OneCare Vermont Accountable Care Organization, LLC
Board of Managers Meeting Agenda
July 16, 2019
4:30 p.m. – 7:00 p.m.
Central Vermont Medical Center – The Board Room

Time	Agenda Item	Presenter
4:30 p.m.	Call to Order	Steve Leffler
4:32 p.m.	Consent Agenda Items - Approval* *Vote to approve Consent Agenda Items*	Steve Leffler
4:35 p.m.	Finance Committee Charter* *Vote to Approve and Adopt Finance Committee Charter as proposed by the Finance Committee*	Tom Borys
4:40 p.m.	GMCB Update • 2020 Budget Guidance • Scale Target Report* • GMCB Survey* • CMMI Site Visit • State Auditor*	Kevin Stone/Vicki Loner
4:50 p.m.	ACO Finance 101 Presentation*	Tom Borys
5:45 p.m.	Public Comment Move to Executive Session	Steve Leffler
6:55 p.m.	Votes TBD	Steve Leffler
7:00 p.m.	Adjourn	Steve Leffler

*Denotes Attachment

Attachments:

1. Consent Agenda Items
   - Draft of OneCare Board of Manager Minutes from June 18, 2019
   - Board Committee Report outs
2. Finance Committee Charter
3. GMCB Scale Target Report
4. GMCB Regulatory Alignment Survey Responses
5. State Auditor Letter
6. ACO Finance 101*(Forthcoming)*

ONECARE VERMONT ACCOUNTABLE CARE ORGANIZATION, LLC
BOARD OF MANAGERS MEETING
JUNE 18, 2019

MINUTES

A meeting of the Board of Managers of OneCare Vermont Accountable Care Organization, LLC ("OneCare") was held at OneCare Vermont on June 18, 2019.

I. Call to Order

Steve Leffler, M.D., called the meeting to order at 4:00 p.m. and introduced Alison Calderara, who will fill the Federally Qualified Health Center (FQHC) Manager seat.

II. Minutes, Committee Reports and Monthly P&L

The consent agenda items were approved unanimously.

III. Governance

The Nominating Committee recommended two new members to the Patient and Family Advisory Committee (PFAC). The Board was provided with the candidates' bio-sketches. A motion was made, which was seconded, and the two new members of the PFAC were approved unanimously.

IV. Public Comment

There was no public comment.

V. Executive Session

VI. Voting

a. The motion to approve the Executive Session Minutes from May 21, 2019 was approved by the supermajority of the Board.

b. The motion to approve the following new and revised policies as endorsed by the finance committee was approved by a supermajority of the Board.

   i. OneCare HSA Benchmark Policy
   ii. OneCare Dues Policy
   iii. OneCare Fixed Payment Policy
   iv. OneCare BCBSVT Primary Program Policy
   v. OneCare Program Settlement Policy
   vi. OneCare Value Based Incentive Fund Policy

c. The motion to approve the application of the program year 2018 risk mitigation arrangement with conditions was approved by the supermajority of the Board.

VII. Adjourn

Upon a motion that was seconded, the meeting adjourned at 6:15 p.m.

Attendance:

OneCare Board Members

☐ Dan Bennett	☒ Joe Haddock, MD	☐ Judy Morton
☒ Jill Berry Bowen	☒ Tomasz Jankowski	☒ Pamela Parsons
☒ John Brumsted, MD	☒ Todd Keating	☐ Joseph Perras, MD
☒ Alison Calderara	☒ Sally Kraft, MD	☒ Judy Peterson
☒ Betsy Davis	☒ Steve LeBlanc	☒ Toby Sadkin, MD
☒ Tom Dee	☒ Steve Leffler, MD	☒ John Sayles
☒ Steve Gordon	☒ Sierra Lowell	

OneCare Risk Strategy Committee

☐ Claudio Fort	☐ Tom Manion	☐ Anna Noonan
☐ Jeffrey Haddock, MD	☐ Brian Nall	☒ Shawn Tester

OneCare Leadership and Staff

☒ Kevin Stone	☒ Tom Borys	☒ Martita Giard
☒ Vicki Loner	☐ Sara Barry	☒ Linda Cohen Esq.
☒ Norm Ward, MD	☐ Susan Shane	☒ Spenser Weppler
☐ Greg Daniels	☐ Joan Zipko	☒ Amy Bodette

OneCare Board of Manager Committee Report-outs For July

Executive Committee

At its June 25th meeting, the committee was updated on payer program discussions and negotiations including self-funded programs for 2020. The committee discussed risk mitigation for 2019 and 2020. The committee also discussed network participation for 2020 and how remaining hospitals who are not a part of OneCare might be able to participate in 2020. There was a discussion around the GMCB Budget Process for 2020, the upcoming CMMI Site Visit later this summer and the first meeting of the GMCB's Rural Health Task Force.

Finance Committee

At its July 10th meeting, the committee was given a presentation by the Terry Group an outside consulting that highlighted the benefits of effective documentation, reporting, education and communications in a Healthcare Reform environment. The Committee discussed risk mitigation for 2019 and 2020, while also being updated on current 2019 YTD performance. There was no monthly financial report this month due to completion of the 2018 audit.

Finance Committee Charter

Charge: The Finance Committee is a standing committee of the OneCare Vermont Accountable Care Organization, LLC ("OneCare~~OCVT~~") Board of Managers. The Finance Committee is charged with reviewing and providing input into the financial ~~operations~~ aspects of OneCare~~OCVT~~ programs and operations and making recommendations to the Board of Managers to ensure that the financial operations enable OneCare~~OCVT~~'s purpose of achieving high quality, coordinated, and efficient health care delivery across the OneCare~~OCVT~~ beneficiary population.

Committee Leadership and Member Appointment: The Finance Committee will be chaired by a member of the Board of Managers appointed by the Board of Managers. The Chair will preside over each meeting. In the absence of the Chair, the Vice-Chair will act as Chair. ~~In the absence of both the Chair and Vice-Chair, the OCVT Director of Finance/Chief Financial Officer will act as the Chair.~~ If neither the Chair nor the Vice-Chair can attend, the Chair will appoint a member of the committee or management to preside over the meeting. The Finance Committee will be comprised of members based on the composition outlined below. The Board of Managers will appoint members to the Finance Committee based on nominations by the Executive Committee. The Finance Committee may be comprised of a majority of non-~~-~~manager members, because the Finance Committee's scope of work may benefit from the perspective of finance officers and other leaders not represented on the OneCare~~OCVT~~ Board of Managers.

Committee Composition: The Finance Committee shall be comprised of no more than thirteen (13) voting members ~~and four (4) non-voting members. E~~ with each member ~~shall~~ having one (1) vote ~~except that members serving *ex officio* shall be non-voting~~. The Finance Committee composition shall be based on the following guidelines:

- One (1) Chair who shall be a member of the Board of Managers
- One (1) Vice-Chair who shall also be a member of the Board of Managers
- ~~Two (2)~~One (1) additional member~~s~~ of the Board Managers
- One (1) representative of University of Vermont Medical Center
- One (1) representative of Dartmouth Hitchcock Medical Center
- ~~Two (2)~~One (1) Chief Executive Officer~~s~~ of a hospital~~s~~ participating in all core OneCare risk programs~~with OCVT~~
- Three (3) Chief Financial Officers (or equivalent) of hospitals participating with OCV~~T~~

- ~~Two (2)~~Four (4) "at large" executives/finance leaders from other provider organizations participating with OneCare~~OCVT~~
- ~~Two (2) OCVT staff members serving *ex officio*~~
- ~~TwoOne (21) finance staff members serving *ex officio* from the University of Vermont Medical Center~~
- ~~andOne (1) finance staff members serving *ex officio* from Dartmouth Hitchcock Medical Center~~
- ~~Three (3) OCV staff members serving *ex officio*~~

In addition, members of the Budget Advisory Group (BAG) will be invited to participate in the meetings on a non-voting basis. The BAG is comprised of up to two (2) representatives from each risk-bearing hospital participating in OneCare risk programs. At the discretion of the Chair or by majority vote, all or part of the meeting may be closed to the BAG members. OneCare management will be responsible for maintaining the roster of BAG members on behalf of the Finance Committee.

Accountabilities: The Finance Committee reports to the Board of Managers. The primary role of this committee is to review and provide input to ~~and support~~ the financial operations of OneCare~~OCVT~~. The Finance Committee is limited to making recommendations to the Board of Managers.

OneCare~~OCVT~~ Staff Support: The Finance Committee will be assisted, as necessary, by OneCare~~OCVT~~ staff.

Scope: The principle responsibility of the Finance Committee is to review and provide input to the financial aspects of OCV programs and operations~~oversee the financial management of OCVT~~ and make recommendations to the Board of Managers.

This will require the following activities:

1. Recommend an annual operating budget to the Board of Managers.
2. Engage key stakeholders in support of financial decision making.
3. Provide input and recommend policies to the Board of Managers that maintain and improve the financial health and integrity of the organization.
4. Review and make recommendations of adoption of a long-range financial plan to the Board of Managers.
5. Review annual operating and capital budgets for consistency with the long range financial plan for the organization.
6. Review the financial aspects of ~~major proposed transactions,~~ new programs and services, and proposals to discontinue programs or services.
7. Monitor the financial performance of the organization against approved budgets, long-term trends and industry benchmarks.
8. ~~8.~~ Provide input into the risk sharing policy and methodologies used to share costs across the participants..~~regarding the creation of any new financial risk models, whether upside only or two-sided.~~
8. ~~Review shared savings distribution models.~~

9. Review Value Based Incentive Fund distribution models.
10. Participate in and oversee audits and periodic financial performance assessments which will include receiving reports from staff on audit progress, reviewing and approving final reports, and making recommendations to the Board of Managers and staff.

Frequency of Meetings: The Finance Committee will meet at least six ~~four~~ (6~~4~~) times per year~~, on a quarterly basis~~. Notices of meetings and related materials will be distributed to members at least three (3) business days prior to the meeting date. Members will be allowed to participate via teleconference. Minutes will be taken at each meeting.

Vermont All-Payer ACO Model
Annual ACO Scale Targets and Alignment Report
Performance Year 1 (2018)

Submitted June 28, 2019

Green Mountain Care Board

1. Executive Summary

The Annual ACO Scale Target and Alignment Report, as required by the Vermont All-Payer Accountable Care Organization Model ("All-Payer ACO Model" or "APM") Agreement, illustrates Vermont's progress toward achieving Scale Targets and alignment of ACO Scale Target Initiatives. Included in this report are quantitative and qualitative analyses of Vermont's progress in Performance Year 1 (PY1, 2018), and an outline of key challenges, and opportunities to support further progress.

Progress Toward Achieving Scale Targets

In PY1, four Scale Target ACO Initiatives operated through contracts between payers and OneCare Vermont: the Medicare Next Generation ACO Program; the Vermont Medicaid Next Generation ACO Program; the BlueCross BlueShield of Vermont (BCBSVT) Commercial Next Generation ACO Program; and the University of Vermont Medical Center (UVMMC) Shared Savings ACO Program.

Performance Year 1 results reflect significant growth in attributed lives since PY0 (2017), growing from 29,102 attributed lives to 112,756. Performance Year 1 was the first year of implementation for the Medicare and BCBSVT Next Generation ACO programs, as well as the UVMMC Shared Savings ACO Program. The number of Medicaid beneficiaries attributed under Vermont Medicaid Next Generation ACO Program, which launched in 2017, increased by 45% (from 29,102 to 42,343) and nearly doubled again in the current PY (79,150).

