FY2021 Budget and Certification
Responses to Round 1 Questions from
Green Mountain Care Board and Health Care Advocate

Index

OneCare Vermont

GMCB Questions for FY21 Budget

Section 1: ACO Information and Background/Executive Summary

1. **The executive summary states OneCare "has expanded attribution by approximately 28,000 lives" and that "in total, OneCare anticipates 238,467 scale target qualifying attributable lives in 2021." However, attribution presented in the Excel workbook does not align with these estimates. Average attribution presented in tables 4.4, 4.5, 5.1, 5.2 is 226,432 lives (difference of 12,035).**
    a. **Explain the discrepancy between the summary and the data tables for 2021 projected lives.**

       Response pending.

    b. **GMCB most recent scale data projects 223,158 lives for 2020, this is a difference of 15,309 lives between 2020 and projected 2021. Explain how you arrive at 28,000 additional lives for 2021.**

       Response pending.

    c. **The tables report BCBSVT attributed lives as either "QHP" or "Primary." It is our understanding from the 2020 BCBS contract that the Primary program consists of several groups, not all scale target qualifying. Please break out the attributed lives by group using the table template provided below.**

       Response pending.

    d. **Explain any programs for 2021 that are not scale target qualifying. What is the benefit to the ACO and to the payer or providers for programs that are not scale target qualifying?**

       BCBSVT Primary is the only program that includes a non-scale component due to some employer groups opting out of the BCBSVT model that holds providers accountable for cost and quality. OneCare intends to maintain the non-scale component as a transition strategy into the accountability model in future years.

e. **Fill out the table below for questions 1.b. and 1.c. to show the number of lives by payer program from 2018 to 2021. Please include brief footnotes to describe the population of each program.**

Payer Program	Final Attributed Lives 2018	Final Attributed Lives 2019	Attributed Lives 2020	Estimated Attributed Lives 2021	Scale Target Qualifying?
Medicare					
Medicaid Trad.					
Medicaid Expand.					
BCBSVT QHP					
BCBSVT LG					
BCBSVT SF					
BCBSVT ASO only					
MVP QHP					

Response pending.

Section 2: ACO Provider Network

2. **In Appendix 2.1 Provider Network, explain your footnote, why are projections not available at the organization level?**

   To develop the 2021 budget, OneCare estimates aggregate attribution at the payer program level as well as an HSA-level breakdown. Estimates down to the provider level are generally not produced because OneCare possesses no specific information other than historical figures to generate an informed estimate. Organizational attribution is determined during the first quarter of 2021 when attribution data and historical claims files are received from payers.

3. **Describe the amendments made to the provider agreement after the negotiations between OneCare and HealthFirst, as documented in the letter to Chair Mullin dated 9/10/20. Reference "Table 2: Primary Care Program Incentives" from your budget submission to describe these changes. Can these practices still get up to $4.75 PMPM? To be eligible, do they need to prove economic stress as indicated in the letter?**

   In the first quarter of 2021, OneCare plans to provide a contract amendment to independent primary care practices whom requested this opportunity through our fall contracting process. This amendment is necessary because the change occurred in the final two days of OneCare's contracting cycle. Through execution of the amendment, practices will attest to experiencing

economic stress during the pandemic; no further substantiation is anticipated. The amendment will allow organizations the option to receive $3.25 per member per month (PMPM) payment for attributed lives, with the understanding that $1.50 PMPM will be subject to recoupment if programmatic shared savings are not earned. Organizations remain eligible to receive the full $4.75 PMPM based on performance. If the ACO does not meet its performance goals, primary care organizations will be required to pay back the balance owed, up to $1.50 PMPM. OneCare revised its Population Health Management Payments policy to reflect this agreement in its October Board cycle. This will be supplied to the GMCB with other policy updates.

4. **Table 1: 2021 ACO Network Participation indicates a loss of provider organizations from 2020 to 2021, specifically independent primary care, specialist, and continuum of care providers. Please explain why these providers are leaving the network. Address the following:**
    a. **For example, the table indicates the network dropped from 29 to 25 independent primary care practices, are these the practices that signed the letter with HealthFirst indicating they would pull out of the network? Did the agreement indicated in the follow-up letter from HealthFirst and OneCare result in retaining these providers or bringing other providers in?**
    b. **Do you conduct exit interviews or provider surveys to better understand provider experience with the ACO and to understand why providers join, leave, or decline participation?**

    In 2021, OneCare projects an overall growth in participation and attribution. For primary care, most organizations chose to remain engaged with OneCare; however, four independent practices, two of which were affiliated with HealthFirst, elected not to participate. While OneCare recognizes the value that specialists contribute to reform efforts, the foundation of our model is on primary care and the 2021 budget does not include new specialty fund investments or specific programs for specialists. This may have dissuaded some specialists from ongoing participation. In terms of the continuum of care, some organizations were acquired by another organization already in the OneCare network, thus the total count decreased. OneCare appreciates the importance of understanding the provider experience and feedback is gathered on an ongoing basis through the governance process and through individual dialog with providers, organizations, and association leaders that represent providers.

5. **In the "eligibility" column of Table 2: 2021 Primary Care Program Incentive, indicate which provider types are eligible to receive these payments (e.g. hospital-based or independent primary care, FQHCs, or other provider types).**

    Table 2 demonstrates the 2021 program incentives available to all primary care (e.g. hospital-based primary care, independent primary care, and FQHCs). The only exception is the CPR program that is offered only to independent primary care.

6. **Why do variable payment programs make sense in early stream services (i.e. primary care/prevention) if the theory of change supposes that we must maximize prevention and primary care to prevent downstream chronic care? Provide tangible examples/scenarios of the modeling OneCare does to help inform participation by provider organizations.**

    OneCare's population health management investment strategy for 2021 went through OneCare's population health and financial governance committees, with ultimate approval by our Provider and Consumer Representative Board of Managers. The supplemental payments, which are above and beyond their payer revenues, is meant to broaden accountability and provide for additional

financial opportunity when the ACO systems goals around financial targets and improvements in prevention and chronic disease management are met. By example, OneCare provides financial modeling data for all potential independent primary care practices that indicated interested in possibly joining the CPR program for the next contract year. These data are reviewed via consultative discussions with financial leaders from the interested practice and OneCare.

7. **What are the areas of opportunity for expanding primary care participation in the ACO network?**

   OneCare's 2021 network development strategy focuses on retaining primary care, while ensuring primary care providers are ready and willing to engage in the accountability of the care delivery and payment reforms. Several incentives are offered to strengthen, recruit, expand capacity and reduce administrative burden of primary care. OneCare's Population Health Investments provide direct funding streams to increase capacity and strengthen patient access to primary care. Investments in primary care further aim to improve population health management, increase the utilization of available data provided by OneCare, and drive continuous quality improvement efforts to advance patient outcomes and experience of care.

Section 3: ACO Payer Program

8. **Section 3, Question 2 states hospitals "use their own financial management methodology to distribute payments within their organization." How does this apply to primary care program payments described in Table 2 of the budget submission? How do the primary care incentives work if it is up to a hospital to determine what to do with the payment?**

   The population health management payments made to providers come with expectations set in provider contracts and in reference to OneCare's Board approved policies. While OneCare does not have the ability to control any participant's accounting or financial management decisions, it is expected that the participant fulfill those expectations.

9. **Why don't we see more fixed payment programs from our commercial payers? Has OneCare discussed a fixed prospective payment pilot with MVP? Why or why not?**

   OneCare continues to work with contracted commercial insurers on fixed payment models and with our participant network to address operational challenges to this transition. The challenge is to create a model that is agreeable to both the insurer and the providers accepting the fixed payment downstream. As with Medicare, reconciled fixed payments are a particular concern for providers transitioning to value-based care arrangements. The concept of fixed payment has been discussed with all commercial insurers with whom OneCare is currently contracted, but the specifics of any 2021 offerings remain a topic of negotiation.

