OneCare Vermont

FY 2023 Budget & Certification
Responses to Round 2 Questions from
Green Mountain Care Board

Follow-Up from 11/9 OCV Budget Hearing

1. **Data Analytics**:
   a. **Provide the OCV-UVMHN Agreement for data analytics and all documents reflecting compliance with state and federal privacy and securities laws and regulations. As a reminder, on October 24, the Board requested this be provided within five business days of execution; OCV stated at the 11/9 hearing that the contract had been executed.**

   OneCare provided contractual documents to the GMCB on November 15, 2022, upon final execution. The documents include the Master Services Agreement, Amended Business Associate Agreement, and the Data and Analytic Service Order.

   When reviewing those documents, you will see that privacy and data security standards are addressed throughout. OneCare's payer contracts often require standards that are more stringent than HIPAA (for example, Medicare requires one hour breach notice and NIST compliant infrastructure), and those requirements are addressed in the same documents. Note that OneCare is not subject to federal securities laws.

   During vendor selection, and at the direction of its Board of Managers, OneCare worked through the Request for Proposals (RFP) process for a data vendor to develop a robust, cost effective and compliant platform for its provider network. Initially, OneCare provided input about its data storage and security requirements. Once a vendor was selected, OneCare was represented by independent, external counsel in the assessment of its regulatory and contractual obligations with respect to storage and sharing of data and the negotiation of contractual terms that met those requirements in the arrangements with UVMHN and Arcadia.

   Further, the payers who provide OneCare with data have the opportunity to receive privacy and security information and audit to their standards. MVP has evaluated the current system. Medicare and BCBSVT intend to evaluate the UVMHN/Arcadia arrangement. This is in addition to OneCare independently evaluating compliance.

b. What is the total value of OCV's contract with UVMHN for analytic services? Please provide a list of all OCV budget lines impacted by this change (to include salary, contracted/purchased services, software, legal, and any other budget lines impacted), including the amount of the increase or decrease.

The contracted amount can be found in the confidential version of the contract supplied to the GMCB. The amount contracted includes both personnel (salaries and benefits) and the VITL contract. As OneCare begins 2023, it will maintain its existing contract with the current data platform vendor. OneCare anticipates transitioning to the new data platform in summer of 2023, at which time it will begin to phase out current software and analytics contracts and amend the agreement with UVMHN to begin paying for the new platform.

The following table shows the conversion of expenses from salaries/fringe and direct software to a purchased services arrangement.

	Prior Expense Model		New Expense Model	
Expense	**Salaries/Fringe**	**Software**	**Purchased Services**	**Overall Impact**
Analytics FTE (9)	[redacted]			$0
VITL				$0
Total				**$0**

*Amount budgeted. Final agreed upon amount is [redacted]

c. Please provide information about OCV's evaluation of UVMHN's response to their data breach and how the evaluation factored into the decision to move OCV analytics to UVMHN. The response should include diligence around UVMHN privacy and security practices, including diligence around UVMHN breach and subsequent remedial measures taken.

Like many organizations in the health care industry in recent years, UVMHN was the victim of a cyber-attack in October 20201, however, there was no data breach associated with that attack.

OneCare's internal staff, including the Chief Compliance and Privacy Officer, worked with counsel provided under its cybersecurity policy, Kevin Mekler of Mullen Coughlin, to review the investigative steps taken by UVMHN and its outside experts, confirm there had not been a breach, and evaluate UVMHN's data security safeguards relative to storage of OneCare Data, including evaluation of regulatory and contractual obligations. No corrective actions were recommended by counsel.

Additionally, OneCare reported the cyberattack to the payers who provide it with sensitive and confidential data – CMS (Medicare), DVHA (Medicaid), BCBSVT and MVP (commercial plans) per the requirements of the Data Use Agreements in place between OneCare and each of these organizations. As those organizations were apprised of the events, each accepted there had been no data breach, and none of them made any subsequent request that OneCare take any additional action with respect to the safeguarding of protected or confidential information or data they entrust to OneCare.

[1] Healthcare Cyberattacks Doubled in 2020, with 28% Tied to Ransomware (healthitsecurity.com)

d. OCV budgeted $1.87M for software. Please provide a breakout of software expenses by product, noting which software packages/investments are projected to sunset and when.

