VERMONT
GREEN MOUNTAIN CARE BOARD

ACO Oversight
FY 2023 Budget and Certification
OneCare Vermont

Staff Analysis and Preliminary Recommendations

December 7, 2022

CONFIDENTIAL INFORMATION HAS BEEN REDACTED

Agenda

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- Introduction and Background
  - Public Comment Received to Date
- FY 2023 Staff Analysis & Preliminary Recommendations
- Next Steps
- Board Questions and Discussion
- Public Comment

FY 2023 ACO Budget Key Areas of Review

- Certification
- Budget & Financials
- Payer Programs & Risk Model
- Payment Models & FPP/CPR
- Population Health, Quality, Model of Care
- Performance Measurement & Improvement
- Results

ACO Oversight Statute/Rule

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- Oversight of Accountable Care Organizations (18 V.S.A. § 9382 and Rule 5.000)
  - **Certification**: Occurs one-time following application for certification; eligibility verifications performed annually.
  - **Budget**: Review of ACO budget occurs annually, usually in the fall prior to start of budget/program year; payer contracts/attribution are finalized by spring of the budget year and the ACO submits a revised budget.

ACO Oversight: Standards of Review

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The standards and requirements by which we review the ACO submissions are set forth in:

1. 18 V.S.A., Chapter 220 (primarily 18 V.S.A. § 9382 "Oversight of Accountable Care Organizations");
2. GMCB Rule 5.000; and
3. All-Payer ACO Model Agreement.

Specifically, under Rule 5.405 the Board considers:

1. any benchmarks established under section 5.402 of this Rule;
2. the criteria listed in 18 V.S.A. § 9382(b)(1);
3. the elements of the ACO's Payer-specific programs and any applicable requirements of 18 V.S.A. § 9551 or the Vermont All-Payer Accountable Care Organization Model Agreement between the State of Vermont and CMS; and
4. any other issues at the discretion of the Board.

The ACO shall have the burden of justifying its budget to the Board.

OCV Budget and Certification Review Timeline FY 2023

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Jul 1, 2022	GMCB issues FY23 ACO oversight guidance
Sept 1, 2022	ACO submits certification materials
Oct 1, 2022	ACO submits FY23 budget
Oct 12, 2022	GMCB staff ACO Oversight Background presentation
Nov 9, 2022	OneCare Vermont Budget Hearing
Nov 21, 2022	ACO 2021 Financial Settlement & Quality Performance panel
Dec 7, 2022	GMCB staff analysis presentation: OneCare Vermont
Dec 14, 2022	GMCB deliberations on OneCare Vermont FY23 budget
Dec 21, 2022	GMCB potential vote on OneCare Vermont FY23 budget
Ongoing 2022 - 2023	GMCB monitors FY23 actual performance against budget and conditions

Public Comment
Themes

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- Value of OCV's data analytics, population health initiatives, and transition to value-based care
- Value of care coordination and strengthened partnerships with local care organizations
- Concerns related to the transition of OCV data analytics to UVMHN
- Concerns related to measures of OCV's performance and overall value to Vermont's healthcare system
- In total, 19 comments were received as of 12/5.*

*All public comments are posted on GMCB website unless commenters request otherwise.

Public Comment
Themes

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From OneCare Vermont Board of Managers

- Executive Compensation
- Cyber-Attack
- Data Security
- Tax-Payer Dollars

Public Comment
Themes

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From the Health Care Advocate

- OCV's deepening ties to the University of Vermont Health Network (UVMHN)
  - Risks undermining the effectiveness of Vermont's All-Payer Model (APM)
- OCV'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

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STAFF ANALYSIS FY 2023

High-Level Overview

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- Provider Network
- Payer Programs
- Income Statement
- Approach to FY2023 Staff Recommendations

High-Level Overview
2023 Provider Network

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Minimal changes between 2022 and 2023: 1 independent primary care practice closed (retirement), 4 SNFs added, increased payer program participation, including 1 CPR practice

- **14 Hospitals**
- **9 FQHCs**
- **27 Independent Primary Care**
  - 19 CPR Primary Care Practices
- **5 Naturopaths**
- **21 Specialists**
- **47 Continuum**
  - Including SNF, Home Health and Hospice, Designated Agencies, Special Services Agencies, Ambulatory Surgery Centers

Approximately 82% **of Vermont primary care providers** participate in OCV: of 3,794 providers eligible to attribute patients to the model, 3,118 are in OneCare's network.

See PY4 APM Scale and Alignment Report (June 2022)

The OneCare participation data is available in the FY23 Budget Submission
- Section 1, Attachments A and B, Network and Hospital Participation
- Section 2, Appendices, Organizations and Providers

High-Level Overview
2023 Payer Programs

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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

High-Level Overview
Summary Income Statement

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Full-Accountability (Total Cost of Care) Budget

- **Submitted budget is the result of provider network participation, negotiated payer program terms, and OneCare strategies to develop their network and payer programs**

Summary - Full Accountability Budget (Non-GAAP)	
Budgeted FY2023 Revenue	$1,448,894,369
Budgeted FY2023 Expense	$1,448,894,369
Budgeted Net Income (Full Accountability)	$0

Full-Accountability Budget includes…

- Health care spending for OneCare attributed lives for TCOC services processed externally to OneCare (97%)
- Population health expenses (2%)
- Administrative expenses (1%)

Entity-Level (Organization-Level) Budget

- **Submitted budget is elements that are not contractually obligated and are at the discretion of OneCare governance and leadership**

Summary - OCV Entity-Level Budget (GAAP)	
Budgeted FY2023 Revenue	$25,491,500
Budgeted FY2023 Expense	$25,491,500
Budgeted Net Income (Entity-Level)	$0

Entity-Level Budget includes…

Revenues and expenses that are not contractually obligated as pass-through to providers, e.g.,

- Revenues: Participation fees; shared savings distribution (if any)
- Expenses: Shared losses distribution (if any); PHM investments; Admin expenses

High-Level Overview

Financial Context – Full Accountability

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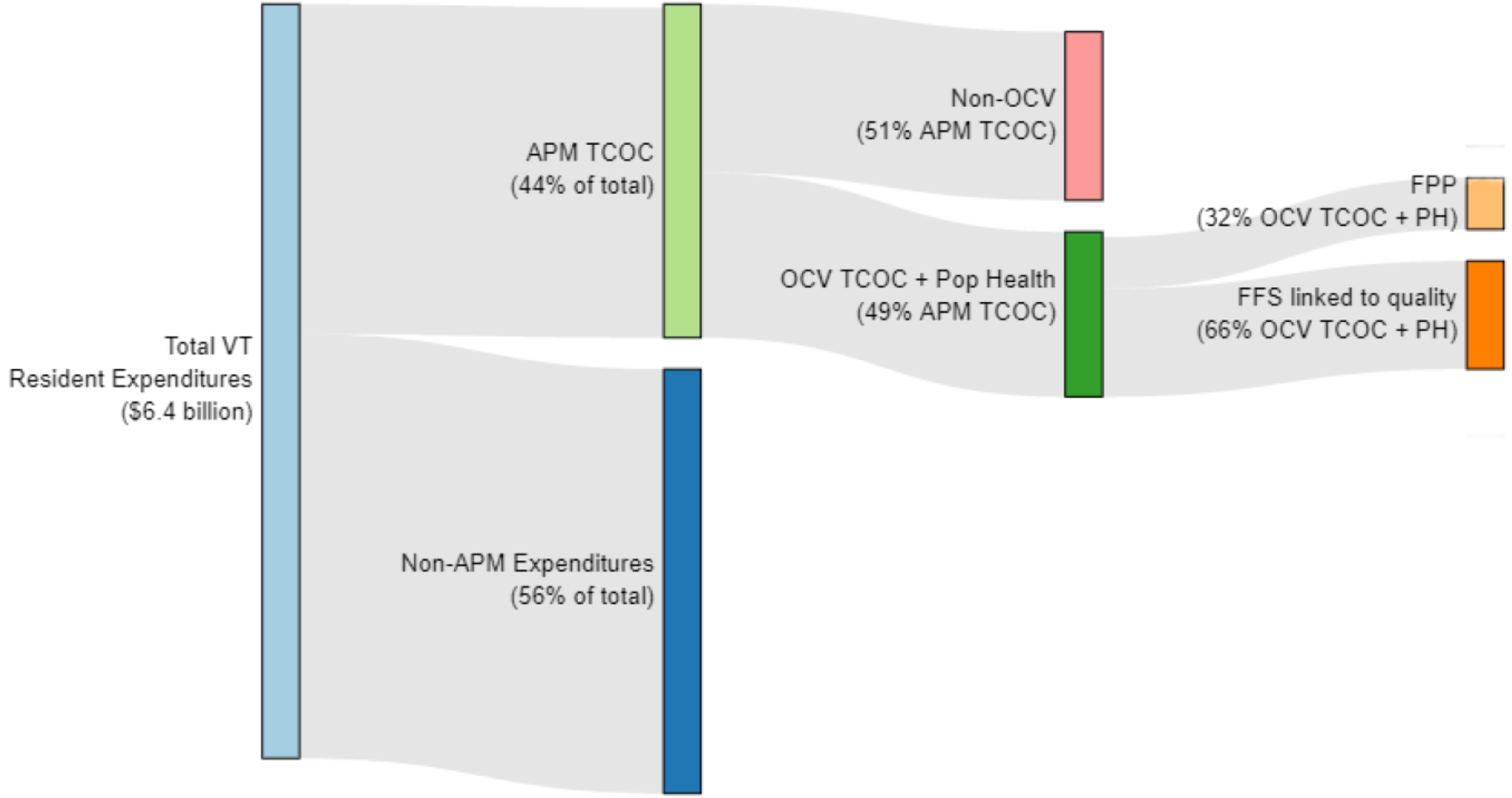

High-Level Overview
Administrative Costs

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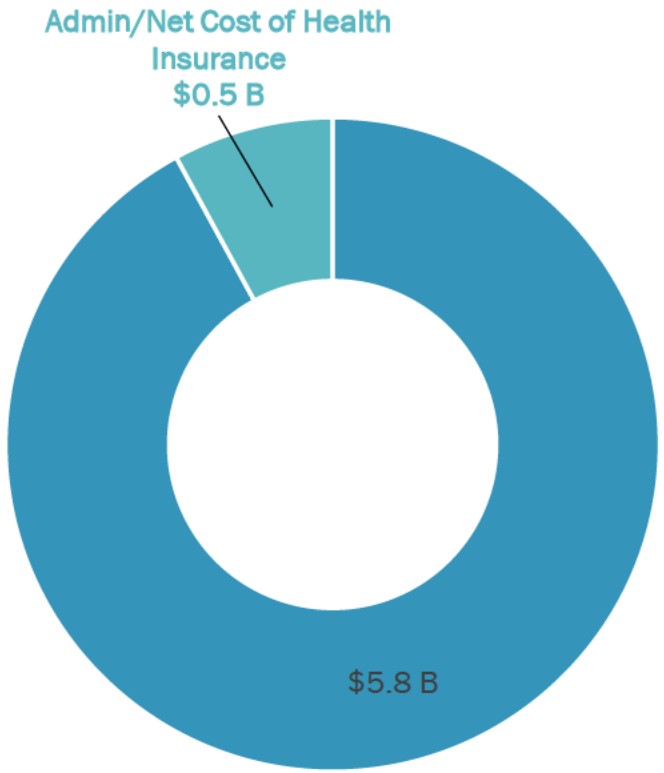
Administrative costs associated with insurance were **8.3%** of total Vermont resident expenditures in 2020.



For small group and individual commercial plans review by the GMCB In 2020, the administrative expenses were **~7.5%** of premium.

The administrative tasks for commercial plans are much broader than an ACO, but the premiums include contributions to support these tasks.

Actual administrative PMPMs in 2020 were approximately **$44 for QHPs** and **$6 for OCVT**.

High-Level Overview
Impact of COVID-19

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- The COVID-19 public health emergency has created unique uncertainty for providers, ACOs, and payers in designing and implementing value-based models
  - Volatile utilization patterns
  - Impacts on quality measurement
  - Linking results to performance
  - Financial uncertainty

High-Level Overview
Approach to FY23 Recommendations

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- The FY22 budget order conditions reflected a focus on data-driven monitoring and oversight.
  - Focus on ensuring that the ACO's management drives continuous improvement consistent with a high-performing ACO and that it supports achieving the state's health reform goals
- This was envisioned as a multi-year approach, to be refined in 2023 through the FY23 ACO budget review and FY24 guidance development process. Staff recommend continuing to strengthen this approach over the coming year, keeping data-driven ACO performance monitoring at the center of our ACO oversight.
  - Focus on performance benchmarking, target-setting, and evaluation

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KEY AREAS OF REVIEW FY 2023

FY23 Key Areas of Review

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- Certification
  - Review of Data Analytics Transition
- ACO Budget & Financials
- Total Cost of Care (TCOC) and Trend Rates
- Payer Programs & Risk Model
- Payment Models & Fixed Prospective Payments/Comprehensive Payment Reform Program
- Population Health, Quality, and Model of Care
- Performance Measurement and Improvement
- Results to Date

FY 2023 Certification Eligibility Verification

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Once certified, an ACO must annually submit a form to the GMCB (1) verifying that the ACO continues to meet the requirements of 18 V.S.A. § 9382 and Rule 5.000; and (2) describing in detail any material changes to the ACO's policies, procedures, programs, organizational structures, provider network, health information infrastructure, or other matters addressed in the certification sections of Rule 5.000.

- 5.201 - Legal Entity
- 5.202 - Governing Body
- 5.203 - Leadership and Management
- 5.204 - Solvency and Financial Stability
- 5.205 - Provider Network
- 5.206 - Population Health Management and Care Coordination
- 5.207 - Performance Evaluation and Improvement
- 5.208 - Patient Protections and Support
- 5.209 - Provider Payment
- 5.210 - Health Information Technology

Certification
Executive Compensation

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- Board issued guidance regarding Rule 5.000, § 5.203(a) on May 12, 2021.
- An ACO must structure its executive compensation to achieve specific and measurable goals that support the ACO's efforts to reduce cost growth or improve the quality and overall care of Enrollees, or both.
- OneCare Vermont has corporate goals that align with their strategic plan. Variable pay is a component of each eligible employee's total compensation but is only paid if the ACO and its employee successfully achieve these goals.

Certification
Executive Compensation

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- Variable pay ranges, as a percentage of base pay (2022):
  - 0-10% Directors
  - 0-20% VPs
  - 0-25% CEO
- Determination of the attainment of these goals is made by the next level of leadership. In the case of the CEO, the Board of Managers must approve the attainment of these goals.

Certification
Executive Compensation

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2022 Goals (provided by OCV)

- Payment Reform: Evolve and enhance payment reform programs
  - Expand PHM and/or risk models to promote enhanced performance and sustainability under value-based contracts for future performance years
  - Develop a plan for revenue strategy for risk and reserves
- Network Performance: Ensure a high quality, equitable system that continuously strives to improve health care delivery and outcomes
  - Implement, support, and evaluate network performance on care coordination accountabilities
  - Prioritize diversity, equity, and inclusion (DEI) in OneCare's actions through governance, communications, and staff development
  - Develop and implement a plan that deepens network engagement in OneCare's communications
- Data and Analytics: Deliver actionable insights to network in support of better outcomes
  - Deliver and implement an ACO data strategic plan

The focus for the 2023 goals should be consistent with the strategic plan and the weighting is expected to be similar.

