FY 2022 Budget and Certification
Responses to Round 1 Questions from
Green Mountain Care Board and Health Care Advocate

Index

GMCB Questions

Questions – Narrative

1. **Provider network survey: Please share a copy of the survey instrument, a summary of the results, and the top three priority follow-up actions that resulted from the survey.**

   2020 Care Coordination Survey

   Survey Monkey was the instrument used for the Care Coordination Survey. A total of 121 responses were received, representing diverse organization types across the state. Results showed a wide range of care coordination expertise with most respondents having greater than six years of experience in the field. More than half of respondents identified reduced hospital admissions, reduced emergency department utilization, increased engagement in self-management, and increased engagement with primary care as expected outcomes of care coordination. Specific barriers and benefits of OneCare's tools, including Care Navigator, and desired educational topics were reported.

   OneCare's three priority follow-up actions were:

   - Re-evaluation of Care Navigator use, which has since resulted in a decoupling of payments from documentation required in Care Navigator.
   - Conducted two in depth training sessions on Motivational Interviewing in direct response to the survey feedback.
   - Developed 2021 educational plan based on specific education topics requested.

   See Attachment 1-Care Coordination Survey 2020.

   2021 Analytics Survey

   Survey Monkey was the instrument used for the Analytics survey. From the analytics survey we learned that respondents are using static reports, self-service analytics tools and direct support from analysts in decision making. A total of 60 responses were received and 78% of the network survey respondents indicated they currently use OneCare data for organizational decision making in the areas of financial decision, quality improvement work, and workflow refinement. Areas for improvement include data availability, ease of use, and more customized reporting.

   OneCare's three priority follow-up actions are:

   1. Identifying opportunities for changes in workflow or improvement in quality of care.
   2. Interacting with participants to determine where data could support improvement efforts.
   3. Simplifying and streamlining reporting.

   See Attachment 2-Analytics Survey 2021.

   2021 Finance Survey

   Survey Monkey was the instrument used for the Finance survey. The finance survey focused on operational aspects of OneCare programs to help ensure effective financial interactions with participants. Through the 78 responses, there were a number of important findings:

   - The survey aimed to identify whether or not financial communications were reaching the appropriate personnel within participant organizations. 29% of responses said they did not perform the accounting/financial tasks. As such, OneCare was either provided with a replacement or is actively outreaching to organizations to find the appropriate

recipient for future financial communications.

- There was a diverse response in regard to general understanding of programs and payments, with some feeling informed, others reporting only a base level of understanding, and some needing very basic training. The survey results allow OneCare to outreach specifically to each subgroup based on their level of need.
- Most respondents indicated written documents would be helpful to expand understanding of programs. Personalized conversations with OneCare staff was the next most preferred approach. Webinars or other standardized group presentations were generally not preferred. These data will be used to inform future communication approaches.
- 37% of respondents indicated changes to the payment statements would be helpful. While the majority did not indicate changes are necessary, OneCare will still explore some enhancements in spirit of continuous improvement.

See Attachment 3-Finance Survey 2021.

2. The total starting attribution assumed is ~288,000 (Section 1, Q1d, p.10). Using the table below, please break out the starting attribution assumptions by payer program (Medicare, Medicaid traditional/expanded, BCBS QHP, BCBS Primary risk/non-risk, MVP QHP) and the average attribution assumptions used to develop the budget, by payer program.

Payer Program	**FY22 Starting Attribution Estimated** *Used to Measure APM Scale*	**FY22 Average Attribution Estimated *** *Should match data provided in Appendix Tabs 5.1 and 5.2*
Medicare	61,788	49,017
Medicaid – Traditional	88,784	86,343
Medicaid – Expanded	28,366	20,721
BCBSVT QHP	22,212	20,316
BCBSVT Primary – Risk	45,018	42,350
BCBSVT Primary – Non-Risk	31,004	30,278
MVP QHP	10,692	9,901
TOTAL	287,864	258,926
* The Medicare figures included in Appendices 5.1 and 5.2 also have an adjustment for QEM exclusions. PHM investment calculations are based on the figures above.		

a. We understand the information provided above represents assumptions; please describe how OneCare develops the attribution assumptions for the budget by payer program. For example, Section 3, Q1c, p.31 states that the BCBSVT attribution numbers are based on OneCare's assumptions about which employer groups will choose scale vs non-scale – how were these assumptions developed?

As part of the annual budget build process, OneCare develops rough attribution assumptions to help gauge anticipated program risk/reward, potential payer revenues, and expected PHM investments. Assumptions are based on previous year attribution counts and factor in projected changes to the population and network participants. The Medicare attribution estimate balances an aging Vermont population with an increase in patients choosing Medicare Advantage plans in the state. The Medicaid Traditional estimate includes the return of two participants that had previously left the

network. Both the Medicaid Traditional and Expanded estimates include a small projected growth in FQHC/RHC attribution due to a refinement of the attribution algorithm. The BCBSVT QHP, BCBSVT Primary Risk and Non-Risk, and MVP QHP estimates all include additional network participants. Current attrition models are used to project FY 2022 attrition.

3. **Regarding mechanisms to ensure FPP is not "too high" or "too low" (Section 3, Q2, p.32) it is stated that the OneCare finance committee regularly reviews FPP and has recommended adjustments to the amounts in the past. What is the frequency of review and adjustments? What is the magnitude of adjustments? How are participants notified of adjustments? Are these questions addressed in the Hospital or Participant Fixed Payment Policy (04-11)? If so, please provide the policy.**

   What is the frequency of review and adjustments?
   The frequency of review is determined by management or at the request of committee members. There is often an initial review once adequate claims are available, and then periodic reviews continue through settlement of the program year.