Software	Budgeted Amount	Description	Sunset Date
Health Catalyst	[redacted]	Data platform	Estimated July 2023
Bamboo Health		Event notifications	TBD – Arcadia Plan Dependent
DST Johns Hopkins		Risk score calculator	TBD – Arcadia Plan Dependent
Other Informatics Tools		Miscellaneous expenses related to variations in attribution and/or upgrades	N/A
Qlik End Printing		Data visualization software	Estimated July 2023
Care Navigator		Care coordination platform	February 2023
Milliman Grouper		Health care expense categorization tool	TBD – Arcadia Plan Dependent
ELearn Platform		Provider education platform	N/A
Nasdaq		Board and governance committee document solution	N/A
Concord		Contract management	N/A
Network Navigator		Provider network management	N/A
DataStat		CAHPS survey data collection services and reporting	N/A
Quality Compass		Quality score benchmarking	N/A
SOVOS		1099 preparation software	N/A
Video Conferencing		Platform for virtual meetings	N/A
Knowledge Wave platform		Learning modules	N/A
Microsoft Mac License		Graphic design license	N/A
Total	**$1,871,810**		

*Note that this excludes Professional Services fees which are included in the current contractual arrangement

e. Please provide a breakdown of FY22 projected and FY23 costs related to the transition of analytics to UVMHN, including by budget category. How is this transition budget neutral given that some systems would run simultaneously during the transition?

See 1.a and 1.b for detailed responses. This is net neutral to OneCare as the amount of the new UVMHN services contract is set to be exactly what OneCare would have otherwise paid absent this transition.

2. **Compensation:**
   a. **Please explain variance in management compensation from FY22 submission to FY23 submission (table below).**

Variations between the 2022 and 2023 submissions are driven by a number of factors:

- The 2023 budget guidance specifically requested a projection of 2022 compensation in a manner that aligns with W2 Box 5. The 2022 budget guidance did not ask for a projection, and thus OneCare relied upon actual (final) 2020 W2 information for the budget submission. This means that there is a two-year gap between the 2022 budget submission figures and the 2023 budget submission figures due to the change in budget guidance language.
- In 2020, due to the emerging Covid-19 pandemic, OneCare leadership took pay reductions and did not receive the variable pay component of compensation. This means that actual 2020 compensation was lower than it otherwise would have been absent the pandemic. The projection of 2022 compensation supplied in the 2023 budget submission assumes variable pay components will be distributed.
- Between 2020 and 2022 there were a number of position changes. Specifically, the VP of Finance, CMO, Director of Value Based Care, and the Director of Payment Reform positions are all occupied by different employees in 2022 than in 2020. There are both timing impacts as well as changes to actual pay levels determined through the hiring process.
- Between 2020 and 2022 some positions were eliminated and others created as new.

The following table displays a categorized reconciliation of the 2020 management compensation supplied in the 2022 budget submission with the 2022 management compensation projection supplied in the 2023 budget submission. In aggregate, these changes result in a **$88,502** increase over the two-year span.

Component	Amount
Variable pay projected for 2022, did not occur in 2020	$364,230
Positions eliminated	($412,545)
New positions	$163,498
Positional changes due to promotion/turnover re-evaluation	($82,257)
Changes in individuals deemed reportable	($3,157)
COLA on positions not impacted by other changes	$58,733
Total Difference between Submissions	**$88,502**

The table below shows a comparison between years on a position-by-position basis.

Position	2022 Budget Submission - 2020 Compensation	2023 Budget Submission - 2022 Compensation Projection	$ Difference	% Difference
Board Chair	$0	$0	$0	0%
Board Members (18)	$0	$0	$0	0%
CEO	$377,819	$491,674	$113,855	30%
CCO	$152,875	$183,084	$30,209	20%
VP/COO	$284,492	$361,504	$77,012	27%
VP/Finance	$39,762	$270,915	$231,153	581%
VP/CMO	$303,792	$252,779	($51,013)	(17%)
Asst Medical Director	$172,926	$0	($172,926)	(100%)
Director, ACO Operations	$175,401	$199,998	$24,597	14%
Director, Strategy and Planning	$172,230	$192,338	$20,108	12%
Director, Value Based Care	$185,926	$191,889	$5,963	3%
Director, Payment Reform	$198,809	$182,954	($15,855)	(8%)
Manager, Finance and Accounting	$113,992	$143,481	$29,489	26%
Director, Public Affairs	$136,716	$169,646	$32,930	24%
Asst. Director ACO Population Health Model Integration	$0	$144,764	$144,764	100%
Manager, ACO Clinical Programs	$139,005	$0	($139,005)	(100%)
Manager, ACO Operations	$0	$127,056	$127,056	100%
ACO Financial Data Science Supervisor	$130,213	$0	($130,213)	(100%)
Director, RiseVT	$134,532	$0	($134,532)	(100%)
Care Coordination Supervisor	$105,088	$0	($105,088)	(100%)
Total	**$2,823,579**	**$2,912,082**	**$88,502**	**3%**

