STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

FY20 ACCOUNTABLE CARE ORGANIZATION BUDGET ORDER

In re:	OneCare Vermont Accountable Care Organization, LLC Fiscal Year 2020	)))
		) Docket No. 19-001-A

INTRODUCTION

The Green Mountain Care Board (GMCB or Board) is charged with reviewing, modifying, and approving the budgets of accountable care organizations (ACOs). 18 V.S.A. § 9382(b). Fiscal Year 2020 (FY20) is the third year that ACO budgets are subject to Board review. Below, we describe the relevant legal framework, outline the criteria that the Board considered during its review, and present specific Findings and Conclusions in support of our Order establishing an FY20 budget for OneCare Vermont Accountable Care Organization, LLC (OneCare).

LEGAL FRAMEWORK

In its review of an ACO's budget, the Board must consider statutory factors that generally fall into the following categories:

- Historic and future expenditures and the effects of care models on utilization, including the provision of innovative services;
- The ACO's efforts to strengthen and provide resources to primary care, invest in social determinants of health, address the impact of childhood trauma, integrate community providers, improve care coordination, and reduce duplication of services in partnership with the Blueprint for Health;
- Health resource allocation priorities;
- Transparency of the ACO's costs;
- Effects of Medicaid reimbursement on other payers;
- Solvency and ability to assume financial risk;
- Administrative costs;
- The character, competence, fiscal responsibility and soundness of the ACO and its leaders; and
- The Office of the Health Care Advocate's (HCA) feedback and public comment.

See 18 V.S.A. § 9382(b)(1). In addition to these statutory criteria, the Board will consider the requirements of the Vermont All-Payer Accountable Care Organization Model Agreement (APM Agreement) between the State of Vermont and the Centers for Medicare & Medicaid Services

(CMS), any benchmarks established in the Board's ACO budget guidance, and the elements of the ACO's payer programs. GMCB Rule 5.000, § 5.405(b).

The APM Agreement provides for Medicare's participation in a statewide health care payment and delivery system reform effort referred to as the "All-Payer ACO Model" (hereafter "the Model"). The Model relies on private-sector health care providers voluntarily working together, as part of an ACO, to reduce health care spending and improve health care quality and outcomes for Vermonters. Relevant requirements of the APM Agreement include:

- **Total Cost of Care (TCOC) Growth Targets.** The State is responsible for limiting per person spending growth over the five performance years of the agreement.
    - The target for Medicare TCOC per Beneficiary Growth is a compounding rate that is at least 0.2% below projected national Medicare growth.
    - The target for All-Payer TCOC per Beneficiary Growth is a compounding rate of 3.5% or less over the five performance years of the APM Agreement.
- **Statewide Health Outcomes and Quality of Care Targets.** The State is responsible for meeting a series of targets tied to three overarching population health goals:
    - Improving access to primary care;
    - Reducing deaths due to suicide and drug overdose; and
    - Reducing the prevalence and morbidity of chronic disease.
- **Scale Targets.** Over the five performance years of the agreement, the State is responsible for steadily increasing the percentages of Vermont Medicare Beneficiaries and Vermont All-Payer Scale Target Beneficiaries that are aligned to a Scale Target ACO Initiative.
    - By the end of the 2020, the third performance year of the APM Agreement, the State is expected to have 58% of All-Payer Scale Target Beneficiaries and 79% Vermont Medicare Beneficiaries aligned to a qualifying initiative.
- **Alignment.** Scale Target ACO Initiatives offered by payers must reasonably align with the Medicare program, referred to as the Vermont Medicare ACO Initiative.

APM Agreement, §§ 6-9, Appendix 1.

FY20 REVIEW PROCESS

An ACO bears the burden of justifying its budget proposal. GMCB Rule 5.000, § 5.405(a). The Board issued FY20 budget guidance on July 1, 2019. 2020 Budget Guidance and Reporting Requirements for Vermont Certified Accountable Care Organization: OneCare Vermont, ACO, LLC. The FY20 budget guidance provided OneCare with a detailed framework for its FY20 budget submission. OneCare submitted its proposed FY20 budget on October 1, 2019 and presented it at a public meeting on October 30, 2019. OneCare Vermont 2020 Fiscal Year Budget Submission (Budget Submission); OneCare PowerPoint (Oct. 30, 2019). At the Board's November 20, 2019 meeting, Board staff and payer representatives presented data regarding OneCare's 2018 performance under the Vermont Medicaid Next Generation Program, the Vermont Modified Next Generation ACO Initiative, and the Blue Cross and Blue Shield of Vermont Next Generation Qualified Health Plan (QHP) Program. 2018 ACO Quality and Financial Results by Payer (Nov. 20, 2019). At a public meeting on December 11, 2019, Board staff presented data regarding OneCare's proposed FY20 budget. GMCB PowerPoint (Dec. 11,

2019). Board staff made recommendations regarding the approval of OneCare's FY20 budget on December 18, 2019. GMCB PowerPoint (Dec. 18, 2019). Throughout the budget review process, OneCare responded to questions from the Board, Board staff, and the Office of the Health Care Advocate (HCA). The Board accepted public comments on OneCare's proposed budget from October 3 through December 18, 2019. On December 18, 2019, the Board voted to establish OneCare's budget on terms and subject to conditions described below. Minutes, Green Mountain Care Board Meeting (Dec. 18, 2019). The written materials from this process are posted on the Board's website[1] and video recordings of the meetings are available from ORCA Media.[2]

FINDINGS

Changes in Leadership and Management

1. OneCare is a "manager-managed" limited liability company organized under Vermont law in 2012 by the University of Vermont Medical Center (UVMMC), a Vermont nonprofit corporation, and Dartmouth-Hitchcock Health (DH-H), a New Hampshire nonprofit corporation. Sixth Amended and Restated Operating Agreement of OneCare Vermont Accountable Care Organization, LLC (Operating Agreement), 1; 11 V.S.A. § 4054.

2. OneCare is governed by a Board of Managers that is comprised largely of representatives of participating health care providers, as required by the Board's rules and federal requirements for participation in Medicare ACO programs. Operating Agreement, 7-8; Certification Eligibility Verification Form for OneCare Vermont Accountable Care Organization, LLC (Sept. 3, 2019) (Verification Form), OneCare Vermont Board of Managers Effective as of September 2019; GMCB Rule 5.202(b); 42 C.F.R. § 425.106(c)(3). In 2019, OneCare expanded the number of Managers on its Board of Managers from 19 to 21, six of which are appointed by the Members, UVMMC and DH-H. Budget Submission, 7; *see also* Operating Agreement, 7-9.

3. FY19 saw several changes to OneCare's executive team. Early in the year, CEO Todd Moore left the organization for a job opportunity out of state. He was replaced on an interim basis by Kevin Stone, the Chair of OneCare's Board of Managers. Following an extensive national search, Victoria Loner was chosen to serve as OneCare's new CEO, effective August 1, 2019. Budget Submission, 8. Ms. Loner previously worked as OneCare's Vice President/Chief Operating Officer. *Id.*; Verification Form, OneCare Leadership Team. The vacancy created by Ms. Loner's appointment as OneCare's CEO was filled by Sara Barry, formerly OneCare's Senior Director of Value Based Care. Budget Submission, 8; OneCare Vermont, Leadership, https://www.onecarevt.org/leadership/. OneCare's Vice President of Finance and Strategy, whose time was split between OneCare and the Adirondacks ACO, also left OneCare in FY19 to dedicate fulltime efforts to the Adirondacks ACO. The vacancy created by her departure will be filled as a Chief Financial Officer, with fulltime efforts dedicated to OneCare. Budget Submission, 8.

[1] Written budget materials are available at https://gmcboard.vermont.gov/content/2020-aco-oversight. Board presentations are available at https://gmcboard.vermont.gov/board/meetings.
[2] https://www.orcamedia.net/series/green-mountain-care-board.

FY20 Payer Programs/ACO Initiatives

4. OneCare expects to contract with Medicare, Medicaid, Blue Cross and Blue Shield of Vermont (BCBSVT), and MVP Health Plan, Inc. (MVP) in FY20. OneCare PowerPoint (Oct. 30, 2019), 13. 2020 will be OneCare's third consecutive year participating in a Medicare program based on the Medicare Next Generation ACO Model[3] and its fourth consecutive year participating in the Vermont Medicaid Next Generation Program. GMCB PowerPoint (Dec. 11, 2019), 34.

