2025 Certification Eligibility Verification Form for OneCare Vermont Accountable Care Organization, LLC

Date Issued: June 11, 2024
Submission Due By: September 1, 2024
Submission Date: August 28, 2024

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 2025 (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, Michelle Sawyer, Health Policy Project Director, at Michelle.Sawyer@vermont.gov and copy the GMCB ACO Oversight Team, at GMCB.ACO@vermont.gov. The form must be received on or before September 1, 2024. ***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 Michelle Sawyer by sending an email to the ACO Team address above.

IV. DESCRIPTION OF CHANGES AND QUESTIONS FOR ONECARE

1. Please complete **FY25 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 **FY25 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*

   No, OneCare has not had any material changes in structure, composition, ownership, governance, and/or management. Updates to OneCare's board roster, leadership table, polices, and procedures are provided to the GMCB per Attachment A.

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 Family Advisory Committee** will receive in 2025. (*See* § 5.202(c).) *Word limit: 100*

   OneCare board members and Patient and Family Advisory Committee (PFAC) members were offered the CDC Foundations of Health Equity training plan designed to ensure that health equity is embedded in all public health work. The trainings are asynchronous to provide more flexibility and build on prior diversity, equity, and inclusion trainings. Consumer managers were also offered training and resources through the Patient Advocate Foundation and the National Association of Healthcare Advocacy for advocating for consumers on health care issues.

5. Provide the total count of enrollees, a count of enrollees that are representative of each participating payer, and a count of enrollees who are family members or caregivers on the ACO's **consumer advisory board**. Provide an update on how the ACO's recruitment process ensures that the consumer advisory board is comprised of enrollees who are representative of the communities served by the ACO as compared to OneCare's response to the 2024 Certification Eligibility Verification Submission Follow-Up #2. (*See* § 5.202(g).) *Word limit: 500*

   The Patient and Family Advisory Committee (PFAC) consists of ten (10) members from many counties across the state including Chittenden, Franklin, Grand Isle, and Windham counties. Member representatives enrolled with ACO participating payers bring their experiences and

voices to make up the committee; this representation is visualized in the chart below. Members encompass that of caregivers, family, and patients and range in age from 30s to 80s. The members' backgrounds include advocacy, mental health, education, marketing, and special needs.

Recruitment of new members consists of advertising via broad channels including website postings, newsletters, and personal invitations. OneCare utilizes an application process via an online recruitment form; an initial orientation introductory meeting is held with OneCare and an existing PFAC member. All new members must be approved by the OneCare Executive Committee, which serves as the Nominating Committee, and Board of Managers.

Payer	Member Count*
Medicaid	6
Medicare	8
MVP	1

*Numbers are not unique, multiple members carry more than one insurer

6. 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 and 2025? If so, when will that meeting take place? (*See* § 5.202(h).) *Word limit: 100*

   OneCare's most recent PFAC meeting with the Office of the Health Care Advocate occurred on November 28, 2023. The Office of the Health Care Advocate prepared a report for OneCare in December 2023. In 2024, OneCare has arranged for the Office of the Health Care Advocate to meet with PFAC on October 29, 2024.

7. Provide an update to OneCare's process for monitoring and evaluating 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, as reported in OneCare's response to the 2024 Verification of Eligibility Form Response #6. (See §5.206(c).) *Word limit: 200*

   Through annual policy and procedure review, data analysis, and network feedback, OneCare monitors the effectiveness of its care coordination policies and procedures. Effectiveness of care coordination policies and procedures is gauged by monitoring performance rates of several quality care metrics, and through an annual care coordination patient experience survey.

   Physical and mental health care coordination are evaluated by tracking care managed rates of individuals within a newly established Impact score program. The Impact score program identifies individuals in need of care coordination services based on medical, clinical, and socioeconomic factors. Care managers can filter by risk level and condition to identify

individuals that require outreach and intervention. OneCare enables care coordination teams across primary care, home health and hospice, Designated Mental Health Agencies, and Area Agencies on Aging to identify opportunities and develop data driven performance improvement plans using data and care team composition insights provided by OneCare, at the patient level tri-annually. These reports enable increased physical and mental health care coordination and collaboration across primary care and mental health organizations that support at-risk populations including those with substance use disorder. Information contained in the reports enhances shared care planning and helps reduce communication challenges presented by the current lack of system interoperability at these organizations. This allows for cross-organizational care coordination workflow improvements to address challenges that would not otherwise be apparent. OneCare shares care coordination rates at the population level with the network at site-specific, regional, and statewide care coordination meetings.