Section 4: Total Cost of Care

10. **Projected total cost of care appears to have increased at approximately twice the rate as attribution, year over year. Is this expansion associated with the attribution of a higher- risk/higher-cost population? If so, where do you see opportunity for savings/efficiencies?**

    As a general theme, there has been a modest increase in the risk of the attributed population over time. Some of this is associated with network expansion and not

necessarily the population becoming less-well. While the risk of the population has increased, it's also important to note that risk scores and costs are not always perfectly aligned. In large part due to our rural state, varying reimbursement rates, limitations inherent in risk modeling, as well as a lack of financial coding incentives, the risk score in some regions of expansion may be comparatively low and the cost comparatively high (and vice versa).

11. **In reference to the last paragraph of Section 4, Question 3a, please explain the "opportunities to more favorably balance public and private trend rates to create sustainability for both consumers and providers"—are you affecting the cost shift now? If so, please explain how? If not, what are the barriers? If removed, how could you implement such a balancing of public and private trend rates, and what results would you expect to achieve for providers and consumers?**

    The ACO total cost of care targets are intended to be set in a manner that reflects what the healthcare costs would be absent ACO activities. Because the commercial targets are built upon factors such as insurance rate approvals, commercial rate changes have been predetermined before the ACO targets are set. The quote from the budget narrative makes reference to the state's ability to utilize the Medicare terms in the All Payer Model to impact the cost shift.

12. **Section 4, Question 3d – While there is undoubtedly uncertainty around COVID-19 and its implications for health care into the future, please explain what assumptions you have baked into this budget and the Total Cost of Care (TCOC) estimates, and explain how you arrived at these estimates.**

    Response pending.

Section 5: Risk Management

13. **Please explain your revised risk model in 2020 (from calculation of risk/risk transfer through settlement). What is different and what was the impetus for that change? How does it compare to the risk model initially proposed with your October 1 submitted 2020 Budget?**

    The submitted 2020 Program Settlement Policy contains more detail, but the amount of the OneCare settlement to be allocated to network participants will be proportionally assigned to HSAs based on member months of attribution. The following table shows a simple example in a scenario with $1M of shared to distribute for a program:

	Member Months	% of Member Months	Shared Savings Amount
HSA A	180,000	75%	$750,000
HSA B	60,000	25%	$250,000
Total	**240,000**	**100%**	**$1,000,000**

This risk model is designed to:

- create a statewide system of health;
- align provider success with Vermont's success under the All Payer Model;
- provide a simpler and more stable financial model for participants; and
- avoid actuarial challenges with small populations.

The original 2020 budget submitted by OneCare included an HSA-accountability model which required OneCare to set individual HSA spending targets and then monitor healthcare costs down to that level. Migrating to this approach solidifies the fact that OneCare is one network and all participants need to work together to succeed in a value-based healthcare approach.

14. **GMCB understood that OCV's originally submitted 2020 risk sharing model combined savings/losses across all payer streams and then distributed savings/losses to HSA risk-bearing entities (RBEs). Is it accurate that the changed policy means that savings/losses will be calculated and allocated to RBEs by payer?**

    Due to the varied timing of settlements and participation decisions within each HSA, OneCare has always prepared the network settlement separately for each payer. This approach will continue in 2021.

15. **Does the change in policy modify HSA-specific maximum risk limits (MRLs)? Please address, based on the final 2020 OCV risk model, the following requests:**
    a. **What is the risk by payer program, the Maximum Risk Limits (MRLs) for each hospital, and any risk mitigation arrangements? Complete a revised Appendix 2.3 (FY20 Risk by Pay Program, Maximum Risk Limit, and Risk Mitigation by HSA). Alternatively, OneCare could complete the new templates Appendices 5.1 and 5.2 with revised FY20 data.**

    The risk model change has a very modest impact on HSA maximum risk/reward calculations. For HSAs with above average healthcare costs, migrating their MRL to the network average slightly reduces their max risk/reward. Conversely, for an HSA with below average healthcare costs, migrating to the new model slightly increases their max risk/reward. The FY20 risk/reward model remains in negotiation with payers. Once terms have been finalized and final attribution determined the updated risk/reward tables can be supplied.

16. **How does your 2021 risk model differ from the revised 2020 risk model described previously, and what was the impetus for that change?**
    a. **Is risk-mitigation down-side only, or does ACO (or founders) gain access to those potential savings?**
    b. **What is the risk you are keeping on your books? Have you considered holding the risk for the advanced shared savings or other system-wide "risk"? Why or why not?**

    The 2021 risk model is very similar to that of 2020, but incorporates a "performance incentive pool" to reward exceptional performance. The performance incentive pool will be 10% of any shared savings earned and awarded based on specific performance measures. The specific measures are in development through OneCare's governance committees and will be approved by OneCare's Board.

    Risk mitigation arrangements are set up so that the risk bearing entity (RBE) has the risk up to the midpoint of the MRL, and then OneCare takes on the second half. In exchange, OneCare is entitled to 25% of any shared savings earned by the RBE.

The risk retained by OneCare includes both the impact of the risk mitigation arrangements, and programs in which OneCare intends to maintain risk centrally rather than implementing a risk settlement model with the network. Because the MAPCP (Multi-Payer Advanced Primary Care Practice) adjustment in the Medicare target (referred to as advanced shared savings in the question) is fully at risk, OneCare would need to hold the full amount in reserve (i.e. $8.4M) to be able avoid incorporating that component into the network settlement model. At present, OneCare does not maintain reserves at that level.

17. **Under what conditions would you dip into OCV risk reserves? Is there a scenario under which the founders would ever have to cover shared losses? Please explain.**

    OneCare will access its reserves in order to fulfill obligations under the risk mitigation arrangements, for "non-HSA attributed lives" as noted below, or any programs in which risk is held centrally at OneCare. Additionally, OneCare may utilize reserves to address ordinary business timing issues or to meet other unforeseen business needs. The founders are not direct counterparties to any of the risk mitigation arrangements for 2021.

18. **In Appendix 5.1—What is "risk for non-HSA attributed lives"?**

    Occasionally OneCare is unable to assign an attributed life to a primary care provider. This often occurs when the life attributes through a specialist or there is an abundance of data protected by 42 CFR Part 2. Despite the fact that these lives cannot be assigned to an HSA, there is still risk/reward and that risk/reward amount was assigned to OneCare in the budget template.

19. **Appendix 5.2—Please separate risk for TCOC versus variable payment for PHM.**

    Please see Appendix 5.2.

Section 6: ACO Budget

20. **Please provide a crosswalk/reconciliation between your submitted budget financial statements to what they would be on a GAAP basis of accounting.**

    The process of producing financial statements in compliance with GAAP standards is dependent on actual events and terms in contracts that have not been solidified. In order to ensure that the final OneCare financial statements meet GAAP standards, an independent auditing firm is hired annually to review supporting documentation and provide an opinion on their overall accuracy. After this has been completed for the 2021 fiscal year, OneCare will be happy to provide a crosswalk between the submitted budget information and the outcome of the final audited financial statements.

21. **Please disclose any transfers of dollars in and out of the organization that are not part of your ordinary course of business.**

    There are no such transfers to disclose.

22. **In the 2018 OCV audit, it is noted, "UVM Medical Center bills the Organization monthly for rental expense; however, there is no formal agreement with UVM Medical Center under this arrangement." Do you have a formal agreement now? If not, what is the current arrangement and what is driving the rent increases?**

    OneCare has a signed Service Order for Office Space as a sublease through UVMMC for occupancy of the building. The lease arrangement includes annual increases to the monthly rent payments as dictated by the master agreement with the building owner.

