1. **Please provide an update on the current status of implementation of the data analytics transition and a current projected timeframe for the transition.**

The elements for the transition are in place. The Data and Analytics Services Service Order ("Service Order") between UVMHN and OneCare has been fully executed; the organizational structures of the UVMHN Data Management Office ("DMO") have been established; the reporting and budgetary structures for the technology, data systems management, and analytics teams has been reconfigured and are now under the control of UVMHN's Data Management Office; all policies and procedures to fulfill data requests, separate, segregate, and protect data are in place. Key employees have received training to ensure that commercially sensitive information is safeguarded. OneCare data has not yet been received by UVMHN's Data Management Warehouse. The parties expect that Medicare and Medicaid data, which does not raise antitrust concerns, will be transmitted first. The current timeframe for full implementation is September 2023. See response to Appendix I, Request to Produce 9, for copies of the respective policies.

2. **Will all data received by OneCare from its provider network be covered by the arrangement set out in the Service Order? If not, please specify.**

All of the data received by the DMO on behalf of OneCare, and all data received by OneCare and then transmitted by OneCare to the DMO, will be covered by the arrangement set out in the Service Order

OneCare also receives some demographic and management data from its provider network, such as lists of provider personnel, contact information, and the like. This information is not transmitted to the DMO and is therefore not covered in the Service Order but, instead, is maintained and protected by OneCare in other systems.

3. **As outlined in Service Order Attachment C, Section IIb, is it correct to assume that this data could include commercial payer data?**

Yes. It is intended that commercial data will be included and is subject to the controls and protections described in Section III of the attached narrative document.

4. **Please explicitly confirm or deny that ACO data will not be used for business purposes, including but not limited to UVMHN's Medicare Advantage Plan with MVP or other planned business ventures in the future under any circumstances.**

Confirmed. The UVMHN DMO will utilize the data it receives from OneCare solely for the ACO purposes identified in and permitted by the Service Order. Neither OneCare, nor the DMO, acting on its behalf, will share that data with UVMHN for any other purpose. Of course, UVMHN and its affiliated hospitals and providers may receive appropriate ACO data from OneCare, and the DMO acting on its behalf, in their capacity as OneCare network providers, just as any other participating providers or hospitals would.

5. Please explicitly confirm or deny that ACO data will not be sold to other business partners or entities under any circumstances.

Confirmed.

6. Was this contract approved and supported by other participating providers in OneCare's network? If so, why is it in their interest to do so? Please provide all communications between OneCare's provider network and OneCare in support of or in opposition to the data analytics transition to UVMHN.

Yes. GMCB Rule 5.202(a)(4)) requires that an ACO governing body maintain strategic control over the ACO's activities. Consistent with Rule 5.000's requirements for Board representation, the ACO Board is comprised largely of representatives from various types of network providers. The representative form of governance captures the diverse perspectives of its constituents, including the providers. OneCare's representative board approved OneCare's decision to enter into the contracts with UVMHN in response to the directive of AHS to OneCare to improve its data analytics capabilities (please see response to question 22), which will in turn benefit all participating providers and their patients.

Since network providers' input is incorporated through their representatives on the Board, OneCare has not separately maintained a file of all communications it has had with all the members of its provider network. It has, however, maintained and can provide to the GMCB the resolution approved by its Board regarding the transition, which cites the reasons for the decision. (See attached Resolution). OneCare also provided a communication regarding the transition to all participants, a copy of which is attached to this response.

7. OneCare's Policy 01-02, Section VI C 1 states: "Recusal. In all cases, an Interested Person with a Personal Interest relating to a specific Network Member, Subcontractor, Vendor, or other third party should refrain from voting, or participating on behalf of OneCare, or from exercising influence or control, with respect to decisions or actions affecting or benefiting [sic] that Network Member, Subcontractor, or Vendor." Please indicate whether any members of OneCare's Board of Managers who are also employed by and/or associated with UVMHN participated in a vote to approve the data analytics contract with UVMHN. If so, please explain why the decision not to recuse was made and how it complies with this policy.

One member of OneCare's Board of Managers, who was also employed by an affiliate of UVMHN, participated in the vote to approve the data analytics contract. Upon further analysis, this member should have recused themselves from the vote. However, the vote to approve the analytics contract was unanimous, so excluding the vote of this manager would not have affected the outcome of the Board of Manager's decision.

