To: Kevin Mullin, Chair, Green Mountain Care Board
From: Todd Moore, CEO OneCare Vermont, Accountable Care Organization, LLC.
Date: October 1, 2018
Subject: OneCare Vermont ACO 2019 Fiscal Year Budget Resubmission

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Dear Chairman Mullin,

OneCare is pleased to present our 2019 annual budget to the Green Mountain Care Board based on our finalized network as of September. Please note that we are still working to receive or negotiate our full attribution numbers, trends and targets from payers, and therefore this budget relies on our best available projections. As you will see, this budget continues to focus on helping providers and communities move ahead on promoting wellness, coordinating a fragmented system, further improving quality and access, and delivering better care at a more predictable and affordable cost.

Per the GMCB's instructions and guidance, please accept OneCare Vermont's 2019 Fiscal Year Budget Package including our narrative responses, worksheets and attachments as needed.

Section:

1. OneCare Vermont Information and Background (Executive Summary)
2. OneCare Vermont Network
3. OneCare Vermont Payer Programs
4. OneCare Vermont Budget and Financial Plan
5. OneCare Vermont Quality, Population Health, Model of Care and Community Integration Initiatives

My team and I want to extend a special thanks to the staff members at the GMCB. They have all been exceedingly helpful in answering questions and aligning expectations for this submission.

If you have any questions please feel free to contact me directly at the number below or Vicki Loner, OneCare's Chief Operating Officer, at (802) 847-6255.

Thank you,

Todd B. Moore, MBA
CEO, OneCare Vermont
(802) 847-1844

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1. Provide an executive summary of the changes in the Accountable Care Organization's (ACO) budget submission from 2018 to 2019. Include major network changes; program highlights; programmatic, staffing, and operational changes; and any assumptions made to create the budget submission.

OneCare Vermont (OneCare) was organized and founded in 2012 by the University of Vermont Medical Center (UVMMC) and Dartmouth Hitchcock Health (DH-H). In 2018, we were certified by the Green Mountain Care Board to operate as Vermont's only statewide multi-payer Accountable Care Organization (ACO), currently serving over 100,000 Vermonters.

OneCare supports a large statewide network, which includes the majority of hospitals in Vermont and Dartmouth-Hitchcock Hospital, the largest out-of-state provider of care to Vermonters. Additionally, a majority of the primary care and specialty providers (including hospital employed and private community practices) in the state participate in at least one of our ACO programs. From 2018 to 2019, our network will further expand, bringing on three (3) additional Vermont hospitals, four (4) FQHCs, seven (7) independent primary care practices, and four (4) specialty practices. In total, our network will include 13 hospitals and their employed providers (including primary and specialty care), six (6) FQHCs/RHCs, 29 independent primary care practices, 25 independent specialist practices, 23 SNFs, nine (9) mental health agencies, and nine (9) home health and hospice organizations. See Attachment A and B in Part 1 Attachments for an updated Network grid (A) and Network progression since 2017 (B). The incremental growth of the Network each year is evidence of provider support of this reform effort. The voluntary participants in the Network have formed a coalition of the willing to propel forward Vermont's health care reform efforts.

OneCare is estimating that we will increase the number of attributed lives that will count towards scale targets by >70,000 Vermonters in 2019. This estimate is based on the addition of new attributing providers, providers signing on to multiple ACO payer programs versus Medicaid only, and the potential addition of new self-insured programs in 2019. Final attribution numbers will not be available until 2019 when we receive our final counts from the payers. It is important to note that OneCare is still actively negotiating with all payers; thus, budget information as presented in this report is based on currently known or assumed program terms but could be subject to change based upon the final contract negotiations.

Preparing and implementing the programs and structures necessary to operate under the All Payer ACO Model in 2018 represented a significant achievement on behalf of the Provider Community. In addition to participating

in and expanding the Medicaid Next Generation program, OneCare stood up new value-based programs for Medicare, Blue-Cross Blue-Shield of Vermont, and the UVM Self-Funded employee benefit plan. This required major training and education for participating communities that increased from four (4) communities in 2017 to 10 communities in 2018. Training and educational efforts were most intensive in the first and second quarter of the year as communities were on-boarded to our care coordination trainings and systems, the quality measure sets, prior-authorization waivers, attribution logic, data literacy training, and the new financial funding model.

In addition to standing up new programs with Payers and expanding our population health and care coordination programs to six new communities, OneCare also worked collaboratively with our Network and other partners to implement new innovative models and pilots with a focus on primary prevention and the social determinants of health. OneCare has worked with the Vermont Department of Health, the Blueprint for Health, participating providers, and the Accountable Communities for Health to increase network utilization of Medicare's annual wellness visits, adolescent wellness visits, and developmental screening by 5%. Results thus far are promising.

OneCare also partnered with RiseVT on an integrated approach to primary prevention with the aim of putting in place a statewide system that is able to improve the overall health of the communities. RiseVT was first implemented in 2015 in Grand Isle and Franklin Counties as a community collaborative spearheaded by Northwestern Medical Center and the Vermont Health Department. RiseVT is leading an expansion of this innovative model focusing on community wellness and prevention in partnership with OneCare and its extensive network of providers has supported the spread of this unique wellness and prevention model to six (6) additional communities in 2018 outside of Franklin and Grand Isle counties.

OneCare also supports two pilot initiatives. The first pilot is a partnership with Support and Services at Home (SASH) and the Howard Center. For this pilot, OneCare is providing the funding for a full-time mental health clinician through the Howard Center. The embedded clinician supports residents on site at Burlington congregate housing locations where SASH has onsite programs. With the help of the embedded clinician, residents have initiated welcoming committees and new social groups to reduce loneliness and isolation among residents. The interventions have also led to the halting of evictions by working with residents and staff to address emotional and mental health issues. The second pilot is working with Algorex Health and our pediatric community to evaluate the reliability of augmenting risk stratification models to include social determinants of health data that could provide a more comprehensive view of the population and their needs. Initial feedback from pediatric providers indicated that in some cases it confirmed their knowledge and in other cases provided valuable new information to support their patients. A complete write up of all these initiatives as well as the many other population health initiatives can be found in Section 5 of this report.

In addition to operating our existing population health programs in 2019, OneCare will be launching additional programs and investments. The new major programmatic highlights that are being proposed under this budget include:

1. ***Comprehensive Payment Reform Program Expansion**: OneCare is expanding the Comprehensive Payment Reform Program (formerly a pilot) to qualifying independent primary care practices that participate in all three (3) core payer programs (Medicaid, Medicare and Commercial). At present nine (9) independent organizations have expressed intent to participate in the partial or full capitation models offered in 2019. The program provides independent primary care providers additional investments and resources that support the transition to a value based payment model. Participating practices are expected to leverage the new resources and payment model to implement service delivery and clinical quality improvements that meet the Quadruple Aim.*

2. ***Self-Insured Programs Expansion**: OneCare is actively working to expand our footprint into the self-funded market beyond our current program with UVMMC and its employees. The goal is to develop a model that qualifies for scale targets, aligns clinical initiatives, incorporates financial reform, and provides an attractive program for Vermont employers. At present, OneCare is in discussions with employers and Payers around such self-insured partnership opportunities.*

3. ***Payment Reform Pilot(s) for Specialists**: OneCare intends to design and implement one or more specialty pilot programs that will support efforts to improve access, quality, and outcomes while reducing costs. The pilot program(s) will be designed to align with our population health approach, with special attention to populations from quadrant 2 and 3, where timelier access to care and a strong connection between primary and specialty care would better support the patients' needs. OneCare will be hosting focus groups and the program will supported by OneCare's Population Health Strategy Committee with advice from select subject matter experts.*

4. ***Primary Prevention and Adverse Childhood Events Pilot**: OneCare is exploring a partnership with the Vermont Department of Health and the Developmental Understanding and Legal Collaboration for Everyone (DULCE) Program in selected communities beginning in 2019. DULCE is an innovative pediatric-care-based intervention through which pediatric clinical sites proactively address social determinants of health and promote the healthy development of infants from birth to six months of age while also providing educational and legal support to their parents. The DULCE Family Specialist supports families as part of the health center team, by meeting with them at the infant's routine healthcare visits and providing home visits and telephone, email, and text-messaging support. 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.

5. ***Community Based Innovation Funds****: OneCare has proposed including funds that would support innovative evidenced-based (or informed) programs that align with OneCare's priorities and could be readily spread and sustained by the ACO and participating communities. OneCare's Population Health Strategy Committee will design the application process and selection criteria, and will monitor and evaluate progress of the selected programs. Final approval of programs will be made by the OneCare Board of Managers in accordance with Board approved policies.*

6. ***St. Johnsbury Accountable Community for Health (ACH) Pilot Study****: OneCare will work collaboratively with the ACH and the Department of Vermont Health Access to explore future innovations to enhance the Accountable Communities for Health model and its potential to extend OneCare's population health approach in 2019 by exploring: a) an enhanced attribution model, with a geographic focus and b) interventions and investment opportunities that address the ACH's social determinant of health priorities.*

These projects and their budgetary impact are further detailed in this submission.

In regards to staffing and operational changes, the minor changes that have been made have been in support of our growing network of participating providers and health service areas, the addition of new payer programs, and the diversity of our population health initiatives that support our inclusive care model. Specific leadership additions include the addition of a Vice President of Strategy and Finance who oversees payment reform initiatives and commercial payer strategies and a Chief Compliance and Privacy Officer who is dedicated half time to the work of OneCare. Staffing at OneCare has been stable with a few newly proposed positions in 2019 that are needed to support the growing network of providers and the expanding portfolio of programs.

There have been no changes to our Governance structure since the last certification submission, but the structure will be examined in the near future to accommodate our growing network. It should be noted, however, that we have expanded our Patient and Family Advisory Committee (formally named the Consumer Advisory Group) to include representatives from the southern half of the state and a youth representative. Additionally, we are working with our hospital partners to host public forums in their community to foster discussion and feedback about the ACO and healthcare in that community. Brattleboro was the first to host a session and had approximately 40 people in attendance. OneCare is actively working with communities to bring this work to a statewide level.

In 2018, OneCare expanded our participation in a single value-based Medicaid program to include all payers in Vermont, reimbursing health care

providers in line with the All-Payer ACO Model. This represented an exciting milestone in our progress to transition away from fee-for-service reimbursements to a value-based system. Changing the payment model and providing additional upstream investments in primary care and to communities has provided the resources and flexibility necessary to drive innovation throughout Vermont. Additionally, it is important to recognize the willingness of providers to take risk for the total cost of care in the model. OneCare has been able to take incremental steps to reduce administrative burdens on primary care and other providers of care through changes such as prior approval exemptions, benefit waivers, and quality measurement alignment and reduction. OneCare, as a collaborative and voluntary network of health care providers and health-related community based service agencies, have become innovators driving toward excellence in health care quality, person-centeredness, and affordability. We believe that by working together, we can help to keep Vermonters healthier. OneCare is proud to be part of this health care transformation and appreciate the tangible examples of the innovative work being done around the state by the OneCare network.

Part 1
Attachments

Attachment A – OneCare 2018 Network Grid

Attachment B – Network Progression from 2017

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Part 2: ACO Provider Network

1. Provide, as an attachment, a completed **2019 ACO Provider Network Template (Appendix 2.1)**.

   Please see Attachment A. in Part 2 attachments titled "Summary of Provider Network by Provider Type" for a Summary list of the OneCare's Provider Network across all three payer programs by provider type.

2. Provide a written summary analysis of the **2019 ACO Provider Network Template (Appendix 2.1)**, highlighting any changes from 2018 to 2019, including changes in network by Health Service Area.

   As noted above from 2018 to 2019, our network will further expand to an additional 3 Health Service Areas, bringing on 3 additional Vermont hospitals, 4 FQHCs, 7 independent primary care practices, and 4 specialty practices. In total, our network will include 13 hospitals and their employed providers (including primary and specialty care), 6 FQHCs/RHCs, 29 independent primary care practices, 25 independent specialist practices, 23 SNFs, 9 mental health agencies, and 9 home health and hospice organizations.

3. Submit, as an Excel spreadsheet (printout not required), your provider list submitted to Medicare for your 2019 Next Generation program.

   Please see Electronic File on the Flash Drive provided titled "Complete Physician Network" for a complete list of the OneCare's Provider Network across all three payer programs.

4. The All-Payer ACO Model Agreement contains Medicare and all-payer scale targets. The State will need to evaluate an ACO's payer contracts to determine if they meet the definition of a "Scale Target ACO Initiative."[1] There are several areas that may impact scale, including payer participation (including self-insured plans), provider participation, and attribution methodology. Please provide a written plan on the ACO's strategies during the remaining years of the Agreement to work with the State and other stakeholders to increase payer participation, increase provider participation, and develop changes to attribution methodology, with the goal of maximizing scale and achieving scale targets. Please provide the ACO's targets by year for both providers and attributed lives, by Health Service Area.

   Achieving scale remains core to the overall ACO strategy. Increasing the number of providers and lives in the model both furthers Vermont All-Payer Model goals and the clinical aims of OneCare. This endeavor requires distinct strategies to address each element affecting overall attribution to the ACO's value-based programs.

