FY 2023 Budget & Certification
Responses to Round 1 Questions from
Green Mountain Care Board and Office of the Health Care Advocate

Contents

Green Mountain Care Board Questions

Section 1: ACO Budget Executive Summary

1. ***Section 1, Question 1a, pg. 5: OneCare's current strategic plan runs from 2021 through 2023. Many goals and strategies discussed in the submission are long-term. When does the ACO expect to develop its strategic plan for beyond 2023?**

   Management will work with the Board of Managers in Q1 of 2023 to refresh the strategic plan.

2. **Section 1, Question 1, pg. 5: Is the 90% of Vermont primary care within the OneCare network a OneCare calculated figure, or are you citing a GMCB or other source for this figure? If GMCB, that figure is inaccurate and has been updated in the most recent scale report (PY4 2021 Scale Report, p. 4). Please use the updated figure if you are using that figure in future materials.**

   OneCare will align with the GMCB's updated PY4 2021 Scale Report with the 82% figure.

3. ***Section 1, Question 1a, pg.6: OneCare's narrative states that a longer-term tactic in achieving payment reform goals to evolve commercial contracts away from FFS include, "developing a roadmap to evolve the commercial payer strategy…" Developing a "roadmap" (i.e., a plan, milestones, strategies) has been in discussion for several years, including in the 2020 All-Payer Model Implementation Improvement Plan and the FY 2021 OneCare Budget Order. Why has this not been developed yet and what is the timeframe?**

   OneCare's multi-year strategic approach to achieving payment reform goals with commercial payer partners has evolved based on payer response and engagement. OneCare accepts this ongoing challenge, but learned it is difficult to substantively advance efforts with commercial insurers in the absence of a shared vision for payment reform. OneCare's focus in evolving the commercial roadmap for the past several years has been on developing fair and sustainable target methodologies with each commercial payer. This has involved significant resources and time which have precluded other evolutions; however, strategically, advancement in this area will provide the foundation for future payment reform initiatives.

4. **Section 1, Question 1b, pg.7: The total starting attribution is budgeted at 296,658 lives. Using the table below, please break out the starting attribution assumptions and the average attribution assumptions used to develop the budget, by payer program (Medicare, Medicaid traditional/expanded, BCBSVT QHP, BCBSVT Primary risk/non-risk, MVP QHP).**

Payer Program	FY23 Starting Attribution Estimated *Used to Measure APM Scale*	FY23 Average Attribution Estimated *Aligns with data provided in Tabs 4.1, 4.3, and 5.1*
Medicare	67,558	50,430
Medicaid – Traditional	95,175	88,393
Medicaid – Expanded	30,563	20,216
BCBSVT QHP	20,584	18,864
BCBSVT Primary – Risk	43,527	40,900
BCBSVT Primary – Non-Risk *	28,829	28,147
MVP QHP	10,422	9,642
TOTAL	**296,658**	**256,592**

* Does not qualify for Vermont scale targets

5. **Section 1, Question 1b, pg.7: What do you project the impact of the growth of Medicare Advantage enrollment will have on the Medicare ACO program in areas such as acuity and utilization?**

   OneCare data suggests that the population leaving traditional Medicare for Medicare Advantage has lower costs on average. Assuming this dynamic holds true, it means that the average cost (which incorporates acuity and utilization) for the remaining traditional Medicare population will be higher due to the removal of lower cost beneficiaries. To address this in the target setting process, OneCare recommends the base 2022 spend, upon which the 2023 target will be built, is properly adjusted to reflect base costs of just the beneficiaries remaining with traditional Medicare coverage. Else, the target may be understated relative to the expected cost of the attributed population.

6. **Section 1, Question 1d, pg. 7: The second sentence states, "The major difference between the two is *the entity-level budget reflects all revenue* [emphasis added], 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." The GMCB considers the GAAP presentation to be the "*entity-level*" budget presentation. The non-GAAP presentation that includes the pass- through is referred to as the "*Full-Accountability*" budget. Please clarify the italicized phrase. Do you mean "*the full-accountability budget reflects all revenue"*?**

   Yes, the full accountability budget reflects *all revenue*, whereas the GAAP budget presentation excludes pass-through revenue for which OneCare is deemed to be acting in an agency capacity (e.g., TCOC/health care spend).