Certification
Decision Support Tools

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- ACOs must apply or support participants in applying shared decision-making processes that must use decision support tools and other methods that enable Enrollees to assess the merits of various treatment options and their relative risks and benefits.
- Care coordination tools versus decision support tools
- Providers given data and opportunities for best-practice collaboration
- Requirement may be discussed in the future

Certification
Health Information Technology

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- Details of new analytics platform were unavailable
- Attestation made to new platform meeting certification requirements

Certification
Recommended Approach/Next Steps

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- The GMCB does not need to vote in order to continue OneCare's certification.
- Action would be needed if the GMCB concludes that OneCare no longer meets the requirements to be eligible for certification. In that case, the Board would provide notice to the ACO and an opportunity to respond before requiring corrective action.

Review of Data Analytics Transition
Recommended Approach/Next Steps

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- Under Rule 5.503, "The Board may use any and all powers granted to it by law to monitor an ACO's performance or operations or to investigate an ACO's compliance with the requirements of this Rule, other applicable laws or regulations, and decisions and orders of the Board."
- Reviews may be performed at any time, not limited to the FY23 budget process.
- Review outside of FY23 budget process would allow, for example, a specific hearing on the data analytics transition requested by the HCA in their comments.
- To conduct an examination of an ACO's operations, the GMCB "shall advise an ACO of the specific areas that will be reviewed and any statutory or regulatory provisions under examination." Rule 5.503(b).

ACO Budget & Financials

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- Full Accountability (non-GAAP) Budget
- Entity-level (GAAP) Budget

ACO Budget & Financials

Full Accountability vs. Entity Level Budgets

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- OCV's Full Accountability (non-GAAP) budget is an "all-in" financial perspective which captures Expected TCOC pass-through, Contract revenues (incl. FPP), and organizational revenues and expenses. The Full Accountability budget is not in line with US GAAP as most of the revenues are the responsibility of third-party fiduciaries.
- OCV's Entity-Level (GAAP) budget captures only the revenues and expenses derived from and incurred by the organization's operating activity in line with US Generally Accepted Accounting Principles (GAAP).*

* OCV presented an FY23 budget of $45.1 million. This is an amalgamation of the entity-level (GAAP) budget ($25.5M), the full value of the PHM base payment, and Blueprint and SASH funds.

ACO Budget & Financials

Full Accountability vs. Entity Level Budgets

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Full-Accountability (Total Cost of Care) Budget

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ACO Budget & Financials

Full Accountability Summary Income Statement

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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%

ACO Budget & Financials

Budget Components: Full Accountability Revenue (2019-2023)

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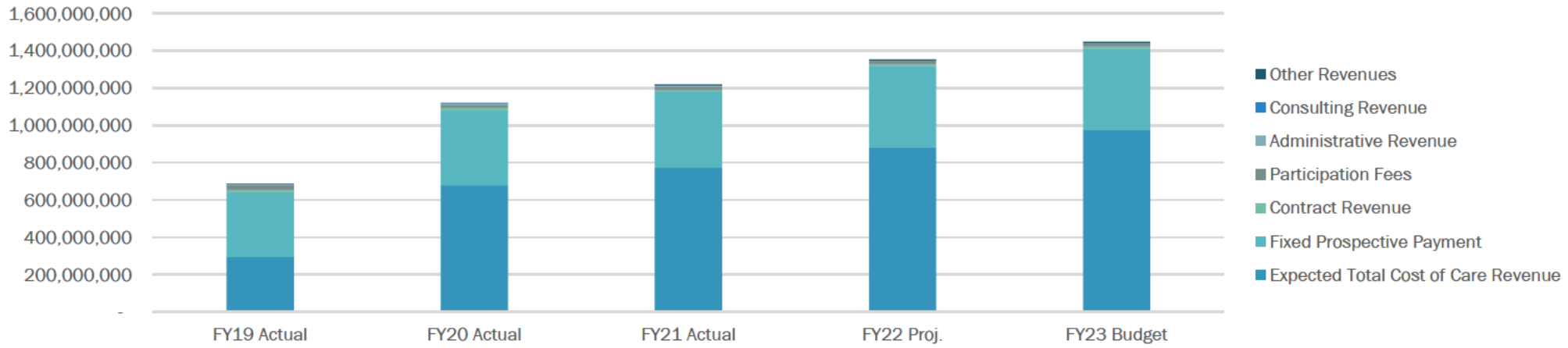
	FY19 Actual		FY20 Actual		FY21 Actual		FY22 Proj.		FY23 Budget	
Total Revenue	**685,821,095**		**1,118,699,486**		**1,220,443,196**		**1,353,799,222**		**1,448,894,369**	
Expected Total Cost of Care Rev.	294,018,591	42.9%	677,948,979	60.6%	771,837,967	63.2%	882,713,433	65.2%	974,663,796	67.3%
Fixed Prospective 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%



ACO Budget & Financials

Budget Components: Full Accountability Expenses (2019-2023)

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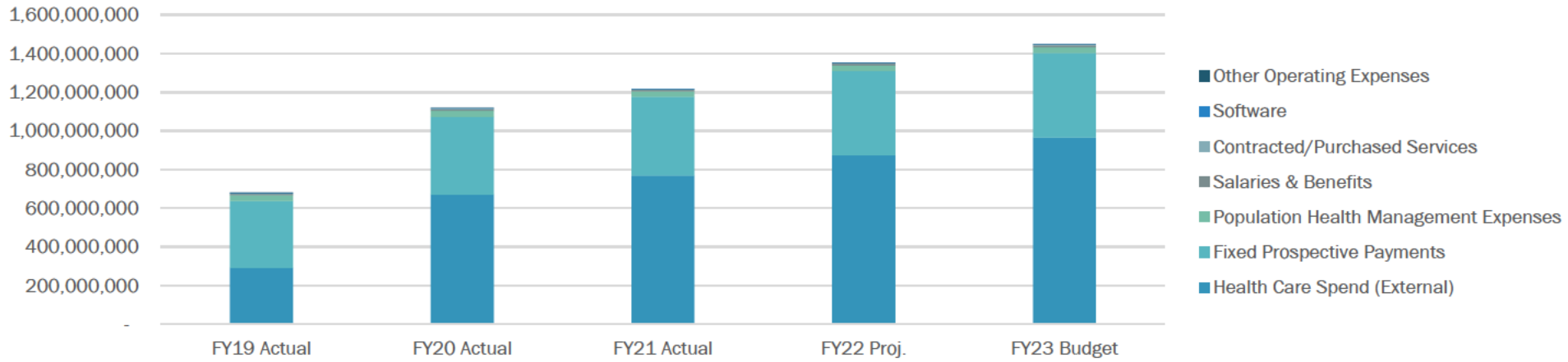
	FY19 Actual		FY20 Actual		FY21 Actual		FY22 Proj.		FY23 Budget	
Total Expense	**681,131,922**		**1,118,699,485**		**1,218,542,658**		**1,353,799,222**		**1,448,894,369**	
Health Care Spend (External)	289,987,490	42.6%	669,547,321	59.9%	769,024,703	63.1%	873,639,451	64.5%	965,117,880	66.6%
Fixed Prospective 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%



ACO Budget & Financials

FY22 Revised to FY23 Budget (Full Acct.)
Revenue Reconciliation

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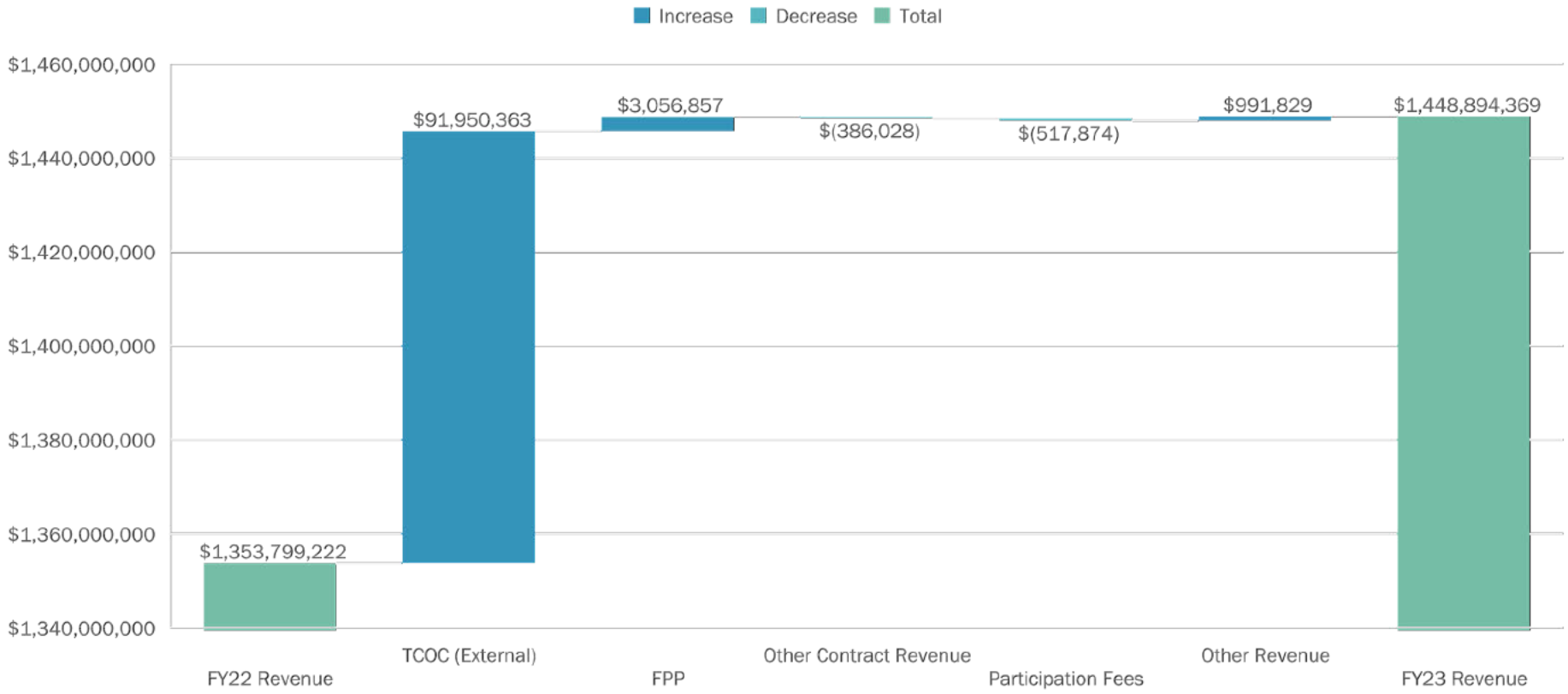

ACO Budget & Financials

FY22 Revised to FY23 Budget (Full Acct.)

Expected Total Cost of Care (TCOC) Reconciliation

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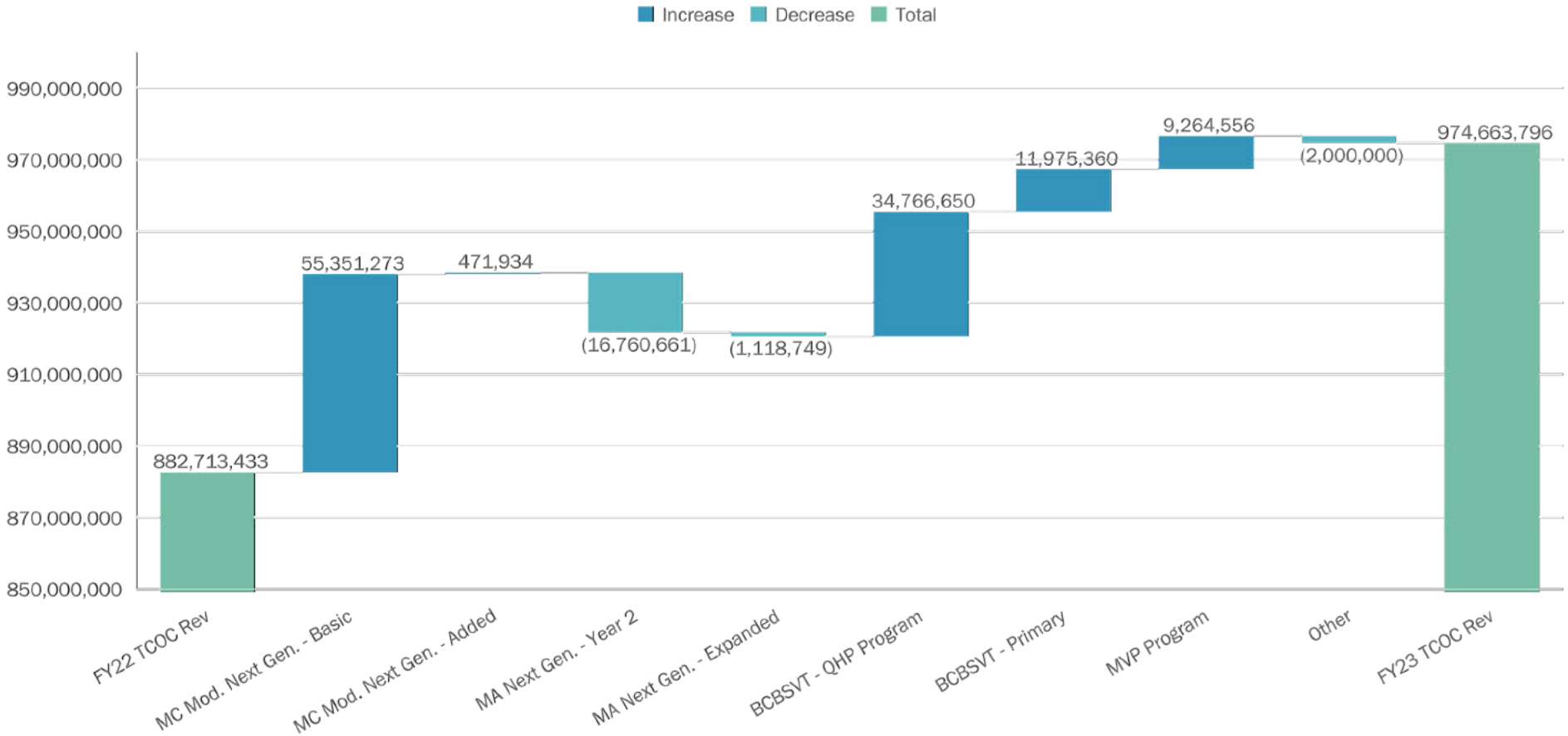
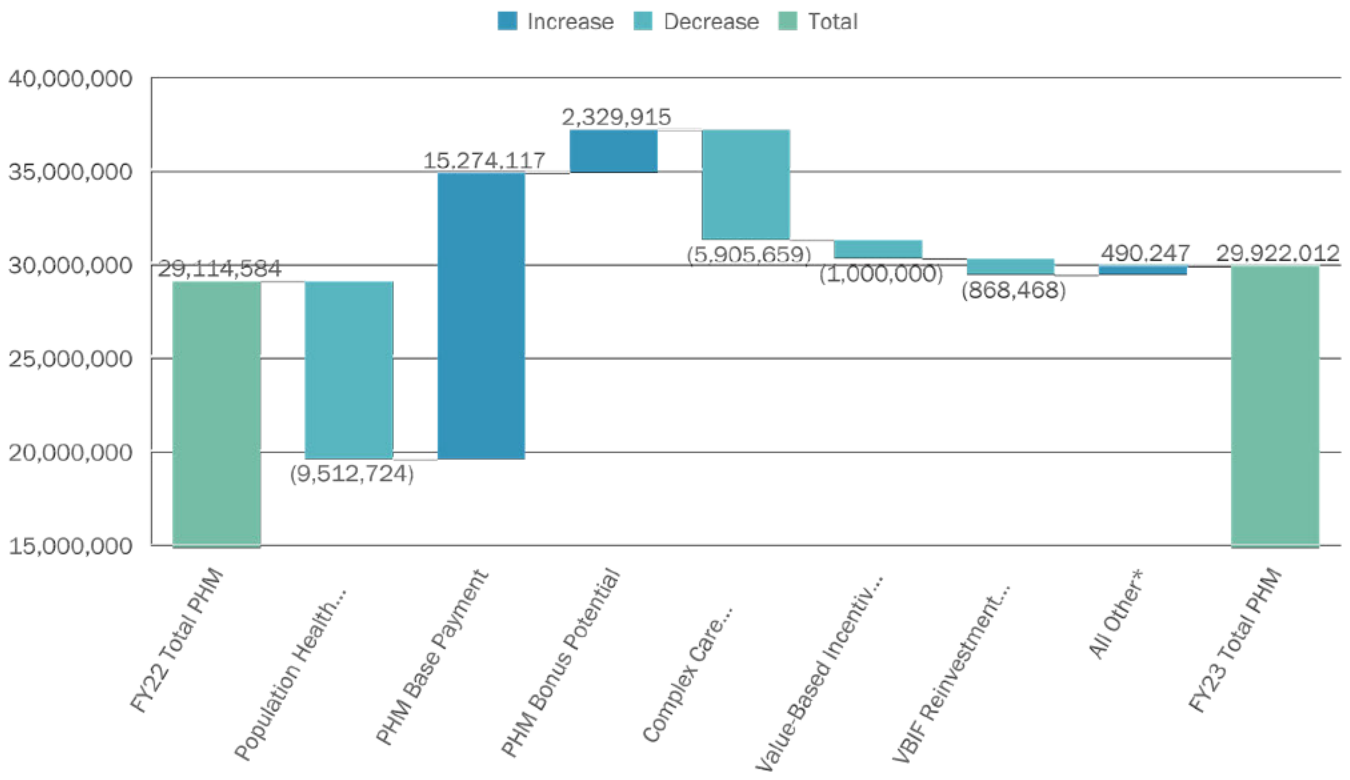


