OneCare Vermont

FY24 Budget Submission
Responses to Round 1 Questions

Executive Summary

1. **Question 1a – The new OCV Strategic Plan identifies the need for providers to demonstrate their commitment to value based care. There are new provider/network accountabilities and a shift in PHM base to bonus payment ratio; in what other ways (if any) will OCV be implementing these strategic initiatives?**

   OneCare began implementing its multi-year strategy to clarify provider accountabilities and supports, as identified in the most recent strategic plan, by adding specific expectations in each of six provider accountabilities into provider contracts in summer 2023. These include expectations for 2024 as well as directional signals for increasing accountabilities in 2025. In addition, OneCare is in the process of notifying providers that are not meeting care coordination standards of their obligations and steps that need to be remediated if payments are to continue. OneCare is communicating an updated guidance document to its network to provide clarity on expectations and supports for 2024. A draft document was shared earlier in the fall, feedback was gathered, and a revised guidance document will be shared in November.

2. **Question 1f – What "industry standard" PHM measures are being used for FY24?**

   Under the 2024 Population Health Model, OneCare will incentivize standard quality measures with national benchmarks, including:

Quality Measure Name and Measure Steward (HEDIS/CMS)
Hypertension: Controlling High Blood Pressure (HEDIS CBP)
Follow Up After Emergency Department Visits for Patients with Multiple Chronic Conditions (HEDIS FMC)
Medicare Annual Wellness Visits
Child and Adolescent Well-Care Visits (HEDIS WCV)
Developmental Screening in the First 3 Years of Life (CMS Child Core CDEV)
Initiation of Substance Use Disorder Treatment (HEDIS IET)
Engagement of Substance Use Disorder Treatment (HEDIS IET)
30 Day Follow-Up After ED Visit for Substance Use (HEDIS FUA)
30 Day Follow Up After Emergency Department Visit for Mental Illness (HEDIS FUM)
7 Day Follow Up After Hospitalization for Mental Illness (HEDIS FUH)

3. **Question 1f – How is UVMHN's planned work to improve coding accuracy expected to impact OCV and OCV's ability to achieve TCOC targets?**

   Improved coding accuracy is valuable to OneCare's work in a number of ways. For example, coding improvements help to ensure risk scores are calculated accurately. These risk scores are used to stratify patients and identify those who may benefit from interventions such as care coordination or other preventative approaches. Further, accurate risk scores allow for more reliable financial comparisons across practices and populations.

   Though coding accuracy improvements are worth monitoring, neither the Medicaid nor Medicare TCOC models incorporate dynamic risk adjustment, which means there is no direct correlation between coding changes during the performance year and the TCOC targets to which OneCare is accountable. However, the Medicare USPCC FFS trend rate developed by the CMS Office of the Actuary implicitly incorporates ongoing coding improvement activity across the health care industry. This means that the Medicare ACO benchmark model considers the fact that coding improvement efforts are to be expected. The commercial targets are in development and OneCare will be able to provide further analysis pending the conclusion of contract negotiations.

   In total, coding accuracy improvements by UVMHN or any other provider may lead to some changes to provider reimbursement levels, but due to the ongoing nature of coding accuracy improvement efforts this does not present as a major concern at this time.

4. **Question 1g – "In 2023, OneCare contracted with an external evaluation firm to independently evaluate three specific areas: care coordination, the 2022 Value Based Incentive Fund (VBIF), and the Comprehensive Payment Reform (CPR) Program." Is OCV willing to share the complete results of what the firm found with the Board and the general public?**

   OneCare has provided the full evaluation report with this submission. Further, OneCare is willing to make the contractor available for one meeting with GMCB to discuss the results of their evaluation work.

Provider Contracts

1. **Question 2 – For the engagement requirement in the provider accountabilities, will all providers be required to attend these meetings? If not, who from practices will be required to attend?**

   OneCare will not require all providers to attend all engagement meetings, this would create an undue burden on the providers. Instead, representatives from each contracted Participant and Preferred Provider will be required to attend at least 50% of the meetings. This includes organizations such as primary care, home health and hospice agencies, and designated mental health agencies. The organizations can select whom will attend and it may vary by organizational role (e.g. care coordination, quality, administration) across engagement sessions.

2. **Question 2 – Are preferred providers (DAs, AAAs, home health) also required to implement and utilize a 2015 CEHRT-level EHR as part of the provider accountabilities?**

   No, only Participants are required to implement and utilize a 2015 CEHRT as part of provider accountabilities. This accountability is intended to increase alignment with CMMI expectations for Advanced Alternative Payment Models to use certified electronic health record technology.

3. **Question 2 – How many providers/participants in the 2024 ACO network do not have EHRs that meet this standard, and what is the count by provider/practice-type? Is the ACO offering any support/resources to these practices to obtain necessary upgrades?**

   Annual outreach around the CERHT certification showed that out of the 43 attributing TINs, 31 are currently meeting this expectation. Of the 12 who do not meet the expectation, four practices do not have EMRs, two are closed or closing, and six have not yet responded to the status request. OneCare can aid practices in understanding the CEHRT requirements, but does not anticipate funding EHR installations or upgrades.

4. **Question 3 – "In the regulatory alignment arena, there is need for proactive regulatory support to educate and encourage commercial insurers to participate in Vermont's All-Payer Model (APM) and the regulatory budgeting process needs to be aligned to promote coordination and efficiency across the health care system (hospitals, payers, and ACOs)." In an ideal world for OneCare, what would this "support" look like in practice?**

   Ideally the regulatory process would support OneCare by focusing on the benefits of value-based payment models, delivery system reform efforts, information sharing and shared care approaches. Further, the GMCB would look to align incentives between hospitals, providers, insurance companies and the ACO for participation in the All Payer Model. During the budget hearing, the board would engage in respectful and curious discussion about the initiatives and strategies included in the budget that will build upon the collaborative work occurring in Vermont to improve an already industry-leading health care system.

