STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

FY24 ACCOUNTABLE CARE ORGANIZATION BUDGET ORDER

In re:	OneCare Vermont Accountable	)	
	Care Organization, LLC	)	
	Fiscal Year 2024	)	
		)	Docket No. 23-001-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 2024 (FY24) is the seventh 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 FY24 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 performance period of the APM 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.
- **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.** The State is responsible for making efforts to maximize the percentages of Vermont Medicare Beneficiaries and Vermont All-Payer Scale Target Beneficiaries that are aligned to a Scale Target ACO Initiative.[1]
- **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.

FY24 REVIEW PROCESS

The review process for OneCare's FY24 budget is reflected in the following timeline:

07.14.23: The Board issued FY24 ACO budget guidance and reporting requirements to OneCare.
10.02.23: OneCare submitted its proposed FY24 budget to the Board.
10.27.23: Board staff and HCA requested additional information from OneCare regarding its proposed FY24 budget.
11.06.23: OneCare responded to Oct. 27, 2023 questions from Board staff and HCA.
11.08.23: OneCare presented its proposed FY24 budget to the Board at a public hearing.

[1] The APM Agreement contains targets for performance years 1 – 5. By the end of 2022, the fifth performance year of the AP Agreement, the State was expected to have 70% of All-Payer Scale Target Beneficiaries and 90% of Vermont Medicare Beneficiaries aligned to a qualifying initiative. The Centers for Medicare and Medicaid Services waived enforcement of these targets. For subsequent performance years, there are no numerical targets. However, the State is obligated to make efforts to maximize scale.

11.29.23: Board staff and payer representatives presented data at a public Board meeting regarding OneCare's 2022 financial settlement and quality performance under payer programs.
12.06.23: Board staff presented their analysis and preliminary recommendations regarding OneCare's proposed FY24 budget.
12.13.23: Board staff presented additional analysis and updated recommendations regarding OneCare's proposed FY24 budget.
12.20.23: Board voted to approve OneCare's FY24 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[2] and video recordings of the meetings are available from Onion River Community Access (ORCA) Media[3] and on the Board's YouTube channel.[4]

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.

FY24 Payer Programs/ACO Initiatives

3. At the time the Board reviewed and voted on the FY24 budget, OneCare was still negotiating payer contracts for FY24. OneCare Vermont FY24 Budget Submission (Budget Submission), 19-20. At the time of its budget submission, OneCare expected to continue existing programs with Medicare, Medicaid, MVP Health Plan, Inc. (MVP), and the University of Vermont Health Network Self-Funded Plan in FY24. Budget Submission, 19-20. OneCare does not anticipate any new payer programs in FY24. Budget Submission, 21. OneCare does not expect to have a contract with Blue Cross and Blue Shield of Vermont (BCBSVT) in FY24. *See* Budget Submission, 19-20.

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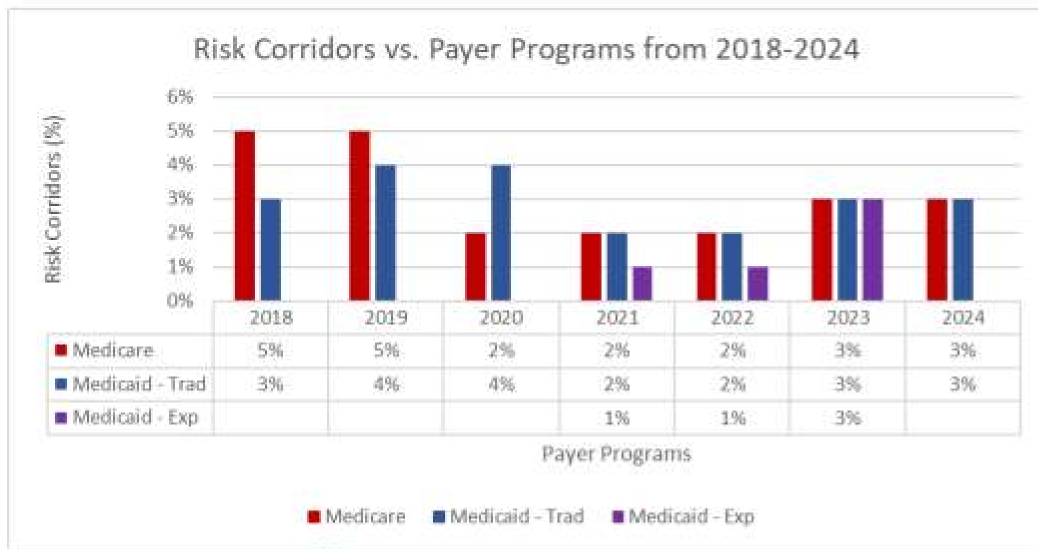
[2] Written budget materials are available at https://gmcboard.vermont.gov/aco-oversight/FY24OneCareVermont. Board presentations are available at https://gmcboard.vermont.gov/2023-meetings.
[3] https://www.orcamedia.net/series/green-mountain-care-board.
[4] https://www.youtube.com/@GreenMountainCareBoard.

4. OneCare's FY24 budget assumes risk corridors that are the same as FY23 for Medicare and Medicaid, and similar to FY23 for commercial plans. *See* OneCare Budget Presentation, 6. The total "upside" risk for OneCare's FY24 budget is $26.4 million, slightly less than the $26.7 million for its FY23 budget, and the "downside" risk (for shared losses) reflected in OneCare's proposed FY24 budget is $36.4 million. *See* OneCare Budget Presentation, 6; *see also* Budget Submission, App. 5.1. OneCare's actual downside risk for FY24 will depend on final attribution and the terms of its payer contracts.

5. OneCare's FY24 budget assumes 3% risk corridors for Medicare and Medicaid. *See* Budget Submission, App. 5.1. OneCare's FY24 risk corridor assumptions are the same as its FY23 risk corridors for Medicare and Medicaid. *See* FY23 OneCare Vermont ACO Budget Order, ¶6.

6. The following table summarizes OneCare's risk corridors for Medicare and Medicaid from 2018 through OneCare's FY24 budget:



	2018	2019	2020	2021	2022	2023	2024
Medicare	5%	5%	2%	2%	2%	3%	3%
Medicaid - Trad	3%	4%	4%	2%	2%	3%	3%
Medicaid - Exp				1%	1%	3%	

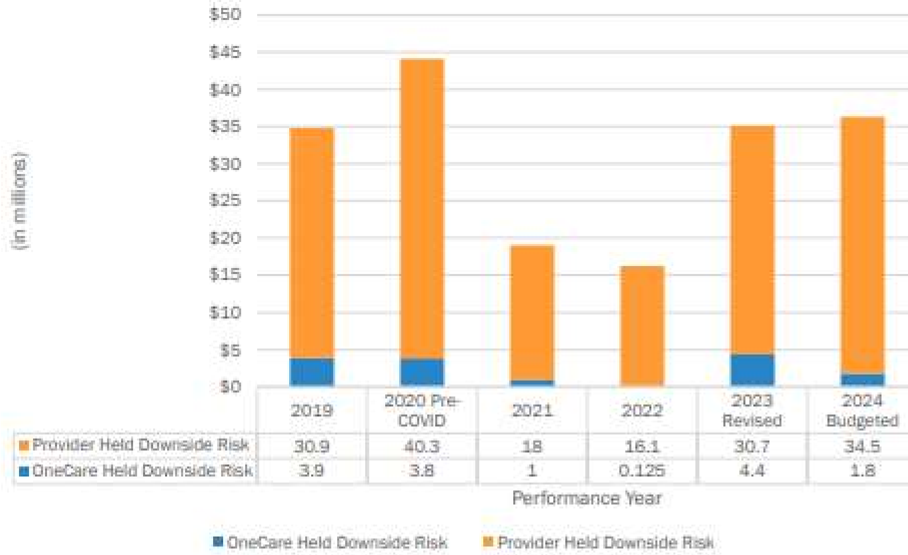
Staff Presentation (December 6, 2023), 21.

Risk Management

7. OneCare plans to transfer almost all of its anticipated downside risk exposure, approximately $36.4 million, to network providers. *See* Budget Submission, 40-42 and App. 5.1.

8. OneCare's FY24 budget submission assumes that OneCare will hold 8.8% of the risk of repayment of Medicare Advanced Shared Savings. *See* Budget Submission, App. 5.1.

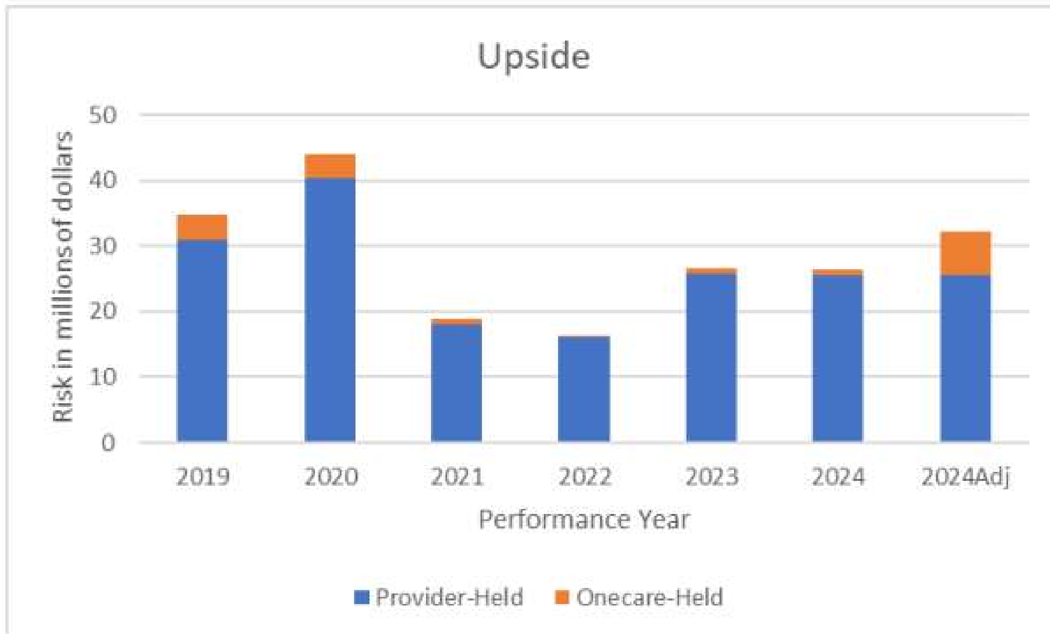
9. The following chart summarizes the OneCare network downside risk, including allocation of risk, from 2019 through OneCare's budgeted FY24:



	2019	2020 Pre-COVID	2021	2022	2023 Revised	2024 Budgeted
Provider Held Downside Risk	30.9	40.3	18	16.1	30.7	34.5
OneCare Held Downside Risk	3.9	3.8	1	0.125	4.4	1.8

Staff Presentation (December 6, 2023), 20.

10. The following chart summarizes the OneCare network upside risk, including allocation of risk, from 2019 through OneCare's budgeted FY24:



See GMCB PowerPoint, 13 (Dec. 20, 2023).

11. 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, 41. Of the shared savings earned at the ACO level, 10% is allocated to a performance incentive pool that the

ACO distributes in accordance with its Accountability Pool settlement policy as set out in OneCare Policy F04-22-PY21 Performance Incentive Pool PY 2022. *See* Budget Submission, 41.

12. OneCare provided its actual and projected distribution of shared savings by risk-bearing entity for 2018 through 2023, and its budget for FY24. *See* Budget Submission, App. 5.1-5.2.

13. Under OneCare's policies, "the first $1.50 PMPM of downside exposure would be covered by attributing primary care providers and the risk-bearing hospitals would owe the remaining program loss." *See* Budget Submission, 42.

14. OneCare's FY24 budget does not include the cost of any third-party risk protection arrangements. *See* Budget Submission, 42. OneCare concluded that the premium for a risk protection product would be high relative to the value of any potential return. *See id*.

15. OneCare's budget included net assets of $8.4 million in reserve for FY24. *See* Budget Submission, App. A1 (Balance Sheet).

