

**Green Mountain Care Board
Payment Reform Pilot Application
OneCare Vermont
January 14, 2013**

General Information

1) Please name the provider group(s) or organization(s) participating in the pilot and their qualifications to manage the pilot:

OneCare Vermont Accountable Care Organization, LLC ("OneCare Vermont") is a limited liability company organized in Vermont in June 2012 by Fletcher Allen Health Care, an academic medical center based in Burlington, Vermont ("Fletcher Allen") and Dartmouth-Hitchcock Health, an academic medical center and health system based in Lebanon, New Hampshire ("DHH") for the purpose of applying to CMS to be recognized as an Accountable Care Organization ("ACO") eligible for participation in the Medicare Shared Savings Program ("MSSP"), starting January 1, 2013. OneCare Vermont is governed by an operating agreement initially executed by Fletcher Allen and DHH on August 3, 2012 and amended and restated as of September 4, 2012. Fletcher Allen and DHH are the sole members of OneCare Vermont and have equal membership shares. Participating members include the following:

- OneCare Vermont founding members (i) Fletcher Allen Health Care and its employed primary care and specialist physicians and (ii) Dartmouth-Hitchcock Health including their employed specialist physicians
- Seven (out of eight in Vermont) Critical Access Hospitals and their employed physicians
- Six (out of six in Vermont) community PPS Hospitals and their employed physicians
- One Behavioral Health Specialty Hospital and its employed Physicians (only one in Vermont)
- Two FQHC organizations
- Five RHC organizations
- Fifty-eight (58) community/private physician practices and other independent provider types

All together, these providers represent approximately 280 primary care physicians and likely a large majority of the specialty and hospital-based services to Vermont Medicare beneficiaries.

2) What are the goals of the project?

The mission of OneCare Vermont is to create efficiencies in order to improve quality and health care outcomes, reduce costs and to enhance the patient experience for Medicare beneficiaries in Vermont. OneCare Vermont embraces as part of its mission the leadership commitment to work in a highly collaborative fashion with a network of providers that includes the founding academic medical centers in order to improve the quality of care while slowing the growth in the cost of care delivered to Vermont Medicare beneficiaries.

3) How will the pilot aim to achieve the objectives of reducing the growth of health care expenditures, improving the quality of care for the population, and improving patient experience/satisfaction?

The OneCare ACO Participant Network is a collaborative effort among participating professionals and provider organizations serving Medicare beneficiaries. OneCare Vermont believes that a high level of collaboration and care coordination represents the best path toward measurable improvement for Vermont's health care system. The voluntary, widespread participation in this collaborative endeavor is significantly better than having pieces of the delivery system compete against one another. It should also naturally result in a high degree of voluntary cooperation in OneCare Vermont's efforts to promote evidence-based medicine, promote beneficiary engagement, and enhance reporting internally on quality and cost metrics, and coordination of care. OneCare Vermont's quality improvement and assurance policies and procedures to meet MSSP criteria and the promotion of those goals will be encompassed in the "Clinical Model." As defined in the Participation Agreement, the Clinical Model is the written clinical guidelines, processes and procedures for quality and cost control founded on three inter-related mutually supporting elements of: (1) quality performance measure management; (2) case management; and (3) clinical data sharing. Participants will have significant input in the development and refinement of the Clinical Model, which we expect to result in widespread acceptance and compliance.

As an ACO being founded and anchored by two academic medical centers, OneCare Vermont will have substantial access to both established Evidence Based Medicine (EBM) and quality measurement programs, but also to emerging EBM research arenas, some of which Fletcher Allen and Dartmouth-Hitchcock are driving (or participating in) together. We expect the OneCare Vermont ACO collaboration will create additional opportunity to focus on additional EBM studies applicable to Medicare populations in our region.

Fletcher Allen Health Care brings to OneCare Vermont existing quality improvement and EBM capabilities in the form of the Jeffords Institute for Quality and Operational Effectiveness (Jeffords Institute) and Vermont Managed Care (VMC).

It is also important to be aware that both Fletcher Allen and Dartmouth-Hitchcock have applied EBM in alignment with payment incentives and risk sharing agreements for approximately 20 years. Incorporation of all of these elements and the capacity and experience of OneCare Vermont will lead to success in achievement of the objectives of improving quality, improving patient experience, and reducing the growth of health care expenditures.

4) What is the scope of services included in the pilot?

