To: **Kevin Mullin, Chair, Green Mountain Care Board**
From: **Todd Moore, CEO OneCare Vermont, Accountable Care Organization, LLC**
Date: **June 23, 2017**
Subject: **OneCare Vermont ACO 2018 Fiscal Year Budget**

Dear Chairman Mullin,

OneCare is pleased to present our first-ever annual budget to the Green Mountain Care Board. As you know, 2018 represents Year One under Vermont's All Payer Accountable Care Organization Model (APM) and OneCare is poised to take major steps forward in nearly every way. We are submitting a budget focused on helping OneCare providers and communities move ahead on promoting wellness, coordinating a fragmented system, further improving quality and access, and delivering better care at a more predictable and affordable cost.

Please accept the attached OneCare Vermont's 2018 Fiscal Year Budget Package which includes the following sections as outlined by the GMCB:

Section:
1. OneCare Vermont Information, Background & Governance
2. OneCare Vermont Network
3. OneCare Vermont Payer Programs
4. OneCare Vermont Budget and Financial Plan
5. OneCare Vermont Model of Care & Community Integration

My team and I also ask that you extend a special thanks to the staff members at the GMCB who have all been exceedingly helpful in answering questions that we have had along the way and aligning expectations for this submission. We look forward to working with the GMCB and its staff during this initial budget process in order to learn and streamline the process in preparation for fulfilling the requirement for fiscal year 2019. If you have any questions please feel free to contact me directly at the number below or Vicki Loner, OneCare's Chief Operating Officer, at (802) 847-6255.

Thank you,

Todd B. Moore, MBA
CEO, OneCare Vermont
(802) 847-1844

Table of Contents:

This page intentionally left blank

Green Mountain Care Board, 2018 Budget Submission

Executive Summary

OneCare Vermont (OneCare) was organized and founded in 2012 by the University of Vermont Medical Center (UVMMC) and Dartmouth Hitchcock Health (DH-H). We are Vermont's largest statewide multi-payer Accountable Care Organization (ACO), currently serving over 100,000 Vermonters.

OneCare currently supports a large statewide network, which includes the majority of hospitals in Vermont and Dartmouth Hitchcock, the largest out-of-state provider of care to Vermonters. Additionally, a majority of the primary care and specialty providers (including hospital employed and private community practices) in the state participate in at least one of our ACO programs. OneCare's current continuum of care provider network consists of 21 SNFs, 9 designated mental health agencies and 10 home health and hospice organizations.   Nationally, the unique scope of the OneCare participant network described above is itself a major accomplishment and represents a commitment to statewide collaboration by providers on behalf of its attributed populations.

In 2013, OneCare started participating in the Medicare Shared Savings Program (MSSP) created by the Affordable Care Act. In January of 2014 OneCare became a multi-payer ACO, entering into contracts with the Department of Vermont Health Access (DVHA) for a Medicaid Shared Savings Program (VMSSP) and Blue Cross Blue Shield of Vermont (BCBSVT) for a Commercial Exchange Shared Savings Program (XSSP). In 2015, OneCare was selected to participate in the Medicare Next Generation program, but chose to defer and reapply in 2017 for a January 2018 start to better align with the timing of the All-Payer ACO Model. Lastly, in 2016, OneCare was the sole bidder for the Medicaid Next Generation ACO program, and implemented the program in partnership with the Department of Vermont Health Access on January 1, 2017.

In addition to the ACO Program contracts, in December of 2014 OneCare was awarded a Vermont State Innovation Model contract. The purpose was to further all three (3) ACOs' efforts towards innovative, highly reliable, evidenced-based population health care strategies for Vermonters. The funding is primarily directed to providing support for developing community-learning collaboratives through expanding the role of the Community Collaboratives (Regional Clinical Performance Committees) that serve every health service area (HSA) in Vermont. Because of the successful attainment of contract objectives, the contract was extended through June of 2017.

In 2016, OneCare was also one of only six entities that was awarded a two-year Robert Wood Johnson Foundation grant for Transforming Complex Care. This funding will allow us to strengthen community partnerships by removing barriers and coordinating care for Vermonters with complex health care needs.

OneCare has a track history of improving quality while slowing expenditure growth. For example, in Medicare for Performance Year (PY) 2015, while OneCare did not qualify for shared savings, it was among the highest-value ACOs across the county when mapped on cost per beneficiary and overall

quality score. For Medicaid, OneCare received savings in PY 1 but in 2015 ended up 1.3% above our spending target for the performance year, and therefore did not achieve shared savings. However, OneCare scored in the top benchmark percentile or showed statistically significant improvement in 11 quality measures and increased our quality score from 63% to 73% from 2014 to 2015. For Commercial Exchange Shared Saving Program, our expenditures decreased by 0.1% from 2014 to 2015 but still exceeded the target. The target was based on Blue Cross Blue Shield of Vermont's budgeted medical costs included in its Green Mountain Care Board approved rates for its health plans on the States' Health Exchange and increased by 3% from 2014. OneCare scored in the top benchmark percentile or showed statistically significant improvement in 15 quality measures for the commercial program.

OneCare has made solid progress on quality outcomes and programs to better control illness and deliver care in lower cost settings but we have felt the motivational limitations of a shared savings incentive model on top of a FFS system and against a retrospectively set target. OneCare participants desire a model that provides predictable revenue stability as we strive to meet the Triple Aim. We desire the Next Gen path to capitation to redesign provider payment models to move away from FFS reimbursement. With our involvement in a 2017 Medicaid Risk program, OneCare is well positioned to pursue a fixed payment reform model for all hospitals. We estimate that network hospital providers who wish to be directly rewarded for value and access instead of volume provide a large amount of care, approximately 2/3 for Medicaid and Medicare, to our population.

OneCare holds an important and proactive leadership role in Vermont's transition to value-based reform of its delivery system. We have played a major role in the provider-led transformation processes and collaborated extensively with the other ACOs and the Vermont Blueprint for Health. We are also supportive of the State of Vermont's All-Payer ACO model and its goals to improve the experience of care and the health of the populations while reducing cost growth. Like our founding owners, we are collectively committed to moving from a "Sick Care" to a "Health Care" system by investing in solutions that will promote health and well-being and make care more affordable for Vermonters.

This page intentionally left blank

Green Mountain Care Board, 2018 Budget Submission

Part 1: ACO Information, Background and Governance

1. *Date of Application:*
    June 23, 2017

2. *Name of ACO:*
    OneCare Vermont Accountable Care Organization, LLC

3. *Tax ID Number:*
    455399218

4. *Identify and describe the ACO and its governing body, including:*
    a. *Legal status of the ACO (e.g., corporation, partnership, not-for-profit, LLC);*
    b. *Members of the Board and their organizational affiliation (for consumer members, identify whether the member is a Medicaid beneficiary, a Medicare beneficiary and/or a commercial insurance plan member);*
    c. *Board officers;*
    d. *Board committee and subcommittee structure, as applicable;*
    e. *Description of Board voting rules; and*
    f. *Copy of ACO bylaws, or equivalent.*

OneCare Vermont (OneCare) is a "manager-managed" Not for Profit VT LLC. Other than powers reserved to the Members in the Operating Agreement, OneCare's affairs are under the exclusive management and control of the Board of Managers (BOM).   The BOM has responsibility for oversight and strategic direction that is implemented by OneCare's leadership. The BOM appoints a CEO, CCO and CMO to manage the daily affairs. Each reports to the BOM, is accountable for OneCare's activities, and may be removed by the BOM.

Board committees are accountable to the BOM and include Executive, Finance and Population Health Strategy (PHS) Committees. They provide strategic and organizational recommendations: input on key policies, budget approval, direction on the clinical model and oversight of cost and utilization performance.

The CEO sets and executes corporate strategy with the support of the CMO, CCO, and COO. The CMO, a board-certified VT MD, directs the non-board level clinical committees and sub-committees to effectively execute on the Clinical Model. The CCO manages the compliance risks providing regular reports to the CEO and BOM. The COO leads and coordinates OneCare's strategic and operational functions.

To represent the consumer's interests on OneCare's Board of Managers, OneCare has an independent Medicare, Medicaid and Commercial beneficiary representing all three ACO programs.