16. OneCare's total risk and reserve from 2019 to its FY24 budget are summarized in the following chart:

	2019	2020	2021	2022	2023 revised.	2024	2024 Adj.
TCOC (Budgeted)	$823.3M	$1,086.1M	$1,178.3M	$1.278.8M	$950.1M	$963.8	$963.8
Total Risk	**$34.8M**	**$44.1M**	**$19.0M**	**$16.2M**	**$26.7M up; $35.1M down**	**$26.4M up; $36.4M down**	**$32.1M up; $42.1M down**
Total Risk as % TCOC	4.20%	4.10%	1.60%	1.30%	2.8% up; 3.7% down	2.7% up; 3.8% down	3.7% up; 4.8% down
Provider Held Risk	$30.9M	$40.3M	$18.0M	$16.1M	$25.8M up; $30.7M down	$25.5M up; $34.5M down	SAME
% of Total Risk	*89%*	*91%*	*95%*	*99%*	*96.8% up; 87.4% down*	*96.6% up; 94.8% down*	*79% up; 82% down*
OneCare Held Risk	$3.9M	$3.8M	$1.0M	$125k	$861k up; $4.4M down	$961k up; $1.842M down	$6.7M up; $7.5M down
% of Total Risk	*11%*	*9%*	*5%*	*1%*	*3.2% up; 12.6% down*	*3.6% up; 5.1% down*	*21% up; 18% down*
Net Assets/Equity*	**$5.6M**	**$5.6M**	**$7.0M**	**$7.8M**	**$8.4M**	**$8.4M**	**$8.4**

SOURCE: OCV FY24 Budget Submission, Appendix 4.1 (TCOC amounts) and 5.1 (FY24 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 2022, latest available) and OCV provided balance sheets.

GMCB PowerPoint, 12 (Dec. 20, 2023).

17. The following table sets out Medicare settlements for FY20128 through FY2022:

	2018	2019	2020	2021	2022
Gross Savings / (Losses)	$ 17,845,450	$ 11,285,496	$ 27,002,622	$ 22,318,060	$20,378,944
Cap on Savings / (Losses)	$ 20,634,180	$ 24,790,486	$ 20,391,839	$ 10,026,241	$ 9,574,335
Capped Savings / (Losses)	$ 17,845,450	$ 11,285,496	$ 20,391,839	$ 10,026,241	$ 9,574,335
Quality Adjustment	$ -	$ (196,758)	$ -	$ -	$ (786,302)
ACO Risk Arrangement	80%	100%	80%	100%	100%
Adjusted capped savings / (Losses)	$13,990,833*	$11,285,496*	$ 16,313,471	$10,024,813*	$9,564,328*
Advanced Shared Savings	$ 7,776,760	$ 6,342,236	$ 8,401,660	$ 8,767,133	$ 9,073,982
Net Settlement Adjusted for Advanced Shared Savings	**$ 6,214,073**	**$ 4,943,260**	**$ 7,911,811**	**$ 1,233,926**	**$ 490,346**

* Includes deduction for sequestration

GMCB PowerPoint, 31 (Dec. 20, 2023)

18. For FY24, OneCare expects to receive $9,954,481 in Medicare Advanced Shared Savings, which is paid to SASH and Blueprint for Health. *See* Budget Submission, App. 5.1, 6.4. In the event that OneCare's performance resulted in shared losses that exceeded the risk corridor, some portion of the Medicare Advanced Shared Savings amount may need to be repaid.

FY22 Programmatic Performance

19. The 2022 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. 29, 2023). OneCare's performance in the 2022 Medicare program was approximately $20.4 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,[5] and after accounting for the financial impact of OneCare's quality performance, OneCare earned approximately $0.5 million in shared savings under the 2022 Medicare program. *See id.*

20. The 2022 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 the target, OneCare would earn 100% of any savings and would be responsible for 100% of any losses. The 2022 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, 20-22 (Nov. 29, 2023). OneCare's performance in the 2021 Medicaid program was approximately $12.1 million below the target, and outside of the risk corridor, for the traditional attribution cohort, and approximately $3.7 million below the target, and outside of the risk corridor, for the expanded attribution cohort. After application of necessary adjustments,

[5] Approximately $9 million was included in OneCare's 2022 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. 29, 2023).

DVHA will issue OneCare a reconciliation payment of approximately $11.8 million in shared savings. *Id.* at 21.

21. BCBSVT continued its risk corridors from 2021 in its 2022 OneCare contract in light of the COVID-19 pandemic. *See* GMCB PowerPoint, 31 (Nov. 29, 2023). The final shared loss for OneCare under the BCBSVT program was $75,000. *See* Budget Submission, App. 4.1. BCBSVT, which decided to forego contracts with OneCare in FY23 and FY24, noted several challenges, including being "[u]nable to link ACO's efforts with providers to quality outcomes," "[l]ittle evidence that the quality and financial metrics are trending in a way that benefits our members," and composite scores related to care coordination that remained static from 2018-2021 and declined in 2022. *See* GMCB PowerPoint, 29 (Nov. 29, 2023).

22. 2022 was the third year of MVP's contract with OneCare. *See* GMCB PowerPoint, 48 (Nov. 29, 2023). The actual total cost of care for 2022 was approximately 3% above the target. *See* GMCB PowerPoint, 49 (Nov. 29, 2023). The MVP contract with OneCare for 2022 allowed for shared savings but no shared losses; because no savings were earned, the settlement amount was $0. *See* Budget Submission, App. 4.1.

23. Within the 2022 Medicare program, OneCare's quality score was 65.63% for 20 quality measures. *See* GMCB PowerPoint, 11, (Nov. 29, 2023). For 2022, it was a mix of pay-for-reporting and pay-for-performance. *See id*. The following tables show the performance for each quality metric:

Measure	2022 Denominator	2022 Performance	2022 Benchmark Achieved	*2021 Performance*
CAHPS: Getting Timely Care, Appointments, and Information	220	**81.31%**	30th percentile	*82.95%*
CAHPS: How Well Your Providers Communicate	233	**94.06%**	70th percentile	*94.25%*
CAHPS: Patients' Rating of Provider	228	**91.78%**	40th percentile	*92.17%*
CAHPS: Access to Specialists	154	**70.40%**	<30th percentile	*69.40%*
CAHPS: Health Promotion and Education	253	**60.75%**	60th percentile	*64.24%*
CAHPS: Shared Decision Making	229	**60.56%**	60th percentile	*60.24%*
CAHPS: Health Status/Functional Status	255	**78.80%**	-	*81.38%*
CAHPS: Stewardship of Patient Resources	243	**15.84%**	<30th percentile	*24.78%*
CAHPS: Courteous and Helpful Office Staff	230	**94.01%**	70th percentile	*94.59%*
CAHPS: Care Coordination	255	**83.39%**	<30th percentile	*87.93%*

Measure Number	Measure Name	Numerator	Denominator	2022 Performance	2022 Benchmark Achieved	2021 Performance
ACO-8*	Risk-Standardized, All-Condition Readmission	-	-	**12.84%**	-	*13.63%*
ACO-38*	All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions	-	-	**30.35%**	-	*31.61%*
ACO-14	Influenza Immunization	284	355	**80.00%**	*80th percentile*	*80.36%*
ACO-17	Tobacco Use: Screening and Cessation Intervention	33	47	**70.21%**	*70th percentile*	*80.77%*
ACO-18	Screening for Clinical Depression and Follow-Up Plan	322	520	**61.92%**	*60th percentile*	*64.67%*
ACO-19	Colorectal Cancer Screening	184	250	**73.60%**	*70th percentile*	*76.81%*
ACO-27*	Diabetes Mellitus: Hemoglobin A1c Poor Control	58	580	**10.00%**	*90th percentile*	*9.98%*
ACO-28	Hypertension: Controlling High Blood Pressure	189	270	**70.00%**	*70th percentile*	*71.48%*
VT-1	Follow-Up After Discharge from the ED for Mental Health of Alcohol or Other Drug Dependence					
FUA	Alcohol of Other Drug Dependence Follow-Up Within 30 Days	69	121	**57.02%**	-	-
FUM	Mental Illness Follow-Up Within 30 Days	69	142	**48.59%**	-	-
VT-2	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment					
	Initiation	294	945	**31.11%**	-	-
	Engagement	38	945	**4.02%**	-	-

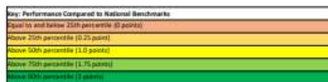
GMCB PowerPoint, 12-13 (Nov. 29, 2023).

24. Within the 2022 Medicaid program, OneCare's overall quality score was 65% based on ten pre-selected payment measures and three reporting measures, which was a decline from 2021. GMCB PowerPoint, 25 (Nov. 29, 2023). Results and benchmark percentiles for individual quality metrics are included in the following table:

DEPARTMENT OF VE[RMONT]

			TRADITIONAL COHORT			EXPANDED COHORT									
Item #	Measure Description	NQF #	Numerator	Denominator	2022 Rate	Numerator	Denominator	2022 Rate	2021 Rate (for reference, traditional cohort)	2021 Rate (For reference, expanded cohort)	Quality Compass® 2022 Benchmarks (CY 2021) National Medicaid (ALOB) Percentiles 25th	50th	75th	90th	Points awarded
1	30 Day Follow-Up after Discharge from the ED for Alcohol and Other Drug Abuse or Dependence	2605	532	867	61.36%	92	177	51.98%	32.89%	34.01%	10.72	21.24	25.81	32.38	2(+)
2	30 Day Follow-Up after Discharge from the ED for Mental Health	2605	602	720	83.61%	89	119	74.79%	81.66%	74.11%	44.82	54.51	63.44	72.01	2
3	Child and Adolescent Well Care Visits (ages 12-17)	N/A	9,338	15,171	61.55%	585	1658	35.28%	61.60%	36.42%	44.72	50.62	58.69	64.17	1.75
4	All Cause Unplanned Admissions for Patients with Multiple Chronic Conditions	CMS ACO #38 (under NQF review)	17	2,142	0.79%	2	86	2.33%	0.80%	1.89%	N/A	N/A	N/A	N/A	1
5	Developmental Screening in the First 3 Years of Life	CMS Child Core CDEV	3,370	5,949	56.65%	287	696	41.24%	56.10%	45.71%	27.10	35.60	57.40	N/A	1
6	Diabetes Mellitus: Hemoglobin A1c Poor Control (>9%)	0059	93	369	25.20%	N/A	N/A	N/A	31.99%	N/A	46.96	39.90	35.52	30.90	2(+)
7	Hypertension: Controlling High Blood Pressure	0018	237	372	63.71%	N/A	N/A	N/A	62.37%	N/A	54.50	59.85	65.10	69.19	1
8	Initiation of Alcohol and Other Drug Abuse or Dependence Treatment	0004	931	2,562	36.34%	279	604	46.19%	36.71%	42.99%	40.36	43.79	48.38	52.81	0
9	Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	0004	353	2,562	13.78%	142	604	23.51%	15.65%	19.44%	9.30	14.03	17.93	22.12	0.25(-)
10	Screening for Clinical Depression and Follow-Up Plan	418	123	239	51.46%	N/A	N/A	N/A	54.28%	N/A	N/A	N/A	N/A	N/A	1
														Total	13
11	Follow-Up after Hospitalization for Mental Illness (7 Day Rate)	0576	399	730	54.66%	50	106	47.17%	50.92%	42.02%	29.97	37.99	46.10	55.00	N/A
12	Tobacco Use Assessment and Tobacco Cessation Intervention	0028	285	308	92.53%	N/A	N/A	N/A	92.46%	N/A	N/A	N/A	N/A	N/A	N/A
13	Patient Centered Medical Home (PCMH) Consumer Assessment of Healthcare Providers & Systems (CAHPS®) Survey Composite Measures Collective 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

Notes: 1) For HbA1C Poor Control and All Cause Unplanned Admission measures, a lower rate indicates higher performance.
2) Benchmarks for Developmental Screening in 1st 3 years of Life are multi-state benchmarks: 30 states reporting (FFY 2020)



Key: Performance Compared to National Benchmarks
Equal to and below 25th percentile (0 points)
Above 25th percentile (0.25 point)
Above 50th percentile (1.0 points)
Above 75th percentile (1.75 points)
Above 90th percentile (2 points)

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CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

GMCB PowerPoint, 25 (Nov. 29, 2023).

