STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

FY23 ACCOUNTABLE CARE ORGANIZATION BUDGET ORDER

In re: OneCare Vermont Accountable)
Care Organization, LLC)
Fiscal Year 2023)
) Docket No. 22-001-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 2023 (FY23) is the sixth 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 FY23 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. This waiver of enforcement for the remainder of the APM Agreement, including any extension years, was codified on November 30, 2022, when an extension to the APM Agreement was executed.
- **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.

FY23 REVIEW PROCESS

The review process for OneCare's FY23 budget is reflected in the following timeline:

07.01.22: The Board issued FY23 ACO budget guidance and reporting requirements to OneCare.
10.01.22: OneCare submitted its proposed FY23 budget to the Board.
10.24.22: Board staff and HCA requested additional information from OneCare regarding its proposed FY23 budget.

11.04.22: OneCare responded to Oct. 24, 2022 questions from Board staff and HCA.
11.09.22: OneCare presented its proposed FY23 budget to the Board at a public hearing.
11.12.22: Board staff and HCA sent second round of questions to OneCare regarding its proposed FY23 budget.
11.18.22: OneCare responded to Nov. 12, 2022 questions from Board staff and HCA.
11.21.22: Board staff and payer representatives presented data at a public Board meeting regarding OneCare's 2021 financial settlement and quality performance under payer programs.
12.07.22: Board staff presented their analysis and preliminary recommendations regarding OneCare's proposed FY23 budget.
12.14.22: Board staff presented additional analysis and updated recommendations regarding OneCare's proposed FY23 budget.
12.21.22: Board voted to approve OneCare's FY23 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. 2023 Certification Eligibility Verification Form for OneCare Vermont (Certification Submission), Eleventh Amended and Restated Operating Agreement of OneCare Vermont (Operating Agreement), 1 (eff. August 29, 2022). 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. *See* Certification Submission, Operating Agreement, 8-10.

FY23 Payer Programs/ACO Initiatives

3. At the time the Board reviewed and voted on the FY23 budget, OneCare was still negotiating payer contracts for FY23. OneCare Vermont FY23 Budget Submission (Budget Submission), 20. At the time of its budget submission, OneCare expected to continue existing programs with Medicare, Medicaid, Blue Cross and Blue Shield of Vermont (BCBSVT), and

[1] Written budget materials are available at https://gmcboard.vermont.gov/FY23OneCareVermont. Board presentations are available at https://gmcboard.vermont.gov/board/meeting-information/2022-meetings.
[2] https://www.orcamedia.net/series/green-mountain-care-board.

MVP Health Plan, Inc. (MVP) in FY23. Budget Submission, 20-21. OneCare does not anticipate any new payer programs in FY23. Budget Submission, 20.

4. On December 20, 2022, BCBSVT released a statement that the insurer would "forego a contract" with OneCare for FY23 because of its inability to reach an agreement with OneCare "due to the lack of tangible quality outcomes, inability to bend the cost curve, and the new data approach that introduces concerns about security and privacy." Press Release, BlueCross BlueShield of Vermont, Blue Cross Will Pause Relationship with OneCare Vermont in 2023 (December 20, 2022), available at https://www.bluecrossvt.org/health-community/news/blue-cross-will-pause-relationship-onecare-vermont-2023. OneCare notified the GMCB by letter that BCBSVT "has advised OneCare that it will not enter into a program agreement with OneCare for 2023" and that OneCare "remain[s] hopeful that negotiations can resume and we can move forward for 2023." Letter from Sara Barry to Susan Barrett, Re: OneCare Vermont Budget (December 21, 2022).

5. In FY22, OneCare maintained the narrower risk corridors with payers that were agreed to in FY21 in response to the financial impact of COVID-19 on OneCare's provider network. Budget submission, 19-21. OneCare planned to expand its risk corridors in its FY23 payer contracts. *Id*. The total "downside" risk (for shared losses) reflected in OneCare's proposed FY23 budget is just over $36.5 million. *See* Budget Submission, App. 5.1. OneCare's actual downside risk for FY23 will depend on final attribution and the terms of its payer contracts.

6. The following is a summary of OneCare's expected risk model by payer for FY23:

	Payment Model	Budget Risk Corridor FY23	Link to Quality*
Medicare	Reconciled AIPBP for eligible participants; FFS for others	Two-sided; **3% risk** corridor (increase from 2% in FY22); 80-100% 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; 3% risk corridor (increase from 2% in FY22); 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; 2% risk corridor (increase from 1% in FY22); 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

SOURCE: FY23 Budget Submission Appendix 3.1. GMCB staff will review in more detail once contracts are final.
* Excludes BCBSVT Non-Risk Contract.

GMCB PowerPoint, 55 (Dec. 7, 2022).

Risk Management

7. OneCare plans to transfer almost all of its anticipated downside risk exposure, just under $36 million, to network providers. *See* Budget Submission, 36-37 and App. 5.1.

8. OneCare's risk model, which was changed in 2020, accrues shared savings and losses at the ACO level and then distributes almost all the shared savings and losses proportionally across HSAs based on member months of attribution, and then splits the shared savings and losses within each HSA between primary care and risk bearing hospital. *See* Budget Submission, 35. 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, 35.

9. OneCare provided its actual and projected distribution of shared savings by risk-bearing entity for 2017 through 2022, and its budget for FY23. *See* Budget Submission, App. 5.1-5.2.

10. Under OneCare's policies, "the first $1.50 PMPM of downside exposure would be covered by attributing primary care providers via the Accountability Pool and the risk-bearing hospitals would be invoiced to fund the remainder of any program loss." *See* Budget Submission, 36.

11. OneCare's FY23 budget does not include the cost of any third-party risk protection arrangements. *See* Budget Submission, 36. OneCare concluded that the premium for a risk protection product would be high relative to the value of any potential return. *See id*.

12. The following table shows the expected allocation of risk for FY23 within OneCare's network:

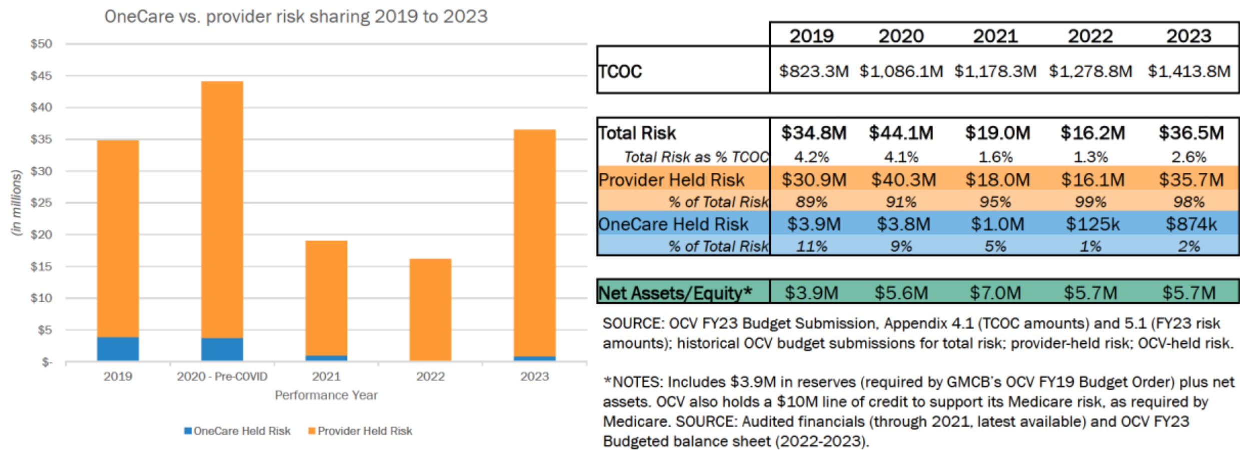
	Primary Care Accountability Pool		Risk Bearing Entity (Hospital) Share	Total Risk/ Reward
	Non-Hospital Primary Care	Hospital Primary Care		
Bennington	$47,483	$171,468	$2,247,560	$2,466,512
Berlin	$42,899	$403,308	$4,343,058	$4,789,266
Brattleboro	$49,738	$76,986	$1,263,612	$1,390,337
Burlington	$750,108	$529,614	$11,167,438	$12,447,160
Lebanon	$46,456	$54,900	$789,144	$890,500
Middlebury	$85,252	$118,818	$1,811,813	$2,015,883
Morrisville	$108,549	$306	$643,121	$751,975
Newport	$13	$113,742	$613,851	$727,606
Randolph	$74,270	$486	$335,648	$410,404
Rutland	$360,742	$6,048	$3,445,700	$3,812,490
Springfield	$115,242	$774	$643,225	$759,241
St. Albans	$288,369	$2,214	$2,646,950	$2,937,533
St. Johnsbury	$130,301	$115,704	$1,359,551	$1,605,556
Townshend	$0	$0	$0	$0
Windsor	$260	$54,072	$599,228	$653,560
OneCare Vermont	–	–	$874,125	$874,125
Total	$2,099,682	$1,648,440	$32,784,024	$36,532,148
	6% of total risk	**5% of total risk**	**90% of total risk**	

NOTES: Percentage of total risk does not total 100% due to rounding. Accountability Pool Share for Non-Hospital and Hospital Primary care are based on the proportion of the HSA attributed through those practice types.
SOURCE: Appendix 5.1

See Budget Submission, App. 5.1-5.2; GMCB PowerPoint, 60 (Dec. 7, 2022).

13. OneCare's budget included a reserve of $5.6 million for FY23, which is the same as FY22. *See* Budget Submission, App. A1 (Balance Sheet). OneCare funds its reserves through payment of hospital dues.

14. OneCare's total risk and reserve from 2019 to its FY23 budget are summarized in the following chart:



	2019	2020	2021	2022	2023
TCOC	$823.3M	$1,086.1M	$1,178.3M	$1,278.8M	$1,413.8M
Total Risk	$34.8M	$44.1M	$19.0M	$16.2M	$36.5M
Total Risk as % TCOC	4.2%	4.1%	1.6%	1.3%	2.6%
Provider Held Risk	$30.9M	$40.3M	$18.0M	$16.1M	$35.7M
% of Total Risk	89%	91%	95%	99%	98%
OneCare Held Risk	$3.9M	$3.8M	$1.0M	$125k	$874k
% of Total Risk	11%	9%	5%	1%	2%
Net Assets/Equity*	$3.9M	$5.6M	$7.0M	$5.7M	$5.7M

SOURCE: OCV FY23 Budget Submission, Appendix 4.1 (TCOC amounts) and 5.1 (FY23 risk amounts); historical OCV budget submissions for total risk; provider-held risk; OCV-held risk.

*NOTES: Includes $3.9M in reserves (required by GMCB's OCV FY19 Budget Order) plus net assets. OCV also holds a $10M line of credit to support its Medicare risk, as required by Medicare. SOURCE: Audited financials (through 2021, latest available) and OCV FY23 Budgeted balance sheet (2022-2023).

