To: **Michael Barber, Pat Jones, Melissa Miles; Green Mountain Care Board**
From: **Spenser Weppler OneCare Vermont, Accountable Care Organization, LLC**
Date: **June 25, 2018**
Subject: **OneCare Vermont ACO Request for Consideration of Technical changes for the 2019 Vermont Medicare ACO Initiative Participant Agreement**

Dear Michael, Pat and Melissa,

Per the request of the Green Mountain Care Board (GMCB) and the Center for Medicare and Medicaid Innovation (CMMI) we are formally submitting our proposed technical changes for inclusion in the 2019 Medicare Vermont Medicare ACO Initiative Participant Agreement. Our proposed changes reflect an attempt to streamline and align the contracting and regulatory oversight process of the Medicare ACO initiative with the GMCB's ACO Regulatory duties as adopted by Rule 5.000. Below is a summary of our proposed modifications t for 2019 along with supporting documentation.

Governance:

The intent of these requirements is to ensure that the ACO's governing body has sufficient representation of health care providers who are actively pursuing the ACO's clinical and financial model. OneCare's Board includes many provider representatives across the continuum, both Participants and Preferred Providers of care who meet this goal. For example, home health and skilled nursing facility representatives, although classified as Preferred Providers, are active participants in our clinical and financial model. . OneCare is seeking to formalize that these provider representatives are included in the calculation of governance by providers.

Section III.B.2(f) of the Vermont Modified Next Generation ACO Participant Agreement states the following in regards to the ACO's composition of its governing body.

"At least 75 percent control of the ACO's governing body shall be held by Next Generation Participants or their designated representatives. The Beneficiary and Consumer Advocate required under this Section shall not be included in either the numerator or the denominator when calculating the percent control. The ACO may seek an exception from the 75 percent control requirement by submitting a proposal to CMS describing the current composition of the ACO's governing body and how the ACO will involve Next Generation Participants in innovative ways in ACO governance. Any exception to the 75 percent control requirement will be at the sole discretion of CMS"

The language from GMCB's rule 5.00 section 5.202(b) states the following in regards to composition of the ACO's governing body.

"*An ACO must have a governance structure that reasonably and equitably represents ACO Participants, including a governing body over which at least seventy-five percent (75%) control*

is held by ACO Participants or representatives of ACO Participants. An ACO's governing body must also include the following Enrollee members, whose positions may not be filled by the same person"

CMS specifically defines "Preferred Providers" and will need to maintain this category and its definition in order for OneCare (and any Next Gen ACO) to submit and finalize its performance year 2019 network as the specifically differentiate "Participants" and "Preferred Providers" into two separate lists for submission. GMCB's language and definition for participants under rule 5.000 is not as prescriptive, and is instead broader to include all types of providers under the category of "participants". The simple solution to achieve this would be to add language to the existing Governance section of the Vermont Medicare ACO Initiative Participant Agreement that the "Governing Body will be comprised of at least 75% of participants *and preferred providers* in its network" while striking out the words *"their designated representatives".* See suggested addition below in red.

Readiness Review and Audit Functions of CMS involving the ACO:

CMS annually conducts an Initial Readiness Review audit to make sure an ACO complies with specific provisions within the following categories of the Vermont Medicare Next Generation ACO Participant Agreement: (Please see Attachment A)

Section III: Governance and Leadership Team
Section V: Beneficiary Notification
Section XIV: Financial Guarantee
Section XVI: Public Reporting and Transparency
Section XVII: Compliance Plan

Many of the aforementioned requirements are also required as part of the GMCB ACO certification requirements. To the extent possible, where materials and documentation are required by CMS as part of an audit and readiness review which overlaps with already existing materials and documentation provided to the GMCB as part of its certification requirement, we request that the CMS requirements be deemed as met. In situations where CMS requires additional documentation that is not required by the GMCB, then CMS will contact OneCare directly to request these documents.