25. BCBSVT did not calculate a quality score for OneCare for 2022 but did compare results to benchmarks where available. *See* GMCB PowerPoint, 33, 36 (Nov. 29, 2023). There was an improvement in some benchmarks (including alcohol and drug initiation and depression screening and follow-up) and a decline in some benchmarks (including child and adolescent well care visits, all cause readmissions, and CAPHS care coordination). *See id*. Results and benchmark percentiles for individual quality metrics are included in the following tables:

QHP Population

	OneCare Vermont Quality Results							Benchmarks					
	2018 Rate	2019 Rate	2020 Rate	2021 Rate	2022 Denominator	2022 Numerator	2022 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	2	1	**50.00%**	11.43%	14.56%	18.36%	23.53%	**90th Percentile**	**N/A**
30 Day Follow-Up after Discharge from the ED for Mental Health	83.33%	65.63%	96.55%	NA	4	4	**100.00 %**	57.63%	64.19%	70.77%	76.06%	**90th Percentile**	**N/A**
Child and Adolescent Well Care Visits	62.62%	61.02%	64.22%	68.82%	2,779	1,878	**67.58%**	50.68%	56.39%	63.31%	72.72%	**75th Percentile**	**N/A**
ACO All-Cause Readmissions	0.852	0.6932	0.6096	0.5052	30.11	19	**0.6310**	0.6750	0.6070	0.5170	0.4420	**25th Percentile**	**N/A**
Diabetes Mellitus: Hemoglobin A1c Poor Control (>9%)	23.11%	11.44%	24.65%	20.44%	411	83	**20.19%**	47.81%	36.50%	30.17%	25.55%	**90th Percentile**	**N/A**
Hypertension: Controlling High Blood Pressure	61.07%	67.15%	59.61%	62.29%	411	269	**65.45%**	54.50%	61.10%	68.60%	75.20%	**50th Percentile**	**N/A**
Initiation & Engagement of Alcohol and Other Drug Dependence Treatment (Composite)*	23.87%	20.71%	24.65%	19.85%	180	I: 68 E: 27	**26.39%**	20.00%	22.70%	25.70%	29.70%	**75th Percentile**	**N/A**
Follow-Up after Hospitalization for Mental Illness (7 Day Rate)	69.23%	62.07%	61.54%	60.00%	32	19	**59.38%**	N/A	N/A	N/A	N/A	**N/A**	**N/A**
CAHPS Patient Experience: Care Coordination Composite Score	89.39%	85.56%	89.56%	89.93%	1,994	NA	**86.16%**	81.45%	83.66%	85.72%	86.75%	**75th Percentile**	**N/A**

Reporting Measures							
Developmental Screening in the First Three Years of Life	79.11%	76.82%	77.00%	68.62%	203	143	**70.44%**
Preventive Care and Screening: Screening for Depression and Follow-Up Plan	51.09%	48.30%	43.73%	43.70%	365	191	**52.33%**

Bonus Points	**N/A**
TOTAL POINTS	**N/A**

Large Group Population

	OneCare Vermont Quality Results					Benchmarks					
	2020 Rate	2021 Rate	2022 Denominator	2022 Numerator	2022 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	27.27%	32.35%	22	11	**50.00%**	11.24%	14.66%	19.73%	24.64%	**90th Percentile**	**N/A**
30 Day Follow-Up after Discharge from the ED for Mental Health	81.25%	90.00%	52	45	**86.54%**	56.46%	63.83%	71.23%	77.19%	**90th Percentile**	**N/A**
Child and Adolescent Well Care Visits	70.37%	70.95%	9,890	6,648	**67.22%**	50.99%	56.94%	64.08%	72.73%	**75th Percentile**	**N/A**
ACO All-Cause Readmissions	0.6172	0.4079	35.8	22	**0.6145**	0.624	0.5662	0.5154	0.4475	**25th Percentile**	**N/A**
Diabetes Mellitus: Hemoglobin A1c Poor Control (>9%)	22.14%	17.52%	411	81	**19.71%**	39.17%	30.90%	26.03%	22.49%	**90th Percentile**	**N/A**
Hypertension: Controlling High Blood Pressure	59.61%	65.45%	411	255	**62.04%**	51.82%	60.12%	67.11%	72.62%	**50th Percentile**	**N/A**
Initiation & Engagement of Alcohol and Other Drug Dependence Treatment (Composite)*	27.04%	25.83%	162	I: 68 E: 25	**28.70%**	20.88%	23.57%	25.94%	28.99%	**75th Percentile**	**N/A**
Follow-Up after Hospitalization for Mental Illness (7 Day Rate)	69.77%	71.95%	88	42	**47.73%**	41.51%	48.15%	54.23%	61.43%	**25th Percentile**	**N/A**
CAHPS Patient Experience: Rating of Personal Doctor		93.24%	407	NA^	**81.00%**	65.33%	69.30%	72.62%	76.13%	**90th Percentile**	**N/A**

Reporting Measures					
Developmental Screening in the First Three Years of Life†	76.03%	76.69%	702	512	**72.93%**
Preventive Care and Screening: Screening for Depression and Follow-Up Plan	42.35%	53.20%	372	208	**55.91%**

*68 indicates the numerator for the initiation portion of the measure and 25 the numerator for

GMCB PowerPoint, 43-44 (Nov. 29, 2023).

26. 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, 53 (Nov. 29, 2023). OneCare earned 45 points out of a possible 100 points for 2022. *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 1/1/22-12/31/2022
Quality Performance Time Period 1/1/22-12/31/2022

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)	% of Available Points Earned	Performance Year Points Earned	Benchmark used
CBP	Controlling High Blood Pressure	271	411	20	65.94%	61.10%	68.60%	75.20%		50%	10	QRS
FUA-30DAY	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence - 30-Day Follow-Up	0	1	0	0.00%	14.56%	18.36%	23.53%		0%	0	PPO
FUH-7DAY	Follow-Up After Hospitalization for Mental Illness - 7-Day Follow-Up	2	6	0	33.33%	N/A	N/A	N/A		0%	N/A	QRS
FUM-30DAY	Follow-Up After Emergency Department Visit for Mental Illness - 30-Day Follow-Up	4	4	0	100.00%	64.19%	70.77%	76.06%		100%	0	PPO
IET	Initiation & Engagement of Alcohol and Other Drug Dependence Treatment (Composite)	33	194	20	17.01%	22.70%	25.70%	29.70%		0%	0	QRS
WCV-Total	Child and Adolescent Well-Care Visits MY - Total	799	1162	20	68.76%	56.39%	63.31%	72.72%		75%	15	PPO
HBD-HBAPC	HbA1c Poor Control	92	410	20	22.44%	36.50%	30.17%	25.55%		100%	20	PPO
PCR	ACO All-Cause Readmissions	10	14.3336	20	0.6977	0.607	0.517	0.442			0	QRS
		Total Available Points		100						Performanc	45	

Benchmark Comparison - Quality Metric Scoring
(1) Points earned by reaching quartiles listed below when Performance Year Rate is compared to benchmark scores and

	50th Percentile	75th Percentile	90th Percentile
% Points Earned	50%	75%	100%

GMCB PowerPoint, 53 (Nov. 29, 2023).

FY24 Provider Network

27. OneCare has a broad provider network for FY24 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 FY24 network is generally consistent with its FY23 network, losing 4 specialist providers, 2 skilled nursing facilities, and six primary care practices (5 of which closed or merged/were acquired). *See* Budget Submission, 16.

28. OneCare's FY24 network development strategy is largely unchanged from the prior year, with "a continued focus on retaining current network participation for organizations committed to ACO programs by aligning programmatic financial risk and opportunity with provider risk tolerance levels and making modest adjustments to programs in response to participant input." Budget Submission, 15. OneCare reported increased challenges for its network development, specifically that "several hospitals indicated their potential withdrawal from OneCare programs citing financial fragility, the regulatory environment, and the potential to "do better" under Medicaid fee-for-service" as well as "some frustration with OneCare data reporting." *See id*.

Scale and Program Alignment

29. The original terms of the APM Agreement required 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 established 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.

30. On October 12, 2021, the State of Vermont received a letter from the 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). In 2022, the APM Agreement was extended and amended. Consistent with the waiver of enforcement, failure to meet the ACO scale targets was removed from the list of events that could trigger a need for corrective action and Vermont agreed to make efforts to maximize performance relative to the ACO scale targets. *See* First Amended and Restated All-Payer Accountable Care Organization Model Agreement, 3.

31. 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. See *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.

32. Based on OneCare's projections, and assuming that the payer programs OneCare is negotiating will qualify as Scale Target ACO Initiatives, the following chart sets out starting and average scale by category of payer contract for FY23 and FY24:

	Starting Attribution			Average Attribution		
	2023	2024	Change	2023	2024	Change
Medicare	68,605	67,870	(735)	51,159	53,145	1,986
Medicaid	142,410	113,575	(28,835)	126,880	86,129	(40,751)
Commercial	19,925	19,833	(92)	18,253	18,986	733
Total	**230,940**	**201,278**	**(29,662)**	**196,292**	**158,260**	**(38,032)**

OneCare Presentation, 3 (Nov. 8, 2023).

Financials (Revenues and Expenses)

33. GMCB considered both full accountability and entity-level perspective on OneCare's FY24 budget. *See* GMCB PowerPoint, 31 (Dec. 6, 2023). Full accountability is an "all-in" financial perspective that 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*.

34. The following table shows the full accountability (Non-GAAP) summary income statements for OneCare's proposed FY24 budget, as compared to prior budgets:

	2018 Actual	2023 Projected	2024 Budget	FY23-FY24 Δ		FY18-FY24 Δ	
Total Cost of Care Target Components (External)	605,433,215	539,337,038	543,704,548	4,367,510	0.8%	(61,728,667)	-10.2%
Fixed Prospective Payment Funding (FPP)	-	474,019,206	430,080,208	(43,938,998)	-9.3%	430,080,208	
Other Contract Revenue	4,326,298	7,920,095	7,649,807	(270,288)	-3.4%	3,323,509	76.8%
State Support	3,500,000	-	-	-		(3,500,000)	-100.0%
Participation Fees	17,397,929	18,054,633	17,643,487	(411,146)	-2.3%	245,558	1.4%
Administrative Revenue	3,086,492	-	-	-		(3,086,492)	-100.0%
Consulting Revenue	309,407	-	-	-		(309,407)	-100.0%
Other Revenue	1,393,945	21,075,698	4,739,167	(16,336,531)	-77.5%	3,345,222	240.0%
Income and Other Total Cost of Care Components	**635,447,286**	**1,060,406,670**	**1,003,817,217**	**(56,589,453)**	**-5.3%**	**368,369,931**	**58.0%**
Total Health Care Spend Components (External)	360,711,323	529,658,426	533,750,067	4,091,641	0.8%	173,038,744	48.0%
Fixed Prospective Payments (FPP)	237,390,466	474,019,206	430,080,208	(43,938,998)	-9.3%	192,689,742	81.2%
Population Health Management (PHM)	22,637,268	42,025,323	25,701,581	(16,323,742)	-38.8%	3,064,313	13.5%
				-		-	
Salaries and Benefits	7,344,815	7,538,119	8,191,655	653,536	8.7%	846,840	11.5%
Contracted / Purchased Services	1,746,953	3,723,145	4,327,955	604,810	16.2%	2,581,002	147.7%
Software	2,795,193	1,746,660	494,951	(1,251,709)	-71.7%	(2,300,242)	-82.3%
Other Operating Expenses	1,852,142	1,100,937	1,270,800	169,863	15.4%	(581,342)	-31.4%
Subtotal Operating Expenses	**13,739,102**	**14,108,861**	**14,285,361**	**176,500**	**1.3%**	**546,259**	**4.0%**
Expenses and Health Care Spend Components	**634,478,160**	**1,059,811,816**	**1,003,817,217**	**(55,994,599)**	**-5.3%**	**369,339,057**	**58.2%**
Net Income	**969,126**	**594,854**	**-**	**(594,854)**	**-100.0%**	**(969,126)**	**-100.0%**
Administrative Ratio	2.17%	1.33%	1.42%				
PHM Ratio with Blueprint	3.57%	3.97%	2.56%				
PHM Ratio without Blueprint	2.34%	3.34%	1.57%				

GMCB PowerPoint, 32 (Dec. 6, 2023)

35. OneCare's budgeted balance sheet for FY24 includes $8,355,368 in net OneCare assets. *See* Budget Submission, App. A1 (Balance Sheet).

