VERMONT
GREEN MOUNTAIN CARE BOARD

ACO Oversight
FY 2022 Budget and Certification
OneCare Vermont

Staff Analysis and Preliminary Recommendations

December 8, 2021

CONFIDENTIAL INFORMATION HAS BEEN REDACTED

Acronym List

VERMONT
GREEN MOUNTAIN CARE BOARD

- ACO—Accountable Care Organization
- AHS—Vermont Agency of Human Services
- AIPBP—All-Inclusive Population-Based Payment
- APM—All-Payer Model
- BCBSVT—Blue Cross Blue Shield of Vermont
- 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
- FY – Fiscal Year
- GAAP (or US GAAP) – Generally Accepted Accounting Principles in the United States
- GMCB—Green Mountain Care Board
- HCA—Health Care Advocate
- HCP-LAN—Health Care Payment Learning and Action Network
- HSA—Health Service Area
- IIP—APM Implementation Improvement Plan (AHS)
- I/S—Income Statement
- OCV—OneCare Vermont
- QHP—Qualified Health Plan
- OpEx—Operating Expenses
- PCMH—Patient-Centered Medical Home
- PCP—Primary Care Provider
- PHM—Population Health Management
- PMPM—Per-Member Per-Month
- PMPY—Per-Member Per-Year
- PY—Performance Year
- SNF—Skilled Nursing Facility
- SS/SL—Shared Savings/Shared Losses
- TCOC—Total Cost of Care

Agenda

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- Introduction and Background
  - Public Comment Received to Date
- FY 2022 Staff Analysis
- Summary of FY 2022 Recommendations
- Next Steps
- Board Questions and Discussion
- Public Comment

FY 2022 Key Areas of Review

- ACO Certification
- ACO Budget & Financials
- Total Cost of Care (TCOC) & Trend Rates
- Payer Programs & Risk Model
- Payment Models & FPP
- Population Health, Quality, Model of Care
- Results to Date
- GMCB Regulatory Levers to Foster a High Performing Health System

ACO Oversight Statute/Rule

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

OCV Budget and Certification Review Timeline FY 2022

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Jul 1, 2021	GMCB issues FY22 OCV ACO oversight guidance
Sept 1, 2021	OCV submits certification materials
Oct 1, 2021	OCV submits FY22 budget
Nov 10, 2021	OCV FY22 Budget Hearing
Dec 8, 2021	**GMCB staff analysis presentation – OCV FY22 Certification and Budget**
By Dec 31, 2021	Board vote on OCV FY22 budget (tentatively planned for December 22)
December 2021	Medicare Benchmark and Medicaid Advisory Rate Case
Jan/Feb 2022	GMCB issues OCV FY22 budget order
Spring 2022	GMCB review of final OCV FY22 attribution, budget, contracts
Spring 2022	Development of FY23 budget guidance and certification form
Ongoing 2022	GMCB monitors OCV FY22 actuals/performance against budget and conditions

Public Comment
Themes

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- Value of OneCare's data and analytics to providers, especially for population level insights and prevention initiatives
- Value of care coordination investments enabled by OCV funding
- Concerns related to decreased population health management and mission-related investments
- Concerns related to OneCare's leadership compensation

In total, 43 comments were received as of 12/7.*

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

Public Comment
Themes

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From the Health Care Advocate

- **Population health**: Concern about the cuts to PHM program funding and deprioritizing program evaluation (only 0.5 FTE dedicated to evaluation).
  - *"OCV's PHM strategy should be based on a clear accounting of costs and an evaluation of savings and quality outcomes stemming from each investment."*
- **Transparency**: Concern about OneCare's commitment to transparency, citing failure to provide direct and complete answers to written questions.
- **Evaluation**: HCA highlights major conclusions of the NORC evaluation, including the need for further transparency and PHM investment.
- **Cost Estimation for Vermonters**: OneCare is working to stabilize payments for providers. Along the same lines, OneCare should work with stakeholders to find ways to provide more predictable out-of-pocket cost estimates for Vermont consumers.

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STAFF ANALYSIS FY 2022

High-Level Overview

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- Provider Network
- Payer Programs
- Income Statement
- Impact of COVID-19
- Approach to FY2022 Staff Recommendations

High-Level Overview
Provider Network

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Minimal changes between 2021 and 2022, typically due to mergers, acquisitions and retirements.

- **14 Hospitals** (no change)
- **9 FQHCs** (no change)
- **25 Independent Primary Care** (2 returning, 2 terminations)
  - 13 in CPR Program (2 joined)
- **5 Naturopaths** (1 retirement)
- **24 Specialists** (2 terminations, 3 joined)
- **47 Continuum** (1 termination, 1 joined)
  - Including SNF, Home Health and Hospice, Designated Agencies, Special Services Agencies, Ambulatory Surgery Centers

Approximately **90% of Vermont primary care providers** participate in OCV: of 3,796 providers eligible to attribute patients to the model, 3,398 are in OneCare's network.

See PY3 APM Scale and Alignment Report (June 2021)

High-Level Overview
Payer Programs

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Payer Program	Participation by HSA /VT Hospital	Anticipated Scale for FY22
Medicare	9 HSAs / 8 VT Hospitals	62,707
Medicaid	14 HSAs / 13 VT Hospitals	126,291
BCBSVT QHP	13 HSAs / 12 VT Hospitals	22,212
BCBSVT Primary	13 HSAs / 12 VT Hospitals	*Risk*: 45,018
		Non-Risk: 31,004*
MVP	13 HSAs / 12 VT Hospitals	10,692
All Payer Programs		**266,920 (Scale only)** **297,924 (including non-Scale*)**

*BCBSVT Primary Non-Risk group does not meet criteria for a scale-qualifying ACO initiative under the APM Agreement (see slides 86-88).

High-Level Overview
Summary Income Statement

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Summary Income Statement – Full Accountability Budget (non-GAAP)	
Budgeted FY2022 Revenue	$1,365,345,843
Budgeted FY2022 Expenses	$1,365,345,843
Budgeted FY2022 Net Income	$0

Summary Income Statement – OCV Entity-Level Budget (GAAP)	
Budgeted FY2022 Revenue	$27,294,211
Budgeted FY2022 Expenses	$27,294,211
Budgeted FY2022 Net Income	$0

High-Level Overview
Impact of COVID-19

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

- Silver lining: COVID-19 has laid bare the challenges of FFS payment; fixed payments can be critical for stabilizing health care providers in times of great uncertainty.

High-Level Overview
Approach to FY22 Recommendations

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- The FY2022 staff recommendations for budget order conditions reflect a focus on data-driven monitoring and oversight.
  - Focus on ensuring that the ACO's management drives continuous improvement consistent with a high-performing ACO and that it supports achieving the state's health reform goals, rather than GMCB as a regulator managing the ACO through conditions
  - Reduce administrative burden for regulated entity by simplifying reporting
  - Less GMCB focus on granular budget line items, more focus on results

High-Level Overview
Approach to FY22 Recommendations

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- Core recommendation is to require OneCare to measure their performance against a group of peer ACOs and report this information to the GMCB
  - Opportunity to learn from high-performing peers and implement national best practices
  - Measures to focus on utilization, cost, patient satisfaction/engagement, quality, and evidence-based clinical appropriateness

- This approach, if approved by the Board, would be reflected in updated ACO Reporting Manual and FY2023 OneCare Vermont ACO Budget Guidance

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KEY AREAS OF REVIEW FY 2022

Certification

Operating Agreement & Governance Changes

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- Dartmouth-Hitchcock Health withdrew their membership interest from OneCare Vermont; UVM Medical Center transferred the sole remaining membership interest to UVM Health Network.
- The OCV Operating Agreement has been updated to the 9th version; the primary updates are surrounding the above transition in membership, including the areas of Board of Manager composition and dispute resolution.

Certification

Operating Agreement & Governance Changes

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- The 3 seats on the Board of Managers formerly from D-HH are now:
  - An At-Large member
  - An academic medical center in NH serving Vermonters
  - An academic medical center in VT serving Vermonters
- 3 of 21 seats appointed by UVM Health Network
  - Chair must be an appointed member
- Membership change and accompanying Operating Agreement changes do not violate certification requirements of 18 V.S.A. § 9382(a) or GMCB Rule 5.200.

Certification
Executive Compensation

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- Board issued guidance regarding Rule 5.000, § 5.203(a) on May 12, 2021.
- An ACO must structure its executive compensation to achieve specific and measurable goals that support the ACO's efforts to reduce cost growth or improve the quality and overall care of Enrollees, or both.
- OCV responded to a question issued following FY2021 certification process explaining their compensation benchmarking procedures.
- Staff are gathering information to confirm OCV's compliance with executive compensation guidance separate from the ACO budget and certification process.

Certification
Follow up

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- Population Health Management & Care Coordination: 5.206(g)(i)(k)
- Performance Evaluation and Improvement: 5.207(b)
- Executive Compensation: 5.203(a)
- Policies and documents

Certification
Next Steps

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RECOMMENDATION: No necessary GMCB action on certification at this time.

- *Note: Does not require a vote to re-certify.*

ACO Budget & Financials

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

ACO Budget & Financials
Funds Flow

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

*OCV presented a FY22 budget of $44.2 million. This is an amalgamation of the entity-level budget plus Medicaid NextGen-Added (TCOC) and confidential contract revenues as well as full responsibility for Medicaid Admin (Trad. & Exp.) revenues. These are offset by PHM/PMT Reform Program and Operating Expenses.

ACO Budget & Financials

Full Accountability (Non-GAAP) Summary Income Statement

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Full Accountability (Non-GAAP)	**2018 Actual**	**2019 Actual**	**2020 Actual**	**2021 Revised**	***2021 Projection****	**2022 Budget**
Expected Total Cost of Care Target (External)	605,433,215	294,018,591	677,948,979	792,975,361	*766,163,732*	884,356,005
Fixed Prospective Payment/Funded CPR	-	346,341,673	402,406,905	407,254,322	*403,900,213*	445,882,154
Other Contract Revenue	7,826,298	13,090,261	15,155,666	10,748,878	*10,704,617*	7,371,394
Participation Fees	17,397,929	25,842,028	15,273,570	18,917,509	*16,595,361*	19,231,028
Administrative Revenue	3,086,492	5,395,629	7,432,261	7,428,852	*7,560,687*	7,978,014
Consulting Revenue	309,407	355,289	193,289	18,000	*18,000*	-
Other Revenues (incl. Settlement)	1,393,945	777,624	288,816	115,000	*14,186,141*	527,247
Total Revenues	635,447,286	685,821,095	1,118,699,486	1,237,457,922	*1,219,128,751*	1,365,345,843
Expected Health Care Spend (External)	360,265,990	289,261,914	669,547,321	784,208,228	*761,927,779*	875,282,023
Fixed Prospective Payments	237,390,466	346,341,673	402,406,905	407,254,322	*403,900,213*	445,882,154
Population Health Management (incl. Settlement)	23,082,601	30,186,885	32,700,998	30,089,714	*37,439,346*	28,894,128
Operational Expenses	13,739,102	15,341,451	14,044,262	15,905,658	*13,464,440*	15,287,538
Total Expenses	634,478,160	681,131,922	1,118,699,486	1,237,457,922	*1,216,731,778*	1,365,345,843
Net Income	969,127	4,689,173	(0)	-	*2,396,973*	-
Administrative Ratio	**2.16%**	**2.24%**	**1.26%**	**1.29%**	***1.10%***	**1.12%**
PHM Ratio with Blueprint	**3.56%**	**4.30%**	**2.92%**	**2.43%**	***3.07%***	**2.12%**
PHM Ratio without Blueprint	**2.34%**	**3.60%**	**2.17%**	**1.72%**	***2.35%***	**1.45%**
Operating Margin	**0.15%**	**0.68%**	**0.00%**	**0.00%**	***0.20%***	**0.00%**
Total Margin	**0.15%**	**0.68%**	**0.00%**	**0.00%**	***0.20%***	**0.00%**
FTEs - Fiscal Year (budgeted)	**46.05**	**49.15**	**60.00**	**61.37**	***N/A***	**61.40**

***Includes $14,071,141 in settlement revenue and $9,638,875 in settlement expense**

ACO Budget & Financials

OneCare's Budget Components: Full Accountability Revenue (2019-2022)

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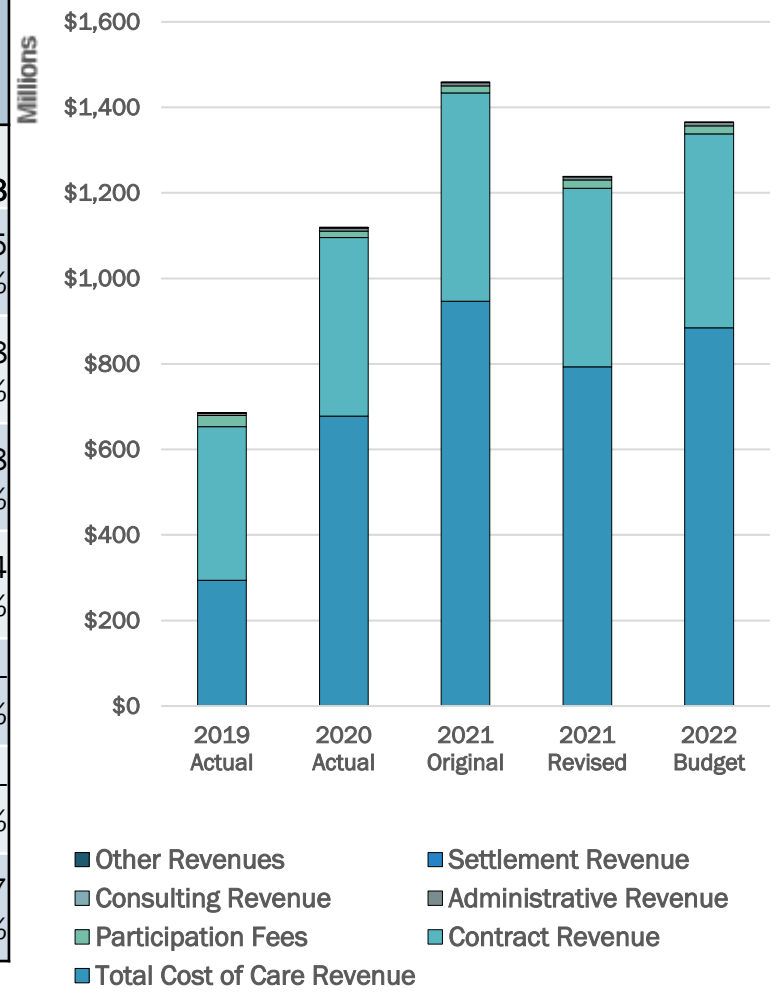
	FY19 Actual *% of Total*	FY20 Actual *% of Total*	FY21 Budget (Oct 1 - Approved) *% of Total*	FY21 Budget (May 24) *% of Total*	FY22 Budget *% of Total*
Total Revenue	**685,821,095**	**1,118,699,486**	**1,459,165,761**	**1,237,457,922**	**1,365,345,843**
Expected Total Cost of Care Revenue	294,018,591 *42.9%*	677,948,979 *60.6%*	946,683,974 *64.9%*	792,975,361 *64.1%*	884,356,005 *64.8%*
Contract Revenue	359,431,934 *52.4%*	417,562,571 *37.3%*	486,722,289 *33.4%*	418,003,200 *33.8%*	453,253,548 *33.2%*
Participation Fees	25,842,028 *3.8%*	15,273,570 *1.4%*	17,108,917 *1.2%*	18,917,509 *1.5%*	19,231,028 *1.4%*
Administrative Revenue	5,395,629 *0.8%*	7,432,261 *0.7%*	7,451,403 *0.5%*	7,428,852 *0.6%*	7,978,014 *0.6%*
Consulting Revenue	355,289 *0.1%*	193,289 *0.0%*	149,178 *0.0%*	18,000 *0.0%*	- *0.0%*
Settlement Revenue	415,240 *0.1%*	32,986 *0.0%*	- *0.0%*	- *0.0%*	- *0.0%*
Other Revenues	362,384 *0.1%*	255,830 *0.0%*	1,050,000 *0.1%*	115,000 *0.0%*	527,247 *0.0%*



Presentation slightly different due to template changes

ACO Budget & Financials

OneCare's Budget Components: Full Accountability Expenses

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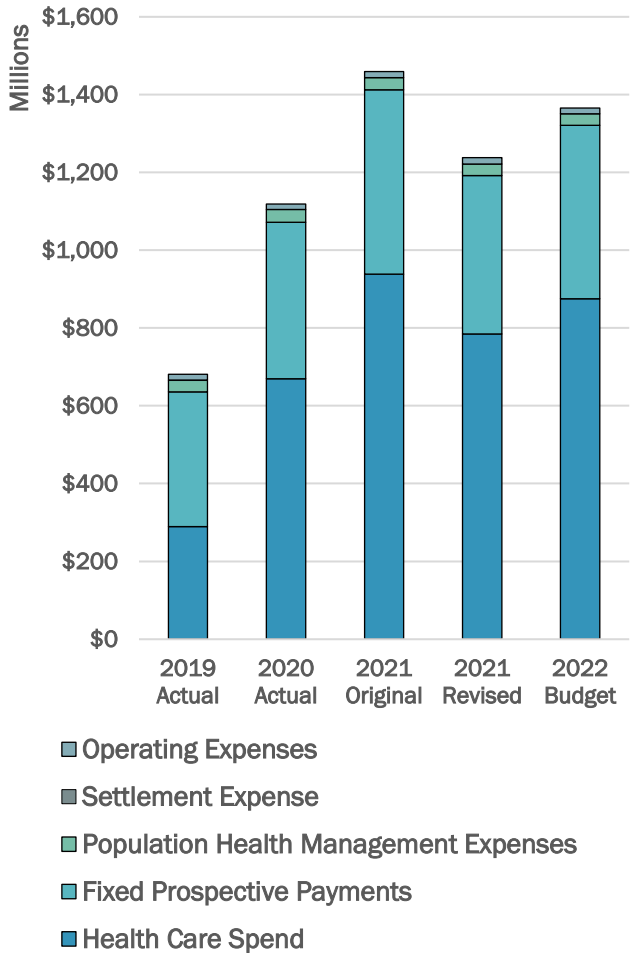
GREEN MOUNTAIN CARE BOARD