5. OneCare's negotiations with the Department of Vermont Health Access (DVHA) regarding the specifics of the 2020 Medicaid program are ongoing. In 2019, OneCare and DVHA piloted a geographic attribution concept in the St. Johnsbury Health Service Area (HSA) and are discussing a potential statewide expansion of this approach for 2020. Budget Submission, 13-14. Due to the timing of these discussions, OneCare's FY20 budget does not include additional Medicaid beneficiaries who may be attributed under an expanded geographic attribution approach or their expected cost of care. *Id.* at 22. OneCare hopes to be able to expand the geographic attribution approach to other payer programs in future years of the APM. *Id.* at 15.

6. 2020 will be OneCare's third consecutive year participating in the BCBSVT Next Generation QHP Program. GMCB PowerPoint (Dec. 11, 2019), 34. OneCare and BCBSVT will be piloting a fixed payment model for this program that will likely start in the second quarter of FY20. OneCare PowerPoint (Oct. 30, 2019), 13.

7. While negotiations are still ongoing, OneCare anticipates contracting with BCBSVT in 2020 for its Administrative Services Only (ASO) and large group business. Budget Submission, 15. OneCare is also negotiating with MVP for its qualified health plan (QHP) business. Budget Submission, 6, 15. Because negotiations are ongoing, the details of these programs are uncertain.

FY18 Performance

8. The 2018 Medicare program included a +/- 5% risk corridor and 80% risk sharing, meaning that within five percentage points of the target, OneCare would earn 80% of any savings and would be responsible for 80% of any losses. OneCare's 2018 performance in the Medicare program was within the risk corridor. Excluding money that was paid to OneCare in advance of program settlement and that the Board required OneCare to use to fund Blueprint for Health programs,[4] spending for OneCare's attributed population was approximately 2.8% below the target and OneCare earned approximately $5.6 million in shared savings. Medicare 2018 Settlement, https://gmcboard.vermont.gov/aco-certification-and-budget-review; GMCB PowerPoint (Nov. 20, 2019), 13.

[3] In 2018, performance year 1 of the APM, OneCare participated in a modified version of Medicare's Next Generation ACO Model. Beginning in 2019, OneCare began participating in the Vermont Medicare ACO Initiative, which is based largely on the Next Generation ACO Model, but which can be tailored to support alignment with other payer's ACO programs. APM Agreement, § 1.dd.

[4] Approximately $7.7 million was included in OneCare's 2018 benchmark and distributed to OneCare in advance of settlement. OneCare used this money to fund Blueprint for Health programs, including Supports and Services at Home (SASH). GMCB PowerPoint (Nov. 20, 2019), 13.

9. 2018 was the first year that OneCare participated in a Medicare program based on the Medicare Next Generation ACO Model. As is common in the first year of a Medicare program, 2018 was a reporting-only year in terms of quality measurement. GMCB PowerPoint (Nov. 20, 2019), 16. Because OneCare satisfied its reporting obligations, it earned a quality score of 100%. Had its results been scored, OneCare would have earned a score of 82.4% because it received 32.95 out of a possible 40 points. GMCB PowerPoint (Nov. 20, 2019), 16.

10. The 2018 Medicaid program included a +/- 3% risk corridor with 100% risk sharing, meaning that within three percentage points of the target, OneCare would earn 100% of any savings and would be responsible for 100% of any losses. OneCare's performance in the 2018 Medicaid program was $1,540,534 or 1.3% above the target and within the risk corridor. Thus, OneCare was required to pay DVHA $1,540,534 in losses. GMCB PowerPoint (Nov. 20, 2019), 8; Vermont Medicaid Next Generation Pilot Program 2018 Performance (Sept. 20, 2019), 7, https://dvha.vermont.gov/administration/1final-vmng-2018-report-09-20-19.pdf.

11. OneCare's losses under the 2018 Medicaid program were driven by higher than projected fee-for-service spending—payments that DVHA made on OneCare's behalf for services delivered to attributed Medicaid beneficiaries. However, zero-paid "shadow" fee-for-service claims were $7,663,309 less than projected (i.e., less than the fixed prospective payments from DVHA). The savings realized on the fixed prospective payment portion of the Medicaid target is not reflected in the program's shared savings/loss calculation. Vermont Medicaid Next Generation Pilot Program 2018 Performance (Sept. 20, 2019), 7-8.

12. OneCare's performance in the 2017 Medicaid program was also within the +/- 3% risk corridor, and resulted in savings of approximately $2.7 million DVHA has described this as an encouraging signal about the potential for an ACO to moderate healthcare expenditures relative to a prospectively agreed upon price. *See* Vermont Medicaid Next Generation Pilot Program 2018 Performance (Sept. 20, 2019), 7; 2017 Vermont Medicaid Next Generation Pilot Program 2017 Performance (Sept. 20, 2018), https://legislature.vermont.gov/assets/Legislative-Reports/VMNG-2017-Report-FINAL-09-20-18.pdf.

13. OneCare earned 17 out of 20 possible points on the ten payment measures that were included in the 2018 Medicaid program. OneCare's overall quality score was therefore 85%. Vermont Medicaid Next Generation Pilot Program 2018 Performance (Sept. 20, 2019), 9. In describing OneCare's 2018 performance, DVHA noted that OneCare exceeded the national 75th percentile on measures relating to developmental screening in the first three-years of life and 30-day follow-up rates after discharge from Emergency Departments for mental health, alcohol, and other drug abuse or dependence. GMCB PowerPoint (Nov. 20, 2019), 28. DVHA also described progress on the expansion of OneCare's care coordination model. *Id.* at 30.

14. The 2018 BCBSVT QHP program included a +/- 6% risk corridor with 50% risk sharing, meaning that within six percentage points of the target, OneCare would earn 50% of any savings and would be responsible for 50% of any losses. OneCare's performance in 2018 was 1.3% above the target and it was required to pay BCBSVT $645,574 in losses. GMCB PowerPoint (Nov. 20, 2019), 39.

15. OneCare earned a quality score of 86% in the 2018 BCBSVT QHP program. OneCare PowerPoint (Oct. 30, 2019), 9. In describing the 2018 results, BCBSVT noted that it had seen early indicators of positive impact based on utilization and quality metrics. GMCB PowerPoint (Nov. 20, 2019), 40.

16. While OneCare lost money in the 2018 BCBSVT QHP program, the money it was required to pay under the program reduced BCBSVT's 2020 QHP rates by 0.2%. Decision and Order, *In re Blue Cross and Blue Shield of Vermont 2020 Individual and Small Group Rate Filing*, Docket No. GMCB-006-19rr, Findings, ¶ 51.

FY20 Provider Network

17. OneCare has a broad provider network for FY20 that includes all but one of Vermont's 14 community hospitals, as well as Dartmouth Hitchcock Medical Center (DHMC), which is located just across the border in New Hampshire. OneCare's FY20 network will also include federally qualified health centers (FQHCs), skilled nursing facilities (SNFs), home health agencies, designated agencies (DAs), area agencies on aging, independent primary care and specialist practices, and an ambulatory surgical center. Budget Submission, Part 1, Attachments A & B, 11.

18. Hospital participation in payer programs is expected to expand slightly in FY20 compared to FY19. Copley hospital, which is located in the Morrisville HSA and did not participate in OneCare in FY19, is expected to participate with OneCare in the Medicaid program in FY20. North Country Hospital, which participated only in the Medicaid program in FY19, is expected to expand its participation in FY20 to the BCBSVT QHP program as well. Springfield Hospital, which filed for Chapter 11 bankruptcy on June 26, 2019, will continue to participate in the Medicaid and BCBSVT QHP programs but will no longer participate in the Medicare program in FY20 due to the amount of risk involved. Budget Submission, 30; TR (Oct. 30, 2019) at 111.

19. OneCare added FQHCs, primary care practices, and specialty practices to its FY20 network. Budget Submission, 5, Appendix 2.1. While OneCare lost several independent practices from the network, analysis of OneCare's budget submission shows that more independent practices, including primary care, specialists, and physical therapists, were added to the network than dropped out. GMCB PowerPoint (Dec. 11, 2019), 45.

Population Health Management and Payment Reform Spending

20. OneCare's Clinical Consultants collaborate with the Blueprint for Health (the Blueprint) on quality and population health initiatives. OneCare and Blueprint leaders co-plan and facilitate monthly meetings of Blueprint Project Managers and Quality Improvement Facilitators, Community Health Team (CHT) Leads, Agency of Human Services Field Directors, and Vermont Department of Health District Directors. At these meetings, participants discuss quality gaps, identify root causes, consider possible strategies for collaboration, and plan future work. OneCare's Clinical Consultants and Blueprint staff also meet with HSA community collaboratives, comprised of a broader range of stakeholders and providers, to provide technical

assistance and support each community in meeting the objectives it has identified to achieve the ACO and community quality goals. Budget Submission, 39.

