To: **Kevin Mullin, Chair, Green Mountain Care Board**
From: **Vicki Loner, CEO OneCare Vermont, Accountable Care Organization, LLC.**
Date: **October 1, 2019**
Subject: **OneCare Vermont ACO 2020 Fiscal Year Budget Submission**

Dear Chair Mullin,

OneCare Vermont is pleased to present our 2020 annual budget to the Green Mountain Care Board based on our contracted network as of September. Please note that we are still working to receive or negotiate our full attribution numbers, trends and targets from payers, and therefore this budget relies on our best available projections. As you will see, this budget continues to focus on helping providers and communities move ahead on promoting wellness, coordinating a fragmented healthcare delivery system, further improving quality and access, and delivering better care at a more predictable and affordable cost.

OneCare Vermont's 2020 Fiscal Year Budget Package includes our narrative responses, worksheets and attachments as set forth in the GMCB instructions and guidance. We have also included the Verifications under Oath of the Chair of the Board of Managers and the Chief Executive Officer.

Sections:

1. OneCare Vermont Information and Background (Executive Summary)
2. OneCare Vermont Network
3. OneCare Vermont Payer Programs
4. OneCare Vermont Budget and Financial Plan
5. OneCare Vermont Quality, Population Health, Model of Care and Community Integration Initiatives

My team and I want to extend a special thanks to the staff members at the GMCB who have all been exceedingly helpful in answering questions and aligning expectations for this submission.

If you have any questions please feel free to contact me directly at the number below or Spenser Weppler at (802) 847-3773.

Thank you,

Vicki Loner, RN.C, MHCDS
CEO, OneCare Vermont
(802) 847-6255

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Green Mountain Care Board, 2020 Budget Submission

Part 1: ACO Information, Background (Executive Summary)

1. Provide an executive summary of the budget submission, referencing Part I, Sections 1-5, and Parts II-III.

   OneCare Vermont's (OneCare) 2020 budget represents another important step forward for the Vermont All Payer Model. The 2020 budget includes two new payer programs designed to add additional lives to the model and broaden the scope of reform across the state. The first anticipated program is with MVP and aims to bring their Qualified Health Plan (QHP) lives into the model. Next is an additional payer program with Blue Cross Blue Shield of Vermont (BCBSVT) to incorporate a large cohort of self-funded lives into an ACO program. The existing payer programs are anticipated to remain relatively stable from 2019 to 2020 with no major changes to risk corridors, risk sharing terms, or other program design elements. One possible enhancement is an expansion of the Medicaid geographic attribution concept. While the details are presently in discussion, this approach could deliver additional lives to the model.

   OneCare's provider network continues to expand in 2020 with the Morrisville community participating for the first time in value-based contracts. Thus, 13 out of 14 Vermont Health Service Areas (HSA), and one New Hampshire HSA are participating in value-based care programs with OneCare. In addition to HSA growth, the network now includes three additional FQHCs and a number of other provider types that play an important role in our health system. Newport HSA is also expanding their participation and will join the BCBSVT QHP program in 2020. Between the expansion of the provider network and these two new payer programs, attribution is budgeted to reach 250,000 lives, which represents an increase of 90,000 lives from the current year.

   With the sizeable increase to attribution, OneCare's provider network is taking greater accountability for the cost and quality of care for Vermonters. While the expanded accountability aligns with the goals of the All Payer Model and providers' desire for one aligned clinical and financial model for all Vermonters, the total budgeted downside risk exposure is significant at $44 million.

   The operational budget supports the expansion in attribution and anticipates an increase in state funding support while alleviating some pressures on hospital dues. Of note, the 2020 operating budget represents a $1.25 reduction in costs on a per-member-per-month basis as well as a per-total-cost-of-care reduction compared to 2019, demonstrating economies of scale as the ACO expands. OneCare has maintained and enhanced the Population Health Management (PHM) investments in 2020 for a total of $43 million reinvested in its network.

   OneCare continues to provide high quality care across payer programs, as evidenced by its 2018 quality scores of 85% and 86% for Medicaid and BCBSVT QHP, respectively. OneCare achieved a 100% Medicare quality score in the first year of the new program. OneCare continues to invest in a diverse portfolio of population health management strategies to support healthy individuals as well as those at risk or experiencing serious illness. Key programs include: RiseVT, a primary prevention program; clinical education of the network to support improved chronic condition management and improvement; a complex care coordination program that has increased care

management engagement almost five-fold between January – September 2019; and new investments in mental health, clinical pharmacy, technology-facilitated care, and chronic disease management, among others. In 2020, OneCare continues to provide significant resources to primary care, the area agencies on aging, designated mental health and substance use agencies, and home health agencies.

This point in time represents a pivotal stage for OneCare. Emphasis on scale target growth needs to be balanced with the need to continuously improve and evolve the existing programs to deliver positive outcomes for Vermonters.

2. Provide an overview of the changes in the Accountable Care Organization's (ACO) budget submission from 2019 to 2020 (overview should include narrative, tables requested below, or other formats as needed). Include major network changes; program highlights; programmatic, staffing, and operational changes; and any assumptions made to create the budget submission.

Each year OneCare aims to build upon the previous year to advance Vermont's All Payer Model goals and overall healthcare reform efforts. The 2020 budget model includes new initiatives and program modifications all thoughtfully crafted to deliver value to network participants and the Vermonters they serve. The 2020 budget expands upon the core Medicaid, Medicare, and BCBSVT QHP programs and includes anticipated contracts with MVP for their Qualified Health Plan (QHP) population and BCBSVT for self-funded lives across multiple employers. OneCare is presently in active negotiations with both payers and is encouraged by the highly collaborative discussions. While the program terms are still being finalized, these arrangements are being crafted to develop programs/services that combine the resources and expertise of all parties. Inclusion of these programs is expected to add 90,000 scale-target qualifying lives. When combined with the existing programs, the 2020 OneCare budget includes nearly 250,000 Vermonters.

OneCare's network will continue to grow with the addition of Copley Hospital and other practices in the community including an FQHC, independent primary care practice, independent specialist, mental health agency, and skilled nursing facility. Beyond the Morrisville HSA, two other FQHCs and a number of other providers are joining OneCare in 2020. Please see Section 2 for more detail regarding network growth. In total, OneCare will include 14 hospitals and their employed providers (including primary and specialty care), nine FQHCs/RHCs, 29 independent primary care practices, seven naturopath practices, 25 independent specialist practices, four independent physical therapy practices, 27 skilled nursing facilities, 11 mental health agencies, nine home health and hospice organizations, four special service agencies and one surgical center. See Attachment A and B in Part 1 Attachments for an updated network grid (A) and Network progression since 2017 (B). The growth of the network each year is evidence that providers continue to support OneCare's healthcare reform efforts.

In 2020, OneCare will continue its existing population health initiatives and launch additional programs and investments. The new programmatic highlights proposed in this budget include:

Complex Care Coordination	OneCare has made significant strides to transition the network from a capacity-building to a value-based complex care coordination payment model through a collaborative process with diverse stakeholders. The result is a significantly enhanced PMPM for patients under active care management that is provided to the lead care coordinator and care team members. Funding in this area also supports expanded work in pediatric care coordination, a longitudinal care home health pilot program, and continued work on the DULCE program.
Specialist Payment Reform	OneCare plans to investments and test new care delivery innovations in the areas of mental health services, embedding clinical pharmacists in primary care, testing an eConsult model between primary and specialty care, and focused interventions for patients with chronic kidney disease.
RiseVT	Since the start of OneCare's partnership with RiseVT in 2018, there has been a rapid expansion of the program to eight new hospitals reaching 36 towns in Vermont. Using evidence-based models, RiseVT program managers work with local partners to identify opportunities to enhance the overall wellness of our towns by offering health programs, working to improve local systems such as walkability and school wellness policies, and making grants to aligned community programs. RiseVT recently launched a new social marketing campaign called "Sweet Enough" that targets Vermonters age 18-35 to reduce their sugar sweetened beverage consumption. Sweet Enough is working in a unique partnership with Vermont's beverage industry to brand merchandise coolers at point of purchase with beverages that contain no added sweetener to make choosing a healthy option easier for the consumer. RiseVT is in talks with three additional hospitals interested in starting RiseVT campaigns within the next six months. By the end of 2020 the goal is to have a RiseVT presence in all 14 counties.
Comprehensive Payment Reform (CPR)	OneCare will continue to offer the CPR program to interested independent primary care practices in 2020 and will introduce new accountability through a variable component of the fixed payment. The variable portion of the payment will be tied to care coordination engagement and care delivery transformation targets being achieved.
Innovation Fund	Overseen by the Population Health Strategy Committee, OneCare has invested in nine distinct innovative projects in 2019. OneCare will track progress and outcomes of these projects in 2020 and will offer a new opportunity to its network to propose additional high value projects.

Since OneCare's last certification submission in 2018 there have been changes to the configuration of the Board of Managers (Board). These changes are reflected in OneCare's Operating agreement, specifically Section VI. "Management," in which the Board voted to increase capacity from 19 to 21 seats. The two additional seats are designated as at-large seats. The Board also adopted a provision that set a term for board members at three years, with a limit of three terms. The terms will be staggered to limit large turnover at any given time. Lastly, changes clarified the nomination provision for provider associations to propose a candidate for their representative seat, should an opening occur.

Former CEO Todd Moore departed for a job opportunity out of state and was replaced on an interim basis by Kevin Stone. An extensive national search for a permanent CEO was conducted and resulted in Victoria Loner being chosen as permanent CEO effective August 1, 2019. When Kevin Stone became interim CEO he resigned his seat as Chair of the Board. Dr. Stephen Leffler assumed the role of Chair of the Board during this transition and was succeeded by Dr. John Brumsted in September.

OneCare's Vice President of Finance and Strategy, whose time was split between OneCare and the Adirondacks ACO, departed OneCare to dedicate fulltime efforts to the Adirondacks ACO. This vacancy will be filled as a Chief Financial Officer with fulltime efforts dedicated to OneCare. The Vice President/Chief Operating Officer vacancy that was created by Ms. Loner's appointment as CEO will be backfilled. OneCare has also continued to grow in key areas by adding analytics, finance, and quality staff.

Preparing and implementing the programs and structures necessary to operate under the All Payer ACO Model in 2018 and 2019 represented a significant achievement on behalf of the Provider Community, but has not been without challenges. Specifically, operational issues with some of the payer programs has impacted payments and availability of data to inform clinical and financial decision-making. While this type of transformational change is going to come with unforeseen challenges, significant improvement in 2020 is critical. Continued operational issues will further delay momentum and necessitate careful consideration of the financial reform strategy.

In 2019, OneCare continued its participation in value-based contracts with Medicaid, Medicare, and BCBSVT, reimbursing health care providers in line with the All-Payer ACO Model. Changing the payment model and providing additional upstream investments in primary care and resources to communities provides the flexibility necessary to drive innovation throughout Vermont. Additionally, it is important to recognize the willingness of providers to take risk for the total cost of care in the model. OneCare has been able to take incremental steps to reduce administrative burdens on primary care and other providers of care through changes such as prior approval exemptions, benefit waivers, and quality measurement alignment and reduction. OneCare's providers have become innovators driving toward excellence in health care quality, person-centeredness, and affordability. OneCare continues to believe that by working together, we can help to keep Vermonters healthier.

a. Provide an updated OneCare Network Grid for 2020

   Please see Attachment A in Part 1 Attachments

b. Provide an updated OneCare Hospital Participation Table for 2020

   Please see Attachment B in Part 1 Attachments

Part 1
Attachments

Attachment A – OneCare 2020 Network Grid

Attachment B – Network Progression from 2017

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Green Mountain Care Board, 2020 Budget Submission

Part 2: ACO Provider Network

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1. Provide, as an attachment, a completed **2020 ACO Provider Network Template (Appendix 2.1)**.

   Please see Attachment A. in Part 2 attachments titled "2020 ACO Provider Network Appendix 2.1" for a Summary list of the OneCare's Provider Network.

2. Provide a written summary analysis of the **2020 ACO Provider Network Template (Appendix 2.1)**, highlighting any changes from 2019 to 2020, including changes in network by Health Service Area.

   OneCare will grow in 2020 to include one additional Health Service Area, one additional Vermont hospital, three Federally Qualified Health Centers (FQHCs), three independent primary care practices, one naturopath, three independent specialty practices, four independent physical therapy practices, one designated mental health agency, three skilled nursing facilities, and one surgical center.

   a. Discuss implementation of your 2020 Network Development Strategy and Timeline.

      The network development strategy has two components: bringing on new providers and expanding existing provider participation into more of the payer program offerings.

      OneCare focused its network development strategy on both maintaining the current network and growing the network in support of All Payer Model scale targets. OneCare strengthened relationships with membership organizations such as Health First and United Health Alliance to enhance outreach and identified additional organizations to recruit through relationships with participating hospitals.

      OneCare also worked with existing providers and communities to expand participation beyond Medicaid. As a result of these efforts, the Newport HSA and Community Health Centers of Burlington are expanding into the BCBSVT QHP program. While there was significant effort to expand Medicare participation, the magnitude of downside risk and operational concerns prevented gains.

   b. In a narrative response, describe your provider network regarding specialty type in 2020. Do you have an expanded network of primary care and mental health providers? Are you having difficulty contracting with certain specialties and why? Have you identified gaps in access to care statewide or by Hospital Service Area?

      The 2020 provider network includes 25 independent specialist practices, three of which are new to the ACO. OneCare has increased participation of primary care and mental health providers by recruiting three new FQHCs, five new independent primary care practices, one new naturopath, and one new mental health agency.

One challenge in the recruitment of independent specialists has been the lack of eligibility for incentives in the Medicare Merit-based Incentive Payment System (MIPS) that are currently available to hospitals and primary care. Since each specialty type has unique needs and presents unique opportunities to impact healthcare delivery and reform efforts, OneCare is supporting specialists in the network by implementing project-based initiatives in the areas of mental health, pharmacy, nephrology, and a technology-based pilot to facilitate primary care/specialist consultations.

OneCare has not done an independent comprehensive analysis to specifically identify gaps in access to care statewide or by HSA

3. Submit, as an Excel spreadsheet (printout not required), your 2020 provider lists submitted to Medicare, Medicaid and Commercial payers as **2020 Complete Physician Network – Electronic Only (Appendix 2.2).**

   Please see Electronic File on the Flash Drive provided titled "Complete Physician Network" for a complete list of the OneCare's Provider Network across all three payer programs.