The scope of services for OneCare Vermont ACO program is the total Part A (i.e. hospital) and Part B (i.e. Physicians and other providers) services spend by CMS for the attributed beneficiary population. Although the OneCare Vermont network will directly provide only a portion (perhaps a majority) of the total services to attributed patients, the network will be measured and held accountable for the total cost of care provided to these patients. The attribution methodology ensures a relevant primary care or specialist physician relationship with the beneficiary which should allow for the health maintenance and coordination of care required to better manage the total spend for these beneficiaries. The network described above is, in of itself, a major accomplishment in the state of Vermont, and represents a commitment to statewide clinical collaboration by providers on behalf of the Vermont Medicare population.

5) What payers are participating in the pilot?

Medicare is the only payer participating in the Pilot at this time

6) What population will be included in the pilot? How will they be attributed or assigned to the pilot?

It is anticipated that approximately 40,000 to 45,000 Medicare beneficiaries will be attributed to the Pilot. This population will be attributed based upon Medicare's attribution rules.

7) How will you measure outcomes related to each of the pilot's goals?

Although OneCare Vermont believes its design will result in a functional, self-directed network that will implement the steps to achieve higher levels of clinical effectiveness and a lower growth in expenditures for attributed Medicare beneficiaries, OneCare Vermont has designed mechanisms to ensure network participants meet the quality goals of OneCare Vermont as set forth in the MSSP. These mechanisms will be coordinated by a Chief Medical Officer in conjunction with a Clinical Advisory Board (and reporting overall to the Board of Managers) for the quality assurance and improvement program. The primary mechanisms include:

- Performance and Quality Measurement Reporting - Participants will be provided with ongoing data to measure the effectiveness and quality of their treatment of attributed lives so that they are not "flying blindly". Participants will receive reporting of pertinent information and comparisons at many levels.
- Review and analysis of all available data to identify areas of interest related to the quality improvement and assurance process and use that analysis to inform the Clinical Advisory Board (CAB), local clinical performance boards if established, provider relations staff and individual participants.
- Use of case managers in individual participants' offices in addition to using existing facility case managers. It is expected that these case managers will

evaluate compliance with the Clinical Model and provide feedback to participants regarding their compliance with its requirements.

- Utilize provider relation's staff to interact with participants about their performance.
- Support the State of Vermont health care reform policies by working with the GMCB to ensure visibility to and alignment of the OneCare Vermont clinical approach.
- Develop common tools to implement ACO-wide policy as designed by CAB and approved by the OneCare Vermont Board of Managers (BOM). These tools will be used to create network-wide work lists from which participants will be measured, engaged and evaluated. There may also be opportunities for local care management plans developed by the sub-geographic clinical advisory boards.
- Monitor participant compliance with processes as well as actual clinical and cost results. Participants will be required to engage and accountable for those results. OneCare Vermont has the contractual right, via the participant agreement to monitor compliance with the Clinical Model.

It is the intent of OneCare Vermont to work collaboratively with its participants and providers/suppliers to ensure they understand the purpose and rationale for complying with the quality assurance and improvement program. The goal is to modify, change and improve clinical behavior by providing an explanation of the non-compliance with a request for a corrective action plan within a certain period of time when appropriate to do so. The event would be monitored for compliance within the specified timeframe.

Financial model

1) What is the general model of payment change you will be testing in this pilot?

This is a 3 year shared savings program, upside only, known as "Track One" for the Medicare Shared Savings Program. The ACO will be provided with historical expenditures related to an attribute population of Medicare Beneficiaries. These historical expenditures will be trended forward based on an expected national growth trend established by CMS. This will serve as the baseline expenditure target for the ACO. If the actual ACO expenditure for their attributed population falls below this target by a pre-established "minimum savings rate" percentage, the ACO will be entitled to share 50% of those savings back to the first dollar with CMS. The amount of savings the ACO will receive is also contingent upon their meeting certain quality performance scores in years two and three of the pilot. In year one, the ACO qualifies for any earned savings simply by reporting performance on the 33 measures required by CMS. It is anticipated that the attributed population of OneCare Vermont will allow the minimum savings rate to be approximately 2.3% out of the CMS range of 2.0% to 3.9%. Larger ACOs qualify for a lower minimum rate because the statistical validity of the savings against the target is more robust given a larger sample size.

It is also worth noting that current MSSP rules require subsequent reenrollment/reapplication for the program at the end of year three and requires the ACO to adopt "Track Two" which involves two-sided (downside) risk.

2) Does the pilot necessitate any investment in financial or clinical management capacity or other infrastructure? If so, please describe and quantify the necessary investments?

Yes, the pilot will require significant expenditures and investments both for central operational and technical infrastructure and for the providers and provider organizations participating.

