Green Mountain Care Board

Medicaid Advisory Rate Case for ACO Services

Review of OneCare Vermont's All-Inclusive Population-Based Payment

December 8, 2017

ACTUARIAL REPORT

Lewis & Ellis, Inc.

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December 8, 2017

Green Mountain Care Board

Re: Actuarial Report on the OneCare Vermont's All-Inclusive Population Based Payment

To the Board:

Lewis & Ellis, Inc. was engaged to assist the Board in providing a review and recommendations that could be shared with the Department of Vermont Health Access (DVHA) and their actuaries prior to the finalization of the payments.

If you have any questions regarding this report, do not hesitate to contact me.

Sincerely,

Jacqueline B. Lee
Vice President & Principal
Lewis & Ellis, Inc.

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EXECUTIVE SUMMARY

The Green Mountain Care Board (GMCB, Board) is required by the Vermont Legislature[1] to review any all-inclusive population-based payment arrangement between the Department of Vermont Health Access (DVHA) and accountable care organizations (ACOs) effective for Calendar Year 2018. The Board's review shall include the number of attributed lives, eligibility groups, covered services, elements of the per-member, per-month (PMPM) payment, and any other non-claims payments.

GMCB engaged Lewis & Ellis, Inc. (L&E) to provide a review of the payment arrangement between DVHA and the ACO, OneCare Vermont. This report is the documentation of the review and recommendations to the Board that may be passed on to DVHA and its actuary, Wakely Consulting Group (Wakely), prior to the issuance of the final capitation rates and report. The recommendations presented to DVHA are intended to be advisory and non-binding.

L&E and GMCB worked with Wakely and DVHA to understand the process they were using and obtain data used to calculate the capitation payments. Based on the individual assumptions and recommendations discussed in the report, L&E has provided an estimated rate calculation for each Medicaid Eligibility Group (MEG).

Capitation Rate Development			
	ABD (A&C)	**Adult**	**Child**
2016 Attributed PMPM	$565.54	$315.11	$104.49
Completion Adjustment (IBNR)	1.010	1.015	1.004
Benefit Adjustment	1.000	1.000	1.000
Adjusted 2016 Attributed PMPM	$571.20	$319.84	$104.91
2 Year Trend Adjustment	1.082	1.067	1.069
Additional Benefit Adjustment	1.000	1.000	1.000
ACO Efficiency Adjustment	0.998	0.998	0.998
Population Adjustment	0.987	1.035	1.006
2018 Projected Cost of Care	$608.55	$352.54	$112.61
Administrative Cost (PMPM)	$6.50	$6.50	$6.50
Risk	0.25%	0.25%	0.25%
2018 Capitation Rate	$616.60	$359.94	$119.41

CY2017 Contracted Capitation Rates			
	ABD (A&C)	**Adult**	**Child**
2017 Capitation Rate	$616.07	$376.49	$120.97

It is important to note that L&E is not recommending that Wakely's calculation or the final rates need to match L&E's estimation. This is L&E's best estimate based on the information provided by Wakely and DVHA. L&E recommends that DHVA and Wakely compare each assumption with the similar assumption used in Wakely's calculation and consider if L&E's development of the assumption is a more appropriate approach or accounts for other information that Wakely should further research.

[1] 2017 Vt. Acts & Resolves, No. 3 (Budget Adjustment Act), § 80

REVIEW OF ALL-INCLUSIVE POPULATION-BASED PAYMENT

Background

On April 7, 2016, DVHA released a request for proposal (RFP) that sought interested Accountable Care Organizations (ACOs) to participate in a population-based payment model similar to the Centers for Medicare & Medicaid Services (CMS) Next Generation ACO Model. As part of this model, the ACO will receive monthly capitation rates for all services covered under this program. As part of this endeavor, DVHA engaged Wakely Consulting Group (Wakely), an actuarial firm, to develop and certify to these capitation rates.

OneCare Vermont was the only successful bidder under the RFP. Therefore, Wakely has been tasked with developing capitation rates for OneCare Vermont for use in performance year (PY) 2018. This is the second year that L&E has reviewed the capitation rates.

Scope of Work

The Green Mountain Care Board is required by the Vermont Legislature[2] to review any all-inclusive population-based payment arrangement between the Department of Vermont Health Access and accountable care organizations effective for calendar year 2017 and beyond. The Board's review shall include the number of attributed lives, eligibility groups, covered services, elements of the per-member, per-month payment, and any other non-claims payments.