	FY19 Actual *% of Total*	FY20 Actual *% of Total*	FY21 Budget (Oct 1 - Approved) *% of Total*	FY21 Budget (May 24) *% of Total*	FY22 Budget *% of Total*
Total Expense	681,131,922	1,118,699,486	1,459,165,761	1,237,457,922	1,365,345,843
Health Care Spend	289,261,914 *42.5%*	669,547,321 *59.9%*	937,916,841 *64.3%*	784,208,228 *63.4%*	875,282,023 *64.1*
Fixed Prospective Payments	346,341,673 *50.8%*	402,406,905 *36.0%*	474,418,818 *32.5%*	407,254,322 *32.9%*	445,882,154 *32.7%*
Population Health Management Expenses	29,461,309 *4.3%*	32,700,998 *2.9%*	30,924,444 *2.1%*	30,089,714 *2.4%*	28,894,128 *2.1%*
Settlement Expense	725,576 *0.1%*	- *0.0%*	- *0.0%*	- *0.0%*	- *0.0%*
Operating Expenses	15,341,451 *2.3%*	14,044,262 *1.3%*	15,905,658 *1.1%*	15,905,658 *1.3%*	15,287,538 *1.1%*



ACO Budget & Financials

FY21 Revised – FY22 Budget Full Accountability (Non-GAAP)
Revenue Reconciliation

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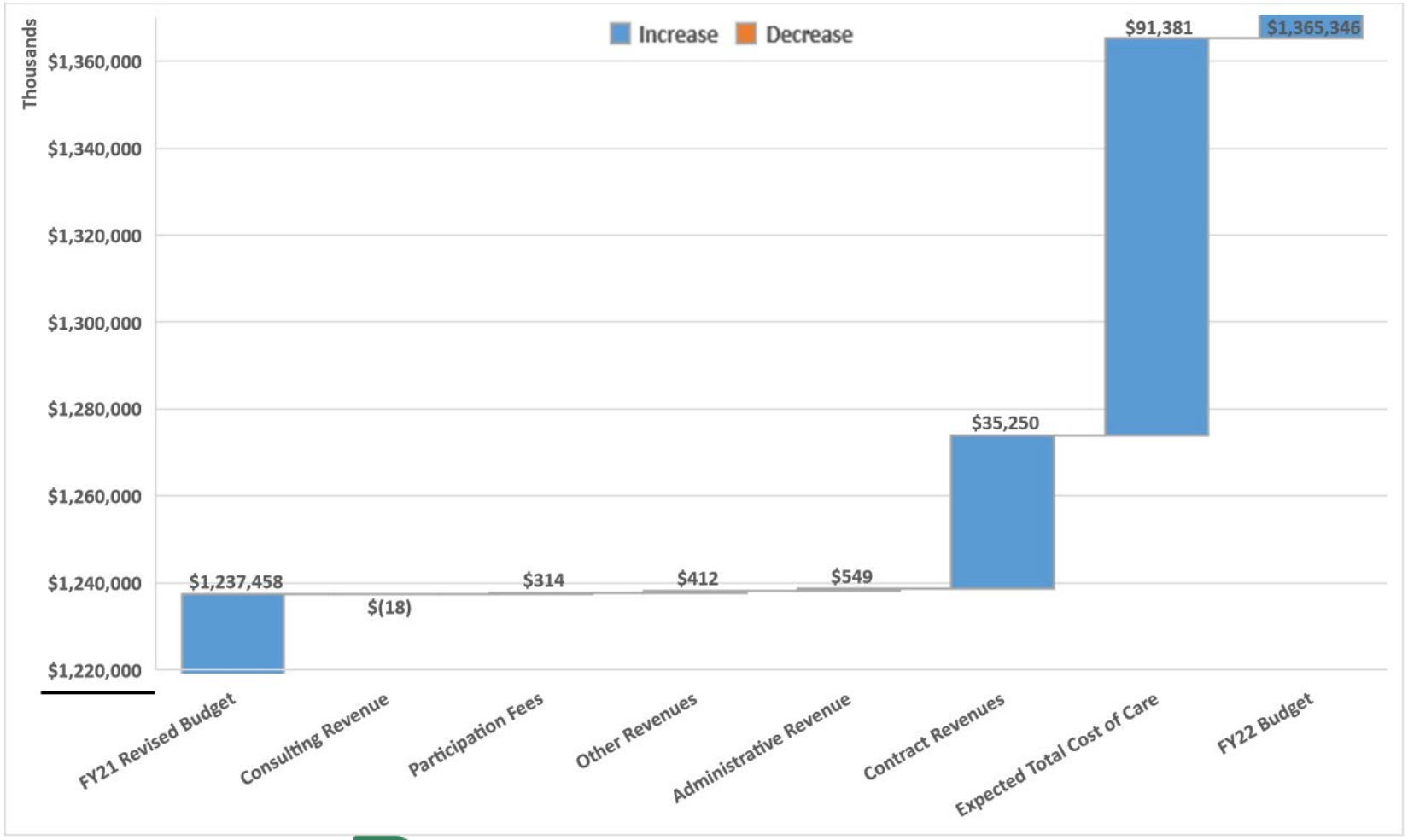

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FY21 Revised – FY22 Budget Full Accountability (Non-GAAP)
Expected TCOC Health Care Spend Recon.

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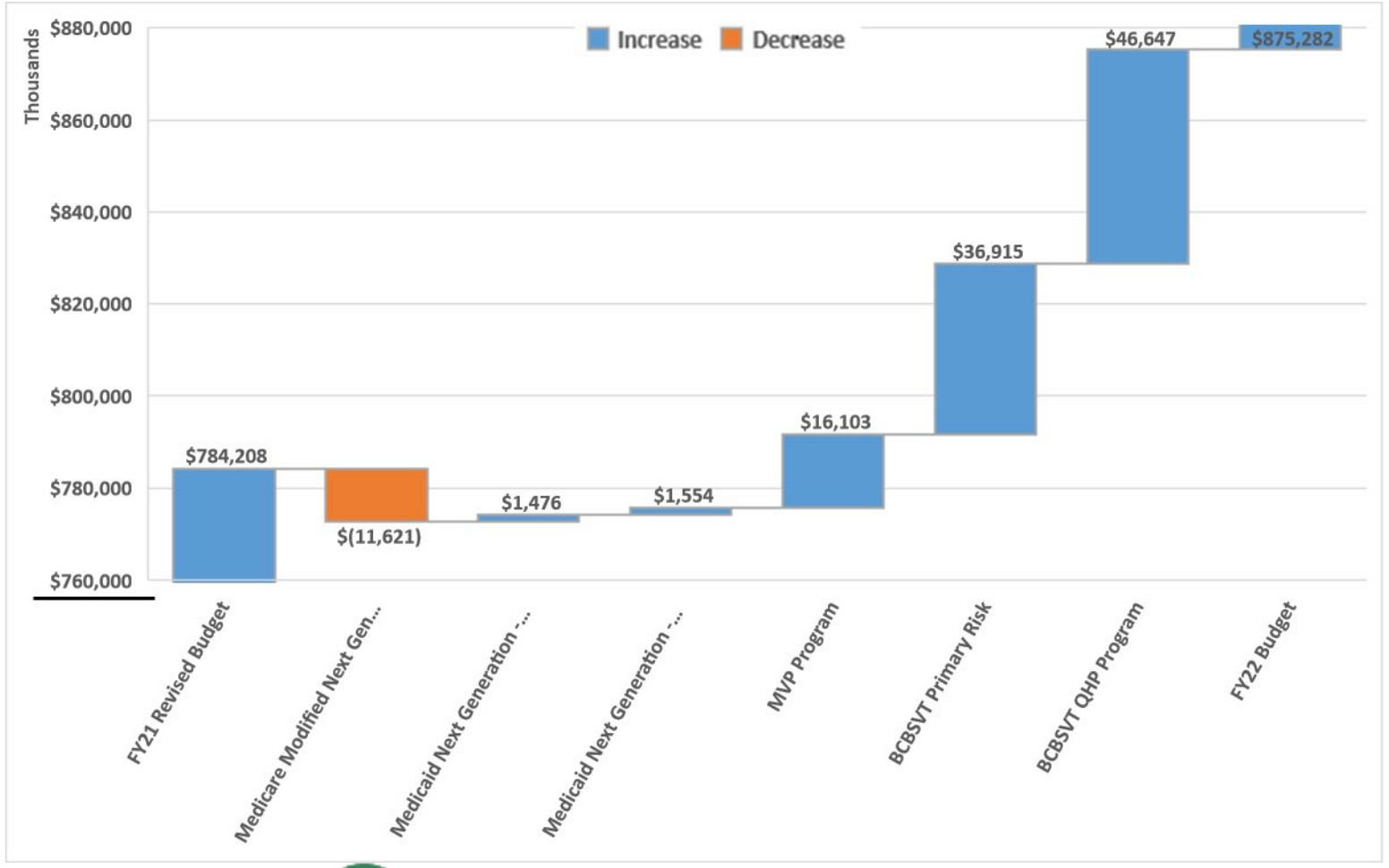

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FY21 Revised – FY22 Budget Full Accountability (Non-GAAP)
PHM/Payment Reform Expense Recon.

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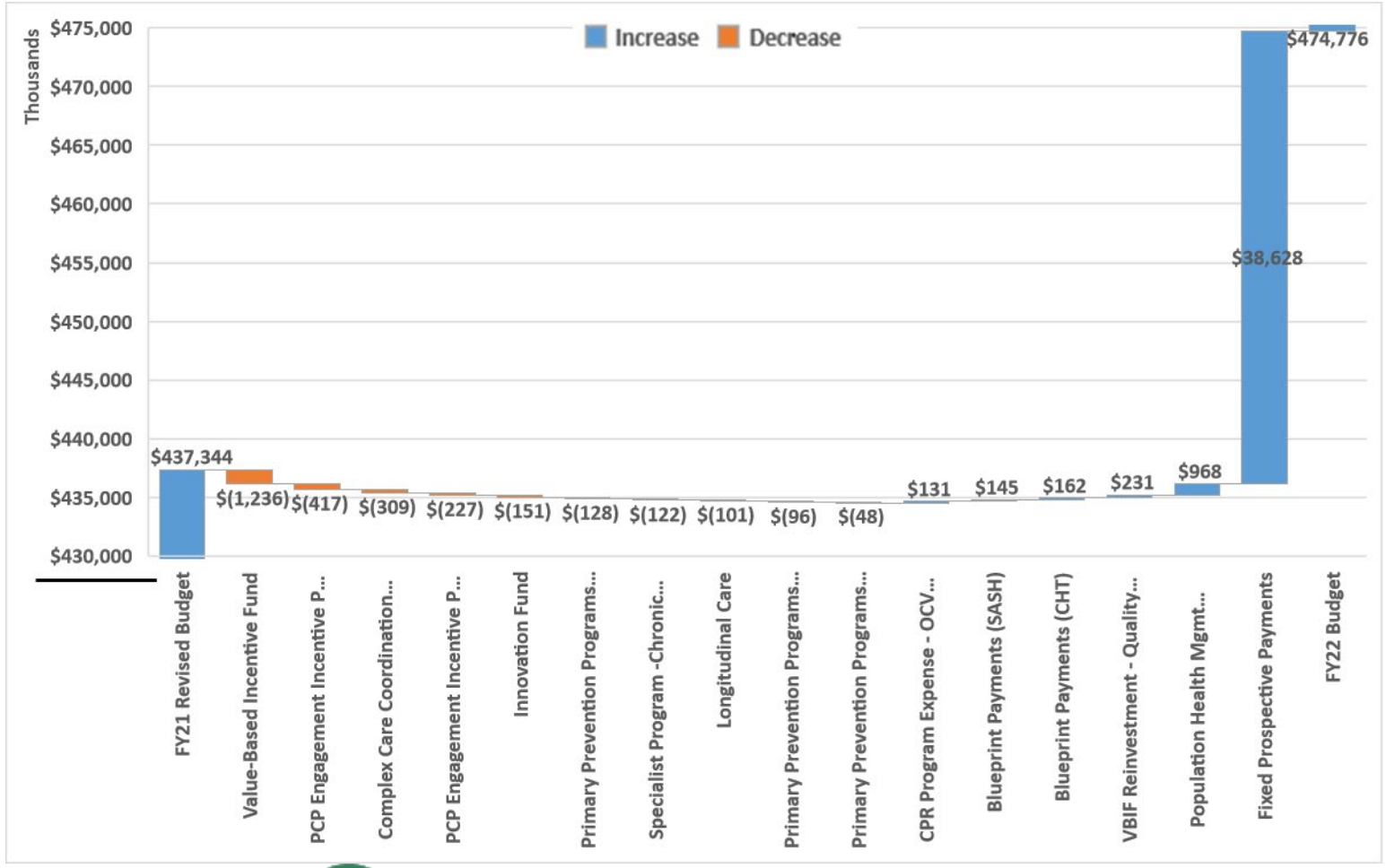

ACO Budget & Financials

FY21 Revised – FY22 Budget Full Accountability*

Operating Expenses Recon.

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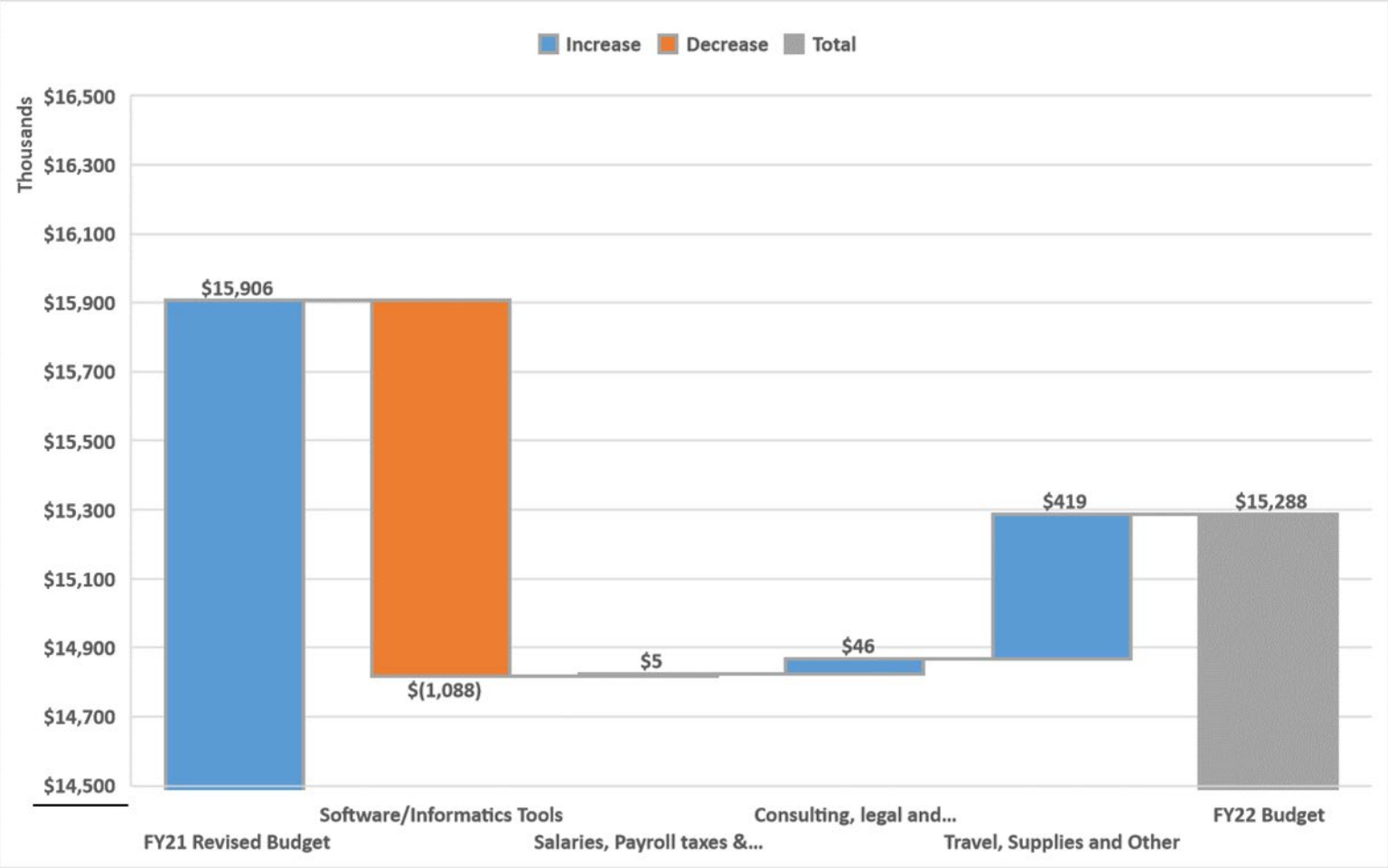

*Operating Expenses are at Entity Level/ GAAP Only

ACO Budget & Financials

Entity Level (GAAP) Summary Income Statement

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Entity Level (GAAP)	2018 Actual	2019 Actual	2020 Actual	2021 Revised/Projection	2022 Budget
Expected Total Cost of Care Target (External)	-	0	-	-	-
Fixed Prospective Payment/Funded CPR	-	-	-	-	-
Other Contract Revenue	3,771,184	10,771,692	11,194,712	7,254,110	3,360,439
Participation Fees	17,397,929	25,842,028	15,273,570	18,917,509	19,231,028
Administrative Revenue	1,543,246	2,697,815	3,897,306	3,893,058	4,175,496
Consulting Revenue	309,407	355,289	193,289	18,000	-
Other Revenues (incl. Settlement)	1,393,945	777,624	288,816	115,000	527,247
Total Revenues	24,415,710	40,444,448	30,847,693	30,197,677	27,294,211
Expected Health Care Spend (External)	-	-	-	-	-
Fixed Prospective Payments	-	-	-	-	-
Population Health Management (incl. Settlement)	9,711,238	20,413,825	16,803,432	14,292,018	12,006,673
Operational Expenses	13,735,346	15,341,450	14,044,262	15,905,658	15,287,538
Total Expenses	23,446,583	35,755,274	30,847,693	30,197,677	27,294,211
Net Income	969,127	4,689,173	(0)	-	-
Administrative Ratio	**56.26%**	**37.93%**	**45.53%**	**52.67%**	**56.01%**
PHM Ratio with Blueprint	**37.95%**	**48.68%**	**54.47%**	**47.33%**	**43.99%**
PHM Ratio without Blueprint	**37.92%**	**48.68%**	**54.47%**	**47.33%**	**43.99%**
Operating Margin	**3.97%**	**11.59%**	**0.00%**	**0.00%**	**0.00%**
Total Margin	**3.97%**	**11.59%**	**0.00%**	**0.00%**	**0.00%**
FTEs - Fiscal Year (budgeted)	**46.05**	**49.15**	**60.00**	**61.37**	**61.40**

