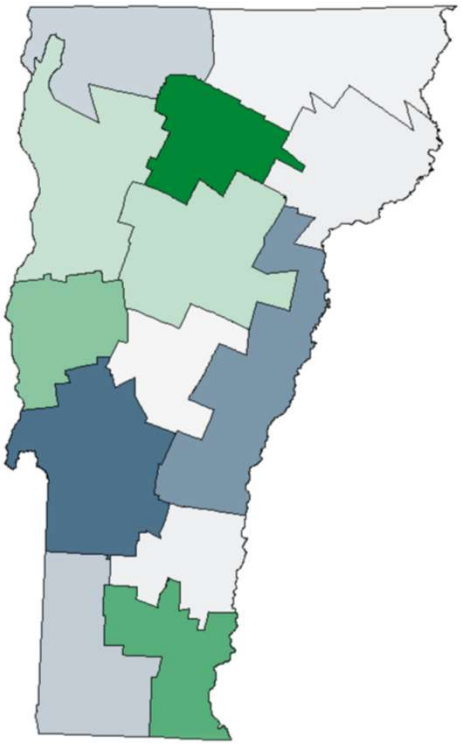


2019 Vermont Medicare ACO Initiative Benchmark for OneCare Vermont

&

OneCare Vermont's FY 2019 Budget and Payer Programs

December 12, 2018

VERMONT
GREEN MOUNTAIN CARE BOARD

Agenda

1. Payer Programs
2. Rates of Growth
3. Risk
4. ACO Budget/Administrative Expenses
5. Programs & Investments
6. Next Steps

Payer Programs

Payer Programs

Medicare

- Vermont Medicare ACO Initiative (2019 = Year 1*)

Medicaid

- Medicaid Next Generation Program (2019 = Year 3)

Commercial

- Blue Cross Blue Shield QHP Next Generation (2019 = Year 2)
- UVMMC Self-Funded Program (2019 = Year 2)
  - Expansion
  - Progression from Shared Savings to Shared Risk
- Potential New TPA-level Self-Funded Program (2019 = Year 1)

* The Medicare program is changing from the Vermont Modified Next Generation Program (the standard Medicare Next Generation program except the GMCB sets the trend rates, subject to CMS approval) to the Vermont Medicare ACO Initiative (the GMCB still sets the trend rates, subject to CMS approval, but can seek other modifications).

Scale Target ACO Initiatives

Only those attributed to a Scale Target ACO Initiative count towards scale targets.

There are four requirements a program must meet to qualify as a Scale Target ACO Initiative:

1. Possibility of Shared Savings for achieving goals related to quality of care or utilization.
2. The ACO's Shared savings, as a percentage of its expenditures less than the benchmark, is at minimum 30%; if the ACO is also at risk for Shared Losses, its Shared Losses, as a percentage of its expenditures in excess of the benchmark, is at minimum 30%.
3. Services comparable to, but not limited to, the All-payer Financial Target Services and their associated expenditures are included for determination of the ACO's Shared Losses and Shared Savings;
4. The ACO Benchmark, Shared Savings, Shared Losses, or a combination is tied to the quality of care the ACO delivers, the health of its aligned beneficiaries, or both.

Scale Target ACO Initiatives

Potential Changes to Existing Programs in 2019: None we think would disqualify the programs from being considered Scale Target ACO Initiatives.

- Medicare:
  - increasing gain/loss share from 80% to 100%
  - VBIF quality framework to align with other payers
- Medicaid:
  - increasing VBIF withhold as percentage of benchmark
  - increasing gain/loss corridor from 3% to 4%
- BCBSVT QHP:
  - removing non-specialty pharmacy
- Self-Funded:
  - Shared savings → shared risk (6% corridor and 30% share)

Potential New Self-Funded Program: Still being negotiated. Not described in sufficient detail to allow us to determine whether it would qualify, although OneCare states that this is its intent.

Alignment with Medicare

The All-Payer ACO Model Agreement requires that programs reasonably align with the Vermont Medicare program in the areas of alignment/attribution methodologies, quality measures, payment mechanisms, and services included in determining shared savings and losses.

Potential 2019 Changes to Existing Programs

- Alignment/Attribution Methodologies:
  - Potential changes in Medicaid. None anticipated for other payers.
- Quality Measures:
  - Changes to Medicare measures. Increasing alignment.
- Payment Mechanisms:
  - No changes. Only public payers will offer AIPBP mechanism.
- Risk Arrangements:
  - All are symmetrical shared risk arrangements. Levels in Medicare and Medicaid getting closer (e.g., 3%→4% and 80%→100%).
- Services Included in Determining Shared Savings and Losses:
  - Potential loss of non-specialty pharmacy in BCBSVT QHP program (not currently in any other programs).

Staff Recommendations for Conditions:

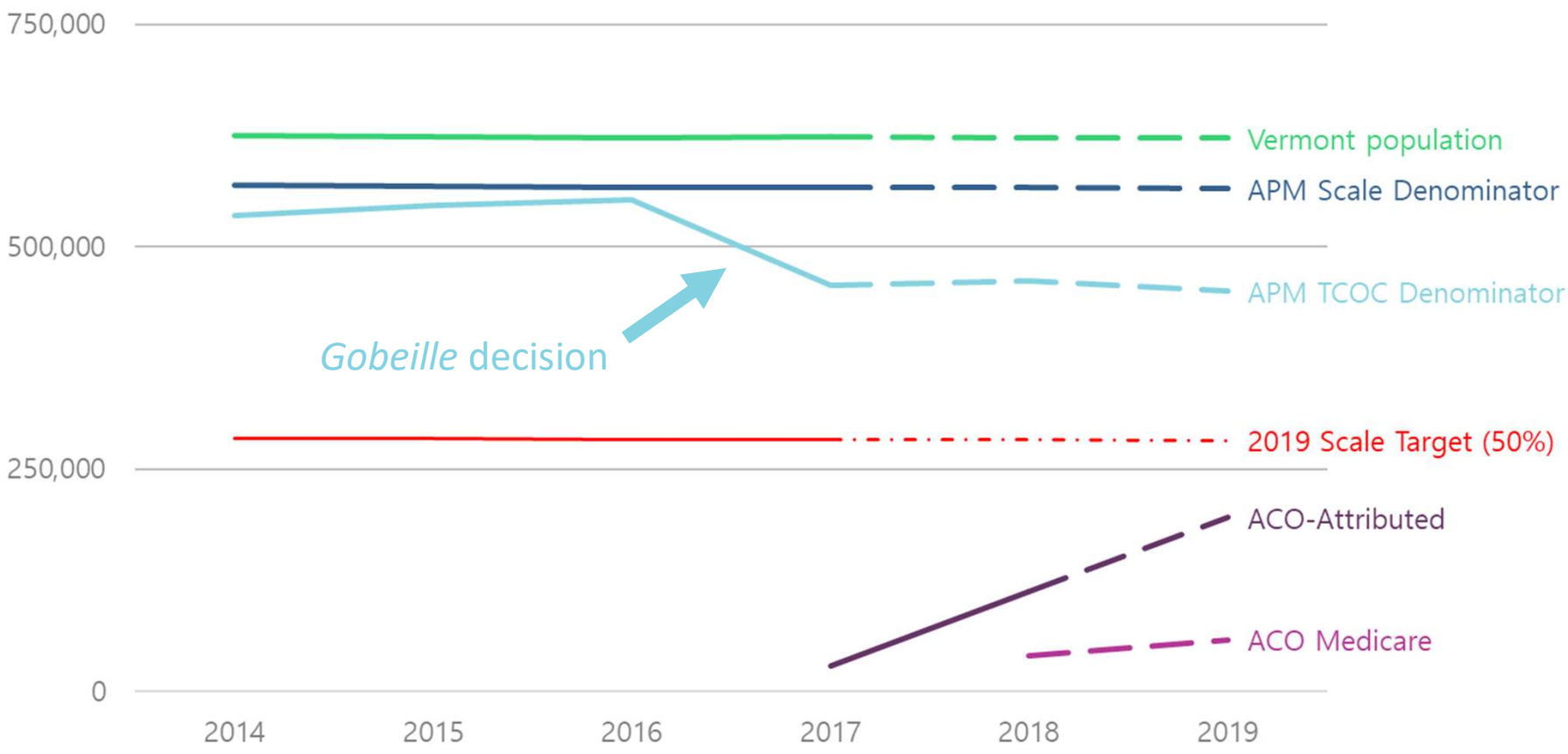
Payer Programs

1) No later than 30 days after end of Q1 2019, OneCare must submit a written report to the Board which demonstrates to the Board's satisfaction that its payer programs (other than the Vermont Medicare ACO Initiative) qualify as Scale Target ACO Initiatives under section 6.b. of the All-Payer ACO Model Agreement, and which describes (a) how these programs align with the Vermont Medicare ACO Initiative in the areas of attribution methodologies, quality measures, payment mechanisms, services included in determining shared savings and losses, patient protections, and provider reimbursement strategies and (b) the rationale(s) for any differences in these areas. Thereafter, OneCare must update this report no later than 15 days after entering a new payer program covering any portion of 2019.

2) At times specified by the Board, OneCare must submit documents or summary information needed to prepare reports required by the All-Payer ACO Model Agreement (e.g., the Payer Differential Report).

Rates of Growth

All-Payer Model (APM) Populations



VERMONT
GREEN MOUNTAIN CARE BOARD

Statewide Financial Targets

All-Payer Growth Target: Vermont is expected to maintain a compounding growth rate of 3.5% or less over the course of the agreement.

Medicare Growth Target: Vermont is expected to maintain a compounding growth rate that is 0.2% or less than national projections.

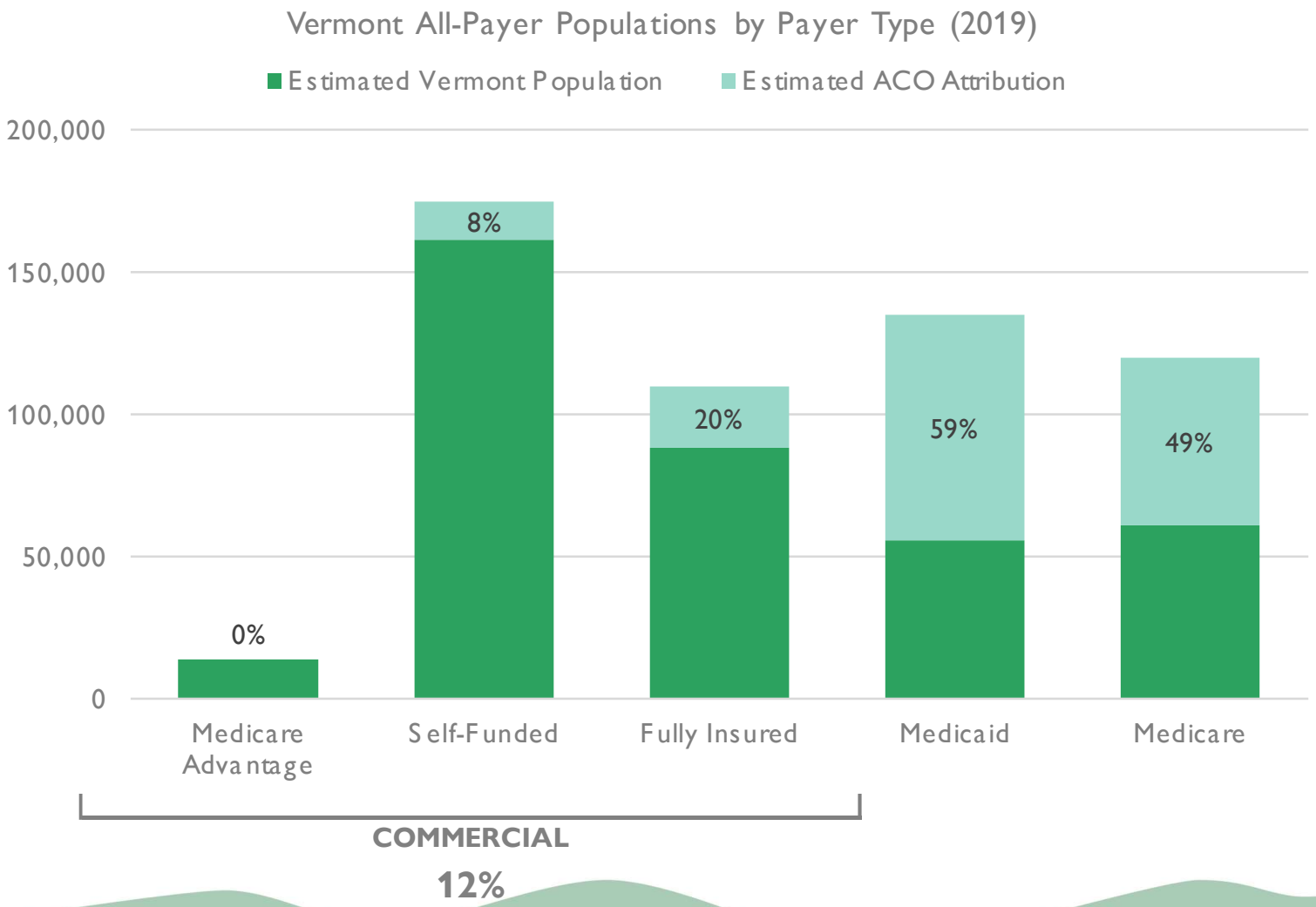
- Performance on these targets is calculated over the 5-year agreement (2018 – 2022).
- Baseline year is 2017. Growth is measured from 2017 – 2022.
- During the agreement term, failure to be "on track" to meet these targets could require a corrective action plan:
  - All-Payer Target: Corrective action would not be triggered unless the compounding growth rate were to exceed 4.3%.
  - Medicare Target: Corrective action would not be triggered unless the compounding growth rate were to exceed 0.1% of national projections.

