Green Mountain Care Board

FY 2023 Budget Submission

OneCare Vermont Accountable Care Organization

September 30, 2022

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Section 1

ACO Budget Executive Summary

PART I. REPORTING REQUIREMENTS

Section 1: ACO Budget Executive Summary

1. **Provide brief narratives to summarize the components of the budget submission and describe the ACO's vision for the coming budget year. Include key assumptions and limitations of the budget, including:** ***(Word Count 2,000)***

   The 2023 budget submitted by OneCare Vermont (OneCare) represents continuation and advancement of large-scale multi-payer Accountable Care Organization (ACO) programming. This budget incorporates a pivotal transition from pandemic-limited program design to more traditional ACO arrangements, and comes at a challenging time for health care providers when staffing shortages, burnout, and inflation present tangible challenges to operations. OneCare and its participants remain committed to value-based health care initiatives, which is reflected in its plans to:

   - Maintain a vast statewide network of providers representing 14 hospitals and 90% of primary care;
   - Continue with all current payer contracts, returning to more traditional risk sharing terms;
   - Advance the focus and effectiveness of provider investments through an integrated Population Health Management program; and
   - Enhance analytic capabilities through a new contracted relationship with the University of Vermont Health Network (UVMHN).

   Each focus area will be detailed in this budget narrative. OneCare is also looking ahead to the future of value-based care, both nationally and in Vermont. Our providers are committed to advancing value-based arrangements with partners who are equally interested in innovating around provider-driven reform efforts.

   a. **An update on the goals and strategies of the current organization-wide strategic plan and future strategic planning process;**

      In 2021, OneCare's Board of Managers (Board) developed a strategic plan focused on the ACO's core capabilities: Network Performance Management, Data and Analytics, and Payment Reform. The key goals and strategies within this plan remain, with the emphasis on progress towards attainment of associated tactics.

      In Network Performance Management, OneCare aims to "ensure a high quality, equitable system that continuously strives to improve health care delivery and outcomes." Strategies include:

      - Evaluating ACO investments in core population health programs;
      - Engaging the network in refining the care model and clinical committees to maximize performance under value-based contracts;
      - Engaging with the Agency of Human Services (AHS) as part of the improvement plan to strengthen collaboration for people with complex needs; and
      - Developing a deeper connection between prevention and clinical programs to increase the impact on hypertension and diabetes quality measures.

OneCare has made measurable progress including: modifying core clinical and care coordination programs and investments; engaging stakeholders in OneCare's care coordination program evaluation; redesigning clinical committees; testing a model of social determinant of health data integration with AHS; and developing a plan to bring prevention activities into alignment with our clinical programs.

OneCare's Payment Reform goal is to "evolve value-based care contracts to move away from Fee for Service (FFS)." Strategies include:

- Developing, negotiating, and delivering on payer programs that include a true fixed/predictable payment model; and
- Expanding participation in a comprehensive primary care program.

OneCare has made demonstrable improvements by: gathering stakeholder input and implementing new financial reports; setting guidelines and processes for discussions regarding the Vermont All Payer Model (APM) waiver renewal; establishing capitated payments plans for select provider types, care bundles, and conditions; and refining and streamlining the Comprehensive Payment Reform (CPR) program for independent primary care practices.

Longer-term tactics in process include: engaging with stakeholders on APM and/or Medicare payer strategy; evaluating payer contracts for consistency with OneCare participants' needs and the reform landscape; developing a roadmap to evolve the commercial payer strategy; expanding risk and reward corridors over time to create a sustainable source of funding and investments; and evolving the CPR program to bring in additional provider types.

OneCare's Data and Analytics goal is to "increase provider understanding of ACO's value and their active engagement in messaging this value." Strategies include:

- Refining OneCare's tools and methods to deploy data and analytics;
- Identifying and implementing best practice methods to share information with the network; and
- Refining reporting to meet evolving network needs.

With this direction, OneCare sought new opportunities to advance analytic tools and resources and developed a contractual relationship with UVMHN to transition to a services-based arrangement (described later in detail), evaluated legal and compliant mechanisms for data sharing, formed a data and analytics subcommittee to guide focus areas and integrate network feedback; and improved reporting (scope, actionability, and timeliness).

OneCare will continue to work in support of these goals and strategies in the forthcoming budget year. For additional background on the OneCare Strategic Plan, visit OneCare's website at https://www.onecarevt.org/strategic-plan/.

b. Total projected attributed lives and projected attribution by payer program;

OneCare has budgeted starting attribution at 296,658 lives, of which 67,558 are Medicare, 125,738 are Medicaid, and the remainder are commercially insured. This is consistent with 2022 attribution. Commercial attribution estimates remain steady; however, OneCare did budget for minor adjustments to the Medicare and Medicaid attribution projections.

For the Medicare program, while Vermont does have an aging population, OneCare is not projecting widespread growth in attribution because members aging into traditional Medicare will be substantially offset by Medicare Advantage elections. The St. Johnsbury Health Service Area (HSA) (hospital and Federally Qualified Health Center (FQHC)) were added to the Medicare attribution estimate for 2023.

For Medicaid, initial attribution is expected to be flat year-over-year. However, the budget reflects the expectation that redetermination will resume during 2023, resulting in higher-than-normal attrition. This does not impact initial attribution, but it will impact monthly attribution throughout the year. It is difficult to project the actual impact of redetermination on programs, the total cost of care (TCOC) target, or the fixed payment allocation. OneCare will work collaboratively with the Department of Vermont Health Access (DVHA) to navigate the process.

See Appendix 4.1 in the enclosed ACO Budget Guidance Workbook.

c. Summary of the Full Accountability Budget (Non-GAAP);

The Full Accountability Budget contains all components within OneCare's scope of influence, including funds that flow through the organization as well as funds that flow from payers directly to OneCare's network through risk arrangements. The 2023 budget contains similar components as in prior years (TCOC, contracted revenues, FFS health spend, OneCare payment reform program spend and operating expenses). New this year, is a $2M "unsecured revenue" line which reflects funds subject to ongoing contract negotiation with DVHA that OneCare has budgeted to flow via OneCare to providers. If the funds materialize but remain administered by DVHA (as the case for 2022), OneCare's budgeted program expenses would be reduced by that amount with no risk to the organization. In addition, guided by the strategic plan, OneCare worked to simplify payment reform program investment streams for 2023, by combining the previous population health management, care coordination, and Value Based Incentive Fund (VBIF) payments, while also increasing focus and accountability across OneCare's network. Discussion of this advancement can be found in Section 5, below.

d. Summary of the Entity-Level Budget (GAAP);

The Entity–Level (GAAP) Budget reporting seeks to demonstrate which of the full accountability items (income and expense) would remain in the budget in a traditional GAAP presentation. The major difference between the two is the entity-level budget reflects all revenue, whereas the true GAAP presentation excludes all pass-through revenue for which OneCare is deemed to be acting in an agency capacity, e.g., TCOC/health care spend. There

are no significant changes included in the GAAP budget that are not discussed in previous question(s).

e. Summary of changes to ACO Network Programs, Population Health Programs, and Care Model; and

OneCare continues its evolution to drive improved health care outcomes through strategies and tactics outlined in the strategic plan. OneCare gathered feedback from stakeholders throughout the year and relied on clinical governance committees to inform measure selection, analytic reporting improvements, and increasing expectations for 2023. OneCare continues its four-quadrant population health model to guide our work. Within the healthy/well quadrant (category one), OneCare has focused on strengthening connections between prevention and clinical programs to specifically improve diabetes and hypertension quality measures. To improve engagement, OneCare developed and distributed new reports to share actionable and targeted data which requires minimal interpretation to put into action. OneCare's care model remains largely consistent for quadrants 2-4, with the focus on providing actionable data to engage focused subpopulations (high ED utilization, high inpatient utilization, high medical and social risk, and high cost of care) in care coordination services and supports. In addition, OneCare piloted and is implementing a new triannual reporting process with its network to support the move away from Care Navigator as a required documentation tool.

As mentioned above, the most significant change for 2023 is the integration of the previous population health management, care coordination, and VBIF payments into one stream of payments consisting of base plus incentive components that are tied to specific accountabilities. Care coordination activity was built in as a base expectation for payment eligibility. The accountability measures were researched and discussed by stakeholders and committees to ensure buy-in and focus on areas of need. More detail is provided in Section 5 of this narrative.

To support and deepen engagement in care delivery and payment reform changes, OneCare redesigned its Health Service Area (HSA) consultations and added new supports (e.g., monitoring and coaching) between sessions. In Q4 2022 and into 2023, OneCare will broaden and deepen engagement in these consultations within local HSAs. Finally, OneCare seeks to advance work to address health equity and social determinants of health by deploying its first iteration of HSA health disparities scorecards to aid local communities in data-driven gap analysis and planning.

f. Summary of lessons learned through evaluation and future evaluation plans. Include a summary of ACO benchmarking results to date.

OneCare's network is a learning healthcare system in which key lessons about how to improve its programs and services are surfaced through varying quantitative and qualitative methods. Key lessons include: how to convey data in more meaningful ways for recipients (resulting in new reports and refined HSA consultations); a need to make local recommendations for change; larger sample sizes for incentivized quality metrics (thereby requiring the majority to be claims-based); need to deepen engagement in clinical governance committees; and the challenge of measuring aggregate ACO performance with a shifting clinical and measurement landscape.

Building off these lessons, OneCare has devoted considerable energy into formative evaluation efforts in 2022 that will begin to be realized in 2023. Specifically, OneCare sought expertise from the University of Vermont College of Medicine's Health Services Research team (UVM COM) to support research-based selection of key performance indicators and to develop a provider satisfaction survey (see Section 8, question 1). To support evaluation and comparison to other ACOs, OneCare engaged with an industry-leading organization to develop a Medicare benchmarking solution. Preliminary reports are anticipated in October 2022 and will be used to meet regulatory requirements and to inform internal evaluation of areas of strength and opportunity.

OneCare will use the provider satisfaction survey, benchmarking data, and key performance indicators to serve as a baseline to inform ongoing monitoring and evaluation efforts. These will be organized and led by a new program evaluator to be hired in the 2023 budget. Together, these tools will advance OneCare's insights into potential areas of focus for 2024 and beyond.

2. Provide Section 1 Attachments A and B.

a. Attachment A: 2023 OneCare ACO Network

b. Attachment B: 2023 OneCare ACO Hospital Participation Year Over Year

See enclosed Attachment A: OneCare ACO Network and Attachment B: OneCare ACO Hospital Participation Year Over Year.

Section 1: Attachments

Attachment A: 2023 OneCare ACO Network

Attachment B: 2023 OneCare ACO Hospital Participation Year Over Year

Attachment A: 2023 OneCare ACO Network

	Medicare, Medicaid & Commercial (BCBSVT, MVP)									Medicaid & Commercial Only (BCBSVT, MVP)			Medicaid and MVP Only	Medicare and Medicaid Only
	Health Service Area*													
ACO Entities Within Each HSA**	**Bennington**	**Berlin**	**Brattleboro**	**Burlington**	**Lebanon**	**Middlebury**	**St. Albans**	**Rutland**	**St. Johnsbury**	**Morrisville**	**Newport**	**Springfield**	**Randolph**	**Windsor**
Hospital	Southwestern Vermont Medical Center	Central Vermont Medical Center	Brattleboro Memorial Hospital	UVM Medical Center	Dartmouth Hitchcock	Porter Medical Center	Northwestern Medical Center	Rutland Regional	Northeastern VT Regional Hospital	Copley Hospital	North Country Hospital	Springfield Hospital	Gifford Medical Center	Mt. Ascutney Hospital
FQHC	--	The Health Center	--	CHCB	--	Five Town Health Alliance	NOTCH	CHCRR	Northern Counties Health Care	Lamoille Health Partners	--	SMCS dba North Star	Gifford Health Care	--
Independent Primary Care	4 Organizations	--	--	12 Organizations	2 Organizations	2 Organizations	2 Organization	--	--	1 Organization	--	--	1 Organization	--
Independent Specialist	2 Organizations	3 Organization	--	9 Organizations	1 Organization	--	1 Organizations	--	--	1 Organization	1 Organization	--	--	--
Home Health	VNA & Hospice of the SW Region[2]; Bayada[1]	Central VT Home Health & Hospice	VNA of VT & NH[3]; Bayada[1]	UVM Health Network Home Health & Hospice; Bayada[1]	VNA of VT & NH[3]	Addison County Home Health & Hospice	Franklin County Home Health Agency	VNA & Hospice of the SW Region[2]; Bayada[1]	Lamoille Home Health Agency[7] (Hardwick); Caledonia Home Health & Hospice[4]	Lamoille Home Health Agency[7] (Hardwick)	Orleans Essex VNA & Hospice	VNA of VT and NH[3]	VNA of VT & NH[3]	VNA of VT & NH[3]
SNF	2 SNF	3 SNFs	3 SNFs	4 SNFs	--	1 SNF	3 SNFs	3 SNFs	1 SNF	1 SNF	2 SNFs	1 SNFs	--	1 SNF
Designated Agency	United Counseling Service of Bennington County	Washington County Mental Health	Health Care & Rehab Services of SE VT[6]	Howard Center	Health Care & Rehab Services of SE VT[6]	Counseling Service of Addison County	Northwestern Counseling & Support Services	Rutland Mental Health Services	Northeast Kingdom Human Services[8]; Lamoille County Mental Health Services[5]	Lamoille County Mental Health Services[5]	Northeast Kingdom Human Services[8]	Health Care & Rehab Services of SE VT[6]	Clara Martin Center	Health Care & Rehab Services of SE VT[6]
Other	1 Special Service Agency	1 Special Service Agency	1 Other (Brattleboro Retreat)	3 Naturopath; 1 Special Service Agency; 1 Surgery Ctr; 3 Physical Therapy	1 Other (DH Clinic)	1 Naturopath	1 Physical Therapy	1 Physical Therapy	--	--	--	1 Special Service Agency	1 Naturopath	--

Notes:

OneCare has Collaborator Agreements with Area Agencies on Aging (AAAs) across Vermont as well as with the SASH Program

[1] Bayada serves the entire State of Vermont, these are the communities where there are main offices

[2] VNA & Hospice of the Southwest Region services both the Bennington and Rutland HSAs

[3] VNA of VT and NH services the Brattleboro, Lebanon, Windsor, Springfield and Randolph HSAs

[4] Caledonia Home Health & Hospice is part of Northern Counties Health Care

[5] Lamoille County Mental Health Services covers both the Morrisville and St. Johnsbury HSAs

[6] Health Care and Rehabilitation Services of Southeastern Vermont services the Brattleboro, Lebanon, Windsor and Springfield HSAs

[7] Lamoille Home Health Agency services the Morrisville and St. Johnsbury HSAs

[8] Northeast Kingdom Human Services covers both Newport and St. Johnsbury HSAs

*The HSAs listed are contracted with the payer programs indicated

**Not all Entities within each given HSA participate in the payer programs listed above; the table shows the Entities in the given HSA.

Attachment B: 2023 OneCare ACO Hospital Participation Year Over Year

			Payer Programs by Year *(see key below)*						
#	HSA	Hospital Assigned	2017	2018	2019	2020	2021	2022	2023
1	Burlington	UVM Medical Center	VMNG & Shared Savings	All Risk Programs	All Risk Programs & BCP	All Risk Programs, BCP & MVP	All Risk Programs, BCP & MVP	VMNG, VMAI, BCBSVT, MVP	VMNG, VMAI, BCBSVT, MVP
2	Berlin	Central Vermont Medical Center	VMNG & Shared Savings	All Risk Programs	All Risk Programs & BCP	All Risk Programs, BCP & MVP	All Risk Programs, BCP & MVP	VMNG, VMAI, BCBSVT, MVP	VMNG, VMAI, BCBSVT, MVP
3	Middlebury	Porter Medical Center	VMNG & Shared Savings	All Risk Programs	All Risk Programs & BCP	All Risk Programs, BCP & MVP	All Risk Programs, BCP & MVP	VMNG, VMAI, BCBSVT, MVP	VMNG, VMAI, BCBSVT, MVP
4	St. Albans	Northwestern Medical Center	VMNG & Shared Savings	All Risk Programs	All Risk Programs & BCP	All Risk Programs, BCP & MVP	All Risk Programs, BCP & MVP	VMNG, VMAI, BCBSVT, MVP	VMNG, VMAI, BCBSVT, MVP
5	Brattleboro	Brattleboro Memorial Hospital	Shared Savings	All Risk Programs	All Risk Programs & BCP	All Risk Programs, BCP & MVP	All Risk Programs, BCP & MVP	VMNG, VMAI, BCBSVT, MVP	VMNG, VMAI, BCBSVT, MVP
6	Springfield	Springfield Hospital	No Participation	All Risk Programs	All Risk Programs	VMNG, BCBSVT QHP, BCP & MVP	VMNG, BCBSVT QHP, BCP & MVP	VMNG, BCBSVT & MVP	VMNG, BCBSVT & MVP
7	Lebanon	Dartmouth Hitchcock Hospital	Shared Savings	VMNG & BCBSVT	VMNG, BCBSVT & BCP	VMNG, BCBSVT QHP, BCP & MVP	VMNG, BCBSVT QHP, BCP & MVP	VMNG, BCBSVT & MVP	VMNG, BCBSVT & MVP
8	Bennington	Southwestern VT Medical Center	Shared Savings	VMNG Only	All Risk Programs & BCP	All Risk Programs, BCP & MVP	All Risk Programs, BCP & MVP	VMNG, VMAI, BCBSVT, MVP	VMNG, VMAI, BCBSVT, MVP
9	Windsor	Mt. Ascutney Hospital	Shared Savings	VMNG Only	All Risk Programs & BCP	All Risk Programs & BCP	All Risk Programs & BCP	VMNG, VMAI, BCBSVT	VMNG, VMAI
10	Newport	North Country Hospital	Shared Savings	VMNG Only	VMNG Only	VMNG, BCBSVT QHP, BCP & MVP	VMNG, BCBSVT QHP, BCP & MVP	VMNG, BCBSVT & MVP	VMNG, BCBSVT & MVP
11	Rutland	Rutland Regional	BCBSVT & Shared Savings	No Participation	VMNG Only	VMNG, BCP & MVP	VMNG, VMAI, BCP & MVP	VMNG, VMAI, BCBSVT, MVP	VMNG, VMAI, BCBSVT, MVP
12	St. Johnsbury	Northeastern VT Regional Hospital	No Participation	No Participation	VMNG Only	VMNG, BCP & MVP	VMNG, BCP & MVP	VMNG, BCBSVT & MVP	VMNG, VMAI, BCBSVT, MVP
13	Randolph	Gifford Medical Center	No Participation	No Participation	VMNG Only	VMNG & MVP	VMNG & MVP	VMNG & MVP	VMNG & MVP
14	Morrisville	Copley Hospital	Shared Savings	No Participation	No Participation	VMNG & MVP	VMNG & MVP	VMNG, BCBSVT & MVP	VMNG, BCBSVT & MVP
15	Townshend	Grace Cottage	No Participation	No Participation	No Participation	No Participation	No Participation	No Participation	No Participation

All Risk Programs: VMAI, VMNG & BCBSVT QHP **BCBSVT:** For 2017-2021 represents QHP only; For 2022 represents QHP, BEE, Fully-Insured LG, Self-Insured LG **BCP:** BCBSVT Primary **MVP:** MVP QHP
Shared Savings: Medicare and BCBSVT Shared Savings Programs **VMAI**: Vermont Medicare ACO Initiative **VMNG:** Vermont Medicaid Next Generation

Section 2

ACO Provider Contracts

Section 2: ACO Provider Contracts

1. **Submit Appendix 2.1, 2023 ACO Organizations List and Appendix 2.2, 2023 ACO Provider List as soon as they are final and no later than October 15, 2022.[1] Additionally, complete the following summary tables in the Excel Workbook:**

   OneCare will submit Appendices 2.1 and 2.2 no later than October 15, 2022, as required.

   a. **2.2.1 Count of Individual Practitioners Contracted with the ACO**

      OneCare will submit Appendix 2.2.1, Table 1 no later than October 15, 2022, as required.

   b. **2.2.2 Count of Entities by Contract Types**

      OneCare will submit Appendix 2.2.2, Table 2 no later than October 15, 2022, as required.

   c. **2.2.3 Count of Entities by Organization Type**

      See Section 1, Attachment A for the FY 2023 count of entities by organization type. Additionally, see the response to Section 2, question 4 for an explanation of network changes.