Section 2: ACO Provider Contracts

7. **Section 2, Question 4, pg. 15: Do you have any plans to implement a fixed payment or risk model for specialists (e.g., such as a shadow bundles program)?**

   There are no current plans to implement an ACO-wide fixed payment or risk model specifically for specialists (though many OneCare network specialists and specialty clinics are employed by risk-bearing hospital organizations that receive fixed payments from OneCare). OneCare and its provider network have started exploring available payment reform options for specialists. For now, one network hospital is working in collaboration with OneCare to explore participation in the new CMS Enhancement of Oncology Model, and the CPR program is evolving to focus on mental health access expansion. This is an area of further planning and evaluation for 2023 and beyond.

Section 3: ACO Payer Contracts

8. **Section 3, Question 2d, pg. 21: OneCare states that it "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." Please elaborate on why these priorities appear to be "competing."**

   OneCare does not contend health equity and coordination of care, prevention and chronic disease management, or the use of data to identify opportunities for improved care are competing priorities against each other, as the question suggests. To clarify, these are the priorities OneCare takes into its negotiations with payers, where it is commonly met by differing competing priorities held by each payer (e.g., competition among insurers for market share).

9. ***Section 3, Question 2e, pg. 21: Narrative states that OneCare views the BCBSVT Primary Non- Risk cohort as an "on-ramp" to move employer groups to risk-based arrangements. Has this effort been successful? How many employer groups have transitioned from non-risk to risk?**

   BCBSVT works directly with employer groups to present the risk-based arrangement and potentially migrate health plans towards the risk track. OneCare is not provided data on employer groups, nor are we party to the contracts BCBSVT engages in with these groups.

10. **Section 3, Question 3b, pg. 22: OneCare describes upcoming Medicaid redeterminations as a challenge in managing the DVHA contract and fixed payments in FY23. What is your assumption about average attribution in FY23 for the purpose of the submitted budget and how did you arrive at your assumption? If there are financial risks associated with likely redeterminations, what strategies will OneCare employ to mitigate this challenge and associated risk?**

    Due to lack of specific data on the current Medicaid members who may be impacted by redetermination, budget assumptions were based on anecdotal information gleaned through discussions with DVHA. At this point, however, DVHA has done further analysis and indicated roughly 12,000 lives will potentially be impacted, which is close to the assumption in the budget

submission. The other important variable is the timing of redetermination. If the 12,000 lives are transitioned early in the year, it will result in a larger reduction to member months. If the transitions happen later in the year there will be a smaller reduction to member months.

From a budget standpoint, OneCare previously implemented pre-set provider payments that prospectively incorporate attribution attrition. Due to the increased magnitude and uncertainty of attrition, OneCare will need to carefully monitor attribution levels, PMPM payments into OneCare, and the payments to providers. Adjustments to provider PMPM payments may be necessary throughout the performance year to ensure alignment between the revenue and expense.

For this budget, OneCare assumes the Public Health Emergency will not get extended again after January 11, 2023 and that Medicaid redetermination will then resume. Allowing time for DVHA to begin their process in Q1, OneCare anticipates that attribution counts will be impacted starting in April, and have modeled a higher attrition rate starting at that time.

Lastly, both OneCare and DVHA, in conjunction with their actuaries, are working to model how redetermination might affect the 2023 Medicaid TCOC and use this information to update the spend targets accordingly. There may be a dynamic similar to the one discussed regarding Medicare Advantage.

Section 4: Total Cost of Care

11. **Section 4, Question 2b, pg. 27 and Appendix 4.1: Describe the adjustment factors, by payer program if necessary, used for calculating the final settlement result, i.e., what is the difference between the "Amount Over/(Under) Target" and the "Settlement" cells in Appendix 4.1.**

    The difference between the "Amount Over/(Under) Target" and the "Settlement" is driven primarily by contractual risk corridor and risk sharing terms. As an example, while the health care costs may have been 8% below target, the shared savings payment may be contractually limited to 2%. In this scenario, the providers collect the first 2% of savings, and the payer retains the remaining 6% beyond that threshold. Some programs also have a sharing rate, which means that for every dollar saved, the savings/losses are split between the OneCare providers and the payer. These risk sharing terms are agreed to between OneCare and the contracted payer annually.

