VERMONT

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Vermont All-Payer ACO Model and GMCB ACO Oversight
Frequently Asked Questions

Background Questions

1. What is Vermont's All-Payer Accountable Care Organization Model Agreement and what is OneCare's role in the Agreement?

The All-Payer Accountable Care Organization Model Agreement (sometimes referred to as the All-Payer Model, APM, the "Model", or the "Agreement") is a five year (2018-2022) agreement between Vermont and the federal government that allows the three major health care payers—Medicare, Medicaid, and commercial insurance—to pay for the value of care over the volume of care. The goal of the APM is to shift Vermont's health care system from a fee-for-service payment model to one that uses fixed payments to support a given population while improving health outcomes for Vermonters and limiting the health care cost growth to historic state economic growth. New payment models change incentives to reward improved provider communication and patient outcomes to improve the lives of Vermonters.

OneCare Vermont Accountable Care Organization (OneCare) is the vehicle used to implement the All-Payer Model. OneCare is a voluntary network of health care and social services providers that have joined together to be accountable for the health of a population and work toward the goals of the APM. OneCare network providers work together to improve health for Vermonters by providing the right care, at the right place, at the right time. OneCare is also the mechanism that allows population-based payments to be made to providers through contracts with all payers.

OneCare works to improve care and reduce cost through:

1) *Care coordination.* OneCare supports improved communication among health care and social service providers who are caring for the sickest or most at-risk patients. Care coordination is shown to improve patient outcomes for the highest risk patients.

2) *Information.* OneCare provides data analytics on care delivery patterns and patient outcomes. OneCare shares data with health care providers who then use the information to improve care and invest in population health programs to address patient and community needs.

3) *Innovation*. OneCare supports innovative pilot projects that are developed in communities and can be scaled more broadly if shown to be successful.

4) *Investment dollars*. Hospital participation fees and state funding make up the investment dollars that support the programs available to participating providers. Investment dollars, which are focused on primary care, care coordination, and prevention, are distributed to providers within the network to best care for patients. This results in a shift of dollars from hospitals to community providers.

Sources:
Vermont All-Payer ACO Model. Centers for Medicare & Medicaid Services (CMS).

Report to the Legislature: Evaluation of Social Service Integration with Accountable Care Organizations. Green Mountain Care Board. December 2019.

Vermont All-Payer Model Agreement. Signed October 2016.

2. What is an Accountable Care Organization? Is it related to the Affordable Care Act?

An Accountable Care Organization (ACO) is a group of health care providers that agree to be accountable for the care and cost of a defined population of patients. The Affordable Care Act (ACA) included incentives for creating Medicare ACOs because the ACO model was identified as a promising way to reduce the ever-rising cost of health care nationwide.

Sources:

Kaiser Health News. "Accountable Care Organizations, Explained." 2015.

3. What does the All-Payer Model and OneCare ACO do for Vermonters?

Hospitals and surrounding communities are shifting resources toward investments known to improve overall health such as primary care, lifestyle medicine, health education and prevention, mental health counseling, and nutrition. The APM benefits Vermonters by providing incentives to increase access to primary care and social services, improve access to services not always covered by insurance, and promote efficiency across the system. Under the APM, Vermonters continue their health insurance coverage and benefits as provided under their plan. Neither the APM nor the ACO limit the benefits or provider choice available under patients' insurance plans. Payer and provider participation in the APM through the ACO may enhance the benefits of insurance plans in some cases. As population health initiatives are funded by the ACO, Vermonters receive greater access to programs they can benefit from, such as care coordination and telehealth.

The APM seeks to limit the rate of growth in health care costs (measured over the five-year Agreement from 2018-2022), as well as increase access to services that address primary and preventive care. If successful, Vermonters should see a moderation in the growth of health care premiums and taxes that fund health insurance; however, this will take time and is hard to measure due to differences in population, covered services, and providers. The most vulnerable populations should see increased care coordination and better access to social services. Vermonters should see an increase in services known to improve overall health, such as preventive care, and services that address social determinants of health.

The All-Payer ACO Model is built on Vermont's existing health care delivery foundation and its success depends on collaboration among the full delivery system to achieve the statewide population health goals, not just ACO efforts alone. The ACO works with state agencies, the Blueprint for Health, hospitals, primary care and specialty providers, community and social service providers, mental health, home health, housing, and others to achieve the goals of the model.

