OneCare Vermont Accountable Care Organization, LLC
Board of Managers Meeting Agenda

February 16, 2021
4:30 p.m. – 7:00 p.m.
Teleconference Only

Time	Agenda Item	Presenter
4:30 p.m.	Call to Order and Board Announcements	John Brumsted, MD
4:31 p.m.	Consent Agenda Items* *Vote to Approve Consent Agenda Items*	John Brumsted, MD
4:32 p.m.	Welcome Members of the Public	John Brumsted, MD
4:35 p.m.	Governance* *Vote to Approve Resolution Appointing Representative to the Board of Managers*	John Brumsted, MD
4:40 p.m.	Lessons Learned from HSA Consultation Quarterly Meetings*	Norman Ward, MD/ Tom Borys
4:55 p.m.	Policies* *Vote to Approve Resolution Adopting Policy 07-03 Privacy and Policy 07-09 Security*	Sara Barry
5:05 p.m.	Public Comment Move to Executive Session *The Board will now move into executive session in order to discuss subjects that are outside of the scope of the ACO's public meetings. For this meeting, these include: (1) the status of ongoing contract negotiations; (2) strategic and planning subjects that are or use trade secret information; (3) information that is protected against disclosure by Data Use Agreements; and (4) attorney client communications.*	John Brumsted, MD
6:59 p.m.	Votes 1. Approve Executive Session Consent Agenda Items 2. Approve Resolution Amending the 2021 Program of Payments and Attached Policies 3. Approve Resolution Adopting 2021 Annual Compliance Work Plan	John Brumsted, MD
7:00 p.m.	Adjourn	John Brumsted, MD

*Denotes Attachments

<u>Attachments</u>:

1. Consent Agenda Items
    a. Draft of OneCare Public Session Minutes January 19, 2021
    b. Board Committee Reports February 2021
    c. Financial Statement Package December 2020
    d. CMO Corner February 2021
    e. Public Affairs Report February 2021
2. Governance
    a. Robert William Bick C.V.
    b. Resolution Adopting Representative to the Board of Managers
3. Lessons Learned from HSA Consultation Quarterly Meetings Presentation
4. Operations
    a. Summary of Policy Changes
    b. Policy 07-03 Privacy
    c. Policy 07-09 Security
    d. Resolution Adopting Policy 07-03 Privacy and Policy 07-09 Security
5. 2021 Budget Orders from GMCB *(FYI Only)*

OneCare Vermont Accountable Care Organization, LLC
Board of Managers Meeting
January 19, 2021

Minutes

A meeting of the Board of Managers of OneCare Vermont Accountable Care Organization, LLC ("OneCare") was held remotely via video and phone conference on January 19, 2021.

I. Call to Order and Board Announcements

Board Chair John Brumsted, M.D., called the meeting to order at 4:32 p.m. and Vicki Loner, Chief Executive Officer introduced new Board Managers Dr. Adriane Trout, who is now serving in the Independent Practice seat, and Dr. John Saroyan, who is now serving in the Home Health and Hospice seat.

II. Welcome

Dr. Brumsted welcomed members of the public and invited guests in attendance.

III. Consent Agenda Items

The Board reviewed Consent Agenda Items including: (1) Draft of OneCare Public Session Minutes December 15, 2020; (2) Draft of OneCare Public Session Minutes December 29, 2020; (3) Board Committee Reports January 2021; (4) Financial Statement Package October 2020; (5) Financial Statement Package November 2020; (6) CMO Corner January 2021; and (7) Public Affairs Report January 2021. An opportunity for discussion was offered.

A Motion to Approve the Consent Agenda Items was made by C. Kohaut, seconded by J. Sayles and approved by a unanimous vote.

IV. Governance

Chair Brumsted introduced the resolution to approve nominees to the Population Health Strategy Committee and to the Finance Committee. An opportunity for discussion was offered.

DRAFT FOR APPROVAL

A Motion to Approve the Resolution Adopting Representatives to the Population Health Strategy Committee and the Finance Committee was made by T. Keating, seconded, and approved by a unanimous vote.

V. Developmental Understanding and Legal Collaboration for Everyone (DULCE)

Sara Barry, Chief Operating Officer, introduced Scott Johnson, Dr. Breena Holmes, Dr. Leah Costello, and Theresa Soares to present on the Developmental Understanding and Legal Collaboration for Everyone (DULCE) initiative. DULCE is located in five sites in Vermont and serves families with children 0-6 months of age. The presenters described results of the DULCE model and Vermont family acceptance of DULCE. Dr. Costello and Ms. Soares described how the DULCE program at Timber Lane Pediatrics helped identify families in need of services and to connect these families to food, mental health, and substance use treatment services. The Board expressed interest in the model and discussed expanding DULCE statewide, partnerships with other statewide services and initiatives for children, qualifications for family specialists in the program, and case load for practices participating in DULCE. As a next step, OneCare's analytics team will explore whether they can replicate a study conducted by California Medicaid that found a substantial return-on-investment for the DULCE program.

VI. Conflict of Interest (COI) Training and Conflict of Interest Form

Greg Daniels, Esq., Chief Compliance and Privacy Officer, provided annual COI training for the Board. During his discussion he highlighted the definition of a key person, the definition of a financial interest, and timing for when to disclose information to the Board, including annual disclosure using the 2021 Conflict of Interest Form. Conflicts must be disclosed as part of a legal liability to the Board and must be documented appropriately. The Board discussed disclosures required for the form. Given the limited time and questions raised, the Board decided it would bring this subject back for additional education and opportunity for further clarifications at the next meeting.

VII. Public Comment

There were no comments from the public.

VIII. Executive Session

A Motion to move to Executive Session was made by T. Keating, seconded by D. Bennett and was approved by a unanimous, supermajority vote.

IX. Votes

1. Approve Executive Session Consent Agenda Items - Approved
2. Approve Resolution Invoking 2021 Participation Waivers – Approved by Supermajority
3. Approve Resolution Adopting 2021 MVP Contract Terms – Approved by Supermajority
4. Approve Resolution Adopting 2020 Risk Mitigation Contract Adjustment – Approved by Supermajority: S. Gordon and T. Dee recused themselves from the vote.

Upon a Motion made and seconded, the meeting adjourned at 6:55 p.m.

DRAFT FOR APPROVAL

Attendance:

OneCare Board Members

- ☒ Dan Bennett
- ☒ John Brumsted, MD
- ☐ Michael Costa
- ☒ Betsy Davis
- ☒ Tom Dee
- ☒ Claudio Fort
- ☒ Steve Gordon
- ☒ Joe Haddock, MD
- ☒ Coleen Kohaut
- ☒ Sally Kraft, MD
- ☒ Todd Keating
- ☒ Steve LeBlanc
- ☒ Sierra Lowell
- ☒ Pamela Parsons
- ☒ Joseph Perras, MD
- ☒ Robert Pierattini, MD
- ☒ Toby Sadkin, MD
- ☐ John Saroyan, MD
- ☒ John Sayles
- ☒ Adriane Trout, MD

OneCare Risk Strategy Committee

- ☒ Jeffrey Haddock, MD
- ☒ Shawn Tester
- ☒ Brian Nall
- ☒ Robyn Alvis
- ☒ Steve Leffler, MD
- ☐ Joe Woodin

OneCare Leadership and Staff

- ☒ Vicki Loner
- ☒ Sara Barry
- ☒ Greg Daniels, Esq.
- ☒ Tom Borys
- ☒ Katie Muir
- ☒ Norm Ward, MD
- ☒ Amy Bodette
- ☒ Martita Giard
- ☒ Marissa Parisi
- ☒ Linda Cohen, Esq.
- ☒ Lucie Garand
- ☒ Ginger Irish
- ☒ Matt McLaughlin

Invited Guests

- ☒ Scott Johnson
- ☒ Theresa Soares
- ☒ Kevin Stone
- ☒ Breena Holmes, MD
- ☒ Anne Koffel
- ☒ Stephanie Sherline
- ☒ Leah Costello, MD
- ☒ Joe Mitchell, MD

DRAFT FOR APPROVAL

OneCare Board of Managers Committee Reports February 2021

Executive Committee (meets monthly)
The executive committee did not meet in February. It is next scheduled to meet on March 4, 2021.

Finance Committee (meets monthly)
At its February 10 meeting, the December 2020 Financial Statement were shared. OneCare presented the 2020 Net Income Dues Policy. In addition, descriptions and key updates for the following policies were discussed: Population Health Management Payments 2021 & 2022, Program Settlement 2021, and Value Based Incentive Fund 2021. The 2020 Settlement projections were provided to the members and the meeting also covered 2021 Contract & Program Updates. The Finance Committee meets next on March 10, 2021.

Population Health Strategy Committee (meets monthly)
At its February 8 meeting, Rachel Wallace-Brodeur from the Vermont Children's Health Improvement Program presented on opportunities for OneCare Vermont network practices to use the on-line Ages and Stages developmental screening tool in their offices. Portal access and per-screening fees are covered by the Vermont Department of Health. The 2020 Utilization Review Committee year-end reports of the Quality, Utilization Management, and Finance workgroups were presented. Two "deep dive" analysis projects were presented. The first was correlation of low rates of screening mammography with high poverty zip codes. The second was demonstration of an overall 40% reduction in pediatric primary care services since the pandemic inception versus a 20% reduction for adults 18 and older. The committee discussed potential interventions to address financial inequities in preventive care and the need to address severe financial stresses on pediatric practices. A new COVID vaccine tracking application was presented. This tool represents possibly the only current method to track vaccine uptake in high risk disease categories in the state and will be presented to the Health Department. The committee continued discussion on options for quality improvement project funding from undistributed Value Based Incentive Funds from prior years. The committee is next scheduled to meet on March 9, 2021.

Patient & Family Advisory Committee (meets monthly)
At its January 26 meeting, OneCare presented the current strategic planning initiatives and the committee members had the opportunity to share feedback regarding their community concerns and hopes for the committee for 2021, including an increased committee focus on care coordination. The committee also learned about the DULCE model and provided positive feedback regarding early intervention. The committee discussed their reflections from the visit by the Office of the Health Care Advocate and would like to learn more about the Health Care Advocate's work and the goals the annual visit. The committee is next scheduled to meet on February 23, 2021.

Clinical & Quality Advisory Committee (meets bi-monthly)
At its February 11 meeting, the committee opened up with opportunity for committee members to share in an open dialogue around what was happening in their communities. Members heard a presentation from highlighting data about mammography coding in low socioeconomic zip codes and as

well as comparisons of primary care in adults and pediatrics during the pandemic. OneCare shared topics ideas for upcoming Primary Care Workgroup meetings and offered an invitation to committee members to participate in the meetings if they wished. The meeting closed with OneCare Updates on the topics around CKD Project and the 2021 CPT Evaluation and Management Coding Changes. This committee meets next on April 8th, 2021.

Pediatric Subcommittee (meets bi-monthly)
At its January 21 meeting, the members heard a presentation from Ena Backus, director of healthcare reform from the state of Vermont. Ms. Backus provided an overview of the 1115 Waiver Process to the members with time for questions and answers. Drs. Ward and Davis held conversations with the group about Pediatric Strategic Planning efforts for 2021 and Dr. Ward updated the committee regarding current work at OneCare. The committee meets next on March 18, 2021.

Laboratory Subcommittee
The committee is next scheduled to meet next March 2, 2021.

Prevention and Health Promotion Advisory Committee (meets quarterly)
At its February 12 meeting, the members of the committee heard a short update from OneCare that the self-management program will not be moving forward. Blueprint for Health decided in December to hold on to that program as part of their restructure. Tristan Devine, a nursing student who has been working with RiseVT and Jennifer Laurent, PhD, gave a presentation highlighting cost analysis of the RiseVT obesity prevention programming in Franklin and Grand Isle Counties. OneCare then went through an overview of outcomes of the Amplify Grants from the past three years of granting. The committee meets again on May 4, 2021.

Audit Committee (meets quarterly)
At its February 11 meeting, the Audit Committee reviewed and discussed the Program Year 2019 audit of financial statements and the timing and process of the upcoming Program Year 2020 audit of financial statements. The committee also reviewed and discussed Chief Compliance and Privacy Officer's Quarterly Report, the Annual Compliance Work Plan, and OneCare policies. The committee is next scheduled to meet on May 12, 2021.

OneCare Vermont
Statement of Financial Position

For the Periods Ended	12/31/2020	11/30/2020	Variance
ASSETS			
Current assets:			
Unrestricted Cash	20,594,819	17,384,574	3,210,244
OCV Reserve Funding	4,000,000	4,000,000	-
Oustanding VBIF	5,723,007	5,301,732	421,275
Advance Funding-Medicaid	-	13,651,387	(13,651,387)
Deferred par fees	2,747,265	3,302,225	(554,960)
Undistributed Grant Funding	37,695	-	37,695
Undistributed Medicare - 2019	6,442,801	6,442,801	-
Total Cash	39,545,586	50,082,720	(10,537,134)
Network Receivable	354,688	259,903	94,785
Network Receivable-Settlement	1,387,213	897,310	489,903
Other Receivable	110,679	3,361,142	(3,250,463)
Other Receivable-Settlement	4,717,550	4,717,550	-
Prepaid Expense	125,385	747,361	(621,976)
Property and equipment (net)	40,741	41,783	(1,042)
TOTAL ASSETS	**46,281,842**	**60,107,769**	**(13,825,926)**
LIABILITIES AND NET ASSETS			
Current liabilities:			
Accrued Expenses	2,442,645	2,661,265	(218,620)
Accrued Expenses -Settlement	19,580,117	18,788,224	791,893
Network Payable	7,663,076	8,369,196	(706,120)
Network Payable-settlement	791,794	301,891	489,903
Notes Payable	0	0	-
CTO Liability	557,094	589,863	(32,769)
Payroll accrual	42,756	(19,902)	62,658
Deferred Income	3,443,912	19,477,142	(16,033,230)
Deferred Grant Income	37,695	-	37,695
Due to Related Parties - UVMMC	2,207,572	3,361,367	(1,153,795)
Due to Related Parties - DHH	0	0	-
Total Liabilities	**36,766,662**	**53,529,046**	**(16,762,384)**
Net assets:			
Unrestricted - UVMMC	2,843,213	2,843,213	-
Unrestricted - DHH	2,843,213	2,843,213	-
Current Year Profit to Date	3,828,755	892,297	2,936,457
Total net assets	**9,515,180**	**6,578,723**	**2,936,457**
TOTAL LIABILITIES AND NET ASSETS	**46,281,842**	**60,107,769**	**(13,825,926)**