OneCare works with Vermont's Legal Aid and the Healthcare Advocate to provide advocacy training to our Consumers on our Board and to provide training to our separate consumer advisory group that provides input to the Board of Managers. Each Manager participates in Board meetings with the same level of authority as their fellow Managers.

OneCare's providers are broadly represented in the governing Board of Managers and committees. Of the 18 managers, 15 or 83% represent ACO providers elected by their peers. Both owners elect three (3) Managers and the nine (9) at-large Managers are elected by their peers. This allows for broad input and a substantial voice in ACO governance. Each Manager has one vote. The Operating Agreement provides for supermajority votes of the Board, a 2/3 vote that must include at least one Manager appointed by each owner. This permits owners additional say on significant matters while allowing for ample provider and consumer input. Participating providers and consumers also populate all other committees on the OneCare organizational chart and are active participants in strategy, finance, clinical, and consumer policymaking.

OneCare's current Board of Managers can be found in Attachment A in Part 1 Attachments.

OneCare's Governance Structure including Committees, Subcommittees and Officers can be seen in Attachment B in Part 1 Attachments.

OneCare's By-Laws can be found in Attachment C in Part 1 Attachments.

5. *Identify and describe each member of the ACO's executive leadership team, including name, title, tenure in current position, and qualifications for current position.*

Leadership Team Member and Credentials	Position/Role	Tenure with OneCare VT
Executive Team		
Todd B. Moore, MBA	Chief Executive Officer	5 years
Vicki Loner, RN.C, BS, MHCDS	Vice President and Chief Operating Officer	4 years
Norman Ward, MD, MHCDS	Chief Medical Officer	5 years
Jennifer Parks, JD	Chief Compliance Officer	5 Years
Heather Rozkowski, D.SC., CISSP	Chief Information Security Officer	5 Years
Senior Leadership		
Susan Shane, MD	Medical Director	5 Years
Martita Giard, AS	Director, Programs Strategy & Network Development	5 Years
Sara Barry, MPH	Director, Clinical & Quality Improvement	1 Year
Leah Fullem, MHCDS	Director, Informatics	5 Years
Tom Borys, MBA	Director, Finance	1 Month
Joan Zipko, MHCA	Director, ACO Operations	3 Years
Management Team		
Shawntel Burke, CPC	Manager, ACO Operations	5 Years
Becky Colgan, PhD	Manager, ACO Analytics	4 Years
Theresa Connolly, MSN, RN, CPN	Manager, Clinical and Quality Improvement	3 Weeks

6. *Provide a list of ACO employees, direct or contracted, their titles, and an organizational chart.*

   Please see Attachment D in Part 1 Attachments.

7. *Describe any legal actions taken against the ACO or against any members of the ACO's executive leadership team or Board of Directors related to their duties.*

   No Legal Action has been taken against OneCare Vermont, its leadership team, or its Board of Managers.

8. *With respect to the ACO's executive leadership team or Board members, describe any legal, administrative, regulatory or other findings indicating a wrongful action involving or affecting the performance of his or her duties, or professional fiscal irresponsibility.*

   No Legal, Administrative, Regulatory or other findings including wrongful action has been taken against OneCare Vermont, its leadership team, or its Board of Managers.

9. *If the ACO has been accredited, certified or otherwise recognized by an external review organization (e.g., for NCQA accreditation or payer assessments), submit the review organization's determination letter, associated assessment documents and results. If the ACO is working toward certification, please describe.*

   OneCare has not been accredited or certified by an external review organization.

Part 1
Attachments

Attachment A – OneCare Vermont Board of Managers

Attachment B – OneCare Vermont Governance Structure

Attachment C – OneCare Vermont By-Laws

Attachment D – OneCare Vermont Staff Organizational Chart

Green Mountain Care Board, 2018 Budget Submission

This page intentionally left blank

Green Mountain Care Board, 2018 Budget Submission

Part 2: ACO Provider Network

1. *Provide, as an attachment, a completed **Appendix A1 – ACO Provider Network Template** which will include*:*
   a. *Name*
   b. *Provider type: (e.g., academic medical centers; critical access, sole community and other hospital types; federally qualified health centers; independent physician office practices; mental health and substance use treatment providers; home health providers, skilled nursing facilities, community long-term services and supports providers; facility post-acute care providers, SASH providers, Blueprint for Health Community Health Teams.)*
   c. *Contract type and payment model: Payer-defined and administered fee-for-service (FFS); ACO- defined FFS; ACO capitation, including all-inclusive population-based payment (AIPBP); global budget; shared savings; shared risk, or as otherwise defined.*

   Please see Attachment A in Part 2 attachments titled "Complete Physician Network" for a complete list of the OneCare's Provider Network across all three payer programs.

   Please see Attachment B in Part 2 attachments titled "Summary of Provider Network by Provider Type" for a Summary list of the OneCare's Provider Network across all three payer programs by provider type.

2. *Provide, as an attachment, a completed **Appendix A2 – Summary ACO Provider Network Template** which will include*:*
   a. *Count of providers by provider type and specialty, by county*

   Please see Attachment B in Part 2 attachments titled "Summary of Provider Network by Provider Type" for a summary list of the OneCare's Provider Network across all three payer programs by provider type.

   Please see Attachment C in Part 2 attachments titled "Summary Provider Network by HSA/County by Provider Type" for a Summary list of the OneCare's Provider Network across all three payer programs by provider type and county.

3. *For provider contracts for which the provider is assuming risk, describe the ACO's current contract with the provider: (TB)*
   a. *The percentage of downside risk assumed by the provider, if any;*
   b. *The cap on downside risk assumed by the provider, if any, and*
   c. *What risk mitigation requirements the ACO places on the provider, if any (e.g., reinsurance, reserves).*

   OneCare as the ACO ultimately holds the risk for the VMNG contract which has a symmetrical 3% risk corridor with 100% risk sharing. The downside risk is also capped at this 3% level. The four (4) risk-bearing hospitals, through their contractual agreement with OneCare, have committed to a maximum 3% of target risk exposure corridor for their community, which is prorated by the NPSR.

To provide evidence that OneCare has sufficient financial resources for the risk associated with the DVHA VMNG Risk program, OneCare has obtained a letter of credit from the University of Vermont Health Network in order to cover any losses above and beyond what it is capable of covering. For 2018, when OneCare has risk for 3 payer programs, we are exploring re-insurance.

4. *Submit provider contracts as requested by the GMCB.*

Please see Attachment D in Part 2 Attachments titled OneCare Provider Base Risk Contract with Medicare, Medicaid and Commercial Rider.

Part 2
Attachments

Attachment A – Complete Physician Network

Attachment B – Summary of Provider Network by Provider Type

Attachment C – Summary Provider Network by HSA by Provider Type

Attachment D – OneCare Provider Base Risk Contract with Medicare, Medicaid and Commercial Rider

This page intentionally left blank

Green Mountain Care Board, 2018 Budget Submission

Part 3: ACO Payer Programs

1. *Provide copies of existing agreements or contracts with payers. If 2018 contracts not available, please submit as an addendum when signed*.*

   To view OneCare Vermont's Vermont Medicaid Next Generation Contract (VMNG) with the Department of Vermont Health Access, please visit the following links:

   Link to DVHA VMNG Contract "Attachment A and B":
   http://dvha.vermont.gov/administration/onecare-aco-32318-final-searchable.pdf

   Link to DVHA VMNG Contract Exhibit 1 (Complete list of included and excluded service codes)
   http://dvha.vermont.gov/administration/exhibit-1-to-attachment-a-service-codes-final.pdf

   Link to DVHA VMNG Contract Exhibit 2 (Attribution Technical Specifications)
   http://dvha.vermont.gov/administration/exhibit-2-to-attachment-a-evaluation-managment-services-final.pdf

   OneCare currently only participates in the Shared Savings Program with Medicare and does not have a risk-based Next Generation contract with Medicare at this time. It is anticipated, upon being awarded participation in the Next Gen Program sometime in August 2017, that a contract will be signed later in the fall of 2017.

   OneCare currently is finalizing negotiations with Blue Cross and Blue Shield of Vermont for a risk-based program to be effective in 2018. Upon completion of negotiations and the execution of a contract, OneCare will provide a copy of the contract to the GMCB.