All-Payer Growth

Payer	Growth
Commercial	ACO
	Non-ACO
Self-Insured	ACO
	Non-ACO
Medicare	ACO
	Non-ACO
Medicaid	ACO
	Non-ACO

- All-payer cost growth is a combination of every payer type.
- The All-Payer Target will count all Vermont residents regardless of whether they are in an ACO.
- It includes all spending, but payer types may have different growth rates for ACO and non-ACO populations.
- GMCB has regulatory influence over these different factors in different ways.

Vermont All-Payer ACO Attribution



VERMONT
GREEN MOUNTAIN CARE BOARD

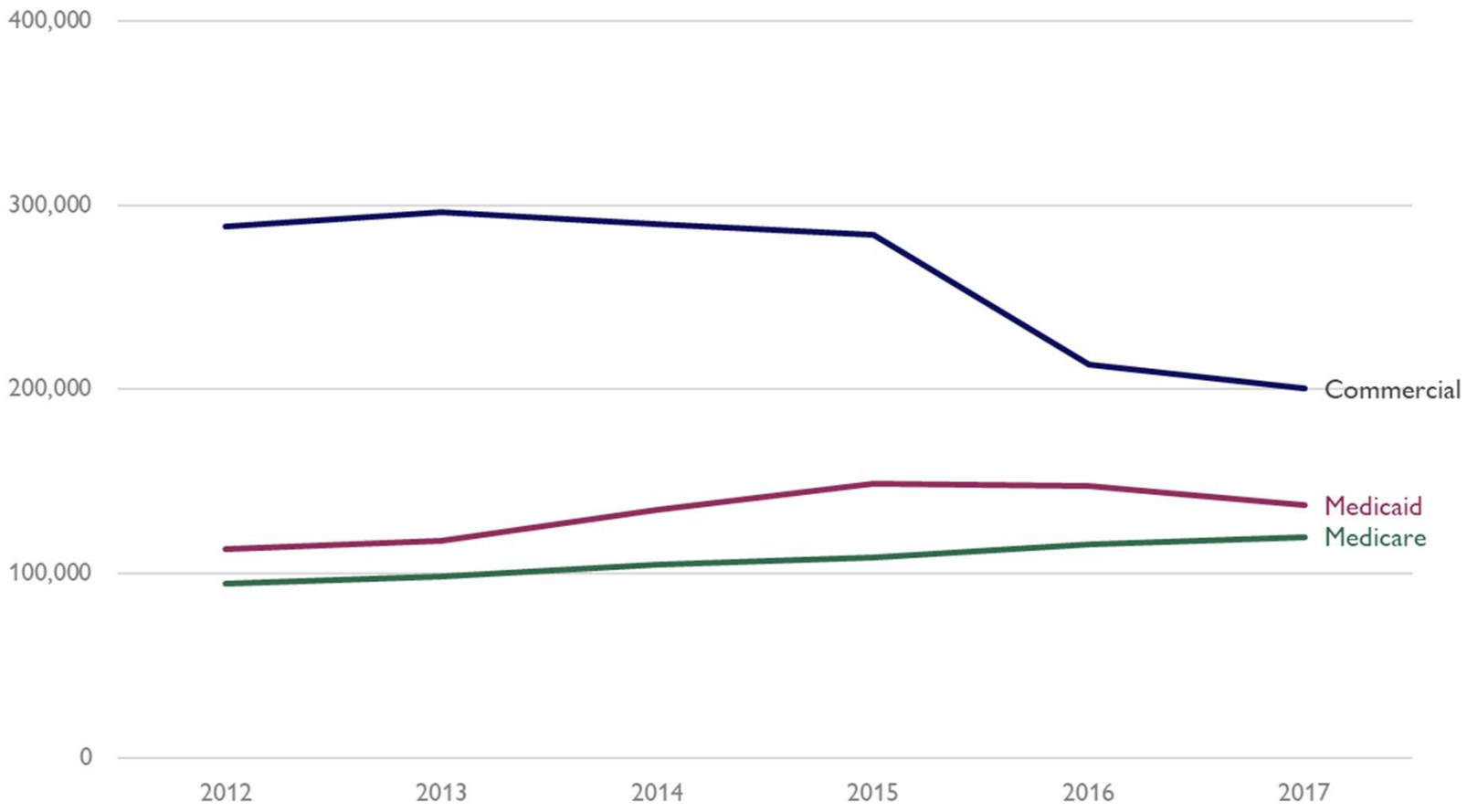
Vermont All-Payer Total Cost of Care (TCOC) Over Time