23. **Also, in the UVMHN 2019 audit, it notes "Additionally, UVM Medical Center provides various administrative services to OCV, including the processing of payroll and accounts payable transactions. All employees of OCV are UVM Medical Center employees and are covered under UVM Medical Center's insurance policies and employee benefit plans. OCV reimburses UVM Medical Center for all administrative and payroll-related costs, which totaled $12,595,000 and $10,289,000 for the years ending September 30, 2019 and 2018." Even though your year ends are different, actual salary costs are only about $6.6M in 2018 and $8.2M in 2019. Please provide a breakdown of what is going into those transactions. What are you projecting for 2020 and what are you budgeting for in 2021? Please include a breakdown for those as well (I.e. $X salaries, $X rent, etc.).**

    We cannot comment on the UVMHN audit as it is outside our purview. We can provide relevant aggregate information within OneCare's budget; this information is forthcoming.

24. **Management compensation accounts for almost 14% of total operational expenses. What benchmarks are reviewed to ensure that OneCare's business is not "top-heavy"?**

    OneCare's leadership structure is in accordance with the requirements in Section 5.203-5.210 of Rule 5 and payer contract requirements. All OneCare personnel are employed through UVMMC. Compensation for UVMMC employees, including OneCare dedicated employees, is determined using current market research. A third party consultant is used for benchmarking executive positions. When setting base pay for executives, we target the market median (50th percentile) rate. When setting total direct compensation (base pay plus variable pay) for executives, we target the market 65th percentile. A third party consultant is occasionally used to benchmark director level roles, but the rest are benchmarked in-house using over 18 market surveys and utilizing software which aggregates all the survey data. For non-executive pay, we target the market median (50th percentile).

25. **Please explain your proposal to level fund Blueprint, SASH, and Community Health Teams.**

    The 2021 OneCare budget reflects the desire to continue with value-based care arrangements despite a general aversion to risk due to the pandemic. While Blueprint and SASH funding are allocated statewide, the risk associated with them is held by a smaller number of communities participating in Medicare risk programs, thus proportionately increasing their risk. Additionally, pre-obligating a portion of shared savings (~$8.5M of $13M) means there is less shared savings opportunity ($4.5M) for participating providers to support ACO population health investments and reward effective care delivery for participants. Under this scenario, the risk/reward ratio is unbalanced with $4.5M of potential reward compared to $21.5M of potential loss. This significant imbalance in risk, coupled with funding uncertainty for providers during 2020 and 2021, cannot be minimized. Funding at current levels

is a way to ensure hospital participation in Medicare risk-based programs and investments in population health programs beyond the scope of the Blueprint.

26. **All variance analyses: Please disclose a dollar value associated with your explanations to assist in transparency/completeness in the explanations.**

    Response pending.

27. **Table 5: Balance Sheet Variation. Why is retained earnings going down if the budgeted amounts are break even? Is there a projected loss missing?**

    The most important retained earnings comparison is between the FY19 Actual, the FY20 Projection, and the FY21 Submitted Budget. All show retained earnings of $4,073,682, which aligns with $0 gain/loss over the corresponding period. The number that likely causes confusion is the FY20 Budget Approved amount of $5,917,147, which was prepared before finalizing the FY19 financial statements.

28. **Table 6: Cash Flow Variation. Can you be more specific on the "(Increase)/Decrease Other Changes"? The variation is significant and more disclosure of the drivers of the change would be helpful, in addition to the dollar value of the explanation (Medicare AIPBP recon).**

    The revised Value Based Incentive Fund (VBIF) strategy is the primary driver. By moving a portion of quality accountability to the time of settlement in order to avoid pre-funding the full VBIF, it means that OneCare will have less cash on the balance sheet at the fiscal year cross-over. Additionally, in 2021 OneCare plans to distribute some of the VBIF during the performance year, which will also reduce cash held by OneCare at the fiscal year crossover. In 2020, the Medicare AIPBP reconciliation is expected to be roughly $30M. This materializes as a receivable from the network participants and a payable due to Medicare in balancing amounts.

29. **Balance Sheet: Do your reserves have to be increased now that Rutland Regional Medical Center has joined the Medicare program?**

    While Rutland's participation in the Medicare program does contribute to increased risk comparatively, the overall lower risk corridors mean that both OneCare and the network have less risk in 2021. For this reason, it is not believed that reserves need to be increased.

30. **Income statement: You appear to be adding 3 FTEs but your salary cost is increasing by almost $1.5M. What is driving this increase?**

    The increase is due to restoring temporary leadership compensation reductions implemented in 2020 and restoring positions held open during the hiring freeze. These steps were taken in 2020 to offer dues relief to hospitals in response to COVID-19. As requested in the budget testimony meeting, a breakdown of the impact of the leadership compensation adjustments against the hiring freeze will be supplied.

31. **What is the status of the 2019 audit?**

    The 2019 audit is nearing completion and is anticipated to go through our governance cycle before the end of 2020. Delays to program settlements resulted in an extended timeline.

32. **Please update the "Sources and Uses" in Appendix Tab 6.4 per the revised table and for any amounts listed in "other," please explain how these are funded.**

    Response pending.

Section 7: ACO Quality, Population Health, Model of Care, and Community Integration

33. **Have you explored any programs to specifically benefit patients with disabilities? Where would these patients typically fall within your quadrant system (i.e. potential benefit for advanced care coordination payments, etc.)?**

    OneCare programs focus on need and risk versus specific conditions or disabilities. This allows anyone who is in need of care coordination services to access those services when in need. An adult or child with disabilities who is medically stable and well managed may fall into the medium risk category. If however, complex medical needs arise and/or escalate; individuals with disabilities may fall into the high or very high-risk categories. OneCare's Care Coordination program allows for care coordination supplemental payments when supporting individuals at any risk level when the need for care coordination arises. This means that individuals with disabilities who have medical or social determinant of health complexities, regardless of their risk level classification, are eligible for care coordination services and that those providers supporting them are incentivized to outreach and engage with such individuals.

34. **Section 7, Question 1b asks you to discuss anticipated changes to your 2021 programs (proposed budget year), but the response focuses on 2020 progress. For example, you mention expanding DULCE in 2020, are there plans to further this expansion in 2021?**

    c. **Please break out the funding amount for DULCE in the Income Statement. Is it rolled into the Primary Prevention line item for years 2019-2021?**

       The budgeted DULCE investment is $300,000. DULCE is considered part of the overall care coordination model and is included in that line item accordingly.

    d. **Please provide more detail on the inclusion of Blueprint self-management plans (SMPs) into your 2021 budget. Which SMPs? How are these programs being funded? Where in the proposed budget is this associated cost? Are there also associated costs with adding these programs into WorkBenchOne?**

       Blueprint will transfer the diabetes prevention and diabetes self-management programs to OneCare in January 2021. In addition to the diabetes programs, OneCare will add an evidence-based hypertension self-management program to the portfolio of offerings. The programs will be funded by a contract with DVHA that transfers the current funding for the self-management programs to OneCare. The costs for the program are budgeted in primary prevention. There were minimal costs in 2020 to create a self-management patient prioritization app to help identify the attributed population who might benefit from self-management programs. This work was paid for by a grant from the Vermont Department of Health where OneCare is a sub grantee of an NACDD grant to increase outreach to FQHC patients on the future program offerings.

e. **In what areas is the Longitudinal Care Program expanding in 2021? What is the funding stream for this program?**

The Longitudinal Care program is funded through delivery system reform dollars. OneCare can provide plans for the 2021 program if funding is appropriated by the state and contracted with OneCare.

f. **You mention an investment of $500,000 for mental health services in Emergency Departments (p.44)—which hospitals are part of this investment? Which population health line item does this fall under in the budget? Do you plan to continue this program for 2021?**

The following organizations are part of this investment:

- Washington County Mental Health Services is working with Central Vermont Medical Center
- Northwestern Counseling and Support Services is working with Northwestern Medical Center
- Northeast Kingdom Health Services is working with North Country Hospital

OneCare does not have a funding stream for this line item in 2021 other than hospital dues.