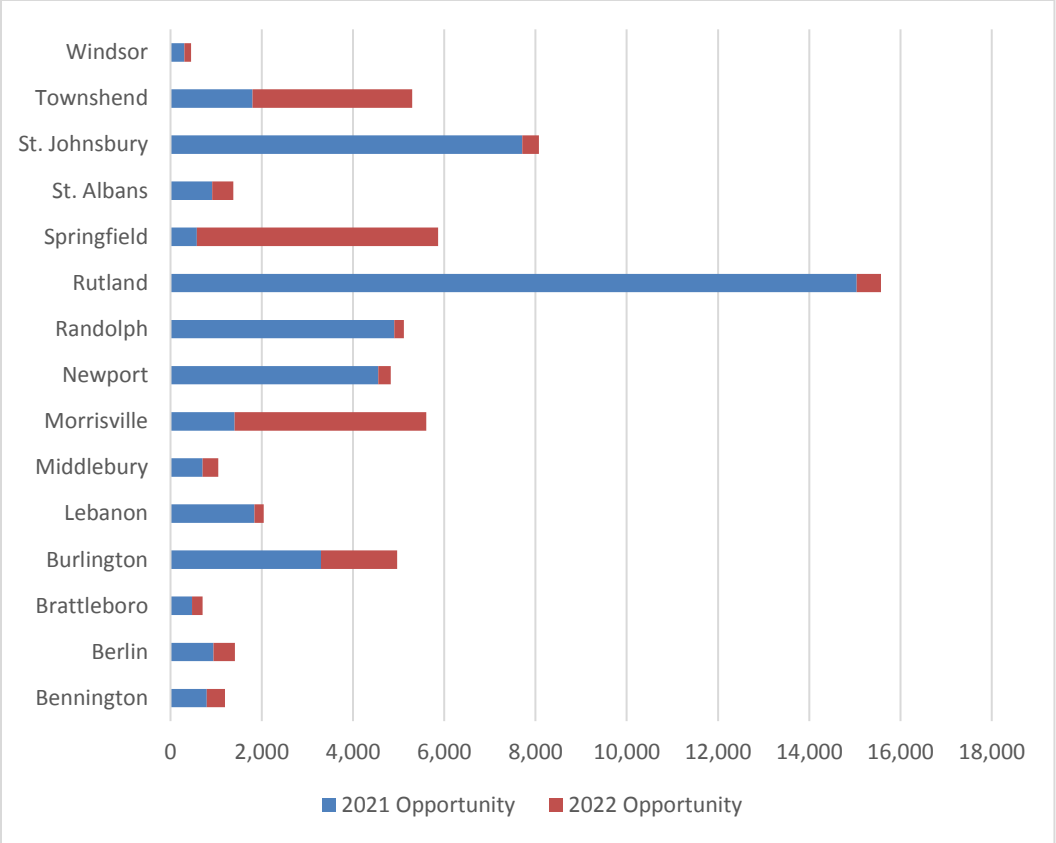
   a. Provide a count of network providers affiliated by Hospital, FQHC, Independent Primary Care, Independent Specialist, Home Health, Skilled Nursing Facility, Designated Agency, if not already provide elsewhere in the submission.

      Please see question two above and the submitted provider roster templates.

4. Provide a written plan on the ACO's strategies, by year, during the remaining years of the All-Payer ACO Model Agreement to work with the State and other stakeholders to increase payer participation, increase provider participation, and develop changes to attribution methodology, with the goal of maximizing scale and achieving scale targets as outlined in the Agreement. In your response provide:

   a. The ACO's targets by year for both provider entities and attributed lives, by Hospital Service Area.

      The following grid provides attribution opportunity targets through 2022. Neither the decision to expand participation nor the timing has been agreed to by the HSAs at this time. Success of the scale strategies outlined below will determine whether or not these targets are achieved. Note that the potential gains from the Medicaid geographic attribution approach are still being explored, and evaluations for the other programs has not begun. Reasonable estimates were used to project gains. Most of the growth opportunity comes from expanded program participation.



b. A strategic plan to include activities implemented in 2019, activities planned for 2020 and for the remaining years of the Agreement, and the anticipated impact of each activity.

Achieving scale remains core to the overall ACO strategy. Increasing the number of providers and lives in the model furthers Vermont's All-Payer Model goals and OneCare's clinical and financial aims. This endeavor requires multiple strategies to address each of the elements affecting overall attribution to the ACO's value-based programs. In 2019, OneCare piloted a Medicaid geographic attribution concept with the St. Johnsbury HSA. There were a number of key findings that are helping to craft a potential statewide geographic attribution approach in 2020. Also in 2019, a non-scale target program designed to encourage primary care engagement was developed in partnership with BCBSVT. This program focused on the self-funded population and placed focus on the covered lives who did not have a recent primary care visit. Developing these primary care relationships can help achieve scale under traditional attribution methods.

Scale Strategy 1: Attribution Methodology

While the details are different for each payer program, attribution methodology typically revolves around a relationship with a primary care provider (PCP) in the OneCare network. To date this model has ensured that OneCare providers have a direct relationship with the attributed population and therefore have the ability to implement population health initiatives intended to coordinated care and improve patient wellbeing. This approach does not attribute patients who do not receive the eligible primary care services (i.e. specific Evaluation and Management codes),

patients who do not see primary care providers during defined look-back periods, or patients who do not use the health care system at all. OneCare recognizes this as a limitation to achieving scale targets and is actively working with payers to explore evolving the attribution methodology in ways that incorporate more Vermonters into the model.

Building on the St. Johnsbury geographic attribution pilot in 2019, OneCare and DVHA are actively discussing an expansion of the model across all participating HSAs. Learnings from the 2019 pilot and subsequent analyses are being used to define potential new sub-populations and discuss appropriate integration with OneCare's care model and feasible economic terms. While this new geographic attribution approach has the potential to increase the number of lives attributed to ACO programs, these choices need to be considered in the context of the financial models in place. Both the payers and OneCare are exposed to potential financial risks when attributing lives with little or no claims history and the lack of an established PCP relationship presents new challenges for OneCare's network to address in order to support effective healthcare management for this population.

In addition to the geographic attribution expansion discussions with Medicaid, OneCare is also working to refine attribution methodology with commercial payers to ensure that the model captures all eligible members. Based on learnings from the Medicaid program, OneCare plans to explore future expansion of a geographic attribution model with Medicare and commercial payers in 2021 and beyond.

Scale Strategy 2: Network Participation

A main strategy of network participation is creating conditions in which hospitals increase their ability in bearing risk in additional programs, particularly in helping hospitals expand beyond Medicaid-only participation. There are a number of barriers that impeded further expansion in 2020; all of which need to be addressed for gains to be realized in 2021:

- Magnitude of downside risk
- Medicare cost report questions
- Medicare claims processing
- Medicare benchmark
- Hospitals reserves for new risk accompanying ACO program participation
- Hospital dues/lack of external funding support for value-based transition
- Payer data availability/accuracy/timeliness
- Regulatory alignment of ACO budget/hospital budgets/insurance rates
- Hospital board education

OneCare is actively working with its community of providers, payers, state leaders, and regulators to reduce or eliminate these barriers to full adoption of the value-based care model. Until these issues are ameliorated, expanded hospital participation in 2021 will remain challenging.

OneCare continues to work with non-hospital attributing providers as a core component of the network contracting process. OneCare has had encouraging conversations with Grace Cottage hospital and both parties have expressed interest in

continuing discussions around the clinical, quality, and financial programs in 2020 to prepare them for possible network participation in 2021.

Scale Strategy 3: Expanded Payer Program Offerings

OneCare contracted with UVMMC in 2018 and 2019 to bring their health-plan lives into a value-based program that qualifies for scale targets. While successful, a direct program with an employer health-plan took significant time and resources to operate and it was determined that alternative strategies needed to be identified to achieve scale with employers. OneCare has since evolved its strategy and is actively working with BCBSVT to develop a program that brings in their Administrative Services Only and Large Group lives. This approach has the potential to yield material scale target gains in 2020 and beyond. Additionally, OneCare is in active discussions with MVP to develop a program for their QHP population. This program represents an important step to ensure that all payers offering QHPs in Vermont have a value-based program to help manage cost growth and share in savings to manage premiums.

Multi-Year Strategy

Year	Strategies	Opportunity
2020	• Medicaid geographic attribution expansion • BCBSVT ASO/LG program • MVP program • Network recruitment	90,000
2021	• Hospital participation expansion • Expand geographic attribution to additional payers • Network recruitment	45,000
2022	• Hospital participation expansion • Expand geographic attribution to additional payers • Network recruitment	18,000

5. For each ACO provider that will assume risk in 2020, describe the ACO's risk arrangements with the provider, including:

    a. The percentage of downside risk assumed by the provider, if any;
    b. The cap on downside risk assumed by the provider, if any; and
    c. The risk mitigation measures the ACO requires, undertakes for the provider, or is aware of the provider taking if any (e.g., reinsurance, reserves).
    d. In narrative form, describe changes in the ACO's risk arrangements with providers from 2019 to 2020.

OneCare, as the contract holder with each of the payer partners, is the entity that either pays or receives the program settlement amount. The risk management strategy employed by the ACO delegates the risk, and potential shared savings entitlements, down to the network hospitals. This model is designed to protect smaller attributing providers, and provide the hospitals the shared savings opportunity to offset the dues investments they are making to fund the value-based transition.

OneCare implements this model by setting HSA spending targets for each of the HSAs participating in the payer program. These targets are based on the historical cost of care data blended with the risk profile of the attributed lives. The overall program risk corridor and sharing terms are then applied to the HSA spending target to determine the HSA Maximum Risk Limit (MRL). For example, if the overarching program has a 4% risk corridor, that same corridor is applied to each of the participating HSAs. OneCare's Program Settlement Policy outlines this process in a more detailed fashion. In certain cases, as determined by the OneCare Board of Managers (BOM), a risk mitigation arrangement is offered to eligible HSAs/hospitals. These arrangements encourage hospitals to participate in all value-based programs during a transition period. Offering these arrangements means that either OneCare retains undelegated risk, or the Founders agree to provide a backstop.

Some modest reserves retained at OneCare are important to accommodate risk mitigation arrangements, provide general liquidity to manage financial operations, and protect against any credit/default risk should a hospital be unable to pay an obligation. In 2019 OneCare is building reserves that are expected to total $3.9M by year end. The 2020 budget model does not include building any additional reserves; rather, the aim is to maintain that amount throughout the year. Overall this strategy reflects the need to keep reserves at OneCare for specific OneCare risk, but not duplicate reserves built elsewhere in the health system. The risk-bearing hospitals need be able to maintain their own reserves for the additional risk that comes with participation in ACO programs.

Another risk mitigation strategy OneCare is pursuing is more appropriate high-cost case truncation. The concept behind this approach is that the provider layer is willing to take accountability for their performance, however, there is incident risk that is unpredictable (ex. bad accident, rare diagnosis, etc.). A more appropriate truncation point can help better distinguish between performance risks, which the ACO should bear, from incident risk, which is more appropriate with an insurer. Even in the event of a high-cost case the provider layer plays a role in managing spend, but the providers are not specifically reserved for this type of risk in the same manner as an insurer.

Lastly, the budget includes a continuation of the risk protection arrangement in place for the Medicare program (i.e. if aggregate ACO Medicare spend reaches the mid-point of the maximum risk, a third party pays 90% of any spend thereafter). This protection provides coverage in the event the entire network experiences spending significantly over target and helps the risk-bearing entities mitigate the large magnitude of risk that comes with participation in the Medicare program.

The 2020 budget model does not assume any significant changes to the core risk arrangements with any of the payers or the providers. It is expected that components such as risk corridor, sharing, and general approach will remain unchanged. More nuanced risk protections such as the truncation option are being pursued, but are not expected to affect the aggregate budget model.

6. Provide, as an attachment, a completed **2020 Health Service Areas and Associated Risk Totals (Appendix 2.3) and a 2020 Budgeted Risk Model (Appendix 2.4)**

Please see Attachment C and D in Part 2 attachments titled "2020 HSA and Associated Risk Totals" (Appendix 2.3) and "2020 Budgeted Risk Model" (Appendix 2.4) respectively.

7. Submit copies of each type of your provider contracts and agreements (i.e. risk contracts, non-risk contracts, collaboration agreements and Memoranda of Understanding).

   Please see Attachment E in Part 2 Attachments titled 2020 OneCare Provider Base Risk Contract with Payer Addendums as well as sample Exhibit 1 Maximum Risk Addendums for hospitals, CPR Program Amendment #2, Amendment 1 specifically for University of Vermont Health Network hospitals, and Collaboration Agreement.

Part 2
Attachments

Attachment A – Summary of Provider Network by Provider Type

Attachment B – Summary Provider Network by HSA/County by Provider Type

Attachment C – 2020 HSA and Associated Risk Totals

Attachment D – 2020 Budgeted Risk Model

Attachment E – OneCare Provider Base Contract with associated addendums

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Part 3: ACO Payer Programs

1. Provide copies of existing agreements or contracts with payers if they have been updated since they were submitted to the GMCB. If 2020 contracts are not available, please submit the contracts as an addendum when they are signed. Also include the latest Next Generation benefit enhancement implementation plans.

   OneCare is in active negotiations with its payer partners and final contracts are not yet available. They will be sent to the GMCB as soon as they have been finalized. Note that the budget model includes a number of assumptions related to these contract negotiations and all of those terms are subject to change based on final agreements.

   a. When the Medicare contract is submitted, include the latest benefit enhancement implementation plans.

      The latest Medicare benefit enhancement plans for Telehealth and Post Discharge Home Visits were submitted to the GMCB via the ACO Certification process.

2. Complete attached B20 ACO Scale Target Initiatives and Program Alignment Form (**Appendix 3.2,** including Form Appendices A and B) with your 2020 proposed contractual arrangements, by payer.

   Please see Attachment A. in Part 3 Attachments titled "2020 Program Alignment Form." Please note that Program aspects for BCBSVT QHP, Medicaid and Medicare have not changed since 2019, while BCBSVT self-funded and MVP QHP are "To-Be-Determined" and labeled as such until contract negotiations are complete.

3. Provide an explanation for your projected growth rates, referencing Part II: Benchmark Guidance, which provides background on the All-Payer and Medicare Total Cost of Care per Beneficiary Growth outlined in the Vermont All-Payer ACO Agreement. Complete the table **Projected and Budgeted Trend Rates, by Payer Program (Appendix 3.1)**.

   a. Briefly explain the source and assumptions used for the budgeted trend rate for each program (and provided in column D). 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.

      Medicaid

      OneCare attempted to prospectively replicate the upcoming actuarial process to determine the Medicaid PMPM estimate in the 2020 budget. Existing 2018 actual spend data was used as the base year, and two subsequent annual trends were applied. The first evaluated the difference between the actual 2018 spend and the year-to-date 2019 experience data. This suggested an increase of 2.2%. Then, a very modest estimate of 0.5% was applied for the 2019 to 2020 increase. Note, OneCare was not able to incorporate an estimate of repricing adjustments in the

budget due to inherent complexity. Any pricing increases could yield a more substantial year-over-year trend rate, but the All Payer Model exempts this type of cost increase from the calculation of actual trend.

Medicare

The assumed Medicare trend rate is derived from the Vermont All Payer Model contract. Per that contract, the nation Medicare Advantage United States Per Capita Cost (USPCC) year-over-year forecast is used as the basis for the annual increase, subject to GMCB approval. The forecast published in April 2019 presented a 4.1% trend rate (blended between ESRD and non-ESRD). The Vermont All Payer Model contract also calls for a 0.2% discount factor, which nets to a 3.9% assumed annual trend. Note that a different mix of ESRD and non-ESRD lives could cause slight variation in the blended trend rate.

Another factor considered in the budget was any expected shared savings carryforward. This is a critical component of the program financial model and essential to sustain funding for SASH, Community Health Teams, and primary care sites receiving Patient Centered Medical Home payments from OneCare. The current forecast of 2019 performance suggests that there will be enough shared savings earned to sustain the funding for those programs, but nothing in excess.

Commercial QHP

The trend rates used in budget development for commercial payers offering Qualified Health Plans (QHPs) were derived from the GMCB rate approvals. OneCare examined these rate approvals to evaluate the sufficiency of the trends and whether or not they will yield an adequate benchmark. If there are changes to the filed rates, OneCare must assess whether or not the change could result in benchmarks that are below an actuarially supported total cost of care estimate. Inclusion of these commercial QHP programs in the budget is an indication that the approved rates are sufficient to move forward, but the full actuarial process remains a critical step.

Commercial Self-Funded

As described earlier, OneCare is developing a program with BCBSVT to bring in attributed lives from a number of their non-QHP product lines. 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.

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

Medicare

The overall expected growth rate of 3.1% compared to the annual growth rate of 3.9% is driven by a change in network configuration. The Springfield HSA, which historically participated in the Medicare program, will not be attributing lives in 2020. That HSA had the highest baseline spend and was 9.7% above the network

average. When these lives are excluded from the modeling, it results in a base year spend that is lower than what is expected in the 2019 performance year, and a raw year over year increase of 3.1% even though the full 3.9% factor is applied to generate the budgeted benchmark.

