19 Actual *% of Total*	FY20 Actual *% of Total*	FY21 Budget (Oct 1 - Approved) *% of Total*	FY21 Budget (May 24) *% of Total*	FY22 Budget *% of Total*
Total Expense	**681,131,922**	**1,118,699,486**	**1,459,165,761**	**1,237,457,922**	**1,365,345,843**
Health Care Spend	289,261,914 *42.5%*	669,547,321 *59.9%*	937,916,841 *64.3%*	784,208,228 *63.4%*	875,282,023 *64.1*
Fixed Prospective Payments	346,341,673 *50.8%*	402,406,905 *36.0%*	474,418,818 *32.5%*	407,254,322 *32.9%*	445,882,154 *32.7%*
Population Health Management Expenses	29,461,309 *4.3%*	32,700,998 *2.9%*	30,924,444 *2.1%*	30,089,714 *2.4%*	28,894,128 *2.1%*
Settlement Expense	725,576 *0.1%*	- *0.0%*	- *0.0%*	- *0.0%*	- *0.0%*
Operating Expenses	15,341,451 *2.3%*	14,044,262 *1.3%*	15,905,658 *1.1%*	15,905,658 *1.3%*	15,287,538 *1.1%*



GMCB PowerPoint, 26 (Dec. 8, 2021)

Entity-level:

	FY19 Actuals *% of Total*	FY20 Actuals *% of Total*	FY21 Budget (Oct 1 - Approved) *% of Total*	FY21 Budget (May 24) *% of Total*	FY22 Budget *% of Total*
Total Expense	**35,755,274**	**30,847,693**	**29,668,631**	**30,197,677**	**27,294,211**
Health Care Spend	- *0.0%*	- *0.0%*	- *0.0%*	- *0.0%*	- *0.0%*
Fixed Prospective Payments	- *0.0%*	- *0.0%*	- *0.0%*	- *0.0%*	- *0.0%*
PHM Expenses	19,688,249 *55.1%*	16,803,432 *54.5%*	13,762,972 *46.4%*	14,292,018 *47.3%*	12,006,673 *44.0%*
Settlement Expense	725,576 *2.0%*	- *0.0%*	- *0.0%*	- *0.0%*	- *0.0%*
Operating Expenses	15,341,450 *42.9%*	14,044,262 *45.5%*	15,905,658 *53.6%*	15,905,658 *52.7%*	15,287,538 *56.0%*



GMCB PowerPoint, 33 (Dec. 8, 2021)

36. The increase in FY22 budgeted expected Total Cost of Care spending on a full accountability basis is driven mostly by increases in the MVP program ($16 million), the BCBSVT primary program ($37 million), and BCBSVT QHP program ($46.6 million). *See* GMCB PowerPoint, 28 (Dec. 8, 2021). The increase in FY22 budgeted expected Population Health Management and payment reform on a full accountability basis is driven mostly by a $38.6 million increases in fixed prospective payments. *See* GMCB PowerPoint, 29 (Dec. 8, 2021).

Administrative Expenses

37. OneCare's administrative expense budget decreased from $15.9 million in FY21 to $15.3 million in FY22. *See* Budget Submission, App. 6.2. As a percentage of expenses on a full accountability basis, OneCare's administrative expenses account for 1.1% of all expenses in its FY22 budget, which is the same as its FY21 budget. *See* above, Finding ¶ 35. Population health management expenses account for 2.1% of OneCare's FY22 budget on a full accountability basis. On an entity level basis, administrative expenses account for 56% of OneCare's FY22 budget, which is an increase from 53.6% in FY21. *See* above, Finding ¶ 35.

38. OneCare's FY22 administrative expenses are set out below:

Salaries and Benefits	$ 9,651,315
Purchased Services	$ 1,193,249
Software/Informatics	$ 2,516,505
Occupancy	$ 421,503
Insurance / Risk Protection	$ 150,000
Assessments	$ 384,417
Other Expenses***	$ 970,549
Total Operational Expenses	**$ 15,287,538**

See Budget Submission, App. 6.4

39. OneCare provided a breakdown of its budgeted FY22 administrative expenses as follows:

Other Expenses Breakdown	2022 Budget
Contract & Maintenance	$432,500
Food & Beverage	$13,257
Advertising	$110,000
Travel	$63,250
Books, Dues, Subscriptions and Licenses	$84,000
Mail & Production	$35,000
Office Supplies	$37,500
Other Operating Expenses	$99,400
Professional Development	$65,380
Utilities	$30,262
Total	**$970,549**

See OneCare Responses to FY22 Budget Round One Questions, 16.

40. The decrease in administrative expenses is partly attributed to OneCare's decision to eliminate the position of RiseVT director. *See* Budget Submission, 53; OneCare Responses to GMCB Round Two Questions, 5-6; *see* below, Finding ¶ 64. OneCare provided the following comparison of the change in employee count and salary expenses between FY21 and FY22 budget.

	2021 vs. 2022		
	Δ Base FTE	Δ Fiscal FTE	Δ Salary
Senior Leadership	(1.35)	(0.38)	($171,592)
Compliance	(1.00)	0.00	$5,289
Contracting	(1.00)	(0.67)	($78,068)
Finance	(0.75)	1.58	$230,144
Outreach and Engagement	0.00	0.00	$32,999
Care Coordination & Clinical	0.00	0.33	$22,427
Population Health Analytics	(1.00)	(0.33)	$46,532
Quality Programs	1.00	1.50	$205,174
Program Operations	(1.00)	(1.00)	($87,090)
Primary Prevention	(1.00)	(1.00)	($200,561)
Total	**(6.10)**	**0.03**	**$5,253**

See OneCare Responses to FY22 Budget Round One Questions, 14.

Benchmark Trend Rates

41. 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.[6] APM Agreement, § 8.b.ii.