Response pending for additional detail on the budget line item.

35. **In Table 7: 2020 Supplemental Care Coordination Payments, could you show cumulative payout under each of these Roles/Interventions? If so, please provide for all Performance Years.**

OneCare provides care coordination payments at the organization level and does not analyze at the granular level of individual roles within those organizations.

g. **The explanation for the expenditure variation of -25% on this Complex Care Coordination Program states, "refining program for 2021." Please explain why 2021 program changes result in 25% less investment in this program.**

In 2021, OneCare is aligning care coordination payments with anticipated costs under the value-based payment model implemented in July 2020. Further, in 2021, OneCare will work with its network to focus efforts on high-risk sub-populations including those with high emergency department utilization and inpatient readmissions as well as developing/refining graduation protocols, both of which we anticipate will yield improved focus on those who can best benefit from care coordination supports and services.

36. **You state that the 2020 all payer blended care managed rate of 15% of high and very high-risk lives has been met (p.44). What is the goal for the 2021 Care Managed Rate? Why is the commercial care managed rate so much lower (3%)?**

The 2021 goal for the care managed rate remains at 15% of high and very high-risk lives and can be referenced in 02-04 Community Care Coordination Program PY 2021 policy provided to the GMCB in OneCare's FY2021 ACO Certification submission on September 1, 2020. Each payer has a different risk profile based on populations served.

37. **Do you have any insights on how COVID-19 may impact 2020 rates as seen in Table 8: Summary of Clinical Priority Area Results for 2018 and 2019? Given potential decreased utilization, would these goals/targets be revisited to address current state?**

The clinical priority categories shown in Table 8 were chosen for monitoring to provide "signals" for the clinical care of the entire age span of attributed individuals (young pediatric, adolescents, older Vermonters), chronic disease management (heart failure, asthma, COPD, diabetes), post-acute care efficiency, and trended utilization patterns for individuals identified as in need for complex care coordination. The impact of the COVID-19 pandemic may result in temporary reductions in some metric performance (e.g. annual wellness visits, adolescent well visits, developmental screening, and A1C monitoring) and improvements in others (e.g. ED utilization, inpatient admissions, asthma and COPD admissions) likely relating to reluctance to seek care for safety considerations and reduced exposures to other viral illnesses circulating in the community as a result of the pandemic. The trended patterns of these metrics will be assessed after there has been sufficient claims "runout" to determine if any longer term changes in performance patterns have occurred that might warrant recalibration of goals.

38. **Please provide more detail on how the COVID-19 patient prioritization application was implemented.**
    a. **Did providers receive a list of members at risk for Covid-19 or were they given a set of criteria to use to identify which patients were at risk? How was this risk level or criteria determined? How did you distribute this to members and how do you determine how many providers used the application? OneCare noted that 80 providers used its COVID- 19 prioritization tool. How many providers was this offered to? Does the 80 refer to individual providers or provider organizations?**

Within just weeks of COVID-19 arriving in Vermont, OneCare developed and deployed an interactive, self-service application on Workbench One that was designed with the primary purpose to make sure every practice and provider could quickly and systematically identify their most at-risk individuals. The application, called COVID-19 Care Coordination Prioritization, was offered to all provider organizations serving primary care either through direct access to the tool or via one-on-one support by OneCare staff. The 80 users previously identified are individual providers.

The application leverages guidance from Johns Hopkins, the World Health Organization, and the Centers for Disease Control and Prevention to find individuals who are highest risk for a poor outcome if the individual were to contract COVID-19. These six key risk factors are:

- Individuals over the age of 60 who also have diabetes, heart disease, lung disease, hypertension, and/or cancer
- Individuals who are considered frail
- Individuals who have been identified as having high use of healthcare resources
- Individuals who have seen at least 7 different providers in the past year indicating a potential coordination issue
- Individuals with evidence of a mental health comorbidity
- Individuals with high social complexity risk and evidence of food access issues and/or social isolation

The application is designed to allow end users to identify individuals with any or all of the key risk factors. This flexibility in identifying patient populations was a deliberate design decision to meet organizations where they are at with regard to available resources in the midst of the pandemic.

OneCare looks at utilization by individuals, as well as organizations. In addition, users from OneCare have provided at the elbow support to organizations who did not initially feel confident accessing the data themselves through Workbench One. This broad data support model ensured that technology was not a barrier to any organization that wished to leverage the information from the COVID-19 application to identify their most at-risk individuals, and therefore this resource was available to every attributing organization in the OneCare network.

Helping organizations prioritize their outreach efforts systematically meant organizations were able to spend less time sifting through reports in their EHRs and more time focusing on their patients. Providers and care coordinators focused on reinforcing COVID-19 education, precautions, and prevention, as well as reassuring patients there was always a way to connect with their provider when needed using technology such as telephone and video visits.

39. Starting with Graph 4, please provide this data unblinded. It would be helpful to see who are high vs. low performers as we evaluate Population Health Management investments and programs.

These reports are automatically generated by our software and cannot be unblinded without intensive manual work that would detract from supporting provider reform efforts. Individually identifiable HSA-level reports are generated and shared with communities monthly. OneCare's population health management programs are universal across the ACO and not differential based on high/low performers.

40. What is the Value-Based Incentive Fund (VBIF) distributive model for 2021? Please provide the policy when it is finalized.

OneCare will shift the timing of VBIF payments from program settlement (approximately 18 months post performance year start) to a distributive model that facilitates funds flow throughout the performance year to align with focused quality initiatives as set by the Population Health Strategy Committee. Additionally, as a means of ensuring long-term sustainability, the budget model also aims to move some of the program quality accountability factors to settlement (i.e. quality will affect shared savings/losses). These details are reflected in 04-13 Value Based Incentive Fund PY 2021 policy that was provided to the GMCB on October 1, 2020.

41. In Table 10: OneCare Population Health Investment, please confirm attribution numbers and update as necessary for 2020 contracts (under base OneCare PMPM). In addition, please quantify spending in each investment category (tie to PHM/Payment Reform Program Expenses in Income Statement).

Please find the investment amounts for each category in the previously submitted Appendix 7.2. OneCare's response regarding the attribution numbers is pending.

42. What hospital houses the chronic kidney disease program? Was this through innovation funding? If so, what was the total amount awarded to fund this program? UVMMC since they hold the preponderance of cases.

The Chronic Kidney Disease Program is facilitated by the University of Vermont Medical Center, who provides care for the majority of attributed lives with end stage renal disease. The contract for $254,800 was allocated from the specialist funding line item in the budget.

43. Please provide a shading key and HSA key for Exhibit C to Section 7: HSA Cost and utilization Variation Tables by Payer, as you have provided with this data previously.

Here is the shading key for Exhibit C:

- Dark Blue represents the lowest data point, light blue is second lowest.
- Dark yellow represents the highest data point, light yellow is second highest.

Please note high/low does not indicate good or bad consistently across measures.

The HSA key for Exhibit C is pending.

44. Is OneCare planning to enter into any contracts for independent evaluation of their care model? How is OneCare participating and/or planning to participate in the federal evaluation?