b. Please provide a breakdown of projected FY22 compensation (FY23 submission Tab 6.7), separately listing projected base pay and variable compensation.

Position Title	Base Pay	Variable Pay	Budgeted Gross Compensation
Board Chair	$0	$0	$0
Board Trustees (18)	$0	$0	$0
CEO	$393,637	$98,037	$491,674
CCO	$166,539	$16,545	$183,084
VP/COO	$301,495	$60,009	$361,504
VP/Finance	$225,942	$44,973	$270,915
VP/CMO	$210,649	$42,130	$252,779
Director, ACO Operations	$181,928	$18,070	$199,998
Director, Strategy/Planning	$174,994	$17,344	$192,338
Director, Value Based Care	$174,552	$17,337	$191,889
Director, Payment Reform	$166,425	$16,529	$182,954
Director, Public Affairs	$154,319	$15,327	$169,646
Assistant Director ACO Population Health Model Integration	$144,764	$0	$144,764
Manager of Finance and Accounting	$143,481	$0	$143,481
Manager ACO Operations	$127,056	$0	$127,056
Total	**$2,565,781**	**$346,301**	**$2,912,082**

** Figures represent a projection of compensation based on the information available at the time of submission. A final presentation of taxable income will be included in the 2022 990 filing.*

Please note that base pay is calculated to reflect the salary expenses incurred in OneCare's fiscal year from January 2022 through December 2022. However, variable pay is based on the UVMMC fiscal year, and does not reflect the annual COLA increases applied in October of 2022. Because of this, the percentage of variable pay will differ slightly from the standard targets due to this timing circumstance.

c. Please provide the anticipated breakdown of FY23 compensation broken down by base pay and variable compensation.

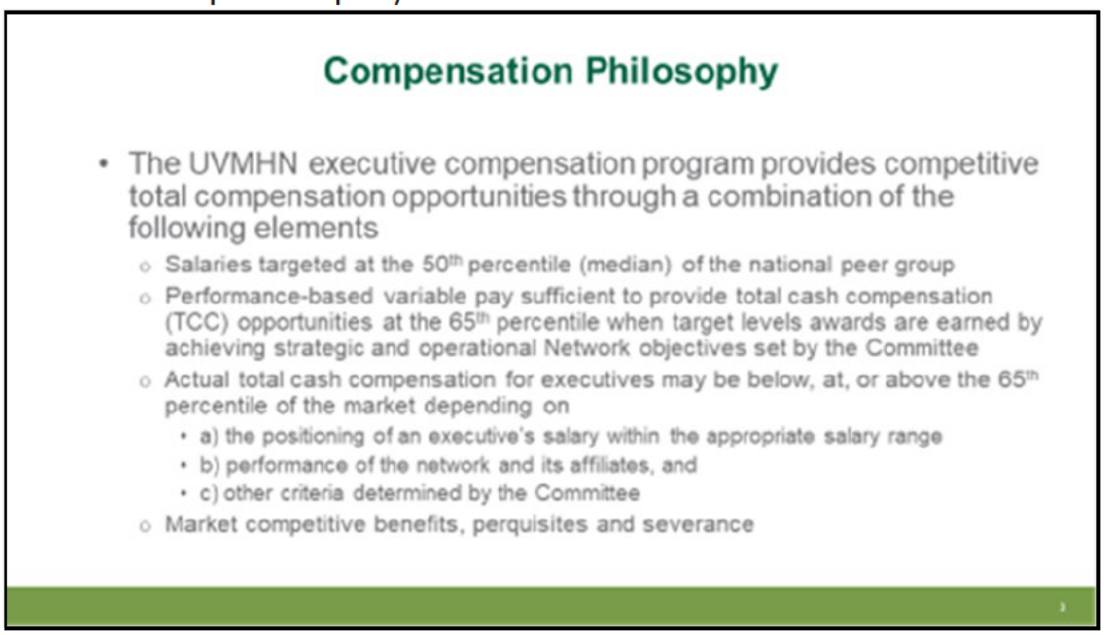
The following positions have a variable pay component included in the FY23 budget:

Position Title	Base Pay	Variable Pay	Budgeted Gross Compensation
Board Chair	$0	$0	$0
Board Trustees	$0	$0	$0
CEO	$401,558	$107,414	$508,972
CCO	$169,123	$20,106	$189,230
VP/COO	$307,318	$66,982	$374,300
VP/CFO	$264,815	$57,718	$322,533
VP/CMO	$188,784	$41,147	$229,930
VP/CLC	$188,047	$22,356	$210,403
Director, ACO Operations	$185,073	$22,002	$207,075
Director, Strategy/Planning	$181,574	$21,587	$203,161
Director, Value Based Care	$177,598	$21,114	$198,712
Director, Payment Reform	$169,384	$20,137	$189,521
Director, Finance and Accounting	$163,352	$19,420	$182,772
Director, Public Affairs	$157,063	$18,673	$175,736
Total	**$2,553,689**	**$438,656**	**$2,992,345**

Note that base pay is calculated to reflect the salary expenses incurred in OneCare's fiscal year from January 2023 through December 2023. However, variable pay is based on the UVMMC fiscal year, and does not reflect the annual COLA increases anticipated to be applied in October of 2023, and incorporated into OneCare's budget. Because of this, the percentage of variable pay will differ slightly from the standard targets due to this timing circumstance.

d. Provide UVMMC/UVMHN variable compensation policy.

The UVMHN compensation policy is as follows.



e. Please provide additional information regarding salary benchmarking. Is fair market value determined by salary survey and benchmarking data for ACOs specifically, or are other health care executives included (e.g., hospital executives)? What justification does OCV use when selecting the percent of median compensation to which executive pay is tied?

UVMHN uses a variety of third-party surveys to determine salary benchmarks, including: Mercer IHN – Healthcare System and Hospital Executives; Integrated Healthcare Strategies – National Healthcare Leadership Survey; Towers Watson – Health Care Executive Survey Report; and Sullivan Cotter & Associates – Manager & Executive Compensation in Hospitals and Health Systems Survey Report. These include comparisons to ACO executives where data exist. For example, for OneCare's CEO, the following title matches were used:

- Accountable Care Organization (ACO) Executive/President;
- Head of Accountable Care Organization;
- Top Accountable Care Organization (ACO) Executive; and
- Top Accountable Care Organization Executive

See the response to question 2.d for the philosophy on how the range midpoint for executive base pay and total compensation are targeted.

3. **Please explain the 12.4% increase in the combined salary and purchased/contracted service lines between the FY22 Revised budget and FY23 submitted budget, given that there has been a decrease in total employees and the UVMHN data contract will be budget neutral according to OCV.**

Some of the 12.4% variance is due to account reclassifications. After adjusting for these reclassifications, the combined categories changed by 4.1% between the 2022 budget and the 2023 budget. See below for complete budget change analysis for lines currently appearing in the Salaries/Fringe and Purchased Service categories, as well as the account reclassifications.

Salary and Purchased Services Lines	2022 Budget	2023 Budget	$ Change	% Change
Salaries & Fringe – Excluding Analytics Staff	[redacted]	$8,704,465	[redacted]	[redacted]
Salaries & Fringe – Analytics Staff	[redacted]	$0	[redacted]	(100%)
UVMHN Analytics Contract	$0	[redacted]	[redacted]	100%
Actuarial & Audit	$388,000	$400,000	$12,000	3.1%
Space Vendors	$33,636	$0	($33,636)	(100%)
Legal & Lobbying	$424,096	$404,068	($20,028)	(4.7%)
Benchmarking Tool *	$0	$150,000	$150,000	100%
Health Catalyst Professional Services *	$0	$297,675	$297,675	100%
Consulting / Other	$520,389	$569,233	$48,844	9.4%
Total Salaries & Purchased Services	[redacted]	[redacted]	[redacted]	[redacted]
Items Budgeted as Software in 2022	**2022 Budget**	**2023 Budget**	**$ Change**	**% Change**
VITL Contract **	[redacted]	[redacted]	[redacted]	(100%)
Benchmarking Tool *	$150,000	$0	($150,000)	(100%)
Health Catalyst Professional Services *	$283,500	$0	($283,500)	(100%)
Total Reclasses	[redacted]	**$0**	[redacted]	**(100%)**
Combined Total	[redacted]	[redacted]	[redacted]	[redacted]

* Budgeted in 2022 in the Software category. Reclassified due to the final nature of the arrangement.
** Budgeted in 2022 in the Software category. In 2023, this expense is included as part of the UVMHN Analytics contract under Professional Services.