OneCare Vermont

Surplus & Loss Statement: YTD December 2020

	Annual Budget	December Actual	December Budget	Month Variance	YTD Actual	YTD Budget	YTD Variance
Hospital FPP - Medicare	$ 219,868,930	18,448,383	18,322,411	125,972	222,876,298	219,868,930	3,007,368
Hospital FPP - Medicaid	$ 159,598,851	13,431,703	13,299,904	131,799	163,523,082	159,598,851	3,924,232
Hospital FPP - BCBS	$ 4,491,125	448,362	374,260	74,102	4,241,052	4,491,125	(250,073)
CPR FPP- Medicare	$ 2,126,846	177,237	177,237	0	2,141,315	2,126,846	14,469
CPR FPP - Medicaid	$ 2,496,946	219,699	208,079	11,620	2,656,290	2,496,946	159,344
Program Support - Medicaid CCC/DULCE	$ 4,300,000	369,901	358,333	11,568	4,494,710	4,300,000	194,710
Fixed Prospective Payments Funding	$ 392,882,697	33,095,285	32,740,225	355,061	399,932,747	392,882,697	7,050,049
Program Support - Medicaid Trad $3.25	$ 3,000,410	256,731	250,034	6,696	3,112,213	3,000,410	111,803
Program Support - Medicaid Expanded $1.75	$ 415,385	35,138	34,615	523	422,742	415,385	7,357
Program Support - Blue Cross QHP $3.25	$ 720,798	53,979	60,066	(6,087)	696,664	720,798	(24,134)
Program Support - Blue Cross Primary $3.25	$ 3,161,780	230,422	263,482	(33,060)	2,900,622	3,161,780	(261,158)
Program Support - MVP 3.25	$ 360,025	27,817	30,002	(2,185)	363,669	360,025	3,644
Program Support - MVP CCC	$ 46,872	(42,966)	3,906	(46,872)	-	46,872	(46,872)
Program Support - Addtl DSR Funding	$ 3,900,000	2,500,313	325,000	2,175,313	3,900,002	3,900,000	2
Payer Contract Provider Support	$ 11,605,269	3,061,433	967,106	2,094,327	11,395,911	11,605,269	(209,358)
Operations Funding - Medicaid Trad $3.25	$ 3,000,410	256,731	250,034	6,696	3,112,213	3,000,410	111,803
Operations Funding - Medicaid Exp $5.00	$ 771,430	65,257	64,286	971	785,093	771,430	13,663
Program Support - Medicaid HIT	$ 2,800,000	-	233,333	(233,333)	2,800,000	2,800,000	-
Payer Contract Operations Support	$ 6,571,839	321,987	547,653	(225,666)	6,697,306	6,571,839	125,466
Payor Contracts Funding	$ 18,177,109	3,383,420	1,514,759	1,868,661	18,093,217	18,177,109	(83,892)
Medicare Shared Savings/Blueprint	$ 8,401,660	700,138	700,138	(0)	8,401,658	8,401,660	(2)
Robert Wood Johnson Grant	$ 75,000	22,305	6,250	16,055	68,064	75,000	(6,936)
VBIF Reinvestment	$ 33,000	17,000	2,750	14,250	17,000	33,000	(16,000)
Miscellaneous Revenue	$ 240,753	$ 163,676	20,063	143,613	236,066	240,753	(4,687)
Other Funding	$ 8,750,413	903,119	729,201	173,918	8,722,788	8,750,413	(27,625)
Participation Fees	$ 19,706,093	2,073,775	1,642,174	431,600	18,971,186	19,706,093	(734,906)
Total Funding	**$ 439,516,312**	**39,455,600**	**36,626,359**	**2,829,240**	**445,719,937**	**439,516,312**	**6,203,626**
Hospital FPP - Medicare	$ 219,868,930	18,448,383	18,322,411	(125,972)	222,876,298	219,868,930	(3,007,368)
Hospital FPP - Medicaid	$ 159,598,851	13,431,703	13,299,904	(131,799)	163,523,082	159,598,851	(3,924,232)
Hospital FPP - BCBS	$ 4,491,125	448,362	374,260	(74,102)	4,241,052	4,491,125	250,073
Hospital FPP	$ 383,958,905	32,328,448	31,996,575	(331,873)	390,640,432	383,958,905	(6,681,527)
CPR FPP- Medicare	$ 2,126,846	177,237	177,237	(0)	2,144,932	2,126,846	(18,086)
CPR FPP - Medicaid	$ 2,496,946	219,684	208,079	(11,605)	2,656,275	2,496,946	(159,329)
CPR FPP	$ 4,623,792	396,921	385,316	(11,605)	4,801,206	4,623,792	(177,414)
Populations Health Mgmt Payment	$ 8,420,662	686,602	701,722	15,120	8,306,036	8,420,662	114,626
Complex Care Coordination Program	$ 8,872,306	418,994	739,359	320,365	7,028,336	8,872,306	1,843,970
PCP Engagement Incentive Pmt - Medicaid Expanded	$ 415,385	34,615	34,615	0	535,246	415,385	(119,861)
PCP Engagement Incentive Pmt - BCBSVT Primary	$ 221,051	-	18,421	18,421	-	221,051	221,051
Value-Based Incentive Fund	$ 5,640,553	552,202	470,046	(82,156)	5,722,709	5,640,553	(82,156)
Primary Prevention Programs	$ 540,000	29,531	45,000	15,469	405,846	540,000	134,154
CPR Program Expense - OCV Funded	$ 1,178,196	79,015	98,183	19,168	1,176,668	1,178,196	1,528
DULCE	$ 300,000	(5,000)	25,000	30,000	142,512	300,000	157,488
Longitudinal Care	$ 500,000	411,051	41,667	(369,384)	411,051	500,000	88,949
Network Reform Projects	$ 1,480,321	70,171	123,360	53,189	781,991	1,480,321	698,330
PCHP Program Initiative	$ 14,000	-	1,167	1,167	-	14,000	14,000
VBIF Quality Initiatives	$ 33,000	3,000	2,750	(250)	9,000	33,000	24,000
PCMH Legacy Payments - Blueprint	$ 1,993,092	170,839	166,091	(4,748)	1,988,344	1,993,092	4,748
CHT Block Payment - Blueprint	$ 2,440,322	203,360	203,360	(0)	2,440,323	2,440,322	(1)
SASH- Blueprint	$ 3,968,246	330,687	330,687	(0)	3,972,994	3,968,246	(4,748)
PHM Expense	$ 36,017,134	2,985,067	3,001,428	16,361	32,921,057	36,017,134	3,096,077
Salaries and Fringe	$ 8,442,999	676,867	703,583	26,716	8,196,085	8,442,999	246,914
Purchased Services	$ 1,374,263	34,600	114,522	79,922	1,198,017	1,374,263	176,246
Contract & Maintenance	$ 155,250	(70,200)	12,938	83,137	8,503	155,250	146,747
Lease & Rental	$ 383,015	41,804	31,918	(9,886)	371,232	383,015	11,783
Utilities	$ 39,724	2,497	3,310	813	33,486	39,724	6,238
Other Expenses	4,521,229	123,137	376,769	253,632	3,721,164	4,521,229	800,065
Operating Expenses	$ 14,916,480	808,706	1,243,040	434,334	13,528,488	14,916,480	1,387,993
Total Expenses	**$ 439,516,312**	**36,519,142**	**36,626,359**	**107,217**	**441,891,183**	**439,516,312**	**(2,374,871)**
Net Income (Loss)	**$ -**	**2,936,457**	**-**	**2,936,457**	**3,828,755**	**-**	**3,828,755**

OneCare Vermont Board of Managers

CMO Corner – February 2021

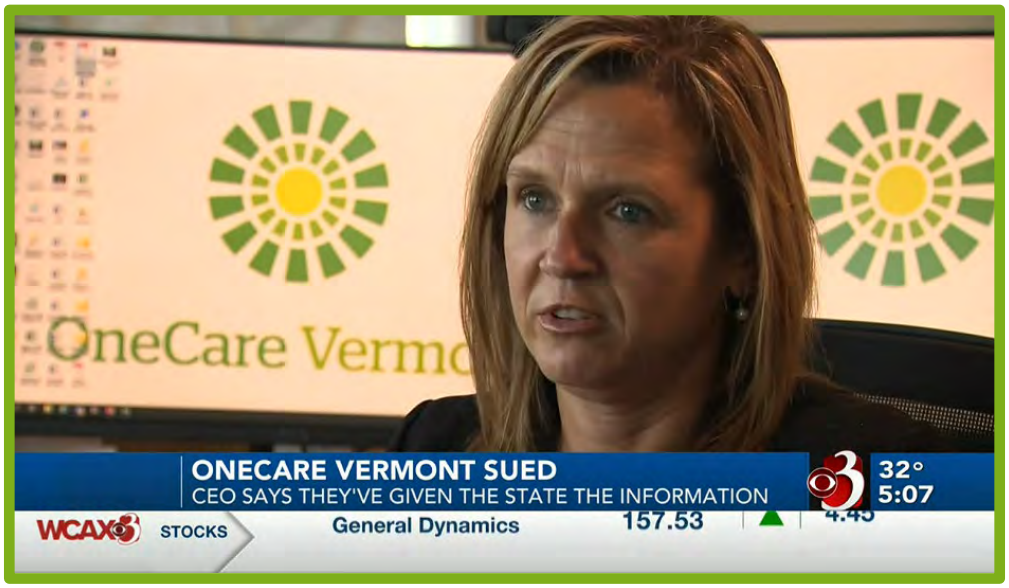
1. **Health Service Area Consultations – Burlington 1/20/21, Morrisville 2/11/21 –** Leaders from OneCare and representatives from the OneCare clinical and analytics teams continue their financial and clinical utilization pattern presentations to each Health Service Area. The presentations focus on as up-to-date as possible financial trending during the performance year, analysis of numerous clinical utilization trends highlighting variations between communities and between practices, and orientation to analytic tools that are available to the OneCare Network participants. An in depth presentation of this program will be shared at the OneCare Board of Managers meeting February 16.
2. **COPD/Asthma Learning Collaborative – 2/5/21 –** Dr. Keith Robinson, Pediatric Pulmonology, Vermont Children's Hospital presented to the Collaborative on optimizing office care of asthma patients using a standardized care template. The learning collaborative teams met after the didactic presentation for additional questions and data submission discussion and planning.
3. **2021 Current Procedural Terminology (CPT - AMA) Evaluation and Management Code Guidelines –** The impact of changes to the American Medical Association CPT definitions and relative value units (RVUs) for the most commonly coded evaluation and management codes for ambulatory medical care will be assessed by OneCare management. In general, it is anticipated that the combination of increased RVU weights for these services and a reduced RVU conversion factor (from $36.09 to $32.41 – a 10.6% reduction) will result in improved primary care revenues in 2021. Additional rules that redefine documentation guidelines, medical decision making, and billing on aggregate time will require considerable network education.

OneCare Vermont

Public Affairs Report | February 2021

Media Coverage

OneCare Responds Strongly to Auditor's Baseless Lawsuit



On February 3, OneCare responded swiftly to a lawsuit filed by state auditor Doug Hoffer requiring the organization to provide payroll, salary, and benefit information no other contractor or state partner is required to share. WCAX interviewed CEO Vicki Loner, pictured above. News organizations including Seven Days, VPR, and the Burlington Free Press covered the story. Board members Claudio Fort and Michael Costa were also quoted: "This lawsuit asks for information that is not relevant to [OneCare's] performance and diverts resources from the important work of healthcare reform in Vermont," Fort said. Costa added: "Vermont's All-Payer Model assumes an extraordinary degree of collaboration between the State and [OneCare], and, sadly, the Auditor's decision to file a lawsuit creates a significant obstacle to that partnership."

The Saint Albans Messenger published an oped by Emerson Lynn on February 5 about the lawsuit filed against OneCare Vermont. Lynn writes, "The problem with Mr. Hoffer's claim and Mr. Donovan's supporting lawsuit — aside from the fact that the information has already been provided — is that it raises all sorts of questions for OneCare and any other business that has a signed contract with the state of Vermont. For example, virtually all of the Agency of Human Services contracts include the same language as the state's contract with OneCare. Does the auditor have the right to ask each business with a state contract for the names, rate of pay, and benefits for each employee?"

OneCare's RiseVT Removes Barriers to Winter Recreation

NECN recently covered organizations across Vermont working to make free equipment available to encourage people to stay active during the pandemic. RiseVT, OneCare's lead prevention program and RiseVT director Marissa Parisi is interviewed. Parisi said of the program, "So that everyone in the community could enjoy those public lands and get exercise, and get out - because it's not only good physical health...but it's great for your mental health." Making winter recreation equipment free is the kind of behavior change intervention RiseVT works to amplify in communities across the state to make the healthy choice, the easy choice.

State of Vermont Employee Health Plans Join OneCare

WCAX, the Brattleboro Reformer and VTDigger reported on February 2 that state employee health plans will participate with OneCare Vermont, resulting in an additional 13,300 lives attributed to the ACO. The Reformer included a quote from AHS Secretary Mike Smith: "Healthcare reform is still taking shape in Vermont, but we're moving in the right direction towards our goals to prioritize prevention, improve patient outcomes and make health care more affordable in future years. By including the state employee health plan members ... it will not only help the program to better meet the participation goals of the all-payer model but will provide more experience to judge the efficacy of this approach."

Southwestern Vermont Medical Center Wins National Leadership Award

The Bennington Banner and VTBiz reported that the American Hospital Association (AHA) has awarded Southwestern Vermont Medical Center (SVMC) the Rural Hospital Leadership Award for their health care reform efforts, reported the Bennington Banner. AHA highlighted SVMC's Community Transitional Care Nursing Program and partnership with OneCare as examples of transformational care systems. "Like many rural health systems across the country, SVMC serves a patient population that is experiencing increased rates of chronic illness associated with advanced aging. One of SVMC's strategies was to use its nursing workforce as part of a transitional care model oriented at keeping older adults out of the hospital, reducing readmissions and delivering the right care in the right setting," said AHA.

Government Relations

Legislative Update

Members of OneCare leadership are meeting with legislators and elected officials to clarify OneCare's role in statewide health care reform, to answer questions, and to provide information.

Tom Borys, VP of finance, testified in the Senate Health and Welfare committee on January 27. He gave an introduction to OneCare for new members and focused on core business areas, underlining why OneCare's statewide care model, data analytics, and payment reform offerings support health care reform efforts. Slides from the presentation can be found here.

Green Mountain Care Board

On January 15, the Green Mountain Care Board (GMCB) issued 2021 budget orders for OneCare Vermont. The budget orders will be reviewed by the OneCare Board of Managers at its February 16 meeting.

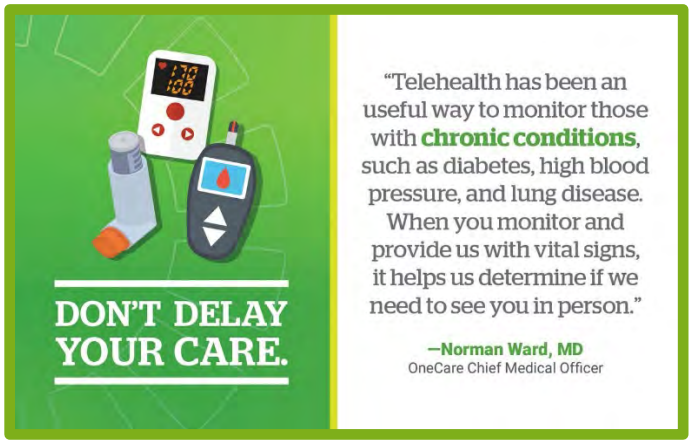
Outreach and Advocacy

Mental Health Advocacy Day

OneCare co-sponsored the National Alliance on Mental Illness Vermont (NAMI VT) Advocacy Day, held virtually on February 1 and organized by NAMI VT, Vermont Care Partners, and Vermont Association of Mental Health and Addiction Recovery. NAMI VT described the event: "…the event started with supportive, encouraging and welcoming remarks from Representative Peter Welch, Lt. Governor Molly Gray, Secretary of Human Services Mike Smith, Commissioner of the Department of Mental Health Sarah Squirrell, Speaker of the House Jill Krowinski, and Senate President Pro Tempore Becca Balint." A recording can be found here.

Social Media Outreach and Advocacy

OneCare is supporting efforts to outreach to New American communities in Vermont through its social media channels in a February 8 post about WCAX coverage of work by the Vermont Department of Health and UVMMC. The post said, "Vulnerable populations such as former refugees and immigrant communities may face obstacles to accessing care such as linguistic and cultural barriers. Vermont Department of Health and UVM Medical Center are working to ensure New American communities in Vermont have info about and access to the COVID-19 vaccine." In addition, OneCare is continuing our campaign to encourage Vermonters not to delay health care due to the pandemic. Read more on LinkedIn and Twitter (@OnecareVermont).