OneCare does not intend to invest in contracts for independent evaluation of the care model. OneCare and its provider network continue to engage in all requests from NORC, CMMI's federal evaluation contractor. In addition, OneCare has welcomed independent case studies from Mathematica, The Commonwealth Fund, Center for Health Care Strategies, and has received two rounds of funding through the Robert Wood Johnson Foundation in support of our programs.

45. What is OneCare's approach to measuring return on investment of its population health programs? For example, how is OneCare measuring a return on investment of care coordination activities as mentioned on p. 45?

To analyze the impact of care coordination interventions on the patient engagement level, a pre and post methodology is used to compare key performance indicators including utilization of services 12 months before intervention to the six months after intervention. A significant amount of time after intervention is needed to perform this type of evaluation, but early indicators demonstrate increases in engagement in the cohorts who receive the care coordination intervention. For example, OneCare has identified that 96% of the care-managed population is engaged with a primary care provider year-over-year across payer populations.

46. You reference challenges of COVID-19 and deferred care with downstream effects of limited disease management (end of question 2)—has this subsided? What will you do if there is another surge, including through the possible "twindemic"?

The Governor's Stay Home, Stay Safe order in March, April and May of 2020 resulted in a precipitous decline in in-person medical care across primary and specialty care that was unprecedented. Telehealth visit volume helped to mitigate the effects of this in person decrease. Telehealth proved to be quite adaptable to the management of chronic disease. Medication management augmented with patient collected data (e.g. home blood pressures, glucose values, and weights), symptom assessment, counseling, and education could be delivered in non-face-to-face encounters. Access to laboratory services for monitoring of chronic conditions was also reduced due to avoidance of in person phlebotomy services. We cannot speculate about the impact of a potential second Stay Home period other than to say that the system is much more prepared to quickly switch to telehealth provision of services given the learnings of the first pandemic wave.

47. **Please describe in detail the data reports that participating providers receive from OneCare, including how often providers receive the reports and a description of any relevant data lags.**
    a. **Please provide example reports for each provider type.**

    See Exhibit 1.

GMCB Questions for FY21 Certification Eligibility Verification

1. ***Governing Body 5.202(f)2.*** **Do the agendas or publicly posted minutes of the OneCare Board of Managers meetings specify the topics of business to be conducted or actually conducted during executive sessions? If the topics of business discussed under executive session are not itemized in the agenda or minutes, please explain why and address how the public is supposed to know that the topics discussed in executive session are allowed under 18 V.S.A. § 9572. Please provide any policies governing the conduct of OneCare Board of Managers meetings.**

   The business conducted in Executive Session is reflected on the public agenda in the itemized list of votes to be taken; including those related to business conducted in executive session. OneCare uses *Roberts Rules of Order* to guide board meetings.

2. ***Governing Body 5.202(h).*** **Please provide the date the consumer advisory board will have its annual meeting with representatives of the Office of the Health Care Advocate (HCA). Submit any report the HCA provides to the ACO following that meeting.**

   Representatives from the Office of the Health Care Advocate will attend OneCare's Patient and Family Advisory Committee on December 8, 2020. Reports provided to OneCare by the HCA will be submitted following that meeting.

3. ***Leadership and Management 5.203(a).*** **Why has OneCare had difficulty filling the position of Chief Financial Officer?**

   Effective 10/19/20 Tom Borys has been promoted to the Vice President for Finance for OneCare.

4. ***Leadership and Management 5.203(a).*** **The current Leadership Team Table dated August 2020 includes a vacant position of Vice President and Legal Counsel that was not included in the 2019 Leadership Team Table; the 2019 table also included a position of Chief Information and Security Officer that is not included in the current submission. Please explain these changes to the composition of OneCare's Executive Team.**

   The Chief Information and Security Officer position is a contracted position from the UVMHN. The VP and Legal Counsel position was built into the 2020 budget and held vacant due to the pandemic. In 2020, all legal services were provided via contract. OneCare anticipates migrating legal counsel in-house in 2021.

5. ***Solvency and Financial Stability 5.204(a).*** **What legal and financial vulnerabilities does OneCare routinely assess? Please provide examples. Please also provide any policies or procedures describing the process for reporting the results of any assessments of the ACO's legal and financial vulnerabilities to the ACO's Board of Managers. If no such policies or procedures exist, how do you ensure that the Board of Managers is adequately informed? Incorporate financial reports and performance dashboards presented monthly to BOM,**

   Legal and compliance vulnerabilities are identified on an ongoing basis by executive management, the Chief Compliance and Privacy Officer, Audit Committee and legal counsel. Vulnerabilities that are identified are assessed by an appropriate team and guidance given to management and/or the Board as appropriate for the nature of the issue. Additionally, many operational processes drive identification of legal and compliance vulnerabilities. By way of example, contractual arrangements are comprehensively reviewed and evaluated for legal and compliance issues.

   The process for assessing financial vulnerabilities starts with monthly program performance reporting developed internally by OneCare teams. These reports utilize regular claims feeds from payers, other supplemental payer reports, and internally-developed IBNR models to project and forecast overall program performance. The data are reviewed by internal OneCare teams and posted to the secure portal for risk-bearing entities. If in the process of the regular review, financial vulnerabilities are noted, these vulnerabilities are evaluated by OneCare management to determine the appropriate course of action. For example, there could be specific outreach to a risk-bearing entity, legal review, presentation to the OneCare Finance Committee, presentation to the OneCare Population Health Strategy Committee, and/or presentation to the OneCare Board of Managers. Through this process it will be determined whether the financial vulnerability needs continued monitoring or if immediate action is needed. If the latter, management will seek the appropriate guidance from governance bodies to determine next steps.

OneCare Vermont

Health Care Advocate Questions

1. **OneCare's fixed prospective payments (FPPs):**
    a. **OneCare's FPPs were not designed for circumstances like COVID-19, when care was largely unavailable to patients. Is it a general goal for providers to get predictable payments regardless of the care provided (e.g., even if their offices are closed and no care is provided)?**

    It is a general goal for providers to be paid in a manner that is disaggregated from billing volume so that the best patient care dictates day-to-day decision making.

    b. **There is an apparent conflict between the goal of giving providers stable payments with consistent increases and the goal of lowering costs for Vermonters. How do you see FPPs fulfilling each of these goals?**

    Stabilizing provider revenue is a critical step in order to shift provider focus to population health investments and outcomes. Over time, improved population health outcomes can decrease the overall costs to the healthcare system.

    c. **Do FPPs help insulate providers from shifts in payer mix?**

    No; each fixed payment is set based on existing provider reimbursement schedules.

2. **How did OneCare determine that the cut-off for provision of care management was a blended 15% of high risk and very high risk patients?**

    After much research based on other ACOs and insurers, OneCare identified ranges from 1% to 40% depending on the population served. Most tended to be in the 2-5% range of the entire population. OneCare then chose to create a stretch goal of 15% of the top 16% (or roughly 3% of the entire population care managed). We intend to monitor this rate and adjust based on continual learning with our provider community.

    a. **Is this a budgetary decision or based on a certain level of acuity where care coordination would be expected to have the biggest impact?**

    This was a decision based on the level of anticipated impact that care coordination could have on improving outcomes and reducing total cost of care for the populations at greatest risk and need.

        i. **If it is the latter, was this established internally or based on external recommendations?**

        This was established internally, based on research and external consultation described above.

b. **Is there variation by payer on how you apply the metrics to establish which patients receive care coordination?**

OneCare's very high-risk individuals for commercials payers are considered the top 3% and therefore, our metrics for these payers reflect 15% of the top 3%. Individuals at any risk level regardless of payer can receive care coordination based on need and clinical judgement. Providers are able to perform care coordination and receive supplemental payments for medium and low risk individuals with a documented reason for engagement.