MA = Medicaid

MC = Medicare

ACO Budget & Financials

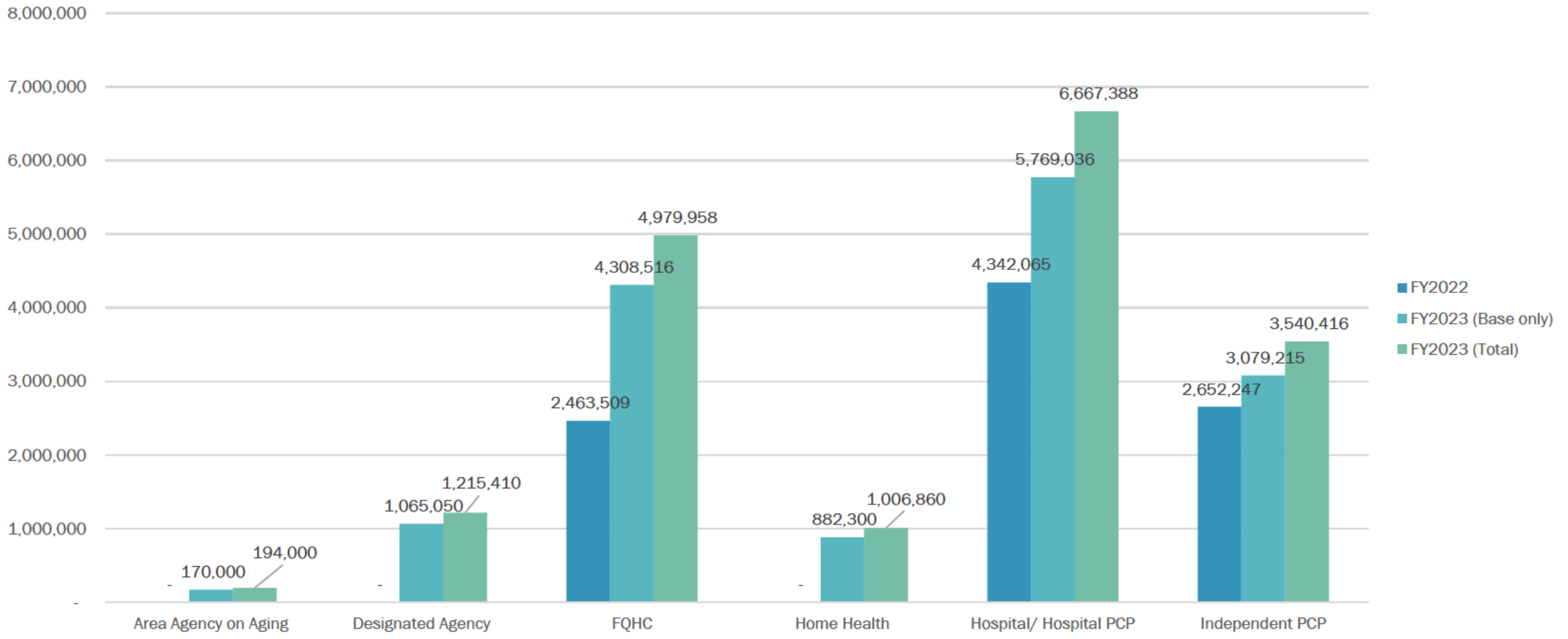
FY22 Revised to FY23 Budget (Full Acct.)
PHM/Payment Reform Expense Reconciliation



*All Other Breakout	
Comprehensive Payment Reform Program	351,615
SASH Funding	222,901
SNF Support	201,299
Specialist Funding	150,000
CHT Funding	148,725
PCMH Legacy Payments	100,308
Chronic Kidney Disease	(23,165)
Amplify Grants	(35,000)
DULCE	(59,119)
Program Match	(120,000)
Mental Health Initiatives	(147,550)
Innovation Fund	(299,767)
Longitudinal Care	
Total All Other	**490,247**

ACO Budget & Financials

PHM Payments by Provider



ACO Budget & Financials

Entity-level Summary Income Statement (GAAP)

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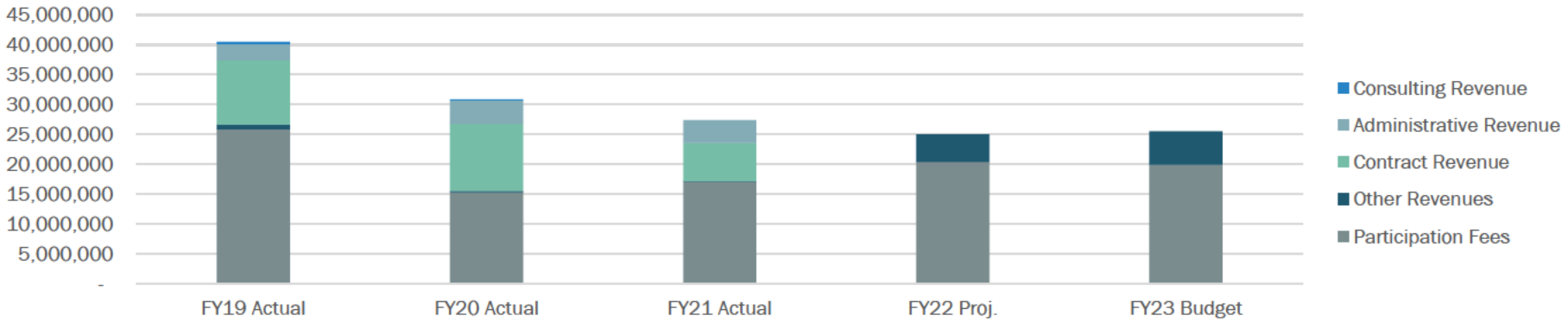
Entity-level (GAAP)	2018 Actual	2019 Actual	2020 Actual	2021 Actual	2022 Revised	2023 Budget
Total Cost of Care Target Components (External)	-	-	-	-	-	-
Fixed Prospective Payment Funding (FPP)	-	-	-	-	-	-
Other Contract Revenue	3,771,184	10,771,692	11,194,712	6,449,190	-	-
Participation Fees	17,397,929	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%

ACO Budget & Financials

Budget Components: Entity-level Revenue (2019-2023)

VERMONT
GREEN MOUNTAIN CARE BOARD

	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%

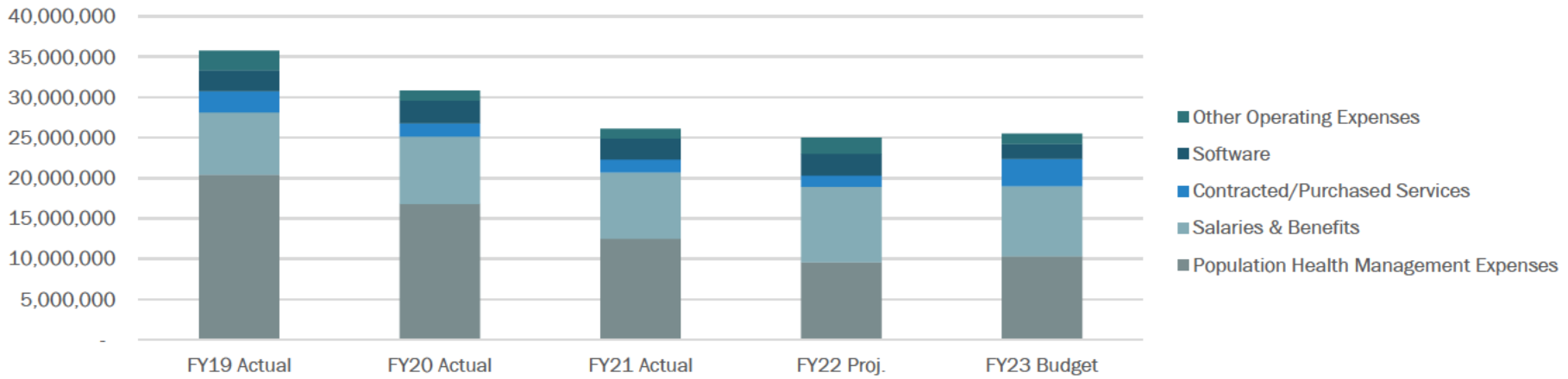


ACO Budget & Financials

Budget Components: Entity-level Expenses (2019-2023)

VERMONT
GREEN MOUNTAIN CARE BOARD

	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%



ACO Budget & Financials

FY22 Revised to FY23 Budget (Entity-level) Revenue Reconciliation

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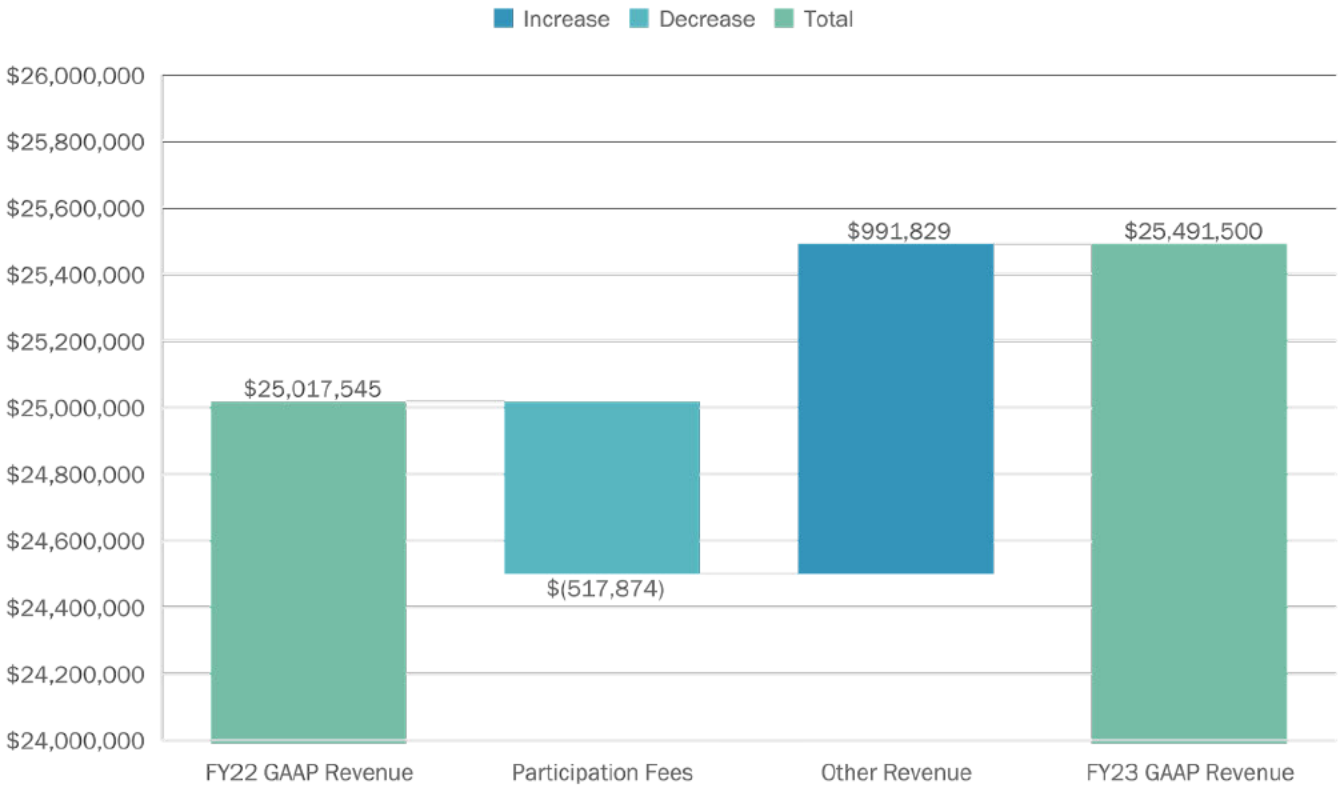
GREEN MOUNTAIN CARE BOARD

