VERMONT

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Questions for OneCare Accountable Care Organization on October 20, 2017 budget resubmission

Provider Network

1. It is unclear from the OneCare Savings/Losses Policy how risk for the fee-for-service spending is managed outside of the hospital risk HSAs. Please explain.

   Per the OneCare Savings/Losses Policy, the HSA home hospital bears the risk on the total cost of care for their locally attributed lives. In other words, the home hospital is at risk for spending in their facility, for services delivered by other in-network providers, and for services delivered at other out-of-network providers for the lives attributed to their HSA.

2. How and why will the ACO pay fixed payments to the hospitals when the attributed lives count will drop throughout the year?

   Attribution is set prospectively and unless the attributed life no longer has coverage with the payer, OneCare will maintain accountability for that patient for the entire performance year. However, the question is correct that attributed lives will drop coverage during the year and as such we will not have ongoing full year accountability.

   For the fixed payment model, OneCare Vermont will be paid monthly by payers prospectively for the services to be delivered to the attributed lives by participating hospitals. The amount of payment to OneCare, and then subsequently out to the hospitals, is based on the expected spending at those hospitals if OneCare were to meet its overall target, and with the underlying patterns matching historic spending at those providers.

   Whether through monthly adjustments or retrospective settlement, OneCare will only be accountable (and entitled to the revenue) for the actual member-months based on attributed lives with continuing coverage. Because of these eligibility changes, the amount OneCare Vermont and the fixed payment providers will receive may be adjusted monthly or reconciled retrospectively on a periodic or annual basis. We are currently unsure of the Medicare methodology and are still negotiating the Blue Cross Blue Shield of Vermont methodology. Once those mechanisms are known, we can finalize our fixed payment approach which may include monthly adjustments, withholds, or interim reconciliations. OneCare will provide monthly reconciliation statements to providers to accompany the monthly fixed payments, and which will contain any specific factors or calculations for changes on continuing coverage for attributed lives.

   OneCare is implementing the fixed payment model to help manage the overall healthcare spend and more clearly drive hospitals away from a pure fee-for-service, volume-based focus. The model is not unlike the GMCB's enforcement of the hospital budget NPSR caps. For OneCare's overall risk performance, the hospitals agreeing to deliver care at a fixed revenue level on a prospective basis effectively "locks in" a large portion of the overall cost of care. This means the remaining FFS is the variable component that will ultimately drive shared savings or overruns on our payer targets.

3. Please provide more information to explain how "the worst-case payback scenario is affordable for hospitals." The GMCB is interested in evidence that each risk-bearing hospital has identified funds to address the worse-case financial scenario, not only if each individual hospital's losses reach their own risk-capped amount, but if the aggregate ACO losses reach the ACO's capped amount.

OneCare has been transparent with the budget models and maximum risk estimates, which allows individual hospitals to assess the possible impact of a worst-case scenario of downside risk payback. OneCare has not conducted an analysis of the margin performance or balance sheet soundness of risk-bearing hospitals as we believe they are in the best position to judge their readiness to assume risk at the levels projected. Because the risk-bearing hospitals were given an estimate of their maximum risk limit, it was entrusted upon hospital leadership and their boards to determine whether or not participation in a year when maximum risk is endured would jeopardize financial solvency.

We also justified our statement using a degree of knowledge on the magnitude of other potential risks against hospital budget performance and/or hospital balance sheets including worse than expected volume or acuity levels in a fee-for-service system, worse than budgeted annual changes in reimbursement by Medicare, unexpected changes in Medicaid reimbursement levels or methodologies, decreases in DSH payments, unexpected emergent capital needs based on unexpected equipment failure or newly discovered physical plant deficiencies, lower than expected cost report-driven settlements and related payment adjustments. Any one of these could and likely have been of similar magnitudes to the maximum OneCare risk levels.

For the ACO risk programs in aggregate, the sum of the maximum risk limits for each hospital is equal to the maximum ACO-wide risk if the aggregate ACO losses reach the ACO's capped amounts.

4. Is OneCare Vermont having discussions or making plans to work with the independent providers who will be providing services at the Green Mountain Surgery Center?