Attributed Lives by Program to Date

Payer	2017 PY0	2018 PY1	2019 PY2
Medicaid	29,102	42,342	79,150
Medicare	-	39,702	58,782
Commercial	-	30,712	28,000 – 75,000*

* Current estimate

Vermont did not achieve the Medicare and All-Payer Scale Targets for PY1. The State achieved **35% Medicare Scale Performance** in PY1 (target: 60%) and **22% All-Payer Scale Performance** (target: 36%). The APM Agreement anticipates that scale will increase over the life of the agreement. Program launch is challenging and requires significant operational and financial readiness from the ACO, payers, and providers; a gradual ramp up from PY1 is expected and intentional. The GMCB will continue to monitor new payer programs as they are developed, ensuring that services remain in alignment and qualify as scale target initiatives.

Challenges Encountered in Achieving Scale Targets

A number of challenges prevented Vermont from achieving scale targets as outlined in the APM Agreement.

1. **The APM Agreement sets ambitious scale targets and includes populations over which the state has no authority.** In particular, the inclusion of self-funded employer plans and Medicare Advantage plans – which together cover nearly 1 in 3 Vermonters presents an outreach and engagement challenge. In PY1, the population included for APM scale represents 83% of the entire Vermont population. However, the State can impact only 42% of the Vermont population outside of the Agreement (i.e. state employees, Medicaid beneficiaries, and fully insured plans subject to rate review). Medicare covers just under 20% of the remaining population. Initial analysis suggests that even if all Vermont primary care providers had been participating in the ACO network in 2018, fewer than 75% of Vermont Medicare beneficiaries would be attribute using the current methodology.
2. **Providers in Vermont are new to fixed payments.** Prospective payments for Medicaid and Medicare patients require time and learning to implement properly. Providers differ in their readiness to assume, manage, and monitor that risk. The lack of clarity about how Medicare's All-Inclusive Population Based Payment (AIPBP) interfaces with Critical Access Hospital's cost reporting coupled with a lack of modeling data and financial limitations make decisions related to participating in the Medicare program particularly challenging for Vermont's Critical Access Hospitals.
3. **Challenges in Medicare's implementation of new payment methodologies.** The calculation of the AIPBP and errors in payment created uncertainty and some financial challenges that may affect providers' willingness to participate.

Moving forward, there are opportunities for improvement on both the State and Federal level that may help to alleviate these challenges as we work together to incentivize population health and delivery system reform.

1. Consideration of alternate attribution methodologies;
2. Improvement of timelines and clarity of data provided to participants;
3. Alignment of ACO participation requirements to those existing State and Federal rules in place; and
4. Enhancement in monitoring of new payment mechanisms.

Looking ahead to PY2 (2019), the four Scale Target ACO Initiatives in place in 2018 have continued to mature with two hospitals adding additional risk programs and three additional hospitals joining the network. All payer programs were renewed in 2019 with the hope of an additional program launching by the end of the year. Currently, the GMCB estimates a 50-90 percent increase in attributed lives (between 50,000 and 100,000 more attributed lives).

Alignment of Scale Target ACO Initiatives

The four Scale Target ACO Initiatives in 2018 were well aligned on most components. All initiatives used prospective attribution methodologies, included services akin to Medicare Part A and B coverage, worked to use similar sets of quality measures, and included similar approaches to risk. The biggest opportunity for increasing alignment going forward relates to the payment mechanisms employed. The State would like to expand the capitated model being implemented by its Medicaid program to other payer programs because it maximizes the stability, predictability, transparency, and relative simplicity that mark successful reform programs.

2. Introduction

The Vermont All-Payer Accountable Care Organization Model ("All-Payer ACO Model" or "APM") Agreement was signed on October 26, 2016, by Vermont's Governor, Secretary of Human Services, Chair of the Green Mountain Care Board (GMCB), and the Centers for Medicare & Medicaid Services (CMS). The All-Payer ACO Model aims to reduce health care cost growth by moving away from fee-for-service reimbursement to risk-based arrangements for ACOs; these arrangements are tied to quality and health outcomes.

This report provides an annual update on the State's performance on the Vermont All-Payer and Medicare beneficiary participation targets (ACO Scale Targets) for Performance Years 1-5 and describes the alignment of key program components of the four Scale Target ACO Initiatives in 2018. This report is required by section 6.j of the APM Agreement, which provides as follows:

i. *"In accordance with section 6.f, the GMCB, in collaboration with AHS, shall submit to CMS for its approval, no later than June 30th of the year following the conclusion of each of the Performance Years 1 through 5, an assessment describing how the Scale Target ACO Initiatives' designs compare against each other on key design dimensions such as services included for determination of the ACO's Shared Losses and Shared Savings as described in section 6.b.iii, risk arrangement, payment mechanism, quality measures, and beneficiary alignment ("Annual ACO Scale Targets and Alignment Report"). This assessment must also describe how the Scale Target ACO Initiatives' designs are aligned across all payers, how they are different, the justification for differences that will remain, and a plan to bridge differences that should not remain. CMS has the sole discretion to approve or disapprove the State's assessment. If CMS disapproves the State's assessment, it may qualify as a Triggering Event as described in section 21."*

ii. *The GMCB shall submit to CMS for its approval, no later than June 30th of the year following the conclusion of each of the Performance Years 1 through 5, the State's performance on the ACO Scale Targets described in sections 6.a, 6.b, and 6.c."*

3. Methodology

3.1. : All-Payer Scale Target

$$\frac{\textit{Vermont All-Payer Scale Target Beneficiaries Aligned to a Scale Target ACO Initiative}}{\textit{Vermont All-Payer Scale Target Beneficiaries}}$$

All-Payer Scale Target Numerator

The All-Payer Scale Target Beneficiary numerator includes all Vermonters aligned to a Scale Target ACO Initiative as described in Section 6.b of the APM Agreement.

All-Payer Scale Target Denominator

The Vermont All-Payer Scale denominator includes:

Payer	Subcategory
Medicare	All Vermont Medicare FFS enrollees
Medicaid	All Vermont Medicaid enrollees (see below for exceptions)
Commercial	Fully Insured
	Members of Self-Insured Health Plans
	Medicare Advantage Plans

The following groups are excluded from the Scale Target denominator:

1. Members of Federal Employee and Military Health Plans
2. Non-ACO-Eligible Medicaid Enrollees (e.g., individuals dually eligible for Medicare and Medicaid, with evidence of third-party coverage, or who receive a limited Medicaid benefit package)
3. Members of Insurance Plans without a Certificate of Authority from Vermont's Department of Financial Regulation
4. Uninsured Individuals

Estimates are provided for primary coverage for comprehensive major medical insurance as of January of the performance year.

3.2. Methodology: Medicare Scale Target

$$\frac{\textit{Vermont Medicare Beneficiaries Aligned to a Scale Target ACO Initiative}}{\textit{Vermont Medicare Beneficiaries}}$$

Medicare Scale Target Numerator

The Medicare Scale Target numerator includes all Vermont Medicare Beneficiaries aligned to a Scale Target ACO Initiative, as described in Section 6.b of the APM Agreement.

Medicare Scale Target Denominator

The Medicare Scale Target denominator includes all Vermont Medicare Beneficiaries with Parts A and B coverage enrolled at the beginning of the performance year.

4. Progress Toward Achieving Scale Targets

Relevant Language:

> *6.j.ii. "The GMCB shall submit to CMS for its approval, no later than June 30th of the year following the conclusion of each of the Performance Years 1 through 5, the State's performance on the ACO Scale Targets described in sections 6.a, 6.b, and 6.c."*

Table 4, below, shows progress toward achieving All-Payer and Medicare scale targets by performance year, as required by section 6.j.ii of the APM Agreement.

Table 4: Progress Toward Achieving All-Payer and Medicare Scale Targets by Performance Year

		PY1 (2018)	PY2 (2019)	PY3 (2020)	PY4 (2021)	PY5 (2022)
Vermont All-Payer Scale Target Beneficiaries	*Target*	*36%*	*50%*	*58%*	*62%*	*70%*
	Actual	22%	30%-40%*			
	(Difference)	(-14%)	(-20% to -10%)			
Vermont Medicare Beneficiaries	*Target*	*60%*	*75%*	*79%*	*83%*	*90%*
	Actual	35%	52%*			
	(Difference)	(-25%)	(-23%)			
*PY2 numbers are preliminary. Ranges represent approximate totals across these contracts and potential impact on All-Payer Scale.						

While Vermont did not achieve the Medicare and All-Payer Scale Targets for PY1, the APM Agreement anticipates that scale will increase over the life of the agreement, with a more significant growth trajectory after PY1. Program launch is challenging and requires significant operational and financial readiness from the ACO, payers, and providers. A gradual ramp up from PY1 is expected and is an intentional design of the scale targets. During the APM negotiations, CMMI expressed concern that in some areas of the country, ACOs had attempted to ramp up too quickly and were unsuccessful in launching effective programs. The scale targets in the Agreement attempted to balance achieving scale within the time period of the Agreement with these concerns. In addition, one lesson learned from Vermont's State Innovation Model Grant was that provider readiness is a necessary component for delivery system reform. Without operational change by providers, payment reform does not successfully modify how care is delivered and operational change requires providers to be ready to change their systems. Allowing scale targets to gradually increase over the course of the Agreement takes into consideration the practical realities of operational change at the provider level and allows time providers to successfully change the way they deliver care. Section 4 of this report further discusses the factors contributing to the successes and challenges in achieving scale.

4.1. Scale Results

The APM Agreement sets ambitious scale targets and includes populations over which the state has no authority. In particular, the inclusion of self-funded employer plans and Medicare Advantage plans – which together cover nearly 1 in 3 Vermonters presents an outreach and engagement challenge. In PY1, the population included for APM scale represents 83% of the entire Vermont population. However, the State can impact only 42% of the Vermont population outside of the Agreement (i.e. state employees, Medicaid beneficiaries, and fully insured plans subject to rate review). Medicare covers just under 20% of the remaining population. These factors make achieving scale challenging. Table 4.1, below, summarizes Vermont's scale estimates for 2018.