5. **Question 4 – Are there any updates from the 2 specialist providers and 1 SNF regarding their decision not to return to the ACO network for FY24?**

   The two specialist providers and one Skilled Nursing Facility chose not to return their contractual documents for 2024. OneCare has not received, nor do we anticipate, any further information related to their decision not to participate in the 2024 network.

Payer Contracts

1. **Question 2b – "While material changes are not expected to the Medicare contract, OneCare continues to observe that beneficiaries migrating to Medicare Advantage plans are generally lower cost. This means that the morbidity, which affects both acuity and utilization, of the remaining population covered by traditional Medicare will increase. This is one factor among many demonstrating that the maximum allowable trend rate will be critical to support Vermont providers participating in the program". How does OneCare reconcile its work to improve quality and reduce total cost of care with the fact that its parent organization runs a Medicare Advantage plan?**

   This dynamic does not present a concern to OneCare. UVMHN's investment in quality improvement and cost control efforts represents the commitment necessary to succeed in both Medicare Advantage and ACO arrangements.

Network Programs and Risk Arrangement Policies

1. **Question 1 – Is OCV measuring primary care spend across its network? How does primary care spend as a percentage of TCOC compare between CPR practices and non-CPR practices?**

   OneCare does not regularly monitor the primary care spend rate across its network, but periodically calculates primary care spending as part of payment reform initiative modeling and design. Through this, OneCare learned that it is particularly challenging to compare data across different primary care practice types. For example, FQHCs have specific service offering requirements, which significantly complicates comparisons to independent primary care and hospital-owned primary care. Additionally, due to billing dynamics, it is difficult to capture "primary care" services within a hospital entity as some primary care work is imbedded within other parts of the organization (ex., centralized care coordination). With these learnings in mind, most of OneCare's work to date has been related to the CPR program. Practices participating in the CPR program receive from 9%-10% of the total health care spend while other independent primary care practices remaining fee-for-service receive approximately 7%.

2. **Question 1 – OneCare reports that the CPR program has been very popular with its participants. Please share reasons why any eligible practices are not participating in the program; it is our understanding that 19 of 24 eligible providers are in for FY23. Does OCV know how many Vermont independent primary care practices do not participate in the network?**

   Each year, larger non-participating independent practices are offered participation and provided financial modeling of CPR payments relative to fee-for-service payments, generally for the current and following performance years. Based on interactions with practices evaluating participation in the program, the two primary reasons a practice might decline participation are trepidation about a fixed payment, and what is deemed to be insufficient financial basis to participate in the CPR program. The first involves providers' comfort with surrendering the control of fee-for-service payments (under fee-for-service, providers can control gross revenue by seeing more patients). The second scenario, in which the CPR payment model is deemed financially insufficient, is related to the practice's fee-for-service billing levels, which can be highly variable between practices, compared to CPR program reimbursement. OneCare does not know exactly how many other independent primary care practices do not participate in OneCare's programs but would value that information.

3. **Question 1 – Please provide an update for the CPR program in FY24. How many practice sites will be participating and what are the number of attributed lives expected to be covered? Are any changes to the model anticipated? Will MVP lives be included as they were for FY23?**

   In 2024, the CPR program includes 13 TINs and 19 unique practice sites, covering care for an estimated 25,412 attributed lives. For 2024, OneCare is advancing the model by increasing the primary care spend percentage to 9% base.

   The strong preference is to have true commercial fixed payments included in the program model in 2024 rather than the hybrid fee-for-service model utilized in 2023. As such, the budget was built to incorporate only payer programs with a fixed payment option. This position will be reevaluated after the conclusion of the commercial contracting process to determine the best course of action.

4. **Question 1 – How is OCV working to spread successful aspects of the CPR program to other provider types?**

   OneCare is working closely with some of its participating FQHCs to pilot a CPR-like model in 2024. At the time of this submission no formal commitments from FQHCs have been made but conversations have been very positive. Some FQHCs expressed hesitation to take on a new initiative with the future of reform efforts in flux.

5. **Question 5 – Appendix 5.2 – Why are the anticipated SS/SL at $0 for the self-funded program for FY23?**

   With apologies for the lack of clarity in the initial response, this figure reflects an absence of information rather than a projection of $0. Due to the late start of this program, OneCare worked to develop this program throughout the spring and summer of 2023. Only recently (October) has claims data been shared to inform target development and thus no projection of spending performance is available at this time.

6. **Question 5a – How was the self-funded program risk corridor of [redacted] selected?**

   This figure was the result of a negotiation process and reflected an agreeable amount based on the position of both parties. From the OneCare perspective, having a risk level [redacted] was ideal in that both primary care organizations and the risk bearing entities would have a financial stake in the program outcome. Also, OneCare learned from earlier self-funded programs that the magnitude of risk was a significant barrier to self-funded participation. Agreeing to a more palatable risk level for health plans was a strategy to launch the program and create the potential for expansion to other self-funded plans in future years.

Finances

1. **Adaptive – Please define the difference between the contents captured in the line-item contracted services and purchased services. Is the sum of these two items the same as the line "Consulting, legal, and purchased" in 6.2 FY2022 Budget?**

   OneCare has only one financial statement line item "Purchased Services" which captures payments for all contracted services. In the FY2022 document noted above, the line for this was named "Consulting, legal and Purchased Services." This was a legacy name from the template provided by the GMCB in years past. Finance staff at OneCare and the GMCB are working to remove a duplicate line named "Contracted Services" that exists in Adaptive to avoid confusion in the future. In the 2023 budget, OneCare used that line in error. Upon communication with GMCB staff, it was decided that we would use it for the 2023 quarterly reporting.