2. **Submit copies of each type of provider contract, agreement, and addendum for 2023 (i.e. risk contracts, non-risk contracts, collaboration agreements, and memoranda of understanding).**

   See enclosed Attachment C-2023 Network Agreements.

3. **Provide an update on the FY23 Network Development Strategy (submitted 4/28/22). In your response, discuss any new provider programs or pilots and progress on 2023 provider network goals, challenges, and opportunities.** ***(Word Count 500)***

   OneCare's 2023 network development strategy remains consistent with the approach submitted to the Green Mountain Care Board (GMCB) in April 2022. There is a continued focus on retaining current participation, expanding participation in existing payer programs, managing risk and opportunity, and making modest adjustments to programs to continue to create sustainability that adjusts with migrations of the programs over time. The 2023 primary care network development strategy includes: continuing resource supports for primary care through OneCare's integrated Population Health Model (PHM); maintaining aligned participation in ACO payer programs, excepting Medicare; communicating network accountabilities and ACO supports; reaching out to remaining hospitals offering a pathway to onboard them to ACO programs; and exploring expansion of the CPR Program to hospital employed primary care and FQHCs.

One of the most significant challenges remaining is the absence of Medicare and commercial unreconciled fixed payments. In addition, hospital financial stability continues to preclude tolerance for significant changes in risk and the ability to increase investments in population health beyond current levels. Further, the expansion of enrollment in Medicare Advantage programs, which puts beneficiaries outside the ACO model, needs to be addressed in future visioning. These issues will need to be addressed systematically in order to further grow participation in value-based care programs.

4. **Quantify the number and type of providers that have dropped out of the network 2021-2023 (prior, current, and budget years) and to the best of your knowledge, their reasons for exiting.**

	# Departing Organizations			
Departure Reason	2021	2022	2023	Type/Comment
Merged, Acquired or Closed	4	4	1	Independent PCP practice closed (owner retired)
Lack of Specialist Program	2	2	0	N/A
COVID-19 Impacts	4	0	0	N/A
Primary Care funding	2	0	0	N/A
Total per Year	**12**	**6**	**1**	

In terms of additions to OneCare's network, four Genesis skilled nursing facilities (SNFs) were added for PY 2023. OneCare also expanded participation in payer and CPR programs. Medicare participation increased by one hospital, one FQHC, and one independent primary care practice. Blue Cross and Blue Shield of Vermont (BCBSVT) has two additional SNFs, and MVP Health Plan (MVP) has added one SNF. Participation in the CPR program increased by one new independent primary care practice.

5. **Describe changes to the base Provider Agreements for 2023, if any. Discuss any differences in the base agreement by provider type where applicable. (*Word Count 500*)**
    a. **In your response, compare the 2022 Program of Payments to 2023 (Reference Attachment Provider Agreements and Addenda Provider Agreement Performance Year Program of Payments, Participant and Preferred Providers).**

    OneCare's most substantive changes impacting provider agreements are incorporated through policies that are presented to the Population Health Strategy Committee and Finance Committee for endorsement, and then to the Board of Managers for approval. The provider base agreement was amended to extend the term to 2024 and the payer addenda had minimal changes applied to provide additional clarity. Policies

related to this subject have been shared with GMCB, as part of OneCare's FY 2023 ACO Certification process, and are referenced below.

The following changes were made to the Program of Payment for PY 2023:

- Updated references to all 2023 policies;
- Added a new section for Population Health Model (PHM) Payments and made reference to Policies 04-19-PY23-25 Participant Population Health Model and Payments PY 2023-2025, and 04-20-PY23-25 Preferred Provider and Collaborator Population Health Model and Payments PY 2023-2025; and
- Revised the payment summary chart by provider type for clarity.

[1] The ACO Provider List is due to CMS on September 30. Preparing the list for the GMCB customized format required an extension in previous years, so GMCB is allowing the extension upfront for the FY23 Budget.

Section 2: Attachments

Attachment C: 2023 Network Agreements

- Electronic Version: See file “OCV_FY23-Budget_Attachment-C-Network-Agreements_Sent-09-30-2022.zip"
- Print Version: See section labeled “Attachment C-2023 Network Agreements”

Section 3
ACO Payer Contracts

Section 3: ACO Payer Contracts

1. **Complete Appendix 3.1, ACO Scale Target Initiatives and Program Alignment Forms and submit copies of each 2023 payer program contract, within ten (10) days of execution.**
   a. **An ACO Scale Target Initiative and Program Alignment Form must be completed for EACH sub-group within a payer contract (i.e., risk/non-risk programs under the same contract).**

   See enclosed draft Appendix 3.1 ACO Scale Target Initiatives and Program Alignment Forms to reflect anticipated program terms. OneCare will submit final forms within 10 days of execution of payer agreements, as required.

2. **Explain changes made to your portfolio of payer programs for the proposed budget year using the below table and relevant narrative as described below. For new and continuing payer programs discussion of anticipated changes should include changes to specific groups covered under payer contracts such as the traditional and expanded Medicaid cohort, QHP, insured, or self-insured groups within commercial contracts. If payer contracts are not finalized by the date of the budget submission, please respond as completely as possible to the applicable questions. Contracts must be submitted within 10 days of execution and the GMCB may request an update on the status of contract negotiation at any time.** *(Word Count: 500)*

Payer Program	Program Start Year	Anticipated Changes?	Scale Qualifying?
Medicare	1/1/2023	Moving to a 3% risk corridor	Yes
Medicaid Traditional	1/1/2023	Exploring a fixed payment expansion pilot to include additional lives under fixed payments (not budgeted, but being discussed); discussing risk corridor adjustments	Yes
Medicaid Expanded	1/1/2023	Same as above	Yes
BCBSVT QHP	1/1/2023	Proposing [redacted]; Refining target methodology	Yes
BCBSVT Primary: BEE	1/1/2023	Same as QHP above	Yes
BCBSVT Primary: Fully Insured Large Group	1/1/2023	Same as QHP above	Yes
BCBSVT Primary: Self-Funded Large Group (Risk Cohort)	1/1/2023	Same as QHP above	Yes
BCBSVT Primary: Self-Funded Large Group (Non-Risk Cohort)	1/1/2023	None	No
MVP	1/1/2023	[redacted]	Yes

a. **For any new payer program in 2023, describe the anticipated size and scope of the program and the impact on the budget model.**

There are no new payer programs budgeted for 2023.

b. **For continuing payer programs that have Anticipated Changes, explain the anticipated changes and the overall impact on the budget.**

Payer contracts are in negotiation and updates will be provided when concluded. At the time of the budget submission, OneCare anticipates its payer programs will continue in a generally similar form.

Commercial Programs

For BCBSVT, OneCare anticipates [redacted] and that it will [redacted]. MVP is budgeted [redacted]. Both programs are budgeted with [redacted]. Expansion of commercial payer programs to [redacted] has minimal budgetary impact to OneCare aside from [redacted]; however, it does represent material impact for the risk-bearing hospitals.

Medicaid

The submitted budget incorporates expansion to a 3% corridor for the Traditional cohort, but this is subject to negotiation. OneCare and DVHA are in discussions regarding the $2M VBIF pool, funded by DVHA directly to providers in 2022. From a budgetary perspective, it is unclear whether the fund will flow through OneCare or remain with DVHA to be paid directly to providers. To more transparently show OneCare's PHM spending intent, the budget submission includes $2M of Unsecured Revenue (as opposed to removing expense). If these funds remain with DVHA, the Unsecured Revenue line will be removed, offset by $2M of provider payment expense to be paid by DVHA. There is risk if the funds do not materialize in part or in full as provider payments would need to be adjusted accordingly.

OneCare and DVHA are also working on a fixed payment expansion pilot to incorporate currently unattributed lives into the fixed payment. With respect to the budget, this would substantially grow the percentage of Medicaid revenue being reimbursed through the fixed payment. Note the pilot is not currently budgeted.

Medicare

OneCare budgeted an additional HSA in the Medicare program for PY 2023 and anticipates increasing the risk corridor to 3% to account for the impact of the Blueprint for Health (Blueprint) funds on the upside potential in the risk corridor. An additional HSA requires budgeting additional Accountability Pool contributions.

c. For any terminated payer programs, please explain.

OneCare has not terminated payer program agreements with any of the current payers: Medicaid, Medicare, BCBSVT, and MVP; however, contract negotiations are ongoing and terms will not be finalized until later this fall.

d. **Discuss payer contracting goals, strategies, opportunities, and limitations for creating and maintaining Scale Qualifying lives.**

Sustainability of current ACO programs remains the primary strategy to maintain scale qualifying lives. OneCare's guiding contracting strategy is to negotiate its payer contract terms to align financial components with OneCare strategic priorities, stay within participants' risk tolerance parameters, and generate fair outcomes for all parties. The most common barrier to sustaining these programs is aligning priorities. OneCare works to deliver aligned, payer-agnostic priorities to providers, but each payer presents vastly different priorities (e.g., managing high-cost cases, mental health integration, and building market share). OneCare remains focused on health equity and coordination of care, prevention and chronic condition management, and the use of data to identify opportunities for improved care. These competing priorities and the ensuing provider-payer tensions make it challenging to negotiate annual contracts formulated to grow scale.

Further, complexity and constant change in the insurance coverage landscape are continued challenges to scale. Attribution models need time to "catch up" after an individual changes their insurers. This results in a significant number of lives that are not attributed in any given year despite having a primary care relationship with a OneCare network provider.

e. For any payer programs or groups covered by payer programs that do not generate attribution qualifying for All Payer Model scale targets (not Scale Qualifying), explain the rationale for entering the program and its overall impact on the budget model.

OneCare views the non-risk cohort as an on-ramp to prepare for risk-based arrangements. Within the "Primary" component of the BCBSVT program, self-funded employer groups utilizing BCBSVT as their third-party plan administrator can decline participation in the value-based model. BCBSVT is responsible for marketing ACO participation to its self-funded groups through their relationships with each employer group. Each year, these large self-funded groups are presented with the option to participate in a value-based arrangement, offering the opportunity to move toward being full-risk, scale qualifying lives.

3. **Report the following information on the ACO's budgeted and target fixed prospective payment arrangements for 2023 and beyond, consistent with the template in the ACO Reporting Manual: (*Word Count:750)***

a. **Budgeted and Target Total Fixed Payment (FPP+CPR) as a percent of Expected Total Cost of Care, by payer program for 2023-2026. Total Fixed Payments include both reconciled and unreconciled fixed payment arrangements. Include the numerator and the denominator for the Budget Year 2023. Indicate if targets are for reconciled or unreconciled fixed payments, or unreconciled fixed payments only.**

	Attribution	Expected TCOC	Reconciled & Un-Reconciled FPP Total $	Total FPP %	Un-Reconciled FPP Only $	Un-Reconciled FPP %
Medicare	50,430	$552,916,537	$262,082,439	47.4%	$0	0.0%
Medicaid	108,609	$306,085,016	$171,113,682	55.9%	$171,113,682	100.0%
BCBSVT	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
MVP QHP	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
TOTAL	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

b. The ACO's strategy for achieving the targets, by payer, with timelines, clear goals, and milestones. Discuss barriers, limitations, or other factors, by payer.

Medicare

OneCare, despite continued advocacy, was informed that the current reconciled fixed payment model (AIPBP) will not convert to an unreconciled model through the duration of the APM extension, delaying payment reform options for 2025 and beyond. OneCare and the Vermont Association of Hospitals and Health Systems (VAHHS) formed a provider APM Task Force to discuss future priorities including more effective payment reforms. This information is being shared with state leaders through the fall and winter to inform the state's negotiations for 2025 and beyond. OneCare and its providers continue to champion payment reform as an opportunity to more closely align the way providers are paid in connection with their mission and purpose.

Medicaid (Traditional)

Currently, Medicaid is the only OneCare program that offers an unreconciled fixed prospective payment (FPP) option. The program has been broadly adopted by participating OneCare hospitals and CPR practices, and covers hospital care for over 120,000 VMNG members (pre-attrition). OneCare and DVHA are actively discussing a fixed payment expansion initiative that aims to increase the percentage of Medicaid reimbursement under the fixed payment. The expansion is not yet included in the budget as it is too early in the process to accurately project the new fixed payment model as a percentage of the total cost of care. There is an upcoming challenge that will require strong coordination between OneCare and DVHA in managing the fixed payment arrangement when the Medicaid redetermination process resumes.

OneCare also engaged in further discussions with FQHCs to explore their willingness to participate in a Medicaid fixed payment initiative. Through these discussions, OneCare

was informed that the FQHCs need to prioritize reimbursement rates with Medicaid before entering into a payment reform initiative. This opportunity will be explored again with FHQCs for possible 2024 inclusion.

Commercial

OneCare continues to negotiate with commercial insurers to implement unreconciled fixed payment models. Technical limitations, low marketable value, and low risk tolerance for variation from fee for service (FFS) are understood to be the most immediate barriers to advancing unreconciled commercial insurer fixed payment offerings. From the health care provider side, commitment to payment reform remains strong, but there are concerns related to the magnitude of hospital commercial rate change requests. Ensuring the approved hospital commercial rate changes are incorporated into the fixed payment amounts is essential for hospital sustainability. Additionally, concerns remain about the TCOC target methodology, which represents an essential area of focus. Based on the current status of discussions, it is unlikely there will be any new unreconciled commercial fixed payment offerings for OneCare in 2023.

4. **Provide an update on OneCare's work to develop scale target qualifying programs with Medicare Advantage plans operating in Vermont, with a special focus on Vermont-based plans offered by BCBSVT and UVMMC-MVP.** ***(Word Count: 300)***

OneCare has not initiated contracts with these Medicare Advantage Plans to date due to other priorities; however, OneCare is open to exploring this option for future years. While Medicare Advantage market share is expected to continue growing, the comparatively small number of lives covered by these plans represents a barrier that will require unique considerations.

Section 4

Total Cost of Care

Section 4: Total Cost of Care

1. **Complete Appendix 4.1 TCOC Performance by Payer, Total ACO-Wide (2018-2023). Instructions:**
    a. **Verify actuals for past years 2018-2020.**

        OneCare verified the actuals for past years 2018-2020 as shown in Appendix 4.1.

    b. **Provide projections for the current and prior year (2021-2022) and the timeline for when actuals will be available.**

        See Appendix 4.1 for current and prior year projections (2021-2022). Actual settlement results for 2021 are anticipated to be available in November 2022, and results for 2022 are anticipated to be available November 2023.

    c. **For the budget year (2023), provide expected TCOC.**

        See Appendix 4.1 for 2023 TCOC estimates. Note that the TCOC estimates supplied are forecasts, not actuals. The actual TCOC targets will be determined by payers and the GMCB later this fall/winter. In all cases, OneCare's TCOC estimates are based on underlying FFS with trend estimates gleaned from history, rate filings, or APM terms.

2. **Discuss drivers and assumptions for Total Cost of Care targets and results by payer program.** ***(Word Count: 800)***

    When developing TCOC targets for the budget, the primary aim is to forecast the expected targets. This underscores the perspective that the final TCOC targets should reflect health care expenditures absent ACO activities and interventions. Deviations from this (such as a truncation limit) are designed to ensure the results fairly measure the effectiveness of ACO activities, and are not skewed by a few unpredictable events. Also, since these TCOC targets are built from a FFS base, the targets themselves carry forward trends and dynamics germane to FFS, but the results from prior years are not explicitly incorporated into the TCOC estimates other than through rebasing from prior period FFS.

    a. **Explain the drivers of expected vs. actual Total Cost of Care results by payer program and discuss any significant trends over time.**

        When analyzing and developing forecast figures, OneCare aims to replicate the expected methodology that payers will use to set the performance year target. Generally speaking, the TCOC forecasts rely upon an attribution estimate, an assumption of the base expenditures, a projection of the trend rates payers will apply, and any final adjustments as part of the accountability model established by the payers (such as COVID-19 exclusions).

        The public health emergency continues to present many challenges in the target-setting process across all payers in 2022, particularly in formulating base expenditure assumptions. Different HSAs, age groups, and payers have all

experienced abnormal seasonal trends since 2020, which presents a challenge when trying to forecast TCOC.

In addition to these general considerations, the following are some of the more payer-specific drivers OneCare considered when forecasting expected and actual TCOC results.

Medicare
The public health emergency triggered the exogenous clause in OneCare's Medicare contract, which led to a change in the methodology for calculating the 2020 and 2021 benchmarks. In 2022, the target setting methodology returned to the normal method, with a 2% risk corridor.

The trend rate applied to the base year expenditures was lower than the maximum allowed trend rate by several percentage points. Spend in the spring of 2022 was high and over target, while in the summer months it was lower, unlike 2021. It is likely that spend will increase in the fall months and be over target as the fall is traditionally a high-utilization time for the Medicare population, but as noted, seasonality has been challenging to predict in light of recent claims history.