Strategies to Improve Office Systems and Identify Evidence-Based Interventions to Improve Care Specific to Asthma

February 5, 12:00 – 1:00 pm

OneCare featured a presentation open to the public and for practices participating in its learning collaborative to review methods to improve office systems to achieve goals to improve care of patients with asthma. Dr. Keith Robinson, a pediatric pulmonologist and the Vice Chair of Quality Improvement and Population Health at UVM Children's Hospital presented.

Follow Us

You can keep up with OneCare on our blog, LinkedIn, and Twitter (@OnecareVermont).
We would greatly appreciate it if you like and share our content to help spread awareness.

Questions? Contact OneCare Public Affairs using the Contact Us form on our website or email us at public@onecarevt.org.

OneCare Vermont Accountable Care Organization
Board of Managers Resolution Adopting Representative to the Board of Managers
February 16, 2021

BE IT RESOLVED by the Board of Managers (the "Board") of OneCare Vermont Accountable Care Organization, LLC ("OneCare") as follows:

The Board, having reviewed and discussed the recommendations of the Nominating Committee and the qualifications of the candidate, hereby approves the appointment of the following Manager:

A. Designated Agency Manager for a three-year term beginning on March 1, 2021 and ending on February 29, 2024.

OneCare Vermont Health Service Area Consultation Meetings Report

Norman Ward, MD, CMO

Tom Borys, VP of Finance

OneCare Board of Managers

February 16, 2021

OneCare Vermont

onecarevt.org

Purpose

- Engage with hospital leadership and management to report on Health Service Area clinical and financial performance using network performance as a benchmark
- Demonstrate analytic tools and introduce staff available for support of quality and performance improvement projects

Process

- One hour virtual meetings
- Hospital CEO, COO, CFP, CMO, and management team
- Clinical and Financial presentations – Norman Ward, MD and Tom Borys
- Manager ACO Clinical Programs – Jodi Frei
- ACO Information Analyst – Kevin Contino
- Some delays related to cyber-attack

Health Service Area Level Performance Summary

OneCare Vermont

HSA:
Cohort: 2020 Cohort
Time Period: Data through Aug 2020 with run out through Dec 2020

OneCare selected these focus areas for their impact on cost, quality, and performance under the financial model. This report identifies those focus areas in which your health service area has opportunities for improvement. Further details are available in the OneCare Performance Dashboard Report.

		*Meeting desirable outcome (**Y**/**N**)*			
Outcome Metrics	**Desirable Outcome Indicator**	**Medicare**	**QHP**	**Mcaid Trad**	**Mcaid Exp**
ED Utilization	PKPY **below** OneCare rate	Y	Y	Y	Y
Inpatient Admits	PKPY **below** OneCare rate	Y	Y	Y	Y
Specialty Care Visits	PKPY **below** OneCare rate	N	N	Y	Y
30 Day Readmission Rate	% **below** OneCare rate	Y	Y	Y	N

How to shift the outcomes:

Process Metrics	**Desirable Outcome Indicator**	**Medicare**	**QHP**	**Mcaid Trad**	**Mcaid Exp**
Primary Care Visits	PKPY **above** OneCare rate	N	Y	Y	Y
Home Health Days	Days **less than** OneCare mean	Data Gap			
SNF Length of Stay	Days **less than** OneCare mean	Y	*Medicare Only*		
A1c in last year - Diabetes Patients	Rate **above** target	N	Y	N	Y
Medicare Annual Wellness Visit	Rate **above** target	N	*Medicare Only*		
% Care Managed	% **above** target	Y	Y	Y	*Not Scored*

Themes

- Attribution numbers and claims based risk adjustment
- Care Coordination engagement rates
- Post-acute care performance
- Primary care engagement rates
- Specialty care utilization
- Emergency department utilization and outliers
- Inpatient admission locations and trends
- Preventive services
- Chronic disease management
- End of Life Care

Financial Presentation

- What is the anticipated settlement cash exchange?
- How does the TCOC performance compare to the OneCare average by program/cohort?
- What is the combined financial outcome (including shared savings/losses, PHM investments, dues, etc.)?
- How does the hospital fixed payment compare to the FFS-equivalent?
- COVID year projection cautions
- OneCare is responding to feedback from HSAs and is developing new financial reports

Proposed Projects

- Request for high ED utilizer lists for increased engagement
- Request for risk adjustment of cost and utilization data and illustration of practice variation within an HSA
- Examine reasons for unexpected out of HSA inpatient admissions
- Importance of identifying a data resource person in each HSA who is well trained on OneCare Vermont applications
- Coordinated coverage of skilled nursing facilities to optimize length of stay
- Additional Care Navigator training
- Awareness of Medicaid “expanded attribution” primary care incentives
- RN performed Medicare Annual Wellness Visits

Next Steps

- Next round of HSA Consultation meetings April 2021
- End of year 2020 results and Q1 2021 preliminary data
- Practice-specific reports of selected utilization and cost metrics

Questions

Board of Managers Summary of Policy Changes

Public Session

February 2021

OneCare leadership has reviewed and recommends the following policy changes for approval by the Board of Managers.

- **07-03 Privacy** (Formerly "Privacy and Security")
  - **Description**: Outlines OneCare's privacy compliance program and provides guidelines to maintain the privacy of protected health information ("PHI") created, received, maintained or transmitted by OneCare.
  - **Key Changes:** This policy has been updated in the following ways:
    - No substantial changes to law or policy made.
    - Privacy section separated from Privacy & Security Policy for added clarity.
    - Aligned introduction and ending sections to sections to recently approved Compliance policies and updates to Policy template
    - Incorporated majority of language from former policy into revision, but reorganized and wordsmithed for clarity, and added CFR citations to policy provisions for easier cross-reference to Privacy Rule.
    - Added CCPO designation of Privacy Officer, Workforce Training, and Reporting Violations sections for compliance with HIPAA and DVHA Compliance Program Contractual Agreements.
    - Procedures to be developed under the authority of this policy to detail PHI use, disclosure, and Workforce best practices for safeguarding PHI.

- **07-09 Security** (New policy number)
  - **Description**: Outlines OneCare's security compliance program and provides guidelines to maintain the security of electronic protected health information ("ePHI") created, received, maintained or transmitted by OneCare.
  - **Key Changes:** This policy has been updated in the following ways:
    - No substantial changes to law or policy made.
    - Security section separated from the formerly combined Privacy & Security policy for added clarity.
    - Aligned introduction and ending sections to sections to recently approved Compliance policies and updates to Policy template
    - Incorporated majority of language from former policy into revision, but reorganized and wordsmithed for clarity, organized by Safeguard provisions of the Security Rule, and added CFR citations to policy provisions for easier cross-reference to Security Rule.
    - Procedures to be developed under the authority of this policy to detail ePHI use, disclosure, and Workforce best practices for safeguarding ePHI.
    - Breach Policy included here, procedures to be developed to detail breach investigations and reporting processes.
    - Incorporates compliance with the Vermont Security Breach Notice Act. 9 VSA §435.

Policy Number & Title:	07-03 Privacy
Responsible Department/s:	Compliance
Author:	Gregory Daniels, Chief Compliance and Privacy Officer
Original Implementation Date:	September 23, 2013
Revision Effective Date:	February 16, 2021

I. Purpose

The Privacy Policy ("Policy") outlines the privacy compliance program for OneCare Vermont, Accountable Care Organization ("OneCare") and provides guidelines to maintain the privacy of protected health information ("PHI") created, received, maintained or transmitted by OneCare. OneCare, as a Business Associate ("BA") of its Covered Entity ("CE") Participants and Participating Providers, shall maintain the confidentiality and integrity of its ACO Network attributed patients PHI in accordance with HIPAA, Data Use Agreements ("DUAs"), Business Associate Agreements ("BAAs") and all applicable laws.

II. Scope

This Policy is applicable to all of OneCare's Workforce, Officers, Senior Management Executives, members of the Board of Managers, Board Sub-Committees, any other Committees acting on behalf of or under the authority of OneCare, ACO Network, and anyone else who does business with or on behalf of OneCare.

III. Definitions

Commonly used terms have the same definition as defined in OneCare's Policy and Procedure Glossary, available upon request. For purposes of this Policy, terms shall have the same meaning as defined under the Privacy and Security Rules of the Administrative Simplification provisions of the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), Title XIII of the Health Information Technology for Economic and Clinical Health Act ("HITECH") and implementing rules, the American Recovery and Reinvestment Act ("ARRA"), any and all State of Vermont privacy laws, and the Standards for Privacy of Individually Identifiable Health Information ("Privacy Rule"). Collectively, when referring to healthcare privacy and security laws, this Policy will use the term "HIPAA."

IV. Policy

It is the policy of OneCare to maintain the privacy of personal identifiable information ("PII") and PHI created, received, maintained or transmitted by OneCare and its CE Network. To that end, the following safeguards and privacy elements are implemented to ensure compliance with HIPAA:

A. <u>Designation of OHCA</u>
   OneCare and its ACO Network have designated themselves an Organized Health Care Arrangement ("OHCA") for the purpose of facilitating the use and disclosure of PHI amongst the members of the ACO for treatment, payment and healthcare operations purposes, or as otherwise permitted under HIPAA. 45 CFR §160.103, §160.506 (c)(5)

B. <u>Uses and Disclosures of PHI to Carry Out Treatment, Payment, or Healthcare Operations</u>
   OneCare may use or disclose PHI of its Participants' patients for Accountable Care Organization Activities ("ACO Activities") purposes as described in agreements with its Participants and Participating Providers and as permitted by HIPAA. OneCare uses and disclosures of PHI will generally be for healthcare operations, e.g. carrying out the ACO Activities of care coordination,

quality collection and assessment, and population health management. 45 CFR §164.502(a)(1), §164.506

C. Minimum Necessary Standard
OneCare will make all reasonable efforts to limit PHI to the minimum necessary amount to accomplish the intended purpose of the use, disclosure, or request. 45 CFR §164.502(b)

D. De-Identified PHI
Health information that is not individually identifiable and meets the definition of de-identified information under HIPAA is not subject to this Policy. De-identified information may be used by OneCare as authorized by an executed DUA between OneCare and the CE source of the health information and in compliance with OneCare's Data Use Policy. 45 CFR § 164.514

E. Other Uses and Disclosures of PHI Permitted by Law
OneCare will release health information to the Secretary of the US Agency of Health and Human Services ("HHS"), or any other federal or state government entity with regulatory oversight authority over OneCare, when required to do so under HIPAA, contractual agreement, or applicable law.

OneCare may disclose PHI, without consent, under the following limited circumstances: emergency situations and disaster relief efforts; for public health activities; in response to requests from health oversight agencies; in response to orders or subpoenas issued in accordance with judicial or administrative proceedings; in relation to serious threats to health or safety; in response to discovery requests in workers' compensation matters; in response to qualifying requests related to whistleblowers and victims of crime. All such requests shall be reviewed, authorized, and documented by the CCPO and/or ACO Legal Counsel prior to disclosure. 45 CFR §164.512

F. Disclosures Outside of ACO Activities
If OneCare receives a request(s) for the use or disclosure of PHI outside of ACO Activities the CCPO and/or ACO Legal Counsel will communicate with the requester of the PHI regarding proper use or disclosure of the PHI prior to any such use or disclosure. OneCare will comply with any obligation under HIPAA, its contractual obligations, any applicable privacy laws to disclose the requested PHI. OneCare will maintain an accounting of such uses and disclosures of PHI outside of ACO Activities.

G. Compliance with Network Privacy Practices and Requests for Restrictions and Confidential Treatment
To the extent that a CE Participant has specifically instructed OneCare of a limitation contained in their Notice of Privacy Practices or a restriction of how an attributed patient's PHI may be used or disclosed, OneCare will, if possible, limit its use or disclosure of PHI received from that Participant for that specific patient in accordance with such limitation or restriction. 45 CFR §164.522 OneCare shall also discontinue the permitted use and disclosure of a patient's PHI if the attributed patient has affirmatively opted-out of data sharing with the ACO.

H. Subcontractors
OneCare may use subcontractor(s) to perform certain services for OneCare that may require it to access or use PHI. These subcontractors are required to enter into a subcontractor BAA with OneCare that complies with HIPAA prior to receiving access to any PHI in OneCare's possession or control. Any subcontractor that releases information to a "next level" subcontractor will be required to enter into a contractual agreement with such subcontractor binding it to the same restrictions regarding use of PHI as apply to OneCare and the original subcontractor. 45 CFR §164.502

I. Patient Rights

Under HIPAA, patients have the right to inspect, amend, request restriction or confidentiality of, and/or obtain accountings of disclosures of their PHI. 45 CFR §164.522, §164.524, §164.526 and §164.528 OneCare will direct request(s) by patient's attributed to the ACO directly to payers individual(s) to perform such action(s) to the relevant Participant, Preferred Provider, or Payer. Where OneCare's data systems are implicated by the requested action, OneCare will cooperate with to the extent it is able to accomplish the requested action.

J. Designated Privacy Officer

The CCPO will be the designated Privacy Officer for OneCare. The Privacy Officer will be responsible for the development and implementation of policies and procedures relating to privacy, reporting The Privacy Officer will also serve as the contact person for participants who have questions, concerns, or complaints about the privacy of their PHI. 45 CFR 164.530(a)(1)

K. Training and Education

All OneCare Workforce, Board of Managers and privacy and/or compliance contacts of the ACO Network are required to complete annual Compliance Training, which includes HIPAA and Privacy training. The CCPO will update the required training to reflect changes in applicable laws no less than annually.45 CFR 164.530(b)

L. Reporting and Investigations of Violations, Sanctions and Mitigation

OneCare maintains a confidential communication mechanism so that OneCare's Workforce, ACO Network and others may report compliance concerns, including potential privacy violations, without concern of retaliation. It is the obligation of each member of the OneCare Workforce to report to the CCPO conduct he or she reasonably believes to be in violation of HIPAA, the Compliance Program, and/or applicable law.

When a privacy violation is confirmed to have resulted from a failure by a Workforce member to comply with this Policy, the investigating officer(s) shall ensure that an appropriate sanction is imposed. Sanctions shall be dependent upon the nature of the compliance failure and may range from training to reinforce the policy or procedure violated up to and including termination of employment. To the extent practicable, OneCare will mitigate any harmful effect known to it of a use or disclosure of PHI in violation of this Policy. 45 CFR 164.530(d) & (e)

For detailed information on reporting potential or actual violations, please see OneCare's *Compliance Communication, Reporting and Investigation Policy, Compliance Policy,* and *Code of Conduct*. OneCare will take appropriate action to investigate and take corrective action in response to any identified privacy violations. Such corrective action may include additional training, revision of policies and procedures and/or Workforce discipline.

V. Review Process

This Policy shall be reviewed annually and updated to be consistent with the requirements established by the Board, OneCare Leadership, all applicable laws, and applicable accrediting and review organizations.

