OneCare Vermont

FY25 Budget
Round 1 Staff and Board questions

Section 2 Provider Contracts

1) **In Table 1, under "Reason for departure", the staff find the answer of "Did not return agreement" to be non-responsive. Please provide reasons for each departing organization.**

   In Table 1 (included below), in the "ACO Response (if any)" column, OneCare provided the detailed reasons each departing provider organization did not return their contract. In summary for 2025, the following did not return their agreement for the following reasons.

   - 1 Hospital – After discussions over several months, the hospital decided to exit for 2025.
   - 1 Designated Agency – DA reallocated limited resources to becoming a certified community behavioral health center (CCBHC).
   - 2 Specialists – One exited due to lack of specific ACO programs/incentives for their organization type; one did not respond to multiple outreach attempts.
   - 2 Physical Therapists – No responses to multiple outreach attempts.

Table 1: ACO Provider Departures (2022-2025)

Departing provider type and count	PY of departure	Reason for departure	ACO Response (if any)
1 Primary Care	2023	Merged/Acquired or Closed	N/A
2 Primary Care	2024	Merged/Acquired or Closed	N/A
2 Specialist 1 SNF	2024	Did not return agreement	Multiple outreach attempts made.
1 Hospital	2025	Did not return agreement	After discussions over several months, the hospital decided to exit for 2025.
1 Designated Agency	2025	Did not return agreement	DA reallocated limited resources to becoming a certified community behavioral health center (CCBHC).
2 Specialists	2025	Did not return agreement	One exited due to lack of specific ACO programs/incentives for their organization type; One did not respond to multiple outreach attempts.
2 Physical Therapists	2025	Did not return agreement	No response to multiple outreach attempts.

2) **Per FY2024 Budget Order Condition 20, please provide all written explanations from hospitals receiving primary care investment funds from OneCare on behalf of hospital-owned primary care practice(s) that demonstrate how the hospital plans to use said funds to enhance primary care initiatives that would otherwise not be funded to the same extent.**

   There are nine (9) hospitals that receive primary care funding and are required to submit a written plan for that funding as described in the FY25 Budget Order, Condition 20. These nine hospitals have submitted their written plans; see enclosed.

Section 3 Payer Contracts

1) **Please explain the reasoning behind choosing the 3% risk corridor for the Medicare program versus the asymmetric option. If OneCare's direction has shifted and the ACO is now more heavily considering this alternative, please provide an updated version of appendices 4.1, 5.1, and all others the ACO finds applicable to model this possibility.**

   The primary reason for choosing the 3% risk corridor, as opposed to the asymmetric option, relates to 2025 GMCB budget guidance. It states (emphasis added):

   > *If the ACO elects the asymmetric risk corridor,* ***the ACO must maintain risk for the Medicare hospital AIPBP payment reconciliation at the ACO level*** *consistent with the First Amended and Restated Vermont All-Payer Accountable Care Organization Model Agreement (2024 Amendment No.1). The ACO may propose a payment withhold or other mechanism consistent with the Medicare Participation Agreement.*

   Because the year-end All Inclusive Population Based Payment (AIPBP) reconciliation has been historically volatile, holding this risk at OneCare creates the potential for a financial obligation OneCare cannot afford. For context, the 2022 reconciliation was $13.8M, the 2023 reconciliation was $1.4M, and the 2024 reconciliation is projected to be $27.7M (all payments to Medicare). OneCare does not have the reserves to take on this level of risk.

   Based on past experience, the variation noted above is not isolated to healthcare cost fluctuation. Rather, we believe the financial model used by Medicare to determine the AIPBP amount contributes to the volatility. This means that holding the AIPBP risk includes both healthcare cost risk and "rate setting risk." We recommend that neither OneCare nor any Vermont provider take on the AIPBP rate setting risk until a more reliable methodology is developed by Medicare.