Medicaid
For both the Traditional and Expanded cohorts, the Medicaid targets were built to include adjustments for predicted levels of COVID-19 admissions and vaccination spend in the actual TCOC. To date, spend has had a similar increase to Medicare in the spring with summer months being more level. This slowing over the summer may yield favorable results in the Medicaid program, but there is significant uncertainty driven by the continuing public health emergency into the fall. At least some of the shared savings achieved in the Medicaid program are anticipated to be offset by losses under the unreconciled fixed payment, which is currently projected to be under the FFS equivalent for the Traditional cohort.

BCBSVT QHP
The BCBSVT QHP program is currently forecasted to be over target for performance year 2022. The target setting methodology is different than in the past and includes a risk adjustment that will not be final until after the year is completed. This risk adjustment is intended to make the target more representative of the projected cost of the population minus any ACO activities, but does make the target, and thus the performance, variable throughout the performance year. Higher spend in January and March in particular exceeded expectations. Spend appears to be more level over the summer months, but is projected to be high in the fall, driving the total spend over the projected target for the year.

BCBSVT Primary
The actual total cost of care for the Primary cohort is projected to be fairly stable from 2021 to 2022. While the actual cost of care increased over the spring months, the spend is projected to be lower in the fall, and thus we are projecting a small amount of shared savings, limited by the risk corridor.

MVP QHP

The MVP QHP target was based on a blend of the historical 2020 and 2021 costs, and thus anticipate the target will be lower than the actual cost of care for performance year 2022. Spend for this cohort was high in the late spring months but appears to be level over the summer, following the same patterns seen in the other programs mentioned above. The fall is anticipated to be higher than the summer and thus the spend is projected to remain above target for the year.

The expected TCOC figures can be referenced in Appendix 4.1 enclosed.

b. Discuss assumptions for projections and budget figures (e.g., based on historical seasonal spend plus a particular rate of growth, etc.). Describe all adjustment factors used for calculating the settlement result (e.g., risk sharing, other fees, etc.).

When developing projections and budget figures, OneCare aims to prepare an analysis that will replicate the expected methodology that payers will use to set the performance year target. The TCOC forecasts rely upon an attribution estimate, an assumption of the base expenditures, a projection of the trend rates payers will apply, and any final adjustments as part of the accountability model established by the payers (e.g., COVID-19 exclusions). In 2023, OneCare does not anticipate significant changes to the underlying attribution totals. Assumptions to trend rates are explained in more detail in the response to Section 4, question 3.

3. Complete Appendix 4.2, Projected and Budgeted Trend Rates, by Payer Program, and explain the following, refer to "Part II. ACO Budget Targets" of this guidance in your explanation: (*Word Count:1,000)*

a. All underlying assumptions for these trend rates (Appendix 4.3, Column D) including those related to changes in utilization, service mix, unit cost etc., noting any significant deviations from prior year. For programs subject to rate review by the GMCB, the 2023 benchmark trend rates must be consistent with the ACO-attributed population and the GMCB approved rate filings, if any. See Other Targets/Benchmarks section below (p.16).

OneCare generates its forecast trend rates differently for each payer program and in a manner that aims to generate a result that will align with the way each payer establishes the actual target. Note that discussions are ongoing with payers to determine the methodology that will be in place for the 2023 performance year. The explanations below represent the way in which the budget estimates were built, which was based largely on prior models rather than potential future models due to available information and ongoing contract negotiations.

At the time of the budget submission, it is unclear how the specific changes in factors such as utilization, service mix, and unit cost will be incorporated into each payer's rate development. The budget also incorporates the maximum allowable Medicare United States Per Capita Cost (USPCC) trend rate per the APM. Trend rate assumptions by payer

are noted below.

Medicare
Trend rates are sourced from the USPCC forecast published by the Centers for Medicare and Medicaid Services (CMS) as outlined in the APM. As such, a blended trend of 5.2% was applied to a forecast of 2022 spend, adjusted for network changes, to determine the estimated 2023 benchmark.

OneCare applied the same 5.2% trend increase for the Blueprint for FY 2023. Note that the 5.2% trend was applied to the latest payment information from the Blueprint, which is based on updated attribution runs throughout the year. As a result, there is a small variance between the Patient Centered Medical Home and Community Health Team categories budget-to-budget, but the 5.2% has been applied uniformly when comparing actual-to-budget. Also note that the 5.2% decision for the Blueprint is at the discretion of the GMCB.

Medicaid
Trend rates are determined by reviewing prior rate development models to determine a reasonable budget assumption to be used until Medicaid sets the actual TCOC target. Based on this analysis, a blended 2.05% trend for the Traditional cohort and a blended 2.23% trend for the Expanded Cohort, relative to the expected 2022 spend base, have been incorporated into the forecast.

BCBSVT QHP
OneCare requests input on the medical expense trend data from the payer. BCBSVT supplied a [redacted] for the medical expense trend, derived from the GMCB-approved rate filing, to be used in OneCare's budget development. OneCare applied [redacted] (relative to the 2022 projected spend) to the forecast.

BCBSVT Primary: OneCare requests input on the appropriate trend data from the payer. BCBSVT supplied a [redacted] for the trend estimate. OneCare applied [redacted] (relative to the 2022 projected spend) to the forecast.

MVP QHP: OneCare requests input on the medical expense trend data from the payer. MVP supplied a [redacted] for the medical expense trend, derived from the GMCB-approved rate filing, to be used in OneCare's budget development. OneCare applied [redacted] (relative to the 2022 projected spend) to the forecast.

b. For each program, contrast the budgeted growth rate (Appendix 4.3, Column D) with the expected growth trend for the ACO (Appendix 4.3, Column G). Include analysis for reasons why the ACO's performance differs from the trend rates used in the budget.

The submitted budget assumes that the expected spending is appropriately set and aligns with the anticipated actual spending that will occur absent OneCare and provider ACO interventions for all payers. If the budgeted growth rates are appropriately set and align with the actual TCOC target trends, ACO performance will differ from the trend rates

through either effective or ineffective population health management. Activities such as coordination of care, use of data, and a general focus on whole-health outcomes are designed to generate an actual trend that lands below the targeted trend.

c. Recognizing that COVID-19 has resulted in unexpected utilization trends that could continue into 2023, what assumptions are you making around fluctuating utilization estimates, or any other factors that could result in material changes to these budgeted figures and what is the anticipated impact to the proposed budget? Include a description of how you approach calculating the base experience (Appendix 4.3, Column C).

Many unknowns remain regarding both the current and future impacts of COVID-19 on health care costs. However, it appears most targets will begin to naturally incorporate COVID-19, as opposed to excluding COVID-19 episodes entirely. This approach reflects the realization that COVID-19 care is likely to become a more "normal" component of our health care landscape. In some cases, there may be a specific COVID-19 adjustment built into the target but incorporation of a specific factor is dependent on the target methodology employed.

d. How these growth rates and targets support the All-Payer Model goal to manage overall health care cost growth to be in line with that of the Vermont economy.

The pivotal first step in managing overall health cost growth is to transition the health system from one rewarded by volume to one that rewards cost-effective and high-quality care. OneCare's 2023 budget anticipates another year with a significant number of attributed lives in value-based care programs, indicating ongoing commitment by Vermont's providers to this transition. The trend rates themselves are a means to establish an accountability target and install a paradigm in which providers are rewarded for effective health care cost management.

Section 5

ACO Network Programs and Risk Arrangement Policies

Section 5: ACO Network Programs and Risk Arrangement Policies

1. **Describe provider payment strategies, methodologies, and rationale. Reference relevant contract terms or policies. Include in your response, which provider types are eligible for which types of payments? Why?** ***(Word Count: 500)***

OneCare payments include performance incentive payments and payment reforms that convert from FFS to a fixed payment.

Performance Incentive Payments
Prior experience and feedback from providers suggest a more focused program with a clear connection to payment is more likely to generate measurable improvements. The 2023 budget consolidates former $3.25 per member per month (PMPM), care coordination, and VBIF payments into one Population Health Model (PHM) payment stream. See the response to Section 5, question 2.d below for additional details about OneCare's 2023 Population Health Model.

Payment Reforms
Medicaid FPP and CPR program payments represent examples of OneCare paying for care in a reformed way (other fixed payments reconcile to FFS and don't materially alter the reimbursement dynamics).

One payment reform strategy is to expand the Medicaid fixed payment, making it a more holistic reform that would substantially grow the percentage of Medicaid revenue reimbursed through fixed payment. Another strategy is to deepen the connection between CPR payments and total health care expenditures. Some states have established guidelines for primary care reimbursement models based on a percentage of the TCOC. Building on this idea, OneCare is actively working with CPR participants to further this linkage, whereby the financial resources to primary care more closely follow overall total health care expenditure trends (e.g., if the TCOC is expected to increase by 4%, then CPR reimbursement would similarly increase by 4%).

a. Participant vs. Preferred Providers

Payments to Participants are often established on a PMPM basis to align with attribution, while payments to Preferred Providers are typically based on allocation approved through the budget process because they do not attribute lives. See questions 1.b-1.e below for more information.

b. Risk-bearing Participants

A "Risk-bearing Participant" is a hospital Participant that bears downside risk on behalf of its HSA for shared losses in excess of available Accountability Pool funding. By assigning programmatic risk/reward to hospitals, it provides a direct incentive to support ACO activities that result in overall health care cost containment that would otherwise harm hospital revenue generation. Despite this, the financial health of Vermont's hospitals

represents a significant concern to the general strategy of relying upon hospitals to bear programmatic risk.

c. Primary Care

In 2023, primary care providers are eligible for the following: a) payer program shared savings or losses through the Accountability Pool, b) performance incentive pool funds, c) PHM base and bonus payments, and d) CPR payments (as eligible).

d. Specialty Care

OneCare budgeted one-time funds for SNFs to address gaps in post-acute care services. Details currently under discussion with key stakeholders.

e. Continuum of Care (i.e., HHH, DAs, SNFs)

In 2023, HHH, DAs, and AAAs are eligible for PHM base payments and bonus payments.

See *4-07-PY23 ACO Program Settlement PY 2023 Policy* and *04-19-PY23-25 Participant Population Health Model and Payments PY 2023-2025 Policy,* submitted to the GMCB on August 31, 2022. See also Attachment D-04-08-PY23 Comprehensive Payment Reform Program PY 2023 Policy.

2. **Discuss ACO program goals, strategies, opportunities, and limitations for the following:** ***(Word Count: 1,000)***

a. The ACO's strategy for increasing the opportunity for upside/downside risk

The single largest impediment to increased downside risk in 2023 is the financial instability underscoring the health care landscape in Vermont. Operating under historically challenging financial circumstances is a barrier to increasing the magnitude of risk/reward. OneCare leadership will continue to strategically approach risk/reward as an opportunity, but one that needs to be measured against the overall financial health of the health care system and, in particular, the risk bearing entities.

It is important to recognize each payer program presents different opportunities and challenges. Having confidence in the target methodologies will help to expand the provider network's tolerance for wider risk corridors.

In the Medicare program, additional downside risk will require decoupling the program from the Blueprint, which is funded as advanced shared savings and therefore creates asymmetric risk (far more downside risk than upside). This is difficult to justify financially.

Within the Medicaid program, the history of year-to-year strong performance must also be measured against the financial instability mentioned above. Given this instability, OneCare's provider network is cautious of the magnitude of risk in general, but seemingly feels most comfortable in the Medicaid space.

OneCare has faced longstanding challenges in the commercial target-setting space. A reasonable, industry-standard, actuarially-sound process for modeling fair total cost of care targets is a non-negotiable prerequisite for taking more downside risk with commercial payers.

b. The ACO's strategy for better aligning provider risk with ACO risk

While the plurality of risk remains with the risk bearing hospitals, the new PHM is strategically designed to provide a tighter linkage between individual provider performance and the outcomes that are expected to generate shared savings at the ACO level, creating a dual accountability model. Providers have financial opportunity for their own actions through the PHM, and accountability at the ACO level through the Accountability Pool, which ensures a proportionally reasonable amount of risk assigned to primary care.

c. Strengthening Primary Care

The CPR program is OneCare's primary strategy to strengthen primary care practices, by supporting the transition from a FFS payment model to a value-based payment model. PMPM payments for non-core services are now more dynamic, allowing practices to be reimbursed for additional non-core capacity in a more real-time way.

OneCare continues to refine the CPR program, and is now modeling CPR payments as a percentage of the total cost of care, as opposed to a factor of FFS payments. The goal is to more closely link primary care reimbursement with overall health care trends.

Under its committee structures, OneCare will construct clinical and finance advisory/work groups consisting of CPR participants and other network clinical and financial leaders. The continued strengthening of the primary care delivery model will be the driving focus, but OneCare believes any call for change will be more effective if it is provider-led. To that end, the clinical advisory group will be called upon to help shape the CPR program, such that its funding and accountabilities support advanced primary care delivery in areas such as provider accountability, mental health integration, and program measurement. The CPR finance work group will continue to oversee the calculation of rates and program administration.

d. Reducing Administrative Burden

OneCare is a learning organization; gathering feedback, measuring progress, and supporting programmatic changes to achieve population health goals, while simplifying and aligning across payers. OneCare's 2023 PHM integrates previously separate care coordination, VBIF and population health management ($3.25 PMPM) programs into a single blended program and payment stream. Under this new design, primary care

providers will receive a single PMPM capacity payment for acting as a Patient Centered Medical Home and engaging in care coordination. Incentive payments will be tied to quality measures known to impact improved quality and lower cost. The simplification of this payment stream supports providers' request for a reduction in administrative burden.

Practices will receive quarterly PHM reports displaying practice performance on the quality measures impacting bonus payments. Presenting these data in a singular report, on a more regular basis, will help participants identify areas for improvement with minimal administrative burden.

Additionally, OneCare continues to align quality measures across payer programs to streamline work in furtherance of the APM population health goals. Of the eighteen measures for performance year 2022, fifteen are applicable across multiple payer programs and five are applicable to all payer programs. OneCare is eager to continue this standardization across programs to reduce administrative burden while facilitating coordinated quality improvement efforts across the network to better serve Vermonters.

e. Expanding Fixed Prospective Payment Arrangements

While at present the probability of new unreconciled fixed payment offerings in 2023 is low, OneCare continues to operate the same suite of fixed payment programs as a readiness strategy for more true payment reforms. For example, the CPR program, which requires complex upstream reconciliations with both Medicare and BCBSVT (with the hospitals bearing the cost of any reconciliation back to the payer), is a fully unreconciled model for CPR participants. While the magnitude of the reconciliations is a growing concern, OneCare continues to offer unreconciled fixed payments to the independent primary care practices and are prepared to expand the program to additional provider types should the circumstances align appropriately. Additionally, OneCare is exploring a fixed payment expansion concept with DVHA to expand the scope of the current arrangement.

Expanding fixed payment offerings to provider types beyond hospitals and primary care is dependent on payer willingness to offer unreconciled models. At this time, building out new initiatives on top of reconciled models only increases complexity for our providers, which is the opposite of the desired outcome. Therefore, OneCare's focus on payment reform is centered on expansion of the Medicaid fixed payment model, and further aligning provider incentive payments with population health management strategies.

f. Expanding Payer Program Participation across the Network.

Aside from adding the St. Johnsbury HSA into the Medicare program, operational and financial challenges across the provider network present barriers to more uniform participation. There is hope that there will be increased financial stability amongst participating providers that would then help expand participation in future years.

3. **Complete Appendix 5.1, ACO Risk by Payer and by Risk Bearing Entity for the budget year.** ***(Word Count: 500)***

   a. **Describe the ACO's risk model.**

   OneCare's risk model can be described as a delegated, shared risk model. Under this model, savings/losses are first apportioned by HSA, and then split between primary care and the risk bearing hospital. The inter-HSA split assigns the primary care network the first $1.50 PMPM in downside risk and is entitled to the first $1.50 PMPM of shared savings via the Accountability Pool. Contributions to the Accountability Pool are required for all programs in which risk is delegated to providers. Each primary care provider organization can elect to contribute to the Accountability Pool throughout the year or via year-end invoice for shared losses if owed. Savings or losses in excess of $1.50 PMPM are paid to/by the hospitals who bear all remaining financial risk. If no losses are owed, contributions are refunded and primary care has access to the first $1.50 PMPM of shared savings. The submitted budget includes [redacted] and the risk model is [redacted].

   See *04-07-PY23 Program Settlement PY 2023 Policy* submitted to the GMCB on August 31, 2022.

   b. **How is risk delegated and how does the risk delegation support the goals of the ACO?**

   OneCare contracts with its provider network to delegate the funding of shared losses, as available. As described above, OneCare attributing providers contribute $1.50 PMPM to the Accountability Pool. In the event there are shared savings at the ACO level, primary care Accountability Pool contributions are refunded and matched by up to $1.50 PMPM of shared savings. This effectively delegates risk to the provider network in a proportionally reasonable amount (primary care vs. hospital), supporting the goals of the ACO by aligning primary care providers and hospitals in the effort to perform well against our total cost of care targets.

   There are occasionally risk coverage arrangements that represent a deviation from this approach. Please see the response to question 4.a below for the 2023 specifics.

   See *04-07-PY23 Program Settlement PY 2023 Policy* submitted to the GMCB on August 31, 2022

   c. **Include discussion of any significant changes over the prior year and the rationale for such changes.**

   There is no significant change to the ACO risk model from 2022 to 2023.

4. **Explain how the ACO would manage the financial liability for the risk included in the ACOs payer program agreements for the proposed budget year should the ACO's losses equal 100% of maximum downside exposure. In doing so, please discuss the following:** ***(Word Count: 500)***

If the OneCare network were to suffer losses equaling 100% of the possible downside exposure, by way of OneCare's *04-07-PY23 Program Settlement PY 2023 Policy*, the first $1.50 PMPM of downside exposure would be covered by attributing primary care providers via the Accountability Pool and the risk-bearing hospitals would be invoiced to fund the remainder of any program loss.

a. If any risk is retained by the ACO or the founders, what is this risk associated with, and how much, and how is this obligation funded (reserves, collateral, other liquid security, reinsurance, payer withholds, commitment to pay at settlement, etc.)?