OneCare has contracted with many independent providers under our current ACO models and payment reforms which include substantial programs for independent primary care physicians. We plan to engage with independent specialists on how to better include their practices in OneCare population health management and value-based models for the 2019 budget. On the Green Mountain Surgery Center (GMSC), discussions have not occurred to date on how the addition of a new surgical facility might impact, and can best align with the population-based economics and quality metrics (including access and satisfaction) for OneCare's attributed lives. We expect to begin such discussions in 2018 with GMSC leaders and the providers expected to perform procedures at that facility.

5. What network changes do you anticipate for any lines of business in 2018? Do you anticipate any providers previously participating only in the CHAC network joining the OneCare network for 2018 for any business lines?

OneCare does not anticipate any changes to networks on any lines of business in 2018. Due to payer programmatic requirements, we have already committed to our 2018 network and are unable to add additional attributing providers now or during 2018. Beginning in 2018 we will start to have discussions with any willing providers who were a part of CHAC and wish to participate in OneCare for the 2019 performance year.

Payer Contract/Agreement Questions

6. Please provide final executed payer contracts, as soon as available, including for the self-insured business you have listed on the payer table.

OneCare currently has not executed contracts with any of the payers for 2018. We anticipate signing agreements later this fall/early winter but no later than December 31st. As we execute our contracts with payers, we will provide to the GMCB accordingly.

7. Please explain whether the ACO is assuming risk for self-funded business and the accounting for self-funded business. Are there additional plans for other self-insured plans?

The self-funded program included in our revised budget is anticipated for a single employer (UVMMC) and is budgeted as including funding from the employer for aligned population health approaches and payment reforms with our other programs, and including upside-only risk on total cost of care with 30% sharing by OneCare. There is no downside risk for the ACO on excess spending against the target.

OneCare Vermont is very interested in growing the self-insured model beyond UVMMC for the 2019 plan year. One of the specific goals of the initial 2018 program with UVMMC is to serve as a pilot for building OneCare's capabilities and value proposition for self-funded employer plans.

8. Please decompose the components of growth for the Medicare, Medicaid, and Commercial trends of 3.5%, 6%, and 3.8% respectively. What are the drivers of these growth trends?

The rate trends in the budget are the current best estimates available. Negotiations and analysis with the payers to finalize the projected targets and the calculated rates of increase from base data are ongoing and expected to conclude later this fall.

9. You indicate that OCV has developed tailored applications that help both internal and external parties monitor their financial performance. You also noted that the Medicaid contract is overspending in the FFS line. Are there any changes mid-course you have made to remedy this? How will you prevent and monitor this with 3 payers in 2018?

Due to the January 1, 2017 start of the program and claims runout requirements, it has only been in recent weeks that initial 2017 data is meaningful and capable of driving conclusions and areas of focus. One of the immediate, and in our opinion constructive conclusions supported by the performance, is the need for the network to truly focus on the "remaining FFS" spending. We are currently responding to multiple requests to better drill down on explanations for that performance including which providers and where, which types of services and which Medicaid enrollment populations. As VMNG becomes a continuing program, more ongoing longitudinal analysis and patterns will be available for new population health programs and patient engagement strategies.

Regarding specific changes mid-year, in July 2017, OneCare Vermont launched the Complex Care Coordination program which targets the high and very high risk Medicaid covered lives attributed to the program. This was pre-planned rather than a reaction to early performance, but does focus on supporting our highest complexity and cost enrollees in ways which may mitigate spending through more proactive and preventative care with less waste and duplication. Whether or not this helps measurably impact utilization or spending through the remainder of 2017 is unclear, but builds the foundation for a program that will be rapidly expanded for the larger population across three payer programs in 2018.

OneCare has also significantly stepped up its efforts in 2017 on driving analysis and best practice conversations around episodes of care and disease states. On episodes of care, OneCare has built and deployed an analytic tool focused on the CMS-defined set of 48 specific clinical episodes which are selected for focus based on an acute care inpatient stays but which typically also has significant pre and post-acute care delivery. The OneCare network has taken the significant variation in episode spending patterns to heart with at least one large HSA implementing a specific focus on post-acute care which has decreased use of more expensive follow-up when not clinically required. On disease states, OneCare has created and facilitated statewide activities and clinician-to-clinician best practice sharing on hypertension, diabetes and CHF.

10. It was noted that you have significantly increased your analytical and best practice conversations around episodes of care and disease states. How will you leverage episode analysis that identifies areas of practice variation to standardize care processes and thereby eliminate waste and avoidable complications?