GMCB PowerPoint, 57 (Dec. 7, 2022).

15. For FY23, OneCare expects to receive $9,545,916 in Medicare Advanced Shared Savings, which is paid to SASH and Blueprint for Health. See Budget Submission, Appendix 6.4. In the event that OneCare's performance was below the target and exceeded the risk corridor, some portion of the Medicare Advanced Shared Savings amount may need to be repaid. OneCare characterizes this as an asymmetrical risk. *See* Budget Submission, 32; *see also* Letter from OneCare to Green Mountain Care Board, 1-2 (December 20, 2022).

<u>FY21 Programmatic Performance</u>

16. The 2021 Medicare program included a +/- 2% risk corridor and 100% risk sharing, meaning that within two percentage points of the target, OneCare would earn 100% of any savings and would be responsible for 100% of any losses. *See* GMCB PowerPoint, 7 (Nov. 21, 2022). OneCare's performance in the 2021 Medicare program was approximately $22 million below the target, and 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,[3] and after accounting for the financial impact of OneCare's quality performance, OneCare earned approximately $1.23 million in shared savings under the 2021 Medicare program. *See id.* OneCare's projected distribution of all FY21 shared savings is set out above in Findings ¶ 8 above; for OneCare's actual FY21 distribution of Medicare shared savings by HSA, see OneCare Vermont 2021 Settlements in footnote 3, above.

17. The 2021 Medicaid program included a +/- 2% risk corridor with 100% risk sharing for the traditional attribution cohort, meaning that for that cohort, within two percentage points of

[3] Approximately $8.8 million was included in OneCare's 2021 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, 7 (Nov. 21, 2022).

the target, OneCare would earn 100% of any savings and would be responsible for 100% of any losses. The 2021 Medicaid program included a +/- 1% risk corridor with 100% risk sharing for an expanded attribution cohort, meaning that for that cohort, within one percentage point of the target, OneCare would earn 100% of any savings and would be responsible for 100% of any losses. GMCB PowerPoint, 21-23 (Nov. 21, 2022). OneCare's performance in the 2021 Medicaid program was approximately $15.1 million below the target, and outside of the risk corridor, for the traditional attribution cohort, and approximately $6.4 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 $7.1 million in shared savings. *Id.* at 22-23. OneCare's projected distribution of all FY21 shared savings is set out above in Findings ¶ 8 above; for OneCare's actual FY21 distribution of Medicaid shared savings by HSA, see OneCare Vermont 2021 Settlements in footnote 3, above.

18. BCBSVT continued reduced its risk corridors from 2020 in its 2021 OneCare contract in light of the COVID-19 pandemic. *See* GMCB PowerPoint, 33 (Nov. 21, 2022). The final shared loss for OneCare under the BCBSVT program was $110,000. *See* GMCB PowerPoint, 61 (Dec. 7, 2022). The effect of COVID-19 on utilization impacted performance relative to the TCOC target; BCBSVT stated that the effect of the pandemic have made it difficult to consider claims experience relative to target and year-over-year comparisons for the years affected by the pandemic. *See* GMCB PowerPoint, 33 (Nov. 21 2022).

19. 2021 was the second year of MVP's contract with OneCare. *See* GMCB PowerPoint, 45 (Nov. 21, 2022). The actual total cost of care for 2021 was approximately 25% above the target, with a target set of approximately $405 per member per month, and actual results of approximately $509 per member per month. *See* GMCB PowerPoint, 46 (Nov. 21, 2022). The MVP contract with OneCare for 2021 allowed for shared savings but no shared losses; because no savings were earned, the settlement amount was $0. *See* GMCB PowerPoint, 61 (Dec. 7, 2022).

20. Within the 2021 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 2021. 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 82.5%. GMCB PowerPoint, 10-11 (Nov. 21, 2022).

21. Within the 2021 Medicaid program, OneCare's overall quality score was 68.75% based on ten pre-selected payment measures and three reporting measure. GMCB PowerPoint, 26 (Nov. 21, 2022). Results and benchmark percentiles for individual quality metrics are included in the following table:

FU	TRADITIONAL COHORT			EXPANDED COHORT									
Measure Description	Numerator	Denominator	2021 Rate	Numerator	Denominator	2021 Rate	2020 Rate (for reference, traditional cohort)	2020 Rate (For reference, expanded cohort)	Quality Compass 2021 Benchmarks (CY 2020) National Medicaid (ALOB) Percentiles				Points awarded
									25th	50th	75th	90th	
30 Day Follow-Up after Discharge from the ED for Alcohol and Other Drug Abuse or Dependence	199	605	32.89%	50	147	34.01%	32.68%	29.13%	10.75	21.31	26.22	32.60	2
30 Day Follow-Up after Discharge from the ED for Mental Health	463	567	81.66%	83	112	74.11%	79.36%	72.78%	45.48	53.54	64.65	73.56	2
Child and Adolescent Well Care Visits (ages 12-17)	8,543	13,869	61.60%	512	1406	36.42%	57.93%*	35.82%*	39.45	45.06	54.04	62.45	1.75
All Cause Unplanned Admissions for Patients with Multiple Chronic Conditions	16	2,012	0.80%	2	106	1.89%	0.92%	4.17%	N/A	N/A	N/A	N/A	1
Developmental Screening in the First 3 Years of Life	3,282	5,850	56.10%	325	711	45.71%	58.69%	39.44%	27.10	35.60	57.40	N/A	1
Diabetes Mellitus: Hemoglobin A1c Poor Control (>9%)*	119	372	31.99%	N/A	N/A	N/A	38.98%	N/A	51.98	43.30	38.44	34.06	2
Hypertension: Controlling High Blood Pressure	232	372	62.37%	N/A	N/A	N/A	56.87%	N/A	50.61	55.47	62.53	66.42	1
Initiation of Alcohol and Other Drug Abuse or Dependence Treatment	739	2,013	36.71%	230	535	42.99%	41.07%	47.93%	40.96	44.85	48.85	54.13	0
Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	315	2,013	15.65%	104	535	19.44%	19.07%	25.29%	9.38	13.99	17.86	22.83	1
Screening for Clinical Depression and Follow-Up Plan	146	269	54.28%	N/A	N/A	N/A	45.82%	N/A	N/A	N/A	N/A	N/A	2
												Total	13.75
Follow-Up after Hospitalization for Mental Illness (7 Day Rate)	277	544	50.92%	50	119	42.02%	50.45%	40.94%	30.87	38.99	47.75	57.81	N/A
Tobacco Use Assessment and Tobacco Cessation Intervention	319	345	92.46%	N/A	N/A	N/A	80.81%	N/A	N/A	N/A	N/A	N/A	N/A
Patient Centered Medical Home (PCMH) Consumer Assessment of Healthcare Providers & Systems (CAHPS) Survey Composite Measures Collected by DVHA	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

1) For HA1C Poor Control and All Cause Unplanned Admissions measures, a lower rate indicates higher performance.
2) Benchmarks for Developmental Screening in First 3 Years of Life are multi-state; 30 states reporting (FFY 2020).
* Showing rate for ages 12-17 for 2020 in order to compare to 2021 rate.

Key: Performance Compared to National Benchmarks or Change Over Time
- Equal to and below 25th percentile (0 points)
- Above 25th percentile (0.25 point)
- Above 50th percentile or no significant change (1.0 points)
- Above 75th percentile (1.75 points)
- Above 90th percentile or significant improvement (2 points)

GMCB PowerPoint, 27 (Nov. 21, 2022).

22. BCBSVT did not calculate a quality score for OneCare for 2021 but did compare results to benchmarks where available. See GMCB PowerPoint, 35 (Nov. 21, 2022). There was improvement in some benchmarks (child and adolescent well care visits, ACO all-cause readmission, a diabetes benchmark, and controlling hypertension) and a decline in some benchmarks (alcohol and other drug initiation, follow up from hospital inpatient and outpatient mental illness, and a development screening benchmark). GMCB PowerPoint, 36 (Nov. 21, 2022). Results and benchmark percentiles for individual quality metrics are included in the following table:

QHP Population

	OneCare Vermont Quality Results						Benchmarks					
				2021								
	2018 Rate	2019 Rate	2020 Rate	Denominator	Numerator	Rate	25th Percentile	50th Percentile	75th Percentile	90th Percentile	Percentile Band Performance	Quality Points
Payment Measures												
30 Day Follow-Up after Discharge from the ED for Alcohol and Other Drug Dependence	19.35%	26.92%	28.57%	NA	NA	**NA**	12.70%	15.22%	18.33%	23.38%	NA	NA
30 Day Follow-Up after Discharge from the ED for Mental Health	83.33%	65.63%	96.55%	NA	NA	**NA**	54.23%	61.41%	67.72%	72.94%	NA	NA
Child and Adolescent Well Care Visits	62.62%	61.02%	64.22%	2,296	1580	**68.82%**	45.29%	52.59%	61.22%	69.03%	**75th Percentile**	NA
ACO All-Cause Readmissions	0.852	0.6932	0.6096	25.73	13	**0.5052**	0.6918	0.6023	0.5222	0.4131	**75th Percentile**	NA
Diabetes Mellitus: Hemoglobin A1c Poor Control (>9%)	23.11%	11.44%	24.65%	411	84	**20.44%**	50.36%	39.42%	31.85%	28.22%	**90th Percentile**	NA
Hypertension: Controlling High Blood Pressure	61.07%	67.15%	59.61%	411	256	**62.29%**	50.85%	57.79%	65.45%	72.06%	**50th Percentile**	NA
Initiation & Engagement of Alcohol and Other Drug Dependence Treatment (Composite)	23.87%	20.71%	24.65%	204	I: 57 E: 24	**19.85%**	19.91%	23.63%	26.37%	30.58%	**<25th Percentile**	NA
Follow-Up after Hospitalization for Mental Illness (7 Day Rate)	69.23%	62.07%	61.54%	25	15	**60.00%**	33.71%	41.09%	50.00%	57.89%	**90th Percentile**	NA
CAHPS Patient Experience: Care Coordination Composite Score	89.39%	85.56%	89.56%	1,123	NA	**89.93%**	81.02%	83.27%	85.55%	87.16%	**90th Percentile**	NA
Reporting Measures											**Bonus Points**	NA
Developmental Screening in the First Three Years of Life	79.11%	76.82%	77.00%	188	129	**68.62%**					**TOTAL POINTS**	**NA**
Preventive Care and Screening: Screening for Depression and Follow-Up Plan	51.09%	48.30%	43.73%	389	170	**43.70%**						

Blue Cross VT's HEDIS vendor did not produce results for FUA & FUM measure in 2021

GMCB PowerPoint, 39 (Nov. 21, 2022).

