OneCare Vermont

December 20, 2022

Dear Green Mountain Care Board:

We appreciate the opportunity to address several of the staff recommendations presented at the meetings on December 16 and 19, 2022, and to provide additional clarification around points of confusion or misunderstanding. The issues we will address are: impact of the Advanced Shared Savings; GMCB options to cover the Advanced Savings Liability; risk corridor decisions; and enhanced program evaluation.

Impact of the Advanced Shared Savings

Rule 5 states that, **"**If an ACO wishes to bear risk during the next Budget Year, the ACO must propose and the Board must establish as part of the ACO's budget, a Risk Cap that the ACO can cover. The ACO must support its proposed Risk Cap with the following information as part of the ACO's budget proposal or during the next Budget Year or both, as required by the Board: 1. information specified by the Board regarding the ACO's maximum potential losses under the Risk Contracts it is a party to or seeks to become a party to and the threat that these losses may pose to the ACO's solvency, which information may include reports, certifications, and other representations prepared by an Actuary, a certified public accountant, an auditor, or other financial professional; 2. a full risk mitigation plan describing how the ACO would cover the losses it could incur under the Risk Cap (e.g., through reserves, collateral, or other liquid security; risk transfers to ACO Participants; or reinsurance, withholds, or other risk management mechanisms)." OneCare has never exercised this option, as our provider network bears any risk associated with our payer contracts. If we were to change that arrangement, we would urge the Board to carefully evaluate any change, as contemplated in Rule 5, and assess how much and from what source we should hold reserves for that risk.

During the GMCB meeting on December 19, board members requested clarity regarding asymmetry in the Medicare settlement process driven by the inclusion of Advanced Shared Savings. To demonstrate that this asymmetry is a valid and substantive concern, OneCare has prepared three scenarios using the actual 2021 Vermont Medicare ACO Initiative settlement template from Lewin (please see accompanying Excel file). While some minor modifications to the template were necessary to avoid confusion and better align with the 2023 budget submission, all calculations remain aligned with the actual settlement mechanics. The template shows that the maximum payment to OneCare is $7.2M and the maximum payment from OneCare is $25.9M (please see the yellow cells).

A common misconception is that the Advanced Shared Savings are taken "in and out" of the settlement calculation without regard to spending performance and therefore represent no additional exposure for OneCare or its providers. This is not the case. While the Advanced Shared Savings are added to the target, the amount remains fully at risk. For example, if healthcare spend is approximately 4.7% above the benchmark, it will mean the full 3% risk corridor and the Advanced Shared Savings add-on will be

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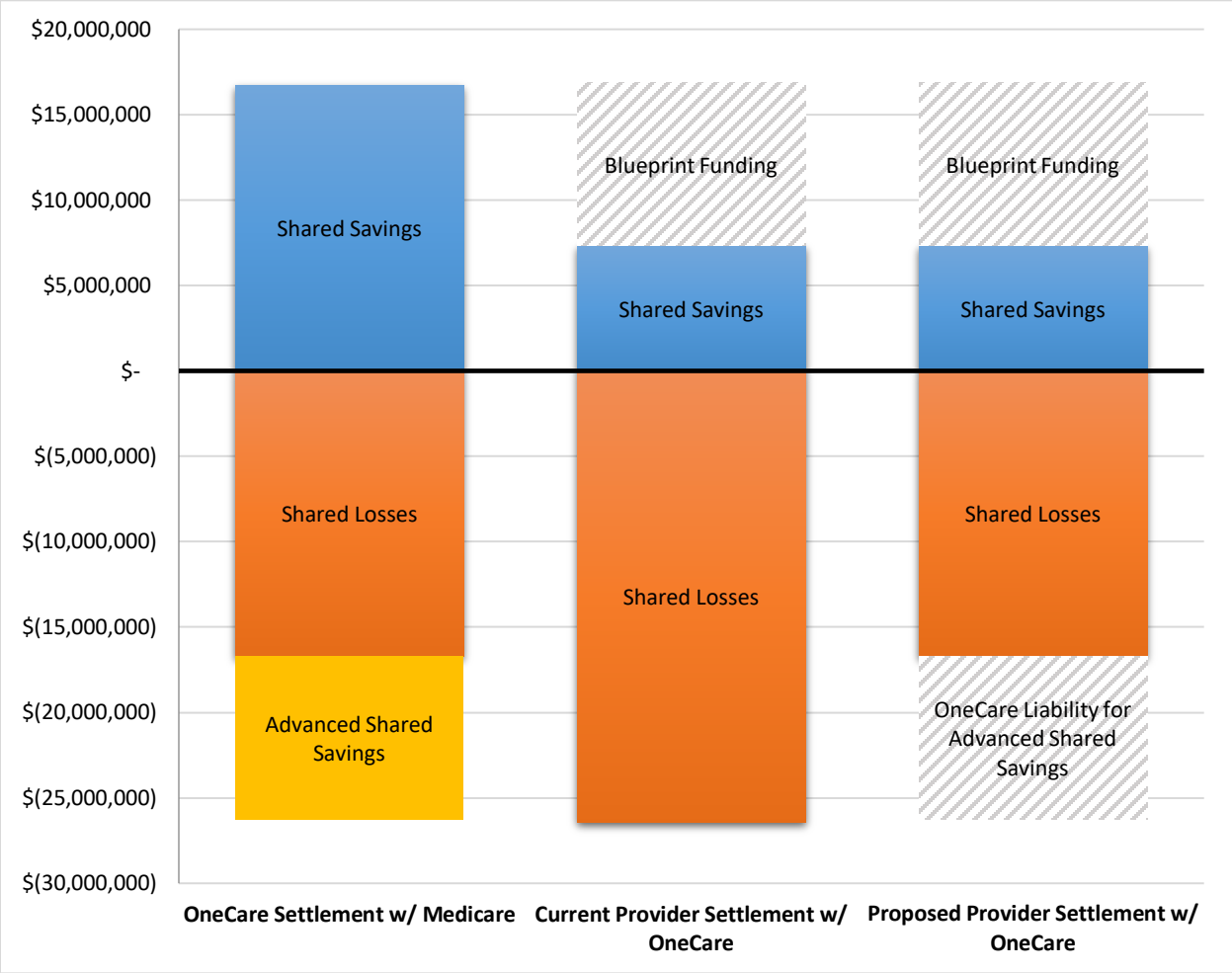
owed to Medicare. This variation from target is within a normal range and OneCare needs to consider the possibility of this outcome in its financial planning and all of its contractual arrangements with participating providers. Recall that not all organizations that receive Advanced Shared Savings funds are in OneCare's network.