    As it relates to the budget, it is assumed that all total cost of care targets will be equal to total health care expenditures (with the exception of Medicare where we budget shared savings to cover the Blueprint). This means the budget submission does not include any adjustment factors, and risk corridor terms are used to generate the best estimate of maximum savings/losses.

Section 5: ACO Network Programs and Risk Arrangement Policies

12. **Section 5, Question 2a, pg. 33: Narrative states, "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." OneCare's current commercial targets are actuarially certified; if there is disagreement between the parties about the reasonableness of these targets, please describe. In addition, commercial ACO programs are fairly common nationally. What can we learn from the national experience about setting fair targets? Has OneCare explored industry standard for how this is done?**

    OneCare continues to believe that it is not the proper entity to supply this type of certification. The payers set the targets and have a much more robust dataset to evaluate and defend the final figures. The requirement of OneCare to supply actuarial certifications results in a circumstance where OneCare's actuarial contractor is opining on the work of another without access to the same information and data. As a result, the actuarial certifications speak broadly to the methodology used, whether the target is excessive, and the adequacy of the target relative to the risk sharing arrangement and potential impact to solvency.

    When contemplating the return to more traditional risk sharing levels, OneCare reviewed prior year results and concluded more accurate target models are necessary. To this end, OneCare worked in concert with its retained actuarial firm to incorporate the national experience into its thinking and approach, and is advocating for models closer to industry standard.

13. **Section 5: What are the potential advantages and challenges OneCare sees in extending a model like the Comprehensive Payment Reform (CPR) program to hospitals (i.e., unreconciled, multi- payer fixed payments)?**

    The potential advantages would look similar to those of the CPR program: stable, consistent payment in a payer-agnostic clinical and reimbursement model, and a linkage to accountabilities and advanced primary care expectations. Challenges include availability of unreconciled fixed payments with payers, and technical complexity associated with isolating primary care services within a hospital. The latter adds complexity and may require some modifications to the financial model, but the challenge is not insurmountable. OneCare is actively exploring the viability of CPR expansion to hospital-owned practices.

14. **Section 5, Question 2c, pg. 33: What feedback have CPR practices offered on potential methodology change to tie CPR payments to total cost of care rather than FFS equivalent?**

    The concept of tying CPR rates to the total cost of care was born out of earlier discussions with primary care network providers and OneCare medical leadership on the subject of the primary care spend rate (PCSR). PCSR is a metric used by other states to express funding underlying a particular state's primary care delivery model. Early work in this area centered on expressing Vermont primary care reimbursement, and ultimately CPR reimbursement, in the form of a PCSR, or as a percentage of total spend. Feedback throughout this process was positive in that the providers sensed it represented an attempt to discuss primary care reimbursement more in terms of a "share" of total

spend (as opposed to relating primary care reimbursement to fee-for-service spend, for example). In working through that process, it seemed prudent to expand this well-received thinking to rate-setting in the CPR program. We have since carried this approach forward to the CPR Clinical Advisory Group, which consists of six CPR practice providers. The advisory group has met and issued their feedback, which has also been positive.

15. **Section 5: Is the new PHM payment model described in Section 5 expected to result in different payment amounts for some practices or provider types compared to the previous PHM payment streams?**

The new payment model was designed to be net neutral at the macro level across provider types. When breaking the program down to the provider level, there are two notable changes. First, approximately 15% of PHM funding is accountability-driven, so practices will achieve different quality scores driving differing PHM payments. This means practices earning less (or more) money on a per patient basis will do so on the basis of their performance on the PHM quality measures, not on the basis of a difference in funding from OneCare. Next, the allocation methodology used to distribute funds amongst the different Preferred Provider and Collaborator provider types was reviewed with the participants. Some changes were made in spirit of aligning payment with the size of the organization and the attributed population they serve.