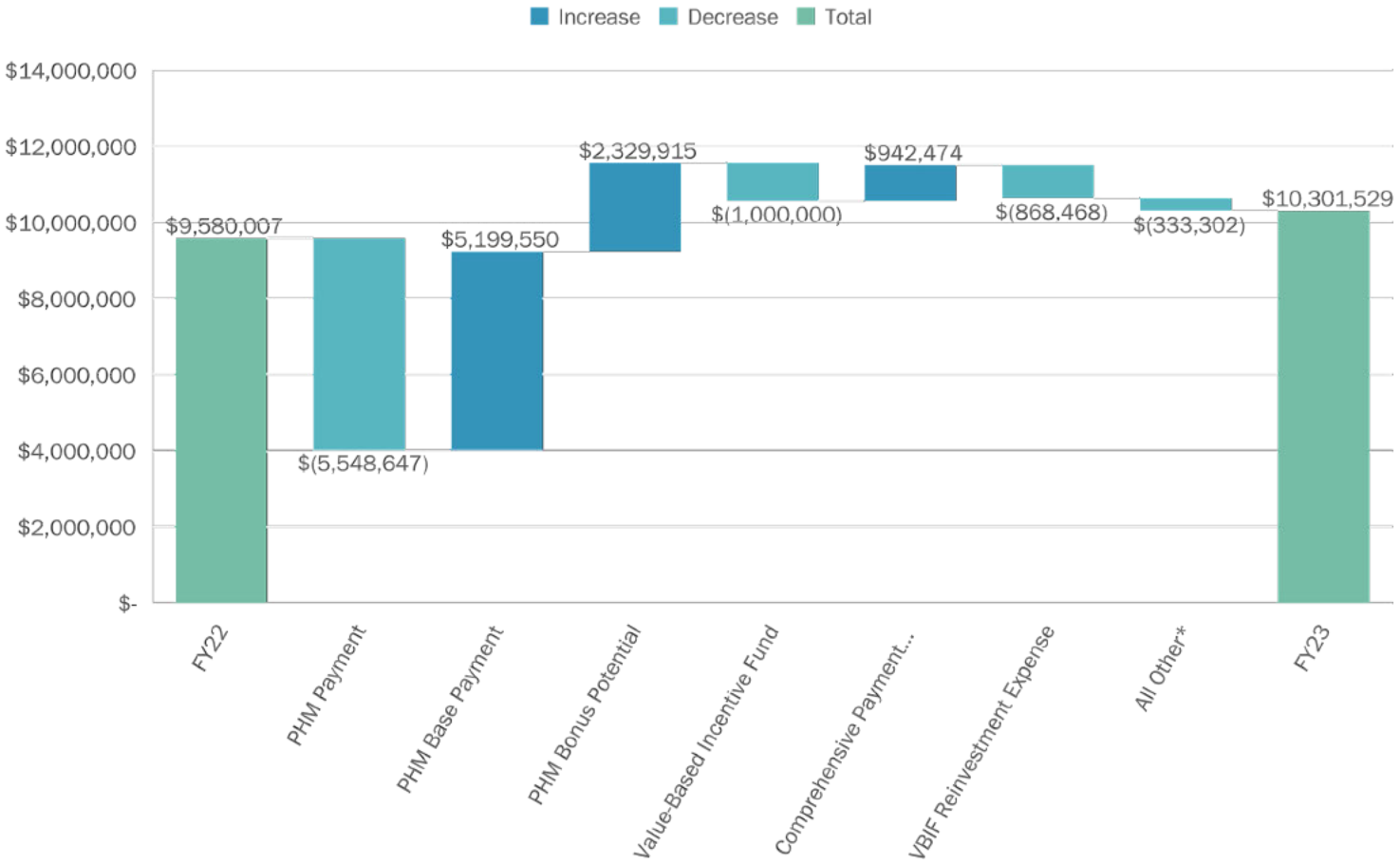


- All entity-level revenues provided by hospitals
- Net increase of $474K

ACO Budget & Financials

FY22 Revised to FY23 Budget (Entity-level)

PHM/Payment Reform Expense Reconciliation

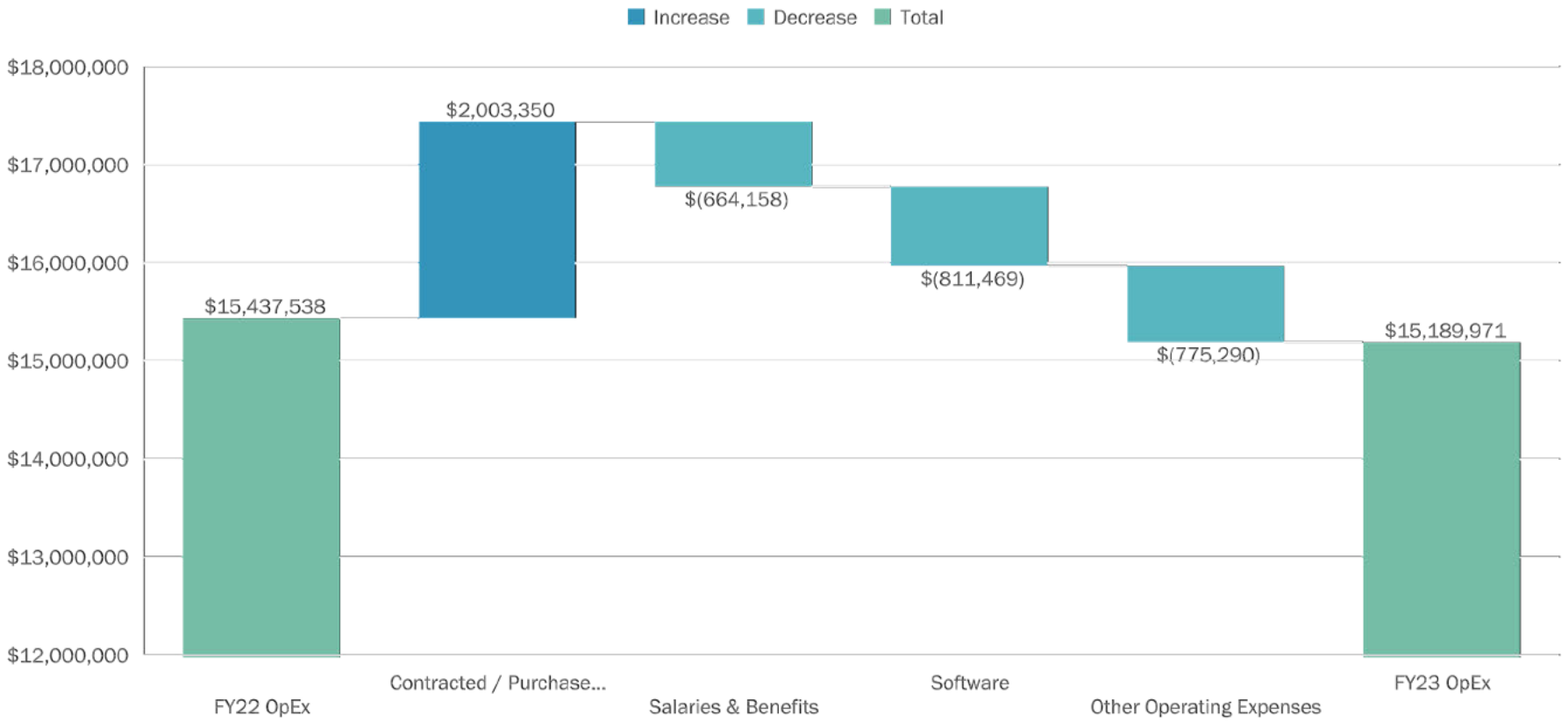


***All Other Breakout**

	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)**

ACO Budget & Financials

FY22 Revised to FY23 Budget (Entity-level)
Operating Expenses Reconciliation



ACO Budget & Financials

Operating Expense Concentrations: Year-over-Year as % of Total

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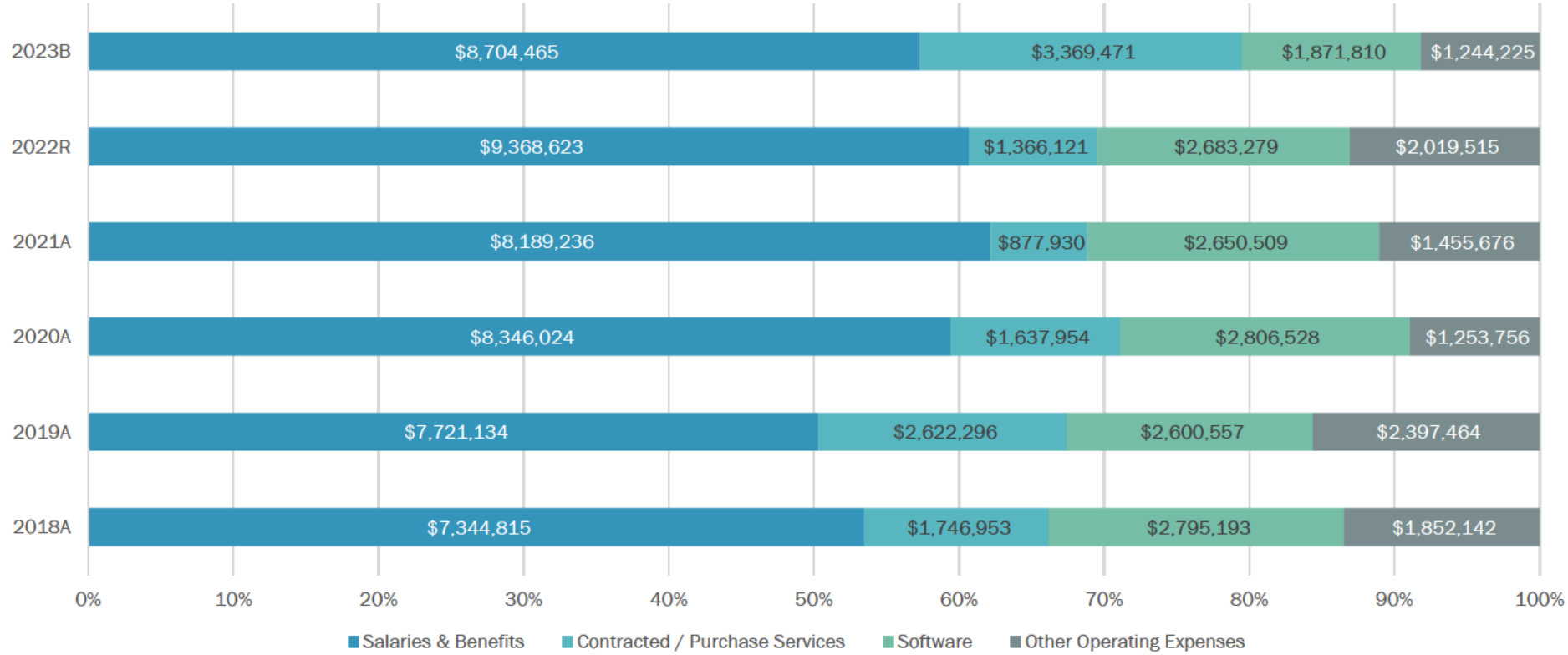

ACO Budget & Financials
Key Takeaways

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- Growth in OneCare's Full Accountability budget is largely driven by external health care spend (Total Cost of Care)
  - Within the $92M net increase to TCOC, we're seeing a nearly -$18M reduction in Medicare revenues being offset by increases in Medicaid and private payers.
- The shift in analytics to a UVMHN contract is net neutral but for some overlap in services during the transition.
- OneCare's overall operating expenses remain relatively stable (down 1.6% from FY22)

ACO Budget & Financials
Recommended Approach

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- Require OCV to notify GMCB of any material changes to their budget and explain variance. (Consistent with past years)
- Require OCV to submit a revised budget by March 31, 2023, and present on the revised budget in April 2023, including final payer contracts, attribution by payer, a revised budget, hospital dues and risk, any changes to the risk model, source of funds for population health programs. (Consistent with past years)
- Require that Operating Expenses must not exceed $15.2M, including the cost of all required evaluation and reporting activities. (Consistent with past years, with additional language regarding evaluation and reporting costs)
- Require OCV to notify GMCB of any use of reserves or line of credit or any adjustment to participation fees. (Consistent with FY22)
- NOTE: Audited Financials and Form 990 will be collected through ACO Reporting Manual. (Consistent with past years)

Total Cost of Care & Trend Rates

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- Attribution and TCOC over time 2018-2023
- Trend rates over time 2018-2023

Total Cost of Care & Trend Rates
Setting Trends and Benchmarks

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	How is the trend and benchmark (ACO Total Cost of Care spending target) set?
Medicare	GMCB-calculated and proposed Medicare ACO Benchmark
Medicaid	Medicaid and ACO negotiation; GMCB reviews in Medicaid advisory rate case
BCBSVT	BCBSVT and ACO negotiation; GMCB rate review decision on medical trend is an input
MVP	MVP and ACO negotiation; GMCB rate review decision on medical trend is an input

Total Cost of Care & Trend Rates
Budgeted Trend Rates & TCOC

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	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.

Total Cost of Care & Trend Rates
Key Takeaways

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- Setting financial targets remains challenging due to the ongoing pandemic
- Staff will discuss implications of trend rates (especially Medicare trend) for All-Payer Model Agreement TCOC (APM TCOC) targets at the December 14 presentation and staff recommendation for the Vermont Medicare ACO Initiative benchmark (ACO financial target)

Total Cost of Care & Trend Rates
Recommended Approach

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- Require OCV to implement benchmark trend rates for payer contracts in alignment with the GMCB's decision on the Medicare ACO benchmark; the GMCB's Medicaid Advisory Rate Case; and, for commercial payer contracts, in alignment with ACO-attributed population and the GMCB approved rate filings. (Consistent with past years)
    - Staff may also recommend requiring additional information from OCV to support better understanding of what commercial payer data is available to OCV during trend and benchmark negotiations. (NEW)

Payer Programs & Risk Model

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- Summary of risk models by payer program
- Total risk by HSA, including breakout by risk-based entity and primary care accountability pool
- Summary of OneCare policies related to shared savings (SS) and shared losses (SL) distribution and process for distributing SS/SL upon settlement

Payer Programs & Risk Model
Background on OneCare's Risk Model

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- **OneCare Vermont assumes risk from payers** for the care of a particular population as specified in their payer contracts
  - These contracts do not specify distribution of shared savings or losses to the ACO provider network
- **OneCare Vermont designs and implements the methodology for distributing risk to its provider network**, establishing TCOC targets for participating providers and methods for distributing shared savings or losses
  - For example: Primary Care Accountability Pool; Performance Incentive Pool
  - Documented in OneCare policies

Payer Programs & Risk Model

OneCare's Payer Programs: Disclaimer

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Analyses are based solely on OneCare's budget submission. GMCB staff have not yet analyzed pending payer contracts, which are still under negotiation.

Payer Programs & Risk Model

Risk Models by Payer (update FY23)

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	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.