36. OneCare's net assets have increased from $1 million in 2018 to the FY24 budget of $8.4 million, as summarized in the following chart. The primary reason for the increases in OneCare's net assets has been OneCare's overbudgeting of operating expenses.

FY	Increase to Net Assets (*millions*)	Key Drivers
2018	$1.0 (Base)	NA
2019	$4.69*	Overbudgeted OpEx $0.6M
2020	$0.00	Overbudgeted OpEx $0.9M
2021	$1.29	Overbudgeted OpEx $2.3M
2022	$0.90	Overbudgeted OpEx $1.8M
2023	$0.59	Projected Overbudgeting of OpEx $0.7M
Total	**$8.48**	

**Board ordered OneCare to hold at least $3.9 million in reserves by the end of 2019.*

GMCB PowerPoint, 17 (December 20, 2023)

Operating Expenses

37. OneCare's operating expense budget decreased from $14.8 million in FY23 to $14.3 million in FY24. *See* Budget Submission, App. 6 (variance analysis); OneCare PowerPoint, 17 (Nov. 6, 2023). As a percentage of expenses on a full accountability basis, OneCare's

administrative expenses account for 1.4% of all expenses in its FY24 budget, which is an increase from 1.3% in OneCare's FY23 projections. *See* GMCB PowerPoint, 32 (Dec. 7, 2023).

38. OneCare's FY24 operating expenses are set out below:

Salaries and Benefits	$8,191,655
Purchased Services	$4,327,955
Software/Informatics	$494,951
Occupancy	$53,064
Insurance / Risk Protection	$274,050
Assessments	$567,000
Other Expenses*	$376,686
Total Operational Expenses	**$14,285,361**

* includes items such as utilities, office supplies, professional development, travel, mailing, etc.

See Budget Submission, App. 6.5.

39. OneCare provided the following break-down of its $8.2 million budgeted salary and benefits expense:

Accounts by Time	FY2023	FY2024
Operations	562,433.00	555,568.00
Finance	1,622,632.00	1,765,723.00
Public Affairs	757,261.00	660,759.00
Compliance	365,477.00	466,815.00
Central Admin	2,242,722.00	2,267,466.00
Contracting	644,074.00	648,258.00
Value-Based Care		
Uncategorized	1,865,374.00	1,827,067.00
Analytics	0.00	0.00
Care Coordination	0.00	0.00
Prevention	0.00	0.00
Quality	0.00	0.00
Total	**1,865,374.00**	**1,827,067.00**
Total FTEs	8,059,973.00	8,191,656.00

See Budget Submission, App. A-4

40. OneCare provided projected FY23 compensation for its leadership in the following chart:

FY2023 Projected							
Position Title*	Base Pay	Base Pay percentile among benchmarked salaries**	Max Available Variable Pay	Max Variable Pay Range (% of base pay)	Anticipated Total Compensation	Total compensation percentile among benchmarked salaries**	50th percentile among benchmarked salaries ($)**
CEO ***	446,577		57,684	13%	$504,261		
VP/COO	314,647		60,599	19%	$375,246		
VP/Finance	260,460		48,903	19%	$309,363		
VP/CMO	208,699		39,627	19%	$248,326		
Chief Legal Officer	197,308		22,754	12%	$220,062		
CCO	168,113		16,512	10%	$184,625		
Director, ACO Contracting	183,967		17,728	10%	$201,695		
Director, Payment Reform	172,994		16,659	10%	$189,653		
Director, Finance and Accounting	162,000		12,600	8%	$174,600		
Director, Public Affairs	167,054		16,087	10%	$183,141		
Director, Value Based Care	180,943		17,424	10%	$198,367		
Director, ACO Planning & Operations	183,967		18,070	10%	$202,037		
Total Compensation Reported	$2,646,729	n/a	$344,647	n/a	$2,991,376	n/a	$0

See Budget Submission, App. 6.7.

41. OneCare provided budgeted FY24 compensation for its leadership in the following chart:

FY2024 Budgeted							
Position Title*	Base Pay	Base Pay percentile among benchmarked salaries**	Max Available Variable Pay	Max Variable Pay Range (% of base pay)	Budgeted Total Compensation	Total compensation percentile among benchmarked salaries**	50th percentile among benchmarked salaries ($)**
CEO	$391,464		$97,017	25%	$488,481		
VP/COO	$316,342		$62,720	20%	$379,062		
VP/Finance	$264,536		$52,448	20%	$316,984		
VP/CMO	$206,870		$41,015	20%	$247,885		
Chief Legal Officer	$181,666		$36,018	20%	$217,684		
CCO	$169,019		$16,755	10%	$185,774		
Director, ACO Contracting	$184,958		$18,335	10%	$203,293		
Director, Payment Reform	$173,927		$17,242	10%	$191,169		
Director, Finance and Accounting	$162,873		$16,146	10%	$179,019		
Director, Public Affairs	$167,954		$16,650	10%	$184,604		
Director, Value Based Care	$181,918		$18,034	10%	$199,952		
Director, ACO Planning & Operations	$184,958		$18,335	10%	$203,293		
Total Compensation Reported	$2,586,485	n/a	$410,715	n/a	$2,997,200	n/a	$0

greater than or equal to $150,000 as well as all leadership positions (VP, all C-Suite, including Chief Compliance Officer) with gross compensation (the equivalent of Box 5 on a W-2 and any other compensation as reported on IRS Form 990) greater than $100,000. Add additional rows as necessary.
** OneCare defers answering this question pending the outcome of its appeal of the GMCB's amendment to its FY23 budget.
*** Combines both the former CEO and the Interim CEO

See Budget Submission, App. 6.7.

42. Using OneCare's budgeted FY24 average attribution, the operating expenses and population health spending per attributed life can be calculated for OneCare's FY24 budget. The following charts show that calculation using different methodologies, as noted for each chart:

As Presented 12/06	2018A	2019A	2020A	2021A	2022A	2023P	2024B
Average Attributed Lives	91,651	137,012	203,794	214,040	224,763	189,175	154,665
Pop. Health Spending ($M)	$22.64	$29.46	$32.70	$28.21	$28.42	$25.30	$25.70
Pop. Health Spend / Attributed Life	$246.99	$215.03	$160.46	$131.80	$126.45	$133.73	$166.18
Operating Expenses ($M)	$13.74	$15.34	$14.04	$13.61	$13.61	$14.11	$14.29
Operating per Attributed Life	$149.91	$111.97	$68.91	$63.58	$60.57	$74.58	$92.36

- Includes Blueprint
- Nominal dollars
- Average attribution
- Actuals/projected (FY18-23)

Actuals (Including Blueprint)	2018A	2019A	2020A	2021A	2022A	2023P	2024B
Average Attributed Lives	91,651	137,012	203,794	214,040	224,763	189,175	154,665
Pop. Health Spending ($M)	$26.50	$33.87	$37.15	$32.05	$29.87	$25.30	$24.78
Pop. Health Spend / Attributed Life	$289.10	$247.23	$182.30	$149.74	$132.90	$133.73	$160.25
Operating Expenses ($M)	$16.08	$17.64	$15.96	$15.46	$14.31	$14.11	$13.78
Operating per Attributed Life	$175.46	$128.74	$78.30	$72.23	$63.66	$74.58	$89.07

- Includes Blueprint
- 2023 dollars
- Average attribution
- Actuals/projected (FY18-23)

Actuals	2018A	2019A	2020A	2021A	2022A	2023P	2024B
Average Attributed Lives	91,651	137,012	203,794	214,040	224,763	189,175	154,665
Pop. Health Spending ($M)	$17.39	$28.40	$27.61	$22.09	$20.33	$18.66	$15.19
Pop. Health Spend / Attributed Life	$189.73	$207.31	$135.47	$103.21	$90.45	$98.63	$98.18
Operating Expenses ($M)	$16.08	$17.64	$15.96	$15.46	$14.31	$14.11	$13.78
Operating per Attributed Life	$175.46	$128.74	$78.30	$72.23	$63.66	$74.58	$89.07

- Excludes Blueprint
- 2023 dollars
- Average Attribution
- Actuals/projected (FY18-23)

Budget	2018B	2019B	2020B	2021B	2022B	2023B	2024B
Average Attributed Lives	109,728	159,916	215,809	224,259	236,537	203,534	201,278
Pop. Health Spending ($M)	$23.92	$36.33	$31.37	$27.22	$21.06	$16.71	$15.19
Pop. Health Spend / Attributed Life	$217.97	$227.21	$145.38	$121.36	$89.05	$82.09	$75.44
Operating Expenses ($M)	$14.62	$18.30	$16.95	$18.07	$16.22	$14.79	$13.78
Operating per Attributed Life	$133.26	$114.43	$78.53	$80.58	$68.59	$72.67	$68.44

- Excludes Blueprint
- 2023 dollars
- Starting Attribution
- Budgeted (FY18-23)

See GMCB PowerPoint, 14 (Dec. 20, 2023).

<u>*Benchmark Trend Rates*</u>

43. A “benchmark” is a payer-specific financial target against which expenditures for ACO-aligned beneficiaries are assessed to determine whether an ACO earned savings or is responsible for losses. GMCB Rule 5.000, § 5.103(8). The APM Agreement authorizes the Board to prospectively develop the benchmark for the Medicare program, the Vermont Medicare ACO Initiative, subject to CMS approval.[6] APM Agreement, § 8.b.ii.

44. In developing its FY24 budget, OneCare assumed a blended 4.28% trend rate would be used in developing the 2024 benchmarks for the Medicare program, based on the Medicare USPCC. *See* Budget Submission, 30.

45. On December 13, 2023, Board staff presented a proposed approach to developing the 2024 benchmarks for the Medicare program and proposed benchmarks rates of 4.3% for non-ESRD and 6.7% for ESRD. *See* GMCB PowerPoint (Dec. 13, 2023). On December 20, 2023, the Board approved the proposed Medicare benchmark rates. *See* GMCB PowerPoint (Dec. 20, 2023).

46. For Medicaid, in its FY24 budget OneCare assumed a blended 2.91% trend for the combined traditional and expanded cohorts (relative to the 2023 base spend). Budget Submission, 30.

47. The following table summarizes OneCare’s budgeted trend rates for FY24:

[6] The APM Agreement grants the Board’s authority to set Medicare benchmarks; the authority is distinct from ACO budget review authority which the Board has under Vermont law.

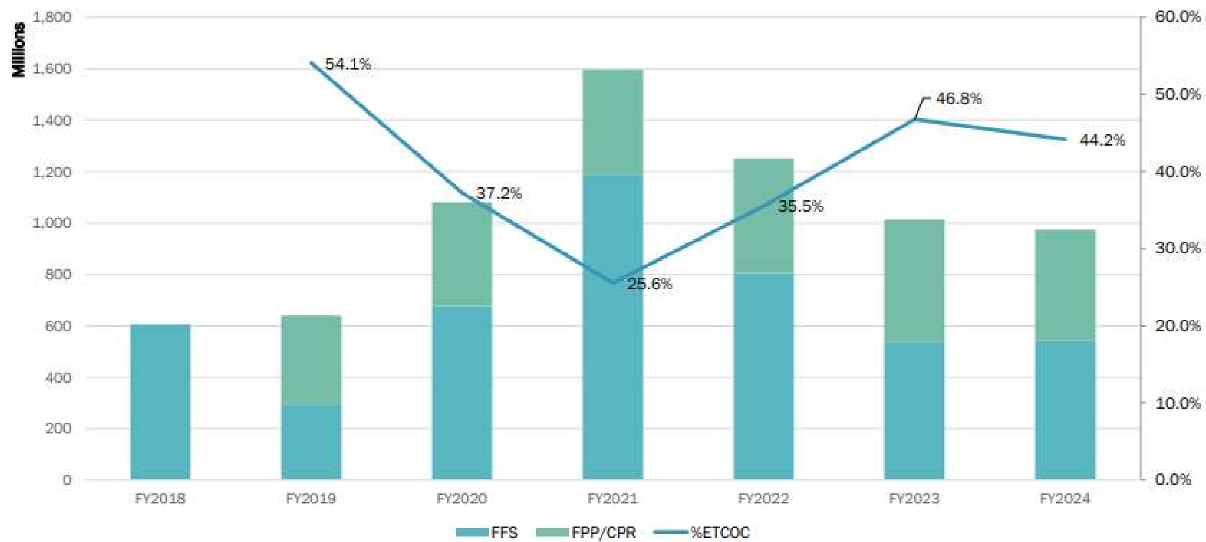
	FY2023 Expected TCOC	FY2024 Benchmark (Expected TCOC)	Budgeted Trend from Base Experience
Medicaid Blended	$342,972,529	$259,971,659	7.1%
Medicare	$541,014,988	$573,603,715	4.5%
MVP - QHP	REDACTED	$67,482,473	17.3%
UVMHN – self-funded	REDACTED	$72,726,909	5.0%

GMCB PowerPoint, 15 (Dec. 6, 2023)

Provider Reimbursement

48. Most of the projected provider reimbursement reflected in OneCare's FY24 budget will be paid directly by payers to providers. Prospective payments, which do flow through OneCare, are projected to account for approximately 44% of OneCare's budgeted total cost of care in 2024 across all payers. GMCB PowerPoint, 17 (Dec. 6, 2023). OneCare has no commercial fixed payments expected in FY24; OneCare expects 50.8% of Medicare and 55.2% of Medicaid to be fixed payments. *See* OneCare Presentation, 5 (Nov. 8, 2023).