Central Infrastructure

OneCare Vermont central operations will consist of a combination of (i) deploying capabilities from existing human resources and tools residing at Dartmouth-Hitchcock and Fletcher Allen Health Care (ii) creation and funding of new positions and (3) Technology costs, which may likely include external 3rd party expenses. The approved 2013 budget for OneCare Vermont ACO LLC is \$2.6M to be borne equally by the corporate members. Additional detail on the OneCare 2013 budget can be provided upon request.

Participant Expenses

Expenses borne by participant hospitals and provider offices will range across a number of items including:

- Administrative support or analyst time to get information on participant's attributed beneficiaries to ensure current addresses and physician relationships are accurate before OneCare Vermont sends out the approximately 43,000 required letters to attributed beneficiaries
- Time from clinical leadership and quality improvement staff to understand the MSSP and develop participating organization's approaches in implementing the clinical priorities set by the MSSP and the OneCare Vermont Clinical Advisory Board
- Time of one or more physician leaders from the participants serve on the OneCare Vermont Clinical Advisory Board
- Tuition/expenses for conferences, webinars, speakers, or materials on the MSSP to provide educational opportunities for physicians and staff on the program
- Time from participant's information services leadership to understand the informatic needs of the MSSP and develop plans to meet those needs
- Investment in information technology staff time and vendor/consultants to modify if necessary participant's EHR and/or purchase/configure appropriate interfaces to VITL or OneCare Vermont which will contain the clinical information for the 26 clinical quality measures (of 33 total) defined by the MSSP
- Expense to do local CG-CAHPS satisfaction surveying for participant's Medicare patients to self-measure our performance on the 7 satisfaction measures (remainder of the 33 total) defined by the MSSP. CG= "Clinician/Group" = physician visits rather than regular HCAHPS for inpatient encounters
- Training staff, and the time for participant's physicians and clinic staff to be trained in information necessary to provide to and collect from our attributed beneficiaries

- Ongoing physician/staff time for collecting/documenting the required information once trained (which will be higher in early months as we implement new processes)
- Time and effort from care/case managers (or equivalent) to review/investigate attributed beneficiaries listed on OneCare-provided work lists and patient registries (or out of approved systems you already use for such purposes), and provide proactive care planning and coordination for those patients who would benefit from such

3) How will the pilot limit cost increases?

The Medicare Shared Savings Program is designed to be a strong voluntary incentive to reduce the population spend for attributed Medicare beneficiaries. The requirements of the program and commitments in the application are highly consistent with the types of approaches used to limit cost increases on a population-based level. CMS is currently piloting ACO program audits with Pioneer ACOs and has made it clear that the implemented efforts must match the application. Key elements include strong cost performance measurement, application of Evidence Based Medicine, focus on quality measures, beneficiary engagement, shared decision making, and a shared savings distribution designed to incent the network.

It is also anticipated that the large network commitment to OneCare Vermont represents an acknowledgement that the delivery system must build the capabilities in order to succeed under more fixed streams of revenue for attributed populations, which means attempting to limit the overall costs while maintaining quality and satisfaction. The "Track One" model has allowed the providers to build these capabilities for Medicare, which is typically the largest payer for providers. Building clinical integration and comparative analytics for attributed Medicare beneficiaries will form the basis of both the "halo effect" to all Medicare beneficiaries and could be applicable to potential multi-payer programs.

4) How will financial risk (risk for exceeding the target rate of growth) be assigned under the pilot?

This is a Medicare ACO-SSP Model, Track 1, upside only, with no downside risk for the first three years.

5) How are you proposing to share any financial savings that might be achieved through the pilot?

The plan for sharing savings with the participating providers is described in the "Savings Distribution Plan" in the CMS Application. It is intended that 90% of the earned savings will be shared with the PCPs, Specialists, and participating hospitals in accordance with the shared savings plan. When OneCare Vermont qualifies for shared savings, the first 50%, as defined under MSSP Track One, is retained by CMS. Once actual shared savings dollars payable to OneCare Vermont are calculated and received, they will be distributed as follows:

- 90% will be distributed to the network participants:
 - Half of the 90% will go to the participants (as defined at the Tax Identification Number level) who contribute attributed Medicare beneficiaries "and" meet the minimum quality score for those specific attributed Medicare beneficiaries. Those eligible for payout will then

receive a share based on the attributed lives they represent out of the total population of attributed Medicare beneficiaries. It is anticipated that OneCare Vermont will consider adding distribution parameters to reward higher quality performance above the minimum based on actual scores achieved for a provider's Medicare beneficiaries. OneCare Vermont envisions working with the Clinical Advisory Board on the exact parameters of this model. The Medicare MSSP attribution model is heavily based on PCP relationships, and as such, we generally refer to this component of savings as the "PCP Share." However, other providers, including specialist physicians, can drive attribution in certain instances and are also eligible for this sharing mechanism.