   What is the magnitude of adjustments?
   The magnitude of the adjustments, if any, vary by year and by participant.

   How are participants notified of adjustments?
   Participants are often notified by email. If more secure communication is required, files can be exchanged through OneCare's portal.

   Are these questions addressed in the Hospital or Participant Fixed Payment Policy (04-11)? If so, please provide the policy.
   Yes, the policy outlines the guardrails for operating the fixed payment programs.

   See Attachment 4-Policy 04-11-PY22 Hospital Fixed Payment PY 2022.

4. **Medicaid total cost of care (TCOC): Please provide insight into the decision not to adjust TCOC for the public health emergency, other than the removal of some COVID-19 admissions and vaccination spend from TCOC (Section 4, Q1, p.38).**

   OneCare does not make decisions regarding TCOC adjustments for any of its ACO programs; these decisions rest with the contracted payers. Throughout the pandemic, OneCare has advocated on behalf of its provider network for terms that helped the provider community navigate through the unforeseen and unpredictable COVID-19 pandemic.

5. **Commercial TCOC: (Section 4, Q1, p.38) (Refers to CONFIDENTIAL information)**
   a. [redacted]

[redacted]

6. **How are payments aligned to incentivize primary care physicians, specialists, and hospitals to ensure quality care is delivered in the lowest cost locations, improve quality and satisfaction, and reduce TCOC?**

   ACO contracts are structured to promote accountability for health care costs and quality onto health care providers. Through these arrangements, OneCare and its providers may receive a shared savings payment if cost and quality outcomes meet the expectations set forth in the program agreement. From this construct, receipt of a shared savings payment is aligned to incentivize primary care physicians, specialists, and hospitals to ensure quality care is delivered in the lowest cost locations, quality and satisfaction are improved, and TCOC is reduced.

   In addition to shared savings opportunities, there are other provider investments: the Value Based Incentive Fund incentivizes high-quality care, care coordination payments have bonus potential for effective TCOC management, and fixed payment conversions like the Comprehensive Payment Reform program are designed to shift resources into primary care as a means to reduce the need for higher cost services. All of these investments are designed to be in alignment with behaviors that yield the TCOC and quality outcomes called for in payer contracts.

7. **Accountability Pool: (See Section 4, Q2, p.40; Section 5, Q1, p.47)**
   a. **What is the total dollar amount of the accountability pool for FY2021, and how much is anticipated for FY2022?**

      The value of the accountability pool for 2021 is $2,504,769. In 2022, the accountability pool contributions are expected to total $2,513,934. Potential shared savings for primary care totals $2,692,152.

   b. **Please explain the decision to hold primary care accountable for the <u>first</u> $1.50 of losses (versus provider types who contribute more to total spending, e.g., hospitals).**

      The ACO concept is centered on the primary care relationship. As such, OneCare invests in primary care to help them successfully transition into the value-based paradigm. In tandem with the investments, the $1.50 PMPM components install an element of accountability and opportunity to all primary care in the network. To make this model effective, it's important that it is simple and understandable. If primary care incentives were to be incorporated later in the model, other variables would impact their accountability/opportunity, and thereby dilute the effectiveness of this important evolution.

   c. **Are participating FQHCs paying into the accountability pool and accountable for losses?**

      Yes. All attributing providers make accountability pool contributions.

8. **Please provide a table comparing the HSA-based risk model by provider entity with the current network-based risk model, using 2019 actuals data on shared savings and losses, using the template below.**

Hospital	**HSA**	**Actual 2019 Savings/Risk Distribution** *(HSA-based risk model)*	**Hypothetical 2019 Savings/Risk Distribution** *(Network risk model)*
Southwestern VT Medical Center	Bennington	($1,740,490)	($44,396)
Central Vermont Medical Center	Berlin	($3,616,892)	($231,588)
Brattleboro Memorial Hospital	Brattleboro	$383,751	($45,934)
The University of Vermont Medical Ctr.	Burlington	$2,058,511	($832,774)
Dartmouth-Hitchcock	Lebanon	($272,282)	($267,195)
Porter Medical Center	Middlebury	$1,035,601	($168,867)
Copley Hospital	Morrisville	$0	$0
North Country Hospital	Newport	($411,851)	($431,140)
Gifford Medical Center	Randolph	($312,001)	($302,292)
Rutland Regional Medical Center	Rutland	($892,265)	($858,118)
Springfield Hospital	Springfield	$636,267	$2,494
Northwestern Medical Center	St. Albans	($618,914)	($452,794)
Northeastern VT Regional Hospital	St. Johnsbury	($625,624)	($639,348)
Mt. Ascutney Hospital & Health Ctr.	Windsor	($204,793)	$1,324
OneCare Vermont	OneCare	($447,172)	($757,527)

9. **Does OneCare use any benchmarking data from national sources to compare utilization and TCOC for Commercial, Medicaid, and Medicare populations such as Premier's ACO benchmarking or Milliman well managed or managed populations? This benchmarking data could include hospital admissions/1000, ED visits/1000, total per capita cost, post-acute care per capita cost, per capita cost per diabetic, etc.? If so, how is it used and if not, have you considered it?**

   OneCare deploys national benchmarking within its quality measurement and improvement work for both annual quality reporting and the VBIF program. For annual reporting, OneCare's payer partners utilize national benchmarking data to evaluate program performance. These results are shared throughout OneCare's network, and publicly on OneCare's website. Additionally, OneCare uses national benchmarks, created by industry leading organizations such as HEDIS, to create measure-specific target and stretch goals for the VBIF program. OneCare's Quality team then works with provider practices to target improvement efforts relative to these benchmarks. The VBIF program incentivizes organizations for their performance in four specific quality measures, as detailed in OneCare's GMCB budget submission.