ACO Budget & Financials

OneCare's Budget Components: Entity Level (GAAP) Revenue (2019-2022)

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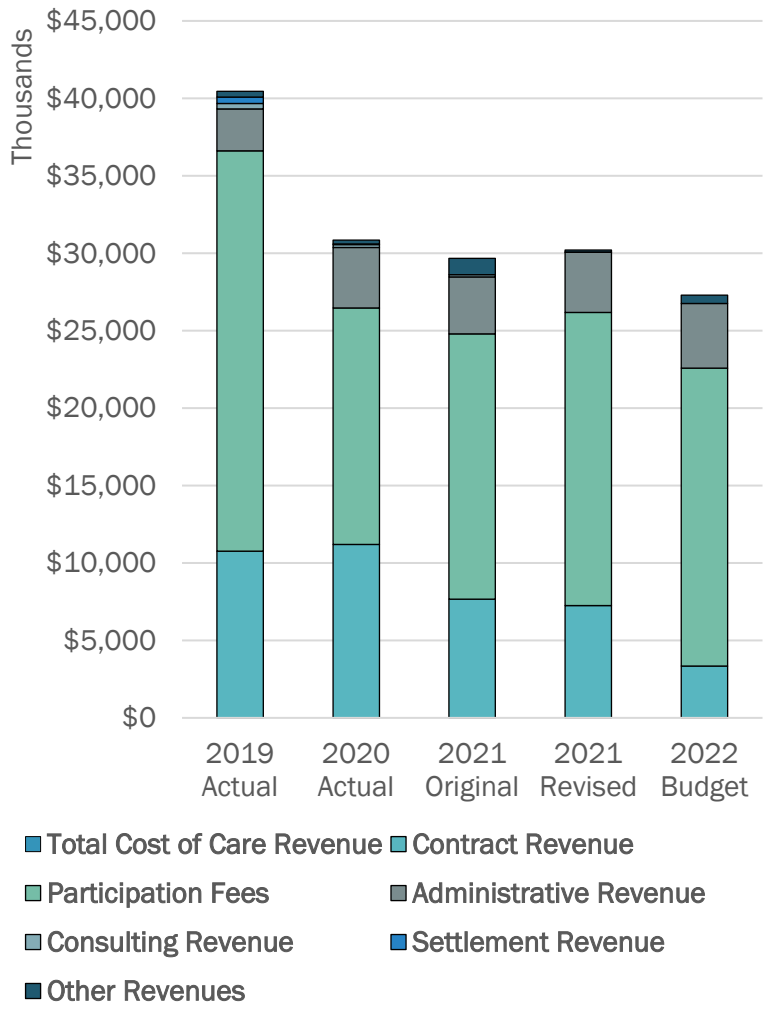
	FY19 Actual *% of Total*	FY20 Actual *% of Total*	FY21 Budget (Oct 1 - Approved) *% of Total*	FY21 Budget (May 24) *% of Total*	FY22 Budget *% of Total*
Total Revenue	**40,444,448**	**30,847,693**	**29,668,631**	**30,197,677**	**27,294,211**
Expected Total Cost of Care Revenue	- *0.0%*	- *0.0%*	- *0.0%*	- *0.0%*	- *0.0%*
Contract Revenue	10,771,692 *26.6%*	11,194,712 *36.3%*	7,680,835 *25.9%*	7,254,110 *24.0%*	3,360,439 *12.3%*
Participation Fees	25,842,028 *63.9%*	15,273,570 *49.5%*	17,108,917 *57.7%*	18,917,509 *62.6%*	19,231,028 *70.5%*
Administrative Revenue	2,697,815 *6.7%*	3,897,306 *12.6%*	3,679,701 *12.4%*	3,893,058 *12.9%*	4,175,496 *15.3%*
Consulting Revenue	355,289 *0.9%*	193,289 *0.6%*	149,178 *0.5%*	18,000 *0.1%*	- *0.0%*
Settlement Revenue	415,240 *1.0%*	32,986 *0.1%*	- *0.0%*	- *0.0%*	- *0.0%*
Other Revenues	362,384 0.9%	255,830 *0.8%*	1,050,000 *3.5%*	115,000 *0.4%*	527,247 *1.9%*



ACO Budget & Financials

OneCare's Budget Components: Entity Level (GAAP) Expenses

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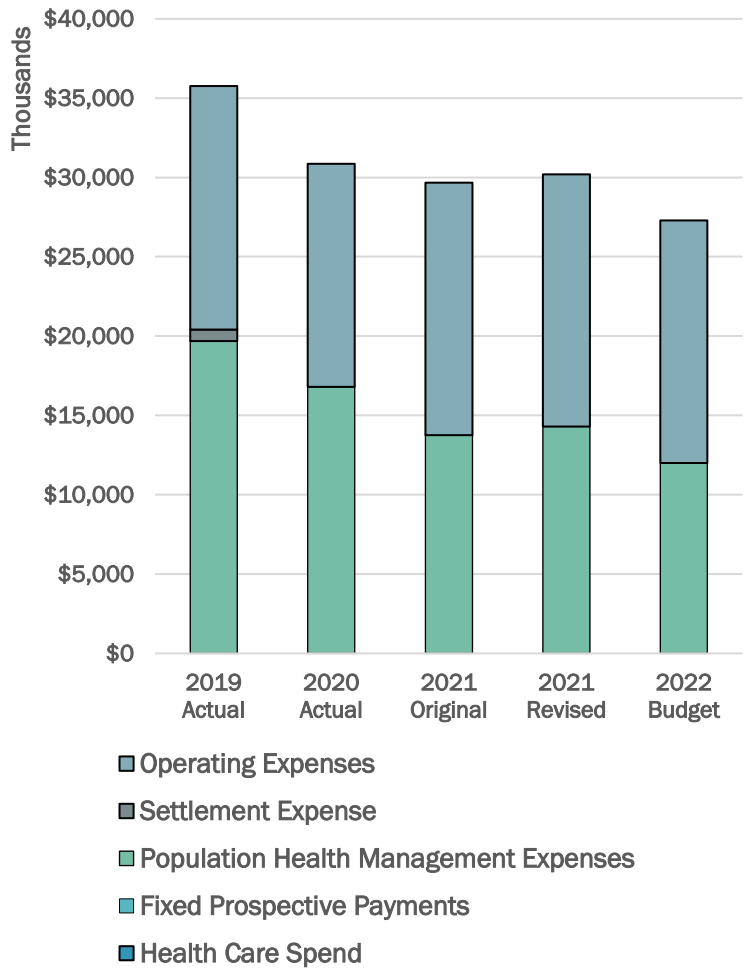
	FY19 Actuals *% of Total*	FY20 Actuals *% of Total*	FY21 Budget (Oct 1 - Approved) *% of Total*	FY21 Budget (May 24) *% of Total*	FY22 Budget *% of Total*
Total Expense	35,755,274	30,847,693	29,668,631	30,197,677	27,294,211
Health Care Spend	- *0.0%*	- *0.0%*	- *0.0%*	- *0.0%*	- *0.0%*
Fixed Prospective Payments	- *0.0%*	- *0.0%*	- *0.0%*	- *0.0%*	- *0.0%*
PHM Expenses	19,688,249 *55.1%*	16,803,432 *54.5%*	13,762,972 *46.4%*	14,292,018 *47.3%*	12,006,673 *44.0%*
Settlement Expense	725,576 *2.0%*	- *0.0%*	- *0.0%*	- *0.0%*	- *0.0%*
Operating Expenses	15,341,450 *42.9%*	14,044,262 *45.5%*	15,905,658 *53.6%*	15,905,658 *52.7%*	15,287,538 *56.0%*



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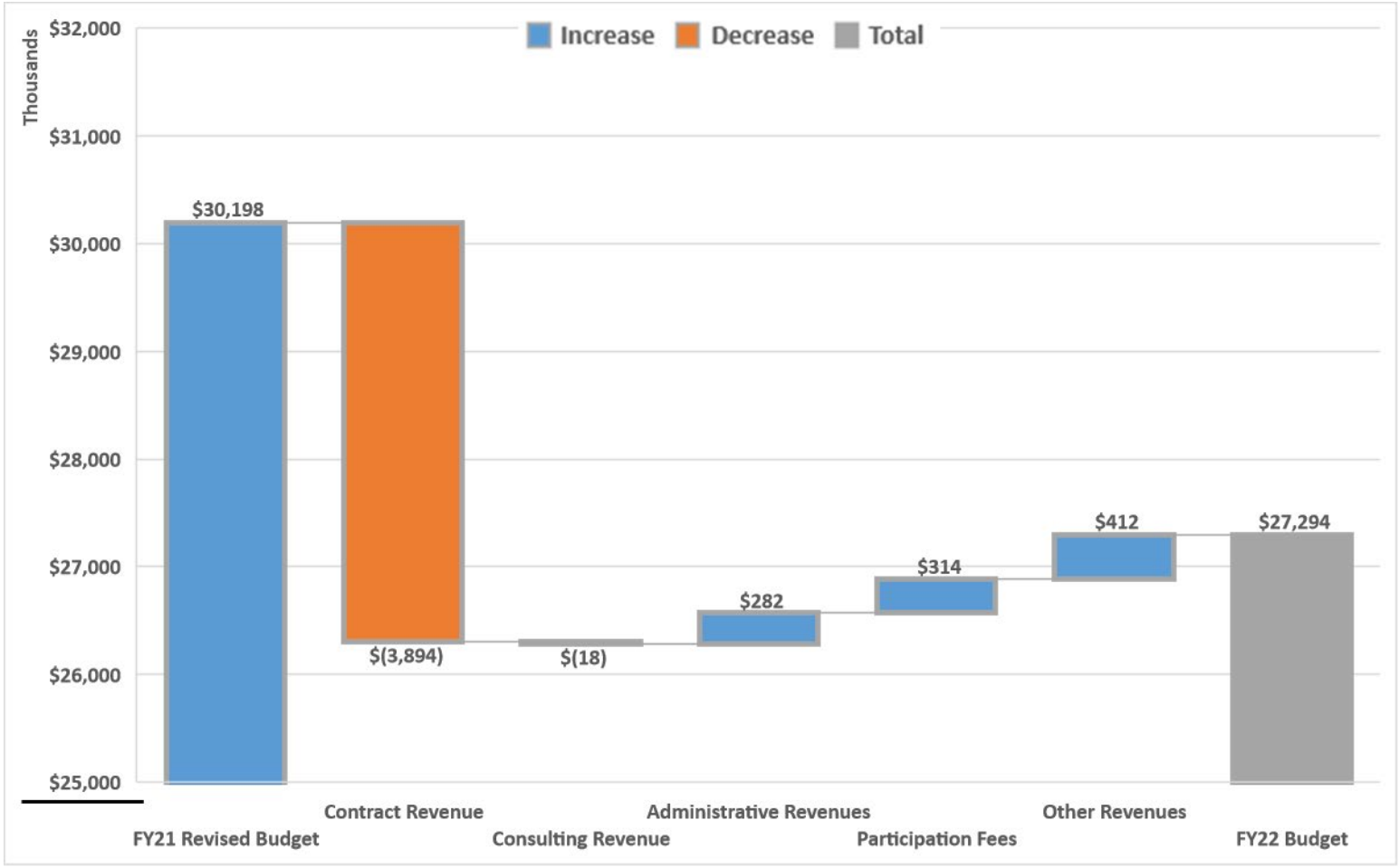
ACO Budget & Financials

FY21 Revised – FY22 Budget Entity Level (GAAP) Revenue Reconciliation

VERMONT
GREEN MOUNTAIN CARE BOARD



ACO Budget & Financials

FY21 Revised – FY22 Budget Entity Level (GAAP)

PHM/Payment Reform Expense Reconciliation

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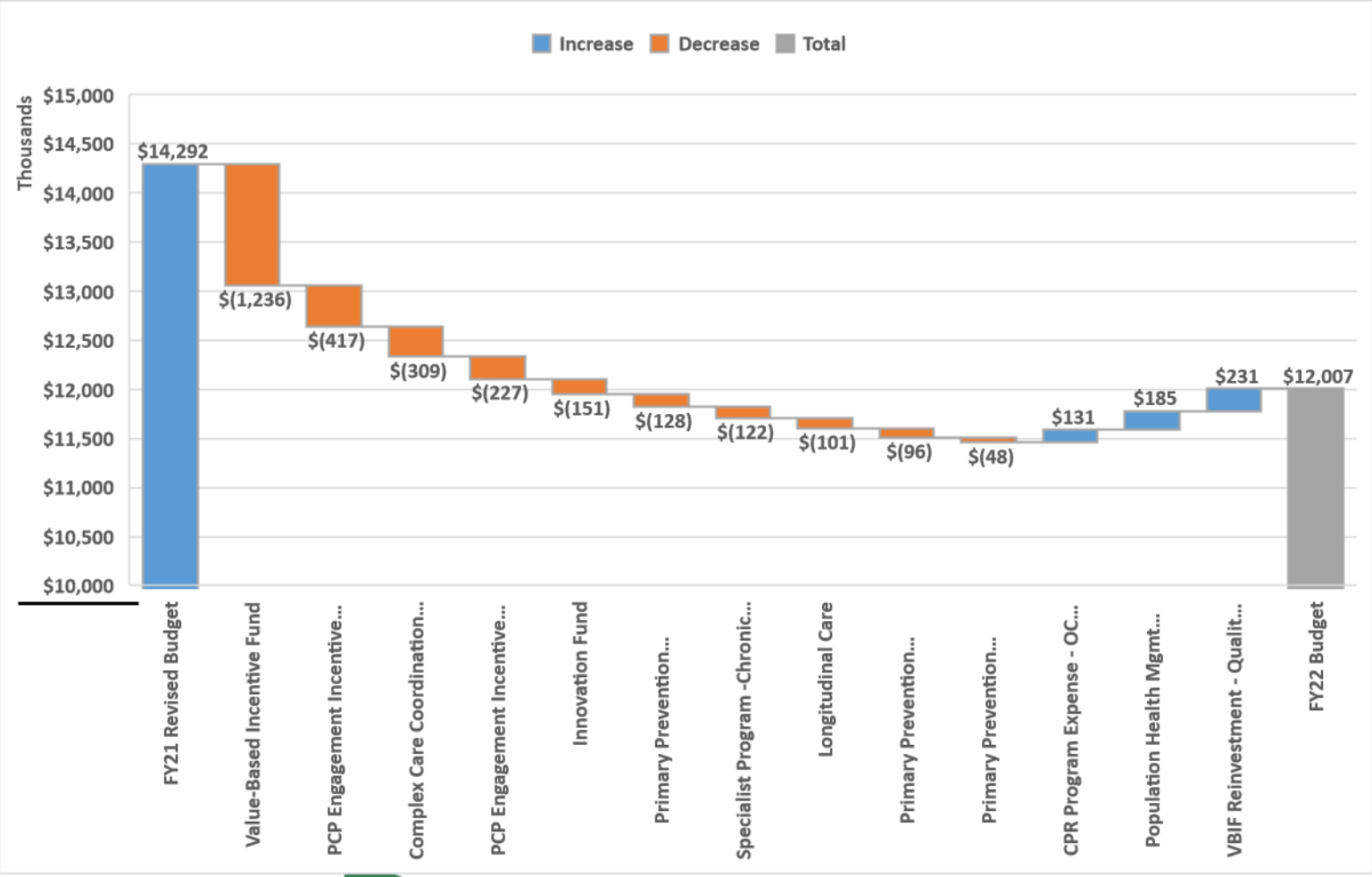

ACO Budget & Financials

FY21 Revised – FY22 Budget Entity Level (GAAP)