It is important to remember that improvements in population health take time and are not simple to measure. Improvements will also take scale, meaning more patients included in the model. Providers are more likely to alter investments and change behavior when the majority of their reimbursements are driven by value, not volume. It will take time to add more patients to the model and to shift more payments away from fee-for-service. The All-Payer Model involves long term investments in improving health and it will take years before researchers can assess the impact of the APM on population health outcomes in any statistically meaningful way.

Sources:
ReThink Health. "The Sense--and Nonsense--of using ROI in Population Health." 2017.

4. Why did Vermont decide to pursue the All-Payer Model? Who decided Vermont should pursue it? How were Vermonters informed?

The Vermont health care system and State government have been working for years to lay the foundation for statewide payment reform. The APM and ACO pick up on successful reform efforts that Vermont has adopted and expanded since the early 2000s, through several administrations and legislative sessions (see "A Brief History of Health Care Reform"). The Blueprint for Health was created by legislation in 2006 and expanded statewide in 2013. The Blueprint builds a strong foundation upon the Patient Centered Medical Home (PCMH) model with an important focus on complex care coordination. From 2013-2017, the federal government awarded Vermont a $45 million dollar State Innovation Model (SIM) grant to develop value-based payments for Vermont providers, assist

providers with their readiness for practice transformation under new payment models, including health data infrastructure, and provide evaluation of investments and policy decisions.

SIM tested an early ACO payment model known as the Shared Savings Program, and without waiting for results of the formal evaluation, there were indicators that this payment model was not a strong enough incentive for change. These efforts put the building blocks in place for the federal government to consider entering into the All-Payer ACO Model Agreement with Vermont, shifting to a two-sided risk model and fixed prospective payments. The Agreement was negotiated from 2015-2016. During this time, the GMCB held at least 16 public Board meetings to discuss the details of the proposed Agreement. The GMCB also participated in public informational meetings held around the state in partnership with the administration to present details of the proposal and answer questions from the public. The Vermont Legislature took testimony and debated implementation of the APM and oversight of ACO's in Vermont, passing Act 113 of 2016, "An act related to implementing an all-payer model and oversight of accountable care organizations."

The Vermont All-Payer ACO Model Agreement was signed in October 2016 by the federal government and Vermont's three Agreement partners: the Governor, the Secretary of the Agency of Human Services, and the Green Mountain Care Board.

Sources:
Carbee, J; Langweil, N. Vermont: A Brief History of Health Care Reform. 2019.

The Commonwealth Fund. Vermont's Bold Experiment in Community-Driven Health Care Reform. 2018.

5. What is the role of the Green Mountain Care Board and other State agencies in the APM and in overseeing OneCare?

Under Vermont law, the GMCB is given rulemaking and oversight authority over Vermont ACOs through two key processes: 1) certification and 2) budget review. See 18 V.S.A. § 9382 and GMCB Rule 5.000. The certification process ensures appropriate governance, policies, and procedures necessary to operate an ACO. Budget review and approval provides oversight over ACO revenues, expenses, and risk mitigation. In addition, the GMCB is one of three State signatories of the Vermont All-Payer ACO Model Agreement, along with the Governor and the Secretary of the Agency of Human Services (AHS). The GMCB's responsibilities under the APM Agreement include Medicare ACO growth rate setting and reporting to the federal Center for Medicare and Medicaid Innovation (CMMI). The Vermont Agency of Human Services is a partner in the APM Agreement and carries out its responsibilities through the Department of Vermont Health Access (DVHA) and the Vermont Department of Health (VDH). DVHA oversees the Vermont Medicaid Next Generation ACO Program contract with OneCare and associated reporting to CMMI. AHS, with VDH and the GMCB is responsible to develop a plan "that provides an accountability framework to the public health system to ensure that any Vermont ACO funding allocated to community health services is being used towards achieving the Statewide Health Outcomes and Quality of Care Targets" in Year 3 of the Agreement (see the VT All-Payer ACO Model Agreement).

6. Do any other states have models like Vermont's All-Payer ACO Model Agreement?

According to an article published in the journal *Health Affairs* in 2019, there were 995 active ACOs nationwide, with 1,588 contracts with public and private insurers, and including 44 million assigned beneficiaries. The ACO model of payment reform is not unique to Vermont!