The budget includes a risk mitigation arrangement for the St. Johnsbury community, limiting Medicare savings/losses to 1%. Additionally, there is an independent practice desiring to participate in the CPR program from a community in which the risk-bearing hospital does not hold contracts with all payers; as a result, OneCare will cover risk for their attributed lives to the BCBSVT QHP program. OneCare will pay/receive any risk/reward beyond the risk mitigation thresholds and use its risk reserve pool, if needed. Please note that for the purposes of the 2023 budget submission, OneCare is budgeting a break-even model, meaning the settlement results show no forecast shared savings or losses. This approach is consistent with prior years and the rationale behind it is that the budgeted TCOC factors are derived from the costs expected to be incurred. As such, the risk mitigation amount budgeted is also zero.

b. Does the ACO intend to purchase any third-party risk protection? If so:

After careful consideration, the OneCare budget does not include the cost of a third-party risk protection arrangement. The premium for a risk protection product would be high relative to the dollar amount of potential return. In light of this dynamic and the need to manage hospital participation fees, OneCare is forgoing this expense in 2023. This will be reconsidered if the risk corridor is expanded in future years.

i. Explain the nature of the arrangement.

Not applicable.

ii. How does the anticipated protection compare to prior years?

Not applicable.

iii. How much of the downside risk would be covered?

Not applicable.

iv. Which programs would have this protection?

Not applicable.

c. If applicable, explain the nature and magnitude of any solvency or financial guarantee requirements imposed through payer contract arrangements and how the ACO aims to satisfy those requirements.

OneCare expects the Medicare program to require one percent of the TCOC to be covered by a financial guarantee. OneCare intends to use the same line of credit approach to satisfy this program requirement.

d. Explain any other risk management strategies or arrangements that affect either aggregate ACO risk or individual provider risk.

OneCare does not have any other risk management strategies or arrangements to report.

5. **Complete Appendix 5.2, Shared Savings and Losses by Payer, HSA, Primary Care/Risk Bearing Entity,**

a. **Describe the actual or expected distribution of earned shared savings or losses, in the prior year (2021), in the current year (2022) and in the proposed budget year (2023), noting any significant changes in methodology or practice over time.** ***(Word Count: 250)***

The current projection of total distribution amounts for earned shared savings for the prior year (2021) and current year (2022) are $5,187,622 and $5,013,884, respectively. These figures include shared savings for all payer programs and exclude Blueprint funding. There are no changes in the methodology or practice for distribution of these shared savings.

Per OneCare's *04-07-PY23 Program Settlement PY 2023 Policy*, attributing primary care providers are entitled to reimbursement of the first $1.50 PMPM in shared savings for the Medicare and Medicaid Traditional Programs, with the remainder of shared savings for those programs being distributed to the risk-bearing hospitals (given the absence of attribution, the entirety of shared savings in the Medicaid Expanded program is distributed to the risk-bearing hospitals). Under this policy, OneCare is projecting to distribute $2,501,100 in shared savings to the primary care provider network, with an additional projected distribution of $1,378,529 in 2022.

For the proposed budget year (2023), the OneCare budget does not include shared savings or losses, because the TCOC targets represent OneCare's best estimate of total health care expenditures by program for the year. However, in the event any shared savings or losses are experienced, OneCare would distribute those savings/losses per the terms of OneCare's *04-07-PY23 Program Settlement PY 2023 Policy*. Note that with the commercial programs budgeted to have [redacted], the [redacted].

6. **Discuss the ACO's Total Cost of Care accountability strategy at the HSA level.** ***(Word Count: 500)***

a. How is the ACO using TCOC and quality data at the local HSA level to identify high- value and low-value care? Specifically, how is the ACO helping hospitals and other community providers to reduce avoidable utilization, low-value care, and lower their TCOC at the local HSA level? Cite specific examples and where possible, quantify the ACO's direct impact on reducing avoidable utilization and/or low-value care and lowering TCOC in specific HSAs.

OneCare presents TCOC and quality data in its HSA consultations and supports teams between consultations to make progress on high- and low-cost care opportunities, such as inpatient admissions and emergency department utilization, preventive care, and financial risks and opportunities. The goal is to deliver insights tailored to each community. OneCare is in the process of expanding participation in these consultation meetings, and over time, anticipates that focused improvement efforts in these areas will have a positive impact on the TCOC. For an example of a presentation recently delivered in an HSA consultation, see Section 7, Attachment E: HSA Quarterly Consultation Presentation.

Quality and care coordination teams at OneCare perform community-focused network outreach and engagement. Examples include care coordination core team meetings with HSA care coordination representatives and Blueprint Quality Improvement Specialist(s); care coordination education sessions such as best practices, care model implementation and expectations; and on-demand education via the online learning platform Vermont Health Learn.

Examples of how HSAs, with OneCare support, are improving care include:

- Leaders from Southwestern Vermont Health Care described how OneCare's VBIF program led to their quality improvement efforts, including detailed training for clinical teams, electronic health record enhancements, and the creation of forums for collaboration and planning. SVHC shared data and improvements on four quality measures, including increasing hypertension management rates from 70% to 76% within Q1 2022 and improving diabetes A1c>9, from 50% to 35% (lower better) between January to April 2022 due to the activities spurred by OneCare's programs.

- OneCare has observed the Burlington HSA has a consistently lower TCOC than the payer-adjusted network comparison, and improvement in inpatient admissions in relation to the network, adjusted by payer mix. The predicted increase in inpatient admissions rate from May 2021 to May 2022 was 7.94% and the Burlington HSA successfully limited it to 1.21%. The HSA has used ACO data to support business decisions, including alignment of resources with OneCare financial incentive programs.

- The Brattleboro HSA has taken a similar data-informed approach to decision making including implementing monthly quality meetings with key stakeholders and developing a task force focused on hospital readmissions. By building strong community relationships through ACH engagement and an active Community Health Team, and focusing on care coordination, Brattleboro consistently outperforms the network for payer-adjusted TCOC, inpatient admissions and emergency department visits.

- Based on HSA consultation data and discussion, the St. Albans HSA implemented a new method for managing high and very high-risk individuals. The approach involves care coordination and a committee structure focused on transitions of care. The consistent impact of their approach can be seen in their performance, including inpatient admission rates 2.75% lower than the OneCare network in Q1 2022.

b. Discuss the extent to which providers have control over the risk for which they are responsible. Describe how the ACO's TCOC accountability strategy allows providers to benefit from their ability to provide high-value care (low-cost, high-quality) and impact TCOC growth.

Under the OneCare risk model, network risk is almost entirely held by hospital participants and primary care providers. Shared savings are earned when the ACO provides high-value care relative to the TCOC target. Primary care providers who take steps to lower the TCOC for their attributed lives directly contribute to shared savings and have the most direct control over the risk for which they are responsible. Hospitals have limited opportunities to directly control the risk for which they are responsible, in that the goal of value-based care is largely to avoid utilization of costly and unnecessary hospital services. For this reason, partnering with primary care to undertake effective care coordination, discharge planning, etc., presents the best opportunity to directly control their TCOC risk.

7. Provide any further documentation (i.e., policies) for the ACO's management of financial risk.

OneCare has provided all documentation pertaining to its management of financial risk.

Section 5: Attachments

Attachment D: 04-08-PY23 Comprehensive Payment Reform Program PY 2023 Policy

- Electronic Version: See file “OCV_FY23-Budget_Attachment-D-04-08-PY23 Comprehensive Payment Reform Program PY 2023 Policy _Sent-09-30-2022.pdf"

- Print Version: See section labeled “Attachment D-04-08-PY23 CPR Program PY 2023 Policy”

Section 6

ACO Budget

Section 6: ACO Budget

1. **Complete the GMCB financial statements A1, A2, and A3 (Income Statement, Balance Sheet, Cash Flow) in the Adaptive Database.**

   See enclosed A1 Income Statement, A2 Balance Sheet, and A3 Cash Flow, downloaded from the Adaptive Database.

2. **Complete Appendix 6.4, Sources and Uses in the Budget Guidance Workbook (Excel)**.

   See Appendix 6.4 in the enclosed ACO Budget Guidance Workbook.

3. **For Questions 4-7, complete the Variance Analysis Report through the Adaptive Database.**

   Per discussion with GMCB Staff, the variance analyses for questions 4, 5, 6, and 7 have been completed in the Section 6 Variance Analysis tab in the enclosed ACO Budget Guidance Workbook.

4. **Revenues: Explain any line-item variations greater than 10% evident on your budgeted income statement as compared to prior year projected actuals and prior year revised budget. Please also explain:** ***(Word Count: 500)***

   The main drivers for revenue variance are the following targets: Medicare increased by 24% due to the projected trend increase and the addition of the St. Johnsbury HSA, Medicaid decreased by 13% due to the anticipated redetermination process, Commercials are expected to [redacted]. From the GAAP perspective, there is also a new Unsecured Revenue line item that did not exist in 2022.

   See the Section 6 Variance Analysis in the enclosed ACO Budget Guidance Workbook for a complete view of variances, including explanations for revenue line-item variations greater than 10%.

   a. **Any significant risks associated with the budgeted revenue sources. If substantial risk exists, explain how the ACO would respond.**

      The most significant risk in the 2023 budget relates to $2.0M in Unsecured Revenue anticipated through DVHA contract negotiations. If this funding were to be eliminated or reduced, it would have an impact on the budget model, most notably a reduction in PHM investments.

   b. **Budgeted contracted payer contributions to the ACO as well as any significant changes from the prior year.**

      There is no material variation in budgeted contracted payer contributions to the ACO from the prior year. All line-item variations are related to changes in attribution estimates or to TCOC targets.

See Section 6 Variance Analysis in the Budget Guidance Workbook.

c. Budgeted provider contributions to the ACO as well as any significant changes from the prior year.

There is no material variation in budgeted provider contributions to the ACO from the prior year.

d. Budgeted governmental/public contributions as well as any significant changes from the prior year.

There is no material variation in budgeted governmental/public contributions to the ACO from the prior year.

5. Expenditures: Explain any line-item variations greater than 10% and $100,000 evident on your budgeted income statement as compared to prior year projected actuals and prior year revised budget. Please also explain: ***(Word Count: 600)***

The main drivers of the expense variance are the payer program expected health care costs, which mirror changes to the revenue targets discussed above. Additionally, there are a number of variances that relate to the PHM evolution. From a GAAP perspective, there are shifts in the operating expense line due to changes such as the movement of the data analytics team and VITL to UVMHN.

See the Section 6 Variance Analysis in the enclosed ACO Budget Guidance Workbook.

a. Any significant changes to the population health programs and/or care model, including temporary or permanent changes due to COVID-19, and the budgeted impact on expenses.

Refer to Section 5, question 2.d for details regarding programmatic changes to OneCare's population health programs (largely centered on PHM). From a budgetary perspective, the convergence of a number of programs into the new PHM was designed to be as net-neutral as possible.

Together, OneCare's ongoing commitment to population health management investments totals $30M across the continuum of care for PY 2023.

b. How this budget is affected by any significant changes to clinical and quality priorities for the year.

OneCare aims to increase provider-level accountability for the clinical and quality measures through the PHM. Since PHM payments are tied directly to those clinical and quality priorities, the total amount paid to providers is dependent on their performance. In 2023, the mix is roughly 85% base payment and 15% bonus payment, which means variability is limited to the 15% component. However, as the bonus portion grows in future years, the potential for budgetary variability will also

grow. In the 2023 budget, it was assumed that 80% of the PHM bonus amounts will be paid out. If performance exceeds that level, it will represent a budgetary overrun. Performance in 2023 will help inform the estimate incorporated into the 2024 budget.

c. Any changes, including significant new investments to the ACO's infrastructure and the budgeted impact on expenses.

The 2023 budget includes two notable changes. First, OneCare is reducing its physical office space by approximately 80% to align with a primarily remote working configuration. While some office space is retained for on-demand in-person work, the reduction generated significant savings related to rent and utilities.

Next, as OneCare informed the Board in its letter of June 24, 2022, as a result of OneCare's strategic plan, and informed by the state's All Payer Implementation Improvement Plan, OneCare is focused on elevating data and analytics capabilities to support health care provider partners through actionable, useful data. OneCare is entering into an agreement to transition data and analytics services (i.e., data platform and staffing) to UVMHN, in a subcontracted arrangement. This will facilitate access to a sophisticated data platform, through Arcadia, and enhanced tools and reporting, without incurring additional expenses for OneCare or its participants. OneCare has engaged outside counsel to draft the agreement with UVMHN to ensure that payer, provider, and member data security, privacy, and contractual accountabilities are met and that OneCare's proprietary data will be used only in OneCare-related work. The transition process will begin in October 2022 and is anticipated to continue through summer 2023. With respect to OneCare's submitted budget, this analytics transition means that rather than having direct salary expense for the staff in 2023, the expense has been converted into a contracted service with UVMHN. In future years the data platform costs will also transition. This arrangement was designed to be net-neutral, but does result in categorical shifts that can be seen on the income statement.

d. If applicable, how Delivery System Reform funds are being utilized in the proposed budget.

There are no Delivery System Reform funds included in the 2023 budget.

e. Whether and how this budget supports the maintenance or improvement of the ACO's health information technology system and the drivers of these investments (provider feedback, payer contract etc.).

The budget incorporates the initial components of the analytics transition to UVMHN. This strategy is designed to enhance overall analytic output through an improved software platform and more efficient analytics. From a budgetary standpoint, this transition is designed to be net-neutral to OneCare, with the cost of analytic staff being offset by a services agreement with UVMHN. During 2023, OneCare will continue to pay for most of the existing data platform while the new system is being implemented. In a future year, the costs to OneCare for the new

data platform will be incorporated into the service agreement.

6. **Balance Sheet: Explain any variations greater than 10% and $100,000 evident on your budgeted balance sheet as compared to prior year projected actuals and prior year budget and provide an analysis of the ACO's solvency, providing metrics that you use and noting any areas of concern.** ***(Word Count: 200)***

Due to changes in the GMCB Budget Order language, there is no longer a restricted cash line presented. Additionally, accrued expenses are decreasing 44% due to an expected shift of assignment of payments made. Due to a new 2023 streamlined PHM, liabilities are decreasing at year end.

From a solvency standpoint, OneCare functions in two primary capacities. First, OneCare operates as a fiduciary agent for many funding streams obligated to be paid to providers. For example, OneCare takes in the monthly fixed payments and then apportions those funds to participants in the network based on policy and program design. In general, these pass-through arrangements are designed to be net-neutral to OneCare, and solvency is ultimately dependent on timely receipt of the funds from the source (typically payers). Second, OneCare collects revenue that helps to support its programs, discretionary program investments, and operations. This component is largely sourced from hospital participation fees. The budget model is designed to collect only the revenues needed to execute the operational model. The current ratio and the debt ratio are two metrics used to monitor solvency and both are noted on OneCare's balance sheet in Adaptive. At the time of this submission, there are no concerns regarding the solvency of the organization.

See the Section 6 Variance Analysis in the enclosed Budget Guidance Workbook and A2 Balance Sheet downloaded from the Adaptive Database.

7. **Cash Flow: Explain any variations greater than 10% and $100,000 evident on your budgeted cash flow statement as compared to prior year projected actuals and prior year budget and provide an analysis of the ACO's current cash position, as well as expectations for the upcoming budget year, noting any potential timing challenges. Please explain the use of, or access to, any revolving debt (including maximum allowable draw) or other debt used to mitigate cash flow challenges.** ***(Word Count: 200)***

Cash is expected to decrease 24% due to the new 2023 streamlined PHM model, whereby cash is distributed earlier and more frequently to providers.

OneCare maintains a small operating budget, but manages significant funds-flow due to fixed payments and other provider investments. This dynamic typically results in a balance sheet with significant liquid assets and offsetting liabilities. OneCare's cash position is sufficient to enable the organization to weather timing delays in payment (with hospital fixed payments being an exception due to magnitude). In the event OneCare liquidated or ceased operations, the remaining cash in the organization would be roughly equivalent to the current equity or reserves in the company.

OneCare rarely has the need to invest in capitalized assets or projects, therefore, there are no

budgeted or anticipated material cash outlays outside of normal provider payments. OneCare does not maintain revolving debt. Its line of credit is used solely to satisfy the Medicare financial guarantee (not for operational purposes).

See the Section 6 Variance Analysis in the Budget Guidance Workbook.

8. If the proposed budget includes a gain or a loss, please provide a rationale. Otherwise explain how you arrived at a break-even budget (surplus to reserves, etc.). ***(Word Count: 200)***

The submitted budget is break-even. This is achieved by budgeting all OneCare expenses in excess of revenue and then calculating hospital participation fees to achieve balance.

a. Discuss any prior or current year surplus or losses and their intended use and how they were earned. How does non-profit status affect treatment of reserves?

OneCare had a $0 gain/loss in 2020. The final outcome for 2021 is not expected to be significant in either direction. The 2022 budget is break-even, which means that there are no planned additions to reserves. Achievement of a 501(c)(3) tax exempt status does not have any impact on the treatment of reserves.

OneCare has adopted a reserve strategy to help guide balance sheet management. This strategy provides a structure to inform the level of reserves that are appropriate for OneCare and its unique role. The approach recognizes that OneCare is responsible for a significant amount of cashflow, and includes:

- Risk reserve set at 10% of total downside risk
- No reserves at OneCare for fixed payments
  - Reserves for a fixed payment timing issue should remain with the providers rather than transferring funds to OneCare
- 30 days cash on hand reserve for PHM payments
- 30 days cash on hand reserve for operating expenses
- Management to explore options for an operational line of credit

9. Complete Appendix 6.5, Hospital ACO Participation-All Hospitals for the proposed budget year.

See Appendix 6.5 in the enclosed ACO Budget Guidance Workbook.

10. Submit the ACO's most recent (2021) IRS Form 990 (Appendix 6.6).

OneCare's 2021 Form 990 is pending submission to the IRS. OneCare anticipates providing the form to the GMCB in November, once it has been submitted to the IRS.

11. Complete Appendix 6.7, ACO Management Compensation (projected for the current year, 2022) with the following:

a. A list of all the ACO's current officers, directors and trustees, regardless of whether any compensation was paid to such individuals.

b. List all positions with gross compensation (the equivalent of Box 5 on a W-2 and any other compensation as reported on IRS Form 990) greater than or equal to $150,000.

c. List all leadership positions (VP, all C-Suite, including Chief Compliance Officer) with gross compensation (the equivalent of Box 5 on a W-2 and any other compensation as reported on IRS Form 990) greater than $100,000.

See Appendix 6.7 in the enclosed ACO Budget Guidance Workbook.

12. **Complete Appendix 6.8, Population Health Management Expense Breakout**.

a. Identify bonus payments where the ACO will budget the dollar amount, but not the actual distribution across provider types.

b. Identify blank cells where provider types are ineligible for payments.

See Appendix 6.8 in the enclosed ACO Budget Guidance Workbook.

13. **Please provide details for any expected capital expenditures over the next three years.** ***(Word Count: 200)***

OneCare does not anticipate any significant capital purchases over the next three years. The most likely expenses that would be capitalized are anticipated leasehold improvements.