Operating Expenses Reconciliation

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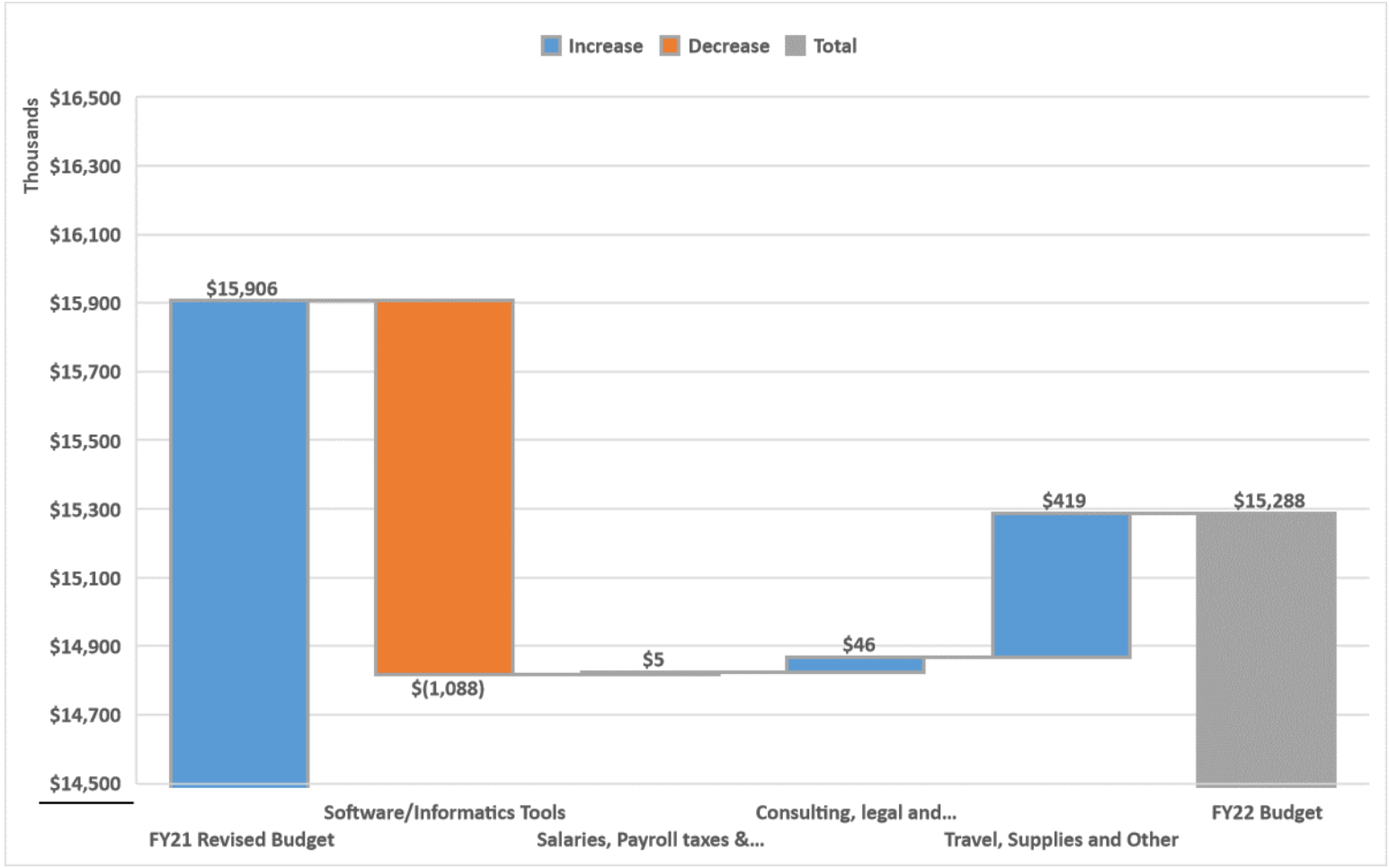

ACO Budget & Financials

Operating Expense Concentrations year-over-year as % of Total

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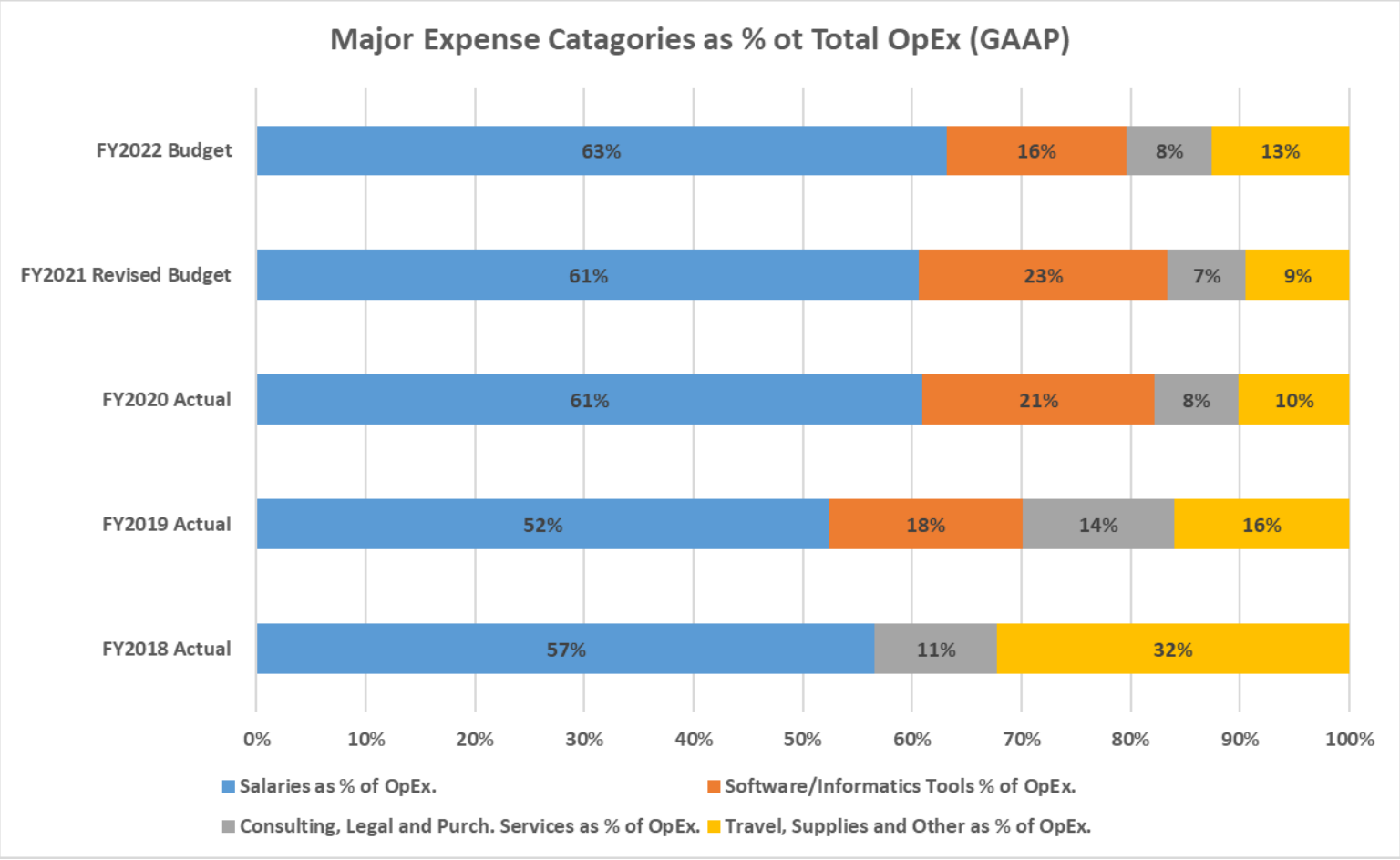
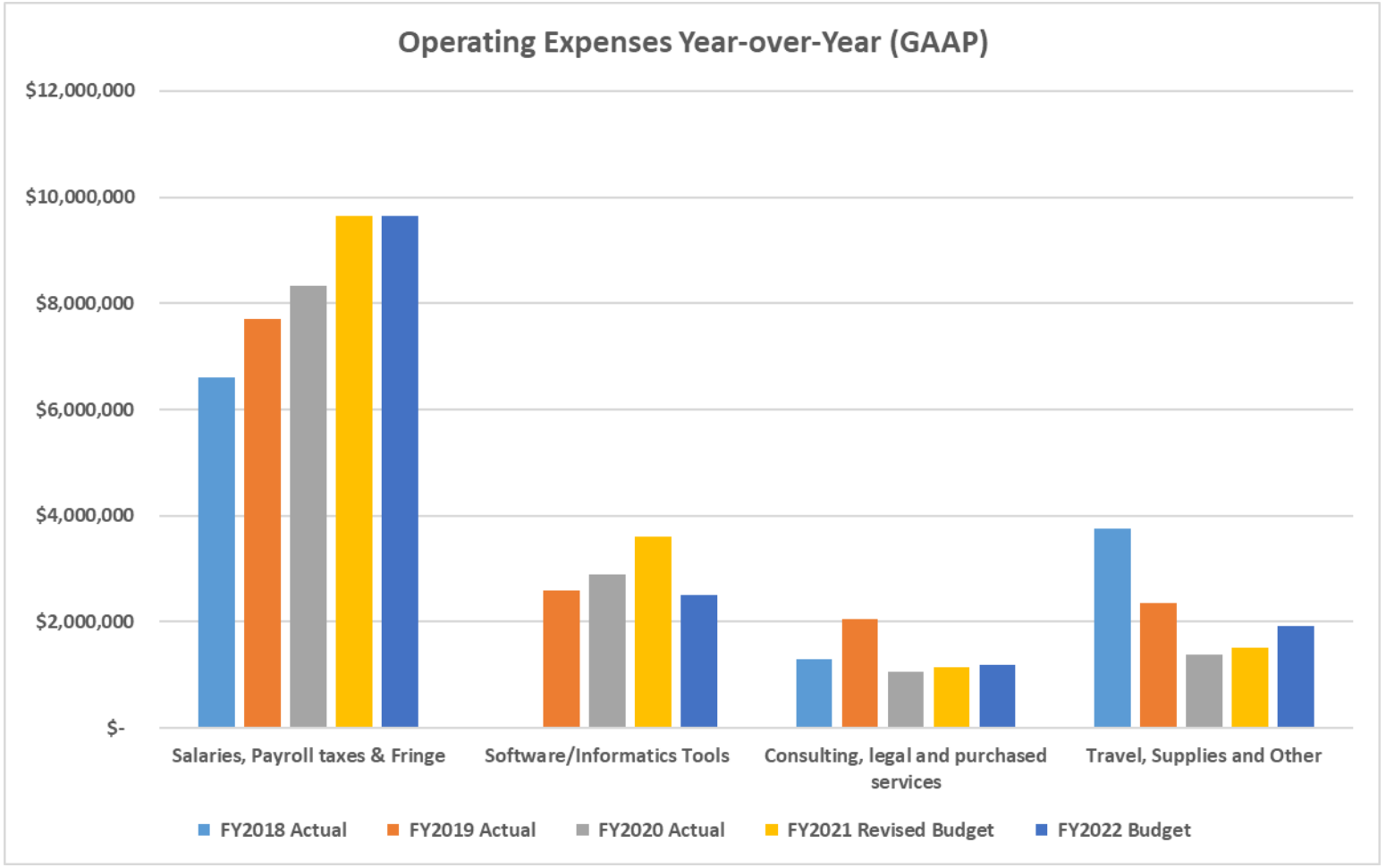


ACO Budget & Financials

Operating Expenses year-over-year



ACO Budget & Financials
Recommendations

VERMONT
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RECOMMENDATION: OneCare to 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.

Additional GMCB Staff Next Steps

- *For ACO Reporting Manual*: OneCare to provide updated projections for FY2022 budget on a quarterly basis in conjunction with quarterly reporting as described in the updated ACO Reporting Manual.

ACO Budget & Financials
Recommendations (cont.)

VERMONT
GREEN MOUNTAIN CARE BOARD

RECOMMENDATION: No later than March 31, 2022, OneCare must provide GMCB staff with the supporting documentation relevant to the topics identified in Condition [X]. 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;
e. Hospital dues for 2022 by hospital;
f. Hospital risk for 2022 by hospital and payer;
g. Documentation of any changes to the overall risk model for 2022;
h. Source of funds for its 2022 population health management programs;
i. Update on purchase of approved Medicare benchmarking system for use in FY2022;
j. Proposed options for benchmarking systems for Medicaid and commercial payer programs for use in FY2023; and
k. Any other information the GMCB deems relevant to ensuring compliance with this order.

ACO Budget & Financials
Recommendations

VERMONT
GREEN MOUNTAIN CARE BOARD

RECOMMENDATION: At its presentation of the revised budget and no later than April 30, 2022, OneCare must present to the GMCB on the following topics:

a. Final FY2022 attribution and finalized payer contracts;
b. Revised budget, based on final attribution;
c. Final description of population health initiatives;
d. Expected hospital dues for 2022 by hospital;
e. Expected risk for 2022 by risk bearing entity and by payer;
f. Any changes to the overall risk model for 2022;
g. Source(s) of funds for OneCare's 2022 population health management programs;
h. Any other information the GMCB deems relevant to ensuring compliance with this order.

ACO Budget & Financials
Recommendations

VERMONT
GREEN MOUNTAIN CARE BOARD

RECOMMENDATION: In 2022, OneCare's Operating Expenses must not exceed $15.3 million, plus the cost of the benchmarking system to be purchased as required in Condition [X] following approval by Board staff.

a. If the Board requires changes to the total amount of OneCare's Value-Based Incentive Fund, OneCare may adjust total allowable Operating Expenses commensurate with such required changes.

ACO Budget & Financials
Recommendations

VERMONT
GREEN MOUNTAIN CARE BOARD

RECOMMENDATION: 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:
    I. Additional funding for population health investments;
    II. Financial backing for risk incurred by participating providers;
    III. Maintaining ACO-wide risk on behalf of participating providers;
    IV. Temporary cash flow issues associated with payer revenue delays; and
    V. Other uses pre-approved by the GMCB.

ACO Budget & Financials
Recommendations

VERMONT
GREEN MOUNTAIN CARE BOARD

RECOMMENDATION: OneCare must submit its audited financial statements as soon as they are available and must submit information as required by the GMCB to monitor OneCare's performance. OneCare must crosswalk submitted actuals per its budget submission to audited financial statements for FYs 2018-2022.

RECOMMENDATION: OneCare to provide the GMCB with the most recent version of the ACO's IRS Form 990 as soon as it is available.

Total Cost of Care & Trend Rates

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- Projected FY22 TCOC by payer
- Budgeted payer-specific trend rates

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

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	FY2021 Projected TCOC (FY21 Q3 Financial Reporting)	FY2022 Expected TCOC (FY22 Budget Submission)	Budgeted Trend from Base Experience* (FY22 Budget Submission, Appendix 4.3)
Medicare	$473,112,042	$533,210,803	10.6%
Medicaid - Traditional	$225,873,046	$245,245,465	2.1%
Medicaid - Expanded	$46,197,634	$47,558,217	0.7%
BCBS QHP	$113,960,875	$159,654,505	[redacted]
BCBS Primary **	$240,642,412	$277,644,746	[redacted]
MVP	$50,821,592	$66,924,423	[redacted]
TOTAL	$1,159,374,734	$1,365,345,843	N/A

*Base year varies by program; **budgeted trend does not represent FY21→FY22 growth**.
**Includes expected TCOC for BCBSVT Primary – Risk lives only; excludes BCBSVT Primary – Non-Risk lives.

Total Cost of Care & Trend Rates
Key Takeaways

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- Setting financial targets remains challenging due to the ongoing pandemic
- Staff will discuss implications of trend rates (especially Medicare trend) for All-Payer Model Agreement TCOC (APM TCOC) targets at the December 15 presentation and staff recommendation for the Vermont Medicare ACO Initiative benchmark (financial target)

Total Cost of Care & Trend Rates
Recommendations

VERMONT
GREEN MOUNTAIN CARE BOARD

RECOMMENDATION: OneCare must ensure that its payer contracts are consistent with the following 2022 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 consistent with the GMCB's recommendations in the Medicaid advisory rate case.
c. Commercial:
    i. The 2022 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.

Payer Programs & Risk Model

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

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

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

Payer Programs & Risk Model

OneCare's Payer Programs: Disclaimer

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

Payer Programs & Risk Model
Risk Models by Payer

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	Payment Model	Budgeted Risk Corridor	Link to Quality**
Medicare	Reconciled AIPBP for eligible participants; FFS for others	Two-sided; 2% risk corridor; 100% sharing	Yes, component of settlement calculation
Medicaid - Traditional	Combination unreconciled FPP and FFS (with total reconciled to expected TCOC) for eligible participants; FFS for other	Traditional: Two-sided; 2% risk corridor; 100% sharing	Yes, component of settlement calculation; PHM payments
Medicaid - Expanded	Combination unreconciled FPP and FFS (with total reconciled to expected TCOC) for eligible participants; FFS for others	Expanded: Two-sided; 1% upside, 1% downside; 100% sharing	Yes, component of settlement calculation; PHM payments
BCBS	FPP (pilot with one hospital, reconciled) & FFS	[redacted]	Yes, component of settlement calculation
MVP	FFS	[redacted]	Yes, component of settlement calculation

*Projected by OCV as of 10/01/2021 Budget Submission, payer contracts still under negotiation.
**Source: FY22 Budget Submission Appendix 3.1 Scale Target Initiatives and Program Alignment Form. GMCB staff will review in more detail once contracts are final.

Payer Programs & Risk Model

Savings/Risk Distribution to Provider Network

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- Program Settlement Policy (04-07-PY21)
  - $1.50 PMPM “first-dollar” savings or risk for primary care practices
  - Funding “obligated to cover expenses per Board-approved OneCare budget” is subtracted from settlement; 90% of remaining settlement dollars go to HSA RBEs, 10% allocated to Performance Incentive Pool
  - Savings/Losses are calculated for each Program and HSA, based on HSA-level attribution, with hospitals serving as the Risk Bearing Entity (RBE) for their HSA

Payer Programs & Risk Model

Savings/Risk Distribution to Provider Network, cont.

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- Primary Care Accountability Pool
  - Practices can pay into accountability pool throughout the year (withhold from base PMPM) or elect to receive an invoice from OCV at settlement if ACO is required to pay back shared losses
  - Projected total = $2.4M (15% of total risk) in 2022
  - Current policy: 2021 (04-07 Program Settlement PY 2021)
- Performance Incentive Pool
  - Sets aside 10% of total shared savings to reward HSAs that perform well on two measures: PMPM cost and avoidable ED visits
  - Distributed based on accrual of “PIP points”
  - Current policy: 2021 (F04-22-PY21 Performance Incentive Pool PY 2021)

Payer Programs & Risk Model

FY22 Savings/Risk by Risk Bearing Entity

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	Primary Care Accountability Pool				Risk Bearing Entity (Hospital) Share	Total Risk/ Reward
	Non-Hospital Primary Care		Hospital Primary Care			
	Accountability Pool Share	Proportion of HSA Attributed through Non-Hospital PC*	Accountability Pool Share	Proportion of HSA Attributed through Hospital PC*		
Bennington	$58,210	31%	$130,050	69%	$1,226,281	**$1,414,541**
Berlin	$37,371	12%	$219,150	88%	$1,840,424	**$2,096,945**
Brattleboro	$42,504	38%	$69,570	62%	$712,189	**$824,263**
Burlington	$407,431	59%	$286,362	41%	$4,230,828	**$4,924,621**
Lebanon	$38,002	53%	$27,576	47%	$318,037	**$383,615**
Middlebury	$61,426	43%	$73,368	57%	$764,217	**$899,011**
Morrisville	$68,360	99%	$0	1%	$175,475	**$243,835**
Newport	$600	1%	$84,438	99%	$212,313	**$297,351**
Randolph	$65,188	100%	$0	0%	$156,698	**$221,885**
Rutland	$278,842	100%	$0	0%	$1,718,442	**$1,997,284**
Springfield	$86,234	99%	$0	1%	$212,343	**$298,577**
St. Albans	$123,958	55%	$104,796	45%	$1,374,330	**$1,603,084**
St. Johnsbury	$59,203	55%	$58,392	45%	$278,574	**$396,170**
Townshend	$0		$0		$0	**$0**
Windsor	$979	1%	$54,468	99%	$388,078	**$443,526**
OneCare Vermont	$0		$0		$125,000	**$125,000**
Total	**$1,328,310**		**$1,108,170**		**$13,733,228**	**$16,169,708**
	8% of total risk		**7% of total risk**		**85% of total risk**	

* Accountability Pool Share for Non-Hospital and Hospital Primary care are based on the proportion of the HSA attributed through those practice types.
SOURCE: OCV Response to Round 2 Questions, Q10.