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

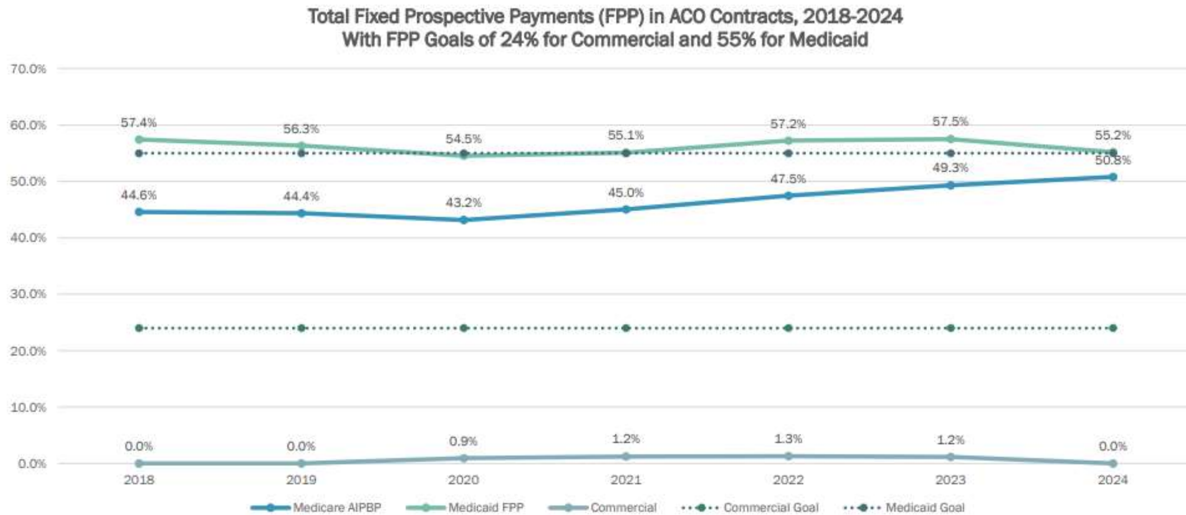


See GMCB PowerPoint, 17 (Dec. 6, 2023).

50. OneCare states that "OneCare's provider payment strategy focuses heavily on replacing fee-for-service (FFS) payments with fixed payment alternatives and offering program payments designed to incentivize quality-improvement in key defined areas. Payment methodologies include fixed payment reform programs and performance incentive payments." *See* Budget Submission, 34.

51. 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, 38-39.

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



See GMCB PowerPoint, 18 (Dec. 6, 2023).

Population Health Management and Payment Reform Programs

53. OneCare has developed a variety of programs to implement its care model, with a total population health management investment of $25.7 million for FY24. *See* Budget Submission, App. 7.2. This represents an increase of approximately $2.6 million from FY23. *See* OneCare Presentation, 13 (Nov. 8, 2023).

54. Appendix 7.2 in OneCare's budget submission provides PHM payments by program, with investment amounts and descriptions for each program. *See* App. 7.2. The following table summarizes OneCare's budgeted PHM investments:

	2023 *	2024	Change
PHM Bonus Payments **	$2,276,379	$3,353,192	$1,076,813
PHM Base Payments	$11,425,898	$8,731,119	($2,694,779)
Longitudinal Care	$399,000	$399,000	$0
DULCE	$145,366	$68,162	($77,204)
CPR Program	$2,106,823	$1,323,900	($782,923)
Specialist/Innovation	$515,907	$0	($515,907)
MH Screening and Follow-Up	$1,638,140	$1,671,727	$33,587
SNF Support	$201,299	$0	($201,299)
Waiver Implementation Funds	$0	$200,000	$200,000
PCMH Payments	$2,062,850	$2,223,276	$160,426
Community Health Team	$2,974,370	$3,029,537	$55,167
SASH	$4,508,696	$4,701,668	$192,972
Total	**$28,254,727**	**$25,701,580**	**($2,553,147)**

** 2023 figures include DVHA direct payments*

*** Budgeted at 60% earned rate*

See OneCare Presentation, 13 (Nov. 8, 2023).

55. OneCare is changing the distribution of PHM payments to increase the total potential PHM payment and shift the allocation from base to bonus, as illustrated in the following chart:

See GMCB PowerPoint, 26 (Dec. 6, 2023).

56. OneCare continues to use 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, 64-66. While individuals in quadrants three and four comprise less than 16% of OneCare's attributed

population, they account for approximately 60% of total spending. *Id.*; *see* Budget Submission, App. 7.3.

57. OneCare stated that its internal and external model of care goals are as follows:

Table 9: Internal Goals (2023)

Internal Goal	Achievements to Date
Develop a means to support and track provider care coordination accountabilities	Achieved: defined a strategy to track and support care coordination accountabilities (minimum engagement, timely reporting, process improvement, and professional development); engaged quarterly with individual primary care practices, providing data-informed technical assistance to meet expectations.
Work to share admission, discharge, transfer (ADT) data among the network	In progress: Workbench One configured to allow network providers to create actionable lists of patients at risk for avoidable ED visits. Work underway to transition functionality into new data analytics platform.
Gather feedback from network to inform care coordination planning and future state	Achieved: Hosted four focus groups with participants representing the continuum of care, state partners, and payers. Topics included a review of existing efforts, challenges, opportunities to better support team-based care, cross organizational collaboration, shared care planning, designation of lead care coordinators, support for individuals with high/avoidable utilization of care, and care coordination reporting. All participants voiced the value of the current team-based care approach and tactics. OneCare learned of varying experiences with shared care plan implementation due to workforce challenges and the lack of a common tool to automate care coordination reporting, close referral loops, and provide visibility of care teams.
Inform a 2024 care coordination reporting strategy	Achieved: OneCare gathered network feedback on care coordination reporting processes (e.g., existing, claims-based, Arcadia, HIE). The network strongly requested to maintain current reporting until a long-term interoperable solution is established.
Assess annual ACO-wide quality performance for 2022	Achieved: All payer data were collected through manual and automated means. Final scorecards were presented to OneCare's Board on 9/19/23 and subsequently published on OneCare's website for public review.
Engage the network in performance improvement opportunities	In progress: Focus on 2023 PHM measure improvement, providing actionable data, tools, training and technical assistance, and facilitating spotlights on best practices for peer-to-peer learning.

Table 10: External Goals (2023)

External (Network) Goal	Achievements to Date[1]
Child and Adolescent Well Visits	Target: 57.5% Progress to date: 35 of 88 practices (40%) met target
Developmental Screening	Target: 57.4% Progress to date: 35 of 88 practices (40%) met target
Diabetes A1c Poor Control	Target: 39.9% Progress to date: 96 of 99 practices (97%) met target
Annual Wellness Visit 40+ [2]	Target: 10% improvement Progress to date: 14 of 72 practices (19%) met target
Annual Wellness Visit 40+ [2, 3]	Target: 10% improvement Progress to date: 0 of 10 HSAs (0%) met target
Potentially Avoidable ED Revisits	Target: 10% improvement Progress to date: 6/14 HSAs (43%) met target
Initial Hypertension	Target: 10% improvement Progress to date: 1/14 HSAs (7%) met target
Routine Hypertension	Target: 10% improvement Progress to date: 5/14 HSAs (36%) met target

Table footnotes:
1. Progress to date reflects most recently available data (released September 2023) for the period of April 1, 2022 March 31, 2023.
2. Practices with more than 300 members in the denominator as of the baseline period were evaluated at the practice level for this measure. All others were evaluated at the HSA level.
3. Only 10 of 14 HSAs have any practices that are evaluated at the HSA level for 40+ Annual Wellness Visits. Practices with fewer than 300 members in the denominator are measured at the HSA level for the 40+ Annual Wellness Visits.

See Budget Submission, 67-68.

58. For FY24, OneCare budgeted funding for primary care at a total of $12.8 million, of which approximately $5 million is budgeted for hospital owned primary care, $4 million for independent primary care, and $3.65 million for FQHC primary care:

	2022			2023 (rev)*			2024		
	Hospital-Owned	Independent	FQHC	Hospital-Owned	Independent	FQHC	Hospital-Owned	Independent	FQHC
Total by Type	$6,570,743	$5,851,376	$3,687,099	$5,131,970	$4,575,545	$4,112,999	$5,077,536	$4,063,926	$3,646,576
TOTAL non FPP/FFS Primary Care	$16,109,218			$13,820,514			$12,788,038		
Average Attribution	228,459			190,642			154,665		
Amount per Life	$71			$72			$83		

*non-inclusive of DVHA funds

See GMCB PowerPoint, 10 (Dec. 13, 2023).

59. 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, 34, 37-38. OneCare's FY24 budget includes a 1% increase in the percent of total cost of care the goes to primary care spending (from 9% to 10%). *See id*.

60. OneCare is coordinating with the Blueprint for Health (Blueprint) and AHS regarding continual collaboration between OneCare, Blueprint, and AHS/DVHA. *See* Budget Submission, 72. This coordination includes OneCare participating in Blueprint-led collaboration activities and Blueprint participation in OneCare forums. *See id*.

61. OneCare stated that it "enhanced its data reporting to practices and continuum of care entities by including overall and population of focus specific care managed rates as compared to network averages. Further, OneCare has increased its use of transparent comparative data reports, identifying high and low performers and discussing strengths and opportunities within practice specific value-based care engagement sessions and semiannual HSA consultations. Using these reports, OneCare works with ACO participants to provide targeted technical assistance and hosts network-wide forums to facilitate sharing of best practices." *See* Budget Submission, 72-73.

62. OneCare states that it works to address social determinants of health by flagging food insecurity, transportation, housing, and social isolation as part of its review of health disparities. *See* Budget Submission, 84. OneCare states that it "flows this information through its analytics platform and assists ACO members in identifying individuals that may benefit from outreach and/or enhanced care coordination services." *See* Budget Submission, 74. OneCare states that it plans to advance social determinants of health screening through its provider network and with its state partners. *See* Budget Submission, 84.

63. OneCare states that 2024 is OneCare's final year of partial funding support (alongside the Vermont Department of Health) for the Developmental Understanding and Legal Collaboration for Everyone (DULCE) sites as the Blueprint expansion takes on spreading this important work statewide. *See* Budget Submission, 81. OneCare further reports that based on mid-year 2023 reports, in one site, 147 children, speaking 10 different languages, were served by DULCE. *See id*.

64. OneCare does not calculate its return on investment by individual program. *See* Budget Submission, 56 ("OneCare does not budget or track administrative expenses on a program-by-program basis.").

65. OneCare's proposed FY24 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 FY23 levels. *See* OneCare Presentation, 13.

66. OneCare's ratio of operating expenses to PHM/payment reform payments (including FPP and budgeted bonus payments) for FY24 is budgeted at 3.1%. *See* GMCB PowerPoint, 27 (Dec. 20, 2023). The following chart summarizes the ratio from FY2018 through budgeted FY24:

	FY2018A	FY2019A	FY2020A	FY2021A	FY2022A	FY2023P	FY2024B
Total PHM/Payment Reform Program less Settlement Expenses	260,027,734	375,802,982	435,107,902	436,367,075	473,336,001	499,317,118	455,781,789
Total Operating Expenses	13,739,102	15,341,451	14,044,262	13,608,546	13,613,662	14,108,861	14,285,361
	5.28%	4.08%	3.23%	3.12%	2.88%	2.83%	3.13%
					5-year AVG	**3.23%**	

See GMCB PowerPoint, 27 (Dec. 20, 2023)

Performance Monitoring and Assessment

67. 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 its first benchmarking report to the GMCB on October 31, 2022. *See* OneCare Medicare Benchmarking Report – October 2022. OneCare submitted its updated Medicare benchmarking report to the GMCB on September 29, 2023. *See* OneCare Medicare Benchmarking Report – September 2023.