8. Provide an update on the mechanisms OneCare employs to **obtain consumer input**, as compared to the information contained in OneCare's response to the 2024 Verification of Eligibility Form Response #7? (*See* § 5.202(g); 5.206(d).) *Word limit: 100*

   OneCare continues to obtain consumer input through PFAC and its Board of Managers. In 2024, OneCare received input from the patient and caregiver perspective and addressed barriers experienced. OneCare has discussed and gained insights and obtained consumer input on important topics such as care coordination, avoidable hospital utilization, mental health screenings, benefit enhancement waivers, and progress towards OneCare's strategic plan and corporate goals. OneCare continues to work to expand PFAC membership to further diversify its membership including representation from additional regions of the state, youth, and individuals within Black, Indigenous, (and) People of Color (BIPOC) communities. OneCare's Board of Managers also includes representative seats for individuals representing the consumer perspective.

9. Provide an update to 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 2024 Verification of Eligibility Form Response #8. (*See* § 5.206(g).) *Word limit: 200*

   The transition to a new data analytics system has provided targeted performance reporting and appropriately provisioned user access to detailed patient lists to identify care coordination needs. The Impact score program can be filtered by risk level and assists care managers in identifying individuals in need of care coordination services based on medical, clinical, and socioeconomic factors. Within this new system, users can screen for specific conditions or quality metrics to identify a subset population that may require outreach and/or intervention.

With the recent release of updated Care Managed Metrics reports, OneCare continues to actively engage network providers in the assessment of these reports to ensure they are specific and actionable for their care coordination efforts.

10. 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** as compared to the information contained in OneCare's response to the 2024 Verification of Eligibility Form Response #9. Also describe the ACO's method(s) for supporting participants in providing processes that **foster health literacy**, as compared to the information contained in OneCare's response to the 2024 Verification of Eligibility Form Response #9. (*See* § 5.206(i).) *Word limit: 200*

    OneCare offers 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. To inform 2024 program planning, OneCare surveyed approximately 75 network entities at the end of 2023 regarding their health literacy needs and current strategies. Network responses demonstrated that solid strategies are in place at the organizational level, including health literacy screening for all patients over 13, provision of interpreter services, and revision of public facing websites with a focus on health literacy. OneCare hosted a voluntary health literacy training in the fall of 2023 attended by individuals from various roles and organizations across the network. Training content reflected topics identified by the network in a 2023 year-end survey, including defining health literacy, types of health literacy, risk factors, impacts of low health literacy, action steps, and an open question and answer session. This training will be provided annually to support processes that foster health literacy across the network and is available as an enduring self-paced training resource.

11. Provide an update on the ACO's method(s) for supporting participants in providing processes that implement strategies for **engaging enrollees with limited English proficiency**, as compared to the information contained in OneCare's response to the 2024 Verification of Eligibility Form Response #10 (*See* § 5.206(k).) *Word limit: 200*

    The OneCareVT.org website has continued to provide eight languages to support the network in engaging enrollees. OneCare partners with UVMMC to provide access to translation services in the event of inquiries from enrollees who have a preferred language other than English.

    Following the completion of the care coordination triannual narrative, OneCare queried the responses from the network to the question regarding the current strategies for engaging enrollees with health literacy and/or English proficiency. Several organizations have already developed documentation and processes to support enrollees with limited English

proficiency. OneCare continues to assess the network's needs around health literacy and provide additional training as requested by the network.