2. **Adaptive – Hospital Participation report, please explain the Grace Cottage Hospital $43,495 (Blueprint – PCMH)**

   OneCare passes Blueprint payments through to providers regardless of their participation in OneCare programs.

3. **Adaptive – Hospital Participation report, why are there negative amounts in the Medicaid Expanded hospital fixed payments line?**

   The negative amounts included in the Medicaid Expanded hospital fixed payments line in Adaptive represent a fixed payment allocation from hospitals to OneCare. They were input into the Medicaid Expanded hospital fixed payments line solely because a different line was not available in Adaptive at the time of submission. The appropriate header for this line is "Fixed Payment Allocation." It should also be noted that in 2024, all Medicaid dollars are blended such that no separate tracking of the Traditional and Expanded Cohorts are necessary. OneCare finance staff are working with GMCB finance staff to correct the labeling in Adaptive.

4. **Question 3 – Some expenses rely on deferred or more variable revenue sources (for example, Mental Health Screening being funded by deferred revenue, or a portion of salaries funded with interest income). Has OneCare considered more permanent sources of funding for these or other expenses?**

   Sustainability of programs is something that is contemplated thoroughly. Shifting the Mental Health Screening funding to a deferred revenue source was a strategy that enabled OneCare to reduce hospital participation fees while also sustaining the initiative. One potential for 2025 or beyond is to roll the mental health screening initiative into the PHM model. Regarding interest income, while it subject to variation, utilizing that revenue stream to fund salaries helps OneCare to reduce the costs borne by hospitals supporting ACO programming.

5. **Question 4c – Please explain waiver implementation.**

   Waiver Implementation refers to a new pilot payment model where OneCare will provide funding for care delivery innovation projects related to eliminating barriers to medically appropriate patient discharge from emergency departments and inpatient units. The details of this pilot program are still being developed; OneCare would be happy to update GMCB once the design and details are established.

6. **Question 5 – For PMPMs, the budgeting approach was 100% of the base payments and a 60% estimate applied to participants earning bonus payments. How did you arrive at the 60% estimate for the bonus payments?**

   At the time of budget planning, the network had earned 42% of total incentive payments available during Q2-Q3. OneCare used this baseline to estimate and budget an improvement to 60% by the end of the 2024 performance year. While this is believed to be a reasonable target, the PHM program and the underlying data dynamics are new, and OneCare continues to learn from initial results.

7. **Question 5c – What will the $800,157 in savings from the data analytics transition be used for/allocated towards?**

   The savings from the analytics transition helped to reduce the hospital participation fees required to balance the 2024 budget.

8. **Question 7 – Please provide a complete list of goods and services for which OCV contracts with UVMHN. What steps have been taken to ensure that these goods and services are procured at fair market value consistent with the policy on related party transactions?**

   Although the excess benefit transaction rules under IRC Section 4958 do not apply to transactions between OneCare and UVMHN, to the extent UVMHN or its affiliated entities contract with OneCare to provide OneCare with employees, services, or goods, they are provided without markup or financial benefit to the providing entity.

   OneCare contracts with UVMHN to pay for the following services: personnel costs, office space, and data and analytics services performed by the UVMHN Data Management Office. OneCare approaches all related party services from the perspective of an independent organization. As such, all negotiations incorporate information such as: price transparency, reasonability of hours or effort spent for services, clear accountabilities and expectations, performance monitoring protocols, and any other information relevant to the initiative. Overall, the ability to utilize existing infrastructure rather than building separate infrastructure helps to manage the cost of reform efforts.

9. **Question 7 – What steps have been taken to ensure that the self-funded UVMHN payer contract represents fair market value consistent with the policy on related party transactions?**

   The program design was heavily influenced by previous commercial contracts and learnings from prior self-funded arrangements. This helped OneCare know that the terms it sought were fair market.

   Although the excess benefit transaction rules under IRC Section 4958 do not apply to transactions between OneCare and UVMHN, to the extent UVMHN or its affiliated entities contract with OneCare to provide OneCare with employees, services, or goods, they are provided without markup or financial benefit to the providing entity.

10. **Question 8 – "Vermonters benefit when providers can better coordinate care, use data to improve population health outcomes, and close care gaps. Regular use of the reports and analytics functionality will enhance the quality of care Vermonters receive by providing timely and actionable information to support their care". Does OneCare track how often providers use "reports and analytics functionality"? What percentage of providers in its network use this data?**

    OneCare currently provides data to its network via multiple channels, including Workbench One, the OneCare Secure Portal, email, and other means. While there is not currently a consistent means to monitor network access, OneCare is actively transitioning its data delivery to Arcadia which will streamline delivery and allow for improved and more consistent monitoring of network usage.

11. **Question 13 – Why did OCV decide to update their reserve strategy for FY24?**

    OneCare adopted a reserve strategy/policy for the first time in 2023, and there are no changes effective in 2024. The purpose of this policy is to help guide balance sheet management of the organization. When considering the significant cashflow through the organization each year, an appropriate level of liquidity is necessary to sustain financial operations and protect against timing issues and other unforeseen financial circumstances. This reserve policy established benchmarks to help guide financial monitoring and decision-making so that the organization is adequately reserved relative to the business it conducts.

12. **Question 16 – Which UVMHN compensation surveys include specific compensation data on ACO executive positions (rather than data on hospital positions)?**

    As the GMCB is aware, the Board and OneCare have a principled disagreement regarding the Board's statutory authority to set the compensation of individual OneCare employees. That disagreement is currently being litigated in the Vermont courts. This question appears to seek information that is relevant to the ACO budget setting process only to the extent the Board has the authority to set individual employees' compensation and should, therefore, wait until the litigation regarding that issue is resolved. If there is a different reason the Board is seeking this information, we would be happy to discuss and better understand the purpose of the request.