Section 7

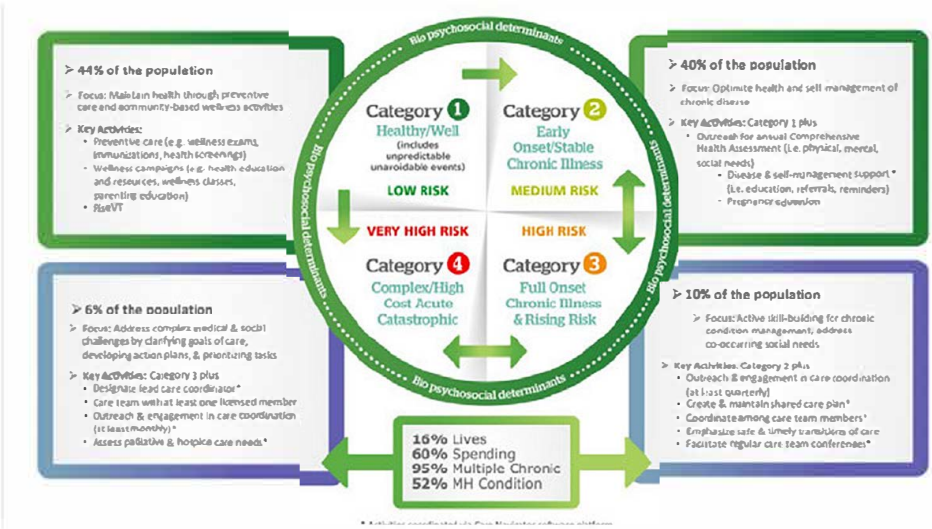
ACO Quality, Population Health, Model of Care, and Community Integration

Section 7: ACO Quality, Population Health, Model of Care, and Community Integration

1. ***Model of Care.*** **Please briefly explain progress to date on implementing the Model of Care, including significant changes made during the current year. Include what changes will be anticipated for the proposed budget year, and describe any lessons learned and the rationale for the(se) change(s). (*See* § 5.403(a)(11); § 5.403(a)(16)) In doing so, please discuss the following:** ***(Word Count 2,500)***

   a. **Any elements of the care model that OneCare has either eliminated or scaled up for FY23 including rationale for changes; Any areas in which OneCare would like to put more resources if available;**

   OneCare's four-quadrant population health model recognizes each individual's unique health needs and aligns supports through the provider network and local communities (see diagram below). OneCare's programs are designed as population-level strategies to protect and improve health outcomes. Updates and changes to the care model made within 2022 were based on feedback from providers, insights from other partnerships across the state, and results of OneCare's performance. They include: updates to the care coordination payment model, a refined focus on primary prevention, and updated clinical committee structure.

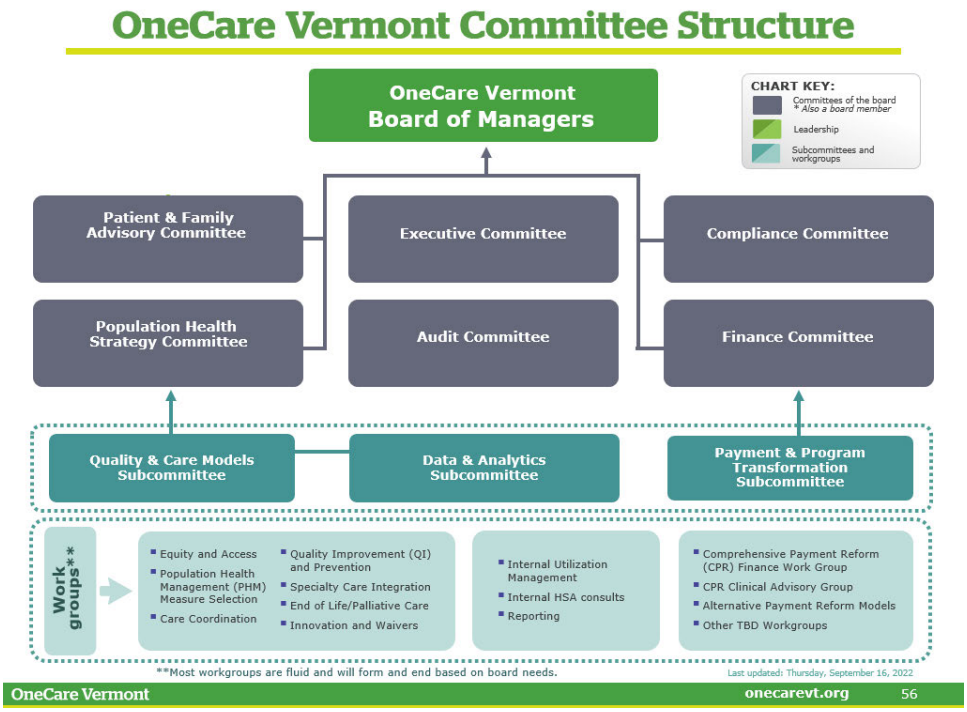


   Within Category 1, OneCare prioritizes clinical prevention activities in three areas: food insecurity, suicide prevention, and investigating opportunities for improvement within quality measure PQI-90 (a composite, prevention-focused, quality measure established by U.S. Agency for Healthcare Research and Quality (AHRQ)). OneCare is in the planning stages around these new focus areas and anticipates new activities to be deployed, in partnership with community organizations, in FY 2023.

   Within Categories 2-4, OneCare included improvements to the VBIF program (see Section 8, question 3.a) and, as a result of feedback provided during OneCare's strategic planning process (e.g., administrative burden and double documentation), OneCare de-coupled care coordination payments from Care Navigator reporting. In response to

decreasing usage of the online platform and OneCare's acceptance of triannual reporting on care coordination process metrics from its network, Care Navigator will be deactivated at the end of 2022. OneCare is working with its network to assess the greatest care coordination needs and to ensure continued focus on community-based teams supporting person-centered care coordination through the use of shared care plans, care conferences, and enhanced communication and collaboration. For 2023, OneCare will continue triannual reporting and has embedded care coordination expectations into base PHM payments as described in the following OneCare Policies: 04-19-PY23-25 Participant Population Health Model and Payments PY 2023-2025 and 04-20-PY23-25 Preferred Provider and Collaborator Population Health Model and Payments PY 2023-2025.

In 2022, OneCare refined its clinical committees to maximize performance under value-based contracts (see below). These committees provide feedback regarding the evolution of the care model, recommend accountability/quality measures, inform health equity work, and help OneCare refine its data and analytic work products.



While the pace of change is rapid within health care reform, OneCare believes that putting additional resources into incentive payments (as opposed to guaranteed payments) will lead to a deeper level of accountability and more effective initiatives. As part of the new PHM design, a multi-year strategy to adjust the mix of base and bonus payments is underway, and was designed to allow for a smooth transition period.

b. All goals or objectives in PY22 related to the model of care and the status of the achievement of those goals;

OneCare works to align clinical priorities and quality objectives, and reduce administrative burdens where possible. In PY 2022, OneCare continued its focus on four key measures for its VBIF program and simultaneously adapted its care coordination incentive program as described in the responses to Section 7 questions 2 and 1.a., respectively. In addition, this year OneCare has created a new health disparities scorecard for each HSA that provides HSA-level insight into performance for key metrics across several domains of equity to better support organizations in their value-based efforts within the ACO. These domains include food access, transportation access, housing instability, social isolation, and poverty. Data from this scorecard will be included in OneCare's HSA consultations, in an effort to advise key regional leaders about the impact of social factors on priority ACO performance metrics. These consultations will facilitate conversations about addressing key social issues. See below for an example of a de-identified adult population Health Disparities Scorecard draft. The first scorecards will be deployed at the end of Q3 2022.

OneCare Vermont Health Disparities Dashboard

Difference from OneCare Total Rate: 25% Better | No Difference | 25% Worse

Data Sources: - Claims for 2022 OneCare cohort - Clinical feed (HbA1c readings only)		HSA Total	Social Risk Level				Social Risk Flags				Area
			Low	Medium	High	Very High	Food Access	Transportation Access	Unstable Housing	Social Isolation	High Poverty Zip Code
	Members (#)	19,619	10,362	7,322	1,895	40	4,076	7,240	167	596	4,415
KPI Metrics	Total Cost of Care (PMPM)	$618	$627	$622	$556	$348	$585	$624	$454	$871	$623
KPI Metrics	Primary Care Visits (PKPY)	3,010	2,934	3,199	2,718	1,760	3,000	3,064	3,456	3,671	3,286
KPI Metrics	Potentially Avoidable ED Visits (PKPY)	210	193	234	212		190	195	240	233	272
KPI Metrics	Inpatient Admissions (PKPY)	102	99	113	80		96	100	108	158	113
PHM Metrics	Developmental Screening (%)	NaN	NaN	NaN	NaN	NaN	NaN	NaN	NaN	NaN	NaN
PHM Metrics	Child and Adolescent Well Visits (%)	16.7%	20.3%	13.2%	14.8%	0.0%	22.8%	21.0%	0.0%	41.5%	16.3%
PHM Metrics	Adult 40+ Wellness Visit (%)	50.8%	53.0%	47.6%	52.1%	26.4%	46.1%	50.9%	39.6%	44.6%	47.3%
PHM Metrics	Uncontrolled Diabetes (%)	20.6%	19.8%	21.7%	20.2%	33.3%	22.4%	21.0%	12.5%	24.6%	25.0%
PHM Metrics	Hypertension Follow-Up (%)						Metrics Under Development				
PHM Metrics	Potentially Avoidable ED Revisits										

DRAFT

Additionally, OneCare is exploring a pilot project to address food insecurity in partnership with an FQHC, Bi-State Primary Care Association, Hunger Free Vermont, the Vermont Food Bank, and our data science vendor. The goal of this project is to identify opportunities to enroll individuals eligible for federal nutrition programs, and directly reflects OneCare's prioritization of preventive efforts. This partnership provides an opportunity to evaluate the impact of addressing food insecurity on key ACO goals such as quality metrics and financial performance metrics. As an example, OneCare may find that an increase in federal food program uptake is associated with improved hypertension management for reasons such as individuals no longer needing to choose between prescription refills and a trip to the grocery store.

Throughout PY22, OneCare worked to educate its network about the use of key OneCare tools for supporting improved outcomes in the diabetes and hypertension domains. Specifically, the Hypertension and Diabetes Workbench One Application provides insight into individuals requiring intervention; members who are diabetic or pre-diabetic and those who are hypertensive or pre-hypertensive. Additionally, OneCare selected two of six

measures for the 2023 PHM which address patient outcomes in diabetes and hypertension.

c. All goals or objectives associated with the model of care for the proposed budget year and the strategy for their achievement;

OneCare's strategic plan details a goal for increasing network accountability as well as setting and monitoring progress toward performance goals. In an effort to more clearly hold providers accountable while simultaneously simplifying its approach, OneCare combined previously disparate programs into a single, unified, PHM accountability framework. This new approach is intended to facilitate greater incentives for action and is central to OneCare's strategy to achieve its care model goals and objectives. See section 5 for more specific PHM details.

The new PHM approach provides a mechanism to adjust accountabilities and expectations for the network and directly aligns with the strategic plan by holding participants accountable for achieving targets. OneCare's goal for 2023 is to demonstrate statistically significant improvement (at the ACO-level) for all measures included in its PHM accountability policies and to ensure health equity permeates throughout organizational efforts. In 2023, OneCare will focus on six key metrics for primary care providers and one key metric for continuum of care partners (i.e., AAA, DA, and HHH). Primary care provider measures include focus areas of hypertension management, diabetes care, wellness visits, avoidable ED care, and developmental screening whereas measures applicable to continuum of care partners focus on primary care engagement (DAs and AAAs) and return to hospital after establishing care (HHH).

Another goal in 2023 related to OneCare's care model is to revise its care coordination and payment models. Care coordination activity in 2023 is now a "gateway" to receiving payments under the 2023 payment models. Organizations eligible for payment will need to meet specific care coordination activity as outlined in OneCare's policies in order to remain eligible to receive payment. This framework will evolve in future years, but will remain consistent at its core. OneCare may leverage this new approach to adjust accountability focus areas, targets to achieve bonus payments, baseline requirements for payment eligibility, or ACO network partners to whom this program applies.

An additional goal for the care model within 2023 as described in the strategic plan is to provide the network with enhanced reporting on quality metric opportunities that would enhance patient outcomes and success under value-based care contracts. OneCare is currently in the process of establishing a new population health data platform, which is being built in a manner which supports network providers and drives them to action. Program design for 2023 was deliberately built to enhance the actionable nature of data for the OneCare network. As an example, five of six primary care quality measures are claims-based measures, which enables insight into a practice's full eligible population.

By engaging stakeholders via its clinical committees, governance structures, and other network interactions, as well as evaluation of program results, the PY 2023 program

objectives were crystalized earlier than in prior years, with program policies finalized in May of 2022 and communicated via contracts shortly thereafter. By increasing lead time, providers will have more time than in prior years to better understand OneCare's programs and to prepare, and ultimately, to achieve OneCare's PHM goals.

d. How the ACO intends to measure progress for the proposed budget year, including any quantitative measures, reporting, and analysis; and

In 2022, OneCare contracted with UVM College of Medicine (UVM COM) to inform several aspects of our evaluation framework including the creation of key performance indicators (KPIs) and the development and implementation of a provider survey. Due to overlapping timing with the GMCB Budget Order on benchmarking, OneCare has worked to align these efforts where possible.

To develop a set of KPIs, the UVM COM team explored key findings in academic literature, interviewed OneCare leaders, applied best practices, and provided a set of recommendations to OneCare. OneCare established KPIs in a phased approach: Phase One consists of metrics which are readily available and later phases will address additional KPIs in the context of ongoing enhancements to technical infrastructure. The Phase One KPIs include metrics that address a combination of quality, cost, and utilization and reflect performance in outcomes related to OneCare's care model. The framing questions for this research and recommendations were:

- Which metrics are within the sphere of influence for the ACO? and
- Which metrics best demonstrate value or potential value of OneCare?

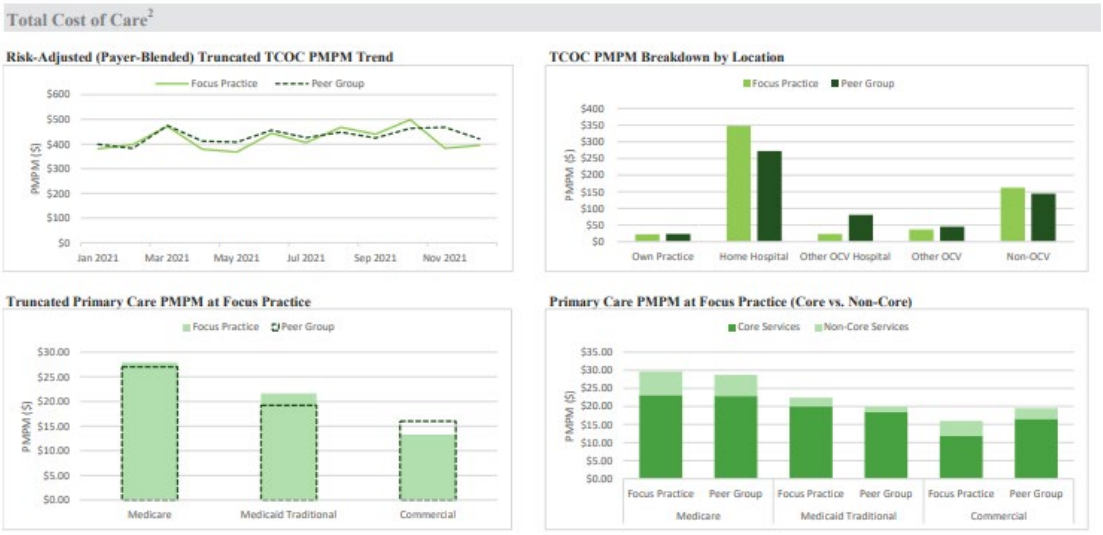
OneCare's work with the UVM COM team also included the development and deployment of a primary care provider ACO satisfaction survey. The audience for this survey was intentionally limited to primary care in an effort to explore the practical implications of deploying such a survey. OneCare developed this survey with the intention to repeat it annually, considering how to best expand the effort to other individuals engaged in ACO activities. The survey team is currently working to increase the number of survey responses before analyzing findings. The survey findings will then be used to identify opportunities to improve ACO provider satisfaction. OneCare has added a new program evaluator role into the FY 2023 budget to aid in integrating efforts and ensuring focused evaluation of key payment and program reform efforts.

In alignment with the GMCB Budget Order, OneCare is in the process of creating a new benchmarking report to compare its performance to a national cohort of peer ACO organizations. This work, in conjunction with the KPIs work described above, will serve as a key guide to OneCare prioritization and deployment of resources. Feedback loops incorporated into this process include discussion of findings in clinical committees and administration of the provider satisfaction survey. OneCare could leverage this work in future network activities with the integration of benchmarks into network reporting,

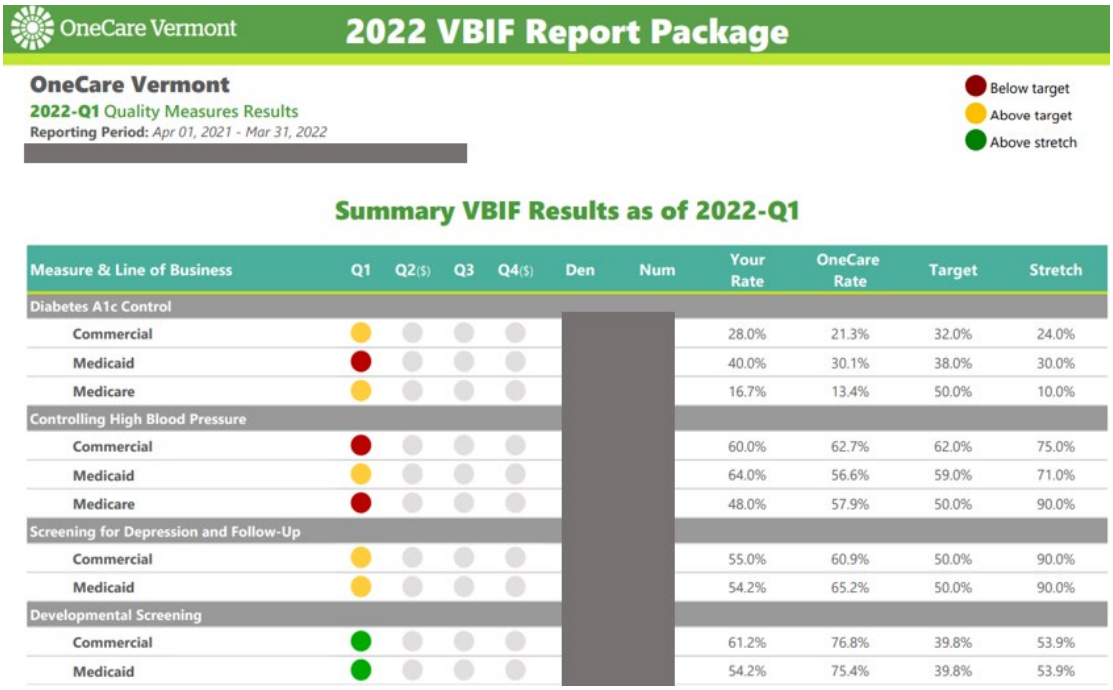
delivery of findings during HSA consultations, and within oversight and accountability activities.

