2024 Certification Eligibility Verification Form for OneCare Vermont Accountable Care Organization, LLC

Date Issued: July 1, 2023
Submission Due By: September 1, 2023
Submission Date: August 29, 2023

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) that are required to be certified under 18 V.S.A. § 9382. To be eligible to receive payments from Vermont Medicaid or a commercial insurer, an ACO must obtain and maintain certification from the GMCB. 18 V.S.A. § 9382(a).

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).

Additionally, the GMCB reviews and verifies a certified ACO's ongoing certification eligibility annually. As part of that annual review, each certified ACO must (1) verify that the ACO continues to meet the requirements of 18 V.S.A. § 9382 and Rule 5.000, including any related guidance or bulletins issued by the GMCB regarding certification requirements; and (2) describe 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 18 V.S.A. § 9382 and Rule 5.000 that the ACO has not already reported to the GMCB. 18 V.S.A. § 9382(a); GMCB Rule 5.000, §§ 5.301(d), 5.305(a), 5.503(d). An ACO chief executive, with the ability to sign legally binding documents on the ACO's behalf must verify under oath that the information contained in the ACO's eligibility verification submission is accurate, complete, and truthful to the best of his or her knowledge, information, and belief. *See id.* § 5.305(b). See **Attachment B: Verification on Oath or Affirmation**. In addition to the submission, an ACO may be required to answer questions or provide additional information requested by the GMCB for its review. *See id.* § 5.305(c).

Because each ACO is unique and the documentation each ACO submits for certification (and subsequent verifications of eligibility) may differ, the GMCB develops 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 2024 (Eligibility Verification Form).

II. REVIEW PROCESS

Within 30 days of receiving a completed Verification of Eligibility 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.* § 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.* § 5.503.

III. INSTRUCTIONS

OneCare must complete each section of this form and submit an electronic copy of the completed form to, Sarah Kinsler, Director of Health Systems Policy, at Sarah.
Kinsler@vermont.gov and copy the GMCB ACO Oversight Team, at GMCB.ACO@vermont.gov. The form must be received on or before September 1, 2023. ***You must copy the Office of the Health Care Advocate on the filing.*** *See id.* § 5.104. If the OneCare representatives completing this form have any questions, contact Sarah Kinsler or Michelle Sawyer by calling (802) 828-2177, or by sending an email to the ACO Team address above.

IV. DESCRIPTION OF CHANGES AND QUESTIONS FOR ONECARE

1. Please complete **FY24 ACO Certification Attachment A: OneCare Vermont Certification Documents, Policies & Procedures** and provide any necessary documents**.** Instructions can be found in Tab 1 of Attachment A.

   See Attachment A and related documents enclosed.

2. Please submit a copy of the current **Policy and Procedure Glossary.**

   See Attachment C OneCare Policy and Procedure Glossary enclosed.

3. Since OneCare's certification eligibility was last reviewed, have there been any material changes to OneCare's structure, composition, ownership, governance, and/or management? Please use **FY24 ACO Certification Attachment A** to provide a brief description of the changes and include additional narrative below as needed to explain rationale. (*See* §§ 5.201-5.203.) *Word limit: 200*

   Since the FY23 certification eligibility form was submitted, there was one material change in leadership whereby Abe Berman was appointed as Interim Chief Executive Officer effective May 29, 2023, after Vicki Loner stepped down from the position after nearly four years in the role. Changes to board membership are reflected in the Board of Managers Roster submitted to the GMCB on July 31, 2023. Notably, the long-serving Medicare consumer representative resigned, and recruitment efforts are underway to fill the vacant seat.

4. Provide an update on any planned **advocacy trainings that the consumer/enrollee members of OneCare's Board of Managers and the members of OneCare's Patient and Patient Family Advisory Committee** will receive in 2024. (*See* § 5.202(c).) *Word limit: 100*

   New consumer board managers receive onboarding orientation and can participate in peer mentorship. OneCare offers Board meeting attendees accommodations, including captioning, ASL interpreter, and visual descriptors for low vision or blind attendees. New and existing Patient Family Advisory Committee (PFAC) members receive onboarding education including patient and family centered care advocacy training in collaboration with the UVMMC Patient Experience Department. This PFAC training is planned for Sept 26, 2023, and again in fall 2024.

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** in 2024? If so, when will that meeting take place? (*See* § 5.202(h).).