Segment	2022	2023	Comment
Primary Care			
Base Payment	$3.25 PMPM $1.50 Care Coordination	$4.75 PMPM	Maintains the same regular cash flow to primary care providers
Bonus Payment	VBIF: $0.47 Care Coordination $0.33	$1.00 Blended PHM	Combines the bonus potential into one pool Amounts represent AVERAGE earning levels Not all participants will earn maximum amount in 2023
Continuum of Care (i.e., HHH, DAs, SNFs)	Under the Care Coordination program, 85% of budgeted funds (by provider type) in the form of a monthly base payment, with the remaining 15% available to be paid as annual performance bonuses.	Under the PHM program, 85% of budgeted funds (by provider type; budget neutral from 2022) in the form of a monthly base payment, with the remaining 15% available to be paid as annual performance bonuses.	Maintains the same regular cash flow to this segment of providers

Section 6: ACO Budget

16. **Section 6, pg. 44: How does OneCare plan to appropriately protect network data in the new PHM Platform arrangement with UVMHN? Please provide OneCare's final agreement with UVMHN regarding these shared services within 5 business days of execution.**

    OneCare follows CMS requirements and industry standards for secure protection of electronic information. All data provided to OneCare is securely brought into physical and/or cloud-based storage areas to clean, organize, and transform it into reports and tools to support OneCare's network. Storage areas will be set up to ensure all ACO-related data is kept separate from other non-ACO information. These firewalls are tested to ensure appropriate protections remain in place. OneCare approves all provisioned users and access to ACO data is limited to select staff members who have a need-to-know and require access in order to support ACO activities.

    OneCare also protects data through the governance structure. Policies and procedures outline permissions to view the information and in what circumstances, and holds the data and analytics vendors to these same permission standards. If questions arise, OneCare consults with legal and compliance experts to inform business decisions. OneCare will continue to maintain oversight for the data in compliance with all contracts and regulatory requirements. A further governance measure is the establishment of a Steering Committee to monitor performance under the new arrangement and to make recommendations for changes and/or improvements. OneCare will seek feedback from participants to continually refine and improve data and reports.

    Ongoing auditing and monitoring activities provide additional data safeguards. Specifically, compliance and cybersecurity teams will perform regular data use audits. OneCare will monitor vendor performance quality and report to the Board of Managers on a quarterly basis.

17. **Section 6, Appendix 6.2 Income Statement with Accountability (Adaptive A2): Lines 102, 107-110 represent the FY23 budgeted Blueprint for Health and SASH funding that comes through OneCare from Medicare. Are the CHT and SASH funding lines meant to be broken out by risk communities and non-risk communities?**

    The current reporting in the 6.2 Income Statement rows for Blueprint (PCMH and CHT) and SASH spend to the providers is not currently broken out into risk and non-risk communities to simplify the presentation. All provider payments have been included in totals provided.

18. **Section 6: Are there any updates or changes to information on actions, investigations, or findings involving the ACO or its agents or employees (Rule 5.403(a)(6)) from what has been previously provided to the GMCB?**

    Through the GMCB annual certification, budget, and reporting processes, OneCare provides all required documents, including Compliance Policies.

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

19. **Section 7, Question 1a, pg. 49: There appear to be several programs that have been eliminated between 2022 and 2023 or are expected to be discontinued in 2023. Please explain the rationale for the following changes in the model: reduction of DULCE funding/elimination of the program; reduction of Innovation Grant funding/lack of new initiatives; elimination of Chronic Kidney Disease program; and the elimination of the Mental Health Initiatives program.**

    From the time of inception, the Chronic Kidney Disease (CKD), Innovation Grants, and mental health initiatives were intended to be time limited. The Covid-19 pandemic actually extended them beyond the timeframe of initial contracting periods. DULCE support was also designed to wean over time. These programs were launched as pilots for which OneCare provided upfront financial support to determine efficacy and feasibility.

    Participating entities were encouraged to create plans for sustainability if programs were determined effective and feasible. For example, UVMMC Nephrology found the CKD program impactful and was able to embed costs within their own budget moving forward. The program remained active with funding not dependent on OneCare.

    OneCare is executing a pre-planned step-down funding strategy for DULCE that spans multiple years. In 2022, OneCare funds 75% of the costs and in 2023 the planned (and budgeted) amount is 50% of the total costs. These funds are then supplemented by the Vermont Department of Health's investments.

20. **Section 7, Question 1a, pg. 49: In the FY22 budget narrative, it was explained that the RiseVT program would be funded through the first half of 2022. The organizational chart provided to the GMCB staff in August 2022 shows the elimination of the Director position for this program, but two RiseVT positions remain under the Director of Public Affairs. What is the plan for these positions in FY23?**

    Human resource transitions are underway to redeploy the two RiseVT positions within the organization. Once complete, OneCare will provide an updated organizational chart to reflect these changes.