GMCB engaged Lewis & Ellis, Inc. (L&E) to provide a review of the payment arrangement between DVHA and the ACO, OneCare Vermont. This report is the documentation of the review and recommendations to the Board that may be passed on to DVHA and Wakely prior to the issuance of the final capitation rates and report. The recommendations presented to DVHA are intended to be advisory and non-binding.

Methodology

L&E and GMCB worked with Wakely and DVHA to understand the process they were using and obtained data used to calculate the capitation payments. Wakely provided L&E with the historical claims experience for Base Years (BY) 2014, 2015, and 2016 and with the base model they used to develop the capitation rates. These claim amounts were provided for each Medicaid Eligibility Group (MEG), split between those attributed to OneCare Vermont and those who were not.

[2] 2017 Vt. Acts & Resolves, No. 3 (Budget Adjustment Act), § 80

L&E received the following information from Wakely. The chart shows by MEG the OneCare VT eligible population and compares it to the total eligible population (including OneCare VT).

Enrollment (Member Months)				
MEG	**Cohort**	**BY2014**	**BY2015**	**BY2016**
ABD[4] (Adult & Child)	OneCare VT	31,461	32,235	32,941
	All Eligible	77,404	79,850	82,404
Consolidated Adult	OneCare VT	143,128	174,043	198,005
	All Eligible	396,454	484,125	551,437
Consolidated Child	OneCare VT	195,729	216,997	231,150
	All Eligible	467,808	512,604	539,455
Total	OneCare VT	370,318	423,275	462,096
	All Eligible	941,666	1,076,579	1,173,296

Historical Claim Costs PMPM				
MEG	**Cohort**	**BY2014**	**BY2015**	**BY2016[3]**
ABD[4] (Adult & Child)	OneCare VT	$329.93	$323.60	$376.87
	All Eligible	$330.36	$350.03	$384.62
Consolidated Adult	OneCare VT	$269.34	$274.54	$287.01
	All Eligible	$281.91	$291.73	$305.75
Consolidated Child	OneCare VT	$288.25	$279.00	$298.61
	All Eligible	$322.61	$308.93	$329.34
Total	OneCare VT	$284.48	$280.57	$299.22
	All Eligible	$306.11	$304.25	$322.14

Risk Scores				
MEG	**Cohort**	**BY2014**	**BY2015**	**BY2016**
ABD[4] (Adult & Child)	OneCare VT	1.5628	1.6339	1.6262
	All Eligible	1.5681	1.6225	1.6287
Consolidated Adult	OneCare VT	1.1097	1.1445	1.1825
	All Eligible	1.0986	1.1562	1.2054
Consolidated Child	OneCare VT	0.3639	0.3739	0.3667
	All Eligible	0.3555	0.3709	0.3679
Total	OneCare VT	0.7549	0.7946	0.8151
	All Eligible	0.7512	0.8163	0.8472

Wakely received detailed claim data that included dates of service, Medicaid Eligibility Group, CPT (Current Procedural Terminology) codes, Categories of Service (COS), paid amounts, dates of birth, Eligibility Start and End dates, and many other fields. L&E received a complete list of the data fields during the 2016 review that Wakely received for both the claims file and the eligibility file.

[3] Includes a completion factor adjustment.
[4] Aged, Blind, & Disabled

Data Scrubbing

The historical figures were adjusted to reflect the anticipated population and covered services for 2018. The adjustments made to the original data Wakely received included:

- Attributees
- Covered Services
- Completion of Claims for BY2016

ATTRIBUTEES

Wakely grouped the claims data and enrollment based on which individuals would be attributed to OneCare Vermont and those who would not in 2018. This attribution process uses the attribution years to assign members to the ACO. L&E has relied on Wakely to work with the health policy vendor, Burns and Associates, Inc.[5] (Burns) and the ACO to correctly assign the appropriate members to the ACO. This prospective process alleviates the need to project potential changes in the population. Due to the prospective attribution process, there is no need for an adjustment to account for the anticipated 2018 population.

Due to the complex nature of the attribution process, L&E did not have an opportunity to review or audit Wakely's categorization of the attributed members. However, L&E reviewed and agreed with Wakely's overall attribution methodology.

As of the date of this report, the attribution process was using individuals eligible as of January 1, 2018.