13. **Question 16 – Please provide a list of those positions UVMHN's compensation professionals found no "comparable external benchmark" for. For each, please provide the determined "most comparable position at the UVM Medical Center/Health Network."**

    As the GMCB is aware, the Board and OneCare have a principled disagreement regarding the Board's statutory authority to set the compensation of individual OneCare employees. That disagreement is currently being litigated in the Vermont courts. This question appears to seek information that is relevant to the ACO budget setting process only to the extent the Board has the authority to set individual employees' compensation and should, therefore, wait until the litigation regarding that issue is resolved. If there is a different reason the Board is seeking this information, we would be happy to discuss and better understand the purpose of the request.

Population Health/Model of Care

1. **Question 1a – It was mentioned in Section 6, question 6, that "The number of ACO initiatives can correspond with the required level of operating expenses." Has the combining of programs and the iterative streamlining and simplification of programs resulting in the current PHM program saved administrative dollars? If so, has OCV calculated how much in savings have been experienced? If not, why not, and do you see opportunities for administrative savings in the future?**

   The intent when OneCare consolidated multiple programs into the new PHM model was to simplify provider messaging and enhance focus. The administrative work "behind the scenes" at OneCare to support the PHM is similar (if not greater) than in previous years. This includes care coordination support and reporting, data collection efforts related to quality measures, and payment arrangements that need to be processed each month. Thus OneCare did not anticipate administrative savings specific to this outward-facing consolidation.

   Procedurally, each budget build represents an assessment of resources relative to the work planned for the year. The team must evaluate the myriad opportunities to support the provider system under the ACO structure and balance that with the available budget funding level.

2. **Question 1c and 1e – Regarding the internal goal of working to share ADT data among the network and the future ability to send "care gap reports": will these functionalities in the new data analytics platform push the actionable lists directly to provider organizations, or will providers need to create these lists themselves?**

   Appropriately provisioned providers will have the ability to access actionable care gap lists within the new system through a link embedded in reports that are pushed. The ability to request data will continue for those that wish.

3. **Question 1c – It's mentioned that a challenge that the network has shared with OCV is that there is a lack of a common tool to document care coordination reporting. It seems that Care Navigator had been an attempt at such a tool; does OCV/state partners have any ideas for the future to meet this need?**

   OneCare is exploring options for a future interoperable care coordination system. This work will happen in collaboration with state partners who are responding to a consultant's recent statewide care coordination assessment and recommendations, part of which addresses infrastructure.

4. **Question 1f – What is OCV doing to support and drive improvement across its network (e.g., sharing best practices, coaching) in addition to changing payment models and providing data? For example the ACO identified annual wellness visits for those over 40 is an area ripe for improvement. What are the specific interventions OneCare would expect a practice to implement to improve these rates? What support will OCV providers receive in acting on new data and analytics provided by Arcadia?**

   OneCare provides quarterly PHM data reports that offer insight into practice and health service area performance on PHM measures. OneCare also convenes network participants to highlight best practices and evidence-based care guidelines and give examples of performance improvement in action. Specific quality improvement workflows vary across practices and are dependent on practice capacity and resources. The new Arcadia platform will support these efforts and allow providers greater visibility into their patient panels to help them prioritize patients for outreach. OneCare is currently piloting the Arcadia platform with a group of network users who are receiving specific training on navigating the software platform and report interpretation. This pilot will inform ongoing network education and outreach for Arcadia in 2024.

5. **Question 1g – "To increase network focus on the PHM measure achievement, OneCare plans to evolve it defined Populations of Focus in 2024 which may include a shift to prioritizing individual predicted to benefit most from care coordination services. The exact details are subject to final operationalization of OneCare's new data platform." How does OneCare plan to define who they think will benefit the most from care coordination services? Does OneCare have any plans to phase out its care coordination activities, if not, why?**

   OneCare plans to use a standard care coordination "impactability" tool embedded within Arcadia. This tool defines an individual's potential to benefit from care coordination based on multiple inputs ranging from medical claims to social determinants of health data. OneCare holds a belief that care coordination is an essential means of achieving high quality measure performance, strong patient experience ratings, and lower total cost of care, and has no plans to phase out its care coordination activities. Ongoing annual program evaluation will continue followed by synthesis of results and program evolution based on learnings.

6. **Question 4b – For PY22, avoidable ED utilization was lower for CPR participants than CPR-eligible non-participants. Do you have data showing that ED utilization was higher for these lives prior to the practice joining the CPR program? In other words, are you able to demonstrate that ED utilization has decreased as a result of joining the CPR program?**

   Increased ED utilization throughout and following the pandemic, coupled with the sporadic timing of practices joining the CPR program, make it very difficult to demonstrate that ED utilization has decreased "as a result of joining the CPR program." OneCare can demonstrate that most CPR practices managed avoidable ED utilization below practice-specific expected values during a multi-year span of unprecedented ED utilization driven by the public health emergency.

CPR Participant Avoidable ED Utilization PKPY 2022		
CPR Practice	Avoidable ED Utilization (PKPY)	Peer Group Expected Avoidable ED Utilization (PKPY)
A	129.2	140.7
B	23.5	37.2
C	44.4	99.8
D	87.8	54.9
E	215.1	130.7
F	36.1	90.1
G	43.2	49.1
H	47.6	39.8
I	10.6	74.0
J	101.8	58.0
K	57.1	84.9
L	128.3	128.1
M	11.9	25.4
N	56.5	56.3
O	18.1	33.5
P	-	9.5
Q	33.1	118.0
R	33.9	51.0

7. **Question 5 – Appendix 7.3 Care Coordination – Why are numbers of lives in the subpopulations for 2023 significantly lower than they were in 2022?**

   The 2023 data in Appendix 7.3 represents partial year data. At the time of this report's generation, the care coordination data available represented January to March activity. These numbers increase throughout the year. Another factor limiting numbers of lives in 2023 subpopulations is the absence of Blue Cross Blue Shield attributed lives.

