Green Mountain Care Board

FY 2021 Budget Submission

OneCare Vermont Accountable Care Organization

October 1, 2020

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Section 1

ACO Information and Background

PART I. REPORTING REQUIREMENTS

Section 1: ACO Information and Background

1. Provide an executive summary of the budget submission. In doing so, please address the following:

    a. OneCare's value proposition and business model;
    b. Main outcomes, objectives, opportunities and challenges faced when developing the budget, including the impact of COVID-19;
    c. Changes to the provider network;
    d. Changes to payer programs;
    e. Changes to population health and preventative programs and the effect on the budget;
    f. Changes to staffing and other administrative operations and the effect on the budget;
    g. Key assumptions made during budget development.

Vermont is faced with rising health care costs and a rapidly aging, rural population, which influenced the creation of the All Payer Model (APM) agreement between the Federal government and the State of Vermont. The APM establishes a pathway to address affordability and better health. More recently, the COVID-19 pandemic has created a spotlight on the fragility of a volume-based fee-for-service (FFS) healthcare delivery system and emphasized the need for transformation to one that is predictable, stabilizes costs and continues to achieve high quality care outcomes for Vermonters.

OneCare Vermont (OneCare), a cooperative effort of thousands of providers across the continuum of care, seeks to further the goals of the APM. In this transforming system, providers are accountable and take responsibility for the cost and quality of the care they deliver. Through a shared statewide infrastructure, OneCare supports providers with the data and analysis they need to meet the goals of the APM while on a fixed budget. OneCare encourages increased communication and coordination between healthcare providers, especially those caring for the highest-needs individuals. Thus, OneCare's 2021 budget remains in alignment with the goals set forth in Vermont's APM.

OneCare will Expand Vermonters Covered by Value-Based Care Programs in 2021

OneCare will begin 2021 with a strong and committed network of ambulatory, acute, and continuum of care providers statewide that includes 14 hospitals, nine FQHCs, six naturopaths, 25 independent primary care organizations, 18 independent specialist organizations, and 49 continuum of care organizations all aligned around Vermont's APM goals. Further, four independent practices will be joining the Comprehensive Payment Reform (CPR) fixed payment program for the first time, bringing the total to 11 organizations across 17 primary care sites. OneCare will continue to offer the same suite of payer programs in place during the 2020 performance year and has expanded attribution by approximately 28,000 lives due, in part, to the addition of Rutland Regional Medical Center and the Community Health Center of the Rutland Region (CHCRR) to the Medicare Program and new self-funded employer groups entering scale target qualifying programs. In total, OneCare anticipates 238,467 scale target qualifying attributable lives in 2021. There are no new payer arrangements anticipated for 2021, nor are there any plans to terminate existing payer programs.

OneCare Evolves Payment Reform Programs

OneCare's payer contract negotiations are in process for 2021 with an objective of achieving predictability and sustainability. Specifically, OneCare continues to emphasize the value of payment

reforms and aims to offer tighter risk corridors and quality measurement metrics that allow the provider network to remain focused on population health while recovering from the pandemic. OneCare will advance payment reforms by advocating for unreconciled fixed payments with payers and incorporating a BCBSVT fixed payment component for CPR practices for the first time. In order to more fully transition into value-based care, public and private payers will need to operationalize true, unreconciled fixed payments, akin to Medicaid's current model. It will also be important as we move more payments away from FFS to evaluate the changes that will need to be implemented in regulation, legislation, and the setting of total cost of care (TCOC) trend rates to reflect the true costs. With growing experience, OneCare has evolved its risk sharing model to move away from community specific "mini ACOs" which are subject to volatility due to small numbers, to a combined ACO-level risk pooling arrangement with a payment incentive for exceeding performance expectation at the health service area level. Additionally, supporting providers during the pandemic is balanced with the need to expand accountability throughout the system, particularly as Vermont moves into year four of the All Payer Model. In 2021, OneCare will introduce a variable population health management (PHM) payment, on top of primary care payer reimbursement, that rewards high quality performance above preexisting levels to incrementally increase provider accountability. This approach provides an opportunity for financial rewards above and beyond the total primary care financial investments of approximately $18 million annually. All of these financial rewards offered through the ACO are on top of FFS or fixed payments in 2021.

OneCare Plans Operations for 2021

OneCare has continued work to manage the costs of healthcare reform efforts and move the system to a path of predictability and long-term sustainability. In developing OneCare's 2021 budget, COVID-19 introduces additional uncertainty which may require OneCare and payers to incorporate actuarial factors to account for the expected impact of deferred disease management and/or increased demand in 2021.This budget assumes stable payer programs with no significant program changes, appropriately set TCOC targets accounting for anticipated response to COVID-19, focused population health investments emphasizing the most promising strategies, and ongoing commitment to providing data and insights to drive clinical and financial reforms. The 2021 budget results in a $9.2M reduction in hospital dues as a result of COVID-19 response efforts and increased focus on long-term sustainability. It is reflective of the reduction in $2.8M of health information technology funding no longer available federally and is conditional on receipt of a stable $3.9M in Delivery System Reform funding. The 2021 budget includes 13.1 fewer FTEs when compared to OneCare's pre-COVID 2020 budget, which is largely effectuated by eliminating currently vacant positions. Operational resources and capacity will have to be continuously evaluated and monitored, as despite the work we have done to streamline operations and focus programs, the workload and administrative demands have continued to grow as we expand the network and grow payment reform programs.

OneCare Provides Population Health Investments to Transform Care Delivery

In 2021, OneCare's population health investment portfolio continues to facilitate care delivery transformation and provide opportunities for innovation and incentives in the transition to value-based healthcare. The specific ongoing investments include: a base population health payment with financial accountability; complex care coordination payments tied to active care management measures; Value-Based Incentive Funding (VBIF) with a more immediate distribution of funds; primary prevention programming; maintaining the Medicare Patient Centered Medical Home, Community Health Team, and Supports and Services at Home (SASH) payments to all eligible providers regardless of participation in the Medicare ACO program at current levels; and expanding the CPR program which offers predictable revenue plus an enhanced revenue of $5 PMPM for independent primary care. In addition, OneCare has been working with the Blueprint for Health, the Vermont Department of Health, and key stakeholders

statewide to reimagine and advance self-management programming to meet individual's evolving preferences. OneCare anticipates contracting with the Blueprint for Health in early 2021 to assume accountability for administering the self-management program. In doing so, OneCare has identified opportunities for organizational synergy and alignment between some primary prevention activities in OneCare's RiseVT program and local self-management activities. This is anticipated to result in further integration and efficiency for patients, community-members, and the local organizations administering these programs.

Providers Deliver High Quality Care

OneCare providers have made impressive advancements over the past year including achieving quality scores of 95% for Medicaid, 81% for BCBSVT QHP, and 91.88% for Medicare. In support of the State's larger population health goals, OneCare participating providers are demonstrating measurable improvement in the care of individuals with chronic conditions (i.e. diabetes or hypertension), increased screenings (e.g. developmental screening of young children, influenza immunization, and colorectal cancer screening), and follow-up care for individuals with alcohol or substance use disorders. Continued focus on the care coordination program and improving engagement has resulted in 4,178 individuals active in care management as of September 2020, achieving our goal of a 15% all payer blended care managed rate. Building on this success, OneCare's 2021 care coordination goals include: refining the identification of special high risk populations to prioritize for outreach (e.g. high ED utilizers, patients with multiple chronic conditions), conducting quality assurance monitoring to assure fidelity to the model, advancing knowledge of best practices in care management, and establishing protocols to ensure that patients who have either completed their care management goals or are no longer engaged are discharged from the program. These advancements aim to ensure that the care coordination investments have the opportunity to yield favorable results under value-based contracts.

Data-Driven Response to the COVID-19 Public Health Emergency

Early in the onset of the public health emergency, OneCare built and rapidly deployed a COVID-19 Patient Prioritization Application to aid providers in identifying individuals at highest risk of serious illness and supporting outreach. Using these data, providers made care and concern calls, conducted scripted assessments and addressed unmet care needs, identified medication renewal needs, reinforced social distancing recommendations, inventoried available social supports for emergency needs planning, and identified the need for telephone or video visit(s). Network participants reported that this application was of great benefit to the practices and patients. The application continues to be updated as high risk criteria are released or updated. Recent application enhancements have included the addition of clinical data on patients tested for COVID-19, and additional risk fields such as the addition of race data, food access challenges, and social isolation.

OneCare Provides Predictability, Stabilizes Costs, and Improves Health for Vermonters

All of the activities above link back to the central themes of the 2021 budget: driving care delivery success and improving provider financial predictability and stability in support of Vermont's All Payer Model healthcare reform. In driving toward the goals, the 2021 budget continues investments in core population health programs, expands provider reward and accountability, offers a greater array of payment reform options, fosters continued care delivery transformation, builds upon positive quality outcomes, and responds to ongoing learning from the early years of the All Payer Model. To continue to grow participation, the budget tightly balances the importance of a continued population health focus with the cost of investing in and operationalizing healthcare reform efforts. The COVID-19 pandemic created great uncertainty worldwide; yet now clearer than ever are the flaws in a volume-based

healthcare system. This budget continues to support the State and Federal governments' desire to move toward a stabilized and value-based approach to meeting the healthcare needs of Vermonters.

Section 2

ACO Provider Network

Section 2: ACO Provider Network

1. Explain the 2021 network development strategy and any anticipated changes to the provider network including areas of growth, areas of decline and general observations as to what is driving participation decisions and how these changes affect the overall budget. Discuss both the challenges and opportunities associated with 2021 network recruitment activities, including the impact of COVID-19.

   Despite the COVID-19 challenges, OneCare worked diligently to maintain its network composition from 2020 into 2021. The 2021 network development strategy focused on supporting primary care, engaging with organizations that take risk, working to reduce barriers to joining additional payer programs, and ensuring adequate knowledge of participation expectations. In addition, OneCare is actively negotiating payer contract terms to align the financial terms with the risk tolerance of network participants, many of whom are financially fragile as a result of the pandemic. During recruitment, participants were encouraged to join all applicable payer programs to include Medicare, Medicaid, BCBSVT QHP, BCBSVT Primary and MVP QHP. The result of the network development cycle is a 2021 network that is very similar to 2020. Because of this, there are minimal impacts on the overall budget model specifically resulting from changes to network participants. In prior years, significant changes to the network composition resulted in changes to total risk and population health investments. While both are changing in 2021, they are not changing as a direct result of network participation decisions.

   There are challenges in growing the provider network from the financial, regulatory, and operational perspectives. Financially, there is insufficient funding for healthcare reform efforts; difficulty providing predictable financial payments for risk-bearing entities; the need for additional incentive for the risk to reward (savings/loss) ratio; challenges in supporting rural hospitals' unique financial models; and a lack of predictability in fixed payment models that require reconciliation to fee-for-service (FFS). In terms of regulatory alignment, there is a need for cohesion with commercial insurers and the All Payer ACO Model; the regulatory budget review processes need to be aligned to promote coordination and efficiency across healthcare delivery organizations; and the increase in regulatory administrative burden needs to be reevaluated to allow for a financially sustainable model. Operationally, OneCare seeks to align care and financial models when adding commercial insurers; address challenges with payers to operationalize true fixed payment models; address the clarity needed for critical access hospital (CAH) cost reporting processes; and reduce provider and ACO administrative burdens to allow increased focus on care delivery.

   As OneCare prepares for year four of the All Payer Model, there is a need to focus on accountability and self-sustainability across the system. This continued evolution builds upon fixed payments for risk bearing entities as well as the advancement of the care coordination payment model from a capacity to a value-based payment stream. In 2021, OneCare will further increase accountability by creating a variable population health management payment for risk based programs (i.e. the $3.25 per member per month (PMPM) payment to all attributing primary care practices). This approach ties population health management (PHM) payments to financial performance and increases accountability while also providing upfront investments in primary care.

   OneCare is successfully navigating the pandemic and supporting the ongoing need to evolve healthcare reform efforts as evidenced by the retention of the provider network from performance year (PY) 2020 to PY 2021. See Table 1: 2021 ACO Network Participation below. Notable changes for the PY21 provider network include the addition of both Rutland Regional Medical Center (RRMC) and the Community Health Center of the Rutland Region (CHCRR) to the Medicare Program, retention of 25 of 29 independent primary care practices, and the addition of four new entrants into the Comprehensive Payment Reform (CPR) program for a total of 11 organizations and 17 primary care practice sites.

Table 1: 2021 ACO Network Participation

	Number of Organizations	
Organization Type	**PY 2020**	**PY 2021**
Hospitals (includes employed providers)	14	14
FQHCs	9	9
Independent Primary Care* • *CPR Program*	29 7	25 11
Naturopaths	7	6
Specialists	23	18
Continuum	56	49

**Note: Two independent PCPs have two organizational tax identification numbers (TIN) each. For simplicity we have counted them once each, not twice for each TIN.*

2. Please populate **Appendix 2.1, 2021 ACO Provider Network Template, Appendix 2.2, 2021 Provider Lists**, and submit Copies of each type of provider contract, agreement, and addendum for 2021 (i.e. risk contracts, non-risk contracts, collaboration agreements, and memoranda of understanding).

   See copies of each provider agreement, amendment and addendum enclosed. As agreed, OneCare will supply Appendices 2.1 and 2.2 no later than October 16, 2020. OneCare appreciates the provider roster submission extension for the Medicare, Medicaid, BCBSVT QHP and MVP QHP programs. OneCare does not anticipate any changes to the network roster for these programs. For the BCBSVT Primary program however, the provider contracting process is still underway and the roster will be submitted upon completion with any resulting budget adjustments.

3. Please describe how your provider contracts support and further the goals of reducing cost and improving quality, including reference to the following:

   a. Provider payment strategies and methodologies.

      OneCare's risk payer programs include shared savings and risk components driven by financial and quality improvement incentives that promote accountability for OneCare and its network participants. For the 2021 performance year, OneCare has modified the incentive payment strategy in the following ways:

      - Introduction of a variable population health management (PHM) PMPM payment to primary care providers. This payment migrates from a flat, fixed amount ($3.25 PMPM) to a variable payment ($1.75 to $4.75 PMPM) that ties to ACO and local health service area (HSA) financial results. This advancement is intended to increase and expand accountability under the model. The variable payment is in effect for payer risk contracts where risk is held by OneCare's network; for shared savings only contracts, the variable payment ranges from $3.25 to $4.75 in alignment with success in the

program; for risk programs where the risk is held by the ACO, a straight $3.25 PMPM is distributed to primary care. See Table 2. 2021 Primary Care Program Incentives.

- OneCare will shift the timing of Value Based Incentive Fund (VBIF) payments from program settlement (approximately 18 months after the start of the performance year) to a distributive model that facilitates funds flow throughout the performance year to align with focused quality initiatives as set by the Population Health Strategy Committee.
- OneCare will change the way in which shared savings or losses earned by OneCare are allocated to participants within the network. Rather than setting HSA-specific total cost of care (TCOC) targets, OneCare will implement a simplified approach that distributes any savings or losses earned/owed by OneCare proportionally to HSAs based on attribution. OneCare will also allocate 10% of any shared savings earned at the OneCare level to a Performance Incentive Pool that will be used to reward HSAs for furtherance of OneCare strategies. The outcome(s) that will determine which HSAs are eligible for a share of this Performance Incentive Pool will be decided later this fall through governance processes. This change simplifies the incentive model and provides clearer communication of results. Also, sharing savings/losses proportionally across the network aims to instill a statewide system paradigm. Through this approach, there is increased alignment between the Vermont All Payer Model goals, which are measured at the state level, and the results of OneCare and its participants.

b. A description of the any new or expanded ACO incentives to strengthen primary care, including strategies for recruiting additional primary care providers to the model, providing resources to expand capacity in existing primary care practices, and reducing the administrative burden of reporting requirements for providers while balancing the need to have sufficient measures to evaluate adequately the quality of and access to care.

OneCare's 2021 network development strategy focuses on retaining participants, including primary care, while ensuring participants are ready and willing to engage in the accountability of the care delivery and payment reforms.

Several incentives are offered to strengthen, recruit, expand capacity and reduce administrative burden of primary care. OneCare's Population Health Investments provide direct funding streams to increase capacity and strengthen patient access to primary care. Investments in primary care further aim to improve population health management, increase the utilization of available data provided by OneCare, and drive continuous quality improvement efforts to advance patient outcomes and experience of care.

OneCare's Population Health Strategy Committee formed a primary care workgroup to assess strengths and opportunities and inform future directions. The workgroup is gathering provider feedback regarding administrative burdens and assessing potential strategies to mitigate them. Recommendations from this work are expected later this fall. OneCare continues to welcome primary care provider engagement in other standing committees and with representation on the Board of Managers.

The CPR program supports participating independent primary care practices by providing a predictable revenue stream and additional enhanced financial resources. This program designed specifically for independent primary care allows them to make the transition from a FFS payment model to a value based payment model with a fixed PMPM payment. The

fixed monthly payment also includes an additional $5 PMPM to support the practices in evolving care models. The predictability and reliability of a fixed revenue stream allows for long term strategic investment and innovation within the practices. In 2020, OneCare has seven organizations across ten practice sites participating in the CPR program. In 2021, OneCare grew CPR program participation to 11 organizations across 17 practice sites. OneCare's recent report to the GMCB on the CPR program showed that practices that participate are better off financially than those that do not participate. For example, OneCare estimates that CPR practices received an additional $850,000 in 2020 that they would not have received in light of the pandemic. This additional revenue would not have been possible without the CPR program.

Throughout 2020, OneCare worked with the Blueprint for Health (Blueprint) and the Vermont Department for Health (VDH) on a plan to transform self-management programs for Vermonters who have or are at risk for hypertension or type 2 diabetes. OneCare anticipates contracting with the Blueprint in early 2021 to assume accountability for administering the self-management programs. In advance of this transfer, OneCare created a patient prioritization application to perform targeted outreach to providers and patients that may benefit from the free self-management program offerings through Vermont Health Learn, a digital learning platform maintained by OneCare in collaboration with state and community partners. OneCare also intends to offer a mobile application to participants in the self-management programs to support their efforts to improve their conditions. Coupled with the patient education, OneCare will offer educational sessions for providers regarding the self-management offerings and work together with providers on outreach to patients who may benefit. In each HSA, an aligned self-management and prevention staff person will support program participants in their home communities by making connections to other services and activities that improve health. In 2021, the self-management program intends to better serve patients and providers as their preferences and knowledge of self-management resources and best practices continue to evolve.

OneCare continues to align quality measures across all applicable payer programs in order to reduce administrative burden for primary care. Providers receive consolidated measure specification training and access to a monitoring application to support this process. OneCare staff continue to collect necessary quality measure data on behalf of providers to meet reporting requirements.

Table 2 below demonstrates the 2021 program incentives available to primary care. Together, they represent total investment opportunity of approximately $18 million to primary care in addition to their payer FFS or fixed payments in 2021.

Table 2: 2021 Primary Care Program Incentives

Benefit	Revenue	Program(s)	Eligibility
Population Health Management (PHM) Payment *Network Risk-Based Programs*	$1.75, up to $4.75 PMPM dependent on payer program performance	Medicare, Medicaid	Based on attribution
Population Health Management (PHM) Payment *Shared Savings Only Program*	$3.25, up to $4.75 PMPM dependent on payer program performance	MVP QHP	Based on attribution
Population Health Management (PHM) Payment *OneCare Held Risk Only*	$3.25 PMPM	BCBSVT QHP, BCBSVT Primary	Based on attribution
Primary Care Engagement Incentive	$100 PMPY paid to primary care TIN that engages an eligible patient in a qualifying visit in the contract year	BCBSVT Primary; Medicaid Expanded	Based on engagement with individuals who have not seen a primary care provider in defined lookback period
Care Coordination	$80 PMPM – Lead $60 PMPM – Care Team members $300 PMPY – Lead for care conference $150 PMPY for Care Team member care conference	MVP QHP, BCBSVT QHP, Medicare, Medicaid, Medicaid Expanded [Note: BCBSVT Primary TBD for 2021]	Based on engagement with ACO eligible patients: Top 3% risk commercial payers Top 15% risk government payers
Value Based Incentive Fund	70% of total earned distributed to Primary Care	BCBSVT QHP and Primary, Medicaid, MVP based on shared savings [Note: Medicare TBD for 2021]	Based on quality performance standards of the ACO and primary care engagement rate
Quality Payment Program (QPP)(MACRA)	5% bonus, reduced admin cost, no MIPS reporting.	Medicare	Participation in an ACO = Advanced Alternative Payment Model (APMs) are a track of the Quality Payment Program that offer a 5% percent incentive and you are excluded from the MIPS reporting requirements and payment adjustments.
Prior Authorization Exemption	Admin costs	Medicaid	Good standing with the ACO
Blueprint PCMH Payment	$2.05 PMPM	Medicare	Based on Medicare attribution. ~$1.9M of PCMH payments
Blueprint CHT Payment	$2.56 PMPM	Medicare- Paid to the Blueprint entity in the HSA	~$2.4M of CHT payments
Quality Measure Data collection	Reduced administrative cost and burden	All programs with Quality Measure reporting requirements	ACO participant in good standing
CPR Program	Predictable PMPM payments, unreconciled at year end	Medicare, Medicaid, BCBSVT QHP	Participants in full capitation

Table 2: 2021 Primary Care Program Incentives (continued)

Benefit	Revenue	Program(s)	Eligibility
Benefit Enhancement Waivers: **1. SNF** **2. Post-Acute Home Discharge** **3. Telehealth**	Enhanced patient experience and reduced total cost of care by providing the right acuity of care	Medicare	Attribution in the Medicare program
ACO Fraud and Abuse Waivers	Exemption from specific federal regulations for ACO Activities	Medicare	ACO participant in good standing with specific program approved by OneCare's Board for waiver

c. Any strategies related to the expansion of fixed prospective payments (FPP) across the ACO provider network, recognizing provider types. Please identify any provider types for which FPP may not be an appropriate payment reform strategy and explain why.