	2012	2013	2014	2015	2016	BASELINE 2017	
TCOC (billions)	$2.4	$2.6	$2.7	$2.9	$2.7	$2.7	2022
Average Members	496,276	511,801	529,134	541,490	476,127	457,544	TARGET
Per member per month	$397	$416	$428	$442	$465	$496	$589
Per member per year	$4,758	$4,994	$5,130	$5,303	$5,583	$5,954	$7,068

Gobeille decision

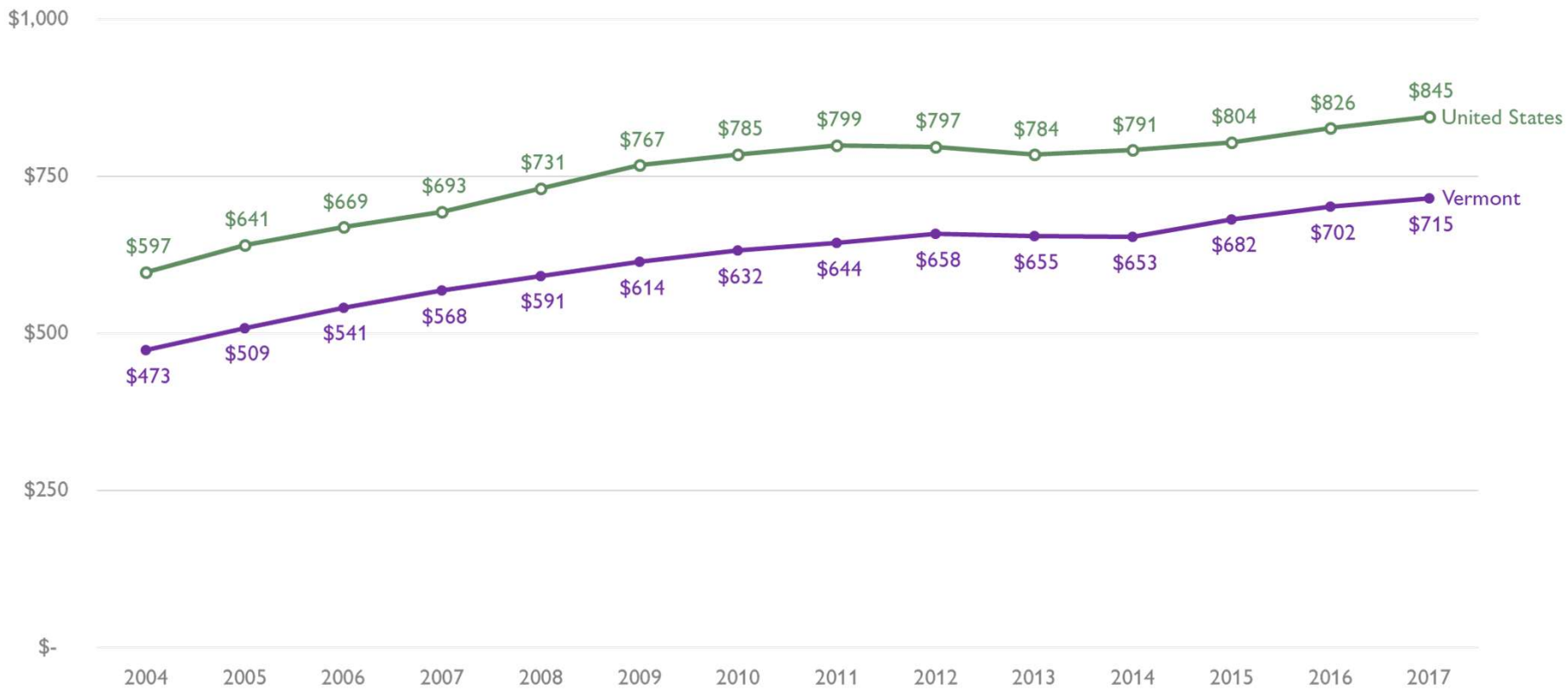
- These PRELIMINARY estimates are not final and will change.
- Estimates include a claims-based portion (derived from VHCURES) and a non-claims portion (derived from payer reports and Blueprint for Health data).
- Claims-based spending incorporates the total *allowed* amounts for the *primary payer type* for the member month.

Vermont All-Payer TCOC Membership Over Time



VERMONT
GREEN MOUNTAIN CARE BOARD

Medicare TCOC Paid Amounts Over Time



	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
US		7.4%	4.4%	3.6%	5.5%	4.9%	2.3%	1.8%	-0.3%	-1.6%	0.9%	1.6%	2.8%	2.2%
VT		7.6%	6.3%	5.0%	4.0%	3.9%	2.9%	1.9%	2.2%	-0.5%	-0.2%	4.3%	2.9%	1.8%

VERMONT
GREEN MOUNTAIN CARE BOARD

Medicare National Projections

Aged and Disabled	Letter	2017	2018	2019	2020	2021	Growth Rate
	Apr-17	**$ 825.00**	**$ 847.73**	$ 888.97	$ 929.95		2.8%
	Apr-18	$ 832.55	**$ 856.41**	**$ 891.07**	$ 926.74	$ 969.98	4.0%

End Stage Renal Disease (ESRD)	Letter	2017	2018	2019	2020	2021	Growth Rate
	Apr-17	**$ 6,933.11**	**$ 7,133.42**	$ 7,434.24	$ 7,745.31		2.9%
	Apr-18	$ 7,067.89	**$ 7,586.28**	**$ 7,833.28**	$ 8,099.11	$ 8,439.59	3.3%