- The remaining half of the 90% will go to participants providing hospital services and/or specialty physician services to the attributed Medicare population. These participants will receive a share based on the Medicare net revenue they received for the attributed Medicare beneficiary population for these services divided by the total of net revenue for these services to the attributed population across all participants. It is anticipated that OneCare Vermont and the Clinical Advisory Board will design for year two and beyond, a OneCare Vermont-defined quality measurement and incentive mechanism appropriate for hospital and/or specialist services to attributed Medicare beneficiaries.
- 10% of any shared savings will be retained by OneCare Vermont to partially offset the investment and ongoing costs to provide tools, data, and methodologies to support the participant network. It is not anticipated that this share will fully cover or exceed the required expenditures, and the OneCare Vermont Board of Managers and executive leadership will assess the implications in the unlikely event that this share exceeds the required expenditures.

6) How will provider compensation plans be structured within the pilot, and how will they align financial incentives for physicians and other health care practitioners with the performance goals of the pilot?

Under the MSSP program, provider reimbursement will come from the regular FFS model applied by Medicare. For physicians, however, the change in "compensation" model will be the ability to strive for hospital-based savings and share in those on top of receiving their FFS reimbursement. The Shared Savings distribution model described in the previous question, with 50% of total savings going to attributing physicians, should provide significant incentive to drive physician behavior across the network. If OneCare does qualify for savings by beating the minimum savings rate, the shared savings amount on over 43,000 Medicare beneficiaries will be material. Although OneCare did not make this a requirement in the Participant Agreement, it is anticipated that OneCare Vermont hospital-based organizations with employed, salaried physicians will ensure that any savings checks they receive from the physician attribution pool will in one form or another be given to or shared with their physicians to reinforce their efforts.

Clinical model

1) How will Care Management responsibility be assigned or shared under the pilot?

The Medicare vision anticipates that the primary care office, and in some cases a specialist office, will be the core of care management for individuals. OneCare Vermont plans to supply both population performance reports and patient level tools that can be used for care management by primary care physicians, staff in the primary care office, community health teams, hospital-based care management staff in support of employed practices, and central care managers at OneCare Vermont for selected patient populations. Given the multi-geography nature of the OneCare network, the model may vary across the network but be measured for results accountability. Evidence of care coordination across the care continuum will be discerned through use of OneCare's well-developed analytical tools and data warehouses. Extraction and combination of clinical, claims, Admissions Discharges and Transfers (ADT) and other data elements will allow OneCare to link hospital, primary care and specialty care professional practice, and sub-acute and community-based experience within beneficiary-specific episodes of care. Breaks in the care chain or incomplete care chain patterns will result in follow up analysis and interventions comparable to those described above.

2) How will the pilot project align with the Blueprint for Health?

OneCare Vermont will benefit from the State of Vermont's Blueprint for Health and its Patient Centered Medical Home designs for primary care delivery. The State of Vermont's policy for rapid adoption of the NCQA medical home model will facilitate supportive communications with participating providers. These models are predicated on achieving patient engagement—supported by care coordinators who will assist beneficiaries in navigating the health care system to obtain their needed care. The Blueprint model includes multi-modal patient engagement practices, in particular the multidisciplinary provider-specific Community Health Teams that are tailored to local population needs. For example, Community Health Teams in greater Burlington Vermont include translator, interpreter and cross-cultural expert resources to engage the area's large and growing population of resettled elder refugees from Sub-Saharan Africa and Central and Southeastern Asia as well as the large legacy population of French-speaking Medicare beneficiaries.

As ACO provider participants continue to develop and evolve use of Electronic Medical Record systems (EMR), wider use of patient portals being made available as another means of engagement is expected. OneCare will promote and align with already established meaningful use standards for access to medical records. State of the art Epic patient portals are in place at Fletcher Allen Health Care and Dartmouth Hitchcock and will soon be available at Central Vermont Medical Center. These three providers represented over half of Vermonter's hospital admissions in 2010. As mentioned in OneCare's application, the ACO also anticipates extending shared decision making throughout the network over time. These shared decision making efforts may include sharing of tools developed and resident in the Dartmouth-Hitchcock system, utilization of web based tools, and provision of clinician training about effective ways to incorporate shared decision making into clinical practice. All these efforts will be informed by our internal data warehouse and reporting capabilities.