OneCare recognizes that the FFS payment model is not sustainable and is committed to working with payer partners to migrate to a fixed prospective payment (FPP) methodology. An ongoing challenge with the FPP reform effort is that only Medicaid offers a true fixed payment model while all other payers have an end-of-year reconciliation back to the FFS equivalent amount. This reconciled model offsets the benefits of the fixed payment conversion and impacts OneCare's ability to bring additional hospitals into the Medicare program. This may also limit desire to participate in commercial program payment reforms unless a path to an unreconciled fixed payment is clear. OneCare continues to explore this possibility with Medicare and commercial insurers. To date, OneCare has not encountered any specific provider types that are a poor fit for the fixed payment transition. An ill fit with the fixed payment model is more often the result of timing concerns related to general business changes such as practice mergers, provider turnover, or service line expansions.

As a new initiative for 2021, OneCare is working with BCBSVT to implement a fixed payment for practices in the CPR program.

d. Strategies for expanding provider participation across payers – how are we working toward an "all payer" model?

Section 2: Attachments

Attachment A: OneCare Provider Agreements

Section 3

ACO Payer Programs

Section 3: ACO Payer Programs

1. Complete **Appendix 3.1, ACO Scale Target Initiatives and Program Alignment Form**, submit copies of your 2021 proposed contractual arrangements, by payer, and explain changes made to your portfolio of payer programs for the proposed budget year, including reference to the following:

   Payer agreements are currently under negotiation. Upon execution of signed payer agreements later this year, OneCare will supply an updated Appendix 3.1 and executed payer agreements to the Board.

   See Appendix 3.1 enclosed.

   a. Any anticipated new payer programs and/or terminating payer programs and the overall impact on the budget model.

      The payers for 2021 remain the same as 2020 and include Medicaid (traditional and expanded cohorts), Medicare, BCBSVT QHP, BCBSVT Primary, and MVP QHP. There are no new payer arrangements anticipated for the 2021 performance year, nor are there any plans to terminate existing payer programs. Negotiations are ongoing with all payers through the end of the year to finalize contract terms.

   b. For continuing payer programs, explain any anticipated changes and the overall impact on the budget.

      At the time of the budget submission, OneCare anticipates that the payer programs will continue in a generally similar form. There are some anticipated modifications that largely respond to the COVID-19 pandemic which aim to minimize financial risk and examine attribution methodologies to ensure OneCare does not experience a significant attribution loss stemming from the stay-at-home period. OneCare's 2021 budget is forecasting an increase of 28,000 scale-target qualifying lives, due, in part to RRMC and CHCRR joining the Medicare program as well as anticipated growth in the BCBSVT Primary participation. Here are some of the anticipated changes:

      Medicare: The budget incorporates a 2% risk corridor with 100% sharing, reduced from 4% with 80% sharing in 2020.

      Medicaid: The budget incorporates a 2% risk corridor with 100% sharing for the traditionally attributed population, reduced from 4% with 100% sharing in 2020. The budget incorporates a 1% risk corridor with 100% sharing for the expanded attribution cohort. Also, the budget no longer includes Health Information Technology (HIT) funding. This was a $2.8M revenue stream in 2020. Delivery System Reform funding is estimated at $3.9M, equal to the 2020 amount, but is not confirmed at this time and is contingent on the state and federal approval processes.

      BCBSVT QHP: The budget incorporates a [redacted] risk corridor. [redacted]

      BCBSVT Primary: The budget incorporates a [redacted] risk corridor. [redacted]

MVP QHP: There are no significant changes to the MVP QHP program incorporated into the OneCare budget.

c. For any programs that do not generate attribution qualifying for All Payer Model scale targets, explain the rationale for entering the program and its overall impact on the budget model.

All budgeted programs include the ability to generate attribution that qualifies for All Payer ACO Model scale targets. OneCare will not pursue any new payers or arrangements for 2021. Within the BCBSVT Primary program, as was the case in 2020, some self-funded health plan organizations utilizing BCBSVT as their plan administrator may decline participation. The budget model makes assumptions about which employer groups will elect to participate in this model for 2021.

2. Please explain any strategies you are pursuing for expanding FPP offerings across payer programs. Please also explain how FPPs are calculated for each program, the rationale for such, including how you will plan to accommodate the unusual utilization patterns associated with COVID-19, and what kinds of providers are eligible for participation. What mechanisms do you have to ensure that FPP is not "too high" or "too low"?

OneCare's strategy is to work with payers to evolve FPP to be true fixed payments, like the Medicaid program, and bring additional independent primary care into fixed payments through the CPR program. Further, OneCare is exploring opportunities to increase hospital participation in the BCBSVT fixed payment option in 2021.

Hospital fixed payments are determined in aggregate by the payers and then divided between the hospitals based on a blend of historical FFS spending and a risk-adjusted spend on a PMPM basis by OneCare. Due to the fixed payment approach, hospitals are now financially incentivized to improve health and wellness, minimize potentially preventable utilization, and deliver high-quality care. The methodology used to generate the payment amounts is the same for each hospital and they use their own financial management methodology to distribute payments within their organization. OneCare actively monitors the FFS equivalent spend compared to fixed payments to ensure the FPP is appropriate (neither "too high" nor "too low"). OneCare also advises participants that receive a fixed payment to monitor their own fixed payments against the FFS-equivalent spend.

In addition to hospitals, since 2018, OneCare has worked with payers to transition independent primary care practices from volume to value-based payment reform in the CPR program. This requires replacing payer FFS payment with a fixed monthly payment from OneCare. The approach combines payer-paid fixed payment dollars with a $5 PMPM supplemental investment from OneCare. Each of the practices participating is subject to the identical methodology. The CPR fixed payment continues to provide predictable cash flow and financial resources to facilitate quality and care delivery improvements.

The COVID-19 pandemic introduced a challenge in both setting the TCOC targets as well as the fixed payment amounts. The volume of deferred care that reemerges in 2021 will be a significant factor along with the downstream effects of limited disease management during the stay-at-home period.

3. Please provide an update on the "expanded" or geographic attribution methodology implemented in the Medicaid ACO program in 2020, including any attribution results to date and any plans to change the methodology for 2021.

In 2020, the Medicaid expanded attribution methodology resulted in an additional 28,552 lives aligned to the ACO. This population includes those that are enrolled in full Medicaid benefits with Vermont Medicaid as primary coverage, reside in an ACO-participating HSA, and are not dually eligible for Medicare. They do not meet the requirements for traditional attribution and do not have historical primary care utilization with providers outside of the OneCare ACO network. Some may be members that are new to Medicaid, as well as those with visits primarily with specialists, continuum of care providers, or hospital services.

To encourage engagement with this expanded Medicaid population, primary care providers were offered a one-time $100 per member per year (PMPY) primary care engagement payment for conducting a qualifying visit during the contract year. Providers are also eligible for supplemental care coordination payments for this cohort. In light of the pandemic, OneCare is monitoring the implementation of this program and will make appropriate adjustments as new learning emerges. OneCare will continue to collaborate with the Department of Vermont Health Access (DVHA) to leverage these preliminary findings to inform future iterations of this program. This cohort was loaded into Care Navigator in April 2020 with the results below illustrating activity through September 3, 2020:

- 113 members are actively care managed (they have engaged with a lead care coordinator and completed a shared care plan).
    - 81 (71%) of these members are considered to be high or very high risk
    - 100 (88%) have a care team member associated with a primary care practice
    - 47 (41%) are considered high utilizers of healthcare resources
    - 66 (50%) have mental health or substance use comorbidities identified through claims
- An additional 230 members, 164 of which are high or very high risk, are engaged with at least one care team member.

OneCare plans to continue to support the Medicaid expanded cohort through similar programming in 2021 and does not currently anticipate making any methodological changes.

Section 3: Attachments

Appendix 3.1: B20 – ACO Scale Target Initiatives

Appendix 3.1: B20 – ACO Scale Target Initiatives Appendices A & B

Section 4

Total Cost of Care

Section 4: Total Cost of Care

1. Please complete **Appendix 4.1, TCOC Prior Year Performance by Payer, by HSA (2019).** Please comment on variations in performance, and any lessons learned, including both challenges and opportunities statewide, and those that may exist in varying capacities across HSAs. How is the ACO helping those communities that did not meet their targets develop further insights and adapt their local strategies?

   Results are often driven by the volatility of small numbers at the local level. With so few lives attributing to some of the HSAs, a small number of expensive cases and/or inherent variation risk can dictate the result for the HSA, even with effective population health practices in place. As a strategy to address these issues, OneCare has moved forward with a pooling of ACO risk to help protect from this volatility.

   One of the lessons learned from prior program performance is that operating as a statewide system is key to success. While setting local HSA targets and evaluating each community or practice may have attractive qualities, there is ordinary volatility at the local level which results in hesitation in expanding financial accountability, particularly in the Medicare program. In order for OneCare's programs to yield positive results under the All Payer ACO Model, the healthcare landscape must be viewed as an integrated network. With this in mind, focus can shift away from dividing healthcare spending into "mini ACO" segments and toward network-wide areas of opportunity. OneCare provides participants with financial, utilization, and quality reporting, key insights, and regular consultation meetings to inform their local decision-making. In 2020, OneCare has expanded its internal data transparency policies to allow for new benchmarking and comparative analytics.

   See Appendix 4.1 enclosed. Note that the settlement numbers contained within this Appendix reflect the HSA results and factors such as risk mitigation arrangements. For this reason the total settlement figures will not tie to the payer settlement total.

2. Please complete **Appendix 4.2, TCOC Current Year Projected Performance by Payer, by HSA (2020).** Please recognize any relevant assumptions for projecting the remainder of the year (e.g. based on historical seasonal spend plus a particular rate of growth etc.). *How is the ACO assisting those communities that are not on target to meet their TCOC for the remainder of the year?*

   Year-end assumptions include the following: factors that incorporate current healthcare utilization relative to historical capacity as a result of the pandemic; seasonality with normal increases anticipated in fall 2020; and a reduction in Medicare seasonal out-migration that results from travel-related pandemic concerns. Additionally, OneCare awaits final decisions regarding payer modifications to TCOC targets for 2020. Many of these factors have no historical basis and thus need to be viewed cautiously.

   See Appendix 4.2 enclosed.

3. Please populate **Appendix 4.3, the Projected and Budgeted Trend Rates by Payer Program, Appendix 4.4, TCOC Budget Year Targets by Payer, by HSA (2021), Appendix 4.5, Service Risk by Payer, by HSA** and explain the following:

   See Appendices 4.3, 4.4 and 4.5 enclosed.

   a. All underlying assumptions for these trend rates (Appendix 4.3 Column D) and TCOC targets (Appendix 4.4), including those related to changes in utilization, service mix, unit cost etc. noting any significant deviations from prior year. For programs subject to rate

review by the GMCB, include details about how the Board's decision factored into the assumptions for the ACO's budgeted trend.

OneCare generates its budgeted trend rates differently for each payer program and in alignment with the way each payer will establish the actual target. Despite best efforts to forecast 2021 targets, the impact of COVID-19 on current healthcare spending patterns may result in adjustments to the underlying payer methodology and incorporate factors to account for the expected impact of deferred disease management and/or increased demand in 2021. It is unclear at the time of the budget submission the specific changes in utilization, service mix, unit cost, etc. each payer will incorporate into their rate development. The budget also incorporates the allowable Medicare USPCC 4.35% trend rate per the Vermont All-Payer Model agreement as a critical lever to offset the cost shift and as a means to support the providers committed to, and investing in, Vermont's healthcare reform efforts.

Medicare: Trend rates are sourced from the United States Per Capita Cost (USPCC) forecast published by CMS as outlined in the All Payer Model. As such, a blended 4.35% trend was applied to a forecasted 2020 spend absent COVID-19, and adjusted for network changes, to determine the estimated 2021 benchmark.

Medicaid: Trend rates are determined by reviewing prior rate development models to determine a reasonable budget assumption to be used until Medicaid sets the actual TCOC target. Because the TCOC between 2018 and 2019 was very consistent, a low-end estimate of 1.6% annual trend factor was selected for the budget model.

BCBSVT QHP: OneCare requests input on the medical expense trend data from the payer. BCBSVT supplied a [redacted] medical expense trend, derived from the GMCB-approved rate filing, to be used in the OneCare budget development.

BCBSVT Primary: OneCare requests input on the appropriate trend data from the payer. BCBSVT supplied a preliminary [redacted] trend estimate.

MVP QHP: OneCare requests input on the medical expense trend data from the payer. MVP supplied a [redacted] medical expense trend, derived from the GMCB-approved rate filing, to be used in the OneCare budget development.

The budgeted trends for programs subject to rate review were supplied by the payers, who are in the best position to distil the approved rates down to the components applicable to the OneCare program design. During the first three years of the APM, OneCare has noted opportunities to more favorably balance public and private trend rates to create sustainability for both consumers and providers. For example, opportunities to leverage the Medicare terms in the APM to help offset the commercial cost shift and flow funds to population health investments across the continuum of care to optimize healthcare delivery and outcomes for Vermonters.

b. For each program, contrast the budgeted growth rate (Appendix 4.3, Column D) with the expected growth trend for the ACO (Appendix 4.3, Column G). Include analysis for reasons why the ACO's performance differs from the trend rates used in the budget.

Budgeted trend rates are projected from varying source data as previously described in Section 4, Q3.a. The submitted budget assumes that the expected spending is appropriately set and

aligns with the anticipated actual spending that will occur absent OneCare interventions. As a result of the pandemic, the actual 2020 PMPM spend is expected to be low relative to what OneCare anticipates the spending targets to be in 2021. Changes in the population will also impact the trend rate change between 2020 actual and 2021 budgeted levels. The actuarial process the payers undertake to set the 2021 targets will aim to capture these impacts.

c. How TCOC targets are distributed by HSA, including discussion of the extent to which providers have control over the risk for which they are responsible (please reference Appendix 4.5 to the extent applicable).

Effective in 2020, HSAs no longer receive an individual HSA TCOC target. Rather, shared savings/losses will be measured solely at the aggregate OneCare level as described in Section 2, Q3.a. This evolution directly supports the All Payer Model goal to align accountability across the healthcare system at the local and state levels. In 2021, OneCare's Population Health Management investment strategy broadens accountability and financial opportunity, enabling primary care providers to benefit from their ability to impact the TCOC growth rate.

d. Recognizing that COVID-19 has resulted in unexpected utilization trends that could continue into 2021, what assumptions are you making around fluctuating utilization estimates, or any other factors that could result in material changes to these budgeted figures and what is the anticipated impact to the proposed budget.

Many unknowns remain regarding both the current and future impacts of COVID-19 on healthcare costs. This creates a challenge for creating and accepting TCOC benchmarks. Presentations from national actuarial firms speak of variables related to a second stay-at-home wave, pent up demand, and the downstream impacts of delayed care or disease management. It is unclear at the time of the budget submission the changes each payer will incorporate into their rate development. Any significant factors incorporated into the targets will result in changed TCOC estimates, which ultimately affects aggregate risk/reward opportunity for OneCare and its provider network.

e. How these growth rates and targets support the All Payer Model goal to manage overall health care cost growth to be in line with that of the Vermont economy.

The pivotal first step in managing overall health cost growth is to transition the health system from one rewarded by volume to one that rewards cost-effective and high-quality care. OneCare's 2021 budget anticipates an additional 28,000 attributed lives in value based care programs, indicating ongoing commitment by Vermont's providers to this transition. As scale continues to grow across multiple payer programs, OneCare's value based care arrangements are increasingly dictated by trend rates set by outside parties (e.g. regulatory, public payers, employers) which need to be re-evaluated. A lack of alignment and predictability challenges providers' ability to fully transition their operations to new value based care models.

Section 5

Risk Management

Section 5: Risk Management

1. Populate **Appendix 5.1, ACO Risk by Payer, Appendix 5.2, Risk by Payer by Risk Bearing Entity** for the budget year and explain how the ACO would manage the financial liability for the risk included in the ACOs payer program agreements for the proposed budget year should the ACO's losses equal 100% of maximum downside exposure. In doing so, please discuss the following:

   OneCare contracts with its provider network to fund shared losses. If OneCare were to suffer losses equaling 100% of the downside exposure, the provider network would be invoiced to fund the payer program loss in alignment with the 2021 Program Settlement Policy. If any of the risk mitigation instruments noted below are activated, they would be utilized first before invoicing the network or accessing OneCare's risk reserves.

   See Appendices 5.1 and 5.2 enclosed.

   a. Any significant changes over prior year and the rationale for such, including changes due to COVID-19.

      In response to both COVID-19 and the desire to continue expanding program participation, OneCare budgeted significantly lower risk corridors in 2021 as described in Section 3, Q1.b. This strategy responds to the financial situation of the provider community while also retaining a reasonable level of overall accountability.

      OneCare will also implement a variable population health management payment in 2021 for risk based programs. The payment will increase based on overall financial performance, offering an additional funding opportunity to primary care on top of their FFS/FPP and additional ACO incentive revenue. This strategy broadens accountability across the network and allows provider types other than hospitals to access shared savings opportunities.

   b. If any risk is retained by the ACO or the founders, what is this risk associated with, and how much, and how is this obligation funded (reserves, collateral, other liquid security, reinsurance, payer withholds, commitment to pay at settlement etc.)?

      [redacted] In addition, OneCare entered into an arrangement with Rutland Regional Medical Center to assume half of their Medicare program risk as they enter the program for the first time. OneCare has budgeted a similar arrangement for Copley Hospital. OneCare reserves will be utilized if a risk payment is required for either of these arrangements.

   c. Does the ACO intent to purchase any third-party risk protection? If so:
      i. Explain the nature of the arrangement.
      ii. How does the anticipated protection compare to prior years?
      iii. How much of the downside risk would be covered?
      iv. Which programs would have this protection?

         After careful consideration, the OneCare budget does not include the cost of a third-party risk protection arrangement. With a narrower risk corridor, the probability of a result nearing either end of the risk corridor limit increases. This means that the

premium for a risk protection product would be much higher relative to the dollar amount of potential return. In light of this dynamic and the need to manage hospital dues, OneCare is forgoing this expense in 2021.

d. If applicable, explain the nature and magnitude of any solvency or financial guarantee requirements imposed through payer contract arrangements and how the ACO aims to satisfy those requirements.

The Medicare program requires 1% of the TCOC to be covered by a financial guarantee. OneCare intends to use a line of credit to satisfy this program requirement.

e. Explain any other risk management strategies or arrangements that affect either aggregate ACO risk or individual provider risk.

OneCare does not employ any other risk management strategies or arrangements that affect either ACO risk or individual provider risk.

2. Please complete **Appendix 5.3, Shared Savings and Losses** and **Appendix 5.4, Shared Savings and Losses by Risk Bearing Entity**, and describe the actual or expected distribution of earned shared savings or losses, in the prior year (2019), in the current year (2020) and in the proposed budget year (2021), noting any significant changes in methodology or practice over time.

The distribution of actual or expected shared savings is described in the Program Settlement Policy for each performance year. OneCare expects to distribute savings/losses via ACH or invoice, consistent with the methodology utilized in prior years.

See Appendices 5.3 and 5.4 enclosed.

3. Provide any further documentation (i.e. policies) for the ACO's management of financial risk.

OneCare's 2021 Population Health Management Policy contains the addition of a variable payment and increased accountability for attributing providers. The policy has been provided for review.

Section 6

ACO Budget

Section 6: ACO Budget

1. Complete the GMCB financial statement sheets in Adaptive, including Income Statement, Balance Sheet, and Cash Flow. Sheets in Adaptive: *A1a-Income Statement (All Accounts); A1b-Income Statement (Excl. Pass-Thru); A2-Balance Sheet; A3-Cash Flow*. Excel versions are **Appendices 6.1-6.3**, for reference. Please also fill out **Appendix 6.4, Sources and Uses** and **Appendix 6.5, Per Member Per Month Revenues by Payer**.

   See Appendices 6.1 through 6.5 enclosed. Note that OneCare is able to assign revenue sources to the population health investments, but does not maintain that type of crosswalk for the operating expenses.

2. Revenues: Please explain any line item variations greater than 10% evident on your budgeted income statement as compared to prior year projected actuals and prior year revised budget.

   Please see Table 3: Income Statement Variation below.

Table 3: Income Statement Variation

Line Item	2020B - 2021B $ Change	2020B - 2021B % Change	Explanation	2020P - 2021B $ Change	2020P - 2021B % Change	Explanation
Medicare - Claims	$ 118,847,051	23%	Addition of Rutland; inflation	$ 118,847,051	23%	Addition of Rutland; inflation
Commercial - QHP	$ 37,771,338	26%	Now showing BCBSVT at allowed amt.; inflation	$ 37,567,766	26%	Now showing BCBSVT at allowed amt.; inflation
Commercial - Self-Funded	$ 34,619,906	15%	Updates to participating health plans	$ 105,464,719	68%	Updates to participating health plans
Informatics Infrastructure Support	$ (2,800,000)	-100%	Funding stream ended	$ (2,800,000)	-100%	Funding stream ended
Hospital Dues	$ (3,290,002)	-18%	Result of overall budget changes	$ (2,694,004)	-15%	Result of overall budget changes
Blueprint Self-Management Contract	$ 861,000	100%	New initiative	$ 861,000	100%	New initiative
Deferred Dues	$ 919,715	62%	Innovation/Specialist; change in revenue recognition std.	$ 919,715	62%	Innovation/Specialist; change in revenue recognition std.