2. *Provide a completed **Appendix B – 2018 ACO Program Elements by Payer** template which will include*:*
   a. *Payer and line of business with which the ACO has agreements:*
      i. *Medicaid*
      ii. *Medicare*
      iii. *Commercial: Individual and Small Group (Vermont Health Connect)*
      iv. *Commercial: Large Group*
      v. *Commercial: Self-insured*
      vi. *Commercial: Medicare Advantage*
   b. *Attributed lives by payer and line of business*
   c. *Projected spending associated with attributed lives by payer and line of business*
   d. *Projected percentage growth rate or projected PMPM for 2018 for All-Payer ACO Model targets. If not available, please use prior years' data and describe.*

Please see Attachment A in Part 3 attachments titled ACO Program Elements by Payer for the 2018 Program Elements by Payer.

3. *If applicable, by payer and line of business, describe program arrangement(s) between the payer and the ACO including**
   a. *Full risk, shared risk, shared savings, other (please specify);*
   b. *The use of a minimum savings rate, minimum loss rate, or similar concept;*
   c. *The percentage of downside risk assumed by the ACO;*
   d. *The cap on downside risk assumed by the ACO, if any;*
   e. *The cap on upside gain for the ACO, if any;*
   f. *Risk mitigation provisions in the payer contract:*
      i. *Exclusion or truncation of high-cost outlier individuals (please describe)*
      ii. *Payer-provided reinsurance*
      iii. *Risk adjustment: age/gender, clinical (identify grouper software)*
   g. *Method for setting the budget target;*
      i. *Trended historical experience*
      ii. *Percentage of premium*
      iii. *Other (please describe)*

The following synopsis represents the current planned approach for the 2018 contract year as negotiations with payers, reinsurance brokers, and the provider network are ongoing:

Please also Attachment B in Part 3 attachments titled ACO Program Arrangements between ACO and Payer.

Medicaid
   a. The 2018 OneCare budget plans for a full risk arrangement with Medicaid.
   b. There is no minimum savings rate or minimum loss rate for this arrangement.
   c. 100% of the downside risk is assumed by OneCare.
   d. The downside risk is capped at 3% of the total cost of care (TCOC).
   e. The upside savings potential is capped at 3% of the total cost of care (TCOC).
   f. Risk mitigation provisions include:
      i. No truncation for Medicaid high-cost outliers.
      ii. The OneCare budget plan does include a commercial reinsurance expense. The details of this reinsurance plan are currently being explored. Possible models include pooled risk capitation as well as provider-specific capitation offered through OneCare.
      iii. No risk adjustments were included in the budget model.
   g. The budget targets were set using 2016 actual spend data for the expected network and attributed population as the base and trended forward with the best OneCare actuarial guidance available at the time of the budget development. For Medicaid, OneCare has set its budget using a 2.0% trend for 2016 to 2017 and another 2.0% for 2017 to 2018.

Medicare
   a. Our budget includes a shared risk model under the Medicare Modified Next Generation Program. Although the OneCare budget plans for this 80% shared risk arrangement with

Medicare, we may shift to a 100% risk arrangement for 2018 at a later date. It is at the Medicare Next Generation ACO's discretion to select either an 80% or a 100% risk-sharing arrangement prior to starting the performance year.

b. There is no minimum savings rate or minimum loss rate for this arrangement.

c. 80% of any downside loss is assumed by OneCare.

d. The downside risk is capped at 5% of the total cost of care (TCOC). It is at the Medicare Next Generation ACO's discretion to choose anywhere from a 5% to 15% "corridor" for which to cap savings or losses. OneCare has selected 5%. Within that 5% downside risk exposure, 80% is assumed by OneCare and 20% is assumed by Medicare. In effect, the total downside risk for the ACO is capped at 4% of TCOC based on a 5% overrun.

e. The upside savings potential is symmetric and is capped at 5% of the total cost of care (TCOC) and the same 80% sharing model for the downside risk applies to savings. In effect, the total upside savings potential for the ACO is capped at 4% based on 5% total savings.

f. Risk mitigation provisions include:

   i. Individual beneficiary expenditures capped by Medicare at the 99th percentile of expenditures to prevent substantial impacts by outliers.

   ii. The OneCare budget plan does include a commercial reinsurance expense. The details of this reinsurance plan are currently being explored. Possible models include pooled risk capitation as well as provider-specific capitation offered through OneCare.

   iii. No risk adjustments were included in the budget model.

g. The budget targets were set using 2016 data for the expected network as the base and trended forward to generate a 2017 projection and then trended forward again to project a 2018 target. OneCare used the best estimates available at the time of the budget development. For Medicare, a trend rate of 3.5% was applied for 2016 to 2017 based on OneCare analysis and actuarial review to establish a projection for 2017 actual expenditures as the "base year" for the All-Payer-Model's Modified Next Generation ACO program. To project a target for 2018 under that program, OneCare again applied a 3.5% trend rate from 2017 to 2018 but for different reason.   OneCare applied the APM terms with best available information which indicates that the 3.7% trend rate floor and a 0.2% discount rate would apply for APM, and which we propose should be the term granted to OneCare.

Blue Cross Blue Shield of Vermont

IMPORTANT NOTE: OneCare Vermont and BCBSVT are in ongoing discussions on the nature and details of an expected 2018 risk program contract. Many elements remain in discussion and any assumptions made below and elsewhere by OneCare for budgeting purposes are subject to change, and it cannot be assumed that BCBSVT has agreed to these program assumptions.

a. The 2018 OneCare budget plans for a shared risk arrangement (50%) with Blue Cross Blue Shield of Vermont of Vermont.

b. For the purposes of budgeting, we have assumed there is no minimum savings rate or minimum loss rate for this arrangement.

c. Fifty percent (50%) of the downside risk is assumed by OneCare.

d. The downside risk is capped at 6% of the total cost of care (TCOC). Of that 6% downside risk exposure, 50% is assumed by OneCare and 50% is assumed by Blue Cross Blue Shield of Vermont. In effect, the total downside risk for the ACO is capped at 3% of TCOC.

e. The upside savings potential is symmetric and capped at 6% of the total cost of care (TCOC) and the same 50% sharing model for the downside risk applies to savings. In effect, the total upside savings potential for the ACO is capped at 3% of TCOC.

f. Risk mitigation provisions include:
    i. No truncation for high cost patients is assumed in the budget, but ongoing discussion with BCBSVT may add such risk protection provided by BCBSVT.
    ii. The OneCare budget plan does include a commercial reinsurance expense. The details of this reinsurance plan are currently being explored. Possible models include pooled risk capitation as well as provider-specific capitation offered through OneCare.
    iii. No risk adjustments were included in the budget model.

g. The budget targets were set using 2016 data for the expected network as the base and trended forward with the estimates developed in cooperation with BCBSVT and based on their overall Medical Expense Trend (MET) figures for their Qualified Health Plan (QHP) rate filings. These factors are 4.5% for 2016 to 2017 and 4.8% for 2017 to 2018. The actual contracted factors for the OneCare-attributed population to determine 2018 targets will be determined later in 2017 through actuarially-supported negotiations.

4. *By payer, describe proposed categories of services included for determination of the ACO's savings or losses, and if possible, projected revenues by category of service and type of payment model (e.g., FFS, capitation or AIPBP).*

Medicaid: For a summary of covered services included and excluded in the VMNG program for determination of the AIPBP payments to hospitals and the Total Cost of Care Spend please Section 3 (pages 22-25) at the following link. DVHA VMNG Contract Attachment A and B
http://dvha.vermont.gov/administration/onecare-aco-32318-final-searchable.pdf

For a list of Service Categories included and excluded in the VMNG program for determination of the AIPBP payments to hospitals and the Total Cost of Care Spend please see the following link. DVHA VMNG Contract Exhibit 1:
http://dvha.vermont.gov/administration/exhibit-1-to-attachment-a-service-codes-final.pdf

Medicare: Service categories included and excluded are in accordance with those outlined in the Medicare's Next Generation agreement, generally described as Part A and B services for aligned beneficiaries.

BlueCross Blue Shield of Vermont Service: Categories are still being determined as part of contract negotiations.

5. *By payer, describe how the proposed ACO benchmark, capitation payment, AIPBP, shared savings and losses, or any other financial incentive program are tied to quality of care or health of aligned beneficiaries*.*

   Please see Attachment B in Part 3 Attachments for a copy of OneCare Vermont's Value Based Quality Incentive Fund Policy.