12. Provide an update on how the ACO's quality evaluation and improvement program **regularly evaluates the care delivered to enrollees against defined measures and standards** regarding enrollee and caregiver/family experience, as compared to the information contained in OneCare's response to the 2024 Verification of Eligibility Form Response #11. (*See* § 5.207(b).) *Word limit: 200*

    Caregiver/family experience remains a focus area for OneCare through administration of the Consumer Assessment of Healthcare Providers & Systems (CAHPS) Survey. Surveys are conducted and facilitated through contracted entities, which contain several domains relative to patient, family, and caregiver experience. Survey results are reviewed, summarized, and shared with network participants as part of the annual quality scorecard performance overview. Payer results are compared against most recently available benchmarks where available. OneCare team members performed outreach ahead of the performance year 2024 survey release to enhance network participation. Results from patient experience engagement will be shared from the payer programs in the fall when OneCare identifies if outreach was impactful on overall scores.

    In addition to caregiver/family experience, OneCare continues to evaluate care delivered to enrollees against defined measures and standards through additional domains including Care Coordination/Patient Safety, Preventive Health, and At-Risk Populations for a total of 23 quality measures across all payers. These include metrics that measure hospital utilization, treatment for mental health/substance use disorder, preventive health care, and screening of chronic disease. In 2024, OneCare added Breast Cancer and Cervical Cancer Screenings in the preventive domain and Follow-Up after ED Visits for Patients with Multiple Chronic Conditions within the At-Risk Population domain.

    OneCare team members collaborate through statewide initiatives on shared priority areas identifying quality improvement opportunities. Quarterly 1:1 meetings allow for data reviews at the practice level and identification of performance improvement projects based on individual results. OneCare team members recently completed bi-annual Health Service Area consultations sharing Population Health Model results, finance performance, and waiver information with hospitals, independent practices, and collaborator partners with the intent to improve the overall patient and family experience.

13. 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 2024 Verification of Eligibility Form Response #12. (*See* § 5.208.) *Word limit: 200*

    OneCare continues to expand public information through the OneCareVT.org website which includes descriptions of OneCare, frequently asked questions, governance structure, salary information, and results. The results page describes quality measures, quality improvement, and shared savings. OneCare created a series of videos that describe value-based care, provide examples of data and analytics improving care for communities, and a patient story that explains care coordination. OneCare's website underwent an accessibility review and remediation, and improved the Web Content Accessibility (WCAG) score by 24 points to 98 out of 100.

    OneCare posts to social media several times each week, providing an opportunity to communicate and share information with partners, affiliates, and the public. The content typically covers OneCare's role in providing waivers, convening our network to address patient concerns such as social determinants of health, and detailing our metrics of success.

    OneCare's board meetings have a public session that regularly highlights the work of the ACO. Additional information sharing occurs through OneCare's quarterly newsletter, presentations to hospital and provider association boards, and outreach to the business community.

14. Provide an update on 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 a brief description of any ACO initiatives that apply to these criteria. Please indicate if there are no other initiatives that apply to these criteria. This response should be compared to OneCare's submission for the 2024 Verification of Eligibility Form Response #13. (*See* §§ 5.209, 5.305(a)(1); 18 V.S.A. § 9382(a)(3).) *Word limit: 500*

    Considering OneCare's diverse network of participants, emphasis is placed on standardized program designs. For example, OneCare program payments are often based on a per member per month (PMPM) amount established in policy so that each participant is paid the same on a per-attributed-life basis. In circumstances where a participant does not attribute, an allocation model is used that apportions payments based on the amount of care delivered to the attributed population relative to others of the same provider type.

    For programs with a performance-based component (ex. PHM and Mental Health Screening and Follow-Up), variation in payment amount will occur. While programs are designed to give each participant the same opportunity, the amount paid reflects their results and will vary based on that participant's performance.

Regarding the hospital fixed payment initiative and the Comprehensive Payment Reform program, a standardized model is employed. The models do not necessarily result in an equal payment per attributed life/payment, rather, the aim is to pay participants fairly based on the services those participants offer and the demographics of the patients they serve.

In all cases, OneCare's payment initiatives are designed to minimize differentials in payment methodology and amounts among comparable participating providers across all practice settings, as long as doing so is not inconsistent with the ACO's overall payment reform objectives.