Please also explain:

a. Any significant risks associated with the budgeted revenue sources. If substantial risk exists, explain how the ACO would respond.

Due to the timing of the ACO budget development, coupled with the uncertainty created by COVID-19, ability to access federal Delivery System Reform (DSR) funding is unknown. In the absence of these funds, significant budget adjustments will be required. A careful balance of sustaining the current reform efforts with continued desire to reduce hospital dues will be required in the decision making process.

b. Budgeted contracted payer contributions to the ACO as well as any significant changes from the prior year.

The budget incorporates similar payer contributions to OneCare as in 2020 with no significant changes.

c. Budgeted provider contributions to the ACO as well as any significant changes from the prior year.

OneCare continues its efforts to reduce hospital dues, which funds the ACO's shared operational infrastructure and population health investments for primary care, home health, Area Agencies on Aging (AAA), and Designated Agencies (DAs). In 2020, OneCare revised its budget, reducing $6M in hospital dues. In 2021, OneCare has further reduced its hospital dues by $3.2M in response to recovery efforts underway related to the pandemic. It will be important to leverage the federally matched DSR dollars to bring more lives into the model while continuing funding of core population health investments such as those in primary care and care coordination.

d. Budgeted governmental/public contributions as well as any significant changes from the prior year.

The 2021 budget does not incorporate Health Information Technology (HIT) funding of $2.8M. This funding stream historically covered a portion of the costs of new technology developments that helped both OneCare and its contracted providers build their data infrastructure and capabilities. The majority of these funds covered expansion of licensed software to cover growing numbers of attributed lives as well as the highly trained technical staff needed to ingest, organize, manage, and report on the diverse data sets OneCare receives. Despite the lack of funding, providing timely and actionable data to providers remains a critical strategy for success and a central tenant of ACO programs nationally.

3. Expenditures: Please explain any line item variations greater than 10% and $100,000 evident on your budgeted income statement as compared to prior year projected actuals and prior year revised budget.

Please see Table 4: Expenditure Variation below.

Table 4: Expenditure Variation

Line Item	2020B - 2021B $ Change	2020B - 2021B % Change	Explanation	2020P - 2021B $ Change	2020P - 2021B % Change	Explanation
Payer-Paid FFS	$ 126,342,361	16%	Flows from TCOC estimates	$ 196,983,601	27%	Flows from TCOC estimates
Fixed Prospective Payments	$ 81,336,121	21%	Addition of Rutland; inflation	$ 81,336,121	21%	Addition of Rutland; inflation
Salaries and Benefits	$ 1,470,182	18%	Restoration of COVID-19 compensation cuts	$ 1,482,170	18%	Restoration of COVID-19 compensation cuts
Contracted Services	$ (583,563)	-38%	Limiting to essential contracts	$ (292,062)	-24%	Limiting to essential contracts
Supplies	$ 133,879	69%	Self-management mobile monitoring technology	$ 208,897	174%	Remote work outcome
Occupancy	$ 111,272	26%	Lease expense increase in April 2021	$ 92,596	21%	Lease expense increase in April 2021
Other	$ 159,641	28%	GMCB bill back increase	$ 149,790	26%	GMCB bill back increase
Basic OneCare PMPM	$ 1,274,139	15%	Attribution increase	$ 916,783	10%	Attribution increase
Complex Care Coordination Program	$ (2,396,654)	-25%	Refining program for 2021	$ (2,396,858)	-25%	Refining program for 2021
Value-Based Incentive Fund - Total	$ (3,640,553)	-65%	Moving quality components to settlement	$ (3,566,458)	-64%	Moving quality components to settlement
Primary Prevention	$ 410,000	76%	Self-Management expenses	$ 410,000	76%	Self-Management expenses
Specialist Program	$ (689,023)	-91%	No new initiatives in 2021	$ (689,023)	-91%	No new initiatives in 2021
Innovation Fund	$ (486,201)	-67%	No new initiatives in 2021	$ (486,201)	-67%	No new initiatives in 2021

Please also explain:

a. Any significant changes to the population health programs and/or care model, including temporary or permanent changes due to COVID-19, and the budgeted impact on expenses.

Significant changes to the 2021 population health programs and care model are designed to enhance the sustainability of reform and support the financial health of the provider community through the COVID-19 pandemic. The following changes related to the pandemic allow OneCare to focus its efforts on programs that support long term success of the model and reduce overall healthcare costs.

Population Health Management Payments: As described in Section 2, Q1., the PHM payments to primary care will be variable based on program performance. This broadens financial opportunity to all types of primary care practices and aligns Vermont's success under the All Payer Model with providers' success in OneCare programs.

Care Coordination: The Care Coordination program is maintaining the same financial model in 2021. Foci for next year include: working to refine identification of special high risk populations to prioritize for outreach (e.g. high ED utilizers, individuals with multiple chronic conditions); conducting quality assurance monitoring to assure fidelity to the model; advancing knowledge of best practices in care management; and establishing protocols to ensure that individuals who have either completed their care management goals or are no longer engaged are discharged from the program. These advancements aim to ensure that the care coordination investments have the opportunity to yield favorable results under value-based contracts.

Value Based Incentive Fund (VBIF): OneCare will shift the timing of VBIF payments from program settlement (approximately 18 months post performance year start) to a distributive model that facilitates funds flow throughout the performance year to align with focused quality initiatives as set by the Population Health Strategy Committee. Additionally, as a means of ensuring long-term sustainability, the budget model also aims to move some of the program quality accountability factors to settlement (i.e. quality will affect shared savings/losses)

Innovation Fund: In recognition of the costs associated with this fund and the need to support the financial circumstances of participating providers largely brought about by COVID-19, OneCare will not fund new innovation projects in 2021. Despite no new investments, all prior commitments will be fulfilled.

Specialist Fund: While OneCare recognizes the value that specialists contribute to reform efforts, related to the aforementioned factors, the 2021 budget does not include new specialty fund investments. Despite no new investments, all prior commitments will be fulfilled.

Blueprint Self-Management: OneCare and Blueprint leadership and stakeholders engaged in a year-long process to evaluate and redesign the self-management programming, taking the opportunity to align focus areas with APM goals. Blueprint asked OneCare to assume leadership for this work moving forward and OneCare has budgeted to take on this initiative beginning in January 2021. The reimagined program will align primary and secondary prevention activities in local HSAs through on-the-ground staffing and access to advanced technologies and self-management support tools to provide options for patient engagement that recognize lifestyle

and personal preferences. This effort will also allow upstream foci on pre-diabetes and pre-hypertension. The alignment of the RiseVT and self-management programs has created fiscal efficiencies realized in the 2021 budget.

Blueprint: The 2021 OneCare budget includes level-funding of the Medicare Patient Centered Medical Home payments, Community Health Team payments, and Support and Services at Home (SASH) payments. With a narrower Medicare risk corridor, this strategy aims to ensure adequate financial incentives remain for the provider network to continue to invest in population health management activities central to APM goals.

b. How this budget is affected by any significant changes to clinical and quality priorities for the year.

OneCare remains focused on key utilization, cost, and quality priorities in alignment with the APM goals. As described in Section 7, Q2.b., OneCare works through its governance committees to review performance data and set specific clinical and quality priorities. For 2021, OneCare anticipates a tight set of measures to inform VBIF financial incentives and TCOC performance rewards in alignment with our 2021 policies (i.e. Program Settlement, VBIF). The budget does not anticipate any adjustments specifically driven by changes to clinical and quality priorities; however, the mechanisms through which financial incentives are provided has been refined for 2021 (described in the immediately preceding question).

c. Any changes, including significant new investments to the ACO's infrastructure and the budgeted impact on expenses.

There are no significant new investments planned for 2021.

d. If applicable, how Delivery System Reform funds are being utilized in the proposed budget.

DSR dollars are incorporated into the budget to fund care coordination program infrastructure within OneCare in consideration of CMS-approved application practices. This is in alignment with our overall strategy to ensure sustainability of the care coordination program after DSR funding ends.

e. Whether and how this budget supports the maintenance or improvement of the ACO's health information technology system and the drivers of these investments (provider feedback, payer contract etc.).

While the absence of HIT funding significantly affects the overall budget model, OneCare remains committed to providing actionable data to its network participants. Since access to data and advanced analytic competencies are essential to the performance of ACO activities, OneCare spends a majority of its operating budget providing network support including analytics, clinical, and quality-related functions. Providers continue to request more analytical perspectives to inform their strategies to succeed in value-based care contracts.

4. If the budget includes a gain or a loss, please provide a rationale. Otherwise please explain how to balance to a break-even budget (surplus to reserves etc.).

The 2021 budget is break-even. Hospital dues are used as the variable to generate the balanced budget result.

5. Balance Sheet: Please explain any variations greater than 10% and $100,000 evident on your budgeted balance sheet as compared to prior year projected actuals and prior year budget and provide an analysis of the ACO's solvency, providing metrics that you use and noting any areas of concern.

   OneCare's balance sheet is subject to significant volatility due to the timing of settlements, All Inclusive Population Based Payment (AIPBP) reconciliations, fixed payment receipts, and Value Based Incentive Fund payouts. The way in which balance sheet health is monitored is by tracking equity. At any given point in time, the assets should be in relative balance with liabilities, leaving only modest company valuation remaining. For example, if there is a liability for the AIPBP reconciliation booked, there should be an offsetting receivable from participating providers. As long as these two offset, the net equity balance remains in the appropriate range. Because of the above, maintaining equity in rough alignment with reserves plus a modest margin to accommodate timing issues is the way in which balance sheet health is evaluated. At present, there are no concerns to note.

   Please see Table 5: Balance Sheet Variation below.

Table 5: Balance Sheet Variation

Line Item	2020B - 2021B $ Change	2020B - 2021B % Change	Explanation	2020P - 2021B $ Change	2020P - 2021B % Change	Explanation
Cash & Investments	$ (7,086,412)	-27%	Spend down of deferred; lower Due to Related	$ (5,094,214)	-21%	Spend down of deferred; lower Due to Related
Accounts Receivable	$ (1,874,885)	-49%	No HIT receivable	$ (33,386,035)	-94%	No HIT receivable; No AIPBP recon budgeted
Deferred Revenue	$ (175,715)	-15%	Timing of Innovation/Spec. spending	$ (2,474,036)	-71%	Spend down of deferred
Due to Related Parties	$ (591,074)	-14%	Ordinary timing of expense reimbursements	$ 102,558	3%	Inflationary estimate on expenses
Accounts Payable	$ (6,269,189)	-28%	Lower VBIF payable	$ (4,131,623)	-20%	Lower VBIF payable
Accounts Payable - Settlement w/ Payers	$ -	0%	n/a	$ (31,986,035)	-100%	No AIPBP recon budgeted
Retained Earnings	$ (1,843,465)	-31%	No gain anticipated	$ -	0%	n/a

6. Cash Flow: Please explain any variations greater than 10% and $100,000 evident on your budgeted cash flow statement as compared to prior year projected actuals and prior year budget and provide an analysis of the ACO's current cash position, as well as expectations for the upcoming budget year, noting any potential timing challenges. Please explain the use of any revolvers or other debt used to mitigate cash flow challenges.

   Much like volatility to the balance sheet, cash is also subject to regular variation. However, timing of payouts for programs like the Value Based Incentive Fund have offered OneCare some cash flexibility and allowed for advanced payments of population health investments during the stay-at-home period when provider revenues were at their lowest. The primary risk relating to cash is a timing issue. Should a payer fail to make a fixed payment on time, OneCare would not have the volume of cash reserves necessary to make the ordinary payment to providers. If such an event were to occur, OneCare would have to prioritize which payments could be made until the payer fixed payment arrived. Outside of a potential timing issues relating to cash inflows, there are neither current nor anticipated cash concerns to note. OneCare also has a line of credit for the purposes of satisfying the Medicare financial guarantee requirement. This line is not structured to be used for operational purposes.

   Please see Table 6: Cash Flow Variation below.

Table 6: Cash Flow Variation

Line Item	2020B - 2021B $ Change	2020B - 2021B % Change	Explanation	2020P - 2021B $ Change	2020P - 2021B % Change	Explanation
Depreciation/Amortization	$ 8,888	100%	New asset	$ (3,681)	-29%	Annual depreciation
(Increase)/Decrease A/R	$ 30,540,048	1073%	Medicare AIPBP recon	$ 41,218,179	-526%	Medicare AIPBP recon
(Increase)/Decrease Other Changes	$ (37,740,817)	5043%	Medicare AIPBP recon	$ (50,539,027)	-419%	Medicare AIPBP recon
Repayment	$ -	0%	n/a	$ 4,124,849	-100%	Closeout of UVMHN loan

7. Complete **Appendix 6.6, Hospital ACO Participation** for the proposed budget year.

   See Appendix 6.6 enclosed.

8. Please complete **Appendix 6.7, ACO Management Compensation** with the following:
   1. A list of all the ACO's current officers, directors and trustees, regardless of whether any compensation was paid to such individuals.
   2. List all positions with gross compensation (the equivalent of Box 5 on a W-2) greater than or equal to $150,000.
   3. List all leadership positions (VP, all C-Suite, including Chief Compliance Officer) with gross compensation (the equivalent of Box 5 on a W-2) greater than $100,000.

   See Appendix 6.7 enclosed.

9. Please provide details for any expected capital expenditures over the next three years.

   At this time, OneCare has no planned capital expenditures for the next three years.

Section 7

ACO Quality, Population Health, Model of Care, and Community Integration

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

1. *Model of Care*. Please briefly explain your statewide model of care and any significant changes made in the current year or anticipated for the proposed budget year. In doing so, please include explanation for the following:

    a. Progress to date on implementing your model of care, including any quantitative evidence. Please note any lessons learned.

    Progress to date regarding OneCare's implementation of the care model is incorporated into the response for 1.b. below.

    b. Any goals or objectives associated with your model of care for the proposed budget year and your strategy for their achievement.

    OneCare's population health model recognizes each individual's unique health needs and aligns programming and supports through our provider network and local communities. OneCare's four quadrant care model segments the population into Vermonter's who are healthy/well; have early onset or stable chronic conditions; have full onset chronic illness and rising risk; or have complex and/or high cost acute catastrophic conditions. The care model is supported by strong relationships between primary care providers and their patients to support appropriate identification of their health status and associated services and supports. OneCare continues to encourage care delivery transformation and supports a diverse portfolio of solutions to improve care outcomes and address ways to reduce healthcare costs under the Total Cost of Care (TCOC). OneCare's programs include population level strategies to protect and improve health outcomes within the four quadrant care model. These programs include:

    Quadrant One: Healthy and Well Vermonters (44% of the population)
    OneCare implements primary prevention programs to maintain health through preventive care and community-based wellness activities. Preventive care includes wellness exams, immunizations, health screenings, social determinants of health screenings, and community programming through RiseVT. In 2020, OneCare continues to promote high-quality screening in the medical home, including proactive panel management to identify individuals missing these health assessments to connect them to these services.

    Research[1] shows that up to 80% of our health is determined by social and environmental factors that occur outside the boundaries of a traditional healthcare settings. RiseVT is OneCare's community-based, primary prevention program to support Vermonters on a path to lifelong wellness. RiseVT works to change systems, local policies, and infrastructure to support Vermonters' health and wellness within identified communities. Over the last two years, the RiseVT model has spread to nine HSAs serving 113,631 Vermonters. Local RiseVT program managers are actively working on 53 projects that focus on a variety of wellness strategies including better access to local recreation, school wellness policies, and mindfulness as an emotional regulation strategy for children and families. This work involves significant engagement with state partners such as the VDH, schools, and local nonprofit organizations. Since 2018, RiseVT has awarded $338,428 in "Amplify Grants" to advance local wellness

[1] https://www.countyhealthrankings.org/explore-health-rankings/measures-data-sources/county-health-rankings-model

initiatives in 36 communities. In the COVID-19 landscape RiseVT has continued to offer virtual programming with statewide campaigns to support community health and wellness. Behavior change campaigns that started in March 2020 saw an average of 300 registrants per initiative with each initiative lasting at least 30 days.

Developmental Understanding and Legal Collaboration for Everyone (DULCE) is an intervention that takes place within a pediatric care office to address social determinants of health in infants, birth to six months, and provides support for their parents. A Family Specialist, trained in child development from the local Parent Child Center, attends the well child visits with families and medical providers. Together with the DULCE team, consisting of nurses, legal help, and pediatricians, the Family Specialist helps connect families with support systems to address the health disparities that often affect low income families, families of color, and immigrants in particular. In 2020, OneCare has continued to fund DULCE at four pediatric practices: Timber Lane Pediatrics in Milton, Timber Lane Pediatrics in South Burlington, Mount Ascutney Hospital and Health Center in Windsor, and the Ottauquechee Health Center in Woodstock. From January to June 2020, 73% of well child visits at DULCE sites were attended by a family specialist from the local Parent Child Center to assist families with resources such as buying food and finding housing.

Quadrant Two: Vermonters with Early Onset/Stable Chronic Conditions (40% of the population)
In close partnership with the Blueprint and VDH, OneCare's providers work to optimize health and self-management of chronic disease. Throughout 2020, OneCare has engaged in an intensive planning process with the Blueprint and VDH to create a new model of delivering self-management programs to Vermonters who have or are at-risk for hypertension and type 2 diabetes. The result of this process which included local stakeholder engagement, focus groups, and literature reviews in partnership with the VDH, is a plan to transfer Blueprint's diabetes and hypertension programs to OneCare starting in January 2021. The new programs will include online course offerings through the Vermont Health Learn platform delivered in partnership with the VDH. OneCare will also deploy strategies to better identify the population who can benefit from the course offerings and outreach directly to them and their providers. The new program will deploy a new mobile monitoring program for enrollees as well as additional wrap around support locally from an aligned RiseVT and self-management team. OneCare's goal with these new programs is to significantly increase the number of Vermonters with pre-diabetes, diabetes, pre-hypertension, and hypertension who take these programs and make improvements in their conditions.

Quadrant Three: Vermonters with Full Onset Chronic Illness and Rising Risk (10% of the population), and Quadrant Four: Vermonters with Complex/High Cost Acute Catastrophic Conditions (6% of the population)
OneCare's community team-based complex care coordination program provides a framework, training, and funding to engage high risk individuals in supports and services to improve their health status and enhance their experience of care. The vision is "to provide high-quality, person-centered, community-based care coordination services in an integrated delivery system to achieve optimal health outcomes." OneCare has made significant advancements to achieve this vision in 2020 and plans to continue to evolve the program from ongoing learnings that best support the needs of high risk Vermonters.

In 2020, OneCare implemented a new payment model designed with input from the ACO provider network that shifts payments from a capacity model to a value-based model with higher rate payments for implementation and documentation of key care coordination

interventions. See Table 7 below for a list of the payments. This model was originally scheduled for implementation in April 2020 as soon as payer data were available; however, it was postponed to July 2020 as a result of the onset of the pandemic. To ensure a smooth transition, OneCare paid providers that would have earned a higher complex care coordination payment under the new model at that higher rate to ensure they were not negatively impacted. In addition, OneCare paid two months of advanced care coordination payments in an effort to support primary care providers' cash flow needs during the public health emergency.

Table 7: 2020 Supplemental Care Coordination Payments

Care Coordination Role/Intervention	Value Based Payment
Lead Care Coordinator	$80 PMPM
Care Team Member	$60 PMPM
Care Conference: Lead Care Coordinator	$300 PMPY
Care Conference: Care Team Member	$150 PMPY

In 2020, OneCare's goal is to achieve an all payer blended care managed rate of 15% of high and very high-risk lives (16% of Medicare and Medicaid, 3% of commercial populations). Care Managed is defined as the presence of a lead care coordinator and a shared care plan with updated goals and tasks. Progress towards this care coordination target steadily increased in 2020 and as of September, OneCare has met the goal of achieving an all payer blended 15% care managed rate with 4,178 individuals actively care managed.

An advancement in the care coordination program in 2020 was the addition of the Longitudinal Care Program. This program supports in-home services provided to Vermonters with chronic disease, a recent hospitalization, and barriers to self-management, who do not otherwise qualify for home health services due to a skilled need. This innovation was originally tested in the Burlington health service area and resulted in a savings of $1,150 PMPM, 26% in inpatient admissions, and 20% in emergency room utilization. OneCare is spreading this innovation to six additional health service areas through their local Visiting Nurse Association (VNA) to evaluate if this model is as effective in other areas and can be sustained through cost savings to the system.

OneCare expanded its investment in mental health services to include a new $500,000 investment to expand mental health access to services in the emergency department (ED) through navigation and follow-up. Three Designated Agencies (DA) have collaborated with their local hospital teams to embed linkage coordinators within EDs to facilitate timely referrals for individuals who present with mental health concerns. Each organization tracks metrics including, but not limited to individuals seen, referred, and readmitted to the ED within 30 days. They also track alignment with Zero Suicide initiatives. One DA noted that this data review process has highlighted a greater need for mental health referrals, which will allow them to have a greater impact community wide. The DA also reported an increased use of Care Navigator as a result of the initiative.