Descriptive ACO Materials and Activities:

Section V.E requires the ACO to submit all ACO Descriptive Materials (where Medicare, and/or a particular ACO Model is referenced) to CMS for review and approval. CMS utilizes a sub-contractor in order to complete these reviews for all ACO's regardless of the program. We would like to be allowed to submit our descriptive materials directly to the CMMI State Innovation Team overseeing the Vermont Medicare ACO Initiative for expedited review and approval.

Beneficiary Notification Letter:

Section V.D requires the ACO to notify any aligned Medicare Beneficiaries that their provider is participating in a Medicare Next Generation ACO. Specifically the following language outlines the ACO's requirement regarding this notification:

1) *In a form and manner and by a date specified by CMS, the ACO shall provide Next Generation Beneficiaries notice in writing that they have been aligned to the ACO for the Performance Year.*
2) *CMS shall provide the ACO with a template letter, indicating letter content that the ACO shall not change, as well as places in which the ACO may insert its own original content.*
3) *Pursuant to Section V.E, the ACO shall obtain CMS approval of the final notification letter content, which includes the ACO's own original content, prior to sending letters to Next Generation Beneficiaries*

The CMS required template used by ACO's to notify its aligned beneficiaries was written in a manner that confused Vermont-Aligned Medicare Beneficiaries, resulting in on over 400 phone calls by beneficiaries seeking more information and complaining that the letter itself was confusing.

In order to minimize future confusion and in order to align the process as much as possible across the payer programs, OneCare requests that we be allowed to draft our own Medicare Beneficiary Notification, which would be prior approved by CMS. OneCare, with input from the Vermont Healthcare Advocate, has drafted a Medicare Beneficiary notification and fact sheet that it would like to use in 2019 when notifying aligned beneficiaries (Please see Attachments B and C respectively). We would request that this notification be submitted on behalf of OneCare by the State Innovation Team for the necessary legal review and approval needed by CMS.

We wish to extend a special thanks to you and other members of your team at the GMCB during these discussions with CMMI. We look forward to working with you to streamline and align expectations for the New Vermont Medicare ACO Initiative in 2019. If you have any questions please feel free to contact me directly at spenser.weppler@onecarevt and/or 802-847-3773 or Vicki Loner at (802) 847-6255.

Thank you,

Spenser W. Weppler

NGACO Leading Practices for Initial Readiness Review

As a courtesy to the 2018 Next Generation Accountable Care Organization (NGACO) cohort, we are providing the following Leading Practices document to help your NGACO prepare for the upcoming Initial Readiness Review audit. Many of the leading practices observed in prior year audits were a result of NGACOs performing a careful review of the Next Generation ACO Model Participation Agreement (PA) requirements and allowing adequate time to create or update existing documentation (e.g., compliance plans, bylaws, policies, etc.) to ensure documents are specific to the NGACO Model. For the governance section, the leading practice was to not only include the applicable PA requirements in the NGACO's bylaws, but also to maintain documentation evidencing how the NGACO complied with each requirement (e.g., maintain a copy of the e-mail showing that the PA was distributed to governing body members).

We have identified the following leading practices in our review:

PA REFERENCE	LEADING PRACTICE
General	Where the PA is not prescriptive, the NGACO works with its own legal counsel to ensure that it is meeting the minimum requirements.
Compliance Plan	
General	Establish a Compliance Plan specific to NGACO requirements.
XVII.A.1.a (designated compliance official or individual)	Ensure the compliance official is not legal counsel to the NGACO and maintain documentation of this individual's attendance and contributions to NGACO governing body meetings.
XVII.A.1.b (Mechanisms for identifying and addressing compliance problems)	Conduct regular auditing and monitoring activities in support of the compliance program and maintain documentation that describes each of these activities in detail.
XVII.A.1.c (Method to anonymously report suspected problems)	Establish a variety of ways to anonymously report suspected problems related to the NGACO to the compliance official (through an online portal, via a hotline, etc.).
XVII.A.1.d (Compliance training)	Require all NGACO personnel, Participants and Preferred Providers to participate in regular compliance training and maintain documentation evidencing that the training was completed.
Compliance with Laws	
XVII.D.2 (State laws regarding risk-bearing entities)	Maintain documentation, such as a written attestation, risk certificate, or a signed letter from a state Department/Division of Insurance to evidence compliance, even if the NGACO is exempt.