The chart below illustrates the different scenarios pictorially. Please note the following:

- **OneCare Settlement w/ Medicare**:
  - Maximum shared savings: 3% risk corridor
  - Maximum losses: 3% risk corridor *PLUS refund of the Advanced Shared Savings*
- **Current Provider Settlement w/ OneCare**:
  - Maximum shared savings: 3% risk corridor *LESS component to cover Blueprint expenses*
  - Maximum losses: 3% risk corridor *PLUS refund of the Advanced Shared Savings*
- **Proposed Provider Settlement w/ OneCare**:
  - Maximum shared savings: 3% risk corridor *LESS component to cover Blueprint expenses*
  - Maximum losses: 3% risk corridor with liability for the refund of the Advanced Shared Savings transitioned to OneCare



GMCB Options to Cover the Advance Shared Savings Liability

Requiring OneCare to assume the full amount of risk for the Advanced Shared Savings without adequate warning and lead-time will force the organization into a precarious financial situation. GMCB staff mentioned various options OneCare could consider to cover the liability, if owed. None of these are a viable solution. We detail our concerns about each below.

Proposal	Analysis
Use Shared Savings from a Different Program	• Has no net effect; the amount will still be charged to the provider network, just under a different settlement label • Contradicts existing contracts and policies which are designed to fully flow share savings/losses to the provider network; will require wholesale re-contracting effort with the provider network for 2023 • There is no guarantee shared savings will be earned in any given year, which makes this an unwise revenue stream to rely upon
Increase Hospital Participation Fees	• Has no net effect; the amount will still be charged to the provider network, just though participation fees in a subsequent year • Creates significant volatility for hospitals; after building their budgets for the upcoming year they could be hit with an unplanned participation fee increase to cover the liability and/or replenish OneCare reserves
Access the Line of Credit	• The OneCare line of credit is intended as/structured for Medicare to extract funds from an insolvent ACO, and not for use as a revolving line of credit • OneCare must repay any balance drawn to the bank within 60 days, which means repayment likely must come from the provider network to comply with that tight timeframe • Drawing on the line results in interest charges, which would be an unnecessary added cost to the provider system
Seek GMCB Budget Order Relief	• Budget order relief from the GMCB will likely result in the providers assuming the liability, only with less lead-time for thoughtful planning and foresight • Reactive measures only add instability to ACO operations

Additionally, as part of OneCare's annual financial statement audit process, the external auditing firm examines the financial solvency of the ACO and determines whether or not the organization is a "going concern." This going concern test assesses whether the organization has sufficient assets or revenue to cover its potential expenses. Lenders and creditors look at this issue closely. In the event that the auditing firm determines that OneCare is not a going concern, it will significantly impede the organization's ability to conduct business as our banking partner may withdraw the line of credit that currently satisfies a Medicare program requirement.