A lesson learned in implementing the care model, given various levels of care coordinator turnover throughout the network, has been the importance of ongoing care coordination skill training to ensure consistent, high quality care coordination. During 2020, OneCare has conducted care coordination education sessions covering topics such as Pre-Meeting Planning for an Effective Care Team Conference, Facilitating an Effective Care Team Conference, OneCare's Social Risk Score: How to use it for Population Health Management, Words Matter: Using Person Centered Language, and Partnering with VCCI in Service to the Medicaid Expanded

Population. The sessions are also made available on the Vermont Health Learn e-learning platform for care coordinators to access at their convenience. In addition, OneCare hosted a Commission for Case Management Certification (CCMC, https://ccmcertification.org/) workshop and certification opportunity for 83 care coordinators throughout the state in fall 2020. This will position local care management certified experts within each health service area throughout the state who are equipped with high quality nationally recognized training to best serve vulnerable Vermonters. The effort has a dual impact of improving the overall quality of care coordination in each health service area (HSA) and also providing professional development opportunities to support workforce satisfaction and retention.

In 2021, OneCare's care coordination goals include: continuing to provide ongoing educational opportunities; focusing efforts on high-risk sub-populations including those with high emergency department utilization and inpatient readmissions; creating care pathways with impact measurement; developing/refining graduation protocols; and further evaluating a return on investment of care coordination interventions.

c. The evidence base for any changes made since the current year and how you intend to measure progress, including any quantitative measures, reporting, and analysis.

RiseVT and DULCE are OneCare's primary prevention programs which will continue to implement robust measurement to evaluate the programs' efficacy and impact. RiseVT will continue to measure the number of projects implemented in communities against the CDC's 24 strategies to reduce overweight and obesity as well as conduct local key informant interview on program impacts. RiseVT will also utilize the Community Programs and Policies Intensity Score (CPPI) as a standard metric to evaluate its multi-sector efforts and correlated reductions in childhood obesity over time. Family Specialists within the DULCE program will collect data on patient visits and referrals to social services including mental health, legal, and housing support.

In 2021, OneCare will assume the current Blueprint self-management program offerings for diabetes and hypertension as a strategy for secondary prevention. The new program strategy includes a patient prioritization application in WorkBenchOne™ to direct people who may benefit from the new programs. The tool will help track outreach and referrals to the program. Pre and post participant surveys will track behavior condition change for program participants.

The care coordination program will evolve in 2021 to a greater focus on care coordination and quality outcomes for key subpopulations within the high and very high-risk cohorts, for example, those individuals with high emergency room utilization. This evolution is supported by a robust set of metrics to track progress toward goals. OneCare will continue to monitor the care coordination program through:

- process metrics (e.g. care team initiated, care team created, lead care coordinator assigned, care plan initiated and other initial engagement activities) available to the network in self-service tools updated nightly, monthly performance reports at the HSA level, and through ad-hoc reporting as needed.
- quality assurance monitoring (e.g. caseloads, care team composition, encounter tracking) by OneCare's care coordination staff using a new internal tool. Staff then engage with providers to clarify expectations, refine workflows, and supports their effective implantation of the care coordination program.
- outcomes evaluation (e.g. emergency room utilization, hospital readmissions, preventive care, SNF length of stay, healthcare expenditures) to assess the overall

return on investment of the program with respect to health status, utilization of services, and cost of care.

d. The ACO's role in implementing this model of care as compared to other relevant stakeholders, including how the ACO collaborates with the Blueprint for Health and continues to ensure non-redundant services and investments, that are in coordination with, and not in contradiction to, state objectives (e.g. All Payer Model, Department of Mental Health's Ten Year Plan, State Health Improvement Plan).

OneCare's role in implementing the care model is that of a leader and facilitator of coordinated efforts amongst care teams, healthcare organizations, communities, and state agencies. OneCare provides the framework, training, tools, data, outcomes reporting, and in many cases, financial support to execute the care model. Collaboration is represented in many venues and joint initiatives as follows:

- OneCare and Blueprint leaders and team members connect regularly to explore strategies to coordinate efforts toward mutual priorities. OneCare and Blueprint co-plan and facilitate a quarterly half-day All Field Team meeting attended by Blueprint staff and contractors, Community Health Team (CHT) Leads, OneCare, Agency of Human Services (AHS) Field Directors, and VDH District Directors. Topics covered in 2020 have included care coordination and review of community profiles.
- The Blueprint, VDH, and OneCare staff collaborate in support of local HSA Community Collaboratives ("Accountable Community for Health"). Intra-agency collaboration allowed health service areas (HSAs) to leverage their Accountable Communities for Health to support broad community needs throughout the pandemic.
- OneCare staff collaborate with Blueprint Practice Facilitators to offer quality improvement support and expertise to the Patient-Centered Medical Home (PCMH) practices in each HSA as they address focus areas and process improvement projects. This partnership creates efficiencies by identifying alignment between the ACO quality measures and the National Committee for Quality Assurance (NCQA) requirements and developing work plans for meeting benchmark goals and expectations.
- As described elsewhere in this document, OneCare and Blueprint are working to transition the Blueprint self-management program fully to OneCare beginning January 2021. This redesign process has facilitated tighter alignment under APM goals and more options for individuals to engage in self-management training and support.
- OneCare participated in the cross agency development of the Department of Mental Health's "Vision 2030: A 10-Year Plan for an Integrated and Holistic System of Care."
- OneCare developed and now hosts the Vermont Health Learn (VTHL), an online learning system in collaboration with the Blueprint, VDH, SASH, and other partners. OneCare has expanded education offerings to remote settings in support of the needs of providers and partners. This has enabled users to have the flexibility to take courses and view content at their convenience. It has also created additional efficiency in receiving and understanding network information and updates. Currently, the 1,172 users of the system range from healthcare administrators, health practitioners, ACO network participants, to the general public in Vermont.
- The Asthma and COPD Learning Collaborative, initiated in September 2020, is a collaborative project organized by OneCare, VDH, Blueprint, SASH, BCBSVT and Bi-State Primary Care Association. It is a nine month quality improvement initiative with sixteen participating teams from around the state representing primary care, pediatrics, specialty practices, home health and congregate housing organizations. It is offered

through virtual, online sessions in Vermont Health Learn (VTHL) conducted by subject matter experts followed by questions and answers. The goal is to improve care of individuals with Asthma or COPD including strategies to reduce environmental triggers, improve medication use, increase chronic condition management plans, and, ultimately, to demonstrate improved asthma or COPD control.

- OneCare supported primary care engagement throughout the COVID-19 public health emergency by compiling and regularly educating network participants and primary care providers on evolving telehealth regulations and waivers, including advocating for Vermont payers to reimburse provider visits conducted via telehealth (including telephone only visits) commensurate with in-person office evaluation and maintenance codes, thereby allowing those Vermonters who lack adequate broadband and/or cell coverage to receive necessary care during the stay-at-home order. OneCare has since surveyed its network providers to garner feedback regarding telehealth use, provider and patient challenges, and plans for post-pandemic telehealth practice. OneCare continues to collaborate with multiple stakeholders including Vermont Program for Quality in Healthcare, Bi-State Primary Care Association, Howard Center, University of Vermont Medical Center, VT Medical Society, Agency of Human Services (AHS), BCBSVT, and DVHA through a statewide telehealth workgroup.
- OneCare collaborated with VDH, Vermont Child Health Improvement Program (VCHIP), and local community pediatricians through the formation of a workgroup to examine strategies to refine the care coordination program to better meet the needs of children and families. The result of these discussions was the implementation of a new way to risk stratify OneCare's attributed populations in 2020 – first segmenting each program by children (0-18 years old) and adults (over 18 years) and then conducting the risk stratification. This segmentation has improved awareness of high-risk children and adolescents for pediatric care team members.

As demonstrated by the aforementioned examples, OneCare is highly committed to cross agency collaboration in an effort to ensure non-redundant services and achieve common goals, objectives, and priorities.

2. *Quality Improvement and Clinical Priorities.* Please complete **Appendix 7.1, ACO Clinical Priorities** and describe your quality improvement framework and your theory of change, including your clinical priorities for the proposed budget year. In doing so, please include an explanation for the following:

OneCare's quality improvement program is based on *The Model for Improvement*[2] and the work of W. Edwards Deming, creator of the Plan-Do-Study-Act (PDSA) cycle of learning[3]. *The Model for Improvement* asks three guiding questions:

- What are we trying to accomplish? (the aim statement)
- How will we know the change is an improvement? (the measures); and
- What changes can we make that will result in improvement? (the changes or interventions)

The answers to these three questions then guide the exploration learning process, in small-scale, rapid tests of change.

[2] Langley GL, Nolan KM, Nolan TW, et al. The improvement guide: a practical approach to enhancing organizational performance. San Francisco: Jossey-Bass; 1996

[3] Deming WE. The new economics for industry, government, education. Cambridge: Massachusetts Institute of Technology; 1994

OneCare then applies a series of core principles to the identification, implementation, and evaluation of change efforts conducted by providers and their organizations, including:

- Defining and aligning quality measures across payers and in support of the population health goals of the All Payer Model; ensuring they are clinically relevant and meaningful and provide opportunities to improve care and/or health outcomes;
- Identifying and communicating quality gaps and clinical priorities to those most able to impact the needed change;
- Using data to guide decision-making and drive change;
- Identifying best practice interventions and disseminate them broadly;
- Using local/regional champions where possible to create the urgency for the need to change;
- Aligning OneCare and Blueprint priorities and resources where possible to eliminate duplication and streamline focus areas for clinicians; and
- Providing financial incentives to support change processes and recognize performance.

Every year, OneCare develops a quality work plan which includes:

- quality assurance activities focused on auditing of internal data collection systems and personnel;
- performance measurement activities around the annual collection of quality measurement data; and
- performance improvement activities supporting the development and continuous improvement of a provider-driven, integrated healthcare delivery system.

OneCare's Clinical Quality Advisory Committee helps to prioritize projects aimed at patient populations. The Pediatric Subcommittee meets to select strategies and projects designed to improve the health of children in Vermont.

OneCare's 2019 quality performance results were recently released. Highlights include:

- 95% quality score for the Medicaid program, including statistically significant improvements in:
    - 30 Day Follow-Up after Discharge from the ED for Alcohol and Other Drug Abuse or Dependence
    - Developmental Screening in the First 3 Years of Life
    - Diabetes Mellitus: Hemoglobin A1C Poor Control (>9%)
    - Engagement of Alcohol and Other Drug Abuse or Dependence Treatment
- 81% quality score for BCBSVT QHP program, including statistically significant improvements in:
    - Hypertension: Controlling High Blood Pressure
    - Diabetes Mellitus: Hemoglobin A1C Poor Control (>9%)
- 91.88% quality score for Medicare, including improvements in:
    - Influenza Immunizations
    - Tobacco Use: Screening and Cessation Intervention
    - Colorectal Cancer Screening
    - Hypertension: Controlling High Blood Pressure
    - Screening for Clinical Depression and Follow-Up

See Appendix 7.1 enclosed.

a. Progress to date and quantitative or qualitative evidence at the ACO, and local (HSA) levels, including an evaluation and the supporting data for the following, over the last three years (2018, 2019, 2020), by HSA:
    1. Variations in care;

OneCare tracks and reports monthly on clinical priority areas at the ACO and HSA levels. Table 8 below provides a summary of achievements of established goals for improvement in these clinical priority areas as well as noting where opportunities remain. Overall, OneCare's network made significant progress in reducing emergency department utilization and inpatient admissions for high and very high risk individuals in both years. More work is needed in addressing ambulatory sensitive conditions including COPD, CHF, and Asthma.

Table 8. Summary of Clinical Priority Area Results for 2018 and 2019

Measure	Goal/ Target	2018			2019		
		Medicare	Medicaid	Commercial QHP	Medicare	Medicaid	Commercial QHP
Acute inpatient admission rate for high and very high risk cohorts	5% ↓	Met	Met	Met	Met	Met	Met
Emergency department utilization rate for high and very high risk cohorts	5% ↓	Not Met	Met	Met	Met	Met	Met
Skilled Nursing Facility RUG Score-Adjusted Length of Stay in Medicare	5% ↓	Met	N/A	N/A			
Ambulatory Sensitive Condition Admissions for COPD in Medicare	5% ↓	Met	N/A	N/A	Not Met	N/A	N/A
Ambulatory Sensitive Condition Admissions for Heart Failure in Medicare	5% ↓	Met	N/A	N/A	Not Met	N/A	N/A
Care Coordination of Identified High Risk Population	15% care managed				Not Met	Not Met	Not Met
Ambulatory Sensitive Conditions: Emergency department visits for asthma for pediatric patients with asthma	5% ↓				N/A	Not Met	Not Met

Table 8. Summary of Clinical Priority Area Results for 2018 and 2019 (continued)

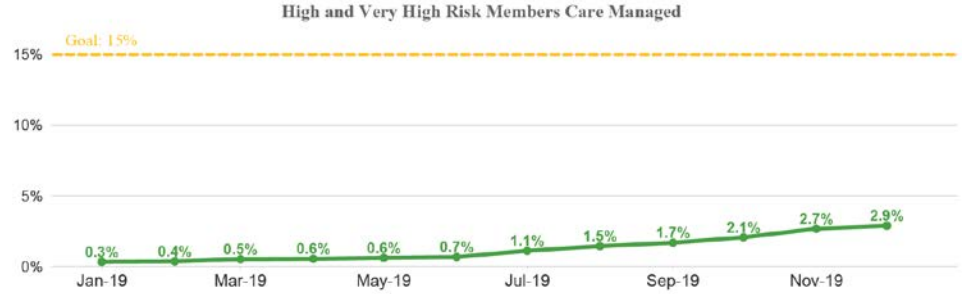
Measure	Goal/ Target	2018			2019		
		Medicare	Medicaid	Commercial QHP	Medicare	Medicaid	Commercial QHP
Ambulatory Sensitive Conditions: Emergency department visits for asthma for adult patients with asthma	5% ↓				Not Met	Not Met	Met
Patients with diabetes with A1C performed within 12 months	5% ↑				Not Met	Met	Not Met
Medicare patients with an annual wellness visit within 12 months	10% ↑				Not Met	N/A	N/A
Medicaid and Commercial (BCBSVT QHP) patients with an adolescent well-care visit within 12 months	10% ↑				N/A	Not Met	Not Met
Medicaid and Commercial (BCBSVT QHP) patients with developmental screening	10% ↑				N/A	Met	Met

In 2019, OneCare set a very aggressive goal of achieving a payer blended 15% care managed rate, knowing the baseline was <1%. In 12 months, providers achieved 11.6% for Medicare, 14.5% for Medicaid and 2.9% for BCBSVT QHP (see Graphs 1, 2, and 3 below). OneCare continued efforts into 2020 and, as reported elsewhere in this document, has achieved this goal.

Graph 1: Care Coordination of Identified Medicare High Risk Population

Graph 2: Care Coordination of Identified Medicaid High Risk Population

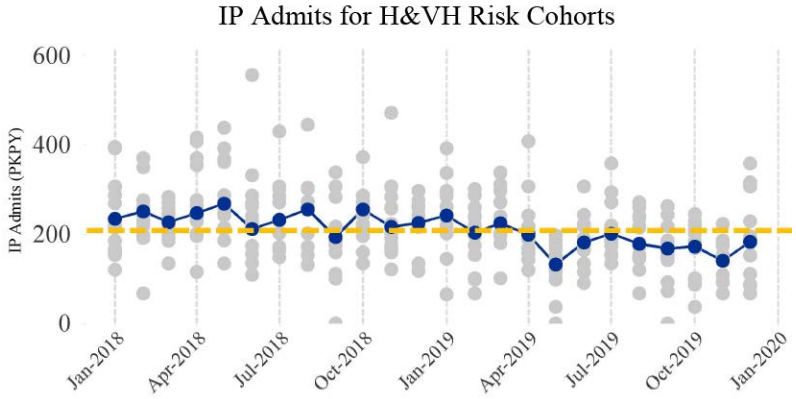
Graph 3: Care Coordination of Identified Commercial QHP High Risk Population



In 2019, OneCare began creating clinical priority area run charts displaying HSA-level variation. See Graphs 4 & 5 below for an example of Medicaid inpatient admissions (4) and emergency department utilization (5) reductions in the high and very high risk cohort. One challenge of doing so is the small numbers associated with some communities create unstable estimates. For example, in the BCBSVT QHP program, measuring emergency department utilization for pediatric patients with Asthma provided very unstable estimates on a month-to-month basis due to the low volume of occurrences (See Graph 6 below).

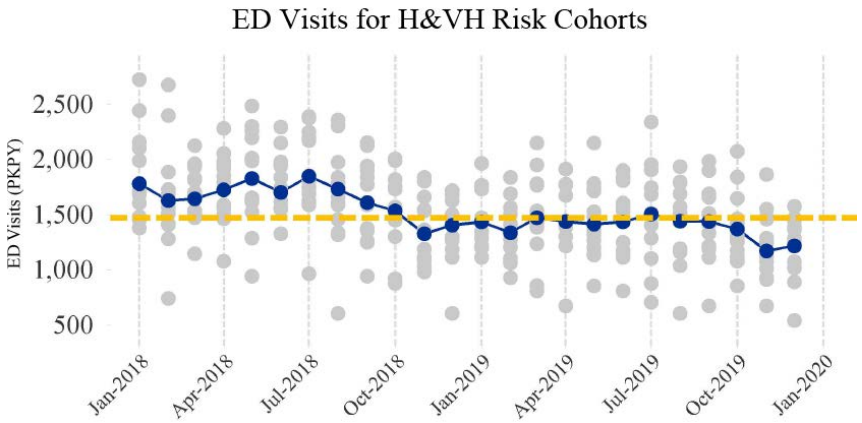
Graph 4: Example of Acute Inpatient Admission rate for Medicaid 2019 high and very high risk cohort

The blue line represents the OneCare network's overall progress towards the goal represented by the gold dashed line. The gray dots represent the individual HSAs to demonstrate variation across the OneCare network. The goal to reduce inpatient admissions for the high and very high risk cohorts by 5% in 2019 was achieved.



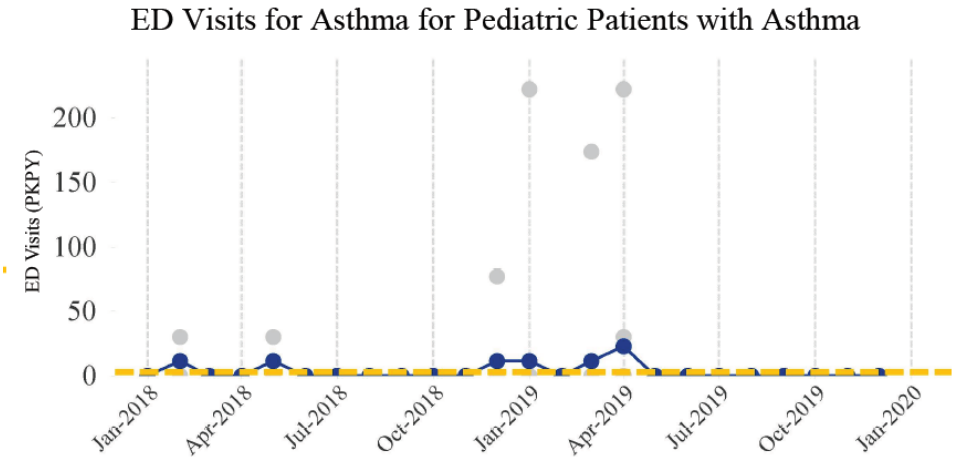
Graph 5: Emergency Department Utilization rate for Medicaid high and very high risk cohort

The goal to reduce ED visits for the high and very high risk cohorts by 5% in 2019 was achieved for the Medicaid program.



Graph 6: Ambulatory Sensitive Conditions: Emergency Department Visits for Asthma for BCBSVT QHP Pediatric Patients with Asthma

The goal to reduce emergency department visits for asthma for pediatric patients with asthma in the Medicaid and BCBSVT QHP programs by 5% in 2019 was not achieved, likely due to small number variation.



In 2019, the goal to increase annual hemoglobin A1C testing for individuals with diabetes by 5% was exceeded in Medicaid program, rising from 83.7% to 89.2%. While the goal was not fully realized for the Medicare and BCBSVT QHP programs, they did see improvement of 3.0% and 2.5% respectively. In response to this priority, one HSA consistently showed low rates of annual hemoglobin A1C tests among their patients with diabetes through claims data, as identified by the clinical priority on the OneCare's standard monthly reporting package. OneCare brought this information to the HSA's attention and worked with the HSA to identify the root cause of the problem. Through this collaborative effort along with the annual quality abstraction process, it was identified that the individuals with diabetes in this HSA were, in fact, receiving the tests

and that there was an opportunity for more uniform documentation of the service to allow for better tracking and coordination of care.

Of note, 2020 data are not provided in this analysis due to ongoing delays from payers in receipt of data due to the pandemic and other operational challenges they are experiencing.

2. Most prevalent chronic conditions;

OneCare reports on the top prevalent conditions by HSA and payer program on a monthly basis to the OneCare network participants, and in some cases payers. The top prevalent conditions affecting the 2020 patient population have been identified with Johns Hopkins ACG algorithm using historical claims data from April 2019 to March 2020, paid through June 2020. Data for each payer are provided in ***Exhibit A to Section 7: Most Prevalent Conditions Tables by Payer***, and briefly summarized below, excluding BCBSVT Primary and MVP QHP as data are not yet available and thus OneCare cannot provide similar reporting.

Medicare: Hypertension is the top prevalent condition for all HSAs, affecting the Medicare population with an overall prevalence of 56.3%. While the prevalent condition ranking differs slightly among the HSAs, all eight HSAs participating in the Medicare program have disorders of lipid metabolism and cataract aphakia ranked among the top five conditions, and seven out of eight HSAs have coronary artery disease ranked among the top prevalent conditions.

BCBSVT QHP: Hypertension is the top prevalent condition for six of the ten HSAs participating in the BCBSVT QHP program, acute upper respiratory tract infection is the top prevalent condition for three HSAs and disorders of lipid metabolism is the top prevalent condition for the remaining HSA. While the prevalent condition rankings differ among HSAs, all ten HSAs have hypertension among the top five conditions, and nine out of ten HSAs have acute upper respiratory tract infection and anxiety ranked among the top prevalent conditions.