21. OneCare's FY20 budget reflects continued investment in the Blueprint's Patient-Centered Medical Home (PCMH), CHT, and Support and Services at Home (SASH) programs. As the Blueprint noted in its 2018 Annual Report, ACOs that include primary care providers working in Patient-Centered Medical Home settings have been found to achieve higher savings and better-quality care. Annual Report on The Vermont Blueprint for Health (Jan. 31, 2019), 8 (citing Patient-Centered Primary Care Collaborative, *Advanced Primary Care: A Key Contributor to Successful ACOs* (August 2018)).

22. OneCare plans to continue its Basic OneCare PMPM payments in FY20—$3.25 per member per month (PMPM) payments to attributing primary care practices for each attributed patient when the practice attests to having achieved a set of criteria to facilitate primary care transformation. OneCare's criteria include population health monitoring activities, utilization of data to identify strengths and opportunities, as well as implementation of quality improvement initiatives to strengthen person-centered care and outcomes. Budget Submission, 42.

23. OneCare's FY20 budget reflects the continuation of the Comprehensive Payment Reform (CPR) Program, which is designed to transition independent primary care practices from fee-for-service reimbursement to a PMPM payment model and facilitate innovation within practices. *See* Verification Form, 13; Budget Submission, 42. OneCare continues to evolve the program with input from independent primary care practices. 2018 Comprehensive CPR Pilot Final Report (Oct. 31, 2019), 1. For FY20, OneCare plans to introduce new accountability to the program through a variable component of the PMPM payment that will be tied to care coordination engagement and achievement of care delivery transformation targets. Budget Submission, 7.

24. OneCare's FY20 budget also reflects the continuation of the value-based incentive fund (VBIF), which is designed to incentivize high quality care and reward the quality achievements of OneCare's network. Funds will be disbursed to network providers based on quality scores and in accordance with OneCare's VBIF distribution policy, which was modified for FY20 to strengthen practice-level quality incentives. Under the modified policy, 70% of the VBIF funds will still be available to attributing primary care providers based on attribution. However, of the 70% that is allocated to primary care providers, 10% will now be reserved for practices that exceed the network average on primary care engagement by payer. Furthermore, 10% of the VBIF will be allocated to quality improvement initiative(s) approved by the Board of Managers. VBIF Variable Memo Q3 (Oct. 31, 2019).[5]

25. OneCare will be continuing its complex care coordination program in FY20. This program provides funding for primary care practices, home health agencies, areas agencies on aging, and DAs to engage patients in need of additional supports and services and to coordinate the provision of these supports and services across organizational boundaries in order to enhance patients' experiences with care and reduce costs. *See* Budget Submission, 42; Verification Form, 9. Under the program, lead care coordinators and care team members are responsible for

[5] The amount of VBIF available for reinvestment in FY19 and FY20 based on FY18 performance is $167,505. Budget Submission, 43.

outreach to patients, participation in care conferences, and addressing patient goals while working to improve the physical and mental health of individuals. Verification Form, 10.

26. In its budget hearing, OneCare noted that it has seen a marked increase in the number of patients whose care is being managed through the care coordination program, from 504 in 2018 to 3,044 as of October 25, 2019. OneCare PowerPoint (Oct. 30, 2019), 34. OneCare also noted that it has seen a 33% reduction in emergency department (ED) utilization among care managed Medicare patients and a 13% reduction in ED utilization among care managed Medicaid patients. OneCare PowerPoint (Oct. 30, 2019), 36.

27. OneCare led an extensive process in FY19 to evolve its complex care coordination payment model away from a capacity-building program to one that pays for effective engagement in care coordination programming. Budget Submission, 44. Part of this evolution is a significant enhancement in the PMPM payments that are provided to the lead care coordinator and care team members for patients under active care management. Budget Submission, 7; OneCare PowerPoint (Oct. 30, 2019), 38.

28. In 2019, OneCare funded Regional Clinical Representatives (RCRs) to facilitate information sharing and communication between itself and the HSAs. Budget Submission, Appendix 4.2; OneCare Responses to Questions on FY20 Budget Submission (Oct. 25, 2019), 9. For FY20, RCRs will continue to function in this way, however, the funding will now come directly from participating hospitals. OneCare Responses to Questions on FY20 Budget Submission (Oct. 25, 2019), 9.

29. OneCare's budget reflects continued funding for the evidence-based Developmental Understanding and Legal Collaborations for Everyone (DULCE) program. GMCB PowerPoint (Dec. 11, 2019), 62. This program seeks to ensure that newborns and their families receive quality medical care as well as the social services and community support they need during the first six months of the newborn's life. Families participating in the program receive comprehensive social determinants of health screening with a unique emphasis on the legal needs that might cause family stress or uncertainty. Verification Form, 15.

30. OneCare's FY20 budget reflects continued support for and expansion of RiseVT, which is part of OneCare's primary prevention strategy to keep people well and to prevent disease before it occurs. Under this program, program managers work with local partners to identify opportunities to enhance the overall wellness of towns by offering health programs, working to improve local systems such as walkability and school wellness policies, and making grants to aligned community programs. Budget Submission, 7. In 2020, RiseVT anticipates expanding to seven additional cities/towns and will implement a campaign to reduce the consumption of sugar-sweetened beverages by people 18 to 35 years old. *Id.* at 44.

31. In FY19, OneCare allocated more than $1 million from its innovation fund to support nine projects across the state that it expects will enhance care delivery transformation and be scalable across the network. The areas that these projects address include mental health, vulnerable populations, technology in rural settings, and specific chronic conditions. Budget Submission, 44. One example is a program in the Bennington area called Psychiatric Urgent

Care for Kids, which aims to provide a more appropriate setting of care for children who are presenting with urgent mental health issues at school and have been receiving care in local emergency rooms. TR, 78-79; 2019 Innovation Fund Q3 GMCB Report Deliverable, 1. Over the next two years OneCare will monitor and evaluate the effectiveness of these programs and determine which investments may be amenable to wider adoption. Budget Submission, 44; TR, 114-15. OneCare's budget includes money to fund additional projects in 2020. Budget Submission, 43; GMCB PowerPoint (Dec. 11, 2019), 63.

32. OneCare also obligated funds in FY19 to support several specialist payment programs relating to care coordination for patients with advanced chronic kidney disease, developing infrastructure for electronic consultation between primary and specialty care practices, and embedding clinical pharmacists in primary care. Budget Submission, 7, 42-43; 2019 Specialist Payment Pilot Q3 GMCB Report Deliverable (Oct. 31, 2019). OneCare is budgeting additional funds to expand support for these programs in FY20. Budget Submission, 42.

33. OneCare's budgeted PHM/payment reform spending is presented in the following table:

PHM/Payment Reform Programs	**FY20 Budgeted Investment**
Basic OneCare PMPM	$8,569,920
Complex Care Coordination Program	$9,423,590
Value-Based Incentive Fund	$8,387,232
Comprehensive Payment Reform Program	$1,606,613
Primary Prevention (RiseVT)	$1,031,752
DULCE	$800,000
Specialist Program Pilot	$3,144,500
Innovation Fund	$1,367,580
Primary Care Engagement Investment	$375,000
PCMH Legacy Payments	$1,894,417
CHT Block Payment	$2,379,711
SASH	$3,968,246
VBIF Quality Initiatives	**$167,505**
Total Investment	**$43,116,066**
Total revenues	$1,362,200,000
Total attributed lives	~250,000

See GMCB PowerPoint (Dec. 11, 2019), 62.

34. While subject to several variables, OneCare projects that, of the $44.3 million in PHM and payment reform investments, approximately $22.7 would go to primary care providers; $5.1 million would go to specialty and acute care providers; $3.9 million would to go SASH; $3.4 would go to DAs; $2.4 million would go to Blueprint CHTs; and $1.9 would go to home health providers; OneCare PowerPoint (Oct. 30, 2019), 20.