Scale Strategy 1: Attribution Methodology

While the approach is different for each payer program, the methodology to determine attribution revolves around a primary care relationship with a provider in the OneCare network. This model ensures that OneCare providers have a direct relationship with the attributed population and therefore the ability to implement population health initiatives aimed at more coordinated care and improved patient wellness. This approach does not take into account patients that do not receive the eligible primary care services that drive attribution, patients that do not see primary care providers, or patients that do not use the health care system. OneCare is actively working with payers to explore evolving the attribution methodology in ways that incorporates more Vermonters into the model. Ideas being explored include:

- *Requiring a primary care provider (PCP) selection process to enable attribution and allow PCPs to reach out and engage with those not routinely seeing a primary care provider*
- *Expanding the code-set used to drive attribution eligibility*
- *Modifying provider credential requirements for attribution*
- *Implementing a longer look-back period for attribution assignment*
- *Rostering-style models that test:*
    - *Geographic attribution*
    - *Family-based attribution*
    - *Practice-panel attribution*
    - *Diagnosis-based attribution*

While all of these approaches have the potential to increase the number of lives attributed to ACO programs, these choices need to be considered in the context of the financial models in place. Both the payers and OneCare are exposed to potential financial risks when attributing lives with little or no historical medical data. Ideas being explored include separate cohorts for patients will little/no historical medical engagement, and risk "carve-outs" for populations being attributed for the first time under more progressive methodology.

While adding lives into the programs remains a central strategy for OneCare, these steps need to be evolved thoughtfully so that the clinical and financial aims of the ACO and the Vermont All Payer ACO Model are furthered in tandem.

Scale Strategy 2: Network Participation

In addition to the methodology used to attribute lives, increasing the number of providers participating in OneCare programs represents a substantial opportunity. Even under the current attribution approach, a considerable number of lives attribute to non-OneCare providers and are therefore excluded from the value-based scale target numerator.

Expanding the network in spirit of scale target goals requires unique strategies to encourage hospital participation in ***all*** *value-based programs (as opposed to*

no participation or Medicaid only) and subsequently, the full participation by other attributing providers in each HSA including FQHCs and independent primary care practices.

Hospitals remain the risk-bearing entities in the OneCare risk delegation model; thus, their participation is required for other attributing providers in the HSA to join. This makes hospital participation expansion a core strategy for OneCare. While 2019 represents another positive step towards this overarching goal, the strategy for 2020 and beyond will need to focus on moving participating hospitals into all value-based programs rather than Medicaid only. The main barrier expressed in the 2019 network development process was the concern of taking accountability for the large dollars at risk for the entire HSA under all programs. For hospitals facing environmental challenges such as a declining population, an aging population, and/or limitations on revenue generation the investment in ACO programs combined with a sizeable downside risk when participating in all programs represents a significant concern. To address this, OneCare strategies include:

- *Continued advocacy for program economic terms that provide fair targets and conditions*
- *Continued limited risk corridors around the targets, and consideration of proposing asymmetric risk with more savings opportunity than downside risk*
- *Advocacy for funding from payers to further population health management objectives and reduce the net cost of supporting the ACO infrastructure and payment reform models required to manage the populations in innovative ways in the absence of adequate Delivery System Reform funding*
- *Building reasonable reserves at the ACO to afford downside protection for hospitals/HSAs with unique economic circumstances. This can be done through savings created by the ACO efforts, but could also be supported by shifting the contributions to reserves from the payers to the ACO for the risk we manage*
- *Evolving existing and developing new clinical programs that are appealing to the provider network and supply appropriate financial resources*
- *Exploring new risk arrangements that incentivize participation from hospitals that need risk relief/mitigation due to their economic conditions and/or governance positions*
- *Advocating for regulatory considerations that recognize the financial commitments and risk associated with ACO participation*
- *Advocating for incentives for providers to join the ACO. These might include additional budget considerations to those participating in all programs which could include, but not be limited to, the building of local hospital-held reserves to manage the risk for their HSA, and/or additional local PHM investments*

Strategies to develop hospital participation in all value-based programs and to attract other attributing providers remains a priority focus area. The absence of downside risk drives the focus to population health management (PHM) resources, balancing clinical independence with an integrated delivery system model, and the community partnerships that may or may not be in place. The OneCare strategy to develop these providers includes:

- *Investing in primary care to support advanced, team-based practices and achieve improved population health and wellness*
- *Supporting a provider-led approach to healthcare reform by relying upon clinical experts to develop programs and address the challenges they face in the delivery system*
- *Working with payers to alleviate administrative burden*
- *Empowering community-based models for collaborative care delivery*

Scale Strategy 3: Payer/Employer Participation

The remaining strategy is to engage with additional payers to attribute lives not covered by Medicare, Medicaid or BCBSVT's Qualified Health Plans; as well as work with payers to add additional service lines and attributed lives not currently managed in partnership with the ACO, such as the self-funded, employer-sponsored health plans. This represents an opportunity to increase scale and to address the challenges of market fragmentation and lack of clear incentives for payers and employers to participate. The strategy unfolding is to either approach the market with one or more committed payer partners to offer aligned payer-ACO hybrid products designed for a strong value proposition, or pursue each employer plan separately with an "add on" program developed by OneCare. The former generates efficiencies as OneCare could facilitate a standard program offering through one or more carriers/third party administrators (TPAs) that could incorporate lives from a number of separate employer-plans and aggregate operational approaches, risk sharing, and payment reforms across a "book of business". This approach is only viable with payer partner(s) who are willing to implement a payer-ACO hybrid product which aligns - at least at some level - with current program models under for Medicare, Medicaid and the BCBSVT QHP approaches. Those payer partner(s) would also be expected to work collaboratively to position the product offering with employers. Without reasonable program alignment there is increased risk of further provider administrative burden and programmatic inefficiencies. Currently, we are experiencing limits to the commercial payers' willingness to align their business models with the All Payer ACO Model and the program parameters, payment reforms, and population health management approaches set forth under the Medicare and Medicaid Next Generation programs.

5. Provide, as an attachment, a completed **2019 Summary ACO Provider Network Template (Appendix 2.2)**, which will include, by Health Service Area:
    a. Count of providers by provider type and specialty; and
    b. Count of Enrollees.

Please see Attachment B in Part 2 attachments titled "Summary Provider Network by HSA/County by Provider Type" for a Summary list of the OneCare's Provider Network across all payer programs by provider type and county.

6. For each ACO provider that will assume risk in 2019, describe the ACO's risk arrangements with the provider, including:

    a. The percentage of downside risk assumed by the provider, if any;
    b. The cap on downside risk assumed by the provider, if any; and
    c. The risk mitigation measures the ACO requires of or undertakes for the provider, if any (e.g., reinsurance, reserves).

OneCare, as the contract holder with each of the payer partners, is the entity that either pays or receives the program settlement amount. The risk management strategy employed by the ACO delegates the risk, and potential shared savings entitlements, down to the network hospitals. OneCare sets HSA spending targets for each of the HSAs participating in the payer program. These targets are based on the historical cost of care derived from modeling and/or historical experience data. The overall program risk terms are then applied to the HSA spending target to determine the HSA Maximum Risk Limit. For example, if the overarching program has a 4% risk corridor, that same corridor is applied to each of the participating HSAs. The accompanying Program Settlement Policy outlines this process in a more detailed fashion.

In certain cases, as determined by the OneCare Board of Managers (BOM), a risk mitigation arrangement is offered to eligible hospitals. These arrangements are intended to allow for a transitional period into the risk arena and to encourage hospitals to participate in all value-based programs. Offering these arrangements means that OneCare retains undelegated risk. To ensure that the ACO is able to fund all potential downside risk, the 2019 budget includes net income for reserves of $2.8M. This, when combined with the $2.2M reserves required in the 2018 GMCB budget orders, results in $5M of reserves accumulated by the end of the program year. The reserve amount covers otherwise undelegated risk for 2019, and also sets course for reserves that can be used to encourage further participation in 2020. This aligns with our overall scale target strategy and addresses concerns related to the magnitude of downside risk that accompanies participation in all value-based programs. The risk mitigation arrangements offered in 2019 include:

Hospital/HSA	Max Covered by OCV
SVMC / Bennington	$2,000,000
Brattleboro / BMH	$900,000
Springfield / Springfield	$1,000,000

Lastly, the 2019 budget includes a continuation of the risk protection arrangement in place in the 2018 program year for the Medicare program. This arrangement is designed such that once the aggregate ACO spend in the Medicare program reaches the mid-point of the maximum risk, a third party

pays 90% of any spend thereafter. Ideally this protection will never be necessary, but it does provide coverage in the event the entire network experiences a spending significantly over target. The budget model does not include similar protection for the Medicaid or BCBSVT QHP program, but those options will be explored to see if the risk protection marked is able to offer a model that adds value to the network.

The following table summarizes the current estimates for maximum risk/reward in each of the programs. These numbers will be modified based on final program terms, attribution, and spending targets agreed-upon with payers.

	Medicare		Medicaid		BCBS QHP		Total			
HSA / Hospital	**% of TCOC**	**Max Downside**	**% of TCOC**	**Max Downside**	**% of TCOC**	**Max Downside**	**% of TCOC**	**Max Downside**	**Risk Mitigation**	**Est. MRL**
Bennington / SVMC	5%	$3,207,210	4%	$617,582	3%	$447,389	4.54%	$4,272,180	$2,000,000	$2,272,180
Berlin / CVMC	5%	$2,675,188	4%	$580,193	3%	$438,350	4.50%	$3,693,731	$0	$3,693,731
Brattleboro / BMH	5%	$1,221,777	4%	$318,183	3%	$120,235	4.58%	$1,660,196	$900,000	$760,196
Burlington / UVMMC	5%	$8,794,030	4%	$2,085,398	3%	$1,497,348	4.48%	$12,376,776	$0	$12,376,776
Lebanon / DH	5%	$0	4%	$242,223	3%	$244,954	3.42%	$487,176	$0	$487,176
Middlebury / Porter	5%	$1,898,569	4%	$499,080	3%	$266,110	4.51%	$2,663,760	$0	$2,663,760
Morrisville / Copley	5%	$0	4%	$0	3%	$0	0.00%	$0	$0	$0
Newport / NCH	5%	$0	4%	$452,664	3%	$0	4.00%	$452,664	$0	$452,664
Randolph / Gifford	5%	$0	4%	$362,194	3%	$0	4.00%	$362,194	$0	$362,194
Rutland / RH	5%	$0	4%	$706,548	3%	$0	4.00%	$706,548	$0	$706,548
Springfield / Springfield	5%	$2,422,080	4%	$326,207	3%	$243,927	4.64%	$2,992,214	$1,000,000	$1,992,214
St. Albans / NMC	5%	$1,879,252	4%	$848,832	3%	$245,421	4.46%	$2,973,505	$0	$2,973,505
St. Johnsbury / NVRH	5%	$0	4%	$560,735	3%	$0	4.00%	$560,735	$0	$560,735
Townshend / Grace Cottage	5%	$0	4%	$0	3%	$0	0.00%	$0	$0	$0
Windsor / Mt. Ascutney	5%	$1,267,514	4%	$133,260	3%	$239,809	4.50%	$1,640,583	$0	$1,640,583

Total	5%	$23,365,621	4%	$7,733,097	3%	$3,743,543	4.46%	$34,842,262	$3,900,000	$30,942,262

Outside of the hospitals serving as the risk-bearing entities for each of the HSAs, there are no other providers in the network that would be owed shared savings or obligated to pay shared losses as part of program settlement.

7. Provide, as an attachment, a completed **2019 Health Service Areas and Associated Risk Totals (Appendix 2.3) and a 2019 Budgeted Risk Model (Appendix 2.4)**

   Please see Attachment C and D in Part 2 attachments titled "2019 HSA and Associated Risk Totals" and "2019 Budgeted Risk Model" respectively.

8. Submit copies of each type of your provider contracts and agreements (i.e. risk contracts, non-risk contracts, collaboration agreements).

   Please see Attachment E in Part 2 Attachments titled 2019 OneCare Provider Base Risk Contract with Medicare, Medicaid and Commercial Rider as well as an amendment for FQHCs.

[1] A "Scale Target ACO Initiative" is defined in section 6.b. of the Agreement.

Part 2
Attachments

Attachment A – Summary of Provider Network by Provider Type

Attachment B – Summary Provider Network by HSA/County by Provider Type

Attachment C – 2019 HSA and Associated Risk Totals

Attachment D – 2019 Budgeted Risk Model

Attachment E – OneCare Provider Base Risk Contract with Medicare, Medic, Commercial and FQHC Rider

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1. Provide copies of existing agreements or contracts with payers if they have been updated since they were submitted to the GMCB. If 2019 contracts are not available, please submit the contracts as an addendum when they are signed. Also include the latest Next Generation benefit enhancement implementation plans.

   OneCare is in negotiations with the Department of Vermont Health Access (DVHA) for the Vermont Medicaid Next Generation program and Blue Cross and Blue Shield of Vermont for a continued risk-based program for the Qualified Health Plans. We are also in discussions with Payers and Employers to explore self-funded program opportunities. Lastly, we are awaiting an updated 2019 participation agreement for the Medicare program. Upon completion of negotiations and the execution of contracts, OneCare will provide a copy of the contract to the GMCB.

2. By payer and line of business, provide an analysis of your most recent annual ACO quality reports for measures. In addition, please include a copy of the results for each contract.

   OneCare evaluated quality for the first year (2017) of the Vermont Medicaid Next Generation Program through a combination of claims and clinical quality measures. The rates for five measures exceeded the national Medicaid 50th percentile benchmark and OneCare was awarded full credit for an additional four payment measures that did not have established benchmarks. OneCare has identified initiation of alcohol and other drug dependence treatment as an area of opportunity, which has remained an area of focus in 2018. The following is a summary of our results.