Medicaid (Traditional): Acute upper respiratory tract infection is the top prevalent condition for all HSAs affecting the Medicaid traditional population with an overall prevalence of 27.3%. All HSAs have at least two mental health conditions ranking among the top five prevalent conditions for their population with anxiety as the most common.

Medicaid (Expanded): Acute upper respiratory tract infection is the top prevalent condition for the Medicaid expanded population as a whole, affecting 12.3% of the population. All HSAs represented in the Medicaid expanded program have anxiety and depression and/or adjustment disorder ranked among the top five prevalent conditions.

3. Most prevalent high cost conditions; and

Exhibit B to Section 7: Most Prevalent High Cost Conditions Tables by Payer details the top prevalent conditions for the high cost patient population. Individuals are identified as high cost if they incurred $15,000 or more in claims expense in the last 12 months. Summary data for each payer is provided below, excluding BCBSVT Primary and MVP QHP as data are not yet available and thus OneCare cannot provide similar reporting.

Medicare High Cost Patients (6,764 individuals): Hypertension is the top prevalent condition for all HSAs, affecting the high cost Medicare population with an overall prevalence of 73.7%. The second most prevalent condition for all the HSAs is coronary artery disease, affecting 59.1% of the high cost Medicare population and the third most prevalent condition for seven of the eight HSAs is disorders of lipid metabolism, affecting 48.6% of the high cost Medicare population.

BCBSVT QHP High Cost Patients (1,376 individuals): Hypertension is the top prevalent condition for all HSAs, affecting the high cost BCBSVT QHP population with an overall prevalence of 32.8%. While the prevalent condition rankings differs among the HSAs, seven HSAs ranked disorders of lipid metabolism among their top five prevalent conditions, five HSAs ranked obesity among their top five prevalent conditions and five HSAs ranked anxiety or depression among their top five prevalent conditions.

Medicaid (Traditional) High Cost Patients (3,516 individuals): Anxiety is the top prevalent condition for the high cost Medicaid (Traditional) population with an overall prevalence of 35.1%. With the exception of Springfield, all HSAs ranked a mental health disorder as the top prevalent condition for their high cost population.

Medicaid (Expanded) High Cost Patients (771 individuals): Developmental disorder is the top prevalent condition for the high cost Medicaid (Expanded) population with an overall prevalence of 32.0%. The majority of the top prevalent conditions among all HSAs are mental health related including anxiety, depression, attention deficit disorder, schizophrenia and affective psychosis, and adjustment disorder.

4. Variations in outcomes.

Exhibit C to Section 7: HSA Cost and Utilization Variation Tables by Payer highlights variation in key cost and utilization metrics across the OneCare network for services included in the financial risk model. This includes Variation Analysis reports for 2018, 2019 and Q1 2020 for Medicare (Tables 19, 20 and 21), Medicaid (Tables 25, 26, 27 and 28) and BCBSVT QHP (Tables 22, 23 and 24) programs. The lowest two data points in each metric are highlighted in blue. The highest two data points in each metric are highlighted in yellow. Note HSA labels are varied, thus HSA "A" cannot be compared across tables.

Overall, HSAs that exhibited a higher than average FFS equivalent spend PMPM, also had a higher than average inpatient spend PMPM driven by higher utilization of inpatient and higher specialty visit PMPM driven by higher utilization of specialty care visits. While other cost and utilization categories may be the key cost driver for a particular HSA, there was not a pattern exhibited network wide.

b. Method for establishing the clinical priorities for the proposed budget year at the ACO and local (HSA) levels.

The process for selecting clinical priority areas remains consistent from year to year. OneCare's Chief Medical Officer (CMO) leads the process in collaboration with the Clinical and Quality Advisory Committee (CQAC). CQAC is comprised of OneCare's Regional Clinical Representatives (RCRs) and other clinical and quality representation from across Vermont and the care continuum. OneCare's CMO will lead CQAC through the selection process in the fourth quarter

of 2020 and the first quarter of 2021 to allow for 2020 claims run out. The final results of the 2020 clinical priority area progress will be reviewed in CQAC and new goals selected for the measures that will continue into 2021. When identifying the 2021 clinical priorities, OneCare will suggest measures that are clinically important, represent areas of opportunity for improvement, and can be monitored on a monthly basis with available data. Once the clinical priority areas are selected and rates set, CQAC votes to adopt them. The final step is to present the clinical priority areas to the OneCare Population Health Strategy Committee for endorsement and review by the Board of Managers.

The same methods described above align with OneCare's changes to the quality incentive pool for 2021. The VBIF includes dollars set aside by OneCare during the performance year to incentivize and reward the network for delivering high quality care. The funds are allocated as part of OneCare's annual budget as approved by the OneCare Board of Managers. The funds are earned by participants when meeting set quality criteria established annually by the Population Health Strategy Committee. The quality criteria will represent areas of opportunity for improvement, and can be monitored on a monthly basis with available data. The VBIF will be distributed during the performance year in accordance with the plan established by the Population Health Strategy Committee and communicated in advance of the performance year to participants.

Aligning methods between programs ensures a consistent and understandable set of criteria and streamlines operational requirements. Furthermore, these aligned methods reduce administrative burden for participating providers and are aimed to increase provider satisfaction, while also ensuring funding streams come at the right time to recognize their efforts.

c. How does the ACO support HSAs in driving change? How is data used to drive change? Is there an accountability or incentive structure for driving change? If so, how does it work?

OneCare uses cost, utilization, and quality measures to assess performance and identify opportunities to improve both across the ACO as well as to identify variations in care. OneCare provides education, training, dating collection and reporting, and offers virtual learning sessions through the Vermont Health Learn platform for all clinical and claims-based quality measures. OneCare receives annual payer scorecards that outline ACO performance in claims, clinical and survey measures. The scorecards are shared with internal and external partners to drive performance improvement activities within our communities that are provider-led. OneCare's accountability structure is through overall ACO performance on risk based contracts and performance monitoring and alignment of quality and financial incentives through the VBIF, described elsewhere in this document.

OneCare has expanded its efforts to strengthen relationships between data experts in network organizations and OneCare's analytics team. These connections support ongoing data literacy, self-paced data training through the OneCare Data Corner available on the Vermont Health Learn platform, standard reporting packages, increased utilization of self-service applications in WorkbenchOne™, and direct support from the OneCare analytics team through ad hoc data requests. The OneCare analytics team supports the data needs of the network by providing critical expertise necessary to evaluate multiple data sources to uncover insights that can lead to positive change and improved performance. These insights are shared through methods

described above as well as through regular meetings and discussions at local steering committees.

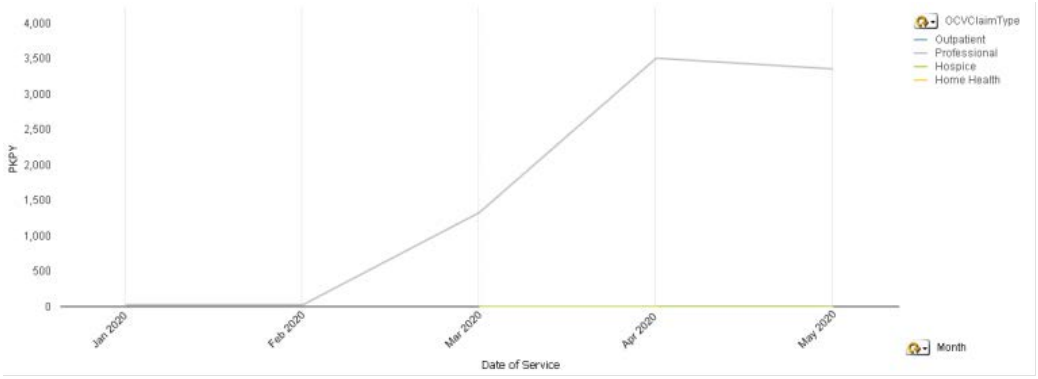
OneCare collaborates with Blueprint practice facilitators to align quality measure focus areas for primary care practices. OneCare also works in collaboration with the Blueprint, BCBSVT, Bi-State, VDH and SASH to provide topic focused learning collaboratives that help peers learn from each other and apply quality improvement techniques with the goal of improving in a focused area of their work. These learning collaboratives bring in subject-matter experts who provide participants the latest evidence-based best practices to try in their own work environments.

d. Please discuss your quality program in the context of COVID-19. Do you believe any additional metrics should be tracked due to COVID-19?

Vermont's provider community has always been committed to providing quality care, outcomes, and supporting health reform efforts. This continues to be true during the public health emergency as providers are very concerned about the health and well-being of each individual they serve, especially those most vulnerable. Providers are building on years of quality improvement experience to solidify and enhance workflows and outreach efforts to reduce the risk of complications related to COVID-19. This focus has shifted some preventive care visits, which will likely be reflected in reduced rates in the corresponding preventative measures. Such areas of active quality improvement include chronic disease management, access to mental health supports, and primary prevention. OneCare has helped to support these quality improvement goals by messaging to Vermonters the importance of following precautions and not delaying physical and mental health.

During the ongoing public health emergency, providers in the OneCare network have delivered consistent, high quality care. When in-person visits were not possible, providers continued to connect with individuals through any means allowed, including telephone and web-based visits. OneCare is tracking the use of telehealth codes in a self-service application that updates as new data are available, see Table 9 below. For Medicare, an increase over 13.1 PKPY was observed for from January 2020 through May 2020. The trend is increasing telehealth through April 2020, with only a slight decrease in May as more practices began to re-open for onsite visits.

Table 9: 2020 Network Telehealth Usage



Further, OneCare assisted providers in identifying those at highest risk of serious illness using guidance from the Centers for Disease Control and Prevention, World Health Organization, and Johns Hopkins University. The COVID-19 Patient Prioritization Application was deployed to the network in April 2020 to support providers in their efforts to continue to care for high risk

individuals during the global pandemic. This tool identifies those patients most at risk of contracting or having negative impacts from COVID-19 by accessing condition and utilization information for those individuals. Providers are able to outreach to high risk individuals to help them manage their chronic conditions and to assure they can receive their prescriptions in order to remain safe in an uncertain time. This tool can be regularly accessed by participants to gain understanding about their patient panel and support outreach as the pandemic continues. The application continues to be updated as high risk criteria are released or updated. Recent changes to the application have included the addition of clinical data on individuals tested for COVID-19 and additional risk fields as more data is available from national experts, such as the addition of race data when available. Lastly, the tool is able to identify individuals with social determinants of health and who may experience food access challenges or social isolation. Through August 2020 this tool has been accessed by more than 80 unique users with over 220 total hours spent using the tool.

3. *Population Health and Payment Reform*. Please complete **Appendix 7.2, Population Health and Payment Reform Details** and explain your strategy for making investments in population health and developing payment reform programs across the continuum of care, including reference to the following:

    a) Progress to date, including quantitative or qualitative evidence at the ACO, and local (HSA) levels.
    b) Methods for establishing new or continued investment in such initiatives/programs.
    c) Measures and methods used to track progress and identify challenges and opportunities.
    d) Whether and how is there an accountability or incentive structure to drive change?

    OneCare's population health management investments are intended to facilitate care delivery transformation supported by unique payment reforms as well as opportunities for innovation and incentives that encourage the transition to value. Each investment is evaluated for its ongoing alignment with ACO strategy, its ability to drive performance, its impact, and its ongoing affordability. As part of a learning system, adjustments and refinements are made regularly in response to network feedback, evaluation data, or other factors to improve the success of the population health program or investment strategy. Table 10 below lists OneCare's population health management investments along with progress to date; methods for establishing new and continued investment; measures and methods used to track progress and identify challenges and opportunities; and whether and how there is accountability or incentives to drive change.

    See Appendix 7.2 enclosed.

Table 10: OneCare Population Health Investments

Investment	Progress to date, including quantitative or qualitative evidence at the ACO and local (HSA) levels	Methods for establishing new or continued investment	Measures and methods used to track progress and identify challenges and opportunities	Whether and how is there an accountability or incentive structure to drive change
Base OneCare PMPM	This population health investment was first implemented in 2017 for Medicaid lives in four health service areas: Burlington, Berlin, Middlebury, and St. Albans for ~29,100 attributed lives. As the model has matured and spread across payer programs, attributed lives have increased. This investment has facilitated scale, serving as an incentive for primary care providers to join OneCare and/or expand their payer program participation. Quantitative growth of this investment by year as demonstrated by the increase in attributed lives: • 2017: 29,100 attributed lives • 2018: 112,000 attributed lives • 2019: 160,000 attributed lives • 2020: 275,000 attributed lives	Sustainability of this population health investment is dependent on continued investment from payer partners and hospitals willingness to contribute to meet funding needs. In 2021, the focus is on spreading provider accountability and financial reward beyond risk-bearing entities; this is achieved by transitioning to a variable payment for risk bearing contracts. For risk-bearing programs the base PMPM will vary from $1.75-$4.75 based on performance. For non-risk contracts it will remain $3.25 PMPM.	Measurable outcomes are number of HSAs participating, number of primary care TINs, number of primary care providers, number of attributed lives. Feedback is gathered through a primary care workgroup of the Population Health Strategy Committee	Research indicates that an increased investment into primary care leads to reduced costs, increased patient satisfaction, reduced ED visits, and improved care coordination[4]. From 2017 to 2020 providers were not required to demonstrate any impacts to cost or quality to receive this payment. In 2021, a variable payment structure is being implemented for risk-based contracts to align accountability and facilitate system-level performance.

[4] https://www.pcpcc.org/primary-care-investment

Table 10: OneCare Population Health Investments (continued)

Investment	Progress to date, including quantitative or qualitative evidence at the ACO and local (HSA) levels	Methods for establishing new or continued investment	Measures and methods used to track progress and identify challenges and opportunities	Whether and how is there an accountability or incentive structure to drive change
Complex Care Coordination Program	Similar to the base OneCare PMPM, this investment began in 2017. From 2017 through June of 2020 OneCare provided capacity payments to primary care practices and continuum of care partners (i.e. AAA, HHA, DAs) based on their anticipated care coordination engagement rates. As the program has matured, this investment has proven to grow adoption of the clinical model and attract additional network participants. In 2020, 142 primary care practices & FQHCs, 10 HHA, 11 DAs, and five AAAs received funding for engagement. Additional details on changes to the payment model can be found in the care coordination section.	Sustainability of this investment is dependent on continued investment from payers, hospitals, and Delivery System Reform dollars. Favorable outcomes from the model help to ensure continued support.	OneCare has an established process, quality assurance monitoring and outcomes measures described previously and referenced in Section 7, Q1.c. of this document.	In July 2020, OneCare implemented a new value based payment model that pays for care management activities. Organizations receive payment for engaging with an individual's care team or participating in a care team conference. OneCare noted significant increases in care management engagement rates as the planned program conversion date neared.

Table 10: OneCare Population Health Investments (continued)

Investment	Progress to date, including quantitative or qualitative evidence at the ACO and local (HSA) levels	Methods for establishing new or continued investment	Measures and methods used to track progress and identify challenges and opportunities	Whether and how is there an accountability or incentive structure to drive change
Value-Based Incentive Fund	In 2020, this population health investment is scaled across all 14 participating health service areas for the following payer programs; MVP QHP, BCBSVT QHP, BCBSVT Primary, and Medicaid. Funding is distributed per policy with the preponderance (70%) to primary care to align with their impact on the payer's quality measures.	Sustainability of this investment is dependent on continued investment from hospitals and negotiation of terms with payers. Improved quality measure performance will ensure continued investment.	The measureable outcomes are number of HSAs participating, number of attributed lives, number of measures in the 75th percentile, number of measures in the 90th percentile, overall quality score by payer and VBIF dollars earned.	Distribution is dependent on the final scorecard for each payer contract. A challenge to the current model is that the financial reward comes 18+ months after the performance year begins. Providers have shared this time lag is a disincentive. Thus in 2021, OneCare is working to change the way the VBIF is funded, to include a fixed pre-funded VBIF in OneCare's operating budget to provide timely incentives for performance improvement and quality adjustment upon settlement of payer contracts. This strategy is still under negotiation with payers.

Table 10: OneCare Population Health Investments (continued)

Investment	Progress to date, including quantitative or qualitative evidence at the ACO and local (HSA) levels	Methods for establishing new or continued investment	Measures and methods used to track progress and identify challenges and opportunities	Whether and how is there an accountability or incentive structure to drive change
Primary Prevention Programs	This population health investment includes three programs: RiseVT, DULCE, and self-management. RiseVT programs are now available in nine participating health service areas inclusive of 36 towns. 143 Amplify Grants have been distributed in RiseVT communities across the state. Each funded initiative ties into at least one of the CDC's 24 Strategies to Prevent Overweight & Obesity. DULCE is an intervention that takes place within a pediatric care office to address social determinants of health in infants zero to six months, and provides social and legal support for their parents. New self-management programs are designed to provide access to diabetes prevention, diabetes self-management, and hypertension programs for all Vermonters. The program will also offer mobile technology to support health maintenance and targeted provider outreach.	Sustainability of this investment is dependent on continued investment from hospitals.	Measurable outcomes: RiseVT: number of HSA participating, number served by the program, number hospitals with a program manager, number of campaigns launched, and number of amplify grants distributed. RiseVT measures intensity of each initiative using an evidence-based "dose" calculation based on the Community Programs and Policy Index (CPPI) which provides standardized measurement for multi-sector community health efforts over time. DULCE: percentage of well child visit, families offered DULCE services, and percentage of individuals screened and referred. Self-management: number of participants engaged, number of completers of the programs, and provide outcomes data from an evidence-based lifestyle management program using mobile technology.	"Amplify Grant" results are tracked using the 24 CDC strategies for overweight and obesity prevention. DULCE program participants are offered direct support for up to six months with the Family Specialist in their practice. New self-management programs will offer a free subscription to a health tracking app as a pilot program to supplement diabetes and hypertension course offerings.

Table 10: OneCare Population Health Investments (continued)

Investment	Progress to date, including quantitative or qualitative evidence at the ACO and local (HSA) levels	Methods for establishing new or continued investment	Measures and methods used to track progress and identify challenges and opportunities	Whether and how is there an accountability or incentive structure to drive change
Comprehensive Payment Reform (CPR) Program	The CPR program provides participating independent primary care with a predictable reimbursement model and added financial resources that allow for clinical flexibility and innovation. The program began in 2018 with three participating primary care organizations with six practice sites. In 2019, participation grew to nine organizations with 12 practice sites: four organizations in the traditional CPR model and five in the new partial capitation model. In 2020, OneCare offered only the full capitation model and grew full participation to seven organizations with 10 practice sites; two organizations were entirely new to the program and two increased their participation from partial capitation in the prior year. In 2021 this will grow to eleven organizations, with 17 practice sites	Sustainability of this investment is dependent on continued investment from hospitals and availability of a fixed payment option from payers.	Measurable outcomes are number of independent primary care TINs participating, number of HSAs participating, number of attributed lives, number of patients care managed, number of patients who positively meet quality measures, percent of patients with primary care engagement.	OneCare works with providers to refine this program annually. For example, in 2020, OneCare enhanced the PMPM payment by an additional 15% variable component tied to performance. In 2021, OneCare is providing a $5 PMPM supplemental payment and practices will be eligible for care coordination and quality payments on top of their CPR fixed payment.

Table 10: OneCare Population Health Investments (continued)

Investment	Progress to date, including quantitative or qualitative evidence at the ACO and local (HSA) levels	Methods for establishing new or continued investment	Measures and methods used to track progress and identify challenges and opportunities	Whether and how is there an accountability or incentive structure to drive change
Specialist Program	OneCare continues to fund previously approved projects in the areas of chronic kidney disease (CKD) and mental health. Both investments were launched in 2020 and will be evaluated per the metrics in their contracts. With this funding, three DAs currently have active projects ongoing in hospital EDs. The CKD program is centered at one pilot hospital because the preponderance of attributed lives with end stage renal disease and/or CKD have care delivered from specialists in this area. If successful, there are opportunities to spread this model to other hospitals.	While OneCare recognizes the value that specialists contribute to reform efforts, the 2021 budget does not include new specialty fund investments. Despite no new investments, all prior commitments will be fulfilled.	Mental health: number of individuals who present to the ED with mental health and substance use treatment issues, number of individuals referred, number of people engaged, and the number who visit the ED for the initial reason of their first referral within a 12 month period. CKD: reductions in total cost of care for participating attributed lives, reduction in avoidable emergency department utilization, number of patients served, number of patients engaged in care coordination, number of patients care managed, and percent patients with primary care engagement.	The implementation of both programs was delayed due to the COVID-19 pandemic. They will be tracked through metrics aligned in each contract.