VI. References

- Payer Program Agreements and Requirements (including BAAs and DUAs)
- OneCare's Policy and Procedure Glossary

VII. Related Policies/Procedures

- 03-03 Data Use Policy
- 03-05 Data Transparency Policy
- 07-02 Compliance Policy
- 07-07 Code of Conduct Policy
- 07-08 Compliance Communication, Reporting and Investigation Policy
- 07-09 Security Policy

Location on Shared Drive: S:\Groups\Managed Care Ops\OneCare Vermont\Policy and Procedures

Management Approval:

_____

Chief Operating Officer Date

_____

Chief Compliance and Privacy Officer Date

Board of Managers Approval:

_____

Chair, OneCare Vermont Board of Managers Date

Policy Number & Title:	07-09 Security Policy
Responsible Department/s:	Compliance
Author:	Gregory Daniels, Chief Compliance and Privacy Officer
Original Implementation Date:	September 23, 2013
Revision Effective Date:	February 16, 2021

I. Purpose

The Security Policy ("Policy") outlines the security compliance program for OneCare Vermont, Accountable Care Organization ("OneCare") and provides guidelines to maintain the security of electronic protected health information ("ePHI") created, received, maintained or transmitted by OneCare. OneCare, as a Business Associate ("BAs") of its Covered Entity ("CE") Network Participants and Participating Providers , shall maintain the confidentiality and integrity of its ACO Network attributed patients ePHI in accordance with HIPAA, Data Use Agreements ("DUAs"), Business Associate Agreements ("BAAs") and all applicable laws.

II. Scope

This Policy is applicable to all of OneCare's Workforce, Officers, Senior Management Executives, members of the Board of Managers, Board Sub-Committees, any other Committees acting on behalf of or under the authority of OneCare, ACO Network, and anyone else who does business with or on behalf of OneCare.

III. Definitions

Commonly used terms have the same definition as defined in *OneCare's Policy and Procedure Glossary*, available upon request. For purposes of this Policy, terms shall have the same meaning as defined under the Privacy and Security Rules of the Administrative Simplification provisions of the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), Title XIII of the Health Information Technology for Economic and Clinical Health Act ("HITECH") and implementing rules, the American Recovery and Reinvestment Act ("ARRA"), the Security Standards for the Protection of Electronic Protected Health Information ("the Security Rule"). Collectively, when referring to healthcare privacy and security laws, this Policy will use the term "HIPAA."

IV. Policy

It is the policy of OneCare to maintain the privacy and security of personal identifiable information ("PII") ePHI, and data created, received, maintained or transmitted by OneCare and its CE Network. To that end, the following safeguards and security provisions are implemented to prevent, detect, contain, and correct security violations:

A. ADMINISTRATIVE SAFEGUARDS *45 CFR §164.308*

1. Designation of Security Officer
   OneCare shall designate a Security Officer as responsible for the development, implementation, maintenance, enforcement, and documentation of policies and procedures required by the Security Rule. 45 CFR §164.308(a)(2)

2. Risk Analysis
   Annually, and as necessary, the Security Officer shall conduct an accurate and thorough assessment of the potential risks and vulnerabilities to the confidentiality, integrity, and availability of ePHI held by OneCare. Upon the conclusion of each such review, the Security

Officer shall document the risk analysis performed and any new administrative, technical, or physical safeguards identified by the review for implementation. 45 CFR §164.308(a)(1)(ii)(A)

3. Risk Management
   As described in this policy, OneCare shall implement security measures sufficient to reduce risks and vulnerabilities to a reasonable and appropriate level. 45 CFR §164.308(a)(1)(ii)(B)

4. Sanctions
   OneCare will apply appropriate sanctions against Workforce and ACO Network members who fail to comply with this Policy, related procedures, and HIPAA. Sanctions shall be dependent upon the nature of the compliance failure and may range from training to reinforce the policy or procedure violated up to and including termination of employment. 45 CFR §164.308(a)(1)(ii)(C)

5. Information System Activity Review
   OneCare shall regularly review records of information system activity, such as system activity reports and audit logs, to assess whether there has been unusual system activity that might indicate a threat to the confidentiality, integrity, or availability of ePHI. 45 CFR §164.308(a)(1)(ii)(D)

6. Information Access Management and Workforce Security
   OneCare shall implement policies and procedures for authorizing access to ePHI and ensure that all Workforce and ACO Network members have appropriate access to ePHI and to prevent unauthorized access ePHI. 45 CFR §164.308(a)(3) & (4)

7. Training and Education
   All OneCare Workforce, Board of Managers and privacy and/or compliance contacts of the ACO Network are required to complete annual Compliance Training, which includes HIPAA security awareness. The CCPO will update the required training to reflect changes in applicable laws no less than annually. 45 CFR §164.308(a)(5)(i)

8. Security Incidents
   OneCare shall identify and respond to suspected or known security incidents promptly, and shall mitigate, to the extent practicable, any harmful effects. Any suspected security incident shall be immediately reported to the Security Officer, who shall be responsible for investigating the incident, implementing any required response and mitigation and documenting the incident and its outcome. 45 CFR §164.308(a)(6)(ii)

9. Contingency Plan
   OneCare will establish and implement policies and procedures for responding to emergencies or other natural disaster occurrences that damage OneCare systems that contain ePHI. To that end, OneCare will:

   (A) Data backup plan: Establish and implement procedures to create and maintain retrievable exact copies of electronic protected health information. 45 CFR §164.308(a)(7)(ii)(A)

   (B) Disaster recovery plan: Establish and implement procedures to restore any loss of data. 45 CFR §164.308(a)(7)(ii)(B)

(C) Emergency mode operation plan: Establish and implement procedures to enable continuation of critical business processes for protection of the security of ePHI while operating in emergency mode. 45 CFR §164.308(a)(7)(ii)(C)

10. Evaluation
    On an annual basis, the Security Officer shall perform a technical and nontechnical review of this Policy and related procedures determine, based on the Security Rule standards and environmental and operational changes that could affect ePHI to determine whether these policies and procedures meet the requirements of the Security Rule. 45 CFR §164.308(a)(8)

11. Business Associate and Other Contracts
    The Security Officer shall annually review relationships with BAs to ensure that relationships are accurately defined in the contracts between parties and OneCare and that the scope or nature of the relationship has not changed. The Security Officer, and/or CCPO or designee, will update, modify or terminate relationships with BAs, as needed, after completion of these reviews. 45 CFR §164.308(b)

    OneCare will ensure that any ACO Network Members and contractors that create, receive, maintain, or transmit ePHI on behalf of OneCare agree to comply with the applicable requirements of the Security Rule by entering into a contract and/or BAA. ACO Network Members and contractors agree to report any security incident of which it becomes aware, including breaches of unsecured PHI as required by the Breach Reporting Rule. 45 CFR §164.314(a)

B. PHYSICAL SAFEGUARDS 45 CFR §164.310

1. Facility Access Controls
   OneCare shall limit physical access to information systems under its direct control and the facilities in which they are housed by locating servers and similar equipment on which ePHI is stored in a locked room or data center to which only properly authorized personnel are allowed access to secure the systems against unauthorized physical access, tampering and theft.

   Access to facilities containing computer equipment on which information systems are loaded, including visitor control, shall be limited based on a person's role and function. OneCare or its outsourcing contractors shall document repairs and modifications to key code access devices, locks and similar physical components of facility security. 45 CFR §164.310(a)(1)

2. Workstation Use and Security
   OneCare shall implement policies and procedures that designed to minimize the risk of improper access to or disclosure of ePHI when using any workstation or other device. These procedures shall include but should not be limited to requiring use of a unique password for access to the system, management of paper containing PHI, use of screen savers or sleep mode functions to obscure screen displays of protected information, device placement or screen orientation and other practices to limit the exposure of PHI.

   OneCare shall implement physical safeguards for workstations to restrict unauthorized access to

ePHI. These physical safeguards can include but should not be limited to passwords, screen savers, locking file cabinets, screen display protections, and secure disposal receptacles. Use of workstations should be limited, to the extent possible, to facilities and facility spaces to which OneCare controls access. 45 CFR §164.310(b) & (c)

3. Media & Device Security
   OneCare shall implement policies and procedures that govern the receipt and removal of hardware and electronic media that contain ePHI including disposal and re-use. In general, OneCare shall track the receipt and removal of hardware and electronic media containing ePHI into and out of a facility and within the facility. All ePHI shall be removed from hardware and electronic media prior to re-use and disposal to prevent the restoration and unauthorized access of ePHI. OneCare shall maintain, directly or through its outsourcing contractors, a record of the movements of hardware and electronic media and the person accountable for that documentation. 45 CFR §164.310(d)

C. TECHNICAL SAFEGUARDS 45 CFR §164.312

1. Access Control
   OneCare shall implement technical policies and procedures for electronic information systems that maintain ePHI to allow access only to those persons or software programs that have been granted access rights in line with *Information Access Management* and *Workforce Security* sections above.

   Workforce members and others authorized to access an information system shall be assigned a unique user identification name and/or number to identify and track that user's identity. ePHI maintained in information systems shall be accessible during an emergency. 45 CFR §164.312(a)(1), §164.312(a)(2)(i) & (ii)

2. Audit Controls and Integrity
   OneCare shall utilize technical mechanisms implemented to record and examine activity in all information systems. OneCare shall protect ePHI from improper alteration or destruction by the periodic review of system activity and audit trail reports to detect data discrepancies. 45 CFR §164.312(b) & (c)

3. Person or Entity Authentication
   OneCare systems ensure that a person or entity seeking access to ePHI is the person or entity claimed by requiring the use of unique user ID's and passwords and other authentication methodologies for system access. 45 CFR §164.312(d)

4. Transmission Security
   OneCare shall ensure that its software contractors implement appropriate technical security measures to guard against unauthorized access to ePHI that is transmitted over an electronic communications network and that they have implemented security measures to ensure that ePHI transmitted electronically is not improperly modified without detection prior to its disposition. EPHI shall be encrypted when appropriate. 45 CFR §164.312(e)(1)

D. DOCUMENTATION REQUIREMENTS 45 CFR § 164.316

Policies and procedures implemented under the Security Rule and all related documents created or maintained in connection with an action required by these policies shall be maintained in written (or electronic) form for six (6) years from the date of creation or the date when the policy, procedure or documentation last was in effect and/or utilized, whichever is later.

Policies and procedures, and related documentation, will be made available to those Workforce responsible for implementing this Policy, associated procedures, and other relevant documentation. 45 CFR §164.316(a) & (b)

E. BREACH NOTIFICATION RULE 45 CFR §164.400 - 164.414

Per the HIPAA Breach Notification Rule, OneCare will cooperate with its CE ACO Network to provide notification following a breach of unsecured PHI. The Privacy Officer (e.g. CCPO) and Security Officer must be notified immediately by Workforce, ACO Network members and others who have access to PHI, of any suspected breaches. The Privacy Officer and Security Officer will investigate any suspected breaches and complaints to determine whether there has been a breach that may require reporting and notification to US HHS OCR and shall notify affected CE ACO Network Members of any such potential breach. The Privacy Officer and Security Officer, as necessary, will be responsible for coordinating with affected CE ACO Network members to provide notifications required by the HIPAA data breach rules or other applicable data breach rules. OneCare shall implement procedures to outline the breach notification reporting and notification process.

OneCare shall also comply with the *Vermont Security Breach Notice Act*. 9 VSA §435

V. Review Process

This Policy shall be reviewed annually and updated to be consistent with the requirements established by the Board, OneCare Leadership, all applicable laws, and applicable accrediting and review organizations.

VI. References

- Payer Program Agreements and Requirements (including BAAs and DUAs)
- OneCare's Policy and Procedure Glossary

VII. Related Policies/Procedures

- 03-03 Data Use Policy
- 03-05 Data Transparency policy
- 07-02 Compliance Policy
- 07-03 Privacy Policy
- 07-07 Code of Conduct Policy
- 07-08 Compliance Communication, Reporting and Investigation Policy

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Management Approval:

Chief Operating Officer	Date
Chief Compliance and Privacy Officer	Date

Board of Managers Approval:

Chair, OneCare Vermont Board of Managers	Date

OneCare Vermont Accountable Care Organization
Board of Managers Resolution
Adopting Policies

February 16, 2021

BE IT RESOLVED by the Board of Managers (the "Board") of OneCare Vermont Accountable Care Organization, LLC ("OneCare"), as follows:

The Board, having reviewed, considered and discussed, hereby approves the following Policies as recommended by the Compliance Committee and by the Audit Committee:

A. Policy 07-03 Privacy
B. Policy 07-09 Security

STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

FY21 ACCOUNTABLE CARE ORGANIZATION BUDGET ORDER

In re:	OneCare Vermont Accountable Care Organization, LLC Fiscal Year 2021	)))
		) Docket No. 20-001-A

INTRODUCTION

The Green Mountain Care Board (GMCB or Board) is charged with reviewing, modifying, and approving the budgets of accountable care organizations (ACOs). 18 V.S.A. § 9382(b). Fiscal Year 2021 (FY21) is the fourth year that ACO budgets are subject to Board review. Below, we describe the relevant legal framework, outline the criteria that the Board considered during its review, and present specific Findings and Conclusions in support of our Order establishing an FY21 budget for OneCare Vermont Accountable Care Organization, LLC (OneCare).

LEGAL FRAMEWORK

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

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

See 18 V.S.A. § 9382(b)(1). In addition to these statutory criteria, the Board will consider the requirements of the Vermont All-Payer Accountable Care Organization Model Agreement (APM

Agreement) between the State of Vermont and the Centers for Medicare & Medicaid Services (CMS), any benchmarks established in the Board's ACO budget guidance, and the elements of the ACO's payer programs. GMCB Rule 5.000, § 5.405(b).

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

- **Total Cost of Care (TCOC) Growth Targets.** The State is responsible for limiting per person spending growth over the five performance years of the agreement.
    - The target for Medicare TCOC per Beneficiary Growth is a compounding rate that is at least 0.2% below projected national Medicare growth.
    - The target for All-Payer TCOC per Beneficiary Growth is a compounding rate of 3.5% or less over the five performance years of the APM Agreement.
- **Statewide Health Outcomes and Quality of Care Targets.** The State is responsible for meeting a series of targets tied to three overarching population health goals:
    - Improving access to primary care;
    - Reducing deaths due to suicide and drug overdose; and
    - Reducing the prevalence and morbidity of chronic disease.
- **Scale Targets.** Over the five performance years of the agreement, the State is responsible for steadily increasing the percentages of Vermont Medicare Beneficiaries and Vermont All-Payer Scale Target Beneficiaries that are aligned to a Scale Target ACO Initiative.
    - By the end of 2021, the fourth performance year of the APM Agreement, the State is expected to have 62% of All-Payer Scale Target Beneficiaries and 83% of Vermont Medicare Beneficiaries aligned to a qualifying initiative.
- **Alignment.** Scale Target ACO Initiatives offered by payers must reasonably align with the Medicare program, referred to as the Vermont Medicare ACO Initiative.

APM Agreement, §§ 6-9, Appendix 1.

FY20 REVIEW PROCESS

The review process for OneCare's FY21 budget is reflected in the following timeline:

07.01.20: The Board issues FY21 ACO budget guidance and reporting requirements to OneCare.
10.01.20: OneCare submits its proposed FY21 budget to the Board.
10.07.20: Board staff and payer representatives present data at a public Board meeting regarding OneCare's 2019 quality performance under payer programs.
10.26.20: Board staff and HCA request additional information from OneCare regarding its proposed FY21 budget.
10.28.20: OneCare presents its proposed FY21 budget to the Board at a public hearing.
11.09.20: OneCare responds to Oct. 26, 2020 questions from Board staff and HCA.

11.19.20: Vermont Agency of Human Services (AHS) releases All-Payer ACO Model Implementation Improvement Plan.
12.02.20: Board staff and payer representatives present data at a public Board meeting regarding OneCare's 2019 financial performance under payer programs and Board staff present data regarding Vermont's performance under the APM Agreement.
12.09.20: Board staff present their analysis and preliminary recommendations regarding OneCare's proposed FY21 budget.
12.11.20: The Board requests clarification regarding information in the FY21 budget submission.
12.15.20: OneCare responds to the Board's Dec. 11, 2020 request for clarification.
12.18.20: Board staff present additional analysis and updated recommendations regarding OneCare's proposed FY21 budget.
12.22.20: Board receives letter from AHS regarding OneCare's proposal to fund the Blueprint for Health.
12.23.20: Board votes to approve OneCare's FY21 budget on the terms and subject to the conditions described in this Order.