4. **Section 6, ACO Financial Plan 6.1-6.3 Variance Analysis Table: In the Revised FY22-FY23 variance analysis, OCV cites a 26% increase in revenues coming from BCBS QHP program attributed to approved premiums in the QHP filings. Premiums did not rise by 26% and according to slide 14, BCBS QHP attribution is predicted to fall. Please provide a breakdown of the 26% increase in revenue from BCBS QHP into component factors.**

[redacted]

5. **Section 7, Appendix 7.4: Please submit FY23 target levels for percent of total attributed population receiving care management by category (risk level) and subcategory (High cost, High inpatient, etc.).**

In 2022 our network is phasing out of using the Care Navigator platform to document care management. As a component of this transition and to shift our care coordination and care management efforts to incorporate additional populations of focus, we are requiring network members to reach for different and more concentrated care management rates. Rather than a single target to care-manage 15% of high and very-high medical risk patients as in the previous years, the goal set for 2022 is to shift and direct care management to populations of focus (also called subpopulations). These populations include: high and very high medical risk (consistent with prior years), high social risk, high TCOC, high inpatient and high ED utilizers. Spreadsheets are being used for care coordination activity data collection this year, although we aspire to work together with our state HIE (VITL) and the existing EHRs in use across the network to develop improved data in 2023. There have been challenges this year when overlaying the templated excel data with VITL such that formatting breaks files, and some care-managed attributed lives are not counted. Currently, it is challenging to tease out the cause of changes in observed care management rates. We continue to work with our network care coordination teams to gather as robust a report as possible by end of year 2022. These data will be evaluated in January 2023, when accurate and complete accountability related to use of resources as well as care provided will be the expectation.

The 2023 Care Coordination activities and requirements are built into the Population Health Model, as presented in OneCare's FY2023 budget materials. OneCare will continue to shift care management of all the populations of focus outlined above along with additional HSA-wide care coordination accountabilities. OneCare's aim is to ratchet up quality, care coordination, and teamwork. After the 2022 care coordination and care management activities are fully assessed in January 2023, OneCare will make a decision, along with its Population Health Strategy Committee, on a reasonable and significant rate by which to raise expected care-managed rates for 2023 and will communicate it to our network.

6. **Please describe OCV's role in addressing wait times and ED overcrowding in Vermont.**

Extensive wait times exist in nearly all health care settings throughout the Vermont health care environment including primary care, specialty care, ED, hospital inpatient, and skilled nursing/rehab settings. The causes for this are multifactorial and need to be addressed as an overall system including clinical staff shortage issues and hours of operation/access. All involved entities, including state and federal government, need to work together to solve the gridlock that has developed. To this end, OneCare is collaborating with skilled nursing facilities, the Agency of Human Services, and UVMHN to develop solutions to address the shortage of skilled nursing facility access. This effort, if successful, could aid throughput from ED to inpatient care to SNF stays. For 2023, OneCare is also incentivizing increased accountabilities for care management and care coordination to support patients with: high medical risk, high social risk, high TCOC, high ED utilization, and high inpatient stays. These efforts could positively impact potentially avoidable utilization of the emergency department.

