2019 Certification Eligibility Verification Form for OneCare Vermont Accountable Care Organization, LLC

I. BACKGROUND

The Green Mountain Care Board (GMCB) is an independent, five-member board charged with overseeing the development and implementation, and evaluating the effectiveness, of health care payment and delivery system reforms designed to control the rate of growth in health care costs; promote seamless care administration and service delivery; and maintain health care quality in Vermont. To complement the GMCB's responsibilities and authorities with respect to health care payment and delivery system reforms, the Vermont Legislature charged the GMCB with certifying accountable care organizations (ACOs).

Once certified, an ACO is required to notify the GMCB of certain matters, such as changes to the ACO's operating agreement or bylaws, within 15 days of their occurrence. GMCB Rule 5.000, § 5.501(c). In addition, an ACO must annually submit a form to the GMCB (1) verifying that the ACO continues to meet the requirements of 18 V.S.A. § 9382 and Rule 5.000; and (2) describing in detail any material changes to the ACO's policies, procedures, programs, organizational structures, provider network, health information infrastructure, or other matters addressed in the certification sections of Rule 5.000 that the ACO has not already reported to the GMCB. *Id.* at § 5.305(a). *Id.* at § 5.503(d). The form must be signed by an ACO executive with authority to legally bind the ACO. The ACO executive must verify under oath that the information contained in the form is accurate, complete, and truthful to the best of his or her knowledge, information, and belief. *Id.* at § 5.305(b).

Because each ACO is unique and the documentation ACOs submit for certification may differ, the GMCB plans to develop a verification form for each ACO it has certified. This form has been developed for OneCare Vermont Accountable Care Organization, LLC (OneCare) for calendar year 2019. Because the statutory certification requirements have been amended since OneCare was certified, this form will ask OneCare about its compliance with the amendments. *See* 2018 Acts and Resolves No. 167, Sec. 13a; 2018 Acts and Resolves No. 200, Sec. 15; 2018 Acts and Resolves No. 204, Sec. 7. Because the GMCB has adopted anti-trust related guidance since OneCare was certified, this form will also ask OneCare whether it engages in conduct described in that guidance. *See* Green Mountain Care Board Guidance re: Referrals of Potential Violations of State or Federal Antitrust Laws to the Vermont Attorney General, *at* http://gmcboard.vermont.gov/sites/gmcb/files/GMCB%20Guidance%20re%20AGO%20Referrals_05.01.18.pdf.

II. REVIEW PROCESS

Within 30 days of receiving a completed form, the GMCB will notify OneCare in writing if additional information is needed. GMCB Rule 5.000, § 5.305(c). OneCare's certification remains valid while the GMCB reviews its continued eligibility for certification. *Id.* If the GMCB determines that OneCare, its Participants, or its Providers are failing to meet any requirement of Rule 5.000 or 18 V.S.A. § 9382, the GMCB may, after providing OneCare with notice and an opportunity to respond, take remedial actions, including placing OneCare on a monitoring or auditing plan or requiring OneCare to implement a corrective action plan. *Id.* at § 5.504. The GMCB may also, after providing OneCare with written notice and an opportunity for review or hearing, revoke its certification or, if appropriate, refer a potential violation of antitrust law to the Vermont Attorney General. *Id.*; Green Mountain Care Board Guidance re: Referrals of Potential Violations of State or Federal Antitrust Laws to the Vermont Attorney General.

The eligibility verification process does not limit the GMCB's authority to review OneCare's continued compliance with the requirements of Rule 5.000, 18 V.S.A. § 9382, or any orders or decisions of the Board. Such reviews may be performed at any time (e.g., in response to quarterly financial reporting). *Id.* at § 5.503.

III. INSTRUCTIONS

You must complete each section of this form and submit an electronic copy of the completed form to the GMCB's Health Policy Project Director, Melissa Miles, at Melissa.Miles@vermont.gov. The form must be received on or before October 1, 2018. You must copy the Office of the Health Care Advocate on the filing. *Id.* at § 5.104. If you have questions about this form, contact Melissa Miles by calling (802) 828-2177 or sending an email to the address above.

IV. DESCRIPTION OF CHANGES

1. Have there been any material changes to the following since they were filed with the GMCB? If so, please provide a brief description of the change(s) and the reason(s) therefore.

Document/Representation	Filed	Changed (Y/N)	Brief description of the change(s) and the reason(s) therefore
Operating Agreement	02/21/18	**N**	
Bylaws for Bd. of Mgrs.	10/20/17	**N**	
Bd. of Mgrs. Roster	02/21/18	**Y**	**Claudio Fort stepped down when he became CEO of Rutland Regional Medical Center, which is not in the 2018 OneCare Network. The seat currently is vacant. Additionally, our Medicaid Beneficiary Representative has changed. Sierra Lowell, has Replaced Angela Allard. Please See Attachment A for updated Board of Managers Roster**
Patient and Family Advisory Committee Charter	02/21/18	**Y**	**Streamlined language to make charter consistent with Rule 5, regarding participation by members who are covered by the different types of payers that have programs with the ACO. Please see Attachment B for the Revised Patient and Family Advisory Committee Charter**
Conflict of Interest Policy	02/21/18	**N**	
Description of mechanisms, other than the Patient Fact Sheet, used to inform the public about how OneCare works	02/21/18	**Y**	**Please see narrative response #3 below.**
Leadership Team Table (Budget Resubmission at 9)	10/20/17	**Y**	**Please See Attachment C for revised leadership team table**
Organizational Chart (Budget Resubmission, Sec. 1, Att. B)	10/20/17	**Y**	**Please See Attachment D for Updated Organizational Chart**

Participant Appeals Policy (06-12)	03/20/18	**Y**	**The OneCare Participant Appeals Policy incurred minor changes. The term "preferred participant" was added throughout the policy and language was broadened to say that appeals can be requested if the ACO decides to deny participation to an applicant.** **See Attachment E for an updated Policy.**
Care Coordination and Disease Mgmt. Program within an Integrated Care Delivery Model (C02-05)	02/21/18	**N**	
Shared Care Plan Template	03/13/18	**Y**	**Please See Attachment F in Certification Appendices for updated Shared Care Plan Template**
Integration with the Blueprint for Health (2018 Budget Resubmission at Part 5)	10/20/17 02/21/18	**Y**	**Please Find Narrative Response Below #14**
Care Coordination Training and Responsibilities Procedure/Toolkit (C02-06)	02/21/18	**N**	
Quality Improvement Procedure (C02-08)	02/21/18	**N**	
Utilization Mgmt. Plan	02/21/18	**N**	
Patient Complaint and Grievance Policy (05-06)	02/21/18	**N**	
Privacy and Security Policy (03-01)	02/21/18	**N**	
Data Use Policy (03-03)	02/21/18	**N**	
Ability to integrate clinical and financial data systems to manage financial risk	03/13/18	**N**	

2. Since OneCare was certified, have there been any material changes to its organization or governance that are not reflected in the table above?

   There have been no material changes to the governing body of OneCare. In the past year, OneCare hired a Chief Compliance and Privacy Officer, whose time is split between OneCare and the Adirondacks ACO. We also hired a Vice President of Finance and Strategy and two of the existing directors now report to that position. Please See Attachment D to see the new reporting structure.

3. Since OneCare was certified, have there been any material changes in the mechanisms it employs to obtain consumer input, as described in Narrative Response 7 (Feb. 21, 2018)?