68. The following table summarizes OneCare's performance for Medicare beneficiaries on certain metrics, which were included in the Medicare Benchmarking Report – September 2023:

Metric	2019	2020	2021	2022	Trend
Percent of Members with an Annual Wellness Visit	35.0%	30.3%	31.6%	31.6%	
Percent of Inpatient Admissions with Readmission within 90 Days	17.0%	15.4%	16.0%	15.9%	
Percent of Members with a Primary Care Visit	71.1%	71.1%	68.2%	67.1%	
Prevention Quality Overall Composite	36.1	27.9	26.9	27.4	
Prevention Quality Acute Composite	11.3	8.1	7.0	6.4	
Prevention Quality Chronic Composite	24.8	19.8	19.9	21.1	
Prevention Quality Diabetes Composite	4.5	3.4	3.1	3.4	
Congestive Heart Failure (CHF)	13.1	11.4	11.2	12.5	
Community-Acquired Pneumonia	7.4	4.7	3.4	3.5	
Urinary Tract Infection	3.9	3.4	3.6	2.9	
Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults	6.5	4.3	4.9	4.7	
Diabetes Long-Term Complications	2.3	1.8	1.9	1.9	
Hypertension	0.6	0.6	0.7	0.4	
Lower-Extremity Amputation Among Patients with Diabetes	0.2	0.2	0.1	0.2	
Diabetes Short-Term Complications	1.1	0.7	0.7	0.8	
Uncontrolled Diabetes	0.9	0.7	0.3	0.5	
Asthma in Younger Adults	0.0	0.0	0.0	0.0	
Total Cost of Care PBPM	$926.08	$832.37	$916.78	$1,002.58	
Total Inpatient Cost of Care PBPM - Medical	$151.52	$136.97	$149.62	$167.89	
Total Inpatient Cost of Care PBPM - Surgical	$129.09	$113.54	$117.86	$127.68	
ED Cost of Care PBPM	$23.74	$18.99	$20.70	$22.55	
Primary Care Cost of Care PBPM	$26.86	$25.22	$23.87	23.0	
Admissions/1000 Inpatient Facility	170.5	142.1	151.1	156.8	
Hospital Days/1000 Inpatient Facility	853.7	728.7	786.0	855.9	
ED Visits/1000	535.9	410.1	461.8	500.2	
Primary Care Visits/1000	3,136.5	2,911.4	2,823.8	2,739.9	

See GMCB PowerPoint, 37 (Dec. 6, 2023). The benchmarking report showed OneCare's Medicare fee for service population emergency department utilization was 37.9% higher than the average of the national peer group in 2022, and OneCare was higher than 10th percentile for emergency department utilization for 2022. *See* OneCare Medicare Benchmarking Report – September 2023, Executive Summary, 5-6. The benchmarking report also showed low numbers for primary care visits and annual wellness visits for OneCare compared to the national peer group: in 2022, the percent of members with a primary care visit was 16.5% lower than the average of the national peer group, primary care visits per 1,000 beneficiaries was 26.1% lower than the average of the national peer group, and the percent of members with an annual wellness visit was 14.4% lower than the average of the national peer group. *See* OneCare Medicare Benchmarking Report – September 2023, Executive Summary, 6-7.

69. Based on its performance on metrics in the Medicare benchmarking report, OneCare selected three areas to target to improve its performance for FY24: Emergency Department (ED) Utilization (below 10th percentile), Percentage of Members with Primary Care Physician Visit (below 10th percentile), and Medicare Annual Wellness Visits (rate decreased from 34.9% in 2019 to 31.3% in 2021). *See* Budget Submission, 100. OneCare reported meeting with two of the top performing ACOs from the benchmarking report peer group to discuss best practices related to these areas. *See id*.

70. 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).

71. In July, 2023, NORC released its third evaluation report of the APM. *See* NORC at the University of Chicago, Third Evaluation Report of the Vermont All-Payer Accountable Care Organization Model (July, 2023) (NORC Report). The NORC Report evaluated the effect of the APM on Medicare expenditures, and not the results of OneCare specifically. *See* NORC Report, 1 ("NORC's evaluation is of the VTAPM as a whole; it is not an evaluation of any individual participating or nonparticipating organizations (including payers, regulatory authority, care providers, or other stakeholders)"). The NORC Report found, among other things, "For Medicare beneficiaries statewide over the first four PYs of the model, the VTAPM was associated with statistically significant cumulative reductions in both gross and net Medicare spending …, of $1,177 (9.9%) and $1,143.2 (9.7%) PBPY, respectively. In PY 4 (2021), the model was associated with a statistically significant reduction in gross Medicare spending of $1,745.1 PBPY (13.2%), and in net Medicare spending of $1,753.3 PBPY (13.3%)." *See* NORC Report, 7.

Public Comments

72. The Board accepted public comments on OneCare's proposed budget from October 2, 2023 through December 20, 2023. These comments are available on the Board's website.[7] The Board received 14 comments regarding OneCare's FY24 budget and the Board's review. Generally, the themes from public comments reflect:

- Value of OneCare's improved health outcomes, higher quality care, lower cost, and enhanced coordination of care;
- Value of care coordination and strengthened partnerships with local care organizations;
- Concerns about access to care and long wait times to see providers;
- Concerns about cost of health care in Vermont; and
- Concerns about the effectiveness of OneCare, administrative cost relative to demonstrated value, the loss of BlueCross BlueShield and increasing executive salaries.

See GMCB PowerPoint, 7 (Dec. 20, 2023).

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

- Questions:
    - If OneCare is providing sufficient value to Vermonter's given its cost
    - Whether OneCare's approach and place in the overall health care reform effort could achieve progress on the goals of the All-Payer Model (APM)
    - If OneCare will be able to help achieve Vermont's health care reform goals
- Concerns due to:
    - Commercial insurance rate increases in Vermont now far outpace the United States average
    - Vermont's rate of underinsurance among Vermont's privately insured residents has increased from 27.3% to 44%
    - Vermont's hospital adjusted expenses per inpatient day are now growing faster than the national average
- Misrepresentation of the NORC evaluation to the Board, the HCA, and the public
- Declining population health management (PHM) expenditures while increasing expenditures on consulting and payroll
- Concerns about the purpose and benefits of Arcadia

Letter from the HCA Policy Team to Owen Foster (Dec. 1, 2023).

74. Board staff considered the public comments and HCA comments and recommendations in developing their recommendations regarding OneCare's proposed FY24 budget. *See* GMCB PowerPoint, 7-8 (Dec. 6, 2023); GMCB PowerPoint, 7 (Dec. 20, 2023).

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

CONCLUSIONS

OneCare bears the burden of justifying its proposed FY24 budget. Rule 5.000, § 5.405(a). In deciding whether to approve or modify the budget, the Board must consider the benchmarks established by the GMCB, the criteria of 18 V.S.A. § 9382(b), the requirements of the APM Agreement, and any other issues in the discretion of the Board. Rule 5.000, § 5.405(b).

I. Modifications

After reviewing OneCare's FY24 budget, we modify the budget and approve it subject to the conditions in this Order. In addition to the other conditions in this Order, we impose two important modifications on OneCare's budget: first, OneCare is required to increase the risk corridor in its Medicare contract from 3% to 4% and hold the additional downside risk at the OneCare entity level, and second we require OneCare to reduce its operating expenses by $957,245 and reallocate that amount to population health and primary care programs that will achieve the best return on investment.

A. *Increase to Medicare risk corridor, with the additional downside risk held by OneCare*.

The GMCB's budget guidance included benchmarks established pursuant to GMCB Rule 5.00, §5.402, including a benchmark that OneCare "[i]ncrease risk corridors for all payer programs above FY23 levels" and "hold 100% of the Medicare Advanced Shared Savings dollars as risk at the entity-level and not pass this risk along to the provider network." *See* GMCB FY 2024 Budget Guidance and Reporting Requirements for Vermont Certified Accountable Care Organization: OneCare Vermont, ACO, LLC, 7 (July 14, 2023) (Budget Guidance). OneCare's FY24 budget did not meet either of these benchmarks. OneCare maintained a 3% risk corridor for its Medicare and Medicaid contracts from FY23 to FY24. *See* Findings, ¶¶ 5, 6. OneCare's FY24 budget included only $880,000 of approximately $10 million in Medicare Advanced Shared Savings Risk, or 8.8%, to be held at the OneCare entity level and not passed to OneCare network participants. *See* Findings, ¶8, 10, 16.

We next consider the criteria from 18 V.S.A. § 9382(b) as they relate to OneCare's risk corridors, and we may consider other issues at our discretion. By increasing the risk corridor, OneCare has the opportunity to increase its potential shared savings, which in turn would increase the value to OneCare's network from the cost of operating the ACO. A 1% increase in the risk corridor for OneCare's FY24 Medicare contract creates an additional $6.7 million in potential upside and potential downside risk. *See* Findings, ¶16. While an expanded risk corridor creates a possibility of shared losses, from 2018 through 2022, OneCare has never had shared losses under its Medicare contract. *See* Findings, ¶17. Its financial performance has always resulted in Medicare spending less than the TCOC benchmark. *See id*. From 2020 through 2022, OneCare's shared savings were capped by its contracted risk corridor, meaning that had OneCare elected a larger risk corridor in those years, it would have received more of the shared savings its network achieved. *See id*.

The larger risk corridor increases the potential shared savings that OneCare's network could earn, which increases the potential return to OneCare network participants and also has the

potential of bolstering OneCare's ability to add participants to its network. We also require OneCare as an entity to hold the additional downside risk of shared losses and not pass that risk to its network. OneCare has net assets on its balance sheet of $8.4 million, which exceeds the $6.7 million in additional risk that we are requiring OneCare to take on. *See* Findings, ¶¶16, 37. OneCare's net assets operate as a full risk mitigation plan, as required by GMCB Rule 5.000, §5.403(b).

Requiring OneCare to hold the risk of shared losses that come with expanding the risk corridor bolsters accountability at the ACO level; OneCare's accountability for its value as an organization and the performance of its network are increased. These are important components of the character and competence of an ACO. *See* 18 V.S.A. § 9382(b)(1)(d). Holding the additional risk of shared losses at the OneCare level also insulates the OneCare network providers, and keeps the additional risk from becoming a barrier to provider participation in the OneCare network.

OneCare will need to update its settlement policy to reflect the additional potential shared savings. The potential to receive more shared savings if OneCare's Medicare financial performance is again below the benchmark and outside of the proposed risk corridor could result in additional funding for OneCare to support population health investments. *See* 18 V.S.A. § 9382(b)(1)(G)-(J).

B. *Reduction and reallocation of Operating Expenses*.

The GMCB's FY24 Certified ACO Budget Guidance included a benchmark that OneCare's budget should have a "Ratio of operating expenses to PHM/payment reform payments (including FPP and budgeted bonus payments) must not exceed the 5-year average of 3.25%." Budget Guidance, 7. OneCare's FY24 budget submission met this benchmark. *See* Findings, ¶¶67. Benchmarks "will assist the Board in determining whether to approve or modify an ACO's proposed budget," but are not the end of the Board's analysis. The fact that OneCare's FY24 budget submission met the benchmark relating to the ratio of operating expenses to PHM/payment reform payments therefore does not remove OneCare's operating expenses from further review in accordance with the Board's ACO oversight rule, which instructs the Board to consider statutory criteria in addition to benchmarks. GMCB Rule 5.000, §§5.402, 5.405.

As part of the review of OneCare's budget, we are required to consider "information on the ACO's administrative costs, as defined by the Board." 18 V.S.A. § 9382(b)(1)(M). We next consider that criteria and other criteria from 18 V.S.A. § 9382(b) as they relate to OneCare's operating expenses, and we may consider other issues in our discretion.