COVERED SERVICES

Similar to the population, the anticipated covered services were well defined in advance of the plan year. Since Wakely had detailed claims data, they were able to remove any services included in the base year data set that were not to be covered by the ACO. Last year's RFP included a list of CPT codes that were covered. This year, the only benefit change was to include J-codes. J-codes generally comprise of drugs with infusions or injections. Because of the tight timeline, L&E did not audit Wakely's assignment of the covered services to the base data, though L&E reviewed and agreed with Wakely's overall methodology.

COMPLETION OF CLAIMS FOR BY2016

Typically, health claims can take up to 12 or 18 months to be fully reported and paid. Because the run out on the BY2016 is through July (or 7 months), an adjustment factor needed to be applied to the BY2016 to estimate completed claims for the base year. For six months of run out, L&E anticipates an increase of paid claims between 0.5% and 2.0% to estimate fully reported and paid claims. L&E's best estimate is between 0.4% and 1.5%, depending on the cohort (e.g. OneCare Attributed Adult, Blind, & Disabled).

Projection

The base period data was projected to calculate 2018 capitation rates. The projection factors included:

- Trend
- Benefit Changes
- ACO Efficiency
- Population Adjustments
- Administrative Expenses
- Risk Charges

[5] http://www.burnshealthpolicy.com/

TREND

In order for the historical experience to be representative of costs in the projection year, the data needed to be trended forward to account for changes in utilization and unit cost of the services provided. Wakely provided claim costs on a PMPM basis, risk score, risk-adjusted PMPM, and membership, each split out between the various cohorts. These figures were provided for Base Years 2014 through 2016. The data was normalized to only reflect the anticipated covered population.

Using this data, L&E was able to calculate the change in costs over the two-year time period by cohort. Ultimately, L&E decided to use the risk-adjusted PMPMs to calculate the historical annual trends experienced by each cohort. Risk-adjusted PMPMs provide more credible results because the risk-adjustment removes some variability captured in the PMPM. Therefore, L&E determined that the risk-adjusted trend produced a better estimate than the unadjusted trends.

Additionally, L&E utilized both the 2015/2014 and 2016/2015 annual trends and all members to estimate the future trends. In the estimation, L&E tested using different weights between the two annual trend figures, such as 50% of each or 40% of the 2015/2014 and 60% of the 2016/2015. Because the ACO had nearly 462,100 member months in BY2016 (representing roughly 39% of all member months), L&E also wanted to weight the ACO's population with all members' data to provide further stability. It was determined that a weighting of 50% of the 2015/2014 and 50% of the 2016/2015 was the most appropriate for the majority of the cohorts except ABD of OneCare and the Child cohorts. For the blend between the attributed members and all members, L&E used a 90% weighting for the attributed members and 10% weighting for all members.

Risk-Adjusted Trends (OneCare Vermont)				
MEG	**Cohort**	**2015/2014**	**2016/2015**	**Projected 2018, Weighted**
ABD (Adult & Child)	OneCare VT	-1.9%	16.5%	3.6%
Adult	OneCare VT	1.9%	4.5%	3.2%
Child	OneCare VT	-3.2%	7.0%	3.4%
Total	OneCare VT	-1.4%	6.6%	3.4%

Risk-Adjusted Trends (All Members)				
MEG	**Cohort**	**2015/2014**	**2016/2015**	**Projected 2018, Weighted**
ABD (Adult & Child)	All Members	6.0%	9.9%	7.9%
Adult	All Members	3.5%	4.8%	4.1%
Child	All Members	-4.2%	6.6%	2.8%
Total	All Members	-0.6%	5.9%	3.8%

The trends above are quite volatile, which challenges the projected trend analysis. The ABD and Child cohorts experienced negative trends for 2015/2014 and then positive trends for 2016/2015 for both OneCare attributed members and all members. Therefore, the blending percentages for ABD (OneCare VT) have been adjusted to 70/30%. The percentages for Child cohorts have been adjusted to 35/65%.

Blended Risk-Adjusted Trends		
MEG	**Blend (OneCare/All)**	**Projected 2018, Blended**
ABD (Adult & Child)	90/10	4.0%
Adult	90/10	3.3%
Child	90/10	3.4%
Total	90/10	3.4%

L&E estimated ranges for each cohort based on different weightings between each blended annual trend. The ranges' bookends were determined by using the various weightings of the 2015/2014 and 2016/2015 annual trends by MEG and blending OneCare's trends with the entire market's trends. L&E's estimate of the capitation rate was set using the trends below, using a 50/50 weighting.