   Embracing the concept of Patient and Family Centered Care, in January 2018, OneCare's Consumer Advisory Group voted to change their name to the Patient and Family Advisory Committee. This committee meets bi-monthly with attendance by members of OneCare's leadership team and at least one member of the Board of Managers. The board member who attends the Committee meeting reports the discussion and recommendations out to the full board. The report out is reflected in the minutes that are available on our website. Our patient and family advisors provided substantive feedback on the newly developed "Introduction to OneCare Vermont ACO" materials, the prevention and wellness opportunities RiseVT offers, and mental health follow up visits after an Emergency Department visit.

   OneCare continues to support Community Collaboratives, which meet monthly in each health service area. These Collaboratives, which many communities have renamed Accountable Communities for Health, allow community stakeholders to discuss pressing local health care issues and implement initiatives to improve the health and the experience of care for their community members. OneCare strongly encourages the inclusion of patients, family members and caregivers. Currently, 60% of the Community Collaboratives include a patient or family member in their membership and we hope our grand rounds on patient and family centered care will be helpful to those still working on including these advisors. The Regional Clinical Representatives, who often the chair the collaboratives, report back to the OneCare Clinical and Quality Advisory Group on their initiatives and outcomes.

   Additional consumer input activities include:

   - *OneCare's website has a "Contact Us" page where patients and members of the public can comment or ask questions. We have received and responded to queries posted on this page. Patients and members of the public may submit suggested topics and concerns for the Patient and Family Advisory Committee for general discussion. OneCare is currently undergoing a website redesign that will result in an informative and easy to understand outlet for the public and other interested parties to learn more about the ACO.*

   - *In response to feedback from our patient and family advisors that they did not like the term "consumer," we edited our Patient and Family Advisory Committee charter to replace the term consumer with such words as "patients and family members" or "individuals."*

   - *At the end of 2017, OneCare created an internal workgroup to address and promote the concepts of Patient and Family Centered Care. This group continues to meet regularly and has implemented a number of changes within the organization such as:*

- *Including a short 5-minute presentation that focuses on patient and family centered care at internal OneCare staff meetings. These presentations are stories of how a person, family, or community has improved health as a result of work connected to OneCare.*
- *Patient- and Family-Centered Care Principles have been integrated into the OneCare new staff orientation.*
- *Developing Patient-Family Centered norms when talking about population health and data. For example, person with diabetes rather than diabetes patients. Another important goal is to reduce and eliminate, when possible, the use of acronyms.*

- *OneCare has committed to including a patient, family member or caregiver as one of the presenters in all of our Educational Grand Rounds and Chronic Condition Symposiums. Evaluations in 2018 have indicated that this portion of the educational sessions are often listed as the most meaningful.*

- *In an effort to increase feedback from across the state, OneCare plans to partner with Network participating hospitals in 2019 to organize public forums to foster discussion and feedback about the ACO and healthcare in that community. Introductory presentations and materials are in development and hospital leaders will be encouraged to sponsor a forum. Brattleboro Memorial Hospital recently organized such an event (see below).*

- *On September 11, 2018 Brattleboro Memorial Hospital (BMH), in partnership with OneCare, hosted a community forum to educate members of their community on the ACO. Invitations were mailed to all of BMH's attributed lives. Approximately 40 community members attended. A representative from OneCare was on hand to answer questions after the presentation by BMH. OneCare will work to replicate this community forum model with other interested hospitals and communities.*

- *OneCare continues to submit op-eds and press releases to statewide print publications to help share information about the benefits of OneCare and the impact on Vermont communities. We have also held informational sessions for legislative representatives, stakeholder groups, news outlets, and other interested parties.*

- *OneCare has increased our educational efforts to the public, by creating more public- focused materials that describe how OneCare works (e.g., introduction to OneCare, an ACO 101). OneCare is in the process of discussing a centralized WebEx in the coming year for patients, families and caregivers to inform and receive feedback. OneCare has also created more of a social media presence, establishing a twitter and Linked-In Account. We currently are exploring other ways to utilize the social media platform.*

4. Did OneCare organize a patient and family member or caregiver work group to provide feedback on Care Navigator, as described in Narrative Response 7 (Feb. 21, 2018)? If so, describe any changes OneCare plans to implement based on the feedback it received.

   Drawing from members of our Patient and Family Advisory Committee and the University of Vermont Medical Center Patient and Family advisors, OneCare has organized a patient/ family member/caregiver work group to provide feedback on our care coordination software platform (Care Navigator), to help with patient engagement, the mobile application and educational materials. Delivery of the patient engagement tools were delayed to Q3, 2018; and we plan to socialize these tools and get feedback in November.

5. Has OneCare arranged for the members of its Patient and Family Advisory Committee to meet with representatives of the Office of the Health Care Advocate, as described in Narrative Response 1 (Feb. 21, 2018)? If so, when did the meeting occur?

   The meeting with the Healthcare Advocate and Members of the Patient and Family Advisory Group is scheduled for November 8, 2018. OneCare will notify the Green Mountain Care Board once this meeting has occurred.

6. Did the Office of the Health Care Advocate prepare a report for OneCare as a result of its meeting with members of OneCare's Patient and Family Advisory Committee? If so, please attach a copy of the report to your filing.

   The meeting with the Healthcare Advocate has not yet occurred this year, so a report has not been provided. We will notify the Green Mountain Care Board when the meeting has occurred and additionally when the report has been provided to us.

7. When can the GMCB expect to receive OneCare's 2020 provider recruitment strategy and timeline?

   OneCare will develop its 2020 Network Development strategy during Q4, 2018 with the goal of the OneCare Board approving the strategy in early Q1, 2019. When the OneCare Board approves the strategy and timeline it will be shared with GMCB.

8. Describe OneCare's progress in adding condition-specific content to Care Navigator that is accessible by patients, as described in Narrative Response 11 (Feb. 21, 2018).

   Condition panels have been added in Care Navigator to assist care coordinators in focusing their interventions for high risk patients. The new condition panels, which include Dementia, Bipolar Disorder, Depression, and Anxiety, allow for the ability to identify specific populations of patients by provider or practice-level and provide appropriate care management strategies. These fields are not accessible to patients.

OneCare has also updated the content in the patient education resource library in Care Navigator. The resource library includes evidenced-based education materials on specific chronic conditions including Asthma, Coronary Artery Disease, Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Diabetes, Hypertension, and Tobacco Use Disorder. The materials are currently accessible to care team members to provide to patients at any time. OneCare is in the process of implementing the Care Navigator mobile application in phases.

The first phase focuses on care team members whom are already knowledgeable about the platform and how it can be used to support and enhance care coordination services and supports with patients. The second phase, will provide direct access to patients with emphasis on the patient's care plan and educational resources and tools.

9. Describe OneCare's progress adding admission, discharge, and transfer (ADT) feeds to Care Navigator for facilities outside of Vermont through Patient Ping, as described in Narrative Response 10 (March 13, 2018).

   OneCare implemented ADT feeds in Care Navigator for out-of-state facilities participating with PatientPing on June 30, 2018. System workflows were developed to automatically populate each event directly to the "Event Notification" section in patient records where they can be viewed by newly associated care team members. Out-of-state ADT events also automatically generate an "Event Notification" to care team members currently connected to that patient, spurring action based on organizational and community-based workflows aimed at improving transitions of care. Anecdotal feedback indicates that this functionality is frequently cited by users as providing high value to the care team. Home Health agencies in particular find value in the ADT feeds and have developed workflows in response to notifications (i.e. generating phone calls or nursing home visits) as families and caregivers do not frequently self-report this information. Many organizations who do not have resources to purchase PatientPing services on their own are finding this feature useful as part of the Care Navigator system.