   OneCare's most recent PFAC meeting with the Health Care Advocate occurred on October 25, 2022. The Office of the Health Care Advocate prepared a report for OneCare dated November 2, 2022. The next meeting is scheduled for November 28, 2023.

6. Please describe OneCare's process for monitoring and reporting the effectiveness of its policies and procedures regarding care coordination, including physical and mental health care coordination and coordination of care for Enrollees with a substance use disorder, and explain how OneCare develops and implements mechanisms to improve coordination and continuity of care based on such monitoring and evaluation. (See §5.206(c).) Word limit: 200

   OneCare monitors and reports the effectiveness of its policies and procedures regarding care coordination through annual policy and procedure review, data analysis, and network feedback. Physical and mental health care coordination are evaluated by tracking care managed rates of individuals within established high-risk populations of focus, by monitoring performance rates of follow-up after emergency department (ED) or hospitalization for mental illness and after ED visit for substance use, and through an annual care coordination patient experience survey. OneCare shares these qualitative and quantitative care coordination results with the network through site specific, regional, and statewide care coordination meetings.

   Care coordination teams across primary care, home health and hospice, Designated Mental Health Agencies, and Area Agencies on Aging identify opportunities for improvement and data driven action plans. For example, after receiving care coordination results from the OneCare team, a hospital in southern Vermont developed a dashboard to organize and support engagement of at-risk individuals, ACO attributed and not, to improve care management and quality outcomes. The dashboard integrates OneCare and hospital data to generate patient lists for outreach. This dashboard has positively impacted their home visit program, staff satisfaction, and existing care coordination workflows.

7. Provide an update on the mechanisms OneCare employs to **obtain consumer input**, as compared to the information contained in OneCare's response to the 2023 Verification of Eligibility Form Response #4? (*See* § 5.202(g); 5.206(d).) *Word limit: 100*

   OneCare continues to obtain consumer input through PFAC and its Board of Managers. In 2023, OneCare deepened consumer input by including a PFAC representative in its Care Coordination Focus Group. In spring 2023 PFAC meetings, members provided input on topics including OneCare's Population Health Model evolution for 2024 and unnecessary ED use. This input ensures that OneCare's work remains relevant from the patient and caregiver perspective and addresses actual barriers experienced. OneCare plans to obtain consumer input in its program evaluation efforts and broaden PFAC membership to other OneCare workgroups. OneCare is working to expand PFAC membership to further diversify

membership including representation from additional regions of the state, youth, and individuals within BIPOC communities. OneCare's Board of Managers also includes representative seats for individuals representing the consumer perspective.

8. Provide and update the ACO's method(s) for **identifying types of services, and entities to provide those services,** to those enrollees that have been identified as potentially benefiting from care coordination, as compared to the information contained in OneCare's response to the 2023 Verification of Eligibility Form Response #8. (*See* § 5.206(g).) *Word limit: 200*

   In February 2023, OneCare created a new care coordination application accessible to the network. The application identifies members in need of key services related to OneCare's PHM focus areas, such as wellness visits and hypertension follow-up. Specifically, the application provides appropriately provisioned care coordination staff with demographic and clinical information signaling the provider type most appropriate to outreach and engage with the individual. The application allows care coordination teams to identify members in need of services using ACO data (e.g. members with A1c out of control or members overdue for a wellness visit).

   As OneCare prepares for 2024, the transition to a new data analytics system will provide targeted performance reporting and appropriately provisioned user access to detailed patient lists to drive action for key ACO initiatives, including care coordination. OneCare has actively engaged network providers in designing these reports to ensure they are specific and actionable.

9. Provide an update on the ACO's method(s) for **supporting participants in providing processes that use decision support tools/enable enrollees to assess the merits of various treatment options?** Also describe the ACO's method(s) for supporting participants in providing processes that **foster health literacy**. (*See* § 5.206(i).) *Word limit: 200*

   OneCare continues to offer decision support tools that enable providers to work with individuals to assess the merits of treatment options including the Care Coordination Toolkit, data functionality, and clinician engagement for the identification and prioritization of patients in alignment with ACO priorities. Providers then use these tools, such as shared care plans and goal development, to engage in shared decision-making conversations around patient preferences for their care.

   OneCare queries its network triannually to gather information regarding network collaboration, the experience of the care coordination program, and educational needs. As part of the most recent survey, OneCare queried approximately 75 network entities regarding their health literacy needs and current strategies. Early responses show solid strategies in place including health literacy screening for all patients over 13, provision of interpreter services, and revising websites with a focus on health literacy.