21. **Section 7, Question 2, pg. 58: How are target rates set, by clinical committee? Why do the rates differ from what is set in the APM agreement for measures that are consistent?**

    OneCare leaders work in partnership with its clinical committees to use standard benchmark values as a guide to setting targets that are both attainable and appropriate for the provider network within the defined measurement period. OneCare evaluates practice performance in a payer-agnostic manner, so each practice will have a clear sense of their target and will not need to take into consideration the weighting of its payer-mix when working to improve performance.

22. **Section 7, Question 3, pg. 61: Can you provide a specific description of the HSA coaching/consulting program? Who is involved in this effort at the HSA level, and how are participants selected?**

OneCare revamped its HSA consultation process throughout 2022 to bring actionable data closer to its network partners. HSA consultations typically include four key areas of discussion: care coordination, utilization, quality, and cost.

Attendee groups vary by HSA and represent a diverse group of organizations, such as hospitals, FQHCs, and other continuum of care providers, with individual participants comprised of each HSA's population health teams. During the final round of 2022 HSA consultations, OneCare is extending invitations to additional organizations and asking attendees to propose leaders from other community organizations.

In an effort to bring the HSA consultations to those who are directly accountable for actions, OneCare established a coaching/consulting program that is activated between HSA consultations. OneCare refers to it as our Oversight & Accountability efforts. See graphic below for a visual of the program's approach.

23. **Section 7, Appendix 7.3: Is the "Specialist Program" described on row 14 of Tab 7.3 the same as the "Specialist Funding" on row 123 of tab A2 of the Adaptive sheets? If not, please describe the Specialist Funding.**

    Yes, row 14 of Appendix 7.3, tab 7.3 describes the intention of the Specialist program funding which is listed on row 123 of tab A2 of the Adaptive Sheet. It appears that the investment amount listed in column E of tab 7.3 was mixed up with the row 12 DULCE description. To be clear, the amount listed in tab 7.3 of Appendix 7.3 on row 14 should be $150,000 and row 12 should be $145,366.

24. **Section 7, Appendix 7.5: Please give examples of types of providers that might be included in the "Other" column. Break out these types into additional columns if possible.**

    The 'Other' column of Appendix 7.5 contains FQHCs.

Section 8: Evaluation and Performance Benchmarking

25. ***Section 8, Question 1, pg. 70: What actions are planned in 2023 to address the top 2-3 concerns voiced in the provider survey?**

    OneCare has just received the preliminary provider survey results and needs to share the report with the provider network through governance processes. This will then allow OneCare to discuss and prioritize potential action steps. In addition to the socialization process through governance, OneCare intends to include the results as an input to its 2023 strategic plan refresh process.

26. **Section 8, Question 5, pg. 74-75: Is OneCare able to discuss the ACO specific KPI measures identified by the UVM College of Medicine? What are the identified KPIs?**

    OneCare worked in partnership to leverage the insight of the UVM College of Medicine team in a manner which directly intersects with OneCare's benchmarking solution. KPIs were informed by the collaboration with the UVM College of Medicine and measures selected were those which best represent OneCare's value, were actionable for the ACO, align with its PHM for 2023-2035, and where possible, are available to benchmark within the new ACO benchmarking tool. Themes present within the KPIs include: cost of care; primary care, emergency department, and inpatient utilization; chronic disease management and prevention; provider satisfaction; and others. Following the discussion and finalization of KPIs with OneCare's Board of Managers, the list of measures will be available.

27. **Section 8: When analyzing outcomes of OneCare's programs, do you have a method of determining causality? For example, if a specific quality measure in the PHM program improves, how are you able to determine if the program is the reason for this improvement? Do you use methods such as difference-in-difference modeling, causal regression models, natural experiment, etc.?**

    Determining causality resulting from specific OneCare program implementation is a highly complex goal as health care reform efforts are often additive over time and influenced by changes in state policy, resources, and participation. OneCare's priorities align with the ways in which it is able to

influence care delivery for improved outcomes. For example, through OneCare's VBIF and future PHM quality measure focus, the OneCare network will receive financial incentives which align with improved patient outcomes.