Table 4.1 Scale Targets and Vermont Population

			Scale Denominator		Scale Numerator		
Payer	**Sub-Category**	**2018 Vermont Population**	**APM Population**	**% of All Vermonters**	**Participating in Scale Target ACO Initiatives**	**2018 Scale Achieved**	**Data Sources**
Medicare	*Parts A & B*	113,272	113,272	18%	39,230	35%	CMMI/VHCURES
	Part A or B only	4,524	0	0%	-	-	
	TOTAL	**117,796**	**113,272**	**18%**	39,230	**35%**	
Medicaid	*Attributable*	135,879	135,879	22%	42,342	31%	VHCURES
	Limited Coverage or Evidence of TPL	4,943	0	0%	-	-	
	TOTAL	**140,822**	**135,879**	**22%**	42,342	31%	
Commercial: Self-Funded Employers	*In VHCURES*	96,996	96,996	15%	9,874	10%	VHCURES
	Not in VHCURES	70,000	70,000	11%		0%	ASSR
	TOTAL	**166,996**	**166,996**	**27%**	9,874	6%	
Commercial: Fully Insured	*COA*	92,978	92,978	15%	20,838	22%	VHCURES
	No COA	5,819	0	0%	-	-	VHCURES
	No evidence of comprehensive, primary coverage	37,901	0	0%	-	-	ASSR
	TOTAL	**136,698**	**92,978**	**15%**	20,838	22%	
Commercial: Medicare Advantage	**TOTAL**	**12,693**	**12,693**	2%	0	0%	VHCURES
TRICARE	**TOTAL**	**16,900**	0	0%	-	-	TRICARE Website
FEHBP	**TOTAL**	**14,594**	0	0%	-	-	ASSR
Uninsured	**TOTAL**	**19,800**	0	0%	-	-	VHHIS
	GRAND TOTAL	**626,299 (Census)**	**521,818**	**83%**	**112,756**	**22%**	

COA = Certificate of Authority from VT Department of Financial Regulation; ASSR = Annual Statement Supplemental Report; VHHIS = VT Household Health Insurance Survey

4.2. Attribution

In PY1, all ACO Scale Target Initiatives were prospective, meaning that additional lives could not be attributed once the PY started. As illustrated in Table 4.2, below, this results in attrition over the course of the performance year. The table tracks cumulative changes over time as the result of life factors, such as death, change in insurance type, or loss in eligibility for a program. Changes in coverage among those enrolled in Medicaid or Qualified Health Plans (QHP) resulted in greater attrition rates than the self-insured and Medicare populations. The Medicare attrition is largely due to death.

Table 4.2: Individuals Attributed to Scale Target ACO Initiatives by Month

	January 2018	February 2018	March 2018	April 2018	May 2018	June 2018	July 2018	August 2018	September 2018	October 2018	November 2018	December 2018
Medicare Next Generation ACO	36,860	36,693	36,571	36,436	36,282	36,175	36,056	35,939	35,842	35,725	35,578	35,466
% Change (Jan)		*-0.5%*	*-0.8%*	*-1.2%*	*-1.6%*	*-1.9%*	*-2.2%*	*-2.5%*	*-2.8%*	*-3.1%*	*-3.5%*	*-3.8%*
Vermont Medicaid Next Generation ACO	42,342	42,005	41,545	41,169	40,769	39,936	39,033	38,569	38,228	37,398	37,110	36,453
% Change (Jan)		*-0.8%*	*-1.9%*	*-2.8%*	*-3.7%*	*-5.7%*	*-7.8%*	*-8.9%*	*-9.7%*	*-11.7%*	*-12.4%*	*-13.9%*
Commercial Next Generation ACO Program (BCBSVT)	20,652	20,222	19,910	19,599	19,294	19,007	18,686	18,409	18,086	17,840	17,590	17,289
% Change (Jan)		*-2.1%*	*-3.6%*	*-5.1%*	*-6.6%*	*-8.0%*	*-9.5%*	*-10.9%*	*-12.4%*	*-13.6%*	*-14.8%*	*-16.3%*
Self-Insured (UVMMC)	9,874	9,738	9,632	9,543	9,471	9,374	9,156	9,076	8,970	8,897	8,844	8,774
% Change (Jan)		*-1.4%*	*-2.5%*	*-3.4%*	*-4.1%*	*-5.1%*	*-7.3%*	*-8.1%*	*-9.2%*	*-9.9%*	*-10.4%*	*-11.1%*
TOTAL	**109,728**	**108,658**	**107,658**	**106,747**	**105,816**	**104,492**	**102,931**	**101,993**	**101,126**	**99,860**	**99,122**	**97,982**
% Change (Jan)		***-1.0%***	***-1.9%***	***-2.7%***	***-3.6%***	***-4.8%***	***-6.2%***	***-7.0%***	***-7.8%***	***-9.0%***	***-9.7%***	***-10.7%***

5. Factors Influencing Progress Toward Scale Targets

As noted above, there are several factors which contribute to achieving scale. Alignment to a Scale Target ACO Initiative is contingent on provider participation, specifically primary care providers participating in the ACO network; the payers engaging in agreements with the ACO; and the methodology used for attribution. Each of these factors is discussed below.

5.1. Provider Network

Table 5.1, below, outlines the ACOs 2018 network composition.

Table 5.1: OneCare Vermont 2018 Network

2018 OneCare Vermont ACO Network

	Multiple Payer Programs							VMNG Only		
	Berlin	Brattleboro	Burlington	Lebanon	Middlebury	St. Albans	Springfield	Bennington	Newport	Windsor
Hospital	CVMC	Brattleboro Memorial Hospital	UVM Medical Center	DHMC	Porter Medical Center	Northwestern Medical Center	Springfield Hospital	SVMC	North County	Mt. Ascutney
FQHC						NOTCH VMNG only	SMCS			
Ind. PCP Practices		1 Practices	14 Practices (2 CPR Practices)		2 Practices	2 Practices (1 CPR Practice)		5 Practices		
Ind. Specialist Practices	4 practices		14 Practices		4 Practices	4 Practices		4 Practices		
Home Health	Central VT Home Health & Hospice	VNA of VT and NH; Bayada*	VNA Chittenden/ Grand Isle; Bayada*	VNA of VT and NH	Addison County Home Health & Hospice	Franklin County Home Health & Hospice	VNA of VT and NH	VNA & Hospice of the Southwest Region; Bayada*	Orleans Essex VNA & Hospice Inc.	VNA of VT and NH
Skilled Nursing Facilities	4 SNFs	3 SNFs	2 SNFs		1 SNF	2 SNFs	1 SNF	2 SNFs	3 SNF	1 SNF
Designated Agencies	Washington County Mental Health	Health Care and Rehabilitation Services of Southeastern Vermont	Howard Center		Counseling Service of Addison County	Northwestern Counseling & Support Services	Health Care and Rehabilitation Services of Southeastern Vermont	United Counseling Service of Bennington County		
All other Providers	1 Naturopath 1 Spec. Svc. Agency	1 Other (Brattleboro Retreat)	1 Naturopath 2 Spec. Svc. Agencies		1 Naturopath		1 other provider	1 other provider		

OneCare has two AAA's who are collaborators and not program participants. They are AGE WELL, and Central Vermont Council on Aging
OneCare also has a collaborator Agreement with the SASH Program.
*Bayada Serves the entire state of Vermont these are the communities where there are main offices.

5.1.1. Successes

DVHA's Medicaid program piloted a capitated payment model in 2017, which helped prepare the provider network for the All-Payer participation in PY1. The Medicaid pilot included four hospitals. In 2018, the ACO's hospital network significantly expanded. Provider participation in Medicaid's program more than doubled to include 10 hospitals in PY1. In addition, a majority of participating hospitals (60%) entered into agreements with all three payer programs (Medicaid, Medicare, and commercial programs through BlueCross BlueShield of Vermont) in 2018.

Many hospitals expanded their participation after starting with the Vermont Medicaid Next Generation Program. Hospitals have reported that beginning with Medicaid eases their operational adjustment from fee-for-service to value-based payment and delivery systems without as much risk as starting in the Medicare program. With success in managing the fixed payments in Medicaid, hospital leadership supports taking on additional risk and patient populations, while changing their operational and care delivery infrastructure to support this new paradigm.

In PY1, three independent physician practices in Vermont joined OneCare's Comprehensive Payment Reform (CPR) pilot, agreeing to receive fixed prospective payments for their attributed lives through a full or partial capitation model. These pilot practice sites are the first non-hospital entities in the state opting to receive payments outside of the fee-for-service structure. Anecdotally, they have found value in the flexibility that this alternative payment model allows them.

5.1.2. Challenges

Providers in Vermont are new to fixed payments and require ample time to adjust to taking on risk and making the operational changes needed to manage to that risk. In addition, challenges in Medicare's implementation of new payment methodologies has created uncertainty and some financial challenges, particularly for Vermont's vulnerable critical access hospitals. Providers report that APM participation presents an enormous risk, particularly to the State's smaller, rural hospitals where risk may be greater than or equal to total operating margin. There are additional constraints placed on service areas where the majority of primary care is delivered by Federally Qualified Health Centers (FQHCs), which are contending with challenges related to integrating the APM with their federally-required cost reporting. In service areas where there is a divide between hospital and FQHC ownership, there can be additional challenges in garnering cooperation between the entities and distributing risk.

In a recent survey of hospitals and FQHCs, providers indicated that in order to increase participation and achieve scale targets, hospitals and FQHCs must believe the payment structure is transparent, predictable and sustainable. Payments must offset any added administrative burden, including new reporting requirements; and, must incentivize population health and delivery reform. Survey respondents suggested both external and internal use of existing regulatory and/or policy levers to help alleviate some challenges, including:

1. Improving communication throughout CMS regarding Vermont's model,
2. Clarifying the interaction between the AIPBP and Medicare Cost Reports,
3. Improving timeliness and clarity of data from all payers,
4. Considering alternate attribution methodologies,

5. Enhancing information available when considering Medicare risk, such as a trial period with shadow attribution before moving into the risk model, and
6. Alignment of ACO participation requirements to existing state and federal rules in place (FQHC, Critical Access Hospitals, Patient Centered Medical Homes, etc.).

The most common and significant challenge for hospitals has been the issues in calculating and executing the prospective AIPBP for Medicare in both 2018 and error in payment in 2018 and 2019. The federal payment errors were exacerbated because hospitals felt that they did not have a reliable, understandable method to track financials associated with their Medicare patients. Unfortunately, additional Medicare payment issues in early 2019 have undermined hospitals' willingness to participate until the methodological and operational issues are resolved.

5.2. Payer Participation

The APM is premised on the inclusion of the major payers present in Vermont. In addition to Medicaid and Medicare, Vermont has three major commercial insurance payers: BCBSVT, MVP, and Cigna. BCBSVT and MVP offer plans in both the merged individual and small group market and the large group market. Cigna is only present in the large group market. In addition, all three payers offer third-party administration to self-insured employers along with Aetna, among others. As shown in Table 4.1 above, Vermont has a robust self-insured market and small membership in several federal sources of coverage, including Medicare Advantage plans.

5.2.1. Successes

All three payer types were represented in the initial performance year. Both the payers and ACO were able to draw on their experiences in the Medicare, Vermont Medicaid, and Vermont commercial shared savings programs (SSPs) from 2014-2016/2017 to help ease the transition to the APM. GMCB is pleased that the state's largest commercial insurer, BCBSVT, participated on behalf of its Qualified Health Plan business (20,838 attributed lives). In addition, BCBSVT worked with the ACO to develop a pilot program for the self-funded plan covering the University of Vermont Medical Center employees (9,874 attributed lives).

5.2.2. Challenges

Vermont is preempted by federal law from influencing self-funded employer groups' choices regarding health insurance. Furthermore, engaging hundreds of employers individually would be difficult for an ACO to scale without unsustainably growing administrative personnel. OneCare is working with insurers to develop programs that allow employers to join through their third-party administrator to minimize this burden. GMCB hopes to see examples of such programs in place for the 2020 performance year (PY3).

Medicare Advantage presents additional challenges, because this business is growing in Vermont, with participation exceeding 17,000 in January of 2019. This was not the case at the time the APM Agreement was negotiated (enrollment was less than 10,500 at that time) and presents an unanticipated challenge. The federal government is in a better position to encourage participation by these plans.