8. Are there any other contracts or written agreements between UVMHN and OneCare related to the data transition other than what was shared with the HCA and the GMCB on November 15th or covered by the document requests in Appendix 1?

A Regulatory Addendum, which had not been executed at the time OneCare submitted documents as requested in Appendix 1, and which is effective March 31, 2023, was entered into by and among OneCare, UVMHN and Arcadia Solutions, LLC for the purpose of flowing through mandatory terms from the Vermont Medicaid Next Generation Program Agreement.

9. Given that ACO data from all participants is to be shared with UVMHN, is it correct that there are no plans to have these non-UVMHN participants represented in the Data Committee? (Refer to Section 3.1.2 of the Service Order).

OneCare's use of data received from its participants and payers will continue to be governed by OneCare's management team and its Board of Managers, which is comprised mostly of non-UVMHN participants. OneCare's network of providers also have the opportunity to provide input into data and analytics matters through participation in committees, subcommittees, and workgroups. The Data Steering Committee, which is a joint OneCare and UVMHN committee, will not oversee or govern how OneCare uses ACO data or how OneCare directs the DMO to analyze that data on OneCare's behalf. Rather, its purpose is to provide operational guidance to the DMO as it fulfills its contractual obligations to OneCare pursuant to the Service Order. As a result, the committee appropriately does not seek to duplicate the representational structure of OneCare's Board of Managers, and is instead comprised of operational experts from OneCare and UVMHN.

10. Will this contract with UVMHN continue indefinitely? (Refer to Section 4.2 of the Service Order).

No. While the Service Order does not contain its own term or termination clause, it can be terminated as set forth in Section 6 of the Master Services Agreement ("MSA") between UVMHN and OneCare. Unless terminated, the Service Order will remain in place for so long as the MSA is in place. The Service Order can be amended upon agreement between UVMHN and OneCare (See Service order Section 11.9).

11. What is the third party in the potential future 2023 contract with VITL? What services will be performed by UVMHN for this work? (Refer to Section 4.14 of the Service Order).

The third party is OneCare. VITL will transition from transferring data to OneCare's legacy platform to UVMHN and the Arcadia platform instead. VITL's role is to provide high-quality clinical data from the Health Information Exchange to support population health management monitoring and to facilitate patient matching for care coordination reporting. UVMHN's DMO will now receive this data and use it in accordance with its role under the Service Order for the performance of data analytics for OneCare.

12. Regarding segregation, sequestration and access as outlined in Section 4.18 of the Service Order, please provide a list of all OneCare policies, including policy number and effective date, for "policies regarding permissible access to ACO Data." If not already provided to the GMCB, please provide as specified in Appendix 1.

Please see response Appendix 1, request to produce 9.

13. During the November 9th hearing, Ms. Barry stated "There is some remaining work to be done before any data are shared und the new arrangement, and that involves ensuring that the final policies and procedures that dictate at the granular level the detail around how data are handled are well spelled out" and also that "In terms of data storage and protection, we have required the UVM Health Network to establish some additional policies and procedures". Are there any other procedures applicable to handling of data in addition to the OneCare data policies referenced in the Service Order?

Ms. Barry's comments were accurate at the time. Since that time, all the policies and procedures necessary to implement this transition have been completed. For a complete list of related policies see those produced in response to Appendix 1, request to produce 9.

14. Please explain how OneCare will audit UVMHN's compliance with the requirements of Section 4.18 of the Service Order.

OneCare intends to engage a third-party auditor to audit UVMHN's compliance with the requirements of Section 4.18 of the Service Order.

15. Please elaborate on what would make adherence be classified as "impracticable," thus rendering UVMHN not responsible for adherence to policies outlined in Section 4.18 of the Service Order.