Payer Programs & Risk Model

HSA-Based vs. Network Based Risk Models

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	HSA-Based Risk Model (through 2019)	Network-Based Risk Model (beginning 2021)
Primary Holder of Risk	Hospitals	Hospitals and 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% performance incentive pool if SS achieved. Primary care providers take on $1.50 PMPM first dollar savings and risk.
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 of Managers agreed to allow network-wide sharing of 2020 savings/losses akin to the Risk Model used in 2021.

Payer Programs & Risk Model

HSA-Based vs. Network Based Risk Models

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- Shifting from the HSA-based risk model to network-based risk model was intended to increase collaboration across the network.
  - Participants (Hospitals) may have more incentive to look outside their HSA for the most efficient care setting.
  - Increased motivation for the ACO to identify and lead strategic planning for system-wide cost control.
- Network-based risk model also decreases year-over-year volatility associated with small numbers.
- In Round 1 questions, staff requested that OneCare provide an analysis of 2019 performance (the most recent year of data available at that time, and pre-COVID)
  - Actual 2019 savings/losses distribution using HSA-based risk model vs. hypothetical distribution if OCV had used the newer network-based risk model; goal was to identify which HSAs fared better/worse under risk model now in use.

Payer Programs & Risk Model

Modeling HSA-Based vs. Network Based Risk (2019)

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Hospital	HSA	Actual 2019 Savings/ Risk Distribution (HSA-based risk model)	Hypothetical 2019 Savings/ Risk Distribution (Network risk model)	Difference	Impact
Southwestern VT Medical Center	Bennington	($1,740,490)	($44,396)	$1,696,094	Worse
Central Vermont Medical Center	Berlin	($3,616,892)	($231,588)	$3,385,304	Worse
Brattleboro Memorial Hospital	Brattleboro	$383,751	($45,934)	($429,685)	Better
The University of Vermont Medical Ctr.	Burlington	$2,058,511	($832,774)	($2,891,285)	Better
Dartmouth-Hitchcock	Lebanon	($272,282)	($267,195)	$5,087	Worse
Porter Medical Center	Middlebury	$1,035,601	($168,867)	($1,204,468)	Better
Copley Hospital	Morrisville	$0	$0	$0	Worse
North Country Hospital	Newport	($411,851)	($431,140)	($19,289)	Better
Gifford Medical Center	Randolph	($312,001)	($302,292)	$9,709	Worse
Rutland Regional Medical Center	Rutland	($892,265)	($858,118)	$34,147	Worse
Springfield Hospital	Springfield	$636,267	$2,494	($633,773)	Better
Northwestern Medical Center	St. Albans	($618,914)	($452,794)	$166,120	Worse
Northeastern VT Regional Hospital	St. Johnsbury	($625,624)	($639,348)	($13,724)	Better
Mt. Ascutney Hospital & Health Ctr.	Windsor	($204,793)	$1,324	$206,117	Worse
OneCare Vermont	OneCare	($447,172)	($757,527)	($310,355)	Better
TOTAL		**($5,028,154)**	**($5,028,155)**		

NOTE: (Negative numbers) represent shared savings; positive numbers represent shared losses.

Payer Programs & Risk Model

Key Takeaways from Modeling HSA-Based vs. Network Based Risk (2019)

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- In HSA-based risk model, there were big winners and losers
- Network-based risk model smooths out savings and risk distribution across HSAs
  - Decreases volatility and protects against small numbers
  - Also results in weaker incentives for participants; total amounts are very small compared to hospitals' total budgets and likely do not outweigh FFS incentives

Payer Programs & Risk Model
SS/SL Distribution – 2020 Settlement

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Payer	2020 Program Settlement Final Settlement: Shared Savings/Shared Losses
Medicare	$7.9M*
Medicaid	$15.4M
BCBSVT	$125,000
MVP	$1.1M

*Medicare 2020 Settlement excludes 2019 ACO Shared Saving Advance (BP and SASH $)

See FY2020 Financial Settlement & Quality Performance Presentation, November 22, 2021 (Medicare, Medicaid, and MVP) and Appendix 5.3 (BCBSVT; note that this appendix includes projections for other payers)

Payer Programs & Risk Model
Key Takeaways

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- Total budgeted FY22 risk and reward = $16.2M
- Primary care accountability pool is pushing first-dollar risk (and potential reward) to primary care practices:
  - Total Primary Care Accountability Pool (FY22 Budget) = $2.4M (15% of total risk)
  - Primary care accountability pool for non-hospital owned primary care (FY22 Budget) = $1.3M (8% of total risk)
- Network-based risk model is intended to increase collaboration across the network; also decreases year-over-year volatility associated with small numbers in individual HSAs
  - Smooths out savings and risk distribution across HSAs
- Performance Incentive Pool sets aside 10% of total shared savings to reward HSAs that perform well on two measures: PMPM cost and avoidable ED visits

Payer Programs & Risk Model
Recommendations

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RECOMMENDATION: 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 Reporting Manual.

Payer Programs & Risk Model
Recommendations

VERMONT
GREEN MOUNTAIN CARE BOARD

RECOMMENDATION: 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:

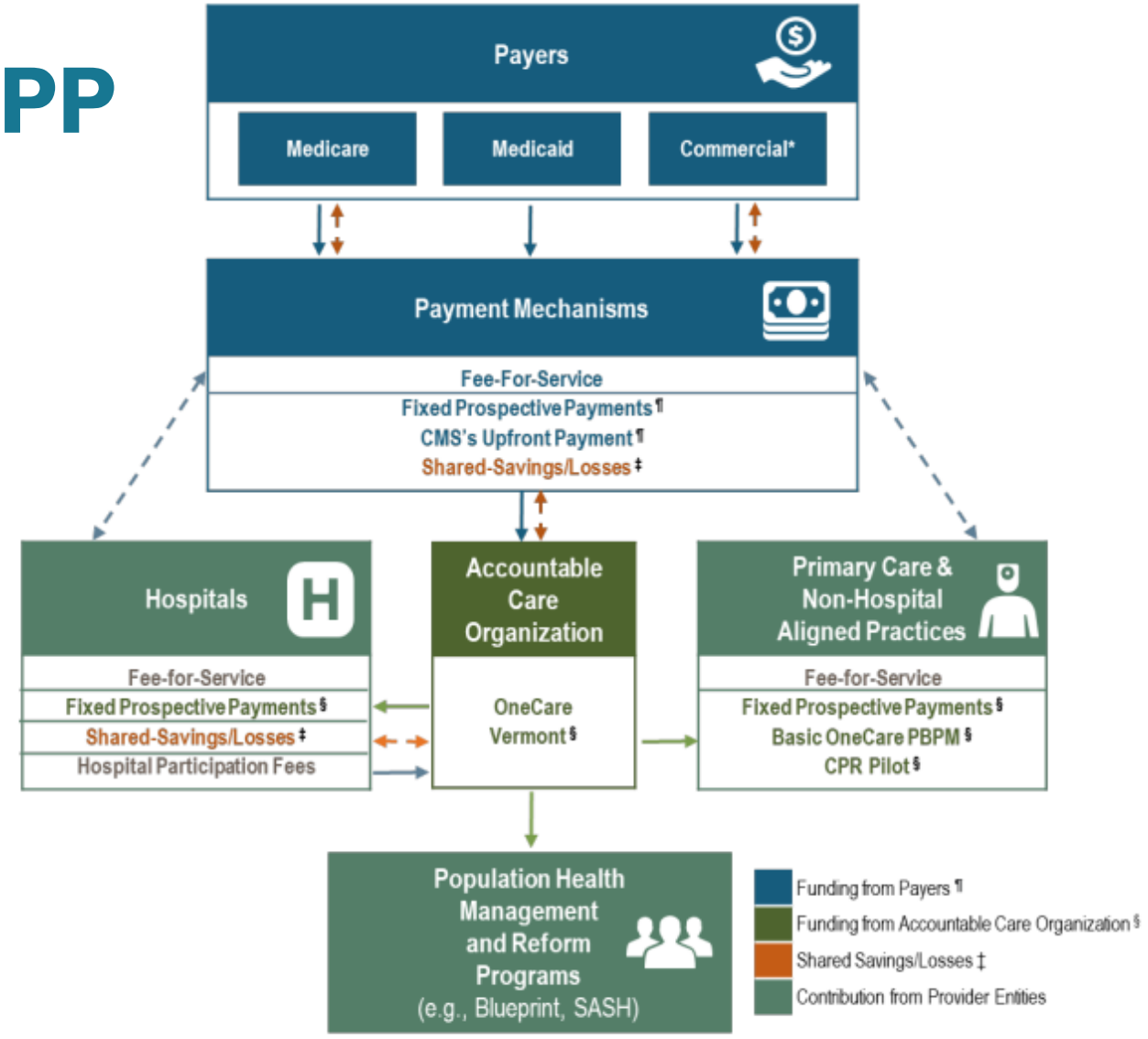
a. Submit to the GMCB copies of the contracts that bind each of the risk bearing entities to OneCare's risk sharing policy no later than 10 days after all contracts have been executed;
b. Notify and seek approval from the GMCB as early as possible of any proposed changes to the risk model and, for any proposed changes determined by Board staff to be material, provide the GMCB with detailed information, including effects by risk bearing entity and parent organization; and
c. The GMCB may require OneCare to come before the GMCB in a public meeting to explain the details of the risk model and its impact on incentive structures to the GMCB on or before April 15, 2022

Additional GMCB Staff Next Steps

- *For ACO Reporting Manual*: Submit any relevant policies or 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 March 31, 2022.

Payment Models and FPP

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



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

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

Payment Models and FPP
Other Provider Payment Models

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- **Fixed Prospective Payments (FPP) to Hospitals**
  - Medicare FPP *reconciled*
  - Medicaid FPP *unreconciled*
  - BCBSVT FPP pilot *reconciled*
- **Comprehensive Payment Reform (CPR) Program to Independent Primary Care**
  - Payer-blended fixed payments for independent primary care practices for core primary care services plus additional PMPM for non-core services
  - Total CPR payments projected for FY21: $6,856,618
    - FY21 OCV-funded share: $1.2M
    - FY22 OCV-funded share: $1.3M

Payment Models and FPP

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

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	Attribution (Average)	Expected TCOC (ETCOC)[1]	Total Fixed Payments (FPP + CPR)[2]	Total Fixed Payments (FPP + CPR) as % of Expected TCOC	HCP-LAN Category *For more information, see HCP-LAN Alternative Payment Model Framework, slide 136)*
Medicare	49,017	$533,210,803[3]	$272,551,147	51%	4B (*reconciled* to FFS)
Medicaid – Trad.	86,343	$245,245,465	$141,997,124	58%	4B (*unreconciled* to FFS)
Medicaid – Expand.	20,721	$47,558,217	$25,586,321	54%	4B (*unreconciled* to FFS)
BCBSVT	92,944	$437,299,251	[redacted]	1.1%	BCBSVT General: 3B[4] BCBSVT FPP Pilot: 4B (reconciled)
MVP QHP	9,901	$66,924,423			MVP: 3A[4]
TOTAL	258,926	$1,330,238,159	$445,882,154	34%	

1. Projected (Expected) TCOC: FY22 Budget Tab 5.1 ACO Risk by Payer and Tab 6.5 PMPM Rev by Payer. 2. See "FPP/CPR" line in FY22 Budget Tab 6.4 Sources Uses. 3. Medicare TCOC: Includes Blueprint/SASH at $9,073,983 for FY22. 4. BCBSVT and MVP payment model HCP-LAN categorizations according to filings from the GMCB's review of plans' Qualified Health Plan (QHP) premiums for 2022.

Payment Models and FPP

OneCare Targets and Strategy for FPP

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- OneCare reported targets and strategy for increasing FPP as required by GMCB in FY21
- *Unreconciled* Medicare payments represent the biggest impact; however, Medicare AIPBP is already considered an HCP-LAN advanced alternative payment model
- FY22 minimal increase in commercial FPP
- FY23-FY25 commercial targets are ambitious, strategies include:
  - ↑ hospital fixed payment programs
  - ↑ inclusion of FQHCs
  - ↑ CPR program

Table 1: Percentage of Contract Revenue in FPPs

Program (TOTAL $)	Hospital FPP	Primary Care FPP	TOTAL Contract Revenue Under FPP*
Medicare ($494M)	0.0%	0.0%	0.0%
Medicaid Traditional ($211M)	49.5%	0.9%	50.4%
Commercial ($129M)	0.0%	0.0%	0.0%

*Program year 2019 utilized as the baseline to avoid the impacts of Covid

Table 2: Targets and Milestones for Contract Revenue in FPPs

Program	Baseline	PY22	PY23	PY24	PY25
Medicare	0.0%	0.0%	53.4%	53.9%	54.4%
Medicaid	50.4%	50.7%	58.2%	58.5%	58.8%
Commercial	0.00%	2.9%	23.9%	44.9%	65.9%

Please see Section B, below, for detailed explanation of targets/timing.

Note that these figures are illustrative of targets and milestones based on the 2019 network configuration. Changes to program offerings and network configuration may affect these targets.

Source: OneCare FY21 Budget Order Condition 15 FPP Target, Strategy and Timeline Report (7/1/21)

Payment Models and FPP
Key Takeaways

VERMONT
GREEN MOUNTAIN CARE BOARD

- In past years and in other regulatory processes, GMCB members have indicated a desire to move more of Vermont's health care spending to fixed payments
  - Increasing FPP – and in particular unreconciled FPP – requires regulatory action across processes
  - Changing Medicare payment model requires continued partnership with Medicare and providers
- Progress on OneCare's ambitious targets, especially for the commercial program, will require continued monitoring and reporting

Payment Models and FPP
Recommendations

VERMONT
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RECOMMENDATION: No recommendations at this time.

GMCB Staff Next Steps:

- As previously instructed by the Board, GMCB staff to continue to engage in rule development as precursor to formal rulemaking process for new rule to increase FPP, with potential rule to span GMCB's ACO oversight, hospital budget review, and health insurance premium rate review processes.
  - First step: Work with contractor on options.
- In FY 2022, staff-developed reporting templates will better capture payer-ACO payment arrangements, provide guidance to OCV on where current payer-ACO payment arrangements fall on the LAN framework, and require reporting of reconciled FPP and unreconciled FPP separately.

Population Health, Quality, Model of Care

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- Major programmatic and budget changes (Care Navigator, Rise VT)
- Population health/quality-related payment changes (VBIF, care management payments)
- Clinical Focus Areas/VBIF Priorities

Population Health, Quality, Model of Care
Model Review Criteria

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Review and consider	Key Criteria
• Incentives/Resources (Payment Changes) • Information (Data) • Efforts (Tools) 18 V.S.A. § 9382 (A)(F)(G)(H)(I)(J)(P)	• 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

Population Health, Quality, Model of Care
Model Review Criteria

VERMONT
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Payment Changes

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

Data

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

Tools

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

Population Health, Quality, Model of Care
2022 Changes to Population Health Programs

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Value Based Incentive Fund

- VBIF reduced
- FY22 budget is $1 million compared to $2.24 million in FY21

RiseVT

- Phasing out RiseVT in favor of clinical prevention work
- RiseVT still funded for first half of FY22

Care Navigator

- Documentation in Care Navigator is optional.
- Use of Care Navigator is no longer required for care coordination payments.

Care Coordination Payments

- OneCare is decoupling care coordination payments from Care Navigator.
- Payments now tied to TCOC and other metrics, still TBD.