Measure	Y1 2017	Quality Compass 2017 National Medicaid Benchmarks				Adherence Rate			Quality Points
		25th 1 point	50th 1.5 points	75th 2 points	90th 2 points	2015	2016	2017	
30 Day Follow-Up after Discharge from the ED for Alcohol and Other Drug Dependence	P	-	-	-	-			30.25	2.00
30 Day Follow-Up after Discharge from the ED for Mental Health	P	-	-	-	-			80.93	2.00
Adolescent Well-Care Visits	P	43.06	50.12	59.72	68.06			57.50	1.50
All Cause Unplanned Admissions for Patients with Multiple Chronic Conditions	P	-	-	-	-			1.48	2.00
Developmental Screening in First 3 Years of Life	P	15.70	36.00	50.50	N/A			59.74	2.00
Diabetes Mellitus: Hemoglobin A1c Poor Control (>9%)*	P	48.57	41.12	35.52	29.07			31.52	2.00
Hypertension: Controlling High Blood Pressure	P	47.69	56.93	64.79	71.69			64.61	1.50
Initiation of Alcohol and Other Drug Dependence Treatment	P	35.79	40.72	45.13	50.00			35.39	0.00
Engagement of Alcohol and Other Drug Dependence Treatment	P	7.98	12.36	16.25	21.31			17.63	2.00
Screening for Clinical Depression and Follow-Up Plan	P	-	-	-	-			47.37	2.00
Follow-Up after Hospitalization for Mental Illness (7 Day Rate)	R	34.00	46.36	56.22	65.01			37.02	-
Timelines of Prenatal Care	R	77.66	83.56	88.59	91.67			70.16	-
									17.00

Quality Points Summary			
Points Earned	Total Possible Points	Percent of Possible Points	VBIF
17	20	85%	0.4250% (Network) 0.0750% (ACO QI Initiatives)

All other 2017 Payer Program Quality results are being finalized. Once they are final and reviewed by our Board of Managers we will share them with the Green Mountain Care Board.

3. If applicable, by payer and line of business, describe program arrangement(s) between the payer and the ACO including:

   a. Full risk, shared risk, shared savings, other (please specify);
   b. The use of a minimum savings rate, minimum loss rate, or similar concept;
   c. The percentage of downside risk assumed by the ACO;
   d. The cap on downside risk assumed by the ACO, if any;
   e. The percentage of upside gain for the ACO, if any;
   f. The cap on upside gain for the ACO, if any;
   g. Risk mitigation provisions in the payer contract:
      i. Exclusion or truncation of high-cost outlier individuals (please describe)
      ii. Payer-provided reinsurance
      iii. Risk adjustment: age/gender, clinical (identify grouper software)
   h. Method for setting the budget target;
      i. Trended historical experience
      ii. Percentage of premium
      iii. Other (please describe)

The following synopsis represents the current planned and budgeted approach for the 2019 contract year. Negotiations with payers, reinsurance/risk protection brokers, and the provider network are ongoing. These terms will not be final until contracts are fully executed by both parties. This description only serves to document what has been incorporated into this submitted budget and is the best information available at this point in time.

Medicaid

a. The 2019 OneCare budget plans for a full risk arrangement with Medicaid.
b. There is no minimum savings rate or minimum loss rate budgeted for this arrangement.
c. 100% of downside risk is assumed by OneCare.
d. The downside risk is capped at 4% of the total cost of care (TCOC).
e. 100% of shared savings is assumed by OneCare.
f. The upside savings potential is capped at 4% of the total cost of care.
g. Risk mitigation provisions include:
  i. No truncation for Medicaid high-cost outliers
  ii. No payer-provided reinsurance components to the program
  iii. No risk adjustments are included in the budget model
h. The Medicaid trend rate and target will be negotiated with the Department of Vermont Health Access (DVHA) and will fall within a range supported by separate actuarial firms representing OneCare and DVHA. The actuarial process will also include any adjustments for repricing and/or other systematic changes as appropriate to set a fair target. Given the positive performance in 2017 and year to date in 2018, we took a modest approach of adding a small trend rate of 0.5% to the 2018 target set for the ACO; well below the overall statewide annual target growth of 3.5%.

Medicare

a. The 2019 OneCare budget plans for a full risk arrangement with Medicare.
b. There is no minimum savings rate or minimum loss rate budgeted for this arrangement.
c. 100% of any downside loss is assumed by OneCare. This is a change (from 80% in 2018) built into the budget model and will be subject to a final decision by the OneCare BOM.
d. The downside risk is capped at 5% of the total cost of care (TCOC).
e. 100% of any upside savings potential is assumed by OneCare. This is a change (from 80% in 2018) built into the budget model and will be subject to a final decision by the OneCare BOM.
f. The upside savings potential is capped at 5% of the total cost of care.
g. Risk mitigation provisions include:
  i. Potential option to incorporate a truncation model into the program. In 2018 this model was initially offered to OneCare, but the actuarial mechanics of building a truncation point on a partial year of claims proved challenging. The budget model does not incorporate truncation, but this will be explored further with Medicare as the plan year approaches.
  ii. No payer-provided reinsurance components to the program

iii. No risk adjustments were included in the budget model

h. The budget targets were set primarily using 2018 experience data for the expected network as the base and trended forward using the Medicare Advantage United States per Capital Cost (MAUSPCC) projection published by Medicare. This projection, less the 0.2% discount factor incorporated into the All Payer ACO program model, resulted in a 3.8% trend rate being applied to the 2018 base spend. In addition, the target included a carryforward of shared savings projected to be earned in 2018. This is primarily driven by the $7,762,500 of conservatism applied to the target in 2018, which enables OneCare to contribute to Patient- Centered Medical Home (PCMH), Community Health Team (CHT), and Supports and Services at Home (SASH) programs.

Blue Cross Blue Shield of Vermont Qualified Health Plan Program

OneCare and Blue Cross Blue Shield of Vermont (BCBSVT) are in ongoing discussions on the nature and details of a continued 2019 risk program contract. Many elements remain in discussion and any assumptions made below and elsewhere by OneCare for budgeting purposes are subject to change, and it cannot be assumed that BCBSVT has agreed to these program assumptions.

a. The 2019 OneCare budget plans for full risk program with BCBSVT.

b. There is no minimum savings rate or minimum loss rate budgeted for this arrangement.

c. 50% of any downside loss is assumed by OneCare.

d. The downside risk is capped at 6% of the total cost of care. Of that 6% downside risk exposure, 50% is assumed by OneCare and 50% is assumed by BCBSVT. In effect, the total downside risk for the ACO is capped at 3% of TCOC.

e. 50% any upside savings potential is assumed by OneCare.

f. The upside savings potential capped at 6% of the total cost of care (TCOC). Of that 6% upside savings potential, 50% is assumed by OneCare and 50% is assumed by BCBSVT. In effect, the total upside savings potential for the ACO is capped at 3% of TCOC.

g. Risk mitigation provisions include:

i. No truncation for high cost patients is built into the budget model, but OneCare has provided a proposal to BCBSVT for consideration.

iv. No payer-provided reinsurance components to the program.

ii. No risk adjustments were included in the budget model, however this is under discussion with BCBSVT as this program does not have a stable membership and individuals make decisions annually that are in their best financial interests. If BCBSVT continues to lose membership because other QHP carriers have lower premiums, it could potentially leave the BCBSVT QHP program with higher risk populations. This movement between payers creates the inability to simply apply basic trends on prior years' experience to reach a fair target.

*h. The budget targets were developed using the actual claims expense for all OneCare attributed lives in 2017 and then trended forward using the factors incorporated into the 2019 BCBSVT Qualified Health Plan (QHP) rate filings that affects claims cost. OneCare did not include the 1% **premium reduction** levied by the GMCB in our trend, and has communicated to BCBSVT that it will not accept this as a claims cost adjustment to our program. Additionally, the trend has been adjusted to add 2.3% to account for the higher anticipated costs BCBSVT anticipates for QHP membership moving from their QHP product to their AHP product as discussed in further detail later on in this document. The actual contracted factors for the OneCare-attributed population to determine 2019 targets will be determined at a later date through actuarially-supported negotiations.*

Self-Funded Program(s)

OneCare is working to develop and evolve a self-funded program model that is both attractive to employers of all types and increases scale under the Vermont All Payer ACO Model. This work is ongoing and data points are limited. The budget incorporates a program that includes the health plans for some participating hospitals, although no final agreements are in place. While all plans and employers with whom we are currently in discussion are included in the budget, program terms are still in negotiation and nothing is finalized as of this submission.

a. The 2019 OneCare budget plans for full risk program with some employer self-funded plans.
b. There is no minimum savings rate or minimum loss rate budgeted for this arrangement.
c. 30% of any downside loss is assumed by OneCare for a portion of the self-funded program. The remaining portion has no downside risk.
d. The downside risk, if any, is capped at 6% of the total cost of care. Of that 6% downside risk exposure, 30% is assumed by OneCare and 70% is assumed by the health plan. In effect, the total downside risk for the ACO is capped at 1.8% of TCOC.
e. 30% any upside savings potential is assumed by OneCare under all self-funded programs.
f. The upside savings potential capped at 6% of the total cost of care. Of that 6% upside savings potential, 30% is assumed by OneCare and 70% is assumed by the health plan. In effect, the total upside savings potential for the ACO is capped at 1.8% of TCOC.
g. Risk mitigation provisions include:
   i. No truncation for high cost patients is built into the budget model, however there is expected to be a truncation program for all programs.
   ii. No payer-provided reinsurance components to the program.
   iii. There is likely to be a risk adjustment component for some of the employer groups in this program. Nothing has been included in the budget model as the details have not been finalized.

h. The budget targets for a portion of the self-funded model were developed using data from the current UVMMC plan operating in 2018. At the time of submission, plan data for each of the new potential participants was not yet available.

4. Complete **Appendix 3.1 Program Arrangements** with the same information as above.

   Please see Attachment A. in Part 3 Attachments titled "2019 Program Arrangements between ACO and Payer"

5. Provide an explanation for your projected growth rates, referencing Part II: Budget Guidance, which provides background on the All-Payer and Medicare Total Cost of Care per Beneficiary Growth outlined in the Vermont All-Payer ACO Agreement.

   The trend rates applied represent a very significant component of the OneCare budget as they affect a substantial portion of the healthcare spending against which our overall Vermont All Payer ACO Model growth is measured. With this in mind, the budget aims to incorporate trends at levels in the spirit of the overarching statewide goal of 3.5% annual healthcare cost growth. Balancing the desire to align cost trends consistently with the All Payer ACO Model annual growth target is the need to ensure the trend rates do not negatively impact both provider and ACO participation in the payer programs. This requires that rates are developed in a way that intends to produce achievable benchmarks (i.e. not underwater), sustainable funding for all providers, and benefits for ACO participation in order to justify continued investment in value-based care that help improve scale. The budget model incorporates separate growth rates for each program and are based on either existing contract terms or best estimates for actuarially-supported growth trends.

   Note that changes to the network configuration can affect the overall program PMPMs significantly, and require appropriate adjustments to account for each new HSA. Adding HSAs with a historically high or low PMPM spend can move the aggregate PMPMs materially and adding a new provider within an HSA can drive HSA PMPMs materially. As a result, overall PMPM growth or decline needs to be considered in the context of the network included in the model.

   Medicare

   The 3.8% trend applied to the 2018 expected spend is derived from the Vermont All Payer ACO Model contract and the 'Part II: Budget Guidance' section of this document. This rate is built off of the MA USPCC blended rate of 4.0%, and then incorporates a 0.2% efficiency factor per the Vermont All Payer ACO Model. A strong trend in the Medicare program is essential to the sustainability of the model. As mentioned previously, one of the main strategies to achieving increased scale is expanding participation in the Medicare program. Stepping into a value-based

Medicare arrangement represents a significant step for the risk-bearing hospitals as the downside exposure is substantial enough to consume a sizeable portion of annual margin. With this in mind, the trend rate is often a deciding factor for hospitals. Incorporating the 3.8% trend per the Vermont All Payer ACO Model in the budget conveys the importance of furthering Medicare participation and positions the ACO to contribute towards a slowing of the cost-shift.

Medicaid

The Medicaid program incorporates modest trend rates that reflect the overall economic circumstance for Vermont and the continued partnership between DVHA and OneCare to administer a program that adds value to all stakeholders. Ultimately, both parties are aspiring for a trend rate that produces sustainable financial terms for the provider network and the State of Vermont. This means that the final targets reached through negotiation and actuarial analysis need to fairly reflect the expected spend experience in a FFS environment and also recognize the early results experienced in the Medicaid program. Without adequate trend rates that incorporate early success, spending targets could begin to drop and such disincentives could discourage continued participation. The budget model presented applies a 0.5% trend from 2017 to 2018 and a 0.5% from 2018 to 2019. Note that changes to the network configuration also affects the aggregate PMPM growth on a year-to-year basis.

BCBSVT QHP

The budget model presented incorporates trend rates that are intended to represent a fair PMPM spending target for the OneCare network. The basis for these trends are built upon the chassis of the approved QHP rate filings but modified where appropriate to yield a target that is reflective of the experience expected for the OneCare network. This approach is intended to align and integrate the overall QHP market rates, the hospital budget rate approval process, and the ACO spending target into a uniform system. The budget model includes all amounts affecting the 2019 expected claims cost that were approved by the GMCB moving from 2017 to 2019 which includes, but is not limited to, a 5.9% cost trend from 2017 to 2018 and an estimated cost trend of 4.1% moving from 2018 to 2019. Additionally, the trend has been adjusted to add 2.3% to account for the higher anticipated costs BCBSVT anticipates for QHP membership moving from their QHP product to their AHP product. BCBSVT testified they believe this will increase the cost trend by 2.3% in the QHP product. BCBSVT, however, will benefit from the 2.3% lower costs in their AHP plans. (No other payer is offering an AHP program, so all these members will remain with BCBSVT.) Therefore, it makes sense that they were not allowed to increase premiums by this amount. The ACO, however, will not have risk for AHP, therefore has no offsetting savings and requires the additional 2.3% trend factor. Note that changes to the network configuration also affects the aggregate PMPM growth on a year-to-year basis.

