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GREEN MOUNTAIN CARE BOARD

Accountable Care Organization Oversight

FY 2021 Staff Analysis and Preliminary Recommendations

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December 9, 2020

Agenda

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1. ACO Oversight – Background
2. Certification Eligibility Verification
3. Budget Review
4. 2021 Recommendations
5. Next Steps
6. Questions/Public Comment

Acronym List

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- ACO—Accountable Care Organization
- AIPBP—All Inclusive Population Based Payments
- APM—All-Payer Model
- ASO—Administrative Services Only
- BCBS—Blue Cross Blue Shield
- CMMI—Centers for Medicare & Medicaid Innovation
- CMS—Centers for Medicare & Medicaid Services
- CPR–Comprehensive Payment Reform Program
- FFS—Fee-for-service
- FPP—Fixed Prospective Payment
- FQHC—Federally Qualified Health Center
- GMCB—Green Mountain Care Board
- HCA—Health Care Advocate
- HSA—Health Service Area
- IIP—Implementation Improvement Plan
- OCV—OneCare Vermont
- QHP—Qualified Health Plan
- PCMH—Patient-Centered Medical Home
- PCP—Primary Care Provider
- PHM—Population Health Management
- PMPM—Per Member Per Month
- PY—Performance Year
- SNF—Skilled Nursing Facility
- TCOC—Total Cost of Care
- US GAAP—Generally Accepted Accounting Principles in the United States

ACO Oversight Statute/Rule

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Oversight of Accountable Care Organizations

(18 V.S.A. § 9382 and Rule 5.000)

1. **Certification**: Occurs one-time following application for certification then eligibility verifications done annually
2. **Budget**: Review of ACO budget occurs annually during fall prior to start of budget/program year with payer contracts/attribution finalized by spring of the budget year.

ACO Oversight Timeline FY 2021

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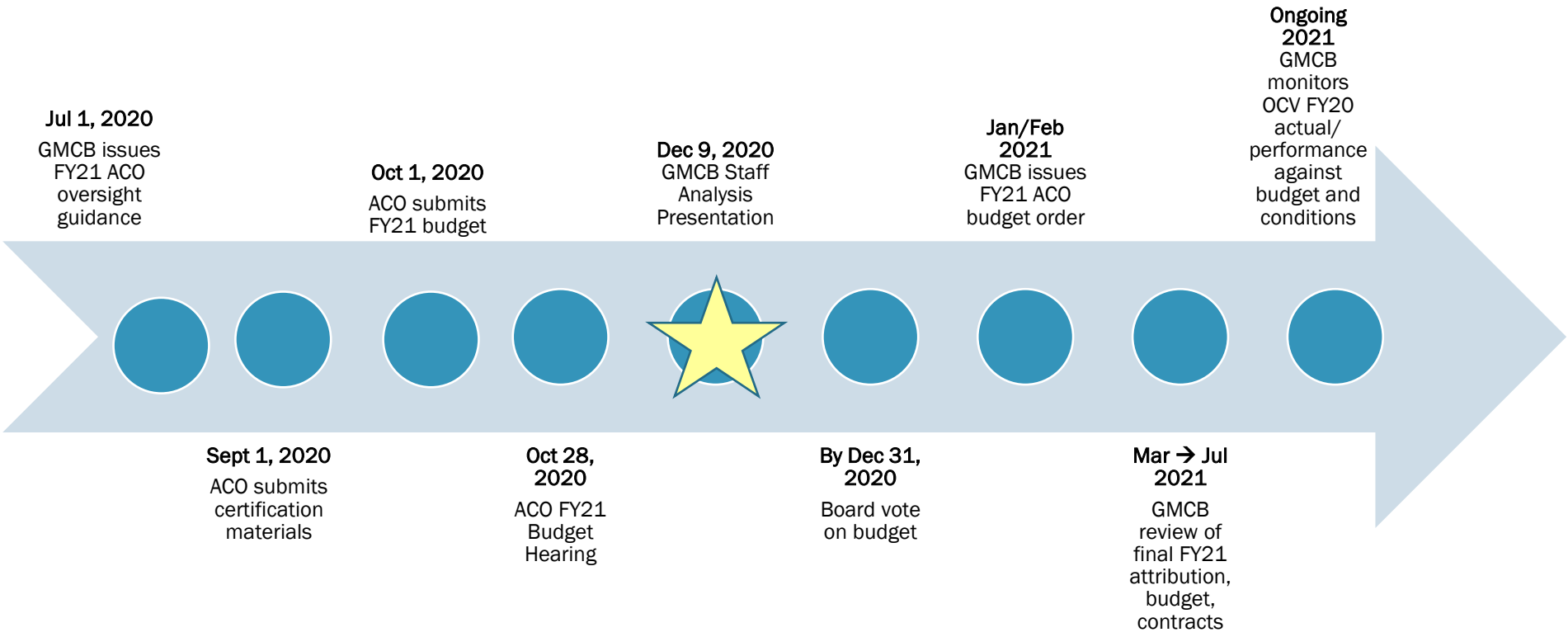

Public comment accepted throughout - comment submitted by December 2 was considered in today's staff analysis; additional comment submitted by December 21 will be considered in the final Board deliberation/vote

FY2021 ACO budget and certification materials are available here: https://gmcboard.vermont.gov/aco-oversight/2021

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ACO Certification Eligibility Verification FY 2021

FY21 Certification Eligibility Verification: Process

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5.305 Annual Eligibility Verifications

- An ACO must annually submit to the Board an eligibility verification which:
  - verifies that the ACO continues to meet the requirements of the 18 V.S.A. § 9382 and this Rule; and
  - describes in detail any material changes to the ACO's policies, procedures, programs, organizational structures, provider network, health information infrastructure, or other matters addressed in sections 5.201 through 5.210 of this Rule that the ACO has not already reported to the Board.
- Review Timeline 2020:
  - Form issued **July 1**
  - Submission received **September 1**
  - Responses to follow-up questions received **November 9**
  - Staff presentation of monitoring and reporting conclusions **December 9**
  - **Materials available here:** https://gmcboard.vermont.gov/aco-oversight/2021

ACO Oversight: Certification Criteria

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- The GMCB monitors that the ACO meets criteria in the following ten sections from Rule 5.000:
  - 5.201 - Legal Entity
  - 5.202 - Governing Body
  - 5.203 - Leadership and Management
  - 5.204 - Solvency and Financial Stability
  - 5.205 - Provider Network
  - 5.206 - Population Health Management and Care Coordination
  - 5.207 - Performance Evaluation and Improvement
  - 5.208 - Patient Protections and Support
  - 5.209 - Provider Payment
  - 5.210 - Health Information Technology

FY21 Certification Eligibility Verification

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Rule 5.000 & Statute	Key Criteria	Ongoing Monitoring & Reporting	FY21 Staff Conclusions & Additional Monitoring
Legal Governing Body, Leadership, & Management 5.201-5.203	• ACO as a separate legal entity • Authorization to do business in VT • Governance, organizational leadership & management structure • Transparency of governing processes • Mechanism for consumer input	• Operating Agreement • Compliance Plan • Conflict of Interest policy • Governance, leadership, and organizational charts • Executive Team resumes	• Continue to monitor • COI policy up for review Q4
Solvency & Financial Risk 5.204	• Mechanisms/processes for assessing legal and financial risks • Financial stability/solvency	• Financial audit • Quarterly financial statements • Finance Committee Charter	• Require more timely documentation of risk analysis and assessment • GMCB review of BOM meeting materials

FY21 Certification Eligibility Verification

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Rule 5.000 & Statute	Key Criteria	Ongoing Monitoring & Reporting	FY21 Staff Conclusions & Additional Monitoring
Provider Network 5.205	• Written agreements with ACO Participants • Criteria for accepting providers • Provider appeals	• Provider agreements • Network Development Strategy • Network Support and Access Policy; Provider Appeals Policy	• 2021 Network Development Strategy (See Budget recommendation) • OCV to submit data as requested for GMCB curated provider network list
Population Health Management & Care Coordination 5.206	• Coordination of services among Payers, Participants, and non-Participant providers, incl. community-based providers • Care coordination	• Care Coordination & Disease Management Policy • Care Coordination and Training & Responsibilities • Utilization Management Plan	• Policies up for review Q4 • Continue to require more robust monitoring and evaluation plan for community-specific population health investments, i.e. innovation fund and specialty pilots (See Budget recommendation)

FY21 Certification Eligibility Verification

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Rule 5.000 & Statute	Key Criteria	Ongoing Monitoring & Reporting	FY21 Staff Conclusions & Additional Monitoring
Performance Evaluation & Improvement 5.207	• A Quality Improvement Program actively supervised by the ACO's clinical director or designee that identifies, evaluates, and resolves potential problems and areas for improvement.	• Quality Improvement Procedure and Utilization Management Plan • Clinical Priorities and Quality Improvement Plan	• Continue to monitor
Patient Protections & Support 5.208	• Enrollee freedom to select their own health care providers • ACO may not increase cost sharing or reduce services under enrollee health plan • Patients are not billed on the event an ACO does not pay a provider • ACO maintains grievance and complaint process	• Patient Complaint and Grievance Policy • Bi-annual complaint and grievance reporting to GMCB and HCA • Beneficiary notification letters	• Semi-annual complaint and grievance information. • Continue to review public comment submitted to the Board and collect feedback through the GMCB's Advisory Committees