42. In developing its FY22 budget, OneCare assumed a 10.6% trend rate would be used in developing the 2022 benchmarks for the Medicare program, based on the Medicare USPCC. Budget Submission, 42-43.

43. On December 15, 2021, Board staff presented a proposed approach to developing the 2022 benchmarks for the Medicare program. On December 22, 2021, Board staff provided an updated recommendation of 7.3% benchmark trend rate, which the Board approved. *See* GMCB PowerPoint (Dec. 22, 2021).

44. For Medicaid, in its FY22 budget OneCare assumed a blended 2.12% trend for the traditional cohort and a blended 0.74% trend for the expanded cohort (relative to the 2021 target). Budget Submission, 43.

45. OneCare and DVHA were still negotiating the terms of the FY22 Medicaid contract, including the appropriate trend rate, when the Board voted on OneCare's FY22 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, 10 (March 31, 2021).

[6] 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.

46. At the time of the Board review and deliberation on OneCare FY22 budget, OneCare was still negotiating with BCBSVT and MVP regarding the trend rates that will be used to develop the financial targets for the FY22 commercial programs. OneCare used trend rates supplied by the insurers in developing its FY22 budget proposal. OneCare states that, for QHP programs, the trends were derived from the Board-approved rate filings. Budget Submission, 43.

47. The following table summarizes OneCare's budgeted trend rates for FY22:

	FY2021 Projected TCOC (FY21 Q3 Financial Reporting)	FY2022 Expected TCOC (FY22 Budget Submission)	Budgeted Trend from Base Experience* (FY22 Budget Submission, Appendix 4.3)
Medicare	$473,112,042	$533,210,803	10.6%
Medicaid - Traditional	$225,873,046	$245,245,465	2.1%
Medicaid - Expanded	$46,197,634	$47,558,217	0.7%
BCBS QHP	$113,960,875	$159,654,505	[redacted]
BCBS Primary **	$240,642,412	$277,644,746	[redacted]
MVP	$50,821,592	$66,924,423	[redacted]
TOTAL	$1,159,374,734	$1,365,345,843	N/A

*Base year varies by program; **budgeted trend does not represent FY21→FY22 growth**.
**Includes expected TCOC for BCBSVT Primary – Risk lives only; excludes BCBSVT Primary – Non-Risk lives.

GMCB PowerPoint, 46 (Dec. 8, 2021)

Provider Reimbursement

48. Most of the projected provider reimbursement reflected in OneCare's FY22 budget will be paid directly by payers to providers. Prospective payments, which do flow through OneCare, are projected to account for approximately 34% of OneCare's budgeted total cost of care in 2022 across all payers, about the same as in 2021. GMCB PowerPoint, 66 (Dec. 8, 2021).

49. The following table summarizes OneCare's expected fixed prospective payments by payer:

	Attribution (Average)	Expected TCOC (ETCOC)[1]	Total Fixed Payments (FPP + CPR)[2]	Total Fixed Payments (FPP + CPR) as % of Expected TCOC	HCP-LAN Category *For more information, see HCP-LAN Alternative Payment Model Framework, slide 136)*
Medicare	49,017	$533,210,803[3]	$272,551,147	51%	4B (*reconciled* to FFS)
Medicaid – Trad.	86,343	$245,245,465	$141,997,124	58%	4B (*unreconciled* to FFS)
Medicaid – Expand.	20,721	$47,558,217	$25,586,321	54%	4B (*unreconciled* to FFS)
BCBSVT	92,944	$437,299,251	[redacted]	1.1%	BCBSVT General: 3B[4] BCBSVT FPP Pilot: 4B (reconciled)
MVP QHP	9,901	$66,924,423			MVP: 3A[4]
TOTAL	258,926	$1,330,238,159	$445,882,154	34%	

1. Projected (Expected) TCOC: FY22 Budget Tab 5.1 ACO Risk by Payer and Tab 6.5 PMPM Rev by Payer. 2. See "FPP/CPR" line in FY22 Budget Tab 6.4 Sources Uses. 3. Medicare TCOC: Includes Blueprint/SASH at $9,073,983 for FY22. 4. BCBSVT and MVP payment model HCP-LAN categorizations according to filings from the GMCB's review of plans' Qualified Health Plan (QHP) premiums for 2022.

GMCB PowerPoint, 66 (Dec. 8, 2021).

50. The goals of payment reform, as OneCare notes, are to stabilize provider revenue, stabilizes healthcare costs, and move away from volume-based incentives that are inherent with fee-for-service payments. *See* Testimony of Sara Barry, Hearing Transcript, 40:21-42:1; OneCare PowerPoint, 19 (Nov. 10, 2021).

51. 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, 23.

52. OneCare intends to pursue unreconciled fixed prospective payments for all in-network hospitals and core primary care services across all payer programs during the period of 2022 through 2025. *See* Budget Submission, 9. OneCare described reconciled fixed payments as an added administrative burden that discourages OneCare's providers. *See* Testimony of Victoria Loner, Hearing Transcript, 162:10-163:14. OneCare notes that the move to unreconciled fixed prospective payments requires the support and participation from external public and private stakeholders, as well as favorable market conditions and regulatory support. *See* Budget Submission, 9.

53. OneCare provided the following Tables 1 and 2, showing OneCare's calculation of the current percentage of contract revenue that is in the form of fixed perspective payments, along with OneCare's targets, by payer and by year:

Table 1: Percentage of Contract Revenue in FPPs

Program (TOTAL $)	Hospital FPP	Primary Care FPP	TOTAL Contract Revenue Under FPP*
Medicare ($494M)	0.0%	0.0%	0.0%
Medicaid Traditional ($211M)	49.5%	0.9%	50.4%
Commercial ($129M)	0.0%	0.0%	0.0%

*Program year 2019 utilized as the baseline to avoid the impacts of Covid

Table 2: Targets and Milestones for Contract Revenue in FPPs

Program	Baseline	PY22	PY23	PY24	PY25
Medicare	0.0%	0.0%	53.4%	53.9%	54.4%
Medicaid	50.4%	50.7%	58.2%	58.5%	58.8%
Commercial	0.00%	2.9%	23.9%	44.9%	65.9%

Please see Section B, below, for detailed explanation of targets/timing.

