VERMONT
GREEN MOUNTAIN CARE BOARD

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MEMORANDUM

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

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

RE: Round 2 Questions to OneCare Vermont ACO on the FY 2023 Budget Submission

DATE: 11/11/2022

Green Mountain Care Board staff have prepared the following questions following OneCare's FY23 Budget Hearing on November 9, 2022.

Please submit written responses to the questions by November 18, 2022. We may permit responses to be submitted in more than one batch to allow us to get responses as soon as possible.

Responses are to be submitted to the GMCB ACO oversight team, copying the Office of the Health Care Advocate, at the following email addresses: Sarah.Kinsler@vermont.gov; Marisa.Melamed@vermont.gov; Michele.Degree@vermont.gov; Michelle.Sawyer@vermont.gov; Jennifer.DaPolito@vermont.gov; Russ.McCracken@vermont.gov; Flora.Pagan@vermont.gov; Matthew.Sutter@vermont.gov; hcapolicystaff@vtlegalaid.org

Follow-Up from 11/9 OCV Budget Hearing

1. **Data Analytics**:
    a. Provide the OCV-UVMHN Agreement for data analytics and all documents reflecting compliance with state and federal privacy and securities laws and regulations. As a reminder, on October 24, the Board requested this be provided within five business days of execution; OCV stated at the 11/9 hearing that the contract had been executed.
    b. What is the total value of OCV's contract with UVMHN for analytic services? Please provide a list of all OCV budget lines impacted by this change (to include salary, contracted/purchased services, software, legal, and any other budget lines impacted), including the amount of the increase or decrease.
    c. Please provide information about OCV's evaluation of UVMHN's response to their data breach and how the evaluation factored into the decision to move OCV analytics to UVMHN. The response should include diligence around UVMHN privacy and security practices, including diligence around UVMHN breach and subsequent remedial measures taken.

   d. OCV budgeted $1.87M for software. Please provide a breakout of software expenses by product, noting which software packages/investments are projected to sunset and when.
   e. Please provide a breakdown of FY22 projected and FY23 costs related to the transition of analytics to UVMHN, including by budget category. How is this transition budget neutral given that some systems would run simultaneously during the transition?
2. **Compensation:**
   a. Please explain variance in management compensation from FY22 submission to FY23 submission (NOTE: See Tab 6.7, Marisa Melamed emailed Tom Borys on 11/9).
   b. Please provide a breakdown of projected FY22 compensation (FY23 submission Tab 6.7), separately listing projected base pay and variable compensation.
   c. Please provide the anticipated breakdown of FY23 compensation broken down by base pay and variable compensation.
   d. Provide UVMMC/UVMHN variable compensation policy.
   e. Please provide additional information regarding salary benchmarking. Is fair market value determined by salary survey and benchmarking data for ACOs specifically, or are other health care executives included (e.g., hospital executives)? What justification does OCV use when selecting the percent of median compensation to which executive pay is tied?
3. Please explain the 12.4% increase in the combined salary and purchased/contracted service lines between the FY22 Revised budget and FY23 submitted budget, given that there has been a decrease in total employees and the UVMHN data contract will be budget neutral according to OCV.
4. **Section 6, ACO Financial Plan 6.1-6.3 Variance Analysis Table:** In the Revised FY22-FY23 variance analysis, OCV cites a 26% increase in revenues coming from BCBS QHP program attributed to approved premiums in the QHP filings. Premiums did not rise by 26% and according to slide 14, BCBS QHP attribution is predicted to fall. Please provide a breakdown of the 26% increase in revenue from BCBS QHP into component factors.
5. **Section 7, Appendix 7.4:** Please submit FY23 target levels for percent of total attributed population receiving care management by category (risk level) and subcategory (High cost, High inpatient, etc.).
6. Please describe OCV's role in addressing wait times and ED overcrowding in Vermont.

Benchmarking Report Follow-up Questions

7. **Comparison Group:**
   a. For OCV's Medicare benchmarking report, do the selection criteria include other ACOs with multi-payer contracts, or are the comparison ACOs Medicare-only?
   b. Though Vermont is a small state, OCV as a statewide ACO is large relative to ACOs nationally with over 250,000 lives attributed statewide, including over 60,000 Medicare lives. Did the vendor consider size (attributed population) as part of the selection criteria? Why or why not? Does the comparison group include any similar sized ACOs overall to OneCare, e.g., other large multi-payer, statewide network ACOs?
   c. Provide a step-down diagram of the number of ACOs excluded after each criterion was applied.
   d. Is there a side-by-side of demographic factors (age, gender, urban/rural, acuity, etc.) between OCVT's Medicare aligned-beneficiaries to the national average from the comparison group? (This could include HCC/Risk scores)
8. **Report Methodology:**
   a. OCV and its vendor have elected to include in the benchmark report a 90th percentile benchmark that selects 2 ACOs with overall success controlling cost – rather than identifying high performance levels for each measure included in the measure set. This means that for

some measures, the results presented as "90th percentile" are in fact lower than median performers; it also fails to give OneCare (and GMCB and other reviewers) an accurate sense of the potential ceiling for high performance. Why did OCV and its vendor make this choice, and does OCV believe that 2 ACOs overall is an acceptable benchmark group?

b. How was the median national ACO peer cohort (50th percentile) calculated?
c. Why does OCV and its vendor believe that OCV should be benchmarked against the median and not the high-performance 90th percentile?

Additional Questions **–** In lieu of responding by November 18, please indicate OCV ability to answer the following questions, including whether you would need to produce new analyses to respond fully. GMCB will require responses to these questions in future quarterly monitoring materials.

9. Please provide information about the subset of OCV's attributed population diagnosed with diabetes:
    a. What proportion of your attributable lives are patients with diabetes?
    b. Of those, what proportion have an A1C greater than 9, i.e., are very ill?
        i. Of those, how many have not been seen in the last six months?
            - How many deaths were counted among these patients?
            - How many ED visits (any cause) were by patients diagnosed with diabetes?
                - How many unplanned inpatient stays (any cause) were by patients diagnosed with diabetes?
10. Please conduct the same analysis for patients with hard-to-control hypertension.
11. What proportion of your attributable lives are patients with a positive depression screen?
    a. What proportion has not had a treatment session with a mental healthcare provider?
    b. What proportion has had 1 treatment session with a mental healthcare provider?
    c. What proportion has had 2 or more sessions?
    d. Stratify by those three categories, and answer the following:
        i. How many deaths were counted among these patients?
        ii. How many died by suicide?
        iii. How many ED visits (any cause)?
        iv. How many unplanned inpatients stay (any cause)?
12. Outcomes measurement and KPIs:
    a. What specific outcome measure does OCV believe best demonstrates its value to Vermonters?
    b. Is that outcome the same for each health service area and primary care service area (HSA and PCSA)? If not, please provide a table showing the result for each HSA and PCSA.
    c. Is that outcome measure the same for all races/ethnicities and payers? If not, please provide a table showing the result for each HSA and PCSA.
    d. Please specify OCV's top three KPIs and your baseline assessment of each.
13. OCV's 2021 Medicaid Annual Quality Scorecard score is less than 70. What specific corrective actions will be taken to improve that score?
14. Please identify the process most improved by OCV's performance improvement initiatives and specify how that improvement will enhance the well-being of Vermonters. Using a table, specify the baseline measure, improvement activities, and the change in the measure.
15. Benchmarking data found ED visits 29-37% over comparison ACOs. Please explain your interpretation of these data and specifically describe your corrective actions to address your performance.