VERMONT

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The following are questions based on 11-2-2017 presentation and 10-20-2017 budget resubmission

Green Mountain Care Board's Questions

1) Your days cash on hand makes a large jump from 2016 to 2017 and remains high in 2018 while the income statement shows a net $0. Please explain.

2) Please break down the 'Due to Other' liability account on the balance sheet.

3) Expanding on Part 4, Question 5 of your resubmission, please break down the $10.9 million in Population Health Management programs and operations both by account and by hospital.

4) Please explain how the $7.6 million in payment reform payments will be divided at the community level by provider type.

5) Will you have a different Grievance and Appeals Policy for each payer? If not, why?

Please refer to L&E's 11-6-2017 draft actuarial recommendations document when answering the following (all are also listed in the memo):

Payer

6) Provide additional quantitative and qualitative support of the flow of funds between projected balance sheets and income statements. Provide detailed illustrations of the flow of fund between the parties involved in the operation.

7) Provide finalized versions of the payer contracts before executed, for review, by November 15th.

8) Provide detailed calculations of the TCOC targets, including an example from the table on Slide 15 of your OneCare VT November 2, 2017 presentation, and much stronger documentation for actuarial soundness.

Budget

9) Please justify why 3.5% was chosen as the growth rate, and how OneCare projects future growth rates in light of the requirements set forth in the All-Payer ACO Model Agreement.

10) Provide additional quantitative and qualitative support for items that have changed since the last budget submission (e.g. VMNG PHM Program Pilot - Complex CC).

Risk Mitigation Strategy

11) Please explain why you have categorized the Medicare and Commercial payer programs as "Full Risk."

12) There is a solvency concern for OneCare if a big Health Service Area (HSA) generates a huge loss at the HSA's MRL but the other HSAs generate small savings. This would result in an overall loss for OneCare, and it is unclear if the pooling mechanism is effective in mitigating the risk in this situation. Please provide an example where there is equitable gains and losses among the HSAs and an example where multiple, larger HSAs have losses.

13) If the other hospitals cannot or choose not to help out if there are overages, is OneCare responsible or do the hospital face the risk entirely? If the responsibility falls on OneCare, is the reinsurance great enough to cover this?

14) L&E recommends that OneCare consider adding a risk adjustment process to the claim costs to take into account the health status differences between:
    - The HSAs, or
    - The actual and target populations.

    Please describe if you will take L&E's following recommendation into account in your planning. If not, please explain why.

15) Please provide a formal reinsurance quote or agreement. If this will not be provided by November 15, 2017, please explain why.

16) Based on the Shared Savings results and the fee-for-service spending in the 2017 Medicaid Contract, please explain how the steps you are taking now and in future years are expected to be effective in controlling your increasing costs and utilization.