2) [redacted]

[redacted]

3) **Describe OneCare's activities in compliance with FY24 Budget Order Condition 6, which states "OneCare shall work with Medicare Advantage plans operating in Vermont – with a special focus on Vermont-based plans offered by BCBSVT and UVMMC-MVP- to develop scale target qualifying programs" recognizing that the mentioned MVP program is sunsetting at the end of 2024.**

To comply with GMCB Budget Target three advising "the ACO's administrative budget should not support new programs in FY25," OneCare has not actively pursued new payer contracts in the final year of the All-Payer Model. Any new payer contracts would necessitate additional administrative costs to negotiate the agreements and recruit network participants. Further, Medicare Advantage (MA) plans are experiencing significant changes nationally and several are known to be struggling financially in Vermont as evidenced by publicly available information announcing three current MA plans are withdrawing from the state. This rapidly shifting landscape also makes it unlikely that MA plans would be willing to negotiate favorable ACO arrangements even if the APM were not in its final year.

Section 4 TCOC

1) **Explain why the Medicare amounts on appendices 4.1 and 5.2 for 2024 projected settlement do not tie out. 4.1 shows Medicare projected settlement at $2.2M coming to the ACO, while 5.2 shows $7.7M returning to CMS.**

The difference between the numbers referenced above relates to "advanced shared savings." Based on the projections included in the budget submission, the year will end with $2.2M in shared savings. However, because the advanced shared savings amount is pre-paid to OneCare the settlement would result in a $7.7M payment to Medicare.

Medicare Settlement Component	**Amount**
Projected Final Savings/(Loss) Figure	$2,217,425
LESS Advanced Shared Savings	-$9,954,481
Final Transaction	**($7,737,056)**

2) **Given that there has been an update to the 2024 Medicare benchmark since the budget submission, does any portion of the budget submission such as appendix 4.1 and/or appendix 5.2 need to be updated? If so, please resubmit an updated version.**

The Medicare benchmark has been updated, will continue to change throughout the course of the year, and will be updated substantially at settlement (ex. QEM adjustment). Additionally, the estimate of spend is revised periodically based on the latest claims files. In sum, this highlights the dynamic nature of ACO programs throughout the course of a performance year. OneCare thinks of these adjustments as ordinary in nature and they do not impact the plan articulated in the 2025 budget.

3) **In appendix 4.2, why is the trend for Medicare at 4% and not 3.8% (USPCC: 4% - 0.2% = 3.8%)?**
The trend rate incorporated into the budget is based on data sourced from the following link: https://www.cms.gov/files/document/2025-announcement.pdf

The table on page 15 includes a "Part A + Part B Current estimate" for both 2024 and 2025. Our math was:

($1,130.85 / $1,085.48) - 1 = 0.041797.

We rounded the result to 0.042, and then subtracted the 0.2% discount factor to come up with 0.040, which is a 4.0% trend. Note that the figures above are for the non-ESRD population. We also did the math in a manner that blends in the ESRD population (which has a higher trend rate), but it did not change the result due to the very low number of attributed lives in the ESRD category.

4) **In appendix 4.1, it appears there's a 13% increase in expected TCOC with a 3% average attribution drop. Please explain this trend.**

This response assumes the question relates to Medicaid. In 2024 OneCare is observing high spend in the Medicaid program. This has been discussed with DVHA and their actuaries. While work is ongoing to analyze the results to date, OneCare believes there are multiple contributing factors:

1. Repricing: Medicaid has improved reimbursement rates for a number of services such as FQHCs, rural health clinics, and ambulances, among others. While some of the rate increases appear minor at a claim level, they sum to significant amounts due to the overall size of this program.
2. Redetermination: Data shows that the lives being disenrolled due to redetermination are lower cost on average. This means that as the lower cost lives are disenrolled, the remaining pool of lives is higher cost on average. This was contemplated in the benchmark model, but OneCare suspects the adjustment didn't fully account for this dynamic based on the latest information available.
3. Utilization: Emerging data suggests there is an increase in certain types of utilization such as physician, rural health clinical, medical supply, hospice, inpatient, psychologist, and ambulance claims. While some of these are encouraging trends, the uptick contributes to the 2025 benchmark projection. Redetermination may also be a contributing factor as lower utilizers are disenrolled.