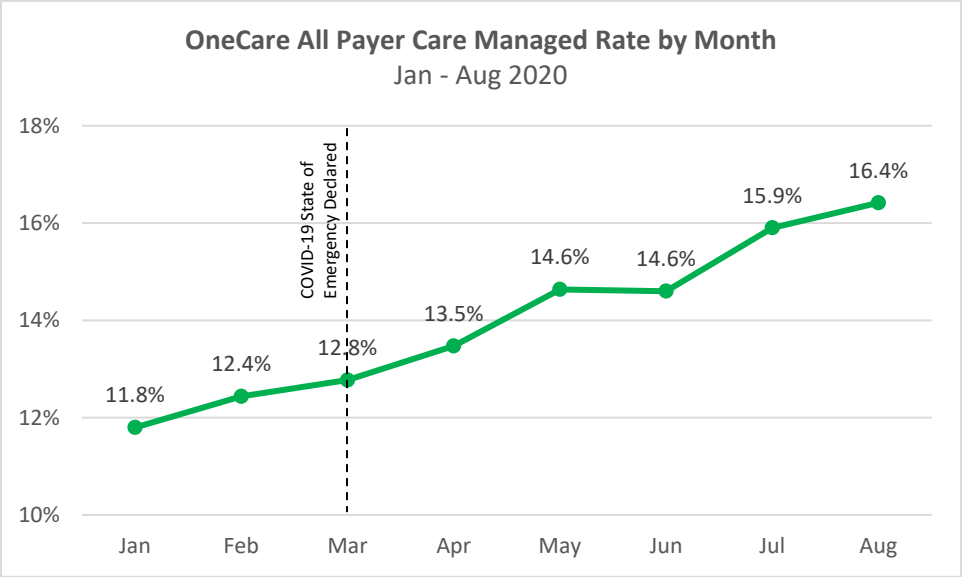
4. *Care Coordination and Care Navigator*. Please complete **Appendices 7.3, 7.4**, and **7.5** for the proposed budget year and explain any opportunities or challenges you have experienced in your continued implementation of care coordination and the use of Care Navigator. In doing so, please discuss the following:

   The COVID-19 pandemic created both a challenge and an opportunity related to implementation of the care coordination model and documentation within Care Navigator. The challenge was that some organizations had to furlough and/or redeploy care coordinators to other roles and shift their attention to efforts focused directly on COVID-19. The opportunity was OneCare's creation of an innovative analytics tool, the COVID-19 Patient Prioritization Application, to aid clinicians and care teams in identifying individuals most at risk for complications associated with COVID-19. The application has been used by practices to conduct care and concern calls, conduct a scripted interaction to assess/address unmet care needs, identify medication renewal needs, reinforce social distancing recommendations, inventory available social supports for emergency needs planning, and identify the need for telephone or video visit(s). Network participants reported that this application was of great benefit to the practices and patients. In addition, OneCare leveraged Care Navigator, a collaboration and communication tool, to further respond to the pandemic to facilitate cross-organizational coordination and collaboration specific to care and support for individuals at risk for complications related to COVID-19.

   As demonstrated by data compiled within Appendix 7.4, Care Navigator users span multiple organizations including hospital, primary care, area agencies on aging, DAs, home health and hospice, and SASH. An opportunity exists to expand on the depth or numbers of users per organization in certain health service areas and to engage DAs as Care Navigator users. Though many organizations shifted attention to the pandemic, key HSA leaders are currently refocusing on care coordination in new and invigorated ways. Many are seeking guidance and reconvening cross-organizational forums to align care coordination efforts and further engage within the new payment model. A specific example of increased engagement relates to care coordination education attendance. OneCare experienced exceptionally high attendance, 87-130 participants each, in four care coordination education sessions conducted in June 2020, indicating strong network engagement in care coordination efforts. Based on these successful early signs of response to the new payment model, OneCare anticipates a positive trajectory of care team membership, care managed rates and care conferences conducted through 2020 and into 2021.

   Of significance to the sustainability of the care coordination model throughout the pandemic, it is helpful to measure the rate of care managed individuals. Graph 7 below demonstrates the continued focus on care coordination before and during the pandemic. As illustrated, the rates of care managed individuals, care team membership and care conferences have increased month over month.

Graph 7: OneCare All Payer Care Managed Rate by Month



Progress toward this care coordination target steadily increased in 2020 and as of September, OneCare has met the goal of achieving an all payer blended 15% care managed rate with 4,178 individuals care managed.

See Appendices 7.3, 7.4, and 7.5 enclosed.

a. An update on your Care Coordination Effectiveness and Outcomes Analysis Framework using data.

To understand the impact its care coordination investments, OneCare has implemented methods to evaluate care coordination interventions on patient engagement and utilization.

Evaluation of Patient Engagement

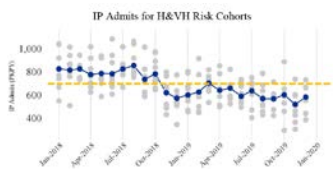
To analyze the impact of care coordination interventions on the patient engagement level, a pre and post methodology is used to compare key performance indicators including utilization of services 12 months before intervention to the six months after intervention. A significant amount of time after intervention is needed to perform this type of evaluation, but early indicators demonstrate increases in engagement in the cohorts who receive the care coordination intervention. Overall, OneCare has identified that 96% of the care-managed population is engaged with a primary care provider year-over-year across payer populations.

Evaluation of Utilization for High and Very High Risk Populations

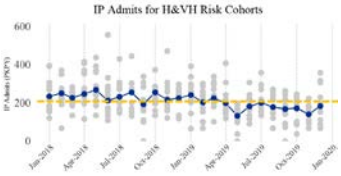
OneCare tracks utilization for the high and very high risk populations to identify the impact of care coordination effectiveness and outcomes. As demonstrated in Graph 8 and Graph 9 below, OneCare has identified a decline in both ED utilization and inpatient admissions for the high and very high risk population across the Medicare, Medicaid and BCBSVT QHP programs.

Graph 8: Acute inpatient admission rate for high and very high risk cohorts in 2019

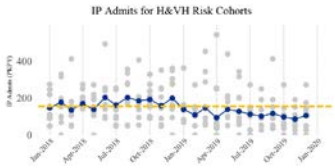
Medicare:



Medicaid:

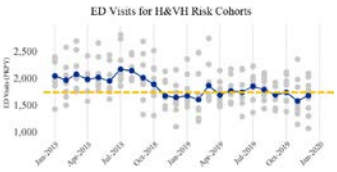


BCBSVT QHP:

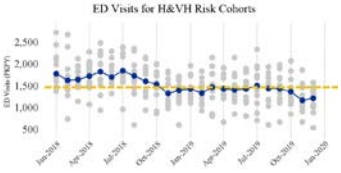


Graph 9: Emergency department utilization rate for high and very high risk cohorts in 2019

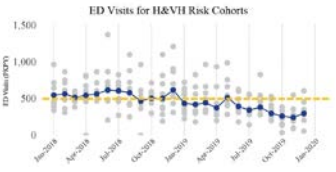
Medicare:



Medicaid:



BCBSVT QHP:



Individual Success Story

The individual is a middle-aged male with numerous complex, chronic needs and accompanying financial and transportation constraints that prevented him from managing his health at many levels, including inability to afford dentures that assure proper nutrition and access primary care when his conditions exacerbated. This resulted in many trips to the ED for health needs that could have been managed through coordinated care. OneCare's care coordination model provided the structure and support for the development of a cross-organizational care team that built a trusting relationship with him, coordinated his care, and addressed his social determinants of heath challenges. The individual now attends follow-up appointments for management of his chronic health conditions and reports any signs and symptoms of disease exacerbation to his primary care provider immediately. He went from not communicating at all with the primary care practice and letting medical issues flare, to reaching out regularly, trusting that his team will try everything possible to help him no matter the issue. As a result, his ED visits went from 10 visits during the 12 months prior to care coordination intervention to zero during the six months following intervention. His PMPM cost during these same intervals was reduced by 98% from approximately $24,500 to $450 and his risk level decreased from very high risk in 2019 to medium risk in 2020.

b. An overview of your risk stratification methodology, and rationale for its selection/continued use, among others.

OneCare uses the John Hopkins Adjusted Clinical Grouper (ACG) algorithm to assign a risk score based on the 12 months of claims data prior to the contract year for each member. The score predicts the cost of the service for that member in the coming 12 months. Risk scores are calculated separately for each payer program and for the pediatric and adult age groups and then assigned one of four risk levels: the top 6% are very high risk, the next 10% are high risk, the next 40% are medium risk and the lowest 44% are low risk. Separation of the pediatric population (0-18 year olds) from the adult population (over 18) was initiated in 2020 based on feedback from the pediatric workgroup. The rationale was that the pediatric high and very high risk population may be underrepresented in the top 16% when blended with adults who have more robust claims histories. This separation has increased awareness of high risk children and adolescents for care team members.

It is important to recognize that a claims-based risk stratification algorithm is an important tool to aid in the identification and prioritization of individuals for outreach, and that it is most effective when combined with timely, proximate knowledge of each individual's clinical and social needs. OneCare's new care coordination payment model recognizes this distinction and provides payment for individuals whose clinician or care team member identifies the individual as at increased risk due to a circumstance not identified by the risk algorithm. The reason for the change in risk category is noted in Care Navigator by a care team member and tracked by OneCare. Thus a low or medium risk individuals at the beginning of the year can experience new episodes of illness that require care coordination.

c. How is the ACO incorporating provider and patient input on the use of these software tools? Please share any relevant lessons learned.

In preparation for changes to the care coordination payment model, OneCare convened a stakeholder group with diverse expertise in care coordination to review the 2020 payment model expectations and make recommendations in support of implementation of the value-based payments. This process resulted in a system design change to add a new care team conference section to Care Navigator. This new section both guides care team members through a care conference and ensures that key elements of care conferences are met and made visible to teams. This visibility supports individuals and their families by ensuring that all care team members are aware of patient centered goals and tasks. Elements of this new section include fields for patient invitation, addition of non-ACO members to care teams, a shared care plan update section, automated care team notifications triggered by completion of care team conference, and the means by which to track and schedule care team conferences.

In addition to receiving input that drives changes to Care Navigator, OneCare gathers broad input from providers and their representatives from across the network through the Care Coordination Core Team meetings and regular presence at regional Accountable Community for Health and Community Collaboratives. A formal survey to network care coordinators is planned in fall 2020 seeking additional feedback on the care coordination model, meeting forums (including the Care Coordination Core Team meeting), and aforementioned updates to Care Navigator. If gaps in knowledge are identified through this survey, OneCare will coordinate outreach and education activities to address them.

OneCare incorporates patient feedback through regular discussions with the Patient and Family Advisory Committee (PFAC). This group provides important insights and set priorities to inform software adoption and advancements. In 2020, the PFAC expressed strong support for the ongoing growth and expansion of the care coordination model to meet the needs of individuals and families with complex needs. Additionally, the Committee has provided valuable feedback regarding their experiences with telehealth during the pandemic.

With respect to WorkBenchOne™, providers share feedback and ideas for enhancements to reporting and self-service tools through governance committees, output from training sessions, monthly user group sessions, and informal discussions with clinical and analytics staff in the field. As a result of this feedback, OneCare has developed several new applications in 2020 and has significantly refined and improved the monthly ACO and HSA-level standard reports. OneCare has also initiated a Performance Dashboard Companion Application, which allows hospitals to explore more deeply cost and utilization variation at the HSA, organization, practice and provider levels.

d. How does the ACO's care coordination align with other payer care coordination programs?

OneCare aligns with each of its payer care coordination programs by creating mutually reinforcing contractual elements for care coordination and service delivery across payers that, together, drive network-wide alignment and integration. OneCare and payers work collaboratively to align strengths, share best practices, and successfully transition ongoing care coordination supports to local care teams. OneCare staff meet regularly with Medicaid and commercial payer analytics, quality, and care management teams to facilitate patient hand-offs, ensure appropriate coordination of care, and discuss advancements in care management.

For example, OneCare and DVHA Vermont Chronic Care Initiative (VCCI) staff are working closely in 2020 to implement an expanded attribution initiative, which scales statewide a 2019 pilot program conducted by the St. Johnsbury HSA. This program engages individuals insured by Medicaid who have not had a primary care relationship during the past several years (and thus are not eligible to be traditionally attributed to the ACO model). VCCI staff provide short-term, holistic, intensive case management to Vermonters who are new to Medicaid and may therefore may have relationships with this expanded attribution population. OneCare and VCCI are aligning efforts to avoid duplication and ensure a smooth transition between VCCI and OneCare network care coordinators. The OneCare care coordination team, in partnership with VCCI, offers technical assistance, education, and training in support of HSA communities to connect these beneficiaries to a patient-centered medical home by increasing access to primary care.

e. How is the ACO expanding access and usage of care navigator to non-participating providers?

OneCare has expanded Care Navigator access in 2020 to contracted payers, such as VCCI staff, to help facilitate effective transitions of care. OneCare is in ongoing conversations with the AHS around opportunities to link healthcare providers and human services staff in support of person-centered team-based care. OneCare evaluated access to Care Navigator for non-participating providers and support organizations such as school nurses. This review included a privacy analysis focused on HIPAA, 42CFR Part 2, and FERPA regulations. OneCare's legal and compliance teams identified significant barriers in each of these aspects and discussions are ongoing to consider future opportunities.

5. *Integration of Social Services*. Please explain how the ACO integrates or facilitates the integration of healthcare and social services.

OneCare continues to deepen collaborations with and facilitate integration of healthcare and social services. OneCare engaged relevant stakeholders in its process to evaluate its care coordination payment model and developed an inclusive payment structure that moved from capacity-building to value-based payments that recognize an individual's preference for the person to serve as their lead care coordinator – cementing the concept of a diverse, community-wide team working together to support the identification and attainment of patient goals. Further, at the request of pediatric serving care team members, OneCare examined the tools used for risk stratification and the method to conduct it. As a result, in 2020, OneCare began segmenting each payer population by age (pediatric/adult) before applying the algorithm. Further, social determinants of health data were integrated into Care Navigator and new fields created to identify diverse care team members outside of OneCare's current payment model. These steps enhance human service participation and integration into care teams and, as their use grows, will help inform OneCare's prioritization of other key human services partners to deepen

engagement. OneCare continues to explore the legal and compliance frameworks necessary to share data and information across health and human services providers in support of person-centered care.

As described in detail in the GMCB Report on Integration of Social Services Act 52[5], OneCare continues to support a variety of community-level programs that support increased integration between health and human services through its innovation fund. In addition to these ongoing projects, in 2020, OneCare funded three DAs to embed mental health staff in local emergency departments to help identify preventable visits and connect individuals to needed community services and supports.

In addition, through the *Advancing Integrated Models* (AIM) grant from the Robert Wood Johnson Foundation, OneCare and the AHS are continuing to build a data and systems-driven collaboration to develop the legal and operational pathways to integrate social needs data within OneCare that will enhance the risk stratification process. This will allow providers to better identify individuals that could benefit from enhanced services and supports, reduce duplication and enhance individual's experience of care, and align and integrate health and human services supports in local communities.

6. *Childhood Adversity*. How is the ACO providing incentives for preventing and addressing the impacts of adverse childhood experiences and other traumas? Please identify any significant changes in this work over prior year.

Childhood trauma has a tremendous impact on future health and opportunity for children. It is linked to many chronic health problems including mental illness and substance misuse in adulthood. Toxic stress experienced in childhood is also connected to a wide range of chronic illnesses including cancer, diabetes, heart disease, and suicide. In order to better identify potential presence of childhood adversity, OneCare evolved its care coordination program for 2020 in response to pediatric provider feedback. First, clinical judgement can be used to justify care coordination and receive care coordination payments for high risk individuals classified as low or medium risk via the Johns Hopkins ACG risk stratification. This was requested and acted upon in consideration of the information that providers are aware of specific to social determinant of health issues that impact children and families that are not captured through the Johns Hopkins claims based risk stratification method. Second, as described in Section 7, Q5., the pediatric population (0-18 year olds) are separated from adults (over 18) in the risk stratification process to facilitate improved identification of children at risk for adverse outcomes.

In 2020, OneCare continues to fund the DULCE model in four pediatric practices statewide to proactively address social determinants of health, reduce family stress, and promote the healthy development of infants by providing social and legal support to their parents during the critical first six months of life. Through DULCE, a Family Specialist trained in child development from the local Parent Child Center attends well child visits with families and medical providers. Together with the DULCE team, consisting of nurses, legal help, and pediatricians, the Family Specialist is able to help connect families with support systems to address the health disparities that often affect low-income families, families of color, and immigrants in particular. Of note, the COVID-19 pandemic presented challenges and the need for some participating pediatric primary care sites to switch from in-person to telemedicine visits. Some teams were able to pivot quickly to overcome these challenges while others are still working to fully integrate back into pediatric practices. The pandemic did allow Family Specialists more time to work with the legal partners to discuss family needs and encourage legal assistance. For example, one family who initially did not feel they needed support was able to get help navigating and resolving a difficult situation with a

[5] https://gmcboard.vermont.gov/sites/gmcb/files/files/payment-reform/GMCB%20Report%20on%20the%20Integration%20of%20Social%20Services%20-%20Act%2052%20of%202019.pdf

landlord. The family was proud to say that they are now living in a safer home. This legal support also created a stronger relationship with the family specialist.

7. *All Payer Model Quality and Population Health Goals*. Please complete Appendix 7.6, ACO Activities related to the Vermont All-Payer Model ACO Agreement Population Health and Quality Goals to describe results to date and explain your strategies for assisting the state achieve its quality and population health goals as specified in the APM. *In particular, please rank HSAs in their contribution to the State's performance on the quality goals of the APM and explain how you are supporting their continuous improvement on these goals.* Please discuss the expected impact of COVID-19 on 2020 performance, sharing any early indicators or relevant insights.

   Vermont's provider community has always been committed to providing quality care, outcomes, and supporting health reform efforts. This continues to be true during the public health emergency as providers are very concerned about the health and well-being of each individual they serve, especially those most vulnerable. Vermont providers are building on years of quality improvement experience to solidify and enhance workflows and outreach efforts to reduce the risk of complications related to COVID-19. This focus has shifted some preventive care visits, which will likely be reflected in reduced rates in the corresponding preventative measures. Such areas of active quality improvement include chronic disease management, access to mental health supports, and primary prevention. OneCare has helped to support these quality improvement goals by messaging to Vermonters the importance of following precautions and not delaying physical and mental health.

   During the ongoing public health emergency, when in-person visits were not possible, providers continued to connect with individuals through any means allowable, including telephone and web-based visits. OneCare is tracking the use of telehealth codes in a self-service application that updates as new data are available. For Medicare, an increase over 13.1 PKPY was observed for from January 2020 through May 2020. The trend is increasing telehealth through April 2020, with only a slight decrease in May as more practices began to re-open for onsite visits.

   Further, OneCare assisted providers in identifying those at highest risk of serious illness using guidance from the Center for Disease Control, World Health Organization, and Johns Hopkins University. The COVID-19 Patient Prioritization Application was deployed to the network in April 2020 to support providers in their efforts to continue to care for high risk individuals during the global pandemic. This tool identifies those individuals most at risk of contracting or having negative impacts from COVID-19 by accessing condition and utilization information for those individuals. Providers are able to outreach to high risk individuals to help them manage their chronic conditions and to assure they can receive their prescriptions in order to remain safe in an uncertain time. This tool can be regularly accessed by participants to gain understanding about their patient panel and support outreach as the pandemic continues. The application continues to be updated as high risk criteria are released or updated. Recent changes to the application have included the addition of clinical data on individuals tested for COVID-19 and additional risk fields as more data is available from national experts, such as the addition of race data when available. Lastly, the tool is able to identify individuals with social determinants of health and who may experience food access challenges or social isolation. Through August 2020 this tool has been accessed by more than 80 unique users with over 220 total hours spent using the tool.

   See Appendix 7.6 enclosed.