Note that these figures are illustrative of targets and milestones based on the 2019 network configuration. Changes to program offerings and network configuration may affect these targets.

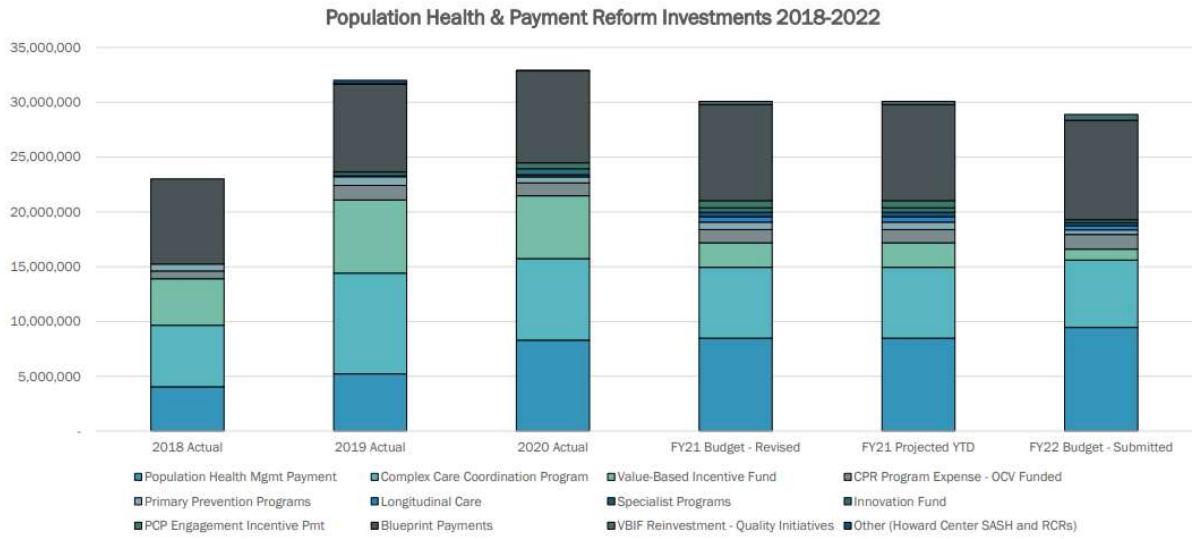
Source: OneCare FY21 Budget Order Condition 15 FPP Target, Strategy and Timeline Report (7/1/21)

See GMCB PowerPoint, 67 (Dec. 8, 2021).

54. When Vermont hospitals submitted their FY22 budgets to the Board, approximately 14% of all hospitals' total budgeted net patient revenues would come in the form of fixed prospective payments, although there was significant variation amongst hospitals. *See* FY2022 Vermont Hospital Budgets Board Deliberations, GMCB PowerPoint, 13 (Sept. 15, 2021). The 14% of net patient revenue is not limited to "true" fixed prospective payments but also includes payments that are reconciled at the end of each year. *See* Findings, ¶51-52. Commercial payers have a significantly lower percentage of expected total cost of care paid as FPP than Medicare and Medicaid in the OneCare network – 1% for commercial payers compared to 51% for Medicare and 54%-58% for Medicaid. *See* Findings, ¶49.

Population Health Management and Payment Reform Programs

55. OneCare has developed a variety of programs to implement its care model, with a total population health management investment of $29 million for FY22. *See* Budget Submission, 11. This represents a decrease of approximately $2.8 million from FY21. *See* GMCB PowerPoint, 77 (Dec. 8, 2021). The following chart presents OneCare's population health management (PHM) and payment reform investments in the proposed FY22 budget and previous budgets:



GMCB PowerPoint, 76 (Dec. 8, 2021).

56. The following table presents the detailed FY22 budgeted population health management (PHM) and payment reform investments, compared to prior years.

PHM/Payment Reform Programs	2018 Actual	2019 Actual	2020 Actual	2021 Projected	2022 Budget
Population Health Mgmt Payment	$ 4,040,926	$ 6,549,415	$ 8,562,787	$ 8,949,557	$ 9,457,821
Complex Care Coordination Program	$ 5,618,420	$ 9,219,158	$ 7,271,848	$ 5,408,355	$ 6,150,463
Value-Based Incentive Fund	$ 4,133,951	$ 6,673,056	$ 5,157,013	$ 2,012,391	$ 1,000,000
CPR Program Expense - OCV Funded	$ 715,808	$ 1,338,005	$ 1,179,831	$ 818,151	$ 1,331,256
Primary Prevention Programs - Program Match	$ 347,647	$ 406,865	$ 173,087	$ 290,000	$ 165,000
Primary Prevention Programs - Amplify Grants				$ 97,500	$ 50,000
Primary Prevention Programs - DULCE			$ 232,029	$ 250,981	$ 204,485
Self-Management Network Payments					
Longitudinal Care			$ 411,051	$ 124,878	$ 399,000
Specialist Program -Chronic Kidney Disease		$ 139,240	$ 356,757	$ 127,400	$ 10,874
Specialist Program -Mental Health Initiatives				$ 116,090	$ 255,009
Innovation Fund		$ 351,818	$ 376,068	$ 190,751	$ 268,990
PCP Engagement Incentive Pmt - BCBSVT Primary				$ 227,477	
PCP Engagement Incentive Pmt - Medicaid Expanded			$ 525,200	$ 416,808	
RCRs					
Blueprint Payments (PCMH)	$ 7,780,516	$ 4,756,752	$ 8,401,661	$ 1,993,092	$ 1,993,092
Blueprint Payments (CHT)				$ 2,633,176	$ 2,795,095
Blueprint Payments (SASH)				$ 4,140,865	$ 4,285,795
PCHP Program Initiative					
Howard Center SASH			$ 36,668		
VBIF Reinvestment - Quality Initiatives		$ 27,000	$ 17,000	$ 3,000	$ 527,247
PHM Totals:	**$ 22,637,268**	**$ 29,461,309**	**$ 32,701,000**	**$ 27,800,472**	**$ 28,894,127**

GMCB PowerPoint, 138 (Dec. 8, 2021).

