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MEMORANDUM

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

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

RE: Round 1 Questions to OneCare Vermont ACO on the FY 2022 Budget Submission

DATE: October 22, 2021

Green Mountain Care Board staff have prepared the following questions in response to OneCare's FY22 budget submitted October 1, 2021.

Please submit written responses to the questions by November 5, 2021. If you need more time to prepare any of the responses, please contact us to discuss the timing by October 29, 2021. We may permit responses to be submitted in more than one batch to allow us to get responses as soon as possible.

In addition, the Office of the Health Care Advocate may submit additional questions under separate cover.

Responses are to be submitted to the GMCB ACO oversight team, copying the Office of the Health Care Advocate, at the following email addresses: Sarah.Kinsler@vermont.gov; Patrick.Rooney@vermont.gov; Kaitlyn.Hoffman@vermont.gov; Marisa.Melamed@vermont.gov; Michele.Degree@vermont.gov; Michelle.Sawyer@vermont.gov; Julia.Boles@vermont.gov; Russ.McCracken@vermont.gov; hcapolicystaff@vtlegalaid.org

Questions – Narrative

1. Provider network survey: Please share a copy of the survey instrument, a summary of the results, and the top three priority follow-up actions that resulted from the survey.
2. The total starting attribution assumed is ~288,000 (Section 1, Q1d, p.10). Using the table below, please break out the starting attribution assumptions by payer program (Medicare, Medicaid traditional/expanded, BCBS QHP, BCBS Primary risk/non-risk, MVP QHP) and the average attribution assumptions used to develop the budget, by payer program.

Payer Program	FY22 Starting Attribution Estimated *Used to Measure APM Scale*	FY22 Average Attribution Estimated *Should match data provided in Appendix Tabs 5.1 and 5.2*
Medicare		
Medicaid – Traditional		
Medicaid – Expanded		
BCBSVT QHP		
BCBSVT Primary – Risk		
BCBSVT Primary – Non-Risk		
MVP QHP		
TOTAL		

   a. We understand the information provided above represents assumptions; please describe how OneCare develops the attribution assumptions for the budget by payer program. For example, Section 3, Q1c, p.31 states that the BCBSVT attribution numbers are based on OneCare's assumptions about which employer groups will choose scale vs non-scale – how were these assumptions developed?

3. Regarding mechanisms to ensure FPP is not "too high" or "too low" (Section 3, Q2, p.32) it is stated that the OneCare finance committee regularly reviews FPP and has recommended adjustments to the amounts in the past. What is the frequency of review and adjustments? What is the magnitude of adjustments? How are participants notified of adjustments? Are these questions addressed in the Hospital or Participant Fixed Payment Policy (04-11)? If so, please provide the policy.
4. Medicaid total cost of care (TCOC): Please provide insight into the decision not to adjust TCOC for the public health emergency, other than the removal of some COVID-19 admissions and vaccination spend from TCOC (Section 4, Q1, p.38).
5. Commercial TCOC: (Section 4, Q1, p.38)
   a. [redacted]
6. How are payments aligned to incentivize primary care physicians, specialists, and hospitals to ensure quality care is delivered in the lowest cost locations, improve quality and satisfaction, and reduce TCOC?
7. Accountability Pool: (See Section 4, Q2, p.40; Section 5, Q1, p.47)
   a. What is the total dollar amount of the accountability pool for FY2021, and how much is anticipated for FY2022?
   b. Please explain the decision to hold primary care accountable for the <u>first</u> $1.50 of losses (versus provider types who contribute more to total spending, e.g., hospitals).
   c. Are participating FQHCs paying into the accountability pool and accountable for losses?
8. Please provide a table comparing the HSA-based risk model by provider entity with the current network-based risk model, using 2019 actuals data on shared savings and losses, using the template below.

Hospital	HSA	Actual 2019 Savings/Risk Distribution *(HSA-based risk model)*	Hypothetical 2019 Savings/Risk Distribution *(Network risk model)*
Southwestern VT Medical Center	Bennington		
Central Vermont Medical Center	Berlin		
Brattleboro Memorial Hospital	Brattleboro		
The University of Vermont Medical Ctr	Burlington		
Dartmouth-Hitchcock	Lebanon		
Porter Medical Center	Middlebury		
Copley Hospital	Morrisville		
North Country Hospital	Newport		
Gifford Medical Center	Randolph		
Rutland Regional Medical Center	Rutland		
Springfield Hospital	Springfield		
Northwestern Medical Center	St. Albans		
Northeastern VT Regional Hospital	St. Johnsbury		
Mt. Ascutney Hospital & Health Ctr	Windsor		