Section 7: Exhibits

Exhibit A: Most Prevalent Conditions Tables by Payer, 2020

Exhibit B: Most Prevalent High Cost Conditions Tables by Payer

Exhibit C: HSA Cost and Utilization Variation Tables by Payer

Section 7, Exhibit A

Exhibit A to Section 7: Most Prevalent Conditions Tables by Payer, 2020

Table 11: Medicare Prevalent Conditions

HSA	#1 Prevalent Condition	#2 Prevalent Condition	#3 Prevalent Condition	#4 Prevalent Condition	#5 Prevalent Condition
Bennington	Hypertension	Disorders of lipid metabolism	Coronary Artery Disease	Cataract, aphakia	Benign and unspecified neoplasm
	55.8%	*41.2%*	*35.3%*	*27.3%*	*25.9%*
Berlin	Hypertension	Disorders of lipid metabolism	Coronary Artery Disease	Cataract, aphakia	Diabetes
	57.3%	*49.9%*	*31.4%*	*31.2%*	*21.9%*
Brattleboro	Hypertension	Disorders of lipid metabolism	Cataract, aphakia	Coronary Artery Disease	Refractive errors
	54.3%	*38.3%*	*31.1%*	*29.8%*	*27.2%*
Burlington	Hypertension	Disorders of lipid metabolism	Coronary Artery Disease	Cataract, aphakia	Skin keratoses
	55.1%	*43.5%*	*30.9%*	*29.5%*	*25.7%*
Lebanon	Hypertension	Refractive errors	Skin keratoses	Disorders of lipid metabolism	Cataract, aphakia
	51.6%	*39.9%*	*38.2%*	*36.1%*	*34.1%*
Middlebury	Hypertension	Disorders of lipid metabolism	Cataract, aphakia	Coronary Artery Disease	Skin keratoses
	58.3%	*44.7%*	*32.1%*	*31.4%*	*22.3%*
St. Albans	Hypertension	Disorders of lipid metabolism	Cataract, aphakia	Coronary Artery Disease	Benign and unspecified neoplasm
	66.2%	*55.0%*	*34.9%*	*32.8%*	*26.9%*
Windsor	Hypertension	Cataract, aphakia	Disorders of lipid metabolism	Coronary Artery Disease	Skin keratoses
	57.5%	*32.5%*	*32.2%*	*31.3%*	*30.6%*
OneCare	**Hypertension**	**Disorders of lipid metabolism**	Coronary Artery Disease	**Cataract, aphakia**	**Skin keratoses**
	56.3%	*44.2%*	*31.4%*	*30.4%*	*23.1%*

Table 12: BCBSVT QHP Prevalent Conditions

HSA	#1 Prevalent Condition	#2 Prevalent Condition	#3 Prevalent Condition	#4 Prevalent Condition	#5 Prevalent Condition
Bennington	Hypertension	Acute upper respiratory tract infection	Disorders of lipid metabolism	Anxiety	Benign and unspecified neoplasm
	15.6%	*12.3%*	*11.5%*	*11.2%*	*10.5%*
Berlin	Disorders of lipid metabolism	Hypertension	Acute upper respiratory tract infection	Anxiety	Depression
	14.8%	*14.7%*	*12.2%*	*10.9%*	*9.2%*
Brattleboro	Acute upper respiratory tract infection	Hypertension	Anxiety	Depression	Benign neoplasm of skin and subcutaneous tissues
	12.8%	*12.5%*	*11.1%*	*10.9%*	*10.7%*
Burlington	Acute upper respiratory tract infection	Hypertension	Anxiety	Benign neoplasm of skin and subcutaneous tissues	Disorders of lipid metabolism
	12.8%	*12.5%*	*11.7%*	*10.7%*	*9.9%*
Lebanon	Hypertension	Refractive errors	Skin keratoses	Anxiety	Disorders of lipid metabolism
	15.6%	*12.7%*	*12.7%*	*12.2%*	*10.8%*
Middlebury	Hypertension	Acute upper respiratory tract infection	Anxiety	Disorders of lipid metabolism	Depression
	14.9%	*13.5%*	*11.8%*	*9.1%*	*9.0%*
Newport	Hypertension	Disorders of lipid metabolism	Refractive errors	Acute upper respiratory tract infection	Anxiety
	22.2%	*19.0%*	*10.8%*	*7.7%*	*7.7%*
Springfield	Hypertension	Disorders of lipid metabolism	Obesity	Acute upper respiratory tract infection	Anxiety
	19.3%	*17.2%*	*13.8%*	*13.3%*	*11.4%*
St. Albans	Hypertension	Disorders of lipid metabolism	Acute upper respiratory tract infection	Cataract, aphakia	Anxiety
	22.2%	*15.7%*	*12.7%*	*12.0%*	*10.4%*
Windsor	Acute upper respiratory tract infection	Hypertension	Refractive errors	Skin keratoses	Benign and unspecified neoplasm
	12.8%	*11.9%*	*10.8%*	*9.5%*	*9.4%*
OneCare	**Hypertension**	**Acute upper respiratory tract infection**	**Disorders of lipid metabolism**	**Anxiety**	**Benign and unspecified neoplasm**
	14.7%	***12.4%***	***11.6%***	***11.3%***	***9.4%***

Table 13: Medicaid (Traditional) Prevalent Conditions

HSA	#1 Prevalent Condition	#2 Prevalent Condition	#3 Prevalent Condition	#4 Prevalent Condition	#5 Prevalent Condition
Bennington	Acute upper respiratory tract infection	Anxiety	Otitis media	Depression	Viral syndromes
	32.3%	*19.5%*	*17.3%*	*13.4%*	*11.0%*
Berlin	Acute upper respiratory tract infection	Anxiety	Adjustment disorder	Depression	Refractive errors
	26.0%	*18.7%*	*15.8%*	*15.2%*	*13.7%*
Brattleboro	Acute upper respiratory tract infection	Anxiety	Otitis media	Developmental disorder	Depression
	27.6%	*18.3%*	*13.8%*	*13.8%*	*13.7%*
Burlington	Acute upper respiratory tract infection	Anxiety	Adjustment disorder	Depression	Refractive errors
	24.6%	*18.2%*	*13.8%*	*13.8%*	*12.5%*
Lebanon	Acute upper respiratory tract infection	Anxiety	Refractive errors	Depression	Developmental disorder
	24.1%	*18.8%*	*15.7%*	*14.4%*	*13.2%*
Middlebury	Acute upper respiratory tract infection	Viral syndromes	Anxiety	Otitis media	Depression
	32.9%	*17.2%*	*16.7%*	*15.8%*	*12.7%*
Morrisville	Acute upper respiratory tract infection	Refractive errors	Adjustment disorder	Anxiety	Otitis media
	26.1%	*16.6%*	*15.6%*	*14.1%*	*13.5%*
Newport	Acute upper respiratory tract infection	Refractive errors	Anxiety	Depression	Asthma
	24.7%	*20.2%*	*18.9%*	*15.9%*	*13.4%*
Randolph	Acute upper respiratory tract infection	Ophthalmic signs and symptoms	Anxiety	Adjustment disorder	Depression
	23.4%	*15.9%*	*15.6%*	*12.3%*	*12.2%*
Rutland	Acute upper respiratory tract infection	Anxiety	Otitis media	Depression	Refractive errors
	30.1%	*19.0%*	*16.5%*	*14.2%*	*13.7%*
Springfield	Acute upper respiratory tract infection	Anxiety	Depression	Refractive errors	Tobacco
	30.7%	*21.5%*	*17.0%*	*14.2%*	*12.4%*
St. Albans	Acute upper respiratory tract infection	Otitis media	Anxiety	Tobacco	Adjustment disorder
	32.2%	*18.2%*	*16.4%*	*15.3%*	*13.5%*
St. Johnsbury	Acute upper respiratory tract infection	Refractive errors	Anxiety	Adjustment disorder	Depression
	24.5%	*18.5%*	*17.5%*	*13.1%*	*11.9%*
Windsor	Acute upper respiratory tract infection	Anxiety	Refractive errors	Developmental disorder	Ophthalmic signs and symptoms
	24.7%	*16.7%*	*14.5%*	*12.8%*	*11.1%*
OneCare	**Acute upper respiratory tract infection**	**Anxiety**	**Depression**	**Otitis media**	**Refractive errors**
	27.3%	*18.1%*	*13.7%*	*13.5%*	*13.4%*

Table 14: Medicaid (Expanded) Prevalent Conditions

HSA	#1 Prevalent Condition	#2 Prevalent Condition	#3 Prevalent Condition	#4 Prevalent Condition	#5 Prevalent Condition
Bennington	Acute upper respiratory tract infection	Anxiety	Depression	Adjustment disorder	Attention deficit disorder
	15.9%	*10.4%*	*8.8%*	*6.9%*	*5.7%*
Berlin	Anxiety	Acute upper respiratory tract infection	Refractive errors	Adjustment disorder	Depression
	11.0%	*10.5%*	*10.0%*	*9.1%*	*8.2%*
Brattleboro	Anxiety	Acute upper respiratory tract infection	Depression	Refractive errors	Ophthalmic signs and symptoms
	11.5%	*10.4%*	*9.0%*	*7.9%*	*6.4%*
Burlington	Anxiety	Acute upper respiratory tract infection	Refractive errors	Depression	Adjustment disorder
	12.1%	*10.9%*	*8.7%*	*8.6%*	*8.1%*
Lebanon	Anxiety	Depression	Acute upper respiratory tract infection	Refractive errors	Ophthalmic signs and symptoms
	10.9%	*9.6%*	*9.3%*	*7.4%*	*6.8%*
Middlebury	Acute upper respiratory tract infection	Anxiety	Depression	Refractive errors	Adjustment disorder
	16.4%	*11.0%*	*8.6%*	*8.5%*	*7.9%*
Morrisville	Refractive errors	Acute upper respiratory tract infection	Anxiety	Adjustment disorder	Acute sprains and strains
	10.4%	*9.9%*	*8.5%*	*7.0%*	*5.5%*
Newport	Refractive errors	Acute upper respiratory tract infection	Anxiety	Depression	Adjustment disorder
	16.5%	*12.6%*	*10.2%*	*7.7%*	*6.9%*
Randolph	Anxiety	Ophthalmic signs and symptoms	Acute upper respiratory tract infection	Depression	Refractive errors
	11.7%	*11.5%*	*8.7%*	*7.8%*	*7.3%*
Rutland	Acute upper respiratory tract infection	Anxiety	Refractive errors	Depression	Contusions and abrasions
	15.0%	*11.6%*	*9.1%*	*8.5%*	*5.9%*
Springfield	Anxiety	Acute upper respiratory tract infection	Refractive errors	Depression	Tobacco
	14.5%	*13.5%*	*8.9%*	*8.8%*	*6.0%*
St. Albans	Acute upper respiratory tract infection	Tobacco	Anxiety	Refractive errors	Adjustment disorder
	15.6%	*11.6%*	*11.2%*	*8.6%*	*8.5%*
St. Johnsbury	Acute upper respiratory tract infection	Refractive errors	Anxiety	Depression	Adjustment disorder
	12.2%	*11.5%*	*11.0%*	*7.5%*	*6.6%*

Table 14: Medicaid (Expanded) Prevalent Conditions (continued)

HSA	#1 Prevalent Condition	#2 Prevalent Condition	#3 Prevalent Condition	#4 Prevalent Condition	#5 Prevalent Condition
Townshend	Depression	Refractive errors	Anxiety	Acute upper respiratory tract infection	Adjustment disorder
	10.4%	*10.3%*	*10.1%*	*10.0%*	*7.1%*
Windsor	Acute upper respiratory tract infection	Anxiety	Refractive errors	Acute sprains and strains	Depression
	13.8%	*9.1%*	*8.3%*	*8.1%*	*7.9%*
OneCare	**Acute upper respiratory tract infection**	**Anxiety**	**Refractive errors**	**Depression**	**Adjustment disorder**
	12.3%	*11.3%*	*9.1%*	*8.3%*	*7.1%*

Section 7, Exhibit B

Exhibit B to Section 7: Most Prevalent High Cost Conditions Tables by Payer

Table 15: Medicare Prevalent Conditions (High Cost Patients $15K+)

Health Service Area	#1 Prevalent Condition	#2 Prevalent Condition	#3 Prevalent Condition	#4 Prevalent Condition	#5 Prevalent Condition
Bennington	Hypertension	Coronary Artery Disease	Disorders of lipid metabolism	Deficiency anemias	Fluid/ electrolyte disturbances
	73.3%	*61.5%*	*44.0%*	*40.1%*	*32.6%*
Berlin	Hypertension	Coronary Artery Disease	Disorders of lipid metabolism	Diabetes	Deficiency anemias
	74.6%	*57.6%*	*53.4%*	*37.2%*	*33.2%*
Brattleboro	Hypertension	Coronary Artery Disease	Disorders of lipid metabolism	Degenerative joint disease	Deficiency anemias
	75.2%	*55.4%*	*48.6%*	*31.6%*	*31.3%*
Burlington	Hypertension	Coronary Artery Disease	Disorders of lipid metabolism	Fluid/electrol yte disturbances	Degenerative joint disease
	72.9%	*58.7%*	*46.9%*	*33.0%*	*32.4%*
Lebanon	Hypertension	Coronary Artery Disease	Degenerative joint disease	Disorders of lipid metabolism	Refractive errors, Bursitis, synovitis, tenosynovitis
	67.0%	*56.2%*	*44.7%*	*42.2%*	*67.9%*
Middlebury	Hypertension	Coronary Artery Disease	Disorders of lipid metabolism	Urinary symptoms	Fluid/ electrolyte disturbances
	70.6%	*61.0%*	*51.1%*	*31.4%*	*30.3%*
St. Albans	Hypertension	Coronary Artery Disease	Disorders of lipid metabolism	Benign and unspecified neoplasm	Diabetes
	80.5%	*60.2%*	*57.0%*	*38.3%*	*37.8%*
Windsor	Hypertension	Coronary Artery Disease	Disorders of lipid metabolism	Deficiency anemias	Fluid/ electrolyte disturbances
	78.2%	*65.5%*	*40.8%*	*38.2%*	*37.7%*
OneCare	**Hypertension**	**Coronary Artery Disease**	**Disorders of lipid metabolism**	**Deficiency anemias**	**Diabetes**
	73.7%	***59.1%***	***48.6%***	***33.5%***	***32.8%***

Table 16: BCBSVT QHP Prevalent Conditions (High Cost Patients $15K+)

Health Service Area	#1 Prevalent Condition	#2 Prevalent Condition	#3 Prevalent Condition	#4 Prevalent Condition	#5 Prevalent Condition
Bennington	Hypertension	Benign and unspecified neoplasm	Disorders of lipid metabolism	Coronary Artery Disease	Obesity
	39.1%	*28.9%*	*21.9%*	*20.9%*	*19.5%*
Berlin	Hypertension	Benign and unspecified neoplasm	Disorders of lipid metabolism	Obesity	Degenerative joint disease
	30.4%	*26.9%*	*26.9%*	*20.9%*	*20.8%*
Brattleboro	Hypertension	Benign and unspecified neoplasm	Depression	Benign neoplasm of skin and subcutaneous tissues	Gastroesophageal reflux
	29.3%	*29.3%*	*26.4%*	*26.1%*	*24.1%*
Burlington	Hypertension	Benign and unspecified neoplasm	Anxiety	Bursitis, synovitis, tenosynovitis	Disorders of lipid metabolism
	29.0%	*23.4%*	*21.3%*	*20.2%*	*18.8%*
Lebanon	Hypertension	Anxiety	Disorders of lipid metabolism	Acute sprains and strains	Acute upper respiratory tract infection
	28.3%	*22.5%*	*21.7%*	*21.1%*	*19.0%*
Middlebury	Hypertension	Obesity	Anxiety	Gastroesophageal reflux	Refractive errors
	38.2%	*27.4%*	*22.4%*	*21.3%*	*21.1%*
Newport	Hypertension	Disorders of lipid metabolism	Coronary Artery Disease	Refractive errors	Diabetes
	51.1%	*41.8%*	*25.5%*	*23.0%*	*22.1%*
Springfield	Hypertension	Disorders of lipid metabolism	Obesity	Coronary Artery Disease	Anxiety
	40.7%	*37.9%*	*32.4%*	*25.4%*	*24.8%*
St. Albans	Hypertension	Disorders of lipid metabolism	Gastroesophageal reflux	Coronary Artery Disease	Obesity
	41.7%	*37.4%*	*34.0%*	*31.4%*	*29.4%*
Windsor	Hypertension	Gastroesophageal reflux	Benign and unspecified neoplasm	Degenerative joint disease	Benign neoplasm of skin and subcutaneous tissues
	27.0%	*23.0%*	*21.5%*	*19.1%*	*17.6%*
OneCare	**Hypertension**	**Benign and unspecified neoplasm**	**Disorders of lipid metabolism**	**Anxiety**	**Bursitis, synovitis, tenosynovitis**
	32.8%	***23.8%***	***22.8%***	***19.6%***	***19.3%***

Table 17: Medicaid (Traditional) Prevalent Conditions (High Cost Patients $15K+)

Health Service Area	#1 Prevalent Condition	#2 Prevalent Condition	#3 Prevalent Condition	#4 Prevalent Condition	#5 Prevalent Condition
Bennington	Anxiety	Acute upper respiratory tract infection	Depression	Developmental disorder	Hypertension
	40.3%	*35.8%*	*31.3%*	*26.2%*	*21.6%*
Berlin	Anxiety	Developmental disorder	Depression	Adjustment disorder	Acute upper respiratory tract infection
	34.9%	*32.1%*	*30.8%*	*29.9%*	*23.6%*
Brattleboro	Depression	Anxiety	Developmental disorder	Attention deficit disorder	Refractive errors
	38.9%	*36.8%*	*34.1%*	*29.6%*	*22.9%*
Burlington	Developmental disorder	Anxiety	Adjustment disorder	Depression	Acute upper respiratory tract infection
	36.0%	*33.4%*	*26.7%*	*26.4%*	*23.9%*
Lebanon	Anxiety	Developmental disorder	Depression	Refractive errors	Adjustment disorder
	34.3%	*31.8%*	*31.5%*	*23.3%*	*23.3%*
Middlebury	Anxiety	Developmental disorder	Acute upper respiratory tract infection	Depression	Adjustment disorder
	35.8%	*32.7%*	*30.1%*	*26.0%*	*25.4%*
Morrisville	Anxiety	Acute upper respiratory tract infection	Depression	Developmental disorder	Tobacco
	38.2%	*31.0%*	*29.4%*	*27.2%*	*25.4%*
Newport	Developmental disorder	Anxiety	Acute upper respiratory tract infection	Depression	Adjustment disorder
	44.4%	*29.4%*	*27.8%*	*23.9%*	*23.2%*
Randolph	Adjustment disorder	Anxiety	Developmental disorder	Acute upper respiratory tract infection	Depression
	34.3%	*32.4%*	*31.6%*	*30.9%*	*26.3%*
Rutland	Anxiety	Depression	Hypertension	Developmental disorder	Disorders of lipid metabolism
	32.7%	*31.8%*	*31.7%*	*29.3%*	*27.9%*
Springfield	Ophthalmic signs and symptoms	Anxiety	Depression	Developmental disorder	Acute upper respiratory tract infection
	32.8%	*31.8%*	*29.4%*	*27.7%*	*26.0%*

Table 17: Medicaid (Traditional) Prevalent Conditions (High Cost Patients $15K+) (continued)

Health Service Area	#1 Prevalent Condition	#2 Prevalent Condition	#3 Prevalent Condition	#4 Prevalent Condition	#5 Prevalent Condition
St. Albans	Anxiety	Developmental disorder	Depression	Acute upper respiratory tract infection	Hypertension
	37.8%	*34.2%*	*30.9%*	*30.7%*	*23.0%*
St. Johnsbury	Anxiety	Depression	Acute upper respiratory tract infection	Developmental disorder	Hypertension
	41.8%	*40.6%*	*30.7%*	*30.3%*	*24.5%*
Windsor	Anxiety	Developmental disorder	Depression	Acute upper respiratory tract infection	Hypertension
	31.3%	*27.2%*	*26.5%*	*26.4%*	*21.4%*
OneCare	**Anxiety**	**Developmental disorder**	**Depression**	**Acute upper respiratory tract infection**	**Adjustment disorder**
	35.1%	***32.1%***	***29.5%***	***26.8%***	***23.9%***

Table 18: Medicaid (Expanded) Prevalent Conditions (High Cost Patients $15K+)

Health Service Area	#1 Prevalent Condition	#2 Prevalent Condition	#3 Prevalent Condition	#4 Prevalent Condition	#5 Prevalent Condition
Bennington	Depression	Anxiety	Adjustment disorder	Acute upper respiratory tract infection	Contusions and abrasions
	33.8%	*29.1%*	*24.3%*	*20.5%*	*18.1%*
Berlin	Developmental disorder	Autism Spectrum Disorder	Anxiety	Depression	Refractive errors
	30.5%	*29.0%*	*25.0%*	*23.0%*	*20.7%*
Brattleboro	Depression	Anxiety	Autism Spectrum Disorder	Attention deficit disorder	Schizophrenia and affective psychosis
	30.8%	*21.2%*	*20.3%*	*19.5%*	*18.1%*
Burlington	Developmental disorder	Autism Spectrum Disorder	Anxiety	Depression	Attention deficit disorder
	36.2%	*34.7%*	*30.1%*	*21.4%*	*20.4%*
Lebanon	Developmental disorder	Autism Spectrum Disorder	Depression	Seizure disorder	Adjustment disorder
	32.8%	*25.5%*	*24.6%*	*21.6%*	*16.4%*
Middlebury	Developmental disorder	Anxiety	Depression	Acute upper respiratory tract infection	Tobacco
	33.0%	*32.7%*	*28.0%*	*23.1%*	*16.8%*
Morrisville	Developmental disorder	Autism Spectrum Disorder	Refractive errors	Adjustment disorder	Acute upper respiratory tract infection
	34.2%	*29.0%*	*23.1%*	*20.9%*	*18.2%*
Newport	Developmental disorder	Anxiety	Depression	Adjustment disorder	Hypertension
	34.3%	*27.9%*	*25.3%*	*24.8%*	*17.1%*
Randolph	*Suppressed due to small numbers*				
Rutland	Developmental disorder	Depression	Anxiety	Hypertension	Refractive errors
	36.1%	*32.7%*	*26.3%*	*20.4%*	*17.8%*
Springfield	Anxiety	Developmental disorder	Obesity	Autism Spectrum Disorder	Inherited metabolic disorders
	35.8%	*31.3%*	*25.6%*	*21.1%*	*18.3%*
St. Albans	Anxiety	Developmental disorder	Depression	Adjustment disorder	Acute upper respiratory tract infection
	32.7%	*32.6%*	*25.5%*	*24.9%*	*19.0%*

Table 18: Medicaid (Expanded) Prevalent Conditions (High Cost Patients $15K+) (continued)

Health Service Area	#1 Prevalent Condition	#2 Prevalent Condition	#3 Prevalent Condition	#4 Prevalent Condition	#5 Prevalent Condition
St. Johnsbury	Developmental disorder	Depression	Anxiety	Tobacco	Joint disorders, trauma related
	28.2%	*25.6%*	*24.2%*	*20.1%*	*15.4%*
Townshend	*Suppressed due to small numbers*				
Windsor	*Suppressed due to small numbers*				
OneCare	**Developmental disorder**	**Anxiety**	**Depression**	**Autism Spectrum Disorder**	**Adjustment disorder**
	32.0%	***27.8%***	***25.2%***	***23.6%***	***16.8%***