Benchmarking Report Follow-up Questions

7. **Comparison Group:**
   a. **For OCV's Medicare benchmarking report, do the selection criteria include other ACOs with multi-payer contracts, or are the comparison ACOs Medicare-only?**

      The selection criteria were applied to all ACOs participating in the Medicare Shared Savings Program (MSSP) in PY 2020 and were not limited to ACOs with multi-payer contracts.

   b. **Though Vermont is a small state, OCV as a statewide ACO is large relative to ACOs nationally with over 250,000 lives attributed statewide, including over 60,000 Medicare lives. Did the vendor consider size (attributed population) as part of the selection criteria? Why or why not? Does the comparison group include any similar sized ACOs overall to OneCare, e.g., other large multi-payer, statewide network ACOs?**

      When designing the selection criteria, the contractor considered the number of attributed lives for each ACO in comparison to OneCare's attributed population. The contractor focused on other characteristics of the comparator ACOs that, in the contractor's experience, are drivers of ACO performance and variations in care delivery patterns (e.g., ACO risk model, ACO revenue category, urban/rural beneficiary distribution, specialist provider distribution, and dual beneficiary distribution). Therefore, while the contractor did examine the size of each ACO's attributed population, they decided not to explicitly use it as part of the selection criteria in the interest of providing a robust comparison cohort.

      The contractor's national comparison cohort does include a number of ACOs that were similarly sized to OneCare. Based on publicly available information, some of those were multi-payer ACOs that had networks spanning a large portion of the state(s) in which they operate.

   c. **Provide a step-down diagram of the number of ACOs excluded after each criterion was applied.**

      The table below demonstrates the number of ACOs remaining after each exclusion was applied in a stepwise fashion:

Criteria	# ACOs Remaining	Difference from Previous Step
All 2020 MSSP ACOs	517	
• Limit to ACOs w/ Two-Sided Risk	192	-325
• Limit to High Revenue ACOs	70	-122
• Remove ACOs with <20% or >80% of beneficiaries in urban zip codes	23	-47
• Remove ACOs with <40% specialist providers	21	-2
• Remove ACOs with >15% dual beneficiaries	20	-1

d. **Is there a side-by-side of demographic factors (age, gender, urban/rural, acuity, etc.) between OCVT's Medicare aligned-beneficiaries to the national average from the comparison group? (This could include HCC/Risk scores)**

The table below shows a comparison of average 2020 ACO attribution, 2020 raw risk score, urban attribution percentage, percentage of specialist providers, and percentage of Aged/Dual attribution between OCV and the national comparison cohort (averaged across all 20 ACOs). The demographic factors referenced in the question would require additional scope and work by the vendor.

Demographic Factors	OneCare	Comparison Cohort
Total 2020 Attributed Person-Years*	37,000	686,000 total (34,300 per ACO on average)
2020 Raw CMS-HCC Risk Score	1.028	1.187
Urban Attribution %	40%	59%
% of Specialist Providers	60%	50%
% Aged/Dual Beneficiaries	7%	5%

**Rounded to the nearest 1,000 by ACO from the 100% Medicare FFS Dataset.*

8. **Report Methodology:**
   a. **OCV and its vendor have elected to include in the benchmark report a 90th percentile benchmark that selects 2 ACOs with overall success controlling cost – rather than identifying high performance levels <u>for each measure</u> included in the measure set. This means that for some measures, the results presented as "90th percentile" are in fact lower than median performers; it also fails to give OneCare (and GMCB and other reviewers) an accurate sense of the potential ceiling for high performance. Why did OCV and its vendor make this choice, and does OCV believe that 2 ACOs overall is an acceptable benchmark group?**

In response to discussions about possible benchmarks, the GMCB letter dated August 1, 2022 stated:

"GMCB expects OneCare to submit:

- Draft and final report template showing Loosely Managed (50th%) and Well-Managed (90th%) as well as an indicator of OneCare's performance against these benchmarks."

This requirement was the primary driver for identifying a 90th percentile within the national peer cohort. Based on the contractor's experience performing benchmarking analyses, they used the approach to compare OneCare's performance within each measure to the same metric for high performing ACOs (as measured based on risk-adjusted total cost of care). The contractor believes this approach is more appropriate than identifying the highest performance in each measure in isolation because providing care to individuals involves the interaction and interplay of various service categories in order to provide effective care to Medicare beneficiaries. In the contractor's experience, comparing an ACO's performance on individual measures to the best performing ACO by measure can provide misleading comparisons and performance targets that are neither reasonable nor, in some cases, cost effective.

b. How was the median national ACO peer cohort (50th percentile) calculated?

The National Peer ACO Comparison Cohort Average is calculated by first calculating a member-weighted average of each metric (cost, utilization, etc.) for all beneficiaries within a risk score band (calculated using the CMS-HCC risk model) across all ACOs in the comparison cohort. These metrics by risk score band are then re-weighted to reflect the mix of acuity present in OneCare's beneficiary distribution.

c. Why does OCV and its vendor believe that OCV should be benchmarked against the median and not the high-performance 90th percentile?