9. Does OneCare use any benchmarking data from national sources to compare utilization and TCOC for Commercial, Medicaid, and Medicare populations such as Premier's ACO benchmarking or Milliman well managed or managed populations? This benchmarking data could include hospital admissions/1000, ED visits/1000, total per capita cost, post-acute care per capita cost, per capita cost per diabetic, etc.? If so, how is it used and if not, have you considered it?
10. Please describe the program OneCare or its network utilizes to manage pharmacy compliance? Does OneCare have any data by primary care physician or TIN number? Does OneCare have any trending data and a list of successful performance improvement actions?
11. Has OneCare implemented a statewide approach to managing post-acute care? Has OneCare evaluated the post-acute care provider networks using metrics? Does OneCare have a preferred network of providers who have agreed to a set of care principles that can be shared? Is OneCare measuring the percent of hospital patients discharged to SNFs, rehab institutions, and home care agencies compared to national benchmarks?
12. Does OneCare have a tool to measure clinical appropriateness in 5-6 key clinical areas such as the use of diagnostic technology (CT, MRI, and PET), indications for spinal surgery, etc. Does OneCare facilitate clinicians in using "choosing Wisely" criteria? If so, how and for which conditions? Does OneCare use a clinical appropriateness tool statewide, such as Stanson Health.
13. How are the social determinants of health (SDOH) integrated into the care management process? Is OneCare still working with Algorex Health to integrate SDOH data? How is OneCare supporting the network in integrating SDOH data into care management?
14. Does OneCare have a Population Health Information Technology (PHIT) strategic and operational plan? If so, please share it. If not, how does OneCare establish PHIT priorities annually?
15. Care Coordination Payments:
    a. OneCare's response to Section 2, Q3a, p.21 states: "Care coordination payments have been decoupled from administrative burdens reported in use of Care Navigator and tied to

total cost of care (TCOC)-related or other industry accepted metrics." What are "other industry accepted metrics"?

b. How will this new payment model impact participating providers across the care spectrum in terms of engagement in care coordination and payment for care coordination?

16. Value-Based Incentive Fund:
    a. Please provide the year over year changes to the VBIF/provider incentive payment policy. In doing so, please include a rationale for each noted change.
    b. What assumptions about the FY22 VBIF does OneCare make in its budget submission, and how were these assumptions developed?
    c. Please provide an explanation of the VBIF reinvestment line item in Tab 6.2 of the financial workbook (Full Accountability IS; $527,247).
17. Exhibit C shows the five most prevalent conditions among high-cost patients; not the most prevalent high-cost conditions. Please resubmit according to the guidance.

Questions – Financials

18. Provide the verification under oath for the VP of Finance.
19. What is the new shared resource model with UVMMC?
20. Explain the year-over-year growth since FYE2020 of the liability "Due to UVMMC." In addition, please provide detail of what shared services are driving this liability. Will this figure change with UVMHN as sole parent organization of OneCare?
21. How did the departure of Dartmouth work from OneCare? Was there a buy out as they were 50% members? Describe any financial impact of this governance change.
22. Participation Fees:
    a. Please provide the most recent participation fees policy (Policy #04-10).
    b. How does the accounting for participation fees work? Are they static for the year and then trued up at year end, or are they modified during the year?
    c. It was noted in OneCare's 2020 audit that participation fees were refunded back to the participants (approximately $3.1 million). This was net income that would've gone into reserves. Does OneCare consider refunding participation fees an appropriate use of its reserves? What were the criteria used by OneCare to decide to refund fees instead of putting them into reserves to fund future programs, population health investments, or to prepare for the anticipated instability in revenue streams for DSR and HIT funding that could have been partially funded through the FY2020 refund?
    d. Is there a plan to refund participation fees in FY2021? What criteria will OneCare apply when evaluating whether to refund participation fees in FY2021 or in the future?
    e. If participation fees are increasing to cover loss of DSR and HIT funding, why are Population Health Management programs being eliminated? What Population Health Management investments are being cut due to the loss of DSR and HIT funding?
23. It is discussed in the narrative that the CPR program is expanding. Where is this reflected in the income statement/variance analysis? We only see the approximately $130k increase in the expense category.
24. Staffing:

a. If RiseVT is ending, what is happening to the management and staff positions that oversaw and ran that program at OneCare (3 positions)?
b. Are the Director of Public Affairs, Manager, ACO Finance & Accounting, VP CLC, and Manager ACO Clinical Programs new positions? When did they start?
c. Most of the positions that were "no longer on the FY2022 staff roster" in 6.7 seem clinical in nature. What happened to these positions (Director of RiseVT is included here)? Since FTEs have stayed relatively flat, were these staff reallocated or were there replacements/new staff elsewhere in the organization?