OneCare has developed the OneCare Episode Application in its WorkbenchOne analytic platform. The application mimics Medicare's Bundled Payments for Care Initiative methodology by using their definitions of inpatient DRG families (48 groups) and categories of acute inpatient care, part B professional payments and many categories of post-acute services. These categories of reimbursed services permit analysis of expenditures (claims cost) and utilization metrics such as length of hospital stay, skilled nursing facility days, home health encounters, hospital readmission rates at 30 and 90 days, emergency department services during the 30 and 90 day post discharge period, use of other outpatient therapies and physician office follow-up visits.

This OneCare Episode Application not only allows OneCare medical leaders, clinical consultants, and analysts to easily identify and communicate variances to network participants and accountable communities, it is also part of the self-service toolset of WorkbenchOne with providers being able to drill down examine drivers of variation both within and against other HSAs. Report–based versions of key analytic outputs are also shared on our secure portal with all OneCare participants so that they can see where they compare with other participant service areas and discharging hospitals. It is our belief that sharing this information with our participants will result in changes to clinical processes and refined ordering patterns by discharging physicians.

For improvement, we have driven specific focus on post-acute service referral patterns that reflect careful consideration of why these variations exist in their community and as informed by network benchmarks. The analysis also permits risk adjustment based on the Case Mix Index of the "anchor admission DRG". Our critical access and acute hospital cohorts can also be compared separately since reimbursement methods by DRG payments or cost based reimbursement are quite different. Individual meetings between OneCare personnel and participants in various Health Service Areas also help to educate the communities about how to use this data.

OneCare's CMO, Dr. Norman Ward, has regularly used the Episode Application and the analytic reports on episodes in his interactions with network and HSA physician leaders to point out variation and opportunities for improvement. OneCare is currently preparing to include reducing episode variation in post-acute care and episode-based readmissions in a quantified assessment of financial opportunity for 2018 performance improvement by community. Although we will continue to take a facilitative approach in 2018, we will be signaling in future years that economic models may further incent, or even build in progress toward best practice performance on episode-based expenditures.

11. When do you need to decide whether you will have an 80% or 100% risk arrangement with Medicare?

We are required to notify Medicare of our risk arrangement choice no later than 5:00 pm on December 27, 2017.

12. Please provide any final changes to Template #1: Revenue by Payer (Sect 4. Attachment C-1).

There are no changes to report at this time.

Budget and Risk of ACO

13. How will the CEO, Todd Moore, allocate his time now that he has additional responsibilities managing the New York ACOs? Please explain if there are any firewalls or accounting changes being put in place.

Leaders and staff at OneCare Vermont who have other specific roles or duties unrelated to OneCare have conducted bi-weekly time-tracking for many years to appropriately allocate expenses to OneCare. This has included the OneCare CEO, Todd Moore, who accounted for time spent on the Adirondacks ACO as a Board Member, and now will continue to do when conducting business as its CEO. For Mr. Moore and others expected to spend time on non-OneCare duties including the Adirondacks ACO, the OneCare Vermont operational budget includes only the portion of time expected to be focused on OneCare Vermont. Like any other budgeted expense, these projections may or may not have a variance once actual experience is accounted for and included in financial statements. In the 2018 OneCare Vermont operational budget, Mr. Moore is projected to spend 50% of his time on OneCare Vermont, which is comparable to his past experience when based on actual time tracking.

14. What are the "multiple moving parts" referenced in the budget projections Section 4, Attachment C-1?

This mainly refers to changes in the participating provider network, attributed lives, and available actuarial data for planning and budgeting. Over the past few years, and particularly as OneCare Vermont has progressed towards risk-bearing models, the providers participating in the network have evolved. With this, and also due to general changes in the attributed population, the covered lives have also changed. While it may seem that these changes would have a minimal impact on the overall ACO spending targets, data shows that variation in utilizations and spending among HSAs in Vermont are high enough that adding or dropping providers and their attributed lives can result in material shifts to spending on the PMPM level. This effect also adds uncertainty when adding new network participants, as it's more challenging to project their attributed populations and spending levels without the multi-year longitudinal data we have available for long-term OneCare participating providers..

15. Why are you electing not to pursue high cost truncation in your Commercial and Medicaid contracts? What is your reinsurance strategy?