3. **OneCare's 2019 Medicare quality scores are notably low for two payment measures as compared to national benchmarks: Risk Standardized, All Condition Readmissions (50th percentile) and All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions (40th percentile). These measures appear to be directly aligned with OneCare's primary goals.**
   a. **Please describe in detail what OneCare intends to do to improve performance in these areas.**

Despite OneCare's lack of insight into the specific quality measure rates for the two measures referenced (payers do not provide counts or geographic break-downs), OneCare does feel strongly that reducing readmissions and unplanned admissions for at-risk individuals is important in improving the overall health of the population and meeting the goals of value based care. OneCare supports providers' efforts to reduce readmissions and unplanned admissions for individuals with multiple chronic conditions by providing comprehensive datasets to organizations upon request through the ad hoc data request process and through available data in WorkbenchOne to identify index admissions that result in a readmission. This allows organizations to perform root cause analyses to determine what happened that resulted in the undesirable outcome of either a readmission or unplanned admission.

In October, OneCare released a major update to the Care Coordination Process Metrics application with significant additional functionality and 39 new data filters. The Care Coordination Process Metrics application is a self-service tool designed to support the OneCare network in identifying, monitoring, and prioritizing attributed individuals for care coordination. One of the additional data filters allows care coordinators to quickly identify individuals with chronic conditions who are most at risk of being hospitalized in the next six months. This allows care coordinators to proactively outreach to individuals, host care team conferences, and establish patient-centered goals in order to avoid unplanned hospitalizations.

4. **OneCare's 2019 Medicare quality scores are notably low for two reporting measures: Follow-up After ED Visit for Alcohol and Other Drug Abuse or Dependence within 30 Days (19.9%; 11% with follow-up within 7 days) and Engagement of Alcohol and Other Drug Dependence Treatment (5%). We note that 30 days is a low standard for follow-up (i.e., far too long after discharge for effective follow-up).**
    a. **What are you doing to improve these metrics compared to your past performance?**
    b. **What, if anything, are you doing to encourage providers to follow up in a significantly shorter time period than 30 days for both substance use and mental health ED visits?**

       OneCare relies on nationally set quality measure standards identified in payer contracts and the number of days until follow up are dictated by the measure specification. The sooner that follow up occurs, the better. OneCare has deployed quality measure education so that providers understand the terms in which they are being measured. Traditionally this education was provided in person, however given the impact of COVID-19, OneCare has shifted education material to the Vermont Health Learn education platform. OneCare also provides ad hoc training as requested by the network.

5. **Does switching ACO risk to the network (i.e. state) level present new issues? We understand that presently due to low population and/or attribution, normal random variation in spending could drive outcomes.**
    a. **If risk is shifted to a state-wide level, is ACO risk essentially driven by UVMMC performance given the proportion of the total population in that HSA?**

       UVMMC is a significant provider of healthcare for the attributed population. However, the activities that will yield success in an ACO arrangement are largely driven through effective coordination between primary care and all the supporting provider types across the care continuum in each health service area.

    b. **If ACO performance is driven by UVMMC, is it reasonable to assume that smaller HSAs might not change their practices since they would have a negligible impact on ACO risk outcomes?**

       That assumption is not shared by OneCare. Experience thus far suggests providers across the state are motivated by the desire to deliver excellent patient care and support Vermont's goals of more sustainable healthcare cost growth and high quality care.

    c. **Does this dynamic incentivize OneCare to prioritize UVMMC's services for its population health investments?**

       OneCare does not expect that this dynamic incents OneCare to prioritize any specific provider's services for population health investments.

d. **How do expanded/geographic attribution and the shift to state-level risk interact in terms of payer, ACO, and provider risk exposure?**

There is no material change to payer, ACO and provider risk exposure related to this change.

6. **Please describe in additional detail how the variable population health management (PHM) payments will be calculated for each practice. (They are described as tied to both "ACO and local health service area (HSA) financial results." Narrative, pg. 11.)**
   a. **Does this methodology account for differences in the underlying patient population by HSA?**

   For programs in which this is applicable, primary care providers will receive a PHM payment at $1.75 PMPM. If, shared savings are achieved, primary care providers will receive between $1.50 to $3.00 PMPM additionally.
   This model does not incorporate a factor that adjusted for differences in the underlying patient population.

7. **You mentioned that the expansion of telemedicine is promising. What, if anything, are you doing to educate your participating providers on how to provide quality care through telemedicine?**

   Beginning in the early days of the COVID-19 pandemic, OneCare leadership became highly engaged with DVHA, VPQHC, Bi-State Primary Care, the New England Telehealth Resource Center, Blue Cross and Blue Shield of Vermont, CIGNA, MVP, the National Association of Accountable Care Organizations, and the Vermont Medical Society to advocate for fair reimbursement for a broad range of telehealth services provided with audio-video, audio only, or asynchronous store and forward methods. As commercial and federal payer policies were clarified for permissible benefit expansion and billing codes and as operational best practices for provision of these services by practices became established, OneCare communicated these data to our broad network on our portal with links to the appropriate materials. OneCare's CMO participated in and presented at VPQHC's telehealth office hours across many months. We conducted a large network survey of the barriers to provision of telehealth services and shared these results in multiple forums at the state and network level. OneCare also worked in collaboration with NETRC and Bi-State Primary Care to create the following educational resource link document that is available on the OneCare website and advertised in Network News releases: https://netrc.org/work-group/resources/Telehealth%20Training/TH-Key-Considerations-Vermont.pdf

8. **Has OneCare considered offering to negotiate supply costs for its participating providers in order to leverage the combined size?**

   At this time, OneCare has not considered negotiating supply costs for providers, as this is outside of the ACO's current scope of business.

9. **What is the reason for the improvement on your quality scores - Is it motivation to receive the payments? Education? Data? Focusing on these particular issues? To what extent can these practices be used to expand the areas OneCare improves?**

   The quality measure results are a direct reflection of the high quality care that OneCare's providers are delivering on a daily basis. OneCare actively supplements data that would indicate care gaps, creates educations material and sessions, and is constantly evaluating report and analytic needs. This multifaceted approach, mixed with financial incentive for high performance has resulted in meaningful improvement year over year. The quality improvement framework previously described in OneCare's budget submission clearly articulates the approach, and scalability of these methods to any area.

10. **OneCare noted in its patient example the difficulty faced by patients who are unable to access dentures. This is a serious systemic health care access issue that the HCA has been aware of for many years. Please describe what OneCare did to acquire dentures for this patient, and whether this kind of benefit is offered for other patients.**

    The individual, with help from his Lead Care Coordinator, was able to access an eligibility waiver due to the COVID-19 public health emergency.

11. **OneCare was directed to provide "the methods for establishing new or continued investment" for population health and payment reform investments. In Table 10 on pages 58 through 63, OneCare listed six population health or payment reform investments. Of the five items that OneCare intends to continue in 2021, OneCare stated that the financial sustainability of the program depends on continued investments from partners in the column "Methods for establishing new or continued investment." Please clarify whether OneCare's method for making new or continued population health or payment reform investments is solely that OneCare has the available money, as suggested by OneCare's reference to financial sustainability, or whether OneCare has a different method to decide where to invest available monies. If such a method exists, please provide it for each population health or payment reform investment listed in Table 10.**

    Clinical priority areas and all population health investments are presented and endorsed through the OneCare Population Health Strategy Committee and Finance Committee with review and approval by the Representative Board of Managers.