In FY 2022, OneCare deployed two new standard reports – the primary care panel report (PCPR) and the quarterly VBIF reporting package, providing key insights at the practice level, and including a payer-agnostic view not previously provided in OneCare's reporting. The PCPR includes four key areas of focus: panel composition, total cost of care, quality, and utilization, and reflects a practice's organization in comparison to those of its peer group to allow for more meaningful comparison. Specifically, OneCare creates the PCPR reports targeted at the following peer groups: FQHCs, Pediatrics, Naturopaths, Independent Primary Care, Critical Access Hospital-owned, and non-Critical Access Hospital-owned. Some metrics in the PCPR reflect a new design by using payer-agnostic data. The quarterly VBIF reporting package is a streamlined approach to prior work which brings multiple reports into one and shares TIN-level results transparently to all recipients. The VBIF reporting package has received positive feedback from network teams for its design and usefulness. See below for a de-identified sample page from each report.

PCPR Sample:



VBIF Reporting Package Sample:



OneCare Vermont

2022 VBIF Report Package

OneCare Vermont

2022-Q1 Quality Measures Results

Reporting Period: *Apr 01, 2021 - Mar 31, 2022*

Below target
Above target
Above stretch

Summary VBIF Results as of 2022-Q1

Measure & Line of Business	Q1	Q2($)	Q3	Q4($)	Den	Num	Your Rate	OneCare Rate	Target	Stretch
Diabetes A1c Control										
Commercial							28.0%	21.3%	32.0%	24.0%
Medicaid							40.0%	30.1%	38.0%	30.0%
Medicare							16.7%	13.4%	50.0%	10.0%
Controlling High Blood Pressure										
Commercial							60.0%	62.7%	62.0%	75.0%
Medicaid							64.0%	56.6%	59.0%	71.0%
Medicare							48.0%	57.9%	50.0%	90.0%
Screening for Depression and Follow-Up										
Commercial							55.0%	60.9%	50.0%	90.0%
Medicaid							54.2%	65.2%	50.0%	90.0%
Developmental Screening										
Commercial							61.2%	76.8%	39.8%	53.9%
Medicaid							54.2%	75.4%	39.8%	53.9%

As shared earlier in the summer, OneCare is in the process of implementing a new analytics platform and reporting tools, scheduled to become available in FY 2023. The new tools will balance existing functionality and tools with lessons learned, and will include considerations for benchmarking findings, KPIs, and other priorities in OneCare's strategic plan.

e. The ACO's role in implementing this model of care as compared to other relevant stakeholders, including how the ACO collaborates with the Blueprint for Health and continues to ensure non-redundant services and investments, that are in coordination with, and not in contradiction to, state objectives (e.g. All Payer Model, Department of Mental Health's Ten Year Plan, State Health Improvement Plan).

During 2022, OneCare and Blueprint senior leaders met regularly and are currently strategizing for optimal methods of continued collaboration. This includes OneCare engagement in Blueprint-led collaboration activities and Blueprint participation in OneCare forums where appropriate. OneCare, Blueprint, and AHS/DVHA are also aligning care coordination and quality improvement efforts.

OneCare works closely with partners across the state to ensure efficiency and reduce redundancies. OneCare's eLearn platform, Vermont Health Learn is a tool leveraged statewide to deliver electronic educational materials. The tool is well-utilized, with more than 500 active users through the first eight months of 2022 and more than 800 users within FY 2021. Additionally, OneCare leadership actively participates in the Vermont Department of Health's Mental Health Integration Council, a forum which convenes leaders from across the state to address improving mental health care delivery in Vermont.

Additionally, please address the following:

f. An overview of your risk stratification methodology, and rationale for its selection/continued use;

Since 2016, OneCare has deployed an industry standard risk stratification approach, the John Hopkins Adjusted Clinical Grouper (ACG) algorithm, which assigns a predictive risk score based on the 12 months of claims data prior to the contract year for each member. Risk scores are calculated separately for each payer program and for the pediatric and adult age groups and then assigned one of four risk levels, described in prior budget cycles.

In addition to the Johns Hopkins ACG risk methodology, OneCare is implementing social risk reporting in its HSA consultations by presenting HSA health disparities scorecards. These scorecards will help community leaders to identify risk factors that may impact key outcome metrics applicable to the OneCare population.

OneCare is in the process of revamping its data platform for 2023 and additional risk algorithm methodologies may become available through this process. Also, while the Johns Hopkins ACG risk algorithm and social risk reporting are useful tools, they are most effective when combined with provider insights such as EHR or other clinical data and/or a more intimate relationship with patients or communities.

g. Consistencies and inconsistencies of care delivery and care coordination across HSAs;

OneCare continues to observe both high quality consistent care as well as areas of variation in care delivery and care coordination across HSAs. Most recent findings of variation are related to the newly established care coordination reporting mechanism (replacing Care Navigator as source of payment) and also sometimes seen within the VBIF program.

Variation across HSAs is a common finding when reviewing ACO data. This variation may remain consistent across payer programs for a given HSA, or not. In one example, from January to April 2022, an HSA demonstrated the *lowest* primary care visit rate for three payer programs (Medicaid Traditional, BCBSVT Primary, and BCBSVT QHP) and simultaneously demonstrated the *highest* primary care visit rate for Medicare among all participating HSAs. Another finding of variation of care delivery for this timeframe occurred for emergency department visits, where three HSAs demonstrated consistently lower utilization for the timeframe across several payer programs. Notably, the emergency department utilization rates within these HSAs sometimes fell at a rate of less than half that of the highest HSA's rate. For example, the lowest rates at HSA level for this metric were 518 and 581 per thousand lives per year (PKPY) while the HSAs with highest utilization measured at 1,027 and 1207 PKPY. These findings are consistent with information shared with OneCare during its HSA consultations, in that some communities are working to combat a culture of using the emergency department as the primary source of care. In response to these concerns, some HSAs are focusing efforts on expanding urgent care and same day appointments as a means to curtail unnecessarily

high emergency department utilization.

Over the past year, OneCare has focused on reducing variation and improving quality measure performance across the network. Key strategies have included new transparent reporting, focused incentives, and establishing target and stretch goals tied to incentives. As a result, among pediatric practices, all but two HSAs met the target goal (50th percentile) for depression screening and follow up measure and all HSAs performed above stretch goal (90th percentile) for developmental screening. Among adult practices, all HSAs but four met the target goal (50th percentile) across payer programs for diabetes management while 12 HSAs met the target goal (50th percentile) for hypertension management in at least one payer program and one HSA met the stretch goal (90th percentile) in one payer program.

h. Whether and how social determinant of health-related data is collected and how it is incorporated into the model of care;

OneCare continues to work with its data science vendor to glean important insights into SDOH aspects of its network. OneCare embeds this information in its care coordination program (e.g., filters for food access, social isolation, and social complexity) and its analytics tools. For example, OneCare created heat maps for social risk and shared these in its HSA consultations. The heat maps identified social risk patterns for regions within an HSA. The disparities scorecard (see details Section 7, question 1.i) is another way OneCare incorporates social determinants of health data into its care model.

i. How health equity is being addressed in the model of care.

OneCare has elevated equity as an organizational value and seeks to incorporate health equity in every aspect of our work. OneCare is focused on advancing health equity through robust measurement, thoughtful design and evaluation of our new and existing programs, and support of aligned policy work. OneCare is developing a health disparities scorecard to stratify OneCare's key performance indicators and population health measures across the following five domains: equity, including food access; transportation access; unstable housing; social isolation; and poverty. Data from the scorecard will be incorporated into HSA consultations in late 2022 to help articulate local health disparities and identify opportunities for improvement.

OneCare is also designing a pilot project to identify Vermonters who may be eligible for federal nutrition programs, but are not yet enrolled. This work is happening in partnership with an FQHC in Rutland, as well as Bi-State Primary Care Association, Hunger Free Vermont, the Vermont Food Bank, and others.

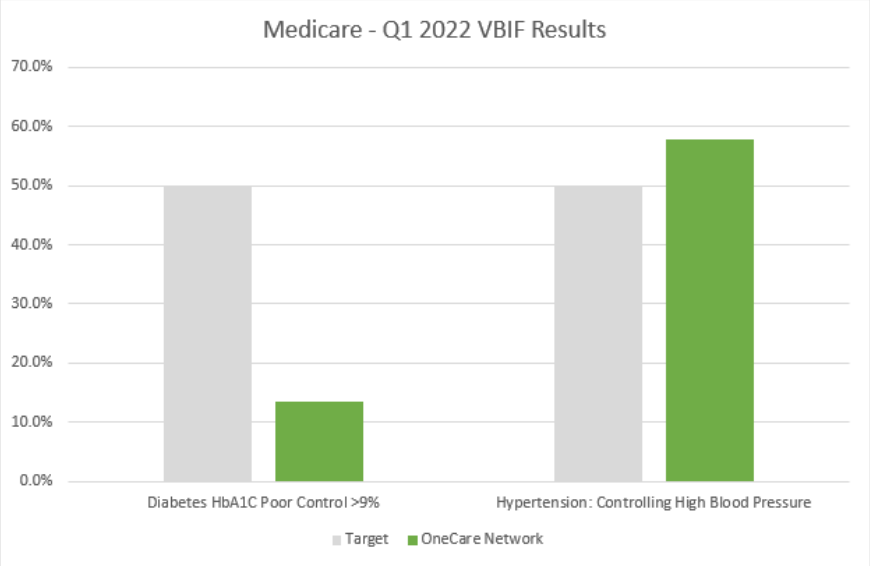
Finally, OneCare incorporates equity into its new clinical committee structure, with charters containing consistent language about diverse representation and participation. Additionally, the new committee structure included the development of a new Health Equity and Access Workgroup. This group will guide and inform OneCare Vermont's health equity strategy and its work will reflect OneCare's focus on promoting diversity,

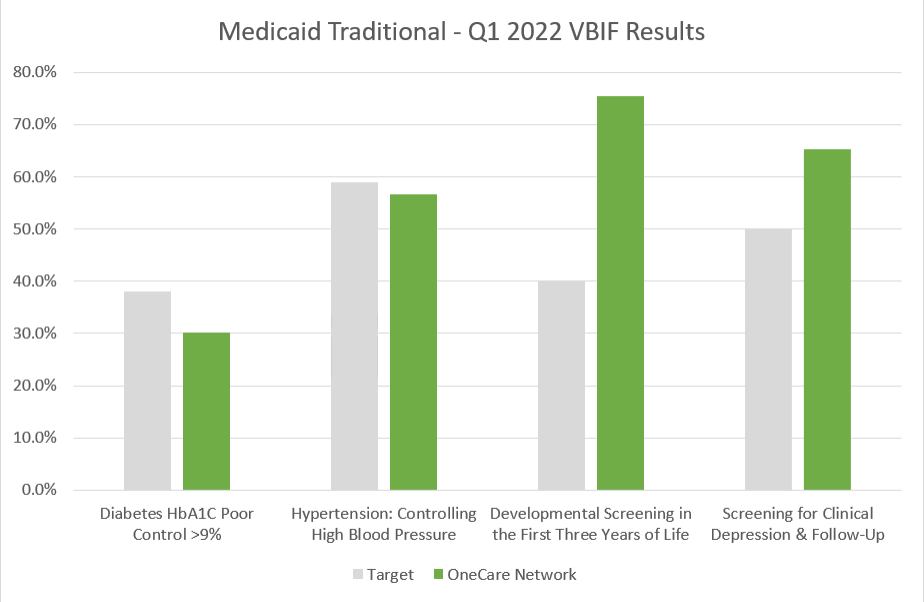
equity, and inclusion through training sessions for leaders, staff, and OneCare's committees.

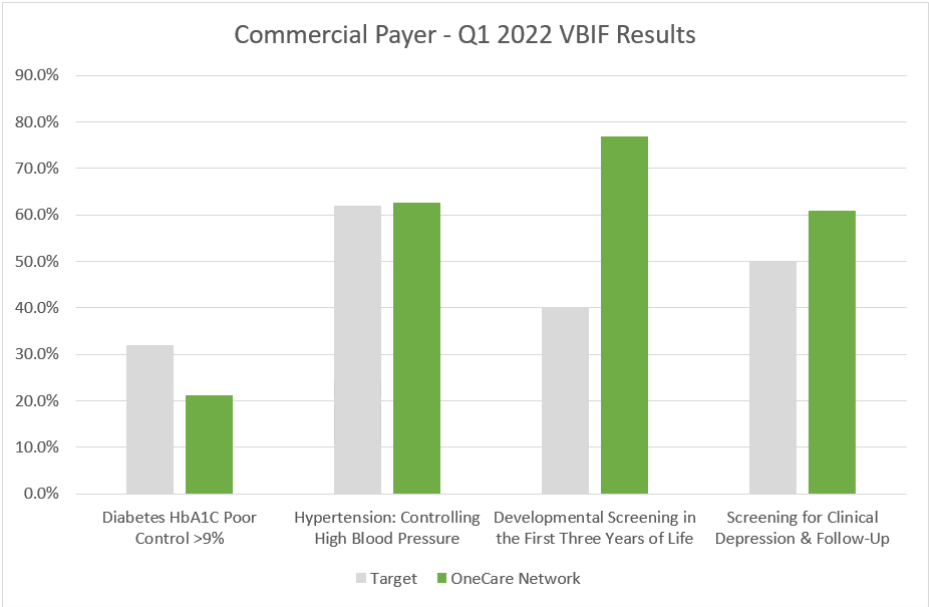
2. ***Clinical Focus Areas.*** **Report any results on your 2021 Clinical Focus Areas (interim, if available) and progress to date on 2022 Clinical Focus Areas using Appendix 7.1 ACO Clinical Focus Areas. Briefly explain how and why these criteria were selected. If any changes in the area of focus have been made during the current program year, please explain the changes and the reasoning behind the changes. (*See* § 5.403(a)(12)) *(Word Count 400)***

In an effort to remain consistent and improve organizational focus, OneCare elected to define its clinical focus areas in alignment with its VBIF program. Clinical focus areas are led by OneCare's Chief Medical Officer, and are developed in conjunction with clinical committee and other stakeholder feedback. These clinical focus areas remained consistent from FY 2021 to FY 2022 based on feedback from clinical committees, HSA consultations, and other stakeholder engagement.

As outlined in Appendix 7.1, OneCare noted success across VBIF-related clinical priority areas in Q4 of 2021 and Q1 of 2022. As demonstrated in the graphs below, OneCare exceeded goals for all measures and payers within the Q1, 2022 VBIF program with just one exception (Controlling Hypertension in the Medicaid program). Note that Diabetes HbA1c Poor Control is an inverse measure, meaning lower scores indicate better performance. While additional data are required to comprehensively assess performance, these data are a positive early sign of success and may indicate that OneCare's approach to clinical focus areas is working well.







For 2023, OneCare is shifting to a wider and more accurate measurement of quality by increasing the number of quality measures and by choosing five of six focus measures in 2023 which are claims-based and thus afford population level insights. OneCare uses findings such as this to inform program design, but did not change its clinical priorities based upon these results.

OneCare's Longitudinal Care Program (LCP) is another clinical focus area. In this program, OneCare partners with the Vermont Visiting Nurses Associations to facilitate home health support for individuals who no longer require skilled nursing resources, but are at risk for hospital readmissions and/or emergency department utilization. Program participation increased 91% in 2021 as compared with 2020 and, as of September 2021, members enrolled in LCP demonstrated positive outcomes following enrollment with a 47% and 39% reduction in inpatient and emergency department utilization, respectively. Given these positive findings, OneCare intends to continue its investment in LCP during FY 2023.

Finally, as discussed in the response to Section 7, question 1.c, OneCare's redesigned PHM accountability approach streamlines and simplifies incentive programs. This new approach is inclusive of clinical focus areas, which are an inherent piece of the 2023 PHM accountability program design.

3. ***Quality Improvement.*** **Describe any changes to your quality improvement framework and your theory of change for 2023. (See § 5.403(a)(12)) In addition, please include the following:** ***(Word Count 800)***

As discussed in previous ACO Budget submissions, OneCare's quality improvement program is based on *The Model for Improvement*[1] and the work of W. Edwards Deming, creator of the Plan-Do-Study-Act (PDSA) cycle of learning[2]. This approach remains part of OneCare's plan for 2023. As set forth within OneCare's Policies 04-19-PY23-25 Participant Population Health Model and Payments PY 2023-2025 and 04-20-PY23-25 Preferred Provider and Collaborator Population Health Model and Payments PY 2023-2025, OneCare is focused on increasing accountability for four types of organizations in the OneCare network: attributing primary care providers, AAAs, DAs, and HHH. Each organization is now required to engage in care coordination activity for payment eligibility and is held accountable to performance targets in order to earn incentive payments.

The new PHM framework was established based upon network feedback and OneCare governance committees. It was built to simplify OneCare's programs into a singular vehicle, while also allowing flexibility to increase and/or refine accountabilities over time. This quality-driven PHM provides financial incentives to primary care organizations for high performance on six quality measures:

1. Potentially avoidable ED visits by those with 2 ED visits in the last 90 days
2. Follow up after hypertension diagnosis
3. Age 40+ all payer annual wellness visits
4. Diabetes poor control (A1c>9)
5. Child and Adolescent Well Visits
6. Developmental Screening

The first two measures specifically align with OneCare's care coordination outcomes focus. In an effort to continue incentives for collaboration, performance for these measures is evaluated at the HSA level. Performance bonuses for measures three through six will be earned based on practice level performance. The six-measure approach reflects an expansion from 2022, however, this is still a relatively narrow scope for quality improvement efforts as compared to all measures contained within OneCare payer contracts. Narrowing down quality measure focus to these six areas and providing education, data reporting, supports, and incentives allows network participants have a clear understanding of ACO quality priorities and how to meet them.