   Using national benchmarks for utilization metrics such as hospital admissions/1000 and ED visits/1000 is currently an area of opportunity and a focus for OneCare's providers. In previous years, OneCare's research determined that available benchmarking tools did not serve the network's needs in a manner that would justify the investment. OneCare's Workbench One platform does allow providers to benchmark themselves against peer organizations, HSA-level data, and aggregate OneCare performance.

As OneCare's network matures, there may be an opportunity to strategically deploy the use of utilization benchmarks in a way that could serve the network and result in a favorable return on investment. The expense to purchase these benchmarks is not included in OneCare's 2022 budget, though OneCare is open to exploring this possibility.

10. **Please describe the program OneCare or its network utilizes to manage pharmacy compliance? Does OneCare have any data by primary care physician or TIN number? Does OneCare have any trending data and a list of successful performance improvement actions?**

    OneCare does not currently provide any reporting on pharmacy data.

11. **Has OneCare implemented a statewide approach to managing post-acute care? Has OneCare evaluated the post-acute care provider networks using metrics? Does OneCare have a preferred network of providers who have agreed to a set of care principles that can be shared? Is OneCare measuring the percent of hospital patients discharged to SNFs, rehab institutions, and home care agencies compared to national benchmarks?**

    OneCare has not implemented a statewide approach to managing post-acute care, although providers are able to review post-acute utilization data in the Workbench One platform. The ACO model does not change the benefits and retains the freedom of choice for any Medicare, Medicaid or commercial beneficiary; thus OneCare does not have a "preferred" network. It is important to note that a limited ("preferred") network that varies from the insurer's network may create a real or perceived barrier to access for patients served by OneCare's network providers.

    As indicated in the response to question nine, OneCare does not currently use national benchmarking data for utilization metrics. In OneCare's previous evaluations of available benchmarking data, OneCare determined that available benchmarks were not sufficiently applicable to the nuance of the ACO structure.

12. **Does OneCare have a tool to measure clinical appropriateness in 5-6 key clinical areas such as the use of diagnostic technology (CT, MRI, and PET), indications for spinal surgery, etc. Does OneCare facilitate clinicians in using "choosing Wisely" criteria? If so, how and for which conditions? Does OneCare use a clinical appropriateness tool statewide, such as Stanson Health.**

    OneCare is not a healthcare provider and does not have direct access to provider EHRs, which limits the ability to measure clinical appropriateness of care in the manner reflected in the question. As such, OneCare does not deploy a clinical appropriateness tool at this time.

13. **How are the social determinants of health (SDOH) integrated into the care management process? Is OneCare still working with Algorex Health to integrate SDOH data? How is OneCare supporting the network in integrating SDOH data into care management?**

    OneCare embeds SDOH data within the Care Navigator system in support of care coordination clinical decision making and outreach efforts. SDOH risk score is also available within the Workbench One Platform, which enables users to filter their population and identify patients in needs of SDOH-related support. OneCare intends to continue its partnership with Algorex Health to integrate SDOH data.

14. **Does OneCare have a Population Health Information Technology (PHIT) strategic and operational plan? If so, please share it. If not, how does OneCare establish PHIT priorities annually?**

    OneCare's strategic plan includes core competencies of Data and Analytics, Network Performance Management, and Payment Reform. One key deliverable of this plan is to create a Data and Analytics Action Plan to include management of data, reporting and support for interpretation and performance. Efforts are currently under way to deliver this action plan in early 2022.

15. **Care Coordination Payments:**
    a. **OneCare's response to Section 2, Q3a, p.21 states: "Care coordination payments have been decoupled from administrative burdens reported in use of Care Navigator and tied to total cost of care (TCOC)-related or other industry accepted metrics." What are "other industry accepted metrics"?**

       OneCare remains in conversations with the industry-groups within its network to determine the most appropriate metrics. The intent is to land on metrics that the industry members feel they can affect, are aligned with other industry-related measures, and will also support performance under the program TCOC and quality targets. Measures such as the change in the TCOC, avoidable ED utilization, and inpatient utilization are examples of focus areas with a clear correlation with desirable TCOC and quality outcomes.

    b. **How will this new payment model impact participating providers across the care spectrum in terms of engagement in care coordination and payment for care coordination?**

       This new payment model will streamline documentation requirements and complexities of payments. A portion of the payment represents a new direct link of care coordination interventions to cost and utilization outcomes. To achieve these outcomes and optimize payments, providers will strengthen cross organizational care coordination efforts focused on improving transitions of care, improving patient experience, reducing avoidable inpatient and emergency department visits, and connecting individuals to primary care, self-management resources, and mental health services.

16. **Value-Based Incentive Fund:**
    a. **Please provide the year over year changes to the VBIF/provider incentive payment policy. In doing so, please include a rationale for each noted change.**

       The VBIF provider payment policy has stayed relatively consistent over time. The most significant change occurred in 2020 when a 10% component was added for quality investments as approved by the OneCare Board of Managers.

       See policy 04-13-PY22 Value Based Incentive Fund PY 2022 that was provided to the GMCB on August 30, 2021.

b. **What assumptions about the FY22 VBIF does OneCare make in its budget submission, and how were these assumptions developed?**

The sole assumption included in the 2022 budget submission is that the VBIF will be decoupled from payer contract requirements, thus allowing OneCare to offer a more effective payer-agnostic population based program to its participants.

c. **Please provide an explanation of the VBIF reinvestment line item in Tab 6.2 of the financial workbook (Full Accountability IS; $527,247).**

Prior year programmatic terms resulted in pools of money obligated for future reinvestment in quality initiatives. The figure noted reflects the amount of funds available for this reinvestment.