Because the 2025 target will be based on historical data and informed by emerging trends, OneCare expects the 2025 target to be higher on a PMPM basis relative to 2024. Ultimately this will be determined through the robust actuarial process between OneCare and DVHA preceding the next performance year.

Section 5 Network Programs and Risk Arrangement Policies

1) **During the Revised FY24 Budget hearing, OneCare mentioned that finding participants for the Regional Clinical Representative program was more difficult than anticipated. What leads OneCare to believe that they will successfully recruit 3 additional RCRs in 2025?**

   Since the revised FY24 Budget hearing, OneCare has successfully engaged with nine Regional Clinical Representatives who are working closely with the Value-Based Care Team and who indicate enthusiasm for the work. Through the RCRs, OneCare fosters trust and collaboration between practices, supporting focused Performance Improvement Plans (PIPs) that help drive local progress. The RCR project has gained momentum over the second half of 2024, leading us to believe that we will be able to engage with as many as 12 RCRs for FY 2025, helping ensure that all primary care participants have access to RCR leadership.

2) **In 2024, has OneCare observed significant improvements in PHM measures in practices with RCR support versus those practices without that support?**

   It is too early to accurately evaluate PHM measure outcome impact based on RCR support, and it is not feasible to separate out RCR impact from the impact of other efforts (such as those of the Blueprint) focused on the same clinical quality measures. As we move into the first half of 2025, OneCare is open to looking for ways to identify RCR impact based on qualitative and/or quantitative outcomes.

3) **Does OneCare track potentially avoidable utilization among its attributed lives? If so, how has performance in this measure changed over time?**

   OneCare tracks avoidable Emergency Department (ED) utilization and potentially preventable Ambulatory Care Sensitive inpatient admissions among its attributed lives. Most recent data shows that avoidable ED visits per thousand during the period of July 2023 to June 2024 have increased by 4% over the prior year. Ambulatory Care Sensitive admissions for the same period have reduced by 2% over the prior year. Avoidable utilization data are shared with the network through quarterly OneCare, Health Service Area, and practice level reports.

4) **Is it correct that OneCare removed the requirement for practices to report follow-up results from the MHSI in 2024? Is it a requirement in 2025?**

   For 2025, follow-up on positive mental health screening becomes a requirement within the PHM. This activity never did require “follow-up results” performance, but rather attestation that this follow-up occurs. Auditing of this practice occurred in 2024 and will occur in 2025 before practices have access to incentive payments.

Section 6 Budget

1) **Why doesn’t the FY25 budgeted amount for salaries and benefits in appendix 6.2 ($7,202,258) tie out to the total in appendix 6.4 ($7,170,026)?**

   The difference between these two numbers relates to budgeted temporary help. The amount budgeted is based on prior year costs, which typically relate to life circumstances such as maternity leave. The temp help amount was excluded from appendix 6.4 as it does not relate to any specific positions or add to the overall FTE count.

2) **In appendix 6.2, it appears that salaries for FY24 are predicted to come in at $6,614,428 and in FY25 they are budgeted at $7,202,258. Meanwhile, the number of FTEs is decreasing. Please explain why and provide the median salary in FY24 versus the budgeted median salary for FY25.**

The number of FTEs budgeted for 2025, and the 2024 projection, are flat at 38.35 (the actual FTE number at 7/31/24). Both are decreasing from the 2024 budgeted amount of 43.5, but that is not a factor in either dollar amount noted above.

In total, the 2025 budget is higher than the 2024 projection by $587,830. This is made up of several components shown in the table below. The 2025 budget is a continuation of the 2024 staffing model inherent in the projection and incorporated the following changes.