35. OneCare has increased the total dollar amount budgeted for population health investments each year since 2018, from $27 million to $43 million. OneCare's budgeted FY20

investments in PHM and payment reform have increased approximately $5.8 million or 16% from FY19, from $37.2 million to $43.1 million. Budget Submission, Appendix 4.2. Due to the large increase in total revenues, OneCare's PHM and payment reform spending represents a smaller percentage of its FY20 total budgeted revenues (3.03%) than its FY19 total budgeted revenues (4.03%). GMCB PowerPoint (Dec. 11, 2019), 65. The following table describes these trends:

Metric	2018 Budget	2018 Actual	2019 Budget	2019 Projected	2020 Budget
Total Revenue	$639 M	$634 M	$899 M	$882 M*	$1,425 M
Pop Health Mgt (PHM) Total	$27 M	$23 M	$37 M	$36 M	$43 M
Blueprint	$7.8 M	$7.8 M	$8.1 M	$8.0 M	$8.2 M
(PHM LESS Blueprint)/Revenues	3.05%	2.40%	3.25%	3.10%	2.45%
PHM/Total Revenues	4.27%	3.63%	4.14%	4.03%	3.03%

36. OneCare's $43.1 million in PHM and payment reform investments are funded by hospital dues (budgeted at approximately $24.5 M) and payer and government contributions. Budget Submission, 30, Appendix 4.2. Some of these investments are tied to attribution. Thus, OneCare's budgeted PHM and payment reform investments may change as OneCare's contract terms and attribution are finalized in the coming months. Responses to Questions (Oct. 25, 2019), 8. Moreover, there is uncertainty regarding $7.8 million in delivery system reform funds ($3.9 million from state funds) that OneCare has budgeted for FY20. TR, 60; OneCare PowerPoint (Oct. 30, 2019), 24.

37. OneCare was asked to provide a monitoring and evaluation plan for each of its PHM programs, including a description of any metrics used. While OneCare described generally how it monitors key process and outcome metrics for the complex care coordination program, as well as its plans to evaluate the projects it has supported through the innovation fund, it did not provide the specific information requested. Responses to Questions (Nov. 22, 2019), 11.

Operating/Administrative Budget

38. OneCare budgeted approximately $19.3 million for operating expenses in FY20, as compared to the approximately $15.9 million that the Board approved in OneCare's FY19 budget. OneCare's operating expense budget includes salaries and benefits (including those of the RiseVT team), contracted services, software, supplies, and risk protection/insurance. Budget Submission, Appendix 4.2; OneCare PowerPoint (Oct. 30, 2019), 21.

39. Though the FY20 budget represents a 21% increase in total operating expenses over the approved FY19 budget, the administrative expense ratio is decreasing from 1.77% to 1.35%. OneCare PowerPoint (Oct. 30, 2019), 22; GMCB PowerPoint (Dec. 11, 2019), 77. Similarly, OneCare's projected FY20 administrative costs amount to $6.44 PMPM, down from $7.69 PMPM in FY19 and $8.49 PMPM in FY18. Budget Submission, 26.

40. The majority of OneCare's FY20 operating budget, 68%, is for network support, including analytics-, clinical-, and quality-related functions, as well as risk protection for the Medicare program. Approximately 24% of the OneCare's operating budget is for ACO administration. OneCare PowerPoint (Oct. 30, 2019), 21.

41. As with most organizations, the majority of OneCare's budgeted operating expenses (61%) are for salaries and benefits. GMCB PowerPoint (Dec. 11, 2019), 75. At the Board's request, OneCare provided salary information with the budget submission. This information shows the number of employees in specified salary ranges. This information has been posted on the Board's website along with other budget materials.[6]

42. GMCB staff performed a sensitivity analysis that looked at holding OneCare's administrative expenses constant and varying assumptions of attribution and other revenue expectations. Under the low growth scenario that was modeled—a reduction in attribution of 15% across payers and no award of DSR/IAPD funding ($13.1 M)—it would not be expected that the administrative expense ratio would increase above 1.60%. In the high growth scenario that was modeled—an increase in attribution of 3% and the full award of DSR/IAPD funding—it would not be expected for the ratio to dip below 1.28%. GMCB PowerPoint (Dec 11, 2019).

Benchmark Trend Rates

43. A "benchmark" or TCOC target is a payer-specific financial target against which expenditures for ACO-aligned beneficiaries are assessed to determine whether an ACO earned savings or is responsible for losses. Rule 5.000, § 5.103(8). The APM Agreement authorizes the Board to prospectively develop the benchmark for the FY20 Medicare program, the 2020 Vermont Medicare ACO Initiative, subject to CMS approval.[7] APM Agreement, § 8.b.ii.

44. The trend rates used to develop the FY20 Medicare program's benchmarks—the rates used to project claims experience to the performance period—must be at least 0.2 percentage points below Annual Projected National Medicare Total Cost of Care per Beneficiary Growth for 2020. APM Agreement, § 8.b.ii.c.i. Furthermore, the FY20 Medicare program's benchmarks must enable achievement of the APM Agreement's financial targets. APM Agreement, § 9.e.

45. Different populations contribute differently to Vermont's All-Payer TCOC. Based on data in the Vermont Health Care Uniform Reporting and Evaluation System, while Medicare

[6] https://gmcboard.vermont.gov/sites/gmcb/files/documents/FY20%20Budget%20Submission%20-%20OCV%20Salary%20Table.pdf.

[7] The APM Agreement grants the Board's authority to set Medicare benchmarks; the authority is distinct from ACO budget review authority which the Board has via statutory mandate.

beneficiaries represent only 27% of the population, the spending for these individuals represents 44% of All-Payer TCOC. Medicaid beneficiaries represent 29% of the overall population but spending on these individuals represents only 16% of All-Payer TCOC. The commercially insured represent 44% of the overall population and spending on these individuals represents 40% of All-Payer TCOC. 2020 Benchmark Recommendation (Dec. 11, 2019) 4.

46. On December 11, 2019, Board staff presented projections of annualized payer-specific TCOC growth rates and All-Payer TCOC growth rates from 2017, the base year of the APM, through 2020. GMCB PowerPoint (Dec. 11, 2019). After considering these projections, as well as Annual Projected National Medicare TCOC per Beneficiary Growth for 2020, the Board voted to approve a 2.9% trend rate for the aged and disabled (A/D) component of the Medicare benchmark and a 3.5% trend rate for the end-stage renal disease (ESRD) component of the Medicare benchmark. GMCB Meeting Minutes (Dec. 18, 2019).

47. OneCare and DVHA were still negotiating the terms of the FY20 Medicaid contract, including the appropriate trend rate, when the Board voted on OneCare's FY20 budget. Due to the state of the negotiations at that time, the Board had received insufficient data to complete the Medicaid advisory rate case required by 18 V.S.A. § 9573.

48. OneCare is involved in negotiations with BCBSVT and MVP regarding the trend rates that will be used to develop the financial targets for FY20 commercial QHP programs. The rates OneCare used to build its budget were derived from the QHP rates that the Board approved in its rate review process this past summer. OneCare cautions that these rates are subject to additional actuarial review. Budget Submission, 21.

49. OneCare is developing a program with BCBSVT to bring in attributed lives from BCBSVT's non-QHP product lines. OneCare states that while the process to collaboratively explore different methodologies to establish benchmarks is underway, the budget model incorporates a PMPM estimate that represents a reasonable spending assumption and trend rates informed by industry experience. Budget Submission, 21.

Scale & Program Alignment

50. The APM Agreement requires Vermont to steadily increase the number of people that are attributed or aligned to an ACO over the life of the model. The APM Agreement establishes attribution targets (scale targets) for two populations—All-Payer Beneficiaries and Medicare Beneficiaries—for each of the model's five performance years. APM Agreement, § 6.a.

51. People that are attributed to an ACO only count towards the APM Agreement's scale targets if they are attributed under a "Scale Target ACO Initiative." APM Agreement, § 6.a. The APM Agreement defines a "Scale Target ACO Initiative" as an ACO arrangement that meets certain minimum standards. *Id.* The APM Agreement also requires the State to ensure that Scale Target ACO Initiatives offered by Medicaid and private payers reasonably align in their design with the Medicare Scale Target Initiative. *Id.* § 6.f.

52. OneCare does not anticipate major changes to existing programs in FY20 that would negatively impact program alignment (apart from geographic attribution in the Medicaid program) or the ability of the programs to quality as Scale Target ACO Initiatives. While OneCare is still negotiating with BCBSVT and MVP on new programs, it expects that both programs will qualify as Scale Target ACO Initiatives. GMCB PowerPoint (Dec. 11, 2019), 36.

53. As a result of additional payer programs and an expanded provider network, OneCare expects to increase the number of people it is accountable for (attributed lives) in FY20 by approximately 90,000 people, from approximately 160,000 to just under 250,000. OneCare PowerPoint (Oct. 30, 2019), 14; Budget Submission, 6.