The written materials from this process are posted on the Board's website[1] and video recordings of the meetings are available from Onion River Community Access (ORCA) Media.[2]

FINDINGS

ACO Governance and Leadership

1. OneCare is a "manager-managed" limited liability company organized under Vermont law in 2012 by the University of Vermont Medical Center, a Vermont nonprofit corporation, and Dartmouth-Hitchcock Health, a New Hampshire nonprofit corporation. 2021 Certification Eligibility Verification Form for OneCare Vermont (Certification Submission), Seventh Amended and Restated Operating Agreement of OneCare Vermont (Operating Agreement), 1 (eff. April 15, 2020).

2. OneCare is governed by a Board of Managers comprised largely of representatives of participating health care providers. 2021 Certification Submission, Operating Agreement, 8 – 9. Since our last review, Claudio Forte, President and Chief Executive Officer of Rutland Regional Medical Center, replaced Jill Berry-Bowen as the representative of community prospective payment system hospitals on OneCare's Board of Managers. *Compare* 2021 Certification Submission, OneCare Vermont Board of Managers (Sept. 2020) *with* 2020 Certification Submission, OneCare Vermont Board of Managers (Sept. 2019).

3. OneCare currently has one vacancy on its executive leadership team, a Vice President and ACO Legal Counsel. *See* 2021 Certification Submission, OneCare Leadership Team (Aug. 31, 2020). Effective Oct. 19, 2020, Tom Borys was promoted to Vice President for Finance for

[1] Written budget materials are available at https://gmcboard.vermont.gov/aco-oversight/2021. Board presentations are available at https://gmcboard.vermont.gov/board/meetings.
[2] https://www.orcamedia.net/series/green-mountain-care-board.

OneCare, filling the previously vacant executive leadership spot. OneCare Responses to Round 1 Questions, 17 (Nov. 9, 2020).

FY21 Payer Programs/ACO Initiatives

4. OneCare is still negotiating payer contracts for FY21. OneCare Vermont FY21 Budget Submission (Budget Submission), 5. OneCare expects to continue existing programs with Medicare, Medicaid, Blue Cross and Blue Shield of Vermont (BCBSVT), and MVP Health Plan, Inc. (MVP) in FY21. OneCare PowerPoint, 12 (Oct. 28, 2020). OneCare does not anticipate any new payer programs in FY21. Budget Submission, 18.

5. OneCare is seeking to negotiate narrower risk corridors with payers for FY21. Given the financial impact of COVID-19 on OneCare's provider network, OneCare explained that it is seeking to balance a desire for lower risk "with the desire to stay on the value-based care path" by maintaining two-sided accountability. Testimony of Tom Borys, Hearing Transcript (Tr.), 36:4 – 23 (Oct. 28, 2020). The total "downside" risk (for shared losses) reflected in OneCare's proposed FY21 budget is just over $19 million, approximately $17.5 million less than the ACO's pre-COVID FY20 budget. OneCare PowerPoint, 15 (Oct. 28, 2020); Testimony of Tom Borys, Tr. 36:24 – 37:6. OneCare's actual downside risk for FY21 will depend on final attribution and the terms of its payer contracts.

Risk Management

6. OneCare plans to transfer the great majority of its anticipated downside risk, just over $18 million, to network providers. *See* Budget Submission, App. 5.1 - 5.2.

7. OneCare changed the way that it manages upside and downside risk in 2020. Prior to 2020, OneCare's approach was to divide its network-wide spending targets into Health Service Area (HSA) spending targets, with the home hospital within each HSA serving as a "mini ACO" that held the upside and downside risk for greater- or lower-than-expected spending on the locally attributed population. *See In re OneCare Vermont Accountable Care Organization, LLC,* FY18 Accountable Care Organization Budget Order, Findings of Fact, ¶¶ 22-23; *see also* Testimony of Tom Borys, Tr., 38:1 – 6. Under the new risk model, shared savings and losses, which accrue at the ACO level, will be distributed proportionally across HSAs based on member months of attribution. OneCare Responses to Round 1 Questions, 6 (Nov. 9, 2020).

8. OneCare intends to continue its new risk model in FY21 but modify it by allocating 10% of any shared savings earned at the ACO level to a performance incentive pool that it will use to reward "exceptional performance" based on measures that are still being developed. OneCare Responses to Round 1 Questions, 7 (Nov. 9, 2020); Budget Submission, 8.

9. OneCare claims that its new network approach to allocating shared savings and losses will avoid a small number of expensive cases or inherent variation dictating an HSA's performance. OneCare also claims that the approach is simpler and more understandable for network participants and will align the financial results for OneCare and its participants with the

goals of the APM, which are measured at the state level. Budget Submission, 3, 8, 20; Testimony of Tom Borys, Tr., 38:15 – 40:4.

10. OneCare intends to assume half of Rutland Regional Medical Center's risk under the FY21 Medicare program as it is entering this program for the first time.[3] OneCare has budgeted a similar arrangement for Copley Hospital. Budget Submission, 25.

11. In FY21, OneCare also plans to implement a variable component to the base payments it makes to attributing providers. Budget Submission, 25. In past years, attributing providers, which are typically primary care providers, received a payment of $3.25 per member per month (PMPM). *Id.* at 7. In FY21, OneCare explained that providers participating in programs where the network holds risk will receive a payment of $1.75 PMPM. However, if shared savings are achieved by the ACO, the providers will receive an additional $1.50 to $3.00 PMPM, for an overall payment of between $1.75 and $4.75 PMPM. OneCare Responses to Round 1 Questions, 22 (Nov. 9, 2020); Budget Submission, 6, 58. For shared savings programs with no downside risk, the variable payments will range from $3.25 to $4.75 PMPM, and for programs where OneCare holds risk, the payments will continue at $3.25 PMPM. Budget Submission, 7, 10. Following pushback from independent primary care practices, OneCare agreed in September of 2020 to give independent primary care practices participating in risk programs the option of continuing to receive $3.25 PMPM (as opposed to $1.75) if they attest to experiencing economic stress during the pandemic, with the understanding that $1.50 PMPM will be at risk and subject to recoupment if programmatic shared savings are not earned. OneCare Responses to Round 1 Questions, 3 – 4 (Nov. 9, 2020); *see also* Letter from Vicki Loner and Susan Ridzon to Kevin Mullin (September 10, 2020).

12. OneCare's FY21 budget does not include the cost of a third-party risk protection arrangement for the Medicare program, as it has in prior years. OneCare stated that, with a narrower risk corridor, the probability of a result nearing either end of the corridor increases and the premium for a risk protection product increases relative to the amount of potential return. OneCare concluded that given this dynamic and the need to reduce hospital dues, it would forego risk protection in FY21. Budget Submission, 25 – 26.

13. The following table shows the expected allocation of risk within OneCare's network:

Risk Bearing Entity (RBE)*	HSA	Downside Risk ($1,000s)	% of Total
Southwestern VT Medical Ctr.	Bennington	$ 1,554	8.2%
Central Vermont Medical Ctr.	Berlin	$ 2,059	10.8%
Brattleboro Memorial Hospital	Brattleboro	$ 996	5.2%
University of Vermont Medical Ctr.	Burlington	$ 6,625	34.8%
Dartmouth-Hitchcock	Lebanon	$ 451	2.4%
Porter Medical Ctr.	Middlebury	$ 1,234	6.5%
Copley Hospital	Morrisville	$ 163	0.9%
North Country Hospital	Newport	$ 310	1.6%
Gifford Medical Ctr.	Randolph	$ 243	1.3%
Rutland Regional Medical Ctr.	Rutland	$ 1,499	7.9%

[3] Risk mitigation arrangements are set up so that the risk-bearing hospital bears risk up to the midpoint of its maximum risk limit or MRL and OneCare is responsible for the second half. In exchange, OneCare is entitled to 25% of any shared savings earned by the hospital. OneCare Responses to Round 1 Questions, 7 (Nov. 9, 2020).

Springfield Hospital	Springfield	$	334	1.8%
Northwestern Medical Ctr.	St. Albans	$	1,634	8.6%
Northeastern VT Regional Hospital	St. Johnsbury	$	433	2.3%
Grace Cottage Hospital	Townshend	$	-	0.0%
Mt. Ascutney Hospital & Health Ctr.	Windsor	$	506	2.7%
OneCare Vermont	Non-HSA Aligned	$	1,006	5.3%
TOTAL		**$**	**19,047**	**1.3%**

***** Figures represent HSA aggregate risk, including PHM component, which may not accrue to the RBE.

See Budget Submission, App. 5.2; GMCB PowerPoint, 46 (Dec. 9, 2020).

14. While OneCare's network providers have agreed to repay most of any shared losses that may be due to payers, as the entity with primary responsibility for repayment, OneCare still has credit risk for these losses. OneCare also has credit risk relating to prospective payment reconciliations. *See* Comments of Vicki Loner, 17:30 – 18:00 (Dec. 18, 2020).

15. OneCare reserves are generated through hospital dues and are intended to cover risk held by the ACO or to address unforeseen cash flow or business issues. OneCare Responses to Round 1 Questions, 8 (Nov. 9, 2020). OneCare's FY21 budget suggests a reserve of $5.6 million, $1.7 million more than the $3.9 million that the Board required OneCare to maintain in 2019 to fund the risk mitigation of three network hospitals and that the Board permitted OneCare to maintain in 2020 for general liquidity concerns, despite the shift of network risk mitigation obligations to the founders. OneCare does not expect any additional surplus or contribution to reserves as result of 2020 retained earnings and does not expect to build additional reserves in 2021. The $5.6 million in reserves on OneCare's balance sheet would more than cover the maximum possible downside risk carried by the ACO. Testimony of Tom Borys, Tr., 91:15 – 22. OneCare believes that maintaining the current level of reserves is appropriate and cited financial uncertainty and the amount of cash flowing through the ACO for fixed payments and other population health investments. OneCare Response to Round 2 Questions, 2 (Dec. 15, 2020).

FY19 Programmatic Performance

16. The 2019 Medicare program included a +/- 5% risk corridor and 100% risk sharing, meaning that within five percentage points of the target, OneCare would earn 100% of any savings and would be responsible for 100% of any losses. OneCare's performance in the 2019 Medicare program was within the risk corridor. Excluding money that was paid to OneCare in advance of program settlement and that the Board required OneCare to use to fund the Blueprint for Health and Support and Services at Home (SASH) programs,[4] and after accounting for the financial impact of OneCare's quality performance, OneCare earned approximately $4.8 million in shared savings under the 2019 Medicare program. *See* GMCB PowerPoint (Dec. 2, 2020), 4.

17. The 2019 Medicaid program included a +/- 4% risk corridor with 100% risk sharing, meaning that within four percentage points of the target, OneCare would earn 100% of any savings and would be responsible for 100% of any losses. GMCB PowerPoint, 11 (Dec. 2, 2020). OneCare's performance in the 2019 Medicaid program was approximately $13.5 million above

[4] Approximately $6.3 million was included in OneCare's 2019 benchmark and distributed to OneCare in advance of settlement. OneCare used this money to fund Blueprint for Health programs, including Supports and Services at Home (SASH). GMCB PowerPoint, 4 (Dec. 2, 2020).

the target and outside of the risk corridor. After application of necessary adjustments, OneCare will be required to pay approximately $6.7 million in shared losses to the Department of Vermont Health Access (DVHA). *Id.* at 12. DVHA explained that OneCare's losses under the 2019 Medicaid program were driven by higher than projected fee-for-service spending; ACO-participating providers that were paid prospectively (instead of fee-for-service) spent approximately $8.2 million less than expected. *Id.* at 14; *see also* AHS, Implementation Improvement Plan: Vermont All-Payer Accountable Care Organization Model Agreement (Implementation Improvement Plan), 11 (Nov. 19, 2020).

18. In discussing the results of the 2019 Medicaid program, DVHA noted that the ACO-attributed population nearly doubled from 2018 to 2019, which introduced relatively more uncertainty into the rate setting process compared to prior years. DVHA also noted that overall utilization trends increased for the entire Medicaid-enrolled population between 2017 (the base year used for rate development) and 2019. GMCB PowerPoint, 14 (Dec. 2, 2020).

19. Because of data challenges, BCBSVT agreed to shift its qualified health plan program from a shared risk to a shared savings program for 2019. BCBSVT stated that actual spending under the program net of member cost share exceeded the spending target by approximately $6.5 million or 6.6%. OneCare was not required to pay any of these losses. BCBSVT identified several dynamics relating to utilization and intensity of services it believes contributed to the overage, namely increased evaluation and management and professional mental health and substance use disorder visits, higher use of urgent care, and more costly and/or intense physical therapy services. GMCB PowerPoint, 25 (Dec. 2, 2020).

20. Within the 2019 Medicare program, OneCare earned 36.75 out of 40 points on 20 measures relating to patient/caregiver experience, care coordination/patient safety, preventive health, and at-risk populations. OneCare's overall quality score was 91.8%. OneCare's performance exceeded the national 90th percentile on three measures; was between the national 80th and 90th percentiles on five measures; was between the national 70th and 80th percentiles on three measures; was between the national 60th and 70th percentiles on one measure; was between the national 50th and 60th percentiles on one measure; and was between the national 40th and 50th percentiles on one measure. The remainder of the measures had no national benchmark. GMCB PowerPoint, 12 (Oct. 7, 2020). Of the 16 measures that were carried forward from 2018, improvement was noted in 12. *Id.* at 14.

21. Within the 2019 Medicaid program, OneCare's overall quality score was 95% based on ten pre-selected payment measures. OneCare's performance exceeded the national 90th percentile on three measures; was between the national 75th and 90th percentiles on one measure; was between the national 50th and 75th percentiles on two measures; and was between the national 25th and 50th percentiles on one measure. On one measure for which there was no 90th percentile (Developmental Screening), OneCare's performance exceeded the national 75th percentile; National benchmarks were unavailable for the remaining two payment measures, so OneCare's 2019 performance was compared to its 2018 performance. For both measures, OneCare's performance improved in 2019. For five measures, there was statistically significant improvement from 2018 to 2019. GMCB PowerPoint, 20 (Oct. 7, 2020).

22. Of the eight clinical measures in the 2019 BCBSVT QHP program, OneCare's performance improved on four measures and declined on four measures. Statistically significant improvement was observed on two measures and there were no measures with statistically significant decreases. OneCare's performance was above the national 90th percentile on three measures; was above the national 75th percentile for one measure; was above the national 50th percentile for three measures; and was above the national 25th percentile on one measure. GMCB PowerPoint, 28 (Oct. 7, 2020).

FY21 Provider Network

23. OneCare has a broad provider network for FY21 that includes all but one of Vermont's 14 community hospitals, as well as Dartmouth Hitchcock Medical Center, which is located just across the border in New Hampshire. OneCare's FY21 network will also include federally qualified health centers, skilled nursing facilities, home health agencies, designated agencies, independent primary care and specialist practices, and ambulatory surgical centers. Budget Submission, App. 2.1.

24. OneCare's FY21 network development strategy focused on maintaining the existing network composition despite challenges associated with COVID-19; increasing support for primary care; engaging organizations that take risk; working to reduce barriers to joining additional payer program; and ensuring understanding of participation expectations. Budget Submission, 10.

25. OneCare's provider network is not expected to change drastically between FY20 and FY21. Because of this, there are minimal impacts on the overall budget model due to changes in network participants. Budget Submission, 10. However, OneCare is losing four independent primary care practices (two of which were affiliated with HealthFirst), as well as several specialist practices. Budget Submission, 11; OneCare Responses to Round 1 Questions, 4 (Nov. 9, 2020).