6. *By payer and line of business, provide a comprehensive list of ACO quality measures that will, or are proposed to, affect payment or be monitored, according to the terms of the agreement with the payer. For public payers, the applicant may provide a link to publicly-available materials. Provide the most recent annual ACO quality reports for measures included in agreements with payers*.*

   Medicaid: For a comprehensive list of the ACO quality measures that are required by VMNG please see pages 85-91 in Section J of Attachment B at the following link. DVHA VMNG Contract Attachment A and B:
   http://dvha.vermont.gov/administration/onecare-aco-32318-final-searchable.pdf

   Medicare: The Next Generation ACO Model Quality Measures and Narrative Specifications can be found at the following link:
   https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/2017-Reporting-Year-Narrative-Specifications.pdf

   Blue Cross Blue Shield of Vermont: The Risk Based Program quality measures are currently being discussed as part of negotiations.

7. *By payer and line of business, describe the current or proposed methodology used for beneficiary/member alignment (also known as attribution). If these differ significantly by payer, please describe. Complete a master table in template to be provided of attribution for each program and by Health Service Area (HSA)*.*

   Medicaid: To see the Attribution Methodology for the VMNG program, please see Section 1 (pages 4-9) at the following link:
   http://dvha.vermont.gov/administration/onecare-aco-32318-final-searchable.pdf

   To see the Attribution Technical Specifications for the VMNG program please visit the DVHA VMNG Contract Exhibit 2:
   http://dvha.vermont.gov/administration/exhibit-2-to-attachment-a-evaluation-managment-services-final.pdf

   Medicare: The Next Generation Program Beneficiary Alignment can be found on pages 20-24 at the following link:
   https://innovation.cms.gov/Files/x/nextgenaco-rfa2018.pdf

Blue Cross Blue Shield of Vermont: The Risk Based Program Attribution Methodology is currently being discussed as part of negotiations.

Part 3
Attachments

Attachment A – ACO Program Elements by Payer

Attachment B – ACO and Payer Program Arrangements

Attachment C – OneCare Vermont Value Based Quality Incentive Fund Policy

Green Mountain Care Board, 2018 Budget Submission

This page intentionally left blank

Green Mountain Care Board, 2018 Budget Submission

Part 4: ACO Budget and Financial Plan

---

1. *Submit most recent audited financial statements and profit and loss statement, including balance sheet, that show at a minimum: assets, liabilities, reserves, sources of working capital and other sources of financial support*.*

   Prior to the 2017 VMNG contract, OneCare was not required to undergo an annual financial audit. In conjunction with that contract, OneCare will face an audit for the 2017 fiscal year. The results of that audit can be provided to the GMCB after completion.

   The 2016 final financial statements and balance sheet summary have been included with this submission. Please see Attachment A Part 4 Attachments.

2. *Submit financial data on 2016 performance under any contracted shared savings, shared risk or full risk payer contracts, inclusive of medical and administrative expenses, by payer. If 2016 performance data is not available, please submit 2015 and supplement with 2016 when available*.*

   The latest available 2016 shared shavings results for Medicaid and Commercial have been included with this submission. Please see Attachment B in Part 4 Attachments.

3. *Answer a or b, according to your type of contractual agreements with payers*:*

   a. *For ACOs who have fewer than 10,000 attributed lives or who are not taking risk, in aggregate forecast for July 1, 2018 across all lines of business, submit the ACO's medical expense and administrative expense budget for 2018.*

   b. *For ACOs with 10,000 or more attributed lives or taking risk in aggregate forecast for July 1, 2018 across all lines of business, provide, as an attachment, a completed **Appendix C – 2017 and 2018 ACO Projected Cost and Revenue Data Templates**. This will ask the ACO, by payer and line of business, to provide information on projected revenues and expenses to flow through the ACO financial statements (including payer revenues, participating provider dues, and grant funding), medical costs and administrative costs (including contracted services, community investments and contribution to reserves), in total dollars and per member per month (PMPM) dollars when applicable. The GMCB may request additional information or copies of grants or agreements as part of the review.*

   These templates have been included with the submission. Please see Attachment C "Complete ACO Projected Cost and Revenue Data Package" in Part 4 Attachments.

4. *Provide a narrative description of the following elements of the ACO's spending plan.*
   a. *ACO industry benchmarks used in developing the administrative budget;*
   b. *The methodology determining the qualification and amount of eligible provider incentive payments;*
   c. *Planned spending on SASH and Blueprint for Health by payer (including practice payments and Community Health Team payments), in comparison with 2016 and 2017 spending levels;*
   d. *Strategy and spending on community investments (e.g. early childhood development, housing, mental health, substance use, and other services that address social determinants of health);*
   e. *Strategy for planned spending on health information technology, at the ACO level and to support individual providers;*
   f. *Budget assumptions related to service utilization, including anticipated changes from prior years' utilization, including anticipated changes in care delivery including but not limited to new and innovative services, service mix, value-based payment model adoption (including risk assumption); and*
   g. *Anticipated changes in provider network configuration, and the expected impact on service utilization.*

   a. At present, the OneCare administrative budget is based on the requirements to achieve its strategy as a risk-bearing, multi-payer, statewide ACO. OneCare's Finance Committee and Board of Managers, which consists of participants from OneCare, approve the annual budget and any material changes occurring mid-year. We provide benchmarks in two ways:
      - First, we review managed care "per member per month" (PMPM) operations benchmarks from Sherlock Company, the national leader in such benchmarking. Based on our proposed budget for 2018, the OneCare total PMPM for operations (excluding budgeted reinsurance policy expense) is $6.68 PMPM. OneCare's analysis shows the Sherlock Company expected range to be $6 PMPM to $8 PMPM based on ACO-applicable categories for medical management, provider network management, and administration including finance and information systems.   In addition, OneCare is currently engaged with the Sherlock Company and other ACOs to pilot an ACO-specific administrative cost benchmark study. At the time of this submission the results of that study are not yet available.
      - As a second benchmark exercise, we apply a "percent of premium" approach. In this approach we divide OneCare administrative expense into the total of our payer risk targets plus those administrative expenses.   Based on our proposed budget for 2018, we calculate the OneCare percent of premium as 1.4%. This is less than one tenth of the ACA-mandated limit of 15% based on a minimum medical loss ratio of 85%. Those guidelines apply to health insurers who have many more requirements and processes than an ACO, but those plans are also allowed to account for quality improvement activities as Medical expense rather than as administrative expense.   If OneCare were to do the same, the 1.4% would shrink further.   Our conclusion is that our expenses are well within, and likely below, an expected "percent of premium" range for a risk-bearing ACO of our size.

b. Please see attached quality incentive payment policy for Medicaid that will be used for all other government and commercial payers. This policy once expanded will need to be amended and approved by our Board of Managers.

c. For Medicare, OneCare, as the risk bearing ACO, intends to continue to fund SASH and Blueprint payments (CHT and practice-level) at the 2017 levels plus an inflationary rate of 3.5%.

d. All of OneCare's investments, which we believe should include our Population Health Management programs with aligned payment reform, must be reviewed by the OneCare Finance and Population Health Strategy Committees and ultimately approved by our Board of Managers. We have attached to this document our list of planned initiatives and a table below outlining the full financial value of each. These programs for 2018 support population management activities from prevention to chronic illness to high risk poly-chronic patients, and provide for support (both clinical and financial) to the full continuum of care, from primary care to designated agencies.