Self-Funded

The self-funded spend is modeled in the budget by beginning with the UVMMC PMPM spend and scaling for the expected attribution for participating hospitals. The actuarial process to determine the appropriate trend for each will be based on any changes to the plan benefits, fee schedules and overall utilization growth. The budget model presented applies a 3.5% trend from 2018 to 2019.

6. The All-Payer ACO Model Agreement requires Scale Target ACO Initiatives to be aligned on key design dimensions, including categories of services, benchmark tied to savings, beneficiary alignment, and quality measures. Complete the table below to describe how your ACO Initiatives are aligned across all payers, how they are different, and a justification for the differences. In addition, provide a written summary if any of the following categories are significantly different from 2018-2019.

All of the information contained in this section is dependent on final contract terms. Once finalized, contracts will be sent to the GMCB for review.

a. By payer, for 2019, include any categories of services for aligned beneficiaries that will be included in your contracts for determination of the ACO's savings or losses that are different from Medicare Part A and B services. In addition, please include a copy of each contract's language.	
Overall Concept	*With few exceptions, the services that are included in the ACO's total cost of care calculation align with the services covered by the payer. In most cases the services covered by Medicaid, BCBSVT QHP, and self-funded plans will include those covered by Medicare Part A and Part B.*
Commercial	*TCOC includes all Part A and Part B equivalent services. Covered service exceptions* • *Services carved out from the Primary Insurer*
Commercial Self-Funded	*TCOC includes all Part A and Part B equivalent services. Covered service exceptions:* • *Services carved out from the primary third party administrator*
Medicaid	*TCOC includes all Part A and Part B equivalent services. Covered service exceptions:* • *Categories of Service 2201, 2901, 501, 502, 2701, 2702, 2703, 2713, 2717, 3301, 3304, 3501, 3507, 3602, 3703, 3705, 3707, 3709, 801, 802, 806, 807* • *1,103 CPT/HCPCS codes (list varies by year) 2018 attached* • *Spend at DAs/SSAs* • *Psychiatric treatment in a state psychiatric hospital or Level-1 (involuntary placement) inpatient psychiatric stays in any hospital when paid for by DVHA* • *SNF* • *Hospice (room and board only)*
Medicare	*TCOC includes all Part A and Part B equivalent services. Covered service exceptions:* • *None.*

b. By payer, describe how the proposed ACO benchmark, capitation payment, AIPBP, shared savings and losses, or any other financial incentive programs are tied to quality of care or health of aligned beneficiaries (i.e. percentage of revenues withheld for quality incentive payments, uses of withholds: incentives tied to provider-level, HSA-level or ACO-level results). In addition, please include a copy of each contract's language.	
Overall Strategy	*The OneCare quality model separates quality incentives from all other components of the program. In traditional upside only models, quality scores would only factor in if shared savings were earned, thus creating a relatively weak incentive. OneCare uses a Value Based Incentive Fund model that withholds a portion of the total cost of care (TCOC) to be distributed to the network based on aggregate quality scores, irrespective of financial performance. This provides the right network incentive to deliver quality care even if the overall spending performance is above target. Therefore, the ACO benchmark, capitation payments, AIPBP, shared savings and losses are all set independently and not tied to quality scores.*
BCBSVT QHP	*Budgeted VBIF Withhold: 1.5%; 50% of any funds that are not distributed based on the quality score will be returned to the payer and the remaining 50% will be reinvested in mutually agreeable quality initiatives.*
Self-Funded	*Budgeted VBIF Withhold: $1 PMPM*
Medicaid	*Budgeted VBIF Withhold: 2.0%; 50% of any funds that are not distributed based on the quality score will be returned to the payer and the remaining 50% will be reinvested in mutually agreeable quality initiatives.*
Medicare	*Budgeted VBIF Withhold: 0.5%; 100% of any funds that are not distributed based on the quality score will be reinvested in mutually agreeable quality initiatives.*

c. By payer and line of business, describe the current or proposed methodology for beneficiary/member alignment (also known as attribution). In addition, please include a copy of each contract's language.	
BCBSVT QHP	*See Supplemental Attachment Part 3 Attachment B. No changes anticipated for 2019*
Self-Funded	*See Supplemental Attachment Part 3 Attachment B. No changes anticipated for 2019*
Medicaid	• *Refine DVHA PCP definition to now include S15-S17 provider specialties* • *Include additional CPT/HCPCS codes to list of qualifying E&M codes used to determine primary care utilization and attribution eligibility* • *Modify claims look-back period to 3 years for attribution determination* • *Modifying/updating MEG or aid categories assignments* • *Update and validate TIN – NPI/Medicaid ID crosswalk* • *Enhancing provider roster to better align OneCare and DVHA data*
Medicare	*None implemented for 2019, but expect to continue exploration for 2020 to potentially include diagnosis-based attribution and a modification to provider credential requirements.*

d. By payer and line of business, provide a comprehensive list of ACO quality measures that will, or are proposed to, affect payment or be monitored, according to the terms of the agreement with the payer. In addition, please include a copy of each contract's language.

Measure	**Medicare**	**Medicaid**	**BCBS QHP**	**UVMMC SF**	**Domain**
30 Day Follow-Up after discharge from the ED for Alcohol and Other Drug Dependence (HEDIS)	(TBD)	x	x	x	Claims
30 Day Follow-Up after Discharge from the ED for Mental Health (HEDIS & NQF)	(TBD)	x	x	x	Claims
Adolescent Well-Care Visits (HEDIS)		x	x	x	Claims
All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions (ACO#38 & NQF)	x	x			Claims
Developmental Screening in the First Three Years of Life (NQF)		x	x		Claims
Initiation of Alcohol and Other Drug Dependence Treatment (HEDIS & NQF)	(TBD)	(HEDIS)			Claims
Engagement of Alcohol and Other Drug Dependence Treatment (HEDIS & NQF)	(TBD)	(HEDIS)			Claims
Initiation & Engagement of Alcohol and Other Drug Dependence Treatment (Composite) (HEDIS & NQF)			(HEDIS)	(HEDIS)	Claims
ACO All-Cause Readmissions (HEDIS & NQF)	(TBD)		(HEDIS)	(HEDIS)	Claims
Follow-Up After Hospitalization for Mental Illness (7 Days) (HEDIS)		x	x	x	Claims
Influenza Immunization (NQF, CMS 147v6)	x				Clinical
Colorectal Cancer Screening (NQF, CMS 130v5)	x				Clinical
Tobacco Use Assessment and Cessation Intervention (NQF, CMS 138v5)	x	x			Clinical
Screening for Clinical Depression and Follow-Up Plan (HEDIS, NQF 418, CMS ACO 18)	(NQF)	(NQF)	(HEDIS)	(HEDIS)	Clinical
Diabetes HbA1c Poor Control (>9.0%) (HEDIS, NQF 0059, CMS 122v5)	(NQF)	(HEDIS)	(HEDIS)		Clinical
Hypertension: Controlling High Blood Pressure (HEDIS, NQF, CMS 165v5)	(NQF)	(HEDIS)	(HEDIS)	(HEDIS)	Clinical
CAHPS Patient Experience	x	x	x		Survey

Part 3
Attachments

Attachment A – 2019 Program Arrangements between ACO and Payer

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1. Submit most recent audited financial statements.

   The 2017 audit of the OneCare financial statements is ongoing at the time of this submission. The final audit will be supplied upon completion.

2. Complete the GMCB financial statement templates (**Appendices 4.1-4.3**).

   Please see Attachment A, B and C in Part 4 with completed Appendices 4.1-4.3 titled "Balance Sheet", "Income Statement" and "Cash Flow" respectively

3. Provide, as an attachment, a completed **Appendix 4.4-4.7**. The Appendix requests the ACO, by payer and line of business, to provide information on projected revenues and expenses to flow through the ACO financial statements (including payer revenues, participating provider dues, and grant funding), medical costs and administrative costs (including contracted services, community investments and contribution to reserves), in total dollars and per member per month (PMPM) dollars when applicable. The GMCB may request additional information or copies of grants or agreements as part of the review.

   Please see Attachment D, E, F and G in Part 4 with completed Appendices 4.4-4.7 titled "Revenues by HCP-LAN APM," "Revenues by Payer," "Medical Costs by Service" and Medical Costs by APM" respectively.

4. Complete all tabs of **Part 4.8 Appendix** – ACO 2019 Budget Submission Reporting APM for Participating Hospitals for the 2019 budget year.

   Please see Attachment H in Part 4 with completed Appendix 4.8 for a summary of APM Reporting by all of OneCare's participating Hospitals.

5. Provide a narrative description of the following elements of the ACO's spending plan:

   a. Relevant industry benchmarks used in developing the administrative budget;
   b. The methodology for determining the qualification for and amount of any provider incentive payments and how those payments align with ACO performance incentives, which may include contractual agreements measures and outcomes.
   c. Quantity of Delivery System Reform dollars and associated goals for stated investments;
   d. Strategy for planned spending on health information technology, at the ACO level and to support individual providers;
   e. Budget assumptions related to service utilization, including anticipated changes from prior years' utilization, including anticipated changes in care delivery including but not limited to new and innovative services, service mix, value-based

payment model adoption (including risk assumption); and

f. Anticipated changes in provider network configuration, and the expected impact on service utilization.

a. At present, the OneCare's administrative budget is based on the requirements to achieve its strategy as a risk-bearing, multi-payer, statewide ACO. OneCare's Finance Committee and Board of Managers, which consists of participants from OneCare, approve the annual budget and any material changes occurring mid-year.

- *As one benchmark exercise, we apply a "percent of premium" approach. In this approach we divide OneCare administrative expense into the total of our payer risk targets plus those administrative expenses. Based on our proposed budget for 2019, we calculate the OneCare percent of premium as 1.8%. This is less than one tenth of the ACA-mandated limit of 15% based on a minimum medical loss ratio of 85%. Those guidelines apply to health insurers who have many more requirements and processes than an ACO, but those plans are also allowed to account for quality improvement activities as medical expense rather than as administrative expense. If OneCare were to do the same, the 1.8% would shrink further. Our conclusion is that our expenses are well within, and likely below, an expected "percent of premium" range for a risk-bearing ACO of this size.*

  Additionally, according to the recently published MedPAC report in June of this year, their analysis of ACO's nationally found that ACOs generally have a 2% administrative cost.

b. All of OneCare's investments and accompanying qualifications, which include the Population Health Management programs with aligned payment reforms, must be reviewed by the OneCare Finance and Population Health Strategy Committees and ultimately approved by the Board of Managers. Through their input and input from other clinical and ACH committees, program models are developed that aim to align care delivery with overall ACO goals, program financial terms, clinical initiatives, and quality initiatives. Feedback from the provider community is an essential component of the methodology used to determine the qualifications and amounts of incentive payments. The models developed need to not only provide the financial resources to incentivize operational alignment with value-based themes, but also aim to alleviate, not generate, administrative burden.

c. The OneCare budget model includes Delivery System Reform dollars for three primary objectives. The following represents the best information available, but discussions are ongoing among OneCare, DVHA, and CMMI regarding the scope and resources available for 2019.

- *Health Information Technology Support for Quality and Health Management Measurement Improvement: $4,250,000.*

  These dollars fund essential technological enhancements that are critical to success in the ACO landscape. The investments intend to support the ACO in aligning with Vermont's All Payer ACO Model and facilitate the creation, implementation, and refinement of tools, resources, training, and supports that promote person-centered care delivery that maximize population health outcomes. Quality and health management improvement funding will further the development of advanced analytics and tools that will be deployed in support of OneCare's four quadrant population health model, which includes programs and supports for primary prevention through RiseVT and specific emphasis on individuals with chronic conditions as well as individuals with complex physical, mental, or social needs through the Advanced Community Care Coordination Program.

- *Primary Prevention: $1,000,000*

  These dollars are used to fulfill the Quadrant 1 strategy of the OneCare clinical model and fund the RiseVT initiative. Funding RiseVT aims to improve population health and reduce the long-term social and economic burden of chronic disease. RiseVT was designed using the an evidence-based, obesity prevention model to achieve improved population health by targeting systems change within public health policies, infrastructure, education, the environment and culture within municipalities, worksites, schools, and families.