OneCare will host the next live annual training for health literacy in fall of 2023, the content of which will be determined by responses to the above queries. Prior agenda items have included: defining health literacy, types of health literacy, risk factors, impacts of low health literacy, and an open question and answer session. During this year's session, OneCare will also provide support to its network for engaging individuals with limited English proficiency.

10. Provide and update on the ACO's method(s) for supporting participants in providing processes that implement strategies for **engaging enrollees with limited English proficiency** (*See* § 5.206(k).) *Word limit: 200*

OneCare continues to support enrollees with limited English proficiency by providing eight languages on the OneCareVT.org website. Additionally, through its partnership with UVMMC, the OneCare team can access translation services in the event of an inquiry from a non-English speaking enrollee.

As part of the triannual network survey described in the response to question 9, OneCare recently queried the network to better understand current and future needs related to engaging enrollees with limited English proficiency. Once complete, the findings will inform OneCare's approach to supporting this topic in its health literacy training as referenced above.

11. Describe how the quality evaluation and improvement program **regularly evaluates the care delivered to enrollees against defined measures and standards** regarding enrollee and caregiver/family experience. (*See* § 5.207(b).) *Word limit: 200*

OneCare regularly evaluates the care delivered to enrollees against defined measures and standards through annual reporting on standard national quality measures. In 2023, OneCare monitors 21 quality measures across all payer programs. These measures provide insights into the quality of care delivered by our network across the following domains: preventive care for both adults and children, screening for and treatment of chronic disease, treatment for mental health/substance use disorder, hospital utilization, and self-reported patient and caregiver experience. OneCare receives results in the early fall and shares them with our contracted network, regulators, and the public via the OneCare website.

In addition to providing insights on performance data, OneCare's value-based care team facilitates ongoing quality improvement collaborations throughout the state on shared priority areas. During these collaborations, the OneCare team identifies opportunities for improvement. Additionally, these collaborations may include support for interpreting OneCare data, technical assistance on quality improvement best practices, help facilitating performance improvement projects, or the sharing of successes from practices across the network. Highlights from the quality improvement work are shared during OneCare's biannual health service area consultations, where PHM and finance performance data are

shared with hospital leaders and their partners. Embedded within each quality improvement collaboration is the goal of improving patient and family experience.

Specific to patient and caregiver experience, OneCare works with partners to administer the Consumer Assessment of Healthcare Providers & Systems (CAHPS) Survey. These surveys are facilitated by a contracted entity, vary by payer, and include several domains of patient, family, and caregiver experience. OneCare summarizes the results of these surveys, compares them against available benchmarks, and provides education on the results to its provider network as part of its annual quality scorecard dissemination plan beginning in the fall. Fall 2023 will be the first time OneCare has received a performance-based CAHPS score from Medicare since 2019, so these data may provide important insights into how the pandemic and other factors may impact overall quality, especially for the patient experience metrics. Of particular note will be any measures where OneCare's network performance declines in benchmarks, giving an indication that the network may be underperforming compared to practices with similar challenges related to the pandemic. OneCare's work is ongoing to identify opportunities for meaningful improvement across its quality scores through the PHM program.

12. Provide an update on the mechanisms (e.g. website, Patient Fact Sheet) OneCare uses to **inform the public about how the ACO works**, as compared to the information contained in OneCare's response to the 2023 Verification of Eligibility Form Response #12 (*See* § 5.208.) *Word limit: 200*

OneCare continues to expand public-facing information and transparency through the OneCareVT.org website which includes information describing OneCare, frequently asked questions, the organization's governance structure, salary information, and results. The results page includes narrative descriptions of quality measures, quality improvement, and shared savings. The news/blog section includes posts about OneCare's work, media coverage, and community partner efforts. OneCare has also created a series of short videos that describe value-based care, provide examples of data and analytics improving care for communities, and a patient story that explains care coordination. These videos, and others, can be found on the video center of the website. As the result of a recent accessibility review in July 2023, the OneCare website's overall accessibility score improved from 74 out of 100 to 94 out of 100, using Web Content Accessibility Guidelines (WCAG) 2 Level AA standards as a baseline. Remaining accessibility items will be remediated to achieve our goal of 95% WCAG AA compliance.