25. Salaries and Compensation:
    a. What did the dollar value of the compensation cuts end up being because of COVID-19? Was there backpay in FY2021 of the budgeted $595K on top of their current pay? Or were the positions only reinstated to their original salaries or above?
    b. The Salaries, Payroll taxes & Fringe increased $5,253. Positions have remained flat (increased 0.03 FTEs) from FY2021 to FY2022. It was discussed that 5 budgeted vacant positions in FY2021 were eliminated out of 12.
        i. In OneCare's responses to GMCB on December 15, 2020, it was mentioned there were 5.62 FTEs adjusted for OneCare's operational needs in FY2021. What caused the FTE vacancies to jump to 12? Last year, the vacancies accounted for $666K.
        ii. What were the 5 positions that were eliminated and what were they replaced with?
        iii. Since there appears to be eliminated positions in FY2022, please provide a table showing the FY2021 budgeted salaries and FTE count, the number of eliminated positions and dollar values, the number of new positions and dollar values, and other reconciling items to land at FY2022 budget. Please provide a description of the terminated/eliminated/new positions. Even though the delta is immaterial, the movement appears to be significant.
    c. Please provide management salaries (similar to appendix 6.7) with budgeted salaries by position for FY2022.
26. Occupancy costs per 6.4 are approximately $421K in FY2022. In FY2021, they were budgeted to be $543K. What were the savings found? Is this expected to continue?
27. Deferred Revenue:
    a. How do the deferred participation fees work? Per OneCare's audit, they represent fees paid by participants specific to programs that did not take place and thus performance obligations have not been met. Since programs are being cut, are any of these deferred revenues being returned to participants as the obligation would be deemed never to be met?
    b. On p.8 of the narrative, it is noted that $2.9 million of deferred revenue was utilized to maintain investments and infrastructure. Per the audit, the deferred revenue was defined as participation fees paid by Participants specific to programs that did not take place and thus performance obligations have not been met. Please explain what the deferred revenue was used for in FY2021 and, if it wasn't, why the deferred revenue wasn't utilized for specific programs.
    c. Is the reduction of population health management efforts causing deferred revenues to be smaller than in prior fiscal years?

d. On p.51, it is said there is "1.6M less deferred revenue to access in 2022." Where is this reflected on OneCare's budgeted Income Statement/Balance Sheet? It is showing a decrease of over $3 million in 2022 variance, but on the balance sheet, it is increasing from FY2021 to FY2022, and is sitting at about $1M. On 6.1-6.3, it is noted "Decrease due to release of remaining deferred par fees on balance sheet. New deferred par fees not assumed in the budget." Please connect these dots.

28. Please break out the other expenses on "Sources and Uses," detail of operating expenses.
29. Is the FY2021 projection provided still accurate? The projection is equal to the revised budget, and the entity has now entered Q4 of the calendar year. Please provide an updated projection, if possible. Assuming no refunded participation fees, please provide the anticipated net income or loss for FY2021.
30. Appendix 6.6 "All Hospitals" does not tie to the Income Statement. There is a note about how this is impossible due to accrual accounting. Please explain. Is OneCare using a hybrid method of accounting?
31. Is there value in calculating Days Cash on Hand or Days in Accounts Receivable metrics? If so, can OneCare do this?
32. Is the $10 million LOC still active and available to draw upon? Does any other party have access to the Line?
33. On the Cash Flow Statement, there is a $13.4 million increase labeled "other." What is driving that sizable figure (e.g., specific line item impacts, timing, etc.)?
34. Is it possible to crosswalk the revenue impact of the rise and fall of attributed lives and member months?
35. What would the budgetary and programmatic impact be if OneCare did not receive the full administrative revenue as budgeted from Medicaid? Per the Sources and Uses, it looks like it goes to Basic OCV PMPM, Complex Care Coordination Program, and Operating Expenses.

Questions – Certification

36. As documented on p.11 of the budget narrative, UVMHN has become the sole parent organization for OneCare.
    a. What are the specific cost savings and quality improvements resulting from this change?
    b. Is there an opportunity to increase the number of primary care providers, add a registered nurse, and enhance gender equality on the BOM?