However, Vermont's innovative All-Payer Model Agreement is unique to Vermont, although Maryland's All-Payer Model and Pennsylvania's Rural Health Model share some similarities. There is growing interest among other states to pursue alternative payment structures and many look to Vermont, Maryland, and Pennsylvania as possible frameworks upon which to build their own models. The goals of Maryland's model are like Vermont's APM goals—both models aim to improve the quality of health care and reduce the total cost of care. In addition to the APM, Maryland has transitioned from fee-for-service rate setting to hospital global budgeting. Pennsylvania's Rural Health Model aims to achieve savings by capping the total Medicare expenditures per beneficiary. The idea of these models is to maintain and improve health care access and quality, while reducing costs for patients and payers.

Sources:
Muhlstein D, Bleser WK, Saunders RS, Richards R, Singletary E, McClellan MB. "Spread of ACOs and Value-Based Payment Models in 2019." *Health Affairs* Blog. October 21, 2019.

States the Reported Accountable Care Organizations in Place (SFY2015-SFY2015). Kaiser Family Foundation. 2019.

State 'Accountable Care' Activity Map. National Academy for State Health Policy. 2019.

Maryland All-Payer Model. Centers for Medicare & Medicaid Services.

Pennsylvania Rural Health Model. Centers for Medicare & Medicaid Services.

7. Where is the federal government going with payment reform?

In 2011, the Center for Medicare and Medicaid Innovation (CMMI), part of the federal Centers for Medicare and Medicaid Services (CMS), was created to begin testing models to reduce the cost of health care. Under both the Obama and Trump administrations, the federal government has continued to move away from fee-for-service health care payment, and toward increased provider accountability for cost and quality of care. CMS Administrator Seema Verma stated in September 2019 that "in order to deliver lower cost higher quality care, we must move past the status quo, and past a fee-for-service payments to a system in which we're paying providers to keep people healthy, reduce costs and deliver better outcomes."

Sources:
What are value-based programs? CMS.gov.

Remarks by Administrator Seema Verma at the American Hospital Association Regional Policy Board Meeting. September 10, 2019.

8. Is Vermont health care spending projected to exceed the 3.5% growth target under the All-Payer Model? What happens if Vermont exceeds the target?

Vermont's All-Payer Model Agreement aims to align health care cost growth with the growth of the Vermont economy. Based on historical growth rates, the APM Agreement targets 3.5% growth for a subset of the state's health care costs over the term of the Agreement, but allows for growth up to 4.3%. It is too soon to tell how Vermont will perform relative to this five-year target, however in FY18, the first performance year of the model, Vermont's all payer model growth reached 4.1%, and while this exceeds the 3.5% target, it is still below the 4.3% limit. The GMCB sets the annual Medicare growth rate with this five-year target in mind, taking into consideration performance to date and a range of possible growth trajectories. If Vermont were to exceed the 4.3% growth in the future, the federal government and Vermont may assess the model to see if there are changes or improvements to promote cost containment if appropriate. There are no penalties associated with missing the target.

Sources:
GMCB Staff Presentation on FY2018 Total Cost of Care Results.

9. How do we know if the All-Payer Model (APM) is working? How do we know if the ACO is implementing the APM as intended?

It is important to remember that performance of the All-Payer Model and the ACO are not mutually exclusive. The APM agreement outlines a number of cost and quality targets for which the *state* is responsible. Success of the APM is measured statewide and tests whether an ACO model combined with other state action can have positive impact on the broader population. ACO success is tied to whether the programs the ACO is offering to providers has a positive impact on the patients for which they are accountable. The ACO is regulated by the GMCB in a way that propels the ACO program to align with the APM agreement but is accountable to cost and quality targets via their *payer contracts*. The GMCB reviews these contracts and the terms therein to ensure alignment across payers.

A formal independent evaluation of the APM is required by federal law and will include an analysis of the state's five-year performance on the total cost of care, quality, and scale. To conduct this evaluation, the Center for Medicare and Medicaid Innovation (CMMI) is contracting with the non-partisan research organization NORC at

the University of Chicago. Unfortunately, due to data availability, the final results of this evaluation will not be available in time to inform further implementation of the APM nor the development of a potential subsequent agreement ("APM 2.0"); final results are expected in Spring 2023. GMCB intends to leverage any relevant findings from reports on the model's early performance years (e.g. 2018 and 2019 which are expected to be available in late 2020) to inform APM 2.0, if possible.