17. **Exhibit C shows the five most prevalent conditions among high-cost patients; not the most prevalent high-cost conditions. Please resubmit according to the guidance.**

See Attachment 5-Section 7 Exhibit C Most Prevalent High Cost Conditions by Payer updated 11-01-2021.

Questions – Financials

18. **Provide the verification under oath for the VP of Finance.**

    See Attachment 6-OneCare FY2022 Budget Submission-VP Finance Oath. Please note that the enclosed Oath has been backdated to October 1, 2021 in alignment with the timeline of the budget submission materials previously submitted to the Board.

19. **What is the new shared resource model with UVMMC?**

    The 2022 budget reflects the continuation of the shared resource model between UVMMC and OneCare. OneCare continues to operate as an independent entity.

20. **Explain the year-over-year growth since FYE2020 of the liability "Due to UVMMC." In addition, please provide detail of what shared services are driving this liability. Will this figure change with UVMHN as sole parent organization of OneCare?**

    That account reflects reimbursement of expenses paid through UVMMC systems. This includes wages, benefits, staff expense reimbursements, and transactions processed through the UVMMC accounts payable system. There are no planned modifications to the mechanism in place as a result of the membership change. While the amount will fluctuate in alignment with regular business activity, the change to a single member structure will have no impact.

21. **How did the departure of Dartmouth work from OneCare? Was there a buy out as they were 50% members? Describe any financial impact of this governance change.**

    The change in membership prompted a review of the appropriate treatment of Dartmouth's $25,000 initial capital investment. The review is underway at the time of this submission. Other than this particular item, there was no "buy-out" or other financial transaction related to this governance change.

22. **Participation Fees:**
    a. **Please provide the most recent participation fees policy (Policy #04-10).**

       See Attachment 7-Policy 04-10-PY22 Participation Fees PY 2022.

    b. **How does the accounting for participation fees work? Are they static for the year and then trued up at year end, or are they modified during the year?**

       Participation fees are established through the OneCare budget approval process. They remain static and are accrued consistently throughout the year unless a change to the budget is approved by the OneCare Board of Managers. If a change is approved, true-ups are processed to reconcile each hospital to their revised amount. The participation fees policy (Policy 04-10-PY22 Participation Fees PY 2022) also allows the Board of Managers to make adjustments outside of a budget approval process under certain circumstances.

c. **It was noted in OneCare's 2020 audit that participation fees were refunded back to the participants (approximately $3.1 million). This was net income that would've gone into reserves. Does OneCare consider refunding participation fees an appropriate use of its reserves? What were the criteria used by OneCare to decide to refund fees instead of putting them into reserves to fund future programs, population health investments, or to prepare for the anticipated instability in revenue streams for DSR and HIT funding that could have been partially funded through the FY2020 refund?**

OneCare does not believe that adjusting the participation fee amounts is the same as using its reserves. In the last year when building of reserves was ordered by the GMCB, OneCare built a specific line item in the budget that hospitals would fund to in order to comply. This was not the case in 2020, since it was heavily disrupted by the pandemic and, as a result, OneCare did not need the full participation fee amount charged to hospitals. As such, the OneCare Board of Managers decided to issue credits to the hospitals.

In consultation with its Finance Committee and independent nationally recognized auditing firm, OneCare strives to operate each program year discretely from an accounting standpoint to avoid the complexities from trying to transfer funds across fiscal years. Also, while retaining cash/reserves on the OneCare balance sheet serves as a protection for unforeseen circumstances, utilizing retained earnings to fund future programs and operations requires running an operating loss in that particular year. This is not a preferred strategy at this time.

d. **Is there a plan to refund participation fees in FY2021? What criteria will OneCare apply when evaluating whether to refund participation fees in FY2021 or in the future?**

No plan has been made regarding any participation fee adjustments for 2021. Whether or not credits are issued will be based on an evaluation of issues such as the status of contract negotiations, outcomes from the budget process, accounting best practices, and the financial condition of the hospitals.

e. **If participation fees are increasing to cover loss of DSR and HIT funding, why are Population Health Management programs being eliminated? What Population Health Management investments are being cut due to the loss of DSR and HIT funding?**

Like most businesses, OneCare has a number of moving parts to accommodate during a budget process. As such, OneCare, in consultation with members of its Finance Committee and Population Health Strategy Committee, evaluated and estimated the impact of these factors to propose a model to the Board of Managers that aimed to meet the strategic goals of the company and its participants. The approved model included a number of expense reductions to both population health management and operating expenses. Given the nature of the OneCare budget, none of the population health management investment cuts are singularly tied to the loss of DSR and HIT funding. All decisions were made holistically and considered other factors such as anticipated changes in payer revenue contributions, access to deferred revenue, tolerance for

participation fee increases, and the long-range sustainability of the investment.

23. **It is discussed in the narrative that the CPR program is expanding. Where is this reflected in the income statement/variance analysis? We only see the approximately $130k increase in the expense category.**

    The $130k noted reflects the increase to the portion that OneCare funds, which is almost entirely driven by the supplemental primary care investment included in the payment model. There is a separate increase reflected under the fixed payment row that represents the estimated amount that will be converted from FFS to a fixed payment under the program.