Payer Programs & Risk Model

Total Risk Over Time – Pre-COVID to Current

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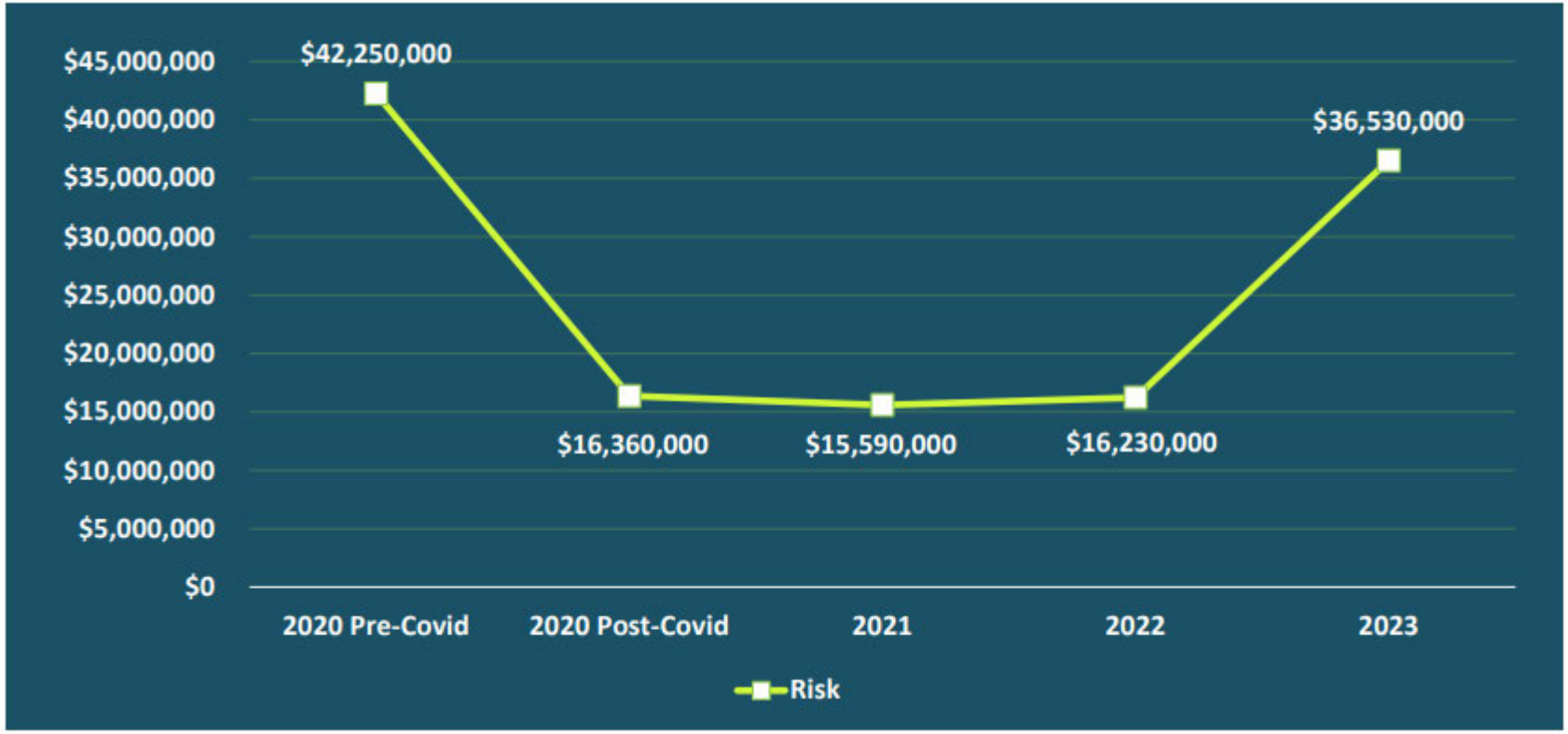
- OneCare Vermont FY23 Budget Presentation, Slide 20



Payer Programs & Risk Model
Total Risk and Reserves Over Time

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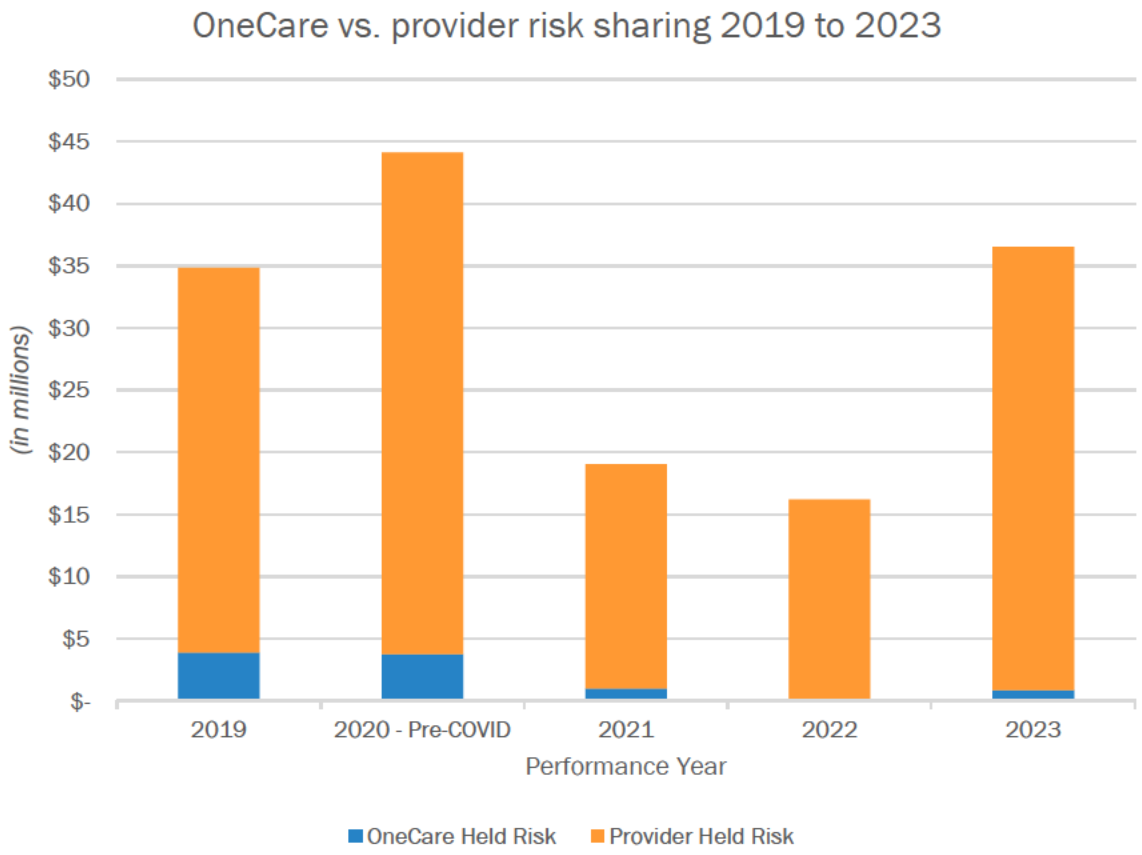

	2019	2020	2021	2022	2023
TCOC	$823.3M	$1,086.1M	$1,178.3M	$1,278.8M	$1,413.8M
Total Risk	**$34.8M**	**$44.1M**	**$19.0M**	**$16.2M**	**$36.5M**
Total Risk as % TCOC	4.2%	4.1%	1.6%	1.3%	2.6%
Provider Held Risk	$30.9M	$40.3M	$18.0M	$16.1M	$35.7M
% of Total Risk	*89%*	*91%*	*95%*	*99%*	*98%*
OneCare Held 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).

Payer Programs & Risk Model

Savings/Risk Distribution to Provider Network

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- Program Settlement Policy (04-07-PY23)
  - Savings/Losses are calculated for each Program and HSA, based on HSA-level attribution, with hospitals serving as the risk-bearing entity (RBE) for their HSA
  - $1.50 PMPM “first-dollar” savings or risk for primary care practices
  - Funding for budgeted OCV expenses* is subtracted from settlement; 90% of remaining settlement dollars go to HSA RBEs, 10% distributed to HSAs based on performance

*Per the policy, defined as expenditures approved by OCV BOM for the fiscal year, “which could include administrative costs, PHM or care coordination payments, pilot payment programs, and contribution to reserves.”

Payer Programs & Risk Model

Savings/Risk Distribution to Provider Network, cont.

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- Primary Care Accountability Pool
  - Practices can pay into accountability pool throughout the year (withhold from base PMPM) or elect to receive an invoice from OCV at settlement if ACO is required to pay back shared losses
  - Projected total = $3.7M (10% of total risk), up from $2.4M in 2021)
  - Current policy: 2023 (04-07 Program Settlement PY 2023)
- Performance Incentive Pool
  - Sets aside 10% of total shared savings to reward HSAs that perform well on two measures: year-over-year PMPM cost and avoidable ED visits
  - Distributed based on performance against network-wide average
  - Current procedure: 2021 (F04-22-PY21 Performance Incentive Pool PY 2021) (new procedure in development)

Payer Programs & Risk Model

FY23 Savings/Risk by Risk Bearing Entity

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	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

Payer Programs & Risk Model
SS/SL Distribution – 2021 Settlement

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Payer	2021 Program Settlement Final Settlement: Shared Savings/Shared Losses
Medicare	$1.2M*
Medicaid	$7.1M
BCBSVT	($110,000)
MVP	$0 (upside-only, no savings earned)

*Medicare 2021 Settlement excludes ACO Shared Saving Advance (BP and SASH $)

See FY2021 Financial Settlement & Quality Performance Presentation, November 21, 2022 & OneCare Vermont ACO results webpage.

Payer Programs & Risk Model

Advanced Shared Savings – Blueprint/SASH Funds

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Of the total $36.5M in risk, $9.5M comes in the form of Medicare Advanced Shared Savings.

- Medicare's investments in the Blueprint for Health Programs ended in 2016, including PCMH, CHT, and SASH
- The Agreement included provisions to allow Medicare to continue to contribute to these foundational programs by providing the ACO with an advance against any future shared savings
  - The funding is attached to the Medicare Benchmark as a manual adjustment (i.e., the benchmark, or ACO spending target, for Medicare is increased by the amount of the shared savings advance), but this does not represent performance risk.
  - The advance is reconciled at settlement; if OCV does not save more than the advance amount, they would be required to pay dollars back to Medicare.
- ACO providers have expressed that they perceive this as an asymmetric risk corridor, though it is accompanied by an equal increase to the benchmark.

Payer Programs & Risk Model
Key Takeaways

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- Total budgeted FY23 risk and reward = $36.5M
  - OneCare-held risk is a very small portion of total risk, and has decreased both in dollars and in percent of total risk over time
- Primary care accountability pool is pushing first-dollar risk (and potential reward) to primary care practices according to total attribution:
  - Total Primary Care Accountability Pool (FY23 Budget) = $3.7M (10% of total risk)
  - Primary care accountability pool for non-hospital owned primary care (FY23 Budget) = $2.1M (6% of total risk)
- Performance Incentive Pool sets aside 10% of total shared savings to reward high performing HSAs based on two measures: year-over-year improvement on PMPM cost and avoidable ED visits
- Advance Shared Savings payments and related manual adjustment to Medicare ACO benchmark create provider confusion and perception of asymmetric risk in Medicare ACO program.

Payer Programs & Risk Model
Recommended Approach

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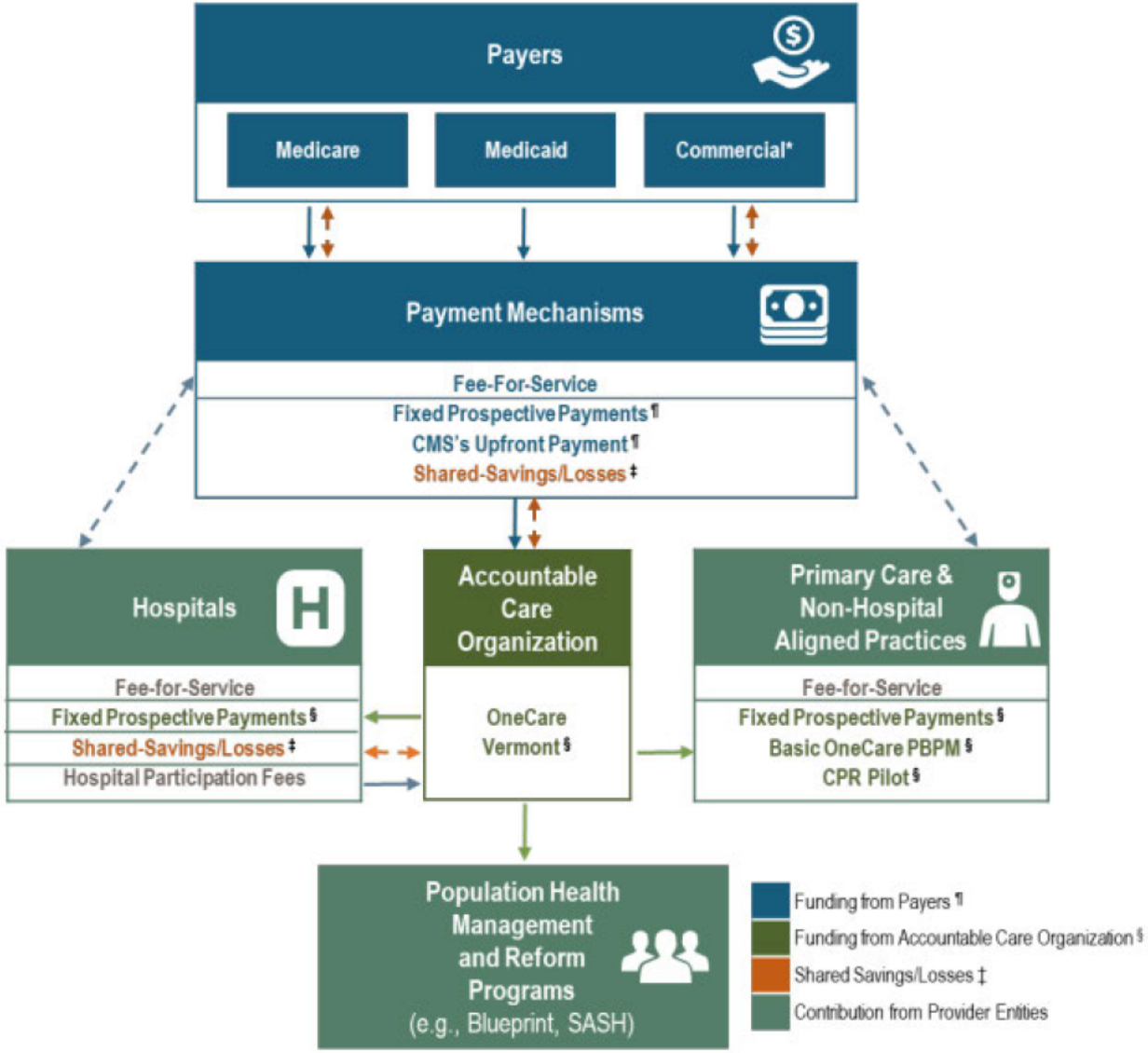
- Require OCV to engage in payer programs that qualify for APM Scale to the greatest extent possible and align payer programs in key areas to the extent reasonable; explain non-Scale qualifying programs and areas of misalignment. Require continued reporting on payer programs. (Consistent with past years)
- Require OCV to work with Medicare Advantage plans operating in Vermont over the next two years – with a particular focus on Vermont-based plans offered by BCBSVT and UVMMC-MVP – to develop Scale-qualifying programs.
- Implement the ACO risk model as described in the budget; notify the GMCB of any changes. (Consistent with past years)
- Recommend that OCV hold risk for Medicare Advanced Shared Savings (Blueprint for Health/SASH funds) rather than delegating risk to network. (NEW –also see Population Health Management recommended approach)

Payment Models and FPP/CPR

- Funds flow:
  - Payer → ACO
  - ACO → Provider
  - Payer → Provider
- Looking at proportion of total payments which are value-based; proportion of total payments which use fixed and/or population-based payments

Chart from Evaluation of the Vermont All-Payer Accountable Care Organization Model, Exhibit 2.5. NORC https://innovation.cms.gov/data-and-reports/2021/vtapm-1st-eval-full-report



NOTE: *Commercial includes self-insured, CPR = Comprehensive Payment Reform, PBPM = per beneficiary per month, SASH = Support and Services at Home.