8. **Question 5 – Appendix 7.3 Care Coordination – OneCare has noted that it plans to evolve its defined populations of focus in FY24 in order to increase network focus on PHM measure achievement. Why do the details depend on the operationalization of the data platform? Can you give more information regarding why this is the right time for OneCare to shift its populations of focus, and more information about potential populations of focus?**

   This is the right time for OneCare to evolve its populations of focus given learnings from the first year of the PHM that recognize the value of direct alignment between care coordination populations of focus and PHM measures. Instead of asking network participants to engage with a broad category of individuals with high ED utilization (2023 population of focus) and concurrently, with those who have had two ED visits in the last 90 days (2023 PHM measure), OneCare plans to align outreach expectations with the 2024 Follow Up after ED Visit for People with Multiple Chronic Conditions (FMC) measure, anticipating greater impact on FMC results and improved provider satisfaction. This timing allows OneCare to leverage a new Arcadia standardized care coordination tool – an "impactability" score – which precisely signals an individual's projected degree of benefit from care coordination interventions based on medical, social, and census data.

Potential 2024 populations of focus include individuals with an "impactability" score of "X" or above and/or individuals presenting to the ED who have multiple chronic conditions as defined by the Follow Up After ED Visit 2024 PHM measure and an "impactability" score of "X" or above. Exact thresholds are to be determined in the coming weeks. OneCare views this evolution of its populations of focus as progression and refinement aimed at achieving greater results.

9. **Question 6a – Rather than measuring if integration of social services across care teams/for care coordination purposes is occurring, the question is asking if the ACO has measured these efforts (integration of social services) as effective in achieving lower cost, better outcomes, etc. Is this the goal of the Team Based Care Model Improvement Project referred to in response to Section 8 Question 4c?**

   Given the many factors that influence cost and outcomes, isolating the effect of social services integration is difficult to ascertain. Therefore, OneCare has not measured the cost and quality impacts of integration of social services itself. The focus of the statewide AHS-hosted Team Based Care Model Improvement Project with the Camden Coalition is to further evaluate the existing team-based care model, foster increased standardization, expand adoption, and make recommendations specific to tools and training rather than to measure the impact of social services integration.

10. **Question 6a – "OneCare measures the effectiveness of integrating social services by gathering a cross organization success score as an aspect of the triannual care coordination reporting. Organizations score their HSA's cross organizational collaboration strength and offer suggestions for improvement. Results from trimester one of 2023, indicate cross organizational collaboration at an average score of 3.6 out of five on a Likert scale. This is a slight increase over the previous cross organizational score of 3.5 from trimester three of 2022". Is this essentially a self-evaluation? Are patients being asked to rate these services or is the organization (OneCare) and its provider team rating itself? What factors go into this "success score"? What survey instrument was used?**

    Each participating organization is asked to provide a rating of their perception of collaboration occurring across the health service area. It is partly a self-evaluation and partly an evaluation of other entities within the health service area. The question "Rate the current strength of cross organizational collaboration in your HSA on a scale of 0-5, 0 being non-existent and 5 being the best it could possibly be" is answered via required narrative triannual care coordination reporting mechanisms. Factors considered include the level of team-based care engagement, regional forum attendance, and overall responsiveness of primary care entities, Designated Agencies, home health and hospice agencies, Area Agencies on Aging, and other community partners.

    Along with this question, OneCare solicits cross organizational collaboration improvement ideas and specific actions taken towards such improvement initiatives. One HSA highlighted implementing a strategy of expanding their monthly Blueprint Spoke meeting to include substance use disorder and behavioral health providers that fall outside the traditional Hub and Spoke system, resulting in improved communication between organizations that may otherwise not have collaborated on patient care.

    Patients are asked to rate these services as part of the annual patient survey, question one, "The people involved in my care communicate about my needs and goals."

Evaluation and Performance Benchmarking

1. **Question 1 – OneCare reports that the CPR program has been very popular with its participants. Please share reasons why any eligible practices are not participating in the program; it is our understanding that 19 of 24 eligible providers are in for FY23. Does OCV know how many Vermont independent primary care practices do not participate in the network?**

   See section Network Programs and Risk Arrangement Policies, question 2.

2. **Question 1 – Please provide an update for the CPR program in FY24. How many practice sites will be participating and what are the number of attributed lives expected to be covered? Are any changes to the model anticipated? Will MVP lives be included as they were for FY23?**

   See section Network Programs and Risk Arrangement Policies, question 3.

3. **Question 1 – How is OCV working to spread successful aspects of the CPR program to other provider types? Performance Measurement**

   See section Network Programs and Risk Arrangement Policies, question 4.