The purpose of the 90th percentile is to demonstrate a data point to better understand how the 90th percentile best performing ACOs (as measured based on risk-adjusted total cost of care) perform on various measures as opposed to providing a target for each individual performance metric. Given the small number of ACOs that constitute the the 90th percentile, OneCare believes this benchmark has limited value, and instead directs readers of the benchmarking analysis to peer cohort performance to gain a clearer insight for strengths and areas of opportunity.

***Additional Questions* – In lieu of responding by November 18, please indicate OCV ability to answer the following questions, including whether you would need to produce new analyses to respond fully. GMCB will require responses to these questions in future quarterly monitoring materials.**

9. Please provide information about the subset of OCV's attributed population diagnosed with diabetes:
- **a. What proportion of your attributable lives are patients with diabetes?**
- **b. Of those, what proportion have an A1C greater than 9, i.e., are very ill?**
  - **i. Of those, how many have not been seen in the last six months?**
    - **How many deaths were counted among these patients?**
    - **How many ED visits (any cause) were by patients diagnosed with diabetes?**
      - **How many unplanned inpatient stays (any cause) were by patients diagnosed with diabetes?**

See consolidated response below.

10. Please conduct the same analysis for patients with hard-to-control hypertension.

See consolidated response below.

11. **What proportion of your attributable lives are patients with a positive depression screen?**
    a. **What proportion has not had a treatment session with a mental healthcare provider?**
    b. **What proportion has had 1 treatment session with a mental healthcare provider?**
    c. **What proportion has had 2 or more sessions?**
    d. **Stratify by those three categories, and answer the following:**
        i. **How many deaths were counted among these patients?**
        ii. **How many died by suicide?**
        iii. **How many ED visits (any cause)?**
        iv. **How many unplanned inpatients stay (any cause)?**

OneCare is able to provide the proportion of attributable lives with diabetes (9.a.) and hypertension diagnoses (10). One note of clarification, for question 9.b. is that an A1c value of greater than 9 does not correspond with the label "very ill". Many patients struggle to control their A1c yet still live relatively healthy lives.

Regarding question 10, OneCare is unable to report for the entirety of its population for hypertension control, A1c control, or related measures because they require data which is either incomplete or unavailable. Due to the clinical nature of these measures, manual chart abstraction or another clinical data source are required. Manual chart abstraction for the whole OneCare network is not feasible and data sources such as VITL lack complete data for all of OneCare's population.

Similarly, for question 11, Depression Screening is also a clinical measure and requires manual chart abstraction or other clinical data source. OneCare performs manual chart abstraction on a random sample of records selected by payers as part of its annual quality measurement requirements in payer contracts. These data are not currently available to OneCare from VITL. If Depression Screening were to become available through VITL, it would have the same limitations as those described above for diabetes and hypertension control measures. An additional consideration for this measure and related sub-metrics is data availability limitations due to regulatory constraints (specifically, 42 CFR Part 2). OneCare does not currently have access to cause of death for this population or others. As an added note, cause of death is not something currently available to OneCare and therefore suicide rates are not available.

As requested in questions 9 and 10, OneCare is able to provide reporting on outcomes for members with diagnoses of diabetes and hypertension including but not limited to: unplanned admissions for those members, ED visits for those members, deaths for those members diagnosed (but not specifically for those out of control due to required clinical data). Some additional definitions are required before pursuing reporting on some of the requests below: how to define "seen" as written in question 9.b.i., how to define "treatment session" in questions 11.a. through 11.c., and how to define "mental health provider" (this is not something OneCare currently defines or reports). Additionally, greater specification of timeframe definitions is necessary with the added note that any claims-based data requires approximately four months lag time.

12. Outcomes measurement and KPIs:

Quality measures are discussed at an annual quality forum that takes place in November of each year. Additionally, the annual quality scorecards by payer are shared on the OneCare website in Q4.

a. What specific outcome measure does OCV believe best demonstrates its value to Vermonters?