There is no formal state-funded evaluation of the APM of this caliber, but if one were to be initiated, it would suffer from the same data lag as the federal evaluation. However, despite data availability and resource constraints, the GMCB is continually assessing APM successes and challenges through a number of pre-designed mechanisms:

- APM Reports to CMMI on scale, quality, and cost (posted to GMCB website):
  - Annual Scale Target Report (2018 results released in July 2019)
  - Annual Statewide Health Outcomes and Quality of Care (Expected Release Late March 2020)
  - Annual All-Payer and Medicare Total Cost of Care (2018 results released February 2020)
  - Other upcoming reports include (1) payer differential and (2) Integration of Mental Health, Substance Use Disorder, and Long-Term Services and Supports
- Payer-specific evaluations (e.g. 2018 contractual results presented to GMCB in November 2019)
- Qualitative stakeholder input (e.g. findings from a 2019 provider survey to identify barriers to model participation)

Though the complete federal APM evaluation results will not be available for some time, there are some promising signs of delivery system reform: hospitals are increasing their investments in primary prevention and the social determinants of health; traditionally siloed providers are finding new ways to coordinate care and reduce duplication of services across the care continuum; and advances in data analytics are helping to reduce unnecessary spending and identify high risk patients who would benefit most from early intervention and complex care coordination. While delivery system reform is by no means complete, we recognize that major transformation requires patience and time and the reallocation of resources towards population health is reassuring.

In addition to delivery system transformation, the APM brought additional flexibility to Vermont providers through Medicare waivers. For example, through a telehealth waiver included in the APM Agreement, the Support and Services at Home (SASH) program was able to provide Medicare recipients with access to primary care visits through an on-site telehealth facility, reducing transportation challenges for elderly residents. At its budget hearing this August, Porter Hospital in Middlebury described using the "three-day stay Skilled Nursing Facility (SNF) waiver" to allow Medicare beneficiaries to access rehabilitation services at skilled nursing facilities without a previous three-day hospital stay. From May 2018 to May 2019 this waiver resulted in 48 patient transfers which resulted in $907,299 of savings to the system (see UVM Health Network FY2020 Budget presentation).

Early data suggest that the All-Payer Model cohort (lives attributed to OneCare under the All-Payer Model) has exhibited positive shifts related to appropriate network utilization. For example, in its 2020 budget hearing, OneCare noted that it has seen a 33% reduction in emergency department (ED) utilization among care managed Medicare patients and a 13% reduction in ED utilization among care managed Medicaid patients.

For the purposes of the All-Payer ACO Model Agreement, quality will be evaluated through 20 measures, each with specific targets and tied to three population health goals:

1. Improve access to primary care
2. Reduce deaths due to suicide and drug overdose
3. Reduce prevalence and morbidity of chronic disease

The Agreement also has Total Cost of Care targets, which are designed to ensure that Vermont achieves cost savings from the All-Payer ACO Model, both for Medicare and for the State of Vermont as a whole. All-Payer Model Total Cost of Care differs from other measures of health system cost such as ACO spending per beneficiary, total Vermont health care expenditures, and hospital net patient revenue; it is limited to a specific population and set of services and excludes costs like most pharmaceuticals, most mental health spending, and more. Cost data and denominator totals are derived from VHCURES, Vermont's All-Payer Claims Database.

At this point in time we only have one year of data (2018) for APM performance and are not able to make any inferences regarding trend for either cost or quality. The only ACO-payer program able to report quality results for more than one year is the Medicaid Next Generation program, which had a pilot year in 2017. Even with similar quality measures, it is not possible to make statistically sound year-over-year comparisons of quality performance at this time given the change in program population. In 2018, the Medicaid scale population was 75,711 adding more than 33,000 lives over the previous year.

For other payer programs (Commercial and Medicare), 2018 was the first year of the Next Generation Multi-Payer ACO Initiative and will serve as the starting point for any trend analyses. Though scale is anticipated to grow in each of these programs, this new starting point allows for a more accurate comparison through the remaining years of the APM agreement, especially within the ACO population.