54. Assuming OneCare's attribution projections are accurate and assuming that the new payer programs OneCare is negotiating will qualify as Scale Target ACO Initiatives, Vermont's scale performance for FY20 is projected to be approximately 48% for All-Payer Beneficiaries and approximately 46% for Medicare Beneficiaries. While this would be a significant improvement over 2019 performance, it would still be below the Performance Year 3 targets under the APM Agreement, which are 58% for All-Payer Beneficiaries and 79% for Medicare Beneficiaries. GMCB PowerPoint (Dec. 11, 2019), 53.

55. In 2019, the Board and state partners surveyed Vermont hospitals and FQHCs in order to identify barriers to scale and potential strategies for state, federal, ACO, and local partners to improve the Model. Strategies fell into two broad categories: (1) Payment structure should be more transparent, predictable, and sustainable and (2) Payments from the ACO and participating payers must offset additional administrative and reporting requirements (reduce burden) and incentivize delivery reform, with a greater emphasis on prevention and health improvement (incentivize population health). *See* Memo to Green Mountain Care Board re Insights from Hospital/FQHC Scale Survey: Results and Reactions (Aug. 16, 2019), *available at* https://gmcboard.vermont.gov/sites/gmcb/files/documents/payment-reform/GMCB%20Scale%20Memo%208-15-2019.pdf.

Risk

56. The magnitude of OneCare's "downside" risk—its risk of having to pay losses—varies by program due to differences in the programs' risk sharing arrangements and spending targets. Because it has a higher spending target, most of OneCare's downside risk in FY20 will be associated with the Medicare program. OneCare expects to bear just over $44.1 million in downside risk across all its FY20 payer programs and, of this, approximately $27.3 million is connected to the Medicare program. Budget Submission, Appendix 2.3. OneCare described this

level risk as a challenge to expanding hospital participation in the Medicare program. OneCare PowerPoint (Oct. 30, 2019), 16.

57. The total downside risk reflected in OneCare's FY20 budget equals approximately 3.2% of the projected spending for its attributed lives. All risk not assumed by OneCare for spending in excess of the targets would reside with payers. GMCB PowerPoint (Dec. 11, 2019), 83.

58. OneCare's strategy for managing downside risk involves delegating this risk, as well as the potential for savings (sometimes referred to as upside risk), to network hospitals. This model is designed to protect smaller network providers and give hospitals the opportunity to offset the dues they pay to OneCare with shared savings. Budget Submission, 15.

59. OneCare implements its risk delegation model by setting spending targets for each HSA participating in a payer program. These targets are based on historical cost of care data blended with the risk profile of the attributed lives in the HSA (and possibly incorporating social determinant scores in the future). Budget Submission, 16, 29. The program risk corridor and sharing terms are then applied to the HSA spending target to calculate a Maximum Risk Limit (MRL). Budget Submission, 16.

60. In last year's budget order, the Board required OneCare to build $3.9 million in reserves by the end of FY19 to fund $3.9 million in risk protection that OneCare sought to provide to three network hospitals. FY19 ACO Budget Order, Docket No. GMCB-18-001-A. Based on current forecasts, OneCare expects to conclude FY19 with approximately $3.9 million in reserves net of any contributions needed to cover these risk mitigation arrangements. OneCare Responses to Questions (Oct. 25, 2019), 4; Budget Submission, 16, Appendix 4.3.

61. OneCare's proposed budget carries the projected year-end reserves of $3.9 million forward into FY20. Budget Submission, 16. However, OneCare will not be responsible for risk mitigation in FY20. While $3.7 million in risk mitigation is expected to be provided to three hospitals in FY20 (limiting their MRLs), this protection will be provided by OneCare's founders, UVMMC and DH-H. OneCare Responses to Questions (Oct. 25, 2019), 4-5. Because OneCare's founders have agreed to assume this risk, the $3.9 million in reserves that OneCare budgets carrying into FY20 is not intended to provide risk mitigation to hospitals, but rather to cover other potential needs, such as to provide general liquidity to manage financial operations. *Id.*; Budget Submission, 16.

62. While the numbers will change as the payer contracts and attribution are finalized, the table below shows each hospital's total MRL in FY20, the effect of any risk mitigation on each hospital's MRL, and each hospital's overall MRL as a percentage of total system risk:

Hospital	Total Risk (MRL)	Risk Mitigation	Est. MRL FY20	% of System MRL
Brattleboro Memorial Hospital	$ 2,368,265	$ 1,184,133	$ 1,184,133	2.9%
Central Vermont Medical Center	$ 4,971,384		$ 4,971,384	12.3%
Copley Hospital	$ 475,334	$ 237,667	$ 237,667	0.6%
Gifford Medical Center	$ 457,211		$ 457,211	1.1%
Grace Cottage Hospital	$ -		$ -	0.0%
Mt. Ascutney Hospital & Health Ctr	$ 2,196,835		$ 2,196,835	5.4%
North Country Hospital	$ 785,616		$ 785,616	1.9%
Northeastern VT Regional Hospital	$ 822,304		$ 822,304	2.0%
Northwestern Medical Center	$ 4,303,405		$ 4,303,405	10.7%
Porter Medical Center	$ 3,447,724		$ 3,447,724	8.5%
Rutland Regional Medical Center	$ 1,297,409		$ 1,297,409	3.2%
Southwestern VT Medical Center	$ 4,696,716	$ 2,348,358	$ 2,348,358	5.8%
Springfield Hospital	$ 825,283		$ 825,283	2.0%
UVM Medical Center	$ 16,830,645		$ 16,830,645	41.7%
DHMC	$ 640,310		$ 640,310	1.6%
Total	**$ 44,118,441**		**$ 40,348,284**	

GMCB PowerPoint (Dec. 18, 2019), 13.

63. Board staff have compared each hospital's overall MRL to its days cash on hand and overall patient revenue—net patient revenue (NPR) + fixed prospective payments (FPP)—as approved for each hospital in its 2020 budget. This analysis is reflected in the tables below:

Hospital	Total Risk (MRL)	Risk Mitigation	Est. MRL FY20	Days Cash on Hand (DCH)	MRL as % of DCH
Brattleboro Memorial Hospital	$ 2,368,265	$ 1,184,133	$ 1,184,133	121.6	1.4%
Central Vermont Medical Center	$ 4,971,384		$ 4,971,384	75.0	2.2%
Copley Hospital	$ 475,334	$ 237,667	$ 237,667	72.1	0.3%
Gifford Medical Center	$ 457,211		$ 457,211	241.4	0.9%
Grace Cottage Hospital	$ -		$ -	87.7	N/A
Mt. Ascutney Hospital & Health Ctr	$ 2,196,835		$ 2,196,835	134.1	4.0%
North Country Hospital	$ 785,616		$ 785,616	201.8	0.9%
Northeastern VT Regional Hospital	$ 822,304		$ 822,304	114.3	1.0%
Northwestern Medical Center	$ 4,303,405		$ 4,303,405	279.2	3.7%
Porter Medical Center	$ 3,447,724		$ 3,447,724	125.3	4.0%
Rutland Regional Medical Center	$ 1,297,409		$ 1,297,409	204.6	0.5%
Southwestern VT Medical Center	$ 4,696,716	$ 2,348,358	$ 2,348,358	35.7	1.4%
Springfield Hospital	$ 825,283		$ 825,283	3.7	1.7%
UVM Medical Center	$ 16,830,645		$ 16,830,645	192.7	1.2%
DHMC	$ 640,310		$ 640,310	N/A	N/A
Total	**$ 44,118,441**		**$ 40,348,284**		

* Southwestern VT Medical Center's days cash on hand does not include its parent corporation's days cash on hand figures.

Hospital	Total Risk (MRL)	Risk Mitigation	Est. MRL FY20	NPR + FPP	MRL as % of NPR + FPP
Brattleboro Memorial Hospital	$ 2,368,265	$ 1,184,133	$ 1,184,133	$ 88,145,092	1.3%
Central Vermont Medical Ctr	$ 4,971,384		$ 4,971,384	$ 218,043,247	2.3%
Copley Hospital	$ 475,334	$ 237,667	$ 237,667	$ 72,658,362	0.3%
Gifford Medical Center	$ 457,211		$ 457,211	$ 52,382,984	0.9%
Grace Cottage Hospital	$ -		$ -	$ 19,967,821	0.0%
Mt. Ascutney Hospital & Health Ctr	$ 2,196,835		$ 2,196,835	$ 53,755,559	4.1%
North Country Hospital	$ 785,616		$ 785,616	$ 83,623,249	0.9%
Northeastern VT Regional Hospital	$ 822,304		$ 822,304	$ 87,253,844	0.9%
Northwestern Medical Center	$ 4,303,405		$ 4,303,405	$ 116,926,579	3.7%
Porter Medical Center	$ 3,447,724		$ 3,447,724	$ 87,487,539	3.9%
Rutland Regional Medical Center	$ 1,297,409		$ 1,297,409	$ 267,787,827	0.5%
Southwestern VT Medical Center	$ 4,696,716	$ 2,348,358	$ 2,348,358	$ 172,284,645	1.4%
Springfield Hospital	$ 825,283		$ 825,283	$ 48,889,189	1.7%
UVM Medical Center	$ 16,830,645		$ 16,830,645	$ 1,348,125,703	1.2%
DHMC	$ 640,310		$ 640,310		
Total	**$ 44,118,441**		**$ 40,348,284**	**$ 2,717,331,640**	

GMCB PowerPoint (Dec. 18, 2019), 14-15.