15. 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 2024 Verification of Eligibility Form Response #14. The response should include a narrative **description** of **OneCare's performance on mental health related quality measures**. Please denote 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 is in its second year of providing an incentive for mental health and depression screening to push toward standardization of screenings to capture higher rates of the population in need of follow-up. Additionally, funds have been allocated for statewide telepsychiatry services for network practices enrolled in the incentive program. To increase access to care, OneCare has aligned with Brightside Health to offer services to Vermont Medicaid members for therapy, crisis care, virtual sessions, and anytime messaging to close the gaps in access to care for populations in need of additional mental health support throughout the state.

The measures within PHM 2024 include:

- 30 Day Follow-Up After Emergency Department Visits for Mental Illness (HEDIS FUM)
- 7 Day Follow-Up After Hospitalization for Mental Illness (HEDIS FUH)

OneCare has performed above established targets at the Medicaid 90th and 75th percentile respectively since implementation of the incentive program. There has been increased collaboration across longitudinal entities and shared best practices and care coordination. Vermont Medicaid has provided the data for the PHM program; however, each payer program requires measurement of follow-up after episodes of mental illness (HEDIS for Medicaid and Commercial payers, NCQA for Medicare) as well as Depression Screening (CMS PREV-12). OneCare's 2023 performance for each payer is not currently available and is expected in fall 2024. At that time, performance will be further evaluated and opportunities for additional action may be identified.

16. Provide an update on 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) as compared to the information contained in OneCare's response to the 2024 Verification of Eligibility Form Response #15. (*See* § 5.210(a); 18 V.S.A. §9382(a)(5)). *Word limit: 500*

OneCare's data systems continue to provide aggregate and patient level care coordination data to attributing providers, Designated Agencies, home health and hospice, and Area Agencies on Aging. Advanced tools that incorporate medical and socioeconomic risk factors and provide visibility to clinical and utilization activity are available in 2024 for provisioned users to identify individuals that may benefit from care coordination. These advanced supports ensure data-informed care coordination remains a priority.

OneCare's 2024 data system generates practice level reports that provide additional detail as compared to 2023, including PHM measure performance over time and number of providers within a practice meeting PHM measures. Links within these enhanced reports allow provisioned users to access additional detail including patients due for services related to PHM priority measures and individual providers' performance over time. Hospital admission, discharge, and transfer data availability is planned by the end of the year. All data 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, and where necessary, overseen by OneCare legal and compliance representatives.

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)(1)) [Yes / No].

   Yes.

b. Is the ACO's data system is accessible to Participants of all sizes? (*See* § 5.210(a)(3)) [Yes / No].

   Yes.

c. Provide an update on how the ACO's data system provides patients access to their own health care information and otherwise complies with HIPAA and other applicable laws as compared to the information contained in OneCare's response to the 2024 Certification Eligibility Verification Submission Follow-up #8. (*See* § 5.210(a)(4))

OneCare's 2024 system maintains the same design described in last year's response including its intended support for providers versus patients and its compliance with HIPAA and other applicable laws.

17. Provide an update on 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) as compared to the information contained in OneCare's response to the 2024 Verification of Eligibility Form Response #16. (*See* § 5.210(b); 18 V.S.A. §9382(a)(5)). *Word limit: 500*

OneCare transitioned to a new data platform in 2024. This platform supports ACO activities through regular standardized reporting, self-service analytics tools, and ad hoc data requests. OneCare continues to leverage its clinical committee structure to perform internal review of data and to guide data-driven performance improvement activities.

The standardized data reporting and self-services tools are examples of how the new platform 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, practice-level reports provide performance and comparison detail specific to PHM measures, ACO membership and financials, and focus areas including cost of care, avoidable ED, and inpatient readmission rates. HSA-level reports allow practices and continuum of care partners to assess their regional performance compared to targets and peers. Setting an individual practice or HSA's performance in the context of their peers provides greater insight and motivation to attain improvement than would a single performance metric on a single practice report. OneCare connects with primary care practices following release of reports to walk through the refreshed data, provide support in quality improvement areas where practices are not meeting target, and share successes from other areas of the network. Data and reports are also reviewed in OneCare committees and community-wide with participating organizations through semiannual Health Service Area (HSA) Consultations. In these settings, performance against targets is shared, variations explored, challenges and barriers identified, and success stories disseminated.