Blended (0.36% ESRD)	Letter	2017	2018	2019	2020	2021	Growth Rate
	Apr-17	**$ 846.99**	**$ 870.36**	$ 912.53	$ 954.49		2.8%
	Apr-18	$ 855.00	**$ 880.64**	**$ 916.06**	$ 952.56	$ 996.87	4.0%

Medicare Benchmark Growth Rate

- The APM Agreement limits the amount the GMCB may set the ACO Benchmark growth rate to 0.2% below the annual national projections:

Aged and Disabled = 4.0% - 0.2% = 3.8%

End Stage Renal Disease = 3.3% - 0.2% = 3.1%

Medicare TCOC per Beneficiary Growth Target Performance Period to Date

- Targets are based on *projected growth rates* for the traditional Medicare population for the *entire United States*.

- Since Vermont elected to use the floor in performance year 1, the first growth target (2017 to 2018) is locked in at 3.7%.

$$Aged\ and\ Disabled\ Target: \sqrt{1.0370 * 1.0405} - 1.002 = 3.7\%$$

$$End\ Stage\ Renal\ Disease\ Target: \sqrt{1.0370 * 1.0326} - 1.002 = 3.3\%$$

Vermont Medicare TCOC per Beneficiary Growth Estimate

- Based on the performance estimates for 2018, if the ACO were to grow at the maximum allowable benchmark rates (3.8% for Aged and Disabled and 3.1% for End Stage Renal Disease), the estimated performance through 2019 would be within the Medicare TCOC target.

$$\sqrt{0.984 * 1.038} - 1 = 1.1\%$$

(Medicare TCOC per Beneficiary Growth Target, 2017 to 2019: 3.7%)

Medicare TCOC per Beneficiary Growth Target Calculation

- Performance years 1 and 2 are tied to the ACO Medicare population.
- The actual ACO spending is compared with a *hypothetical* comparison group.
- The hypothetical comparison group estimates what the TCOC would have been based on the *current provider list*.

$$\frac{Actual\ ACO-aligned\ Medicare\ spending\ per\ member}{Hypothetical\ ACO-aligned\ Medicare\ spending\ per\ member}$$

Medicare TCOC per Beneficiary Growth: 2018 Performance Year Estimate

- Based on the best assumptions and estimates currently available. (These estimates *will change*).

	Estimated Expenditures		Estimated
	2017	2018	Growth
Aged and Disabled	$9,422	$9,559 - $9,566	1.5%
End Stage Renal Disease	$93,970	$84,046 - $84,053	-10.6%
Blended	$9,940	$9,775 - $9,782	-1.6%

National Medicare Growth Rate (L&E)

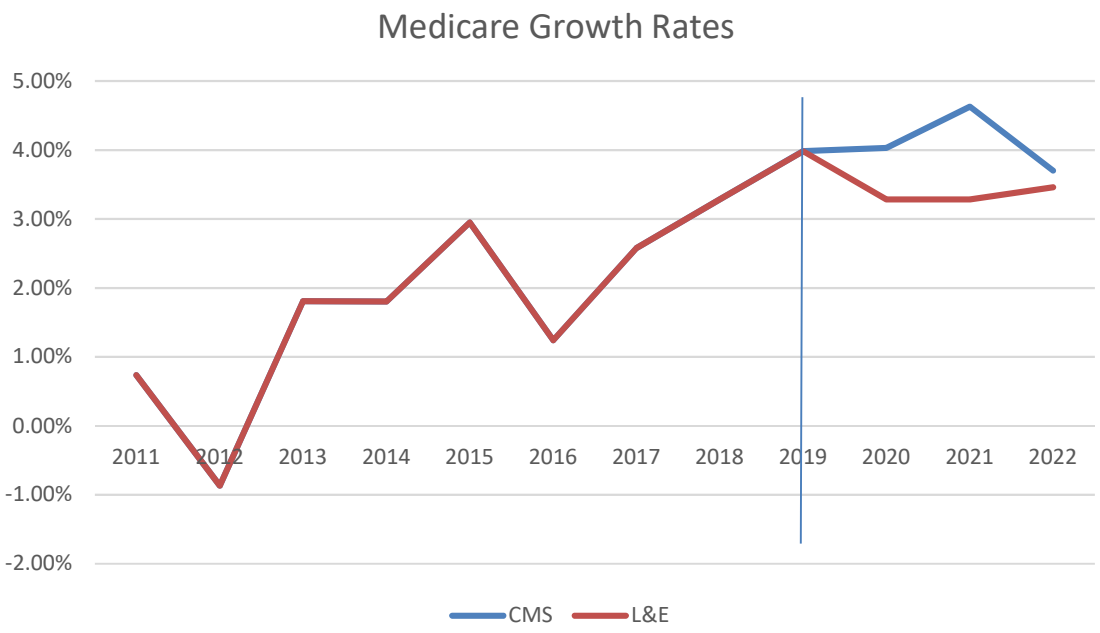
- Years 2010-2020 are based on the 2019 call letter.
- Years 2021 & 2022 show figures based on the 2019 call letter and L&E's estimation based on historical trends

Year	Blended CMS USPCC	Growth Rate
2010	$807.00	
2011	$812.93	0.73%
2012	$805.88	-0.87%
2013	$820.47	1.81%
2014	$835.27	1.80%
2015	$859.92	2.95%
2016	$870.60	1.24%
2017	$893.03	2.58%
2018	$922.36	3.28%
2019	$959.10	3.98%
2020	$997.75	4.03%

Year	Blended CMS USPCC	Growth Rate	L&E's Blended USPCC	Growth Rate
2021	$1,043.93	4.63%	$1,017.22	3.16%
2022	$1,082.56	3.70%	$1,050.88	3.31%

National Medicare Growth Rate (L&E)