4. **Question 1 – How many CPR practices responded to the primary care survey?**

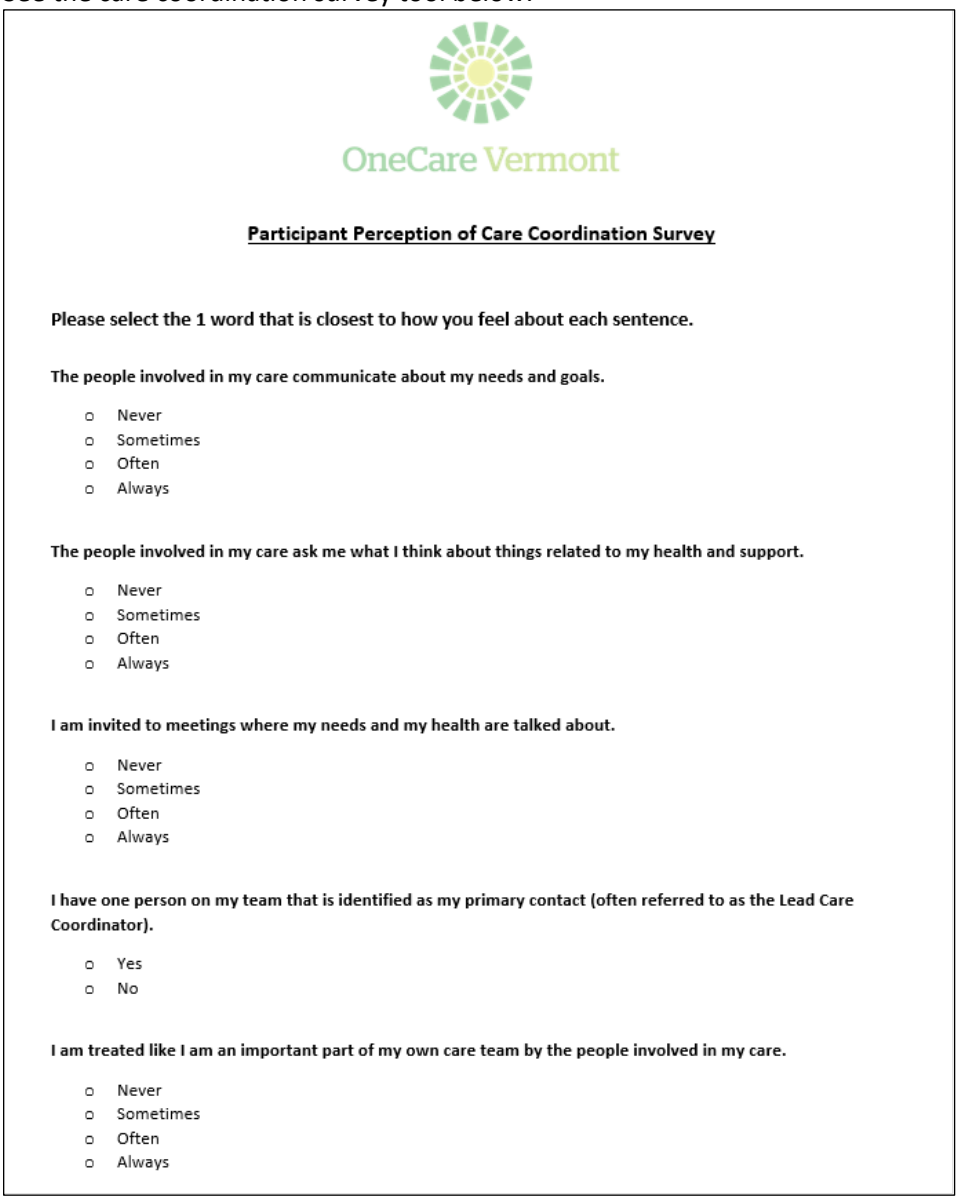
   Presuming the question refers to the CPR surveys conducted during Summer 2023, all 18 CPR practices participated except for one practice that did not participate in the summer meeting process for health reasons (and went on to retire and close their practice).

5. **Question 1 – How did the ACO determine that a 12% primary care spend rate was appropriate for its attributed population?**

   The target of 12% of the total cost of care represents the high-water mark for primary care payment in other states. It should be noted that differences in payer mix can have a very significant impact on the percentage, so OneCare also relied on analyses of historical spending within active ACO program lines to inform the target.

6. **Question 1 – Please provide the current care coordination survey tool. (Narrative, 87)**

See the care coordination survey tool below:



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Participant Perception of Care Coordination Survey

Please select the 1 word that is closest to how you feel about each sentence.

The people involved in my care communicate about my needs and goals.

- Never
- Sometimes
- Often
- Always

The people involved in my care ask me what I think about things related to my health and support.

- Never
- Sometimes
- Often
- Always

I am invited to meetings where my needs and my health are talked about.

- Never
- Sometimes
- Often
- Always

I have one person on my team that is identified as my primary contact (often referred to as the Lead Care Coordinator).

- Yes
- No

I am treated like I am an important part of my own care team by the people involved in my care.

- Never
- Sometimes
- Often
- Always

7. **Question 4a – OCV mentioned that they connected with three peer ACOs to discuss improvement strategies for ED visit and wellness visit rates and that their recommendations aligned with strategies that OCV had recently put in place. What are these strategies and when were they put in place by OCV?**

The strategies referenced include incorporating ED revisit reduction and Increased wellness visits age 40+ into OneCare's 2023 Population Health Model (PHM). Further, OneCare supports patient prioritization through the Patient Prioritization application that can filter for the two metrics mentioned above, as well as other PHM metrics. Outreach to those missing a well visit for the year, or to those with high ED utilization, is then focused by the care team on the ground. Several HSAs have embedded care management in the ED, another strategy that is similar to those of the peer ACOs with whom we shared. The overarching similarity we found to peer ACOs is that

providing a team of care providers who are readily accessible to patients reduces ED utilization. Additional strategies, such as virtual primary care provision 24/7, are needed everywhere to improve primary care access.

8. **Question 4c – It was mentioned that ACO network participants view care coordination as an activity they perform independent of OneCare's program. What insights into OneCare's care coordination efforts and/or actions has the ACO taken as a result of learning this specific information?**

   Participants also responded that they have many care coordination processes well-established in their organizations and communities. Respondents provided examples such as community care coordination meetings and systems to identify and prioritize patients for services. These are examples of strategies that OneCare has been promoting for many years alongside other partners such as the Blueprint. This is another example of how challenging it can be to determine causality when multiple factors are engaged and changing in a broader systems-improvement effort. OneCare continues to engage with state partners and their external consultants to consider next steps and evolutions to the care coordination model in Vermont. OneCare is in the process of discussing the newly released evaluation results and determining next steps based on learnings.

9. **Question 7 – Will ROI study findings be available prior to OneCare's budget hearing on November 8th?**

   OneCare does not anticipate the ROI study findings to be available prior to November 8th as the contractor is currently completing its work. OneCare intends to provide the GMCB with a copy of the final analysis and can make the contractor available to the GMCB or its staff for one consultation on the ROI and evaluation report findings.