OneCare continues to submit op-eds and press releases to statewide print publications to share information about the benefits and impact on Vermont communities. The onecarevt.org website includes a media center to provide fast facts to assist with reporting. OneCare also posts to social media channels several times each week, providing an opportunity to communicate and share information with partners, affiliates, and the general public. The content covers topics that address all four aspects of our Quadruple

Aim: enhancing the patient experience; improving health; stabilizing costs; and supporting the care team.

13. Describe what actions the ACO has taken to receive and distribute payments to its participating health care providers in a fair and equitable manner and to minimize differentials in payment methodology and amount, including an update to items required by the GMCB for compliance with 18 V.S.A. § 9382(a)(3). The response should include the current interim status of the 2023 Comprehensive Payment Reform (CPR) Program, any plans for the 2024 CPR program, and any other initiatives that apply to these criteria. Please indicate if there are no other initiatives that apply to these criteria. (*See* §§ 5.209, 5.305(a)(1); 18 V.S.A. § 9382(a)(3).) *Word limit: 500*

In 2024, OneCare will continue to pay providers in three ways: 1) fixed payments to hospitals; 2) fixed payments to Comprehensive Payment Reform (CPR) Program independent primary care practices; and 3) Population Health Model (PHM) program payments. Within each category, for any given provider type, the payment methodologies are the same in 2024 as they were in 2023.

Hospital fixed payments are paid to OneCare in aggregate by the payers and divided amongst the hospitals based on OneCare policy. The methodology used to calculate the payment amounts is the same for each hospital.

Since 2018, OneCare's CPR program has offered independent primary care practices a fixed monthly payment as an alternative to fee-for-service payments. These payments are derived from a program-wide base per member per month (PMPM) rate, which is then risk-adjusted by practice to ensure the payment aligns with the risk of the practice's patient panel. Each practice is also uniformly supplemented with an additional $5.00 PMPM. OneCare forecasts total CPR program costs for the full year and makes payments based on estimated mid-year attribution. This allows OneCare to make equal payments to practices throughout the year to support stability and predictability of revenue for the CPR practices.

Under the Finance Committee, OneCare constructed the CPR Clinical Advisory Group (CAG), consisting of a half-dozen CPR participant providers, to collaborate with OneCare management on CPR program design, operation, and performance. During 2023, the CAG was critical in developing the mental health integration model and beginning in 2024, participation in the CAG will be open to all CPR practices.

OneCare makes performance-based PHM payments to network providers for engagement in care coordination and quality initiatives designed to further OneCare's population health goals. PHM requires that all Participants, Preferred Providers and Collaborators participate in care coordination as a prerequisite for receiving any PHM payments. This single program and payment stream, with defined quality targets and bonuses, aligns providers with the ACO's population health endeavors while simplifying program structure, payments, and incentives to reduce provider administrative burden.

14. Provide an update on any actions the ACO has taken to ensure **equal access to appropriate mental health care** that meets the requirements of 18 V.S.A. § 9382(a)(2), including an update to items required by the GMCB for compliance with 18 V.S.A. § 9382(a)(2), as compared to the information contained in OneCare's response to the 2023 Verification of Eligibility Form Response #13. The response should include a narrative **description of OneCare's performance on mental health related quality measures**. Please notate where each of these measures are derived (i.e. payer contracts, clinical priorities, etc). (*See* §§ 5.206, 5.305(a)(1); 18 V.S.A. § 9382(a)(2).) *Word limit: 500*

OneCare's approach to ensuring equal access to appropriate mental health care is achieved through ongoing monitoring of mental health care quality and targeted incentives for the provision and expansion of mental health care services.

OneCare monitors network performance on nine mental health and substance use annual quality measures. In 2021, OneCare network performance for both the commercial and Medicaid populations was at the 90th percentile for the two measures that focus on follow up after emergency department use for mental health and substance use disorder treatment and in the 75th and 90th percentiles for follow up after hospitalization for mental illness. OneCare leveraged these findings to inform its Designated Agency (DA) incentive program for 2023, designed to bring all health service areas (HSAs) above target to ensure equitable care across the state. This work is supported by OneCare's collaboration with the Department of Vermont Health Access, which provided resources, directed by OneCare, for DAs to improve mental health quality measures.