Payment Models and FPP/CPR
OneCare's Fixed Payment Models

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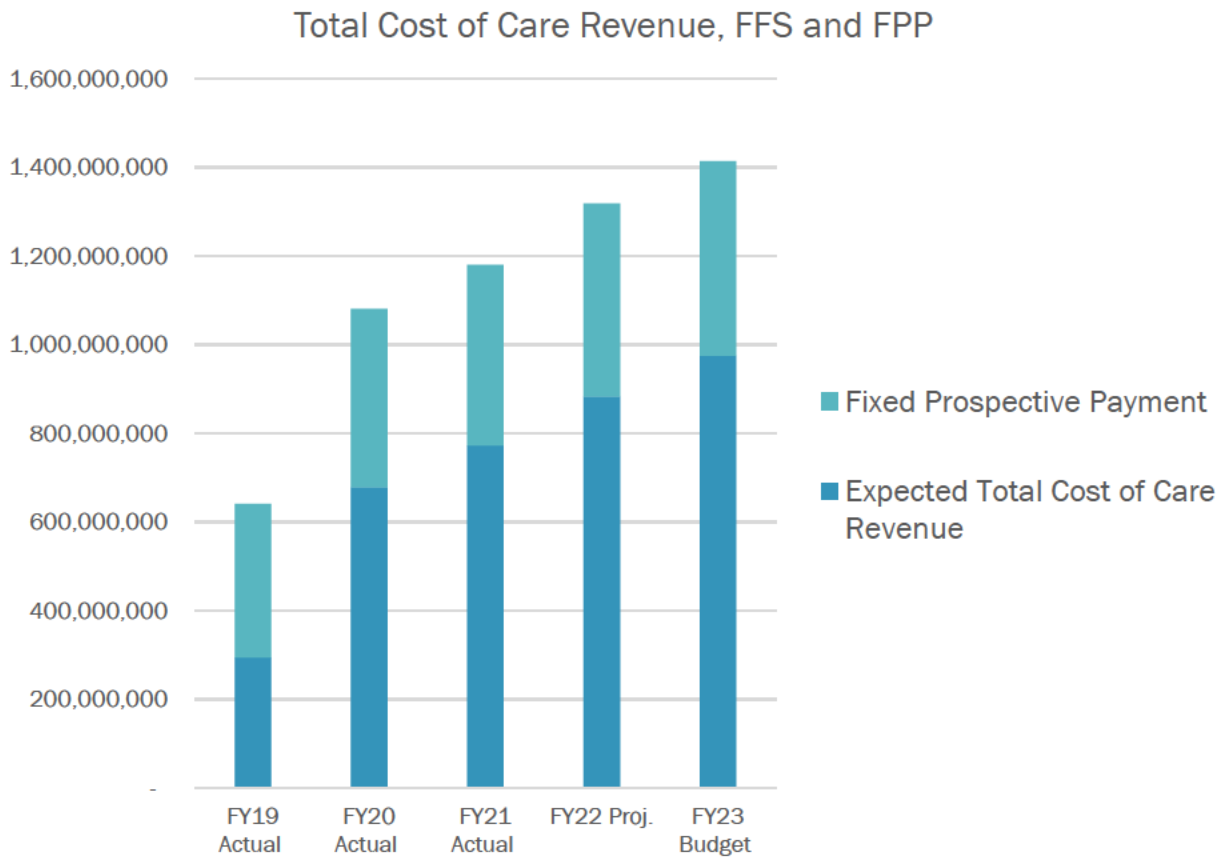
- **Fixed Prospective Payments (FPP) to Hospitals**
  - Medicare FPP (AIPBP) - *reconciled*
  - Medicaid FPP - *unreconciled*
  - BCBSVT FPP pilot - *reconciled*
- **Comprehensive Payment Reform (CPR) Program**
  - Payer-blended fixed payments for independent primary care practices for core primary care services plus additional PMPM for non-core services; CPR payments are fixed for the PC practice but reconciled back to FFS and settled with the HSA risk-bearing entity – *unreconciled at primary care practice level*



Payment Models and FPP/CPR

OneCare's Fixed Payment Models

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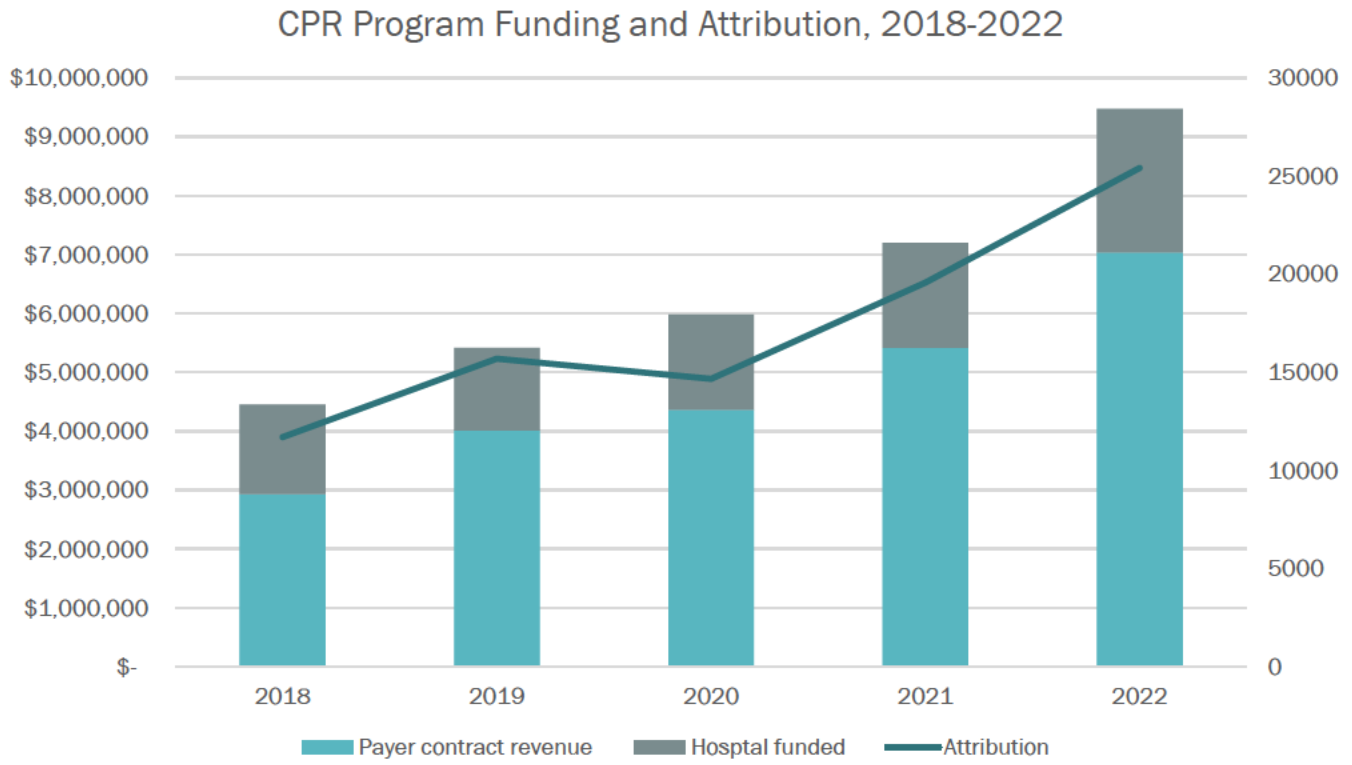
- Growth in CPR Program, 2018-2022
- OneCare reports 19 practice sites in 2023



Year	Count of Practice Sites
2018	6
2019	12
2020	10
2021	14
2022	17

Payment Models and FPP (FY23 Budget)

Fixed Payments as Percent of Expected TCOC and HCP-LAN Categories

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	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	[redacted]	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.

Payment Models and FPP/CPR

Condition 3a: FPP Levels and Targets – Reporting

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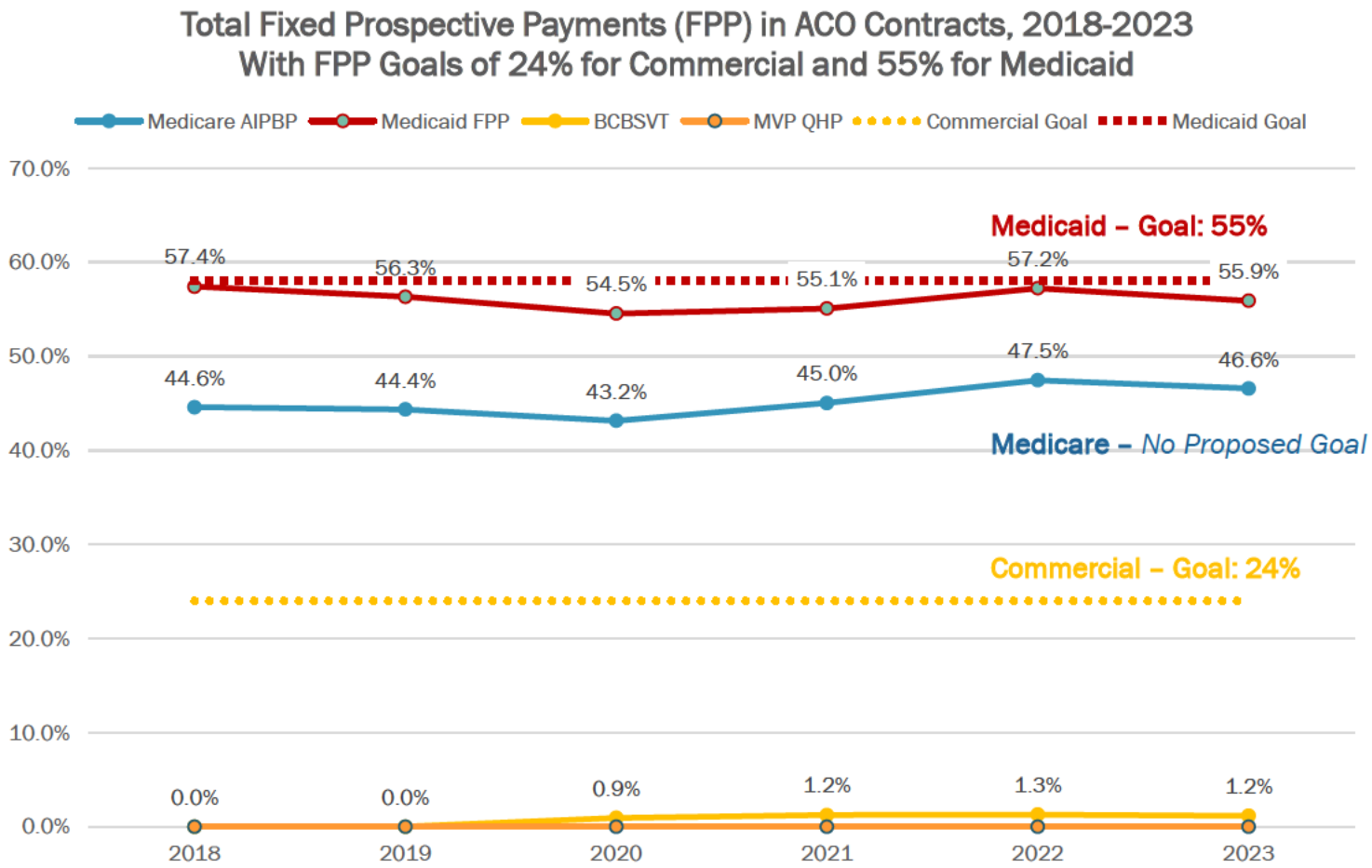

In their July 2022 FPP report, OneCare amended the FPP targets they presented with May FY22 revised budget.

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

Payment Models and FPP/CPR
Key Takeaways

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- Payment models consistent – no major changes
- FPP:
  - Satisfaction with and commitment to unreconciled Medicaid FPP
  - Medicare has indicated it will not convert to unreconciled FPP in the current model
  - Commercial lags in providing any non-FFS payment models within their risk-based contracts; however, payers express willingness and progress
- CPR
  - CPR program receives positive feedback and is expanding; significant expansion could put pressure on hospitals that absorb the FFS settlement
  - Exploring expansion of the CPR Program to hospital employed primary care and FQHCs
  - Exploring CPR program moving to a % TCOC as a way of achieving increased % spent on primary care and linking PC reimbursement with overall trends

Payment Models and FPP/CPR
Recommended Approach FPP

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- Per the FY22 Budget Order and FY23 Guidance, GMCB staff recommend adopting goals for FPP in FY24 Guidance at (NEW)
  - **Medicaid 55%**
  - **Commercial 24%**
- The ACO must continue to report FPP data and progress toward the goals as specified in the ACO Reporting Manual and FY24 Guidance
- Goals reflect an aspiration, not a concrete plan. The ACO shall use best efforts to meet or exceed the goals as modified by the GMCB.
  - BCBSVT, MVP and OneCare have not identified clear milestones for including FPP in new contract model design (APM IIP, Nov 2020)
  - Medicare fixed payment model does not align with Medicaid (APM IIP, Nov 2020)

Reference: Implementation Improvement Plan (APM IIP): Vermont All-Payer Accountable Care Organization Model Agreement (Nov. 19, 2020)
https://gmcboard.vermont.gov/sites/gmcb/files/documents/APM%20Implementation%20Improvement%20Plan%20Final%2011.19.20.pdf

Payment Models and FPP/CPR
Recommended Approach CPR

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- Share OCV-performed CPR Program Evaluation with GMCB (NEW-Reporting Manual)
- Provide information on impact of moving CPR to % TCOC in Revised Budget (NEW)
- Continue to provide CPR standard reporting (Consistent with past years and Reporting Manual)

Population Health, Quality, Model of Care

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- Major programmatic changes

Population Health, Quality, Model of Care
Review Criteria

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Review and Consider

- Incentives/Resources (Payment Changes)
- Information (Data)
- Efforts (Tools)

18 V.S.A. § 9382 (A)(F)(G)(H)(I)(J)(P)

Key Criteria

- Strengthen primary care
- Effects on appropriate utilization
- Integrate with community-based providers and the Blueprint for Health e.g., mental health and substance use disorder
- Address social determinants of health and impact of adverse childhood events

Population Health, Quality, Model of Care
Changes for 2023

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New PHM Payment Model
- Streamline 3 payments into 2
- PHM Base Payment + PHM Bonus

Sunset of Care Navigator
- End of 2022
- New requirements for care coordination payments: triannual reporting, validation audits, annual meeting

Updated Clinical Committee Structure
- To align with strategic plan
- Inform care model, quality/accountability metrics, health equity, data/analytics

Focus Areas
- Food insecurity, suicide prevention, chronic disease
- PHM accountability measures

Provider Reports & Data
- Health Disparities Scorecard
- Primary Care Panel Report (PCPR)
- Quarterly VBIF Reporting
- Key Performance Indicators (KPIs)
- Benchmarking Report
- New analytics platform

Goals
- Demonstrate statistically significant improvement (at the ACO-level) for all measures included in its PHM accountability policies
- Health equity in all efforts

Population Health, Quality, Model of Care
New PHM Payment Model

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- Total FY23 Budget Investment
  - PHM Base Payments $15.3M
  - PHM Bonus Payments $2.3M
  - Budgeted that 80% of the eligible providers will be successful in earning the bonus dollars for 2023.