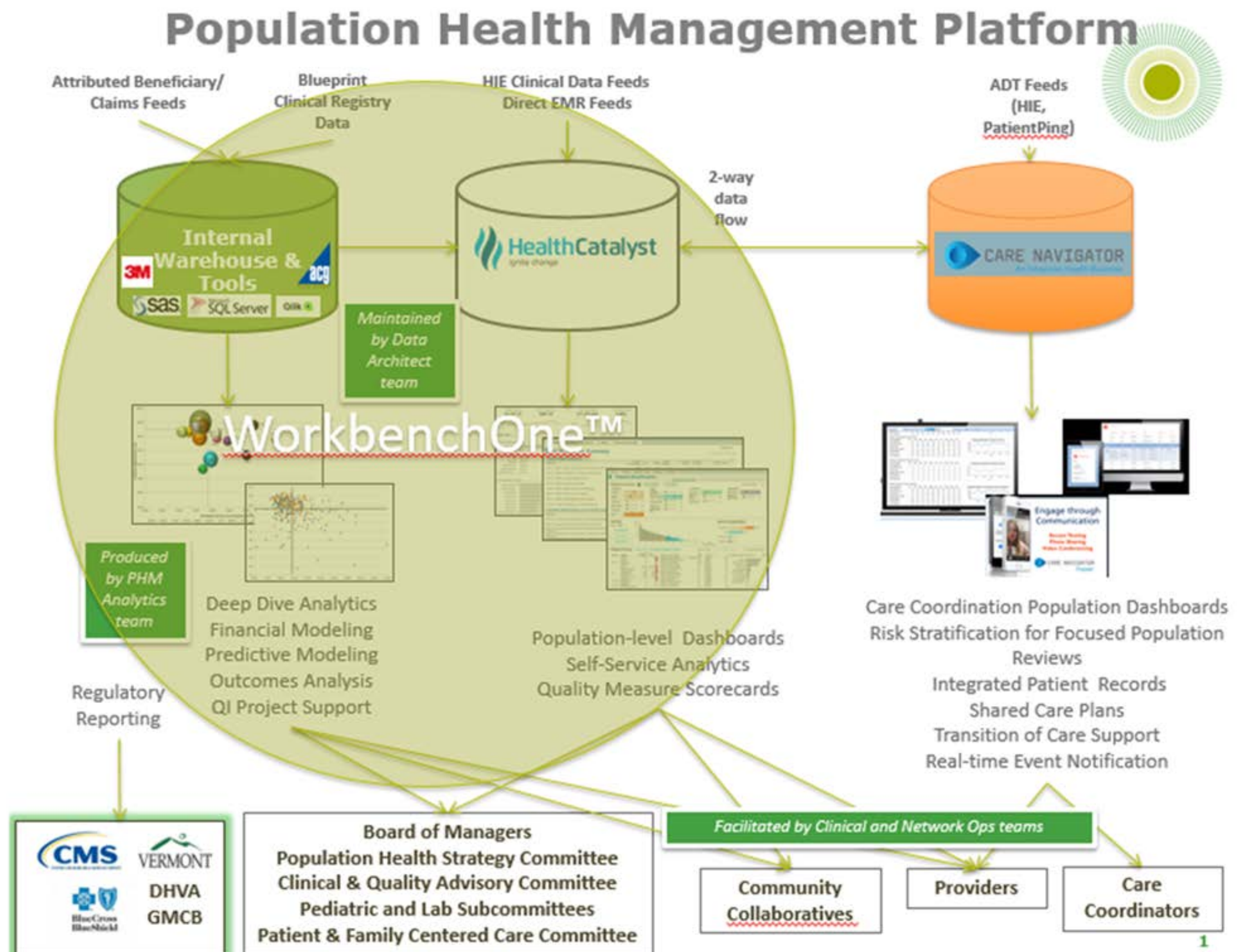
- *Advancing Complex Care Coordination: $5,579,347*

  OneCare is working to establish an integrated care delivery system that is person-centered, efficient, and equitable though the implementation of a community-based care coordination model. The model relies on a team-based approach to care coordination designed to strengthen relationships between primary care and the continuum of care providers to support individual's the physical, mental, and social wellbeing. By building upon the foundation of Patient Centered Medical Homes and Community Health Teams established through Vermont's multi-payer Blueprint for Health initiative, the community-based care coordination model will further organize and refine existing care management and care coordination activities by improving integration and collaboration across local care teams, thus increasing effectiveness and efficiency while eliminating duplication of efforts over time.

  In addition, DULCE is an innovative pediatric-care-based intervention through which primary care clinical sites proactively address social determinants of health and promote the healthy development of infants

from birth to six month of age while also providing educational and legal support to their parents.

d. OneCare has and will continue to invest in health information technology in order to support participants in their desire to enter into contracts that hold them accountable for the cost, quality, and experience of care. The informatics capabilities are provided through partnerships with Health Catalyst, Care Navigator, VITL and the BluePrint for Health to deliver best-in-class solutions. The informatics platform provides a mechanism for combining claims and clinical data from all ACO participants to perform advanced analytics and support clinical decision making. Reporting tools and skilled analysts can deliver cost, utilization and quality information in an actionable and timely manner to develop new models for reimbursement of services. OneCare is continuing the path towards a deployed toolset for network self-service in addition to our central support capabilities. The OneCare PHM Platform provides full-scale informatics and analytic services to our network. (See the following diagram)



e. The budget model does not yet specifically include assumptions relating to material changes in service utilization. However, because fee-for-service (FFS) equivalent spending levels are generally the basis for aggregate and

HSA targets, some of the positive strides are naturally incorporated. While this 2019 budget does not set targets by utilization level, it is a strategy that will be incorporated into future models. One factor that will make this easier to facilitate is a stable network. Adding communities and attributing providers each year creates "noise" in the utilization data and thus affects the base utilization figures for attributed lives being seen by network providers. Ultimately, the shift away from rebasing based on FFS equivalent is essential for the sustainability of the program. Assuming success, a constantly declining target starts to erase the incentives of a value-based model and could prompt a shift back to FFS.

f. *The 2019 OneCare network now includes three (3) additional HSAs: Rutland, Randolph and St. Johnsbury. Additionally, two (2) communities are shifting from a Medicaid-only option to participation in all value-based programs: Bennington and Windsor. This expanded hospital participation enabled other attributing community providers, including four (4) additional FQHCs, to join the network. Adding all of these attributed lives affects not only the attributing provider, but all other network providers (particularly hospitals). While these lives are attributed to the practice/provider entering the program for the first time, the care pattern for these patients is also incorporated into the spending model. This means that adding an FQHC with a high-risk panel, for example, could actually result in an increase to overall high-cost utilization at the local hospital. Because of the material impact that changes to the network have on utilization and cost metrics, the budget model does not assume any specific utilization adjustments. Rather, the historical spending pattern is incorporated into the existing data to determine the new expected HSA spending targets.*

6. Provide a narrative description of the flow of funds in the system or, if described in the ACO's 2018 budget submission, any changes from that submission. The description should include the flow of funds from payers to the ACO, and from the ACO to its providers. The description should demonstrate the ability of the ACO to maintain sufficient funds to support its administrative operations and meet provider payment obligations.

   The funds flow model for 2019 remains similar to that employed in 2018. At the core of the model is a fixed payment approach through OneCare for the hospitals participating in Medicaid and Medicare. BCBSVT has communicated that they are still unable to implement a fixed payment for 2019, therefore the hospitals participating under their program will remain under a payer-paid FFS model. All other non-hospital/hospital owned providers will remain under payers' normal fee structure, with the exception of the independent primary care practices participating in the Comprehensive Payment Reform (CPR) program.

   OneCare generates cash-flow for PHM programs and general operations through payer investments (paid either monthly or quarterly), deductions from hospital fixed payments, and invoices sent to hospitals for programs not offering a viable fixed payment model. The dollars received by the ACO are designed to facilitate

cash flow and fund any remaining PHM and operating costs otherwise unfunded by payer contributions. Funds withheld from fixed payments or invoiced are used in four ways: immediately redistributed to the network in the form of PHM investments, held in the Value- Based Incentive fund, retained by the ACO to cover operations, retained by the ACO to build reserves.

7. Provide a quantitative analysis with accompanying narrative to demonstrate how the ACO would manage the financial liability for 2019 through the risk programs included in Part 3 should the ACO's losses equal to 100% of maximum downside exposure. As part of the narrative response, describe your full risk mitigation plan to cover this liability and the mitigation plan for any contracted providers to which risk is being delegated or with which risk is being shared. This response is to include, but is not limited to:

    a. Portion of the risk delegated through fixed payment models to ACO-contracted providers and the percentage overrun on total expecting spending outside the ACO's fixed payment models that would result in losses of 75% and 100% of the ACO's maximum downside exposure;
    b. Portion of risk covered by ACO providers through mechanisms other than fixed payment models (e.g., withholds, commitment to fund losses at annual settlement, etc.);
    c. Portion of risk covered by reserves, collateral, or other liquid security, whether established as a program contractual requirement or as part of the ACO's risk management plan;
    d. Portion of the risk covered by reinsurance;
    e. Portion of the risk covered through any other mechanism (please specify);
    f. Any risk management or financial solvency requirements imposed on the ACO payers under ACO program contracts appearing in Part 3.

With the exception of the risk mitigation arrangements where the ACO retains some downside risk (and upside potential) in lieu of specific hospitals under our risk-sharing policy, all of the risk is delegated throughout the network. Each hospital, as the risk-bearing entity for its HSA, will be subject to any risk payback up to their Maximum Risk Limit (MRL). This MRL is calculated by applying the program risk corridor and sharing terms to the HSA spending target. This calculation results in the maximum amount that any hospital will owe for a risk settlement exchange. In the event that the ACO is subject to the maximum downside settlement, which means that spending overruns met the risk corridor limits for all programs, each hospital would pay up to their MRL. There are, however, layers of risk protection that would also be incorporated into the settlement, and would decrease the actual cash payment made by hospitals.

<u>Layer #1: Medicare Risk Protection</u>

In the event that the ACO owes maximum downside on all program, the risk protection model for Medicare (the one payer where OneCare maintains total cost of care overrun protection) will be activated and supply financial proceeds to OneCare. Per the Program Settlement Policy, these proceeds

will accrue first to the HSAs whose natural spending would have been above their MRL to minimize the need for HSA cross-coverage.

Layer #2: Risk Mitigation Arrangements
After applying proceeds from the Medicare risk protection layer, any hospital-specific risk mitigation arrangements are incorporated. For any of the risk that would be otherwise owed by the hospital, OneCare intends to first use any available unrestricted reserves or other available OneCare cash to fund the obligation unless the OneCare Board of managers approves a different approach.

Layer #3: Hospital Settlement Payments
Once any proceeds from the Medicare risk protection layer and the risk mitigation arrangements are applied, each hospital will be responsible for the remaining calculated amount based on actual total cost of care spending for the HSA population against the HSA spending target. OneCare will invoice each hospital for the amount owed and the dollars received will be aggregated and paid to the payer to settle the program, or be used internally to OneCare to settle against HSA-level performance results. If OneCare's aggregate overrun is concentrated in some HSAs, the risk payment from hospitals in those HSAs would still be capped at their MRL, with other hospitals contributing up to their MRL to help cover the ACO-wide exposure.

Layer #4: Medicare Required Reserves/Security Instrument
In the event that any unfunded obligation remains for the Medicare program, which could be due to default, timing, dispute, etc., the securitized reserves required by Medicare could be used unless the OneCare Board of Managers approves a different mechanism. The intent is that these funds are not incorporated into regular settlement so that they can be carried forward to fund the subsequent year's requirement.

Layer #5: Remaining OneCare Reserves
In the event that any unfunded obligation remains for the Medicaid, BCBSVT QHP, or self-funded programs, which could be due to default, timing, dispute, etc., any remaining OneCare reserves will be used, subject to any additional approvals required. The intent is that these funds are not incorporated into regular settlement so that they can be carried forward to subsequent years.

Layer #6: Founders
As the last source of funds, the OneCare Corporate Members would be liable to fund any remaining settlement obligation left unfunded by the preceding layers.

There are virtually endless possibilities for the exact year-end results. Because the HSA MRLs are applied by the ACO and not actually a function of the payer-program, its possible (although extremely unlikely) that one HSA would drive all of the downside exposure in each of the programs while all the others earn shared savings in the true payer-program settlement. Because of

the myriad scenarios, the MRL concept is essential to the risk sharing model. This concept ensures that the downside exposure for each hospital/HSA is scaled to the size of the HSA and provides protection in the event of an otherwise catastrophic year.

a. *Spending overrun rates for spend outside of the hospital fixed payments required for 100% downside and 75% downside:*

Program	***Fixed Payments***	***FFS Target***	***Total Target***	***Max Risk***	***FFS Overrun for 100% Downside***	***FFS Overrun % for 75% Overrun***
Medicare	*$203,600,119*	*$263,712,300*	*$467,312,419*	*$23,365,621*	*8.9%*	*6.6%*
Medicaid	*$110,076,275*	*$83,251,157*	*$193,327,432*	*$7,733,097*	*9.3%*	*7.0%*
BCBSVT QHP	*$0*	*$124,784,779*	*$124,784,779*	*$3,743,543*	*3.0%*	*2.3%*
Self-Funded	*$0*	*$65,289,304*	*$65,289,304*	*$1,175,207*	*1.8%*	*1.4%*
Total	***$313,676,393***	***$537,037,540***	***$850,713,934***	***$36,017,469***	***6.7%***	***5.0%***

b. *Technically 100% of the risk is covered by means other than the fixed payments. The fixed payment model can help to minimize the likelihood of a spending overrun deep into the risk corridor. The ACO-level maximum risk exposure is not affected by the level of fixed payments, it simply concentrates the possibility of the maximum overrun being driven by a smaller set of services and providers. It is still possible that an HSA with a hospital accepting fixed payments will maximize their downside exposure and will owe the full amount up to their MRL back to the ACO. This is the essence of the hospitals accepting both the risk of the fixed payment for their own delivered services to the attributed population, as well as the total cost of care risk for the lives in their HSA no matter who else delivers that care and where.*
c. *Outside of the MRLs, the only hospitals with guaranteed risk protection are those with a risk mitigation agreement. Their protections are as follows:*

Hospital/HSA	***Gross Max Risk***	***Max $ Covered by OCV***	***Max % Covered by OCV***
SVMC / Bennington	*$4,272,180*	*$2,000,000*	*47%*
Brattleboro / BMH	*$1,660,196*	*$900,000*	*54%*
Springfield / Springfield	*$2,992,214*	*$1,000,000*	*33%*

In certain circumstances additional layers of risk protection could be applicable (for example the Medicare risk protection arrangement) but the HSAs that would benefit and their amount would be dependent on the performance of all other HSAs.

d. *As budgeted, the Medicare risk protection model could yield financial benefits of $10.5M (45% of the total spend). Proceeds from this protection will first apply to HSA whose natural spending exceeded their MRL for Medicare. Doing so would then reduce the need for HSA cross-coverage, which is a benefit to the HSAs that didn't have an overrun. Because of the numerous scenarios for the way in which the year unfolds, there is no guarantee or predetermined amount for how much any one HSA can benefit.*
e. *Ideally all of the remaining risk will be covered by the hospital share up to the MRL as applicable. Only in an unforeseen scenario would other risk protection layers such as otherwise unobligated reserves or the Medicare program reserve be require to fund downside exposure.*
f. *Medicare is the only payer-program with a reserve requirement. In the 2018 program year, the standard Next Generation reserve requirement was in place, which mandated that 2.0% of the 2014 base benchmark needed to be secured. In total, this resulted in a $4.125M reserve requirement for OneCare. Medicare allows ACOs to develop this reserve in three ways:*

   - *Letter of Credit*
   - *Surety Bond*
   - *Escrow Account*

   OneCare employed the escrow account option in 2018 due to the speed at which the requirement could be met, and the relatively low cost as compared to a letter of credit. It is unclear at the time of this submission whether or not the same reserve requirement expectation will remain in place or if it will be modified as OneCare transitions to the Medicare Vermont ACO Initiative. OneCare's preference is that the ACO maintain overall reserves and that we are not having to create individual reserves by payer program.