10. Have there been any changes to OneCare's risk stratification methodology that are not reflected in the table above? If so, please describe the change(s).

    OneCare continues to use the John's Hopkins Adjusted Clinical Grouper (JH ACG) to risk stratify patient populations by payer program. This grouper uses demographic, condition, and claims-based information to predict future utilization of health care resources. At the same time, OneCare is evaluating the efficacy and reliability of a new risk model from Algorex Health which utilizes social determinants of health data and has the potential, when coupled with the current risk stratification model, to provide a more comprehensive view of the population health of OneCare's attributed patients than what otherwise can be discerned from traditional healthcare cost and utilization data. OneCare has focused thus far on co-designing the

algorithm with the vendor for a pediatric population and conducting validity testing with Network participants. Initial feedback from pediatric-serving providers indicates that the algorithm, in some cases, confirms their existing knowledge of other social or economic risk factors and in other cases provides new information. Based on this initial feedback, in 2019 OneCare will refine the pediatric algorithm and design and test corresponding algorithms for adults. Additional anticipated work includes exploring the possibility of creating an "ACES risk score" in 2019.

11. Have there been any changes to the Care Navigator platform or OneCare's expectations for how providers use that platform in the context of the ACO's population health model (to the extent not captured above)?

    OneCare is committed to improving the Care Navigator platform to add value to care coordination activities and support our population health model. In the past year, OneCare has worked with Care Navigator to enhance the tool and promote care team member engagement. In collaboration with participating Designated Mental Health Agencies, OneCare implemented a universal 42CFR Part 2 consent form and related system workflow this year. These enhancements enable care coordinators who are subject to this regulation to meet the consent and notice of re-disclosure prohibition requirements. The workflow also provides a mechanism for care team members to view a panel of consented individuals by future expiration date less 30 days, which helps them manage this process proactively to plan for re-consent procedures among their care team members.

    Second, the shared care plan template in Care Navigator was updated to provide necessary elements of a Pediatric Shared Care Plan. These enhanced elements included a "Family Goals" section and the addition of a "Family Information" section to the patient-centered "About Me" area.

    Third, condition panels, including Depression, Anxiety, Dementia, Bipolar Disorder, have also been added to the Care Navigator platform. The ability to view and sort populations by conditions assists the care coordinators to manage their patient panels and provide interventions to populations of patients.

    Finally, OneCare has added content to the existing resource library of educational resources in Care Navigator. These resources are located in Care Navigator for quick access to patient educational tools and information. The new resources include information such as Tips for Caregivers, Adolescent Depression, Changing Habits, Alcohol and Drug Problems, Physical Activity Idea, and Stress and Coping/Mindfulness.

12. Have there been any changes to WorkBench One or how providers and the ACO use that platform to monitor utilization, cost, and clinical data (to the extent not captured above)?

    The informatics platform, WorkBenchOne™, provides a mechanism for combining claims and clinical data from all ACO participants to perform advanced analytics and

support clinical decision making. OneCare continues to enhance existing tools and create new tools for population health management.

In May, OneCare partnered with Health Catalyst to enhance PMPM Analyzer, which is a tool that tracks cost and utilization along the continuum of care. The following key performance indicators have been added for performance monitoring: Prescriptions per 1000 per Year (PKPY), ER visits without Admit PKPY, Evaluation & Management Visits PKPY, CT Scans PKPY, Lab/Pathology PKPY, Outpatient Observation PKPY and Urgent Care PKPY. A new payment flag was also created to allow segmentation and monitoring of fee-for-service claims versus shadow claims for our risk contracts. Additionally, a new report tab was added that allows end users to build their own reports and extract patient lists.

This year, OneCare created the Medicare Annual Wellness Visits (AWV) application to improve the rate of Medicare Annual Wellness Visits, which is a Clinical Priority for 2018. The goal of this application is to allow practices to pull the most up-to-date list of patients due for their AWV. This tool provides performance comparisons at the HSA, TIN, Practice and Provider level. Patient lists can be created for individuals that have either never received an AWV, did not have one in the last year or have not had one in the last 24 months. This tool can also be used to track improvement activities for this measure.

Two new applications have been created for our Care Management program: Care Coordination Outcomes Analysis and Care Coordination Process Metrics. The Care Coordination Outcomes Analysis application is an internal tool that monitors the outcomes of the Care Management program. This tool compares cohorts in the Care Management program and analyzes the impacts of care coordination on patient spend and utilization over time. The Care Coordination Process Metrics application reports on activity that is logged in Care Navigator. This app provides the following key process measures: Engaged, In Outreach, Care Team Initiated, Care Team Created, Lead Care Coordinator Assigned, Shared Care Plan Created and Care Managed by HSA, TIN, Practice, Provider and Patient.

13. Have there been any material changes that relate to the requirements of 18 V.S.A. § 9382(a) or Rule 5.000 but that are not noted above? If so, please provide a brief description of the change(s).

    There have been no material changes in OneCare Operations or functions that have not been discussed within.

14. Integration with the Blueprint for Health (2018 Budget Resubmission at Part 5 & Narrative Response 10)

    OneCare and the Blueprint for Health have worked closely to align goals, strategies and resources across Vermont's health service areas. OneCare and the Blueprint for Health team members meet monthly along with members from other partner organizations (e.g. Vermont Chronic Care Initiative (VCCI), Bi-State Primary Care

Association, and Support and Services at Home (SASH)) for a three-hour "All Field Team" (AFT) meeting focused on sharing information from health service areas statewide. Blueprint and OneCare meet at least once a month to plan for the AFT to maximize alignment of topics to organizational goals. Sharing information on initiatives from all of these organizations also supports alignment of efforts and messaging to the communities to avoid duplication of efforts. For example, through the coordination of staffing we created a seamless process whereby OneCare's Clinical Consultants serve the Network at the community level educating on quality measures, care coordination, and data-driven decision-making strategies while the Blueprint Project Managers support community-wide engagement and the Blueprint for Health QI Facilitators assist practices in implementing improvement initiatives.

OneCare and the Blueprint for Health collaborate with several other community organizations (New England Quality Innovation Network - Quality Improvement Organization, Vermont Department of Health (VDH), SASH, and the Vermont Program for Quality in Health Care) to plan and host an annual statewide Learning Collaborative, with monthly WebEx sessions and quarterly in-person all-day learning sessions. OneCare takes the lead on planning content and executing the educational sessions and assists the Blueprint QI facilitators to implement interventions and conduct test of change cycles in the participant's practices. The 2017 Collaborative focused on improving Hypertension control. The Collaborative had 60 participants representing eight primary care practices and one home health agency statewide. The response to the 2017 Learning Collaborative was so positive that another disease-state focused Learning Collaborative was initiated in 2018 on the topic of improving Diabetes control. Planning for the 2019 Learning Collaborative is currently underway with a topic yet to be finalized.

Blueprint for Health and OneCare have also started meeting regularly with other partners including VDH, to focus on increasing self-management workshop participation. This workgroup identifies challenges and barriers to the workshops and develops solutions to implement. All members from the group actively participate and are committed to the joint effort of improving these programs. As an example of the joint effort, the team will present on the self-management programs to the OneCare Clinical and Quality Committee and seek feedback on how these programs benefit patients as well as challenges and barriers to referrals and utilization of the programs.