23. MVP selected eight quality measures to be in alignment with the State's All-Payer ACO Model Agreement, with a total of 100 available performance points. *See* GMCB PowerPoint, 50 (Nov. 21, 2022). OneCare earned 85 points out of a possible 100 points for 2021. *See id.* Results and benchmark percentiles for individual quality metrics are included in the following table:

OneCare VT **QUALITY PERFORMANCE SCORECARD**

Contract Performance Time Period 1/1/21-12/31/2021
Quality Performance Time Period 1/1/21-12/31/2021

Measure ID	Measure Description	Performance Year Numerator	Performance Year Denominator	Available Points	Performance Year Rate	Benchmark 50th Percentile	Benchmark 75th Percentile	Benchmark 90th Percentile	MVP Mean (ED Utilization Metric only)	Percentile or threshold reached Performance Year Rates compared to Benchmark	% of Available Points Earned	Performance Year Points Earned
FUA	30 Day Follow-Up After Discharge from the ED for Alcohol			0							0%	0
FUM	30 Day Follow-Up After Discharge from the ED for Mental	2	2	0	100.00%	61.41%	67.72%	72.94%		90%	100%	0
WCV	Child and Adolescent Well-Care Visits MY	868	1234	20	70.34%	52.59%	61.22%	69.03%		90%	100%	20
PCR	ACO All-Cause Readmissions	6	15.4322	20	38.88%	60.23%	52.22%	41.31%		90%	100%	20
CDC	Diabetes Mellitus: Hemoglobin A1c Poor Control	16	98	20	16.33%	39.42%	31.85%	28.22%		90%	100%	20
CBP	Hypertension; Controlling High Blood Pressure	251	411	20	61.07%	57.79%	65.45%	72.06%		50%	50%	10
IET	Initiation & Engagement of Alcohol and Other Drug	70	264	20	26.52%	23.63%	26.37%	30.58%		75%	75%	15
FUH	Follow-Up after Hospitalization for mental Illness (7 Day	7	11	0	63.64%	41.09%	50.00%	57.89%		90%	100%	0
		Total Available Points		100						Performance Year Total		85

Benchmark Comparison - Quality Metric Scoring	50th Percentile	75th Percentile	90th Percentile
% Points Earned	50%	75%	100%

GMCB PowerPoint, 50 (Nov. 21, 2022).

FY23 Provider Network

24. OneCare has a broad provider network for FY23 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 FY23 network will also include nine federally qualified health centers, 27 independent primary care practices, 21 specialists and 47 continuum of care providers, including skilled nursing facilities, home health agencies, designated agencies, and ambulatory surgical centers. *See* Budget Submission, App. 2.1; GMCB PowerPoint, 11 (Dec. 7, 2022).

25. OneCare's FY23 network development strategy is largely unchanged from the prior year, with "a continued focus on retaining current participation, expanding participation in existing payer programs, managing risk and opportunity, and making modest adjustments to programs to continue to create sustainability that adjusts with migrations of the programs over time." Budget Submission, 14.

26. OneCare's provider network is not expected to change materially between FY22 and FY23. One independent primary care practice will close in FY23. *See* Budget Submission, 15. OneCare will add four skilled nursing facilities to its network for FY23, and increase participation in additional programs by one hospital, one FQHC, one independent primary care practice, and additional skilled nursing facilities. *See id*.

<u>*Scale and Program Alignment*</u>

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

28. 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).

29. 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.

30. Based on OneCare's projections that were provided when it submitted its budget, and without making changes for BCBSVT's announcement that it would not have a contract with OneCare, and further assuming that the payer programs OneCare is negotiating will qualify as Scale Target ACO Initiatives, the following chart sets out APM Agreement scale by payer contract over time and projected prospective attribution for FY23 (representing the starting attribution for FY23):

	PY 1 (2018)	PY 2 (2019)	PY 3 (2020)	PY 4 (2021)	PY 5 (2022) *	PY 6 (2023) **
Medicare[1]	**36,860**	**53,973**	**53,842**	**62,392**	**62,607**	**68,605**
Medicaid[2]	**42,342**	**79,004**	**114,335**	**111,532**	**126,291**	**142,410**
Traditional	*42,342*	*79,004*	*85,937*	*83,685*	*95,727*	*105,101*
Expanded	-	-	*28,398*	*27,847*	*30,564*	*37,309*
Commercial	**30,712[3]**	**30,363[3]**	**62,588[3]**	**68,834[3]**	**76,893[3]**	**74,533[4]**
BCBSVT Fully Insured (included QHP for 2018-2020)	*20,838*	*20,342*	*27,388*	–	–	-
BCBSVT Self-Funded	*9,874*	*10,021*	*25,834*	–	–	-
BCBSVT QHP	–	–	–	*16,964*	*21,183*	*20,584*
BCBSVT Primary - Risk	–	–	–	*41,634*	*45,018*	*43,527*
BCBSVT Primary – Non-Risk[5]	–	–	–	*27,724*	*31,004*	*28,829*
MVP QHP	–	–	*9,366*	*10,236*	*10,692*	*10,422*

[1]Medicare prospective attribution, obtained from CMMI. [2]Medicaid prospective attribution, obtained from DVHA. [3]GMCB Scale Targets and Alignment Reporting. [4]Commercial attribution estimates per FY23 response to round one questions. [5]BCBSVT Primary – Non-Risk contract is not scale qualifying and is not included in totals. NOTE: GMCB Scale Target and Alignment Reports report Commercial programs based on insurance type (e.g., fully- or self-insured).
*Projected **Budgeted

GMCB PowerPoint, 100 (Dec. 7, 2022). Based on the starting attribution, the reduction that would result from not having a contract with BCBSVT is approximately 92,940, as summarized in the following table:

Payer Program	# of HSAs Participating	# and type of hospital			FY23 Starting Attribution Estimated
		CAH	Acute Care	AMC	
Medicare	9	3	5	1	67,558
Medicaid	14	7	5	2	Medicaid – Traditional: 95,175 Medicaid – Expanded: 30,563
BCBSVT	12	5	5	2	*92,940
MVP	13	6	5	2	10,422
Any Payer Program	14	7	5	2	296,658

CAH – Critical Access Hospital
AMC – Academic Medical Center
* Includes 28,829 lives that do not qualify for Vermont scale targets

GMCB PowerPoint, 5 (Dec. 21, 2022).

Financials (Revenues and Expenses)

31. GMCB considered both full accountability and entity-level perspective on OneCare's FY23 budget. *See* GMCB PowerPoint, 29-30 (Dec. 7, 2022). 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 Generally Accepted Accounting Principles (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 GAAP. *See id*.

32. The following table shows the full accountability (Non-GAAP) and entity level (GAAP) summary income statements for OneCare's proposed FY23 budget, as compared to prior budgets:

Full Accountability (Non-GAAP)	2018 Actual	2019 Actual	2020 Actual	2021 Actual	2022 Revised	2023 Budget
Total Cost of Care Target Components (External)	$ 605,433,215	$ 294,018,591	$ 677,948,979	$ 1,188,108,529	$ 882,713,433	$ 974,663,796
Fixed Prospective Payment Funding (FPP)	$ -	$ 346,341,673	$ 402,406,905	$ 408,150,868	$ 435,607,649	$ 438,664,506
Other Contract Revenue	$ 7,826,298	$ 13,090,261	$ 15,155,666	$ 9,959,641	$ 10,460,595	$ 10,074,567
Participation Fees	$ 17,397,929	$ 25,842,028	$ 15,273,570	$ 16,838,987	$ 20,415,985	$ 19,898,111
Administrative Revenue	$ 3,086,492	$ 5,395,629	$ 7,432,261	$ 7,558,032	$ -	$ -
Consulting Revenue	$ 309,407	$ 355,289	$ 193,289	$ 18,000	$ -	$ -
Other Revenue	$ 1,393,945	$ 777,624	$ 288,816	$ 16,460,005	$ 4,601,560	$ 5,593,389
Income and Other Total Cost of Care Components	**$ 635,447,286**	**$ 685,821,095**	**$ 1,118,699,486**	**$ 1,647,094,062**	**$ 1,353,799,222**	**$ 1,448,894,369**
Total Health Care Spend Components (External)	$ 360,711,323	$ 289,987,490	$ 669,547,321	$ 1,195,825,023	$ 873,639,451	$ 965,117,880
Fixed Prospective Payments (FPP)	$ 237,390,466	$ 346,341,673	$ 402,406,905	$ 408,156,421	$ 435,607,649	$ 438,664,506
Population Health Management (PHM)	$ 22,637,268	$ 29,461,309	$ 32,700,997	$ 28,210,654	$ 29,114,584	$ 29,922,012
Salaries & Benefits	$ 7,344,815	$ 7,721,134	$ 8,346,024	$ 8,225,855	$ 9,368,623	$ 8,704,465
Contracted / Purchase Services	$ 1,746,953	$ 2,622,296	$ 1,637,954	$ 1,565,413	$ 1,366,121	$ 3,369,471
Software	$ 2,795,193	$ 2,600,557	$ 2,806,528	$ 2,594,036	$ 2,683,279	$ 1,871,810
Other Operating Expenses	$ 1,852,142	$ 2,397,464	$ 1,253,756	$ 1,223,242	$ 2,019,515	$ 1,244,225
Subtotal Operating Expenses	$ 13,739,102	$ 15,341,451	$ 14,044,262	$ 13,608,546	$ 15,437,538	$ 15,189,971
Total Expenses and Health Care Spend Components	**$ 634,478,160**	**$ 681,131,922**	**$ 1,118,699,485**	**$ 1,645,800,644**	**$ 1,353,799,222**	**$ 1,448,894,369**
Net Income	**$ 969,126**	**$ 4,689,173**	**$ 1**	**$ 1,293,418**	**$ (0)**	**$ -**
Administrative Ratio	2.17%	2.25%	1.26%	0.83%	1.14%	1.05%
PHM Ratio with Blueprint	3.57%	4.33%	2.92%	1.71%	2.15%	2.07%
PHM Ratio without Blueprint	2.34%	3.63%	2.17%	1.18%	1.48%	1.41%
Total Margin	0.15%	0.68%	0.00%	0.08%	0.00%	0.00%

GMCB PowerPoint, 31 (Dec. 7, 2022)