Another challenge with determining causality attributable to specific interventions is the difficulty in attaining appropriate control groups. OneCare is working to address this issue now through its benchmarking solution which identifies a group of peer ACOs nationally to which OneCare can compare its performance to identify both strengths and opportunities. While this may yield helpful results for the Medicare population, there is no similar ACO comparison group available in the Medicaid or commercial space due to differences in benefit plans across different markets.

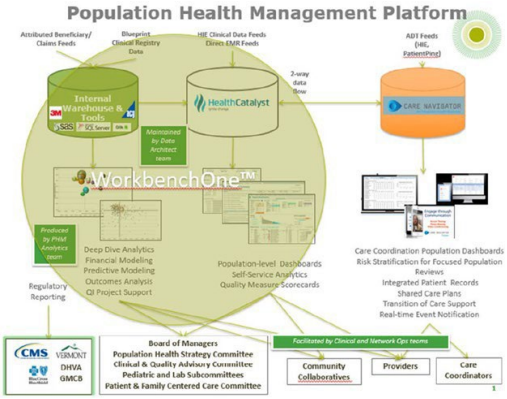
General

28. Beginning with the 2018 Participation Agreement, OneCare elected to utilize several Medicare waivers – notably the SNF 3-day and Telehealth waivers. Does OneCare track or trend rates of utilization of these waivers over time? If yes, please share those results.

The Coronavirus Aid, Relief, and Economic Security (CARES) Act emergency funding passed in March 2020, still in effect, provides blanket waivers intended to create broad uptake and with fewer requirements than the Medicare programmatic waivers. These CARES Act changes essentially negate the use of the ACO waivers during the public health emergency. Prior to the public health emergency, OneCare tracked and reported to CMS volumes of attributed lives that benefited from the Medicare SNF Waiver. The number of individuals served by this waiver program in 2019 was 287. Of these, 86 individuals were admitted to the SNF from an Observation stay; 74 from an Emergency Department; and 127 from a hospital stay of less than three-day hospital stay. Other process data elements such as hand off communication are tracked. When the public health emergency ends OneCare will restart tracking and trending of waiver activity including the highest utilized waiver, the SNF Waiver.

Follow-up Certification Question

29. **5.210: Given that the ACO is undergoing significant changes in its health information technology infrastructure in 2023, please provide verification that the planned information systems fulfill the requirements of GMCB Rule 5.000 § 5.210. If available, please provide an updated version of the 2019 visual below, or another illustrative diagram describing OneCare's PHM platform. If necessary, include a narrative description.**



Source: OCV FY2019 Budget Submission, pg. 32

Per GMCB Rule 5.000 § 5.210: "An ACO must have in place information systems to measure care process improvements, quality improvements, and costs of care, including the ability to retrieve information about individual Provider performance." As OneCare transitions to a new data platform, it will meet these requirements. An updated version of the diagram provided is not currently available. If such a document is created, we will share it with GMCB.

Questions regarding confidential material

1. **Section 3, Question 2, pg. 19:** [redacted]

2. **Section 5, Appendix 5.1 Risk Payer RBE:** [redacted]

3. **Appendix 3.1:** [redacted]

[redacted]

Office of the Health Care Advocate Questions

1. **OneCare states that "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." After this statement, OneCare elaborates on the base expectation for care coordination and that accountability measures were researched and discussed by stakeholders and committees to ensure buy-in and focus on areas of need. Please describe the meaning of the statement of the "base expectation" for care coordination and detail the "specific accountabilities" that incentive programs are tied to. (Narrative, 8).**

   Base expectations are outlined in the PHM Policies provided by OneCare to GMCB and HCA on August 31, 2022.

   Program base expectations outlined in those policies are as follows:
   - Regularly review high risk patient panels, including those with complex needs experiencing avoidable health care utilization, for timely outreach and engagement in Care Coordination.
   - Employ evidence informed patient centered care coordination strategies and tactics for engagement, goal setting, shared care planning, and goal attainment.
   - Engage with OneCare Care Coordination Implementation Specialist in data driven process improvement efforts at least quarterly for Primary Care; annually for community partners.
   - Demonstrate measurable improvement in key care coordination process and outcomes metrics.
   - Commit to ongoing care coordinator professional development through attendance at OneCare education sessions and/or other evidence-based care coordination offerings.