Medicaid

The Medicaid trend is very modest and actual performance should be in line with this estimate. Because of the very similar network configuration, the best estimate for the 2019 spend is a reasonable basis for determining the 2020 spend. The addition of the Morrisville HSA was analyzed to determine whether or not their participation would drive a macro-level change to the benchmark. This analysis showed that their expected spend is less than 2% from the network average and should not materially affect the ACO level benchmark. One factor worth noting is any repricing of historical claims. If there are material adjustments necessary to yield an appropriate benchmark it could result in more year-over-year variance.

Lastly, OneCare remains in discussions with DVHA to explore a widespread geographic attribution methodology across the network. Due to the timing of these discussions, the budget does not include any of these geographically attributed lives or their expected cost of care. Changes to the benchmark should be expected if the geographic attribution model moves forward.

Commercial – QHP

OneCare evaluated the results of the rate hearings to evaluate whether or not there were adjustments that could result in an insufficient target. At present, there are no reasons to believe that the actual ACO performance would be materially different than the approved trends, but final rate development, actuarial analysis, and negotiations with the payers are not complete.

Commercial – Self-Funded

As a new program, the target and trend estimates were developed in partnership with the payer, but the detailed rate development process has not begun. Note that within this category there are a number of sub-groupings each with their own dynamics and nuances. As rates are developed it is likely some different trends for each grouping will emerge.

Part 3
Attachments

Attachment A - 2020 Program Alignment Form

Attachment B - Projected and Budgeted Trend Rates, by Payer Program

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Green Mountain Care Board, 2020 Budget Submission

Part 4: ACO Budget and Financial Plan

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 4.1-4.3**, for reference.

   Please see Attachment A, B and C in Part 4 with completed Appendices 4.1-4.3 titled "Balance Sheet", "Income Statement" and "Cash Flow" respectively

2. Provide, as an attachment, completed **Appendices 4.4-4.5**. The Appendices request the ACO, by payer and line of business, to provide information on projected revenues and total shared savings or loss flowing through the ACO financial statements (including payer revenues, participating provider dues, and grant funding) in total dollars and per member per month (PMPM) dollars when applicable. The GMCB may request additional information or copies of grants or agreements as part of the review.

   Please see Attachment D and E in Part 4 Attachments with completed Appendices 4.4-4.5 respectively.

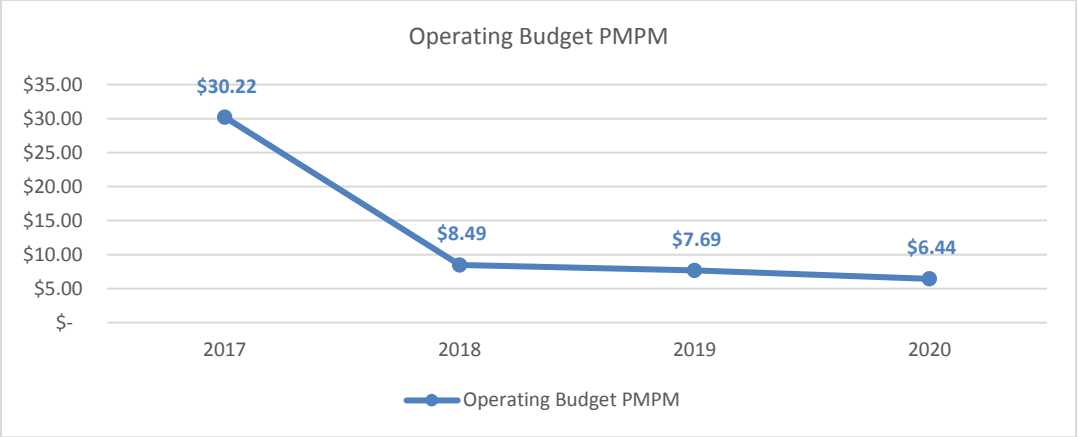
3. Complete all tabs of **Part 4.6 Appendix – ACO 2020 Budget Submission Reporting APM for Participating Hospitals** for the 2020 budget year.

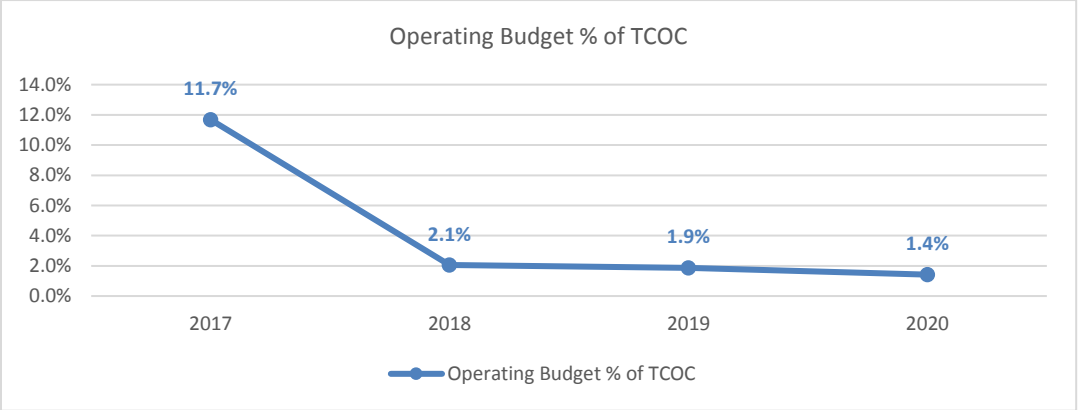
   Please see Attachment F in Part 4 with completed Appendix 4.6 for a summary of APM Reporting by all of OneCare's participating Hospitals.

4. Provide a narrative description of the following elements of the ACO's spending plan:

   a. Relevant industry benchmarks used in developing the administrative budget;

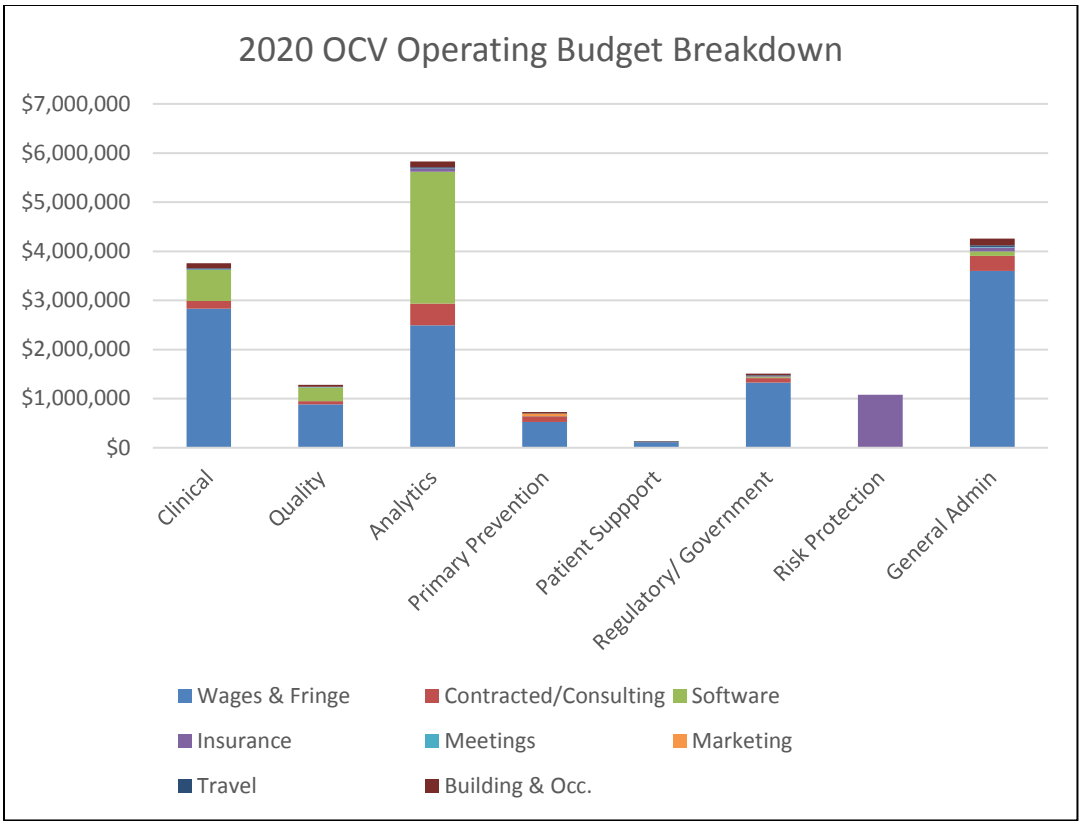
      At present, the OneCare's operating budget is based on the requirements to achieve its strategy as a risk-bearing, multi-payer, statewide ACO as decided by the Board of Managers. Finding relevant industry benchmarks is challenging because most ACOs are private organizations, which means their financial information is not publically available. Additionally, OneCare has a unique model in which the care management functions are fully delegated to the participating providers which shifts potential operating expenses to OneCare's population health investments. Despite the scarcity of relevant industry benchmarks, OneCare monitors its operating costs in relation to the overall total cost of care for the year as well as the budgeted attribution. The following shows that despite modest operating cost increases, there are emerging economies of scale.





These charts demonstrate that as OneCare grows its attribution, the cost on a per-life and per-spend basis decreases. This is encouraging and highlights a benefit of a single multi-payer ACO.

It's also important to note that while OneCare delegates the core the population health initiatives to network providers, a substantive amount of the operating costs are related to supports that directly aid clinical and quality initiatives, and patient care. The following shows a distribution of OneCare operating costs by functional area.



b. Provide brief definitions or narrative descriptions of items that fall under Administrative (Operating) expenses and the Administrative Expense Ratio in Appendix 4.2.

OneCare's operating expenses are driven largely by staffing, but include a number of other expense categories. Of note, the software line includes all of the analytic tools necessary to provide the financial, analytical and clinical data that are essential to OneCare operations.

Category	Budget	Notes
Wages & Benefits	$11,776,602	Staff positions and ordinary benefits
Contracted/Consulting	$1,173,970	Actuarial; software development
Software	$3,726,889	WorkBenchOne; Care Navigator; VITL; eLearn
Insurance	$150,000	General business insurance
Risk Protection	$1,075,912	Medicare risk protection
Meetings	$35,700	Network mtgs; learning collaboratives
Marketing	$67,500	Informational materials; RiseVT
Travel	$103,250	Mileage reimbursement
Supplies	$188,830	Office supplies; mailings; copiers
Other Operating	$418,000	GMCB billback; letter of credit fees
Prof. Development	$103,238	Staff training and development
Occupancy	$456,859	Rent, CAM; utilities
Total	**$19,276,749**	

c. The methodology for determining the qualification for and amount of any provider incentive payments and how those payments align with ACO performance incentives, which may include contractual agreements measures and outcomes.

All of OneCare's investments and accompanying qualifications, which include the Population Health Management programs with aligned payment reforms, must be reviewed by the OneCare Finance and Population Health Strategy Committees and ultimately approved by the Board of Managers. Through their input and input from other clinical and ACH committees, program models are developed that aim to align care delivery with overall ACO goals, program financial terms, clinical initiatives, and quality initiatives. Feedback from the provider community is an essential component of the methodology used to determine the qualifications and amounts of incentive payments. OneCare's investments also aim to alleviate, not generate, administrative burden.

The PHM programs are designed to invest in a number of different provider types across OneCare's diverse network. This strategy is essential to holistic reform. The 2020 budget model builds on this concept and directs reform investments broadly across the provider spectrum.

Provider Type	**Investment Opportunity**
Primary Care Providers	$22,727,529
Designated Agencies / Mental Health	$3,398,514
Home Health Providers	$1,913,538
Area Agency on Aging	$535,415
Community Health Teams	$2,379,711
Supports and Services at Home (SASH)	$3,968,246
Community Investments	$2,206,752
Specialty & Acute Care	$5,068,854
TBD (e.g. Innovation Fund)	$917,505
Total	$43,116,066

Note that these figures represent investment opportunity and in some cases the amount paid to the providers is dependent on their level of engagement, performance, and ACO quality scores. This aligns with OneCare's overall transition from funding capacity to funding value through demonstrable attention and focus on population health initiatives.

d. Quantity of Delivery System Reform dollars and associated goals for stated investments;

The 2020 budget model includes $13.1 million of different kinds of potential Health Care Reform Investments facilitated by the State of Vermont. The exact mechanism and sources for these investments (i.e. DSR, program targets, or other sources) remains under discussion at the time of this submission. Additionally, the specific initiatives and goals are in discussion and not yet finalized and must be approved federally. It must be noted and understood that at the time of this submission, OneCare Vermont is still in active negotiations with the Department of Vermont Health Access about the programs and activities that will be funded through the Vermont Medicaid Next Generation ACO agreement. In total, these requested funds represent a critical increase in funding from

non-hospital sources; should funding fail to materialize, the entire budget will need to be reconsidered by the OneCare Board of Managers.

e. Strategy for planned spending on health information technology, at the ACO level and to support individual providers;

OneCare continues to invest in health information technology in order to further the goals of the ACO and the All Payer Model. Access to quality data and advanced analytic competencies are absolutely essential to performance of ACO activities. OneCare continues to evolve and improve the analytical outputs to ensure the network providers have the information they need to be successful in a value-based paradigm. Some of the challenges faced thus far include the timeliness and accuracy of data feeds, multiple payer programs with different data nuances, an ever-changing industry, and a very diverse provider network with highly varied needs. To address the criticality of these issues, the 2020 budget includes targeted staffing investments in informatics financial-analytics, and program evaluation. These will increase OneCare's capacity to provide more targeted HSA-level outreach and support and accommodate additional payer programs.

f. Budget assumptions related to service utilization, including anticipated changes from prior years' utilization, including anticipated changes in care delivery including but not limited to new and innovative services, service mix, value-based payment model adoption (including risk assumption); and

Each year OneCare evaluates the methodologies used to set HSA benchmarks and fixed payment amounts. The models employed in 2018 were designed to allow for a transition from a FFS structure and relied upon historical spending patterns as the basis for calculations. In 2019 the HSA accountability model incorporated a blend of medical risk score with historical FFS to begin a shift to a true population-based measure. The 2020 budget model incorporates the same concept of FFS blended with medical risk score to set targets, and may incorporate social determinant scores as another critical component. Given this approach, OneCare is setting HSA targets/budgets using a population-based method rather than basing spending expectations on an analysis of utilization trends. Because of the desire to move away from FFS concepts, using person-based drivers such as medical risk score and social determinant factors have the potential to help analyze and evaluate cost of care in a truly value-based way. Despite the focus on population-based spending, it's important to note that the underlying utilization patterns are essential to identify areas of opportunity and evaluate progress. This will continue to be a focus area to drive reform throughout the system.

g. Anticipated changes in provider network configuration, and the expected impact on service utilization.

The 2020 budget model incorporates modest changes to the attributing providers in the network.

- Newport HSA advancing participation to include the BCBSVT QHP program
- Morrisville HSA participating in the Medicaid program for the first time
- Three new FQHCs participating for the first time
    - Northeast Washington County Community Health, Inc.

    - Mountain Health Center
    - Community Health Services of Lamoille Valley
- Springfield HSA not participating in the Medicare program but maintaining participation in the Medicaid and BCBSVT QHP program

The addition of these providers should not be expected to result in significant changes to utilization rates; however, the addition of their attributed lives may. By way of example, the Medicare lives that attributed to the Springfield HSA historically had an above average risk profile. Losing these lives from the program could result in utilization changes even at the ACO level.