57. A high-level summary of changes to OneCare's population health programs is below:

Value Based Incentive Fund	RiseVT	Care Navigator	Care Coordination Payments
• VBIF reduced • FY22 budget is $1 million compared to $2.24 million in FY21	• Phasing out RiseVT in favor of clinical prevention work • RiseVT still funded for first half of FY22	• Documentation in Care Navigator is optional. • Use of Care Navigator is no longer required for care coordination payments.	• OneCare is decoupling care coordination payments from Care Navigator. • Payments now tied to TCOC and other metrics, still TBD.

GMCB PowerPoint, 73 (Dec. 8, 2021).

58. 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, 58-59. While individuals in quadrants three and four comprise 16% of OneCare's attributed population, they account for approximately 49% of total spending. *Id.*; *see* Budget Submission, App. 7.3.

59. The VBIF provides investments linked to quality measures, designed to enhance focus on four key measures: Diabetes Mellitus: Hemoglobin A1C Poor Control (>9%), Hypertension: Controlling High Blood Pressure, Screening for Clinical Depression and Follow Up Plan, and Developmental Screening in First 3 Years of Life. *See* Budget Submission, 25. The VBIF funds are distributed based on those quality measures; 70% are distributed to practices that meet quality measure performance targets, and an additional 10% is awarded to practices that meet the stretch goal for each measure. *See* Budget Submission, 40. The remaining 20% of the VBIF fund is distributed to network specialists and collaborating agencies based on HSA-level performance. *Id.*

60. OneCare's FY22 budget reduces the funding to the VBIF by approximately $1 million, with a prefunded amount from hospital participation fees of $1 million in FY22. *See* Budget Submission, 10, App. 6.4. The total amount in the VBIF for FY22 is $1.2 million in OneCare's budget. *See* Budget Submission, 51.

61. A summary of OneCare's population health programs tied to quality is below:

	2021 Budgeted Amounts	2022 Budgeted Amounts	Change	Key Takeaways
Pre-Funded VBIF	$2,235,990	$1,000,000	($1,235,990)	• Fixed amount; prefunded • Timely • Linked to clinical priorities
Quality Accountability at Program Settlement	$6,317,080**	$6,724,695***	$407,615	• Variable amount • 12+ months removed • Linked to payer contract measures; PIP measures (10% of settlement - cost per capita & avoidable ED utilization)
PHM Investments Linked to Quality and Outcomes*	$0	$982,419	$982,419	• Fixed amount; prefunded • Timely • Linked to Care Coordination measures (not yet defined)
Total	**$8,553,070**	**$8,707,114**	**$154,044**	

*Portion of Care Coordination payments available to providers based on quality and outcomes (15% of total CC payments).
**2021 Budgeted amount from settlement is realized in 2022.
***2022 Budgeted amount from settlement is realized in 2023.

GMCB PowerPoint, 10 (Dec. 15, 2021); OneCare Vermont FY22 Budget Quality Accountability Table.

62. 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, 17, 22. In FY22, OneCare plans to provide a $5 PMPM supplemental payment in addition to monthly PMPM payments for core services. Budget Submission, 22. Two additional practices are joining the CPR program in FY22, bringing the total to 13. Budget Submission, 18.

63. OneCare is coordinating with the Blueprint for Health (Blueprint) and AHS regarding potential improvements in coordination between OneCare and the Blueprint. *See* Budget Submission, 63-64. This coordination includes meetings with Blueprint Administrative Entities to identify opportunities to align services. *See id*.

64. The primary prevention investments included in OneCare's proposed FY22 budget also include investments in 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. *See* Budget Submission, 53. OneCare's contributions to DULCE were reduced in FY22 from FY21, but OneCare cited DULCE's receipt of federal funding that offset the reduction. *See id*.

65. OneCare will phase out RiseVT in FY22. *See* Budget Submission, 53; OneCare Responses to GMCB Round Two Questions, 5-6. OneCare described the decision to shift to a primary prevention strategy that has more emphasis on clinical prevention activities. *See id*.

66. OneCare determined that it was in the interest of its participants to make changes to Care Navigator. *See* Budget Submission, 75-76. These changes include decoupling care coordination payments from the use of Care Navigator; instead, care coordination payments will be made as capacity payments (85%) and incentive payments (15%) based on metrics to be determined. *See*

Budget Submission, 76. Data collection may also be shifted from Care Navigator in FY22. *See id*.

67. OneCare has not included any significant expansion or overall changes in its care model for FY22. *See* Budget Submission, 62-64.

68. As in past years, Board staff recommended that the Board propose an adjustment to the Medicare benchmark calculation to fund shared savings, including the Blueprint for Health, SASH, Patient-Centered Medical Home (PCMH) and Community Health Team (CHT) programs and payments in 2022. GMCB PowerPoint, 28-29 (Dec. 15, 2021). 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).