10. **Question 10 – The OCV FY23 Budget Order Condition 1 stated that "The ACO performance benchmarking tool must "enhance OneCare's ACO-level performance management strategy." OCV's budget submission states that the benchmarking tool "is a tool for the regulator, not the ACO." How is OCV meeting this budget order condition and ensuring it works with its network to make the benchmarking tool actionable?**

    The key opportunities OneCare highlighted in the budget narrative related to the benchmarking tool (e.g. ED utilization and primary care visits) align with strategies identified by OneCare and its network as in need of improvement. As such, they have been included as areas of focus in the 2024 PHM. In this way, the benchmarking tool is aligned with OneCare's performance management strategy. However, the point we are making is that it was not necessary information to arrive at these areas of focus; OneCare used other existing data to identify these areas of concern. Benchmarking report data are shared through OneCare's various communities and workgroups to inform ongoing discussions of areas of strength as well as those in need of improvement.

11. **Question 4c – "External evaluation of OneCare's care coordination program included interviews and focus groups with key stakeholders, including leaders and administrators at the provider and collaborator organizations in the OneCare network". Please describe how interviewing members of the OneCare network qualifies as "external"?**

    "External evaluation" in this sentence was intended to indicate that the evaluation activities were conducted by a third-party contractor, not by OneCare staff. The contractor was therefore external to the programs it was evaluating.

12. **Question 5a – What is the screening rate for the Mental Health Screening and Initiative program? In other words, of the 80% of attributed lives covered by that program, how many have been screened thus far?**

    Based on data submissions through September, the average baseline screening rate was 34% across TINs with reported screening rate percentages ranging from 4% - 100%. Working with provider organizations, it has come to our attention that the overall baseline screening rate may under-report actual screening. As a result, OneCare is investigating what is driving the under-reporting with the goal of improving data integrity for the December reporting period.

13. **Question 5b – "For example, OneCare solicited extensive feedback from patients and providers in the development of the 2024 PHM program." How was this feedback solicited? Provide evidence of this feedback.**

    2024 PHM measure development feedback was solicited from providers via Quality and Care Models Subcommittee, Data Analytics Subcommittee, and Population Health Strategy Committee (PHSC). Feedback was solicited from patients via Patient Family Advisory Committee. As evidence, below are agendas for these meetings.

Quality & Care Models Subcommittee

TODAY'S AGENDA: March 29, 2023

#	Agenda Item	Presenter	Time
1	[redacted]		
2	2024 Population Health Model (PHM) Measure Discussion	Emmy Wollenburg, Jodi Frei & All Members	2:05pm-2:50pm (45 Minutes)

Data Analytics Subcommittee
Agenda: May 17, 2023

- [redacted]
- [redacted]
- **2024 PHM Policy Updates**
  - Measure updates

April 2023 PHSC Agenda

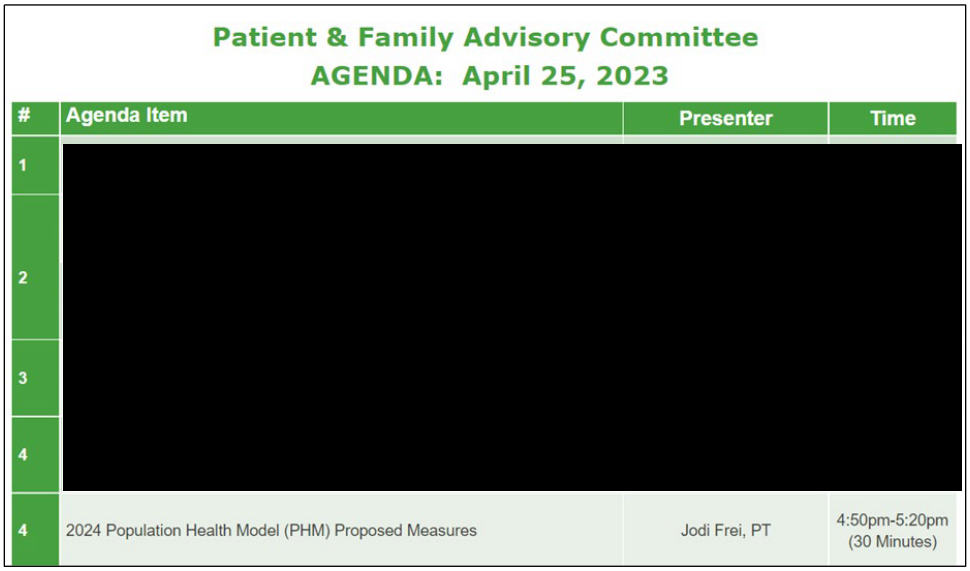
#	Agenda Item	Presenter	Time
1	[redacted]		
	NETWORK PERFORMANCE MANAGEMENT		
2	[redacted]		
	PHM 2024 Goals • Proposed Measures	Josiah Mueller, RN	5:40pm-5:55pm (15 Minutes)

May 2023 PHSC Agenda

#	Agenda Item	Presenter	Time
1	[redacted]		
	NETWORK PERFORMANCE MANAGEMENT		
2	[redacted]		
	2024 PHM Policy: Progress to Date [redacted]	Carrie Wulfman, MD	5:40 pm- 5:55 pm (15 minutes) [redacted]