Based on our review of OneCare budgeted operating expenses, we conclude that a reduction to OneCare's budgeted operating expenses is warranted. Considering both OneCare's operating expenses and the number of attributed lives in OneCare's network, which reflects the number of Vermonters that potentially benefit from OneCare, the FY24 budget proposed by OneCare would spend $89.07 in operating expenses per attributed life. *See* Findings, ¶¶33, 35, 43. This is an increase from a projected $74.58 per attributed life projected for FY23, and $78.30, $72.23, and $63.66 per attributed life for 2020, 2021, and 2022. *See id*. Using a five-year average

(from FY2019 through projected FY2023), adjusted for inflation to 2023 dollars, OneCare's operating expenses per attributed life would be $83.50. Applying that to OneCare's FY24 budgeted attribution results in a reduction of $957,245 to OneCare's budgeted operating expense of $14,285,361 (a 6.7% reduction). We order OneCare to reduce its operating expenses by $957,245, from $14,285,361 to $13,328,116. OneCare shall determine how to implement the budget reduction and present its revised operating budget to the GMCB in the spring.

OneCare has historically and consistently overestimated and overbudgeted its operating expenses, which has been a key reason the ACO has accumulated $8.6 million in net assets on its balance sheet. *See* Findings, ¶37. The overbudgeting has been significant and ranges from $600,000 in 2019 to $2.3 million in 2021, with an average of $1.25 million per year. *See id*. OneCare's average annual overbudgeting of its operating expenses during that period ($1.25 million) exceeds the amount of the reduction that we are ordering from OneCare this year ($957,245).

OneCare's refusal to provide the Board with requested information about how OneCare sets its executives' compensation prevented the Board from establishing Rule §5.402 benchmarks in its FY24 budget guidance. *See* Budget Guidance, 7. OneCare did not provide all requested information regarding salaries in its budget submission, and therefore it was unclear if executive compensation, with total base salaries of $2.59 million, is set relative to an appropriate benchmark, and it is unclear how OneCare's executive potential bonuses, which add a potential $410,000, are appropriately set 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. *See* Findings, ¶ 42.

OneCare does not calculate its return on investment by specific program, and the return on investment for OneCare as a whole has not been adequately calculated, despite conditions in prior GMCB budget orders requiring OneCare to prepare such an analysis. *See* Findings, ¶63; *see also* FY22 OneCare Vermont ACO Budget Order, Condition 17.

OneCare's FY24 budget included several categories of Operating Expenses that OneCare's budget submission does not sufficiently explain or support why the areas were funded at the level they are in the budget in order for OneCare to accomplish its goals. These areas included marketing expense, including "Public Affairs" budgeted at $661,000 FY24 budget, a purchased services line item of $4.3 million, and other expenses that included supplies/occupancy/travel expenses budgeted at $123,000. *See* Findings, ¶¶35, 38, 39, 40. We are required to review the fiscal responsibility of an ACO in its budget submission, and we struggle to assess OneCare's fiscal responsibility in these areas based on the information OneCare submitted. 18 V.S.A. § 9382(b)(1)(D).

To improve OneCare's benefit to Vermonters, we also require that the $957,245 that was reduced from OneCare's operating expenses to be reallocated to population health and primary care programs. OneCare could implement the change by increasing PHM payments, either in the base or bonus or a split between the two, by increasing funding for mental health screenings and follow-up initiatives, or by otherwise increasing payments to primary care providers. OneCare shall determine which primary care or population health payments would result in the best return on investment for these funds, and present its plan for reallocation to the GMCB in the spring.

II. Benchmark Analysis

Under GMCB Rule 5.000, §5.402, the Board "may establish benchmarks for any indicators to be used by ACOs in developing and preparing their proposed budgets." The established benchmarks do not dictate the Board's decisions regarding an ACO's proposed budget, but "will assist the Board in determining whether to approve or modify an ACO's proposed budget." GMCB Rule 5.000, §5.402. In its FY24 Certified ACO Budget Guidance, the GMCB established the following benchmarks.

A. The FY24 commercial benchmark trend rates must be consistent with the ACO-attributed population and the GMCB approved rate filings.

OneCare's FY24 budget meets this benchmark with respect to its expected contract with MVP. *See* Findings, ¶¶44-48.

B. The ACO must use best efforts to meet or exceed the goals for reconciled and unreconciled FPP as adopted by the GMCB as seen below and identify and report specific obstacles to achieving the goals and action steps required (by OCV or others) to overcome those obstacles:

i. Medicaid 55%
ii. Commercial 24%

OneCare's unreconciled fixed payments in Medicaid are 57.5% of its budgeted Medicaid spending, which meets the Medicaid benchmark. *See* Findings, ¶¶ 50, 53. OneCare's commercial FPP is 0%, which does not meet the target. *See* Findings, ¶¶ 52, 53. FPP targets require agreement from both OneCare and the payers, and so we will continue to include FPP targets for OneCare to work towards.

C. The ACO must hold 100% of the Medicare Advanced Shared Savings dollars as risk at the entity-level and not pass this risk along to the provider network.

OneCare's FY24 budget reflected OneCare holding 8.8% of the Medicare Advanced Shared Savings dollars at risk, so OneCare's FY24 budget does not meet this benchmark. *See* Findings, ¶¶ 8, 10, 16. See discussion above at Section I. A.

D. Increase risk corridors for all payer programs above FY23 levels.

OneCare's FY24 budget maintained the same risk corridors for its payer contracts, so OneCare's FY24 budget does not meet this benchmark. *See* Findings, ¶¶ 5, 6. See discussion above at Section I. A.

E. Ratio of operating expenses to PHM/payment reform payments (including FPP and budgeted bonus payments) must not exceed the 5-year average of 3.25%.

OneCare's FY24 budget had a ratio of operating expenses to PHM/payment reform payments (including FPP and budgeted bonus payments) of 3.13%, so OneCare's FY24 budget does meet this benchmark. *See* Findings, ¶¶ 67. See discussion above at Section I. B.

F. The ratio of population health management funding to number of attributed lives must be at a minimum of the FY23 revised budget amount; specific line items may vary based upon any internal evaluation of the effectiveness of individual PHM programs. The ACO must propose a plan to increase the accountability of its provider network for quality. Examples for increased accountability could include adding in an adjustment to hospital fixed payments for quality or increasing the ratio of the PHM bonus payments to base payments for primary care and community providers.

OneCare's FY24 budget included population health management funding of $166 per attributed life, including Blueprint for Health funding, and was calculated using budgeted assumptions for average attribution. *See* Findings, ¶43. OneCare proposed a plan to increase accountability through increasing the ratio of PHM bonus payments to base payments and the addition of network provider accountabilities to contracts. This benchmark was met.

G. March 2023 Medicare Benchmarking Report: Where OCV ranks below the 10th percentile among the national ACO cohort OR for metrics where the trend has shown a decrease in performance between the years of 2019 and 2021, choose three metrics that the ACO will address through the Quality Evaluation and Improvement plan. The ACO should use metrics on which the ACO's provider network has the most influence on the outcomes and should justify their choice of said metrics.

OneCare identified three metrics for improvement (ED Utilization, Annual Wellness Visits, Number of beneficiaries with a primary care visit). *See* Findings, ¶70. This benchmark was met.

III. Statutory Criteria Analysis

(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 2022, the most recent year for which data are available, the actual TCOC for Medicare and Medicaid was below the target TCOC, in each case outside of the negotiated risk corridors. *See* Findings, ¶¶ 19-20.

Payers are responsible for evaluating whether OneCare is positively impacting the cost and quality of care provided to their beneficiaries or members. CMS, DVHA, the commercial payer MVP, and UVMHN self-funded plan 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 decided to forego a

contract with OneCare for FY24, as it did for FY23, and cited several concerns around the lack of value and benefit that BCBSVT and its members realized from participation with OneCare. *See* Findings, ¶ 21.

The Medicare benchmarking report provides insight into the utilization of healthcare services by Medicare beneficiaries within OneCare's attributed population. *See* Findings, ¶¶ 67-69. The report shows a lower Total Cost of Care for OneCare's population compared with the peer group, but there are areas of concern with respect to utilization: emergency department utilization was approximately 38% higher than the average of the peer group in 2022, and higher than the 10th percentile for utilization. *See* Findings ¶ 68. At the same time that emergency department utilization was high, primary care visits were concerningly lower than the national comparison group for 2022: in 2022, the percent of members with a primary care visit was 16.5% lower, primary care visits per 1,000 beneficiaries was 26.1% lower, and the percent of members with an annual wellness visit was 14.4% lower. *See id*. OneCare included both emergency department utilization and primary care visits as two of the three areas for improvement that we required OneCare to focus on in our Budget Guidance. *See* Findings, ¶ 69.

(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.

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

Please refer to Section I above for discussion of this criteria.

We impose conditions on our approval of OneCare's FY24 budget designed to ensure that OneCare's delegated risk model is implemented in accordance with the modifications we made, as set out in this Order, and that OneCare does not 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 initial benchmarking report to the GMCB on October 31, 2022, with updates in March, 2023 and September, 2023. *See* Findings, ¶ 68, 69. Based on our review of that report, we require OneCare to continue improving the report by adding statistical significance analysis to the findings and including risk of all cohorts for each year. 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, ¶ 69, 70, 71.

(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 FY24 budget includes approximately $5.4 million in population health investments that go to the Blueprint for Health. *See* Findings, ¶¶ 18, 55, 66.

(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 FY24 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 – $12.8 million, of which approximately $5 million is budgeted for hospital owned primary care, $4 million for independent primary care, and $3.65 million for FQHC primary care – 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, ¶ 59. OneCare's CPR program, in particular, is a valuable benefit to primary care and an important part of OneCare's budget. *See* Findings, ¶ 60.

For incentives to strengthen primary care, as required by the criteria in 18 V.S.A. § 9382(b)(1)(G), incentive payments must reach primary care providers. OneCare declined to provide requested information about how it ensures primary care-earned incentive dollars are flowing to these providers and/or are being invested into primary care transformation efforts. *See* Budget Submission, 84. We, therefore, require OneCare to provide verification to the GMCB that payments presented by OneCare in its budget as supporting primary care are reaching primary care providers, and therefore able to be considered incentives that support primary care under 18 V.S.A. § 9382(b)(1)(G).

(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 FY24 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, ¶¶ 18, 61, 66.

(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 FY24 budget continues investments designed to strengthen and provide resources to address social determinants of health by focusing on individuals with higher social risk within OneCare care coordination and population health initiatives. *See* Findings, ¶ 63.

(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 FY24 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 final year of support for 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, ¶¶ 62, 63.

(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 2, 2023 through December 20, 2023. These comments are available on the Board's website.[8] The Board received 14 comments regarding OneCare's FY24 budget and the Board's review. Findings, ¶ 71. 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.

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

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

OneCare presented its FY24 budget to the GMCB at a public hearing on November 6, 2023. OneCare also responded to questions from GMCB staff, and provided additional letters regarding its proposed budget. Material provided by OneCare is available on the GMCB website.[9]

(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 FY24 Operating Expenses by at least $957,245, from $14,285,361 to $13,328,116 (a 6.7% reduction). *See* Conclusions, Section I. (B). See discussion above in Section I. (B).

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

OneCare's FY24 budget includes trend rates for the MVP QHP program that are based on Board-approved rate increases for 2024 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. OneCare's costs are described in OneCare's budget submission, supplemented by OneCare's responses to our questions, and this order. *See* Findings, ¶¶ 38-42.

(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 FY24 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 – $12.8 million, of which approximately $5 million is budgeted for hospital owned primary care, $4 million for independent primary care, and $3.65 million for FQHC primary care – 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, ¶ 59.

IV. APM Agreement

[9] See https://gmcboard.vermont.gov/FY23OneCareVermont.

A. TCOC Growth Rates

Total cost of care for services covered by the APM Agreement for 2022 was not available at the time the Board approved OneCare's budget. The actual total cost of care per person across all payers grew 3.8% from 2017 through 2021 for services covered by the APM Agreement, which is within the financial target set by the APM agreement. *See* GMCB Vermont All-Payer ACO Model Total Cost of Care Annual Report Performance Year 4 (January – December 2021) (March 30, 2023).