PA REFERENCE	LEADING PRACTICE
Composition & Limitations	
XIV.D (Financial Guarantee)	Submit a draft Financial Guarantee for CMS review by the specified deadline.
Governance	
III.B.1.a.i-v (Criteria for governing body)	Create or update existing governance documentation so that it is specific to the requirements of the NGACO Model.
III.B.1.a (Identifiable governing body)	Maintain an updated organizational chart that includes the name, position, and role of each governing body member.
III.B.1.a.v (Regular reports from the compliance official)	Have the compliance official attend board meetings on a monthly or quarterly basis and maintain evidence of his/her attendance in the meeting minutes, as well as information on any items reported by the official.
III.B.1.b (Provide a copy of the PA)	Maintain evidence of the distribution of the PA to governing body members (e.g., a copy of the e-mail that was sent to members with the agreement).
III.B.2.a and III.B.2.b (Beneficiary and consumer advocate role criteria)	Have the beneficiary and consumer advocate complete a conflict of interest disclosure form where they attest to meeting the criteria outlined for these roles.
III.B.2.c (Prohibited Participants)	Maintain documentation evidencing that the governing body members have been confirmed as individuals who are not prohibited Participants.
III.B.2.f (75% control)	Maintain documentation that 1) clearly indicates how the 75 percent control is calculated for the NGACO; and 2) indicates which individuals are Participants versus designated representatives.
III.B.3 (Conflict of interest policy)	Create or update the existing conflict of interest policy to speak to each criterion specified by the NGACO Model.
General	In the case that an NGACO is exempt from a PA requirement (such as an exemption from CMS for III.B.2.f for the percentage of control for the NGACO's governing body), document information on such exemption in the bylaws.
Leadership & Management	
III.C.1-2 (Operations and Clinical Management)	Provide the name of the individuals that serve in leadership and management roles specified by the PA, as well as an organizational chart that clearly identifies these individuals. Clearly list the requirements for the leadership and management roles in the bylaws and explicitly state that both the appointment and removal of the individuals are under the control of the governing body.

PA REFERENCE	LEADING PRACTICE
Public Reporting & Transparency	
General	Information on the website is well-organized, with appropriate tabs and section headings and requires little effort to find required information.
XVI.A.1.c (Identification of all Participants and Preferred Providers)	Website lists the names and practices of all Participants and Preferred Providers, rather than ACO organization names only. The Participant and Preferred Provider list on the website is proactively maintained and accurate (e.g., is updated periodically to remove terminated Providers).
XVI.A.1.d (Joint ventures)	The website explicitly states information regarding joint ventures (e.g., indicates that there are no joint ventures when that is the case).
Beneficiary Notification	
V.D.1 (Beneficiary notification)	Maintain evidence of the distribution of the beneficiary notification (e.g., a copy of the invoice or receipt for the beneficiary notification mailing). Provide a communication plan regarding beneficiary notifications.
Participating and Preferred Provider Agreements	
III.D.6.a (Parties to the Agreement)	For entity level agreements, the ACO maintains a list of individual providers included in the agreement.
III.D.6.b (Agree to Participate)	The Participating and Preferred Provider agreements explicitly state that they agree to: • Participate in the model • Comply with terms in the PA • Comply with all applicable laws and regulations
III.D.6.b (Copy of Agreement)	Have copies of e-mails or other proof of sending copies of the PA to all Participating and Preferred Providers.

Attachment B

OneCare Vermont Accountable Care Organization, LLC
356 Mountain View Drive, Suite 301
Colchester, VT 05446
877-644-7176

<BENEFICIARY FULL NAME>
<ADDRESS1>
<ADDRESS2>
<CITY, STATE ZIP>

Dear <BENEFICIARY FULL NAME>,

This letter is to tell you that [name of Provider/Practice] is now part of the OneCare Vermont (OneCare) Accountable Care Organization (ACO). An ACO is a group of doctors, hospitals, and other health care providers who work together to reduce costs and provide high quality care.