26. Rutland Regional Medical Center and the Community Health Center of the Rutland Region are expected to join the Medicare program in FY21. Budget Submission, 10

Scale and Program Alignment

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

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

29. Assuming OneCare's projections are accurate and that the payer programs OneCare is negotiating will qualify as Scale Target ACO Initiatives, and using 2019 population estimates, GMCB staff have projected that approximately 46% of Vermont All-Payer Beneficiaries and 56% of Medicare Beneficiaries could be aligned to a Scale Target ACO Initiative in 2021. While these estimates would represent a slight increase over 2020 estimates, they are below the targets set forth in the APM Agreement for 2021, the fourth performance year of the agreement. GMCB PowerPoint, 33-35 (Dec. 9, 2020); APM Agreement, 8 – 9.

30. On September 14, 2020, the State of Vermont received a warning notice from CMS that it had failed to achieve the ACO Scale Targets described in the APM Agreement for two consecutive performance years (2018 and 2019). Letter from Pierre L. Yong to Susan Barrett (Sept. 14, 2020).

31. On December 10, 2020, the State signatories to the APM Agreement responded to the warning notice and outlined strategies for improving scale performance. Letter from Philip B. Scott, Michael K. Smith, and Kevin Mullin to Pierre L. Yong (Dec. 10, 2020). CMS is currently evaluating the State's response.

Revenues

32. The following table shows the "revenues" in OneCare's proposed FY21 budget, as compared to prior budgets:

	FY18 Budget	% of Total	FY19 Budget	% of Total	FY20 Budget (Oct 1 – pre COVID)	% of Total	FY20 Budget (June 16 – post COVID)	% of Total	FY21 Budget	% of Total
Total Revenue	**639,253,005**		**898,618,967**		**1,424,634,098**		**1,255,590,792**		**1,459,027,177**	
Payer Revenues for Provider Reimbursement	599,469,290	93.8%	844,267,955	94.0%	1,362,241,283	95.6%	1,204,657,177	95.9%	1,412,335,659	96.8%
Payer Program Support (Incl. Blueprint)	17,452,793	2.7%	21,483,731	2.4%	18,999,750	1.3%	19,878,769	1.6%	20,475,699	1.4%
State Support	3,500,000	0.5%	4,250,000	0.5%	16,600,000	1.2%	11,000,000	0.9%	7,680,835	0.5%
Participation Fees (Hospital Dues)	18,459,071	2.9%	28,617,281	3.2%	24,467,227	1.7%	18,225,772	1.5%	14,935,770	1.0%
Oher (Grants & Deferred Revenue)	371,851	0.1%	-	0.0%	2,325,838	0.2%	1,829,074	0.1%	3,599,214	0.2%

GMCB PowerPoint, 22 (Dec. 9, 2020)

33. Due to the continued COVID-19 pandemic, OneCare sought to decrease hospital dues for FY21. Hospital dues for FY21 are projected to be over $9 million less than in OneCare's pre-COVID FY20 budget and approximately $3.2 million less than OneCare's revised FY20 budget. Budget Submission 31, GMCB PowerPoint, 22.

34. Informatics infrastructure support that was available in prior years ($2.8 million in the FY20 budget) will no longer be available in FY21. Budget Submission, 3, 30, App. 6.2.

35. Within the "state support" line, OneCare's FY21 budget includes $3.9 million in delivery system reform (DSR) funding. Budget Submission, App. 6.2. OneCare states that in the absence of these funds, significant budget adjustments will be required. Budget Submission, 31.

36. OneCare budgeted $861,000 in revenue related to its planned assumption of Blueprint for Health self-management programing in FY21. During the Board's review of the FY21 budget, OneCare stated that AHS was re-evaluating this initiative as part of the APM Implementation Improvement Plan. OneCare Responses to Round 2 Questions, 4 (Dec. 15, 2020).

Benchmark Trend Rates

37. A "benchmark" is a payer-specific financial target against which expenditures for ACO-aligned beneficiaries are assessed to determine whether an ACO earned savings or is responsible for losses. GMCB Rule 5.000, § 5.103(8). The APM Agreement authorizes the Board to prospectively develop the benchmark for the Medicare program, the Vermont Medicare ACO Initiative, subject to CMS approval.[5] APM Agreement, § 8.b.ii.

38. In developing its FY21 budget, OneCare assumed a 4.35% trend rate would be used in developing the 2021 benchmarks for the Medicare program, based on the Medicare USPCC. Budget Submission, 21.

39. On December 16, 2020, Board staff presented a proposed approach to developing the 2021 benchmarks for the Medicare program. Given the uncertainty brought on by the pandemic, staff recommended that the Board approve a retrospective approach that would trend historical claims experience forward to 2021 based on the statewide changes in claims between 2020 and 2021. This retrospective approach would allow CMS to incorporate protections currently being offered in other Medicare ACO programs, such as exclusion of expenditures associated with COVID-19 episodes from total cost of care calculations. *See* GMCB PowerPoint, 11 – 13 (Dec. 16, 2020). The Board approved this approach on December 23, 2020.

40. OneCare and DVHA were still negotiating the terms of the FY21 Medicaid contract, including the appropriate trend rate, when the Board voted on OneCare's FY21 budget. Due to the state of the negotiations at that time, the Board had received insufficient data to complete the Medicaid advisory rate case required by 18 V.S.A. § 9573. In 2019, approximately 15% of All-Payer TCOC under the APM Agreement was Medicaid spending. *See* GMCB PowerPoint, 9 (Dec. 2, 2020).

41. OneCare is currently negotiating with BCBSVT and MVP regarding the trend rates that will be used to develop the financial targets for the FY21 commercial programs. OneCare used trend rates supplied by the insurers in developing its FY21 budget proposal. OneCare states that,

[5] The APM Agreement grants the Board's authority to set Medicare benchmarks; the authority is distinct from ACO budget review authority which the Board has under Vermont law.

for QHP programs, the trends were derived from the Board-approved rate filings. Budget Submission, 21.

Expenses

42. The following table categorizes the expenses in OneCare's proposed FY21 budget as compared to prior budgets:

	FY18 Budget	% of Total	FY19 Budget	% of Total	FY20 Budget (Oct 1 – pre-COVID)	% of Total	FY20 Budget (June 16 – post COVID)	% of Total	FY21 Budget	% of Total
Total Expense	**639,253,005**		**895,818,967**		**1,424,634,098**		**1,255,590,792**		**1,459,027,177**	
Provider Reimbursement	599,469,289	93.8%	842,656,459	94.1%	1,362,241,283	95.6%	1,204,657,178	95.9%	1,412,335,659	96.8%
OneCare Admin Expense	12,492,660	2.0%	15,915,189	1.8%	19,276,749	1.4%	14,916,480	1.2%	16,132,547	1.1%
Population Health Investments	27,291,056	4.3%	37,247,319	4.2%	43,116,066	3.0%	36,017,134	2.9%	30,558,970	2.1%

GMCB PowerPoint, 23 (Dec. 9, 2020).

Provider Reimbursement

43. Most of the projected provider reimbursement reflected in OneCare's FY21 budget will be paid directly by payers to providers. Prospective payments, which do flow through OneCare, are projected to account for approximately 33.6% of OneCare's budgeted total cost of care in 2021 across all payers, about the same as in 2020. GMCB PowerPoint, 51 (Dec. 9, 2020).

44. Currently, Medicaid is the only payer offering truly "fixed" prospective payments where payments made to the ACO on behalf of participating providers to care for attributed patients are not later reconciled against the amounts that would have been reimbursed to those providers had they been paid under existing payment methodologies (fee-for-service). Budget Submission, 11.

45. In the Implementation Improvement Plan, AHS notes that true fixed prospective payments offer the strongest incentive for providers to engage in delivery system transformation and emphasizes the ability of such payments to increase predictability, stability, and flexibility for providers. AHS recommends accelerating the transition to fixed prospective payments across all payers by, among other things, identifying clear milestones for including such payments in contract model design. Implementation Improvement Plan, 3, 9, 12.

46. OneCare also discussed the advantages of truly capitated payments and the importance of such payments to payment reform efforts and stated that it intends to explore the possibility of implementing such a truly capitated payment model in the Medicare and commercial programs. Testimony of Vicki Loner, Tr., 135:17 – 136:1; Budget Submission, 11, 15, 19; *see also* Testimony of Tom Borys, Tr., 134:19 – 135:13 (discussing goals for evolution of the comprehensive payment reform or CPR program).

47. When Vermont hospitals submitted their FY21 budgets to the Board, on average, they expected 14.5% of their budgeted net patient revenues would come in the form of fixed prospective payments, although there was significant variation amongst hospitals. GMCB PowerPoint, 52 (Dec. 9, 2020).

Population Health Management and Payment Reform Programs

48. OneCare uses a four-quadrant model to classify its attributed population based on relative risk. Individuals who are healthy/well are in quadrant 1 (low risk). Individuals with early onset or stable chronic conditions are in quadrant 2 (medium risk). Individuals with full onset chronic illness and rising risk are in quadrant 3 (high risk). Individuals with complex and/or high-cost acute catastrophic conditions are in quadrant 4 (very high risk). Budget Submission, 42; OneCare PowerPoint, 31 (Oct. 28, 2020). While individuals in quadrants three and four comprise just 16% of OneCare's attributed population, they account for approximately 60% of total spending. *Id.*; Budget Submission, 42 – 45.

49. OneCare has developed a variety of programs to implement its care model. *See* Budget Submission, 42 – 45. The following table details OneCare's population health management (PHM) and payment reform investments in the proposed FY21 budget and previous budgets:

	2018 Actual	2019 Actual	2020 Budget*	2020 Projected	2021 Budget
PHM/Payment Reform Programs					
Basic OneCare PMPM	$ 4,040,439	$ 6,581,843	$ 8,420,662	$ 8,778,018	$ 9,694,801
Complex Care Coordination Program	$ 5,618,420	$ 9,186,729	$ 9,672,306	$ 9,672,510	$ 7,275,652
Value-Based Incentive Fund - Total	$ 4,243,973	$ 6,224,607	$ 5,640,553	$ 5,566,458	$ 2,000,000
Comprehensive Payment Reform Program	$ 715,806	$ 1,338,005	$ 1,192,196	$ 1,192,196	$ 1,200,000
Primary Prevention	$ 620,381	$ 727,627	$ 540,000	$ 540,000	$ 950,000
Specialist Program	$ -	$ 139,240	$ 754,800	$ 754,800	$ 65,777
Innovation Fund	$ -	$ 351,818	$ 725,521	$ 725,521	$ 239,320
Regional Clinical Representatives	$ -	$ 325,000	$ -	$ -	$ -
VBIF Quality Initiatives	$ -	$ 27,000	$ 33,000	$ 33,000	$ 74,000
PCMH Payments	$ 1,830,264	$ 1,865,619	$ 1,993,092	$ 1,993,092	$ 1,993,092
Community Health Team Payments	$ 2,245,852	$ 2,321,670	$ 2,440,322	$ 2,440,322	$ 2,440,322
SASH	$ 3,704,400	$ 3,834,054	$ 3,968,246	$ 3,968,246	$ 3,968,246
Primary Care Engagement Investment	$ -	$ -	$ 636,436	$ 564,194	$ 657,760
PHM Total	**$ 23,019,535**	**$ 32,923,212**	**$ 36,017,134**	**$ 36,228,358**	**$ 30,558,970**

*Revised budget

See GMCB PowerPoint, 41 (Dec. 9, 2020).

50. The Basic OneCare PMPM provides supplemental payments to the practices of attributing providers, typically primary care providers. As explained above, OneCare plans to introduce a variable component to its Basic OneCare PMPM payments in FY21. *Supra*, Findings, ¶ 11.

51. The complex care coordination program targets patients in quadrants 3 and 4 of OneCare's care model. In July 2020 OneCare shifted the program's payment model "from a capacity model to a value-based model with higher . . . payments for implementation and documentation of key coordination interventions" such as participation in a care team conference. Budget Submission, 43 – 44, 59.

52. OneCare has implemented a value-based incentive fund (VBIF) for all payer programs except Medicare. Budget Submission, 60. OneCare explained that the VBIF has been funded with hospital dues and, as attribution has grown, the impact of the VBIF on hospital dues has become significant. Testimony of Tom Borys, Tr., 81:13 – 82:2. OneCare also explained that distributions from the fund have historically been made following program settlement, which does not occur until well after the performance year ends. OneCare described this time lag as a "disincentive" for providers. Budget Submission, 60.

53. In FY21, OneCare intends to use hospital dues to pre-fund a reduced VBIF that will be distributed to network providers during the performance year in accordance with a plan established by OneCare's Population Health Strategy Committee. *See* Budget Submission, 8, 33, 55. In addition, OneCare stated that it will negotiate with payers to move some of the accountability for quality performance to settlement (i.e., quality will affect shared savings/losses). *See* Budget Submission, 33; Testimony of Tom Borys, Tr., 82:2 – 16.

54. OneCare's comprehensive payment reform (CPR) program is designed to transition independent primary care practices from fee-for-service reimbursement to a PMPM payment model and facilitate innovation within practices. *See* Budget Submission, 62. In FY21, OneCare plans to provide a $5 PMPM supplemental payment and to shift the Basic OneCare PMPM and care coordination payments outside of the CPR payment model. Budget Submission, 62; OneCare Responses to Round 2 Questions, 4 – 5 (Dec. 15, 2020). OneCare expects participation in the CPR program to grow from seven organizations with 10 practice sites in FY20 to 11 organizations with 17 practice sites in FY21. Budget Submission, 62.

55. Included in the budgeted primary prevention investments for FY21 is a transfer of Blueprint for Health self-management programs to OneCare and revisions to these programs developed by OneCare in partnership with the Blueprint and the Vermont Department of Health. Budget Submission, 61. Specifically, OneCare anticipated contracting with the Blueprint for Health in January 2021 to administer self-management programs for individuals who have or are at risk for hypertension and type 2 diabetes. However, during the Board's review, OneCare indicated that this contract may not come to fruition. Budget Submission, 9; Testimony of Sara Barry, Tr., 58:3 – 59:2. OneCare states that its initial focus would be on developing programs to support Vermonters who experience hypertension or diabetes and that it would also look at new ways to identify individuals at risk for these diseases and support early intervention. Testimony of Sara Barry, Tr. 58:3 – 59:2; Budget Submission, 33 – 34; OneCare Responses to Round 1 Questions, 24 (Nov. 9, 2020).

56. The primary prevention investments included in OneCare's proposed FY21 budget also include investments in the RiseVT program and the Developmental Understanding and Legal Collaborations for Everyone (DULCE) program, which provides interventions within a pediatric

care office setting designed to address social determinants of health in infants age zero to six months and offers social and legal support for their parents. Budget Submission, 61.

57. OneCare's FY21 budget does not include new investments in the specialist program. Despite no new investments, OneCare will fulfill prior commitments, including funding for projects related to chronic kidney disease and mental health. *See* Budget Submission, 33, 63.

58. In light of the financial circumstances of participating providers brought about by COVID-19, OneCare will not fund new innovation projects in FY21. Despite not making new investments, OneCare will fulfill prior commitments. *See* Budget Submission, 33.

59. As in past years, Board staff recommended that the Board propose an adjustment to the Medicare benchmark calculation to fund the Blueprint for Health and SASH programs in 2021. GMCB PowerPoint, 14 – 18 (Dec. 16, 2020). This benchmark adjustment allows Medicare funding to continue to be directed to these programs through the ACO. Evaluations of the Blueprint for Health and SASH programs suggest that they generate savings. *See* GMCB PowerPoint, 13 (Dec. 18, 2020); Board Meeting Materials (Oct. 14, 2020).