24. **Staffing:**
    a. **If RiseVT is ending, what is happening to the management and staff positions that oversaw and ran that program at OneCare (3 positions)?**

       The OneCare Board of Managers has approved a directional change for the RiseVT program. Specifically, the focus of prevention work will shift from community based prevention to a clinical prevention model. The RiseVT positions are being addressed as follows: the director level position is vacant and will not be replaced, and the other two positions will continue to work with communities during the first six months and then evolve to support OneCare's clinical primary prevention work.

    b. **Are the Director of Public Affairs, Manager, ACO Finance & Accounting, VP CLC, and Manager ACO Clinical Programs new positions? When did they start?**

       All leadership positions are provided to GMCB in the Leadership Team Table as part of our regular reporting requirements. The status and start dates of these positions are as follows:

       - The Director of Public Affairs position was created and filled in February 2019.
       - The Manager of ACO Finance & Accounting position represented a promotion for a high-performing employee taking on additional accountability and was filled in January 2021.
       - The Manager of ACO Clinical Programs position has been part of the organizational structure of OneCare from inception. The position was most recently filled in July 2019.
       - The Chief Legal Counsel is a new position that will bring a legal position in-house instead of contracting for these services. The specifics of this position will be provided as part of the regular reporting requirements.

    c. **Most of the positions that were "no longer on the FY2022 staff roster" in 6.7 seem clinical in nature. What happened to these positions (Director of RiseVT is included here)? Since FTEs have stayed relatively flat, were these staff reallocated or were there replacements/new staff elsewhere in the organization?**

       Positions are evaluated ongoing to ensure OneCare continues to be fiscally responsible, works within the constraints of the ACO budget, and continues to meet the needs of the organization. The positions listed as no longer included in the 2022 Staff Roster are as follows:

- ACO Financial Data Science Supervisor: This position was converted from a Supervisor role to the senior staff position of ACO Financial Data Scientist to better meet the ACO business needs.
- Director Rise VT: This position was vacated and will not be replaced, but two staff will continue to support OneCare's primary prevention efforts.
- Care Coordination Supervisor: This position was re-evaluated and replaced with a senior staff position of Care Coordination Program Administrator.
- Assistant Medical Director: This position was vacated in December 2020 and was replaced with Medical Liaisons that offer part-time support to OneCare.

25. Salaries and Compensation:

a. What did the dollar value of the compensation cuts end up being because of COVID-19? Was there backpay in FY2021 of the budgeted $595K on top of their current pay? Or were the positions only reinstated to their original salaries or above?

Savings resulting from compensation cuts (salary reductions and loss of 403b contribution) related to COVID was $123,471. In addition, the short term incentive program was cancelled for 2020. There was no back-pay in 2021 to make up for the compensation reductions.

b. The Salaries, Payroll taxes & Fringe increased $5,253. Positions have remained flat (increased 0.03 FTEs) from FY2021 to FY2022. It was discussed that 5 budgeted vacant positions in FY2021 were eliminated out of 12.

i. In OneCare's responses to GMCB on December 15, 2020, it was mentioned there were 5.62 FTEs adjusted for OneCare's operational needs in FY2021. What caused the FTE vacancies to jump to 12? Last year, the vacancies accounted for $666K.

Despite making some FTE changes in a prior year budget submission, other positions that remained in the staffing model were vacant and under recruitment. As such, the difference between the FTE adjustment figure and the total vacancies, amongst other staffing modifications, reflected continuing positions that were unfilled at the point in time. Note that the 5.62 FTE adjustment was just one component of the staffing shifts mentioned in the December 15, 2020 document.

ii. What were the 5 positions that were eliminated and what were they replaced with?

The note supplied in the December 15, 2020 document was in reference to just the workforce being added. They included annualizing 1.62 FTE that were hired at various times during 2020 and revised positions in 2021 including 0.5 FTE in analytics, 2.5 FTE in finance (accounting), and 1.0 FTE supporting ongoing quality data collection.

iii. **Since there appears to be eliminated positions in FY2022, please provide a table showing the FY2021 budgeted salaries and FTE count, the number of eliminated positions and dollar values, the number of new positions and dollar values, and other reconciling items to land at FY2022 budget. Please provide a description of the terminated/eliminated/new positions. Even though the delta is immaterial, the movement appears to be significant.**

	2021 vs. 2022		
	Δ Base FTE	**Δ Fiscal FTE**	**Δ Salary**
Senior Leadership	(1.35)	(0.38)	($171,592)
Compliance	(1.00)	0.00	$5,289
Contracting	(1.00)	(0.67)	($78,068)
Finance	(0.75)	1.58	$230,144
Outreach and Engagement	0.00	0.00	$32,999
Care Coordination & Clinical	0.00	0.33	$22,427
Population Health Analytics	(1.00)	(0.33)	$46,532
Quality Programs	1.00	1.50	$205,174
Program Operations	(1.00)	(1.00)	($87,090)
Primary Prevention	(1.00)	(1.00)	($200,561)
Total	**(6.10)**	**0.03**	**$5,253**

The table above shows the change in Base FTEs, Fiscal FTEs (with proration for time of hire), and Salary by functional area between the 2021 Budget and the 2022 Budget. All of these changes represent regular adjustments to the staffing model in alignment with the goals and needs of the organization.

c. **Please provide management salaries (similar to appendix 6.7) with budgeted salaries by position for FY2022.**

See Attachment 8-Appendix 6.7 ACO Management Compensation 2022 Budgeted Version.

26. Occupancy costs per 6.4 are approximately $421K in FY2022. In FY2021, they were budgeted to be $543K. What were the savings found? Is this expected to continue?

OneCare was able to secure a new lease arrangement that lowered the operating expense budget. This change is expected to continue throughout the lease term.