OneCare and Blueprint leadership meet at least monthly to discuss areas of opportunity and mutual interest. In addition, both organizations meet regularly with all of the Agency of Human Services Commissioners to discuss opportunities for collaboration through healthcare reform efforts.

V. COMPLIANCE WITH AMENDMENTS TO 18 V.S.A. § 9382

1. Describe how OneCare complies or plans to comply with the recent amendment to 18 V.S.A. § 9382(a)(2) by responding to the following questions. *See* 2018 Acts and Resolves No. 200, Sec. 15 (effective July 1, 2018).

    a. Describe how the ACO conceives of its role in ensuring equal access to appropriate mental health care, as defined by the statute, and contrast the ACO's role with the role of payers.

    OneCare's goal is to promote access to high-quality mental health care as part of an integrated system of care at both the local and statewide level. This includes promoting care delivery changes within the existing ACO Network for services under our total cost of care as well as collaborating with leaders from AHS, the designated agencies (DAs) and other community-based organizations to advance mental health payment and delivery system reforms under the All Payer ACO Model. OneCare is investing in local community activities to promote integration of mental and physical healthcare services including providing financial resources, tools, and supports to promote community-based integrated care teams inclusive of Designated Mental Health Agencies (DA) staff, primary care, home health, area agencies on aging, and other identified partners. Through these integrated teams, mental health concerns can be more easily identified, prioritized, and resourced as part of the shared care plan process. OneCare's complex care coordination program continues to provide significant funds to expand capacity by personnel in these organizations to participate on care teams, to coordinate across organizational boundaries, and to support person-centered goal setting and progress. OneCare also promotes evidence-based clinical care delivery through Interdisciplinary Grand Rounds (e.g. suicide prevention) and dissemination of Network Success Stories that highlight results from local improvement efforts (e.g. NOTCH FQHC improving depression screening). OneCare works in partnership with payers to identify strategies to address mental health-related quality measure gaps and to monitor progress. This collaborative information sharing facilitates creative problem-solving and aligns efforts to support care delivery improvements and patient outcomes. Unlike the ACO, the payer is responsible for designing benefit plans that can facilitate access to specific mental health services.

    b. What incentives is the ACO using to include more mental health providers in its network?

    Currently, OneCare's care coordination model provides significant funding to Designated Mental Health Agencies (DAs) through per-member per-month payments for high and very high risk individuals attributed in each health service area (HSA). OneCare estimates that as many as 60% of individuals in an HSA could benefit from mental health services and supports and thus, OneCare funds these care coordination services at that level. These funds flow to the local DAs to enhance their capacity to provide team-based care coordination in the

community. The specific application of funds within each DA is left to that organization to administer in order to provide flexibility and local decision-making around how best to coordinate care and services.

In addition, OneCare anticipates working with mental health providers, both through the DAs and independent mental health providers, in 2019 and 2020 to explore new payment reform models and delivery system reform opportunities in order to improve access to timely, high quality mental health care.

c. How is the ACO coordinating across the continuum of care, including through the use of electronic software and data, to support attributed lives with mental health conditions?

Through the use of Care Navigator, care team members across the continuum of care have access to timely information on individual's shared care plans, as well as admissions, discharges, and transfer information. Care Navigator has been configured to identify key patient panels, including mental health diagnoses such as Anxiety, Depression, and Bipolar Disorder. Further Care Navigator refinements described above have provided a common consent and re-disclosure process to ensure care team members subject to 42 CFR, Part 2 can participate as active care team members, sharing information seamlessly across the team in support of person-centered goals of care.

d. How is the ACO using data to identify and better manage health care or other services for aligned beneficiaries with mental health conditions?

The ACO completes an annual collection of clinical medical record data across the Network each winter to determine performance on specific quality measures, including depression screening with follow up for clinical depression and follow up plan. These manually collected data are supplemented by claims-based data on measures such as 30-day follow-up from the emergency department for mental health or substance use disorders (two distinct measures). OneCare produces quality measure scorecards which are provided to practices on a health service area-level to provide feedback on areas they are performing well and areas of opportunity. In July 2018, OneCare started a new pilot project to collect quarterly data from interested hospitals and health care organizations to supplement their annual reporting. This pilot project is intended to provide more timely information to inform clinical workflow redesign and ultimately, to better serve patients.

In 2018, OneCare has engaged both DVHA and BCBS in identifying new strategies to support data sharing. For example, in OneCare's second quarter comprehensive reporting package, the ANGLER, we were able to provide new information to Network Participants and Collaborators on mental health and substance abuse quality measures for the BCBS QHP population. This is the first time we have been able to share aggregate health service area level data on four key quality measures:

- *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence*
- *Follow-up after Emergency Department Visit for Alcohol or Other Drug Abuse or Dependence*
- *Follow-up after Emergency Department Visit for Mental Health*
- *Follow-up after Hospitalization for Mental Health*

Finally, through the Care Navigator condition panels described above, care team members are able to quickly identify which patients are in need of outreach or already engaged in care coordination and take appropriate action.

e. How is the ACO providing incentives to Designated Agencies and community supports to provide better management of care and other services for individuals with mental health conditions?

Using historical Medicaid data, OneCare estimates that the preponderance of individuals identified through risk stratification as high or very high risk have a mental health diagnosis. The ACO recognizes that person-centered care for high risk individuals must involve a multi-disciplinary care team, including Designated Agencies, Home Health, and the Area Agency on Aging among others. OneCare provides these partners with monthly complex care coordination payments to promote team-based care. The incentive payments help support the resources needed to carry out care coordination activities: participating in care conferences, developing shared care plans, and transitional care planning. These activities aim to provide well-coordinated care to prevent duplication of efforts, improve patient satisfaction, and improve the overall care of the patient.

f. Are there ACO programs or initiatives to address social determinants of health for those with a mental health condition? If yes, please describe.

OneCare collaborated with the Howard Center, a local Designated Agency, and SASH to improve access and utilization of mental health and substance abuse services by residents in low-income housing. Beginning in late 2017, OneCare has funded a full-time mental health clinician through the Howard Center to support this pilot at two Burlington congregate housing locations where SASH has on-site programs. The embedded clinician hosts groups and meets with residents one-on-one. The clinician also joins staff meetings and team discussions on SASH participants. Through these interactions, staff have become more comfortable with warm hand-offs to the clinician and encourage residents to use the services.

With the guidance and help of the embedded clinician, the residents have initiated welcoming committees for new residents and created new social groups, all in an effort to reduce isolation and loneliness among the residents. Additionally, the embedded clinician's interventions have led to the halting of the eviction proceedings of two residents, by working with the residents and staff to address the underlying emotional and behavioral issues that precipitated the

eviction proceedings. Both of these eviction proceedings began prior to beginning of the pilot, but since the initiation of the pilot, no additional eviction proceedings have been started against any additional residents. SASH attributes the lack of new eviction proceedings to the example set by the embedded clinician and the new perspective on why residents may act in ways that negatively impact their ability to remain in housing.

In addition, OneCare is working with a vendor, Algorex Health, to explore other social determinant of health data including factors such as housing instability and social isolation to design and test refinements to risk stratification algorithms that include such factors.

g. How is mental health included in the ACO's quality measurement, clinical priorities, or both?

OneCare incorporates mental health into multiple quality measures, as well as the clinical priorities. One of the clinical priority areas for 2018 was to increase the 30-day ambulatory care follow-up for emergency room discharges for mental health and substance abuse diagnoses.