Reviewing recent data, OneCare and its provider network identified Initiation and Engagement in Substance Use Disorder Treatment (IET) as area of opportunity (e.g. performance for the Medicaid population was below the <25th percentile for initiation and at the 50th percentile for engagement). In 2024, the Population Health Model (PHM) will include Initiation and Engagement in Substance Use Disorder Treatment as an incentive measure to ensure focused attention on this measure.

See the table below for full results for all mental health and substance use measures for 2021. Quality measures are specific to each of OneCare's contracted payers.

Annual Quality Performance PY2021				
Quality Measure Name	Medicaid Traditional	BCBSVT QHP	BCBSVT LRG Group	MVP QHP
30 Day Follow-Up after Discharge from the ED for Alcohol and Other Drug Dependence (FUA)	90th	N/A	90th	N/A
30 Day Follow-Up after Discharge from the ED for Mental Health (FUM)	90th	N/A	90th	90th
Initiation of Alcohol and Other Drug Abuse or Dependence Treatment (IET)	<25th	N/A	N/A	N/A
Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)	50th	N/A	N/A	N/A
Initiation & Engagement of Alcohol and Other Drug Dependence Treatment (Composite) (IET)	N/A	<25th	50th	75th
Follow-Up after Hospitalization for Mental Illness (7Day)	75th	90th	90th	90th
Note: No benchmarks BCBSVT QHP for PY2021. MVP QHP did not supply rates for FUA in PY2021 due to low denominator counts N/A: not applicable to payer.				

Improvements in access to mental health services are supported by three distinct OneCare incentive programs:

1) The Mental Health Integration Model, part of the CPR program, allows participating primary care practices to increase monthly payments from OneCare by committing to additional requirements related to mental health integration in primary care. Practices may access additional funding by meeting requirements around mental health screening, participating in planning for improvements in access to services, and improving access by hiring mental health providers and/or offering services via community health collaborations.

More specifically, CPR offers a tiered payment structure, such that greater investment in mental health access makes participants eligible for larger CPR payments from OneCare. Participants are eligible for three payment tiers, with tier 1 payments representing "base" payment rates. Participants have the option to earn enhanced tier 2 or tier 3 CPR payments as follows:

- Tier 2: Participants must perform Mental Health Screening and comply with the standards for the uniform electronic capture screening results. Participants must also continue to work with OneCare and other stakeholders on a multi-year plan to improve mental health access in Vermont.

- Tier 3: Participants must qualify for tier 2 payments and establish eligibility based on one of the following access improvement models, subject to OneCare approval:

- Staffing of (or direct contracting with) one or more mental health providers in the primary care setting.
- For participants who are unable to staff a mental health provider due to practicality restraints, such as cost, a community-based collaborative model meets the requirement for tier 3 payments. This approach requires documented collaboration (e.g. memorandum of understanding, contract) with other health care practitioners in the community that specifically seek to improve follow-up rates for positive Mental Health Screening results and/or to materially increase or streamline mental health access.

2) OneCare's Mental Health Screening Initiative was launched in 2023 to improve rates of screening for mental health issues, improve follow-up on positive mental health screening results, and expand electronic documentation of mental health screening and follow-up. As of August 2023, 92 of 117 eligible primary care practice locations are engaged in this program, comprising 80% of eligible OneCare attributed lives. This program is intended to move funding into primary care with the long-term goal of increasing access to behavioral health services.

3) In the current 2023 PHM program, both pediatric and adult wellness visits are included as performance measures. These preventive health visits provide a critical forum for screening and follow-up for mental health issues. Additionally, OneCare's Designated Agency (DA) Incentive Program provides performance-based incentives to DAs for appropriate follow up after an emergency department visit for mental health or substance use disorder treatment. The 2023 PHM program also includes a quality measure related to potentially avoidable emergency department (ED) revisits. Early PHM data showed mental health comorbidities are contributing to poor performance on this ED measure, which underscores the need for better care coordination and discharge planning. Recognizing the importance of follow up after emergency department use as a tool to improve quality and manage utilization, OneCare is moving to a follow up after emergency department use measure in the 2024 PHM. OneCare is looking to continue the DA incentive program in 2024 and include a substance use measure for primary care with the goal of focused attention on mental health and substance use disorder as programmatic priorities.