Incorporation of the geographic attribution concept could also affect utilization. While analysis of the sub-populations that do not traditionally attribute is underway, early results show very different utilization and cost patterns. For example, one of these sub-populations is those who have no historical claims. If added, they would at first dilute utilization on a per-person basis, but once successfully engaged with a primary care provider utilization can only go up.

5. Provide a narrative description of the flow of funds in the system for 2020. Include in the narrative description a discussion of any changes in the funds flow from the 2019 submission to the 2020 submission. The description should include the flow of funds from payers to the ACO, and from the ACO to its providers. The description should demonstrate the ability of the ACO to maintain sufficient funds to support its administrative operations and meet provider payment obligations.

The funds flow model for 2020 remains similar to that employed in 2019 and contains two core components:

Fixed Prospective Payments / All Inclusive Population Based Payments

OneCare continues to shift provider reimbursement away from a fee-for-services (FFS) model with select participants accepting fixed payments. For these organizations, claims submitted to the payer for care to attributed lives are adjudicated using the existing payer methodology but are not paid in the regular FFS fashion. Rather, a monthly fixed payment allocation is paid to OneCare, where the total amount is divided up and distributed to the participating providers to replace the historical FFS revenue. Except for any expected reconciling activity, the full amount paid to OneCare is distributed out to the participating providers each month. For providers that are not participating in a fixed payment model, claims are paid directly to the provider by the payer and the funds never flow through OneCare. The FFS amounts paid by the payer are not affected by OneCare, its programs, or the total cost of care trend rates discussed in Section 3.

OneCare Operations and Population Health Management Investments

The revenue inflows to sustain OneCare operations come from three main sources: hospital dues, payer contributions, and government contributions. The hospital dues are facilitated through a deduction from the fixed payments as a means to avoid unnecessary invoicing and thus unnecessary administrative burden. The payer and government contributions are dictated by contract terms and typically include either monthly or quarterly payment frequency. Together these result in monthly cash contributions to OneCare that is used to cover population health management (PHM) and operating expenses.

The PHM investments are generally monthly or quarterly payments to the provider network. One exception to this is the Value Based Incentive Fund (VBIF), which is distributed to the network once the quality scores are known after the conclusion of the plan year. The source funds for the VBIF (hospital dues) are held in a distinct account until the time for their distribution. The operating costs are varied in terms of timing, but subject to ordinary payroll cycles, contract payment cycles, and ad-hoc payments in similar fashion to any other organization.

6. Referring to Appendix 4.4, Total Shared Savings / (Loss) to ACO, provide a quantitative and qualitative summary of your shared savings distribution plan for 2018.

The 2018 shared savings distribution plan is explained in detail in the OneCare 2018 Savings/Losses Sharing Model which the GMCB has been previously provided.

Qualitative Summary

The 2018 methodology yielded the intended result of local HSA accountability and a full delegation of risk/reward to the participants. However, achieving these goals came with significant complexity, which makes the approach difficult to explain and understand. A more simplified model would help all stakeholders comprehend the approach, but could dilute the concept of local accountability. As with all of these policies, modifications are explored each year to improve upon the past experiences and adjust for anticipated or known environmental changes.

Quantitative Summary

Medicare

Gross Shared Savings (Loss)	$17,022,114
Paid Shared Savings (Loss)*	$13,345,337
% Paid Shared Savings (Loss)**	3.9%
HSAs Earning Shared Savings	6
% HSAs Earning Shared Savings	100%
HSAs Over MRL on Savings	2
HSAs Over MRL on Losses	0

* After 80% share and sequestration adjustments

** Based on final benchmark

Medicaid

Gross Savings (Loss) Under Fixed Payment	$7,663,309
Gross Savings (Loss) Under FFS	($1,538,376)
Other Reconciling Activity	($2,157)
Paid Savings (Losses)*	($1,540,534)
Combined Performance Savings (Losses)**	$6,122,776
% Combined Performance Savings (Loss)	5.2%
HSAs Earning Paid Shared Savings	3
% HSAs Earning Paid Shared Savings	30%
HSAs With Combined Performance Savings	9
% HSAs With Combined Performance Savings	90%
HSAs Over MRL on Savings	2
HSAs Over MRL on Losses	4

* Gross savings (loss) under FFS plus other reconciling activity

** Includes the savings (loss) under fixed payments and the savings (loss) under FFS

Commercial QHP

Gross Shared Savings (Loss)	($1,550,338)
Paid Shared Savings (Loss)*	($645,574)
% Paid Shared Savings (Loss)	(0.5%)
HSAs Earning Shared Savings	3
% HSAs Earning Shared Savings	43%
HSAs Over MRL on Savings	0
HSAs Over MRL on Losses	1

* After 50% sharing and paid/allowed ratio adjustment

Commercial Self-Funded

Gross Shared Savings (Loss)	$0
Paid Shared Savings (Loss)	$0
% Paid Shared Savings (Loss)	0%
HSAs Earning Shared Savings	0
% HSAs Earning Shared Savings	0%
HSAs Over MRL on Savings	0
HSAs Over MRL on Losses	0

7. Provide both a quantitative and qualitative summary of your quality withhold distribution plan for 2018.

The 2018 Value Based Incentive Fund (VBIF) distribution plan is explained in detail in the 2018 VBIF Policy, which has been previously provided to the GMCB.

Qualitative Summary

The general approach, which allocated 70% of the VBIF funds to primary care and the remainder to all other participating providers, effectively aligns the reward structure with the measures. Many of the quality metrics are primary care based, resulting in the decision to have a 70/30 split, as outlined in the policy. The 2018 model did not incorporate any HSA or practice-level factor, which would further the concept of local accountability. Developing a model with more local accountability is challenging, however, due to the relative small sample size for some of the measures, the necessity for ongoing manual data abstraction for clinical measures which is costly, and the lack of routine access to quality performance data on mental health and substance abuse which OneCare is precluded from receiving under federal regulation. Despite the challenges facilitating this change, OneCare continues to explore ways to fairly reward the network for its continued high quality care.

Quantitative Summary

Medicare

Total VBIF Pool	$1,744,141
Quality Score	100%
Total Payout	$1,744,141
Amount Paid to Primary Care	$1,220,898
Amount Paid to Other Providers	$523,243

Medicaid

Total VBIF Pool	$1,758,742
Quality Score	85%
Total Payout	$1,494,931
Amount Paid to Primary Care	$1,046,452
Amount Paid to Other Providers	$448,479

Commercial - QHP

Total VBIF Pool	$502,339
Quality Score	86%
Total Payout	$432,564
Amount Paid to Primary Care	$302,795
Amount Paid to Other Providers	$129,769

Commercial – Self-Funded
Due to an absence of data relating to mental health interventions, which is a core component of the quality score, a joint decision was made to roll 100% of the 2018 VBIF pool into the 2019 program. The lack of data is due to a change in the carrier paying mental health claims.

8. Provide a quantitative analysis with accompanying narrative to demonstrate how the ACO would manage the financial liability for 2020 through the risk programs included in Part 3 should the ACO's losses equal 100% of maximum downside exposure. As part of the narrative response, describe your full risk mitigation plan to cover this liability and the mitigation plan for any contracted providers to which risk is being delegated or with which risk is being shared. This response is to include, but is not limited to:

Settlement of the payer programs and the delegation of risk across the network is complex. This complexity is driven by the desire to maintain HSA-level accountability while protecting each HSA from excessive liability. The model provides some network-funded protections, which ultimately means that the performance of one community can affect the financial outcome for another.

With the exception of the risk mitigation arrangements where the ACO or its founders retain some downside risk (and upside potential), all of the risk and reward will continue to be delegated to network participants. Each hospital remains the risk-bearing entity for its HSA and will be subject to any risk payback up to their Maximum Risk Limit (MRL). The MRLs are calculated by applying the contracted program risk corridor and sharing terms to the HSA-specific spending target. This calculation results in the maximum amount that any hospital will owe for a risk settlement. Any amounts in excess of an MRL are pooled and shared across the other risk bearing entities.

One change in place for 2019 and 2020 is pooling of risk for specific population cohorts. For example, the Medicare end-stage renal disease (ESRD) population is very small (~170 people) and subject to material variation. The network decided to move forward in a manner that pools the risk and shares savings or losses proportionally across the risk bearing entities. For more detail on this process please see OneCare's Program Settlement Policy and the HSA Benchmark Policy previously provided to the GMCB.

In the event that the ACO is subject to the maximum downside settlement for a program, which means that spending overruns/savings met or exceeded the risk corridor limit, each hospital would pay up to their MRL. The MRL calculations are designed in a way that ensures these MRL amounts are sufficient to fully cover the liability owed by OneCare. On top of the MRL concept, there are additional layers of risk protection that would also be incorporated into the settlement and could decrease the actual cash payment made by hospitals and protect OneCare. The Program Settlement Policy outlines the steps in much more detail, but the following summarizes the core protection layers and the order in which they are applied:

Layer	Protection	Description
1	Medicare Third Party Risk Protection	Applied first to HSAs that exceeded their MRL to limit HSA cross-coverage
2	Risk Mitigation Arrangements	Applied to the specific HSAs with risk mitigation arrangements
3	Hospital Settlement Payments	Performance settlement payments from hospitals based on their actual spending results; not to exceed their MRL
4	OneCare Reserves	Accessed to fund any intentionally un-delegated risk or cover an unforeseen circumstance
5	Medicare Financial Guarantee	Accessed only if liability remains after layers 1-4
6	Founders	Accessed only if liability remains after layers 1-5

a. Portion of the risk delegated through fixed payment models to ACO-contracted providers and the percentage overrun on total expecting spending outside the ACO's fixed payment models that would result in losses of 75% and 100% of the ACO's maximum downside exposure;

Program	Fixed Payments	FFS	Total Target	Max Risk	FFS Overrun for 100% Downside	FFS Overrun for 75% Downside
Medicare	$271M	$270M	$541M	$27M	10.0%	7.5%
Medicaid	$154M	$129M	$283M	$11M	8.5%	6.4%
Comm. - QHP	$47M	$120M	$167M	$4M	3.3%	2.5%
Comm. - Self-Fund.	$0	$374M	$374M	$2M	0.5%	0.4%
Total	**$472M**	**$893M**	**$1.365B**	**$44M**	**4.9%**	**3.7%**

It's important to note that the Medicare fixed payment is fully reconciled to FFS before the program settlement occurs. This means that there is no true "protection" against an overrun for the services delivered by providers accepting a fixed payment. The exact model and methodology for the Commercial – QHP program fixed payments are in discussion and not final at this time.

b. Portion of risk covered by ACO providers through mechanisms other than fixed payment models (e.g., withholds, commitment to fund losses at annual settlement, etc.);

One hundred percent of the risk is covered by means other than the fixed payments. While the fixed payment model can help to minimize the likelihood of a spending overrun deep into the risk corridor, it is still possible that an HSA with a hospital accepting fixed payments will maximize their downside exposure and will owe the full amount up to their MRL back to OneCare. While a true capitation model (ex. the Medicaid fixed payment) can help minimize the probability of a large settlement payment, its purpose is primarily to reform the way in which providers are paid and move away from a FFS methodology.

c. Portion of risk covered by reserves, collateral, or other liquid security, whether established as a program contractual requirement or as part of the ACO's risk management plan;

Outside of the MRLs, the only hospitals with guaranteed risk protection are those with a risk mitigation agreement. Their protections are as follows:

HSA	Total Risk	Downside Protection *	Max Upside for Founders **
Bennington	$4,696,716	$2,348,358	$1,174,179
Brattleboro	$2,368,265	$1,184,133	$592,066
Morrisville	$475,334	$237,667	$118,834
Total	**$7,540,315**	**$3,770,158**	**$1,885,079**

* Last 50% of the HSA risk corridor

** 25% from first dollar

In certain circumstances additional layers of risk protection could be applicable (for example the Medicare risk protection arrangement) but the HSAs that would benefit and their amount would be dependent on the performance of all other HSAs.

d. Portion of the risk covered by reinsurance;

Based on the budget and assuming the terms of the risk protection arrangement are similar to those in 2019, the model could yield financial benefits of up to $12.1 million. Proceeds from this protection will first apply to HSAs whose natural spending exceeded their Medicare MRL. Doing so would then reduce the need for HSA cross-coverage, which is a benefit to the HSAs that didn't have an overrun. Because of the numerous scenarios for the way in which the year unfolds, there is no guarantee or predetermined amount for how much any one HSA can benefit. In other words, one HSA could exceed their MRL but the network-wide overrun isn't enough to yield any risk protection proceeds.

e. Portion of the risk covered through any other mechanism (please specify);

Only in an unforeseen scenario would other risk protection layers such as reserves, the Medicare financial guarantee, or the founders be required to fund downside exposure.

f. Any risk management or financial solvency requirements imposed on the ACO payers under ACO program contracts appearing in Part 3.

Medicare is the only payer-program with a contracted reserve requirement. In the 2019 program year, a $7.5 million reserve was required. Medicare allows ACOs to develop this reserve in three ways: a letter of credit, surety bond, or escrow account. OneCare employed the escrow account option in 2018 and is in the final stages of transitioning this requirement to a letter of credit. The letter of credit comes with some cost, but doesn't require the need to set aside additional cash. Despite this required financial guarantee, the intent is that it is only used as a last resort. In discussions with commercial payers it was communicated that a financial guarantee will be required if the program adds downside risk in the future. This could be a component of the 2021 budget.

9. Provide an actuarial opinion that the risk-bearing arrangements between the ACO and payers are not expected to threaten the financial solvency of the ACO.

OneCare has enlisted Milliman to provide the actuarial guidance for budget modeling. However, due to the number of remaining variables at play, it is premature to seek actuarial certification. After the final trend analysis and prospective targets and attribution models have been produced, and negotiations are completed and/or contracts signed with payers, OneCare will update the GMCB with actuarial certifications for 2020.

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

OneCare submitted policies through ACO Certification and quarterly reporting to GMCB.

Part 4
Attachments

Attachment A – OneCare Balance Sheet

Attachment B – OneCare Income Statement

Attachment C – OneCare Cash Flow Worksheet

Attachment D – Total Shared Savings or Losses

Attachment E – Revenues by Payer

Attachment F – Summary of APM Reporting by all OneCare Participating Hospitals

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Green Mountain Care Board, 2020 Budget Submission

Part 5: ACO Quality, Population Health, Model of Care, and Community Integration Initiatives

1. Provide an update on your statewide model of care and how it has changed from 2017 to 2019. Narrative can include but is not limited to:

    a. How ACO clinical consultants collaborate with the Blueprint for Health (include any goals and milestones set or achieved);

    OneCare's Clinical Consultants collaborate with the Blueprint for Health staff in multiple venues. OneCare and Blueprint leaders co-plan and facilitate monthly half-day All Field Team (AFT) meetings attended by Blueprint Project Managers and Quality Improvement Facilitators and Community Health Team Leads; OneCare Vermont Clinical Consultants and Quality staff; Agency of Human Services Field Directors; and Vermont Department of Health District Directors. Examples of topics in 2019 have included: mental health follow up visits; initiation and engagement of treatment for substance use disorders; access to primary care; and chronic condition prevention strategies. In each meeting, subject matter experts share new information and perspectives with the attendees and then the attendees work in small groups (typically grouped by HSA) to identify root causes, discuss possible strategies for collaboration and plan future work to address the gaps identified in the presentations and root cause analysis activities. Additionally, the Blueprint and OneCare field staff collaborate in support of local HSA Community Collaboratives (aka Accountable Community for Health). The focus areas and projects initiated by each HSA varies, but clinical consultants and practice facilitators often partner to offer quality improvement support and expertise to the Patient-Centered Medical Home (PCMH) practices in each HSA. 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. Two additional convening's were held between Blueprint and OneCare staff in the spring of 2019 to further strengthen the collaborative relationships across organizations in support of community improvement activities. Discussions centered on Blueprint and OneCare activities and initiatives and further alignment of staff priorities and goals in support of their HSAs. In the July meeting, the Clinical Consultants and Practice Facilitators were grouped together by HSAs to work collaboratively to define the unique and overlapping aspects of each role; identifying individual and shared resources; discuss Quality Improvement (QI) needs for their communities; identify how they will support practices in achieving health and payment reform goals in a coordinated and aligned fashion.

    b. How ACO technical assistance has allowed communities to transform care (e.g. have more care coordinators been hired, new programs been instituted, etc.)