5.3. Attribution Methodology

Attribution methodology influences which Vermont patients are eligible to become members of the ACO, driven by the patients' relationships with primary care providers. Despite the apparent simplicity of this exercise, many Vermont patients may not attribute to the ACO due to a lack of primary care (or any) utilization, receiving care from non-qualifying specialists, or seeking most of their primary care outside of Vermont. Some of these factors are outside the control of the State and ACO, necessitating some potential refinements to appropriate methodologies.

5.3.1. Successes

The Vermont Medicaid Next Generation ACO Program has made incremental refinements and improvements to its attribution methodology for each performance year after 2017, to both better reflect relationships between members and their primary care providers, and (beginning in 2019) to design and pilot a different approach to attribution with select populations. For the 2019 performance year, DVHA and OneCare are piloting geographic attribution in one area for Medicaid beneficiaries where notable differences in patients' patterns of care-seeking made them especially difficult to attribute. The pilot program uses the member's residence to attribute them to a provider, instead of claims associated with primary care. The goal of the geographic attribution pilot is to support a whole-population (panel) approach to implementation of OneCare's Care Management Model to help account for some of the challenges presented by standard attribution methodologies. DVHA will continue to implement improvements to its attribution methodology based on findings from the 2019 performance year.

5.3.2. Challenges

Traditional ACO attribution is provider-driven and there can be a disconnect between where people live (i.e., Vermont residents) and where they seek care. Initial exploration indicates that even if all Vermont primary care providers had been participating in the OneCare network in 2018, fewer than 75% of Vermont Medicare beneficiaries would have attributed to the ACO (see Table 5.2.4). Furthermore, when limiting the comparison of aligned Medicare beneficiaries in 2018 to those who likely would have attributed to a Vermont provider at all, the scale target performance would improve from 35% to over half (52%), which would only be 8 percentage points below the current Medicare Scale Target for PY1. Analyses for the Medicaid population yield similar findings, which is part of the reason DVHA is exploring alternate attribution techniques. Results for commercial are likely to be similar, though these analyses are currently in progress. The GMCB and CMS will discuss these challenges as they pertain to the Medicare program, since these initial analyses suggest that achieving scale for Medicare may be impossible due to the attribution design.

Table 5.2.4: Preliminary Estimate of Vermont Medicare Attribution with 100% of Vermont Primary Care Providers in ACO Network (PY2018)

Alignment Period Result	Eligibile Jan 1st	Total	% Total
No Medicare Spending	247	**299**	**0%**
No QEM Spending	7,575	**7,660**	**7%**
OOS Aligned	20,613	**20,669**	**20%**
VT Aligned	75,455	**75,624**	**73%**
TOTAL	**103,890**	**104,252**	
Alignment Eligible	*96,068*	*96,293*	*92%*

QEM = Qualified Evaluation and Management procedures; OOS = Out of State

6. Scale Target ACO Initiative Design Alignment

6.1. Scale Target ACO Initiative Designs

The APM Agreement is premised on the assumption that alignment between payer programs is desirable because it will create more robust provider incentives to change care delivery and ease provider administrative burden. This is reflected in section 6.f of the Agreement, which requires Vermont to ensure that Scale Target ACO Initiatives *reasonably align* in their design (e.g., beneficiary alignment methodology, ACO quality measures, payment mechanisms, risk arrangements, and services included) with the Vermont Modified Next Generation ACO in PY1 and with the Vermont Medicare ACO Initiative in subsequent performance years. As noted above, the Agreement requires Vermont to submit an 'Annual ACO Scale Targets and Alignment Report' beginning in 2019, for Performance Years 1-5. This section provides a comparison, using definitions from the Agreement, of what elements are incorporated in OneCare Vermont's 2018 Scale Target ACO Initiatives. Reasonable alignment does not require uniformity and allows for some variation among payer programs to reflect legitimate differences, such as those due to different populations (e.g., the elderly versus children).

Table 6.1 below provides examples of relevant programmatic information on key design dimensions of the Medicare Next Generation ACO Initiative, the Medicaid Next Generation ACO Initiative, the Commercial Next Generation ACO Program Agreement between BCBSVT and OneCare, and the Self-Insured ACO Program Agreement between UVMMC and OneCare. Following the table is an analysis of these key features.

Relevant language:

> *6.f "Vermont shall ensure that Scale Target ACO Initiatives offered by Vermont Medicaid, Vermont Commercial Plans, and participating Vermont Self-insured Plans reasonably align in their design (e.g., beneficiary alignment methodology, ACO quality measures, payment mechanisms, risk arrangements, and services included for determination of the ACO's Shared Losses and Shared Savings as described in section 6.b.iii) with the Vermont Modified Next Generation ACO in Performance Year 1 and with the Vermont Medicare ACO Initiative in*

Performance Years 2 through 5. CMS and Vermont will work together to explore modifications to the Vermont Medicare ACO Initiative in order to facilitate design alignment. In accordance with section 8, Vermont may propose such modifications to the Initiative, and CMS may accept such proposals for modifications at its sole discretion."

6.j.i "In accordance with section 6.f, the GMCB, in collaboration with AHS, shall submit to CMS for its approval, no later than June 30th of the year following the conclusion of each of the Performance Years 1 through 5, an assessment describing how the Scale Target ACO Initiatives' designs compare against each other on key design dimensions such as services included for determination of the ACO's Shared Losses and Shared Savings as described in section 6.b.iii, risk arrangement, payment mechanism, quality measures, and beneficiary alignment ("Annual ACO Scale Targets and Alignment Report"). This assessment must also describe how the Scale Target ACO Initiatives' designs are aligned across all payers, how they are different, the justification for differences that will remain, and a plan to bridge differences that should not remain. CMS has the sole discretion to approve or disapprove the State's assessment. If CMS disapproves the State's assessment, it may qualify as a Triggering Event as described in section 21."

Table 6.1: Crosswalk: Key Design Features of 2018 Scale Target ACO Initiatives

	Medicare Next Generation ACO	Vermont Medicaid Next Generation ACO	BCBSVT (QHP)	UVMMC (Self-Insured)
Services Included for Shared Savings/Losses ***See Appendix A for crosswalk of TCOC services***	Parts A & B services for aligned beneficiaries.	Generally, A & B services. Exceptions: • Psychiatric treatment in state psychiatric hospital or Level-1 (involuntary placement) inpatient stays in any hospital when paid for by DVHA • Spend at Designated Agencies/Specialized Service Agencies • Hospice (room and board) • Skilled Nursing Facilities • Selected CPT/HCPCS codes (list varies by year) • Categories of Service: 2201, 2901, 501, 502, 2701, 2702, 2703, 2713, 2717, 3301, 3304, 3501, 3507, 3602, 3703, 3705, 3707, 3709, 801, 802, 806, 807	Generally, A & B services and pharmacy. Exceptions: 5. Services carved out from primary insurer	Generally, A & B services. Exceptions: 6. Services carved out by third party administrator
Risk Arrangement	Two-sided risk arrangement, no minimum savings or loss rate. 5% TCOC risk corridor, 80% share. No payer-provided reinsurance, no risk adjustment (aside from separate ESRD Benchmark).	Two-sided risk arrangement, no minimum savings or loss rate. 3% TCOC risk corridor, 100% share. No truncation, no payer-provided reinsurance, no risk adjustments.	Two-sided risk arrangement, no minimum savings or loss rate. 6% TCOC risk corridor, 50% share. No payer-provided reinsurance, no risk adjustment.	One-sided risk arrangement, eligible for savings after program costs covered, 10% TCOC upside risk corridor, 30% share. No downside risk.
Payment Mechanism from Payer to ACO	AIPBP for eligible participants (e.g. hospitals), FFS for non-eligible.	AIPBP for eligible participants (e.g. hospitals), FFS for non-eligible.	FFS.	FFS.
Quality Measures ***See Appendix B for 2018 measure crosswalk***	Financial arrangement tied to quality of care for health of aligned beneficiaries. 2018 utilized a pay-for-reporting approach. Next Generation ACO quality measures.	Financial arrangement tied to quality of care for the health of aligned beneficiaries. Utilizes Value-Based Incentive Fund (VBIF). Majority of the quality measure align with the APM Agreement.	Financial arrangement tied to quality of care or the health of aligned beneficiaries. Utilizes VBIF. Subset of the APM Agreement; Overlaps with Medicaid.	Financial arrangement tied to quality of care or the health of aligned beneficiaries. Utilizes VBIF. Subset of the APM Agreement; Overlaps with Medicaid.

	Medicare Next Generation ACO	Vermont Medicaid Next Generation ACO	BCBSVT (QHP)	UVMMC (Self-Insured)
Beneficiary Alignment	Prospective attribution, claims-based evaluation.	Prospective attribution, claims-based evaluation.	Prospective attribution, if health plan requires PCP selection, patient is attributed to selected PCP, otherwise claims-based evaluation to determine primary care relationship.	Prospective attribution, claims based evaluation.

6.2. Areas of Difference Between Scale Target ACO Initiative Designs

The 2018 Scale Target ACO Initiatives are reasonably aligned across payers. As noted above, uniformity is not required and some variation is permitted among payer programs to reflect legitimate differences, such as those due to different populations (e.g., the elderly versus children). This section highlights the differences between the key design features described above and indicates where these differences are justified and where additional work is needed.

Services Included for Shared Savings/Losses

The services included for shared savings and losses in PY1 were reasonably aligned across payers and largely aligned with the APM Total Cost of Care. The Agreement does not require that each payer program include only the same services as the TCOC, recognizing that each payer covers different populations with different medical needs. This is demonstrated in the Agreement by the inclusion of additional services for Medicaid in later years.

In 2018, OneCare's contract with Blue Cross and Blue Shield of Vermont included medical services covered under the attributed member's plan as well as non-specialty pharmacy. There are no other contracts that OneCare has with payers where pharmacy was included in the Total Cost of Care, and pharmacy is not included in the Total Cost of Care calculation.

Justification:

OneCare and Blue Cross and Blue Shield of Vermont were interested in monitoring pharmacy as a part of the medical expense of the attributed population. This is not included in the BCBS payer contract for 2019, however.

Monitoring:

The GMCB will continue to monitor any changes to ensure that services remain reasonably aligned and will review any new payer programs as they are developed. It should be noted that the State does not have the legal authority to require self-insured employers to accept alignment of their ACO program design due to the constraints under the Employee Retirement Income Security Act of 1974 (ERISA).

Risk Arrangements

The risk arrangements are reasonably aligned across payers in PY1. Medicare, Medicaid, and BCBSVT each offered a two-sided risk-based initiative. The variation among these programs was the risk corridor and how the savings were split between the ACO and the payer. The Medicaid program has a smaller risk corridor (3%) than the other payers. BCBSVT has variation in the sharing percentage, which is designed to provide value back to premium payers. Lastly, the UVMMC self-insured employer contract was the only program without downside risk.

Justification:

Medicaid: The smaller risk corridor (3%) reflects the Medicaid population, which includes the most vulnerable Vermonters with poor social determinants of health. The 3% corridor provided value to the Medicaid program, provided sufficient incentives for providers, and reflected the financial risk associated with this population.

BCBSVT: A 50% sharing arrangement ensures that half of any PY1 savings are returned to the carrier to increase the affordability of coverage. This arrangement provided value to the carrier

and its customers while also ensuring that the provider network has a financial incentive to contain costs.