Population Health, Quality, Model of Care
Value-Based Incentive Fund (VBIF)

VERMONT
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- Proposed FY22 VBIF amount = $1M (all-payer)
- OneCare's Clinical Focus Areas/VBIF priorities remained the same in the proposed 2022 budget:
  - Diabetes HbA1c Poor Control
  - Controlling High Blood Pressure
  - Early Childhood Developmental Screening
  - Depression Screening and Follow-up

Population Health, Quality, Model of Care

OneCare's PHM & Payment Reform Investments

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PHM & PMT Reform Investments	2018 Actual	2019 Actual	2020 Actual	2021 Projected	2022 Budget
Total Revenue	**$ 635,447,286**	**$ 685,821,095**	**$ 1,118,699,486**	**$ 1,219,128,750**	**$ 1,365,345,843**
Population Health Management (PHM) Total	$ 22,637,268	$ 29,461,309	$ 32,701,000	$ 27,800,472	$ 28,894,127
Blueprint (PCMH, CHT, SASH)	$ 7,780,516	$ 4,756,752	$ 8,401,661	$ 8,767,133	$ 9,073,982
PHM (Less: Blueprint)/Revenue	2.3%	3.6%	2.2%	1.6%	1.5%
PHM/Revenue	3.6%	4.3%	2.9%	2.3%	2.1%

- **Blueprint $ ↑3.5%** (2021 projected to 2022 budget)
  - Blueprint revenues have increased since 2019 low of $4.7 million
- **PHM Investments $ ↑3.9%** (2021 projected to 2022 budget)
  - PHM revenues as a % of total revenue have declined from 2019 peak of 4.3%
- **Total Revenue $ ↑12%** (2021 projected to 2022 budget)
- **PHM Investments**—there is no benchmark for the "right" ratio, programs do not scale up at same rate as attribution

Population Health, Quality, Model of Care

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

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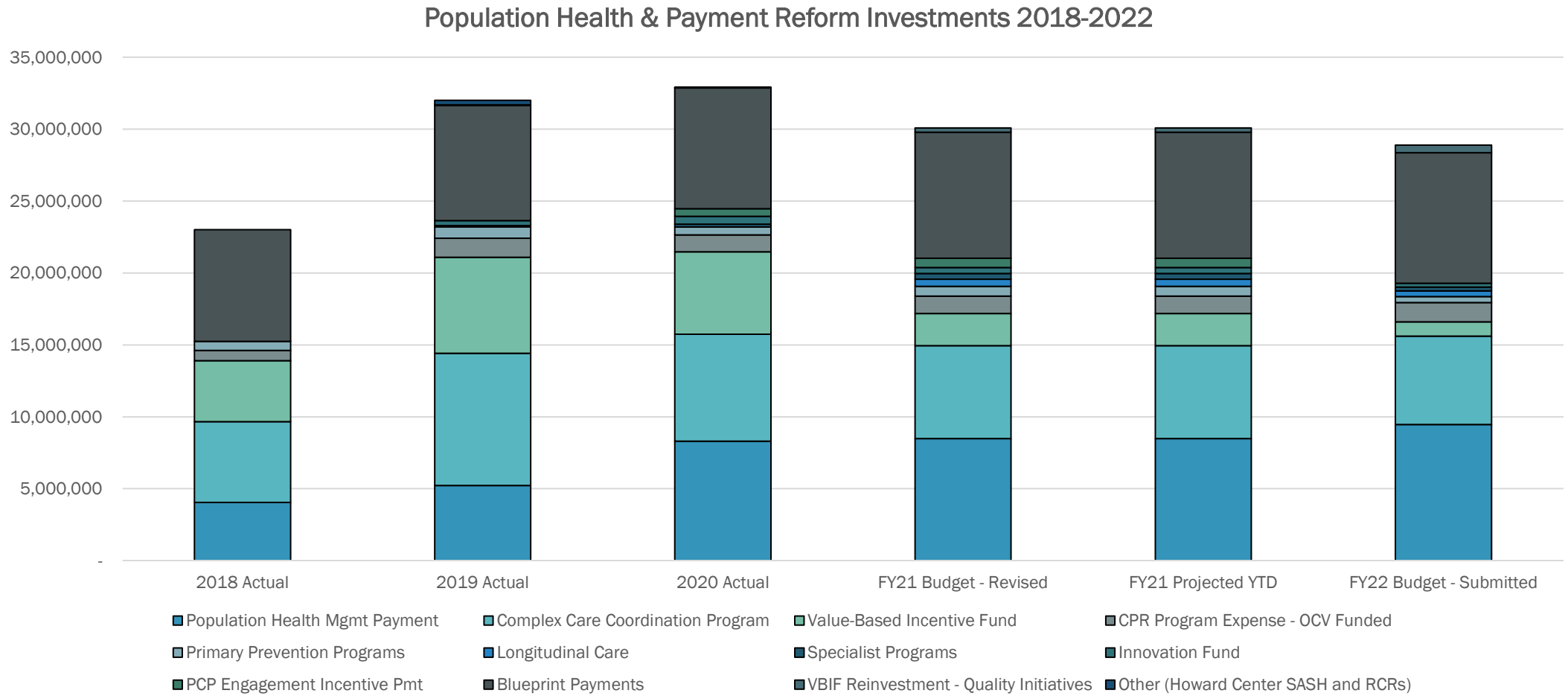

Population Health, Quality, Model of Care
Key Takeaways

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- VBIF reduced
- Phase out of RiseVT and Care Navigator documentation
- Care Coordination payments no longer tied to use of Care Navigator
- Total reduction in PHM expenditures of $2.8 million

Population Health, Quality, Model of Care
Recommendations

VERMONT
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- **RECOMMENDATION:** If population health management and payment reform programs are not fully funded as detailed in OneCare's 2022 budget submission, OneCare must submit a revised proposal no later than March 31, 2022, to the GMCB. 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.

Population Health, Quality, Model of Care
Recommendations

VERMONT
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- **RECOMMENDATION:** In 2022, OneCare must fund SASH in the amount of $4,285,795 equivalent to the 2021 budgeted amount of $4,140,865 plus an inflationary factor of 3.5%, contingent on the increase in funding being used to enhance programs or expand access to Medicare beneficiaries. In 2022 OneCare must fund the Blueprint for Health (PCMH and CHT) investments in the amount of $4,788,187, equivalent to the 2021 budgeted amount of $4,626,268 plus an inflationary factor of 3.5%, consistent with the medical home and community health team program payment design approved by the Agency of Human Services.

Population Health, Quality, Model of Care
Recommendations

VERMONT
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- **Future Recommendation:** Staff expect to recommend an increase to VBIF above the budgeted FY22 amount of $1M. This topic requires additional staff analysis; we expect to present a final recommendation on this topic to the Board on 12/15.
  - Considerations: In FY2018-FY2020, VBIF was >$4-6.5M; the FY21 and proposed FY22 amounts are a steep drop. COVID-related risk corridor reductions and movement of quality programs to reporting-only during the pandemic make this even more important as a means of continuing to promote high-value care and incentivize improvement.

Population Health, Quality, Model of Care
Recommendations

VERMONT
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- **RECOMMENDATION:** 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.

Results to Date

Assessing Performance: APM vs. ACO

VERMONT
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All-Payer Model

- APM Agreement Targets: Cost, quality and population health, scale*
- Ongoing Evaluation and Monitoring: Payer program results, qualitative stakeholder input, analyses on topics of interest
- Federal Evaluation

ACO

- Budget Review: Program and finances
- Certification: Policies, procedures, and governance
- Monitoring Performance: Payer program results, ongoing budget and certification monitoring and reporting

* On October 12, CMMI waived enforcement of APM Agreement scale targets through remainder of current Agreement (Waiver of Enforcement letter), noting that the targets are "unattainable for Vermont based on information not available when the State Agreement was drafted."

Results to Date

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1. APM: Federal All-Payer Model Evaluation by NORC – First Evaluation Report (2018-2019)
2. APM: Scale Targets
3. ACO: 2020 Payer Program Results – Quality and Financial Settlement
4. ACO: Mathematica Policy Research Analyses

Results to Date – Federal APM Evaluation

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

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

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

Results to Date – Federal APM Evaluation

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

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

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

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

Lack of widespread understanding of the model

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

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

Results to Date – APM Scale

Requirements for Scale Qualifying ACO Initiatives

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

- Possibility of Shared Savings for achieving goals related to quality of care or utilization.
- 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%.
- 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;
- 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.

Results to Date – APM Scale

Requirements for Scale Qualifying ACO Initiatives

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Main Points:

- Possibility for shared savings
  - Does NOT require shared risk
- Within the contracted shared savings/risk corridor (% or $), an ACO must be responsible for a minimum 30% share

EXAMPLE
Program TCOC target = $1M
Risk corridor = +/- 3% of target TCOC → +/- $30K
ACO share of savings and risk > 30% of 3%/$30K = > +/- $9K
(*This example uses mock data.)*

- Services included in TCOC target are similar to APM TCOC (~Medicare Parts A and B)
- Financial components (TCOC target/benchmark, shared savings, or shared losses) are tied to quality and/or health outcomes

Results to Date – APM Scale
Evaluating Scale Target ACO Initiatives

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

Results to Date – APM Scale

Scale Performance

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		PY1 (2018) Final	PY2 (2019) Final	PY3 (2020) Final	PY4 (2021) Preliminary*	PY5 (2022) Projected**
All-Payer Scale Target	*Target*	*36%*	*50%*	*58%*	*62%*	*70%*
	Actual	22%	31%	45%	47%	52%
	Attributed Lives	112,756	160,048	230,785	242,298	266,920
Medicare Scale Target	*Target*	*60%*	*75%*	*79%*	*83%*	*90%*
	Actual	34%	47%	47%	54%	54%
	Attributed Lives	39,702	53,973	53,842	59,571	62,707

*Preliminary 2021 results utilize 2020 population estimates; these results are subject to change.
**Projected 2022 estimates are calculated using scale estimates from CMMI, DVHA, and the budget submission and utilize 2020 population estimates; these results are subject to change.

Results to Date – APM Scale

APM Scale by Payer Type Over Time

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	PY 1 (2018)	PY 2 (2019)	PY 3 (2020)	PY 4 (2021)	PY 5 (2022)
Medicare[1]	**38,860**	**53,973**	**53,842**	**61,932**	**62,707**
Medicaid[2]	**42,342**	**79,004**	**114,335**	**111,532**	**126,291**
Traditional	*42,342*	*79,004*	*85,937*	*83,685*	*95,727*
Expanded	-	-	*28,398*	*27,847*	*30,564*
Commercial	**30,712[3]**	**30,363[3]**	**62,588[3]**	**68,834[4]**	**77,922[5]**
Fully Insured	*20,838*	*20,342*	*36,754*	*27,200*	*32,904*
Scale Qualifying Self-Insured	*9,874*	*10,021*	*25,834*	*41,634*	*45,018*

[1] Medicare prospective attribution, obtained from CMMI. [2] Medicaid prospective attribution, obtained from DVHA. [3] GMCB Scale Targets and Alignment Reporting. [4] PY4 Commercial attribution estimates per revised 2021 budget submission. [5] PY5 attribution estimates per 2022 budget submission.

Results to Date – APM Scale

APM Scale by Payer Contract Over Time

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	PY 1 (2018)	PY 2 (2019)	PY 3 (2020)	PY 4 (2021) *	PY 5 (2022) **
Medicare[1]	**38,860**	**53,973**	**53,842**	**61,932**	**62,707**
Medicaid[2]	**42,342**	**79,004**	**114,335**	**111,532**	**126,291**
Traditional	*42,342*	*79,004*	*85,937*	*83,685*	*95,727*
Expanded	-	-	*28,398*	*27,847*	*30,564*
Commercial	**30,712[3]**	**30,363[3]**	**62,588[3]**	**68,834[4]**	**77,922[4]**
BCBSVT Fully Insured (included QHP for 2018-2020)	*20,838*	*20,342*	*27,388*	--	--
BCBSVT Self-Funded	*9,874*	*10,021*	*25,834*	--	--
BCBSVT QHP	--	--	--	*16,964*	*22,212*
BCBSVT Primary - Risk	--	--	--	*41,634*	*45,018*
BCBSVT Primary – Non-Risk[5]	--	--	--	*27,724*	*31,004*
MVP QHP	--	--	*9,366*	*10,236*	*10,692*

[1]Medicare prospective attribution, obtained from CMMI. [2]Medicaid prospective attribution, obtained from DVHA. [3]GMCB Scale Targets and Alignment Reporting. [4]Commercial attribution estimates per FY22 budget submission response to questions 11/5/21 and FY21 revised budget presentation 5/26/21. [5]BCBSVT Primary – Non-Risk contract is not scale qualifying and is not included in totals. NOTE: GMCB Scale Target and Alignment Reports report Commercial programs based on insurance type (e.g., fully- or self-insured)
*Projected **Budgeted

Results to Date – APM Scale
Medicare Advantage Penetration

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Vermont Medicare Enrollment Over Time*

Year	Total Medicare Enrollment	Traditional Medicare	Medicare Advantage	Medicare Advantage Percent
2016	123,732	113,294	10,438	8.4%
2017	127,061	114,318	12,743	10.0%
2018	131,065	116,196	14,869	11.3%
2019	134,433	116,648	17,785	13.2%
2020	138,454	116,612	21,842	15.8%

*Source: CMS Medicare Monthly Enrollment Dashboard

Results to Date – APM Scale
Key Takeaways

VERMONT
GREEN MOUNTAIN CARE BOARD

- On October 12, CMMI waived enforcement of APM Agreement scale targets through remainder of current Agreement (Waiver of Enforcement letter), noting that the targets are "unattainable for Vermont based on information not available when the State Agreement was drafted." Based on attribution estimates in FY22 budget, Vermont will not meet scale targets for 2021 or 2022.
- Scale achievement is not necessarily a reflection of ACO performance; it reflects many factors including care patterns and insurance market patterns (e.g., movement to the self-insured market).
- Continued growth in Medicare Advantage enrollment (vs. traditional Medicare enrollment) will impact Vermont's ability to increase scale and could decrease programmatic alignment and incentives if Medicare Advantage plans do not participate in the Model.

Results to Date – APM Scale
Recommendations

VERMONT
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RECOMMENDATION: OneCare to 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 for FY23.

Additional GMCB Staff Next Steps

- *For ACO Reporting Manual*: OneCare to report on impact of changes in Medicare Advantage enrollment on Medicare risk scores and any impact on OneCare's programs as required in updated ACO Reporting Manual.

Results to Date – 2020 Results

2020 ACO Payer Program Results (Financial)

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Payer	2020 Program Settlement Final Settlement: Shared Savings/Shared Losses
Medicare	$7.9M*
Medicaid	$15.4M
BCBSVT	$125,000
MVP	$1.1M

*Medicare 2020 Settlement excludes 2019 ACO Shared Saving Advance (BP and SASH $)

See FY2020 Financial Settlement & Quality Performance Presentation, November 22, 2021 (Medicare, Medicaid, and MVP) and Appendix 5.3 (BCBSVT; note that this appendix includes projections for other payers)

Results to Date – 2020 Results

2020 ACO Payer Program Results (Quality)

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

Results to Date – Mathematica Analyses

Comparing ACO vs. Non-ACO Populations

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- Mathematica Policy Research (MPR) is the GMCB's Analytics Contractor for the All-Payer ACO Model
  - Scale, Quality, Differential & Financial Reporting
  - Ad Hoc Analyses
- MPR conducted an analysis comparing ACO and non-ACO populations from 2017-2019 using difference-in-difference (DID) and regression analysis for a subset of measures:
  - Cost
  - HEDIS
  - Prevention Quality Indicators (PQI) measures

Results to Date – Mathematica Analyses

Comparing ACO vs. Non-ACO Populations – Limitations

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- Results are not causal
  - Since ACO participation depends on provider participation and characteristics of the patients, the populations of those attributed to the ACO and not are likely to be different.
- Non-ACO group is less representative
  - Patients not attributed to the ACO are relatively more likely to be excluded from the analysis due to < 9 months of enrollment or zero dollars in expenditures. This may distort the comparisons.
- Medicare Advantage is grouped with commercial payers
  - Due to the specifications of the All-Payer Model ACO Agreement, Medicare Advantage is grouped with commercial business, which will affect outcomes in that payer type.

Results to Date – Mathematica Analyses
Comparing ACO vs. Non-ACO Populations

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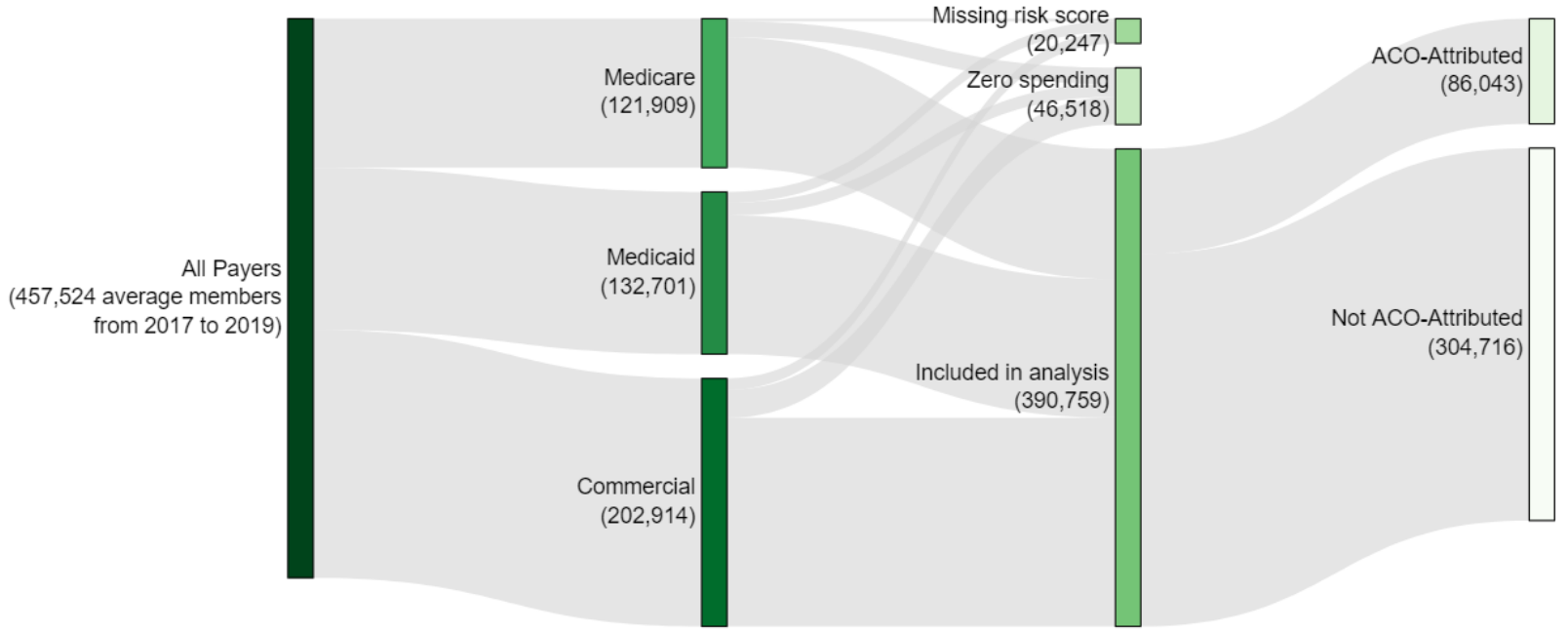
Average membership included in analysis (2017 to 2019)