When the Board approved OneCare's budget, OneCare was still negotiating with DVHA on the terms of the 2024 contract, including the appropriate trend rate(s). The Board 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 2024. 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, ¶ 28-29. 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, ¶ 31. 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 include 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 FY24 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, its FY23 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. The 2024 benchmarking report must additionally include (i) statistical significance analysis and (ii) risk of all cohorts for each year.
f. An updated benchmarking report must be submitted to the Board by March 31, 2024.
g. 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 Deputy 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 Deputy 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, an updated report on OneCare's CPR program, and FPP reporting.

PAYER PROGRAM AND RISK

3. 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.

4. OneCare must ensure that its payer contracts are consistent with the following 2024 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 2024 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 9 and 10.

5. The ACO shall use best efforts to meet or exceed the goals for FPP as adopted by the GMCB in the FY25 budget guidance and identify and report specific obstacles to achieving the goals and action steps required (by OCV or others) to overcome those obstacles.

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

7. OneCare shall implement a risk corridor in its Medicare contract of 4% (increased from 3%). OneCare shall hold the additional 1% risk of shared losses at the OneCare entity level using its net assets as risk mitigation and not pass that amount of the risk on to any OneCare network participant, and OneCare shall update its Settlement Policy to reflect additional potential upside consistent with the GMCB's decision and this Order. Except as modified by the previous sentences, OneCare must implement the risk model that it described in its budget proposal and must request and receive approval from the GMCB prior to making any material changes thereto. OneCare must:

a. Submit to the GMCB copies of the contracts that bind each of the risk bearing entities to OneCare's risk sharing policy no later than 10 days after all contracts have been executed;
b. Notify and seek approval from the GMCB as early as possible of any proposed changes to the risk model and, for any proposed changes determined by Board staff to be material, provide the GMCB with detailed information, including effects by risk bearing entity and parent organization.

ACO BUDGET & FINANCIALS

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

9. No later than April 1, 2024, OneCare must provide GMCB staff with the supporting documentation relevant to the topics identified in Condition 10. Among the supporting documentation, OneCare must submit:

    a. Final payer contracts;
    b. Attribution by payer;
    c. A revised budget, using a template provided by GMCB staff;
    d. Final descriptions of OneCare's population health initiatives, including final care coordination payment model;
    e. Hospital dues for 2024 by hospital;
    f. Hospital risk for 2024 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 2024;
    h. Source of funds for its 2024 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;
    k. Statement of how the funds reduced from Operating Expenses were reallocated to population health and primary care programs; and
    l. Any other information the GMCB deems relevant to ensuring compliance with this order.

10. At its presentation of the revised budget on a date set by the GMCB, and no later than April 30, 2024, OneCare must present to the GMCB on the following topics:

    a. Final FY2024 attribution and finalized payer contracts;
    b. Revised budget, based on final attribution;
    c. Final description of population health initiatives;
    d. Expected hospital dues for 2024 by hospital;
    e. Expected risk for 2024 by OneCare held risk, risk bearing entity and by payer;
    f. Any changes to the overall risk model for 2024;

g. Source(s) of funds for OneCare's 2024 population health management programs;
h. Status of the Medicare ACO Performance benchmarking system;
i. Update on the results of evaluations as described in the FY24 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;
l. Statement of how the funds reduced from Operating Expenses were reallocated to population health and primary care programs; and
m. Any other information the GMCB deems relevant to ensuring compliance with this order.

11. OneCare must submit to the GMCB financial statements, in a form approved by the GMCB, showing accumulated net assets from FY2018 through FY2023 actuals, and OneCare must update the accumulated net assets statement annually thereafter.

12. In FY24, OneCare's Operating Expenses must not exceed $15,242,606, which is a $957,245 reduction (or 6.7%) from OneCare's submitted Operating Expenses of $14,285,361. OneCare shall reallocate the $957,245 to population health and primary care programs that will achieve the best return on investment, consistent with the GMCB's decision and this Order.

13. 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

14. OneCare shall fully fund population health management and payment reform programs as detailed in OneCare's FY24 budget submission, as modified by this Order. OneCare shall notify and seek approval from GMCB for 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.

15. In FY24, OneCare must fund SASH in an amount not less than $4,701,668, which is equivalent to the 2023 budgeted amount of $4,508,696 plus an inflationary factor of 4.3%,

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 $5,252,813, which is equivalent to the 2023 budgeted amount of $5,037,220 plus an inflationary factor of 4.3%, consistent with the medical home and community health team program payment design approved by the Agency of Human Services.

16. OneCare shall provide to the GMCB a reconciliation of all FY24 PHM payments following the end of the fiscal year.

17. OneCare shall provide to the GMBC verification, using a template developed by GMCB staff, with authority delegated to GMCB's Deputy Director of Health Systems Policy, that all OneCare population health payments presented by OneCare in its FY24 budget as incentives that support primary care are reaching primary care providers.

18. Over the duration of the APM Agreement, OneCare's administrative expenses must be less than the health care savings, including an estimate of cost avoidance and the value of improved health, projected to be generated through the Model.

GENERAL

19. After notice and an opportunity to be heard, the GMCB may make such further orders as are necessary to carry out the purposes of this Order and 18 V.S.A. § 9382.

So ordered.

Dated: February 29, 2024 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)

Walsh, concurring

Regulation is a process meant to give the public and policymakers peace of mind. Regulators work to be sure that policies enacted to improve or safeguard public well-being are working as intended, living up to their promises, avoiding harm, and monitoring for unintended outcomes.

OneCare has not lived up to the goals originally set for it or the goals they have set for themselves. *See, e.g.,* OneCare FY2019 Budget Presentation, 11 (Network development strategy that included continued expansion of existing programs and models) (October 24, 2018)[10]; OneCare FY2022 Budget Presentation, 6 (Nov. 10, 2021) (setting core capabilities as network performance and management, data and analytics, and payment reform).[11] Yes, the reform effort was created with good intentions and implemented by dedicated individuals. I will also acknowledge that during this year's OneCare presentation, they introduced several promising changes to their structure, function, and quality performance payments. However, it has not yielded the desired outcomes and appears unlikely to do so in the future.

While OneCare has touted federal reports documenting savings achieved while the ACO has existed, those savings were not for Vermonters. They were for the federal government in Washington, DC. That same federal report clearly articulates that changes in our healthcare delivery systems have occurred over the past decade, not **because** of OneCare. Instead, they have happened **while** OneCare has existed. *See* NORC at the University of Chicago, Third Evaluation Report of the Vermont All-Payer Accountable Care Organization Model (July, 2023), 1.

Despite almost a decade, the reform effort that gave birth to OneCare has not produced the desired results. Vermont's healthcare system has deteriorated. For people across geographic regions, income brackets, ages, and more, affordability is worse, access to care is worse, and quality has not improved. *See* Letter from Office of Health Care Advocate to Chair Foster, 2 (Dec. 1, 2023); Vermont Department of Health. "Vermont Household Health Insurance Survey." (March 2022)[12]; Health Services Wait Times Report Findings from Agency of Human Services, GMCB, Department of Financial Resources (Feb. 16, 2022);[13] *see also* OneCare Medicare Benchmarking Report – September 2023; *see also* Findings, ¶69. In addition, OneCare has ignored several regulatory requests and conditions intended to guide it toward a structure and function like those of successful accountable care organizations. *See* FY22 OneCare Vermont ACO Budget Order, Condition 1; FY23 OneCare Vermont ACO Budget Order, Condition 1. Vermonters are bearing the consequences of this, paying ever greater premiums for services they struggle even to access, exposed to deductibles so high they fear financial ruin if they must visit a health care provider, the emergency room, or a hospital.

OneCare's submitted budget included administrative expenses of $834,000 for marketing, supplies, occupancy, and travel, plus an additional $4.3 million for purchased services. *See* Findings, ¶¶ 38, 39. Furthermore, OneCare has routinely over-budgeted operating expenses – an average of $1.25 million per year. *See* Findings, ¶37. This overbudgeting has led to a total increase in their net assets of $8.48 million. *See id*. These operating expense items total over $13 million, and how they help OneCare achieve its mission is unclear.

[10] https://gmcboard.vermont.gov/sites/gmcb/files/OneCare%20Budget%20Presentation%20-%20GMCB%20Final.pdf

[11] https://gmcboard.vermont.gov/sites/gmcb/files/documents/2022%20OneCare%20Budget%20Presentation%20DF2.pdf

[12] https://www.healthvermont.gov/stats/surveys/household-health-insurance-survey

[13] https://dfr.vermont.gov/sites/finreg/files/doc_library/vermont-wait-times-report-021822.pdf

During the deliberations, OneCare argued that it would be imprudent to decrease their operating budget and, at the same time, increase their proportion of contracted financial risk. *See* comments from OneCare CEO Abe Berman at GMCB Meeting Dec. 20, 2023 (commenting on the GMCB's proposed budget adjustments that "while drastically reducing [OneCare's] funding…you are at the same time asking [OneCare] to hold more risk centrally"). However, no evidence suggests that reducing their administrative portions of their budget identified above would hinder their ability to mitigate their risk.

Following deliberations and a careful review of OneCare's submissions, I came to believe a repurposing of the $13 million noted above would best serve Vermonters. The funds saved could be better utilized for population health initiatives and primary care. This would not have been a cut to the overall budget. It would redirect existing funds from vaguely defined administrative items to services that directly impact the people of Vermont.

Ultimately, the Board has repurposed nearly $1 million toward population health initiatives and primary care. Against my better judgment based on OneCare's performance, I feel that I must approve their budget with these minimal changes. This is why - OneCare has brought more federal dollars to our state's healthcare systems. Hospitals and primary care providers participating with OneCare have been given advanced payments to help them transition away from fee-for-service reimbursement. The intention was to incentivize quality, outcomes, and cost reduction and to improve the providers' and the systems' ability to accept financial risk. This is a fundamental component of alternative payment models, but it has not happened.

Instead of using the dollars for transformation, our delivery systems have come to rely on federal dollars for their basic survival. To be clear, those dollars have not transformed the system. Instead, they have become relied upon for day-to-day operations, so shutting down OneCare immediately would further destabilize our fragile systems.

This arrangement has brought us to a place where we must assess and approve a budget for a failing organization, OneCare, because it is a required component of a plan that funds other useful organizations, such as the Blueprint for Health. This is a big problem; it makes me uncomfortable both in my role as a regulator and based on my knowledge of health systems and policy. OneCare has not lived up to its promises and is enmeshing unproductive and unnecessary expenses into Vermont's healthcare delivery system to the point where our providers cannot function without this failing organization.

It's not just that this effort has failed - that happens often in healthcare policy and delivery reform, where the policies and regulations are designed and implemented by humans in a complex and unique context. The real issue is the ongoing failure to recognize when things aren't working and to continue as if they're succeeding.

Imagine OneCare as a plane with passengers. It had trouble lifting off. It is now flying off course and suffering from recurrent malfunctions. We can't simply let it drop out of the sky or require an emergency landing, nor can we mindlessly allow it to continue its current mission. We must do our best to guide it safely home. Throughout this, we need to learn from our mistakes so that we do our best not to arrive in this situation again.

I understand that some may think that by approving OneCare's budget, I am accepting its current performance. I want to be clear - that is not the case. The Green Mountain Care Board is responsible for passing a budget either in its submitted form or with amendments. I take that very seriously. We cannot simply reject the budget. I am voting in favor of the amended budget because I believe it is the safest and most appropriate option we have found.

Lunge, dissenting in part

I voted no on the decrease to administrative and operating expenses for the following reason. An agency's authority is delegated from the legislature by statute. Administrative rules and guidance flow from that statute. In this case, the Board's FY2024 ACO Annual Reporting and Budget Guidance issued on July 14, 2023 indicated:

> "If the ACO's proposed budget varies from the budget targets below, the Board will review the ACO's proposed budget and its support for varying from these targets in its FY24 budget submission using the factors and criteria set out in statute and rule. *For all budget targets that are met,* the ACO should expect less analysis of this area of the budget from the GMCB and staff." (Emphasis added). Budget Guidance, 7.

As noted in the majority opinion, OneCare met the budget target established in Budget Guidance. This should result in less scrutiny by the Board. Because of the lessened scrutiny called for by the Budget Guidance, I determine that the burden is met on operating and administrative expenses.

Filed: February 29, 2024

Attest: *<u>/s/ Jean Stetter</u>*
Green Mountain Care Board
Administrative Services Coordinator

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