UVMMC self-insured: Whereas OneCare's two-sided risk programs with Medicare, Medicaid, and BCBSVT in 2018 were preceded by several years of shared savings experience, OneCare and UVMMC entered into their first agreement in 2018. A shared savings program offered OneCare and UVMMC time to measure the population's needs. In addition, there are concerns that self-insured employers need to retain sufficient risk in order to maintain their self-insured status under the Employee Retirement Income Security Act of 1974 (ERISA). Due to the legal complications, it may take time for the parties to develop an ERISA-compliant risk arrangement with downside risk. The State, however, cannot compel a self-insured employer to modify their risk arrangement as noted above.

Monitoring:

GMCB will continue to monitor any changes to ensure that risk arrangements remain reasonably aligned and will review any new payer programs as they are developed. It should be noted that the State will not have the authority to require self-insured employers to accept alignment with the APM.

Payment Mechanism from Payer to ACO

The payment mechanisms are reasonably aligned for the public payers, but the commercial sector remained fee-for-service (FFS). In 2018, the Medicare and Medicaid contracts offered an All-Inclusive AIPBP for providers who selected that payment mechanism. This allowed providers, at the TIN level, to select a 100% fee reduction on claims in exchange for a fixed payment. Each of the Commercial plans remained fee-for-service (FFS).

Justification:

The Commercial plans stated that they had limitations in their claims processing system to be able to make the transition from FFS to AIPBP. In 2019, BCBSVT is implementing new claims processing technology, which is expected to provide the operational capability to implement fixed prospective payments.

Monitoring:

BCBSVT and OneCare have stated that the parties will commit best efforts to implement a system whereby the BCBSVT will make fixed prospective payments for medical services to the ACO for designated ACO Participants by January 1, 2020.

GMCB will continue to monitor progress towards this mutual goal.

Quality Measure Alignment

As seen in Appendix B, PY1 quality measures differ across payers in terms of the number of measures required, but do not substantially differ in substance from those measures included in the All-Payer ACO Model Agreement (Appendix 1 – Statewide Health Outcomes and Quality of Care Targets). The exception is Medicare, which in PY1 required the use of the Medicare Next Generation Model measures.

Justification:

Beginning in 2017, the ACO participated in the Vermont Medicaid Next Generation program, allowing a ramp-up in program design and development. This allowed for close alignment with

those measures outlined in the Agreement. In developing payer-specific quality measures for the programs operating in 2018, the ACO worked diligently to align measures within the BlueCross BlueShield of Vermont, University of Vermont Medical Center, and Medicaid Next Generation programs, resulting in alignment across these 3 payers. The variation in number of measures is appropriate, given the differing populations served and the clinical priority areas of each payer.

Monitoring:

In 2018, as outlined in the Vermont All-Payer ACO Model Agreement, CMS and the State of Vermont identified a quality strategy for the Vermont Medicare ACO Initiative for Performance Years 2-5, beginning in January 2019. This strategy includes 13 carefully selected quality measures in close alignment with both the Statewide Health Outcomes and Quality of Care Targets and the Next Generation Accountable Care Organization (NGACO) programs 2019 measure set. This change significantly reduced the ACO's reporting obligations for 2019 thru 2022 and provides alignment across payers in this area.

The GMCB will continue to monitor the quality programs to ensure that they remain in alignment and will review quality measures of any new payer programs as they are developed. It should be noted that the State will not have the authority to require self-insured employers to accept quality measures in alignment with the APM.

Beneficiary Alignment/Attribution

Attribution is primarily based on a member's primary care relationship with a provider participating in the ACO network. The Attribution Element Table found below (Table 6.2) compares the following four categories by payer: Provider Types, Look-back period, Qualifying claims, and Alignment based on selection of PCP. As was discussed in previous sections of this report, the state may want to consider changes to attribution in the future to improve scale performance, so this is an area where it is premature to consider whether the programs are sufficiently aligned. At this time, the program variation is acceptable and justifiable given the issues raised earlier.

Table 6.2: Attribution Elements

Attribution Element	Medicare	Medicaid	BCBS Next Gen	UVMMC Shared Savings
Provider Types	Primary Care and select specialists	Primary Care	Primary Care	Primary Care
Look-back period	24 months (ending 6 months from beginning of PY)	24 months (ending 6 months from beginning of PY)	Most recent 24 months	Most recent 24 months
Qualifying claims (and tie breakers)	Greatest number of weighted claims (most recent visit)	Greatest number of weighted claims (most recent visit)	Greatest number of claims (most recent visit)	Greatest number of claims (most recent visit)
Alignment based on selection of PCP	No	No	Yes	Yes

Justification:

The Medicaid and Medicare attribution are largely aligned; the Medicaid attribution was intentionally built from the Medicare attribution model. Of note, for 'Provider Types', Medicaid only allows primary care providers to attribute while Medicare includes select Specialists. This variation is appropriate, as some Medicare beneficiaries receive the majority of their care from a specialist, which differs from the Medicaid program. The 'Look-back period' and 'Qualifying claims' largely align among all four payers. In the 'Alignment based on selection of PCP', neither Medicare nor Medicaid require the selection of PCP, while Commercial plans participating in the current program do require PCP selection. This variation is also appropriate, as it is inherent in the way the programs are designed.

Monitoring:

The GMCB will continue to monitor the attribution alignment. This will include looking for similar alignment that was found in 2018 and justification for differences if methodology changes. In addition to looking for alignment, we may be evaluating whether some attribution methodologies are more likely to result in the state achieving scale targets.

Medicaid Categories of Service	Medicaid Financial Target Services	Commercial Crosswalk	Agreement Crosswalk - Inclusions	Agreement Crosswalk -- Exclusions
Inpatient	Included	Included	Acute Hospital Inpatient and Outpatient Care	
Outpatient	Included	Included	Acute Hospital Inpatient and Outpatient Care	
Indep. Lab	Included	Included	Acute Hospital Inpatient and Outpatient Care	
Ambulance	Included	Included	Acute Hospital Inpatient and Outpatient Care	
Dialysis Facility	Included	Included	Acute Hospital Inpatient and Outpatient Care	
Ambulatory Surgery Center	Included	Included	Acute Hospital Inpatient and Outpatient Care	
Prosthetic/Orthotic	Included	Included	Durable Medical Equipment	
Medical Supplies	Included	Included	Durable Medical Equipment	
DME	Included	Included	Durable Medical Equipment	
Home Health	Included	Included	Post-Acute Care	
Hospice	Included	Included	Post-Acute Care	
Therapies	Included	Included	Post-Acute Care	
Rehab	Included	Included	Post-Acute Care	
Lay Mid-Wife	Included	Included	Post-Acute Care	
Skilled Nursing	Included	Included	Post-Acute Care	
Physician	Included	Included	Professional Services	
Rural Health Clinic	Included	Included	Professional Services	
FQHC	Included	Included	Professional Services	
Chiropractor	Included	Included	Professional Services	
Nurse Practitioner	Included	Included	Professional Services	
Podiatrist	Included	Included	Professional Services	
Psychologist	Included	Included	Professional Services	
Optometrist	Included	Included	Professional Services	
Optician	Included	Included	Professional Services	
PCPlus Case Mgt and Special Programs Payments	Included	not covered	Professional Services	
Blueprint & CHT Payments	Included	Included	Professional Services	
Nursing Home*	Excluded/Included	Included	Post-Acute Care	excluded PY 1-3
DSH	Excluded	not covered	Acute Hospital Inpatient and Outpatient Care	
Dental	Excluded	Excluded		Dental
Pharmacy	Excluded	Excluded		n/a
MH Facility	Excluded	not covered		Medicaid BH
MH Clinic	Excluded	not covered		Medicaid BH
HCBS	Excluded	not covered		HCBS
HCBS Mental Service	Excluded	not covered		HCBS
HCBS Development Services	Excluded	not covered		HCBS
Enhanced Resident Care	Excluded	not covered		HCBS
Personal Care Services	Excluded	not covered		HCBS
Targeted Case Management (Drug)	Excluded	not covered		n/a
Assistive Community Care	Excluded	not covered		HCBS
Day Treatment MHS	Excluded	not covered		Medicaid BH
OADAP Families in Recovery	Excluded	not covered		Medicaid BH
Non Emergency Transportation	Excluded	not covered		n/a
TBI Services	Excluded	not covered		HCBS
ICF/MR Private	Excluded	not covered		n/a
VPA Premiums	Excluded	not covered		n/a
PDP Premiums	Excluded	not covered		n/a
D+P (Dept. of Health)	Excluded	not covered		n/a
HIPPS	Excluded	not covered		n/a
ESIA/CHAP Premium Assistance	Excluded	not covered		n/a
Provider Non Classified	Excluded	not covered		n/a
TPL	Excluded	not covered		n/a
Cost Settlements	Excluded	not covered		n/a
HIV Insurance	Excluded	not covered		n/a
Drug Rebate	Excluded	not covered		n/a

Notes:
Commercial coverage may have different limitations
Inclusions and Exclusions: See Model Agreement, Section 1(f); definition of All-Payer Financial Target Services.
Where exclusions are categorized as n/a, the Model Agreement is silent.

Measure	Vermont All-Payer ACO Model	2018 Vermont Medicaid Next Gen	2018 Medicare Next Gen	2018 BCBSVT Next Gen	2018 UVMMC Shared Savings
% of adults with a usual primary care provider	X				
Statewide prevalence of Chronic Obstructive Pulmonary Disease	X				
Statewide prevalence of Hypertension	X				
Statewide prevalence of Diabetes	X				
% of Medicaid adolescents with well-care visits	X	X		X	X
Initiation of alcohol and other drug dependence treatment	X	X		X*	X*
Engagement of alcohol and other drug dependence treatment	X	X			
30-day follow-up after discharge from emergency department for mental health	X	X		X	X
30-day follow-up after discharge from emergency department for alcohol or other drug dependence	X	X		X	X
% of Vermont residents receiving appropriate asthma medication management	X				
Screening for clinical depression and follow-up plan (ACO-18)	X	X	X	X	X
Tobacco use assessment and cessation intervention (ACO-17)	X	X	X		
Deaths related to suicide	X				
Deaths related to drug overdose	X				
% of Medicaid enrollees aligned with ACO	X				
# per 10,000 population ages 18-64 receiving medication assisted treatment for opioid dependence	X				
Rate of growth in mental health or substance abuse-related emergency department visits	X				
# of queries of Vermont Prescription Monitoring System by Vermont providers (or their delegates) divided by # of patients for whom a prescriber writes prescription for opioids	X				
Hypertension: Controlling high blood pressure	X**	X	X	X	X
Diabetes Mellitus: HbA1c poor control		X		X	
All-Cause unplanned admissions for patients with multiple chronic conditions		X			
Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient experience surveys***	X	X	X	X	
All-cause readmissions (HEDIS measure for commercial plans)				X	X
Risk-standardized, all-condition readmission (ACO-8)			X		
Skilled nursing facility 30-day all-cause readmission (ACO-35)			X		
All-cause unplanned admissions for patients with Diabetes (ACO-36)			X		
All-cause unplanned admissions for patients with Heart Failure (ACO-37)			X		
Falls: Screening for future fall risk (ACO-13)			X		
Influenza immunization (ACO-14)			X		
Pneumonia vaccination status for older adults (ACO-15)			X		
Body mass index screening and follow-up (ACO-16)			X		
Colorectal cancer screening (ACO-19)			X		
Breast cancer screening (ACO-20)			X		
Statin therapy for prevention and treatment of Cardiovascular Disease (ACO-42)			X		
Depression remission at 12 months (ACO-40)			X		
Diabetes: Eye exam (ACO-41)			X		
Ischemic Vascular Disease: Use of aspirin or another antithrombotic (ACO-30)			X		
Developmental screening in the first 3 years of life		X		X	X
Follow-up after hospitalization for mental Illness (7-Day Rate)		X		X	X
Timeliness of prenatal care					
Acute ambulatory care-sensitive condition composite			X		
Medication reconciliation post-discharge (ACO-12)			X		
Use of imaging studies for low back pain (ACO-44)			X		

*BCBSVT Next Gen treats these measures as a single composite measure; All-Payer ACO Model and Vermont Medicaid Next Gen treat them as two separate measures.