We have and continue to explore high cost case coverage for the Medicaid and BCBSVT populations. Generally, we have focused as a first priority on negotiating a lower risk corridor which will limit the total downside risk to levels less than traditional risk contracts. Based on feedback from OneCare's network participants, limiting total

exposure is the most desired element. Certainly we are also interested in doing what we can, subject to negotiation and affordability, to better ensure that downside risk exposure is not driven by the types of large cases which are more subject to random variation. However, many experts believe that better care coordination for high-risk, high-spend individuals is one of the more proven ways ACOs can save money.

At this time, we continue to craft our reinsurance strategy and are in substantial discussions with our reinsurance broker and carrier on the best approach. Current indications are that purchasing both overall total cost of care protection for the situation where all programs see large overruns, and adding in large case reinsurance for Medicaid and BCBSVT to our policy, will generate a premium well in excess of the amount in the budget approved by the OneCare Board of Managers. Despite the cost, discussions are ongoing to carve out high cost cases where possible.

16. The following question has been posed to the hospitals in reference to the tables below:
    a. Whether or not the maximum upside and downside risk matches what you've determined for risk;
    b. Indicate how you are accounting for the risk on your books; and
    c. Whether or not the fixed payment from the ACO matches what you've been given for information.

    In response to these questions posed to hospitals, how are the hospitals and ACO working together to monitor spend both internally to the hospital for its hospital and employed professional costs, and at the HSA level?

    OneCare Vermont works with the risk-bearing hospitals in important ways. First, we provide transparency in our budget models which project HSA attribution and spending targets as part of our overall ACO population targets. The accuracy of such budgets is impacted by limits on available planning data (especially for Medicare), our ability to predict actual attribution and continuing plan coverage, and our projections of where actuarially-based negotiations or target methodologies will ultimately land. Second, we developed and provided a savings and losses sharing policy which determines how the hospital's cash repayment to, or cash savings from the ACO will be calculated. This includes the approach to maximum cash repayment risk limits, which for 2018 are based on applying the ACO-wide program risk corridors to the HSA-level targets for each risk program. We also provide projections of the fixed payments to be received by OneCare from the payers, and how they will be used and redistributed to OneCare reform programs and to hospitals for payment for services to attributed populations.

    Once we cross over into the risk performance year, all numbers in the budget will be revised based on actual attribution and recalculated figures for actual attribution, but will be highly consistent with the budget methodology. From there, a significant portfolio of reports, self-service applications and responses to ad hoc information requests will guide our hospitals in understanding both their own performance against expectations, but also the totality of experience and expense for their HSA's population when receiving services. For the fixed payment to the hospital, we report the utilization and shadow claims expense (what would have been paid under FFS) against budgeted expectations. For the total cost of care, we report the total utilization and spending to include both the hospital fixed payment program and all other spending for the attributed lives. This information is reported and analyzed through multiple "slices" such as by payer, by service type and by enrollment type. Our approach strives for true understanding of the performance and patterns, and is designed to help set initiatives for improvement during the performance year.

    Based on monitoring of performance during the year, and once enough experience is known, OneCare will also work with risk-bearing hospitals to accrue for any expected cash repayment to the ACO. This accrual shall be

refined up through the time of settlement the following year, such that risk performance has already been matched to the best of our abilities to the period in which the performance occurred. If accurate, the accrual shall mean the cash payment at settlement, if any, will not affect the income statement at the time of settlement.

OneCare Vermont		
GMCB Supplemental Information		
Projected Maximum Risk Limits		
HSA	**Risk Bearing Hospital**	**Projected Max Risk Limit**
Bennington	SVMC	$ 410,124
Berlin	CVMC	$ 3,495,009
Brattleboro	BMH	$ 1,344,808
Burlington	UVMMC	$ 9,596,728
Middlebury	Porter	$ 2,302,326
Springfield	Springfield	$ 1,831,141
St. Albans	NMC	$ 1,626,913
Newport	NCH	$ 263,836
Windsor	MAHHC	$ 84,671
Lebanon	DH	$ 500,926
TOTAL		**$ 21,456,481**

*The numbers above are both the maximum downside risk and upside potential.

OneCare Vermont	
GMCB Supplemental Information	
Projected Hospital Fixed Payments	
Hospital	**Projected Fixed Payment Amt**
DH	$ 11,440,414
SVMC	$ 7,787,263
CVMC	$ 56,878,211
BMH	$ 16,210,940
UVMMC	$ 214,756,490
Porter	$ 23,759,898
Springfield	$ 10,914,223
NMC	$ 23,451,553
NCH	$ 4,778,550
MAHHC	$ 1,074,209
	$ 371,051,749

17. Does the UVMMC letter of credit for 2017 cover the maximum Medicaid loss? Do you anticipate another such letter for 2018?