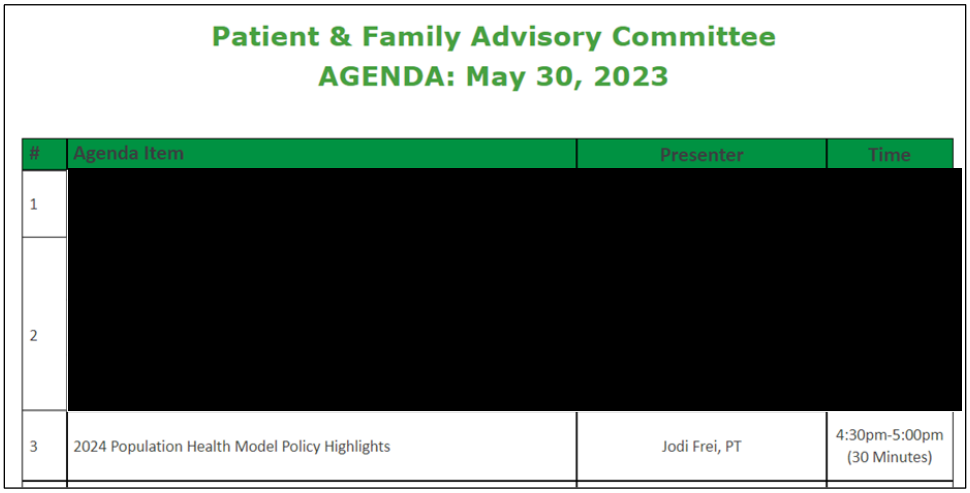
June 2023 PHSC Agenda

#	Agenda Item	Presenter	Time
1	[redacted]		
	NETWORK PERFORMANCE MANAGEMENT		
2	[redacted]		
	2024 PHM Metrics, Targets, and Policy *seeking endorsement [redacted]	Carrie Wulfman, MD	5:35-5:50 pm [redacted]



Patient & Family Advisory Committee
AGENDA: April 25, 2023

#	Agenda Item	Presenter	Time
1	[redacted]		
2			
3			
4			
4	2024 Population Health Model (PHM) Proposed Measures	Jodi Frei, PT	4:50pm-5:20pm (30 Minutes)



Patient & Family Advisory Committee
AGENDA: May 30, 2023

#	Agenda Item	Presenter	Time
1	[redacted]		
2			
3	2024 Population Health Model Policy Highlights	Jodi Frei, PT	4:30pm-5:00pm (30 Minutes)

14. **Question 6 – "As part of its partnership with its evaluation contractor, OneCare is working now to establish processes that will support future evaluation of the 2023 PHM. Through its work thus far, OneCare learned that a need for a control group is paramount to successful evaluation". How is OneCare taking this lesson – the need for a control group – and applying it to its 2024 programs and activities?**

    OneCare's evaluation contractor noted two possible ways control (or comparison) groups may be identified for future analyses. Within evaluations of care coordination and quality performance, they noted that it may be possible to identify suitable comparison groups, such as care coordination "non-participants that are otherwise similar to participants with regard to demographic and clinical factors." OneCare has some experience analyzing care coordination data this way and found the population size to be small in Vermont to allow for refined sample matching; however, it is worth further exploration to see if a more refined model could be more effective. This will be considered in planning 2024 evaluation activities. Second, the evaluator proposed that OneCare could "consider using data from other states, to the extent they are available, to conduct high-level comparisons of statewide outcomes before and after program

implementation." The latter recommendation has limitations for OneCare with respect to data access but could be considered on an aggregate basis. For example, examining population-level indicators as a proxy for ACO-related impact.

15. **Question 7 – "The value of OneCare's efforts will be reported by factors such as sharing improved quality scores and health outcomes; impact on health care utilization, or benefits of standardizing requirements across payers." For clarification, the ROI will show OneCare's impact on health care utilization, but not on quality scores and health outcomes?**

    The ROI analysis will consider cost, quality, and utilization impacts.

16. **Question 9 – There have been several instances in this budget submission where OCV has clearly shown a link between financial incentives to the reduction of ED utilization. OCV noted that there will be incentive payments around this measure and that of 40+ annual wellness visits. Has OCV budgeted specific funds to address the other chosen metric (primary care visits)?**

    OneCare's approach to incentivizing primary care visits is to embed wellness visits for both the pediatric and adult population, developmental screenings ages 1-3, HTN follow-up visits, and reduction of ED visits in the Population Health Model. All of these measures incentivize primary care visits.

APM

17. **Question 1 – "Conversely, the extreme pressure from APM signers to delegate these accountabilities to ACOs has forced OneCare to negotiate within these constraints. These dynamics have led OneCare to sign contracts to meet APM requirements rather than what is best for providers, their patients, and OneCare's sustainability." Please elaborate on how signing the APM is not best for providers, patients, and OneCare's sustainability.**

    While OneCare made considerable progress toward the scale targets agreed to by the State of Vermont, these targets were not attainable for a variety of reasons that have been previously discussed. Barriers to achieving scale include: ambitious targets, a scale denominator which includes populations over which the State has no authority (e.g., self-funded employer groups and Medicare Advantage plans), Vermonters that receive a preponderance of care from out-of-state providers, and a drop in enrollment in state-regulated insurance market segments.

    OneCare did not mean to imply that "signing the APM is not best for providers, patients, and OneCare's sustainability." Rather, the narrative conveyed that the APM signers effectively transferred state-level accountabilities around scale targets to OneCare that fall outside of the traditional role of an ACO. Absent this pressure to build scale, OneCare program models would have been more focused on what was best for providers and their patients rather than generating scale to meet the APM target.

18. **Question 3 – How is OneCare impacting Primary Care Access? How are you measuring accessibility of services?**

    See the response to Evaluation and Performance Benchmarking, question 16 above. OneCare incentivizes multiple types of primary care visits through the Population Health Model. Our measure of increased access is directly linked to improvements in primary care visits that are necessary to improve in the chosen metrics. If progress on these metrics is positive, access to primary care will be increased. Additionally, meeting care coordination requirements is mandatory to access any incentive funds in the model. Referral to care management is via primary care, necessitating access to that setting in order to succeed in the program overall.