OneCare quality measures which are related to mental health or substance abuse include the following:

- *Follow-up After Hospitalization for Mental Illness, 7-day Rate*
- *Depression Remission at 12 Months*
- *30-Day Follow-Up after Discharge from the ED for Mental Health*
- *30-Day Follow-Up after Discharge from the ED for Alcohol and Other Drug Dependence*
- *Initiation of Alcohol and Other Drug Dependence Treatment*
- *Engagement of Alcohol and Other Drug Dependence Treatment*

This represents a significant portion of the ACO's overall quality measure portfolio and is in alignment with Vermont's All Payer ACO Model Population Health Goals.

h. Does the ACO have any ongoing or planned initiatives, trainings, or other efforts that are specifically directed to or focused on prevention and treatment of mental health conditions? If yes, please describe.

In addition to the ongoing pilot with SASH and the Howard Center, OneCare has supported other initiatives and trainings related to mental health. In 2018, OneCare hosted an interdisciplinary Grand Rounds session on suicide prevention and created enduring educational materials, associated with CME/CEU credits, which will be available throughout 2018 through the University of Vermont's Continuing Education Department. OneCare has also partnered with the Blueprint for Health to dedicate the October All-Field Team (AFT) meeting topic on suicide prevention and awareness. The planning committee is

organizing a panel of providers and community organization representatives to speak about suicide, especially among marginalized or minority populations in Vermont. The July AFT also focused on opioid treatment and monitoring in Vermont. The Diabetes Prevention and Management Learning Collaborative (running from April 2018 through January 2019) will focus the final session in January 2019 on the connection between diabetes and prediabetes and mental health and wellness. The Learning Collaborative is a joint effort between OneCare, Vermont Department of Health, Blueprint for Health, QIN-QIO and SASH.

OneCare is also participating in a Medicaid process improvement plan (PIP) with DVHA to improve the initiation and engagement of treatment (IET) for substance use disorders rate for patients in the Medicaid program. Currently the IET PIP team is educating Medicaid substance use disorder (SUD) services providers on the availability to use telemedicine in their practice. The IET PIP will monitor utilization of telemedicine services among the targeted providers to assess if telemedicine increases access to SUD services.

2. Describe how OneCare complies or plans to comply with the recent amendment to 18 V.S.A. § 9382(a)(3) by responding to the following questions. *See* 2018 Acts and Resolves No. 167, § 13a.

   a. To the extent the ACO has established its own reimbursement rates to providers, describe any differentials in the ACO's payment methodologies or amounts among comparable participating providers across all practice settings (e.g. independent and hospital-affiliated practices). In your response please briefly describe the authority and ability of the ACO to establish provider reimbursement rates and what is outside of the ACO's authority and ability to control.

   The ACO model provides OneCare and its network with the ability to transform existing payment mechanisms in ways that facilitate more efficient delivery of care, place incentives on value rather than quantity, and redirect funding towards initiatives aimed at wellness. The two primary approaches OneCare is employing to implement its own provider payment mechanisms are (i.) the "All Inclusive Population Based Payment" (AIPBP) model where certain OneCare participating providers waive FFS payment for most or all of their submitted claims in lieu of an ACO payment model <and> (ii.) direct supplemental payments made by OneCare to providers on top of FFS receipts those providers receive "as usual," meaning paid by the payer programs according to the payer-set reimbursement models and contracts. The funds source for the first mechanism is a monthly lump-sum prospective payment from the payer designed to be generally aligned with the value of expected FFS payments if that were to be the actual reimbursement mechanism for those providers. The source of funds for the second mechanism comes under the overall budgeted revenues and expenses of OneCare and includes financial contributions and investments shared across hospitals and payers.

In 2019, OneCare will be making payments to providers in three ways: fixed payments to Vermont hospitals, capitated payments to some independent practices, and population health management program payments. The first two are under the AIPBP mechanism and the third includes a variety of provider payment programs using supplemental payments. Below we describe these OneCare payment programs further.

Hospital Fixed Payments

OneCare requires participating Vermont hospitals to accept this payment mechanism. The hospitals' fixed payments are determined in aggregate by the payers under the AIPBP model, and then OneCare divides this between the hospitals based on historical FFS spending on a PMPM basis by OneCare. This means that the ACO has limited funds to work with, but does have the ability to reallocate between the hospitals. To facilitate a smooth transition away from FFS, however, the fixed payments are designed to replace the historical cash flow generated from FFS billing. Because of the fixed payment approach, hospitals are now financially incentivized to improve health and wellness, minimize potentially preventable utilization and deliver high-quality care. The methodology used to generate the payment amounts is the same for each hospital, meaning a common way of applying the consistent transition from the FFS era for each organization. In future years, OneCare may implement standard formula-driven adjustments to hospital fixed payments intended to equitably and fairly recognize/ reward value.

Comprehensive Payment Reform Payments

OneCare offers this payment mechanism as an option to participating independent primary care practices who meet a threshold criteria of attributed lives. The 2019 Comprehensive Payment Reform (CPR) program aims to generate a payer-blended PMPM reimbursement model for independent primary care practices. The overarching goal is to reimburse these practices through a fixed payment model that provides appropriate financial resources and facilitates innovative and fluid care delivery models. Mechanically, the approach combines payer-paid fixed payment dollars with supplemental investments from OneCare. These additional investments are designed to incorporate the PMPM receipts these practices would otherwise receive as a OneCare provider, and supplement further to encourage innovative practice delivery and care models. In the end, the financial model aims to calculate an appropriate risk/panel adjusted reimbursement and erase some of the inequities created by a FFS system. Each of the practices participating are subject to the identical methodology.

IMPORTANT NOTES*:*

- *No other providers in 2019 outside of Vermont hospitals and CPR-participating primary care practices will be included in the AIPBP-based mechanism, meaning they are the only providers receiving their base revenue/reimbursement from OneCare. All other providers will receive their base revenue/reimbursement under payer-paid, payer-set FFS.*

- *In the case where a hospital provides primary care services, those services are covered by the hospital-wide Fixed Payment across all services. Comparability of payment for those specific services at hospitals as compared to independent CPR practices who only provide primary care services can be based on historical analysis, but over time such comparability may cease to be meaningful.*

Population Health Management Program Payments
All providers are eligible for the Population Health Management Program Payments as additional payment stream(s) beyond their base revenue/reimbursement models.
OneCare makes these payments to network providers to encourage participation in initiatives designed to further the population health goals of the ACO. In all cases, the amounts paid to each provider type within the network are based on the identical methodology.

b. If applicable, explain how the ACO has taken steps to minimize payment differentials between comparable providers across all practice settings.

All of the methodologies used to develop reimbursement rates are designed to be transparent, equitable, fair, and consistent among comparable providers. This means that the same formulaic approach is applied, but does not necessarily mean that each provider receives the same payment amount. For example, the CPR program model starts from the same base PMPM for each practice and then applies practice-specific age/sex and risk adjustments. By employing a standardized approach across comparable providers, the ACO is effectively implementing a uniform methodology that circumvents some of the imbalances generated by a FFS model. While factors such as fee schedules, payer mix, utilization rates, risk, and practice operations affect FFS PMPM revenue generation, OneCare's philosophy aims to pay providers in a fair and equitable way, and at adequate amounts, to care for their patients within existing ACO funding constraints.

c. If applicable, explain how the payment methodologies and reducing or eliminating payment differential are not inconsistent with the ACO's overall payment reform objectives.

The payment methodologies and reducing or eliminating payment differential are not inconsistent with the ACO's overall payment reform objectives. These methodologies are designed to provide a smooth transition into value-based care, incentivize focus on population health and wellness, facilitate long-term participation in ACO programs, enable sustainable ACO operations, and meet the goals of the Vermont All Payer ACO Model.