**All-Payer ACO Model and Medicare Next Gen treat these measures as a single composite. Medicaid Next Gen and BCBSVT Next Gen treat them as separate measures.

***Surveys vary by program. All-Payer ACO Model includes ACO CAHPS Survey composite of Timely Care, Appointments, and Information for ACO-attributed Medicare beneficiaries. Vermont Medicaid Next Gen includes multiple CAHPS PCMH composites for ACO-attributed Medicaid beneficiaries. Medicare Next Gen includes multiple ACO CAHPS composites for ACO-attributed Medicare beneficiaries. BCBSVT Next Gen includes care coordination composite and tobacco cessation question from CAHPS PCMH for ACO-attributed BCBSVT members.

OneCare VT Responses to GMCB Regulatory Alignment Survey

Section 2 - Regulatory Alignment Overview

This section seeks information on stakeholders' regulatory alignment goals and current alignment across GMCB regulatory processes.

Questions:

1. Refer to the Regulatory Alignment goals listed in the Section Background description, above. Do you agree with these goals? Are there additional goals GMCB should consider for regulatory alignment?
   Before the GMCB establish understanding, metrics, and ultimately the shift to value-based payment models, the initial focus should be on ensuring that the different components of the regulatory mechanism are working together. This means ensuring that hospital budget review, ACO budget reviews, and commercial rate reviews are all working together to ensure a sustainable financial model for Vermont. If each of these regulatory mechanisms are managed independently the hope of a consistent 3.5% trend under the All-Payer Model is at risk.

2. Which of the GMCB regulatory processes listed above are the most important to align? Why?
   The Hospital budget process needs to be better aligned with the goals of the All-Payer Model and must factor that the previous aspects of conducting the hospital budget review and approvals may be antiquated against the new vision for the delivery of healthcare in Vermont including the assumption of risk. There must be acknowledgement of risk being borne by hospitals and their need to meet Auditors requirement for reserves against that risk. As more hospitals accept fixed payments, the rates per unit of service become less relevant and accommodation for this overall revenue blending needs to be considered

3. Current regulatory alignment: Which GMCB regulatory processes are currently MOST aligned? Why?
   The CON process may be most aligned due to the stringent requirements as outlined in statute, which aligns more with a true capitated model by limiting duplicative capacity. In a FFS if the CON requirements were less restrictive, although it may foster hospital delivery alternatives among the larger hospitals, at the same time it would likely harm smaller hospitals and would not be consistent and incentivize them with taking total cost of care risk.

4. Current regulatory alignment: Which GMCB regulatory processes are currently LEAST aligned but should be? Why?
   As Noted before the Hospital budget process and alignment with the All-Payer Model. There are no policy levers being used currently to "reward" those organizations and providers that have adopted and embraced the All-Payer Model while "penalizing" those who continue to delay and resist (most often due to their inability to assume risk given their current financial environment). If the GMCB were to allow hospitals to reserve against downside risk as they should be allowed to, then coupling this with differential regulatory decisions among those who participate and those who opt not to participate would be considered acceptable and likely warranted.

   Additionally Commercial rate review is also not aligned in that Qualified Health Plan risk adjustment is done retrospectively and impacts ACO contracting. In addition, timing and

transparency in Medicare benchmarking requires that ACOs and all participants accept "risk" by signing contracts before data is fully finalized.

Lastly, while not a regulatory process per se, there is a newfound interest in "cost of care" metrics. Currently, there is no alignment in the analytic approaches to understanding "cost". Currently the metrics GMCB uses are very different from metrics that the ACO uses which may also be different from the metrics that the hospitals use and would be able to track themselves. A goal should be to create agreement on those metrics that we will measure, how we will define them, and the methodologies that will be used to calculate them to avoid confusion and potential misinterpretation of the data.

5. Additional comments on this section:
   No Additional Comment

Section 3 - Optimal Regulatory Timeline Design

This section seeks stakeholder feedback on GMCB's annual regulatory timeline. The current regulatory timeline is shaped by a combination of statutory and legal requirements (state and federal), availability of data, timing of regulated entity fiscal years, other State of Vermont agency needs, and historical precedent. GMCB's current annual regulatory timeline is below.

Link to GMCB Regulatory Timeline for Reference:
https://gmcboard.vermont.gov/sites/gmcb/files/GMCBRegulatoryTimeline.jpg;

Questions:

1. If you could change GMCB's regulatory timeline, what would you change? Why?
   If the All-Payer Model and the ACO activities are going to become a greater part of every hospital's business model, then reconciling the Medicare Fiscal Year (FY) for hospital budgets and the Calendar FY for the ACO is needed. In the payer world, a calendar year is the driver not a Medicare year.

   Additionally if the ACO budget is deemed to be a key tool in the regulatory landscape, then it needs to come before the hospital budget reviews. This would not be possible without a fiscal year change to a calendar year since the payer rates and benchmarks would not be ready for ACO review in the summer.

2. What factors should weigh most heavily in optimal regulatory timeline design? (Ranks Answers by High Importance, Moderate Importance, Low importance/Not Important, and Don't Know)

   a) Data and information availability High
   b) Interaction with other agencies or stakeholders (e.g., DVHA, DFR, federal) Moderate
   c) Interaction and alignment with other GMCB regulatory processes High
   d) Consistency of measurement across GMCB regulatory processes High
   e) Convenience for regulated entities Moderate

3. Please explain your answers to the previous question. Are there other factors GMCB should consider?

Most Importantly, the GMCB needs to be internally consistent in its oversight of various entities. Consistency is also needed in the information that is used/required in order to carry out that oversight. It is critical that the validity of the information is congruent and consistent across processes. Timing the GMCB interactions to try to fit fiscal years of the regulated entities or other third parties is less important than internal consistency.

The current timeline of ACO regulation and certification often does not align with any new legislation that passes that requires ACO's to report on additional activities which also is happening during a performance year where payer and provider contracts have already been executed. The ACO cannot unilaterally reopen their contracts during the year if the legislature decides to require new activities by the ACO.

Lastly there needs to be some element of regulatory strategy. The question that everyone should be asking is; "If the goal is a 3.5% statewide growth rate, how do we get there?" Without that higher level thinking we'll never achieve that result.

4. What are the biggest obstacles to optimal regulatory timeline design across regulatory processes (e.g., state and federal timeline constraints in rate review process; hospital fiscal year starting 10/1; claims lag or other data availability issues)? Are there additional obstacles GMCB should consider?
   As previously noted, one of the biggest obstacles is the fiscal year differences by entities. Other issues include the claim lag and run out to final settlements, Medicare operational uncertainties, lack of timeliness, and data transparency with Medicare and Medicaid claims data. Generally the overall transition of the healthcare system will have challenges. To move to a model with a more aligned regulatory system it will require significant change and this will create operational challenges for both the regulator and the regulated which will need to be recognized and taken into account by all parties.

5. Additional comments on this section:
   No Additional Comments

Section 4 - Policy Alignment

FINANCIAL MEASURE ALIGNMENT

OBJECTIVE: Ensure comparable financial regulatory oversight across GMCB regulatory processes, support achievement of All-Payer ACO Model cost containment goals.

Example:
- Per capita cost measures used across hospital budgets, insurance premium review and ACO budget processes for improved alignment with APM total cost of care measure.

Questions:

1. Are there other objectives GMCB should consider when reviewing this area of potential policy alignment?
   The GMCB will likely have to factor in Rural vs. Non Rural in exercising its authority and oversight in order to achieve regulatory alignment and the goals of the All-payer model.

2. How could GMCB better align financial measures across regulatory processes? Consider including: What are the most important factors for GMCB to consider? What obstacles exist?
The GMCB will need to be thoughtful in how it defines cost for its work. Will the GMCB want to consider including Medicare reimbursement policy differences between PPS hospitals and CAH hospitals when evaluating cost 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 - (e.g., if a community has limited Mental Health Capacity available how is this considered within the context of hospital costs that may be incurred because of a lack of lower cost alternatives? If we are truly moving away from FFS, then caution must be exercised not to base cost comparisons on FFS claims history alone.

The GMCB should also remember that with a total cost of care (TCOC) focus under the All-payer model, the hospitals are being asked questions in which they have no data to analyze and therefore are unable answer. While a population spend evaluation is a good measure for cost management, hospitals only have access to data for their own services (and not all of the non-hospital and out of network services). The ACO can aid in this type of analysis, but only if the data and measures are aligned and congruent.

QUALITY MEASUREMENT ALIGNMENT

OBJECTIVE: Ensure comparable regulatory oversight of quality of care across GMCB regulatory processes, support achievement of All-Payer ACO Model population health goals.

Example:
- Review results for All-Payer ACO Model measures in every GMCB regulatory process, and understand how regulated entities are contributing to improving quality.

Questions:

1. Are there other objectives GMCB should consider when reviewing this area of potential policy alignment?
Having access to confidential claims data for Mental Health and Substance Abuse (MH/SA) is critical not only for the ACO but for success of the All-Payer Model and it's statewide population health goals . The ACO is committed to improving the health and delivery of care for those Vermonters with Mental Health and Substance Abuse conditions, however, in the absence of this data, the ACO and its providers are "flying blind".

2. How could GMCB align its review of quality across regulatory processes? Consider including: What are the most important factors for GMCB to consider? What obstacles exist?
The GMCB will need to consider the ACO's ability to consistently measure year over year results by payers especially with increasing and changing population dynamics as well as changing Medicare (and other payer) benchmarks

DELIVERY SYSTEM ROLES AND RESPONSIBILITIES

OBJECTIVE: Understand variation in utilization, understand care management roles and utilization management roles across the delivery system.

Examples:
- Understand evolving care coordination roles across insurers, ACO, Blueprint for Health/Community Health Teams, and community-based providers.
- Understand how care management and utilization management impact utilization, and whether these services support All-Payer ACO Model population health goals.

Questions:

1. Where applicable in its regulatory oversight role, are there other objectives GMCB should consider when reviewing this area of potential policy alignment?
   The GMCB should be mindful that regulating of or mandating the care priorities of the healthcare system should not be a top down government approach (regulators, legislators) but rather should be a collaborative discussion and agreement made by the providers spanning the continuum of the healthcare delivery system.

2. How could GMCB align its review of delivery system roles and responsibilities across regulatory processes? Consider including: What are the most important factors for GMCB to consider? What obstacles exist?
   The GMCB should consider allowance for measurement of process and outcomes over time vs. expectation of major shifts in utilization over one year period. There should also be a consistent framework and questions for ongoing certification and budget approval year over year.