FY21 Certification Eligibility Verification

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Rule 5.000 & Statute	Key Criteria	Ongoing Monitoring & Reporting	FY21 Staff Conclusions & Additional Monitoring
Provider Payment 5.209	• Administer provider payments • Alternative payment methodologies coupled with mechanisms to improve or maintain quality/access • Alignment of ACO-payer incentives and ACO-provider incentives • Provider appeals	• FPP Distribution Procedure • PCCM and PHPM Distribution Procedure • VMNG Advanced Community Care Coordination Payments • QI Procedure • VBIF Distribution Policy • Settlement Policy and Reporting • Provider Appeals Policy	• Policies up for review Q4
Health Information Technology 5.210	• Data collection and integration • Data analytics • Integration of clinical and financial data system to manage risk	• Care Coordination & Disease Management Policy • Care Coordination Training & Responsibilities Policy • Utilization Management Plan • Data Use Policy • Privacy & Security Policy	• Continue to monitor

FY21 Certification Eligibility Verification

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Rule 5.000 & Statute	Key Criteria	Ongoing Monitoring & Reporting	FY21 Staff Conclusions & Additional Monitoring
Mental Health Access § 9382(a)(2)	• ACO role vs. payer role • Financial incentives • Care coordination • Programs or initiatives • Use of data, quality measurement, and clinical priorities	• Performance on mental health related quality measures in payer contracts • Quality Improvement Plan • Clinical Priorities • Report on collaboration with DAs on 42 CFR Pt. 2	• Include in reporting manual
Payment Parity § 9382(a)(3)	• ACO role vs. payer role • Steps to minimize payment differentials	• Interim and annual monitoring of comprehensive payment reform (CPR) program	• Include in reporting manual
Addressing Childhood Adversity § 9382(a)(17) § 5.403(a)(20)	• Connections among ACO providers • Collaboration on quality outcome measures • Incentives for community providers	• Plan and timeline • Social determinants risk scores • Screening tools • Program expansion • Analytics	• Continue monitoring

FY21 Certification Eligibility Verification: Monitoring and Reporting

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OneCare to submit…	When?
Updated and relevant plans, policies, procedures, agreements/contracts, subcommittee charters, and governing documents	ACO Reporting Manual-Quarterly, semi-annually, or annually as determined necessary by staff in collaboration with OneCare
Financial statements	Quarterly
Executive team resumes	Upon hire
Financial and legal vulnerability assessment	Annually
Network Development Strategy	Annually
Population health and care coordination evaluation plan	Annually
Complaint and grievance reporting	Semi-annually
Mental health access, pay parity, addressing childhood adversity reporting	Annually; semi-annually

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ACO Budget Review FY 2021

In approving an ACO's budget the Board will consider…

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- **GMCB Rule 5.405**

  (b) In deciding whether to approve or modify the proposed budget of an ACO projected to have 10,000 or more attributed lives in Vermont during the next Budget Year, the Board will take into consideration:

  1. any benchmarks established under section 5.402 of this Rule;
  2. the [16] criteria listed in 18 V.S.A. § 9382(b)(1);
  3. the elements of the ACO's Payer-specific programs and any applicable requirements of 18 V.S.A. § 9551 or the Vermont All-Payer Accountable Care Organization Model Agreement between the State of Vermont and CMS; and
  4. any other issues at the discretion of the Board

- **Public Hearing/Comments**
- **Questions/Comments by the Health Care Advocate**

Public Comment

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- 13 public comments received (as of 12/8/2020)
  - Thomas A. Dee, President and CEO of SVHC
  - Brian Harwood
  - UVMHN
  - Brattleboro Memorial Hospital
  - Ethan Parke
  - Vermont Health Care Association
  - VAHHS
  - Paul Manganiello, MD, MPH
  - Office of the Health Care Advocate
  - Walter Carpenter
  - Tomasz Jankowski, Northeast Kingdom Human Services
  - Bi-State Primary Care Association
  - Ellen Oxfeld

- Common Themes
  - Increased transparency with the public and regulators
  - Generally a positive reaction from public commenters about care navigation platform, data analytics, and support for providers in network
  - Desire for concentration on expanding health care access to all Vermonters
  - Pleased with population health initiatives overall, but would like to see an increase in funding to further the programs
  - Continuation of value-based care
  - COVID-19 considerations: what does this disruption mean for the evaluation of the APM and OCV's performance?

Budget Review Categories

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- ACO Budget Overview
  - Budget Components
  - Provider Network
  - Payer Programs
  - All-Payer Model Scale
- Population Health and Model of Care
- Risk Model
- Administrative Expenses
- Budgeted Total Cost of Care and Trend Rates
- Quality
- Regulatory Integration

Staff Recommendations Process

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1. Rolling forward relevant prior year recommendations

   RECOMMENDATION: In reviewing prior year Budget Order conditions, to simplify the budget order and ease administrative burden and operational efficiency, staff recommend shifting reporting-related budget order items to a standard reporting manual that will persist and be updated each year as necessary.

2. New Recommendations

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ACO Budget Summary Components

OneCare's Projected and Budgeted Attribution and Total Revenue

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	2018 (actual)	2019 (actual)*	*2020***	*2021****
Total Revenue	$634,311,450	$911,202,326	*$1,184,638,872*	*$1,459,027,177*
Attributed Lives	87,888	148,257	*210,648*	*~238,467*
Medicare	34,096	48,257	*50,554*	*59,571*
Medicaid-trad	36,453	64,132	*82,370*	*85,665*
Medicaid-expand	N/A	18,695	*21,178*	*21,602*
BCBSVT QHP	17,339	17,173	*20,221*	*19,817*
MVP QHP	N/A	N/A	*10,144*	*10,633*
BCBSVT Primary	N/A	N/A	*26,181*	*51,812*

Note: Attribution on this slide are estimated in OneCare budget submission and will not align with GMCB scale target reporting
** Pre-audit estimates*
*** 2020 Revenue is projected; attribution is as of January 1, 2020*
**** 2021 Revenue is budgeted; attribution is budgeted average estimates*

OneCare's Budget Components: Revenue (2018-2021)

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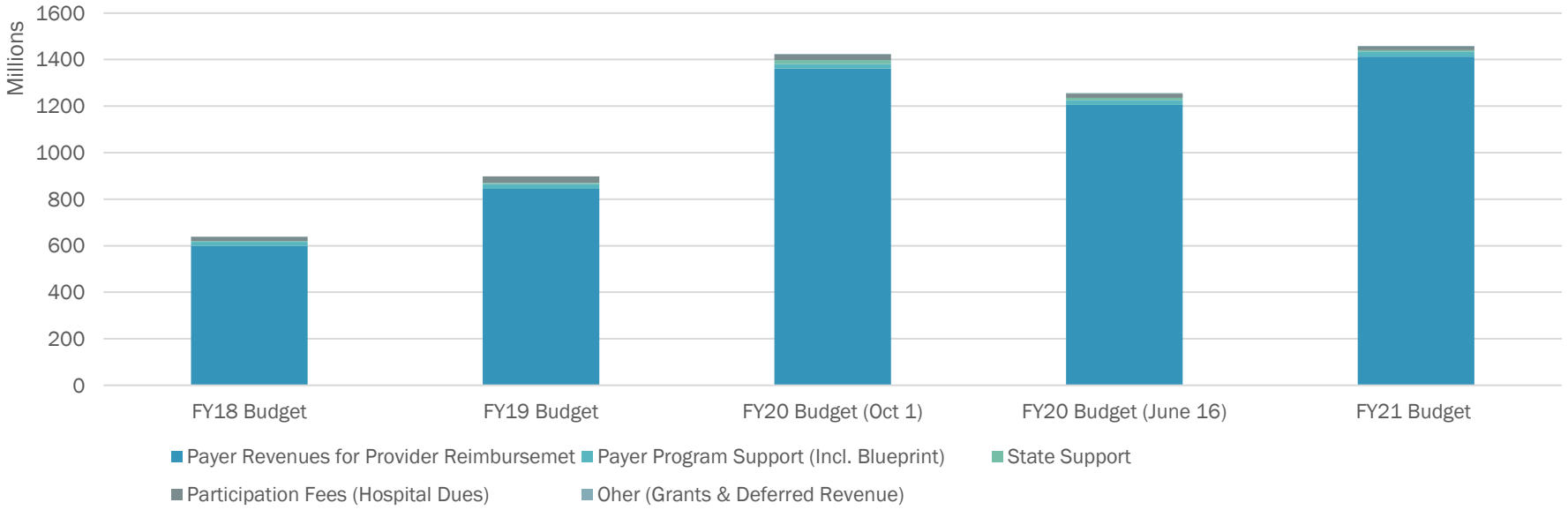