8. Provide an actuarial opinion that the risk-bearing arrangements between the ACO and payers are not expected to threaten the financial solvency of the ACO.

   OneCare has enlisted Milliman to provide the actuarial guidance for budget modeling. However, due to the number of remaining variables at play, it is premature to seek actuarial certification. After the final trend analysis and prospective targets and attribution models have been produced, and negotiations are completed and/or contracts signed with payers, OneCare can update the GMCB with actuarial certifications for 2019.

9. Provide any further documentation (i.e. policies) for the ACO's management of financial risk.

Please see Attachment I in Part 4 Attachments for OneCare's "Program Settlement Policy"

Part 4
Attachments

Attachment A – OneCare Balance Sheet

Attachment B – OneCare Income Statement

Attachment C – OneCare Cash Flow Worksheet

Attachment D – Revenues by HCP-LAN APM

Attachment E – Revenues by Payer

Attachment F – Medical Costs by Service

Attachment G – Medical Costs by APM

Attachment H – Summary of APM Reporting by all OneCare Participating Hospitals

Attachment I – OneCare Vermont Program Settlement Policy

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1. List in the table in **Appendix 5.1, 2018 and 2019 ACO Clinical Priority Areas,** the ACO's 2018 clinical and program priorities, including metrics, targets, and results to date. In addition, list 2019 clinical and program priorities, metrics, and targets. Describe in narrative form progress made on your clinical priorities in the past year, including successes and opportunities for improvement.

   Please see Attachment A. in Part 5 Attachments for completed Appendix 5.1 titled "ACO Clinical Priorities".

   In 2018 OneCare elected to carry forward the clinical priorities identified in 2017, while also adding a new clinical priority around food security. The five (5) clinical priorities from 2017 were continued in 2018 in recognition of the time and effort required to move the dial on complex, population health change. Below, we will highlight the early successes and lessons learned in advancing the goals of the clinical priorities across the OneCare Network.

   For 2019, OneCare will begin engaging our Network Participants and Collaborators in Q4 and will continue the process of data review and discussion through clinical committees in Q1 2019 in order to arrive at a defined set of clinical priority areas by the end of March 2019. This timeframe allows for inclusion of important perspectives and data from our new Network participants joining OneCare in 2019 as well as for sufficient data runout to inform goal setting for 2019. OneCare would be happy to provide a final set of clinical priority areas to the Green Mountain Care Board at that time.

   2018 Progress-To-Date

   <u>High-Risk Patient Care Coordination</u>

   - *Goal: Reduce acute admissions and emergency department utilization by 5% each in this high-risk cohort*
   - *Progress: Results are reflective of the data available from January through April 2018. For acute inpatient admissions, Medicare, BCBSVT QHP and University of Vermont Medical Center (UVMMC) Self-Funded programs all show signs of achieving or exceeding the goal of a 5% decrease from baseline. Medicaid inpatient admissions, however, are not yet on track to achieve the goal. For ED utilization, all payer programs, with the exception of UVMMC Self-Funded are showing signs achieving a 5% reduction in utilization. UVMMC Self-Funded ED utilization has demonstrated more variation on a month-to-month basis.*
   - *Activities: Across OneCare's Network, care coordination teams regularly meet for care team check-ins and monthly Core Team meetings. These meetings provide opportunities for workflow development, identification of barriers, and sharing of lessons learned across health service areas (HSAs).*

The integration of PatientPing event notification in Care Navigator has further enhanced the care teams' ability to initiate care management sooner when a high or very high risk patient has been admitted or utilized the ED.

In the Bennington HSA, a community-based RN Clinical Nurse Specialist follows the utilization and cases of high and very high risk individuals to address root cause of re-hospitalization and acute care admissions. Additionally, RNs embedded in primary care practices follow-up by telephone post-hospital discharge for medication reconciliation and assessment of post discharge needs. During the follow-up calls, referrals are made to services and agencies to support individual's medical and social determinant needs.

In the Burlington HSA, there is a plan to hire a total of 14 RN care managers at UVMMC to support high-risk patient care coordination.

The Newport HSA has recently deepened their engagement with the care coordination model and hosted a state-wide Core Team meeting.

In the Berlin HSA, quality improvement projects are underway to address both readmissions and ED utilization through care coordination. For the readmission project, a readmission process redesign is planned at Central Vermont Medical Center (CVMC) and the project will be aligned with an ongoing primary care practice redesign to include targeted care coordination. For the ED utilization, the Berlin HSA is targeting patients with four (4) or more ED visits within 90 days. This project will involve ED follow up in the practices and work with the community health team (CHT) and other stakeholders involved in the patient's care; bidirectional communication will be a cornerstone of the initiative.

Episode of Care Variation

- *Goal: Reduce Skilled Nursing Facility (SNF) RUG score-adjusted length of stay (LOS) by 5%*
- *Progress: This measure is tracked in the Medicare program. For the reported months (January through April 2018), the SNF length of stay has steadily decreased and in April the rate was better than the goal of a 5% decrease from baseline.*
- *Activities: OneCare and the participating HSAs have ongoing partnerships with SASH programs across the Network to meet needs of older adults in congregate and individual housing.*

In the Bennington HSA, the "Interact" program in all SNFs allows for a structured, consistent communication process and care protocol. The program prompts patient care level staff to notify nursing with concerns, setting in motion additional protocols to identify medical conditions early and preventing ER visits.

The Burlington HSA is preparing to implement the CMS SNF 3-day rule waiver. Burlington HSA medical staff are also being appointed to coordinate work across nursing homes and oversee care coordination and patient transitions.

In the Middlebury HSA, the SNF 3-day rule waiver has also been implemented and an Elderly Services Pilot is ongoing.

Mental Health and Substance Use Disorder

- *Goal: Increase within-30-day ambulatory care follow-up for emergency room discharges for mental health and substance use disorder diagnoses*
- *Progress: OneCare uses the HEDIS follow up after ED visit for alcohol and other drug abuse or dependence (FUA) and follow up after ED visit for mental health (FUM) measures for tracking this clinical priority. These measures are currently only tracked in the BCBSVT QHP program and rates are reported as a cumulative year-to-date rate due to a limited view of claims with mental health and SUD diagnosis codes. At this time, there are no HEDIS national benchmarks for these measures, therefore the final 2017 rate for each measure is used to compare our progress. So far in 2018, there is has been an increase in ED visits for alcohol and other substance use disorders. In 2017 the final rate was 13.64% and for 2018 year-to-date the rate is 20.00%. On a positive note, there is has been a decrease in ED visits for mental health-related reasons. In 2017 - 78.57%; 2018 YTD - 66.67%*
- *Activities: OneCare is 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.*

OneCare is also collaborating with BCBSVT to improve follow-up rates for patients with mental health and substance use disorder diagnoses following inpatient or ED visits. BCBSVT is providing OneCare with quarterly, TIN-level data on four (4) ACO claims-based quality measures and OneCare will be sharing the data at the HSA level as part of the ANGLER Report.

OneCare has also supported a pilot with SASH and Howard Center to embed a Howard Center clinician in SASH programs at two congregate housing sites in Burlington to provide group and individual support for emotional wellness for residents. Data on the progress of the program is still being collected, however early anecdotal feedback shows a positive response from both residents and SASH/housing site staff for the inclusion of the Howard Center clinician.

The Berlin HSA has initiated a program to induct patients with buprenorphine in ED and also make referrals to MAT from ED. They have also instituted walk-in hours for MAT intake in order to reduce the lag between initiations to engagement in treatment.

The Bennington HSA has embedded clinicians in primary care practices to address mental health needs identified in those practices. A Screening Brief

Intervention and Referral to Treatment (SBIRT) process has also been started in the Southwestern Vermont Medical Center (SVMC) ED.

In the Burlington HSA, the UVMMC office of primary care and Area Health Education Center (AHEC) program started the Project ECHO program for the Treatment of Chronic Pain. The ECHO Program highlights best practices and evidence-based care for treating patients who experience chronic pain, and disseminates the best practices to providers participating in the program.

In the Windsor HSA, Mental Health First Aid training was provided to the staff at Mt. Ascutney Hospital and Health Center. Additionally, three (3) Wellness Recovery Action Plan (WRAP) trainings were provided in the community and a project is currently underway to incorporate SBIRT procedures into the ED workflow.

The St. Albans HSA has a developing partnership between the Northwestern Medical Center (NMC) ED and community counseling/support services to increase follow up after ED visits for mental health reasons and substance use disorders.

Providers in the Middlebury HSA are using the Child and Adolescent Needs and Strengths (CANS) assessment in pediatric practice to screen for depression and ACEs.

Chronic Disease Management Optimization

- *Goal: Reduce ambulatory sensitive condition admission/readmission for COPD and Congestive Heart Failure (CHF) by 5%*
- *Progress: These measures are currently only tracked in the Medicare program. For the COPD inpatient admissions (Jan-April 2018), admissions decreased each month and are on average better than the 5% goal. For the CHF inpatient admissions (Jan-April 2018), admissions in last reported month (April) an improvement towards being better than the 5% goal.*
- *Activities: In the Bennington HSA, rehab facilities have created open times to provide ongoing support for cardiac and pulmonary rehab patients. Patients attending the pulmonary rehab maintenance program have a 0% rate of readmission at this time. The Bennington HSA has also established a multidisciplinary group to increase use of palliative care and pulmonary rehab.*

In the St. Albans HSA, CHF and COPD admissions are data driven, using staging algorithms. There is also a partnership between home health, primary care and SNF/palliative care providers to support CHF patients and increase use of palliative care services.

Prevention and Wellness

- *Goal: Increase network utilization of Medicare annual wellness visit (AWV), adolescent well child visit and developmental screenings, each by 5%*

- *Progress: For the Medicare annual wellness visit, the Network is currently tracking to match its 2017 historical rate (32%). For the adolescent well child visit, Medicaid is currently tracking to be just under the 2017 historical rate (52.19%). Likewise, the BCBSVT QHP adolescent well child visit is currently tracking to be just under the 2017 historical rate (56.8%). On a positive note, the UVMMC Self-Funded is currently tracking to be just above the 2017 historical rate (56.9%), bringing it closer to meeting its target of increasing adolescent well child visits by 5%.*

  Developmental screenings are tracked as overall rates, rather than progress against a historical trend line, like the annual wellness and well child visits. The following rates are composites of the developmental screening bands: patients between 0 and 12 months, patients between 13 and 24 months, and patients between 25 and 36 months. OneCare currently has baseline data only for Vermont Medicaid. In 2017, the rate for Medicaid was 64.27% and the 2018 year-to-date rate is 51.44%. The 2018 year-to-date rate for BCBSVT QHP is 54.82% and for UVMMC Self-Funded it is 57.83%.

- *Activities: OneCare is developing tools to support practices in identifying and connecting with Medicare patients who have not had a qualifying AWV in more than 12 months. OneCare also worked with the Vermont Department of Health and the Blueprint for Health to bring Breena Holmes, Director, Maternal and Child Health, Vermont Department of Health, to the January 2018 All-Field Team meeting to present on Help Me Grow Vermont, developmental screening and the Vermont universal developmental screening database. The change packet for meeting the ACO Core-8 measure, "Developmental Screening in the First Three Years of Life," was also shared with the attendees.*

The Bennington HSA has increased primary care practice (PCP) visits for frail individuals in Senior Housing and individual residences through SASH program with Blueprint funded Coordinators and Wellness Nurses. They also have scheduled outreach for AWV and adolescent well visits, and have provided training on ASQ developmental screening tools in SVMC EMR to increase utilization of the screening tool.

The Windsor HSA is recruiting more primary care providers and implementing Medicare annual wellness visits in their primary care practices to increase the number of Medicare patients who have their annual AWV.