Component	$ Change	% Change
Impact of Fringe Benefit Rate Change	$308,377	4.7%
Cost of Living Adjustment – 10/1/2024	$134,823	2.0%
Cost of Living Adjustment – 10/1/2025	$44,941	0.7%
Annualization of staffing changes made in 2024 (ex. mid-year hires)	$107,594	1.6%
Temporary Help Change	($7,905)	(0.1%)
Total	**$587,830**	**8.9%**

The median salary projected for 2024 is $122,459. In 2025 it is budgeted to be $127,194. This is a 3.87% increase, consistent with budgeted COLA and fringe benefit increases reported.

3) **The software line in appendix 6.2 varies significantly from the "analytics software and tools" line in appendix 6.10; please explain.**

The purpose of Appendix 6.10 is to document the functional classification of operating expenses per the request parameters set forth in budget guidance. Our attempt to record the breakout of functional categories provided in that guidance is separate and apart from the natural expense classification necessary under Generally Accepted Accounting Principles.

Included in Appendix 6.10 as "Analytics Software and Tools," but not categorized as "Software" in Appendix 6.2, are expenses for the DMO analytics agreement, a contract for social determinate risk score information, the contract with VITL, and a contract for cloud services that support database infrastructure.

Included in Appendix 6.2 as "Software," but not categorized as "Analytics Software and Tools" in appendix 6.10, are expenses such as OneCare's network database platform, contracting system, and board management system, as well as several other small software tools used for general operating purposes.

4) In appendix 6.4, why aren't there any salaries budgeted for compliance for FY25?

The compliance function has been fully converted to a contracted model. Under this model there are no direct salaries and instead a fixed contract price is included in the Purchased Services category.

5) In appendix 6.7, why are hospital fees positive?

Because the table is not structured in a way that can be summed to draw any aggregate conclusions the numbers were entered as a positive. That said, they are in fact payments from the hospitals to OneCare.

6) In appendix 6.10, please describe what types of work and the dollar amounts of each type of work that are included in the line item under non-salary operating expenses "Regulatory Requirements and Orders".

This category includes the following non-salary expenses:

Expense	Amount
Evaluation Contract	$350,000
Benchmarking Contract	$118,638
GMCB Billback	$652,513
Total	**$1,121,151**

7) In response to question 3.a, OneCare stated that the Medicare benchmarking report and evaluation contract are budgeted at $467k. Please break out these two costs separate and clarify under what line items these fall in appendices 6.2 and 6.4.

The expense breakout is as follows. Both expenses are included in the Purchased Services category of tab 6.2.

Expense	Amount
Evaluation Contract	$350,000
Benchmarking Contract	$118,638
Total	**$468,638**

Section 7 ACO Quality, Pop Health, and Model of Care

1) **Has the introduction of the "Impact Score" increased or decreased the number of patients who might benefit from coordination of care as perceived by network providers?**

   As the Impact Score was implemented in program year 2024, it is too soon to draw a conclusion regarding network provider perception for differences in the number of patients identified for care coordination.

   In prior program years, the risk stratification tool used was based on historical utilization, not the potential benefit of care coordination for an individual. OneCare cannot compare previous numbers of patients receiving care coordination, as the tools are different.

2) **How often is underlying Impact Score data updated? How are potential status changes reflected?**

   Impact Score data is updated on a weekly basis within the Arcadia platform using most recently available data from sources including claims, Johns Hopkins and census data.

3) **In response to question 3.a. OneCare wrote "OneCare's PHM and CPR program both support incremental growth in access." Does OneCare possess any data to show that these programs have improved access in participating practices?**

   Access to clinical encounters with providers is required to perform Child and Adolescent Well visits, Developmental screenings, Medicare Annual Wellness visits, follow-up after ED visits, and mental health referrals. All of these encounter types have increased over time, corresponding to an increase in access. This occurs, at least in part, when the measures are incentivized as they are via the PHM and CPR programs.