- Eligible providers include
  - Hospital/Hospital PCP
  - Independent PCP
  - FQHC
  - Designated Agency
  - Home Health
  - Area Agency on Aging

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

Population Health and Quality
Clinical Committee Structure

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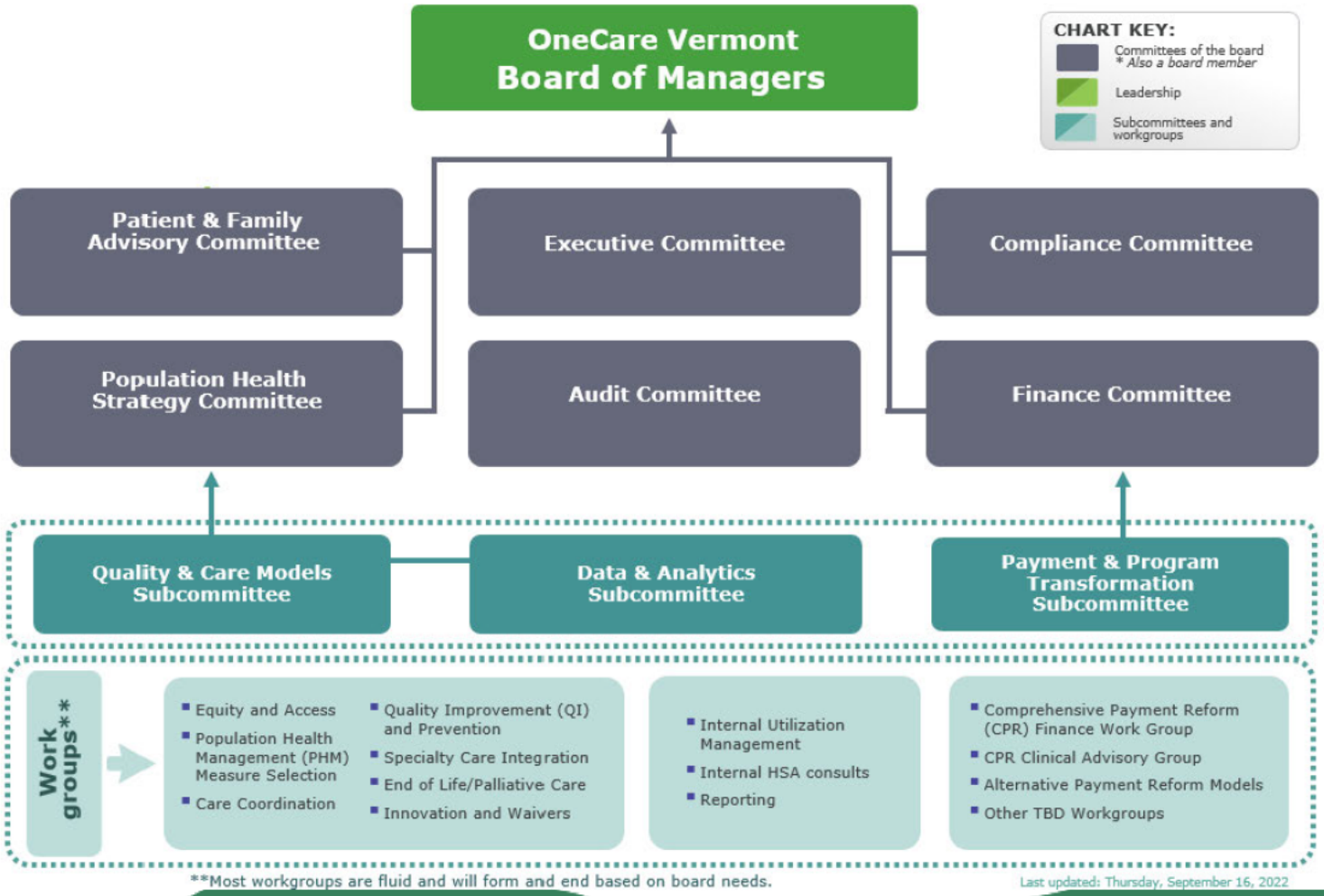
OneCare Vermont Committee Structure



Population Health and Quality
PHM Accountability Measures – Primary Care

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- Potentially avoidable ED visits by those with 2 ED visits in the last 90 days
- Follow up after hypertension diagnosis
- Age 40+ all payer annual wellness visits
- Diabetes poor control (A1c>9)
- Child and Adolescent Well Visits
- Developmental Screening

Goals

- Demonstrate statistically significant improvement (at the ACO-level) for all measures included in its PHM accountability policies
- Health equity in all efforts

Population Health and Quality

Phase One Key Performance Indicators (KPIs)

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Broken out in four groups

- All OneCare
- Primary Care Practices
- HSA Communities
- Hospitals

Phase One KPIs

- Total PMPM Spend
- Primary Care Visits PKPY*
- Surgical Inpatient Admission PKPY
- Medical Admission PKPY
- Post-Acute Care Utilization
- End of Life Care
- Potentially Avoidable ED Visits
- Chronic Disease Management
- Provider Satisfaction

*Per-Thousand Per-Year
SOURCE: OneCare Board of Managers materials, 10/20/22

Population Health and Quality
Reporting to Support Providers

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- Quarterly reporting/consultations by HSA started in 2022
- Two new standard reports in 2022
  - Primary Care Panel Report
  - VBIF Reporting Package
- New analytics platform will evolve reporting further
- May integrate benchmarks into network reporting

Population Health and Quality
Self-Evaluation

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- Care Coordination Evaluation
  - No statistically significant relationship between care managed cohort and inpatient admissions, ED visits, avoidable ED visits, PCP visits, or PCP telehealth visits
  - Positive correlation between care management enrollment and TCOC
  - The key characteristic of care managed members seeing the greatest reduction in TCOC is high inpatient utilizer status
- Provider Survey
  - More information expected in November (not yet received)

Population Health, Quality, Model of Care
Key Takeaways

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- Total PHM expenditures of $29.9 million
  - $10.3M not contractually obligated (Entity-Level)
- PHM investments are concentrated in Blueprint, PMPM Base/Bonus, CPR program
- Evolving PHM payment model
- New care coordination reporting
- Phase out of some program support
- On-going ACO self-evaluation

Population Health and Quality
Recommended Approach

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- Require OneCare to fund population health management and payment reform programs as detailed in the FY23 submission, and to notify GMCB of any changes, including 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. (Consistent with past years)
- VBIF/pre-funded clinical quality incentive is at least $2.4 (in guidance)
- Report self-evaluation results to GMCB (Reporting Manual)
- Fund the Support and Services at Home (SASH) program and Blueprint for Health payments to primary care practices and community health teams consistent with the amount approved by the GMCB in the Medicare ACO Benchmark process (to be presented 12/14) without passing risk associated with Medicare Advanced Shared Saving Payments on to the ACO network. (Largely consistent with past years; underlined is new in FY23). (NEW –also see Payer Programs and Risk Model recommended approach)
  - OCV FY23 budget proposes 5.2% increases for both SASH and Blueprint payments.

Performance Measurement & Improvement

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- History of GMCB's approach to performance measurement and improvement
- FY22 Budget Order Requirement: Medicare Benchmarking Report
- Analysis of first benchmark report
- Staff recommendation FY23 and FY24 approach

Performance Measurement & Improvement
History of Regulatory Approach

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Year	GMCB Approach
2018	Health care savings must be greater than operating expenses
2020	Evaluation of effectiveness of population health programs; HSA variation performance dashboard
2021	Reporting Manual; HSA variation performance dashboard
2022	Benchmarking report • Process: Regular performance reporting comparing OCV's Medicare performance to a group of peer ACOs. • Purpose: Support data-driven monitoring and oversight of OCV while also supporting OCV in identifying ROI and areas of opportunity

Performance Measurement & Improvement
Available Data

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What OneCare and payer data do we use to measure success?

- Quality and Financial Results (annual payer contract scorecards)
- Performance Benchmark Report (semiannual Medicare-only report) (NEW – FY22 Budget Order)
- OCV PHM framework 6 measures
- UVM KPIs (NEW – under development by OCV)

NOTE: For even the highest performing ACO, we would expect to see mixed results and areas of high and low performance, but these measures will help guide our focus as regulators and should similarly guide OCV's focus and investments as well.

Performance Measurement & Improvement
FY22 Budget Order: Benchmarking Report

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"The benchmarking system will:

a) Allow the ACO and the GMCB to assess OneCare's performance against peer ACOs or integrated health systems; [methodology]

b) Enhance OneCare's ACO-level performance management strategy, including integration of best practices and priority opportunities identified through benchmarking and peer networking into the OneCare Quality Evaluation and Improvement Program; and [results and action plan]

c) Improve ACO regulatory reporting and performance assessment by providing the benchmarking comparisons to targets at least semiannually to the GMCB." [regulatory oversight]

Performance Measurement & Improvement
Review of First Benchmarking Report

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Report Methodology:

- Years: 2019-2021
- Benchmark Cohort: 20 ACOs making up ~700k lives
  - Cohort criteria:
    - ACOs with a two-sided risk model
    - High revenue ACOs (i.e., include hospitals)
    - 20-80% of attributed beneficiaries lived in urban zip codes
    - 40% or greater attributing specialists with patient panels
    - Less than 15% of attributed beneficiaries are dually enrolled in Medicaid
  - Utilization and cost metrics were adjusted to account for:
    - Risk scores using CMS-Hierarchical Condition Categories (HCC) risk score model
    - Unit cost adjustment (to estimate AIPBP payments)

Limitations: OCV and contractor chose to identify a 90th percentile cohort rather than evaluating highest performers for each measure. Additionally, Small size of cohort means that 90th percentile is only 2 ACOs, limiting ability to identify best practices

2021 Example

- First report is posted to GMCB website
- Categories:
  - OCV Experience
  - OCV Differential to Avg
  - OCV Differential to 90th Percentile (defined as top 2 ACOs based on risk and price adjusted PMPM)

Still refining report methodology

Not ready to draw conclusions from first benchmarking report due to remaining methodological issues

Metric	OCV Experience	National Peer ACO Comparison Cohort Average	OCV Differential to Average	National Peer ACO Comparison Cohort 90th Percentile*	OCV Differential to 90th Percentile
Total Cost of Care PBPM	$928.39	$1,023.76	-9.3%	$978.11	-5.1%
Inpatient Facility - Medical					
Admissions/1000	152.2	149.7	1.7%	154.3	-1.4%
Hospital Days/1000	793.6	805.6	-1.5%	824.8	-3.8%
Total Inpatient Cost of Care PBPM	$154.74	$170.88	-9.4%	$173.13	-10.6%
Inpatient Facility - Surgical					
Admissions/1000	54.3	57.5	-5.6%	55.2	-1.6%
Hospital Days/1000	333.1	324.3	2.7%	311.2	7.1%
Total Inpatient Cost of Care PBPM	$122.11	$137.81	-11.4%	$132.89	-8.1%
Skilled Nursing Facility					
SNF Admissions	50.8	44.0	15.4%	46.8	8.4%
SNF LOS	28.3	24.8	14.1%	23.2	21.7%
SNF Days/1000	1,435.3	1,090.3	31.6%	1,087.3	32.0%
SNF Cost of Care PBPM	$77.62	$60.17	29.0%	$60.00	29.4%
Emergency Department					
ED Visits/1000	465.1	339.9	36.9%	359.9	29.2%
ED Cost of Care PBPM	$20.86	$15.82	31.9%	$17.64	18.2%
Outpatient Facility - Surgery					
Outpatient Surgery Visits/1000	575.6	424.9	35.5%	338.8	69.9%
Outpatient Surgery Cost of Care PBPM	$81.05	$104.36	-22.3%	$87.32	-7.2%
Professional - Outpatient Surgery					
Oupatient Surgery Visits/1000	643.9	1,800.0	-64.2%	1,379.2	-53.3%
Outpatient Surgery cost PBPM	$6.56	$21.68	-69.8%	$13.48	-51.4%
Professional Office Visits					
Primary Care Visits/1000	2,840.9	3,469.4	-18.1%	3,369.4	-15.7%
Primary Care Cost of Care PBPM	$24.02	$32.99	-27.2%	$31.42	-23.6%
Specialty Care Visits/1000	3,392.1	3,450.8	-1.7%	2,919.3	16.2%
Specialty Care Cost of Care PBPM	$29.65	$33.28	-10.9%	$26.71	11.0%
Part B Pharmacy	$95.02	$112.34	-15.4%	$96.54	-1.6%
Outpatient – Pharmacy Cost of Care PBPM	$71.98	$55.25	30.3%	$59.40	21.2%
Professional – Office Administered Drugs Cost of Care PBPM	$23.04	$57.08	-59.6%	$37.14	-38.0%
Post Acute Care	$109.91	$102.09	7.7%	$93.15	18.0%
Inpatient Facility – Rehabilitation Cost of Care PBPM	$5.21	$17.92	-70.9%	$17.68	-70.5%
Skilled Nursing Facility Cost of Care PBPM	$77.62	$60.17	29.0%	$60.00	29.4%
Home Health Care Cost of Care PBPM	$27.09	$24.01	12.8%	$15.47	75.1%

Performance Measurement & Improvement
Review of Benchmarking Report

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"The benchmarking system will:

December 2022: WE ARE HERE

a) Allow the ACO and the GMCB to assess OneCare's performance against peer ACOs or integrated health systems; [methodology]

b) Enhance OneCare's ACO-level performance management strategy, including integration of best practices and priority opportunities identified through benchmarking and peer networking into the OneCare Quality Evaluation and Improvement Program; and [results and action plan]

c) Improve ACO regulatory reporting and performance assessment by providing the benchmarking comparisons to targets at least semiannually to the GMCB." [regulatory oversight]

Plan for 2023, culminating in FY24 ACO Guidance

Performance Measurement & Improvement
Review of First Benchmarking Report

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Where we are going:

2022 Budget

- Core recommendation was to require OCV to measure their performance against a group of peer ACOs; incorporate results into their Quality Improvement and Management program; and report results to GMCB.
- Report requirements were communicated to OCV, and preliminary performance targets were included in Sec. 8 of the FY23 Budget Guidance.