	FY18 Budget	% of Total	FY19 Budget	% of Total	FY20 Budget (Oct 1 – pre COVID)	% of Total	FY20 Budget (June 16 – post COVID)	% of Total	FY21 Budget	% of Total
Total Revenue	**639,253,005**		**898,618,967**		**1,424,634,098**		**1,255,590,792**		**1,459,027,177**	
Payer Revenues for Provider Reimbursement	599,469,290	93.8%	844,267,955	94.0%	1,362,241,283	95.6%	1,204,657,177	95.9%	1,412,335,659	96.8%
Payer Program Support (Incl. Blueprint)	17,452,793	2.7%	21,483,731	2.4%	18,999,750	1.3%	19,878,769	1.6%	20,475,699	1.4%
State Support	3,500,000	0.5%	4,250,000	0.5%	16,600,000	1.2%	11,000,000	0.9%	7,680,835	0.5%
Participation Fees (Hospital Dues)	18,459,071	2.9%	28,617,281	3.2%	24,467,227	1.7%	18,225,772	1.5%	14,935,770	1.0%
Oher (Grants & Deferred Revenue)	371,851	0.1%	-	0.0%	2,325,838	0.2%	1,829,074	0.1%	3,599,214	0.2%

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OneCare's Budget Components: Expenses

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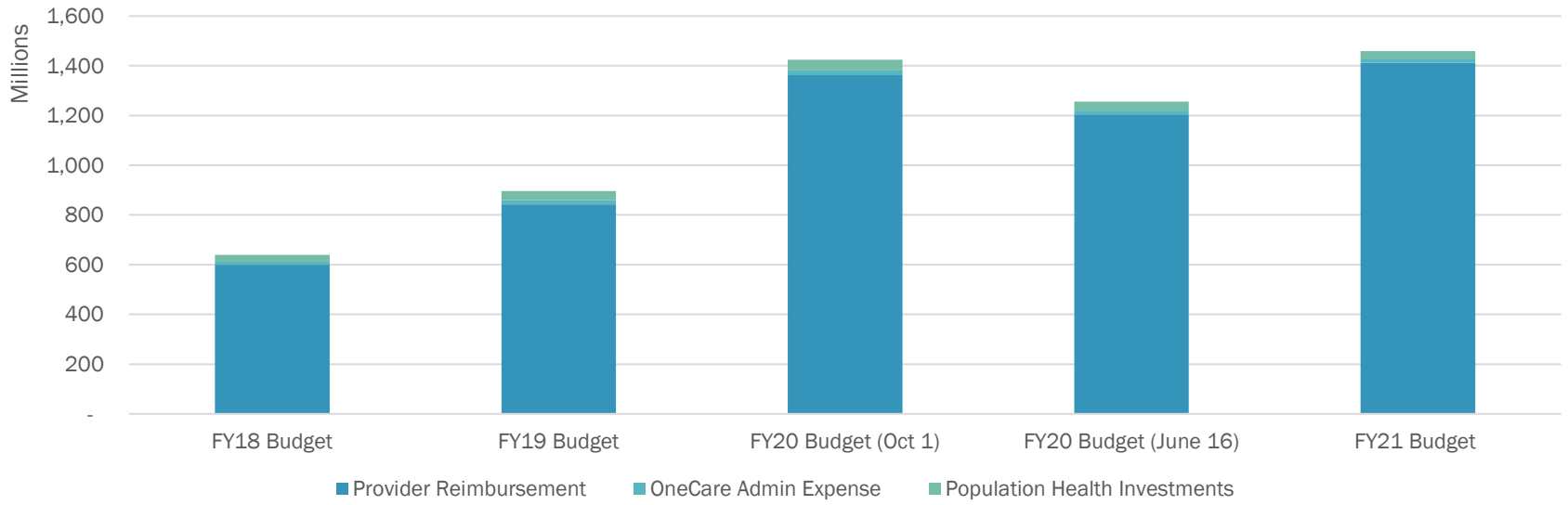

	FY18 Budget	% of Total	FY19 Budget	% of Total	FY20 Budget (Oct 1 – pre-COVID)	% of Total	FY20 Budget (June 16 – post COVID)	% of Total	FY21 Budget	% of Total
Total Expense	**639,253,005**		**895,818,967**		**1,424,634,098**		**1,255,590,792**		**1,459,027,177**	
Provider Reimbursement	599,469,289	93.8%	842,656,459	94.1%	1,362,241,283	95.6%	1,204,657,178	95.9%	1,412,335,659	96.8%
OneCare Admin Expense	12,492,660	2.0%	15,915,189	1.8%	19,276,749	1.4%	14,916,480	1.2%	16,132,547	1.1%
Population Health Investments	27,291,056	4.3%	37,247,319	4.2%	43,116,066	3.0%	36,017,134	2.9%	30,558,970	2.1%

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OneCare's Budget Components by attributed life (PMPY)

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Metric	2018 Actual	2019 Actual*	2020 Budget**	2020 Projection	2021 Budget
Provider Reimbursement (millions)	$597.7	$859.8	$1,204.7	$1,134.0	$1,412.3
Administrative Expense (millions)	$11.7	$15.4	$14.9	$14.4	$16.1
Population Health Management Investments (millions)	$23.0	$32.9	$36.0	$36.2	$30.6
Scale†	112,756	160,048	223,158	223,158	242,298
Provider Reimb. PMPY (Scale)	$5,300.44	$5,372.36	$5,398.23	$5,081.67	$5,828.92
Admin PMPY (Scale)	$103.47	$96.01	$66.84	$64.50	$66.58
PHM PMPY (Scale)	$204.15	$205.71	$161.40	$162.34	$126.12

† Scale numbers as presented in annual federal reporting (January 1 attribution); 2020 and 2021 subject to change.
*Pre-Audit estimates
**Revised budget

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ACO Provider Network and Payer Programs

OneCare Provider Network: 2020 to 2021 Changes

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- The 2021 network development strategy focused on continuing current network composition while increasing,
  - Support for primary care;
  - Engaging organizations that take risk;
  - Working to reduce barriers to joining additional payer programs; and,
  - Ensuring adequate knowledge of participation expectations.
- The network did not see major changes from 2020 to 2021.
  - Expanded network
    - Rutland Regional Medical Center (RRMC) and Community Health Center of the Rutland Region (CHCRR) to the Medicare Program
    - Four new entrants into the Comprehensive Payment Reform Program (CPR)

OneCare's Provider Network: Network List

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- OneCare has provided provider network data to the GMCB through regulatory processes in 2018, 2019, 2020, and for the upcoming 2021 fiscal year
- GMCB data and analytics team created a curated network list with all OneCare provider data that allows stratification by identifying provider information (name, location, organization, etc.), provider type, and payer program.
- Purpose: To better support the providers in the ACO network and be able to look at the data year over year.

OneCare's Provider Network: Staff Recommendation

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- **RECOMMENDATION:** Cross-team collaboration at the GMCB, in partnership with OneCare, will produce a standardized template for data collection, which will be incorporated into the ACO Reporting Manual.

- **RECOMMENDATION:** Network Development Strategy will be incorporated into the ACO Reporting Manual.

OneCare's Payer Programs: Disclaimer

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Analyses are based solely on OneCare's budget submission. GMCB staff have not yet analyzed pending or actual payer contracts. All Payer Contracts are still under negotiation.

OneCare's Payer Programs: APM & Alignment*

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	Medicare	Medicaid	BCBS QHP	BCBS Primary	MVP
Quality	13 aligned measures	13 aligned measures	12 aligned measures**	12 aligned measures**	10 aligned measures**
Payment	AIPBP for eligible participants; FFS for others	AIPBP for eligible participants; FFS for others	FPP (pilot) & FFS	FFS	FFS
Risk	Two-sided; 2% risk corridor; 100% sharing	Traditional: Two-sided; 2% risk corridor; 100% sharing Expanded: Two-sided; 1% upside, 1% downside; 100% sharing	Contracted	Contracted	Contracted
Age of Program	4th year	5th year	4th year	2nd year	2nd year

For all payer programs listed above, the services included in financial targets are aligned. Medicare attribution is claims based, while Medicaid attribution is claims based **and** includes the expanded cohort. BCBS QHP, BCBS Primary, and MVP's attribution methodology are proprietary.

*Projected by OCV as of 10/01/2020 Budget Submission, payer contracts still under negotiation
**Two of BCBS's QHP aligned measures are "composite measures" and 1 aligned measure

OneCare's Payer Programs: APM & Scale

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To qualify as a Scale Target ACO Initiative under the APM a program must meet the following requirements:

1. Possibility of Shared Savings for achieving goals related to quality of care or utilization.
2. The ACO's Shared Savings, as a percentage of its expenditures less than the benchmark, is at minimum 30%; if the ACO is also at risk for Shared Losses, its Shared Losses, as a percentage of its expenditures in excess of the benchmark, is at minimum 30%.
3. Services comparable to, but not limited to, the All-Payer Financial Target Services and their associated expenditures are included for determination of the ACO's Shared Losses and Shared Savings;
4. The ACO Benchmark, Shared Savings, Shared Losses, or a combination is tied to the quality of care the ACO delivers, the health of its aligned beneficiaries, or both.

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All-Payer Model Scale

Scale Performance

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		PY1 (2018) Final	PY2 (2019) Final	PY3 (2020) Preliminary	PY4 (2021) Projected	PY5 (2022)
All-Payer Scale Target	*Target*	*36%*	*50%*	*58%*	*62%*	*70%*
	Actual	22%	30%	42%*	46%**	
Medicare Scale Target	*Target*	*60%*	*75%*	*79%*	*83%*	*90%*
	Actual	35%	47%	44%*	56%**	

*Preliminary 2020 results utilize 2019 population estimates; these results are subject to change.