    OneCare offers technical assistance to support participants and communities on topics that augment their efforts to improve care delivery and health outcomes for Vermonters while managing healthcare costs. OneCare is uniquely positioned to

access information on care that is delivered in various healthcare settings (e.g. hospitals, primary care, skilled nursing facilities, home health, etc.) and uses these data to identify variations in cost, utilization, and quality that can support HSAs in their healthcare reform efforts. The most common forms of technical assistance that are delivered to communities include: data literacy and response to ad-hoc data needs, financial and population health analytics support, care coordination training, education on specific content related to ACO activities, and clinical education topics that are strategic focus areas for the ACO and overall wellbeing of Vermonters. Examples include: an inclusive process to evolve OneCare's 2020 Complex Care Coordination payment model which engaged over 250 leaders and care managers to prepare them for these changes, creation of a patient prioritization self-service application as a result of provider feedback, education on clinical topics of interest through Interdisciplinary Grand Rounds and noontime sessions, and education and training on implementation of benefit enhancement waivers.

c. How ACO is aligning with payer care coordination programs

OneCare aligns with each of its payer care coordination programs by creating mutually reinforcing contractual elements for care coordination innovation and service delivery across payers that together drive the network toward best practice, network-wide alignment and integration. The mutual goals are 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 analytics, quality, and care management teams to facilitate patient hand-offs, ensure appropriate coordination of care, and to discuss advancements in care management. For example, OneCare, DVHA Vermont Chronic Care Initiative (VCCI) staff, and local HSA leaders from St. Johnsbury meet to develop and test the implementation of OneCare's care model for a Medicaid supplemental geographically attributed population. This form of geographic attribution is a pilot at this time and could inform changes to attribution methodology in the future. From early learnings, the local ACH identified the need to develop a workflow to support member engagement and screening. VCCI agreed to conduct the initial screening using a tool they worked to align with OneCare's Care Model and then facilitated appropriate hand-offs to community-based care coordinators embedded in primary care, Community Health Team (CHT), or other community-based organizations. OneCare worked to provide timely access to data and analytics to support knowledge of this population through special provisioning and security groups in WorkBenchOne and Care Navigator.

2. Quantify and describe the transitions communities are making to the Accountable Communities for Health Model. Include a description of how the ACO is involved in these efforts. How have these grown from the Community Collaboratives? What is the team composition? What are the topics the teams are working on? Are the teams meeting more frequently? How is the Blueprint for Health involved?

OneCare serves on the ACH Leadership Team along with Blueprint and Health Department staff. This group has been meeting since 2017 to advance the ACH model in local HSAs. Over the past two years the Team has conducted needs assessments, created enduring materials to support system learning and orientation to the ACH Model, planned and delivered four ACH day-long Learning Labs, supported local ACH evolution through site visits and technical

assistance, and facilitated connections across ACHs where common areas of interest or need were identified. The Blueprint has explicitly made ACHs a program requirement for their practices. All Blueprint for Health grants specify certain accountabilities for local model implementation, and currently 90% of the groups are led by the Blueprint's Administrative Entity/Program Manager relationship. OneCare clinical consultants participate in the ACH Learning Labs as members of their local ACH and have served as facilitators of subgroups and committees. Most ACHs meet bi-weekly or monthly. In addition, some communities have incorporated sub-groups into their structure, who meet outside of the regularly scheduled meeting to address specific content areas and report back on topic-specific work.

In all areas of Vermont, health and social service providers and other community members have spent years building multi-disciplinary workgroups that aim to improve health for their citizens, with awareness of the importance of the social determinants of health. These groups go by many names – Community Collaboratives, Community Health Action Teams, Regional Clinical Performance Committees and more. This means communities aren't building Accountable Communities from scratch, but rather using the model to deepen their collaborations and improve their effectiveness. ACHs are typically made up of representatives, both clinical and non-clinical professionals, from the health service area's hospital, Designated Agency, independent practitioners and community service providers, such as SASH, housing agencies and the Area Agency on Aging (AAA). Vermont Department of Health (VDH) District Directors and Agency of Human Services (AHS) Field Directors have taken an active role in facilitating model implementation and provided leadership in planning and meetings.

While every community has an existing Community Collaborative, Regional Clinical Performance Committee (RCPC), and/or Accountable Community for Health Structure in place, the maturity and efficacy of each group varies greatly. For example, Springfield and Brattleboro have focused on understanding roles and responsibilities of integrator organization, governance and decision-making models, and how to identify and prioritize community needs. In communities such as Middlebury and Berlin, the ACH's focus has been on identifying and prioritizing needs and using multi-sectoral strategies to address opportunities for improved health and wellbeing. They have also identified some project-based funding to support their efforts. Examples of ACH's mission, vision, and can be found at: https://blueprintforhealth.vermont.gov/sites/bfh/files/All_HSA_slides.pdf.

In 2019, OneCare reached out to the four ACHs in our 2017 Medicaid risk contracts (Burlington, Berlin, Middlebury, and St. Albans), asking each ACH to identify a project that was aligned with OneCare's strategic priorities. OneCare provided a total of $60,000 to these communities from the unearned portion of the Value Based Incentive Fund to facilitate their improvement activities. These projects were reviewed jointly by OneCare and DVHA before approving and disbursing funds. The areas of focus for these projects include substance use, chronic health conditions, and prevention.

3. How have OneCare's population health investments supported transformation in care at the local level? This includes the Complex Care Coordination Program, RiseVT, the Regional Clinical Representatives, and other initiatives directly funded by the ACO. For each program, list the population health investment(s) referenced in Appendix 5.4 that the community or OneCare is using to support the program. If you are providing support other than financial, please describe.

OneCare's population health management investments are intended to facilitate care delivery transformations supported by unique payment reforms as well as opportunities for innovation and incentives that encourage the transition to value. Note that the amounts listed below represent investment opportunity and in some cases the amount paid to the providers is dependent on their level of engagement, performance, and ACO quality scores. Final investment amounts are also dependent on final contract terms with payers and associated 2020 attribution.

Basic OneCare PMPM ($8,569,920)
The basic OneCare PMPM payment of $3.25 PMPM is disbursed for each life attributed to the ACO and is paid to the attributing primary care TIN when they attest achieving a standard set of criteria to facilitate primary care transformation. 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.

Complex Care Coordination Program ($10,223,590)
OneCare's Complex Care Coordination program provides funding for the successful engagement of attributed lives who can benefit from supports and services to enhance their experiences with care. The program has a focus on driving down the total cost of care by ensuring communication among the care team. Specific expectations of the program are shared through regional core teams and educations opportunities. This funding supports primary care, Designated Agencies, home health, and Areas Agencies on Aging in care delivery transformation efforts to align across organizations.

Value Based Incentive Fund ($8,387,232)
The Value Based Incentive Fund is a quality withhold of the total cost of care that is set by payer programs, as such it is no longer dependent upon earning shared savings to reward quality achievements. Dollars are disbursed to the network based on quality scores and in accordance with set policy. Any reinvestment by OneCare is made in agreement with our payer partners and is monitored in accordance with the terms outlined in our contracts. This funding supports transformation across OneCare's community of providers.

Comprehensive Payment Reform (CPR) Program Cost ($1,606,613)
Supplemental funding to independent primary care practices enrolled in OneCare's Comprehensive Payment Reform Program. This funding supports primary care transformation by shifting reimbursement away from a FFS incentive structure. Participating practices are able to care for their panel of attributed lives in ways that would have been historically detrimental to revenue generation.

Primary Prevention Programs ($1,031,752)
Ongoing support and future expansion for RiseVT. See Q4 for additional information. This funding supports cities and towns to improve health and wellness in their communities.

Specialist Program Payments ($1,750,000) & Specialist Program Payments – 2019 Obligated ($1,394,500)
OneCare has obligated funds from the 2019 performance year to continue projects in 2020. In addition, OneCare allocating $1,750,000 to expand support of programs. This type of funding enables roll-out of innovative care delivery concepts that would otherwise be unfunded in a FFS environment. Current focus areas include new mental health investments, clinical

pharmacy, developing infrastructure of electronic-consults between primary and specialty care practices in one setting, and a complex care program specifically for high cost/high needs patients with chronic kidney disease.

Innovation Fund ($750,000) & Innovation Fund – 2019 Obligated ($617,580)
OneCare has obligated funds from the 2019 performance year to continue projects in 2020. In addition, OneCare anticipates awarding $750,000 in new innovation fund projects in 2020. This funding supports care delivery transformations in specific pilot programs which, if successful, have the ability to be scaled across organizations and HSAs and benefit both the cost and quality of care.

Primary Care Engagement Investment ($375,000)
OneCare will work to increase primary care engagement and with it access to care, a primary population health goal under Vermont's All Payer Model. OneCare, in collaboration with payers, will explore new strategies to engage Vermonters more proactively in their healthcare and work to facilitate a regular and sustained relationship between patient and primary care provider. The underlying transformation is a heightened focus on prevention and wellness, which begins at the primary care layer.

VBIF Quality Initiatives ($167,505)
These funds consist of the component of the unearned Value Based Incentive Fund from Medicaid and BCBSVT QHP in 2018 that will be available in 2019 and 2020 to invest in specific quality initiatives. Determination of specific quality initiatives will occur later this fall and winter.

Blueprint Investments (PCMH Payments - $1,894,417; CHT Payments - $2,379,711; SASH - $3,968,246)
Continuity of Blueprint for Health payments to Patient Centered Medical Homes, Community Health Teams and Supports and Services at Home funded through pre-paid shared savings from OneCare's Medicare risk contract.

4. Describe goals and objectives planned for future model of care initiatives for 2020-2022 (include a work plan if available or embed in a table).

OneCare is focused on its core goals of supporting healthcare delivery transformation and payment reforms to ensure high quality care for Vermonters while ensuring healthcare cost growth is contained. The foundation of the care model is a belief in primary care and the necessity to make appropriate investments as well as ensuring strong relationships and support of continuum of care partners. OneCare's flagship programs to date include RiseVT and our community-based complex care coordination program. In 2020, subject to available funds, OneCare intends to expand its support to primary care and the complex care program by embedding clinical pharmacists into care teams. Thus, our vision is: "to provide high-quality, person-centered, community-based care coordination services in an integrated delivery system to achieve optimal health outcomes." OneCare continues to encourage innovation and is supporting a diverse portfolio of creative potential solutions to improve care outcomes and address ways to reduce healthcare costs under our total cost of care.

RiseVT

In 2020, RiseVT anticipates expanding to seven additional cities/towns in order to improve the lives of more Vermonters statewide. Further, RiseVT will spread the "Sweet Enough" behavior change marketing campaign statewide with an initial focus on the reduction of sugar-sweetened beverage consumption for the 18 to 35-year-old population focusing on shift workers and young parents. Over the next few years, RiseVT anticipates building additional campaigns and continuing to support the amplification of local health and wellness promotion activities.

Complex Care Coordination Program

OneCare led an extensive process in 2019 to evolve the complex care coordination payment model away from a capacity-building program to one that pays for value. The process involved iterative feedback and refinements through a series of five network focus groups, review and approval by OneCare's Finance and Population Health Strategy Committee and, approval by OneCare's Board of Managers. Upon approval, OneCare staff visited each HSA to conduct a Town Hall with organizational leaders to prepare them for this transition. More than 250 people participated in these educational sessions. HSA-specific performance was discussed along with strategies for organizations to prepare for this next step in the transition to value based care. The new payment model will be implemented April 1, 2020. OneCare submitted its updated payment model through the ACO Certification process.

Clinical Pharmacy Program

OneCare is planning to partner with public and private payers to develop and implement an evidence-based model to embed clinical pharmacists in primary care. Literature has demonstrated a positive clinical and financial impact on the direct medical expenditures of patients receiving specific clinical pharmacy interventions. OneCare intends, pending investments by payers, to test this clinical approach from 2020 to 2022 with a focus on standard interventions and evaluation to determine the effectiveness of this care delivery transformation across Vermont.

Innovation Fund

OneCare has allocated more than $1 million in 2019 to support nine projects across the state as they engage in improvement and care delivery transformation efforts locally. Awarded after a competitive process open to all OneCare Network members, and overseen by OneCare's Population Health Strategy Committee, OneCare is investing in diverse potential solutions addressing mental health, vulnerable populations, technology in rural settings, and specific chronic conditions. 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 and spread. OneCare's Population Health Strategy Committee intends on further expanding the portfolio of projects over time to address varying health needs of Vermonters across the state.

Mental Health Investments

OneCare is expanding its investments in mental health services and supports beyond the existing resources for the complex care program and the innovation-related programs in local HSA to include a new $500,000 investment in expanding mental health access to services in the emergency department through navigation and follow-up. The programs seek to expand Zero Suicide programming and outcomes metrics are directly linked to OneCare's mental health and substance use disorder quality measures. The funds will support approximately six

FTEs in selected HSAs in OneCare's Network. Once contracting is complete, OneCare will publicly announce the selected HSAs.

5. Provide a progress report on the network's use of software tools for care management. In **Appendix 2.1, Provider Network,** the ACO will report the organizations that are using the tool by Hospital Service Area. In addition, the ACO shall report:

    a. The number of patients with information in the system by Hospital Service Area;

    As of September 20, 2019, OneCare has a total of 157,865 attributed patients in Care Navigator (down from approximately 170,000 due to natural attrition over time). The Burlington HSA has the largest number of patients at 52,097.

    Patients in Care Navigator by Health Service Area

Health Service Area	Patients
Bennington	14,344
Berlin	15,467
Brattleboro	7,853
Burlington	52,965
Lebanon	3,675
Middlebury	10,368
Newport	4,133
Randolph	2,954
Rutland	8,326
Springfield	10,468
St. Albans	14,799
St. Johnsbury	6,146
Windsor	6,367
Total	**157,865**

    b. The number of patients with shared care plans in the system by Hospital Service Area;

    OneCare currently has 2,446 patients in Care Navigator with a lead care coordinator assigned and a Shared Care Plan with at least two goals and two associated tasks. The Burlington HSA has the largest number of care managed members at 637.

Shared Care Plans by Health Service Area (All CC Levels)

Health Service Area	Patients
Bennington	385
Berlin	236
Brattleboro	208
Burlington	637
Lebanon	1
Middlebury	53
Newport	110
Randolph	63
Rutland	44
Springfield	172
St. Albans	414
St. Johnsbury	34
Windsor	89
Total	**2,446**

c. A summary of how the ACO is incorporating provider and patient input on software tools (if possible, include a summary of input from providers who have opted not to use Care Navigator and/or are using different software tools); and

OneCare gathered extensive input from providers and their representatives from across our community of providers through the Care Coordination Payment Model Focus Groups in spring 2019, monthly Care Coordination Core Team discussions, and specific Care Navigator visioning sessions in order to inform advancements to our care coordination software tools and analytic resources. In addition, regular discussions with OneCare's Patient and Family Advisory Committee (PFAC) provide important insights and set priorities to inform software adoption and advancements. The PFAC endorsed the concept of provisioning access for patients into the Care Navigator mobile application to increase access to shared care plans and improve communication among the care team. With respect to WorkBenchOne, providers give feedback and ideas for enhancements to reporting and self-service tools through clinical 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 2019 and has significantly refined and improved our monthly ACO and HSA-level Performance Dashboard reports. We have also initiated a new HSA variations of care report which we provide quarterly to risk-bearing hospitals.