64. Of the $27.3 million in risk that OneCare expects to bear in the 2020 Medicare program (5% of the expected target), the maximum risk faced by OneCare's Medicare-participating hospitals (in aggregate) would be approximately $15 million (2.8% of the target) due to OneCare's purchase of third-party risk protection. GMCB PowerPoint (Dec. 11, 2019), 84.

Public Comments

65. The Board took public comments on OneCare's proposed budget and the budget review process from October 1, 2019 through December 18, 2019.[8] During that time, the Board received 19 public comments regarding the OneCare's FY20 budget and the Board's review. Generally, the themes from public comments included:

- Public support for OneCare's continued investments in disease prevention, primary care, home health, mental health, and other community-level services;
- Interest in evaluating OneCare and addressing issues identified;
- Requests for continued monitoring of ACO programs, expenses (including administrative costs), tools (e.g., Care Navigator), quality measures, and TCOC;
- Suggestions for further implementation of care coordination support;
- Consideration of scale, having not yet been achieved, when reviewing results;
- Desire to ensure OneCare's operational transparency.

[8] https://gmcboard.vermont.gov/content/2020-aco-oversight.

CONCLUSIONS

I. Statutory Criteria

A. Historic and future expenditures and the effects of care models on utilization, including the provision of innovative services;

OneCare's budget is driven primarily by its benchmarks or TCOC targets, which are developed by trending past claims experience forward to estimate future expenditures for the people that will be attributed to the ACO in the performance period. In 2018, the most recent year for which data are available, OneCare's performance against these targets was mixed. OneCare achieved savings in the Medicare program, meaning that the cost of caring for Medicare beneficiaries attributed to OneCare under the program was below the established target. Findings, ¶ 8. OneCare's performance in the Medicaid and BCBSVT QHP programs was above the targets for those programs and, as a result, OneCare paid losses to DVHA and BCSBSVT. Findings, ¶¶ 10, 14. While OneCare was required to pay losses under the Medicaid program, it realized savings against the program's fixed prospective payments. Findings, ¶ 11.

Payers are responsible for evaluating whether OneCare is positively impacting the cost and quality of care provided to their beneficiaries or members. CMS, DVHA, and BCBSVT will each continue their existing programs with OneCare in 2020. Additional programs are expected to be established in 2020 as well, suggesting that public and private payers see promise in an ACO model as way to deliver value for their beneficiaries or members. Indeed, in its 2020 QHP rate filing, BCBSVT projected that its collaboration with OneCare would reduce medical claims for attributed members by 0.4%. Decision and Order, *In re: Blue Cross and Blue Shield of Vermont) GMCB-006-19rr 2020 Individual and Small Group Rate Filing*, Docket No. GMCB-006-19rr, Findings, ¶ 52.

While OneCare's budget submission described progress OneCare has made on its clinical priorities—high-risk patient care coordination and chronic disease management optimization, and prevention and wellness—and while OneCare shared success stories during the budget hearing, the Board and the public need a more systematic way to understand the impacts of ACO programs. We therefore require that OneCare work with Board staff to develop a performance dashboard to report population health and financial data. The Board and the public also need to understand in more detail how OneCare is evaluating the effectiveness of its PHM investments and how it intends to scale those investments that are successful and sunset those that are not. *See* Findings, ¶ 37. Thus, as part of our approval of OneCare's FY20 budget, we require OneCare to consult with Board staff to develop a strategy for this work. Finally, while OneCare analyzes cost and quality differences across its HSAs, it has not adequately described how its community investments address these variations and we therefore impose conditions on our approval of OneCare's FY20 budget to address this issue.

B. The ACO's efforts to strengthen and provide resources to primary care, invest in social determinants of health, address the impact of childhood trauma, integrate community providers, improve care coordination, and reduce duplication of services in partnership with the Blueprint for Health.

OneCare's FY20 budget includes continued investments to strengthen and provide resources to primary care practices, address social determinants of health and the impacts of childhood trauma, integrate community providers, improve care coordination for patients, and reduce duplication of services in partnership with the Blueprint for Health. Findings, ¶¶ 20-35. OneCare expects that primary care providers will receive $22.7 million through its PHM and payment reform programs, more than half of the total FY20 PHM spending of $43 million. Findings, ¶ 34. In many instances, these programs address more than one of the APM Agreement's quality and population health goals. *See* Findings, ¶¶ 20-35. Furthermore, OneCare is modifying several of its programs in FY20, including the VBIF, the complex care coordination program, and the CPR program, to increase accountability and reward quality. Findings, ¶¶ 23-24, 27.

There is more uncertainty this year than there has been in previous years regarding the amount of money that will be available to fund OneCare's PHM and payment reform investments. In addition to uncertainty regarding attribution estimates, OneCare is still negotiating the terms of two entirely new payer programs. Findings, ¶ 7. There are also questions regarding the availability of certain state/federal funds. Findings, ¶ 36. Given this uncertainty, and given outstanding questions regarding the scaling of investments as attribution changes from the estimates upon which the budget was based, we are not including a PHM/payment reform ratio in the budget order, as we have done in previous years, we will instead require OneCare to submit a revised proposal to the Board by March 31, 2020 if its PHM and payment reform programs are not fully funded as detailed in the FY20 budget.

C. The Goals and Recommendations of HRAP

The Health Resource Allocation Plan (HRAP) was last updated in 2009 and the recommendations in the HRAP were not relevant to OneCare's budget planning. In accordance with Act 167 of 2018, we are currently working to update the HRAP and will review how it can best be utilized in the ACO budget process in the future. *See* 2018 Sess., No. 167. However, we did not find it relevant to our review.

D. Transparency of ACO's Costs

Through the Board's public budget review process, OneCare has been transparent about its expected costs. OneCare has provided a breakdown of its $19.3 million administrative budget, the majority of which is dedicated to network support functions (e.g., analytic and clinical support and risk protection). Findings, ¶¶ 38-40. OneCare has also detailed how its administrative expenses, both on a percentage-of-total-revenue- and a PMPM-basis have decreased from prior years. Findings, ¶ 39.

As with most organizations, salary and benefits make up the majority of OneCare's administrative expenses. This year, OneCare also provided salary information to the Board showing the number of OneCare employees in specified salary ranges. This information has been posted on the Board's website along with other budget materials. Findings, ¶ 41.

In addition to the details regarding its administrative expenses, OneCare has described the estimated amounts each hospital will receive under its fixed prospective payment model, as well as each hospital's projected MRL. *See* Findings, ¶ 62. It has also described the payments it plans to make under its PHM and payment reform programs and the sources of those funds, including payer support and hospital dues. *See* Findings, ¶¶ 33-36.

E. Effects of Medicaid Reimbursement on Other Payers

OneCare's budget includes trend rates for the FY20 MVP and BCBSVT QHP programs that are based on the rate increases that the Board approved in the 2020 health insurance rate review process. Findings, ¶ 48. These health insurance rate increases are affected by the cost shift. *See* GMCB Annual Report for 2019, 27 (calculating the impact of the cost shift, as defined elsewhere in the report, on QHP rate increases to be approximately 14.7%). Thus, through the cost shift, Medicaid reimbursement levels impact the rates between commercial insurers and OneCare.

More time is needed to understand the impact of Medicaid's ACO rates on the rates that other payers negotiate with the ACO. Under the APM Agreement, the Board must report on what impact, if any, rate differentials have on OneCare's profits, the rates other payers pay, and potential options to reduce payer differential. APM Agreement, § 10. However, this reporting is not available yet to inform the Board's regulation.