With limited results, we do not know whether the results we are seeing are from the addition of sicker (or healthier) individuals to the population, or because of an intervention OneCare is performing. Once the model reaches scale, or the attributed populations stabilize, we will be better able to control for population dynamics. At that point in time, value of the ACO is most aptly judged not by Vermont's performance on its statewide targets as set forth in the APM, for which there are multiple responsible stakeholders and potential external drivers, but by cost and quality performance in- and out- of the ACO, and particularly whether or not the ACO attributed population is experiencing a positive impact, after adjusting for risk.

GMCB will continue to monitor APM and ACO performance as data become available, and once trend data are established, and populations become more stable, will be able to dig into results to perform more robust analyses.

10. What are Scale Targets?

ACO scale is the percentage of Vermonters who are included in the Model. Inclusion in the model means that the patient's provider and insurance program choose to participate in the ACO. Inclusion in the model does not change any of the benefits of a patient's insurance plan or a patient's choice of doctor or medical provider. The All-Payer ACO Model Agreement includes All-Payer and Medicare scale targets for each year. ACO Scale Targets are designed to ensure that a critical mass of Vermont's population is engaged in the All-Payer ACO Model – as such, providers can change their care delivery and business models to support value, not volume.

Scale Targets	PY1 (2018)	PY2 (2019)	PY3 (2020)	PY4 (2021)	PY5 (2022)
All-Payer Scale Target	36%	50%	58%	62%	70%
Medicare Scale Target	60%	75%	79%	83%	90%

	Scale Progress (Prospective Attribution)								
	2018			2019			2020		
	APM Population (Final)	Population In Scale Target Initiatives (Final)	Scale Performance (Target)	APM Population (Estimated)	Population In Scale Target Initiatives (Final)	Scale Performance (Target)	APM Population (Estimated)	Population In Scale Target Initiatives (Final & Estimated)	Scale Performance (Target)
Medicare	**115,029**	**39,702**	**36% (60%)**	**~113,272**	**54,210**	**48% (75%)**	**~117,356***	**53,842***	**~46% (79%)**
Medicaid	136,407	42,342		~135,879	75,711		~129,495**	114,335**	
Commercial Self-Funded	182,151	9,874		~166,996	10,111		~171,795***	~66,387***	
Commercial Fully Insured	105,473	20,838		~92,978	20,074		~88,083***	~35,842***	
Commercial Medicare Advantage	11,749	0		~12,693	0		~16,463****	0****	
All-Payer Total	**550,809**	**112,756**	**20% (35%)**	**~521,818**	**160,106**	**31% (50%)**	**~523,722**	**~250,292**	**~48% (58%)**

*Medicare numerators are final through 2020, but the 2020 denominator will continue to fluctuate throughout the year and are estimated at 90% of "Original Medicare" Vermont 2019: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Dashboard/Medicare-Enrollment/Enrollment%20Dashboard.html
**Medicaid numerators are final and based on October 1, 2019 eligibility
***Commercial programs do not run attribution until March/April – estimates included here are from OneCare's 2020 budget submission
****Estimated Medicare Advantage denominators come from same CMS enrollment dashboard as above and are estimated at 90% of "MA&OTHER" for Vermont in 2019: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Dashboard/Medicare-Enrollment/Enrollment%20Dashboard.html

FY20 OneCare Budget Questions

11. Who controls OneCare?

OneCare Vermont Accountable Care Organization, LLC (OneCare) is a group of health care providers who came together to take accountability for the cost and quality of health care for their patients ("attributed lives"). OneCare is a limited liability company but is seeking non-profit federal tax status.

OneCare is managed by a Board of up to 21 managers. At least 75% of the managers must be participating or preferred providers and to ensure representation of the ACO's provider network, this requires board member representation from federally qualified health centers, various hospital types, independent providers, mental health/substance use disorder providers, and long-term services and supports providers. Three members of the board must also consist of program beneficiaries (patients).

Sources:
OneCare Operating Agreement and leadership and governance documents submitted to the GMCB with certification materials. OneCare leadership information available on their website.

12. OneCare proposed a $1.42 billion dollar budget for FY20, a 59% increase in total revenue over its FY19 projected budget of $899 million. OneCare seems like just another layer of administrative expense. What value do Vermonters get for the cost of administering the program? Will this mean a huge increase in costs to consumers and the State?