Trend setting can be difficult using historical data, especially when historical trends are volatile. In determining our trend range, L&E was consistent with the methodology of the previous projection. L&E's methodology focuses on reducing the weight on extreme values and older information.

Risk-Adjusted Trends (OneCare Vermont)			
MEG	**Low**	**High**	**Recommended**
ABD (Adult & Child)	4.0%	5.0%	4.0%
Adult	3.3%	4.3%	3.3%
Child	1.8%	6.0%	3.4%

Benefit Changes

When projecting historical PMPMs forward, a typical practice includes adjusting for anticipated benefit changes. The RFP outlined the CPT codes to be covered by the ACO, and this year, J-codes will be covered. Since the anticipated benefits have been accounted for in the historical data, L&E does not estimate an adjustment for benefit changes that would need to be captured outside of the trend assumption.

ACO Efficiency

One of the responsibilities of the ACO is to achieve cost savings through high quality coordinated care[6]. Another adjustment to the base period experience includes accounting for the anticipated cost savings for the ACO that is not accurately reflected in the base period experience. L&E asked Wakely if they had any documentation or basis to make an adjustment for the ACO Efficiency, and they stated that they anticipated minor savings that would help to keep trend moderated due to the care management of the ACO and the informatics platforms. Additionally, Wakely informed L&E that the data analytics group at Burns provided a summary of the savings opportunities of the group to be covered under the ACO. Wakely provided L&E with the summary from Burns.

According to L&E's interpretation of the analysis, the report shows that OneCare could potentially have maximum savings opportunities of approximately 10%. A 10% savings in one year is atypical, and

[6] CMS Definition of ACO: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/index.html?redirect=/aco/

therefore appears to be overly optimistic when compared to industry studies[7]. L&E is unaware of OneCare's intentions on achieving savings as the report indicates. Given the timing, there is not sufficient information to properly estimate this type of savings.

Given Burns' analysis, however, L&E believes that a realistic adjustment between 0% and 1% would be an achievable amount for the ACO and a reasonable expectation for the ACO's first year. L&E's best estimate is an adjustment of 0.2% for the ACO Efficiency, which would represent an estimate on the low end.

Population Adjustments

It is also common practice to adjust historical experience for anticipated changes in population. The anticipated changes are based on 2016 historical changes. Enrollment changed for two different populations: 2018 attributees from July to October and 2017 attributees from January to September. The 2018 attributees represents a period where members can be added or removed (due to attrition) so this factor was used to estimate the impact of 2018 attributee changes from October 2017 to the start of the contract (January 2018). The change in PMPMs for the 2017 attributees was estimated based on an enrollment period where members can only drop (no one can be added). This is meant to estimate the impact of attrition for 2018 members from January to December 2018. We believe Wakely applied a reasonable approach to estimate the anticipated population changes. L&E's best estimate takes an amount between Wakely's low and high estimate.

Administrative Expenses

As of the writing of this report, DVHA and OneCare Vermont have agreed to $6.50 PMPM to pay for general administrative expenses, care coordination, provider contracting, call center, and the informatics platform. Last year, DVHA provided L&E with its draft report of the readiness review[8] to provide additional insight into the services OneCare Vermont will be providing. For the general administrative, OneCare will be supporting staff and member services, including member communication, marketing and outreach materials, and member policies. DVHA's review was positive regarding the staff's experience and capabilities of being able to support the members of the ACO. Since this is the second year, it is anticipated that the ACO will be able to controls its costs and remain within the administrative cost target.

For care coordination, the ACO will use their care coordination model. OneCare Vermont appears to be organized and have the methodology well thought out and documented. The care plan team assigned to members is readily available online to continue assisting providers. These efforts should result in reduced costs for the ACO.

The provider contracting to be performed by the ACO is limited in nature because the contracts are mostly in place due to the DVHA contracts. There is an addendum to incorporate the specifics of this arrangement.

The informatics platform is highly sophisticated and a strength of OneCare Vermont. OneCare Vermont will be utilizing WorkbenchOne, Care Navigator, and REDCap to help with data reporting and analysis and to identify opportunity gaps. Available and organized data will greatly help DVHA and the ACO

[7] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4822974/, https://www.healthaffairs.org/do/10.1377/hblog20170619.060649/full/

[8] Assessment of the Readiness of OneCare Vermont to Fulfill Requirements under the Department of Vermont Health Access' Contract to Serve as a Medicaid Accountable Care Organization, dated December 15, 2016.

when determining how the medical services are being utilized and know in quick time where issues are and improvements that can be made.