PHM / Payment Reform Program	Investment Amount
Value-Based Incentive Fund	$ 5,559,260
Basic OCV PMPM	$ 5,348,694
Complex Care Coordination Program	$ 7,580,109
PCP Comprehensive Payment Reform Pilot	$ 1,800,000
RiseVT Program	$ 1,200,000
CHT Funding Risk Communities	$ 1,746,360
CHT Funding Non-Risk Communities	$ 772,538
SASH Funding Risk Communities	$ 2,417,942
SASH Funding Non-Risk Communities	$ 852,012
PCP Payments Risk Communities	$ 1,319,336
PCP Payments Non-Risk Communities	$ 654,313
Total	**$ 29,250,563**

Also please see Attachment D "Population Health Programs Grid" in Section 4 Attachments for more information

e. OneCare has and will continue to invest in health information technology in order to support participants in their desire to enter into contracts that hold them accountable for the cost, quality and experience of care. The Informatics capabilities are provided through partnerships with Health Catalyst, BluePrint HIT's Care Navigator, VITL and the

BluePrint for Health to deliver best in class solutions.   The informatics platform provides a mechanism for combining claims and clinical data from all ACO participants to perform advanced analytics and support clinical decision making. Reporting tools and skilled analysts can deliver cost, utilization and quality information in an actionable and timely manner to develop new models for reimbursement of services. In 2017 and to be expanded in 2018, OneCare is shifting to a deployed toolset for network self-service in addition to our central support capabilities. The OneCare PHM Platform provides full-scale informatics and analytic services to our network. (See the following diagram)

PHM Informatics Platform
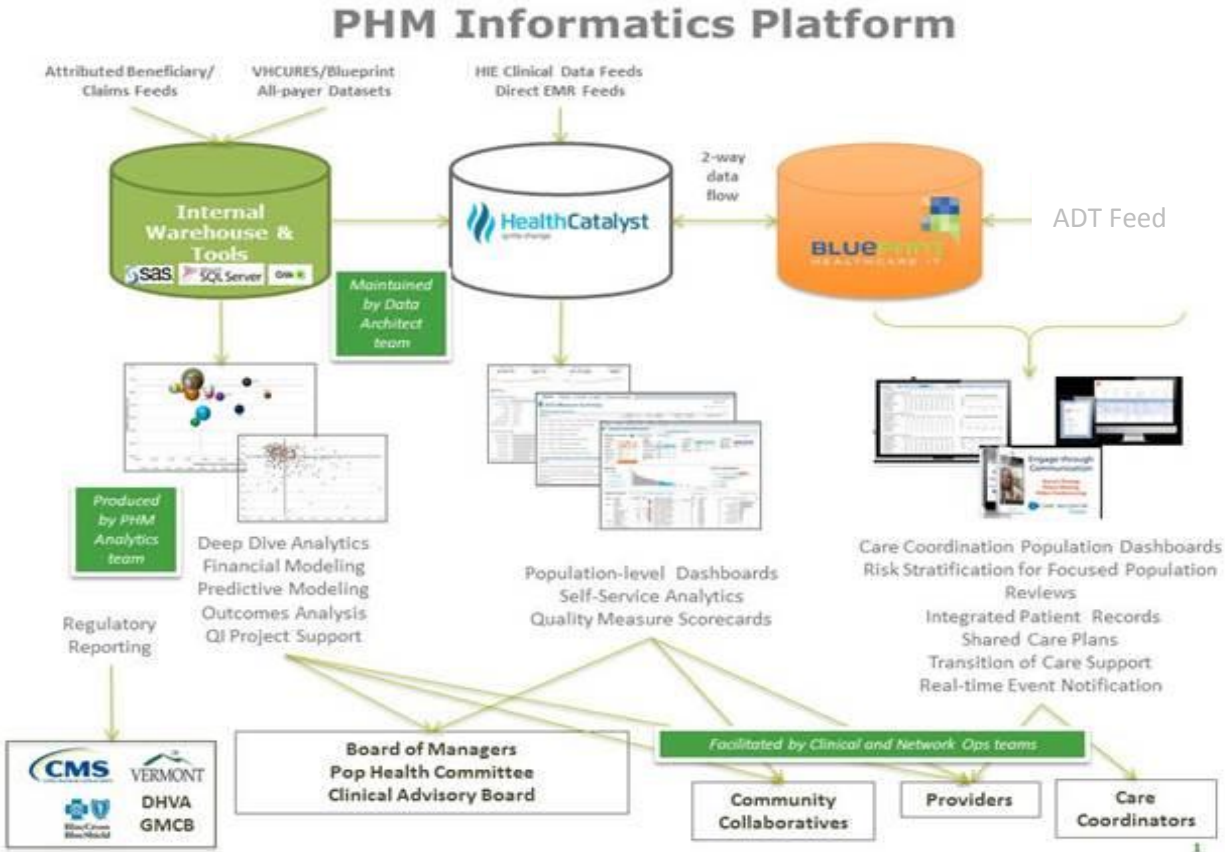
f. There are no assumptions built into the budget model. We believe our program targets will be actuarially sound and represent the expected spend in 2018. We hope our programs and the strength of the incentives under the risk programs will lead to successful efforts on prevention and wellness, avoidance of waste, and innovation on lower cost care delivery. We felt no basis to accurately predict the success of those efforts, and with the fixed revenue models would have no direct impact to our revenue budget as proposed and such savings would accrue to network members as the central theme of population-based payment reform.

g. In May, OneCare requested that providers submit to OneCare a Letter of Interest (LOI) if they wanted to pursue a risk based program contract through OneCare in 2018. The LOI was non-binding.   Participants will have until September 8, 2017 to declare if they would like to withdraw from the risk bearing program(s).   To best project our budget for

the 2018 Medicaid and BCBSVT programs with a network consisting of those submitting the LOI, we requested and received planning data sets representing the attributed members of those providers. For Medicare, we used existing Medicare Shared Savings Program data with selected assumptions where necessary for the presumed 2018 network. NOTE: Review of multi-year, historic OneCare financial models included in the budget spreadsheets will include the shifts in OneCare's provider network and the resulting financial and utilization variability over time and into 2018.

5. *Provide a narrative description of the flow of funds in the system. The description should include the flow of funds from payers to the ACO, and from the ACO to its providers. The description should demonstrate the ability of the ACO to maintain sufficient funds to support its administrative operations and meet provider payment obligations.*

The budgeted programs with payers are budgeted to include a two-part funds flow from payers and to providers.   The approach is based on the All-Inclusive, Population-Based-Payment (AIPBP) method included in the Medicare Next Generation Program. In this approach, the ACO can select one or more ACO-contracted participant providers (identified at the TIN level) to be included in a monthly prospective payment stream.   All other providers, whether contracted with the ACO or not, will receive regular payer-administered, fee-for-service (FFS) payments. We have assumed in our budget that the AIPBP model is available for all three programs, although discussion with BCBSVT is still assessing their operational readiness for the model in 2018. Our budget further includes the assumption that we will only include the ACO-participating **hospitals** in the prospective payment system from the three payers, with all others remaining FFS.   Final decisions on which providers to include in the prospective payment will be made later in 2017. Our budget projects that for those hospitals included in the prospective payment system, OneCare will pay each a calculated component of that payer payment stream applicable to their individual hospital. This payment shall represent a fixed "pre-payment" for all services rendered to the OneCare-attributed populations during that month. Such a model represents the sharpest incentive for hospitals to move away from volume-based FFS optimization.

The prospective payment concept is designed to meet the cash flow requirements of both the providers and OneCare. It is anticipated that the payer-provided payments will be made in a timely enough fashion to not harm the revenue cash flow to the hospitals included. In the current VMNG program, DVHA make payments to OneCare in advance of the month for which the payment is made and OneCare, in turn, distributes the fixed prospective payment and any other payments due to providers shortly thereafter. Any dues or quality incentive components can be withheld from these payments and will be distributed by OneCare in accordance with the Board-approved programs and provider contract terms.

6. *Provide a quantitative analysis with accompanying narrative to demonstrate how the ACO would manage the financial liability for 2018 through the risk programs included in Part 3 should the ACO's losses equal i) 75% of maximum downside exposure, and ii) 100% of maximum downside exposure. As part of the narrative response, describe your full risk mitigation plan to cover this liability and the*

mitigation plan for any contracted providers to which risk is being delegated or with which risk is being shared. This response is to include, but is not limited to:

    a. *Portion of the risk covered by reserves, collateral, or other liquid security whether established as a program contractual requirement or as part of the ACO's risk management plan;*

    b. *Portion of the risk delegated through fixed payment models to ACO-contracted providers;*

    c. *Portion of the risk covered by ACO providers through mechanisms other than fixed payment models (e.g., withholds, commitment to fund losses at annual settlement, etc.);*

    d. *Portion of the risk covered by reinsurance;*

    e. *Portion of the risk covered through any other mechanism (please specify);*

    f. *Any risk management or financial solvency requirements imposed on the ACO by third-party health care payers under ACO program contracts appearing in Part 3.*