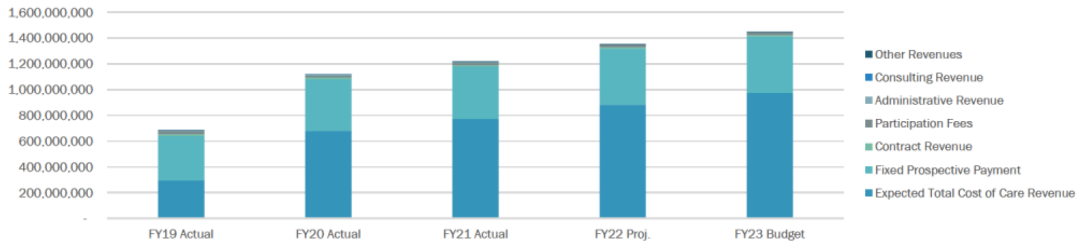
Entity-level (GAAP)	2018 Actual	2019 Actual	2020 Actual	2021 Actual	2022 Revised	2023 Budget
Total Cost of Care Target Components (External)	-	-	-	-	-	-
Fixed Prospective Payment Funding (FPP)	-	-	-	-	-	-
Other Contract Revenue	3,771,184	10,771,692	11,194,712	6,449,190	-	-
Participation Fees	17,397,929	25,842,028	15,273,570	17,065,627	20,415,985	19,898,111
Administrative Revenue	1,543,246	2,697,815	3,897,306	3,779,016	-	-
Consulting Revenue	309,407	355,289	193,289	-	-	-
Other Revenue	1,393,945	777,624	288,816	90,962	4,601,560	5,593,389
Income and Other Total Cost of Care Components	**24,415,711**	**40,444,448**	**30,847,693**	**27,384,795**	**25,017,545**	**25,491,500**
Total Health Care Spend Components (External)	-	-	-	-	-	-
Fixed Prospective Payments (FPP)	-	-	-	-	-	-
Population Health Management (PHM)	9,711,238	20,413,825	16,803,432	12,482,828	9,580,007	10,301,529
Salaries & Benefits	7,344,815	7,721,134	8,346,024	8,225,854	9,368,623	8,704,465
Contracted / Purchase Services	1,746,953	2,622,296	1,637,954	1,565,415	1,366,121	3,369,471
Software	2,795,193	2,600,557	2,806,528	2,594,036	2,683,279	1,871,810
Other Operating Expenses	1,852,142	2,397,464	1,253,756	1,223,243	2,019,515	1,244,225
Subtotal Operating Expenses	13,739,102	15,341,451	14,044,262	13,608,546	15,437,538	15,189,971
Total Expenses and Health Care Spend Components	**23,450,340**	**35,755,276**	**30,847,694**	**26,091,376**	**25,017,545**	**25,491,500**
Net Income	**965,371**	**4,689,172**	**(1)**	**1,293,419**	**-**	
Administrative Ratio	56.27%	37.93%	45.53%	49.69%	61.71%	59.59%
PHM Ratio	39.77%	50.47%	54.47%	45.58%	38.29%	40.41%
Operating Margin	3.95%	11.59%	0.00%	4.72%	0.00%	0.00%

GMCB PowerPoint, 38 (Dec. 7, 2022)

33. The following table shows the full accountability (Non-GAAP) and entity-level (GAAP) "revenues" in OneCare's proposed FY23 budget, as compared to prior budgets:

Full accountability:

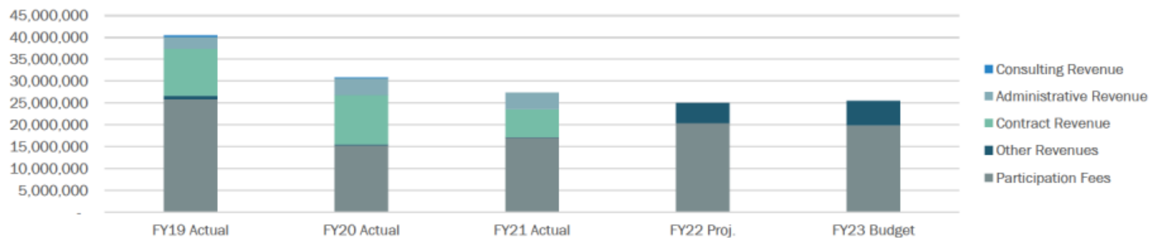
	FY19 Actual		FY20 Actual		FY21 Actual		FY22 Proj.		FY23 Budget	
Total Revenue	**685,821,095**		**1,118,699,486**		**1,220,443,196**		**1,353,799,222**		**1,448,894,369**	
Expected Total Cost of Care Rev.	294,018,591	42.9%	677,948,979	60.6%	771,837,967	63.2%	882,713,433	65.2%	974,663,796	67.3%
Fixed Prospective Payment	346,341,673	50.5%	402,406,905	36.0%	407,618,099	33.4%	435,607,649	32.2%	438,664,506	30.3%
Contract Revenue	13,090,261	1.9%	15,155,666	1.4%	10,476,117	0.9%	10,460,595	0.8%	10,074,567	0.7%
Participation Fees	25,842,028	3.8%	15,273,570	1.4%	16,738,432	1.4%	20,415,985	1.5%	19,898,111	1.4%
Administrative Revenue	5,395,629	0.8%	7,432,261	0.7%	7,558,032	0.6%	-	0.0%	-	0.0%
Consulting Revenue	355,289	0.1%	193,289	0.0%	18,000	0.0%	-	0.0%	-	0.0%
Other Revenues	777,624	0.1%	288,816	0.0%	6,196,549	0.5%	4,601,560	0.3%	5,593,389	0.4%



GMCB PowerPoint, 32 (Dec. 7, 2022)

Entity-level:

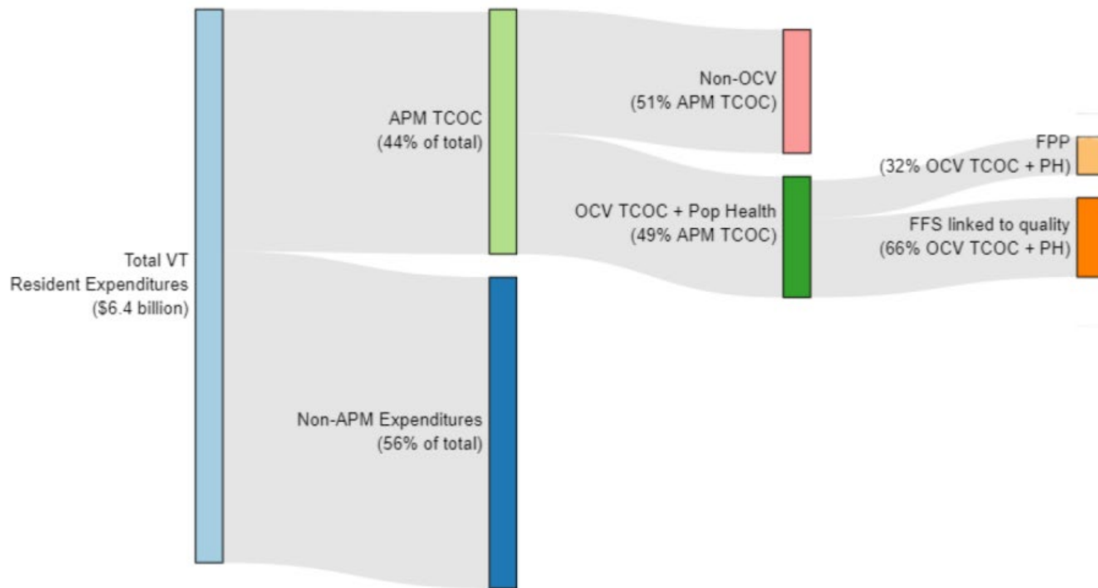
	FY19 Actual (% of Total)		FY20 Actual (% of Total)		FY21 Actual (% of Total)		FY22 Proj. (% of Total)		FY23 Budget (% of Total)	
Total Revenue	**40,444,448**		**30,847,693**		**27,384,795**		**25,017,545**		**25,491,500**	
Expected Total Cost of Care Rev.	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%
Fixed Prospective Payment	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%
Contract Revenue	10,771,692	26.6%	11,194,712	36.3%	6,449,190	23.6%	-	0.0%	-	0.0%
Participation Fees	25,842,028	63.9%	15,273,570	49.5%	17,065,627	62.3%	20,415,985	81.6%	19,898,111	78.1%
Administrative Revenue	2,697,815	6.7%	3,897,306	12.6%	3,779,016	13.8%	-	0.0%	-	0.0%
Consulting Revenue	355,289	0.9%	193,289	0.6%	-	0.0%	-	0.0%	-	0.0%
Other Revenues	777,624	1.9%	288,816	0.9%	90,962	0.3%	4,601,560	18.4%	5,593,389	21.9%



GMCB PowerPoint, 39 (Dec. 7, 2022)

34. The increase in full accountability revenue from FY22 (revised budget) to FY23 budget is driven mostly by increases in expected total cost of care of $91.5 million and FPP increase of $3 million. *See* GMCB PowerPoint, 34 (Dec. 7, 2022). The increase in entity-level revenue from FY22 (revised budget) to FY23 budget reflects an increase of approximately $1 million in other revenue, offset by a decrease of approximately $518,000 in participation fess. *See* GMCB PowerPoint, 41 (Dec. 7, 2022).

35. OneCare’s budget, including the total cost of care of its attributed lives, covers approximately a quarter of Vermont’s healthcare spending, as illustrated by the following chart:

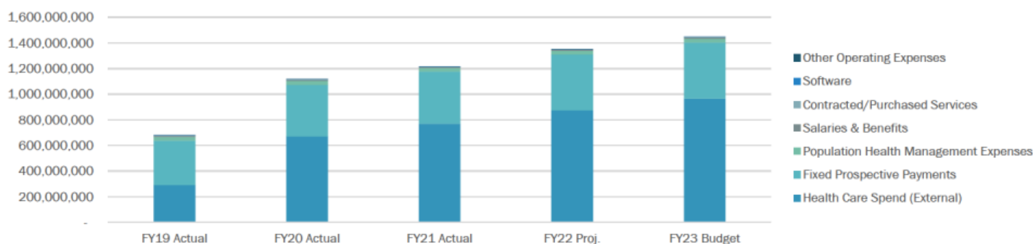


GMCB PowerPoint, 14 (Dec. 7, 2022).