2017-2022	CMS	L&E
National	4.01%	3.54%
VT Target	3.81%	3.34%



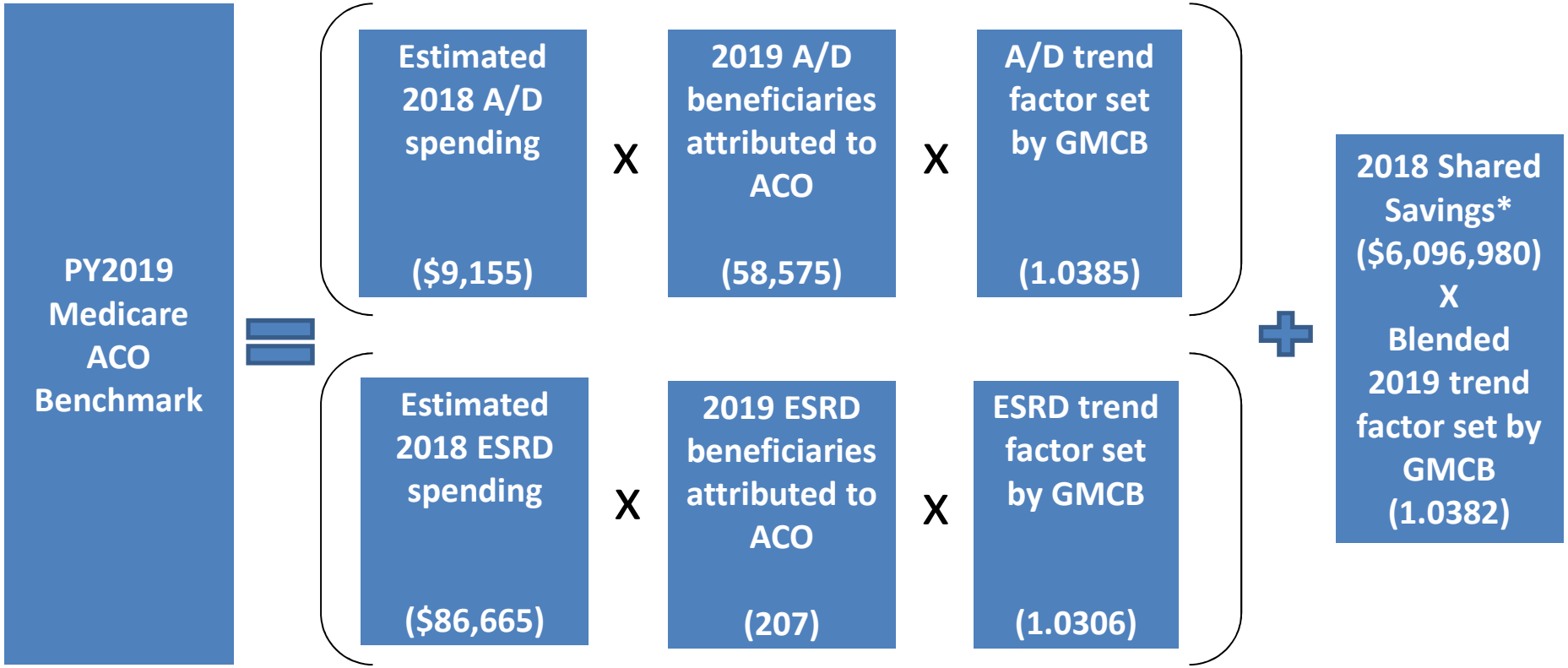
VERMONT
GREEN MOUNTAIN CARE BOARD

Medicare Growth Rate: OneCare Vermont Benchmark Scenarios (L&E)

Year	CMS	L&E
2018*	3.50%	3.50%
2019**	3.80%	3.80%
2020	3.80%	3.40%
2021	3.80%	3.00%
2022	3.80%	3.00%
Average	3.74%	3.34%
Target	*3.81%*	*3.34%*

*From Approved 2018 Budget
**In Proposed 2019 Budget

Medicare Benchmark Calculation



* Initially, the Blueprint/SASH investment will be used to estimate shared savings ($6.1M). The benchmark will be adjusted to reflect actual shared savings or losses after the PY 2018 settlement is finalized (estimated maximum of $16.2M).

Medicare Benchmark Comparison: 2018 to 2019

	Benchmark PMPM		
	2018	2019	*Change*
Aged and Disabled	$830	$792	*-5%*
End Stage Renal Disease	$7,528	$7,443	*-1%*
Total	$880	($825 to $840)	*(-6% to -5%)*

	Benchmark Prospective Members		
	2018	2019	*Change*
Aged and Disabled	38,877	58,575	*51%*
End Stage Renal Disease	195	207	*6%*
Total	39,072	58,782	*50%*

	Benchmark Totals		
	2018	2019	*Change*
Aged and Disabled	$387,291,838	$556,911,283	*44%*
End Stage Renal Disease	$17,615,003	$18,487,775	*5%*
Total	$404,906,840	$581,729,100	*44%*

Staff Recommendations:

Medicare Benchmark

- Recommend approving the 2019 Vermont Medicare ACO Initiative benchmark for OneCare using trend rates of 3.8% for the Aged and Disabled component and 3.1% for the End-Stage Renal Disease component.
    - The recommended rates are within parameters set by the All-Payer ACO Model Agreement and, based on our best estimates, would not cause the State to exceed the Medicare growth target.
    - Savings generated in early years of the model could help offset the additional risk that would come with increasing scale or allow for investments in care transformation.
    - With the high levels of risk in the Medicare program, early successes may help increase participation.

Lewis and Ellis Recommendations for Conditions:
Medicaid

- L&E has received data from Wakely (DVHA's actuarial consultants) for the Medicaid advisory rate case. 18 V.S.A. § 9573.

- The Medicaid advisory rate case is ongoing and is confidential until after the Medicaid contract is finalized.

- Wakely's range for per beneficiary growth will fall within the range that L&E recommends.