2023 Budget

- Improvements to benchmarking methodology
- Incorporate performance benchmarks into FY24 Budget Guidance (June 2023).
- As needed, require OneCare to use benchmark report to create action plans to address opportunities for performance improvement.

Performance Measurement & Improvement
Key Takeaways

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- Existing performance measurement does not satisfy GMCB requests for assessment of:
  - OCV patient and population outcomes at the ACO-level against **high-performance targets and trends**
  - **ROI on OCV investments**, including population health programs and administrative expenses
  - **Relationship** between OCV programs and investments and improved outcomes

Performance Measurement & Improvement
Recommended Approach

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- Build on FY22 budget order by requiring improvements to benchmarking report in FY23 budget order, including:
  - Identifying best performers and best practices
  - Clarifying required methodology for comparison to best performers (per measure, rather than identifying individual high-performing ACOs and comparing across measures)
  - ROI calculation for areas of improvement
  - Larger and more transparent comparison cohort
- Require OCV to meet specific performance targets in FY24 guidance, and to indicate how benchmarking report results drive PHM spending decisions. (NEW)
  - If necessary, require performance improvement plans or corrective action based on performance against targets

Results to Date

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1. APM: Federal APM Evaluation by NORC – Second Evaluation Report (2018-2020)
2. APM: Scale Targets
3. OCV: 2021 Payer Program Results – Quality and Financial Settlement

Results to Date – Federal APM Evaluation

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- NORC at the University of Chicago is contracted by CMMI to evaluate Vermont's All-Payer Model
  - All federal demonstrations are required to be evaluated
  - Evaluation focuses on the Model's impact on the Medicare program and Vermont Medicare beneficiaries; wider impact is a secondary question

Results to Date – Federal APM Evaluation

NORC's First & Second Evaluation Reports (PYs 1-3)

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- First Evaluation Report: Performance Years 1 and 2 (PY1-2, 2018-2019); released August 31, 2021
  - Full First Evaluation Report: Evaluation of the Vermont All-Payer Accountable Care Organization Model
  - Findings at a Glance: Vermont All-Payer Model Evaluation of the First Two Performance Years: 2018-2019
  - Technical Appendices: First Evaluation Report, Evaluation of the Vermont All-Payer Accountable Care Organization Model

- Second Evaluation Report: PYs 1-3, 2018-2020; released December 2, 2022
  - Full Second Evaluation Report: Evaluation of the Vermont All-Payer Accountable Care Organization Model
  - Findings at a Glance: Vermont All-Payer Model Evaluation of the First Three Performance Years: 2018-2020
  - Technical Appendices: Second Evaluation Report, Evaluation of the Vermont All-Payer Accountable Care Organization Model

Results to Date – Federal APM Evaluation

NORC's First Evaluation Report (PYs 1-2) Findings

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Reductions in Medicare spending and utilization for entire Vermont Medicare population vs. comparison group

Improved cohesion around shared goals and collaboration across the State, payers, and various types of providers

Spillover effects to the full population beyond Medicare beneficiaries and ACO attributed lives

Lack of widespread understanding of the model

Transformation will require fuller transition to value-based payment, upstream investment

For more information on results, see GMCB meeting materials from November 5, 2021:
GMCB slides
NORC slides

Results to Date – Federal APM Evaluation

NORC's Second Evaluation Report (PYs 1-3) Findings

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Cumulatively over PY1-3, reductions in Medicare spending and utilization for entire Vermont Medicare population and ACO-attributed population vs. comparison group

COVID response was the priority for providers and the State in 2020-2021; APM and ACO infrastructure (e.g., care coordination) and payment models supported response

Spillover effects to the full population beyond Medicare beneficiaries and ACO attributed lives

Continued lack of widespread understanding of the model

UVMHN cyberattack caused major challenges and is a confounding factor for analysis

Results to Date – APM Scale
Evaluating Scale Target ACO Initiatives

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- GMCB receives standard information about each payer contract anticipated for the following budget year in ACO budget submission.
  - Though contracts are not yet final, provides an early look at whether payer programs are likely to be scale-qualifying
- Once payer contracts are finalized, GMCB legal team reviews payer contracts, focusing on changes from prior year contracts and comparing contract terms to the requirements in the APM Agreement
  - This official determination informs annual ACO Scale Targets and Alignment Report, due to CMMI each year on June 30

Results to Date – APM Scale

APM Scale by Payer Contract Over Time

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	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

Results to Date – APM Scale
Medicare Advantage Penetration

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Vermont Medicare Enrollment Over Time*

Year	Total Medicare Enrollment	Traditional Medicare	Medicare Advantage	Medicare Advantage Percent
2017	139,235	126,487	12,748	9.2%
2018	143,533	128,660	14,873	10.4%
2019	147,222	129,424	17,797	12.1%
2020	151,303	129,452	21,851	14.5%
2021	155,102	124,411	30,691	19.8%
2022**	158,373	115,092	43,281	27.3%

*Source: CMS Medicare Monthly Enrollment Dashboard
** Through August 2022.

Results to Date – 2021 Results

2021 OCV Payer Program Results (Financial)

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Payer	2021 Program Settlement Final Settlement: Shared Savings/Shared Losses
Medicare	$1.2M*
Medicaid	$7.1M
BCBSVT	($110,000)
MVP	$0 (upside-only, no savings earned)

*Medicare 2021 Settlement excludes ACO Shared Saving Advance (BP and SASH $)

See FY2021 Financial Settlement & Quality Performance Presentation, November 21, 2022 & OneCare Vermont ACO results webpage.

Results to Date – 2021 Results

2021 OCV Payer Program Results (Quality)

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	PY1 (2018)	PY2 (2019)	PY3 (2020)	PY4 (2021)	PY5 (2022)
Medicare	100% (reporting only)	91.8%	100% (reporting only)	100% (reporting only)	
Medicaid	85%	95%	100% (reporting only)	68.75%	
BCBSVT	86%	81%	N/A (reporting only)	N/A (reporting only)	
MVP	-	-	50%	85%	

Results to Date
Key Takeaways

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- On October 12, 2022, CMMI waived enforcement of APM Agreement scale targets through remainder of current Agreement (Waiver of Enforcement letter), noting that the targets are "unattainable for Vermont based on information not available when the State Agreement was drafted." In the APM extension years 2023/2024, there are no scale targets; reporting is still required.
- Scale achievement is not necessarily a reflection of ACO performance; it reflects many factors including care patterns and insurance market patterns (e.g., movement to the self-insured market, continued growth in Medicare Advantage enrollment).
- Medicare and Medicaid scale continues to grow; expansion of MA enrollment continues and will likely have future impacts
- Very challenging to identify causal results due to complexities of ACO programming and the overall state health care environment, COVID-19 and national trends
- Payer program performance continues to vary

Results to Date
Recommended Approach

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- Require OneCare to complete a return on investment (ROI) analysis comparing their administrative expenses to health care savings, including an estimate of cost avoidance and the value of improved health.
  - Past budget orders have required that this be done over the duration of the APM Agreement; the Agreement's original term ends on 12/31/22
  - Staff recommend requiring OneCare to submit a methodological approach with their revised budget submission for GMCB discussion and GMCB staff approval, and to provide an analysis by 6/30; if necessary, GMCB could require corrective action to address compliance.
- In addition to the budget review process, per Rule 5.501, OneCare must comply with all GMCB data requests to aid in analysis and evaluation.

Next Steps

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Jul 1, 2022	GMCB issues FY23 ACO oversight guidance
Sept 1, 2022	ACO submits certification materials
Oct 1, 2022	ACO submits FY23 budget
Oct 12, 2022	GMCB staff ACO Oversight Background presentation
Nov 9, 2022	OneCare Vermont Budget Hearing
Nov 21, 2022	ACO 2021 Financial Settlement & Quality Performance panel
Dec 7, 2022	GMCB staff analysis presentation: OneCare Vermont
Dec 14, 2022	GMCB deliberations on OneCare Vermont FY23 budget
Dec 21, 2022	GMCB potential vote on OneCare Vermont FY23 budget
Ongoing 2022 - 2023	GMCB monitors FY23 actual performance against budget and conditions

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Board Discussion

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Public Comment

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REFERENCE SLIDES

Reference Slides

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- Statutory Criteria
- HCP-LAN Alternative Payment Model Framework
- Acronyms

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(b)(1) The Green Mountain Care Board shall adopt rules pursuant to 3 V.S.A. chapter 25 to establish standards and processes for reviewing, modifying, and approving the budgets of ACOs with 10,000 or more attributed lives in Vermont. To the extent permitted under federal law, the Board shall ensure the rules anticipate and accommodate a range of ACO models and sizes, balancing oversight with support for innovation. In its review, the Board shall review and consider:

(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;

(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;

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

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

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(E) any reports from professional review organizations;

(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;

(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;

(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;

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(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;

(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;

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

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

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

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

(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

(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.

HCP-LAN Alternative Payment Model Framework

APM Framework from the Health Care Payment Learning & Action Network

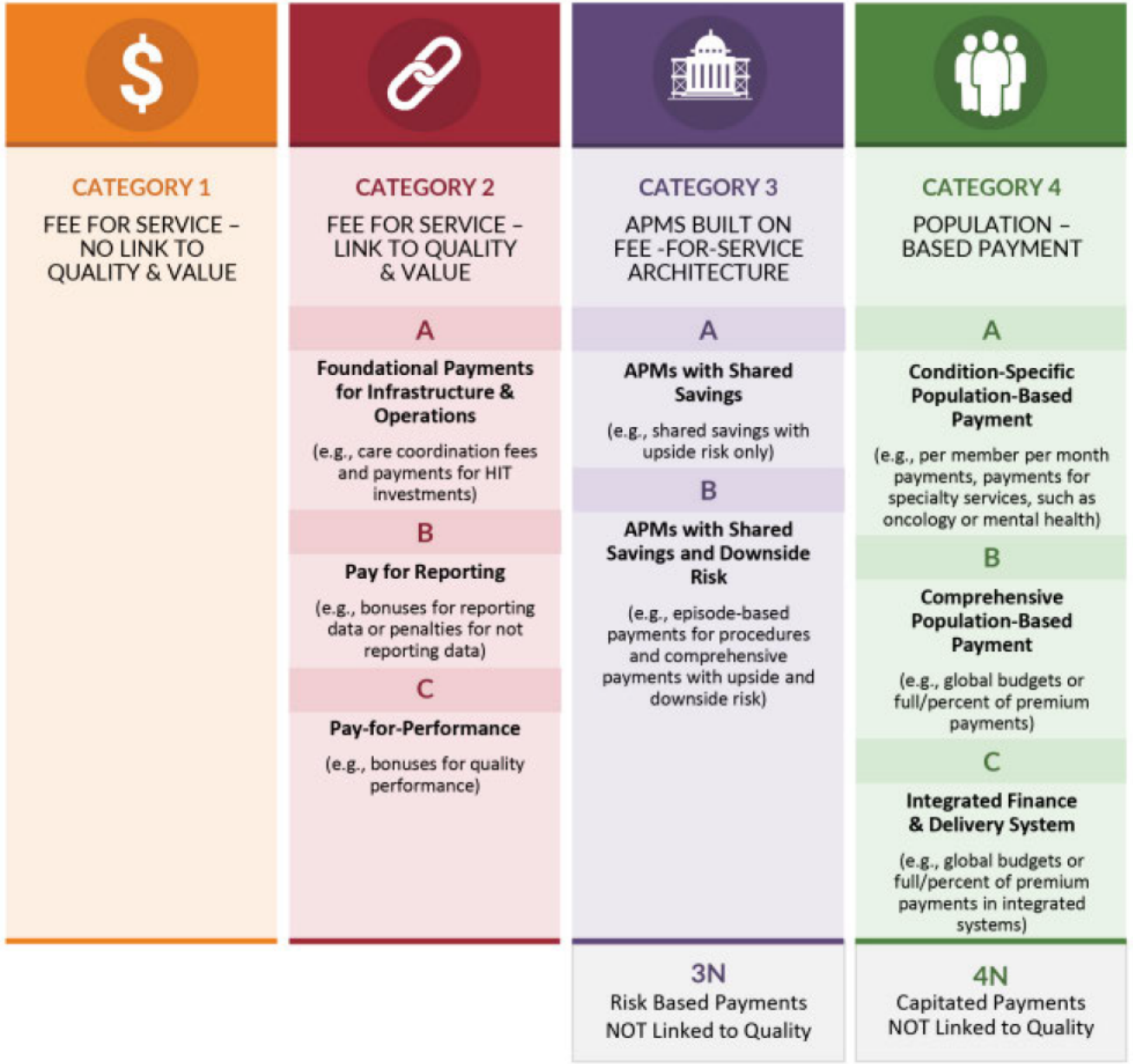

Image source: https://hcp-lan.org/workproducts/apm-figure-1-final.pdf

Acronym List

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- ACO—Accountable Care Organization
- AHS—Vermont Agency of Human Services
- AIPBP—All-Inclusive Population-Based Payment
- AMC—Academic Medical Center
- APM—All-Payer Model
- BCBSVT—Blue Cross Blue Shield of Vermont
- CAH—Critical Access Hospital
- CEO—Chief Executive Officer
- CHT—Community Health Teams
- CMMI—Centers for Medicare & Medicaid Innovation
- CMS—Centers for Medicare & Medicaid Services
- CPR–Comprehensive Payment Reform Program
- DEI—Diversity, Equity, and Inclusion
- ED—Emergency Department
- FFS—Fee-for-Service
- FPP—Fixed Prospective Payment
- FQHC—Federally Qualified Health Center
- FY – Fiscal Year
- GAAP (or US GAAP) – Generally Accepted Accounting Principles in the United States
- GMCB—Green Mountain Care Board
- HCA—Health Care Advocate
- HCC—Hierarchical Condition Categories
- HCP-LAN—Health Care Payment Learning and Action Network
- HSA—Hospital Service Area
- IIP—APM Implementation Improvement Plan (AHS)
- I/S—Income Statement
- KPI—Key Performance Indicators
- OCV—OneCare Vermont
- QHP—Qualified Health Plan
- OpEx—Operating Expenses
- PCMH—Patient-Centered Medical Home
- PCP—Primary Care Provider
- PHM—Population Health Management
- PKPY—Per-Thousand Per-Year
- PMPM—Per-Member Per-Month
- PMPY—Per-Member Per-Year
- PY—Performance Year
- ROI—Return on Investment
- UVMHN—University of Vermont Health Network
- SNF—Skilled Nursing Facility
- SS/SL—Shared Savings/Shared Losses
- SASH—Support and Services at Home
- TCOC—Total Cost of Care
- VBIF—Value Based Incentive Fund