Results to Date – Mathematica Analyses
Comparing ACO vs. Non-ACO Populations

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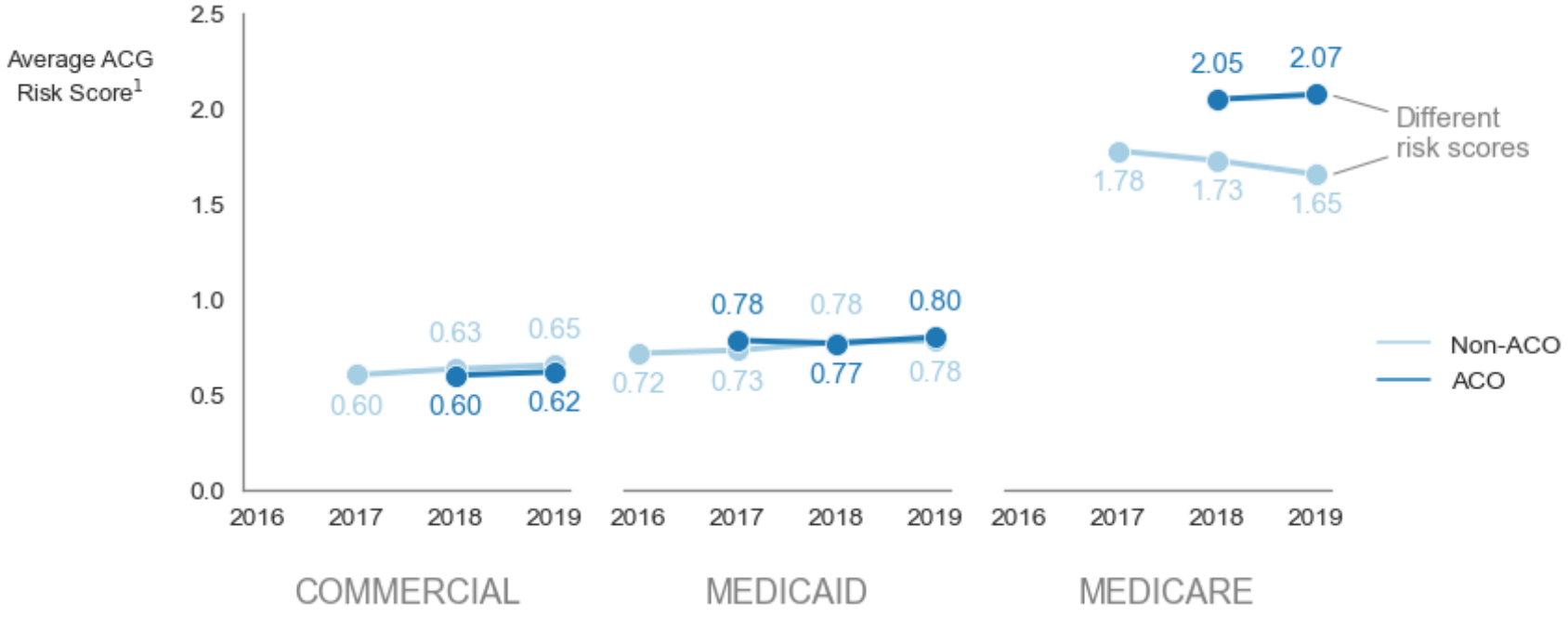
ACO vs Non-ACO Risk Scores[1]



Data Source: VHCURES

[1] Average concurrent risk scores calculated using the Johns Hopkins Adjusted Clinical Groups® System and scaled to the population average in 2017.

Results to Date – Mathematica Analyses
Comparing ACO vs. Non-ACO Populations

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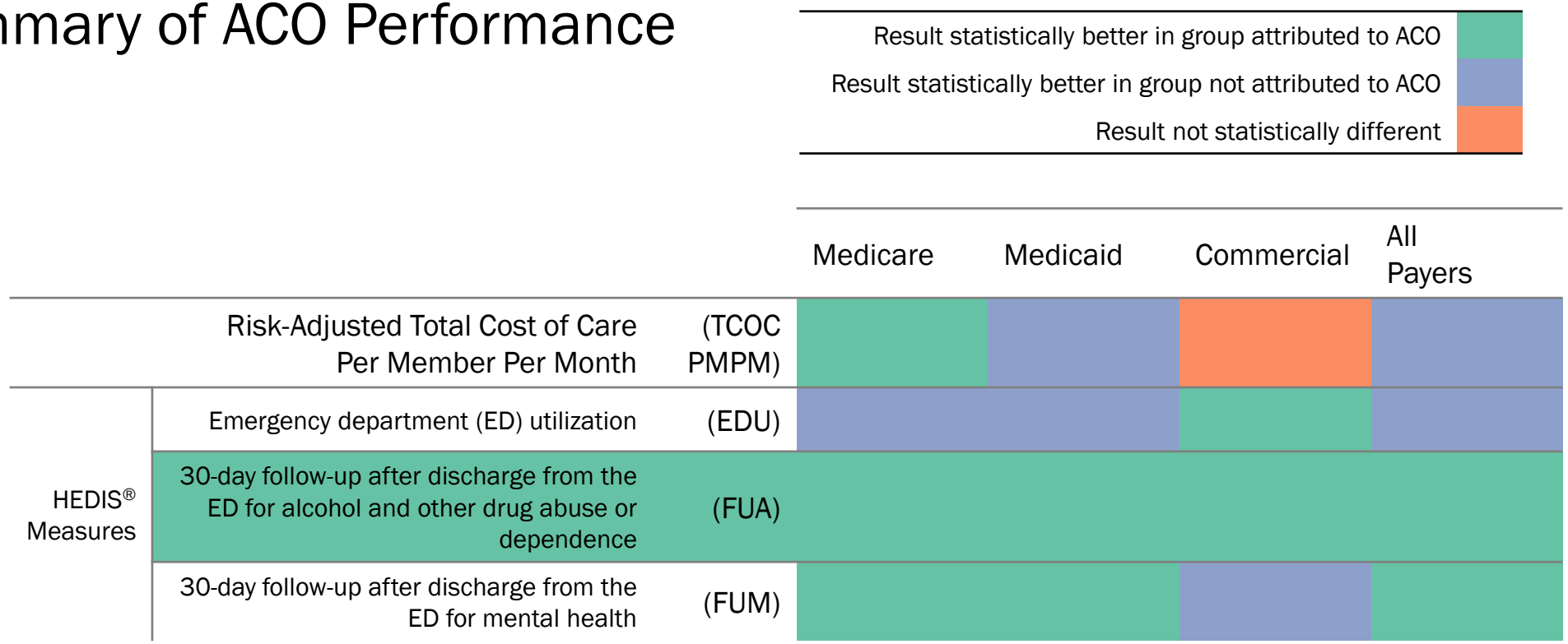
Summary of ACO Performance



Results to Date – Mathematica Analyses
Comparing ACO vs. Non-ACO Populations

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Summary of ACO Performance (continued)

Result statistically better in group attributed to ACO
Result statistically better in group not attributed to ACO
Result not statistically different

			Medicare	Medicaid	Commercial	All Payers
Prevention Quality Indicator (PQI) Measures – Admissions per 1,000 members	Diabetes short-term complications	(PQI-90-1)				
	Diabetes long-term complications	(PQI-90-3)				
	Chronic obstructive pulmonary disease or asthma in older adults	(PQI-90-5)				
	Hypertension	(PQI-90-7)				
	Uncontrolled diabetes admission rate	(PQI-90-14)				

Results to Date – Mathematica Analyses
Key Takeaways

VERMONT
GREEN MOUNTAIN CARE BOARD

- OneCare's Clinical Focus Areas/VBIF priorities remained the same in the proposed 2022 budget:
  - Diabetes HbA1c Poor Control
  - Controlling High Blood Pressure
  - Early Childhood Developmental Screening
  - Depression Screening and Follow-up

- Based on OneCare analysis, and the evaluation conducted by Mathematica Policy Research, these are in line with areas for improvement, and with the All-Payer ACO Model itself

GMCB Regulatory Levers to Foster a High Performing Health System

VERMONT
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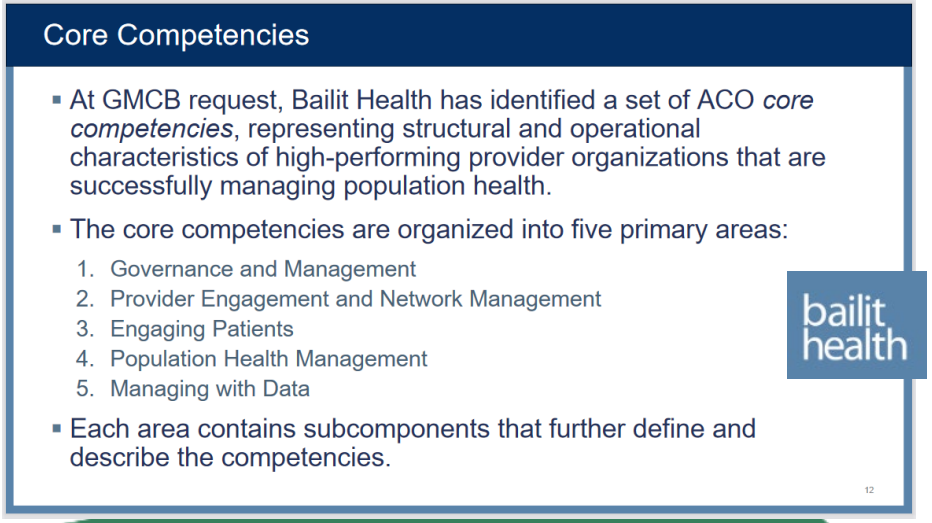
- November 2020: APM Implementation Improvement Plan (AHS)
  - Included recommendations for AHS, GMCB, and OneCare to drive improvement on APM targets
- May 2021: Bailit Health presented on core competencies of high-performing ACOs
- GMCB has expanded on this work in FY22 OCV Budget and Certification review



GMCB Regulatory Levers to Foster a High Performing Health System

VERMONT
GREEN MOUNTAIN CARE BOARD

- In Fall 2021, the Green Mountain Care Board engaged Damore Health Advisors LLC to support its ACO oversight through a subcontract with Bailit Health
  - Expert consultation to support assessing OneCare Vermont's performance on two core competencies (Population Health Management and Managing with Data)
  - Recommendations to GMCB on ACO performance and improvements to oversight/monitoring processes to drive high performance

- Damore Health Advisors: President/CEO Joe Damore
  - 30+ years focused on building and developing regional integrated health systems, including integrating comprehensive delivery systems and health plans, and building several provider-sponsored health plans
  - Former Vice President of Strategy, Innovation, and Population Health at Premier Consulting Solutions, responsible for assisting physician groups, hospitals and health systems, health plans, and integrated health systems in implementing population health management arrangements, including ACOs with a team of 80 consultants
  - Health system CEO and leader for nearly two decades
    - Mission Health System, NC; Sparrow Health System, MI; Greenville Hospital System (now Prisma Health), SC; Sisters of Mercy Health Corporation (now Trinity Health)

Damore Health
ADVISORS LLC

Green Mountain Care Board
Summary of Recommendations for Accountable Care Organization Oversight

December 2021

GMCB/OneCare Oversight Recommendations

- Benchmarking and Dashboards
- Continuous Performance Improvement
- Quarterly Reporting
- Risk Management/Mitigation
- Recommendations to Enhance OneCare Core Capabilities

RECOMMENDATION TO GMCB: Require Benchmarking and Dashboards

- Benchmarking by **major payer**
  - **Medicare initially** due to availability and reliability of data & revenue size
  - Medicaid
  - Commercial Payers
- Select an **established** benchmarking tool that addresses these **5 key areas**
  - Utilization
  - Cost per capita
  - Quality
  - Patient Engagement/Satisfaction
  - Clinical Appropriateness

RECOMMENDATION TO GMCB:
Require Enhanced OneCare Data Driven Continuous Performance Improvement Program

- Identify major opportunities by area based upon **top performer's** (best practices) comparative data
- Develop **return on investment** (ROI) criteria to prioritize opportunities for improvement based on criteria including cost, quality, improving health, etc.
- **"Drill down"** by region, HSA, and provider to identify specific opportunities for improvement
- Integrate priority opportunities into OneCare Annual **Quality and Performance Improvement Plan**

RECOMMENDATION TO GMCB:
Require OneCare Quarterly Reporting as a Key Component of the Movement to Data Driven Regulatory Monitoring

- Develop **quarterly reporting** by payer market in the five benchmarking areas as a part of the movement to a data driven model for performance improvement and regulatory oversight
- Compare to benchmarks (both mean and top performers) using an established and recognized **benchmarking system** (cost is less than $90K/year)
- Develop **action plans for performance improvement** in areas with greatest variance versus benchmarks
- **Identify** top performers and their **key best practices** by area
- **Implement best practices** action plans utilized by top performers
- **OneCare should track ROI** due to actions based on benchmarking resulting in cost reductions, quality improvements, etc., that lead to increased value-based payments
- **Utilize savings to reduce** the cost curve and to add needed services to improve quality, satisfaction, per capita cost management, and clinically appropriate care.

RECOMMENDATION TO GMCB:
Require OneCare Risk Management/Mitigation Plan

- Identify **3-5 areas of greatest risk** to the OCV (such as a major Covid spike or significant staffing shortages)
- Develop **contingency action plans** to address the 3-5 major risk areas
- **Share contingency action plans** with GMCB as a part of the 2023 Financial Plan

RECOMMENDATIONS FOR ONECARE VERMONT: Recommendations to Enhance OCV Core Capabilities*

- Governance and Management
- Provider Engagement and Network Management
- Patient Engagement
- Population Health Management
- Data Management

*Based upon Bailit Health Core Competencies with DHA additions

GMCB Regulatory Levers
Recommendations

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RECOMMENDATION: OneCare Vermont to purchase and implement a reputable ACO benchmarking system for each payer program starting with Medicare. The selected Medicare benchmarking system should provide a payer-specific dataset of peer organizations (ACOs or integrated health systems) against which to assess OneCare's performance; include identification of high performing peer organizations; and identify best practices of high performing organizations. OneCare to select Medicare benchmarking system by February 15, 2022. The benchmarking system must be approved by GMCB staff prior to purchase, and purchased by March 31, 2022.

a. GMCB expects to expand this requirement to Medicaid and Commercial payer populations in FY2023. In spring 2022 budget update, OneCare to propose options for benchmarking systems for use in Medicaid and commercial payer programs in FY2023.

GMCB Regulatory Levers
Recommendations

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RECOMMENDATION: The GMCB will issue updated reporting requirements in the ACO Reporting Manual pursuant to GMCB Rule 5.501 to implement a data-driven monitoring approach relying on payer-specific national ACO benchmarking systems or datasets. OneCare Vermont will report on performance and benchmarking results at least quarterly. OneCare Vermont will work with GMCB staff to finalize reporting templates by June 30, 2022, with first quarterly reports (Q1 2022) due July 31, 2022.

a. The FY2023 ACO budget review guidance for OneCare Vermont should reflect this change in approach and introduce performance targets linked to national benchmarks, along with enforcement mechanisms where OneCare Vermont does not perform at the levels outlined in the guidance.

OCV Budget and Certification Review Timeline FY 2022

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Jul 1, 2021	GMCB issues FY22 OCV ACO oversight guidance
Sept 1, 2021	OCV submits certification materials
Oct 1, 2021	OCV submits FY22 budget
Nov 10, 2021	OCV FY22 Budget Hearing
Dec 8, 2021	**GMCB staff analysis presentation – OCV FY22 Certification and Budget**
By Dec 31, 2021	Board vote on OCV FY22 budget (tentatively planned for December 22)
December 2021	Medicare Benchmark and Medicaid Advisory Rate Case
Jan/Feb 2022	GMCB issues OCV FY22 budget order
Spring 2022	GMCB review of final OCV FY22 attribution, budget, contracts
Spring 2022	Development of FY23 budget guidance and certification form
Ongoing 2022	GMCB monitors OCV FY22 actuals/performance against budget and conditions

Reference Slides

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- Statutory Criteria
- ACO Certification
- ACO Budget & Financials
- Provider Network
- Payment Models
- Population Health, Quality, Model of Care
- Results to Date

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Statutory Criteria

Reference 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;

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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.