3. Describe how OneCare complies or plans to comply with the recent addition of 18 V.S.A. § 9382(a)(17) by responding to the following questions. *See* 2018 Acts and Resolves No. 204, § 7.

a. How is the ACO working with stakeholders tasked in Act No. 204, including but not limited to the Agency of Human Services, the Blueprint for Health, Vermont Care Partners, providers and early childhood educators in the development of a plan to address childhood adversity?

The Population Health Strategy Committee, a subcommittee of the OneCare Board of Managers, is tasked with making recommendations to the full Board on population health management initiatives. This subcommittee includes Board members and community leaders representing primary care, home health agencies, designated agencies, the Vermont Food Bank, the Vermont Commissioner of Health, palliative care, psychiatry, the UVMHN Chief of Population Health, and Vermont Child Health Improvement Program leadership. The committee is charged with directing the ACO's clinical initiatives in cooperation with state, insurer, and community organizations including plans to address childhood adversity.

In addition, OneCare has a standing Pediatric Subcommittee of our Clinical and Quality Advisory Committee made up of academic and community pediatricians and family physicians providing care to children.

Both of these committees in their 2019 agendas will be taking up the issues of childhood adversity and engaging with AHS, the Blueprint for Health, Vermont Care Partners, and our participant network to promote provider and community education, screening initiatives, and cooperative interventions to help address ACEs and their impact on both adults and children.

b. How does the ACO provide or foster connections between its providers and existing community services providers who are addressing the impacts of childhood adversity?

OneCare's complex care coordination program funds both patient-centered medical homes (PCMH) and community partners to perform care coordination services for our highest risk patients (as determined by our John's Hopkins' risk model). Our care coordination training curriculum promotes the use of patient-centered screening tools that help to identify childhood trauma. In turn, the creation of shared care plans in Care Navigator permits multiple medical and community agency personnel to target childhood trauma contributors to current care needs. OneCare is also a significant supporter and convener of Accountable Communities for Health (ACH) (aka Community Collaboratives) in each Health Service Area. OneCare Clinical Consultants and Regional Clinician Representatives attend these meetings along with wide representation of local community agencies and facilitate connections among and across provider and community-based organizations.

c. How is the ACO collaborating on the development of quality outcome measurements for use by primary care providers who work with children and families?

OneCare is currently exploring opportunities to work with a data vendor that will support efforts to create "household stress" and "neighborhood stress" risk scores for our attributed populations. While it is unlikely that such data approaches will permit understanding of all ACE categories of childhood trauma, these efforts can help identify social determinants of health challenges that place children and adults at increased risk for adverse childhood experiences and facilitate the connection to interventions to help prevent and/or ameliorate their impact.

OneCare is also supporting efforts to incorporate adverse childhood experiences (ACEs) screening tools into electronic medical records across our Network. These data will help identify cohorts of at risk patients who may warrant additional engagement services from both ACO clinicians and community support agencies including schools, parent child centers, mental health services, and care coordination. OneCare has met with AHS staff in the Department of Children and Families to explore special interventions for children in DCF custody. Care of these children may be fragmented with multiple placements and the ACO feels that linkages with state agencies can promote better clinical and developmental outcomes for these vulnerable individuals. Further, OneCare's advanced analytic capabilities can identify cost and utilization drivers to help justify additional resources being directed towards mitigating childhood trauma related medical spending.

d. What incentives is the ACO providing or planning to provide to community services providers to specifically address the impact of childhood adversity?

OneCare is exploring a possible collaborative partnership with the DULCE (Developmental Understanding and Legal Collaboration for Everyone) Program in selected communities beginning in 2019. This program targets the first six months of life of children and their families with supports from child health personnel including involvement with well child medical visits, home visits, parent education, and family assessments. The DULCE project has been piloted at Appleseed Pediatrics in Morrisville as part of the Community Health Services of Lamoille County since 2016. The project aims are to ensure that newborns and their families receive high quality coordinated care to address their medical and social needs during the first six months of the newborn's life. The Lamoille Family Center employs the DULCE Family Specialist embedded at Appleseed Pediatrics and works with 150 families and newborns per year to navigate them through the social safety-net as well as coordinate any legal support needed. Using a strengths-based approach, the DULCE Family Specialist seeks to prevent adverse childhood experiences (ACEs) by fostering strong families and promoting the prevention, mitigation, and healing from adversity. In 2019, OneCare will assist the Vermont Department of Health to expand the DULCE project to three new pediatric practices in communities that also have a RiseVT campaign. OneCare will also provide financial assistance for a statewide coordinator for the program as well as funding to continue research on the program's outcomes.

VI. NOTIFICATION OF POTENTIALLY ANTICOMPETITIVE CONDUCT

1. Does OneCare share pricing information (e.g., reimbursement rates paid by commercial insurers or other negotiated fee information) with participants in its network? Does OneCare employ any measures not already described in its Data Use Policy (03-03) to protect such information?

   OneCare does not share pricing information with participants in its network.

2. Does OneCare engage in any of the conduct described in paragraphs 2-5 of the Green Mountain Care Board Guidance re: Referrals of Potential Violations of State or Federal Antitrust Laws to the Vermont Attorney General? If yes, please describe.

   OneCare does not engage in any of the conduct as listed in paragraphs 2-5 in the Green Mountain Care Board's Guidance re: Referrals of Potential Violations of State or Federal Antitrust Laws to the Vermont Attorney General.

VII. VERIFICATION UNDER OATH

Please submit, as a separate attachment, the required verification under oath signed by an executive with authority to legally bind OneCare.

Please see the attachment immediately preceding this document

OneCare Vermont Board of Managers

OneCare Vermont Board as of September 2018

Seat	Individual
Independent Physician	**Lorne Babb, MD -** Cold Hollow Family Practice
Community Hospital - PPS	**Jill Berry-Bowen -** CEO Northwestern Vermont Health Care
UVM Health Network	**John Brumsted, MD -** Chief Executive Officer
Consumer (Medicare)	**Betsy Davis -** Retired Home Health Executive
FQHC	**Tim Ford -** CEO Springfield Medical Care Systems
At-Large	**Steve Gordon -** CEO Brattleboro Memorial Hospital
UVM Health Network	**Todd Keating -** Chief Financial Officer
Dartmouth-Hitchcock Health	**Steve LeBlanc -** Executive Vice President
UVM Health Network	**Steve Leffler, MD -** Chief Population Health Officer
Consumer (Medicaid)	**Sierra Lowell**
Skilled Nursing Facility	**Judy Morton -** Regional Executive Director Genesis
Mental Health	**Mary Moulton -** CEO Washington Country Mental Health
FQHC	**Pamela Parsons -** Executive Director Northern Tier Center for Health (NOTCH)
Dartmouth-Hitchcock Health	**Joe Perras, MD -** CEO Mt. Ascutney Hospital
Home Health	**Judy Petersen -** CEO VNA of Chittenden/Grande Isle Counties
Independent Physician	**Toby Sadkin, MD -** Primary Care Health Partners
Consumer (Commercial)	**John Sayles -** CEO Vermont Foodbank
Dartmouth-Hitchcock Health	**Kevin Stone -** Project Specialist for Accountable Care
Vacant	**Vacant**

OneCareVermont

Patient & Family Advisory Committee

Charter

Purpose: The OneCare Vermont (OCV) Patient & Family Advisory Committee will bring patients and family members together to discuss health care in Vermont. The goal of the committee is to help OneCare Vermont improve patients' experience and care. OneCare Vermont wants to better understand Vermonters' concerns and will work to improve access, quality of care, cost, and patient experience. The committee will talk about health care values, preferences, experiences, and points of view. The OneCare Board of Managers will consider the Patient & Family Advisory Committee's thoughts and concerns when making policy decisions.