Section 7, Exhibit C

Table 19: Medicare Variational Analysis

2018 Cohort, Reporting Period: Jan 2018 - Dec 2018

Blinded HSA	Fee-for-Service Equivalent Spend PMPM	Inpatient Spend PMPM	Emergency Department Spend PMPM	Outpatient Advanced Imaging Spend PMPM	Primary Care Spend PMPM	Specialty Care Spend PMPM	Inpatient Admissions PKPY	Emergency Department Visits PKPY	Outpatient Advanced Imaging PKPY	Primary Care Visits PKPY	Specialty Care Visits PKPY
Total	$794.35	$282.52	$42.21	$7.39	$72.53	$58.89	228.7	841.6	524.3	4,890.2	3,041.4
HSA A	$752.49	$261.33	$32.54	$6.80	$68.27	$63.85	212.1	612.9	533.4	4,488.5	3,167.7
HSA B	$798.44	$288.26	$39.14	$6.46	$80.54	$56.21	231.3	683.1	509.9	4,700.7	2,867.3
HSA C	$920.70	$357.09	$66.45	$7.99	$86.72	$44.78	294.7	1,600.3	456.9	6,159.7	2,658.4
HSA D	$775.23	$245.09	$56.45	$10.71	$82.07	$44.68	202.3	1,258.4	518.7	6,334.3	2,081.0
HSA E	$855.78	$324.03	$43.12	$6.70	$56.02	$63.72	241.0	689.0	467.6	4,128.8	3,677.1
HSA F	$845.78	$313.20	$46.96	$8.50	$64.51	$72.80	246.9	929.0	705.9	4,617.3	3,812.0
HSA G	$708.14	$241.83	$59.21	$6.06	$57.24	$58.13	245.5	1,002.1	428.7	4,072.7	4,156.9

Table 20: Medicare Variational Analysis

2019 Cohort, Reporting Period: Jan 2019 - Dec 2019

Blinded HSA	Fee-for-Service Equivalent Spend PMPM	Inpatient Spend PMPM	Emergency Department Spend PMPM	Outpatient Advanced Imaging Spend PMPM	Primary Care Spend PMPM	Specialty Care Spend PMPM	Inpatient Admissions PKPY	Emergency Department Visits PKPY	Outpatient Advanced Imaging PKPY	Primary Care Visits PKPY	Specialty Care Visits PKPY
Total	$805.33	$281.41	$42.94	$7.68	$73.03	$60.74	223.8	780.0	531.8	4,679.8	3,083.3
HSA A	$745.17	$251.62	$32.99	$6.89	$65.46	$59.91	205.1	616.7	530.0	4,567.2	3,218.0
HSA B	$876.82	$335.31	$39.99	$6.76	$88.61	$65.49	244.3	676.9	549.7	4,586.3	2,920.4
HSA C	$882.46	$300.14	$47.39	$6.66	$89.50	$84.21	259.8	810.5	528.9	3,984.5	3,808.4
HSA D	$857.45	$323.72	$48.06	$7.75	$62.52	$63.07	247.0	948.5	625.4	4,717.8	3,168.4
HSA E	$839.71	$306.93	$56.55	$7.99	$79.03	$45.91	240.9	989.9	483.6	5,303.0	2,793.2
HSA F	$756.50	$238.78	$57.78	$10.70	$79.76	$46.29	208.1	1,186.5	496.0	5,708.5	2,022.1
HSA G	$822.17	$269.54	$58.25	$11.88	$77.73	$41.31	203.8	1,012.4	477.2	5,287.9	2,358.1
HSA H	$825.44	$296.28	$46.54	$7.81	$60.55	$67.89	216.2	699.9	537.3	4,417.1	3,679.0
HSA I	$865.20	$300.39	$37.01	$9.17	$64.77	$69.81	236.4	689.3	480.1	2,785.8	2,629.6

Table 21: Medicare Variational Analysis

2020 Cohort, Reporting Period: Jan 2020 - Mar 2020

Blinded HSA	Fee-for-Service Equivalent Spend PMPM	Inpatient Spend PMPM	Emergency Department Spend PMPM	Outpatient Advanced Imaging Spend PMPM	Primary Care Spend PMPM	Specialty Care Spend PMPM	Inpatient Admissions PKPY	Emergency Department Visits PKPY	Outpatient Advanced Imaging PKPY	Primary Care Visits PKPY	Specialty Care Visits PKPY
Total	$712.18	$257.96	$34.88	$6.34	$49.60	$51.69	205.4	666.0	472.3	3,890.0	2,692.4
HSA A	$671.83	$241.93	$27.87	$5.00	$43.17	$50.48	195.3	560.8	445.2	3,760.9	2,817.1
HSA B	$736.28	$273.82	$32.65	$5.84	$57.82	$53.16	214.9	615.3	487.0	4,021.5	2,506.6
HSA C	$764.72	$262.34	$39.44	$6.36	$69.21	$63.63	237.7	723.4	516.9	3,366.3	3,269.0
HSA D	$795.70	$314.24	$44.12	$5.86	$47.72	$59.08	236.4	899.0	524.0	3,996.8	2,573.9
HSA E	$671.78	$223.31	$49.73	$10.47	$60.19	$37.55	195.7	964.7	476.5	5,044.3	1,825.2
HSA F	$684.55	$254.46	$39.25	$6.41	$34.02	$48.39	189.1	583.3	482.8	3,687.4	3,186.2
HSA G	$797.75	$273.83	$57.94	$14.83	$58.88	$24.75	210.6	1,010.3	470.8	4,819.4	1,847.8
HSA H	$883.73	$357.19	$28.52	$8.75	$43.56	$83.42	223.3	550.5	627.5	2,206.0	2,325.3
HSA I	$686.94	$223.74	$31.00	$7.06	$45.06	$53.39	119.5	519.1	288.4	4,152.4	2,702.4

Table 22: BCBSVT QHP Variational Analysis

2018 Cohort, Reporting Period: Jan 2018 - Dec 2018

Blinded HSA	Fee-for-Service Equivalent Spend PMPM	Inpatient Spend PMPM	Emergency Department Spend PMPM	Outpatient Advanced Imaging Spend PMPM	Primary Care Spend PMPM	Specialty Care Spend PMPM	Inpatient Admissions PKPY	Emergency Department Visits PKPY	Outpatient Advanced Imaging PKPY	Primary Care Visits PKPY	Specialty Care Visits PKPY
Total	$477.10	$102.34	$32.23	$27.25	$39.57	$47.67	34.0	172.4	127.8	1,901.6	1,505.9
HSA A	$487.86	$105.41	$30.32	$28.22	$34.87	$49.06	32.3	152.8	115.9	1,904.4	1,524.6
HSA B	$450.82	$88.88	$31.84	$25.64	$42.25	$42.90	33.2	172.7	133.5	1,883.1	1,427.1
HSA C	$410.79	$85.55	$27.90	$22.29	$36.31	$41.78	29.4	171.6	106.4	1,862.2	1,314.3
HSA D	$440.91	$101.36	$48.00	$26.28	$34.44	$48.32	41.4	238.2	154.7	1,726.9	1,741.4
HSA E	$663.70	$176.17	$34.02	$36.18	$67.16	$57.35	47.9	209.5	183.0	2,005.8	1,489.4
HSA F	$438.42	$95.22	$29.68	$26.56	$34.04	$50.73	30.6	198.3	146.9	1,995.6	1,572.9
HSA G	$414.67	$68.58	$36.79	$23.05	$36.34	$43.78	37.3	184.5	118.0	1,936.0	1,398.5
HSA H	$815.79	$117.97	$25.57	$35.25	$230.93	$59.78	32.5	154.2	211.0	2,677.5	2,547.7

Table 23: BCBSVT QHP Variational Analysis

2019 Cohort, Reporting Period: Jan 2019 - Dec 2019

Blinded HSA	Fee-for-Service Equivalent Spend PMPM	Inpatient Spend PMPM	Emergency Department Spend PMPM	Outpatient Advanced Imaging Spend PMPM	Primary Care Spend PMPM	Specialty Care Spend PMPM	Inpatient Admissions PKPY	Emergency Department Visits PKPY	Outpatient Advanced Imaging PKPY	Primary Care Visits PKPY	Specialty Care Visits PKPY
Total	$556.59	$120.78	$40.27	$28.76	$46.91	$63.71	43.1	198.2	137.9	2,172.8	1,850.8
HSA A	$577.87	$114.34	$37.86	$30.66	$46.88	$66.04	40.0	171.3	128.1	2,298.7	1,870.3
HSA B	$472.80	$96.44	$32.23	$25.41	$44.14	$56.19	31.5	179.5	134.7	2,084.1	1,709.6
HSA C	$625.86	$155.92	$44.89	$30.91	$60.20	$67.16	43.9	205.2	157.6	2,135.0	1,992.8
HSA D	$507.14	$108.57	$39.09	$22.20	$42.71	$73.29	42.5	210.5	105.9	2,293.2	1,631.3
HSA E	$535.44	$126.10	$48.95	$28.29	$37.57	$67.80	55.6	277.4	145.3	2,159.3	2,122.8
HSA F	$604.91	$169.22	$45.59	$29.40	$44.51	$56.23	53.1	242.2	149.8	1,915.8	1,759.8
HSA G	$459.75	$97.68	$51.50	$23.31	$34.68	$52.76	42.3	258.3	141.0	1,881.9	1,957.7
HSA H	$692.00	$135.72	$46.42	$39.65	$73.37	$79.90	46.1	230.7	196.1	2,069.2	1,798.6
HSA I	$540.68	$142.12	$40.38	$28.34	$38.06	$53.53	59.9	162.4	145.2	2,101.4	1,971.2
HSA J	$490.49	$96.23	$26.50	$21.60	$44.22	$36.17	63.3	165.7	144.6	2,265.6	1,563.6

Table 24: BCBSVT QHP Variational Analysis

2020 Cohort, Reporting Period: Jan 2020 – Mar 2020

Blinded HSA	Fee-for-Service Equivalent Spend PMPM	Inpatient Spend PMPM	Emergency Department Spend PMPM	Outpatient Advanced Imaging Spend PMPM	Primary Care Spend PMPM	Specialty Care Spend PMPM	Inpatient Admissions PKPY	Emergency Department Visits PKPY	Outpatient Advanced Imaging PKPY	Primary Care Visits PKPY	Specialty Care Visits PKPY
Total	$527.07	$121.98	$39.80	$26.19	$39.00	$55.65	39.3	181.5	122.6	1,989.2	1,721.7
HSA A	$593.72	$157.49	$37.24	$25.29	$43.26	$55.00	41.3	157.4	101.2	2,147.2	1,720.1
HSA B	$490.26	$97.64	$39.77	$25.83	$38.15	$48.60	43.1	203.2	140.1	1,861.2	1,679.5
HSA C	$443.24	$59.46	$57.41	$20.83	$39.89	$50.42	36.1	212.0	108.2	1,882.8	1,815.1
HSA D	$463.26	$108.60	$34.44	$27.48	$30.64	$42.21	37.1	180.6	133.6	2,085.3	1,526.3
HSA E	$483.63	$129.75	$35.36	$34.05	$42.87	$61.17	43.8	172.3	157.7	1,860.3	1,460.2
HSA F	$473.06	$147.24	$42.33	$25.66	$26.20	$50.14	25.9	240.9	159.4	1,619.5	2,123.5
HSA G	$444.04	$57.03	$36.52	$26.48	$38.56	$89.19	31.3	199.3	144.6	2,247.6	2,032.6
HSA H	$579.22	$156.97	$22.04	$18.87	$37.78	$41.26	43.9	117.1	107.3	1,814.6	1,570.7
HSA I	$551.38	$96.35	$51.45	$32.09	$33.94	$99.79	36.5	206.9	146.0	1,649.1	1,661.3
HSA J	$508.53	$33.09	$56.55	$37.07	$31.43	$57.44	38.4	243.5	141.0	1,749.1	1,787.5

Table 25: Medicaid (Traditional) Variational Analysis

2018 Cohort, Reporting Period: Jan 2018 – Dec 2018

Blinded HSA	Fee-for-Service Equivalent Spend PMPM	Inpatient Spend PMPM	Emergency Department Spend PMPM	Outpatient Advanced Imaging Spend PMPM	Primary Care Spend PMPM	Specialty Care Spend PMPM	Inpatient Admissions PKPY	Emergency Department Visits PKPY	Outpatient Advanced Imaging PKPY	Primary Care Visits PKPY	Specialty Care Visits PKPY
Total	$207.40	$55.64	$24.98	$0.43	$34.86	$13.34	50.0	584.8	86.8	3,180.2	957.3
HSA A	$186.40	$48.60	$17.54	$0.36	$32.49	$10.07	39.4	404.7	70.9	3,153.4	832.9
HSA B	$203.00	$55.62	$23.12	$0.36	$29.59	$13.72	48.3	558.4	73.6	3,066.2	862.0
HSA C	$211.74	$53.31	$28.01	$0.48	$35.65	$14.73	56.4	607.5	97.6	3,725.2	933.5
HSA D	$223.55	$59.11	$29.52	$0.44	$42.47	$12.86	56.7	836.4	86.2	3,019.7	874.2
HSA E	$184.37	$42.99	$26.86	$0.34	$35.69	$11.16	45.3	752.5	66.5	3,274.4	876.4
HSA F	$186.10	$67.69	$20.33	$0.27	$28.77	$9.69	48.0	471.3	59.6	3,022.8	862.8
HSA G	$311.51	$84.95	$41.91	$0.91	$43.44	$29.92	77.4	882.9	183.6	3,256.8	1,742.6
HSA H	$278.28	$78.68	$45.68	$0.59	$49.95	$20.24	73.6	801.7	123.4	3,056.4	1,476.3
HSA I	$206.55	$51.23	$25.77	$0.66	$31.78	$13.45	64.6	624.4	130.2	2,750.9	1,126.4
HSA J	$166.54	$36.97	$22.79	$0.50	$29.05	$11.72	31.2	526.4	102.7	2,757.7	877.6

Table 26: Medicaid (Traditional) Variational Analysis

2019 Cohort, Reporting Period: Jan 2019 – Dec 2019

Blinded HSA	Fee-for-Service Equivalent Spend PMPM	Inpatient Spend PMPM	Emergency Department Spend PMPM	Outpatient Advanced Imaging Spend PMPM	Primary Care Spend PMPM	Specialty Care Spend PMPM	Inpatient Admissions PKPY	Emergency Department Visits PKPY	Outpatient Advanced Imaging PKPY	Primary Care Visits PKPY	Specialty Care Visits PKPY
Total	$222.62	$56.03	$25.97	$0.45	$39.97	$15.45	50.3	620.2	91.0	3,183.4	1,048.0
HSA A	$217.10	$52.48	$21.83	$0.37	$38.63	$14.90	47.3	504.7	79.1	3,149.6	1,025.5
HSA B	$239.11	$61.04	$25.27	$0.41	$52.49	$18.88	59.8	622.7	80.2	3,490.2	1,282.1
HSA C	$218.43	$46.34	$30.35	$0.47	$36.23	$19.55	48.6	735.2	96.8	3,138.0	1,108.6
HSA D	$232.30	$55.26	$31.87	$0.51	$43.39	$12.96	43.0	715.6	106.1	2,981.5	889.5
HSA E	$197.77	$52.74	$22.26	$0.39	$28.68	$12.37	47.1	549.4	78.1	3,049.7	847.1
HSA F	$235.74	$73.14	$24.81	$0.55	$36.50	$14.02	64.0	601.1	111.6	3,578.7	928.1
HSA G	$229.87	$56.50	$35.63	$0.46	$46.63	$21.74	45.1	739.3	90.5	3,043.7	1,566.4
HSA H	$211.82	$53.66	$29.96	$0.44	$41.24	$13.32	47.2	812.6	90.0	3,313.2	871.8
HSA I	$251.94	$65.76	$32.38	$0.51	$47.38	$12.87	54.9	845.5	98.2	2,894.2	913.5
HSA J	$190.19	$51.98	$22.11	$0.41	$28.94	$11.46	46.1	496.7	81.1	3,073.2	996.2
HSA K	$245.41	$59.54	$26.60	$0.67	$46.74	$21.47	54.1	655.1	137.3	3,242.6	1,253.7
HSA L	$227.58	$67.23	$21.70	$0.45	$34.82	$12.35	62.3	523.2	84.5	3,194.9	993.0
HSA M	$194.41	$40.58	$20.25	$0.61	$33.17	$10.86	34.4	505.1	119.3	2,986.4	927.2

Table 27: Medicaid (Traditional) Variational Analysis

2020 Cohort, Reporting Period Jan 2020 – Mar 2020

Blinded HSA	Fee-for-Service Equivalent Spend PMPM	Inpatient Spend PMPM	Emergency Department Spend PMPM	Outpatient Advanced Imaging Spend PMPM	Primary Care Spend PMPM	Specialty Care Spend PMPM	Inpatient Admissions PKPY	Emergency Department Visits PKPY	Outpatient Advanced Imaging PKPY	Primary Care Visits PKPY	Specialty Care Visits PKPY
Total	$215.79	$55.62	$24.20	$0.45	$38.30	$16.26	52.0	589.0	90.3	3,162.7	1,152.6
HSA A	$200.75	$53.34	$20.30	$0.35	$34.91	$14.37	50.8	491.9	74.5	3,158.3	1,055.9
HSA B	$251.27	$74.94	$23.09	$0.41	$51.70	$24.12	65.8	596.0	73.9	3,614.6	1,634.5
HSA C	$226.46	$66.66	$27.81	$0.51	$33.49	$18.98	49.0	695.7	103.2	3,046.5	1,066.6
HSA D	$208.68	$55.27	$24.58	$0.46	$31.95	$14.97	59.8	562.4	84.3	3,204.6	964.6
HSA E	$223.55	$40.14	$26.55	$0.65	$43.05	$15.44	42.1	602.4	125.1	2,839.5	1,023.2
HSA F	$212.96	$62.72	$23.52	$0.56	$34.54	$14.29	66.3	590.1	109.0	3,744.6	933.1
HSA G	$240.68	$63.66	$33.29	$0.50	$45.22	$22.01	59.7	723.7	102.1	3,058.4	1,610.2
HSA H	$181.62	$42.24	$25.36	$0.40	$34.65	$10.91	38.9	678.4	82.4	3,244.1	906.1
HSA I	$232.19	$43.15	$31.37	$0.53	$46.57	$11.78	45.9	831.5	104.2	2,779.2	978.7
HSA J	$193.19	$27.72	$24.28	$0.24	$40.33	$27.29	33.0	588.4	52.4	2,824.7	2,008.7
HSA K	$198.27	$47.45	$22.28	$0.51	$41.78	$13.61	36.1	573.4	106.1	2,943.8	1,018.5
HSA L	$206.49	$74.90	$19.72	$0.43	$26.85	$10.23	58.1	441.2	80.7	3,017.5	973.8
HSA M	$241.94	$62.88	$23.44	$0.66	$36.83	$13.43	60.5	555.9	132.7	3,219.8	1,022.5
HSA N	$210.02	$39.04	$20.21	$0.46	$30.54	$8.71	42.0	455.6	80.8	2,972.5	914.4

Table 28: Medicaid (Expanded) Variational Analysis

2020 Cohort, Reporting Period: Jan 2020 – Mar 2020

Blinded HSA*	Fee-for-Service Equivalent Spend PMPM	Inpatient Spend PMPM	Emergency Department Spend PMPM	Outpatient Advanced Imaging Spend PMPM	Primary Care Spend PMPM	Specialty Care Spend PMPM	Inpatient Admissions PKPY	Emergency Department Visits PKPY	Outpatient Advanced Imaging PKPY	Primary Care Visits PKPY	Specialty Care Visits PKPY
Total	$166.48	$51.52	$19.19	$0.31	$24.01	$12.11	56.2	478.3	67.1	1,979.9	786.7
HSA A	$134.38	$38.56	$14.25	$0.22	$22.89	$9.78	44.1	329.3	49.0	2,080.5	810.5
HSA B	$215.11	$77.72	$19.05	$0.35	$31.64	$14.25	95.4	516.3	84.2	2,184.9	946.5
HSA C	$210.14	$84.14	$17.33	$0.28	$19.55	$12.51	58.9	527.7	62.8	1,942.1	737.6
HSA D	$158.46	$35.24	$21.43	$0.38	$21.14	$10.77	46.2	549.1	80.2	1,960.7	738.6
HSA E	$167.56	$48.08	$23.21	$0.39	$23.64	$15.68	73.9	522.0	68.9	2,107.5	721.4
HSA F	$142.64	$34.92	$22.09	$0.31	$22.71	$9.10	43.6	591.7	59.2	1,498.1	613.5
HSA G	$178.16	$65.27	$17.60	$0.43	$23.37	$27.09	54.0	478.4	82.7	1,802.2	1,010.8
HSA H	$185.57	$39.44	$25.26	$0.33	$29.26	$8.29	43.3	570.4	79.4	2,075.8	552.3
HSA I	$189.93	$58.81	$25.82	$0.25	$30.40	$15.70	51.8	539.7	59.1	1,966.7	1,009.2
HSA J	$144.53	$59.15	$11.72	$0.31	$18.86	$7.08	58.4	319.1	77.8	1,859.9	758.8
HSA K	$141.12	$29.32	$16.72	$0.42	$25.73	$9.48	30.4	359.3	81.0	1,877.7	754.1
HSA L	$124.59	$31.21	$24.68	$0.18	$21.58	$6.09	53.1	679.0	37.1	2,100.8	567.6
HSA M	$188.36	$59.42	$24.19	$0.22	$21.24	$12.96	56.4	513.8	50.1	1,685.6	808.4
HSA N	$153.92	$62.73	$17.90	$0.32	$24.68	$13.77	78.2	430.0	84.7	1,987.0	846.9
HSA O	$135.04	$17.90	$26.18	$0.50	$23.66	$7.52	30.8	694.1	77.1	2,313.6	755.8
HSA P	$152.53	$35.20	$17.05	$0.56	$22.22	$10.50	50.2	401.7	100.4	1,924.7	853.6

* Townshend and out-of-state are considered HSAs in the Medicaid (Expanded) program because HSA alignment is dependent upon the individual's home zip code.