27. Deferred Revenue:

a. **How do the deferred participation fees work? Per OneCare's audit, they represent fees paid by participants specific to programs that did not take place and thus performance obligations have not been met. Since programs are being cut, are any of these deferred revenues being returned to participants as the obligation would be deemed never to be met?**

The deferred funds have evolved over time and in alignment with the transition to Accounting Standards Codification (ASC) 606. There are generally two categories of deferred funds. The first are funds that through programmatic agreements are required to be utilized for a specific future purpose. The payer contract terms and GAAP dictate the appropriate use and recognition of those funds. These funds will be paid out based upon contract terms, with the release of the deferred participation fee revenue being recognized in the period the expense is incurred. Next, early in the participation fee era, unspent participation fees were deferred due to specific programmatic underspending as a result of ramp-up. These funds were originally generated for programs that continue, therefore, there is no risk that the performance obligation will be unmet. After the evolution to ASC 606, specific performance obligations were defined and documented in policy, which changes the nature of any participation fee deferrals moving forward.

b. **On p.8 of the narrative, it is noted that $2.9 million of deferred revenue was utilized to maintain investments and infrastructure. Per the audit, the deferred revenue was defined as participation fees paid by Participants specific to programs that did not take place and thus performance obligations have not been met. Please explain what the deferred revenue was used for in FY2021 and, if it wasn't, why the deferred revenue wasn't utilized for specific programs.**

The funds deferred in 2020 are being used in 2021 in alignment with the nature of their initial purpose or, where discretion exists, through Board of Manager designation. The most significant portions relate to the VBIF and CPR programs. These funds are able to be recognized in 2021, therefore, it directly offsets the need for additional participation fees in 2021. However, because the funds are finite, this opportunity does not exist in 2022.

c. **Is the reduction of population health management efforts causing deferred revenues to be smaller than in prior fiscal years?**

No, this is not occurring.

d. **On p.51, it is said there is "1.6M less deferred revenue to access in 2022." Where is this reflected on OneCare's budgeted Income Statement/Balance Sheet? It is showing a decrease of over $3 million in 2022 variance, but on the balance sheet, it is increasing from FY2021 to FY2022, and is sitting at about $1M. On 6.1-6.3, it is noted "Decrease due to release of remaining deferred par fees on balance sheet. New deferred par fees not assumed in the budget." Please connect these dots.**

The change in deferred revenue shows up on both row 30 and row 45 of the 6.2 Full Accountability IS tab. Of the $2.8M reduction noted in cell AA30 and AA45 of that tab, there are two subcategories. The first relates to funding that supported programs that are not continuing into 2022. From a budgetary standpoint, the revenue is lost but so is the expense and thus there is no impact to the bottom line. Next, there were 2021 deferred revenues released for 2021 programs that will continue or renew in 2022. In this case, the deferred revenue is no longer available but the expense continues on and results in a negative impact to the bottom line. The $1.6M referenced in the narrative speaks to this second dynamic. The first dynamic is not referenced since it has no impact on the bottom line, or on the hospital participation fees. Also of note, the balance sheet projection for December 31, 2022 includes an estimate of 2022 VBIF funds that will be deferred in conjunction with the VBIF distribution policy.

28. **Please break out the other expenses on "Sources and Uses," detail of operating expenses.**

The breakdown of that row is as follows. Note the account categories reflect the labels for OneCare's internal financial management and monitoring.

Other Expenses Breakdown	2022 Budget
Contract & Maintenance	$432,500
Food & Beverage	$13,257
Advertising	$110,000
Travel	$63,250
Books, Dues, Subscriptions and Licenses	$84,000
Mail & Production	$35,000
Office Supplies	$37,500
Other Operating Expenses	$99,400
Professional Development	$65,380
Utilities	$30,262
Total	**$970,549**

29. **Is the FY2021 projection provided still accurate? The projection is equal to the revised budget, and the entity has now entered Q4 of the calendar year. Please provide an updated projection, if possible. Assuming no refunded participation fees, please provide the anticipated net income or loss for FY2021.**

The 2021 revised budget was prepared during the actual fiscal year and serves as a reasonable projection through the summer months. OneCare is in the process of preparing an updated year-end projection and will submit it with the Q3 financial filing. At this point there are many variables that will affect any participation fee adjustment decision.

30. **Appendix 6.6 "All Hospitals" does not tie to the Income Statement. There is a note about how this is impossible due to accrual accounting. Please explain. Is OneCare using a hybrid method of accounting?**

    When researching this question, OneCare was unable to locate the note regarding accrual accounting. The reason that tab does not tie to the income statement is that the OneCare network is comprised of many other provider types. As a result, adding up the hospital components will not tie to the totals reflected on the income statement in some cases.

31. **Is there value in calculating Days Cash on Hand or Days in Accounts Receivable metrics? If so, can OneCare do this?**

    OneCare is able to calculate those measures. Days of Cash on Hand is a reasonably useful measure, however, the prospective nature of most payments paid to OneCare have afforded relatively comfortable operations from a cash perspective. Days of Accounts Receivable tends to be a volatile measure due to the intermittent and large settlement activity on the balance sheet.

32. **Is the $10 million LOC still active and available to draw upon? Does any other party have access to the Line?**

    The line of credit remains in place. There are no active letters of credit built upon the line of credit, which means no other party has access.

33. **On the Cash Flow Statement, there is a $13.4 million increase labeled "other." What is driving that sizable figure (e.g., specific line item impacts, timing, etc.)?**

    It was assumed this question refers to the FY2021 Projection column, which currently reflects budget amounts. The current format of the cash flow statement relative to the balance sheet format results in a lot of activity showing up in just a few rows. The $13.4 million currently reported is all balance sheet line item changes other than profit, depreciation, and change in Accounts Receivable. Notably this includes the following: $14M decrease in settlement activity (projecting zero for 2021 at this time, but $19M known for 2020 remains on the balance sheet as of 12/31/20). It should also be noted that in the most recent version of the file submitted, the amount is now $13,634,648.