Self-service tools provide filtering capabilities that enable users to identify opportunities for improvement. An example of this in the new system is the ability for a practice to compare PHM measure-by-measure results over time by individual provider within their organization. Supports or conditions that existed for individual providers during periods of

high and low performance may be replicated or mitigated through care process improvement initiatives.

Predictive modeling, patient risk stratification, identifying variations in provision of care, and understanding enrollee population characteristics are key components of effective care coordination. Accordingly, OneCare's new platform's functionality includes the ability to identify individuals in need of care coordination services based on medical, clinical, and socioeconomic factors. Care managers can filter by risk level and condition to identify a subset that may require outreach and/or intervention. The system also layers in PHM measure results for attributed lives so that ACO provider organizations can align care coordination efforts with PHM opportunities.

OneCare's approach to using data to measure care process improvements, quality improvements, and cost of care remains the same as reported last year, leveraging its internal resources, clinical committees, and Performance and Utilization Review Committee to analyze, identify, and report opportunities. In addition, OneCare has reinstituted a provider peer-to-peer consultation model, called Regional Clinical Representatives, to help drive performance improvement activities in their assigned organizations.

18. 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 2024 Verification of Eligibility Form Response #17. (*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 for 2024 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. OneCare's 2024 Population Health Model includes a focus on child and adolescent well care and developmental screening. These measures provide incentives for providers to perform critical screenings and to identify potential adverse or traumatic events that may benefit from intervention. OneCare has strengthened its alignment with Blueprint for Health by aligning quality measure work when feasible and collaborating with the Blueprint for Health to identify a set of standardized social determinants of health (SDOH) screening questions for implementation across all

participating organizations. OneCare established a requirement for all ACO member organizations to perform social determinants of health screening utilizing a standard tool and electronic data entry. In 2024, OneCare required organizations to develop a plan to systematically address gaps in care related to needs identified in SDOH screenings, and effective July 1, 2024 to electronically provide SDOH screening rates to OneCare.

19. 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*

    There are no further material changes to report.

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? [Yes/No]

   No, OneCare does not share provider pricing information or other competitively sensitive information among participants in its network. Certain competitively sensitive information is shared with the University of Vermont Health Network (UVMHN) Data Management Office, who act as OneCare's subcontractor for specified data analytics purposes. OneCare and UVMHN have put in place extensive safeguards to ensure this information is compliant with all laws and is properly handled and protected from inappropriate sharing. These documents were previously provided to the GMCB and are available, if requested.

2. Does OneCare employ any measures not already described in its Data Use Policy (03-03) to protect such information? If so, please describe.

   Additional measures relate to gsharing of certain competitively sensitive information with UVMHN Data Management Office, OneCare's subcontractor. Extensive information around these additional measures was shared with the GMCB on March 31, 2023; this information remains up to date. Please reference Section III of the GMCB Narrative Response document.

3. 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 described in paragraphs 2-5 of the referenced guidance.

VI. PATIENT PROTECTIONS AND SUPPORT

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

1. Does the ACO increase an Enrollee's cost sharing under the Enrollee's health plan? (*See* § 5.208(c).) [Yes / No]

   No, OneCare does not increase an enrollee's cost sharing.

2. Does the ACO ensures that no Enrollee or person acting on behalf of an Enrollee is billed, charged, or held liable for Contracted Services provided to the Enrollee which the ACO does not pay the Provider for, or for the ACO's debts or the debts of any subcontractor of the ACO in the event of the entity's insolvency? (*See* § 5.208(d).) [Yes / No]

   Yes, contractual obligations ensure these patient protections.

3. Does the ACO prohibit a Participant from, or penalize a Participant for advocating on behalf of an Enrollee, including within any utilization review, grievance, or appeal processes? (*See* § 5.208(f)(2).) [Yes / No]

   No, contractual obligations prohibit limiting provider advocacy for Enrollees.

VII. VERIFICATION UNDER OATH

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

See Attachment B FY25 Verification on Oath or Affirmation.