   Base requirements for primary care practices outlined in policy are as follows:
   - All Eligible Participants' Primary Care Practices shall act as a Patient Centered Medical Home as an indication the practice is committed to managing its patient population with high-quality, cost-effective, team-based care.
   - Tri-annual Care Coordination reporting of care managed attributed lives and associated care coordination data shall be submitted in a timely, complete, and accurate fashion.
   - Timely response to care coordination validation audits demonstrating supportive evidence of data submitted with tri-annual reports.

- Designation of a dedicated clinical contact to facilitate Care Coordination of Attributed Lives with avoidable health care utilization as identified by OneCare.
- 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 Plan, Do, Study, Act (PDSA) or other nationally recognized methodology. Cross-organizational collaboration and patient-centric shared care planning are required elements of the project. Eligible Participants shall submit written initiatives and progress reports with tri-annual Care Coordination reporting.

Base requirements for Designated Mental Health Agencies, Area Agencies on Aging, and home health and hospice agencies are as follows:

- Tri-annual Care Coordination reporting of care managed attributed lives and associated Care Coordination data.
- Timely response to Care Coordination Validation Audits demonstrating supportive evidence of data submitted with tri-annual reports.
- Preferred Providers and Collaborators shall meet 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.

The following policies submitted on August 31, 2022 provide additional detail: 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.

2. **OneCare states that "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." How are these quality measures reported/captured? What steps, if any, were taken to connect specific interventions and/or provider efforts to observed changes in the measures? (Narrative, 38).**

   These data were tracked by the SVHC team and self-reported in the public domain at a OneCare Board of Manager's meeting in spring 2022. The SVHC team reported on interventions they implemented that resulted in improvements noted in measures.

3. **OneCare observed that 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%." Please provide evidence to support the implied assertion that OneCare's activities in the HSA caused the observed lower TCOC. (Narrative, 39).**

   In OneCare's response outlining the activities in the Burlington HSA, the intention is not to tie direct causation of OneCare activity to the particular outcome of interest. Rather, the narrative is intended to communicate how ongoing support, collaboration, and activities provided by OneCare can contribute to improved outcomes. OneCare engages in collaboration and data-driven support for network providers within the Burlington HSA, and provides support for

ongoing activity. These activities align with the core capabilities OneCare outlined in its strategic plan: payment reform, network performance management, and data and analytics.

4. **It appears that Care Navigator continues to be phased out of OneCare's care coordination activities. Please provide one or more years of Care Navigator usage statistics from when the platform was in operation. Please provide the amount spent on Care Navigator related to its design, implementation, usage, and maintenance. If OneCare is unable to provide an exact figure, please provide an estimate. (Narrative, 66).**

   Care Navigator reporting can be found in OneCare's FY22 Budget Workbook, Appendix 7.4 Care Navigator, located on GMCB's website here: REDACTED FY2022 ACO Budget Workbook 10-01-21.xlsx. In 2021, OneCare spent $387,500 for the Care Navigator platform, including technology access and enhancements.

5. **OneCare states that decommissioning Care Navigator "will result in more clearly focused population interventions and effective panel management which will, in turn, result in improved outcomes within the quadruple aim." Describe how moving away from Care Navigator results in more focused population intervention and effective panel management. (Narrative, 66).**

   OneCare strives to support its network in improving and streamlining care delivery. Moving away from duplicative documentation in Care Navigator to Workbench One as a tool for panel management streamlines care coordination for OneCare's network. It allows users greater customizability for reporting and patient identification efforts. In turn, care coordination staff can identify sub-populations of interest in a manner which aligns with their organizational priorities. As an example, a provider might want to create a report of patients who have a particular comorbidity of interest in addition to the sub-population criteria. The customizability functionality within Workbench One exceed that which was present in Care Navigator. OneCare believes this streamlined process and use of a more robust tool will enhance the ACO network's ability to improve care delivery and patient outcomes.

   In the future, there may be an opportunity at a state level to increase the utilization of the state's HIE, VITL, in this arena. This would require a collaborative effort across the health care reform landscape.

6. **"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." What methods will be used to assess potential causality, if any? (e.g., Difference-in-difference modeling, causal regression models, natural experiment, etc.) (Narrative, 52).**

   As stated above in Question 27, due to the complex health care reform landscape, OneCare does not maintain a goal of determining definitive causality of its programs. However, OneCare will assess PHM accountability measure performance for statistical significance and review those findings in the broader context, such as how OneCare's performance percentile compares to prior periods regardless of statistical significance. Findings will influence future program design and will aid in identifying areas of success and/or continued opportunity.