60. OneCare's proposed FY21 budget would level fund the Blueprint for Health Patient-Centered Medical Home (PCMH) and Community Health Team (CHT) payments, as well as the SASH program at 2020 dollar levels. Budget Submission, 34; OneCare PowerPoint, 21 (Oct. 28, 2020). The following table shows investments in the Blueprint for Health and SASH programs compared to total projected revenue and total PHM and payment reform spending over time:

	2018 Actual	**2019 Actual**	**2020 Budget***	**2020 Projected**	**2021 Budget**
Total Revenue	**$ 634,311,450**	**$ 911,202,326**	**$ 1,255,590,792**	**$ 1,184,638,872**	**$ 1,459,027,177**
Population Health Management (PHM) Total	$ 23,019,535	$ 32,923,212	$ 36,017,134	$ 36,228,358	$ 30,558,970
Blueprint (PCMH,CHT,SASH)	$ 7,780,516	$ 8,021,343	$ 8,401,660	$ 8,401,660	$ 8,401,660
(PHM LESS Blueprint)/Revenue	2.4%	2.7%	2.2%	2.3%	1.5%
PHM/Total Revenue	3.6%	3.6%	2.9%	3.1%	2.1%

*Revised budget

GMCB PowerPoint, 41 (Dec. 9, 2020).

61. While OneCare proposed funding the Blueprint for Health and SASH programs at 2020 dollar levels in FY21, OneCare assumed that the Medicare benchmark will include a 4.35% trend on this funding. OneCare states that it pursued this approach because these additional funds create asymmetric risk for hospitals participating in the Medicare program. *See* Cover Letter for OneCare Responses to Round 2 Questions, 1 – 2 (Dec. 15, 2020).

62. As part of its FY21 budget submission, OneCare described progress and opportunities for improvement on various clinical and quality improvement initiatives. For example, OneCare

stated that it met its goals of reducing acute inpatient admission and emergency department utilization rates for its high-risk and very high-risk cohorts by 5% in all programs in 2019. However, OneCare explained that it had not met its goal of reducing ambulatory sensitive condition admissions for COPD or heart failure in 2019 for the Medicare program or its goal of achieving a payer blended 15% managed care rate in 2019 (although OneCare stated that it continued its efforts into 2020 and has achieved this goal). Budget Submission, 49 – 53.

Administrative Expenses

63. The following table shows the administrative expenses in OneCare's proposed FY21 budget and in prior budgets in comparison to total revenue and PHM and payment reform investments:

Expense/Metric ***($ in millions)***	**2018 Actual**	**2019 Actual***	**2020 Projection**	**2021 Budget**
Admin	$11.7	$15.4	$14.4	$16.1
Pop Health Mgt/Pmt Reform Invest (PHM)	$23.0	$32.9	$36.2	$30.6
Total Revenue	$634.3	$911.2	$1,184.6	$1,459.0
Admin Ratio (Admin/Total Revenue)	1.8%	1.7%	1.2%	1.1%
PHM Ratio (PHM/Total Revenue)	3.6%	3.6%	3.1%	2.1%

*pre-audit estimates

GMCB PowerPoint, 67 (Dec. 9, 2020).

64. The following table breaks down the administrative expenses in OneCare's proposed FY21 budget and prior budgets

Expense (in *millions*)	**Actuals 2018**	**Actuals 2019***	**Budget 2020 (Oct 1)**	**Budget 2020 (Jun 16)**	**Projected 2020**	**Budget 2021**	**Budget 2021 % Total**
Salaries & Benefits	$6.6	$8.2	$11.8	$8.3	$8.3	$9.8	61%
Software	$-	$2.6	$3.7	$3.6	$3.5	$3.5	22%
Contract Services	$1.3	$2.2	$1.2	$1.5	$1.2	$0.9	5%
Other (incl. travel, rounding)	$3.0	$0.7	$0.7	$0.8	$0.7	$1.0	6%
Occupancy	$-	$0.4	$0.5	$0.4	$0.5	$0.5	3%
Supplies	$-	$0.3	$0.2	$0.2	$0.1	$0.3	2%
Risk Protection	$0.8	$1.0	$1.2	$0.1	$0.1	$0.1	1%
Total	**$11.7**	**$15.4**	**$19.3**	**$14.9**	**$14.4**	**$16.1**	**100%**

GMCB PowerPoint, 54 (Dec. 9, 2020).

65. OneCare overestimated the amount of the Board's billback by approximately $170,000. GMCB PowerPoint, 68 (Dec. 9, 2020); *see also* GMCB PowerPoint, 9 (Dec. 18, 2020).

66. While administrative expenses in OneCare's proposed FY21 budget are approximately $3.2 million less than in the pre-COVID FY20 budget, they are approximately $1.2 million greater than in the revised FY20 budget. This is driven in large part by an increase of $1.5 million in salaries and benefits compared to the revised FY20 budget:

#	Type	Amount $	% Increase Over Prior Year	Driver/Reason/Value of Investment
1	Net impact of vacancy reinstatements and other positional changes in 2021	$666k	8%	Reinstatements of positions and other changes necessary to fulfill the expectations set by the OneCare Board of Managers
2	Reinstatement of leadership compensation	$595k	7%	Restoration of temporary COVID-related salary and benefit reductions
3	2% Salary Increase	$209k	3%	Annual increase for continuing staff
Total	Increase over revised 2020 Budget	$1,470k	18%	

OneCare Responses to Round 2 Question (Dec. 15, 2020); GMCB PowerPoint, 7 (Dec. 18, 2020).

67. The reinstatement of leadership compensation reflects the reinstatement of temporary reductions for leadership at the level of Director and above that OneCare implemented in FY20 and does not include any back pay or salary increases. OneCare Responses to Round 2 Questions (Dec. 15, 2020).

68. When asked about the benchmarks OneCare uses in setting management compensation, OneCare responded that it targets the market median (50th percentile) rate when setting base pay for executives, and that it targets the market 65th percentile when setting total direct compensation (base pay plus variable pay) for executives. It stated that a third-party consultant is occasionally used to benchmark director level roles, but the rest are benchmarked in-house using market surveys and software which aggregates the survey data. For non-executive pay, OneCare stated that it targets the market median (50th percentile). OneCare Responses to Round 1 Questions, 9 (Nov. 9, 2020).

69. Uncertainties in OneCare's administrative budget include the availability of $3.9 million in delivery system reform (DSR) funding, as well as approximately $261,000 in administrative funding for the Blueprint for Health self-management programs. GMCB PowerPoint, 9 (Dec. 18, 2020).

Public Comments

70. The Board accept public comments on OneCare's proposed budget from October 1, 2020 through December 21, 2020. These comments are available on the Board's website.[6] The Board received 18 public comments regarding the OneCare's FY21 budget and the Board's review. Generally, the themes from public comments reflect:

- A desire for increased transparency with the public and regulators.
- Generally, a positive reaction about care navigation platform, data analytics, and support for providers in network.
- A desire for concentration on expanding health care access to all Vermonters.
- Pleasure with population health initiatives overall but a desire for an increase in funding to further the programs.
- Continuation of value-based care.
- Questions about what the disruptions from COVID-19 mean for the evaluation of the APM and OneCare's performance.
- Questions about the ability of OneCare to achieve widespread participation in the APM and criticism of its financial and quality performance, its approach to primary care, and its administrative expenses and leadership salaries.
- Support for including an inflationary factor to OneCare's SASH funding for FY21.

See GMCB PowerPoint, 17 (Dec. 9, 2020); GMCB PowerPoint, 5 (Dec. 23, 2020).

Key concerns raised by the HCA in its comments include:

- Proposed changes to the risk model to remove HSA performance accountability may reduce incentives for cost reduction and return to a focus on generating volume.
- OneCare's investments in care management may not be sufficient to bend the cost curve, nor do they provide sufficient support to highest risk patients.
- The impact of OneCare's population health investments should be clear and measurable and, at this time, there is neither an empirical nor conceptual model through which to evaluate these efforts.
- Disruptions associated with COVID-19 will have a profound impact on our ability to empirically evaluate OneCare Vermont's quality and financial performance and its impact on the All-Payer Model goals.
- Recognition of technological disruptions impeding OneCare's ability to submit timely responses throughout the Budget review process this year

Letter from the HCA Policy Team to Kevin Mullin (Dec. 2, 2020).

71. Board staff considered the public comments and HCA comments in developing their recommendations regarding OneCare's proposed FY21 budget. *See* GMCB PowerPoint, 17 (Dec. 9, 2020); GMCB PowerPoint, 5 (Dec. 23, 2020).

[6] https://gmcboard.vermont.gov/aco-oversight/2021.

CONCLUSIONS

Statutory Criteria

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

OneCare's budget is driven primarily by its benchmarks or TCOC targets, which are developed by trending past claims experience forward to estimate future expenditures for the people who will be attributed or aligned to the ACO in the performance period. In 2019, the most recent year for which data are available, OneCare's performance against these targets was mixed. *See* Findings, ¶¶ 16 – 19. OneCare also described mixed results on its internal clinical and quality improvement priorities. *See* Findings, ¶ 62.

Payers are responsible for evaluating whether OneCare is positively impacting the cost and quality of care provided to their beneficiaries or members. BCBSVT noted some concerning utilization trends within its QHP program in 2019. *See* Findings, ¶ 19. However, BCBSVT, MVP, DVHA, and CMS are expected to continue their existing programs with OneCare in 2021, indicating that they see continued promise in an ACO to deliver value for their members or beneficiaries. *See* Findings, ¶ 4.

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

OneCare's FY21 budget continues investments designed to strengthen and provide resources to primary care practices, address social determinants of health and the impacts of childhood trauma, integrate community providers, improve care coordination for patients, and reduce duplication of services in partnership with the Blueprint for Health. *See* Findings, ¶¶ 48 – 60. The total amount of money being invested in these programs is lower than in prior years due in large part to OneCare's desire to reduce hospital dues. *See* Findings, ¶¶ 33, 60. This desire is understandable in light of the strain that COVID-19 has had on hospital finances and the uncertainty it creates for FY21.

Despite a budget review process that lasted several months, OneCare's approach to funding the Blueprint for Health and SASH programs was never clearly articulated. Towards the very end of the process, we came to understand that OneCare proposed to increase payments for those Blueprint for Health practices participating in the Medicare program in 2021 but continue to pay practices not participating in the Medicare program at 2020 levels. AHS informed the Board that it supported this approach as consistent with the APM Implementation Improvement Plan. AHS stated that it would work to amend its contract with OneCare to incorporate this approach. Letter from Michael K. Smith to Kevin Mullin (Dec. 22, 2020). OneCare's approach to SASH funding was not similarly supported; OneCare failed to justify taking the additional money generated by trending 2020 funding out of the program. We will therefore require that OneCare fund this program with the inflationary factor it proposed in the budget. We will request

that the necessary funding be added to OneCare's 20201 benchmarks for the Medicare ACO Initiative.

C. The Goals and Recommendations of HRAP

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

D. Transparency of ACO's Costs

As noted in the Implementation Improvement Plan, it is important that OneCare be transparent and responsive to its payer partners and regulators, who are collectively gauging the progress of payment and delivery system reforms. At times during our review of OneCare's proposed FY21 budget we had difficulty getting clear answers to our questions. We expect this to improve going forward. With respect to the transparency of OneCare's costs, however, they are described in detail in OneCare's budget submission and this order.

E. Effects of Medicaid Reimbursement on Other Payers

OneCare's FY21 budget includes trend rates for the MVP and BCBSVT QHP programs that are based on Board-approved rate increases for 2021 QHPs. Findings, ¶ 41. These health insurance rate increases are significantly affected by the cost shift. *See* GMCB Annual Report for 2019, 27 (calculating the impact of the cost shift, as defined elsewhere in the report, on QHP rate increases to be approximately 14.7%). Thus, as we noted last year, through the cost shift, Medicaid reimbursement levels impact the benchmark rates negotiated by OneCare and commercial insurers.

The payer differential report we just issued describes a significant difference between risk-adjusted ACO benchmarks for Medicaid and other payers. The report suggests, however, that this differential reflects underlying reimbursement differentials between Medicaid and other payers and that the Medicaid benchmarking process is not exacerbating this differential. *See* Payer Differential Reporting for the OneCare ACO, Executive Summary (Dec. 31, 2020).

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

OneCare seeks to negotiate narrower risk corridors with payers for FY21. The total "downside" risk reflected in OneCare's proposed FY21 budget is just over $19 million, approximately $17.5 million less than its pre-COVID FY20 budget. Findings, ¶ 5. OneCare plans to transfer the great majority of its anticipated downside risk, just over $18 million, to network providers, primarily hospitals, although OneCare is also putting some of its supplemental PMPM payments to attributing providers at risk in FY21. Findings, ¶¶ 6, 11. OneCare does not plan to

purchase third-party risk protection for the Medicare program, as it has done in past years. Findings, ¶ 12.

The $5.6 million in reserves on OneCare's balance sheet more than covers the maximum possible downside risk carried by the ACO and will be available to the ACO to address unforeseen cash flow or business issues that may arise. *See* Findings, ¶ 15.

We impose conditions on our approval of OneCare's FY21 budget designed to ensure that OneCare's delegated risk model is implemented as described in the budget submission and that OneCare does not materially change the model without Board approval.

G. ACO's Administrative Costs

OneCare proposes FY21 administrative expenses of just over $16.1 million. This represents a 16% reduction relative to OneCare's originally approved FY20 Budget submitted on October 1, 2019, an 8% increase relative to its revised FY20 budget submitted after the onset of COVID-19 on June 16, 2020, and a 12% increase relative to its projected 2020 actuals as of Oct 1, 2020. *See* Findings, ¶ 64. OneCare stated that this level of administrative expenses will allow the organization to return to a pre-COVID level of operations, while still minimizing hospital dues. Correcting for the overstated billback expense, the administrative budget would total approximately $15.9 million. *See* Findings, ¶¶ 64 – 65. We will therefore require that OneCare's administrative expenses not exceed $15.9 million. We will also require that OneCare submit additional benchmark information on salaries and benefits, which comprise the majority of the organization's administrative expenses. *See* Findings, ¶ 64.

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

OneCare did not make major changes to its Board of Managers or executive leadership teams in FY20. *See* Findings, ¶¶ 2 – 3. Consistent with AHS's Implementation Improvement Plan, we will consider making changes to our ACO oversight rule in the coming year to require a meaningful connection between ACO executive compensation and performance measures that align with broader health reform and value-based care strategies.

I. HCA Participation and Public Comment

The Board took public comments on OneCare's proposed budget and the budget review process from October 1, 2020 through December 21, 2020. During that time, the Board received 18 public comments regarding the OneCare's FY21 budget and the Board's review. Findings, ¶ 70. The Board's staff considered these comments in their analysis and recommendations and we have reviewed and considered them as well. *See* Findings, ¶ 71.

APM Agreement

J. TCOC Growth Rates

The total cost of care per person across all payers grew 4.2% from 2017 through 2019 for services covered by the APM Agreement. GMCB PowerPoint, 10 (Dec. 2, 2020). This growth rate is above the APM Agreement's target of 3.5% but below the corrective action trigger of 4.3%. Due to COVID-19, compounding growth in expenditures from 2017 through 2020 is also expected to be within the range allowed for by the APM Agreement. GMCB PowerPoint, 10 (Dec. 2, 2020); GMCB PowerPoint, 11 (Dec. 16, 2020). On December 23, 2020, the Board voted to propose that retrospective trend factors be used to develop the 2021 benchmarks for the Medicare program. *See* Findings, ¶ 39.