36. The following table shows the full accountability (Non-GAAP) and entity level (GAAP) “expenses” in OneCare’s proposed FY23 budget, as compared to prior budgets:

Full accountability:

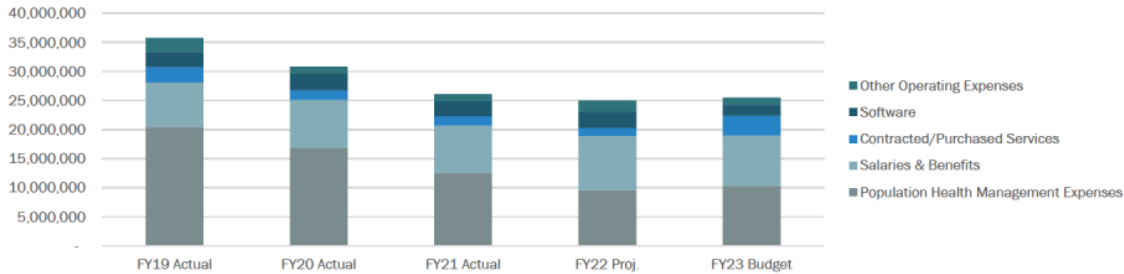
	FY19 Actual		FY20 Actual		FY21 Actual		FY22 Proj.		FY23 Budget	
Total Expense	**681,131,922**		**1,118,699,485**		**1,218,542,658**		**1,353,799,222**		**1,448,894,369**	
Health Care Spend (External)	289,987,490	42.6%	669,547,321	59.9%	769,024,703	63.1%	873,639,451	64.5%	965,117,880	66.6%
Fixed Prospective Payments	346,341,673	50.8%	402,406,905	36.0%	407,629,196	33.5%	435,607,649	32.2%	438,664,506	30.3%
Pop. Health Management Expenses	29,461,309	4.3%	32,700,997	2.9%	28,715,408	2.4%	29,114,584	2.2%	29,922,012	2.1%
Salaries & Benefits	7,721,134	1.1%	8,346,024	0.7%	8,189,236	0.7%	9,368,623	0.7%	8,704,465	0.6%
Contracted/Purchased Services	2,622,296	0.4%	1,637,954	0.1%	877,930	0.1%	1,366,121	0.1%	3,369,471	0.2%
Software	2,600,557	0.4%	2,806,528	0.3%	2,650,509	0.2%	2,683,279	0.2%	1,871,810	0.1%
Other Operating Expenses	2,397,464	0.4%	1,253,756	0.1%	1,455,676	0.1%	2,019,515	0.1%	1,244,225	0.1%



GMCB PowerPoint, 33 (Dec. 7, 2022)

Entity-level:

	FY19 Actual (% of Total)		FY20 Actual (% of Total)		FY21 Actual (% of Total)		FY22 Proj. (% of Total)		FY23 Budget (% of Total)	
Total Expense	**35,755,276**		**30,847,694**		**26,091,376**		**25,017,545**		**25,491,500**	
Health Care Spend (External)	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%
Fixed Prospective Payments	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%
Pop. Health Management Expenses	20,413,825	57.1%	16,803,432	54.5%	12,482,828	47.8%	9,580,007	38.3%	10,301,529	40.4%
Salaries & Benefits	7,721,134	21.6%	8,346,024	27.1%	8,225,854	31.5%	9,368,623	37.4%	8,704,465	34.1%
Contracted/Purchased Services	2,622,296	7.3%	1,637,954	5.3%	1,565,415	6.0%	1,366,121	5.5%	3,369,471	13.2%
Software	2,600,557	7.3%	2,806,528	9.1%	2,594,036	9.9%	2,683,279	10.7%	1,871,810	7.3%
Other Operating Expenses	2,397,464	6.7%	1,253,756	4.1%	1,223,243	4.7%	2,019,515	8.1%	1,244,225	4.9%

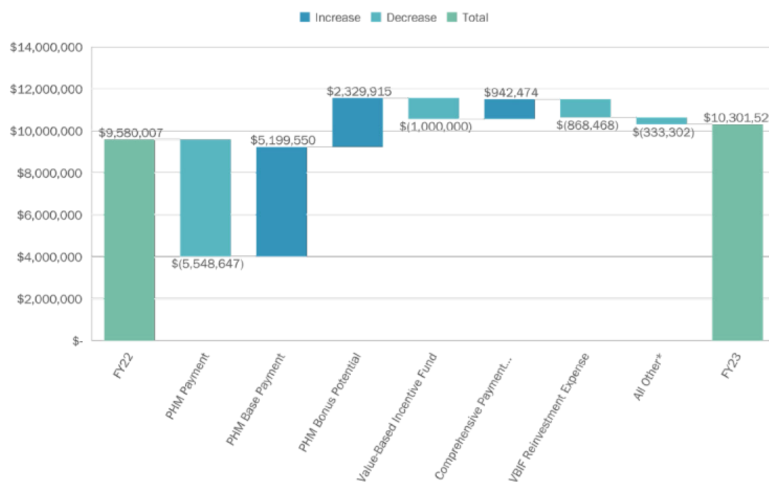


GMCB PowerPoint, 40 (Dec. 7, 2022)

37. The increase in FY23 budgeted expected Total Cost of Care spending on a full accountability basis is driven mostly by increases in the Medicare program ($55.4 million), the BCBSVT primary program ($12 million), BCBSVT QHP program ($34.8 million), and MVP program ($9.2 million). *See* GMCB PowerPoint, 35 (Dec. 7, 2022).

38. OneCare's budgeted balance sheet for FY23 includes $5,686,429 in net OneCare assets, which is the same as FY22. See Budget Submission, App. A1 (Balance Sheet).

39. The increase in Population Health Management and payment reform expenses from FY22 to FY23 results from changes in several different payments, reflected in the reconciliation chart below:



*All Other Breakout	FY23 - FY22
Innovation Fund	(299,767)
SNF Support	201,299
Specialist Funding	150,000
Mental Health Initiatives	(147,550)
Program Match	(120,000)
DULCE	(59,119)
Amplify Grants	(35,000)
Chronic Kidney Disease	(23,165)
Longitudinal Care	-
Total All Other	**(333,302)**

See GMCB PowerPoint, 42 (Dec. 7, 2022).

Operating Expenses

40. OneCare's operating expense budget decreased from $15.4 million in FY22 to $15.2 million in FY23. *See* Budget Submission, App. 6 (variance analysis); GMCB PowerPoint, 43 (Dec. 7, 2022). As a percentage of expenses on a full accountability basis, OneCare's administrative expenses account for 1.05% of all expenses in its FY23 budget, which is approximately the same as its FY22 budget. *See* Budget Submission, Apps. 6 (variance analysis), 6.4. On an entity-level basis, operating expenses account for 60% of OneCare's FY23 budget, which is an increase from 56% in FY22. *See id.*

41. OneCare's FY23 operating expenses are set out below:

Salaries and Benefits	$8,704,465
Purchased Services	$3,369,471
Software/Informatics	$1,871,810
Other Expenses***	$1,244,225
Total Operational Expenses	**$15,189,971**

See Budget Submission, App. 6.4.

42. OneCare's other operating expenses include supplies, interest, advertising, surveys, mail/printing, subscriptions, mileage, food, meetings, travel, marketing, utilities. See Budget Submission, App. 6.4.

43. OneCare provided FY22 compensation for its leadership in the following chart:

Position Title	Base Pay	Variable Pay	Budgeted Gross Compensation
Board Chair	$0	$0	$0
Board Trustees	$0	$0	$0
CEO	$401,558	$107,414	$508,972
CCO	$169,123	$20,106	$189,230
VP/COO	$307,318	$66,982	$374,300
VP/CFO	$264,815	$57,718	$322,533
VP/CMO	$188,784	$41,147	$229,930
VP/CLC	$188,047	$22,356	$210,403
Director, ACO Operations	$185,073	$22,002	$207,075
Director, Strategy/Planning	$181,574	$21,587	$203,161
Director, Value Based Care	$177,598	$21,114	$198,712
Director, Payment Reform	$169,384	$20,137	$189,521
Director, Finance and Accounting	$163,352	$19,420	$182,772
Director, Public Affairs	$157,063	$18,673	$175,736
Total	**$2,553,689**	**$438,656**	**$2,992,345**

See Budget Submission, App. 6.7; OneCare Responses to GMCB Round 2 Questions, 7.

Benchmark Trend Rates

44. 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.[4] APM Agreement, § 8.b.ii.

45. In developing its FY23 budget, OneCare assumed a blended 5.2% trend rate would be used in developing the 2022 benchmarks for the Medicare program, based on the Medicare USPCC. *See* Budget Submission, 28.

46. On December 19, 2022, Board staff presented a proposed approach to developing the 2023 benchmarks for the Medicare program and proposed benchmarks rates of 5.2% for non-ESRD and 3.9% for ESRD. *See* GMCB PowerPoint (Dec. 19, 2021). On December 21, 2021, the Board approved the proposed Medicare benchmark rates. *See* GMCB PowerPoint (Dec. 21, 2022).

47. For Medicaid, in its FY23 budget OneCare assumed a blended 2.05% trend for the traditional cohort and a blended 2.23% trend for the expanded cohort (relative to the 2022 target). Budget Submission, 28.

48. The following table summarizes OneCare's budgeted trend rates for FY23:

	FY2022 Projected TCOC	FY2023 Benchmark (Expected TCOC)	Budgeted Trend from Base Experience*
Medicare	$481,045,996	$562,462,453	5.2%
Medicaid - Traditional	$264,758,623	$264,095,487	2.0%
Medicaid - Expanded	$41,965,623	$41,989,529	2.2%
BCBS QHP	[redacted]	$176,399,528	[redacted]
BCBS Primary **	[redacted]	$294,897,695	[redacted]
MVP	[redacted]	$73,483,610	[redacted]
TOTAL	$1,256,455,218	$1,413,328,302	N/A

SOURCE: FY23 Budget Submission, Appendix 4.1 and Appendix 4.3

*Base year varies by program; **budgeted trend does not represent FY22→FY23 growth**.
**Includes expected TCOC for BCBSVT Primary – Risk lives only; excludes BCBSVT Primary – Non-Risk lives.

GMCB PowerPoint, 49 (Dec. 7, 2022)

[4] 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.

Provider Reimbursement

49. Most of the projected provider reimbursement reflected in OneCare's FY23 budget will be paid directly by payers to providers. Prospective payments, which do flow through OneCare, are projected to account for approximately 31% of OneCare's budgeted total cost of care in 2022 across all payers, slightly less than the 34% in FY22. GMCB PowerPoint, 68 (Dec. 7, 2022).