Are my Medicare benefits changing?
No. Your Medicare benefits are not changing. If you have questions about your benefits please call Medicare at 1-800-633-4227.

- Your eligibility for Medicare has not changed.
- Your Medicare benefits have not changed in any way.

Do I need to do anything? Why am I receiving this letter?
You do not need to do anything. Medicare requires OneCare to send this letter to tell you that your provider is part of the ACO. Your health care provider's office is not moving.

What is OneCare?
OneCare is a statewide ACO working with Medicare and other insurance programs to provide coordinated health care to Vermonters. It includes several Vermont hospitals and many other providers, including primary care and specialists. OneCare helps providers share information so they can improve care and engage patients in decision making. For more information about OneCare, see the Patient Fact Sheet or visit OneCareVT.org.

How does OneCare use my health care information?
Medicare and your health care providers share your health care information with OneCare. OneCare uses your information to measure the quality of the care you receive. OneCare also uses all its patients' information to measure the ACO's overall quality of care. Measuring health care quality helps OneCare and its providers improve quality.

OneCare helps your providers get information about health care that you get everywhere, not just at your hospital or primary care provider's office. If your providers know about all the care you get, they can improve care and reduce some risks to your health.

OneCare also gives its providers information about how medical conditions are treated by other providers in the ACO. This information helps providers learn from each other and offer the best treatment options.

If you do not want Medicare to share your information with OneCare, call Medicare at 1-800-633-4227.

OneCare Questions and Conerns:
If you have questions or concerns about OneCare, please call OneCare at 1-877-644-7176, Option 1, and then Option 1. You can also email OneCare at OneCareVT@OneCareVT.org.

Health Care Advocate:
The Office of the Health Care Advocate (HCA) gives free advice and help to all Vermonters with health care and health insurance concerns. The HCA is part of Vermont Legal Aid, an independent non-profit law firm. The HCA does not represent OneCare Vermont. To get help with a health care or health insurance issue, call the HCA Helpline at 1-800-917-7787 (toll-free) or visit http://www.vtlawhelp.org/health

Patient Fact Sheet

OneCareVermont

What is the OneCare Vermont (OneCare) Accountable Care Organization?

OneCare is a group of doctors, hospitals, and other health care providers who work together to give coordinated, high quality care to their patients. OneCare providers benefit if they help keep health care costs under control and keep quality high. OneCare works to bring together health care and other service providers across Vermont to provide coordinated care and keep patients healthy and.

Nine communities are participating in OneCare. OneCare providers include:

- 10 hospitals and all of their employed providers
- 31 independent primary care practices and 30 independent specialty practices
- 2 Federally Qualified Health Centers (FQHCs)
- OneCare partners with: Home Health and Hospice, Skilled Nursing Facilities, Area Agencies on Aging, and Designated Agencies for Mental Health and Substance Use

Will my Insurance Benefits change?

No. OneCare will not change your insurance benefits.

- Your eligibility for insurance has not changed
- Your insurance benefits have not changed

How will OneCare benefit me?

OneCare should make it easier for doctors and hospitals to work together to provide high quality care in the right place and at the right time. OneCare prioritizes prevention and engaged decision-making for patients. With greater access to information, providers can improve their patients' care and ultimately their health.

Is my provider part of OneCare?

Visit OneCareVT.org to see a list of participants, or call OneCare at 1-877-644-7176. You can also email OneCare Vermont at OneCareVT@OneCareVT.org.

What if some of my providers are not part of the OneCare ACO network? What about care I get outside of Vermont?

You are still free to see any doctor and you can still get care outside of Vermont. OneCare does not affect your insurance company's provider network..

Do I need to sign up for OneCare?

No, you do not need to do anything. If your provider is participating in OneCare, you will get a notice letter.

Can I opt out of OneCare?

You can choose to opt out of OneCare's information sharing. Contact your insurance company (Medicare, Medicaid, or Blue Cross Blue Shield of Vermont) to find out about your options.