69. OneCare's proposed FY22 budget includes increased total funding for Blueprint for Health Patient-Centered Medical Home (PCMH) and Community Health Team (CHT) payments, as well as the SASH program from projected FY21 levels. OneCare Presentation, 37, 41. 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:

PHM & PMT Reform Investments	2018 Actual	2019 Actual	2020 Actual	2021 Projected	2022 Budget
Total Revenue	**$ 635,447,286**	**$ 685,821,095**	**$ 1,118,699,486**	**$ 1,219,128,750**	**$ 1,365,345,843**
Population Health Management (PHM) Total	$ 22,637,268	$ 29,461,309	$ 32,701,000	$ 27,800,472	$ 28,894,127
Blueprint (PCMH, CHT, SASH)	$ 7,780,516	$ 4,756,752	$ 8,401,661	$ 8,767,133	$ 9,073,982
PHM (Less: Blueprint)/Revenue	2.3%	3.6%	2.2%	1.6%	1.5%
PHM/Revenue	3.6%	4.3%	2.9%	2.3%	2.1%

GMCB PowerPoint, 75 (Dec. 8, 2021).

70. OneCare assumed that the Medicare benchmark will include a 3.5% trend on this funding. Budget Submission, 43; OneCare Presentation, 40 (Nov. 10, 2021).

Performance Monitoring and Assessment

71. OneCare does not currently use national benchmarks to measure utilization or Total Cost of Care but considers that an area of opportunity. *See* OneCare Responses to FY22 Round One Questions, 6-7 (Nov. 5, 2021). OneCare does use national benchmarking comparisons in its quality measurements for both annual quality reporting and the VBIF program. *See id*.

72. The Board received advice that national benchmarking is a fundamental element for an ACO to "1) developing a more effective performance improvement program and thus improved performance; 2) sharpening an ACO's focus on the priority areas that will result in the most significant return on investment (ROI) in terms of both cost and quality; 3) identifying best practices; 4) presenting specific opportunities to implement best practices for ACO providers that have been effective in ensuring success for other ACOs; and 5) further embedding an operational culture of continuous improvement in performance." See Damore Health Advisors LLC,

Recommendations to the Green Mountain Care Board: Accountable Care Organization (ACO) Oversight (December 2021).

Public Comments

73. The Board accept public comments on OneCare's proposed budget from October 1, 2021 through December 20, 2021. These comments are available on the Board's website.[7] The Board received comments from 46 people regarding the OneCare's FY22 budget and the Board's review. Generally, the themes from public comments reflect:

- Value of OneCare's data and analytics to providers, especially for population level insights and prevention initiatives
- Value of care coordination investments enabled by OCV funding
- Concerns related to decreased population health management and mission-related investments
- Concerns related to OneCare's leadership compensation
- Concerns related to OneCare's performance to date

See GMCB PowerPoint, 3 (Dec. 22, 2021).

74. Key concerns raised by the HCA in its comments include:

- Population health: Concern about the cuts to PHM program funding and deprioritizing program evaluation (only 0.5 FTE dedicated to evaluation).
    - "OCV's PHM strategy should be based on a clear accounting of costs and an evaluation of savings and quality outcomes stemming from each investment."
- Transparency: Concern about OneCare's commitment to transparency, citing failure to provide direct and complete answers to written questions.
- Evaluation: HCA highlights major conclusions of the NORC evaluation, including the need for further transparency and PHM investment.
- Cost Estimation for Vermonters: OneCare is working to stabilize payments for providers. Along the same lines, OneCare should work with stakeholders to find ways to provide more predictable out-of-pocket cost estimates for Vermont consumers.

Letter from the HCA Policy Team to Kevin Mullin (Nov. 30, 2021).

75. Board staff considered the public comments and HCA comments in developing their recommendations regarding OneCare's proposed FY22 budget. *See* GMCB PowerPoint, 6-7 (Dec. 8, 2021); GMCB PowerPoint, 3 (Dec. 22, 2021).

CONCLUSIONS

[7] https://gmcboard.vermont.gov/aco-oversight/2022.

OneCare bears the burden of justifying its proposed FY22 budget. Rule 5.000, § 5.405(a). In deciding whether to approve or modify the budget, the Board must consider the criteria of 18 V.S.A. § 9382(b) and the requirements of the APM Agreement. Rule 5.000, § 5.405(b).

I. Statutory Criteria

A. Historic and future expenditures and the effects of care models on utilization, 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 2020, the most recent year for which data are available and a year in which utilization was significantly impacted by the COVID-19 pandemic, the actual TCOC for Medicare and Medicaid was below the target TCOC, in each case outside of the negotiated risk corridors. *See* Findings, ¶¶ 14, 15. For 2020, quality scores were not generated and quality metrics were reporting only because of the COVID-19 pandemic, but within its Medicare and Medicaid reported quality metrics, OneCare's results were mixed compared to 2019. *See* Findings, ¶ 18-21.

Payers are responsible for evaluating whether OneCare is positively impacting the cost and quality of care provided to their beneficiaries or members. CMS, DVHA, and the commercial payers BCBSVT and MVP are expected to continue their existing programs with OneCare in 2022, indicating that they see continued promise in an ACO to deliver value for their members or beneficiaries. *See* Findings, ¶ 3.

With respect to utilization, cost per capita, patient satisfaction/engagement, quality, and evidence-based clinical appropriateness health care services provided by OneCare's network, we conclude that OneCare would benefit from comparing its metrics to benchmarks for high-performing ACOs around the country. OneCare currently does not utilize national benchmarks in this way. See Findings, ¶ 71. By utilizing national benchmarks, OneCare could identify areas of success and prioritize its efforts on areas to improve. See Findings, ¶ 72.

OneCare provided the Board with its calculations of percent of payments that were in the form of fixed prospective payment. See Findings, ¶ 53. We do not necessarily agree with OneCare's methodology for calculating the FPP baseline and targets, and this order includes monitoring and reporting for FY22 with updated templates for reporting FPP levels and targets.