Most of OneCare's proposed FY20 budget represents spending that already exists in our health care system, with 95% of OneCare's overall budget reflecting payments made directly to providers for health care services – now just having the option to be paid differently. The increase in revenue is almost entirely explained by the increase in patients that OneCare has added to its network in the past year. Growth in the number of patients attributed to OneCare is key to the success of the Model. As more providers agree to be accountable for the cost and quality of care for more patients, we will see greater investment in the cost-effective services that improve population health. In 2019, OneCare assumed the responsibility of paying for the care of approximately 160,000 Vermonters. In 2020, OneCare's proposed budget assumes responsibility for paying for the care of approximately 250,000 Vermonters. As the number of patients grows, so will the OneCare budget.

Reform is not possible without investment in transformative change. The ACO allows for this investment to be centralized rather than duplicated for each provider. The administrative budget of OneCare is $19.3 million, or 1.4% of OneCare's 2020 proposed budget. Through this administrative budget, OneCare provides information and communication tools to help health care providers to identify and better serve our most vulnerable Vermonters. OneCare also supports innovative programs that can be scaled across communities. The APM, through OneCare, also opens up funding that comes through the federal government that would not otherwise be available, such as funding for Blueprint and SASH, two proven programs. If OneCare did not exist, the administrative work they perform would be duplicated across the system as an administrative burden to our providers, because each hospital and provider's office would have to do the data and analytical work.

Sources:
OneCare salary information is available on the GMCB website.

For information on OneCare's operating budget and administrative spending, see October 30, 2019, OneCare presentation to GMCB, pgs. 21-25.

13. How is OneCare accountable to taxpayers for handling public money (Medicare, Medicaid) that is passed through to providers?

There are three layers of accountability built into the APM and Vermont's ACO programs:

1. *The ACO's contracts with payers*. OneCare is accountable for Medicaid dollars through its contract with the state Medicaid agency, the Department of Vermont Health Access. OneCare is accountable for Medicare dollars through its contract with the federal Centers for Medicare and Medicaid Services (CMS). OneCare's contracts with payers also tie funding to quality performance through quality measures included in each contract which are largely aligned with the All-Payer ACO Model Agreement.
2. *Vermont's All-Payer ACO Model Agreement with CMS*. OneCare is also accountable for cost and quality targets through Vermont's All-Payer ACO Model Agreement with CMS, which is monitored by both CMS and the GMCB and holds the state accountable for cost and quality targets.
3. *GMCB's oversight of ACOs*. Includes ACO certification and budget review, enacted by the Vermont Legislature in Act 113 of 2016 (18 VSA Sec. 9382).

14. How does OneCare's budget allow the organization to invest in population health and community investments that improve the lives and health of Vermonters, i.e. where does the money come from for these investments and how does it get spent? How does OneCare monitor and evaluate its spending on population health and community investments?

OneCare's population health investments are from three main funding sources: a) payer contracts and hospitals dues, which go toward quality and financial incentives or projects that payers have an interest in funding, b) Medicare funding to continue the Medicare portion of the Blueprint for Health programs, and c) hospital funding for testing innovative projects. The Medicare funding is distributed, according to a contract with the Blueprint for Health, by the ACO on a quarterly basis to providers who the Blueprint states should receive the funding. The remaining dollars are allocated for primary care capacity payments, care coordination, quality performance, and competitive grants and special projects for care transformation and delivery of services otherwise not paid for by fee-for-service to existing primary care and community providers, designated mental health agencies, area agencies on aging, and home health providers. In 2018, $21 million dollars were distributed and in 2019 an expected $37 million is expected to be distributed. Final dollar amounts spent are based on final attribution and engagement in care coordination activities.

For any grant administered, the recipient has monitoring requirements. OneCare will be reporting to the Board in 2020 an analysis of how to scale population health programs that are successful, sunset those that are not, and report on opportunities for sustainability. The plan must include the identity of each entity receiving funding, the funding amount, any evidence supporting the purpose(s) of the corresponding project, a distribution plan for the funding, the scope of project, relevant timeframe(s) for implementation and evaluation, any measurable outcomes, and any risks, issues, or challenges. This work plan may exclude the Blueprint for Health investments (SASH, CHT, and PCMH). For competitive grants, OneCare should provide an explanation of the criteria by which it evaluates proposals for funding.