Committee Composition: The Patient & Family Advisory Committee will be populated as required by Program Agreements and regulations. OneCare staff will support the committee, and members of management and the Board will regularly attend meetings. Members will be appointed by the OneCare Vermont Board of Managers, and nominees should provide a brief biography for consideration by the Board. OneCare will educate committee members about its structure and mission.

Accountability: Members will discuss their ideas and issues, and make recommendations to the OneCare Board of Managers. Part of each member's role is to attend four group meetings per year and to participate in one annual meeting with a representative of the Office of the Health Care Advocate.

Scope: The committee's purpose is to make recommendations to OneCare about its policies and initiatives to improve healthcare outcomes, access, quality and cost, and patient experience.

Meetings: The committee meets the 2nd Thursday of the odd months: January, March, May, July, September and November. A calendar with specific dates will be provided to the members.

Members will be given a $50 stipend and travel reimbursement for the cost of transportation to and from the meetings.

The committee chair will plan the meeting agenda and OneCare staff will record minutes. A summary of the committee's discussions and recommendations will be provided to the OneCare Board of Managers after each meeting.

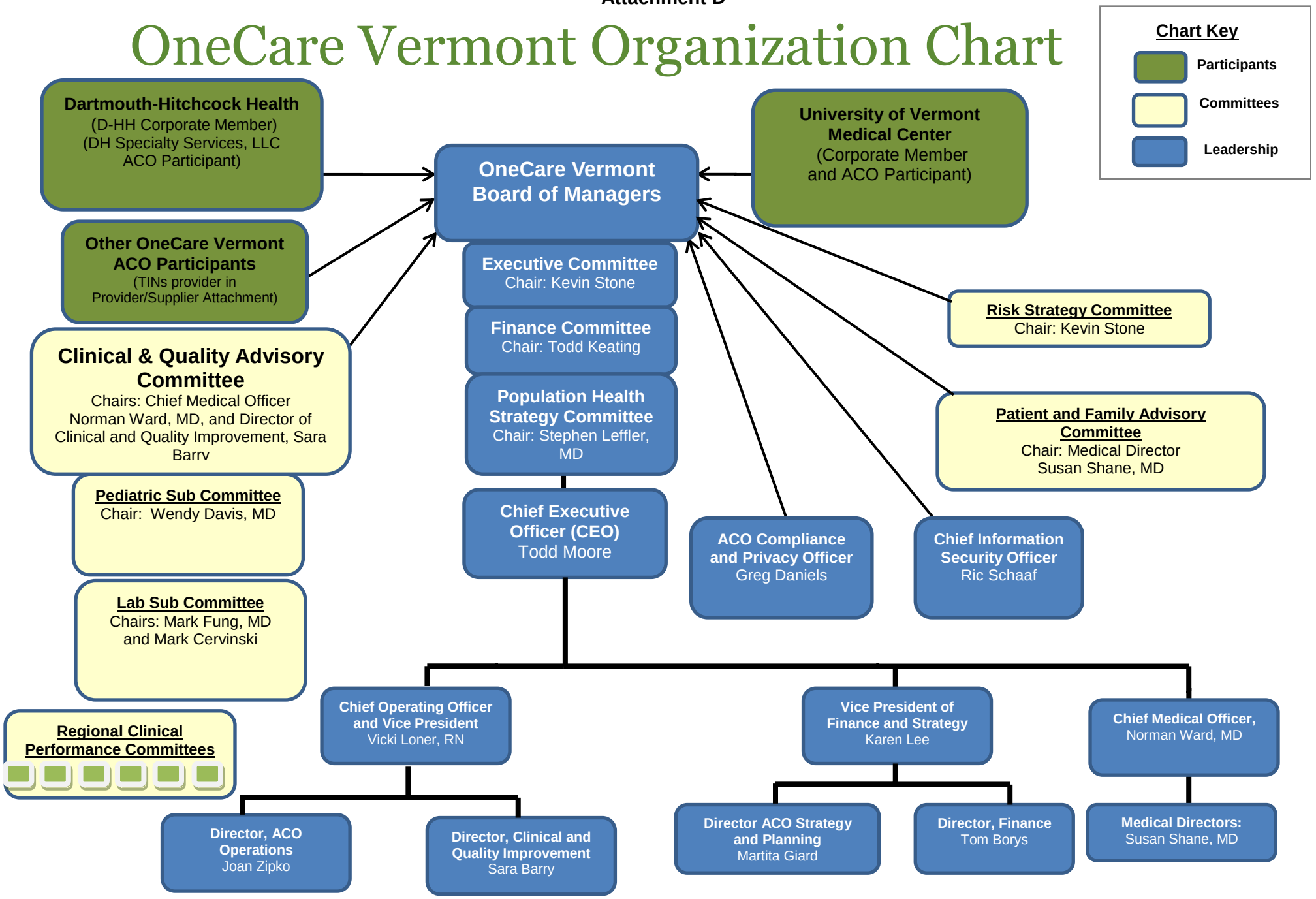
Attachment C

OneCare Vermont Leadership Team

Leadership Team Member and Credentials	Position/Role	Tenure with OneCare VT
Executive Team		
Todd B. Moore	Chief Executive Officer	6 years
Vicki Loner	Vice President and Chief Operating Officer	5 years
Karen Lee	Vice President of Revenue and Strategy	6 Months
Norman Ward	Chief Medical Officer	6 years
Gregory Daniels	Chief Compliance and Privacy Officer	4 months
Ric Schaaf	Chief Information Security Officer	1 Year
Senior Leadership		
Susan Shane	Medical Director	6 Years
Martita Giard	Director, Network and Strategy	6 Years
Sara Barry	Director, Clinical & Quality Improvement	2 Year
Tom Borys	Director, Finance	1 Year
Joan Zipko	Director, ACO Program Operations	4 Years
Management Team		
Tyler Gauthier	Manager, Quality Measurement and Innovation/Analytics	1 Year
Grace Bissonette-Broz	Manager of ACO Operations	6 Months
Vacant	Manager, Clinical Programs	*Vacant*
Amy Bodette	Manager of Outreach and Engagement	1 year

Attachment D

OneCare Vermont Organization Chart



9/21/18

OneCareVermont

Policy Title:	OneCare Participant Appeals Policy
Policy Number:	06-12
Responsible Department/s:	ACO Program Operations
Author:	Joan Zipko
Date Implemented:	7/19/16
Date Reviewed/Revised:	12/19/17
Approved by:	OneCare Board of Managers
Next Review Date:	12/31/18

Purpose: To have an Appeals Policy for OneCare Network Participants and Preferred Providers to access if necessary.

Statement: This Participant Appeals Policy ("Policy") describes the process through which Participants may have grievances related to their participation in ACO Programs heard and addressed by OneCare Vermont Accountable Care Organization ("ACO").

An appeal may only be requested under this Policy by a Participant or Preferred Provider for a dispute related to performance in ACO Programs including, but not limited to:

1. The shared savings or losses (risk) calculations, distributions or assessments made by ACO, as applied to the Participant;
2. Any capitated payments or other payments made as an alternative to Fee For Service, calculated by and paid to Participant by ACO;
3. An ACO decision to deny participation to an applicant or to discipline, sanction or terminate a Participant, Preferred Provider or Provider under an ACO Program;
4. The distribution or sharing of Participant's or Preferred Provider's performance data by the ACO.