50. The following table summarizes OneCare's expected fixed prospective payments by payer for FY23:

	Attribution (Jan. 1)	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 reference slide: HCP-LAN Alternative Payment Model Framework)*
Medicare	67,558	$562,462,453[3]	$262,082,439	47%	4B (*reconciled* to FFS)
Medicaid – Trad.	95,175	$264,095,487	$147,893,473	56%	4B (*unreconciled* to FFS)
Medicaid – Expand.	30,563	$41,989,529	$23,220,209	55%	4B (*unreconciled* to FFS)
BCBSVT	92,940	$471,297,223		1.2%	BCBSVT General: 3B[4] BCBSVT FPP Pilot: 4B (reconciled)
MVP QHP	10,422	$73,483,610			MVP: 3B[4]
TOTAL	296,658	$1,413,328,302	$438,664,506	31%	

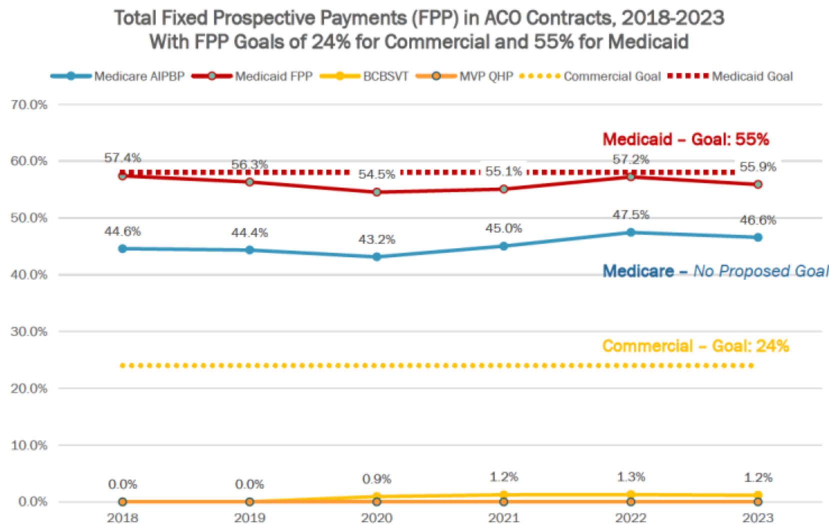
1. Projected (Expected) TCOC: FY23 Budget (9/30/22) Tab 4.1 Payer TCOC. 2. FPP and CPR lines in FY23 Budget (9/30/22) Tab 6.4 Sources Uses. 3. Medicare TCOC: Includes Blueprint/SASH at $9,545,916 for FY23 Budget. 4. BCBSVT and MVP payment model HCP-LAN categorizations according to filings from the GMCB's review of plans' Qualified Health Plan (QHP) premiums.

GMCB PowerPoint, 68 (Dec. 7, 2022).

51. OneCare's payment reform goals are to "evolve value-based care contracts to move away from Fee for Service (FFS)." *See* Budget Submission, 6.

52. Currently, Medicaid is the only payer offering unreconciled "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, 22-23.

53. The following chart summarizes total FPP levels by payers along with the goals for each payer:



In their July 2022 FPP report, OneCare amended the FPP targets they presented with May FY22 revised budget.

Targets:

Medicare 53.4% → 0.00%

- Medicare has indicated it will not convert to unreconciled FPP in the current model

Medicaid 58.2% → 51.0%

- Reflects current commitment to unreconciled FPP

Commercial 23.9% → 0.00%

- No new commercial offerings

See GMCB PowerPoint, 69 (Dec. 7, 2022).

Population Health Management and Payment Reform Programs

54. OneCare has developed a variety of programs to implement its care model, with a total population health management investment of $29.9 million for FY23. *See* Budget Submission, App. 7.3. This represents an increase of approximately $0.9 million from FY22. *See id.*

55. Appendix 7.3 in OneCare's budget submission provides PHM payments by program, with investment amounts and descriptions for each program. See App. 7.3.

56. OneCare is instituting a new PHM payment model for FY23, with total base payments of $15.3 million and total bonus payments of $2.3 million. See Budget Submission, Narrative, 52. The following chart summarizes changes from the prior PHM payment structure:

Segment	2022	2023	Comment
Primary Care **Base Payment**	$3.25 PMPM $1.50 Care Coordination	$4.75 PMPM	Maintains the same regular cash flow to primary care providers
Bonus Payment	VBIF: $0.47 Care Coordination $0.33	$1.00 Blended PHM	Combines the bonus potential into one pool Amounts represent AVERAGE earning levels Not all participants will earn maximum amount in 2023
Continuum of Care (i.e., HHH, DAs, SNFs)	Under the Care Coordination program, 85% of budgeted funds (by provider type) in the form of a monthly base payment, with the remaining 15% available to be paid as annual performance bonuses.	Under the PHM program, 85% of budgeted funds (by provider type; budget neutral from 2022) in the form of a monthly base payment, with the remaining 15% available to be paid as annual performance bonuses.	Maintains the same regular cash flow to this segment of providers

OneCare Response to Round 1 Questions, 7 (Nov. 8. 2022); GMCB PowerPoint, 76 (Dec. 7, 2022).

57. 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, 8, 49-50. While individuals in quadrants three and four comprise 16% of OneCare's attributed population, they account for approximately 60% of total spending. *Id.*; *see* Budget Submission, App. 7.4.

58. Within the low risk quadrant, OneCare focuses on clinical prevention activities in the areas of food insecurity, suicide prevention, and improvement for quality measure PQI-90, for which new activities will be deployed in FY23. *See* Budget Submission, 49.

59. For FY23, OneCare is integrating the previous population health management (PHM), care coordination, and VBIF payments "into one stream of payments consisting of base plus incentive components that are tied to specific accountabilities." *See* Budget Submission, 8. This new PHM design includes a multi-year strategy to adjust the mix of base and bonus payments to put additional resources into incentive payments. *See* Budget Submission, 50.

60. For FY23, OneCare is funding primary care at a total of $14.7 million to $16.7 million, comprised of $13.2 million in PHM base payments, up to $2 million in PHM bonus potential, and $1.5 million in the comprehensive payment reform program, which were the amounts

submitted by OneCare in its FY23 budget submission and approved by the GMCB. *See* OneCare FY23 Budget Submission, Appendix 7.3

61. 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, 33. In FY23, OneCare plans to provide a $5 PMPM supplemental payment in addition to monthly PMPM payments for core services. Budget Submission, Attachment D, 2. One additional practice is joining the CPR program in FY23, bringing the total to 19. *See* Budget Submission, 15, 78; OneCare Presentation, 9.

62. OneCare is coordinating with the Blueprint for Health (Blueprint) and AHS regarding continual collaboration between OneCare, Blueprint, and AHS/DVHA. *See* Budget Submission, 55. This coordination includes OneCare participating in Blueprint-led collaboration activities and Blueprint participation in OneCare forums. *See id*. OneCare holds care coordination core team meetings at the HSA level that includes Blueprint Quality Improvement Specialists. Budget Submission, 38.

63. OneCare determined that it was in the interest of its participants to decommission Care Navigator at the end of 2022. Participating providers will still have access to real-time utilization data. *See* Budget Submission, 50, 65, 66. Care coordination reporting is now completed though tri-annual submissions from its provider network. *See* Budget Submission, 8, 50.

64. OneCare has not included any significant expansion or overall changes in its care model for FY23. *See* Budget Submission, 49-50.

65. OneCare states that it works to address social determinants of health by embedding a focus on individuals with high medical and social risk in its care coordination program. See Budget Submission, 66-67. For 2023, OneCare states these expectations are "embedded in the PHM as a gateway to associated base and bonus payments" and OneCare's VBIF program incentivizes care related to six quality measures, "all of which contain a component of SDOH such as access to care and ongoing management of chronic conditions" which are also impacted by social determinants of health factors for OneCare attributed lives. *See id*. OneCare also cites the creation of "heat maps" to identify social risk within each HSA. See Budget Submission, 57.

66. OneCare plans to hire a program evaluator for FY23 to "become more sophisticated in the structure and type of evaluations that we can perform on individual programs and investments." *See* Testimony of Sara Barry, Hearing Transcript, 91:15-93:8. OneCare has not previously employed a program evaluator. *See id*. OneCare states that its clinical committees and population health committees "look at the investments that the providers feel will have the biggest opportunity" and leverage OneCare data as part of that effort, but OneCare does not do a cost-benefit analysis in connection with determining how to deploy its population health spending. *See* Testimony of Vicki Loner, Hearing Transcript, 89:12-90:2. OneCare was still developing or reviewing key performance indicators at the time of its budget hearing before the GMCB. *See* Testimony of Vicki Loner, Hearing Transcript, 183:8-183:18.

67. OneCare's proposed FY23 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 FY22 levels. *See* OneCare Presentation, 27.

68. OneCare assumed that the Medicare benchmark will include a 5.2% trend on this funding. Budget Submission, 28; OneCare Presentation, 17 (Nov. 9, 2022).

69. Board staff recommended a condition that $3.9 million of the Medicare Advanced Shared Savings be held by OneCare rather than delegating the risk to its network. GMCB PowerPoint, 10 (Dec. 21, 2022)

Performance Monitoring and Assessment

70. OneCare was required by the GMCB in FY22 to implement a reputable benchmarking system. See FY22 OneCare Vermont ACO Budget Order, Condition 1. OneCare delivered that benchmarking report to the GMCB on October 31, 2022. *See* OneCare Medicare Benchmarking Report – October 2022.

71. The benchmarking report submitted by OneCare did not align with the GMCB's expectations regarding the selection of a comparison cohort and the decision to compare performance against a 90th percentile cohort (which consisted of two comparison ACOs) rather than identifying the scores of the highest performing ACOs for each measure. See GMCB PowerPoint, 88-91 (December 21, 2022).

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 accepted public comments on OneCare's proposed budget from October 1, 2022 through December 16, 2022. These comments are available on the Board's website.[5] The Board received 33 comments regarding the OneCare's FY22 budget and the Board's review. Generally, the themes from public comments reflect:

- Value of OneCare's data analytics, population health initiatives, and transition to value-based care

[5]https://gmcboard.vermont.gov/board/comment/previous.

- Value of care coordination and strengthened partnerships with local care organizations
- Concerns related to the transition of OneCare data analytics to UVMHN
- Concerns related to measures of OneCare's performance and overall value to Vermont's healthcare system

See GMCB PowerPoint, 6 (Dec. 7, 2022).

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

- OneCare's deepening ties to UVMHN
    - Risks undermining the effectiveness of Vermont's All-Payer Model (APM)
- OneCare's continued lack of demonstrated benefit to Vermonters and the state
    - Insufficient evidence to support claims that their programs improve population health outcomes, care coordination for Vermonters, or reduce costs.

Letter from the HCA Policy Team to Owen Foster (Nov. 29, 2022).

75. Board staff considered the public comments and HCA comments in developing their recommendations regarding OneCare's proposed FY23 budget. *See* GMCB PowerPoint, 6-8 (Dec. 7, 2022); GMCB PowerPoint, 3 (Dec. 14, 2022).

CONCLUSIONS

OneCare bears the burden of justifying its proposed FY23 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).

This is the sixth year that the GMCB has reviewed OneCare's budget. We acknowledge the most recent years have been a challenging period for health care providers and health care reform, which have been significantly impacted by the pandemic. We are approving a budget with modifications that we believe will improve the results of OneCare's efforts to reduce costs and improve quality of care in its network. Importantly, we note that OneCare is losing a large portion of its attributed lives as a result of BCBSVT and OneCare not having a contract for FY23. *See* Findings, ¶ 4. That development would present a material change to the budget OneCare submitted and that we are approving today, and therefore we are requiring OneCare to submit an updated budget by the end of January showing the resulting changes. *See* Order, 5. OneCare's final budget, which is required to be submitted by March 31, 2023 in accordance with Condition 11, will be carefully reviewed in light of the changes in OneCare's attributed lives.