F. ACO's Solvency and Ability to Assume Financial Risk

OneCare manages the downside risk that it assumes under its payer contracts primarily by delegating that risk to network hospitals. *See* Findings, ¶ 58. Although the numbers will likely change as contracts are finalized in the coming months, OneCare expects to delegate slightly more than $44.1 million in risk to these hospitals in FY20. When third-party risk protection is factored in, the hospitals' aggregate maximum risk drops to $31.8 million. . *See* Findings, ¶¶ 62, 64. Board staff have compared each Vermont hospital's projected MRL to its budgeted days cash on hand and overall patient revenue—NPR + FPP. This analysis showed that no hospital's projected MRL exceeds 4% of its budgeted days cash on hand and only one hospital's projected MRL as a percentage of budgeted NPR + FPP is greater than 4.0% (4.1%). Findings, ¶ 63. While the MRL for any one hospital is relatively small compared to its days cash on hand and total patient revenue, hospitals are currently dealing with a variety of financial pressures. *See generally* FY20 Hospital Budget Orders.[9] We impose several conditions on our approval of OneCare's FY20 budget designed to ensure that OneCare's delegated risk model is implemented as described it the budget submission and that OneCare notifies the Board of any changes to the model.

OneCare projects that it will end FY19 with just under $4.0 million in reserves. Findings, ¶ 60. OneCare seeks to carry these projected reserves forward into FY20. Findings, ¶ 61. While it may be appropriate for OneCare to maintain some reserves to address, for example, potential cash flow problems, these reserves were built for a specific purpose—to provide hospitals with risk mitigation and to thereby expand provider participation in the model. *See* Findings, ¶ 60. The reserves will no longer be used for this specific purpose since risk mitigation in FY20 will

[9] https://gmcboard.vermont.gov/content/FY2020-Budget.

be provided by OneCare's founders. Findings, ¶ 61. Because OneCare's reserves were built to support the model, we impose a condition in our Order establishing OneCare's FY20 budget that is designed to ensure these reserves continue to serve that purpose.

G. ACO's Administrative Costs

Although OneCare's proposed FY20 budget represents a 21% increase in overall operating expenses from the approved FY19 budget, the administrative expense ratio is decreasing from 1.77% to 1.35% for FY20. Findings, ¶ 39. Similarly, on a PMMP basis, administrative costs are decreasing, from $7.69 in the approved FY19 budget to $6.44 in the proposed FY20 budget. Findings, ¶ 39. The majority of OneCare's FY20 administrative budget, 68%, is for network support functions, including analytics-, clinical-, and quality-related functions, as well as risk protection for the Medicare program. Approximately 24% of the FY20 administrative budget is for ACO administration. Findings, ¶ 40.

GMCB staff completed a sensitivity analysis that looked at holding OneCare's administrative expenses constant and varying assumptions of attribution and other revenue expectations. Under the low growth scenario that was modeled—a reduction in attribution of 15% across payers and no award of DSR/IAPD funding (the $13.1 million in Healthcare Reform Investments included in the FY20 budget)—it would not be expected that the current administrative expense ratio would increase above 1.60%. In the high growth scenario that was modeled—an increase in attribution of 3% and the full award of DSR/IAPD funding—it would not be expected for the ratio to dip below 1.28%. Findings, ¶ 42. In our Order establishing OneCare's FY20 budget, we impose a limit on the permissible administrative expense ratio that is informed by this sensitivity analysis.

H. The character, competence, fiscal responsibility and soundness of the ACO and its leaders.

OneCare made several changes to its Board of Managers and executive leadership team in FY19. *See* Findings, ¶¶ 1-3. These changes do not cause us to have concerns about OneCare's management or leadership and our interactions with OneCare's executive team during the budget review process have raised no concerns regarding their competence, character, fiscal responsibility, or professionalism.

I. HCA Participation and Public Comment

We have sought to address some of the concerns raised by the public and the HCA through the conditions we are imposing on our approval of OneCare's FY20 budget. For example, several commenters advocated for more transparency and continued monitoring of OneCare's programs, expenses, quality measures, and TCOC. *See* Findings, ¶ 65. We heard these concerns. For example, we impose a condition in our Order approving OneCare's FY20 budget that requires OneCare to work with Board staff to develop a performance dashboard to present population health and financial data (with input from the HCA). We also impose a condition requiring OneCare to develop a workplan to evaluate its PHM investments, including analysis of how to scale those investments that are successful, sunset those that are not, and report on

opportunities for sustainability. We also require that OneCare report data on its complex care coordination program implementation in FY20, including enrollment, payments, patient satisfaction, challenges and learning opportunities.

II. APM Agreement

A. TCOC Growth Rates

After considering projections of TCOC growth, as well as Annual Projected National Medicare TCOC per Beneficiary Growth for 2020, we approved a 2.9% trend rate for the A/D component of the 2020 Medicare benchmark and a 3.5% trend rate for the ESRD component of the 2020 Medicare benchmark. Findings, ¶ 46. These trend rates are within parameters of the APM Agreement and, based on the Board's best estimates, will enable the State to achieve the APM Agreement's financial targets.

At the time the Board approved OneCare's budget, OneCare was still negotiating with DVHA on the terms of the 2020 contract, including the appropriate trend rate(s). Furthermore, give the state of these negotiations, the Board had not finalized the Medicaid Advisory Rate Case. Findings, ¶ 47. Only around 16% of All-Payer TCOC under the APM Agreement is Medicaid spending. Findings, ¶ 45. We therefore do not expect OneCare's Medicaid rate to have a dramatic impact the State's ability to meet its financial targets for 2020. We require that OneCare ensure the Medicaid contract's trend rate fall within the actuarial range after completion of the Medicaid Advisory Rate Case.

At the time the Board approved OneCare's budget, OneCare was still negotiating final trend rates with commercial payers as well. Findings, ¶ 48. While it is not ideal to move forward with the budget without more information about the 2020 commercial contracts, this uncertainty is not new. Similar to last year, we believe the appropriate course of action is to allow OneCare and commercial payers to negotiate trend rates so long as they are tied to the Board-approved QHP rates, are actuarially sound for the attributed populations and, to the extent possible, align with the All-Payer TCOC target growth rate of 3.5% or less. We therefore impose conditions similar to those we imposed last year on the commercial trend rates.

B. Scale and Program Alignment

We have reviewed OneCare's proposed changes to its existing programs and believe they are unlikely to affect the programs' status as Scale Target ACO Initiatives. With respect to the alignment of these programs, the piloting of a fixed payment model in the BCBVT QHP program should increase the alignment of that program with the Medicare and Medicaid programs and is a positive step in the evolution of the Model. *See* Findings, ¶ 6. While OneCare and DVHA are contemplating a significant change in the Medicaid program's attribution methodology (decreasing alignment), *see* Findings, ¶ 5, this is the type of innovation that is required if the State is to meet the scale targets in the APM Agreement and therefore can likely be justified. So that we can better understand this new attribution approach, we will require that OneCare submit

the Medicaid geographic attribution implementation manual to the Board once the 2020 Medicaid contract is finalized.

We do not have sufficient information at this time to assess whether OneCare's potential new programs with MVP (QHP) and BCBSVT (ASO and large group) will qualify as Scale Target Initiatives or whether they will be reasonably aligned with the Medicare program, as required by the APM Agreement. Findings, ¶¶ 7, 52.

We require as part of our Order below that OneCare report to the Board on how all its payer programs qualify as Scale Target ACO Initiatives and how each program aligns with the Medicare program in key areas (e.g., attribution methodologies, quality measures, payment mechanisms, included services, etc.). If one or more programs are not expected to qualify as a Scale Target ACO Initiative, we require that OneCare justify the arrangement. Finally, to further progress on achieving the APM Agreement's scale targets, we require that OneCare provide a written follow-up on each action item identified in the scale report completed in August 2019. *See* Findings, ¶¶ 53-55.

ORDER

Based on our Findings and Conclusions above, and pursuant to 18 V.S.A. § 9382, we hereby approve OneCare's FY20 budget on the terms, and subject to the conditions, set forth below:

1. No later than April 30, 2020, or a date agreed to by OneCare and GMCB staff, OneCare must submit a 2021 Network Development Strategy that includes the following elements:
    a. A definition for ACO "network composition" necessary to maximize value-based incentives;
    b. Provider outreach strategy;
    c. Provider recruitment and acceptance criteria;
    d. Network development timeline;
    e. Providers dropping out of the network (quantify) and reasons why; and
    f. Challenges to network development.