15. Please describe how the ACO's data system supports appropriate access to and sharing of the data or information required to address the care management needs of enrollees (e.g., patient portals to enhance enrollee engagement, awareness and self-management; ability of providers to review medication lists for Enrollees; and alerts and notifications regarding critical incidents and hospital admissions, transfers, and discharges). (*See* § 5.210(a); 18 V.S.A. §9382(a)(5)). *Word limit: 500*

    OneCare's data systems provide aggregate care coordination data to attributing providers, Designated Agencies, home health and hospice agencies, and Area Agencies on Aging. In addition, provisioned users receive access to information to support specific care coordination activities (e.g. identification of individuals that may benefit from care coordination, clinical information such as wellness visits for patients engaged in care coordination). These tools and supports ensure data-informed care coordination activity remains a priority. OneCare's data system support includes a newly developed application (described below), engagements with the provider network in large and small settings, and user data access. All data sharing is appropriate for purposes of ACO activities, compliant with HIPAA standards (including but not limited to the "minimum necessary" requirement), managed in accordance with contractual obligations, guided by existing policies and procedures, and, where necessary, overseen by OneCare legal and compliance representatives.

    In 2023, OneCare deployed a new care coordination application that allows provisioned providers access to the minimum necessary information to identify individuals targeted for care coordination, individuals due for services related to PHM priority measures, and further focus on specific risk levels and/or health conditions. OneCare's care coordination team then works closely with the provider network to leverage data tools in support of enhanced care coordination. For example, through OneCare's Care Coordination Core Team meetings in early 2023, OneCare demonstrated functionality of the Patient Prioritization Application, showed how the tool can support care coordination activity and prioritization of specific populations, and shared best practices for how to leverage trimester care coordination reporting to improve care coordination activity. Admission, Discharge and Transfer data is used within the Patient Prioritization Application to notify providers and continuum of care partners when an individual has experienced multiple ED visits and requires outreach to prevent an unnecessary emergency department visit. This timely information has been reported by the network as an essential component of care coordination and achievement of PHM measures.

    a. Does the ACO's data system have records structured (searchable) demographic, claims, clinical, and other data or information required to meet the population health management and performance evaluation and improvement needs of the ACO? (*See* § 5.210(a)) [Yes / No].

        Yes. OneCare's data system provides filters to identify specific members in support of population health management.

b. Is the ACO's data system is accessible to Participants of all sizes? (*See* § 5.210(a)) [Yes / No].

   Yes. All attributing providers may submit a user access request to be approved for specific levels of access to the data system; there are no size-related restrictions affecting data access for OneCare ACO participants.

c. Does the ACO's data system provide patients access to their own health care information and otherwise comply with HIPAA and other applicable laws? (*See* § 5.210(a)) [Yes / No].

   No, OneCare's data system is designed to support the provider network and is not designed to provide direct patient access. Yes, OneCare's data system is compliant with HIPAA and other applicable laws.

16. Please describe how the ACO's data system standardizes, analyzes, and makes actionable data for detecting practice or physician patterns, predictive modeling and patient risk stratification, identifying variations in care provided to enrollees, and understanding enrollee population characteristics. Please include an explanation of how that data is used to measure care process improvements, quality improvements, and cost of care. (*See* § 5.210(b); 18 V.S.A. §9382()(5)). *Word limit: 500*

    OneCare leverages its current data system in numerous ways to support ACO activities and is in a transitional period as it prepares to launch its new data platform later in 2023. Data analytics operations in support of the ACO network include recurring standardized reporting, self-service analytics tools, and ad hoc data requests; all of which will continue in the new system. OneCare leverages its clinical committee structure to perform internal review of data and to guide data-driven performance improvement activity. These activities support OneCare in measuring care process improvements, quality improvements, and cost of care.

    OneCare's standardized data reporting and self-service tools are examples of how the current data system standardizes, analyzes, and makes actionable data for detecting practice or physician patterns, conducting predictive modeling and patient risk stratification, identifying variations in care, and understanding enrollee population characteristics. For example, OneCare's quarterly PHM performance reports provide quality and finance performance insights and include measure by measure performance against targets as well as an explanation for how a practice or HSA's PHM bonus was impacted by performance. In addition to the practice-level reports, OneCare produces HSA-wide reports which capture performance on PHM measures for all primary care practices within an HSA. This report demonstrates how each practice contributes to the overall performance of that health service area. Setting an individual practice's performance in the context of their peers provides greater insight into performance than a single practice-level report alone. After the release of each quarterly PHM report, OneCare's value-based care team connects with primary care practices to walk through the refreshed data, provide support in quality

improvement for areas where practices are not meeting targets, and share successes from other areas of the network. Self-service tools in the current data system provide filtering capability that enables users to identify opportunities for improvement.