Payer	Fixed Hospital Payments	Remaining FFS	Total Cost of Care	75% Maximum Downside	100% Maximum Downside
Medicare	$262,126,842	$179,100,743	$441,227,585	$13,236,828	$17,649,103
Medicaid	$109,848,140	$67,744,059	$177,592,199	$3,995,824	$5,327,766
BCBS	$95,065,733	$42,782,097	$137,847,830	$3,101,576	$4,135,435
TOTAL	$467,040,715	$289,626,899	$756,667,614	$20,334,228	$27,112,304

Providers participating in the risk programs are not currently required to maintain any collateral reserves.   In the 2018 budget model, 62% of the Total Cost of Care (TCOC) risk is delegated through the hospital prospective payment model as described in the previous section. Hospitals, by contract, will deliver services to the OneCare attributed population under this fixed model, and will absorb the cost of any excess utilization required which to the hospital will be at the true variable cost to deliver such care. This model shields the ACO from any losses on the majority (62%) of the spending target. For the remaining amount which remains Fee-For-Service (FFS), it would then take a 7.0% overrun on those services to reach 75% risk liability, and a 9.4% FFS overrun is required to reach 100% risk liability. We believe it unlikely to approach outcomes in this range, but we must have additional plans to fulfill the obligation if owed. To do this, our budgeted risk model assumes the Health Service Area's (HSA's) hospital also bears all risk for the FFS spending on the attributed population of that HSA, regardless of which provider attributed the lives in that community. Ultimately, each contracted hospital must be willing to accept the risk for their actual HSA FFS overrun up to the maximum risk corridor. Throughout the year, OneCare will monitor actual results against spending targets and provide risk-bearing hospitals the information necessary to manage both their financial statements and reserves as needed. To lower the maximum downside risk, a reinsurance premium estimate is included in the OneCare budget to protect its risk-bearing hospitals. The details of this reinsurance protection are currently being explored, but may include large-case coverage and/or reinsurance coverage of an upper-level band of the maximum risk on the total cost of care.

7. *Provide actuarial certification that the risk-bearing arrangements between the ACO and payers are not expected to threaten the financial solvency of the ACO.*

OneCare has enlisted Milliman to provide the actuarial guidance for budget modeling. However, due to the number of remaining variables at play, it is premature to seek actuarial certification. After the provider network is finalized and final trend analysis has been produced and negotiations are complete with payers, OneCare can update the GMCB with any actuarial certifications for 2018.

Part 4
Attachments

Attachment A – 2016 OneCare Final Financial Statements and Balance Sheet Summary

Attachment B – 2016 Shared Savings Results for Medicaid and Commercial

Attachment C – Complete ACO Projected Cost and Revenue Data Package

Attachment D – Population Health Programs Grid

Attachment E – Concept P & L for Entire Budget   NOTE: Although not a formal budget submission requirement, this attachment represents a holistic view of how the entire budget fits together for illustrative purposes

This page intentionally left blank

Green Mountain Care Board, 2018 Budget Submission

Part 5: ACO Model of Care and Community Integration

1. *Describe the ACO's Model of Care, including but not limited to how it may address:*
   a. *Support for person-directed care;*
   b. *Support for appropriate utilization;*
   c. *Seamless coordination of care across the care continuum, including specialty medical care, post-acute care, mental health and substance abuse care and disability and long-term services and supports, especially during care transitions;*
   d. *Integration efforts with the Vermont Blueprint for Health, regional care collaboratives and other state care coordination initiatives;*
   e. *Identification of, and care coordination interventions for, high risk and very high risk patients; and*
   f. *Use of comprehensive integrated/shared care plans and interdisciplinary care teams.*

   Please see response to this question as well as questions 2, 3, 4, and 5 in the narrative below.

2. *Describe new strategies for bringing primary care providers into the network*

   Please see response to this question in the narrative below.

3. *Describe strategies for expanding capacity in existing primary care practices, including but not limited to reducing administrative burden on such practices.*

   Please see response to this question in the narrative below.

4. *Describe the participation and role of community-based providers that are included in the ACO, including any proposed investments to expand community-based provider capacity and efforts to avoid duplication of existing resources*

   Please see response to this question in the narrative below.

5. *Describe the ACO's population health initiatives, including programs aimed at preventing hospital admissions or readmissions, reducing length of hospital stays, providing benefit enhancements resulting from delivery system flexibility, improving population health outcomes, addressing social determinants of health (e.g. Adverse Childhood Events), and supporting and rewarding healthy lifestyle choices. Describe how the ACO will measure success of these initiatives, and what will constitute success.*

   MODEL OF CARE AND COMMUNITY INTEGRATION: Health care system reform is one of the most pressing and complicated challenges we face, both locally and nationally. The ultimate goal in health care reform is to optimize the health system performance in pursuit of the Triple Aim: to improve

patient experience (quality, access and reliability), improve the health of defined populations and control per capita costs. As a statewide Accountable Care Organization (ACO) focused across the full continuum of care, OneCare Vermont (OneCare) is positioned to achieve the Triple Aim by acting as the "macro-integrator" capable of and committed to accepting responsibility for all three legs of the Triple Aim for a defined population. Our role as an ACO is to support our frontline systems such as primary care medical homes, community-based continuum of care providers, hospitals, specialists, etc., by providing them with the systems and resources necessary to redesign care delivery. We will also work with the State and Payers to design innovative financial models that support the clinical model. OneCare is a strong proponent of the three goals the State of Vermont negotiated under the All Payer Model Waiver: improving access to primary care, reducing deaths due to suicide and drug overdose, and reducing the prevalence and morbidity of chronic disease. As providers, we recognize this is a unique opportunity to shape the future.   In partnership with the State of Vermont, Green Mountain Care Board, Blueprint for Health, and our payers, we can direct the transformation necessary for Vermont to deliver on its ambitious goal of creating a high-value health care system for all Vermonters, regardless of employer, employment status, or income.

Population Health Management (PHM)
The Affordable Care Act and the advent of ACOs has drawn the attention of policy makers, health care providers, public health professionals, and other interested parties to assess and manage the health of whole populations as a framework to improve health outcomes and reduce cost growth. More specifically, it calls upon stakeholders to look beyond the traditional boundaries of the healthcare delivery system to identify social determinants of health and recognizes the impact of these factors on the burden of disease at the individual, family, community, and health systems levels. In addition, PHM emphasizes wellness and prevention rather than focusing solely on "illness care" within the population. OneCare's PHM approach embraces a set of diverse but interconnected activities that address preventive and chronic needs of every Vermonter in the ACO. These activities include but are not limited to: addressing upstream social determinants of health to prevent disease, supporting primary care practices through practice redesign, improving coordination between primary and specialty care, risk stratification and identification of high-risk individuals that could benefit from enhanced care coordination which includes the integration of care delivery with community partners. To support these activities, OneCare will be the vehicle to help disseminate success and lessons learned and will provide access to high-quality and reliable data as well as consultants to facilitate change and improvement activities. OneCare has recently focused on numerous initiatives to address effective population health management, including but not limited to the following:

- Developing and implementing a controlling hypertension quality improvement project in partnership with the Blueprint for Health, Health Department, and other community partners.
- Promoting preventive/wellness care through local community initiatives such as RiseVT and the 3-4-50 campaign.

- Collaborating with the Vermont Child Health Improvement Program (VCHIP) to support 22 pediatric and family medicine practices in a quality improvement collaborative to improve pediatric quality measures of developmental screening and the adolescent well visit.
- Engaging in and promoting Accountable Communities for Health to advance Community Collaborative foci beyond traditional boundaries of clinical care to embrace broader definitions of population health and improve partnerships with various human service organizations (e.g. housing, food, economic services, and childcare).
- Partnering with The Permanent Fund for Vermont's Children to investigate opportunities to promote health for children and families through the door of early care and education settings.
- Examining opportunities to promote team-based care in primary care settings (e.g. care coordination, embedded behavioral health).
- Researching and planning for the first disease management focused patient resource library to be developed and embedded in Care Navigator, OneCare's shared care coordination software tool.
- Developing partnerships to investigate social determinant of health screenings in primary care settings (e.g. ACES, food insecurity, and maternal depression).
- Providing training for primary care medical homes on effective panel management to identify sub-populations that could benefit from enhanced care planning.
- Implementing a new risk stratification algorithm, the John's Hopkins Adjusted Clinical Grouper, to identify prospective risk for all attributed patients.
- Providing intensive education and training for the network on the use of risk stratification, OneCare's Care Coordination model, and expectations for team-based care.
- Implementing a waiver of prior authorization for a specific set of services under the Medicaid risk contract that reduces the administrative burden on providers; simultaneously developing an analytic application to monitor utilization and identify any unwarranted variation in services.
- Organizing, evaluating, and obtaining feedback on current and proposed ACO quality measures under the All Payer ACO Model Waiver to identify efficiencies and align priorities with gaps in care that are actionable for change and improvement.
- Facilitating the development and deployment of best practices for congestive heart failure, reducing readmission rates, and high emergency room utilization.