34. **Is it possible to crosswalk the revenue impact of the rise and fall of attributed lives and member months?**

    Yes, this is possible. The budget is designed, however, to be as dynamic as possible when it comes to attribution-based investments. While potentially not dollar for dollar (depending on the payer program), modest changes to attribution do not present a significant budget risk.

35. **What would the budgetary and programmatic impact be if OneCare did not receive the full administrative revenue as budgeted from Medicaid? Per the Sources and Uses, it looks like it goes to Basic OCV PMPM, Complex Care Coordination Program, and Operating Expenses.**

    While the assumed use of the funds noted in the question is accurate, loss of this revenue stream would necessitate holistic budget review. The potential impact and response would not be limited to those three areas.

Questions – Certification

36. **As documented on p.11 of the budget narrative, UVMHN has become the sole parent organization for OneCare.**
    a. **What are the specific cost savings and quality improvements resulting from this change?**

    OneCare continues to receive the same cost savings from the services and infrastructure that UVMHN provides, including human resources, payroll, and IT. If OneCare had to independently purchase these services and resources the cost would be passed onto OneCare participants. OneCare also shares positions with UVMHN, such as Director of Care Coordination and Chief Medical Officer, which results in lower salary costs. Administrative efficiencies will continue to be achieved, such as streamlined internal processes including securing a banking (debt) guarantor and approval process for risk sharing backstop.

    b. **Is there an opportunity to increase the number of primary care providers, add a registered nurse, and enhance gender equality on the BOM?**

    Seats on the 21 person Board of Managers (BOM) are designated for representatives of specific provider types, including two seats designated for independent primary care. The BOM currently has a total of five MDs. OneCare's clinical committees consist 41 MDs, 11 Nursing Professionals, seven social workers, and other certified professionals that advise the BOM. OneCare recently undertook an assessment of our board and committees to determine areas of opportunity for diverse representation in the governance structure and will work to identify additional opportunities in 2022.

Health Care Advocate Questions

ACO Governance and Planning

1. **As is documented on page 11 of OneCare Vermont's (OCV) FY 2022 Budget Narrative submitted to the Green Mountain Care Board (GMCB), University of Vermont Health Network has become the sole parent organization for OCV. Please describe specific cost savings and quality improvements that will result from this change.**

   This is a duplicate of question 36.a. See above for the combined response to GMCB and HCA questions.

2. **Bailit Health presented a report, "Core Competencies of High-Performing Accountable Care Organizations (ACOs),"[1] at the May 12, 2021 Green Mountain Care Board meeting. The report noted that a) hospital-led ACOs have generally not been successful at saving money and b) when hospital-led ACOs have achieved cost-savings, it is typically by reducing post-acute care costs.[2] In light of these findings, please respond to the following questions:**

   a. **Most hospital-led ACOs cover a limited service area within a state. How is the ability to save money easier or harder for a hospital-led ACO that is state-wide such as OCV?**

      While hospitals represent an important participant type in the OneCare network, OneCare is a statewide ACO led by a diverse array of providers. Statewide hospital participation helps alleviate the tension between primary care and hospital care that can be created through ACO arrangements. As a result, the widespread engagement helps to align goals across a wide array of providers and provider types. Additionally, operating larger ACO programs adds an element of stability. In a smaller ACO model, there may be opportunity for short term savings that may or may not yield long-term benefit. The larger ACO programs place more emphasis on macro-level results, which necessitate a deeper commitment to population health and coordination of care. These mechanisms for success have the potential to deliver lasting value to the health system.

   b. **How does OCV save money without paying providers less, especially hospitals?**

      OneCare aims to manage health care cost growth to the terms within its payer contracts through enhanced coordination of care, use of data, and effective provider incentives.

[1] Bailit Health. (2021). *Core Competencies of High-Performing Accountable Care Organizations (ACOs).* Green Mountain Care Board, https://gmcboard.vermont.gov/sites/gmcb/files/documents/CoreCompentenciesofHighPerformingACOs_Bailit_BoardPres_20210512.pdf.

[2] Bailit Health, 2021, slide 8

c. **How does OCV ensure that pay isn't allocated by relative bargaining power or power within OCV so that all essential providers, including mental health and home and community- based services remain solvent?**

OneCare is led by a diverse Board of Managers (BOM) representing an array of provider types, and the committees that advise the BOM are comprised of diverse participants. Through this committee structure, the perspectives of all provider types are considered when making key decisions. Also, participation in the OneCare ACO is entirely voluntary, which gives all participants an option, should they feel their solvency is in jeopardy.

d. **Please specify, how will OCV's model increase healthcare affordability for Vermonters on commercial plans in the next five years?**

OneCare facilitates payer contracts on behalf of its participants that are designed to transfer accountability for health care cost and quality. Through the "shared savings/losses" concept, either a share of the savings or a share of the losses are retained/paid to the insurer. As a result, an ACO model can increase healthcare outcomes and affordability over any duration.

3. **Does OCV offer a means for participating providers and payers to provide confidential feedback, so they feel free to speak honestly? What steps have you taken to receive feedback on Vermonters' access and affordability needs?**

As described in OneCare's response to Section 2, question 3.f. of the FY 2022 Budget narrative, OneCare conducted participant surveys on the topics of care coordination, data and analytics, and finance. These surveys provided an opportunity for candid feedback. Providers and payers have many connection points within the organization to share feedback in trusted relationships. OneCare also continues to offer a confidential Compliance Hotline for any patient or provider concerns, and this information can be shared anonymously.