RISK AND RESERVES

OBJECTIVE: Understand and support appropriate distribution of risk and reserves across payers and providers.

Example:
- Consider how reserves should be allocated at the payer (in partnership with Department of Financial Regulation), ACO, and hospital levels.

Questions:

1. Are there other objectives GMCB should consider when reviewing this area of potential policy alignment?
   The GMCB will need to consider the magnitude of Hospital revenue that is derived from capitation or total cost of care arrangements within the context of in rate setting. Additionally the GMCB will need to consider what is "new risk" vs. what is "old risk" that existed in the FFS world. The hospitals are now exposed to new risk that was not in play prior to ACO programs. Hospitals need to be allowed to reserve for this new risk and the GMCB should meet with the key hospital audit firms - especially those for the Critical Access Hospitals - to better understand how auditors view risk and advise Trustee Boards and their Finance Committees about reserve requirements.

2. How could GMCB align its review of risk and reserves across regulatory processes? Consider including: What are the most important factors for GMCB to consider? What obstacles exist?
The GMCB needs to consider the risk that payers are transferring to providers, in particular when this risk is from 'first dollar' (i.e., immediately when actual performance varies from premium target expense) vs. after a minimum threshold (known as a minimum savings rate). The probability of actual performance falling within the first 2-5% of target expenditures is much higher than actual performance falling beyond this initial risk tranche. The allowance of reserves against risk should reflect this likelihood of incurrence.

AREAS OF POLICY ALIGNMENT

Questions:

1. Considering what you wrote above, which areas of policy alignment are most important? (Rank Answers by High Importance, Moderate Importance, Low Importance/Not Important, and Don't Know)

    a) Financial Measure Alignment High
    b) Quality Measurement Alignment Moderate
    c) Delivery System Roles and Responsibilities Moderate
    d) Risk and Reserves High

2. Why?
There must be alignment in how financial performance is measured and reported and accounts for risk under this newly reformed payment model. Otherwise there will be different conclusions drawn, finger pointing about methodology appropriateness, and we will fail to achieve our overall aim for healthcare reform in Vermont

3. Should GMCB consider additional areas of policy alignment across regulatory processes?
No additional Comments

Section 5 - Additional Comments

1. Please share any additional thoughts about GMCB regulatory alignment here.
There needs to be balance in the regulatory system. Financial data suggest that the Vermont hospitals, particularly the rural hospitals, are struggling under the current regulatory schema. Success needs to be defined as an efficient and financially stable health care delivery system. Without that, a transition to valued-based care is unattainable.

DOUGLAS R. HOFFER
STATE AUDITOR

STATE OF VERMONT
OFFICE OF THE STATE AUDITOR

July 10, 2019

Ms. Martha Maksym
Acting Secretary
Agency of Human Services

Mr. Cory Gustafson
Commissioner
Department of Vermont Health Access

Mr. Kevin Mullin
Chair
Green Mountain Care Board

Ms. Susan Barrett
Executive Director
Green Mountain Care Board

Dear Colleagues:

This letter is to inform you that my office will be conducting an audit related to Vermont's accountable care organization (ACO) model. The audit will be conducted in accordance with our responsibilities and authority contained in 32 V.S.A. §163 and §167.

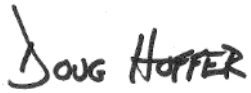
The preliminary objectives of this engagement are to: (1) describe Vermont's ACO model, (2) describe the State's role in overseeing and monitoring OneCare, and (3) explain the basis of payments the State makes to OneCare and the network of ACO providers. During the course of the audit these objectives may change based on the information gathered during the planning phase of the audit. We will inform you if the objectives change in such a way as to significantly change the scope of the audit.

The audit will be conducted by Linda Lambert and Jonathan Kingston, who can be reached at 828-0796 and 828-0763, respectively. During the risk assessment phase, the points of contact for AHS/DVHA was Anne Petrow and for the GMCB it was Michael Barber. Unless you prefer us to contact another individual, we plan on contacting Anne and Michael shortly to schedule an entrance conference to formally begin the audit.

At the conclusion of our field work, we will meet with you to discuss any findings and recommendations and will provide you with a draft report for comment. After considering your response to the draft report, and revising the report as necessary, we plan to issue a final report to the Governor, legislative leaders, other statutorily mandated addressees, and the public.

We look forward to working with you or your staff on this engagement.

Sincerely,



Douglas R. Hoffer
Vermont State Auditor

OneCare ACO Finance 101

OneCare Vermont

onecarevt.org

OneCare Budget Components

ACO Payer Contracts

The agreements with payers to transition to value-based reimbursement

Board Involvement:

- Determine overall payer strategy
- Direction and guidance on risk tolerance
- Guide negotiations and determine any non-negotiables
- Approval for management to execute contracts

Internal Risk Sharing Model

The way in which risk/reward is shared within the network

Board Involvement:

- Direction and guidance on methodology
- Review and approval of policies that dictate the sharing model
- Approval of any risk mitigation strategies to encourage participation

Pop Health Investments & Operating Costs

The budget for PHM investments and OCV infrastructure

Board Involvement:

- Direction and guidance on key investment areas
- Review and approval of program designs
- Review and approval of policies
- Set expectations for administrative growth
- Set expectations for dues growth

PART 1: ACO Payer Contracts

ACO Payer Contracts

<u>Purpose:</u> transfer accountability to the provider network

- Flips the financial incentive to reward providers for a healthy population
- Has the potential to alleviate top-down insurance mandated requirements (ex. prior auth)
- Places additional emphasis on quality

<u>Method:</u> negotiate a pre-set price to deliver care

- If the ACO is efficient and delivers care for less than that price, there is the potential for shared savings
- If the ACO fails to deliver care for that price, a payback is owed (in two-sided risk models)

ACO Payer Contracts

These programs work by comparing the actual cost of care against the pre-set price

- If the actual spending is below the pre-set price, the ACO earns shared savings
- If the actual spending is above the pre-set prices, the ACO owes shared losses

KEY POINT: In both cases, the final spending is equal to the pre-set price

ACO Payer Contracts Cont.

Other Components: While complex, these exist to set limits on the amount of risk exposure for both the ACO and the payer

- Risk Corridor: Sets a limit on shared savings/losses payments
- Sharing Within the Corridor: Percentage of shared savings/losses that the ACO keeps (remainder goes back to the payer)
- Minimum Savings Rate: Savings threshold before and shared savings/losses payment is made
- Efficiency Factor: Built in reduction to the target
- Advanced Shared Savings: Shared savings paid prior to the conclusion of the plan year

Current Minimum Requirements: For these agreements to move forward there are certain base expectations

- $3.25 PMPM paid to OneCare
- Total risk < 3% of target
- Quality measures aligned with the All Payer Model
- Contributions to care coordination
- Commitment to fixed payments in the future

ACO Payer Contracts Cont.

Key Considerations: There is a need to balance scale target growth pressures with reasonable expectations for contract terms and focusing on performance

- The commercial market comes with added complexity
  - Some are national payers and only offer "their model"
  - Need to have some comfort with program variability
- Cannot "forget about" the current programs
  - Continued opportunity to improve
  - Enhanced utilization and cost analyses and reporting
  - Reduce variation
  - Develop best practices

ACO Payer Contracts Cont.

Fixed Payments

- For payers that offer this model, it allows the ACO to convert a portion of the spend into a monthly lump sum payment
  - This payment is made to the ACO rather than the participating providers
  - The ACO then distributes to the providers using its own methodology
- This model has a number of benefits:
  - Can "lock in" a significant portion of the spend and limit variability in the overall spend (for hard caps only)
  - Allows the ACO to move off of payer reimbursement models
    - This enables flexibility that does not exist under FFS
  - Changes thinking
    - When capitated, providers can approach work in ways that would be detrimental when billing FFS

PART 2: Internal Risk Sharing Model

Internal Risk Sharing

<u>Purpose:</u> Equitably divide shared savings/losses across network participants

- The ACO Payer Contracts are all between OneCare and the payer
  - This means that if there are shared savings or losses, OneCare is the one sent the check/invoice
  - The ACO needs to decide who contributes or benefits
  - Need to balance local accountability with economic equity and statistical stability

<u>Method:</u> Develop a methodology/policy to determine how those shared savings/losses are handled

- This is completely up to the ACO
- Initial models placed emphasis on HSA accountability for their local lives

Internal Risk Sharing Cont.

<u>Challenges:</u> While we are one network, we are not all the same

- Each community is different
  - Some provide a lot of services domestically while others refer a lot of care out
- Some hospitals employ primary care while others do not
  - Changes the dynamic of what risk they "control"
- Each hospital's financial circumstance is different, which makes risk more or less tolerable
- Right now, risk/reward only flows only to the hospitals; other provider types are not yet financially incentivized to perform
  - How can some performance-based financial incentive spread to non-hospitals?

KEY POINT: This is an important topic. Decisions in this area will affect participation, financial outcomes, and performance of the ACO.

PART 3: Population Health Investments and Operating Costs

Pop Health Investments and Operating Costs

<u>Purpose:</u> Identify priorities and set a budget for investments in pop health and administrative/operating costs of the ACO

- This process is key to identifying the priorities that ensure the ACO is meeting the needs of the network
- Most costs are at the discretion of the ACO, although there are some important political considerations

<u>Method:</u> Solicit input from the network; present the Board and sub-committees with proposals for consideration; make adjustments as necessary

- The budget process is the time to influence where/how we invest to yield the best results for the network
- There are always multiple initiatives to prioritize
- As the ACO evolves, increased opportunity to define what is operationalized at OneCare vs. delegated out

Pop Health Investments and Operating Costs

<u>Challenges:</u> How are we going to pay for all of this?

- Objective #1 is to secure as much funding as possible from outside sources
  - Delivery System Reform (DSR) investments
  - Payer contributions
  - Other contracts
- Anything that is not funded by an outside sources needs to be funded internally
  - Initial models have had the hospitals pay dues to fill the budget gap
  - With many hospitals across the state facing tight financial circumstances, there are pressures to manage dues
- Adding additional lives and payer contracts adds to both the PHM investments and the ACO responsibilities
- **KEY QUESTION**: When do we shift from "pre-investment" to more dependence on ACO performance?