**Projected 2021 estimates are calculated using scale estimates as reported in the budget submission and utilize 2019 population estimates; these results are subject to change.

All-Payer Scale

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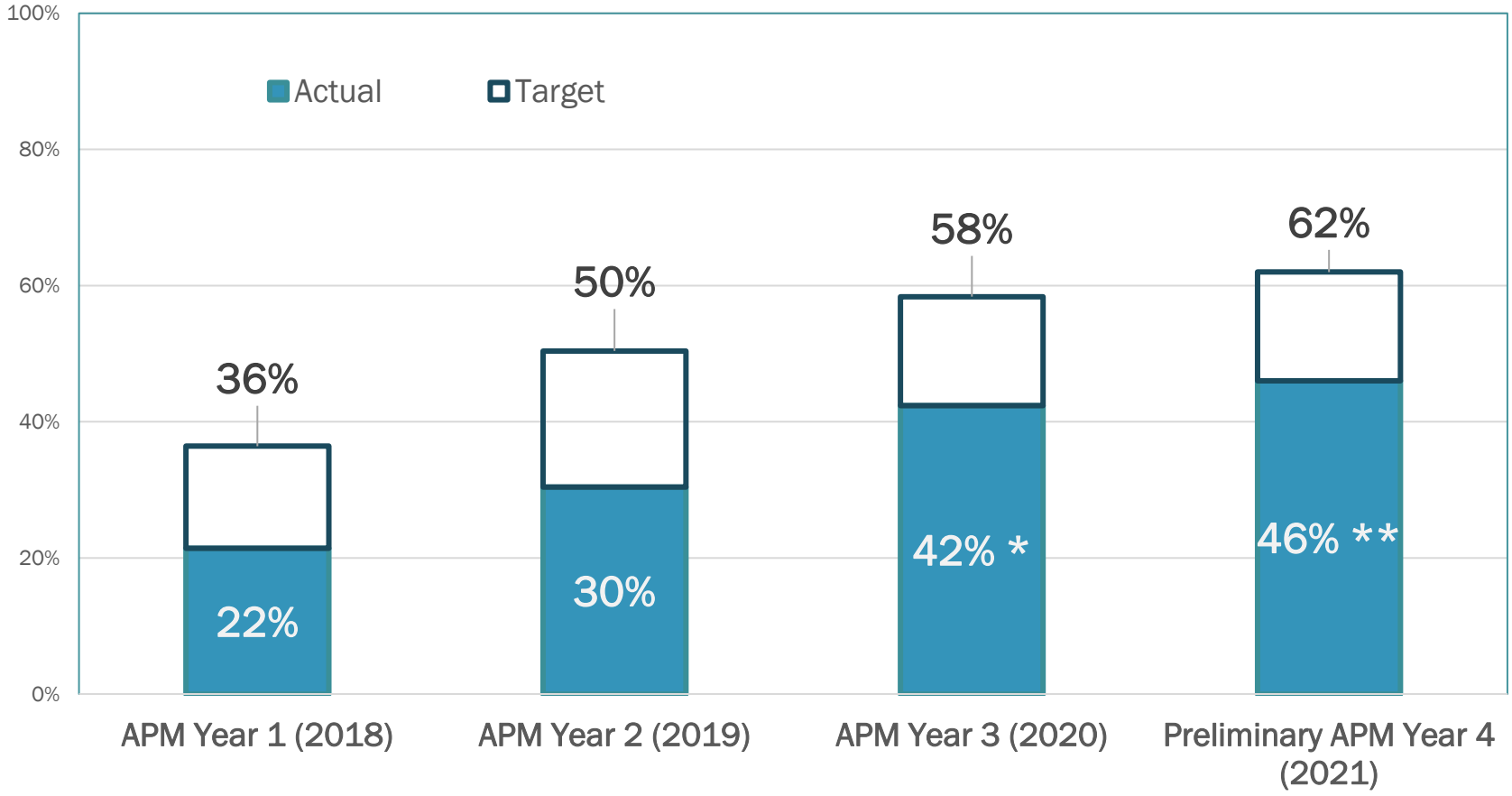

* Preliminary results, utilizes 2019 population estimates.
** Preliminary results based on attribution presented in 2021 budget submission; utilizes 2019 population estimates.

Medicare Scale

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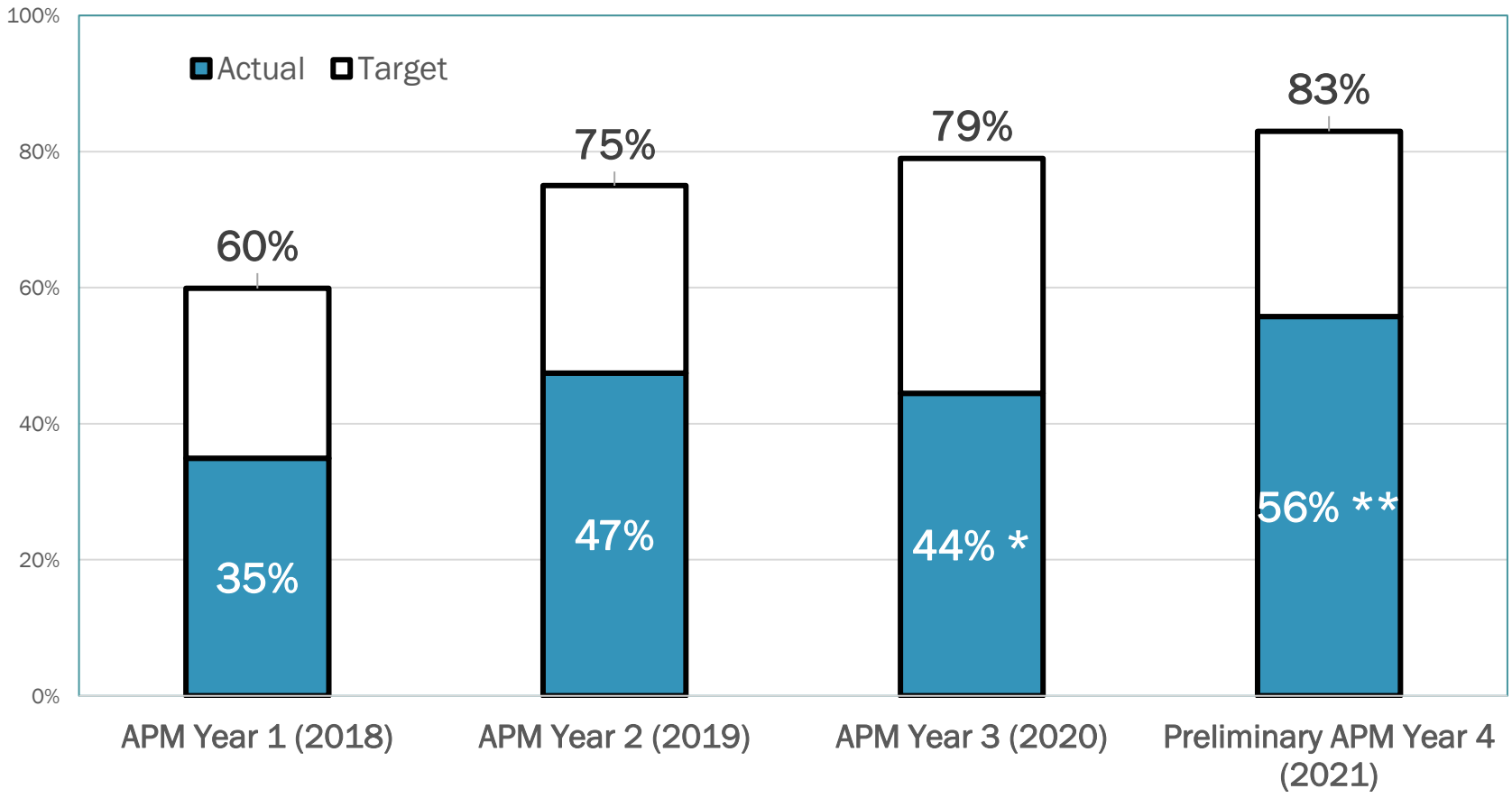

* Preliminary results, utilizes 2019 population estimates.
** Preliminary results based on attribution presented in 2021 budget submission; utilizes 2019 population estimates.