The St. Albans HSA has ongoing work to increase adolescent well-child visits and integrate depression screening as part of the adolescent well-child visits.

Both the Burlington and Berlin HSAs have primary care practices that are conducting RN-performed Medicare AWVs. Further, the Burlington HSA's Accountable Community for Health (ACH) is developing a project to increase adolescent well-child visits.

<u>Social Determinants of Health (SDoH) Screening</u>

- *Prototype measure: Develop a process measure to identify food insecurity screening rates*
- *Progress: OneCare has engaged in extensive discussions in its clinical committees around the current practices, opportunities for standardization, and possible methods to support an ACO-level approach to food insecurity screening. As a next step, OneCare has developed a network survey for food insecurity that will be distributed in Q3 2018. OneCare is also considering developing a process to search for food insecurity screenings for all patients selected for chart review as part of the 2018 clinical quality measure data abstraction.*
- *Activities: Through its pediatric subcommittee, OneCare is supporting a pilot to create a pediatric household-derived risk model to provide a risk score for each identified member. Risk score can be used to identify members with rising risk and increasing value of existing risk models by adding an SDoH component.*

In the Berlin HSA, at the CVMC practices, all children and their families will be screened at regular intervals for the presence of four Adverse Childhood Events (ACEs) and/or developmental delays.

In the Bennington HSA, screening tools for SDoH for adults and pediatric populations are being implemented as part of the PCMH standards and best practices. In May 2018, Bennington HSA hosted a community-wide learning collaborative on addressing food insecurity and a Community Supported Agriculture (CSA) program for patients in the cardiac and pulmonary rehab programs has been created to bring fresh, local food to patients.

Providers in the Windsor HSA have the ability to write prescriptions for produce from the VeggieVanGo. The prescription service serves between 90-183 families each month.

In the Burlington HSA, food insecurity screening questions are included in the EMR for most PCP practices within UVMMC network.

The Newport HSA also has a successful program to provide participating patients and their families with CSA shares and education around how to prepare the food.

While many of the HSAs are focused on food insecurity, some HSAs have chosen other aspects of SDoH to focus on. The St. Albans HSA has a focus on housing as an SDoH, specifically, housing for homeless families and rent support through community partners. The Middlebury HSA is using the Child and Adolescent Needs and Strengths (CANS) assessment in pediatric practice to screen for depression and ACEs.

2. Provide a completed **Appendix 5.2, 2018 and 2019 Network and/or ACO Initiatives to Address All-Payer ACO Model Quality Measures,** to briefly describe results to date on ACO initiatives to address the quality measures.

Please see Attachment B. in Part 5 Attachments for a completed Appendix 5.2 titled "APM Quality Measures".

3. Describe how you are using surveys, qualitative input, or other methods to assess and improve patient experience and provider satisfaction with the state's transition to a value-based payment model.

OneCare is committed to assessing improving patients' health care experience and values qualitative input and perspectives from patients and families and employs several strategies to gather this information on a regular basis. Current and ongoing activities are described below:

OneCare utilizes patient experience surveys to capture feedback from patients about their health care experiences with physicians, hospitals, and other health care providers. The patient caregiver experience survey covers several domains including Coordination of Care, Access to Care, and Health Promotion, and Education. The survey assists in identifying opportunities to help improve the quality of care and patient satisfaction. Patient experience survey results contribute to the hospital's overall quality score. Based on these results, providers are eligible for financial incentives through quality withholds associated with each payer program.

OneCare's Patient and Family Advisory Committee, a major source of input, is comprised of patients, family members and caregivers, who intentionally reflect the diversity of OneCare's Network with respect to payer programs, geography, and age. The Committee meets every other month to share their stories regarding health care, discuss clinical initiatives, and provide feedback that informs ACO decision-making. For example, the Patient Family Advisory Committee has provided feedback to inform the development of OneCare's care coordination platform and will be meeting again to review and provide input on the patient engagement tool. Recommendations from the Committee are forwarded to the OneCare Board of Managers after each meeting. OneCare has also presented an overview of OneCare and ACOs to interested public groups and obtained feedback from them about the presentation and health care reform efforts in general.

OneCare's Board of Managers includes three consumer representatives, one of whom represents each of the payers: Medicare, Medicare and Commercial insurance. These board members are vital in bringing the patient and family voice to the table and ensuring their perspectives and concerns are represented in discussions and decisions. OneCare has also instituted a public session at all Board meetings and members of the public have attended to observe and listen to the Board's deliberations as well as to give voice to their ideas and concerns about the healthcare delivery system.

OneCare continues to promote the inclusion of patient and family advisors in participating communities, and currently six (6) of the eleven participating

communities have a patient/family advisor on their Community Collaborative/Accountable Community for Health to assure that patient and family perspectives are represented in planning and initiatives.

Over this past year, OneCare has worked to integrate the Institute for Patient-and-Family-Centered Care (PFCC) concepts into our organization. This included the development of an internal workgroup which meets regularly to continue the development of a patient- and family-centered care culture in our office and provide tangible connections between OneCare's work and the health of individuals. In December 2018, "Patient- and Family-Centered Care" will be the subject of our statewide Interdisciplinary Grand Rounds to educate our Network on the principles of Patient- and Family-Centered Care and provide best practices and interesting innovations for possible inclusion in local sites of care.

OneCare strives to incorporate feedback from across our Network and partner organizations in an effort to improve providers' and patient's experiences while transitioning to a value-based payment model. Providers are active members various OneCare committees including the Population Health Strategy Committee, the Clinical and Quality Advisory Committee, the Pediatrics Subcommittee and the Lab Subcommittee. These Committees review new and current OneCare initiatives as well as promote peer learning by sharing network-wide community initiatives. Provider input is a valuable resource in these Committees. Recommendations from these Committees are also provided to the Board of Managers. When needed, OneCare also convenes subject matter expert groups to help guide new initiatives – for example a Primary Care Workgroup and a SNF 3-day rule Waiver Workgroup. By including providers from the beginning of new initiatives, their perspective will not only help lead change but may help improve overall provider, and in turn patient, experience and satisfaction.

4. In **Appendix 5.3, ACO Population Risk Stratification Summary Analysis 2018/2019,** provide a summary analysis of your population, including variations in risk by health service area; a breakdown of population distribution and associated spend into the four population health quadrants, by health service area.

   Please see Attachment C. in Part 5 Attachments for a completed Appendix 5.3 titled "Population Risk Summary".

5. Provide a progress report on the implementation of Care Navigator. In **Appendix 2.1, Provider Network,** the ACO will report the organizations that are using the tool by health service area. In addition, the ACO shall report:

   Please see Attachment A, in Part 2 Attachments for a completed Appendix 2.1 which lists those providers and entities that are currently using Care Navigator

   a. The number of active users (i.e. those who use the tool daily by Health Service Area);

Total currently active Care Navigator users as of 9/6/18: 547

b. The number of patients with information in the system by Health Service Area;

Number of Patients with Information in the System by HSA	
HSA	**Patient Count as of 09/06/18**
Bennington	643
Berlin	1,765
Brattleboro	318
Burlington	2,313
Lebanon	66
Middlebury	894
Newport	60
Springfield	801
St. Albans	1,037
Windsor	85
Total	7,982

c. The number of patients with shared care plans in the system by Health Service Area;

Number of Patients with SCP Initiated by HSA	
HSA	**Patient Count**
Bennington	66
Berlin	171
Brattleboro	46
Burlington	479
Middlebury	27
Newport	1
Springfield	21
St. Albans	116
Windsor	9
Total	936

d. A summary of how you are incorporating provider and patient input on Care Navigator (if possible, include a summary of input from providers who have opted not to use Care Navigator);

OneCare recognizes the importance of the perspectives that patients, family members, and care team members can bring directly into the planning, delivery and evaluation of our programs. Feedback from patients and providers is compiled from various sources including OneCare Committees, Care Coordination Core Teams, Care Navigator User Groups, and surveys.

OneCare incorporates patient and family member input into the care coordination program, the care coordination model and care management software through our Patient and Family Advisory Committee (PFAC). OneCare collaborated with the University of Vermont Medical Center Patient and Family Advisor Program Manager to identify and engage additional patient family advisors, who, combined with a subset of self-identified members of the PFAC, formed a focused workgroup of advisors to share input on the care coordination software tool. Multiple demonstrations of the care coordination software platform to receive patient and family member feedback occurred spanning early implementation through 2018, resulting in valuable feedback that continues to inform development of the user interface. For example, suggestions were made with respect to organization of information, field labels, and clarifying language. In the next phase, deployment of a mobile application, OneCare will continue to engage the Patient and Family Advisory Committee on design and implementation strategies as well as to conduct small scale pilot testing in advance of any

broader dissemination in order to identify opportunities to enhance and refine the tool and/or implementation strategies. Additionally, OneCare has created and actively maintains an Advancing the Practice of Patient-and-Family-Centered Care Action Plan, which identifies, among other action items, "Integrate Patient and Family Feedback and Recommendations into the OneCare Care Coordination Model, Tools and Practice" as a high priority ongoing action item.

In 2017, OneCare's Coordination Program Administrator created Care Coordination Cross-Community Core Teams. The teams are organized into two (2) regional teams: Northern (Berlin, Burlington, Middlebury, Newport and St. Albans) and Southern (Bennington, Brattleboro, Lebanon NH, Springfield, and Windsor). Each of the 10 risk-participating communities has representation from 5-10 key stakeholders that contribute to local care coordination activities, and participate in the use of OneCare's care coordination software program. Members include cross-community care coordination key stakeholder representatives from each active participating community. Members represent adult primary care (FQHCs, Independent, and hospital-owned practices), pediatric primary care, Designated Agencies (mental health), Hospitals, Home Health, Blueprint for Health, Area Agency on Aging, SASH, and other community agencies. These teams convene on a monthly basis to review, share, recommend and disseminate a variety of care coordination implementation strategies, workflows, results, feedback and lessons learned to support continuous performance improvement in support of optimal patient/client outcomes, enhanced community alignment and integration, and success under risk-based contracts. Review, discussion and feedback regarding the care coordination software system is a monthly topic.

OneCare's Care Coordination Implementation Specialist and/or the Care Coordination Program Administrator facilitate topic discussions, and bring input provided to OneCare's weekly meetings with the Care Navigator development team for implementation discussion, which results in either real-time changes if indicated and possible; incorporating suggestions into quarterly system enhancements, and/or incorporating vetted suggestions into the succeeding year's Care Coordination Software Project Development Road Map for development and implementation.

Examples of provider input and enhancements that have been incorporated by OneCare include: comprehensive refinements/additions to community programs types; addition of "Identified Gender" to patient details section; addition of secure care team messaging; addition of the ability for a care team member to reflect a change in patient's risk level and required intervention frequency based on identified SDoH or direct clinical knowledge; as well a mechanism to capture data indicating reason for revision.

Provider input on the care coordination software system is additionally gained through three active sub-groups within the Care Coordination Core Team, including the examples below.

- *Metrics and Measurement: Making recommendations for additions needed in the care coordination software system to track workflow.*
- *Kids and Family Care Coordination Team: Making recommendations to meet the needs of the pediatric population in the care coordination software system, such as addition of free text field for Adverse Childhood Experiences score.*
- *Documentation Standardization**:** Creating a unified, electronic version of the VT Self-Sufficiency Matrix for inclusion in the software system, addition of drop down field to report SDoH screenings.*

During monthly Care Navigator all-user group meetings, OneCare's Care Coordination Program team solicits feedback and system suggestions from active users of all provider types, across communities, roles and organizations. The Care Coordination Implementation Specialist follows the same process regarding subsequent evaluation and implementation of feedback and/or suggestions as that for Core Team provider input.

At the end of Q3 2018, OneCare is deploying an all-user Care Navigator survey to assess user-friendliness, ability to communicate with the care team, and satisfaction with various components of the tool. OneCare will be reporting out the results of that survey broadly in Quarter 4 and identifying areas for improvement for the upcoming year.

e. Progress made on the evaluation plan for Care Navigator, as described in your 2018 budget submission.

During the past year, OneCare has incorporated several features and enhancements to Care Navigator. These features are intended to add value to the care team in order to promote engagement of Care Navigator in the health service areas. OneCare has successfully increased the patient educational resources available to care team members. Resource topics include education on chronic disease, nutrition, and support services. OneCare collaborated with Designated Agencies to develop and implement a universal consent process within Care Navigator for providers who are subject to 42CFR Part 2 regulations. Care Navigator added features including family information and family goals to develop a pediatric shared care plan. Care Navigator is now receiving information from PatientPing's event notification in order to receive out-of-state hospital notifications. This provides the care team members will real-time event notifications for these transitions in care. Within the next quarter, OneCare will be piloting the Care Navigator mobile application. The mobile app will allow care team members to access information from a hand-held device when they are working in the field.

OneCare tracks several process metrics in Care Navigator which are shared with payers and across health service areas through the quarterly reports as well as during monthly Care Coordination Core Team meetings. Current highlights include:

- *Currently, there are 17,541 high and very high risk attributed patients in Care Navigator.*
- *OneCare has trained approximately 350 people to use Care Navigator in 2018. This brings the total number of active users to nearly 600.*
- *14% of high and very high risk patients have a Lead Care Coordinator assigned*
- *8% of high and very high risk patients have a care team created with at least two people on their care team.*
- *256 of the high and very high risk patients have a Lead Care Coordination with a shared care plan that identifies at least two goals with two associated tasks.*

6. Describe how you are measuring success of the care model, including numbers of patients receiving care management interventions, the number of care management encounters by type of intervention, and measures of success (e.g., utilization by category of service, quality measure results). Provide results if available.