A Participant or Preferred Provider may not request an appeal for any issue that the ACO is prohibited from appealing to the Payer under the relevant ACO Program. For example, if ACO may not appeal the programmatic calculation of shared savings, Participant or Preferred Provider may not appeal that issue to ACO.

A Participant or Preferred Provider must request a Level 1 Appeal within ninety (90) days of the date the Participant or Preferred Provider was notified of the issue in dispute. For example, if the Participant is requesting a Level 1 Appeal of its shared savings payment, Participant must do so within ninety (90) days of receiving notice from the ACO of the shared savings payment.

Before a Participant or Preferred Provider files an appeal, we recommend contacting the ACO to identify whether a grievance might be clarified or more suitably addressed outside the appeals process.

If a Participant or Preferred Provider decides to proceed with an appeal for the enumerated issues, there are two (2) levels of appeals available, as described below.

Actions/Responsibilities:

Level 1 Appeal

A first level appeal must be filed, in writing, to:

Attn: Appeals
OneCare Vermont Accountable Care Organization
356 Mountain View Drive, Suite 301
Colchester, Vermont 05446

The appeal request should include basic identifying information, such as the Participant or Preferred Provider name and TIN and, if applicable, Provider(s) name(s) and NPI(s). The request should state the reason for the appeal with sufficient detail to apprise ACO of all relevant issues and include all supporting information. ACO will respond within fifteen (15) business days acknowledging receipt of the appeal request and identifying any additional information that may be needed to proceed.

Once OneCare has sufficient information to initiate the Level 1 Appeal, it will be considered by the Director, ACO Program Operations and other individuals designated by the aforementioned Director, with expertise as to the subject of the appeal. A decision will be issued within sixty (60) days of receipt of the initial appeal request or receipt of additional requested information, whichever is later. The decision will explain the rationale supporting the decision.

If the Participant or Preferred Provider is not satisfied with the Level 1 Appeal decision, Participant or Preferred Provider may pursue a voluntary second-level appeal.

Level 2 Voluntary Appeal

A Level 2 Voluntary Appeal must be requested no later than ninety (90) days after receipt of the Level 1 Appeal decision. Level 2 Appeal requests must be made in writing to the same address as Level 1 Appeals. On notice of a Level 2 Appeal, the Director, ACO Program Operations will coordinate the Level 2 Appeal request and will transfer the records and materials from the Level 1 appeal to its Appeals Committee. The Appeals Committee shall consist of the Chief Medical Officer, the Chief Operating Officer, the Director of Finance, the VP, Finance and Strategy and the Committee may designate additional members with expertise as to any subject of appeal. Only members of the Appeals Committee who did not participate in the Level 1 decision will participate in Level 2 decisions. Participant should submit any additional, relevant information it wishes the Appeals Committee to consider with its request for a Level 2 appeal.

OneCare will acknowledge the receipt of the Level 2 Appeal request within fifteen (15) days. The Participant or Preferred Provider will also be asked whether they would like the opportunity to participate in a telephone or in-person meeting with a panel of at least three (3) ACO representatives, with decision making authority, who will review and decide the appeal. If a meeting is requested, Participant or Preferred Provider and ACO will work in good faith to identify a meeting time that is satisfactory to both parties and that takes place within forty-five (45) days of the Level 2 Voluntary Appeal request is received by ACO. In the event ACO and Participant or Preferred Provider are unable to meet within forty-five (45) days, the Participant or Preferred Provider may: (1) request to proceed without a meeting; or (2) request an extension, as provided below.

ACO will decide Level 2 Appeals within sixty (60) days of the latest of: (1) the date ACO has sufficient information to review and decide Level 2 Voluntary Appeal; (2) the date of Participant's or Preferred Provider's request to proceed without a meeting; or (3) the date ACO representatives met with Participant.

Appeal Extension Guidelines

Participant or Preferred Provider may request an extension of a timeline applicable in a Level 2 Voluntary Appeal if ACO and Participant or Preferred Provider, after working in good faith to schedule a meeting, have been unable to do so before the time expires.

ACO may, at its sole discretion, extend an applicable Level 1 or Level 2 Voluntary Appeal timeline in the event: (1) the information supporting the appeal request is voluminous or complex and requires additional time to review; or (2) ACO and Participant or Preferred Provider are unable to establish a meeting time prior to the deadline under a Level 2 Voluntary Appeal.

Effect of Appeal Decisions

Level 2 Voluntary Appeal decisions are final. After exhausting the appeals process, a Participant or Preferred Provider must look to its Participant or Preferred Provider Agreement with ACO for any further process. Participant or Preferred Provider and ACO have agreed that Provider(s) employed by Participant or Preferred Provider do not have an individual right under the terms of the Participant or Preferred Provider Agreement or this Appeals Policy.

Location on Shared Drive: S:\Groups\Managed Care Ops\OneCare Vermont\Policy and Procedures\Policies

Management Approval:

Joan Lipkin — 8/9/18

Director, ACO Program Operations — Date

[signature] — 8/9/18

Chief Operating Officer — Date

Board of Manager Approval:

Kevin C. Flow — 08/16/18

Chair, OneCare Board of Managers — Date

Attachment F

Shared Care Plan

Patient Information					
Patient's Name:	Primary Phone#: Age:	Type:		Email Address:	
Birthdate:		Gender:	Identified Gender:	Secondary Phone:	Type:
Address: (Street, City, State, Zip)		Preferred Method of communication:		Communication Challenges:	
Legal Guardian:		Advanced Directive:		AD Location: PCP office	
Primary Contact:		Primary Contact#:			

Insurance Information		
Primary Insurance:	Current PCP:	Attributed Provider:
Member ID:	Current PCP#:	Attributed Practice:

Emergency Crisis Plan	
ED/Crisis Plan:	Crisis Plan Uploaded:

About Me	
Preferred activities:	Tips to avoid triggers/behaviors:
How I learn:	Physical Mobility:
Interaction tips:	Mode of transportation:
Communication style:	Important Family information:

My Strengths

My Care Team			
Lead Care Coordinator:	Organization:	Phone#:	Email:
Other Support:		Other Support:	

Name	Organizatio	Description	Role	Email	Phone

Community Programs

Program	Date Of Enrollment	End Date

My Goals

PERSONAL

GOAL	STEPS TO ACHIEVE MY GOAL	PRIORITY	STATUS	PERSON RESPONSIBLE	ACTUAL START DATE	DATE COMPLETED

TREATMENT

GOAL	STEPS TO ACHIEVE MY GOAL	PRIORITY	STATUS	PERSON RESPONSIBLE	ACTUAL START DATE	DATE COMPLETED

FAMILY						
GOAL	STEPS TO ACHIEVE	PRIORITY	STATUS	PERSON RESPONSIB	ACTUAL START	DATE COMPLET

FUTURE						
GOAL	STEPS TO ACHIEVE	PRIORITY	STATUS	PERSON RESPONSIB	ACTUAL START	DATE COMPLET

Possible Challenges with Meeting My Goals		
CHALLENGE	TYPE	PLAN FOR HOW TO HANDLE THE

My Signature_____ Date:_____

Parent/ Legal Guardian Signature_____ Date:_____

Lead Care Coordinator's signature_____ Date:_____