In 2019, OneCare approved one request to use an alternative data system: the Rutland HSA built out the hospital's electronic medical record, Cerner, as their care coordination management software. OneCare required Rutland to meet care coordination standards for data collection and reporting including providing a monthly flat file on care management metrics that aligned with metrics captured in Care Navigator. The Rutland team has found the implementation more challenging than anticipated, including recognizing significant capacity concerns related to ongoing software changes and enhancements, training of new care coordination staff, and data

extraction and support. Additionally, there was significant financial consideration associated with the pilot. After careful review and analysis of the pilot, the Rutland HSA care coordination leadership team has made the decision to cease the pilot and they are currently in the process of converting their software usage to Care Navigator.

d. Any other key process metrics demonstrating adoption of the care management model.

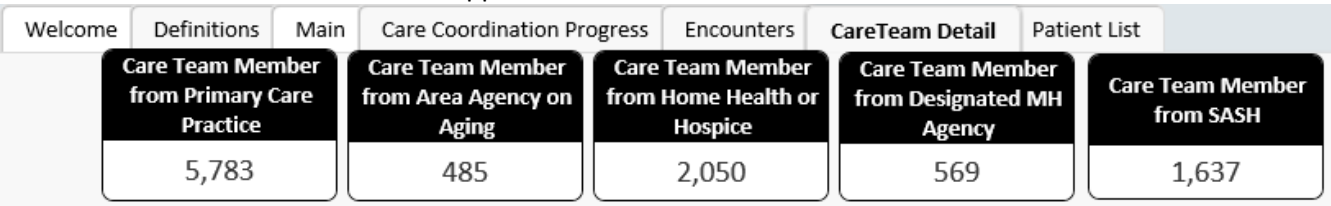
Other key process metrics OneCare uses to demonstrate adoption of the care management model are the following:

Patients in Care Navigator with assigned Care Coordination Status

Care Coordination Status	Patients
In Outreach	2,415
Engaged	4,395
Declined	358
Care Coordination Not Needed	2,064
Moved	609
Deceased	607
Total	**10,448**

Composition of Care Teams by Organization Type

Data Source: Process Metrics Application



Encounters by Type for all HSAs

(Definition of Encounters: The recording of interactions with the patient, family member and/or Care Team member indicating Care Coordination activity the patient is engaging in as identified by all HSA/WBO data.)

Data Source: Process Metrics Application

Encounters by Type

TypeofMeetingName	CCLevel	Low Risk	Medium Risk	High Risk	Very High Risk
Care Team Conference		1	16	31	26
Email		1	9	15	12
Facility Visit		1	3	6	9
Home Visit		17	24	25	65
In Person		59	239	191	391
Letter		30	68	60	62
Office Visit		29	152	188	259
Other		4	19	19	39
Phone		39	199	231	439
Review and Coordination of Care		1	17	15	16

6. Provide an update on your Care Coordination Effectiveness and Outcomes Analysis Framework using data.

   In 2017 OneCare piloted a Complex Care Coordination program which has now expanded to include approximately 170,000 Vermonters across 13 HSAs. OneCare is working to understand the outcomes of these participants in care management through ongoing outcomes analysis and evaluation. Data have been collected around the experience of participants in care management including utilization of emergency and inpatient services and cost of care for members attributed to the ACO. Pre and post run charts that align intervention dates and compare rate trends for 12 months prior to the intervention are being used to visualize trends in utilization across payers. To enhance this monitoring effort statistical analyses are run to determine if the difference in experience pre intervention and post intervention is likely correlated. Early analysis has shown a decrease in Emergency Department (ED) utilization rates for the high and very high risk cohorts. The pre and post analysis of the intervention group demonstrated statistically significant reductions in ED utilization in the first 6 months of the intervention for Medicare and Medicaid members. Other outcomes continue to be monitored, but due to small numbers with sufficient time in the intervention cohorts, conclusions cannot yet be made. These outcomes will continue to be monitored. As evidenced by the large increase in the care managed population in 2019, OneCare anticipates opportunities for robust analysis of care coordination outcomes in the 2020 and 2021 performance years.

7. Complete **ACO Clinical Priority Areas (Appendix 5.1)**. In the appendix provide the ACO's 2018 clinical and program priorities, metrics, targets, and actual results, by payer. The appendix also lists the 2019 clinical and program priorities, metrics, and targets, by payer. In addition:

   Please see Attachment A in Part 5 Attachments for completed Appendix 5.1 titled "ACO Clinical Priority Areas".

   a. Describe in narrative form what changed or stayed the same from 2018-2019 and progress made on your clinical priorities in 2019 to date, including successes and opportunities for improvement.

      When identifying the 2019 Clinical Priorities, OneCare selected measures that were clinically important, represented areas of opportunity for improvement, and that could be monitored on a monthly basis with available data. Reviewing the 2018 Clinical Priorities, measures that met this criterion were continued in 2019, while measures that depend on annual reports from the payers, such as the mental health and substance use-related measures, were retired. This decision was made due to the lack of monthly data to drive focused change and improvement. In addition to reviewing and selecting from the 2018 Clinical Priorities, OneCare also selected new Clinical Priorities including: Increasing the percent of patients with diabetes with an A1c performed within 12 months and decreasing emergency department visit rates for asthma for patients with asthma (pediatric and adult).

      Note: The following results are reflective of the 2019 data available from January through April with claims paid through July for the Medicaid and Medicare programs.

Goals have been set for the BlueCross and BlueShield of Vermont (BCBSVT) Qualified Health Plan (QHP) and results will be monitored and evaluated once data are available.

2019 Progress-To-Date

Note: all progress discussed in this submission is as of September 1, 2019.

High-Risk Patient Care Coordination

- Goals: There are three goals for this priority area:
  - 15% of high and very high risk patients are engaged in care coordination
  - 10% reduction from 2018 average rate in the inpatient admission rate for high and very high risk 2019 cohorts
    - Medicare 10% target: less than 698.5 IP admits
    - Medicaid 10% target: less than 207.9 IP admits
  - 10% reduction from 2018 average rate in the emergency department utilization rate for high and very high risk 2019 cohorts
    - Medicare target: less than 1,740.3 ED visits
    - Medicaid target: less than 1,469.5 ED visits

- Progress: For Medicare, the number of inpatient admissions (639.5) and emergency department visits (1,708.6) are both less than the targets set. For Medicaid, the number of inpatient admissions (212.8) is slightly higher than the target, but the number of emergency department visits (1,400.9) is lower than the target. For care coordination, 6% of Medicare patients in the high and very high risk cohorts are engaged in care coordination and for Medicaid the care coordination engagement rate for the high and very high risk cohorts is 7%.

- Successes/Opportunities for Improvement: While it is positive that Medicare's rates for inpatient admissions, and Medicare and Medicaid's emergency department visits, are lower than their respective targets, there is an opportunity to improve on the Medicaid emergency department visit rate for the coming year. For both Medicare and Medicaid, there is still time to increase the rate of care coordination engagement for the high and very high risk cohorts to reach the goal of 15% and trending indicates that both Medicare and Medicaid are on track to meet the 15% goal.

Chronic Disease Management Optimization

- Goals: There are five goals for this priority area:
  - 5% reduction from 2018 average rate in the inpatient admission rate for COPD, for patients with COPD within the 2019 cohort
    - Medicare 5% target: less than 52.1 IP admits
    - Medicaid 5% target: N/A
  - 5% reduction from 2018 average rate in the inpatient admission rate for CHF, for patients with CHF within the 2019 cohort
    - Medicare 5% target: less than 118.1 IP admits
    - Medicaid 5% target: N/A
  - 5% reduction from 2018 average rate in the emergency department visits for asthma, for pediatric patients with asthma within the 2019 cohort
    - Medicare 5% target: N/A
    - Medicaid 5% target: less than 34.0 ED visits

- 5% reduction from 2018 average rate in the emergency department visits for asthma, for adult patients with asthma within the 2019 cohort
  - Medicare 5% target: less than 45.0 ED visits
  - Medicaid 5% target: less than 39.4 ED visits
- 5% increase from 2018 average rate of patients with diabetes with A1c performed within 12 months within the 2019 cohort
  - Medicare 5% target: at least 96.9% patients with diabetes
  - Medicaid 5% target: at least 95.4% patients with diabetes

- Progress: For Medicare, the number of COPD-related inpatient admissions for adults with COPD (55.3) and CHF-related inpatient admissions for adults with CHF (130.0) are both more than the targets set. For Medicaid, the number of asthma-related emergency department visits (29.8) is lower than the target set for 2019. The number of asthma-related emergency department visits for adults with asthma for Medicare (45.1) is lower than the goal but for Medicaid (43.1) the number is higher than the goal. The current rate of patients with diabetes with A1c performed within 12 months is 91.6% for Medicare and 88.1% for Medicaid, both of which are lower than the targets set for 2019.

- Successes/Opportunities for Improvement: Within the Chronic Disease Management Optimization clinical priority, there have been successes with the number of asthma-related emergency department visits for adults with asthma is holding just below the target, which is positive. Additionally, for Medicaid, the number of asthma-related emergency department visits for pediatric patients with asthma is also below the target. For the other inpatient and emergency department related goals, however, both Medicare and Medicaid have exceeded their targets. The rates of A1c performed within 12 months for patients with diabetes are still below the target for Medicare and Medicaid, however there is still an opportunity to improve these rates before the end of the year.

Prevention and Wellness

- Goals: There are three goals for this priority area:
  - 10% increase from 2018 average rate in the Medicare beneficiaries in the 2019 cohort with an annual wellness visit within 12 months
    - Medicare 10% target: at least 39.2% of Medicare beneficiaries
    - Medicaid 10% target: N/A
  - 10% increase from 2018 average rate in adolescent well-care visits for patients in the 2019 cohort
    - Medicare target: N/A
    - Medicaid target: at least 65.9% of adolescents
  - 10% increase from 2018 average rate in developmental screening in the 2019 cohort
    - Medicare target: N/A
    - Medicaid target: at least 70.2% of applicable children

- Progress: 34.3% of the Medicare attributed lives have received their annual wellness visit, 55.6% of the Medicaid attributed lives aged 12-21 have received their adolescent well-care visits and 66.8% of the Medicaid attributed lives aged 0-3 have received their annual developmental screening. While the overall OneCare

rates in the three measures are currently below the end of year goals of a 10% increase, there are four HSAs that have achieved the developmental screening goal, one HSA that has achieved the adolescent well-care visit goal and one HSA that has achieved the Medicare annual wellness visit goal.

- Successes/Opportunities for Improvement: For all three measures, there is an opportunity to improve the rates before the end of the year. The rate of developmental screening is on track to meet the 2019 goal, while the Medicare annual wellness visits and the Medicaid adolescent well-care visits will need to catch up more significantly before the end of the year to meet their respective goals.

b. Describe in narrative form your process for developing 2020 Clinical Priority Areas.

The process for selecting Clinical Priorities Areas is effectively the same from year to year. The process is led by OneCare's Chief Medical Officer (CMO) and is discussed through the Clinical and Quality Advisory Committee (CQAC). CQAC is made up of OneCare's Regional Clinical Representatives (RCRs) and additional clinical and quality representation from across Vermont and the care continuum. To set the 2020 Clinical Priority Areas, the CMO will begin to lead CQAC through the selection process in the fourth quarter of 2019 and the first quarter of 2020, to allow for 2019 claims run out. The final results of the 2019 Clinical Priority Area progress will be reviewed in CQAC and new goals selected for the measures that will be continued into 2020. Additionally, CQAC may decide to remove Clinical Priority Areas or add new ones. Clinical Priority Areas can be removed from year to year for reasons such as insufficient data to accurately track progress, as was the case in 2019 with the mental health and substance abuse Clinical Priority Areas. Once the Clinical Priority Areas are selected and rates set, CQAC votes to adopt the Clinical Priority Areas. The final step is to present the Clinical Priority Areas at the OneCare Population Health Strategy Committee for endorsement and review by the Board of Managers.

c. How does each community prioritize and choose their clinical priorities?

Each Regional Clinical Representative is required to report out on their HSA's progress towards each of the Clinical Priority Areas at least once at CQAC during the calendar year. The RCR may report on work that is happening at the community level through an Accountable Community for Health (ACH) and also what is happening within the HSA's hospital and/or other care providers. These community groups and organizations may choose to focus on certain Clinical Priority Areas based on their HSA's progress towards the Clinical Priority Goals in the previous year and/or alignment with other focus areas, such as the results of the Community Health Needs Assessment. Clinical Priority decision-making is informed by OneCare's analytic reports and tools as well as support through their OneCare Clinical Consultants and Population Health Analysts.

8. Complete **ACO Quality Activities Related to the Vermont All-Payer ACO Model Agreement (Appendix 5.2)**, to describe results to date on ACO initiatives to address the quality measures. Be prepared at the budget hearing to respond to questions about the All-Payer Model Statewide Health Outcomes and Quality of Care Targets Report for 2018 that will be submitted to CMMI in September.

   Please see Attachment B in Part 5 Attachments for completed Appendix 5.2 titled "ACO Quality Activities Related to the Vermont All-Payer ACO Model Agreement."

9. By payer and line of business, provide an analysis of your most recent annual ACO quality reports for measures. In addition, provide results and analysis for the measures included in each payer contract, including the quality score, benchmark, and percentile for each payment and reporting measure for 2018, and any results of patient or provider experience surveys. Describe how these results, and results from previous years, have informed the ACO's programs and model of care, including the ACO's annual quality improvement work plan. In your discussion of results from previous years, identify and explain any statistical limitations.

   OneCare participated in three payer programs in 2018, each of which measured quality through a combination of claims, clinical and survey quality measures. At the conclusion of each performance year, the payer programs evaluate the care that was delivered and provides OneCare with final quality scorecards. OneCare uses the quality scorecards to identify opportunities for healthcare delivery improvement by comparing the Network's performance against national benchmarks from each payer and reviewing annual trends. The benchmarks used for each payer program are as follows: Quality Compass Medicaid All Lines of Business for the Medicaid program, Centers for Medicare and Medicaid Services Quality Rating System (CMS QRS) and Commercial Preferred Provider Organization (PPO) for the BCBS QHP program and CMS quality performance benchmarks for ACOs for the Medicare program. The identified opportunities are then used to inform OneCare's next performance year's clinical priorities, the annual quality improvement work plan and quality measure specific network education.

   Outlined below are two specific examples of quality opportunity informed decisions:

   - Through the annual quality abstraction process, OneCare observed opportunities at practices for enhanced documentation and workflows for clinically based measures including screening for clinical depression and follow-up, tobacco use assessment and tobacco cessation intervention, diabetes A1c poor control and controlling high blood pressure. This informed the development of the Quality Measure Boot Camp, an educational series designed to enhance practices understanding of the quality measure specifications. For example, ensuring the practices understood that for the tobacco screening measure it was important to ask patients about all tobacco use and that only asking about smoking was not sufficient. As part of the Quality Measure Boot Camp, OneCare has been working with interested practices to perform a mid-year abstraction and provide detailed feedback on opportunities for improvement in workflows and enhanced documentation. The diabetes A1c poor control measure is used to track the percent of patients with diabetes who have an A1c over 9% or who have not had the A1c test performed during the year. OneCare created a clinical priority to increase the percent of patients with diabetes who are receiving the A1c

test in order to help the Network think about different strategies to both help patients lower their A1c and help engage patients who are not receiving the test at all. The progress towards this clinical priority is shared with the Network on a monthly basis across all of the payer programs.