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 FY22 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, ¶¶ 62-67.

We are concerned with the reduction in OneCare's funding for population health management investments, particularly OneCare's reduction in funding for its Value Based Incentive Fund (VBIF). See Findings, ¶¶ 55, 57, 60, 61. These investments are an important component of the ACOs role in building a high-performing health system, and we therefore require OneCare to fund the VBIF or other pre-funded clinical quality incentive programs at not less than the FY21 VBIF funding amount of $2.24 million.

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

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. OneCare's costs are described in detail in OneCare's budget submission, supplemented by OneCare's responses to our questions, and this order.

E. Effects of Medicaid Reimbursement on Other Payers

OneCare's FY22 budget includes trend rates for the MVP and BCBSVT QHP programs that are based on Board-approved rate increases for 2022 QHPs. Findings, ¶ 46. These health insurance rate increases are significantly affected by the cost shift. *See* GMCB Annual Report for 2021, 38 (calculating the impact of the cost shift, as defined elsewhere in the report, on QHP rate increases to be approximately 13.7%). Thus, as we noted last year, through the cost shift, Medicaid reimbursement levels impact the benchmark rates negotiated by OneCare and commercial insurers.

The most recent payer differential report issued by the Board suggests that the differential between risk-adjusted ACO benchmarks for Medicaid and other payers, while significant, 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 maintain in FY22 the narrower risk corridors with payers that it negotiated in FY21. The total "downside" risk reflected in OneCare's proposed FY22 budget is just over $16 million, which is similar to its FY21 budget but significantly less than its pre-COVID 19 budgets. Findings, ¶¶ 4, 6, 12. OneCare plans to transfer the great majority of its

anticipated downside risk, approximately $16 million, to network providers, primarily hospitals, to which OneCare will transfer approximately $13.7 million of its downside risk. Findings, ¶¶ 6, 12. OneCare does not plan to purchase third-party risk protection for the Medicare program, as it has done in past years. Findings, ¶ 11.

OneCare anticipated approximately $6.8 million in lost revenue in FY22 compared to FY21, which would have resulted in a budget shortfall for FY22, and as result increased the participation fees it charged to hospitals to reach a breakeven budget. See Findings, ¶¶32-34. Prior to realizing it would have an anticipated shortfall, OneCare refunded FY20 participation fees to hospitals in the amount of $3.1 million. See Findings, ¶13. We include a condition that OneCare notify the Board of any future decision to refund participation fees within 15 days of refunding the participation fees.

The $5.7 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, ¶ 12.

We impose conditions on our approval of OneCare's FY22 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. We also require OneCare to notify the Board in the event that OneCare adjusts its participation fees, including an adjustment by refunding participation fees.

G. ACO's Administrative Costs

OneCare proposes FY22 administrative expenses of approximately $15.3 million. This represents a slight decrease relative to OneCare's originally approved FY21 budget. *See* Findings, ¶¶ 37-38. We require that OneCare's administrative expenses not exceed $15.3 million plus the cost of third-party benchmarking as required by this order. With respect to OneCare's salaries, we will monitor and enforce compliance with the Board's guidance on compliance with Guidance re Rule 5.000, § 5.203(a), adopted by the Board in 2021, regarding the executive compensation.

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

The changes in OneCare's membership and composition to its Board of Managers OneCare, while not immaterial, do not undermine the character, competence, fiscal responsibility or soundness of the ACO. *See* Findings, ¶¶ 1, 2. We will continue to monitor and enforce the ACO's compliance with its certification requirements, including that the ACO must structure its executive compensation to achieve specific and measurable goals that support the ACO's efforts to reduce cost growth or improve the quality and overall care of enrollees, or both.

I. HCA Participation and Public Comment

The Board took public comments on OneCare's proposed budget and the budget review process from October 1, 2021 through December 20, 2021. During that time, the Board received comments from 46 people regarding the OneCare's FY22 budget and the Board's review. Findings, ¶ 73. The Board also received comments from the HCA. Findings, ¶ 74. The Board's staff considered the public comments and comments from the HCA in their analysis and recommendations, and we have reviewed and considered them as well. *See* Findings, ¶ 75.

II. APM Agreement

A. TCOC Growth Rates

Total cost of care for services covered by the APM Agreement for 2020 was not available at the time the Board approved OneCare's budget. The actual total cost of care per person across all payers grew 4.6% from 2017 through 2019 for services covered by the APM Agreement. GMCB PowerPoint, 11 (March 31, 2021). This growth rate is above the APM Agreement's target of 3.5% and the corrective action trigger of 4.3%. Due to COVID-19, compounding growth in expenditures from 2017 through 2021 is expected to be lower. GMCB PowerPoint, 17 (March 31, 2021).

At the time the Board approved OneCare's budget, OneCare was still negotiating with DVHA on the terms of the 2022 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, ¶ 45. 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 2022. *See* Findings, ¶ 45. 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 2022 commercial contracts, this uncertainty is not new. Similar to prior years, 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.

B. Scale and Program Alignment

The State is currently below the scale targets in the APM Agreement. *See* Findings, ¶ 28. Although CMS informed the State that scale targets in the APM Agreement would not be enforced, the State will continue to report scale to CMS. *See* Findings, ¶ 29. 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 add reporting requirements and targets for fixed prospective payments as part of OneCare regular reporting to the Board.