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ACO Population Health & Model of Care

OneCare's Model of Care

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Source: OneCare VT 2021 Budget Presentation 10/28/2020

ACO Population Health & Care Model Review Criteria

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Review and consider	Key Criteria
• Incentives/Resources (Payment Changes) • Information (Data) • Efforts (Tools)	• Strengthen primary care • Integrate with community-based providers and the Blueprint for Health e.g. mental health and substance use disorder • Address social determinants of health and impact of adverse childhood events • Effects on appropriate utilization

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

OneCare's Model of Care

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Payment Changes

- Value-based payment design and distribution
- Financial support through program investments

Actionable Data

- Four quadrant risk stratification model
- Practice- and HSA-level population health analytics
- Evaluation of process, outcomes, return on investment

Tools for Care Redesign

- Leader and facilitator of delivery system coordination
- Care management and care coordination support
- IT applications for clinical care

2021 Changes to Population Health Programs

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Blueprint Self-Management Programs (primary prevention)	• Diabetes and hypertension management • Self-management team, RiseVT, data apps • Increase engagement in these programs and improve health outcomes
Complex Care Coordination (complex care coordination)	• Greater focus on subpopulations, support increased engagement, "robust set of metrics" • Increased skills training • Outcome evaluation and return on investment • Explanation for ↓25%: refining program for 2021
Longitudinal Care Program (complex care coordination)	• Expanding from Burlington to 6 additional HSAs • "[Currently] funded through Delivery System Reform dollars. OneCare can provide plans for the 2021 program if funding is appropriated by the state and contracted with OneCare."
Value-Based Incentive Fund (VBIF)	• More immediate distribution of funds throughout the performance year • Explanation for ↓64%: moving quality components to settlement

OneCare's Population Health Management (PHM) & Payment Reform Investments

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	2018 Actual	2019 Actual	2020 Budget*	2020 Projected	2021 Budget
PHM/Payment Reform Programs					
Basic OneCare PMPM	$ 4,040,439	$ 6,581,843	$ 8,420,662	$ 8,778,018	$ 9,694,801
Complex Care Coordination Program	$ 5,618,420	$ 9,186,729	$ 9,672,306	$ 9,672,510	$ 7,275,652
Value-Based Incentive Fund - Total	$ 4,243,973	$ 6,224,607	$ 5,640,553	$ 5,566,458	$ 2,000,000
Comprehensive Payment Reform Program	$ 715,806	$ 1,338,005	$ 1,192,196	$ 1,192,196	$ 1,200,000
Primary Prevention	$ 620,381	$ 727,627	$ 540,000	$ 540,000	$ 950,000
Specialist Program	$ -	$ 139,240	$ 754,800	$ 754,800	$ 65,777
Innovation Fund	$ -	$ 351,818	$ 725,521	$ 725,521	$ 239,320
RCRs	$ -	$ 325,000	$ -	$ -	$ -
VBIF Quality Initiatives	$ -	$ 27,000	$ 33,000	$ 33,000	$ 74,000
PCMH Payments	$ 1,830,264	$ 1,865,619	$ 1,993,092	$ 1,993,092	$ 1,993,092
Community Health Team Payments	$ 2,245,852	$ 2,321,670	$ 2,440,322	$ 2,440,322	$ 2,440,322
SASH	$ 3,704,400	$ 3,834,054	$ 3,968,246	$ 3,968,246	$ 3,968,246
Primary Care Engagement Investment	$ -	$ -	$ 636,436	$ 564,194	$ 657,760
PHM Total	**$ 23,019,535**	**$ 32,923,212**	**$ 36,017,134**	**$ 36,228,358**	**$ 30,558,970**

*Revised budget

OneCare's Population Health Management (PHM) & Payment Reform Investments

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	2018 Actual	2019 Actual	2020 Budget*	2020 Projected	2021 Budget
Total Revenue	**$ 634,311,450**	**$ 911,202,326**	**$ 1,255,590,792**	**$ 1,184,638,872**	**$ 1,459,027,177**
Population Health Management (PHM) Total	$ 23,019,535	$ 32,923,212	$ 36,017,134	$ 36,228,358	$ 30,558,970
Blueprint (PCMH,CHT,SASH)	$ 7,780,516	$ 8,021,343	$ 8,401,660	$ 8,401,660	$ 8,401,660
(PHM LESS Blueprint)/Revenue	2.4%	2.7%	2.2%	2.3%	1.5%
PHM/Total Revenue	3.6%	3.6%	2.9%	3.1%	2.1%

*Revised budget

- **Blueprint $ level-funded** (+3.1% '18-'19 and +4.74% '19-'20)
- **PHM Investments ↓15%** (2020 projected to 2021 budget)
- **Total Revenue ↑24%** (2020 projected to 2021 budget)
- **PHM Investments**—there is no benchmark for the "right" ratio, programs do not scale up at same rate as attribution

Growth and Composition of OneCare's Population Health & Payment Reform Investments

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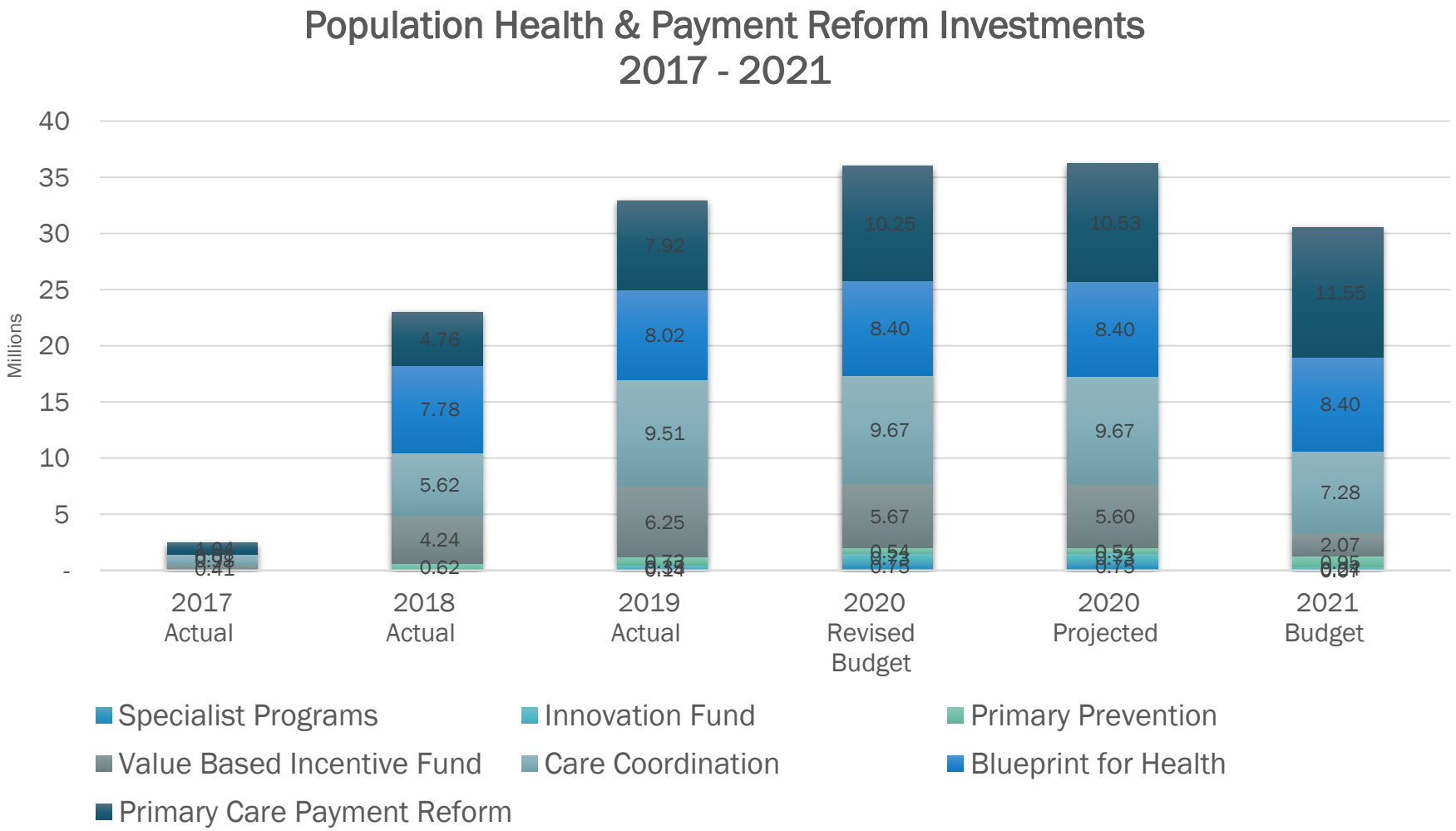

Population Health & Blueprint Recommendations

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- **RECOMMENDATION:** Shift reporting requirements to ACO Reporting Manual
  - E.g. population health programs and investments; quality; variations in cost and quality; ACO performance dashboard
- **RECOMMENDATION:** If population health management programs are not fully funded as detailed in OneCare's 2021 budget submission, OneCare must submit a revised proposal no later than TBD Spring, 2021 to the Board. This should include any requests for budget revisions, for changes to OneCare programs, including any funding shortfalls, changes in program scope, and an analysis for each program line item as to whether and why the funding is appropriately scaled by attribution, or some other factor.
- **RECOMMENDATION:** In 2021, OneCare must fund the SASH and Blueprint for Health (PCMH and CHT) investments in the amount of $8,401,660 plus an inflationary factor.
- **RECOMMENDATION:** OneCare to provide Value Based Incentive Fund (VBIF) policy and to quantify the proportion of the VBIF that is now operationalized at settlement, versus distributed throughout the performance year; explaining and quantifying any and all other mechanisms that tie financial incentives to quality performance.