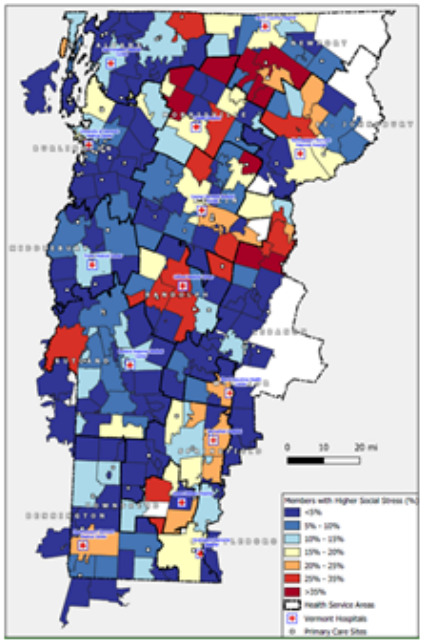
7. **Please further describe what OneCare's collaboration with the Blueprint entails. The collaboration is referenced, in general terms, on page 55 of the Narrative.**

OneCare's Chief Medical Officer and Blueprint's Director collaborate on a regular basis, discussing how best to align ongoing work in the larger context of challenges and opportunities. This collaboration supports transparency and coordinated efforts to drive toward achievement of mutually beneficial goals. Other OneCare and Blueprint leaders convene on a regular basis to align efforts in the areas of quality and care coordination. These teams work together to update each other about programmatic changes or other news relevant to addressing care coordination and quality goals.

OneCare and Blueprint staff also collaborate in varying degrees across the state in their support of practice care delivery. This is, in part, due to the varied nature of Blueprint roles; what works well in one community for the OneCare and Blueprint staff may not work well in another. An example of OneCare and Blueprint staff collaboration exists within the Bennington and the St. Albans health service areas where the OneCare Quality Improvement Specialist and Blueprint Program Manager work together on local readmissions taskforces.

8. **Please detail the method used to create "social risk heat maps" and provide an example "heat map." (Narrative, 57).**

OneCare has an ongoing partnership with a data science firm to gain social determinants of health insights about its attributed population which would otherwise be unavailable. One such insight includes a social stress model, which estimates the category of social stress as Low, Medium, High, or Very High. The graphic below is an example of a heat map.



Social Stress Heat Map

- The **Social Stress Score** is best used as a household-level social risk score that complements clinical risk scores such as Johns Hopkins ACG
- Factors include educational attainment, employment status, housing security, housing quality, and neighborhood stress
- Model inputs are weighted differently depending on the age group of the individual (under 18, 18-65, 65+)
- Scores are for active OneCare members as of November 2021
- Only zip code areas with at least 50 ACO members are shown

9. OneCare states it advances its focus on health equity through "robust measurement" and "thoughtful design and evaluation." Please further describe what such measurement and design and evaluation entails including the various elements and weightings used to construct indices for the five domains. (Narrative, 57).

In September of 2022, OneCare deployed its first ever Health Disparities Scorecard. This scorecard was developed to identify the intersection of several key themes which relate to health equity, including key ACO outcomes of interest, SDOH impact on those metrics, and providing insight to OneCare's network in a manner that supports ongoing work efforts. Through exploratory data analysis in early 2022, OneCare learned that many data elements that would be valuable to health equity related ACO efforts are not consistently available across all payer programs.

To support streamlined and efficient data insights, OneCare worked to develop a scorecard which could readily apply across all payer populations. The measures include: patients Social Risk Level (low to very high) and provides a yes or no flag for several key equity-related issues: food access, transportation access, unstable housing, and social isolation. In addition, high poverty zip code is provided through US Census data.

An example of the Health Disparities Scorecard is shown below. OneCare shared a pediatric and adult population version of this scorecard for each of its HSAs. Following the sharing of the scorecards, OneCare coordinated several opportunities to further improve on this effort in an iterative nature. Three examples of where OneCare sought feedback to improve the scorecard include the Population Health Strategy Committee, the Data & Analytics Subcommittee, and a special one-time joint workgroup session to elicit feedback from attendees.

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										

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