Pop Health Investments and Operating Costs - Step 1: Outside Revenues -

Outside Revenues		2019 Budget - Operating -
Revenues	Medicaid Admin - $6.50 PMPM	$5,495,372
	Medicaid Complex Care Coordinatic	$5,500,000
	BCBS QHP PHM $3.25 PMPM	$714,203
	BCBS Primary PHM $3.25 PMPM	$1,421,875
	SF PHM $3.25 PMPM	$361,981
	Medicare Shared Savings	$8,021,268
	Primary Prevention	$1,100,000
	Informatics Infrastructure Support	$4,250,000
	Total Revenues	**$26,864,699**

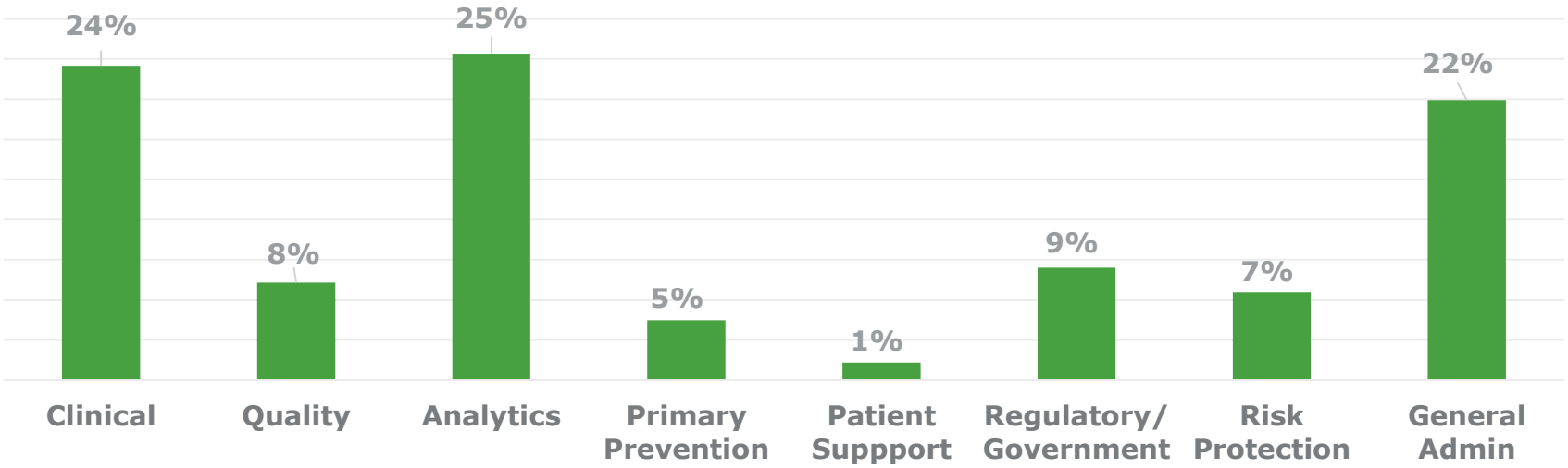
Pop Health Investments and Operating Costs - Step 2: Pop Health Investment Expenses -

PHM Expenses		2019 Budget - Operating -
PHM/Reform Exp.	Basic OCV PMPM	$5,346,722
	Complex Care Coordination Program	$9,300,786
	Value-Based Incentive Fund	$7,452,216
	CPR Program Cost	$2,250,000
	Primary Prevention Programs	$910,720
	Specialist Program Pilot	$1,000,000
	Innovation Fund	$2,000,000
	BCBS Primary PHM Pilot	$1,421,875
	RCRs	$375,000
	PCMH Legacy Payments	$1,865,544
	CHT Block Payment	$2,321,670
	SASH	$3,834,054
	Total PHM/Reform Expenses	**$38,078,587**

Pop Health Investments and Operating Costs
- Step 3: Operating Costs -

Function	2019 Budget	% of Total
Clinical	$3,916,408	24%
Quality	$1,215,496	8%
Analytics	$4,067,732	25%
Primary Prevention	$745,178	5%
Patient Support	$219,436	1%
Regulatory/ Govt.	$1,401,687	9%
Risk Protection	$1,090,033	7%
General Admin	$3,487,609	22%
Total	**$16,143,578**	**100%**

- These figures reflect the OneCare functional areas
- Key message is that not all of the OneCare operating costs are traditional back-office functions; significant amount of clinically-focused work



Pop Health Investments and Operating Costs
- Step 4: Reserves -

- For OneCare to accumulate reserves, they need to be incorporated into the budget model

- This is a key issue at present
  - Where do reserves sit? With OneCare? With the risk bearing entities? Both?

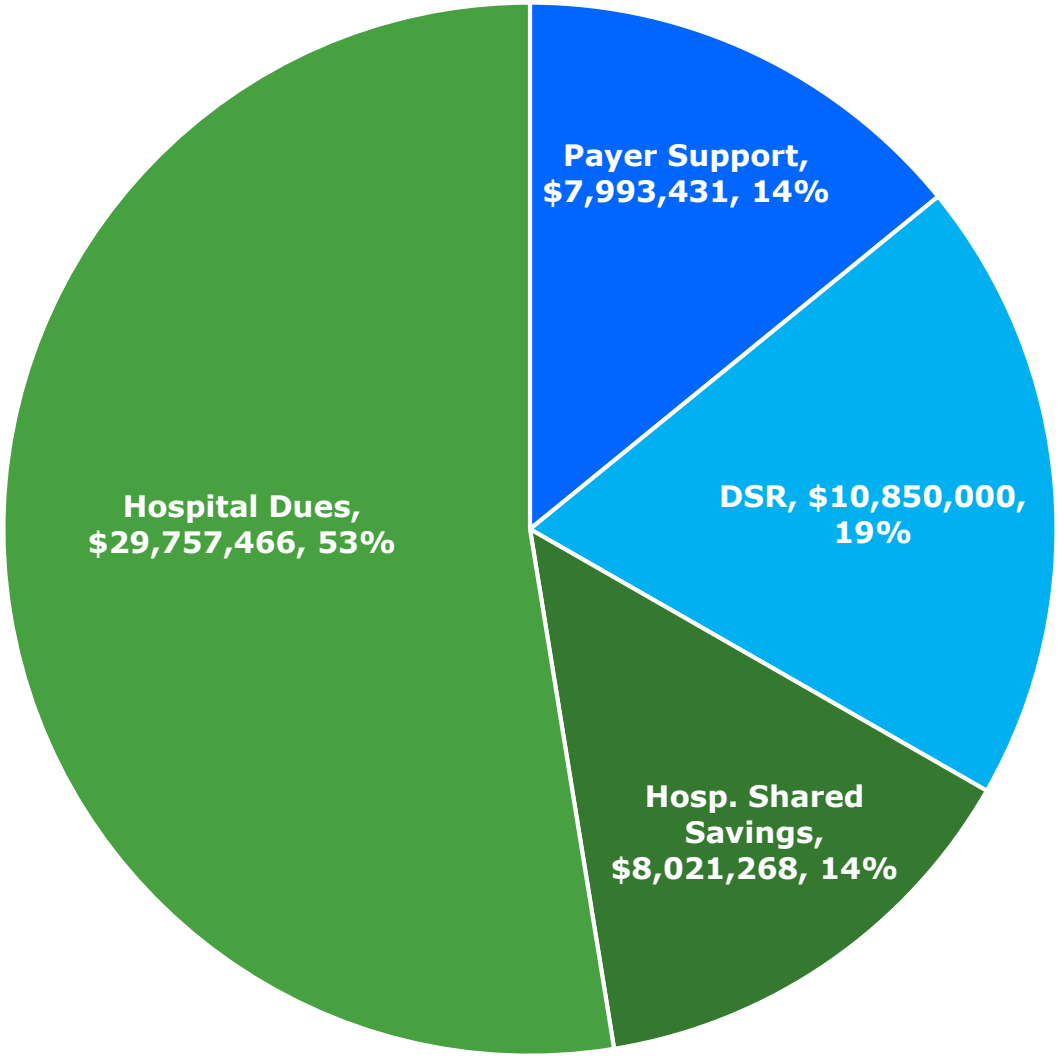
- This is a complex topic with many stakeholders:
  - GMCB
  - Health Care Advocate
  - OneCare
  - Risk Bearing Entities
  - Payers

Pop Health Investments and Operating Costs - Step 5: Calculating Hospital Dues -

Pop Health Investments:	$38.0M
Operating Costs:	$16.1M
Reserves:	$ 2.4M
Total Expenses:	**$56.5M**
Less: Other Revenues:	**($26.8M)**
Unfunded Expenses:	**$29.7M**

- The unfunded expenses become the **hospital dues**
- While the hospitals do get some of funds back via the pop health investments, it is still a sizeable investment

OCV Funding Profile



Questions

ONECARE VERMONT ACCOUNTABLE CARE ORGANIZATION, LLC
BOARD OF MANAGERS MEETING
JULY 16, 2019

MINUTES

A meeting of the Board of Managers of OneCare Vermont Accountable Care Organization, LLC ("OneCare") was held at Central Vermont Medical Center on July 16, 2019.

I. Due to a lack of quorum, Tom Borys presented the ACO 101 Finance presentation beginning at 4:30 p.m. The presentation explained OneCare's budget development process and focused on three key aspects; 1) ACO Payer Contracts, 2) Internal Risk Sharing Model and 3) Population Heath Investments and Operating Costs (see presentation in packet for more detail). Managers asked to receive the presentation to tailor it for their respective communities.

II. Call to Order

Joe Perras, M.D., called the meeting to order at 5:45 p.m.

III. Minutes, Committee Reports

The consent agenda items were approved unanimously.

IV. Finance

The Finance Committee proposed changes to the Finance Committee Charter. A motion was made, which was seconded, and proposed revisions to the Finance Committee Charter were approved unanimously.

V. Green Mountain Care Board (GMCB)

Vicki Loner informed the Board that the GMCB has approved the budget guidance and certification guidance. OneCare management has been working with the GMCB to streamline the process. Certification will be due September 1 and budget is due October 1. The GMCB recently submitted the scale target report to CMMI and it is included in the Board materials packet. Additionally, the GMCB had stakeholders fill out a survey on regulatory alignment and will host a focus group to discuss the results. OneCare responded (responses included in the packet) and Kevin Stone will attend the focus group. CMMI will be in Vermont for a site visit that will include a discussion with parties involved in the All Payer Model. There will be a provider panel with representatives from the OneCare Network, as well as a discussion group regarding Payer Program alignment. Lastly, Kevin Stone shared that OneCare is working to schedule a meeting with the State Auditor to better understand the type of information the Auditor is seeking.

VI. Public Comment

There was no public comment.

VII. Executive Session

VIII. Voting

a. The motion to approve the Commercial Payer Term Sheet and authorize Management to enter into Negotiations was approved by a supermajority of the Board

b. The motion to approve the Executive Session Minutes from May 21, 2019 was approved by the supermajority of the Board.

IX. Adjourn

Upon a motion that was seconded, the meeting adjourned at 7:30 p.m.

Attendance:

OneCare Board Members

☒ Dan Bennett	☒ Joe Haddock, MD	☐ Judy Morton
☐ Jill Berry Bowen	☒ Tomasz Jankowski	☐ Pamela Parsons
☐ John Brumsted, MD	☒ Todd Keating	☒ Joseph Perras, MD
☐ Alison Calderara	☒ Sally Kraft, MD	☒ Judy Peterson
☒ Betsy Davis	☒ Steve LeBlanc	☐ Toby Sadkin, MD
☒ Tom Dee	☐ Steve Leffler, MD	☒ John Sayles
☒ Steve Gordon	☒ Sierra Lowell	

OneCare Risk Strategy Committee

☒ Claudio Fort	☐ Tom Manion	☐ Anna Noonan
☐ Jeffrey Haddock, MD	☒ Brian Nall	☒ Shawn Tester

OneCare Leadership and Staff

☒ Kevin Stone	☒ Tom Borys	☐ Martita Giard
☒ Vicki Loner	☒ Sara Barry	☒ Linda Cohen Esq.
☒ Norm Ward, MD	☐ Susan Shane	☒ Spenser Weppler
☒ Greg Daniels	☐ Joan Zipko	☒ Amy Bodette