Lastly, one of OneCare's core functions is to manage ACO-related funds flow on behalf of its provider network across the state. This is a tremendous responsibility, particularly for the Comprehensive Payment Reform practices. Errors or delays have the potential to interrupt provider financial operations and jeopardize the effectiveness of ACO activities and incentives. Specifically, the 2023 budget included $468 million of cash flow to providers ($438 million in fixed payments and $30 million in population

health management payments), which amounts to $1.3 million per day. This amount, relative to less than $10 million of unrestricted cash, provides very little margin for error in the event of a payment delay from a payer. These payment delays have occurred numerous times since the start of the All-Payer Model (APM) in 2018. Depleting or obligating OneCare's available cash on hand narrows this margin of error further.

Risk Corridor Decisions

We disagree with the GMCB staff's December 16 presentation stating that OneCare alone has repeatedly left federal dollars on the table by accepting lower risk corridors. We also believe that Board Member Walsh's speculative remarks that, "*they don't believe they can achieve their goals, or they don't understand how to maximize their return"* fail to take into account the choices that the health care system, the signers of the APM agreement, and the ACO have made to try to keep health care reform activities from backsliding during the pandemic. Below is a factual timeline and supports Board Member Lunge's suggestion that hospitals are unable to take on additional risk:

- 2018: The Vermont Medicare ACO Initiative began with a 5% symmetrical risk corridor. In OneCare Vermont's risk model, financial risk was and has always been delegated to participating hospitals. During the first few years of the model, preceding the pandemic, OneCare and its provider participants chose the 5% risk corridor.

- 2019: OneCare, as the only participating ACO, responded to the State's request to grow participation in the Medicare model to support the State's scale target goals they set with the federal government.

  Growing risk corridors for participants, even before the onset of COVID-19, was a challenge for hospitals and their boards because of the financial situation of most VT hospitals. In FY 2019, it was reported that half of Vermont hospitals experienced operating losses, with many having experienced operating losses for three or more consecutive years. In order to attract more hospital participation within the 5% corridor, OneCare's two member managers, Dartmouth-Hitchcock Health and the University of Vermont Medical Center backstopped a portion of the risk for many of the critical access hospitals to remove a barrier of participation in the Medicare program.

- 2020: This marked the beginning of a pandemic that we as a state and a nation are still trying to recover from almost three years later. With the financial stressors from the pandemic being realized, many speculated that Vermont providers would back away from health care reform participation due to the tremendous operational and financial strain and uncertainty. Informed by Vermont hospitals, the Vermont Association of Hospitals and Health Systems, and OneCare Vermont, GMCB made a request to CMMI to reduce the risk corridor under the model.

  In that same year, the Agency of Human Services (AHS) made the following recommendation in its All-Payer ACO Model Implementation Improvement Plan, "The symmetrical risk corridor should be reduced if OneCare Vermont is able to maintain or increase scale. If OneCare Vermont is able to maintain the size of their existing network, the risk corridor should be reduced from 5% to 2.5% to lessen the financial burden of participation in the Vermont Medicare ACO Initiative. If OneCare Vermont can increase scale in the Medicare program by attracting new

hospital participants, the risk corridor should be reduced to 2%. If OneCare Vermont is able to increase scale and expand participation to all hospitals in Vermont, then the risk corridor should be reduced to 1.5%."

- 2021: In response to the All Payer Model Improvement Plan and the GMCB request to CMMI, OneCare worked with its Board and its hospital participants to increase scale in order to get to the 2% risk corridor that was being sought by hospitals and endorsed by the GMCB and AHS.

- 2022: Hospitals financial state is still fragile. Vermont hospitals still unable and unwilling to take on any additional financial uncertainty that might threaten their ability to care for their patients. The decision had to be made in late 2021 about risk for 2022. No one knew how long the pandemic was going to last or what impact it would have on utilization. Thus, a 2% risk corridor remained in place.

- 2023 planned: In order to continue to grow critical access hospital participation, OneCare offered to backstop risk for Northeast Vermont Regional Hospital in St. Johnsbury and their community, effectively capping them at 1% risk. Other hospitals in the ACO agreed if **the target was set appropriately** they would seek to return to up to a 3% risk corridor, but would drop out of OneCare Medicare program if asked to take on more financial risk.

Enhanced Program Evaluation

If approved, the draft budget orders related to enhanced program evaluation scope and reporting and further benchmarking adjustments will result in increased costs to OneCare above the current budgeted amounts. Given what is currently known about the Board's expectation, OneCare estimates these costs could range between three and five hundred thousand dollars for 2023. This is an unnecessary expenditure, given that the All-Payer ACO Model is already subject to rigorous evaluations by the federal government's contractor, NORC at the University of Chicago. Further, OneCare will need to identify and contract with outside entities to conduct this work which will take time and effort away from provider support activities. Thus, OneCare's conservative administrative budget, lower than the national ACO average of 2% (MedPac, 2018), and reflecting a 1.6% decrease in spending for 2023, will be adversely inflated if these additional demands are placed upon OneCare, ultimately adding costs to the system.

Thank you for considering our concerns and recommendations.

Respectfully,

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CEO