Background on OneCare's Risk Model

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- OneCare Vermont assumes risk from payers for the care of a particular population as specified in their payer contracts.
  - These contracts do not specify distribution of shared savings or losses.
- Rather OneCare Vermont designs and implements the methodology for establishing TCOC targets for participating providers and methods for distributing shared savings or losses.
  - Documented in OneCare policies (some of which are still under development – i.e. performance incentive pool)

2021 Risk by Risk Bearing Entity

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Risk Bearing Entity	Downside Risk ($1,000s)		% of Total
Southwestern VT Medical Center	$	1,554	8.2%
Central Vermont Medical Center	$	2,059	10.8%
Brattleboro Memorial Hospital	$	996	5.2%
The University of Vermont Medical Center	$	6,625	34.8%
Dartmouth-Hitchcock	$	451	2.4%
Porter Medical Center	$	1,234	6.5%
Copley Hospital	$	163	0.9%
North Country Hospital	$	310	1.6%
Gifford Medical Center	$	243	1.3%
Rutland Regional Medical Center	$	1,499	7.9%
Springfield Hospital	$	334	1.8%
Northwestern Medical Center	$	1,634	8.6%
Northeastern VT Regional Hospital	$	433	2.3%
Grace Cottage Hospital	$	-	0.0%
Mt. Ascutney Hospital & Health Ctr	$	506	2.7%
OneCare Vermont	$	1,006	5.3%
Total	**$**	**19,047**	**100.0%**

Key Takeaway:

- Hospitals in the University of Vermont Health Network (UVMC, Central VT, Porter) collectively hold $9.9m (52%) of the risk in the ACO network.

OneCare Modifications to Risk Model

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Design Element	2019 (HSA Model)	2021 (Network Model)
Primary Holder of Risk	Hospitals	Hospitals, but expanding to Primary Care
Methodology for est. TCOC Targets & Distribution of SS/SL	HSA expected/actual performance in a particular payer program	Network expected/actual performance in a particular payer program with 10% SS incentive pool
Operational Complexity	Complex to administer and methodology often unclear to providers	Simpler to administer and easier for providers to understand

Note: In 2020, OneCare's approved budget used an HSA-specific Risk Model, but post-COVID the OneCare Board agreed to allow network-wide sharing of 2020 savings/losses akin to the Risk Model proposed for 2021.

New Risk Model: A Proposal to Shift Incentives?

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Shifting from the HSA to the Network Model of risk proposes to increase collaboration across the network.

1. Participants (Hospitals) may have more incentive to look outside their HSA for the most efficient care setting.
2. Increased motivation for the ACO to identify and lead strategic planning for system-wide cost control.

New Risk Model: A Proposal to Shift Incentives?

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However, it remains to be seen (or justified) whether these incentives are strong enough for individual providers to motivate the desired collaborative behaviors.

1. A tension may still exist between placement into the most efficient care setting and hospital revenue growth strategies, particularly as fee for service remains the predominant method of payment.
2. The fewer an HSAs attributed lives, the less richly they will be rewarded for their engagement, i.e. motivated by the potential for shared savings/losses.
3. OneCare's 2021 plan is to establish performance incentives to reward HSAs for localized performance – although this is not fully defined in the ACO's budget.
4. There may be variation in efficacy of these incentives depending on whether or not the hospital owns primary care.

Recommendations On OneCare's Risk Model

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While the concept of simplifying the risk model and evolving it to foster collaboration across participating providers appears a good one, it is unclear from OneCare Vermont's 2021 Budget submission how the risk model's underlying methodologies accomplish this objective.

RECOMMENDATION: Condition approval of OneCare Vermont's 2021 Budget on the submission of underlying risk model methodologies for distribution of shared savings or losses (SS/SL), including mechanics of the 10% performance incentive pool, any market factor adjustments, or any other potential adjustments to SS/SL on or before Spring TBD. If the written submission is deemed insufficient by Board staff, OneCare Vermont will be invited to explain the details of the risk model and its impact on incentive structures to the Board on or before Spring TBD.

Fixed Prospective Payments (FPP)

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The percentage of ACO attributing lives covered by fixed prospective payments (FPP) as opposed to fee for service (FFS) is expected to increase slightly from 2020 to 2021, measured as % of TCOC.

2020	2021	Var
32.6%	33.6%	+1%

Fixed Prospective Payments (FPP): Hospitals

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Hospital	2021 Submitted Budget	2021 Budgeted FPP as a % of NPR/FPP
Brattleboro Memorial Hospital	$13,839,826	14.9%
Central Vermont Medical Center	$45,514,084	19.2%
Copley Hospital	$4,820,035	6.3%
Gifford Medical Center	$3,200,000	6.1%
Grace Cottage Hospital	$ -	0.0%
Mt. Ascutney Hospital & Health Center	$1,200,000	2.1%
North Country Hospital	$7,035,060	8.5%
Northeastern VT Regional Hospital	$7,799,000	8.6%
Northwestern Medical Center	$20,376,132	17.5%
Porter Medical Center	$20,661,081	23.0%
Rutland Regional Medical Center	$14,824,780	6.0%
Southwestern VT Medical Center	$37,050,000	22.2%
Springfield Hospital	$5,787,881	11.2%
University of Vermont Medical Center	$225,974,440	15.9%
Total	**$408,082,319**	**14.5%**

Note: From July 2020 Budget Submissions- Submitted FY21 budgets-unadjusted per GMCB decisions.

Increasing Fixed Prospective Payments (FPP): Targets?

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What should our FPP targets be as a state?

1. % of Payer Business?
2. % ACO offerings (TCOC)?
3. % Provider budgets?

OneCare's Administrative Expenses

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Expense (in *millions*)	Actuals 2018	Actuals 2019*	Budget 2020 (Oct 1)	Budget 2020 (Jun 16)	Projected 2020	Budget 2021	Budget 2021 % Total
Salaries & Benefits	$6.6	$8.2	$11.8	$8.3	$8.3	$9.8	61%
Software	$-	$2.6	$3.7	$3.6	$3.5	$3.5	22%
Contract Services	$1.3	$2.2	$1.2	$1.5	$1.2	$0.9	5%
Other (incl. travel, rounding)	$3.0	$0.7	$0.7	$0.8	$0.7	$1.0	6%
Occupancy	$-	$0.4	$0.5	$0.4	$0.5	$0.5	3%
Supplies	$-	$0.3	$0.2	$0.2	$0.1	$0.3	2%
Risk Protection	$0.8	$1.0	$1.2	$0.1	$0.1	$0.1	1%
Total	**$11.7**	**$15.4**	**$19.3**	**$14.9**	**$14.4**	**$16.1**	**100%**

*Pre-Audit estimates

OneCare's Administrative Expenses: Variance Analysis

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Expense (in *millions*)	Budget 2021	Revised Budget 2020	Variance $ Inc/(Dec)	Variance % Inc/(Dec)	Explanation
Salaries and Benefits	$9.8	$8.3	$1.5	18%	Compensation restoration due to COVID-19 (see next slide)
Software	$3.5	$3.6	$(0.1)	(3%)	N/A, immaterial
Contract Services	$0.9	$1.5	$(0.6)	(40%)	Limiting to essential contracts (-584K)
Other (incl. travel, rounding)	$1.0	$0.8	$0.2	25%	GMCB bill back increase (160K)
Occupancy	$0.5	$0.4	$0.1	25%	Lease expense increase in April 2021 (111K)
Supplies	$0.3	$0.2	$0.1	50%	Self-management mobile monitoring technology remote work outcome (133K)
Insurance/Risk Protection	$0.1	$0.1	$0.0	-%	N/A, immaterial
Total	**$16.1**	**$14.9**	**$1.2**	**8%**	

Variance Analysis: OneCare's Salaries and Benefits

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#	Type	Amount $	Driver/Reason/Value of Investment
1	Net impact of vacancy reinstatements and other positional changes in 2021	$496k	Reinstatements of positions and other changes necessary to fulfill the expectations set by the OneCare Board of Managers
2	Reinstatement of leadership compensation	$595k	Restoration of temporary COVID-related salary and benefit reductions
3	2% Cost of Living Increase	$209k	Annual increase for continuing staff
4	Other	$170k	Unexplained variance
Total	Increase over revised 2020 Budget	$1,470k	

Staff Discussion: Human Capital Investment

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- What is the right benchmark for human capital investments?
  - For an ACO?
  - For the broader health-system?
- What kind of return should we expect from this level of investment?