ORDER

Based on our Findings and Conclusions above, and pursuant to 18 V.S.A. § 9382, we hereby approve OneCare's FY22 budget on the terms, and subject to the conditions, set forth below:

1. OneCare must implement a reputable and effective ACO benchmarking system to compare key quality, cost, and utilization metrics to national benchmarks, utilizing OneCare claims data and potentially clinical data, and acquiring data from third party sources as needed. The benchmarking system and data source must be approved in advance by GMCB staff, built for each payer program, and include national benchmarks (and regional, if available) and identify best-practices based on the data in five key areas: 1) utilization, 2) cost per capita, 3) patient satisfaction/engagement, 4) quality, and 5) evidence-based clinical appropriateness. The benchmarking system will:
    a. allow the ACO and the GMCB to assess OneCare's performance against peer ACOs or integrated health systems;
    b. enhance OneCare's ACO-level performance management strategy, including implementation of processes and programs that have been implemented at best practice sites, and integration of these priority opportunities in the OneCare Quality Evaluation and Improvement Program; and
    c. improve ACO regulatory reporting and performance assessment by providing the benchmarking comparisons to targets at least quarterly to the GMCB.

    Implementation of the benchmarking system shall start with the Medicare program in FY22 as a test year. OneCare must select and propose the Medicare benchmarking system for GMCB staff approval by March 31, 2021, and present the Medicare proposal, as well as a plan for Medicaid and commercial benchmarking systems, at the revised budget presentation in Spring 2022.

    Monitoring dashboards and targets will be developed by GMCB staff in collaboration with OneCare and specified in the updated ACO Reporting Manual. The updated ACO Reporting Manual will be modified by GMCB staff to streamline reporting requirements to be focused more on results of the benchmark system.

2. Monitoring and Reporting:
    a. The GMCB will issue updated reporting requirements in the ACO Reporting Manual pursuant to GMCB Rule 5.501 to implement a data-driven monitoring approach relying on payer-specific national ACO benchmarking systems or datasets. OneCare Vermont will report on performance and benchmarking results at least quarterly. OneCare Vermont will work with GMCB staff to finalize reporting templates by June 30, 2022, with first quarterly reports (Q1 2022) due July 31, 2022.
    b. The FY 2023 ACO budget review guidance for OneCare Vermont should reflect this change in approach and introduce performance targets linked to national benchmarks, along with enforcement mechanisms where OneCare Vermont does not perform at the levels outlined in the guidance.

3. OneCare must submit reports and information in accordance with the GMCB Reporting Manual. The content of the GMCB Reporting Manual shall be developed, maintained, and revised by GMCB staff, with authority delegated to GMCB's Director of Health Systems Policy, within the scope of GMCB Rule 5.501. OneCare must consult with GMCB staff as needed in the development of the reporting requirements. The GMCB

Reporting Manual shall be in addition to, and without limitation of, other information, data, and analysis that GMCB or GMCB staff may require OneCare to report, including under GMCB Rules 5.501 and in the GMCB's Annual Budget Review Guidance and Certification Eligibility Review Form.

a. The GMCB Director of Health Systems Policy will specify and determine a methodology for the ACO to report data about ACO FPP levels and targets in the updated ACO Reporting Manual. Based on the additional reporting about ACO FPP levels and targets that GMCB staff will specify in the ACO Reporting Manual, GMCB Director of Health Systems Policy will approve, or modify and approve, a commercial FPP target and seek twice annual reporting from OneCare on progress toward this target.

PAYER PROGRAM AND RISK

4. 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 ACO Reporting Manual.

5. OneCare must ensure that its payer contracts are consistent with the following 2022 benchmark trend rates and related conditions:
    a. Vermont Medicare ACO Initiative: The trend factors proposed by the GMCB and approved by CMS;
    b. Medicaid Next Generation ACO Program: The trend factors that are consistent with the GMCB's recommendations in the Medicaid advisory rate case.
    c. Commercial:
        i. The 2022 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 GMCB 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; and (c) a revised budget based on the finalized benchmarks on the dates specified in Conditions 8 and 9.

6. OneCare shall work with Medicare Advantage plans operating in Vermont – with a special focus on Vermont-based plans offered by BCBSVT and UVMMC-MVP – to develop scale target qualifying programs for FY23.

7. OneCare must implement the risk model that it described in its budget proposal and must request and receive approval from the GMCB prior to making any material changes thereto. OneCare must:
    a. Submit to the GMCB copies of the contracts that bind each of the risk bearing entities to OneCare's risk sharing policy no later than 10 days after all contracts have been executed;
    b. Notify and seek approval from the GMCB 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 GMCB with detailed information, including effects by risk bearing entity and parent organization.

ACO BUDGET & FINANCIALS

8. OneCare must notify the GMCB of any material changes to the budget as approved by the OneCare Board of Managers/Finance Committee/Leadership. Include what line items changed, the dollar value, and the impact on the bottom line as part of quarterly financial reporting, according to specifications to be issued in the updated ACO Reporting Manual.

9. No later than March 31, 2022, OneCare must provide GMCB staff with the supporting documentation relevant to the topics identified in Condition 10. 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, including final care coordination payment model;
    e. Hospital dues for 2022 by hospital;
    f. Hospital risk for 2022 by hospital and payer;
    g. Documentation of any changes to the overall risk model for 2022;
    h. Source of funds for its 2022 population health management programs;
    i. Documentation on the selection and proposal of the ACO benchmarking system for the 2022 Medicare program and status of potential options for benchmarking systems for Medicaid and commercial payer programs for 2023;
    j. A report to the Board on OneCare's progress relative to its targets for commercial payer FPP levels that OneCare set in accordance with its FY21 budget order, condition 15, and any FPP targets set according to conditions in this order; and
    k. Any other information the GMCB deems relevant to ensuring compliance with this order.