OneCare recognizes the critical importance that data and evaluation play in understanding the overall impact and success of the model as well as opportunities to learn and refine the care coordination model over time. To that end, OneCare has designed a Care Coordination Effectiveness and Outcomes Analysis framework to guide and inform the learning system. OneCare is utilizing a variety of data sources it has available to inform the analysis and investigate a variety of questions in the structural, process and outcomes domains. Primary data sources include Care Navigator and WorkBenchOne™ as together they allow for the identification, tracking, and reporting of different levels of care management activity within the attributed population.

These systems have the ability to link patients' care management data to claims data and selected utilization metrics for comparison and analysis over time. While the primary focus of the evaluation framework is a time-series design examining patients engaged in care coordination, OneCare's analytic tools provide the ability to review and analyze data by attributed health services area, organization, practice and provider as well as by patient's care coordination risk level, age, gender and specific high risk chronic conditions (e.g. asthma, coronary artery disease, COPD, diabetes, hypertension, tobacco use and pregnancy).

Data are trended over time to facilitate the identification of shifts in patient outcomes after specific interventions have taken place. This framework includes a rolling 12 months of cost of care and utilization data and run charts capture pre/post care coordination engagement metrics.

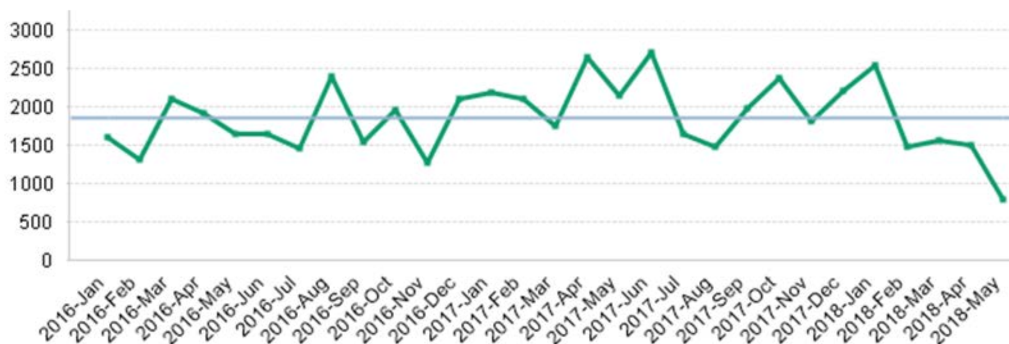
The following table represents the number of patients provided with each type of intervention. Although the table does not represent unique patients, it does demonstrate the variety and frequency of use of interventions provided by care teams.

Number of Encounters by Type of Intervention Total	
Type of Meeting Name	**Patient Count**
Care Team Conference	66
Email	36
Facility Visit	23
Home Visit	128
In Person	874
Letter	244
Office Visit	741
Other	90
Phone	936
Review & Coordination of Care	54
Goal Setting	936

The following table compares utilization metrics over time for high and very high risk beneficiaries who have received care coordination. Although the overall numbers for patients who are receiving care coordination are limited, they are growing as communities increase engagement with Care Navigator. This early data shows improvement for certain measures such as a reduction in in-patient rehab by 14.2%, a 4.7% reduction for in-patient average length of stay in days, and a 2.8% reduction in ER visits.

Results *From Outcomes App for All High and Very High Risk Since Care Management Started			
Metric	**Current Year 01-17 to 05-18**	**Prior Year 01-16 to 05-17**	**% Change**
ER Visits (PKPY)	1,344.4	1,382.9	-2.8%
Inpatient Admissions (PKPY)	347.5	350.1	-0.7%
Inpatient ALOS (Days)	5.3	5.6	-4.7%
30-Day Readmission Rate	13.2%	13.2%	0.1%
Inpatient Rehab (PKPY)	6.9	8.0	-14.2%
Rehab ALOS (Days)	11.6	11.7	-1.1%
Office Visits (PKPY)	9,159.4	9,451.7	-3.1%
High Cost Imaging (PKPY)	1,193.2	1,199.4	-0.5%

The run chart below demonstrates the number of ER visits per thousand per year (PKPY) declining for the population who have been actively care managed for one to six months duration. These data, although still in the early phases, shows a correlation between engagement in care coordination and number of ER visits.



7. Describe the ACO's network capacity for substance use disorder (SUD) treatment programs, including number of practices and/or providers participating in MAT programs, wait time information, and available slots for treatment. This may include current or planned initiatives.

OneCare, as described above, is very engaged in initiatives that support access and treatment for substance use (please refer to Mental health and substance use disorder progress update in the certification update document). As discussed with the Green Mountain Care Board staff, OneCare does not have the ability to track wait times for its attributed populations. Current practice, due to 42CRFR Part 2, is that the payers "blind" claims that contain information about attributed lives that receive substance use diagnosis and treatment.

8. Describe implementation of the ~$1,577,600 outlined in your 2018 Community Program Investments 2018 Guidance for, which included expansion of RISE Vermont. Include goals, metrics, outcomes, and achievements and opportunities for improvement thus far.

RiseVT ($1,200,000)

- *Goals: In 2018, RiseVT formed a partnership with OneCare to spread an evidence-based, primary prevention program to six (6) new communities outside of Franklin and Grand Isle counties where the program was founded in 2015. Initial goals were to onboard a statewide leadership team based at OneCare and to recruit hospital partners to hire RiseVT staff and begin outreach in new communities. Once communities were identified, new RiseVT program managers were tasked with hosting at least three (3) wellness initiatives in new communities by the end of the calendar year. RiseVT also set out to educate Vermonters about the resources available locally to improve health and wellness by creating state and local campaigns that amplify existing health and wellness programs through media promotion and sponsorship.*
- *Metrics: RiseVT compiled 10 key metrics from the 2017 County Health Rankings and 2017 Youth Risk Behavior Survey to create local health outcome snapshots. Community snapshots include 10 measures noting where the county is performing at or below the average Vermont value to help communities identify areas of focus for their RiseVT campaigns. RiseVT statewide also uses the data collected by the local RiseVT team in Franklin and Grand Isle counties from their school BMI measurement study. This study measured the BMI of 1st, 3rd, and 5th graders in 19 schools in Franklin and Grand Isle counties and researchers will return to the schools every two years to follow the BMI rates of each cohort. Lastly, RiseVT is engaging the Center for Research and Public Policy to pre-test messages for a statewide nutrition campaign that will focus on reducing the consumption of sugar-sweetened beverages. This research will identify an audience ready for change, recommend messages that resonate with that audience, and show metrics on baseline beverage consumption to measure change.*
- *Outcomes & Achievements: RiseVT has expanded to 20 new communities statewide with six (6) hospitals hiring RiseVT program managers. Thirty-three wellness events have taken place as of August 30th, 2018 with many more scheduled in the fall of 2018. Three (3) statewide campaigns have amplified partner work including the Girls on*

the Run Northern 5K, the Agency of Education's Summer Food Service Program, and Vermont Fish and Wildlife's "Reel Fun" program.

- *Opportunities for Improvement: RiseVT is getting started in new areas and testing new tools so we'll be continually evaluating outcomes and where programs can be improved. A statewide toolkit for RiseVT was launched in May and as the tools have been implemented we have received helpful feedback for revisions from hospitals and the community. We've started to award amplify grants within communities and have received feedback on the grant application so will be taking steps to revise these tools to meet the communities' needs.*

<u>Regional Clinical Representatives (RCR) ($300,000)</u>

- *Goals: An RCR is identified and contracted with OneCare for six (6) hours per week of service in each health service area; one (1) pediatric-focused RCR is contracted with OneCare to work statewide; RCRs participate in local Accountable Communities for Health (ACH) meetings and serve as the bi-directional eyes and ears for OneCare in local communities*
- *Metrics: 1) RCR contracts established in each health service area; 2) RCRs attend ACH meetings regularly; 3) RCRs attend Clinical and Quality Advisory Committee meetings regularly and report out on progress, challenges, and lessons learned in their communities; 4) Pediatric-focused RCR participates in regular Pediatric Subcommittee meetings*
- *Outcomes & Achievements: RCRs recruited and established in 9 of 10 health service areas; Pediatrician hired to serve as statewide RCR resource; RCRs participate in Clinical and Quality Advisory Committee meetings and local ACH meetings; RCRs participated in a OneCare data literacy training session during summer 2018 and have asked for more training; RCRs are learning the content of the new comprehensive reporting package OneCare produces quarterly and are bringing information forth into their communities to drive decision-making*
- *Opportunities for Improvement: 1) Expand RCR contracts into new communities for 2019; 2) Refine scope of work to include enhanced focus on synthesizing local HSA data and engaging partners in improvement activities in collaboration with OneCare Clinical Consultants; 3) Resolve current vacancy in the Lebanon community.*

<u>SASH/Howard Center Pilot Program ($77,600)</u>

- *Goals: 1) Improve access to mental health services; 2) Individuals have a coordinated team with a mental health clinician on site in two congregate housing locations; 3) Reduction in emergency room utilization; 4) High levels of participant satisfaction*
- *Metrics: 1) Referrals to embedded MH clinician (EMHC); 2) Days from referral to first encounter with EMHC; 3) Number of participants; number of encounters; 4) Participation of EMHC in care coordination; 5) Reduction in ED visits; 6) Participant satisfaction.*

- *Outcomes & Achievements: To date there have been 49 referrals to the EMHC (11/1/17 – 8/28/18); 71% of the time the days to referral was ≤1 while 7% of the time it was > 5 days; 51 participants were seen for shorter-term therapy/ psychosocial support and 66 additional participants engaged in group or other informational encounters with the EMHC; the majority of participants in group sessions responded that that they: a) learned new skills; b) learned about new resources they could use; c) learned where they can go for help and 92% indicated that they plan to apply what they learned from the psychosocial group sessions. Two evictions were prevented after the EMHC was brought into the eviction process to help work with the residents and staff to address the underlying issues.*
- *Opportunities for Improvement: 1) Time constraints regarding increased documentation and workload for staff; 2) More time is needed to measure reductions in ED utilization;*

9. Populate **Appendix 5.4, 2018 Projected Population Health Investments Update** with information submitted in last budget cycle and complete **Appendix 5.5: 2019 Budgeted Population Health Investments** to include:

    - Program name
    - Program description
    - Investment amount
    - Operational models
    - Financial models
    - Recipients
    - Program goals

    Per 18 V.S.A. § 9382, population health program financial investments should include:

    a. Strategies to bring primary care providers into the network
    b. Strategies for expanding capacity in existing primary care practices, including but not limited to reducing administrative burden on such practices
    c. Integration of community-based providers, including expanding capacity to promote seamless coordination of care across the care continuum
    d. Population health programs, including:
        i. preventing hospital admissions or readmissions
        ii. reducing length of hospital stays
        iii. improving population health outcomes, with a focus on the All-Payer ACO Model measures found in Appendix 5.2 APM Quality Measures
        iv. addressing social determinants of health
        v. addressing childhood experiences and trauma
        vi. supporting and rewarding healthy lifestyle choices

Please see Attachment D and E, in Part 5 Attachments for completed Appendices 5.4 and 5.5 titled "2018 Population Health Investments" and "2019 Population Health Investments" respectively.

10. Describe planned ACO investments in community-based provider capacity, efforts to include community-based providers in decision-making and policy development, and efforts to avoid duplication of resources.

Person-centered care is the focus of the OneCare population health model. In order to achieve well-coordinated, high quality care, all of the care team members across the care continuum must be involved. OneCare provides care coordination incentive payments to multiple community-based providers beyond the primary care office. These community providers include the Designated Agencies, Home Health, and Area Agency on Aging. They receive incentive funding to participate on attributed patients' care team and for taking the role as the Lead Care Coordinator. It is the responsibility of the Lead Care Coordinator and the members of the care team to help facilitate seamless transitions in care and prevent duplication of efforts; from medical tests to human services paperwork. This not only increases patient satisfaction but lowers health care costs.

Community-based provider perspectives are valuable to the ACO's work and policy development. Community providers are regular participants on OneCare clinical governance committees and action teams. For example, voting members for the Population Health Strategy Committee include representatives from AgeWell, the Vermont Department of Health, the VNA of Chittenden and Grand Isle Counties, the Vermont Food Bank, Washington County Mental Health, and the Vermont Child Health Improvement Program. Community-based providers are integral to the development and implementation of the Medicare patient benefit enhancement waivers including the skilled nursing facilities, home health agencies, and SASH. The Designated Agencies have also collaborated with the Care Coordination Program to develop and implement the 42CFR Part 2 consent form and process for Care Navigator. Further, OneCare's Board of Managers includes representatives from community providers including the DAs and home health as well as consumers. Through its clinical governance structure, all policies are ultimately approved by the Board of Managers.

11. Refer to PART III: Primary Care Spend Measurement and use the specifications provided to report on your proportion of primary care spent by payer for 2017, 2018, and 2019.

Please see Attachment F, G and H Part 5 Attachments for completed Appendices 5.6, 5.7, 5.8, for our primary care spend figures for 2017, 2018, and 2019 respectively.

Part 5
Attachments

Attachment A – ACO Clinical Priorities

Attachment B – APM Quality Measures

Attachment C – Population Risk Summary

Attachment D – 2018 Population Health Investments

Attachment E – 2019 Population Health Investments

Attachment F – 2017 Primary Care Spending

Attachment G – 2018 Primary Care Spending

Attachment H – 2019 Primary Care Spending