Beneficiary communication standards for OneCare Vermont will stem from established best practices for individualized and population-based patient-centered messaging as well as from related evolving science. Established best practice standards include those embedded in the NCQA standards for Patient Centered Medical Homes. Again, Vermont's on the leading edge of public policy for health care reform centers on rapid diffusion of the NCQA Patient Centered Medical Home model across the state's primary care community—bringing substantive advantage to OneCare operations.

3) How will the pilot enhance coordination of patient care and provide for a focus on prevention and promotion of wellness?

The MSSP and OneCare Vermont vision strongly support an expanded focus in this area. Some elements include:

- The 33 quality measures contains metrics which directly tie to preventative EBM practices
- A Clinical Advisory Board which will set specific program and process standards for selected areas which may include one or more focus areas on wellness and prevention
- Care management work lists with underlying clinical rules engines to identify “at risk” patients for proactive engagement on wellness and well-being
- The overall shared savings incentive model will incent physicians to take steps to avoid acute care through prevention and wellness on a patient by patient basis

4) How will OneCare encourage adherence to clinical standards, and achievement of desired outcomes for the patients?

OneCare Vermont will rely on the Clinical Advisory Board (CAB) for Evidence Based Medicine (EBM) guideline development and dissemination. The CAB, comprised of clinician leaders from the OneCare network participants, will review clinical performance data to identify areas of high variation within the network and/or where overall network performance against accepted EBM standards should be improved. Where appropriate, this Board will adopt existing EBM protocols or initiate a process to develop new ones to address the areas of concern. Given the geographic and population scope of the OneCare Vermont ACO, we anticipate utilizing regional Clinical Performance Committees (CPC) that will assist in guideline implementation with tailoring to the practice circumstance of its region. As region-specific performance data is generated, each region will identify needed areas for guideline development specific to their beneficiary population and improvement opportunities. Both Dartmouth-Hitchcock's and Fletcher Allen's experience with guideline dissemination reflects that identifying “champions” within local systems of care is important in obtaining overall clinical support and adherence. OneCare anticipates drawing strongly from the resources of our two Academic Medical Center participants to assist with guideline development and the quality departments of the ACO member hospitals.

As OneCare Vermont promotes EBM protocols, we will communicate specific patient or provider criteria to support individualized decision-making use of the EBM protocol. OneCare will monitor both population performance rates against EBM standards as well as individual

clinical cases and provider performance to ensure individual circumstances and guidelines are followed. Expected levels of clinical performance will be set commensurate with expectations that individual circumstances are considered. OneCare appreciates the need to take into account circumstances such as co-morbidities, patient choice, values and priorities. OneCare Vermont will strive to understand and accommodate the many appropriate factors that influence compliance rates and targets, while also supporting the participant network in removing avoidable barriers to improved EBM compliance including access, language, financial concerns, transportation and others.

OneCare Vermont will also take into account individual circumstances through promoting patient shared decision making across the participant network as a cornerstone of our beneficiary engagement strategy. Dartmouth-Hitchcock has a well-established Center for Shared Decision Making which includes counselors, written shared decision making literature, and digital media that beneficiaries can use to identify the values and goals they have for various healthcare decisions. OneCare anticipates that this model and resources will be shared with the ACO network participants to be applied or emulated across the OneCare Vermont geographies and beneficiary populations. The use of shared decision-making aids and tools will enable clinicians to effectively take into account the individual circumstances of OneCare beneficiaries when EBM protocols are being considered.

To support OneCare Vermont providers on both EBM compliance and individual circumstances, EBM reporting (see the example below) will be provided to clinicians at the patient level where the appropriate medical relationship with the beneficiary exists. Clinicians will be able to provide feedback to the ACO medical leadership on the validity of data as well as the appropriateness of the protocol for the individual circumstance. OneCare Vermont medical leadership will consult with the network providers on the specifics pertinent to individual cases when applicable.

5) How will the pilot encourage integration of mental and physical health care services?

It is anticipated that this will be an important year one conversation for the Clinical Advisory Board and we expect to survey for best practices across the network, and ask for leadership from both primary care and behavioral health provider organizations in our network. We hope to also partner in this discussion with the Blue Print for Health, Agencies on Aging, Community Health and SASH teams, and other parties to more clearly understand the needs and opportunities for better integration of mental and physical health for a Medicare population. OneCare Vermont believes this is a highly important driver of success for the MSSP model.

Proposed Timeline:

This Pilot, if approved, will begin on January 1, 2013, will extend through December 31, 2015.