Predictive modeling, patient risk stratification, identifying variations in the provision of care coordination, and understanding enrollee population characteristics are key components of effective care coordination. Accordingly, OneCare's Patient Prioritization Application functionality includes the ability to identify individuals in need of care coordination services. Care managers and those with a treating relationship can filter their patient population by risk level and health conditions to identify a subset that may require outreach and/or intervention. The application also layers in PHM measure results for attributed lives so that ACO provider organizations can align care coordination efforts with PHM opportunities (e.g. members overdue for a wellness visit).

OneCare's approach to using data to measure improvements and cost of care include targeted outreach for review of performance and alignment of priorities; network-wide webinars where top performers share best practices; HSA consultations, a twice-annual executive forum for reviewing ACO progress; and outreach to care coordination teams to facilitate data-driven process improvements.

OneCare uses its data system to measure care process improvements, quality improvements, and cost of care with those internal to OneCare, within its clinical committees, and in partnership with ACO member organizations in other venues. OneCare's Performance and Utilization Review Workgroup analyzes data to identify and report aggregated opportunities to OneCare committees: specifically, to the Data Use Subcommittee and the Population Health Strategy Committee.

17. Please provide an update on how the ACO provides **connections and incentives to existing community services for preventing and addressing the impact of childhood adversity and other traumas**, as well as how ACO collaborates on **the development of quality-outcome measurements for use by primary care providers who work with children and families and fosters collaboration among care coordinators, community service providers, and families**. The response should describe any changes made in comparison with the information contained in OneCare's response to the 2022 Verification of Eligibility Form Response #16. (*See* §§ 5.305(a)(1), 5.403(a)(20); 18 V.S.A. §9382(a)(17).) *Word limit: 500*

OneCare continues to provide connections and incentives to existing community services for preventing and addressing the impact of childhood adversity and other trauma. OneCare collaborates with care coordinators, community service providers, and families on the development of quality-outcome measurements for use by primary care providers by prioritizing appropriate quality measure foci and ensuring adequate representation in decision making.

OneCare has established quality measure priorities through its governance structure, up to its Board of Managers. To ensure adequate representation in the decision-making process, OneCare includes individuals working in pediatric care in its clinical committee structure.

Additionally, the PHM includes a focus on child and adolescent well care and developmental screening for both 2023 and 2024. These measures will provide incentives for providers to perform critical screenings and to identify potential adverse or traumatic events that may benefit from intervention. In the past year, OneCare also strengthened its alignment with Blueprint for Health efforts by collaborating on appropriate referral opportunities to Community Health Team members and aligning quality measure work when feasible. OneCare is incorporating a requirement to perform social determinants of health screening for all ACO member organizations beginning in mid-2024.

18. Have there been any **material changes that relate to the requirements of 18 V.S.A. § 9382(a) or Rule 5.000 that are not noted abov**e? If so, please provide a brief description of the change(s). (*See* § 5.305(a)(2).) *Word limit: 500*

    All material changes in OneCare operations or functions have been discussed within.

V. NOTIFICATION OF POTENTIALLY ANTICOMPETITIVE CONDUCT

1. Does OneCare share provider pricing information (e.g., reimbursement rates paid by commercial insurers or other negotiated fee information) or other competitively sensitive provider information among 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 provider pricing information or other competitively sensitive provider information among participants in its network. Certain competitively sensitive information will be shared with the UVMHN Data Management Office, who will act as OneCare's subcontractor for certain data analytics purposes. OneCare and UVMHN have put in place extensive safeguards to ensure that this information is compliant with all laws and is properly handled and protected from inappropriate sharing. OneCare submitted extensive information to GMCB around these additional measures on March 31, 2023; this information remains up-to-date. In particular, please reference Section III of the GMCB Narrative Response document. OneCare would be happy to resubmit this information, or excerpts therefrom, to the GMCB, if needed.

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?[1] 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.

VI. VERIFICATION UNDER OATH

Please complete and attach the requisite verifications under oath (**Attachment B: Verification on Oath or Affirmation**).

See Attachment B FY24 Verification on Oath or Affirmation.

[1] Available at: https://gmcboard.vermont.gov/sites/gmcb/files/GMCB%20Guidance%20re%20AGO%20Referrals_05.01.18.pdf.