2. No later than March 31, 2020, OneCare must submit a written report to the Board, using a template provided by GMCB staff, which demonstrates that OneCare's payer programs (other than the Vermont Medicare ACO Initiative) qualify as Scale Target ACO Initiatives under section 6.b. of the APM Agreement. The report must describe (a) how each program aligns with the Vermont Medicare ACO Initiative in the areas of attribution methodologies, quality measures, payment mechanisms, services included in determining shared savings and losses, patient protections, and provider reimbursement strategies; and (b) the rationale(s) for any differences in these areas. Thereafter, OneCare must update this report no later than 15 days after entering a new payer program covering any portion of 2020. If programs are not expected to qualify as a Scale Target ACO Initiatives under section 6.b. of the APM Agreement, OneCare must include in the report a justification for such an arrangement.

3. No later than March 31, 2020, OneCare must submit a one-page document summarizing the benefits self-funded payer programs receive from participating in OneCare.

4. OneCare must submit the Medicaid geographic attribution implementation manual to the Board no later than 15 days after finalizing the manual with the Department of Vermont Health Access.

5. OneCare must ensure that its payer contracts are consistent with the following 2020 benchmark trend rates and related conditions:
    a. Medicare: 3.5% (3.5% for A/D and 2.9% for ESRD);
    b. Medicaid: A trend within the actuarial range after completion of the Medicaid Advisory Rate Case;
    c. Commercial:
        i. The 2020 benchmark trend rates for the BCBSVT and MVP QHP programs must be based on the ACO-attributed population and the BCBSVT and MVP QHP approved rate filings; and
        ii. OneCare must provide the Board with (a) actuarial certifications for each of its commercial (including self-funded) benchmarks stating that the benchmark is adequate but not excessive; (b) an explanation of how its overall rate of growth across all payers fits within the overall APM target rate of growth and, if its overall rate of growth exceeds the APM target, how it plans to achieve the target for the term of APM Agreement (2017 to 2022); and (c) a revised budget based on the finalized benchmarks.

6. The maximum amount of risk OneCare may assume for 2020 is the sum of the following: 5% of the Medicare benchmark; 4% of the Medicaid benchmark; and a percentage of the commercial benchmarks in the ranges set forth in the relevant contracts. OneCare must request and receive an adjustment to its budget prior to executing a contract that would cause it to exceed these risk levels.

7. No later than March 31, 2020, OneCare must provide a written follow-up on each action item identified in the August 16, 2019 "Insights from Hospital/FQHC Scale Survey: Results and Reactions" for which OneCare was designated as the responsible party.[10]

8. No later than April 15, 2020, OneCare must present to the Board on the following topics:
    a. 2020 attribution and payer contracts;
    b. Revised budget, based on final attribution;
    c. Final description of population health initiatives;
    d. Expected hospital dues for 2020 by hospital;
    e. Expected hospital risk for 2020 by hospital and payer;
    f. Any changes to the overall risk model for 2020;
    g. Source(s) of funds for OneCare's 2020 population health management programs; and

[10] https://gmcboard.vermont.gov/sites/gmcb/files/documents/payment-reform/GMCB%20Scale%20Memo%208-15-2019.pdf

h. Any other information the Board deems relevant to ensuring compliance with this order.

9. No later than March 31, 2020, OneCare must provide GMCB staff with the supporting documentation relevant to the topics identified in Condition 8. Among the supporting documentation, OneCare must submit:
    a. Final payer contracts;
    b. Attribution by payer;
    c. A revised budget, using a template provided by GMCB staff;
    d. Final descriptions of OneCare's population health initiatives;
    e. Hospital dues for 2020 by hospital;
    f. Hospital risk for 2020 by hospital and payer;
    g. Documentation of any changes to the overall risk model for 2020;
    h. Source of funds for its 2020 population health management programs; and
    i. Any other information the Board deems relevant to ensuring compliance with this order.

10. If total revenues are projected to increase, the administrative expense ratio must not exceed 1.35%, and if total revenues are projected to decrease, the administrative expenses ratio must not exceed 1.60%, unless otherwise approved by the Board. The Board will review this condition based on final attribution.

11. OneCare must implement the delegated risk model it described in its budget proposal, except that it must:
    a. Submit to the Board copies of the contracts that bind each of the risk-bearing hospitals to OneCare's risk sharing policy;
    b. For the hospitals that are not covering 100% of their assumed risk, provide the Board with irrevocable letters of credit or other documentation specifying how UVMMC and/or DH-H will back the uncovered portion(s) of risk;
    c. Inform the Board whether it has secured aggregate Total Cost of Care protection for Medicare or any other payer programs in 2020; and
    d. Notify the Board staff within 15 days of any changes to OneCare's risk model outlining effects by hospital and by founder.

12. If OneCare uses its $4 million reserve, it must notify the Board within 15 days of such use. Notification must include the reason for drawing down the reserve and, for any use authorized under Condition 12(c), a corresponding cash flow analysis. The use of this reserve shall be limited to:
    a. Additional funding for population health investments;
    b. Financial backing for risk incurred by hospitals engaging in sustainability planning;
    c. Temporary cash flow issues associated with payer revenue delays; and
    d. Other uses pre-approved by the Board.

13. If population health management programs are not fully funded as detailed in OneCare's 2020 budget submission, OneCare must submit a revised proposal no later than March 31, 2020 to the Board. This should include any requests for budget revisions, for changes to OneCare programs, including any funding shortfalls, changes in program scope, and an analysis for each program line item as to whether and why the funding is appropriately scaled by attribution, or some other factor.

14. In 2020, OneCare must fund the SASH and Blueprint for Health (PCMH and CHT) investments in the amount of $8,401,660, at a minimum.

15. OneCare must report quarterly on information required by the Board. This Quarterly reporting will include:
    a. Financial statements to include cash flows, income statement, and balance sheet;
    b. Information on population health investments by Health Service Area, program, and provider type;
    c. Information on the 2020 complex care coordination program implementation, enrollment, payments, patient satisfaction, and, as they arise, relevant challenges and learning opportunities; and
    d. Any other information the Board deems relevant to ensuring compliance with this order.

16. OneCare must use its community-specific quality health investments (VBIF and future variable value-based payments) to address cost and quality differences across Health Service Areas as identified in OneCare's variations-in-care analysis. These programs must be evidence-informed, assessed by OneCare for return on investment, and tracked by the ACO.

17. No later than April 30, 2020, OneCare must provide a report on how its population health investments address cost and quality differences across Health Service Areas as identified in OneCare's variations-in-care analysis.

18. No later than June 30, 2020, or a date agreed to by OneCare and GMCB staff, OneCare must develop a workplan to evaluate the effectiveness of its population health investments including analysis of how to scale those that are successful, sunset those that are not, and report on opportunities for sustainability. This plan must include the identity of each entity receiving funding, the funding amount, any evidence supporting the purpose(s) of the corresponding project, a distribution plan for the funding, the scope of project, relevant timeframe(s) for implementation and evaluation, any measurable outcomes, and any risks, issues, or challenges. This workplan may exclude the Blueprint for Health investments (SASH, CHT, and PCMH). For competitive grants, OneCare should provide an explanation of the criteria by which it evaluates proposals for funding.

19. No later than July 31, 2020, OneCare must submit to the Board a prototype for an ACO performance dashboard and a proposed plan to implement the performance dashboard by December 31, 2020. GMCB staff will work with OneCare to determine the required form and content for the submission and to establish appropriate methodologies for reporting

quality results in such a way to allow for valid comparisons where feasible. At a minimum the dashboard shall profile population health and financial data by HSA and payer in a way that promotes variational analysis across HSAs and readily reconciles to Board approved and projected fiscal year budgets and population health performance targets. The Board will also provide an opportunity for the Health Care Advocate to provide input into the dashboard, including methodologies for quality reporting.

20. Over the duration of the APM Agreement, OneCare's administrative expenses must be less than the health care savings, including an estimate of cost avoidance and the value of improved health, projected to be generated through the Model.

21. OneCare must submit its audited financial statements as soon as they are available and must submit information as required by the Board to monitor OneCare's performance.

22. After notice and an opportunity to be heard, the Board may make such further orders as are necessary to carry out the purposes of this Order and 18 V.S.A. § 9382.

So ordered.

Dated: January 31, 2020 at Montpelier, Vermont

s/ Kevin Mullin, Chair)
)
s/ Jessica Holmes) GREEN MOUNTAIN
) CARE BOARD
s/ Robin Lunge) OF VERMONT
)
s/ Maureen Usifer)
)
s/ Tom Pelham)

Filed: January 31, 2020

Attest: */s/ Jean Stetter*
Green Mountain Care Board
Administrative Services Coordinator

NOTICE TO READERS: This document is subject to revision of technical errors. Readers are requested to notify the Board (by e-mail, telephone, or in writing) of any apparent errors, so that any necessary corrections may be made. (Email address: Janeen.Morrison@vermont.gov).