Lewis and Ellis Recommendations for Conditions:

Commercial QHP

- Ongoing negotiations between OneCare and BCBSVT for both 2018 and 2019.
- OneCare quoted figures in their submission for trend that was not consistent with the Board's order.
- L&E recommends that the trend figures for the Commercial rate be developed using the ACO-attributed population.
- L&E recommends that the final QHP filing from BCBSVT be the source if referenced.

Lewis and Ellis Recommendations for Conditions:

Rates of Growth

3) Approve the following benchmark trend rates:
   Medicare: 3.80% (as requested)
   Medicaid: within the Wakely range
   Commercial QHP: See recommendations on previous slide

4) Require that OneCare (a) provide the Board with actuarial certifications for each of its commercial (including self-funded) benchmarks stating that the benchmark is adequate but not excessive; (b) provide the Board with an explanation of how its overall rate of growth across all payers fits within the overall all-payer target rate of growth and, if its overall rate of growth exceeds the target, how OneCare plans to achieve the target for the term of the All-Payer Model ACO Agreement (2017 to 2022); and (c) provide the Board with a revised budget based on the finalized benchmarks.

Risk

Risk Mitigation

Risk Corridor Arrangements by Payer		
Payer	**Corridor**	**OneCare's Share**
Medicaid	96% - 104%	100%
Medicare	95% - 105%	100%
Commercial	94% - 106%	50%
Self-Funded	94% - 106%	30%

- OneCare has a $767K expense for reinsurance/risk protection as part of its administrative budget.
- OneCare has shifted most of the risk to the participating hospitals.
- OneCare has expressed a desire to hold at least $3.9M in reserves by the end of 2019 to cover the risk mitigation it is offering to three hospitals.

Hospital Risk

Hospital	Medicare Risk	Medicaid Risk	BCBSVT QHP Risk	Maximum Risk Limit (MRL)	Risk Mitigation	Est. MRL
BMH	$1,221,777	$318,183	$120,235	$1,660,196	$900,000	$760,196
CVMC	$2,675,188	$580,193	$438,350	$3,693,731	-	$3,693,731
Copley	$0	$0	$0	$0	-	$0
Gifford	$0	$362,194	$0	$362,194	-	$362,194
Grace Cottage	$0	$0	$0	$0	-	$0
MAHHS	$1,267,514	$133,260	$239,809	$1,640,583	-	$1,640,583
North Country	$0	$452,664	$0	$452,664	-	$452,664
NVRH	$0	$560,735	$0	$560,735	-	$560,735
Northwestern Medical Center	$1,879,252	$848,832	$245,421	$2,973,505	-	$2,973,505
Porter	$1,898,569	$499,080	$266,110	$2,663,760	-	$2,663,760
RRMC	$0	$706,548	$0	$706,548	-	$706,548
SVMC	$3,207,210	$617,582	$447,389	$4,272,180	$2,000,000	$2,272,180
Springfield	$2,422,080	$326,207	$243,927	$2,992,214	$1,000,000	$1,992,214
UVMMC	$8,794,030	$2,085,398	$1,497,348	$12,376,776	-	$12,376,776
DH	$0	$242,223	$244,954	$487,176	-	$487,176
TOTAL	**$23,365,621**	**$7,733,097**	**$3,743,543**	**$34,842,262**	**$3,900,000**	**$30,942,262**

Hospital Risk

Hospital	HSA	MRL	Days Cash on Hand*	MRL as Days Cash on Hand	MRL as % of Days Cash on Hand
BMH	Brattleboro	$760,196	196.2	1.81	0.9%
CVMC	Berlin	$3,693,731	112.7	1.96	1.7%
Copley	Morrisville	-	66.4	N/A	N/A
Gifford	Randolph	$362,194	177.5	1.22	0.7%
Grace Cottage	Townshend	-	92.5	N/A	N/A
MAHHS	Windsor	$1,640,583	176.4	5.50	3.1%
North Country	Newport	$452,664	196.3	1.08	0.6%
NVRH	St. Johnsbury	$560,735	122.3	0.86	0.7%
Northwestern Medical Center	St. Albans	$2,973,505	306.5	8.28	2.7%
Porter	Middlebury	$2,663,760	134.9	4.32	3.2%
RRMC	Rutland	$706,458	205.7	0.57	0.3%
SVMC	Bennington	$2,272,180	46.3	2.59	1.4%
Springfield	Springfield	$1,992,214	106.8	3.61	3.4%
UVMMC	Burlington	$12,376,776	192.4	1.85	1.0%
DH	Lebanon	$487,176	Information not available - Not a regulated hospital		

*per approved 2019 hospital budgets

Staff Recommendations for Conditions:

Risk

5) The maximum amount of risk OneCare may assume for 2019 is the sum of the following: 5% of the Medicare benchmark; 4% of the Medicaid benchmark; 3% of the commercial Blue Cross Blue Shield QHP benchmark; and 1.8% of the commercial self-funded program benchmark(s). OneCare must request and receive an adjustment to its budget prior to executing a contract that would cause it to exceed these risk levels.

6) OneCare must provide the Board contracts that obligate each of the risk-bearing hospitals to OneCare's risk sharing policy.

7) OneCare must hold at least $3.9 million in reserves by the end of 2019.

8) OneCare must inform the Board whether it has secured aggregate total cost of care protection for Medicare or any other payer programs in 2019.

Budget/Administrative Expenses

Budget/Administrative Expenses

	FY2018 Budget Approved	FY2018 Projection	FY2019 Budget Submitted
Operating Margin	0.0%*	0.3%	0.3%
Total Margin	0.0%*	0.3%	0.3%
Administrative Expense Ratio*	1.95%	1.72%	1.77%
Debt Ratio	1.00	0.91	0.84
Current Ratio	1.17	1.35	1.49

*Does not include reserves

Staff Recommendations for Conditions:

Budget/Administrative Expenses

9) OneCare's administrative expense ratio must be consistent with its proposed budget. If the expense ratio increases by more than one percent (1%) from the budget, OneCare must promptly inform the Board.

10) OneCare must ensure that its administrative expenses are appropriately allocated by state.