A comparison of the quality measure rates from 2017 to 2018 is only available in the Medicaid program, due to the Medicare program and the BCBSVT QHP program beginning in 2018. Year-to-year comparisons become available starting in the second year of a payer program.

Vermont Medicaid Next Generation (VMNG) Program

The Vermont Medicaid Next Generation (VMNG) Program began in 2017 with four HSAs and expanded to ten participating HSAs in 2018. Below is the 2018 VMNG quality scorecard for the claims and clinical quality measures included in the calculation of the overall quality score. The measure status in 2017 and 2018 is indicated for each measure, as well as the respective years rates compared to the national benchmarks. OneCare scored at the 50th percentile or above for all but one of the payment measures with available benchmarks, earning a composite score of 85.0%.

Measure	Y1 2017	Y2 2018	Quality Compass 2018 National Medicaid Benchmarks				Rate 2017	Rate 2018	Num	Den	Bonus Points	Quality Points
			25th *1 point*	50th *1.5 points*	75th *2 points*	90th *2 points*						
30 Day Follow-Up after Discharge from the ED for Alcohol and Other Drug Dependence	P	P	10.07	16.26	**24.48**	32.15	**30.25**	**29.15**	72	247	0.00	2.00
30 Day Follow-Up after Discharge from the ED for Mental Health	P	P	45.58	52.79	66.25	**74.47**	**80.93**	**81.74**	282	345	0.00	2.00
Adolescent Well-Care Visits	P	P	45.74	**54.57**	61.99	66.80	**57.50**	**56.40**	4,903	8,693	0.00	1.50
All Cause Unplanned Admissions for Patients with Multiple Chronic Conditions	P	P	-	-	-	-	**1.48**	**1.02**	11	1,078	0.00	2.00
Developmental Screening in First 3 Years of Life	P	P	17.80	39.80	**53.90**	N/A	**59.74**	**59.27**	1,861	3,140	0.00	2.00
Diabetes Mellitus: Hemoglobin A1c Poor Control (>9%)*	P	P	46.96	**38.20**	33.09	29.68	**31.52**	**33.33**	122	366	0.00	1.50
Hypertension: Controlling High Blood Pressure	P	P	49.27	**58.68**	65.75	71.04	**64.61**	**63.90**	223	349	0.00	1.50
Initiation of Alcohol and Other Drug Dependence Treatment	P	P	**38.62**	42.22	46.40	50.20	**35.39**	**38.87**	494	1,271	0.00	1.00
Engagement of Alcohol and Other Drug Dependence Treatment	P	P	9.11	**13.69**	17.74	21.40	**17.63**	**16.21**	206	1,271	0.00	1.50
Screening for Clinical Depression and Follow-Up Plan	P	P	-	-	-	-	**47.37**	**43.43**	142	327	0.00	2.00
Follow-Up after Hospitalization for Mental Illness (7 Day Rate)	R	R	29.61	**36.54**	45.79	54.13	**37.02**	**37.50**	159	424	-	-
Tobacco Use Assessment and Tobacco Cessation Intervention	R	R	-	-	-	-	**N/A**	**60.76**	223	367	-	-

* Inverse rate measure

Points Earned: 17.00

Total Possible Points: 20.00

2018 Final Score: 85.00%

Key: P – Payment, R – Reporting

Modified Medicare Next Generation (MMNG) Program

While OneCare is currently in the Vermont Medicare ACO Initiative, during the 2018 performance year, OneCare was in the Modified Medicare Next Generation (MMNG) Program. Thus for the purpose of quality measure reporting, the 2018 measures are for the MMNG program. Below is the quality score card for the claims, clinical, and survey measures included in the overall score. The performance year 2018 measure status is indicated for each measure, as well as the rate compared to the national benchmark. OneCare scored at the 50% percentile or above for 17 out of the 22 measures with identified national benchmarks. OneCare received a 100% quality score based on successfully submitting data for all measures for the first year of the MMNG program.

		Measure	PY 2018	Scoring Based on Benchmarks from Reporting Year							2018 Rates	Num	Den	Quality Points
				30th	40th	50th	60th	70th	80th	90th				
				1.10	1.25	1.40	1.55	1.70	1.85	2.00				
Patient Caregiver Experience	1	Getting Timely Care, Appointments, and Information	R	30.00	40.00	50.00	60.00	70.00	**80.00**	90.00	84.62	—	269	2.00
	2	How Well Your Providers Communicate	R	30.00	40.00	50.00	60.00	70.00	80.00	**90.00**	93.59	—	309	2.00
	3	Patient's Rating of Provider	R	30.00	40.00	50.00	60.00	70.00	80.00	**90.00**	92.14	—	304	2.00
	4	Access to Specialists	R	30.00	40.00	50.00	60.00	**70.00**	80.00	90.00	73.55	—	191	2.00
	5	Health Promotion and Education	R	54.18	55.48	56.72	**57.95**	59.39	60.99	63.44	59.05	—	334	2.00
	6	Shared Decision Making	R	54.75	**55.97**	57.05	58.10	59.27	60.58	62.76	56.95	—	297	2.00
	7	Health Status/Functional Status	R	-	-	-	-	-	-	-	76.93	—	340	2.00
	34	Stewardship of Patient Resources	R	24.25	25.57	26.74	28.12	29.43	31.08	33.43	23.80	—	307	2.00
Care Coordination Patient Safety	8	Risk Standardized, All Condition Readmissions	R	15.18	15.04	14.91	14.79	**14.65**	14.50	14.27	14.62	—	—	2.00
	35	Skilled Nursing Facility 30-day All-Cause Readmission measure (SNFRM)	R	19.22	18.81	18.47	18.15	**17.80**	17.41	16.85	17.54	—	—	2.00
	36	All-Cause Unplanned Admissions for Patients with Diabetes	R	39.00	35.81	33.20	30.86	28.48	26.05	23.12	40.75	—	—	2.00
	37	All-Cause Unplanned Admissions for Patients with Heart Failure	R	**82.32**	76.20	71.24	66.71	61.91	57.13	50.99	79.91	—	—	2.00
	38	All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions	R	**65.99**	61.21	57.25	53.51	50.00	46.16	41.39	63.84	—	—	2.00
	43	Ambulatory Sensitive Condition Acute Composite (AHRQ* Prevention Quality Indicator (PQI #91))	R	-	-	-	-	-	-	-	1.59	—	—	2.00
	12	Medication Reconciliation	R	-	-	-	-	-	-	-	94.48	582	616	2.00
	13	Falls: Screening for Fall Risk	R	43.42	50.42	58.45	66.00	**73.39**	81.79	90.73	79.85	210	263	2.00
	44	Imaging Studies for Low Back Bain	R	-	-	-	-	-	-	-	73.98	—	—	2.00
Preventive Health	14	Preventive Care & Screening: Influenza Immunization	R	30.00	40.00	50.00	60.00	**70.00**	80.00	90.00	70.20	172	245	2.00
	15	Pneumococcal Vaccination Status for Older Adults	R	30.00	40.00	50.00	60.00	70.00	**80.00**	90.00	84.32	500	593	2.00
	16	Preventive Care & Screening: Adult Weight Screening and Follow-Up	R	30.00	40.00	50.00	**60.00**	70.00	80.00	90.00	65.65	193	294	2.00
	17	Tobacco Use Screening and Cessation Intervention	R	-	-	-	-	-	-	-	81.82	18	22	2.00
	18	Depression Screening	R	30.00	40.00	**50.00**	60.00	70.00	80.00	90.00	57.55	141	245	2.00
	19	Colorectal Cancer Screening	R	30.00	40.00	50.00	60.00	**70.00**	80.00	90.00	75.00	186	248	2.00
	20	Mammography Screening	R	30.00	40.00	50.00	60.00	**70.00**	80.00	90.00	72.09	439	609	2.00
	42	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	R	-	-	-	-	-	-	-	82.39	468	568	2.00
At-Risk Populations	40	Depression Remission at Twelve Months	R	-	-	-	-	-	-	-	1.33	1	75	2.00
	DM*	ACO #27: Percent of beneficiaries with diabetes whose HbA1c in poor control (>9 percent) **and** ACO #41: Diabetes - Eye Exam	R	29.90	34.33	38.81	43.32	48.21	**53.64**	60.37	58.02	152	262	2.00
	28	Hypertension (HTN): Controlling High Blood Pressure	R	30.00	40.00	50.00	**60.00**	70.00	80.00	90.00	68.12	250	367	2.00
	30	Percent of beneficiaries with IVD who use Aspirin or other antithrombotic	R	30.00	40.00	50.00	60.00	70.00	80.00	**90.00**	96.68	378	391	2.00

* DM = Diabetes Composite

Total: **58.00**

Notes:
- Green and bold indicates the 2018 percentile
- P: Performance Measure and R: Reporting Measure - Medicare awards full points for reporting measures and points for performance measures based upon benchmarks
- CMS did not perform significance testing from prior years to deterime quality improvement points due to this being the first year in the Next Generation ACO Model program.

2018 Final Score
100.00%

Blue Cross and Blue Shield Qualified Health Plans (BCBSVT QHP) Program

The Blue Cross and Blue Shield Qualified Health Plans (BCBSVT QHP) Program began in 2018. Below is the quality scorecard for the claims, clinical and survey measures included in the overall score. The performance year 2018 measure status is indicated for each measure, as well as the rate compared to the national benchmarks. OneCare scored at or above the 75th percentile for five of eight quality measures with available benchmarks, earning a composite score of 86.12%.

Measure	Y1 2018	HEDIS 2018 Benchmarks CMS QRS and Commercial PPO				Rate 2018	Num	Den	Quality Points
		25th	50th	75th	90th				
		1 point	1.5 points	2 points	2 points				
30 Day Follow-Up after Discharge from the ED for Alcohol and Other Drug Dependence	P	10.26	13.14	**16.07**	20.11	**19.35**	6	31	2.00
30 Day Follow-Up after Discharge from the ED for Mental Health	P	53.63	60.64	67.02	**73.42**	**83.33**	35	42	2.00
Follow-Up after Hospitalization for Mental Illness (7 Day Rate)	P	31.25	41.03	55.10	**63.89**	**69.23**	18	26	2.00
Adolescent Well-Care Visits	P	36.56	43.61	**51.51**	64.68	**62.62**	1,238	1,977	2.00
ACO All-Cause Readmissions	P	**0.86**	0.76	0.66	0.53	**0.85**	43	455	1.00
Diabetes Mellitus: Hemoglobin A1c Poor Control (>9%)*	P	45.50	35.89	29.93	**25.55**	**23.11**	95	411	2.00
Hypertension: Controlling High Blood Pressure	P	48.91	**60.83**	69.34	76.88	**61.07**	251	411	1.50
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Composite)	P	19.49	**22.97**	26.66	30.79	**23.87**	53	222	1.50
CAHPS Patient Experience: Care Coordination Composite Score	P	-	-	-	-	**89.39**	-	-	1.50
Development Screening in the First Three Years of Life	R	-	-	-	-	**79.11**	231	292	-
Screening for Clinical Depression and Follow-Up Plan	R	-	-	-	-	**51.09**	210	411	-

* Inverse rate measure

Points Earned: **15.50**

Total Possible Points: **18.00**

2018 Final Score: **86.12%**

Key: P – Payment, R – Reporting

10. Describe strategies for expanding capacity in existing primary care practices, including but not limited to reducing administrative burden on such practices.

    OneCare provides Population Health Management investments in primary care to support advanced, team-based care practices and the achievement of improved population health and wellness outcomes. These investments are meant to enhance capacity in the Network and promote seamless coordination of care across the care continuum. In addition to these investments, OneCare has continued to partner with DVHA to refine the Medicaid Prior Authorization waiver to reduce administrative burden on practices. OneCare provides analytics, clinical, and operational support to facilitate education and training of primary care on effective population health management strategies including panel management, care coordination, and operational best practices. In 2019 OneCare expanded its Comprehensive Payment Reform (CPR) program for independent primary care practices. This program has been reported on throughout 2019 to GMCB, thus details are not repeated here.

    In summer 2019, OneCare entered into an agreement with Blue Cross and Blue Shield of Vermont (BCBSVT) to implement the BCBSVT Primary program (including the large group self-funded and Administrative Services Only (ASO) populations). As part of the new primary care focused clinical program, participating providers are eligible to receive payments for primary care engagement:

    - $3.25 per member per month (PMPM) to the attributing provider's TIN for patients that are actively engaged (i.e. had a visit with a PCP in the prior 12 months)
    - $100 per member per year (PMPY) to the participating provider's TIN that delivers a qualifying primary care service to patients that are NOT actively engaged (i.e. have not had a visit with a PCO in the prior 12 months)

    OneCare, BCBSVT, and Blueprint have come together to support practices as they work to re-engage with patients and improve access to primary care. The aim of addressing this population is to find ways to ensure preventive screening and care, and manage ongoing health concerns. In order to support practices in their effort to re-engage with patients, OneCare and Blueprint created at toolkit of best practices and strategies to improve primary care engagement. OneCare and Blueprint began disseminating the toolkit in August. As we move forward, OneCare and BCBSVT will increase focus on specific chronic conditions (e.g. CHF) as well.

11. Provide a summary analysis of your population in **ACO Population Risk Stratification Summary Analysis (Appendix 5.3)**, including variations in risk by Hospital Service Area; a breakdown of population distribution and associated spend into the four population health quadrants, by Hospital Service Area, for 2018 and 2019.

    Please see Attachment C in Part 5 Attachments for completed Appendix 5.3 titled "ACO Population Risk Stratification Summary Analysis."

    a. Provide a narrative overview of the risk stratification methodology and rationale.

OneCare uses the John Hopkins 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 to the service for that member in the coming 12 months. The risk scores are run by payer and then stratified within payer populations to assign 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. Care managers prioritize their workload based on this risk stratification methodology. Note that while a claims-based risk stratification algorithm is an important tool in prioritizing which patients to evaluate for outreach and engagement in the complex care coordination program, it is likely that for some patients more proximate events than appear in claims (i.e. a recent car accident) or clinical or social knowledge of the patient could inform the need to adjust the care coordination level. Any such revised care coordination levels are noted in Care Navigator by a care team member.

b. How does OneCare use risk stratification data to inform 2020 budget assumptions and model of care?

OneCare uses risk stratification to budget for the Care Coordination Payment Model. The payment model assumes engagement with 15% of the high and very high risk members attributed to the ACO for that year. Beginning in 2019, OneCare has also started using the HSA-level risk scores to set the HSA-specific spend targets used to determine shared savings or losses. Incorporating risk stratification data into the financial accountability model is a means to both transition to population-based measures of performance and step further away from FFS concepts and thinking.

c. Provide the prevalence of the most common conditions among ACO attributed lives, by Hospital Service Area.

For Medicaid the top prevalent conditions, for YTD 2019 include, acute upper respiratory tract infections, anxiety, adjustment disorder, depression, and otitis media. For all Medicaid HSAs, acute upper respiratory tract infection had the highest prevalence, ranging from 33.7% prevalence (Middlebury) to 22.3% (Windsor). For the Medicare population the top prevalent conditions include, hypertension, disorders of lipid metabolism, coronary artery disease, cataract aphakia and skin keratosis. Hypertension is the most prevalent condition for the Medicare population for all HSAs except Bennington in which hypertension was not a top 10 most prevalent condition. Disorders of lipid metabolism is the second most prevalent condition for the Medicare population with prevalence ranging from 54.3% (St. Albans) to 36.1% prevalence (Brattleboro). See tables below.