10. At its presentation of the revised budget and no later than April 30, 2022, OneCare must present to the GMCB on the following topics:
    a. Final FY2022 attribution and finalized payer contracts;
    b. Revised budget, based on final attribution;
    c. Final description of population health initiatives;
    d. Expected hospital dues for 2022 by hospital;

e. Expected risk for 2022 by risk bearing entity and by payer;
f. Any changes to the overall risk model for 2022;
g. Source(s) of funds for OneCare's 2022 population health management programs;
h. Status of the ACO benchmarking system by payer program;
i. Update on the results of evaluations as described in the FY22 budget submission (including care coordination and analysis of variations in care by HSA);
j. Update on the partnership between OneCare and the University of Vermont to explore additional partnerships around evaluation;
k. OneCare's progress relative to its targets for commercial payer FPP levels that OneCare set in accordance with its FY21 budget order, condition 15, and any FPP targets set according to conditions in this order; and
l. Any other information the GMCB deems relevant to ensuring compliance with this order.

11. In FY22, OneCare's Operating Expenses must not exceed $15.3 million, plus the cost of the third-party benchmarking system as required in Condition 1 following approval by GMCB staff.

12. If OneCare uses its reserve, adjusts its participation fees (i.e., invoicing a risk bearing entity for additional fees or refunding fees), or uses its line of credit, it must notify the GMCB within 15 days of such use. Notification must include the reason for the change and, for any use authorized under this condition, a corresponding cash flow analysis. For refunded participation fees, OneCare must provide the date of the BOM decision and documentation of the amounts refunded to each risk bearing entity.
    a. The use of reserves, additional participation fees, or funds drawn from OneCare's line of credit shall be limited to:
        iii. Additional funding for population health investments;
        iv. Financial backing for risk incurred by participating providers;
        v. Maintaining ACO-wide risk on behalf of participating providers;
        vi. Temporary cash flow issues associated with payer revenue delays; and
        vii. Other uses pre-approved by the GMCB.

13. OneCare must submit its audited financial statements as soon as they are available and must submit information as required by the GMCB to monitor OneCare's performance. OneCare must crosswalk submitted actuals per its budget submission to audited financial statements for FYs 2018-2022.

14. OneCare to provide the GMCB with the most recent version of the ACO's IRS Form 990 as soon as it is available.

POPULATION HEALTH AND QUALITY

15. If population health management and payment reform programs are not fully funded as detailed in OneCare's FY22 budget submission, OneCare must submit a revised proposal no later than March 31, 2022, to the GMCB. 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.

16. In FY22, OneCare must fund the VBIF or other pre-funded clinical quality incentive programs at a minimum of $2.24 million, to be reflected in the final budget submission due in Spring of 2022.

17. In FY22, OneCare must fund SASH in the amount of $4,285,795, which is equivalent to the 2021 budgeted amount of $4,140,865 plus an inflationary factor of 3.5%, contingent on the increase in funding being used to enhance programs or expand access to Medicare beneficiaries. In 2022 OneCare must fund the Blueprint for Health (PCMH and CHT) investments in the amount of $4,788,187, which is equivalent to the 2021 budgeted amount of $4,626,268 plus an inflationary factor of 3.5%, consistent with the medical home and community health team program payment design approved by the Agency of Human Services.

18. 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.

GENERAL

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

20. After notice and an opportunity to be heard, the GMCB 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: February 17, 2022 at Montpelier, Vermont

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

Pelham, concurring

While I support and concur with the votes of the majority in approving OneCare's 2022 budget, there is one critical area where the submitted financial data notably conflicts with a key OneCare strategic goal.

OneCare's Strategic Plan establishes the goal to "[e]volve value based care contracts to move away from Fee for Service." *See* OneCare Strategic Plan, page 14. Further, in the 2022 Budget Narrative, OneCare states: "The pivotal first step in managing overall health cost growth is to transition the health system from one rewarded by volume to one that rewards cost-effective and high-quality care." Budget Submission, 45. OneCare contents such will "support the All-Payer Model goal to manage overall health care cost growth to be in line with that of the Vermont economy." Budget Submission, 45. Yet, OneCare's financial projections do not well align with this key goal.

OneCare's Budget Submission Appendix 6.2: Income Statement with Accountability profiles "Spend Components processed EXTERNALLY to OneCare" including Fee for Service Claims. Separately, under "Payment Reform Prgm.", OneCare profiles "Fixed Prospective Payments" including both truly capitated payments as well as certain payments that subsequently get reconciled to fee for service. The associated payment amounts profile as follows:

Payment Type	FY 2021 Projected	FY 2022 Budget Submitted	Difference	Percent Change
Externally Processed incl. FFS	$784,208,228	$875,282,023	$91,073,795	+11.6%
Fixed Prospective Payments (FPP's)	$407,254,322	$445,882,154	$38,627,832	+ 9.5%

The above profile is worrisome. First, while the dollar amount of FPP's is expected to grow, that growth is projected at a lower rate relative to the already more dominate non-FPP payments, which are projected to grow 22% faster than FPP payments. Secondly, a sizable portion of the payments classified as FPP's are not truly capitated payments, the type that will drive constraints in "overall health care cost growth". And third, OneCare has already engaged large portions of the total Vermont Medicaid and Medicare populations in the OneCare network, indicating there is not much left in those two arenas to grow FPP volume. For example, OneCare projects 107,000 Medicaid members in 2022 while the Emergency Board projects a total of 140,000 Medicaid beneficiaries. *See* Budget Submission, App. 4.3 Budgeted Member Months; Emergency Board Meeting, Report on Medicaid for Fiscal Year 2021 (July 30, 2021) (available at: https://aoa.vermont.gov/sites/aoa/files/revenue-economy/EboardMinutes/2021-07-30%20Emergency%20Board%20Notice%20and%20Materials.pdf)

Unless OneCare can enhance the quality of FPP's relative to true capitated payments and better engage commercial carrier participation in the OneCare network, "[t]he pivotal first step in managing overall health cost growth" may not be achieved.

Filed: February 17, 2022

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).