Human Capital Investment

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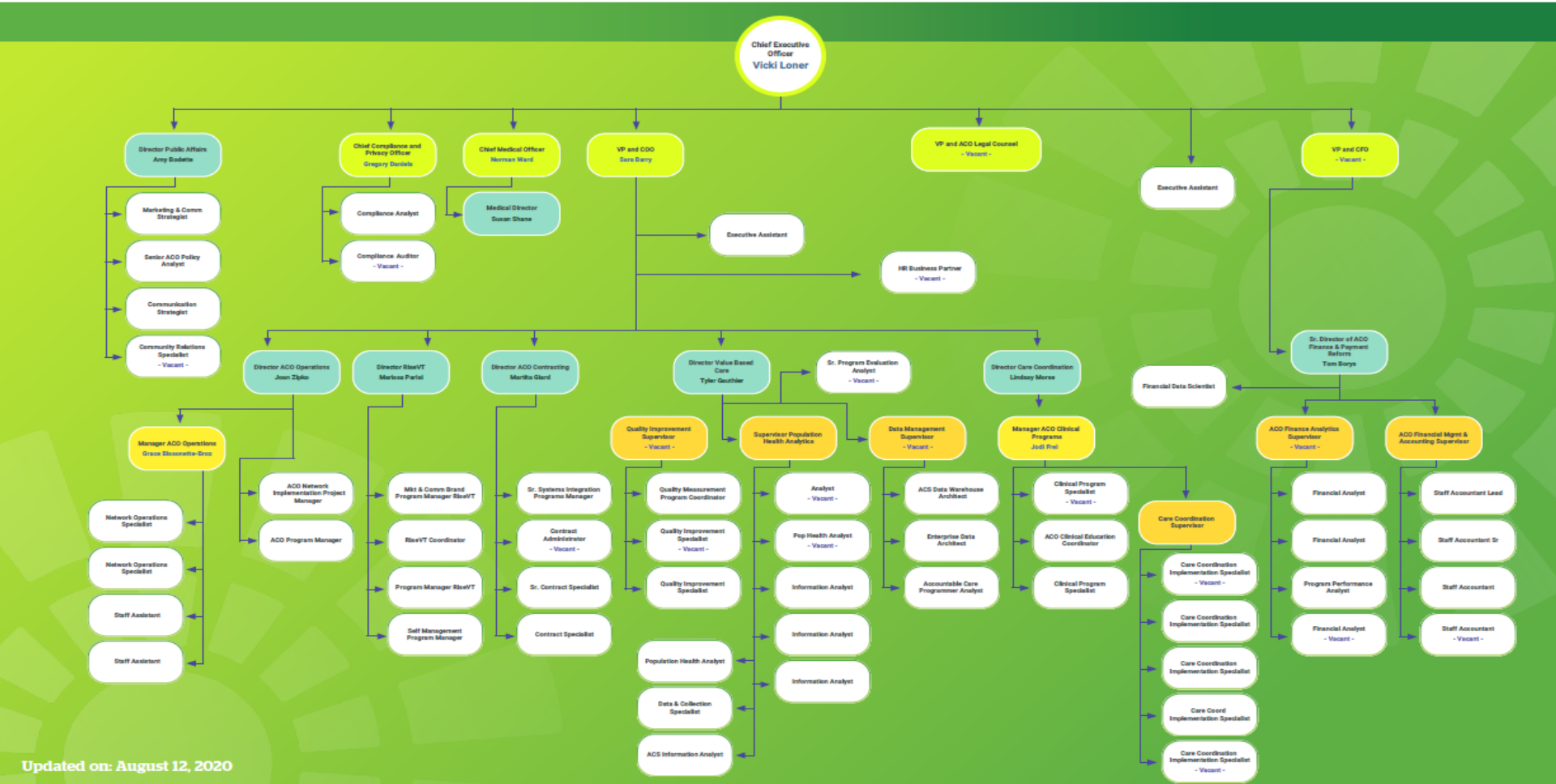
OneCare Vermont

Organizational Chart



Updated on: August 12, 2020

Staff Recommendation: Human Capital Investment

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RECOMMENDATION: GMCB staff to work with OneCare to establish standard reporting of human capital investments as it relates to OneCare's core competencies and overall strategy. These could be separated (for example) as follows:

- FTEs directly involved in population health or payment reform programs (i.e. data specialists, care coordinators, analysts)
- FTEs supporting OneCare's operations (i.e. leadership, finance, legal, human resources)

Retained Earnings

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As noted in a response from OneCare:

"In 2018 and 2019 the GMCB budget orders required OneCare to build and maintain reserves. As a result of this order, OneCare developed a budget with increased hospitals dues which supplied cash flow into the organization and helped satisfy the budget requirement. Prior to closing out any fiscal year, OneCare engages with its governance bodies to evaluate the expected net income and consider options such as credits to dues-paying providers or deferrals in accordance with GAAP."

Retained Earnings

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Fiscal Year	Net Income	Subsequent Use
2018	$969,127	Net assets (reserves)
2019	$4,689,173	Net assets (reserves)
2020	$0, projected	Net assets (reserves)

The net income numbers provided above would leave OneCare with a surplus of about **$5.6 million** as of December 31, 2019.

- **2019**: the Board ordered OneCare to reserve $3.9 million to fund the risk protection of three network hospitals; this leaves about $1.7 million in undesignated surplus as of December 31, 2019.
- **2020**: Reserve requirement held at $4 million, though founders now funding risk mitigation of $3.7 million; the Board expanded potential use of reserve funds to include general liquidity to manage financial operations.
- **2021:** Budget proposes to backstop a proportion of risk for two network hospitals in the amount of $857k, which would be covered by OneCare's existing reserves

Staff Discussion: Retained Earnings

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1. Full 2019 surplus was unaccounted for in 2020 Budget
   - 2019 net income as of 10/1/2019 = $3,898,812
   - 2019 net income as of 12/4/2020 = $4,689,173
2. Uncertainty around impact of 2020 net income to retained earnings
   - Projected 2020 net income as of 10/1/2020 = $0

Staff Recommendation: OneCare's Retained Earnings

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RECOMMENDATION: OneCare to propose plan for disbursement of undesignated reserves or justify maintaining a particular amount of reserves above the reserve requirement.

RECOMMENDATION: OneCare to report updated and final 2020 net income and subsequent use to the Board at year end.

Potential Benefits of US GAAP Based Submissions

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US GAAP based budget/actual submissions allow a better understanding of the following:

1. Cost of operating OneCare and expectations for the coming year
2. Internal flow, key performance indicators, and operations at OneCare
3. Levers that may be used by the Board to adjust OneCare's budget, if necessary
4. How submitted actuals compare to audited financial statements
5. The use of profits/losses at year end (i.e. applied against hospital dues, reinvested in population health, reserved)

Staff Recommendation: US GAAP Based Submissions

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RECOMMENDATION: OneCare to cross-walk submitted actuals per its budget submission to audited financial statements (fiscal years 2018-2021).

RECOMMENDATION: Beginning with ACO Budget Guidance for 2022, we will ask ACO to submit its budget for accountability (the version we have been relying on to date) as well as a budget that aligns with US GAAP.

Administrative Expense Ratio

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Administrative Expense Ratio Calculation:

$$\frac{ACO\ Operational\ Expenses}{ACO\ Total\ Revenue}$$

Operational Expenses:

includes salary, benefits, contracts, supplies etc.; does not include population health investments, provider reimbursements ("existing health care spending")

OneCare's Admin vs. PHM Ratio

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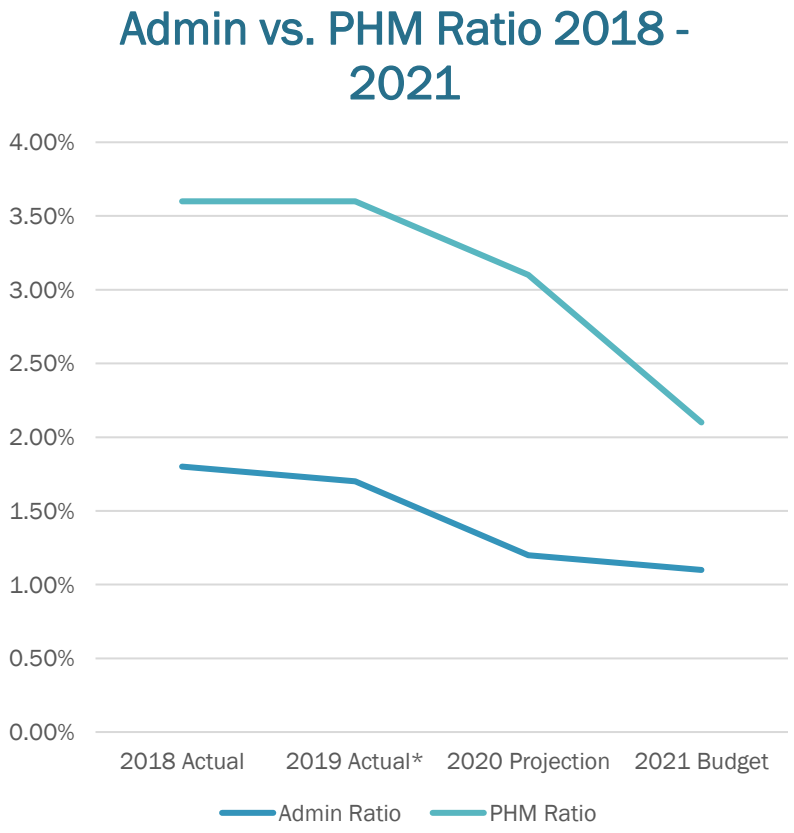
Expense/Metric *($ in millions)*	2018 Actual	2019 Actual*	2020 Projection	2021 Budget
Admin	$11.7	$15.4	$14.4	$16.1
Pop Health Mgt/Pmt Reform Invest (PHM)	$23.0	$32.9	$36.2	$30.6
Total Revenue	$634.3	$911.2	$1,184.6	$1,459.0
Admin Ratio (Admin/Total Revenue)	1.8%	1.7%	1.2%	1.1%
PHM Ratio (PHM/Total Revenue)	3.6%	3.6%	3.1%	2.1%



*pre-audit estimates

OneCare's Administrative Budget Uncertainties

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1. Population Health Management Ratio decreasing at a rate greater than Administrative Ratio decline
2. Number and nature of new positions unclear (~$495k)
3. Unexplained salaries variance (~$170k)
4. Overstatement of GMCB bill back (~$160k)
5. Increasing occupancy and supply costs despite shift to remote working
6. DSR Funding

Staff Recommendation: OneCare's Administrative Expenses

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In light of the financial challenges facing Vermonters and the cost saving measures that businesses, schools, and state and local governments are implementing (such as furloughs and wage freezes) in response to the ongoing pandemic, staff recommends the following:

RECOMMENDATION: Level fund 2021 administrative budget to 2019 actuals (~ **$15.4 million***) with a commensurate reduction to hospital dues or reallocation to population health.