The negotiations between DVHA and OneCare Vermont resulted in an administrative rate of $6.50 PMPM (about 3%), which is the same administrative rate as last year. As indicated above, the ACO's administrative functions are currently being used by the company, and the administrative services are limited in nature. Based on an analysis of administrative costs for 2015 for Medicaid Managed Care Organizations (MCOs) performed by Milliman[9], the average administrative loss ratio is about 12.0%. This appears to be slightly high based on L&E's experience with various Medicaid MCOs. Even if we assume that the average is lower than the 12.0% cited by Milliman, OneCare's administrative rate of $6.50 PMPM, or about 3.0%, appears to be reasonable and not excessive. L&E recommends that the administrative expenses of the ACO be monitored closely to ensure that the ACO is falling in line with these expectations.

Risk Arrangement

In the original RFP and the beginning negotiations, DVHA and OneCare Vermont discussed having a truncation strategy to handle the risk of having large claims and to cap expenditures. However, Wakely reviewed the detailed claims data to determine the frequency of these large claims and determined that large claims were not common historically. Wakely explained that the lack of large claims was expected because of the nature of DVHA's facility contracts. Wakely advised against the truncation approach to handling risk. Because of the uncertainty of this new arrangement, DVHA and OneCare agreed to a risk corridor arrangement to handle profits and losses that would mitigate the risk to the ACO. The arrangement was modified after the initial report was completed. This arrangement would hold OneCare responsible for any profits or losses within 3% of the target. DVHA would be responsible for any additional payments in the event of more than 3% of losses and would require OneCare to pay back a portion of the capitation rate in the event of profits in excess of 3%.

Risk Corridor Arrangement Shares		
Expenditures over/under target	**OneCare VT**	**DVHA**
-3% to 3%	100%	0%
> 3% or < -3%	0%	100%

Evaluation of the risk arrangement using specific data was outside the scope of this assignment. This risk corridor structure eliminates potentially great losses by having lower shares for OneCare. Most of the concern surrounding new capitated arrangements is whether the rate is sufficient to cover all required services. This risk corridor protects OneCare Vermont from large losses. Additionally, L&E has reviewed the risk mitigation arrangements for all payers in the evaluation of OneCare's 2018 budget. These risk mitigation strategies help to shift some of the extreme financial responsibilities from OneCare to DHVA.

L&E's Rate Ranges

L&E has reviewed each assumption and determined a low and high range, where appropriate. This created rate ranges surrounding the best estimate. The rate range and its development are provided below.

[9] http://www.milliman.com/uploadedFiles/insight/2016/medicaid-analysis-administrative-costs-2015.pdf

ABD (Adult & Child) Capitation Rate Development			
ABD (A&C)	**Low**	**Best**	**High**
2016 Attributed PMPM	$565.54	$565.54	$565.54
Completion Adjustment (IBNR)	1.004	1.010	1.015
Benefit Adjustment	1.000	1.000	1.000
Adjusted 2016 Attributed PMPM	$567.80	$571.20	$574.02
2 Year Trend Adjustment	1.082	1.082	1.103
Additional Benefit Adjustment	1.000	1.000	1.000
ACO Efficiency Adjustment	0.998	0.998	0.998
Population Adjustment	0.987	0.987	0.987
2018 Projected Cost of Care	$604.94	$608.55	$623.38
Administrative Cost (PMPM)	$6.50	$6.50	$6.50
Risk	0.25%	0.25%	0.25%
2018 Capitation Rate	$612.97	$616.60	$631.46

Adult Capitation Rate Development			
Adult	**Low**	**Best**	**High**
2016 Attributed PMPM	$315.11	$315.11	$315.11
Completion Adjustment (IBNR)	1.005	1.015	1.015
Benefit Adjustment	1.000	1.000	1.000
Adjusted 2016 Attributed PMPM	$316.69	$319.84	$319.84
2 Year Trend Adjustment	1.067	1.067	1.088
Additional Benefit Adjustment	1.000	1.000	1.000
ACO Efficiency Adjustment	0.998	0.998	0.998
Population Adjustment	1.035	1.035	1.035
2018 Projected Cost of Care	$349.06	$352.54	$359.40
Administrative Cost (PMPM)	$6.50	$6.50	$6.50
Risk	0.25%	0.25%	0.25%
2018 Capitation Rate	$356.46	$359.94	$366.81