Medicaid Prevalent Conditions

Health Service Area	#1 Prevalent Condition	#2 Prevalent Condition	#3 Prevalent Condition	#4 Prevalent Condition	#5 Prevalent Condition
Bennington	Acute upper respiratory tract infection (31.0%)	Anxiety (18.9%)	Otitis media (15.6%)	Adjustment Disorder (14.3%)	Depression (12.9%)
Berlin	Acute upper respiratory tract infection (26.8%)	Adjustment Disorder (20.0%)	Anxiety (18.6%)	Depression (14.1%)	Refractive Errors (13.9%)

Health Service Area	#1 Prevalent Condition	#2 Prevalent Condition	#3 Prevalent Condition	#4 Prevalent Condition	#5 Prevalent Condition
Brattleboro	Acute upper respiratory tract infection (27.9%)	Anxiety (18.9%)	Adjustment Disorder (15.2%)	Depression (14.2%)	Otitis media (14.1%)
Burlington	Acute upper respiratory tract infection (24.4%)	Adjustment Disorder (18.7%)	Anxiety (18.1%)	Depression (13.8%)	Refractive Errors (11.8%)
Lebanon	Acute upper respiratory tract infection (24.0%)	Anxiety (19.6%)	Adjustment Disorder (16.8%)	Refractive Errors (18.8%)	Developmental disorder (14.1%)
Middlebury	Acute upper respiratory tract infection (33.7%)	Viral syndromes (18.0%)	Anxiety (16.3%)	Otitis media (15.5%)	Adjustment disorder (13.7%)
Newport	Acute upper respiratory tract infection (27.2%)	Refractive Errors (20.0%)	Anxiety (16.5%)	Depression (16.5%)	Adjustment disorder (13.8%)
Randolph	Acute upper respiratory tract infection (22.2%)	Adjustment Disorder (15.5%)	Anxiety (15.2%)	Ophthalmic signs and symptoms (14.8%)	Depression (12.1%)
Rutland	Acute upper respiratory tract infection (30.4%)	Otitis media (17.3%)	Anxiety (15.8%)	Refractive Errors (13.4%)	Viral symptoms (12.0%)
Springfield	Acute upper respiratory tract infection (31.3%)	Anxiety (17.5%)	Depression (13.1%)	Refractive Errors (12.8%)	Adjustment disorder (12.2%)
St. Albans	Acute upper respiratory tract infection (30.1%)	Otitis media (18.2%)	Anxiety (17.0%)	Adjustment disorder (16.7%)	Tobacco (15.0%)
St. Johnsbury	Acute upper respiratory tract infection (23.8%)	Refractive Errors (21.2%)	Anxiety (16.2%)	Adjustment disorder (15.6%)	Otitis media (12.0%)
Windsor	Acute upper respiratory tract infection (22.3%)	Anxiety (17.0%)	Refractive Errors (14.2%)	Adjustment disorder (13.4%)	Developmental disorder (11.9%)
OneCare	**Acute upper respiratory tract infection (27.2%)**	**Anxiety (17.4%)**	**Adjustment Disorder (15.8%)**	**Otitis media (13.5%)**	**Depression (13.0%)**

Medicare Prevalent Conditions

Health Service Area	#1 Prevalent Condition	#2 Prevalent Condition	#3 Prevalent Condition	#4 Prevalent Condition	#5 Prevalent Condition
Bennington	Disorders of lipid metabolism (40.1%)	CAD (33.2%)	Cataract, aphakia (24.5%)	Benign and unspecified neoplasm (23.5%)	Skin keratosis (22.6%)
Berlin	Hypertension (55.7%)	Disorders of lipid metabolism (48.6%)	CAD (30.5%)	Cataract, aphakia (30.0%)	Diabetes (20.8%)
Brattleboro	Hypertension (51.5%)	Disorders of lipid metabolism (36.1%)	Cataract, aphakia (32.6%)	CAD (27.8%)	Refractive errors (26.1%)

Health Service Area	#1 Prevalent Condition	#2 Prevalent Condition	#3 Prevalent Condition	#4 Prevalent Condition	#5 Prevalent Condition
Burlington	Hypertension (52.8%)	Disorders of lipid metabolism (43.4%)	Cataract, aphakia (28.9%)	CAD (28.7%)	Skin keratosis (23.2%)
Middlebury	Hypertension (59.2%)	Disorders of lipid metabolism (46.8%)	Cataract, aphakia (32.6%)	CAD (30.1%)	Skin keratosis (21.5%)
Springfield	Hypertension (55.7%)	Disorders of lipid metabolism (46.4%)	CAD (28.9%)	Cataract, aphakia (28.2%)	Skin keratosis (23.1%)
St. Albans	Hypertension (63.4%)	Disorders of lipid metabolism (54.3%)	CAD (31.7%)	Cataract, aphakia (31.6%)	Degenerative joint disease (26.8%)
OneCare	**Hypertension (54.6%)**	**Disorders of lipid metabolism (44.2%)**	**CAD (29.7%)**	**Cataract, aphakia (29.3%)**	**Skin keratosis (21.8%)**

12. Provide an evaluation of variations in your 2018 and 2019 data by Hospital Service Area. Are there specific trends by Hospital Service Area that you have identified? If so, how is this data being used to drive clinical progress and change within the network?

    OneCare has developed new reports in 2019 to monitor the performance of the Network in all payer programs, as well as provide HSA comparisons including cost, utilization, and quality indicators. OneCare has worked closely with the HSAs to interpret data and provide additional analytics drilldowns to assist in decision making to drive clinical progress and positive healthcare reform change. For example, one HSA consistently showed the highest emergency department utilization rate in the Medicaid program compared to the other HSAs in the Network. Based on data and feedback provided by OneCare, the HSA implemented specific interventions to reduce emergency department utilization and with a resulting reduction of ED utilization, OneCare can confirm the success of the interventions implemented. Another HSA noted their population had the lowest rate of adolescent well-care visits in the Medicaid program, which was surprising when compared to their internal tracking of the measure. Investigation into the data highlighted an opportunity to engage with a population of patients who are attributed to the HSA, but who are not considered active in the practice.

    See question 13b for additional insights gleaned from the HSA variation report analysis.

13. Refer to **Part III: All-Payer Total Cost of Care, Per Member Per Month, 5-Year Compounding Growth Rate, 2012-2017** to answer the questions below:

    a. When comparing these HSA-specific resident estimates to those experienced by the population attributed to your ACO, do the trends appear to be similar? Are there notable differences? Provide an analysis that might help explain the variation observed in the ACO population across HSA.

       OneCare monitors total cost of care, per member per month (PMPM), monthly by attributed health service area (HSA), and payer program using run charts. Overall, HSAs have realized stable total cost of care PMPM trends within the payer programs

their HSA has elected to participate. This methodology differs from the 5-Year Compounding Growth Rate, 2012-2017 table in two distinct ways:

1. The attributed HSA in OneCare's reporting structure is based upon the zip code of the primary care provider, not the patient's residence zip code.
2. OneCare does not combine cost data across payer programs because of the differences in reimbursement and the varied participation in the payer programs across the HSAs. The Vermont Health Care Uniform Reporting & Evaluation System (VHCURES) dataset used to calculate the total cost of care growth rate combines data across the payers included in VHCURES without payer mix adjusting.

One aspect worth further exploration is access across communities and the underlying effects on utilization and spending patterns. For example, communities with swing beds tend to have higher swing bed utilization rates. Because of payment differentials, this could result in a higher HSA spending PMPM. Another component to consider is high-cost outliers. In a small community one or two high-cost events could drive a material increase in year-over-year PMPM spend. Isolating these unpredictable events from ordinary process outcomes is important for a fair evaluation; especially over multiple years.

b. In looking at the per-member per month spending and growth for each Hospital Service Area, what observations can you share with the GMCB? Explain any insights you may have as to why an HSA is above or below the 3.5% growth rate, or whose baseline TCOC is above or below the Statewide PMPM.

In addition to monitoring the total cost of care trend on a monthly basis by HSA and payer program, OneCare developed the HSA Variation Report to quickly highlight cost categories where HSAs vary from the OneCare network as a whole. Cost categories by HSA are highlighted if that HSA's experience is between 1 and 2 and beyond 2 standard deviations away from the mean. The Q1 2019 HSA Variation Report highlighted a few HSAs that were between one and two standard deviations away from the mean in the Medicare, Medicaid, and BCBSVT QHP programs, however no HSAs were considered an outlier for total cost of care in any of the payer programs.

OneCare supported the HSAs with additional data drilldowns to understand any variation that was highlighted by the HSA Variation Report. In general, the majority of the variations that were observed were due to high cost cases. For example, one HSA was considered a high outlier in medical pharmacy cost, however further analysis by OneCare staff discovered there was one patient with a higher than average pharmacy costs. After the patient was removed from the data analysis, the HSA was aligned with the rest of the OneCare Network.

Another factor is the underlying risk of the population. A community that attributes a higher-risk cohort would be expected to have a higher-than-average PMPM. A risk-adjusted approach could help to normalize the data.

Particularly related to Medicare, there are a number of Critical Access Hospitals in this state and they are reimbursed on a cost basis. This means that two relatively similar

HSAs/hospitals could have different reimbursement rates and therefore different PMPMs. In general, the healthcare landscape is highly complex and ever-changing which means that while benchmarking across the HSAs is an important performance-evaluation tool, it needs to be done in careful consideration of underlying drivers that may or may not be performance-based.

c. What strategies will the Accountable Care Organization be undertaking to support the State's goal of limiting Total Cost of Care (TCOC) per member growth to 3.5% or less from 2017 to 2022? How are these strategies aligned with the goals of the APM Agreement? How do strategies differ by HSA?

OneCare entering into the value-based contracts with payers is the first step in pursuit of the 3.5% trend rate. Those contracts, in essence, lock in the total cost of care at the agreed-upon amount and ensure that at the end of the year the cost equals that pre-set amount. Without these contracts, healthcare costs for the attributed population will be based on utilization and volume and subject to a high degree of aggregate variation. This transition could be further strengthened by modeling other payer programs upon the true FPP methodology used by Medicaid rather than a reconciled process which is still sensitive to utilization and supports traditional FFS-driven models.

After entering into value based contracts, the focus needs to shift to the providers to facilitate their success under the agreed upon financial terms. OneCare supports its providers through all of the clinical and analytical initiatives mentioned previously. Each HSA's strategy for success will be different. The attributing populations are subject to varying risk scores, social determinant factors, access issues, and cultural norms. OneCare's model to help and facilitate local-level decision making is a key strategy to reflect that each HSA may need a customized approach. The HSA variation analysis is a natural place to begin looking for opportunity under these models.

Payment reform is one other way that OneCare is helping control the overall cost of care. While the contract terms lock in that final spend amount, converting volume-based reimbursement to fixed payments starts to change the underlying drivers for success. When the point is reached that most of the revenues are paid on a population-basis, the underlying incentive to invest in prevention and wellness will emerge as a core business strategy for all of the state's providers.

d. What specific action steps can healthcare stakeholders be doing to support the goals of the Vermont All-Payer ACO Model?

The Vermont All-Payer ACO Model aims to transform healthcare for the entire state of Vermont and its population and to move our healthcare system toward one that focuses on and pays for the quality of care that is delivered. Healthcare stakeholders can support the goals of the Vermont All-Payer ACO Model by providing and aligning incentives which encourage active participation in healthcare reform efforts and disincentives for those that do not participate in value based health care reform efforts. Specifically, ensuring that State, Federal, and regulatory parties are aligned in their vision and have unified support for the model is critical. Holistic reform across the state is a challenging task and it will take commitment from multiple parties to succeed.

Based on learnings from the first several years of the APM, there are opportunities for Vermont to reconsider scale target calculations, particularly populations that should be excluded from the calculation (e.g. Medicare Advantage and Commercial programs lacking compelling reasons to align with Vermont's APM). In addition, regulators could consider adjusting rate setting timelines and processes to facilitate increased alignment across the ACO, hospitals, and payers. Finally, healthcare stakeholders can ensure increased predictability and more creative risk arrangements for risk-bearing entities to help facilitate engagement in the APM and long-term commitment to the care delivery transformation and payment reforms.

e. Finally, as we look to better align our regulatory processes with our federal obligations, please provide any suggestions for how the GMCB could better assess the relationship between hospital spending and the All-Payer TCOC growth targets.

The regulatory process needs to align ACO budget review, hospital budget review, Medicaid rate review, and commercial insurance rate reviews in a coordinated fashion that deliberately yields the targeted trend rate. Without a strategic approach the ultimate trend may be subject to the same annual variation experienced under FFS. Adjustments to the order in which these regulatory reviews occur should be considered.

It's also important to note that while the hospitals are an integral component of the health system, they are only part of the whole. Value-based ACO programs are person-centered with a PMPM target for all of that person's healthcare regardless of where it is delivered. This can mean that a hospital expanding capacity to meet the needs of their community could be a strategy for success under a value-based paradigm if it offsets higher cost care delivered elsewhere. Under the All Payer Model, hospital regulation needs to look more closely at whether or not the proposed budgets are furthering the All Payer Model goals, and the financial solvency of the organizations. Hospital investments in the All Payer Model vision have been integral and continued financial stress on all Vermont hospital presents a significant risk to the model.

If the All Payer Model and the ACO activities are going to become a greater part of every hospital's business model, then a mechanism to reconcile the Medicare fiscal year for hospital budgets and the ACO fiscal year is needed. This would also allow for necessary modifications to the timing of ACO and hospital budget review processes.

As healthcare reform efforts advance, GMCB will need to be thoughtful in how it defines cost for its work. For example:

- How should Medicare reimbursement differences between Prospective Payment Systems (PPS) and Critical Access Hospitals (CAH) be considered when evaluating costs across communities?
- How much will risk adjustment be used in evaluating cost comparisons and will some measure of social determinants be factored into risk adjustment?
- How are costs evaluated within the context of community resources?

The GMCB also needs to consider the new risk that payers transfer to participating providers. Providers have always had risk under FFS reimbursement related to changes in utilization (i.e. if volumes go down revenue goes down). Under the All Payer ACO Model, the hospitals have new risk for all of the care that is delivered outside of their walls. This new risk is often what causes concern amongst hospital leadership and boards and adequate reserves for this new risk may be necessary to expand participation.

Finally, population spend analysis under the total cost of care can be conducted by the ACO, with its access to data across settings of care within and out of network, but this metric remains challenging for hospitals with their current access to population health data. Thus, continued efforts to align metrics, data requests, sources, and timing are needed to ensure high quality analytics to inform critical decision-making in support of the All Payer ACO Model.

14. Population **2020 Population Health Program Investments (Appendix 5.4)**. The table includes:

- Primary and Secondary Investment Type
- Program Name
- Program Description
- Investment Amount
- Operational Model
- Financial Model
- PMPM Amount (if applicable)
- Recipients

Per 18 V.S.A. § 9382, population health program financial investments should include:

a. Strategies to bring primary care providers into the network
b. Strategies for expanding capacity in existing primary care practices, including but not limited to reducing administrative burden on such practices
c. Integration of community-based providers, including expanding capacity to promote seamless coordination of care across the care continuum
d. Population health programs, including:
    a. preventing hospital admissions or readmissions
    b. reducing length of hospital stays
    c. improving population health outcomes, with a focus on the All-Payer ACO Model measures found in Appendix 5.2 APM Quality Measures
    d. addressing social determinants of health
    e. addressing childhood experiences and trauma
    f. supporting and rewarding healthy lifestyle choices.

Please see Attachment D in Part 5 Attachments for completed Appendix 5.4 titled “2020 Population Health Program Investments.”

Part 5:
Attachments

Attachment A - ACO Clinical Priority Areas

Attachment B - ACO Quality Activities Related to the Vermont All-Payer ACO Model Agreement

Attachment C - ACO Population Risk Stratification Summary Analysis

Attachment D - 2020 Population Health Program Investments