12. **Please provide a detailed description of each of the following programs (expanding on the information provided in Table 10), and provide any related contracts and/or protocols:**

    In lieu of the confidential agreements, OneCare has provided information about the programs below.

a. **Primary Prevention: Self-Management Program**

Launching in January 2021, OneCare will implement a new model for diabetes and hypertension self-management programs. OneCare will offer self-management programs on a regular schedule using the online learning platform, Vermont Health Learn (VTHL). Programs offered will include diabetes prevention, diabetes self-management, and hypertension self-management. For participants who may not be interested or able to participate in the online facilitated self-management programs, they will have the option to use a mobile application called *One Drop*. *One Drop* offers diabetes prevention, diabetes self-management, and hypertension prevention education through a mobile app and participants have the choice to receive either a remote monitoring scale, glucose monitor, or blood pressure cuff to monitor their program progress. OneCare is partnering with the Vermont Department of Health to create a "no wrong door" model for signing up for the self-management programs either through the OneCare or MyHealthyVT.org websites. Regional coordinators in the field who previously worked for the Blueprint self-management programs will now work with the RiseVT field team to promote local opportunities to improve their health and wellness and reinforce the tools the self-management participants are learning through the course of their classes. The field team is also available to support participants in signing up for programs as well as supporting provider and participant outreach. For attributed individuals, the OneCare analytics team has created a patient prioritization app to identify individuals who might benefit from the self-management programs. The OneCare prevention team plans to host educational opportunities to share with providers that these programs exist and that we can help identify their patients for referral. The new programs are free and available to all Vermonters. The OneCare prevention team is working in partnership with the Vermont Department of Health to do targeted marketing and advertising to reach as many eligible individuals as possible who may or may not be attributed to OneCare.

b. **Specialist: Chronic Kidney Disease (CKD) program**

OneCare's Board of Managers approved the use of the funding to aid in the implementation of a Chronic Kidney Disease (CKD) Care Coordination Program to improve care of individuals approaching need for renal replacement therapy in partnership with UVMMC through its Division of Nephrology, who also wished to design, implement, and measure a new CKD Care Coordination Program to improve care of advanced chronic kidney disease. The CKD Care Coordination Program emulates patient centered interventions described by Dialysis Clinics Incorporated (DCI) including Life Goal Discussions to help individuals decide on renal replacement therapy (or not) and better manage their chronic condition by being better informed about treatment options in advanced CKD and End Stage Renal Disease. UVMMC has designed the CKD Care Coordination Program to include provision of care coordination activities for all eligible individuals despite payer and/or attribution and is hiring, training and deploying appropriate personnel to implement the CKD Care Coordination Program. Implementation components include medical director oversite, development of patient education materials, personnel training, and workflow development.

c. Specialist: Mental Health Program

OneCare Board of Managers approved investment in mental healthcare delivery innovation as a strategic goal to further core activities of the ACO. OneCare solicited proposals coordinated through Vermont Care Partners for projects in support of specialty reform goals and selected those of Northwestern Counseling and Support Services, Washington County Mental Health Services, and Northeast Kingdom Health Services. These designated agencies agreed to enhance their operating relationships with local hospitals in an effort to reduce high Emergency Department usage and improve quality and timeliness of mental healthcare for ED patients with a primary mental health concern. The projects embed mental health clinicians in Emergency Departments who partner with medical teams to identify and respond to mental health needs early in the triage process which in turn aims to streamline the ED process for individuals, introduce community based, less intensive interventions, and reduce unnecessary ED utilization.

13. **In reference to page 53 of your narrative, is it correct that "most prevalent high cost conditions" was interpreted as "most prevalent conditions for high cost individuals? In other words, the condition may not be high cost? This information does not appear to answer the question that was asked.**

We interpreted the question as "the most prevalent conditions for high cost individuals." We are unable to report on total costs by condition, but we could examine costs per specific primary diagnoses. This would under report the true costs of a condition such as diabetes. VHCURES data may also be able to address this question since these analyses are not typically conducted by OneCare in the manner requested.

14. **Please explain how the patients attributed through the Medicaid expansion methodology in 2020 will be attributed (or not attributed) in 2021.**

Patient attribution methodology is expected to be similar in 2021 as 2020, but is contingent on final payer negotiations at the end of 2020.

Exhibit 1

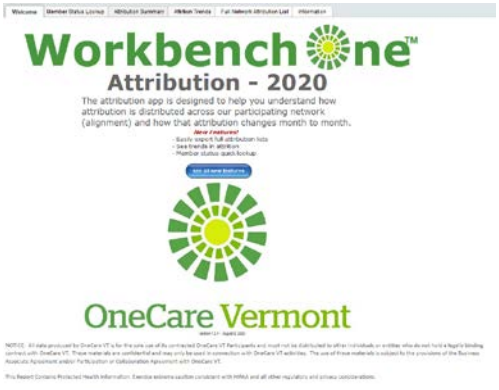
2020 Workbench One Applications

WorkBenchOne™ (WBO) is the platform that hosts OneCare's self-service analytic applications. The WBO data is comprised of claims, clinical and care coordination data that allows users to query independently in the applications, and supports informed decision making that drives a continuous improvement cycle. Inclusion of claims data is dependent on receipt of relevant data from payers. OneCare traditionally deploys a combination of virtual and in-person data literacy training to encourage the provider network to perform queries and generate reports on their own. Below is a list of applications available to the provider network.

Attribution 2020

The Attribution 2020 application was released in April 2020 to provide a simple mechanism for the OneCare network to identify the individuals attributed to a OneCare program in 2020. Attribution is the process by which an ACO becomes accountable for the costs and quality of care for a patient and it is primarily based on a patient's primary care relationship with a provider participating in the OneCare network. This process of linking a patient with their primary care provider is called alignment.

In addition to identifying individuals that are part of a OneCare program in 2020, the Attribution 2020 application allows the OneCare network to determine the individuals aligned to their organization, track individuals who may have lost eligibility at some point in the year, individuals who are eligible for payer specific waivers such as the prior authorization or SNF waiver, and identify those who have opted-out of data sharing. OneCare is accountable for individuals' cost and quality of care for the months in which they are eligible for attribution. However, all individuals attributed to OneCare at the beginning of the year may receive care coordination services for the entire calendar year, regardless of whether they lose eligibility at any point in the year. These complexities in the program structure make it vital for the OneCare network to have an easy and consistent tool, such as the Attribution 2020 application, to understand an individual's attribution, alignment, and eligibility status.



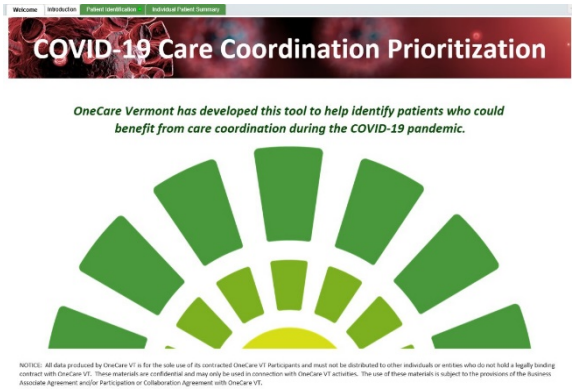
COVID-19 Care Coordination Prioritization

The COVID-19 Care Coordination Prioritization application is a self-service tool designed to identify individuals who are vulnerable to COVID-19 and was released at the beginning of April 2020. The tool is designed to help network healthcare providers prioritize individuals for outreach during the COVID-19 pandemic. The application can be used to:

- Engage and support high risk individuals to help mitigate their risks
- Develop emergency preparedness plans
- Plan for healthcare resource utilization (i.e. ED & ICU)
- Allocate resources within clinical setting
- Expand telehealth services