Integrated Care Delivery Model Promotes Person-Centered Care
OneCare supports a tightly integrated clinical delivery system that delivers Population Health Management (PHM) across the continuum of care using a cohesive community health systems approach to achieve the Triple Aim. Community integration starts with a sustainable governance and operations that assures strategic planning and execution on initiatives, matching capacity and demand for health care and social services across areas. It also includes the development of evidence-based care pathways; use of shared information technology platforms with appropriate interoperability; predictive models and risk assessment that take into account situational factors, medical history as well as utilization use; and a system for ongoing learning and improvement.

OneCare is enabling the transition from a volume- to a value-based structure allowing resources to be used for care coordination, self-management, prevention, and health promotion. OneCare's PHM model focuses on core activities across the continuum from prevention and wellness to high-risk populations that generate the majority of health costs. OneCare's PHM model supports strong: clinical governance, local decision making through Community Collaboratives, Person-Centered Medical Homes/Neighborhoods inclusive of community-based health care services, definition and stratification of populations, identification of care gaps, consumer engagement and promotion of shared decision-making, adoption/implementation of evidenced-based guidelines, access to and efficient use and coordination of specialist, inpatient and outpatient hospital services, and care transitions through care coordination. At the foundation of our model is the person-centered approach that compels and empowers participants to provide care for the whole person. (See Diagram A below)

Diagram A: Person Centered Approach
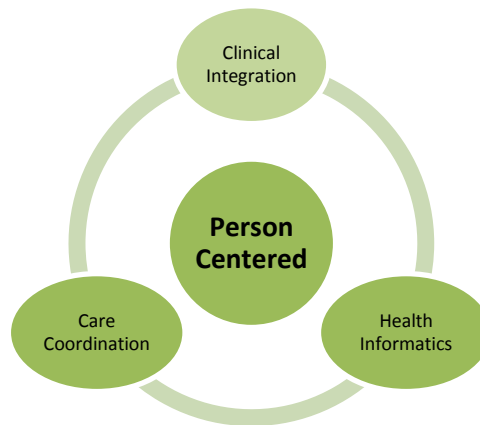
OneCare has demonstrated its commitment to delivering on a fully integrated community-based approach. Our work over the last three years on the Vermont Health Care Innovation Project (VHCIP) grant is one such example of OneCare's leadership in supporting the forward momentum (transition) to a more effective health care delivery system. With support of the VHCIP grant, and in partnership with the Blueprint for Health and the other ACOs, OneCare led the development of fourteen (14) regional multi-disciplinary teams statewide — each with a formalized governance structure focused on improving the health of their communities. These multi-disciplinary teams, called Community Collaboratives, are redesigning the way care is delivered locally and demonstrating measurable improvements in clinical priority areas brought forth through OneCare's clinical committees. For example, the Burlington Health Service Area (HSA) selected hospice care as one of their focus areas and has achieved a 156% improvement in utilization of hospice benefits in a sample of people with dementia as well as corresponding 66% increase among people with congestive heart failure, and 23% increase among people diagnosed with cancer.

As part of its long-term business planning, OneCare identified six core strategies to meet our mission and vision of creating an Accountable Care Community health system based on a PHM model that

meets the Triple Aim, including: governance, community-based integration, support for primary care, care coordination, testing innovations, and quality improvement. Together, these strategies support an integrated community-based care delivery model that will transform the system of care from an often fragmented "place-based" model of care delivery to one that is integrated and "person-based."

Clinical Governance

OneCare has developed a clinical governance structure that ensures broad representation from our members and community partners including both leadership of these organizations and direct care providers who interact with patients and families on a day-to-day basis. This diverse representation facilitates organizing, testing and evaluating innovations, and deploying resources to support clinical integration and population health management. OneCare Vermont is managed by a Board of Managers (BOM). Committees of the Board of Managers are accountable to the BOM and include Executive, Finance, Population Health Strategy Committees and Clinical Advisory Board. Additional committees are the Consumer Advisory Group, Quality Improvement Committee, Informatics Committee, Pediatric Sub Committee, Lab Sub Committee, and a soon-to-be formed Primary Care Sub Committee. Each HSA in OneCare's network organizes and convenes regular meetings called Community Collaboratives, which serve as local organizing bodies to advance population health strategies and improve health care delivery and outcomes. The committees provide strategic and organizational recommendations, input on key policies, direction on the clinical model and oversight of cost and utilization performance.

Clinical committees are supported by the Chief Medical Officer, Medical Director, and staff of the Clinical and Quality Department within OneCare. Externally, OneCare has contracted with a Regional Clinical Representative (RCR) in each HSA within our network. The RCRs provide local content expertise and support to the Community Collaboratives to assist them in identifying clinical priority areas, identifying opportunities for improvement, and encouraging a data-driven focus on achieving identified quality improvement goals. The RCRs are active participants in OneCare's clinical governance committees, bringing fresh ideas and perspectives back to the ACO, and facilitate shared learning and spread of successful change strategies across HSAs. Robust Operations as well as Informatics and Analytics Departments within OneCare support the work of the Clinical and Quality Improvement Department as well as the entire network of providers.

Clinical and Quality Improvement

OneCare is committed to developing an integrated, community-based care delivery model that supports optimal health for Vermonters. We have made significant advancements towards this model by supporting advanced community integration, care coordination, and creating a very nimble health informatics platform, while keeping individuals and their families at the center. Community integration starts with a sustainable governance and operations that assures strategic planning and execution on initiatives, matching capacity and demand for health care and social services across areas. It also includes the development of evidence-based care pathways; use of shared information technology platforms with appropriate interoperability; predictive models and risk assessment that take into account situational factors, medical history as well as utilization use; and a system for ongoing learning and improvement.

Quality Measurement: OneCare's PHM informatics platform supports system levels metrics and ultimately the provision of person-centered care by facilitating access to high-quality, timely data that can be used to monitor the effectiveness and efficiency of care and drive decision making. It supports benchmarking against regional and national peers, guides strategic decision making about performance priority areas, provides mechanisms to monitor quality and experience measures, and guides quality improvement initiatives. Each of OneCare's payer programs require annual collection of quality data tied to the experience of care, preventive services, management of selected chronic conditions, safety, coordination of care, and utilization of resources. Over the past four years, OneCare's Clinical and Quality Improvement and Operations Departments have developed expertise in defining, collecting, and interpreting the measure sets for each program. OneCare dedicates extensive time and resources in training the network and providing resources for data abstraction. We collaborate with the other Vermont ACOs to deliver a unified interpretation of the measures set and share our trainings and our collection tools with the other ACOs. Our team of Clinical Consultants travels statewide each winter to review medical record data and to abstract the needed data elements. Internally, our Operations team, consisting of certified coders, aids in data collection and a highly skilled data analytics team aids in cleaning, submitting, analyzing, and interpreting the data and transforming it into information that is actionable for change and improvement. Once the data is compiled and validated ACO and HSA level data is shared with participants and the OneCare Boards and Committees.

Quality Improvement: OneCare has several years of experience executing on performance improvement activities in support of our clinical priority areas and directed towards achieving the Triple Aim. These quality improvement activities take place within specific clinical settings (e.g. hospital unit or primary care site) and across HSAs through the Community Collaboratives. OneCare has collaborated extensively with the Blueprint for Health and beginning in late2015, OneCare and Blueprint staff have participated in regular structured "All Field Team" monthly meetings and trainings. Led by ACO and Blueprint leadership, these trainings provide an opportunity to strengthen and align quality efforts by providing a mechanism for shared learning as well as an avenue to identify areas of concern or opportunity that could benefit from enhanced supports. OneCare has also collaborated with the Vermont Health Care Innovation Project (VHCIP) to enhance community-based infrastructure through the deployment of Clinical Consultants and Regional Clinical Representatives within each HSA in our network. OneCare joined VHCIP leadership in planning and conducting the Integrated Communities Care Management Learning Collaborative (ICCMLC) and is building on its success by further resourcing and supporting communities' care coordination activities. Currently, OneCare is partnering with the Vermont Department of Health, Blueprint for Health, and others to plan and execute a learning collaborative to improve the proportion of people with high blood pressure that have their blood pressure under control. Early in 2017 OneCare identified this as a gap in care, noting that across payers, only 70% of patients with hypertension demonstrated sufficient blood pressure control. Partnering with the Department of Health to refine and finalize a toolkit of evidence-based strategies and co-mingling community-based resources with Blueprint for Health, yielded a robust project team and a structured, focused quality improvement initiative to rollout to all interested HSAs. Currently 10 practices and one home health & hospice organization have enrolled in this intensive eight-month project.