The GMCB approves OneCare's budget subject to the conditions in this order, which we conclude will require OneCare to better evaluate its programs, take on greater accountability for the results of its programs, and focus its fiscal responsibility. Specifically, we require that OneCare hold at least $3.9 million of the risk associated with Medicare Advanced Shared Savings Payments and not pass that amount of the risk on to any OneCare network participant. *See* Findings, ¶¶ 15, 38. OneCare's proposed budget did not include OneCare holding any of

that risk, but by holding that risk itself, OneCare takes on accountability for the results of its programs, and the risk that any Medicare Advanced Shared Savings Payments would need to be repaid. Additionally, we require OneCare to make changes to the methodology of its benchmarking report. *See* Findings, ¶¶ 70-72. The benchmarking report submitted by OneCare does not provide as much information as it could to help OneCare assess its performance and target resources to areas where those resources could be most beneficial. We also conclude that a 2.0% reduction in OneCare's proposed Operating Expenses, from $15,189,971 to an amount not to exceed $14,886,172 is warranted. *See* Findings, ¶¶ 41-43. Each of these requirements is discussed further in the following consideration of the applicable statutory criteria of 18 V.S.A. § 9382(b).

I. Statutory Criteria

(A) information regarding utilization of the health care services delivered by health care providers participating in the ACO and the effects of care models on appropriate 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 2021, 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, ¶¶ 16-17. For 2021, 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 similar to 2019. *See* Findings, ¶¶ 20-21.

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 payer MVP are expected to continue their existing programs with OneCare in 2023, indicating that they see continued benefit in an ACO to deliver value for their members or beneficiaries. *See* Findings, ¶ 3. Commercial payer BCBSVT announced that it did not intend to contract with OneCare in FY23. *See* Findings, ¶ 4. To understand the impact of not having a contract with BCBSVT in FY23, if that is the situation that results, we require OneCare to provide an updated budget showing the impact of BCBSVT's withdrawal.

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 needs to do more to evaluate the effectiveness of its programs. *See* Findings, ¶ 66. OneCare appears not to have a systematic process for evaluating the success of its population health initiatives, or which initiatives it should fund to most effectively allocate its resources, and is only now hiring a program evaluator. *See* Findings, ¶ 66. Another part of the evaluation, discussed more below, would be a utilizing an improved methodology for OneCare's benchmarks against high-performing ACOs around the country. *See* Findings, ¶¶ 71-72.

(B) the Health Resource Allocation Plan identifying Vermont's critical health needs, goods, services, and resources as identified pursuant to section 9405 of this title;

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.

(C) the expenditure analysis for the previous year and the proposed expenditure analysis for the year under review by payer;

The expenditure analysis is relevant to the Board's review as it relates to the total cost of care under the APM, discussed in Section III.A. of the Board's conclusions. Of approximately $6.4 billion in health care spending in Vermont, 56% is non-APM expenditures, and of the 44% that is APM expenditures, approximately half of that is OneCare's total cost of care and population health related expenditures. *See* Findings, ¶ 35.

(D) the character, competence, fiscal responsibility, and soundness of the ACO and its principals;

OneCare's proposed budget includes entity-level Operating Expenses of $15,189,971. *See* Findings, ¶ 41. After review of OneCare's proposed Operating Expenses in the context of OneCare's budget, programs, and operations, we conclude that in the interest of fiscal responsibility, OneCare must impose at least a 2% reduction in its entity-level Operating Expenses for FY23. Specifically, Operating Expenses in OneCare's FY23 budget include salaries for OneCare's management budgeted at $2.9 million, with $438,656 of that amount in variable compensation, and purchased services budgeted at $3.4 million (combined, salaries and purchased services increased 12.4% from FY22 to FY23), and OneCare must find a reduction of at least 2.0%, which is equal to $303,799. See Findings, ¶ 41, 43. OneCare must determine how to achieve that reduction in its Operating Expenses. We suggest that OneCare consider possible reductions in one or more of the following areas: base and variable compensation and vacancy savings, marketing and communications, contracted services, supplies/occupancy/travel expenses, administrative and/or contractual costs associated with withdrawal of BCBSVT (E.g., actuarial costs associated with finalizing rates, legal, and operational costs, which is subject to further analysis based on OneCare's submission of a revised budget at the end of January, 2023 and final budget in March, 2023).

OneCare's network receives approximately $9.5 million in Medicare Advanced Shared Savings, which are subject to repayment in the event that FY23 shared losses exceed the risk corridor. *See* Findings, ¶ 15. OneCare's proposed budget makes risk-bearing providers in OneCare's network responsible for any such repayment. *See* Findings, ¶¶ 7, 9-13. The risk of shared savings being required to be repaid is unlikely based on prior year results. *See* Findings, ¶

16. To strengthen OneCare's accountability, we are requiring OneCare to hold a portion of the risk of repayment of Medicare Advanced Shared Savings, in an amount of $3.9 million.

OneCare's total potential downside risk for FY23 is $36.5 million, which is an increase from FY22 although remains lower than the pre-COVID downside risk of FY20. *See* Findings, ¶ 14. OneCare still plans to transfer the great majority of its anticipated downside risk to network providers, primarily hospitals. Findings, ¶¶ 9-13. OneCare's proposed budget only held approximately $875,000 of risk. *See* Findings, ¶ 12. OneCare holds approximately $5.7 million in reserves on its balance sheet to cover possible downside risk carried by the ACO, and functions as a sufficient risk mitigation plan. *See* Findings, ¶¶ 13, 38. OneCare does not plan to purchase third-party risk protection for the Medicare program. Findings, ¶ 11.

We impose conditions on our approval of OneCare's FY23 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.

(E) any reports from professional review organizations;

The GMCB's FY22 budget decision required OneCare to 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. See FY22 OneCare Vermont ACO Budget Order, Condition 1. OneCare provided its benchmarking report to the GMCB on October 31, 2022. *See* Findings, ¶ 70. Based on our review of that report, we are requiring OneCare to implement improvements to the benchmarking report to identify best performers and best practices, clarify required methodology for comparison to best performers (per measure, rather than identifying individual high-performing ACOs and comparing across measures), establish a ROI calculation for areas of improvement, and implement a larger and more transparent comparison cohort. An improved benchmarking report is an asset to high-performing ACOs and will benefit OneCare and its ability to monitor its programs' effectiveness and outcomes, and identify focus areas for population health investment. *See* Findings, ¶ 72.

(F) the ACO's efforts to prevent duplication of high-quality services being provided efficiently and effectively by existing community-based providers in the same geographic area, as well as its integration of efforts with the Blueprint for Health and its regional care collaboratives;

OneCare's FY23 budget includes approximately $9.5 million in population health investments that go to the Blueprint for Health. *See* Findings, ¶¶ 15, 62, 67.

(G) the extent to which the ACO provides incentives for systemic health care investments to strengthen primary care, including strategies for recruiting additional primary care providers, providing resources to expand capacity in existing primary care practices, and reducing the administrative burden of reporting requirements for providers while balancing the need to have sufficient measures to evaluate adequately the quality of and access to care;

OneCare's FY22 budget continues investments in a value-based care program with cost and quality accountability designed to strengthen and provide resources to primary care practices. *See* Findings, ¶¶ 59-61. The level of support for primary care resources proposed in OneCare's budget – a total of $14.7 million to $16.7 million, comprised of $13.2 million in PHM base payments, up to $2 million in PHM bonus potential, and $1.5 million in the comprehensive payment reform program, which includes the BCBSVT payer program – is vital to the goals of strengthening primary care and providing a value-based care program, including accountability for cost and quality, that can expand primary care capacity. *See* Findings, ¶ 60. OneCare's CPR program, in particular, is a valuable benefit to primary care and an important part of OneCare's budget. *See* Findings, ¶¶ 60-61.

(H) the extent to which the ACO provides incentives for systemic integration of community-based providers in its care model or investments to expand capacity in existing community-based providers, in order to promote seamless coordination of care across the care continuum;

OneCare's FY23 budget continues investments designed to strengthen and provide resources to integrate community providers, improve care coordination for patients, and reduce duplication of services in partnership with the Blueprint for Health. *See* Findings, ¶¶ 24, 62, 67.

(I) the extent to which the ACO provides incentives for systemic health care investments in social determinants of health, such as developing support capacities that prevent hospital admissions and readmissions, reduce length of hospital stays, improve population health outcomes, reward healthy lifestyle choices, and improve the solvency of and address the financial risk to community-based providers that are participating providers of an accountable care organization;

OneCare's presentation and budget provided examples of how its FY23 budget continues investments designed to strengthen and provide resources to address social determinants of health by embedding a focus on individuals with higher social risk within OneCare care coordination and population health initiatives. *See* Findings, ¶ 65.

(J) the extent to which the ACO provides incentives for preventing and addressing the impacts of adverse childhood experiences (ACEs) and other traumas, such as developing quality outcome measures for use by primary care providers working with children and families, developing partnerships between nurses and families, providing opportunities for home visits, and including parent-child centers and designated agencies as participating providers in the ACO;

OneCare's FY23 budget continues incentives for preventing and addressing the impacts of adverse childhood experiences (ACEs) and other childhood traumas through its population health programs, including through screenings and other work to increase its understanding of aspects of social determinants of health within its network and through a $150,000 investment 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* Findings, ¶¶ 59, 64.

(K) public comment on all aspects of the ACO's costs and use and on the ACO's proposed budget;

The Board accepted public comments on OneCare's proposed budget from October 1, 2022 through December 16, 2022. These comments are available on the Board's website.[6] The Board received 33 comments regarding the OneCare's FY23 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.

(L) information gathered from meetings with the ACO to review and discuss its proposed budget for the forthcoming fiscal year;

OneCare presented its FY23 budget to the GMCB at a public hearing on November 9, 2022. OneCare also responded to two rounds of questions from GMCB staff, and provided additional letters regarding its proposed budget. Material provided by OneCare is available on the GMCB website.[7]

(M) information on the ACO's administrative costs, as defined by the Board;

As set out and explained above, we require OneCare to reduce its FY23 Operating Expenses by at least 2.0%, from $15,189,971 to not more than $14,886,172. *See* Conclusions, Section I.(D). OneCare's Operating Expenses for FY23 are subject to adjustment reflecting the withdrawal of BCBSVT in FY23 and pending the GMCB review of OneCare's planned transition of its data analytics platform to UVMHN. 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.

(N) the effect, if any, of Medicaid reimbursement rates on the rates for other payers;

OneCare's FY23 budget includes trend rates for the MVP and BCBSVT QHP programs that are based on Board-approved rate increases for 2023 QHPs. Findings, ¶ 48. The GMCB is re-assessing its analytic process regarding the impact of Medicaid reimbursement rates on the rates for other payers. See Green Mountain Care Board Annual Report for 2022 (Submitted January 17, 2023), 35 ("the Board is working to refine its understanding of the cost shift") (available at https://gmcboard.vermont.gov/sites/gmcb/files/documents/2022_GMCB-Annual-Report_01.17.2023.pdf).