The 2017 letter did cover the maximum Medicaid loss in support of finalizing the first year program contract before the final risk-sharing agreement was reached among the program participants. In light of the OneCare Board of Managers approved risk sharing policy for 2018, and contractual commitments by participating providers including the risk-bearing hospitals, we believe that such a letter of credit is not necessary for 2018.

Model of Care

18. You are investing significantly in your Complex Care Coordination Program to assist in providing care delivery in the most appropriate settings. What are your projections for how this model will reduce the total cost of care? How will the operations of the Complex Care Coordination Program, including decisions regarding which patients to target and how, be integrated with the efforts of risk-bearing hospitals to manage their budget?

We have not calculated a specific targeted cost reduction from the Complex Care Coordination Program which just truly began in July of 2017 for our VMNG program. Our community-wide team-based approach to addressing the diverse care needs of high cost/high needs individuals, rather than a single remote care coordinator, is innovative and we are unaware of any similar programs nationally. In looking to other ACOs for cost savings, there is a small body of literature that addresses cost savings: the most recent article published in Health Affairs May 2017, identified $101 PMPM savings (6% reduction) in a Medicare population due to their complex care program.

Patients are identified through prospective risk stratification using the John's Hopkins Adjusted Clinical Grouper to create a risk score and corresponding risk rank for every patient attributed to OneCare. The top 16% of Medicaid and Medicare beneficiaries and the top 3% of commercial and self-funded beneficiaries are then identified as high/very high risk and potentially able to benefit from the services in the Complex Care Coordination Program. Trained care coordination staff from primary care, community health teams and continuum of care organizations then use these patient lists to identify opportunities to engage individual patients in care coordination. This can include identifying patients that could benefit from preventive care with a primary care provider to the creation of a shared care plan with patient-directed goals and specific follow-up tasks for the identification of a need for palliative care or hospice services. As members of the care teams, hospital staff participate in all of these activities and are supported through additional tools such as financial and utilization reports that examine trends in use of specific services such as emergency department utilization or inpatient readmissions. By examining "super utilizers" of the emergency department, for example, care teams can learn about the root causes for these utilization patterns and begin to address these areas of concerns.

19. You describe on p. 58 of your submission that you will have a care coordination impact and evaluation plan for your implementation of Care Navigator. By when do you expect this plan to be complete?

We have already developed utilization tracking mechanisms for our high-risk cohort to monitor trends on key metrics such as ED usage and impatient admissions. We are actively working on an evaluation plan that will allow for cohort analysis of patients engaged in the complex care coordination program compared to those that are not engaged in the program. We anticipate that the first phase of the evaluation plan and supporting analytics tools will be available by mid-2018; however, complex care coordination interventions are complex and can vary based on patient preferences and local resources, thus we anticipate early indications of outcomes improvement will occur in 2018 and beyond.

20. For your new investments in primary care, what is your anticipated return?

OneCare approaches our primary care investment strategy as a holistic and long-term approach to the goals of the All Payer Model (APM). The APM challenge is to grow health care expenditures at 3.5%, designed to track with general inflation, while simultaneously improving public health status, quality of care, access and satisfaction. We see continued and expanded reliance on the patient-centered primary care medical home as the core ingredient to achieving these objectives. We are not seeing our approach to investment in primary care as an isolated program which can be undone in future years. The philosophy for the 2018 budget is to effectively "prime the pump" by marginally reducing the financial resources allocated to acute care and reallocating those resources toward primary care and other "upstream" community providers and programs which are designed to lower the need and demand for acute care over time. This is the very essence of our strategy.

We also believe that to maintain, let alone expand primary care access and capacity for Vermonters, requires more resources be directed to primary care. We believe primary care has been asked for a decade to do significantly more within the health care system with only limited increases in financial support. We look to change that trajectory, while working with primary care to ensure support toward the overall goals of the ACO and APM models. We believe Vermont can be a leader in a primary care model which attracts and retains physicians, advanced practice providers and practice support staff by better matching resources with the efforts our medical homes are making to deliver true population health management.