*The 2019 actuals submitted to GMCB on October 1, 2020 note a net income of $3,076,425, which is $1,612,748 less than the net income per the response received on December 4, 2020.

Return on OneCare's Administrative Expenses

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FY20 Budget Order Condition #20: 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.

- GMCB Analytics Team working on two projects
  - Project #1: Changes to Provider Outcomes
    - "Does OneCare change provider outcomes?"
  - Project #2: Return on PHM Investment
    - "What is the return on investment (ROI) of OneCare's PHM investments?"

Budgeted Trend Rates & TCOC

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Setting financial targets is particularly challenging due to the ongoing pandemic, and while we don't anticipate any issues meeting the financial targets specified in the All-Payer Model Agreement, it is something that we will look into when we discuss the Medicare Benchmark in the coming weeks.

OneCare's Quality Performance

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	PY1 (2018)	PY2 (2019)	PY3 (2020)	PY4 (2021)	PY5 (2022)
Medicare	100% (reporting only)	91.8%			
Medicaid	85%	95%			
BCBSVT	86%	81%			

Measure	Vermont All-Payer ACO Model	2020 Vermont Medicaid	2020 Medicare Initiative	2020 BCBSVT	2020 MVP
% of adults with a usual primary care provider	X				
Statewide prevalence of Chronic Obstructive Pulmonary Disease	X				
Statewide prevalence of Hypertension	X				
Statewide prevalence of Diabetes	X				
% of Medicaid adolescents with well-care visits	X	X		X	X
Initiation of alcohol and other drug dependence treatment	**X**	**X**	**X**	**X**	**X**
Engagement of alcohol and other drug dependence treatment	**X**	**X**	**X**		
30-day follow-up after discharge from emergency department for mental health	**X**	**X**	**X**	**X**	**X**
30-day follow-up after discharge from emergency department for alcohol or other drug dependence	**X**	**X**	**X**	**X**	**X**
% of Vermont residents receiving appropriate asthma medication management	X				
Screening for clinical depression and follow-up plan (ACO-18)	X	X	X	X	
Tobacco use assessment and cessation intervention (ACO-17)	X	X	X		
Deaths related to suicide	X				
Deaths related to drug overdose	X				
% of Medicaid enrollees aligned with ACO	X				
# per 10,000 population ages 18-64 receiving medication assisted treatment for opioid dependence	X				
Rate of growth in mental health or substance abuse-related emergency department visits	X				
# of queries of Vermont Prescription Monitoring System by Vermont providers (or their delegates) divided by # of patients for whom a prescriber writes prescription for opioids	X				
Hypertension: Controlling high blood pressure	**X**	**X**	**X**	**X**	**X**
Diabetes Mellitus: HbA1c poor control	**X**	**X**	**X**	**X**	**X**
All-Cause unplanned admissions for patients with multiple chronic conditions	X	X	X		
Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient experience surveys	X	X	X	X	X
ACO all-cause readmissions (HEDIS measure for commercial plans)				X	X
Risk-standardized, all-condition readmission (ACO-8)			X		
Influenza immunization (ACO-14)			X		
Colorectal cancer screening (ACO-19)			X		
Developmental screening in the first 3 years of life		X		X	
Follow-up after hospitalization for mental Illness (7-Day Rate)		X		X	X

Looking Ahead

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- Payer crosswalk will be updated to reflect 2021 when payer contracts are finalized
- Reporting Considerations
  - 2020 Medicare will be pay-for-reporting & CMS Final Rule removed CAHPS requirement
  - Utilization is down – small n; will need to consider alternative measurements
- Upcoming quality reporting/work
  - ACO vs. Non-ACO provider analysis
  - Analysis on "stayers" and quality results over time
  - ACO impact on APM measures outside of payer contracts

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Regulatory Integration: ACO Oversight & All Payer Model

ACO Oversight & APM

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GMCB Staff have been working to identify opportunities to drive APM results through ACO Oversight

1. Identify and incorporate concept of ACO Core Competencies & Key Performance Indicators (KPIs) into the ACO Oversight process

RECOMMENDATION: OCV to submit strategic plan to GMCB.

AHS's APM Implementation Improvement Plan (IIP)

1. GMCB Staff analyzed recommendations and identified intersections with ongoing and future potential work

ACO Budget x APM IIP

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APM Improvement Activity	Intersection w/ ACO 2021 Proposed Budget
#2: Reduce Medicare risk corridor thresholds and decrease the financial burden of participation for hospitals.	Reduced risk reflected in ACO's proposed 2021 Budget.
#5: Ensure Medicare 2021 benchmark provides as much stability and predictability as possible to produce financial targets that are adequate and achievable despite the ongoing uncertainty associated with the pandemic.	Underway as part of standard benchmark process with presentation to the Board scheduled for December 16th.
#7: AHS and the Agency of Administration will conduct education and outreach to non-participating self-funded groups about the benefits of participating in value-based payment models and Include State Employee Health Plan members for attribution to OneCare Vermont in 2021 (PY4).	To the extent that the ACO is involved in these efforts, it should be reflected in the existing annual requirement of the ACO to submit details of its scale strategy to the Board. In FY 2020 Budget order the Board asked the ACO to present a one-pager on the benefits of their self-funded programs.

ACO Budget x APM IIP

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APM Improvement Activity	Intersection w/ ACO 2021 Proposed Budget
#8: Prioritize increasing the percentage of fixed prospective payments in the VMNG/OneCare Vermont contract. The GMCB and AHS will request that BCBSVT, MVP, and OneCare Vermont identify clear milestones for including fixed prospective payments in contract model design.	**Recommendation**: ACO to describe its value-based payment strategy, in which it would answer the fundamental question: How are you working with payers and your provider network to increase value-based and fixed prospective payments? Please identify clear milestones and goals for contract design over the next three years.
#9: Under authorities over both ACO and Hospital budgets, the GMCB should explore how ACO participants can move incrementally towards value-based incentives with the providers they employ.	

ACO Budget x APM IIP

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APM Improvement Activity	Intersection w/ ACO 2021 Proposed Budget
#10: Annually, in its budget presentation to the Green Mountain Care Board, OneCare Vermont should identify cost growth drivers across its network and detail its approaches to curb spending growth and improve quality. OneCare should communicate its strategic objectives, plan of action, and how it will monitor progress.	This proposal aligns with many of the fundamental questions and reporting mechanisms already inherent in ACO budget guidance. Staff will clarify related requirements set forth in the 2022 ACO budget guidance as well as the new ACO Reporting Manual to ensure a robust understanding of drivers and strategies employed by the ACO to address cost and quality.
#12: Partner with OneCare Vermont and delivery system users to evaluate efficacy of Care Navigator platform.	**Recommendation**: OneCare to report on outcomes of this coordinated evaluation with AHS and to provide GMCB staff with a demo of tools.
#13: OneCare Vermont should elevate data as value-added product for its network participants and support providers in leveraging the information for change.	**Recommendation**: OneCare to report to the GMCB on efforts related to such evaluations and provide GMCB staff with a demo of data and analytics available to its network participants. Consistent with questions raised by Board member Holmes during OCV's budget hearing on October 28th related to evaluation/feedback-seeking behavior of ACO on provider user experience of data and tools.

ACO Budget x APM IIP

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APM Improvement Activity	Intersection w/ ACO 2021 Proposed Budget
#15: AHS, OneCare Vermont, and community providers should improve collaboration to strengthen integrated primary, specialty, and community-based care models for people with complex medical needs and medical and social needs. Organize VCCI and Blueprint for Health in Office of Health Reform in Secretary's Office.	This will impact Policy 5.206 C02-04 through C02-07 and is related to Board conversation during OCV's 2021 budget hearing on the sufficiency of support across the system for provider transformation. **Recommendation:** OneCare to work with AHS and community providers to document revisioned roles and responsibilities.

Next Steps

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1. Board discussion December 9th
2. Public comment accepted through December 21st for consideration
3. Follow up, if needed, from December 9th
4. Potential Board vote on OneCare Vermont's FY21 Budget and Medicare Benchmark scheduled for December 23rd
5. GMCB will post Medicaid Advisory Rate Case and 2021 Medicare contract once publicly available
6. GMCB to produce FY 2021 Budget Order
7. GMCB staff to update ACO monitoring plan and work with ACO to develop Reporting Manual
8. OneCare Vermont to provide final payer contracts, final attribution, revised budget and present to the Board by TBD spring 2021

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Resource Slides

18 V.S.A. § 9382

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

(A) information regarding utilization of the health care services delivered by health care providers participating in the ACO and the effects of care models on appropriate utilization, including the provision of innovative services;

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

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

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

18 V.S.A. § 9382

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(E) any reports from professional review organizations;

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

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

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

18 V.S.A. § 9382

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

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

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

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

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

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

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

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