Child Capitation Rate Development			
Child	**Low**	**Best**	**High**
2016 Attributed PMPM	$104.49	$104.49	$104.49
Completion Adjustment (IBNR)	1.004	1.004	1.010
Benefit Adjustment	1.000	1.000	1.000
Adjusted 2016 Attributed PMPM	$104.91	$104.91	$105.54
2 Year Trend Adjustment	1.036	1.069	1.124
Additional Benefit Adjustment	1.000	1.000	1.000
ACO Efficiency Adjustment	0.998	0.998	0.998
Population Adjustment	1.006	1.006	1.006
2018 Projected Cost of Care	$109.16	$112.61	$119.06
Administrative Cost (PMPM)	$6.50	$6.50	$6.50
Risk	0.25%	0.25%	0.25%
2018 Capitation Rate	$115.95	$119.41	$125.87

Wakely's ranges are similar to L&E's ranges. It is important to note that L&E is not recommending that Wakely's calculation or the final rates need to match L&E's estimation. This is L&E's best estimate based on the information provided by Wakely and DVHA. L&E recommends that DHVA and Wakely compare each assumption with the similar assumption used in Wakely's calculation and consider if L&E's development of the assumption is a more appropriate approach or accounts for other information that Wakely should further research.

Conclusions and Recommendations

Based on the individual assumptions and recommendations above, L&E has provided an estimated rate calculation for each MEG.

Capitation Rate Development			
	ABD (A&C)	**Adult**	**Child**
2016 Attributed PMPM	$565.54	$315.11	$104.49
Completion Adjustment (IBNR)	1.010	1.015	1.004
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Data Reliance

Wakely, DVHA, and the Board provided all data and information utilized by L&E during this analysis. L&E heavily relied on Wakely's assistance in order to understand the negotiation process that directly impacted the final rates. DVHA and Wakely have been working with OneCare Vermont for months, discussing most components of the rates in great detail, and these discussions did not include L&E. Therefore, L&E spent a significant amount of time reviewing overall methodologies with Wakely. Wakely provided prompt and thorough responses and was readily available via phone call on short notice to provide clarifications and explanations, as needed. Below will outline the various assumptions that were impacted by these conversations.

L&E relied on Wakely's attribution methodology to produce the results above. Wakely and L&E discussed their methodology during a phone call. The data size was very large, and Wakely spent a large amount of time to scrub the data and ensure that only the appropriate claim records were included in the experience.

For the general administrative expenses and risk corridor arrangement, L&E relied on Wakely's data analysis and presence at negotiations to provide insight into the figures and arrangements agreed upon by both parties.

L&E was presented with several challenges during the review. In order to better understand the methodology of the review, it is important to outline the challenges first:

- L&E had the first call with DVHA and Wakely in June 2017. Similar to last year, it was discussed that L&E would not be auditing or performing an independent scrubbing of the data. Instead, L&E discussed Wakely's methodology and process of setting the rate. L&E received the initial draft models from Wakely on October 18, 2017.
- OneCare Vermont and DVHA were in active negotiations during most of Wakely's analysis time and, therefore, L&E's analysis time.
- L&E received the last data file and answers to questions on November 20, 2017. Therefore, L&E's review time was limited and constrained to the information that was provided.

Limitations

The contents of this report are intended for the Green Mountain Care Board to advise the Department of Vermont Health Access (DVHA) and its actuaries before finalizing of the all-inclusive population-based payment arrangement effective in 2018. The Board may distribute this report to those parties stated above, in which case it will be provided in its entirety including all assumptions, caveats, and limitations. In addition, we request that the Board or any recipient notify Lewis & Ellis, Inc. to whom it was distributed.

Any distribution of this report should be made in its entirety. In addition, any third party with access to this report acknowledges, as a condition of receipt, that L&E does not make any representations or warranty as to the accuracy or completeness of the material. Any third party with access to these materials cannot bring suit, claim, or action against L&E, under any theory of law, related in any way to this material.

To the best of our knowledge, our determinations were made in accordance with generally accepted actuarial principles and practices. The American Academy of Actuaries (Academy) requires its members to perform professional services only when qualified to do so, and to meet certain qualification standards. The Academy prescribes qualification standards for individuals who issue prescribed statements of actuarial opinion. This report is not a prescribed statement of actuarial opinion. I certify that I am a member of the Academy, that I am qualified to review this work, but this report and any recommendations should not be considered an actuarial opinion.