OneCare follows the evaluation framework and accountabilities developed by the GMCB in the ACO Oversight Guide. Each year, OneCare works with payers we contract with to set a spending target or benchmark. Staying within the budget and beating this spending target, while meeting quality thresholds, is one way to manage cost and quality. Quality is also a key component and is included in every ACO-payer contract. Providers' shared savings opportunity is limited by quality performance. OneCare maintains a current list of its quality metrics accountabilities for each payer program and their alignment with the State's All Payer Model Population Health Goals. Meeting these predetermined accountabilities contributes to cost control and acceptable quality of care, two issues that are valuable to Vermonters.

b. Is that outcome the same for each health service area and primary care service area (HSA and PCSA)? If not, please provide a table showing the result for each HSA and PCSA.

Each HSA is accountable for the same quality measures.

c. Is that outcome measure the same for all races/ethnicities and payers? If not, please provide a table showing the result for each HSA and PCSA.

The same quality measures are assigned across each HSA that includes all races and ethnicities.

d. Please specify OCV's top three KPIs and your baseline assessment of each.

Below is the preliminary list of first phase KPIs that the OneCare Board of Managers will be considering later this winter:

- Total PMPM Spend
- Primary Care Visits PKPY
- Inpatient Admissions PKPY – Surgical
- Inpatient Admissions PKPY – Medical
- Post-Acute Care Utilization (final metric TBD)
- End of life care - % of patients who die while in hospice
- Potentially Avoidable ED Visits
- Chronic Disease Management KPIs (all part of 2023 PHM)
    - Diabetes poor control (A1c>9)
    - Child & Adolescent Well Visits
    - Developmental Screening First Three Years
    - Age 40+ All Payer Wellness Visits
    - HTN Follow-up

13. OCV's 2021 Medicaid Annual Quality Scorecard score is less than 70. What specific corrective actions will be taken to improve that score?

The Medicaid Annual Quality Scorecard will be discussed at the November 21, 2022 GMCB meeting with payers (All-Payer Model Financial & Quality Results Payer Panel). OneCare's 2021 Medicaid Annual Quality Scorecard demonstrates that OneCare's providers deliver high quality care in many areas. The aggregate score is an imperfect proxy for the true performance on each of the metrics. Examining 2021's performance, and in the context of the ongoing national public health emergency, 8 out of 9 measures with benchmarks available were at or above the national average, and 5 of 9 were substantively better (i.e., ≥75%ile). Of the lowest performing measures, OneCare is limited in its ability to receive data (C.F.R. 42, Part 2) for two metrics (Initiation of Alcohol and Other Drug Abuse or Dependence Treatment and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment) which limits our ability to directly impact performance in these areas. Further, the remaining two lower performing measures (Controlling Hypertension and Developmental Screening) are the focus of PHM incentives for 2023.

14. Please identify the process most improved by OCV's performance improvement initiatives and specify how that improvement will enhance the well-being of Vermonters. Using a table, specify the baseline measure, improvement activities, and the change in the measure.

The grid below reflects OneCare annual quality results for 2019 and 2021 for diabetes poor control >9%, a measure embedded in the Value Based Incentive Fund (VBIF) program, which began in 2021. While these results reflect the earliest part of the VBIF program and 2022 quality results may tell a more complete story, this demonstrates how OneCare's focused quality attention resulted in improved rates and percentiles for diabetes management within the Medicare population.

In effort to support and focus ACO network activities, OneCare's staff regularly connected with participant's quality teams to provide, support, guidance, and education on evidence-based guidelines. OneCare's leadership team provided quality performance monitoring updates, education, and guidance during recurring HSA Consultations. Throughout these processes, OneCare supported its network with data analytics (ad hoc data request support, dynamic app availability through Workbench One, and static reporting such as the Primary Care Panel Report). As of October, 2022, OneCare Diabetes and Hypertension Management application remains one of the most popular tools.

Diabetes Poor Control >9%	2019 Rate	Percentile	2021 Rate	Percentile
Medicare	13.49	80th	9.98	**90th**

Note: this is a reverse scored measure where lower is better.

15. **Benchmarking data found ED visits 29-37% over comparison ACOs. Please explain your interpretation of these data and specifically describe your corrective actions to address your performance.**

Seeing high ED utilization rates in the benchmarking data was not a surprise to OneCare based on known primary care access concerns across the state. This issue is multifactorial and will require participation across the state to address and improve it. This finding in the benchmarking report also validated OneCare's emphasis on avoidable ED utilization in the 2023 PHM incentive model.