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Certification Eligibility Verification

Reference Slides

FY22 Certification Eligibility Verification

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Rule 5.000 & Statute	Key Criteria	Ongoing Monitoring & Reporting	FY22 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 • Patient and Family Advisory Committee Charter • Code of Conduct • Compliance, Communication, Reporting and Investigation Policy • Executive Team Resumes	• Continue to monitor • Additional follow-up necessary regarding executive compensation

FY22 Certification Eligibility Verification

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Rule 5.000 & Statute	Key Criteria	Ongoing Monitoring & Reporting	FY22 Staff Conclusions & Additional Monitoring
Solvency & Financial Risk 5.204	• Mechanisms/processes for assessing legal and financial risks • Financial stability/solvency	• Financial audit • Quarterly financial statements • Finance Committee Charter • Code of Conduct • Compliance, Communication, Reporting and Investigation Policy	• Continue to monitor
Provider Network 5.205	• Written agreements with ACO Participants • Criteria for accepting providers • Provider appeals	• Provider/participant agreements • Network Development and Composition Policy • Participant and Preferred Provider Appeals Policy	• Continue to monitor
Population Health Management & Care Coordination 5.206	• Coordination of services among Payers, Participants, and non-Participant providers, incl. community-based providers • Care coordination	• Community Care Coordination Program Policy • Care Coordination Program Implementation Policy • Care Coordination and Training & Responsibilities Policy • Utilization Management Plan	• Continue to monitor • Additional follow-up necessary regarding OCV's methods for identifying types of services and entities to provide those services to identified enrollees, and how OCV supports participants in providing processes that 1) use decision support tools; 2) foster health literacy; 3) implement strategies toengage enrollees with limited English proficiency,

FY22 Certification Eligibility Verification

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Rule 5.000 & Statute	Key Criteria	Ongoing Monitoring & Reporting	FY22 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 and Management Policy • Utilization Management Plan • Quality Improvement Procedure	• Continue to monitor • Additional follow-up necessary regarding how the care delivered to enrollees regarding enrollee and caregiver/family experience is evaluated.
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	• Continue to monitor

FY22 Certification Eligibility Verification

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Rule 5.000 & Statute	Key Criteria	Ongoing Monitoring & Reporting	FY22 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 • PHPM Distribution Procedure • VMNG Advanced Community Care Coordination Payments Policy • QI Procedure • VBIF Distribution Policy • Settlement Policy and Reporting • Participant and PreferredProvider Appeals Policy	• Continue to monitor
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

FY22 Certification Eligibility Verification

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Rule 5.000 & Statute	Key Criteria	Ongoing Monitoring & Reporting	FY22 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	• Continue to monitor
Payment Parity § 9382(a)(3)	• ACO role vs. payer role • Steps to minimize payment differentials	• Annual monitoring of comprehensive payment reform (CPR) program	• Continue to monitor
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 to monitor

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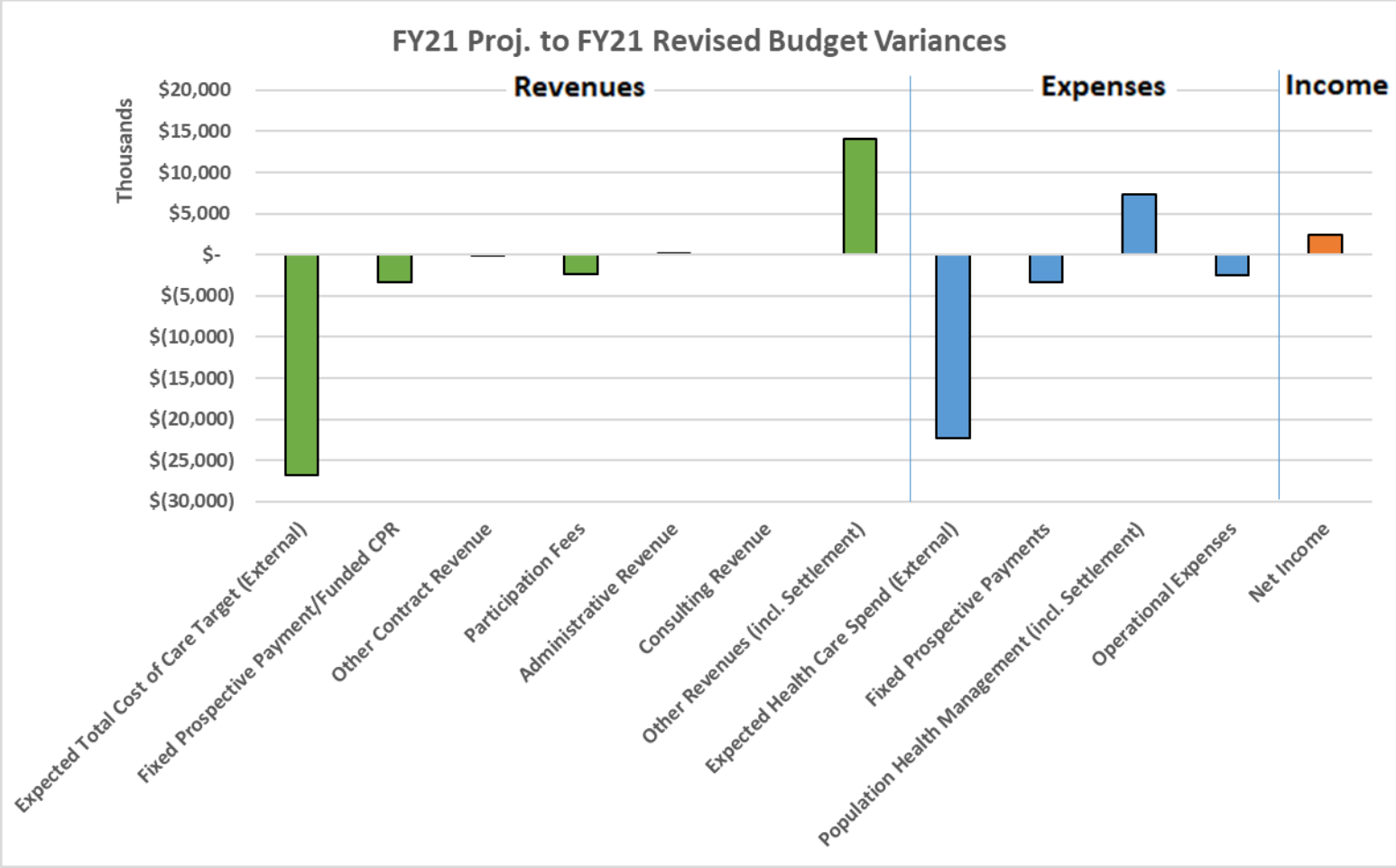
ACO Budget and Financials

Reference Slides

ACO Budget & Financials

Full Accountability (Non-GAAP) FY21 Proj. to FY21 Revised Budget I/S Variances



ACO Budget & Financials
FY2020 Operating Margin

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- FY20 operating margin in final audit was $0 due to approval by OCV BOM to refund the participation fees of risk-bearing entities totaling $3.1 million.

Hospital Name	FY20 Part. Fee Refund Amount
Brattleboro Memorial Hospital	$ 140,412.98
Central Vermont Medical Center	$ 413,737.42
Copley Hospital	$ 23,609.37
Dartmouth-Hitchcock Medical Center	$ 179,726.86
Gifford Medical Center	$ 17,581.54
North Country Hospital	$ 141,979.06
Northeastern Vermont Regional Hospital	$ 90,456.56
Northwestern Medical Center	$ 202,181.63
Porter Hospital	$ 134,747.34
Southwestern Vermont Medical Center	$ 261,605.59
Springfield Hospital	$ 19,993.22
Rutland Regional Medical Center	$ 177,584.77
University of Vermont Medical Center	$ 1,263,438.30
Mount Ascutney Hospital and Health Center	$ 70,102.28
TOTAL:	**$ 3,137,156.92**

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Provider Network

Reference Slides

OneCare Provider Network
2021 to 2022 Changes

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Table 1: 2022 Network Changes

Organization Type	2021	2022	2022 Changes
Hospitals*	14	14	No changes
FQHCs	9	9	No changes
Independent Primary Care	25	25	2 returning; 2 terminations
In CPR Program	11	13	2 joined
Naturopaths	6	5	1 retirement
Specialists	23~	24	2 terminations; 3 joined
Continuum^	46~	47	1 termination; 2 joined

* Includes employed physicians and providers

^ SNF, Home Health and Hospice, Designated Agencies, Special Services Agencies, Ambulatory Surgery Centers

~ In 2021, after the budget was submitted, there were two changes in the network as updated above: 1) an internal reclassification of physical therapists from the continuum

Chart from OneCare Vermont's Budget Narrative Page 18.

OneCare Provider Network
2021 to 2022 Changes

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- Minimal changes anticipated in FY22
- Most common departure reason: Merged, Acquired or Closed

Table 2: Network Departures: 2020-2022

	# Departing Organizations		
Departure Reason	**2020**	**2021**	**2022**
Merged, Acquired or Closed	4	4	4
Lack of Specialist Program	4	2	2
COVID-19 Impacts	0	4	0
Primary Care Funding	0	2*	0
Total per Year	**8**	**12**	**6**

*These two organizations returned to the ACO network for the 2022 performance year.

Chart from OneCare Vermont's Budget Narrative Page 19.

OneCare Provider Network
Participating Providers

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Approximately 90% of potentially attributing providers (e.g., PCPs) are ACO-participating, based on estimates derived from Vermont Department of Health workforce survey data.

For more information, see Vermont All-Payer ACO Model Annual ACO Scale Target and Alignment Report for PY3 (2020).

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Payment Models

Reference Slides

HCP-LAN Alternative Payment Model Framework

APM Framework from the Health Care Payment Learning & Action Network

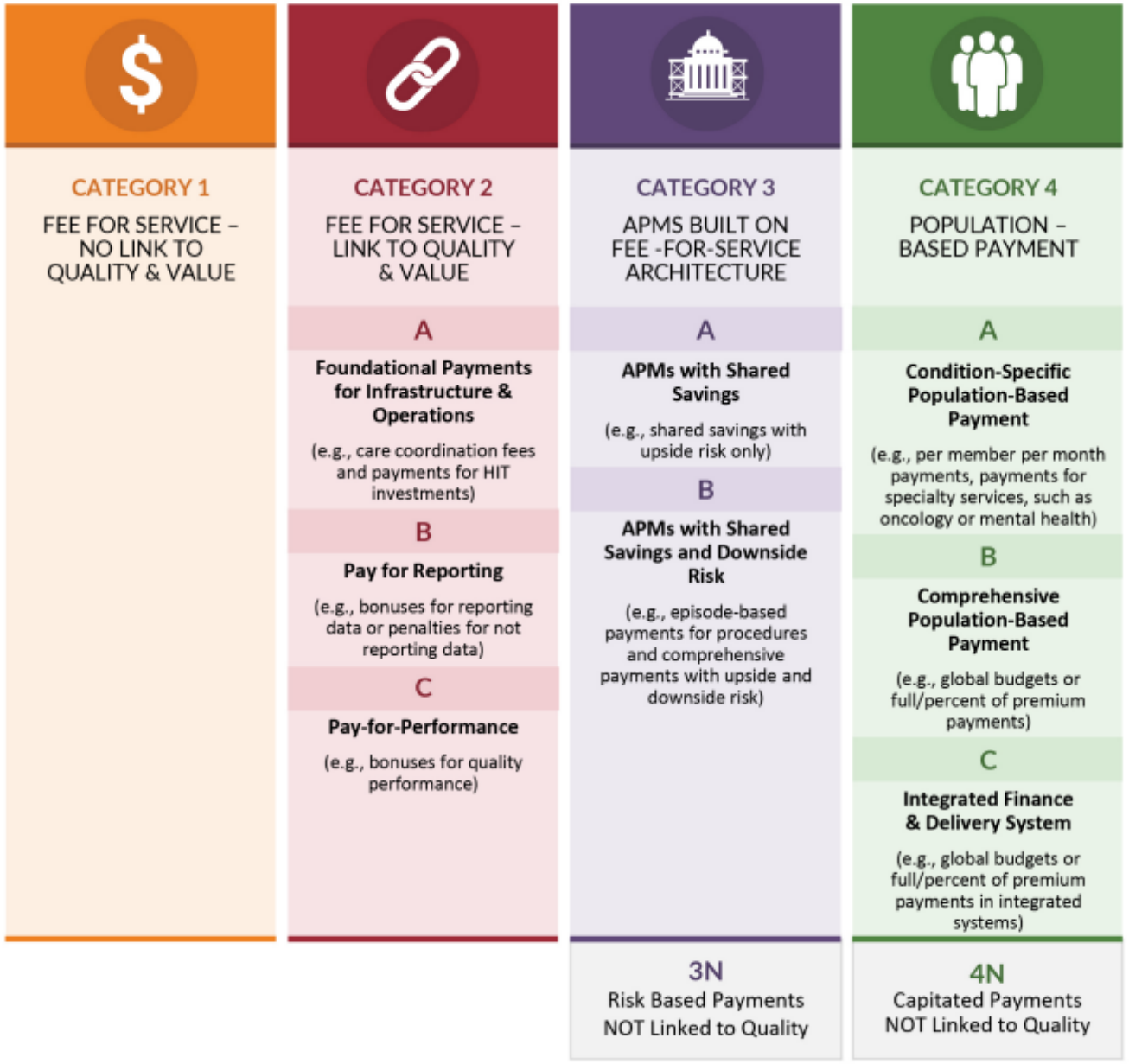

Image source: https://hcp-lan.org/workproducts/apm-figure-1-final.pdf

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Population Health, Quality, Model of Care

Reference Slides

Population Health, Quality, Model of Care

OneCare's PHM & Payment Reform Investments

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PHM/Payment Reform Programs	2018 Actual	2019 Actual	2020 Actual	2021 Projected	2022 Budget
Population Health Mgmt Payment	$ 4,040,926	$ 6,549,415	$ 8,562,787	$ 8,949,557	$ 9,457,821
Complex Care Coordination Program	$ 5,618,420	$ 9,219,158	$ 7,271,848	$ 5,408,355	$ 6,150,463
Value-Based Incentive Fund	$ 4,133,951	$ 6,673,056	$ 5,157,013	$ 2,012,391	$ 1,000,000
CPR Program Expense - OCV Funded	$ 715,808	$ 1,338,005	$ 1,179,831	$ 818,151	$ 1,331,256
Primary Prevention Programs - Program Match	$ 347,647	$ 406,865	$ 173,087	$ 290,000	$ 165,000
Primary Prevention Programs - Amplify Grants				$ 97,500	$ 50,000
Primary Prevention Programs - DULCE			$ 232,029	$ 250,981	$ 204,485
Self-Management Network Payments					
Longitudinal Care			$ 411,051	$ 124,878	$ 399,000
Specialist Program -Chronic Kidney Disease		$ 139,240	$ 356,757	$ 127,400	$ 10,874
Specialist Program -Mental Health Initiatives				$ 116,090	$ 255,009
Innovation Fund		$ 351,818	$ 376,068	$ 190,751	$ 268,990
PCP Engagement Incentive Pmt - BCBSVT Primary				$ 227,477	
PCP Engagement Incentive Pmt - Medicaid Expanded			$ 525,200	$ 416,808	
RCRs					
Blueprint Payments (PCMH)	$ 7,780,516	$ 4,756,752	$ 8,401,661	$ 1,993,092	$ 1,993,092
Blueprint Payments (CHT)				$ 2,633,176	$ 2,795,095
Blueprint Payments (SASH)				$ 4,140,865	$ 4,285,795
PCHP Program Initiative					
Howard Center SASH			$ 36,668		
VBIF Reinvestment - Quality Initiatives		$ 27,000	$ 17,000	$ 3,000	$ 527,247
PHM Totals:	**$ 22,637,268**	**$ 29,461,309**	**$ 32,701,000**	**$ 27,800,472**	**$ 28,894,127**

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Results to Date

Reference Slides

Results to Date
NORC APM Evaluation Objectives

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- Impact of the Model
  - Population health outcomes
  - Statewide spending by Medicare and Medicaid
  - Health care utilization, spending, and quality of care
- Implementation successes and challenges
- Potential replicability in other settings
- Sustainability over time

Results to Date

NORC First Evaluation Report (PYs 1-2) Findings

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Reductions in Medicare spending and utilization for entire Medicare population	Improved cohesion around shared goals and collaboration across the State, payers, and various types of providers	Spillover effects to the full population beyond Medicare beneficiaries and ACO attributed lives
• Report methodology compares Vermont outcomes to a comparison group rather than to Vermont baseline performance • Results may reflect trends in the intervention group (Vermont/Vermont ACO) and/or comparison group trends.	• Provides an important, unifying forum for meaningful discussions around health care reform	• Population health initiatives serve ACO and non-ACO beneficiaries alike. • Vermont has a long history of reform and investment in primary care and population health.

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

Results to Date

NORC First Evaluation Report (PYs 1-2) Findings, cont.

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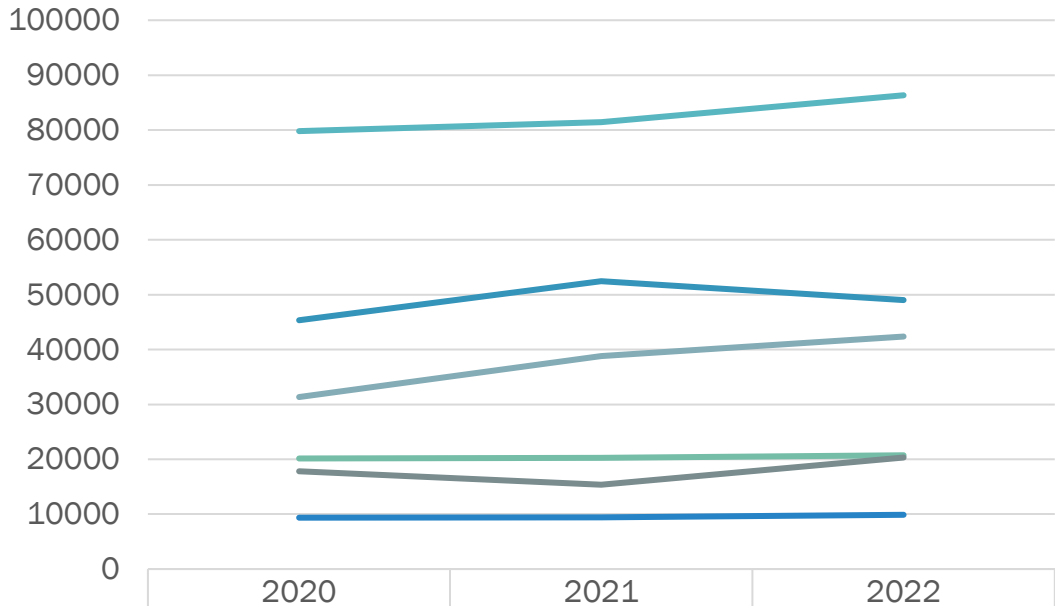
Lack of widespread understanding of the model	Transformation will require fuller transition to value-based payment, upstream investment
• Perceived lack of transparency • Distrust	• More comprehensive transition to value-based payment • Focus on upstream investments that address SDOH

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

Results to Date – APM Scale
Budgeted Attribution by Payer



	2020	2021	2022
Medicare	45339	52476	49017
Medicaid Traditional	79800	81427	86343
Medicaid Expanded	20131	20234	20721
BCBS QHP	17830	15382	20316
BCBS Primary	31329	38798	42350
MVP	9366	9417	9901

Budgeted attribution is estimated member months/12; it is used for ACO and provider budgeting purposes to estimate expected PMPM payments.

Attribution for scale purposes (see slides 89-91) uses **starting attribution**, recognizing that fluctuation throughout the year is expected as attributed individuals may become ineligible during the performance year (e.g., because of insurance coverage changes, because of changes in care patterns, death).

Results to Date

Quality Measure Crosswalk

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Measure	Vermont All-Payer ACO Model	2020 Vermont Medicaid Next Gen	2020 Medicare Initiative	2020 BCBSVT Next Gen/ UVMMC	2020 MVP Next Gen
% 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

Results to Date
Mathematica Analyses

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Member months included for analysis (2017 to 2019)

Payer Type	Base members months	Missing a risk score	Zero spending	Final member months
Commercial	7,304,906	338,758	819,783	6,146,365
	% payer total	*4.6%*	*11.2%*	*84.1%*
Medicaid	4,777,241	315,068	377,221	4,084,952
	% payer total	*6.6%*	*7.9%*	*85.5%*
Medicare	4,388,720	75,068	477,631	3,836,021
	% payer total	*1.7%*	*10.9%*	*87.4%*
ALL PAYERS	16,470,867	728,894	1,674,635	14,067,338
	% payer total	*4.4%*	*10.2%*	*85.4%*