[1] Langley GL, Nolan KM, Nolan TW, et al. The improvement guide: a practical approach to enhancing organizational performance. San Francisco: Jossey-Bass; 1996

[2] Deming WE. The new economics for industry, government, education. Cambridge: Massachusetts Institute of Technology; 1994

Continuum of Care providers (i.e., DAs, HHA, AAA) will be held accountable to performance within a single measure related to their areas of expertise, with 15% of funding available as incentive potential for those who meet or exceed targets.

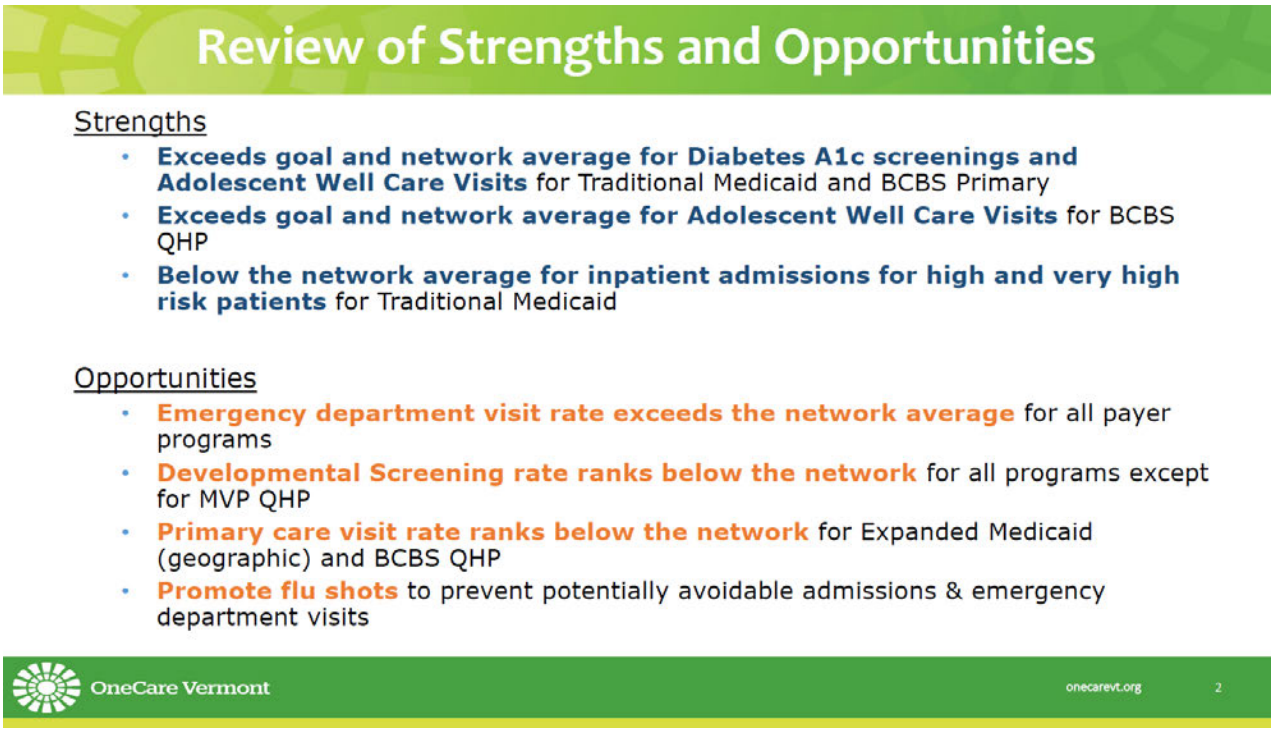
In order to aid in providers' success in these programs, OneCare will use a combination of claims data, self-report data, and chart abstraction to evaluate performance. OneCare's quality team will work directly with network providers to review performance, identify potential gaps in care and determine any opportunities for improvement. OneCare's support for network efforts also include education and guidance about performance improvement methodologies, sharing researched best practices relative to chosen areas of focus, and connecting organizations to other network partners who are successful in areas of interest.

a. Complete Appendix 7.2 High-Cost Conditions

See Appendix 7.2 in the enclosed ACO Budget Guidance Workbook.

b. Discuss how areas for quality improvement are identified

OneCare identifies areas for quality improvement through review of data (e.g., reports and applications) by staff and committees, at HSA consultations, and by local HSA teams. See HSA consultation example below demonstrating how OneCare presents strengths, opportunities for improvement, and sharing of best practices. Following these HSA consultations, OneCare engages network providers to review current performance, identify quality improvement opportunities, and support efforts that best align organizational goals with those of OneCare. For an example of a presentation recently delivered in an HSA consultation, see Attachment E: HSA Quarterly Consultation Presentation.



c. Discuss how results and progress to date are used to support ACO network providers in quality improvement and implementation of the care model.

OneCare shares quality results to support ACO network providers with identifying areas for quality improvement, as outlined above. OneCare clinical and quality team members provide ongoing and ad hoc engagement to support quality improvement efforts by ensuring access to data; evaluating workflows to identify improvement opportunities; and facilitating communication with other community providers.

In FY 2022, OneCare team members are working to revamp outreach efforts and move to a centralized model. OneCare communicates its VBIF quarterly result availability via email and identifies focus areas for communities and individual entities as part of its oversight and accountability partnership work. As a follow up to the availability of quarterly VBIF results, the quality team established a central forum for network participants to facilitate learning and engagement across the network. The first iteration of this forum was held in summer of 2022 and was very well attended, hosting 85 network attendees.

4. ***Population Health and Payment Reform*. Complete Appendix 7.3, Population Health and Payment Reform Details. (*See* § 5.403(a)(11)) In addition, please discuss the ACO's strategy for making investments in population health and developing payment reform programs across the continuum of care, including the rationale/evidence base for the strategy. *(Word Count 200)***

OneCare's population health management investments, both existing and new, are intended to facilitate care delivery transformation supported by unique payment reforms, as well as opportunities for innovation and incentives that encourage the transition to value. Each investment is evaluated for its ongoing alignment with ACO strategy, its ability to drive performance, its impact, and its ongoing affordability. As part of a learning system, adjustments

and refinements are made regularly in response to network feedback, evaluation data, or other factors to improve the success of the population health program or investment strategy.

Decisions to develop new payment reform initiatives often hinge on:

- Nature of the fixed payment options (i.e., reconciled vs. unreconciled)
- Whether or not moving the participant off of FFS generates material value
- Alignment of incentives with ACO goals
- Resource demands/capacity
- Availability of reliable data
- Provider readiness
- Strategic purpose

At present, the reconciled nature of fixed payments (except Medicaid), resource demands on OneCare staff, and provider readiness are the most common barriers. Due to these barriers, OneCare remains committed to the current suite of payment reform initiatives, but did not include any new initiatives in the budget.

See Appendix 7.3 in the enclosed ACO Budget Guidance Workbook.

5. Care Coordination*. Complete Appendix 7.4 Care Coordination and Appendix 7.5 Care Coordination Payments. Explain any opportunities or challenges experienced in the transition away from Care Navigator-based payments and risk-level focused care coordination, and the implementation of the revised care coordination model in FY2022. (See § 5.403(a)(18)) In doing so, please discuss the following: *(Word Count 1,000)

OneCare experienced opportunities and challenges in the recent evolution of its care coordination program. As of FY22, OneCare no longer requires Care Navigator activity for payment eligibility and maintained its shifted focus from medical risk to targeted populations of interest. The changes move financial incentives from a basis of activity within Care Navigator to a more streamlined self-reporting methodology. OneCare has received positive feedback from its network about the new payment and reporting approach due to its simplicity, eased provider burden, and increased focus on outcomes.

While several positive outcomes resulted from OneCare's new approach, some challenges remain. First, the move away from Care Navigator results in decreased visibility of shared information such as care plans across care teams. This has required new thinking about sustaining connections across partner organizations. In some places, this is being addressed through the use of local electronic health records while others rely more on team meetings to coordinate and prioritize outreach and care. Second, OneCare has had to adapt its strategies for providing admission discharge transfer notifications; this will continue to be an area of focus in 2023. Finally, the new self-reported data collection method may have real or perceived biases related to the self-reporting strategy. OneCare is monitoring this area of concern through auditing processes and is supporting education to clarify reporting expectations.

See Appendices 7.4 and 7.5 in the enclosed ACO Budget Guidance Workbook for further detail.

a. **The selection of at-risk populations for care coordination, and the detailed criteria applied to these populations, including any factors of health equity and social determinants of health.**

In 2022, OneCare is focusing care coordination efforts on proactive identification of at-risk individuals who fall into one of four subpopulations: high ED utilization, high inpatient utilization, high medical and social risk, and high cost of care. OneCare provides these patient panels in Workbench One, so providers may use data to inform prioritization of outreach. OneCare offers training on the best use of analytics resources and collaborates with network participants to establish care management targets for these populations.

The four subpopulations are identified by:

- High ED Utilization: 6+ visits in the last rolling 12 months
- High Inpatient Utilization: 3+ visits in the last rolling 12 months
- High Total Cost of Care: ≥$15,000 in the last rolling 12 months
- Patients with High Clinical and High Social Risk Scores: ≥high medical risk and 3+ social risk

b. Any outcomes related to the shift from focusing on high/very high-risk individuals to at- risk subpopulations.

Early successes resulting from the 2022 care coordination program include positive feedback about inter-organizational collaboration, such as shared care plans, HSA-level collaborative meetings, and other forums. Initial reports of challenges resulting from the shift of focus to at-risk populations include limited clinical staffing, lack of specialty care for pediatrics, lack of access to mental health care, and challenges with remote workforce.

In early FY22, OneCare observed care managed rates lower than expected for the identified target subpopulations. In addition to addressing this finding, OneCare viewed it as critical information to inform its 2023 PHM. Due to initial data reporting challenges moving to a new network reporting process, OneCare expects data outcomes analysis of the 2022 care coordination program during mid-2023. In the meantime, OneCare is working closely with the ACO network to improve care coordination data reporting activities and to support care coordination efforts across the state.

In PY 2023, OneCare's primary care providers, AAAs, DAs, and HHH are all accountable to specific care coordination activity to be eligible for payment under OneCare's programs. OneCare believes key components of successful care coordination include shared care plans, care conferences, clear identification of a lead care coordinator, and other interconnected health care provider partnerships including all these provider types. OneCare's PHM program embraces these themes as central to successful care coordination, as care coordination accountabilities are now a gateway to payment opportunities. In FY 2023, Preferred Providers and Collaborators are held accountable to

the following requirements: triannual care coordination reporting; timely response to care coordination validation audits demonstrating supportive evidence of data submitted with triannual reports; and meeting with a OneCare representative at least once annually upon request to review areas of opportunity and/or process improvement initiatives focused on reduction of avoidable health care service utilization.

Primary care providers are held accountable to the following care coordination requirements in order to be eligible for payment: triannual care coordination reporting; timely response to care coordination validation audits demonstrating supportive evidence of data submitted with triannual reports; designation of a dedicated clinical contact to facilitate care coordination of OneCare attributed lives with avoidable health care service utilization as identified by OneCare; and practices not meeting the performance goals for both care coordination PHM accountability measures in all ACO programs are required to conduct a process improvement initiative, focused on reduction of avoidable health care service utilization, using the PDSA or other nationally recognized methodology. Cross-organizational collaboration and patient-centric shared care planning are required elements of the project.

c. Discuss the approach to Care Coordination by payer program. Does the ACO track Care Coordination rates by payer program? If so, please provide. How does the ACO prevent duplication of efforts and collaborate with the payers?

Responsive to provider feedback, OneCare's 2022 care coordination program focuses its care management incentives and efforts on specific population of focus, and does not alter its approach based on payer. Care management rates may be measured by the payer, however payer-specific rates are not how OneCare implements its care coordination work (see Section 7, questions 5, 5.a, and 5.b for more details about how OneCare does implement its care coordination program). Due to ongoing data cleansing and validation efforts, 2022 payer-specific rates are not yet available.

OneCare's network engaged 3,678 members in care management from April to December 2021 (during the ongoing public health emergency). This included 1773 Medicare, 1663 Medicaid, 29 MVP, and 213 BCBSVT members. These figures reflect attributed lives who met OneCare's definition of care management in FY2021, which includes the following documentation in Care Navigator; a lead care coordinator and a shared care plan with two goals and two action items directed at those goals.

Duplication of effort is avoided in our care coordination model by collaboration across teams, organization types, regions, and payers. Payers are clear via contracting process regarding what our network is providing for care coordination which does not duplicate the focus of insurer programs.

d. The plan for Care Navigator in the budgeted year.

After concluding a thoughtful process of network-wide stakeholder engagement and evaluation, Care Navigator will be decommissioned at the end of 2022. OneCare is making a clear shift to network accountability for engaging with data and tools that

enable participants to focus on populations at-risk, and to access real-time hospital, SNF and home health visit utilization data. OneCare believes that this new direction will result in more clearly focused population interventions and effective panel management which will, in turn, result in improved outcomes within the quadruple aim.

6. ***Integration of Social Services*. Please explain how the ACO integrated or facilitated the integration of healthcare and social services in FY22 and give a detailed description of how the ACO plans to further integrate healthcare and social services in FY23. (*See* § 5.403(a)(18); § 5.403(a)(19); § 5.403(a)(20)) In doing so, please discuss:** ***(Word Count 500)***

OneCare remains a driver of deep connections across the continuum of care throughout the state. Through active engagement with these partners, OneCare determines how best to support organizations in their efforts to integrate health care and social services. As discussed above, OneCare's care coordination program focuses on the subpopulation of those with high medical and social risk. This is an important step in the evolution of the program, and demonstrates OneCare's commitment to incorporating social needs into its operational strategy. Additionally, as outlined above, OneCare is working to develop HSA-level health care disparities scorecards to incorporate social needs and outcomes analysis that drive opportunities to reduce disparities and improve health care delivery and health outcomes. Finally, OneCare is leveraging its new governance structure to address integration of social services by the inclusive nature of the groups within the committee structure. Specifically, the Quality Improvement and Prevention Workgroup and the Equity and Access Workgroup, while relatively new, include active participants from DA, AAA, and HHH entities; bringing these perspectives ensures the integration of social services into the group's efforts.

   a. **Whether or not the ACO has measured the effectiveness of integrating social services and if so, please share the results;**

      When 2022 care coordination data are available, OneCare will evaluate primary care engagement rates for individuals care managed by DAs and AAAs as one way to assess the impact of these agencies engagement in care coordination on improved care delivery and outcomes. Incentives for engagement with primary care are embedded within the following policies: *04-20-PY23-25 Preferred Provider and Collaborator Population Health Model and Payments PY 2023-2025 Policy* applicable to DAs and AAAs.

   b. **How the ACO provided incentives for investments to address social determinants of health in FY22 and how the ACO plans to further do so in FY23.**

      OneCare's care coordination program embeds a focus on individuals with high medical and social risk to directly address these issues. For 2023, these expectations are embedded in the PHM as a gateway to associated base and bonus payments (see Section 7, question 1.c). Additionally, OneCare's 2022 VBIF program incentivizes care related to four quality measures, all of which contain a component of SDOH such as access to care and ongoing management of chronic conditions. In FY 2023, this approach is expanded to OneCare's six PHM accountability measures (see Section 7,

question 1.c) which are also impacted by social determinants of health factors for OneCare attributed lives.

Section 7: Attachments

Attachment E: HSA Quarterly Consultation Presentation

- Electronic Version: See file “OCV_FY23-Budget_Attachment-E-HSA-Quarterly-Consultation-Presentation_Sent-09-30-2022.pdf"

- Print Version: See section labeled “Attachment E-HSA Quarterly Consultation Presentation”

Section 8
Evaluation and Performance Benchmarking

Section 8: Evaluation and Performance Benchmarking

1. **Discuss the ACO's approach to evaluating provider satisfaction with ACO participation, including results of any provider satisfaction surveys, and actions the ACO is taking to address areas of provider feedback.** ***(Word Count: 500)***

   As described above, OneCare is dedicated to addressing the quadruple aim in Vermont and an important contributor is provider satisfaction. As part of its partnership with The UVM COM to develop KPIs and expand upon evaluation efforts, OneCare developed a provider satisfaction survey tool. UVM COM began by assessing the current state of provider satisfaction tools for value-based care models, and found that current literature and best practices did not support existing evaluations of provider satisfaction in the context of value-based care delivery. Given this, OneCare and the UVM COM developed a survey throughout the first half of 2022 guided by other satisfaction assessment resources identified in the literature. The provider survey was designed to address provider satisfaction with OneCare and was initially distributed in August 2022 to clinical leaders at all primary care organizations who were asked to forward it to their clinician teams.

   OneCare is actively working to increase survey response rates across the network through targeted outreach. Final results are anticipated in November of 2022 and will be shared more broadly at that time. While data collection efforts are ongoing, OneCare has already identified several important observations through this initial survey experience. First, it is challenging to gain high survey response rates through mass communications; more targeted and deliberate survey distribution approaches may increase survey engagement. Second, this first round of surveys targeted primary care providers which is only one facet of OneCare's statewide network. OneCare chose to first deploy the survey to primary care providers and intends to expand to additional audiences over time after thoroughly testing the instrument

   Later this fall, the UVM COM team will analyze results using factor analysis to determine key findings from the survey tool and recommend how OneCare can improve the tool in future iterations. These findings will then be used to identify strategies to improve primary care provider satisfaction and evaluate next steps to broaden the survey respondents.

2. **Discuss the ACO's approach to evaluating its risk and financial accountability model. Explain how the ACO's risk management arrangements support the ACO accountability strategy and evidence that the local accountability strategy is working.** ***(Word Count: 300)***

   Many of the local accountability strategies, such as the Accountability Pool, practice-specific VBIF payments, and the new PHM are early in their implementation, or are slated to begin in 2023. However, early indications show that providers who see their emerging VBIF quality scores are engaged and interested in learning more. OneCare is in the process of providing enhanced organization-level transparency and EHR efficiencies in quality measure performance to further facilitate information sharing and knowledge transfer.

   Downstream, evidence that the accountability model is working will be determined through evaluation of OneCare's PHM. In alignment with the core concept of value-based health care,

providers generating the best health care outcomes should be those receiving the most funding relative to their peers. This assessment will be evaluated over the next three to five years.

3. **Discuss the ACO's approach to evaluating its Population Health Management programs. Narrative must include, but is not limited to:** ***(Word Count: 800)***

a. Evaluation of Clinical Focus Areas and their outcomes.

OneCare utilizes quantitative (e.g., analysis of claims and clinical data, variation analysis) and qualitative (e.g., gathering input and feedback) methods to evaluate its population health management programs and identify opportunities for improvement.