4) **What is OneCare's plan during the final year of the APM to help network providers transition away from the current model into 2026, including how waivers might transition, changes in support from different population health programs, and changes in financial models?**

   OneCare remains committed to supporting participants as they prepare for new programs and models in 2026. The primary roles OneCare can play are helping educate and explain the changes a participant can expect, and providing advocacy to sustain the benefits afforded through the All-Payer Model era.

   OneCare will be supporting and promoting the SNF 3-day waiver, Expanded Telehealth BE waiver, Concurrent Care for Hospice Beneficiaries BE waiver, Home Health Homebound BE waiver, and fraud and abuse waivers in 2025. It is unclear which of these waivers will be available to providers after the conclusion of the Vermont Medicare ACO Initiative (VMAI). However, through OneCare's work providers now have a greater understanding of the benefit of waivers and how they can be implemented and utilized. As the end of the VMAI nears, OneCare aims to support its providers so that they understand any new waivers that may be available to them as well as the protocol for the operational hand-off.

   Regarding changes to population health programs and changing financial models, OneCare can take a similar role helping to educate providers and providing insight and advocacy to

all stakeholders regarding future programs. For example, financial information related to the Comprehensive Payment Reform (CPR) program has already been shared with the State so that they can explore opportunities to sustain the support of independent primary care.

5) **Please provide a status update for the 2024 PHM program performance for each measure.**

The table below reflects current performance on the seven PHM measures compared to the established targets as of the October 2024 report. Please note that the measurement periods vary as per the footnotes in the table. The three performance rates highlighted in green indicate that the target has been achieved under the 2024 PHM program.

Green shading indicates target met

PHM Measure	Performance Rate*	Target
1. Developmental Screening	74.2	57.4
2. Child & Adolescent Well Care	67.2	61.15
3. Medicare Annual Wellness Visits	46.2	51.8
4. 7 Day Follow Up after ED Visit (FMC)	50.8	56.5
5. Hypertension: Controlling High Blood Pressure	67.9	67.27
6. IET Initiation	36.2	44.32
7. IET Engagement	15.7	18.87

Data Source: October 2024 Release OneCare Executive Summary
Performance Periods:
Claims Measures 1-4: August 1, 2023 to July 31, 2024
Practice-Reported Measure 5: September 1, 2023 to August 31, 2024
DVHA-Reported Measures 6-7: April 1, 2023 – March 31, 2024

6) **Please provide a status update on ADT data integration with VITL.**

OneCare and VITL are in contract negotiations. OneCare recently learned VITL is making some operational changes in their approach to processing and delivering ADT data. OneCare is assessing the technical impacts of this change as well as how it may impact implementation timelines.

7) **In addition to the SNF 3-day waiver, four other waivers are available to the ACO in 2025: Home Health Homebound Benefit Enhancement, Concurrent Care for Hospice Beneficiaries Benefit Enhancement, Conditions of Payment for Inpatient Services Furnished at CAHs (CAH 96-hour Certification), and an Expanded Telehealth Benefit Enhancement. Please describe how the ACO plans to utilize these offerings in the upcoming budget year.**

OneCare engaged in multiple meetings with the VNAs of Vermont to discuss the Home Health Homebound and Concurrent Care for Hospice Beneficiaries BE waivers and subsequently agreed to support both of these waivers through pilots in 2025. One agency will be implementing the Home Health Homebound BE waiver, and two agencies will be implementing the Concurrent Care for Hospice Beneficiaries BE waiver for dialysis patients.

OneCare submitted implementation plans for the two projects above to CMS, as well as a plan for the Expanded Telehealth BE waiver. There was not sufficient interest among OneCare's network to pilot the 96-hour CAH certification waiver in 2025. OneCare will be working closely with all involved parties to implement these three new BE waivers early in 2025.