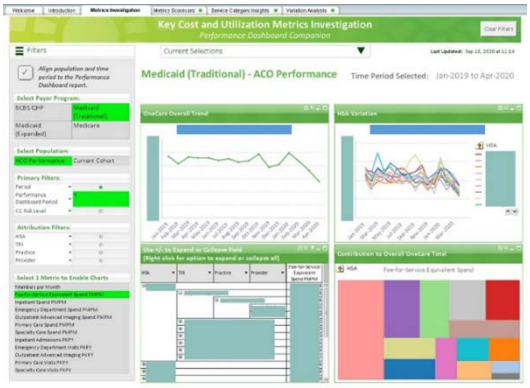
Using World Health Organization (WHO) and Centers for Disease Control (CDC) criteria, the tool identifies individuals who are:

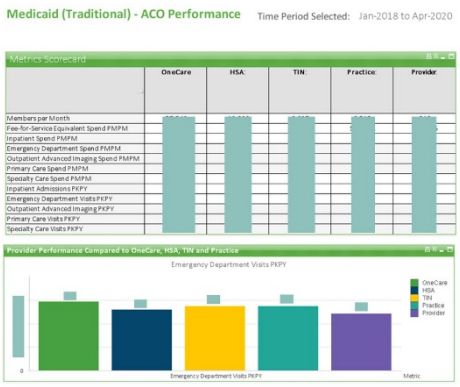
- Older adults
- People with serious medical conditions
- People who are high users of healthcare resources
- People who have seen seven or more healthcare providers in the past year
- People who are frail
- People with mental health disorders



Performance Dashboard Companion

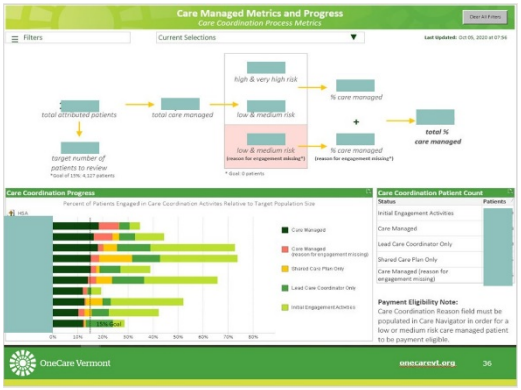
The Performance Dashboard Companion application is a self-service tool designed to complement the Performance Dashboard utilization and spend metrics to identify strengths and opportunities critical to meeting the goals of value-based care. The application was released to the OneCare network in September 2020. The Performance Dashboard Companion allows the OneCare network to monitor trends for the utilization and spend key performance indicators at the health service area, organization, practice, and provider level. Users also have the ability to benchmark their performance against others in the OneCare network who are participating in the same payer programs.

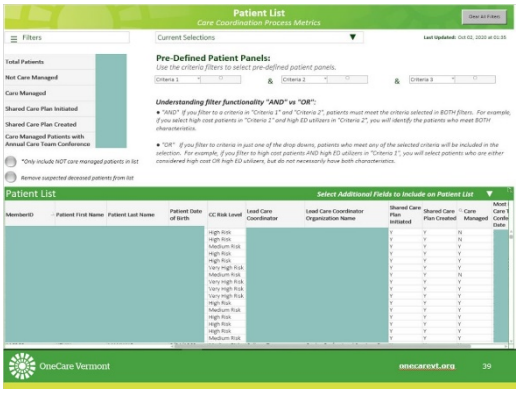




Care Coordination Process Metrics

The Care Coordination Process Metrics application is a self-service tool designed to support the OneCare network in identifying, monitoring, and prioritizing attributed individuals for care coordination. The application received a major update with significant additional functionality and 39 new data filters in October 2020 to continue to help with the implementation of care coordination programs across the OneCare network. The goal of care coordination is to facilitate the appropriate and efficient delivery of healthcare and social services, both within and across organizations. The care coordination payment model is designed to incentivize activities of care coordination that may be associated with improved health outcomes and costs. Those activities may include encounters with a lead or care team member, outreach to a patient, care team conferences, and establishing patient-centered goals. The process metrics included in the Care Coordination Process Metrics application are captured from Care Navigator documentation and used to evaluate and benchmark the performance of the care coordination model.

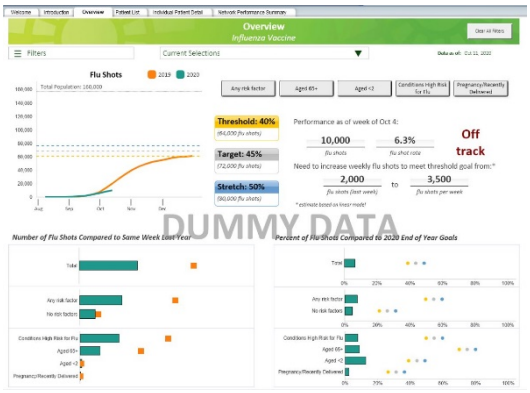


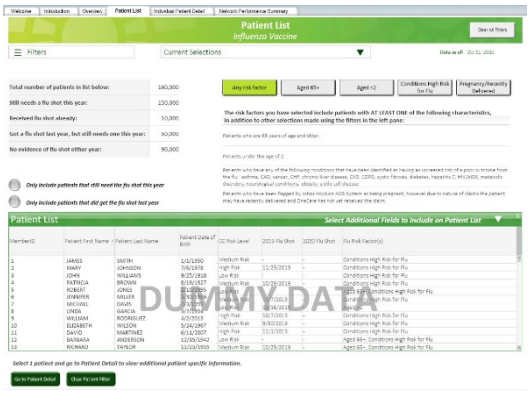


Influenza Vaccine

OneCare developed the Influenza Vaccine application in October 2020 to help providers reach out to as many Vermonters as possible who have not yet received an influenza vaccine. In just one or two clicks, practices and providers are able to identify individuals that have not yet received their flu shot and who are at the greatest risk for poor outcomes if they become ill with the flu. Using guidance from the CDC, the application uses risk factors to identify individuals who are at a greater risk, including those aged 65+, aged less than 2, people with certain chronic conditions such as heart, lung, or liver disease, and women who may be pregnant or who have recently delivered.

The application utilizes payer claims data and clinical data from the Vermont Health Information Exchange to capture flu shot information. This allows for a comprehensive identification of flu shots that may have been provided in locations such as primary care practices, local pharmacies, and grocery stores.





OneCare Data Corner on Vermont Health Learn

The OneCare Data Corner is a course on Vermont Health Learn and is the primary source of self-paced training information for Workbench One applications. Training modules are set up to allow end users to understand the purpose of the application, watch a narrated video on how to navigate the application, and access any additional information that may be pertinent to the objectives of the application. In addition to the individual training modules, new applications and updates to existing applications are announced through the OneCare Data Corner to allow users to quickly learn about recent enhancements on Workbench One.
The OneCare Data Corner currently has the following training modules available for all Workbench One users:

- **Workbench One Introduction** provides an overview of how to access Workbench One, what data is available, and the basic navigation of applications available on Workbench One.
- **Attribution** helps users understand the key terms related to attribution, how to find individuals that are attributed to OneCare, and how to identify individuals eligible for various waivers programs.
- **Performance Dashboard** provides an overview of the Performance Dashboard report and how to navigate the Performance Dashboard Companion application in order to identify strengths and opportunities through trending and variation analyses.
- **Care Coordination Process Metrics** helps users understand key metrics related to the care coordination model and identify areas of strengths and opportunities within a care coordination program.
- **COVID-19 Care Coordination Prioritization** educates users on how to identify individuals who are vulnerable to COVID-19.
- **Medicare Annual Wellness Visits** gives an overview of the benefits and components of the Medicare Annual Wellness Visit, provides a toolkit to help practices increase the number of individuals receiving the service, and teaches users how to identify individuals who are due for their Medicare Annual Wellness Visit.