OneCare uses quantitative data for decision making and program evaluation through performance analysis such as the Performance Dashboard at the ACO, payer, HSA, and organization level. Evaluation of quality performance in payer measures occurs annually for each payer contract. On a quarterly basis, OneCare distributes primary care panel reports to primary care organizations to evaluate performance against key metrics. Additionally, during OneCare's HSA consultations, OneCare evaluates performance and works with leaders to identify mutually agreed upon focus areas for alignment of priorities.

OneCare also gathers input and feedback in smaller settings working directly with care teams in the network to address specific needs. In addition to HSA consultations, OneCare leverages its clinical committee structure to incorporate evaluation into its program design. During 2023 program development discussions, OneCare evaluated findings from the VBIF program which showed that, when measured for all of OneCare, hypertension management consistently performed below target level. These feedback mechanisms are the impetus for the quality improvement process, which is described in Section 7, question 3. Qualitative feedback on the 2022 VBIF program resulted in changes and improvements including: streamlined and actionable quarterly reporting, simpler financial methodology, payout in Q2 and Q4 to avoid back-to-back payment quarters, and the improvement of communication and data transparency.

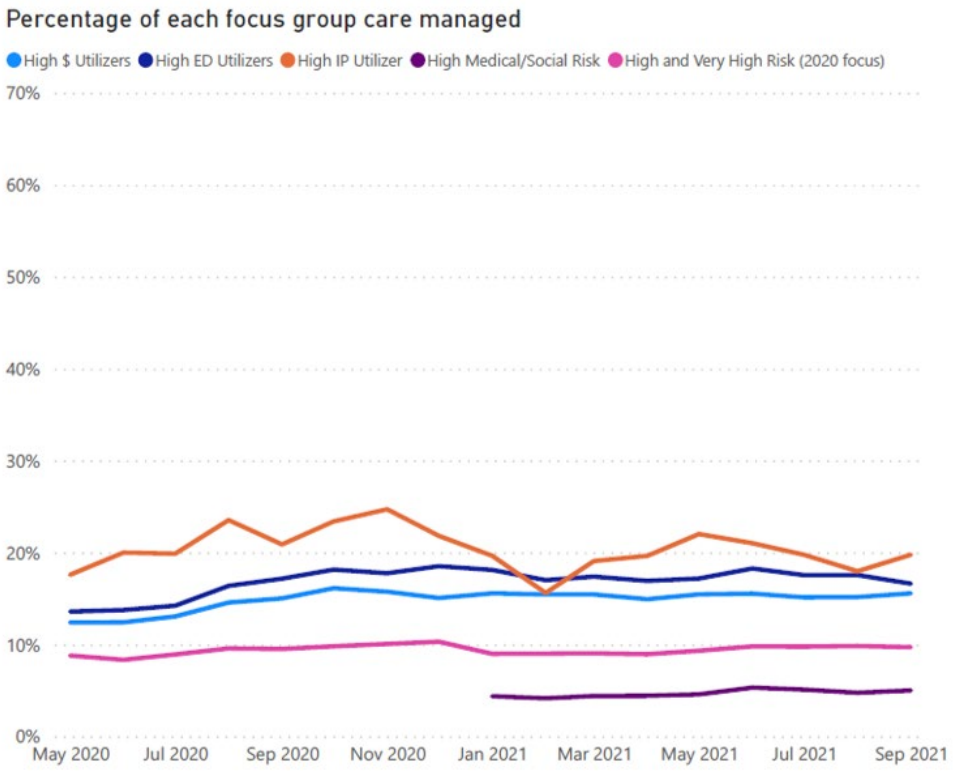
During the development of 2023 PHM measures and targets, OneCare determined that three of six PHM accountability measures will not have national benchmarks. Therefore, OneCare needed to establish programmatic goals outside of traditional national benchmarking. OneCare developed the 2023 program with a balance of statistical validity and program simplicity. Analyses determined that for the two measures attributable to HSA performance, a 10% improvement would be clinically meaningful and demonstrate statistically significant improvement in the majority of HSAs.

Finally, as described above, OneCare leveraged its new partnership with the UVM COM to refine its KPIs and to seek input on potential improvements to its evaluation methodologies. New KPIs are an important focus outlined within OneCare's strategic plan. These metrics, combined with OneCare's new benchmarking solution outlined in Section 8, question 6, will enable OneCare to compare itself to peer ACOs nationally and can be used in future program planning.

b. The results of any evaluations done on the revised care coordination model to date and plans for further evaluation (include how TCOC, ED utilization, and inpatient admission rates have changed as a result of the revised care coordination model and whether or not these results are meeting expectations). Discuss how the ACO is incorporating provider and patient input on the new care coordination model. Please share any relevant lessons learned.

OneCare embarked on a planned evolution of its care coordination program in early 2022. This evolution included changing the care coordination reporting methodology; transitioning accountability back to patient-facing care teams for shared care planning and collaboration; and further refining care coordination efforts for individuals with avoidable hospital utilization. Given the complexity of this transition, and amidst a pandemic, OneCare anticipated that there would need to be a period of adjustment, including orienting and assisting network participants with the new triannual reporting template and requirements.

Although data are not yet available for a comprehensive evaluation of the care coordination program for FY 2022, there are positive findings from the field. For example, care teams are in place for over 80% of Medicaid Traditional patients within at-risk subpopulations of focus. OneCare presented its latest care coordination evaluation during its June Board of Manager's meeting. During this session, presenters highlighted the inherent challenge of evaluating care coordination as a standalone service due to the manner in which care coordination is integrated across the health care continuum. As shown in the graph below, OneCare's care management rates were largely consistent throughout 2020 and into 2021. This is a testament to the success of OneCare's network despite staffing and other challenges posed by the pandemic.



** Only eligible months included in calculation. Medicaid Expanded excluded*

During the same June session, OneCare presented findings from its care coordination patient survey, administered by care coordination team members across the ACO network in late 2021. Over 200 individuals responded to the survey statewide. Most stated that they had a person on their care team who acted as lead care coordinator. Respondents also reported regular invitations to meetings to address their health care needs; feeling like an important member of their own care team; and being engaged by their care team to provide feedback and communicate health needs and goals.

These findings as well as extensive provider and patient input were used to inform changes to the care coordination model. Forums included HSA consultations, statewide care coordination meetings, HSA-specific clinical performance counsels, and OneCare's Patient and Family Advisory Committee. Patient feedback emphasized the importance of both care coordination and the presence of a lead care coordinator. Lessons learned from providers were focused on limiting the burden of systems and improving integration with existing EMR documentation where possible.

4. Discuss the ACO's approach to evaluation of its Quality Improvement Program and provide a couple of examples of how it has improved quality. ***(Word Count: 300)***

OneCare's approach to evaluation of its quality improvement program is multi-faceted. OneCare first assesses results of annual quality performance in each payer program, gathers feedback through its interactions with the ACO network (via forums such as HSA consultations and its committee structure), and then shares the data in an actionable way to facilitate quality improvement.

The VBIF program provides financial incentives for organizations who reach OneCare specified targets and/or stretch goals. In the spirit of continuous improvement, OneCare took into consideration feedback from numerous stakeholders about the VBIF program to improve upon the program's implementation. Improvements for the 2022 VBIF program are outlined in the response to Section 8, question 3.a above. While these improvements are substantial, OneCare continues to focus on improving the programmatic implementation through its new PHM accountability model beginning in 2023.

OneCare evaluates VBIF progress, using a sampling methodology on a quarterly basis. For the quarterly VBIF performance in the five quarters currently available (Q1-2021 through Q1-2022), two key findings were identified. First, the performance on these measures trended positively for all except depression screening and follow-up, which remained largely flat. Second, improvements were noted for nine of ten payer/measure combinations when comparing Q4-2021 with Q1-2021. This data indicates preliminarily positive findings for the results of the program. Ultimately, statistical comparison of year-on-year annual quality results for VBIF measures will provide optimal insight into the program's effectiveness.

Many examples of quality improvement efforts resulting from OneCare's VBIF program were evident when evaluating PY2021. Specifically, several organizations' efforts resulted in improved diabetic hemoglobin A1c control rates between Q1 2021 and Q4 2021. Three HSAs demonstrated improvement above a new threshold (target or stretch goal) for this measure during this timeframe: Middlebury, Rutland, and St. Albans. In Middlebury, new quality improvement-related efforts include scheduling monthly follow up appointments for individuals with A1c>9, using OneCare tools such as Workbench One or VBIF reporting to identify individuals missing A1c values, and adding a dietician on staff to counsel diabetic patients. In the Rutland HSA, increased point of care A1c testing, clinical pathways utilization for diabetes, and increased provider incentives were tools that improved patient outcomes for this measure. Finally, St. Albans imported A1c values into point of care, nursing reminders of A1c in the electronic medical record, assigned a nurse care coordinator to A1c>9, and also used OneCare tools to identify individuals with missing A1c values.

5. Discuss progress on developing Key Performance Indicators to measure ACO-wide progress and performance. *(Word count: 300)*

As described above in Section 8, question 1, OneCare began a new contractual agreement with the UVM COM to inform the research and KPI selection process, and to survey OneCare providers about their satisfaction. They performed a comprehensive literature review to identify ACO-related performance measures well represented within the literature. The team also engaged in informational interviews with OneCare leaders and team members to better inform their recommendations. The UVM COM then shared their findings with OneCare leadership, who used this information to create a focused set of KPIs. Through this process, OneCare learned that some KPIs are readily available within its existing infrastructure while others will require additional technical development. Accordingly, OneCare is using a phased approach to identifying KPIs and is beginning with those that are readily available.

During the first phase of KPI deployment in Q4 2022, OneCare will work within its governance structure to vet the measures selected. Following this process, OneCare will use these KPIs as a guide to develop new reporting for the ACO network. OneCare's plan is to incorporate these focus measures as a strategic guide for reporting directed at four key audiences: ACO governance, hospitals, primary care providers, and HSA communities. The reporting for each of these audiences needs to be tailored appropriately, providing actionable insights for how these groups can ultimately impact the success of OneCare as a whole. This new reporting is estimated to become available in summer 2023. The goal of this approach is to simplify the complexities of health care reform by facilitating focus on goals that are audience-appropriate and ultimately serve the greater strategic direction of OneCare.

6. **Provide the current status of the implementation or use of a benchmarking system or datasets as a tool for assessing ACO performance. Provide available comparisons against regional or national benchmarks of peer ACOs that can be used by GMCB to establish a baseline for data-driven targets and monitoring.** ***(Word Count: 300)***

- **a. NOTE: Any performance targets for FY23 or future years will be determined by GMCB, taking into consideration the implementation status of the benchmarking system, and may include, e.g:**
  - **i. Performance targets (e.g., at or above 50th percentile)**
  - **ii. Enforcement (e.g., range for requiring a Performance Improvement Plan (PIP)**
  - **iii. Performance Improvement Plan requirements (e.g., PIPs should include best practices used by ACOs in 90th percentile)**

As outlined below and largely shared in a memo sent to the GMCB on June 30, 2022, OneCare has completed a great deal of work in support of implementing a benchmarking system:

- Reviewed GMCB budget order with benchmarking requirements provided on February 17, 2022.
- Identified leading vendors in the ACO marketplace and verified vendor ability to meet GMCB requirements.
- Issued an amendment request to GMCB reflecting vendor abilities on March 17, 2022.
- Sent final benchmarking summary with proposed chosen vendor with revised budget on March 30, 2022.
- Continued dialog with GMCB and provided detailed vendor assessment on April 19, 2022.
- Started contracting with chosen vendor based on GMCB revised budget approval on May 11, 2022.
- Met with GMCB to discuss vendor's recommended template on June 13, 2022.
- Received additional feedback on the template from GMCB on June 21, 2022.
- Finalized vendor contract based on based on original scope of template provided on June 28, 2022.
- Refined reporting template with vendor based on GMCB feedback.
- Reviewed new reporting template with GMCB.
- Worked closely with vendor to clarify expectations, resolve issues identified in preliminary analyses, and map out future expectations.

The following steps are estimated to be completed in October 2022:

- Share findings with OneCare governance
- Review preliminary report with GMCB
- Refine report with vendor (as needed)
- Submit initial version of final report to GMCB

Section 9

Other Vermont All-Payer ACO Model Questions

Section 9: Other Vermont All-Payer ACO Model Questions

1. **How are you ensuring that your portfolio of payer programs are aligned to support the goals (scale, cost, quality) of the Vermont All-Payer ACO Model?** ***(Word Count: 500)***

   As described in OneCare's FY22 Budget submission, OneCare's goals are naturally aligned with those of the Vermont All-Payer ACO Model. When OneCare succeeds in supporting providers to improve upon the quadruple aim, this success benefits Vermonters. To that end, OneCare relies on the strategic plan, established by its Board, to guide priorities including programs and investments.

   Since the implementation of the plan, OneCare has made significant progress including clinical committee redesign; identifying strategies to refine OneCare's tools and methods to deploy data analytics; identifying and implementing best practice methods to share information with the network; evaluating ACO investments with an enhanced focus on success in core population health programs; and developing a deeper connection between prevention and clinical programs to increase impact on diabetes and hypertension quality measures.

   From a cost-containment perspective, and in furtherance of OneCare's quality improvement efforts, OneCare has strengthened the alignment of monetary incentives with its clinical initiatives, primarily through the PHM. Reduction in the TCOC is central to the PHM, which focuses quality improvement efforts on wellness visits, depression and developmental screening, and controlling hypertension and diabetes – areas known to be ripe for cost reduction. With quarterly payments, PHM financial incentives are also more aligned in time to the clinical behavior the model seeks to incentivize.

   With regard to scale, OneCare actively works with its current payers to maximize attribution models in an attempt to capture as many attributed lives in the ACO as possible. OneCare maintained scale throughout the pandemic, and takes steps each year in an attempt to expand participation in existing programs. For PY2023, this included adding a hospital to the Medicare program and an additional independent primary care practice to the CPR program. Going forward, the expansion of enrollment in Medicare Advantage programs puts beneficiaries outside the ACO model and likely needs to be addressed.

2. **What other actions can healthcare stakeholders be taking to support the ACO in achieving the goals of the Vermont All-Payer ACO Model?** ***(Word Count: 250)***

   Evolving the Vermont health care system from one that rewards volume to one that reflects the value of care delivered and results achieved is the direction health care is moving nationally, and Vermont continues to be an early adopter and innovator in this space. This willingness to take on challenges is not new to Vermont but it requires stakeholders to work together towards a common vision. In order to enhance the state's ability to achieve the APM goals, stakeholders could be further encouraged to share their experiences and to facilitate public understanding of and engagement in this work. As part of this effort, common and easily understandable vocabularies could be created, agreed upon, and used consistently. New mechanisms for local storytelling could be imagined, and expectations could be appropriately calibrated as to the

timeline and milestones to be achieved over the next 2, 5, and 10 years.

Included in these goals should be an explicit commitment to achieve the recommendations of Vermont's health care providers (through the OneCare/VAHHS APM Extension Task Force). These include achieving an unreconciled Medicare fixed payment model; maximizing the annual Medicare trend rate to facilitate increased scale and reduce the cost shift; moderating risk-sharing levels until the delivery system re-stabilizes from the public health emergency; clarifying settlement issues for Critical Access Hospitals in the Medicare program; addressing the known deficiencies in the scale target methodology calculations; addressing the Medicare Blueprint methodology; and providing investments in shifting the delivery system to a new and sustainable model.

3. ***All Payer Model Quality and Population Health Goals*. Please complete Appendix 9.1, ACO Activities related to the Vermont All-Payer Model ACO Agreement Population Health and Quality Goals to describe results to date and explain your strategies for assisting the state to achieve its quality and population health goals as specified in the APM. In doing so, please also discuss the expected impact of COVID-19 on 2022 performance, sharing any early indicators or relevant insights.** ***(Word Count: 500)***

OneCare deploys numerous strategies to support ACO performance in alignment with APM population health goals. These include negotiating payer contracts that are consistent with APM population health measures; designing programs and incentives that promote population health and OneCare's care model; and providing specific and actionable data to monitor progress and inform improvement opportunities.

OneCare remains successful in its payer contract negotiations in maintaining alignment and focus on APM population health goals. Each payer contract includes focused measures that assess prevention, chronic disease management, and mental health. In addition, the number of measures per contract and across contracts is monitored to ensure providers can maintain focus on specific population health goals that OneCare prioritizes through a data and stakeholder-informed process each year.

As described in Section 7, question 1.c, OneCare is working to increase provider accountability through its programs and incentives by integrating them into its PHM. The PHM structure provides focus and consistency so that providers know what to expect over time (e.g., accountabilities and payments) as well as flexibility to incentivize specific and necessary improvement activities. Thus, it can be utilized to adapt to the evolving needs of Vermont health care providers, while ensuring priorities align well with those of the Vermont All-Payer ACO Model. As an example, OneCare is incentivizing improvements in follow-up for patients with hypertension or high blood pressure diagnosis. These incentives will be paid to organizations based on the HSA's performance. The PHM structure, inclusive of prevention, chronic disease management, and care coordination supports many of the APM population health goals.

Over the past year, OneCare has continued to gather feedback, modify tools, and design new reports to meet the evolving needs of our network. For example, revamped quarterly VBIF reporting highlights an organization's performance through a simplified and streamlined report that has received positive feedback from the network. Additionally, as described in Section 7,

question 1.d and Section 8, question 3, OneCare's new primary care panel report highlights an organization's performance against key objectives on a quarterly basis. As outlined in Appendix 9.1, OneCare's quality improvement plans for 2023 are well aligned with the Vermont All-Payer ACO quality priorities, both for the all-payer goals, and for the payer-specific goals. OneCare is directing efforts to address all three all-payer ACO specific VT APM goals through its 2023 program design.

The impact of COVID-19 on Vermont's health care landscape remained evident throughout 2022. As stated in OneCare's FY22 Budget, telehealth utilization increase was a clearly observable change in utilization patterns directly related to the public health emergency. In addition, health care workforce challenges across the state resulting from the pandemic continue to impact care delivery. From a program design standpoint, COVID-19 cases were initially excluded from TCOC targets and spend. Looking ahead to 2023, it's increasingly likely COVID-19 cases will become part of regular provider accountability as COVID-19 related care is not expected to abate entirely. This can be viewed as both a risk and opportunity under ACO programs. Additional COVID-related concerns expressed by OneCare's network are as follows: significant financial impact, instability due to concerns of future variants, delays to existing operational plans, access to care due to constrained workforce, and others. OneCare must maintain its focus in support of the provider community in an appropriate manner in this landscape.

See Appendix 9.1 in the enclosed ACO Budget Guidance Workbook.