At the time the Board approved OneCare's budget, OneCare was still negotiating with DVHA on the terms of the 2021 contract, including the appropriate trend rate(s). Furthermore, give the state of these negotiations, the Board had not finalized the Medicaid Advisory Rate Case required by 18 V.S.A. § 9573. Findings, ¶ 40. However, since only around 15% of (2019) All-Payer TCOC under the APM Agreement is Medicaid spending, we do not expect OneCare's Medicaid rate to have a dramatic impact the State's ability to meet its financial targets for 2021. *See* Findings, ¶ 40. We will require that OneCare ensure the Medicaid trend rates are consistent with the Board's recommendations in the Medicaid advisory rate case.

At the time the Board approved OneCare's budget, OneCare was still negotiating final trend rates with commercial payers as well. While it is not ideal to move forward with the budget without more information about the 2021 commercial contracts, this uncertainty is not new. Similar to last year, we believe the appropriate course of action is to allow OneCare and commercial payers to negotiate rates for their programs that are tied to the Board-approved rates, are actuarially sound for the attributed populations, and that align with the All-Payer TCOC target growth.

K. Scale and Program Alignment

The State is currently below the scale targets in the APM Agreement. It is therefore disappointing that OneCare does not expect to negotiate any new payer programs for FY21. *See* Findings, ¶ 4. However, given the strain that the pandemic has placed on providers' finances, it was also an achievement for the ACO to not lose ground in FY21. *See id.*

To maximize scale and the consistency of provider incentives, we will require that, to the greatest extent possible, OneCare negotiate payer programs that qualify as Scale Target ACO Initiatives and that align in key areas (e.g., attribution methodologies, quality measures, payment mechanisms, included services, etc.). We will also require that OneCare work with payer partners to establish a target for fixed prospective payment levels and a strategy for achieving those levels, including a timeline with clear goals and milestones. OneCare and AHS have discussed the benefits of fixed prospective payments and have identified the increased

availability of such payments as important to getting more providers to participate in the All-Payer ACO Model. *See* Findings, ¶¶ 45 – 46.

ORDER

Based on our Findings and Conclusions above, and pursuant to 18 V.S.A. § 9382, we hereby approve OneCare's FY21 budget on the terms, and subject to the conditions, set forth below:

1. The GMCB expects to issue reporting requirements in the coming months pursuant to GMCB Rule 5.501. Reporting may be required on network development; attribution; payer programs and their alignment; finances, including dues and administrative expenses; risk; population health programs and investments; quality; and variations in cost and quality, all of which have been the subject of reporting requirements imposed by the Board in prior budget orders. However, reporting may also be required on any other subjects or issues relating to the ACO, ACO activities, or ACO providers or participants. These reporting requirements will be in addition to information required in the Annual Budget Review Guidance and Certification Eligibility Review Form released by the GMCB each summer. Under GMCB Rule 5.501, and as a condition of this budget order, OneCare must consult with GMCB staff as needed in the development of the reporting requirements, including the development of required data templates and formats, and must completely, timely, and accurately report all data and analyses specified therein.

2. To the greatest extent possible, OneCare must design payer programs to qualify as Scale Target ACO Initiatives (as defined by the All-Payer Accountable Care Organization Model Agreement) and to reasonably align in key areas, including beneficiary alignment methodology, ACO quality measures, payment mechanisms, risk arrangements, and services included for determination of any shared losses and shared savings. For each payer program OneCare enters into that does not qualify as a Scale Target ACO Initiative, and for each program element that is not reasonably aligned across payers, OneCare must provide a detailed justification to the GMCB. OneCare must report to the GMCB on its payer programs as specified in the reporting manual.

3. OneCare must ensure that its payer contracts are consistent with the following 2021 benchmark trend rates and related conditions:
    a. Vermont Medicare ACO Initiative: the trend factors proposed by the Board and approved by CMS;
    b. Medicaid Next Generation ACO Program: the trend factors that are consistent with the Board's recommendations in the Medicaid advisory rate case.
    c. Commercial:
        i. The 2021 benchmark trend rates for commercial programs must be consistent with the ACO-attributed population and the GMCB approved rate filings, if any; and
        ii. OneCare must provide the Board with (a) actuarial certifications for each of its commercial (including self-funded) benchmarks stating that the benchmark is adequate but not excessive; (b) an explanation of how its overall rate of growth across all payers fits within the overall APM target rate of growth and,

if its overall rate of growth exceeds the APM target, how it plans to achieve the target for the term of APM Agreement (2017 to 2022); and (c) a revised budget based on the finalized benchmarks.

4. The maximum amount of risk OneCare may assume for 2021 is the sum of the following: 2% of the Medicare benchmark; 2% of the Medicaid benchmark for the traditional attribution cohort and 1% of the Medicaid benchmark for the expanded attribution cohort; and the amounts of commercial risk as described in OneCare's FY2021 budget submission. OneCare must request and receive an adjustment to its budget prior to executing a contract that would cause it to exceed these risk levels.

5. OneCare must implement the risk model that it described in its budget proposal and must request and receive approval from the Board prior to making any material changes thereto. OneCare must:
    a. Submit to the Board copies of the contracts that bind each of the risk bearing hospitals to OneCare's risk sharing policy no later than 10 days after all contracts have been executed;
    b. Notify and seek approval from the Board as early as possible of any proposed changes to the risk model and, for any proposed changes determined by Board staff to be material, provide the Board with detailed information, including effects by hospital and by founder; and
    c. Submit underlying risk model methodologies for distribution of shared savings or losses (SS/SL), including mechanics of the 10% performance incentive pool, any market factor adjustments, or any other potential adjustments to SS/SL on or before March 31, 2021.

    The Board may require OneCare to come before the Board in a public meeting to explain the details of the risk model and its impact on incentive structures to the Board on or before April 15, 2021.

6. No later than April 15, 2020, OneCare must present to the Board on the following topics:
    a. 2021 attribution and payer contracts;
    b. Revised budget, based on final attribution;
    c. Final description of population health initiatives;
    d. Expected hospital dues for 2021 by hospital;
    e. Expected hospital risk for 2021 by hospital and by payer;
    f. Any changes to the overall risk model for 2021;
    g. Source(s) of funds for OneCare's 2021 population health management programs;
    h. Any other information the Board deems relevant to ensuring compliance with this order.

7. No later than March 31, 2021, OneCare must provide GMCB staff with the supporting documentation relevant to the topics identified in Condition 6. Among the supporting documentation, OneCare must submit:
    a. Final payer contracts;
    b. Attribution by payer;

c. A revised budget, using a template provided by GMCB staff;
d. Final descriptions of OneCare's population health initiatives;
e. Hospital dues for 2021 by hospital;
f. Hospital risk for 2021 by hospital and payer;
g. Documentation of any changes to the overall risk model for 2021;
h. Source of funds for its 2021 population health management programs;
i. OneCare must quantify the proportion of the VBIF that is now operationalized at settlement, versus distributed throughout the performance year; explaining and quantifying any and all other mechanisms that tie financial incentives to quality performance;
j. OneCare's most recent strategic plan; and
k. Any other information the Board deems relevant to ensuring compliance with this order.

8. In 2021, OneCare's Administrative Expenses must not exceed $15.9 million. If OneCare does not secure Delivery System Reform funding and the Blueprint Self-Management contract in the amounts reflected in the October 1 Budget submission, then a revised administrative budget must be submitted consistent with Conditions 6 and 7. By March 31, 2021, OneCare shall submit benchmark information on salaries and benefits.

9. If OneCare uses its reserve, it must notify the Board within 15 days of such use. Notification must include the reason for drawing down the reserve and, for any use authorized under this condition, a corresponding cash flow analysis. The use of this reserve shall be limited to:
    a. Additional funding for population health investments;
    b. Financial backing for risk incurred by participating providers;
    c. Maintaining ACO-wide risk on behalf of participating providers;
    d. Temporary cash flow issues associated with payer revenue delays; and
    e. Other uses pre-approved by the Board.

10. If population health management and payment reform programs are not fully funded as detailed in OneCare's 2021 budget submission, OneCare must submit a revised proposal no later than March 31, 2021 to the Board. This should include any requests for budget revisions, for changes to OneCare programs, including any funding shortfalls, changes in program scope, and an analysis for each program line item as to whether and why the funding is appropriately scaled by attribution, or some other factor.

11. In 2021, OneCare must fund SASH in the amount of $4,140,865, equivalent to the 2020 budgeted amount of $3,968,246 plus an inflationary factor of 4.35%, contingent on the increase in funding being used to enhance programs or expand access to Medicare beneficiaries. In 2021 OneCare must fund the Blueprint for Health (PCMH and CHT) investments in the amount of $4,626,268, equivalent to the 2020 budgeted amount of $4,433,414 plus an inflationary factor of 4.35%, consistent with the medical home and community health team program payment design approved by the Agency of Human Services.

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

13. OneCare must submit its audited financial statements as soon as they are available and must submit information as required by the Board to monitor OneCare's performance. OneCare must crosswalk submitted actuals per its budget submission to audited financial statements for fiscal years 2018-2021.

14. OneCare must provide GMCB staff with a demonstration of data, analytics, and tools available to its network participants (including Care Navigator, Workbench One etc.).

15. OneCare must work with payers to propose a target for fixed prospective payment levels, a strategy for achieving those levels, and a related timeline, with clear goals, milestones, and targets.

16. The Board's Director of Health Systems Policy may adjust the dates in this order after consulting OneCare.

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

So ordered.

Dated: January 15, 2021 at Montpelier, Vermont

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

* Board Member Usifer was not present for the Board's December 23, 2020 vote approving OneCare's FY21 budget, but joins in this decision.

Pelham, dissenting

The ACO has yet to become a permanent institution and force in Vermont's health care landscape. The ACO is, as of now, still a temporary entity assigned aspirational expectations of reforming relationships among Vermont's healthcare institutions after the failure to transition to a single payer system pursuant to Act 48 of 2011. Both Vermonters and policymakers across the nation are watching carefully to see if Vermont's ACO can achieve reforms that enhance the affordability of health care while also enhancing the health and wellness of the citizens served by Vermont's healthcare institutions. I dissent from the decision of the majority not because I oppose the ACO. To the contrary, I wish the ACO success.

As noted under the "Introduction" and "Legal Framework" sections of the majority opinion above, the budget now before the Board is the ACO's fourth and the statutory factors under consideration are sweeping. Over the past three years, the mechanics of the ACO have been largely put in place, from its governance structure to methods of transitioning from fee-for-service to fixed prospective payments to an infrastructure and goals supporting population health investments. Some fine tuning is still underway, but it cannot be said that the ACO is in its infancy anymore. Yet, with three years of start-up in the rear-view mirror, there are still significant structural concerns that lack focus and effort.

FPP: Findings 43 through 47 above profile the importance and standing of the transition to fixed prospective payments (FPP). Of note is that Vermont's FY 2021 hospital budgets assigned only 14.5% of budgeted net patient revenues (NPR) to fixed prospective payments. This compares to a FY 2020 budgeted FPP level across hospitals of 14.8%. In 2020, UVMMC, a 50% owner of the ACO, budgeted 16.8% of NPR as FPPs but only 15.9% in 2021. GMCB Health System Finance Team, Fiscal Year 2020 Vermont Hospital Budget Submissions, 37 (July 31, 2019), https://gmcboard.vermont.gov/sites/gmcb/files/documents/FY%202020%20Vermont%20Hospital%20Budget%20Submissions%20-%20Preliminary%20Review%20-%20revised%208.20.19.pdf.

Given that FPPs provide "the strongest incentive for providers to engage in delivery system transformation" and are cited as significant leveraging points for improvements in population health, it is concerning that the Board must order (Condition #15) in 2021, its fourth year, the ACO to establish targets and timelines for this important and central component of Vermont's health care reform strategy.

ACA Benchmark Plan: Another example where the ACO will hopefully become more aggressive is in relation to Vermont's Essential Health Benefits Benchmark Plan. The Affordable Care Act required all non-grandfathered plans in the individual and small group markets to cover a set of 10 essential health benefits (EHB). Federal regulations define EHB based on a state-selected benchmark plan. *See* CMS, Information on Essential Health Benefits (EHB) Benchmark Plans, https://www.cms.gov/CCIIO/Resources/Data-Resources/ehb.

Vermont's Benchmark Plan on file with CMS predates the establishment of the ACO and the All-Payer Model (APM) agreement with the federal government. However, an alignment analysis between Vermont's Benchmark plan and the population health goals embedded in the

APM and the ACO's budget has yet to be conducted, even though over 24,000 Vermonters with Vermont Health Connect plans are expected to be attributed to the ACO in 2021. What is known, for example, is Vermont's plan does not cover participation in the Blueprint for Health's CDC recommended plan or any other provider sponsored diabetes prevention program. Given that diabetes treatment is expensive, and mitigation of this chronic disease is central to the population health goals of the APM and ACO, alignment around prevention among the APM, ACO and the Benchmark Plan should be a top priority. Further, given the expected 2021 premiums paid to BCBSVT and MVP for Vermont Health Connect plans are projected at $540 million and the ACO is strengthening its partnership with the Blueprint for Health's self-management programs, there may be financial efficiencies in addition to wellness benefits with improved alignment of the Benchmark Plan with ACO efforts.

The Cost-Shift Siphon: A fundamental premise of Vermont's healthcare reform effort is that the capitation of payments to providers via FPPs be a strong incentive for providers to emphasize population health over disease mitigation to generate/preserve provider income. A healthy population is less costly than a sick population, allowing providers to keep a larger share of reimbursements is the concept. However, this premise is in direct conflict with the Medicaid cost-shift when Medicaid reimbursement rates are flatlined or increased at less than background inflation over time. Assuming investments in population health and the FPP infrastructure do generate financial efficiencies and savings, the Medicaid cost-shift siphons away such value, thus diminishing or even negating provider incentive to participate or assume risk in alignment with the ACO.

For example, in its 2021 budget submission to the Legislature, DHVA states the following: "In 2021, DVHA will be level funding rates that do not have a federally mandated rule for increase such as FQHC services." DVHA Budget Considerations – State Fiscal Year 2021 Restatement, 2 (Aug. 19, 2020), https://ljfo.vermont.gov/assets/Uploads/62ff558a10/DVHA_2021-Budget-Restatement-Narrative_FINAL-08.19.20.pdf.

Given this context, the incentive is diminished for providers to align themselves with the ACO when the Medicaid portion of the FPP is nominally stagnant and effectively regressive. If the ACO is going to proceed by continuing the practice of embedding the Medicaid cost-shift in the rates of commercial participants, the principles underpinning the concept of FPPs will be severely compromised. The ACO, and the GMCB, need to address and unwind the cost-shift deliberately and incrementally in the name of affordability and transparency and to keep faith with providers and rate payers who align themselves with the ACO.

Fiscal years 2021 and 2022 will prove important relative to the ACO demonstrating effectiveness as the catalyst bringing greater affordability and improved population health to Vermonters. By the end of 2022, the ACO will have existed for 5 years, thus allowing enough time for Vermonters to experience through and with their providers improvements in wellness and the stabilization of health care costs as FPPs supplant the current fee-for-service system. Some say that the ACO is a "coalition of the willing" and I applaud those who have actively embraced the challenges confronting the ACO. But I fear the 2021 ACO budget as proposed is too reflective of the status quo in important areas like FPP participation, alignment with QHP benefit plans, and

mitigation of the cost-shift, among others. Should such be true, the ACO likely cannot demonstrate to Vermonters by 2022 that the ACO is an effective agent of change relative to Vermont's healthcare system. My dissent is to encourage the ACO to adopt a more aggressive posture over the 2021 and 2022 period.

Filed: January 15, 2021

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

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