(O) the extent to which the ACO makes its costs transparent and easy to understand so that patients are aware of the costs of the health care services they receive; and

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.

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[6] See https://gmcboard.vermont.gov/board/comment/previous.
[7] See https://gmcboard.vermont.gov/FY23OneCareVermont.

OneCare's costs are described in detail in OneCare's budget submission, supplemented by OneCare's responses to our questions, and this order. *See* Findings, ¶¶ 40-43.

(P) the extent to which the ACO provides resources to primary care practices to ensure that care coordination and community services, such as mental health and substance use disorder counseling that are provided by community health teams, are available to patients without imposing unreasonable burdens on primary care providers or on ACO member organizations.

As stated above, OneCare's FY23 budget continues investments designed to strengthen and provide resources to primary care practices. *See* Findings, ¶¶ 59-61. The level of support for primary care resources proposed in OneCare's budget – a total of $14.7 million to $16.7 million, comprised of $13.2 million in PHM base payments, up to $2 million in PHM bonus potential, and $1.5 million in the comprehensive payment reform program, which includes the BCBSVT payer program – is vital to the goals of strengthening primary care and providing resources to expand primary care capacity through a value-based care program with cost and quality accountability. *See* Findings, ¶ 60.

II. Benchmarks Established under Rule 5.402

A. Fund the VBIF or other pre-funded clinical quality incentive programs at a minimum of the FY22 revised budget amount.

Although structured differently, OneCare's budget does meet the requirement of having a pre-funded clinical quality incentive program that is funded at the minimum of the FY22 amount because of the $2 million Medicaid value-based incentive funding pool, which will be paid directly from DVHA to providers and not distributed through OneCare. See Findings, ¶ 45.

B. The FY23 commercial benchmark trend rates must be consistent with the ACO-attributed population and the GMCB approved rate filings.

At the time the Board approved OneCare's budget, OneCare was still negotiating final trend rates with at least one commercial payer. While it is not ideal to move forward with the budget without more information about the 2023 commercial contract, this uncertainty is not new. Similar to prior years, we believe the appropriate course of action is to allow OneCare and the participating commercial payer to negotiate rates for their program 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.

C. The ACO shall use best efforts to meet or exceed the target proposed by the ACO and approved or modified by GMCB staff in accordance with OneCare Vermont's FY22 Budget Order, Condition #3.a, for the portion of FY23 commercial payer contract revenue in the form Fixed Prospective Payment.

The GMCB intends to adopt goals for fixed prospective payment in the FY24 guidance, which for Medicaid payments is anticipated to be 55% of payments in the form of FPP, and for commercial payments the goal will be determined. OneCare is required to continue reporting during FY23 regarding its progress toward meeting the FPP goals established in the FY22 budget decision.

III. APM Agreement

A. TCOC Growth Rates

Total cost of care for services covered by the APM Agreement for 2021 was not available at the time the Board approved OneCare's budget. The actual total cost of care per person across all payers grew 0.4% from 2017 through 2020 for services covered by the APM Agreement, which is within the financial target set by the APM agreement. GMCB PowerPoint, 10, 14 (May 25, 2022). This growth rate is significantly lower than the annual growth from 2017 through 2019 because of a decline in total cost of care of 7.4% from 2019 to 2020, which is likely the impact of lower utilization due to the COVID-19 pandemic. *See id*.

At the time the Board approved OneCare's budget, OneCare was still negotiating with DVHA on the terms of the 2023 contract, including the appropriate trend rate(s). On December 12, 2022 the GMCB provided DVHA will a letter confirming that the Board had completed its obligations under the Medicaid Advisory Rate Case required by 18 V.S.A. § 9573. 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 2023. We will require that OneCare ensure the Medicaid trend rates are consistent with the methodology reviewed by the Board in the Medicaid advisory rate case.

B. Scale and Program Alignment

The State is currently below the scale targets in the APM Agreement. *See* Findings, ¶ 27-30. The potential loss of BCBSVT from the OneCare program for FY23 would further reduce scale. *See* Findings, ¶ 29. 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, ¶ 30. 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 FY23 budget on the terms, and subject to the conditions, set forth below:

1. OneCare must continue to support an ACO performance benchmarking tool that compares key quality, cost, and utilization metrics to national ACO metrics in accordance with its FY22 Budget Order and further defined by this Order. The ACO performance benchmarking tool must:

    a. Allow the ACO and GMCB to assess OneCare's performance against peer ACO's or integrated health systems by comparing OneCare ACO-level performance metrics to a broad national cohort of ACOs in five key areas, as available and appropriate:
        i. Utilization
        ii. Cost per capita
        iii. Patient satisfaction/engagement
        iv. Quality
        v. Evidence-based clinical appropriateness
    b. Compare ACO performance metrics to at least the 50th and 90th percentiles, though comparison by quartile or decile is preferred, by each metric to allow for identification of top performers by measure in each key area.
    c. Enhance OneCare's ACO-level performance management strategy, including integration of best practices and priority opportunities identified through

benchmarking and peer networking in the OneCare Quality Evaluation and Improvement Program.

d. Improve regulatory reporting and performance assessment by providing the benchmarking comparisons to targets at least semiannually to the GMCB.
    i. FY23 Guidance laid out future expectations for setting targets for performance benchmarks at or above the 50th percentile and that any Performance Improvement Plans should include best practices identified through top-performers (90th percentile).
e. An updated benchmarking report must be submitted to the Board by March 31, 2023.
f. Meet the standards and methods for the report as specified by this Order and the ACO Reporting Manual. The GMCB Board Chair is authorized to delegate authority to one or two GMCB Board Members and the GMCB Director of Health Systems Policy to review and approve proposed revisions to the report.

2. 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 Rules 5.501 and 5.503. 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 5.503 and in the GMCB's Annual Budget Review Guidance and Certification Eligibility Review Form.

    a. The GMCB Reporting Manual will include, without limitation, submission of audited financial statements, an explanation of any discrepancies from audited financials to GAAP financials, a crosswalk of is actual performance to its submitted budget, IRS Form 990, full time equivalents by ACO functional category, and FPP reporting.

3. OneCare must comply with GMCB requests pursuant to GMCB's review of OneCare's planned transition of its data analytics platform to UVMHN.

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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. The GMCB's approval of OneCare's FY23 budget is conditioned on OneCare participating in FY23 in the Vermont Medicare ACO Initiative and Medicaid Next Generation ACO Program. OneCare must submit an updated budget to the GMCB for review no later than January 30, 2023 reflecting the effects of BlueCross BlueShield of Vermont's decision not to participate with OneCare in FY23.

6. OneCare must ensure that its payer contracts are consistent with the following 2023 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 established using methodology consistent with the methodology reviewed by the GMCB in the Medicaid advisory rate case.
    c. Commercial:
        i. The 2023 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 11 and 12.

7. The ACO shall use best efforts to meet or exceed the goals for FPP as adopted by the GMCB in the FY24 budget guidance and identify and report specific obstacles to achieving the goals and action steps required (by OCV or others) to overcome those obstacles.

8. OneCare shall work with Medicare Advantage plans operating in Vermont over the next two years – with a special focus on Vermont-based plans offered by BCBSVT and UVMMC-MVP – to develop scale target qualifying programs for FY24.

9. OneCare must implement the risk model that it described in its budget proposal, except for the new Medicare Advanced Shared Savings risk requirement, 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

10. 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.

11. No later than March 31, 2023, OneCare must provide GMCB staff with the supporting documentation relevant to the topics identified in Condition 12. 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 2023 by hospital;
    f. Hospital risk for 2023 by hospital and payer;
    g. Documentation of increasing the OneCare held risk in the amount ordered by the GMCB and any changes to the overall risk model for 2023;
    h. Source of funds for its 2023 population health management programs;
    i. Revised benchmarking report pursuant to Condition 1;
    j. A report to the Board on OneCare's progress relative to its targets for commercial payer FPP levels; and
    k. Any other information the GMCB deems relevant to ensuring compliance with this order.

12. At its presentation of the revised budget on a date set by the GMCB, and no later than May, 2023, OneCare must present to the GMCB on the following topics:

    a. Final FY2023 attribution and finalized payer contracts;
    b. Revised budget, based on final attribution;
    c. Final description of population health initiatives;
    d. Expected hospital dues for 2023 by hospital;
    e. Expected risk for 2023 by OneCare held risk, risk bearing entity and by payer;
    f. Any changes to the overall risk model for 2023;
    g. Source(s) of funds for OneCare's 2023 population health management programs;
    h. Status of the Medicare ACO Performance benchmarking system;
    i. Update on the results of evaluations as described in the FY23 budget submission;
    j. Update on the partnership between OneCare and the University of Vermont to explore additional partnerships around evaluation;

k. OneCare's progress relative to targets for commercial payer FPP levels; and
l. Any other information the GMCB deems relevant to ensuring compliance with this order.

13. In FY23, OneCare's Operating Expenses must not exceed $14,886,172, which is a 2.0% reduction from OneCare's submitted Operating Expenses of $15,189,971. OneCare's Operating Expenses for FY23 are subject to adjustment reflecting the withdrawal of BCBSVT in FY23 and pending the GMCB review of OneCare's planned transition of its data analytics platform to UVMHN, provided, however, that the total maximum amount of OneCare's Operating Expenses shall be as set forth in this Order.

14. 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.

POPULATION HEALTH AND QUALITY

15. If population health management and payment reform programs are not fully funded as detailed in OneCare's FY23 budget submission, OneCare must submit a revised proposal no later than March 31, 2023, 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 FY23, OneCare must fund SASH in the amount of $4,508,696, which is equivalent to the 2022 budgeted amount of $4,285,795 plus an inflationary factor of 5.2%, contingent on the increase in funding being used to enhance programs or expand access to Medicare beneficiaries. In 2023 OneCare must fund the Blueprint for Health (PCMH and CHT) investments in the amount of $5,037,220, which is equivalent to the 2022 budgeted amount of $4,788,187 plus an inflationary factor of 5.2%, consistent with the medical home and community health team program payment design approved by the Agency of Human Services. OneCare shall hold at least $3.9 million of the risk associated with Medicare Advanced Shared Savings Payments and not pass that amount of the risk on to any OneCare network participant.

17. 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

18. 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: March 30, 2023 at Montpelier, Vermont

s/ Owen Foster, Chair)
)
s/ Jessica Holmes) GREEN MOUNTAIN
) CARE BOARD
s/ Robin Lunge) OF VERMONT
)
s/ David Murman)
)
s/ Thom Walsh)

Filed: March 30, 2023

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.