The Board has agreed to pay Lewis & Ellis, Inc. a fee for preparing this report. Other than with regard to that contract, L&E is financially and organizationally independent from the Board and any entity or individual related to the Board. There is nothing in our relationship with the Board that would impair or seem to impair the objectivity of our work.

EXHIBIT 1: ASOP 41 DISCLOSURES

The Actuarial Standards Board (ASB), vested by the U.S.-based actuarial organizations[10], promulgates actuarial standards of practice (ASOPs) for use by actuaries when providing professional services in the United States. Each of these organizations requires its members, through its Code of Professional Conduct[11], to observe the ASOPs of the ASB when practicing in the United States.

The ASOPs are not narrowly prescriptive and neither dictates a single approach nor mandates a particular outcome. ASOPs are intended to provide actuaries with a framework for performing professional assignments and to offer guidance on relevant issues, recommended practices, documentation, and disclosure. Each ASOP articulates a process of analysis, documentation, and disclosure that, in the ASB's judgment, constitutes appropriate practice within the scope and purpose of the ASOP.

ASOP 41 provides guidance to actuaries with respect to actuarial communications and requires certain disclosures which are contained in this Exhibit.

Identification of the Responsible Actuary

The responsible actuary is Jacqueline B. Lee, FSA, MAAA, Vice President and Principal of Lewis & Ellis, Inc. This actuary is available to provide supplementary information and explanation.

Identification of Actuarial Documents

The date of this document is December 8, 2017, its subject is the estimation and recommendation regarding the 2018 all-inclusive population-based payment arrangement (capitation rate) for OneCare Vermont, and the document version identification is Version #1 (12/8/2017 12:37 PM).

Disclosures in Actuarial Reports

- The contents of this report are intended for the Green Mountain Care Board.
- The purpose of this engagement is to provide the Green Mountain Care Board with an estimation, recommendation, and guidance on the 2018 all-inclusive population-based payment arrangement (capitation rate) for OneCare Vermont.
- The responsible actuary identified above is qualified as specified in the *Qualification Standards* of the American Academy of Actuaries.
- The projections included in this report involve estimates of historical PMPMs, trends, benefit changes, ACO efficiency adjustments, population adjustments, and administrative expense. Actuarially determined amounts are subject to continual revision as actual results are compared to past expectations and new estimates are made about the future. The results are not to be used for any

[10] The American Academy of Actuaries (Academy), the American Society of Pension Professionals and Actuaries, the Casualty Actuarial Society, the Conference of Consulting Actuaries, and the Society of Actuaries.
[11] These organizations adopted identical *Codes of Professional Conduct* effective January 1, 2001

purpose other than to provide the Board with guidance and recommendations to send to the Department of Vermont Health Access (DVHA) regarding the 2017 capitation rates for OneCare Vermont. These communications should not be relied upon for any other purpose.

- The Green Mountain Care Board has agreed to pay Lewis & Ellis, Inc. a fee for preparing this report. Other than with regard to that contract, we are financially and organizationally independent from the Board. There is nothing in our relationship with the Board that would impair or seem to impair the objectivity of our work.

- The Green Mountain Care Board, Department of Vermont Health Access and Wakely Consulting provided the claims data, enrollment, and other information used to prepare our report. We have reviewed the data for reasonableness, but have not audited it. To the extent that there are material inaccuracies in the data, our results may be accordingly affected.

- The date through which data or other information has been considered in developing the findings included in this report is July 31, 2017.

- We are not aware of any subsequent events that may have a material effect on the actuarial findings.

- The various documents comprising this actuarial report are contained within the document to which these disclosures are attached.

Actuarial Findings

The actuarial findings of the report can be found in the body of this report, as well as the attached exhibits.

Methods, Procedures, Assumptions, and Data

The methods, procedures, assumptions and data used by the actuary can be found in body of this report, as well as the attached exhibits.

Assumptions or Methods Prescribed by Law

This actuarial memorandum was prepared in accordance with generally accepted actuarial principles.

Responsibility for Assumptions and Methods

The actuary does not disclaim responsibility for material assumptions or methods.

Deviation from the Guidance of an ASOP

The actuary has not deviated materially from the guidance set forth in an applicable ASOP.