Participants will convene in three in-person trainings and be supported through regular coaching and measurement to facilitate testing, implementing, and sustaining changes in their clinical practice and workflows that support high-quality, person-centered care for people diagnosed with hypertension.

OneCare is committed to facilitating quality improvement efforts throughout the State. Our Clinical Consultants work within their assigned communities and statewide to assist with project selection, design, and management in each HSA. The Clinical Consultants bring data to these teams to inform and guide their focused quality initiatives as well as to monitor performance across a dashboard of quality metrics over time. Over the past year OneCare has been rolling out a software program, WorkBenchOne (WBO), to our participants to support monitoring of utilization, cost, and clinical data in a timely manner. The software provides a HIPAA compliant, web-based platform that provides summary data (e.g. across the ACO or across the HSA) and allows users to drill down to the individual facility, provider, and/or patient level (as allowed based on user security and configuration to protect patient information). OneCare strongly believes that the investment in WorkBenchOne will lead to better quality through the increased ease of access to actionable data that can be stratified to identify specific populations of concern, providing a new mechanism to conduct gap analysis and inform quality initiatives. OneCare's past four years of collaboration with local community teams, including supporting the formation and development of Community Collaboratives, has been very instructive in guiding our learning about how best to support these teams in designing very simple rapid cycle improvement strategies. These teams have begun to demonstrate visible improvements in their clinical priority areas and quality improvement projects. OneCare highlights these successes and lessons learned through brief, focused "Network Success Stories" that illuminate the key action steps, results, and translatable activities that other facilities and/or communities can adopt or adapt to their specific circumstances. OneCare facilitates additional learning opportunities for our participants including synchronous and asynchronous trainings and events; "story-telling" sessions; skill-based sessions; in-person trainings such as learning sessions;, written materials (e.g. clinical charters); web-based postings to a secure portal; and access to customized data displayed in a variety of ways.

Care Coordination: As part of our larger population health management model, OneCare has a core clinical strategy to improve care coordination for people at high risk. In order to advance this strategy, OneCare has focused on developing rigorous processes and systems to identify high-risk individuals in each community and support a tightly integrated health care delivery model that provides effective communication and coordination of care for these individuals and their family. OneCare has been an active partner working with the Blueprint for Health and VHCIP in the Integrated Communities Care Management Learning Collaborative (ICCMLC) over the past several years. OneCare's Clinical Consultants participated in the Train-the-Trainer program and have planned and facilitated local community skill-based trainings, helping to disseminate the use of evidence-based and/or evidence-informed tools and practices. Early in this process, OneCare volunteered to create and host a Care Coordination Toolkit and make it readily available on our website. Based on the work of the ICCMLC, OneCare leadership recognized a unique opportunity to support our primary care, specialty care and continuum of care providers to improve

communication and collaboration in support of person-centered care by investing in and deploying Care Navigator (CN). CN is a care coordination software platform to promote the use of standardized shared care plans by interagency care teams. A unique feature of this software is that all care team members interacting with a patient can share information with one another in one place and can update tasks associated with the patient's stated care plan goals, thus reducing duplication and fragmentation. As of May 2017, OneCare has deployed this software in five HSAs to more than 225 unique users.

Care coordination, centered on individuals and their families, encourages shared decision making by way of intentional processes that actively engage each individual in creating a shared plan of care. Effective care coordination requires timely identification of individuals who could benefit from coordinated service delivery and transitions of care, and engaging them in a systematic approach to care coordination in the context of strong community-based linkages among clinical and non-clinical services. Over the past nine months, OneCare has developed and refined a Care Coordination Model (see Diagram B) that is inclusive of the entire attributed population. The model uses population segmentation to identify key focus areas and activities based on prospective risk stratification and informed by clinical knowledge and decision making. The model quantifies risk from low through very high and promotes a strong foundation within primary care for effective panel management, preventive care, outreach and engagement, education, self-management support, referrals, and effective coordination of care with all members of a person's care team regardless of organization. Further, the model requires regular outreach to engage people in care as well as specific tools and supports such as the identification of a lead care coordinator, the creation and maintenance of shared care plans, and person-centered care conferences as needed.

Diagram B. OneCare's Care Coordination Model
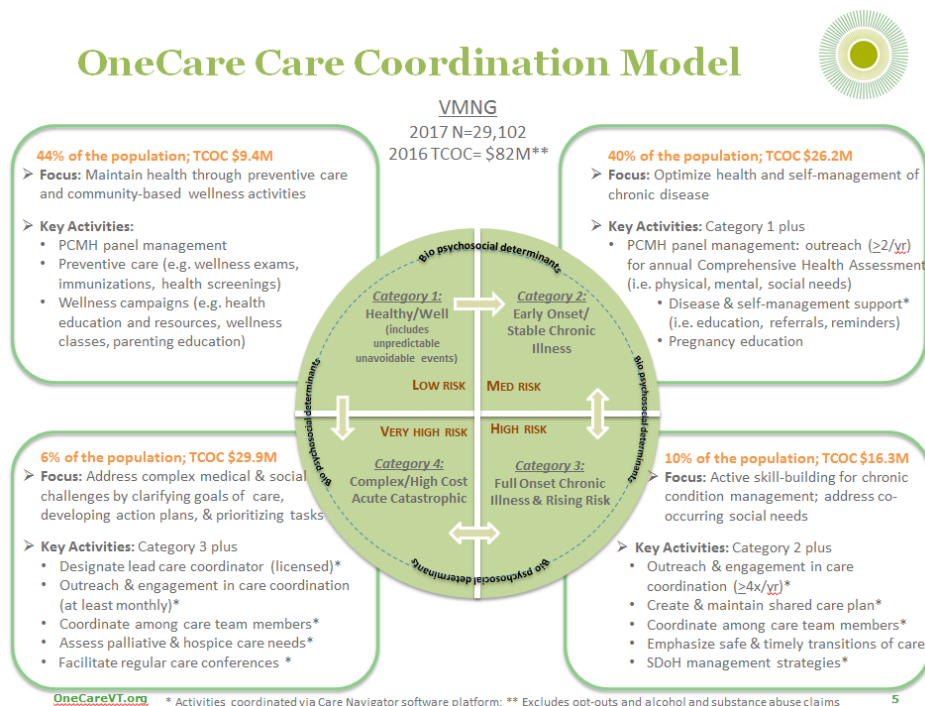
In the coming months OneCare will be deploying additional resources to primary care and continuum of care partners to further align and integrate team-based care and provide care coordination tools and supports to meet people's needs and desires to improve their health and wellbeing. During this same period, OneCare also plans to continue to evolve our care coordination software platform, Care Navigator, to expand capacity to engage individuals and caregivers directly through the software such as through the use of a resource library, event notification, and other features. Finally, OneCare will create a care coordination impact and outcomes analysis application in WorkBenchOne to support community participants in monitoring key utilization and outcome measures to provide input on progress made, gaps in services, and outcomes achieved.

6. *Provide a copy of your grievance and complaint process.*

    Please see Attachment A in Part 5 Attachments "OneCare Vermont ACO Grievance and Appeals Policy."

7. *Provide a completed **Appendix D – ACO initiatives to address All-Payer ACO Model Quality Measures** to briefly describe ACO initiatives to address measures.*

    Please See Attachment B in Part 5 Attachments "ACO initiative to address All-Payer ACO Model Quality Measures."

Part 5
Attachments

Attachment A – OneCare Vermont ACO Grievance and Appeals Policy

Attachment B – ACO Initiative to Address All-Payer ACO Model Quality Measures