OneCare recently hosted two paid focus groups with individuals in the Black, Indigenous, and People of Color (BIPOC) community to explore health care related perspectives and experiences. Access and affordability were topics that were discussed. A paid focus group with Vermonters who identify as disabled will be held in November. These discussions will inform OneCare on ways we can be inclusive and equitable in our governance and decision-making. OneCare's Patient and Family Advisory committee also meets monthly and reports on issues of access and affordability.

Payment Reform

4. **If utilization is much higher than predicted under unreconciled fixed prospective payments, how will health care entities fund high-cost, short-term providers (e.g., locum tenens) as these additional providers will not bring in added revenue?**

   While OneCare cannot predict the strategies providers would employ in the circumstance noted above, stable and reliable provider reimbursement is a concept supported by many participants within the OneCare network. Also, in most cases, there are conditions under which a reevaluation of the fixed payment level is triggered. In the event the scenario presented comes to bear, it would likely trigger this type of review.

Evaluation of ACO Performance

5. **The NORC VTAPM evaluation[3] found that OCV struggled in the first two PYs to engage Critical Access Hospitals (CAHs). Aside from specific issues related to both the Medicare payment mechanism and cost-reporting challenges, please list what OCV learned from its engagement struggles with CAHs and the specific activities OCV is now taking to effectively engage CAHs.**

   OneCare has a different perspective on the conclusion of the NORC VTAPM report regarding Critical Access Hospital (CAH) engagement. Of note, CAH participation in the Medicaid program has grown alongside the growth of other provider types during the last five years. A clear challenge for CAHs is the magnitude of risk they are being asked to undertake by participating in the Medicare program and unclear guidance from Medicare in cost reporting. As a voluntary ACO, OneCare has historically advocated for a more manageable risk corridor in the Medicare program, so that the risk burden on CAHs can be more appropriate and aligned with their underlying financial model.

6. **As the GMCB and the NORC VTAPM evaluation[1] have noted, a lack of understanding of what OCV is and does has created provider engagement and public opinion difficulties. Please list concrete steps OCV has taken, is taking, or intends to take in response to such engagement and opinion difficulties.**

   The NORC Vermont All Payer Model (VTAPM) evaluation points out the confusion about the model; noting that the VTAPM model and OneCare have become synonymous, which has added to the communication challenges. OneCare's work, along with the work of any other ACOs operating in the state, represent the essential provider contributions towards the model, but remain distinct from the State's commitments in the VTAPM agreement. OneCare is one component to the model and has increased efforts to explain the ACO component.

   OneCare is highly engaged with providers in many methods as outlined in the FY 2022 Budget narrative, Section 2, question 3.f. OneCare has also taken several steps to inform and educate interested parties including: revamping the website to have comprehensive information for providers and the public; producing an annual report with a focus on transparency; creating short videos that explain the work and purpose; and purchasing advertising that is not simply intended to build name recognition, but is designed to explain the ACO concept and to further disseminate informational materials. Additionally, OneCare shared short fact sheets and distributed them to the provider partners to supply them with resources to help answer questions that they may receive through their direct relationship with the public.

Population Health

7. **Given an increased awareness at the state and local level in Vermont to invest more in reducing racial disparities in access and quality of care, and given OCV's support of DULCE (p. 58 of the OCV Budget Narrative), why are these population health programs slated to be cut? Why does OCV argue that the only way to support these programs is through increased state and federal dollars (p. 60 of the OCV Budget Narrative)?**

   OneCare thoroughly engaged stakeholders in an effort to prioritize budgetary decisions, based on available funding and potential for shared savings opportunity. This process is vetted through OneCare's Board of Managers and is implemented more granularly by work with internal and external work groups and committees such as OneCare's Patient and Family Advisory Committee and the Board-directed Population Health Strategy Committee. Through these processes, OneCare was able to identify highest priority categories to invest in. These categories include, but are not limited to, population health management PMPM funds, VBIF funding, and care coordination funding. Current investments in delivery system reform exceed reward opportunity.

   a. **Similarly, please explain how important OCV believes care coordination is to its goal of decreasing costs and increasing value. How can you meet your goals when care coordination is an increasingly low priority in your budgeted expenditures?**

      Care coordination is essential in achieving goals of decreasing costs and increasing value. These goals are achieved through a commitment to strong cross organizational engagement and person centered care planning; a commitment that resonates with network providers across the continuum. OneCare has incentivized efforts, initially for capacity building and most recently, for interventions provided. Alongside financial incentives, there have been robust education sessions, targeted technical support, statewide collaborative forums within which care coordination successes and challenges are shared, and advanced analytics that allow for data driven decision making. The network responds to all of the above and because of its commitment to provision of quality care and to reform efforts at large, will continue to engage in the care coordination program for Vermonters despite changes in budgeted expenditures.

8. **OCV's FY 2022 Budget Narrative notes, on page 70, that anxiety and depression have been identified as two of the top five prevalent conditions for Medicaid and Commercial programs. How does OCV plan to address this finding through budgetary investments in FY 2022?**

   The Designated Agencies are engaged in the care coordination and VBIF payment models. These organizations will receive funds for their contributions to improved outcomes for patients with mental health diagnoses. OneCare considers the mental health agencies to be an integral partner in community population health efforts.

a. For example, on page 73 of the OCV Budget Narrative, OCV notes an "opportunity for improvement" is only 5% of pediatric practices meet stretch goals for depression screening. How does OCV plan to address this problem?

As part of the VBIF program, OneCare provides targeted quality improvement support to pediatric practices within the network. These efforts include evidence-based guidance and teaching to improve depression screening performance. Quarterly and ongoing monitoring and evaluation will determine the impact of these efforts and will inform future decision making for how OneCare can better support its network in this work.