11) OneCare must submit its audited financial statements as soon as they are available and must submit information as required by the Board to monitor OneCare's performance.

Programs & Investments

Programs & Investments

PHM/Payment Reform Programs	2018 Approved	2019 Submitted
Basic OCV PMPM	$4,781,010	$5,935,530
Complex Care Coordination Program	$7,064,722	$9,181,362
Value-Based Incentive Fund	$4,035,223	$7,537,231
Comprehensive Payment Reform Program	$1,800,000	$2,250,000
Primary Prevention	$1,577,600	$910,720
Specialist Program Pilot	-	$2,000,000
Innovation Fund	-	$1,000,000
RCRs *(in 2018 was included in Primary Prevention line item; $300,000)*	-	$375,000
PCMH Legacy Payments	$1,973,649	$1,830,264
CHT Block Payment	$2,518,898	$2,411,679
SASH	$3,269,954	$3,815,532
Total	**$27,291,056**	**$37,247,319**

Programs & Investments

Blueprint (PCMH Legacy Payments and CHT Block Grants) & SASH: These payments continue Medicare's participation in the Multi-Payer Advanced Primary Care Practice Demonstration. OneCare's 2019 budgeted Blueprint & SASH expenditures are a **3.8%** increase over 2018 budgeted, which reflects the Medicare benchmark growth trend OneCare is requesting for 2019.

- **PCMH:** The Patient-Centered Medical Home (PCMH) legacy payments support primary care practices that achieve or maintain recognition as a PCMH under the National Committee for Quality Assurance standards.
- **CHT:** The Community Health Team (CHT) block grants support the Blueprint CHTs, which supplement services available in PCMHs and link patients with social and economic services.
- **SASH:** The Support and Services at Home (SASH) program connects local health and long-term care systems for Medicare beneficiaries to support aging at home through partnerships with Housing Organizations, Home Health, Area Agencies on Aging, and Designated Mental Health Agencies.

New Population Health Program Investments

Financial Initiative	Brief Description of Program
Comprehensive Payment Reform Program Expansion	Capitated monthly PMPM for independent primary care practices participating in all core payer programs.
Payment Reform Pilot(s) for Specialists	Program(s) designed to align with OCV's population health approach, to increase timelier access to care and stronger connection between primary and specialty care.
Expansion of RiseVT	Statewide initiative to increase access to programming that promotes healthy lifestyle initiatives.
Developmental Understanding and Legal Collaboration for Everyone (DULCE)	Education and support for healthy development of infants (ages 0-6 mo.) while also providing educational and legal support to their parents.
Community Based Innovation Funds	Financial support for innovative evidenced-based (or informed) programs that could be tested and spread to other communities.

Ongoing Population Health Program Investments

Financial Initiative	Brief Description of Program
Basic OCV PMPM	PMPM payment for primary care practices.
Complex Care Coordination Program	PMPM payment and initiation payments for care coordination for high and very high risk individuals.
Comprehensive Payment Reform Pilot	Capitated monthly PMPM for independent primary care practices participating in all core payer programs.
RiseVT	Statewide initiative to increase access to programming that promotes healthy lifestyle initiatives.
Regional Clinical Representatives	Contracts for a clinical lead in each community.
Value-Based Incentive Fund	Withhold to be distributed to support quality improvement initiatives.
Community Health Teams, SASH, and PCMH Legacy Payments	Continuing support for Blueprint for Health programs.

Staff Recommendations for Conditions:
Programs & Investments

12) PHM/Payment Reform Investment Ratio & Blueprint/SASH Funding: OneCare must fund the population health management and payment reform programs/investments described in its submission at no less than 3.6% of its overall budget (i.e., within 0.5 percentage points of the targeted ratio of 4.1%) and must fund the SASH and Blueprint for Health (PCMH and CHT) investments at 2018 Medicare levels plus an inflationary rate of 3.8% in risk and non-risk communities. If the percentages are projected to be less than those required by this order by the end of 2019, OneCare must promptly alert the Board.

13) Follow-Up on 2018 CPR Pilot: No later than 30 days after the end of Q3 2019, OneCare must submit a final report on its 2018 Comprehensive Payment Reform Pilot that (a) compares the 2018 quality outcomes of the pilot cohort with the non-pilot cohort; (b) analyzes how the capitated payments received by primary care practices in 2018 under the pilot compared to payments hospitals make to primary care providers that did not participate in the pilot; and (c) describes practices' experiences with the pilot (e.g., impacts on administrative burden and any clinical innovations allowed by increased flexibility and/or resources).

14) Follow-Up on 2019 CPR Program: No later than 30 days after the end of Q2 2019, OneCare must submit an interim financial report on the 2019 Comprehensive Payment Reform Program that describes changes made to the program in 2019 and analyzes how the capitated payments received by primary care practices under the program are comparing to payments hospitals make to primary care providers not participating in the pilot.

Staff Recommendations for Conditions:
Programs & Investments

15) Follow-Up on Adjustments to VBIF Distribution Methodology: No later than 30 days after the end of Q3 2019, OneCare must submit a written report describing its progress in testing and implementing a variable component to the VBIF distribution methodology for 2020.

16) Community Innovation Fund and Specialist Pilot: No later than 30 days after the end of Q3 2019, OneCare must submit implementation and evaluation reports for the specialist payment pilot and the community innovation fund. OneCare must work with GMCB staff regarding the subjects to be covered by the reports, which may include, for example, how the innovation fund investments balance a state-wide approach that considers regional innovation and community needs, and how the specialist pilot relates to OneCare's care model and clinical priorities.

Next Steps

- Public comment extended through December 14.
- December 17: Follow-up as needed from staff and potential votes.
    - Vote #1: Recommend approving the 2019 Vermont Medicare ACO Initiative benchmark for OneCare using trend rates of:
        - 3.8% for the aged and disabled component; and
        - 3.1% for the end-stage renal disease component.
    - Vote #2: Recommend approving OneCare's FY2019 Budget with conditions on rates, risk, reporting, investments, administrative expenses, etc.