The concept of "impracticability" in Section 4.18 is simply intended to provide a defined path to address unforeseen operational issues. To the extent that adherence to OneCare policies regarding access, segregation, and sequestration of ACO Data presents operational issues for UVMHN, Section 4.18 requires the parties to propose new procedures and "determine a mutually agreeable solution, and negotiate a Change Order if necessary." Subsection 4.18.3 goes on to state that data will not be provided to UVMHN before procedures are approved. Thus, UVMHN is never "not responsible for adherence." Instead, the parties are charged with working together to revise policies and procedures or come up with alternatives, if necessary, to handle ACO data for the purposes set forth in the Service Order. All such alternatives would be required to comply with all legal, regulatory, and contractual requirements for which OneCare and UVMHN are responsible.

16. As outlined in 5.3, is it correct to assume that if OneCare's Single Point of Contact were to provide written authorization to use ACO data for uses currently prohibited in the contract

– which include "market analysis, research purposes, or formal research outside the terms of OneCare's Data Use Agreements, Associate Agreements, OneCare Data-Related Policies," these same activities could be permitted? Who is OneCare's Single Point of Contact? What are OneCare's Data Related Policies referenced in this section?

No, this assumption is incorrect. This provision is intended to provide a pathway for responding to the occasional one-time request, usually from researchers, to use ACO data in ways that are not specifically contemplated in the Service Order and that may be permitted by the applicable agreement with the data source. The Single Point of Contact is not permitted to authorize the DMO to use ACO data for any purpose that is prohibited under OneCare's payer agreements, provider agreements, the Service Order, policies, or any laws or regulations. The Single Point of Contact is the Chief Operating Officer of OneCare. See response to Appendix I, Request to Produce 9, for copies of the respective policies.

17. **Why are audit rights under Section 6.2 of the Service Order only provided to public payers and not to commercial payers.**

The Service Order incorporates preexisting policy requirements and data use and Business Associate Agreement requirements. The public payers with which OneCare contracts have required audit provisions that were included in the audit rights in Section 6.2. OneCare's agreements with commercial payers do not contain these requirements.

18. **As outlined in Section 10.6 of the Service Order, will there be a role or need for a contract with UVMHN after January 2024, given a full transition to having data analytics work completed by UVMHN is expected to be completed by this time? How does this work intersect or interact with UVMHN's planned population health services organization proposal as discussed in their FY23 hospital budget narrative submission?**

Completion of the transition, as set forth in Section 10.6 of the Service Order, means, in practice, that the DMO, will be OneCare's subcontractor for the full scope of its data and analytics needs that are outlined in the Service Order. Given the contractor/subcontractor relationship between OneCare and UVMHN, respectively, there will continue to be a need for the Service Order, which will govern the relationship with respect to OneCare and the services provided to it by the DMO.

The PHSO is UVMHN's solution to improve population health management and performance in value-based contracts across its affiliates. Its focus is on providing high quality actionable data to monitor and improve performance. In this way, its goals are similar to OneCare's, just with a different reach. The DMO will provide a data analytics platform and data analytics tools and services for utilization by both UVMHN and its affiliates (through the PHSO) on the one hand and OneCare on the other, is intended to reduce unnecessary waste in technology, personnel, and other costs required to perform these functions.

19. **In the event that OneCare were dissolved or cease to operate, which could be affected by UVMHN's holder of more than 75% of OneCare's membership interests, would ACO data**

become property of UVMHN? In that scenario, how would the procedures outlined in Section 11.8 of the Service Order about how and when data is to be "returned" operate?

No. The ACO data would not become the property of UVMHN. The payers with which OneCare contracts own the data that they provide to OneCare, and which the DMO receives for purposes of performing OneCare's data analytics. OneCare, under its payer arrangements, is required to return or destroy data upon the termination of those agreements. Because it is acting as OneCare's subcontractor, the UVMHN DMO would need to either return or destroy all such data if OneCare were dissolved or cease to operate, provide assurances to OneCare of any such destruction, and then OneCare would pass assurances of such destruction on to the payers.

20. If there is a possibility that OneCare may decide not to operate as an ACO and/or may decide to only serve UVMHN providers in FY24 or beyond, explain why the data analytics transition should occur?

OneCare's participating providers and their patients will benefit from the decision to implement and utilize an enhanced common data analytics contractor (the DMO) and vendor (Arcadia) to meet the growing need for such services and that can support expanded accountabilities and fixed payment arrangements. This will remain true regardless of which providers are participating in the ACO. Further, delaying implementation in any way would unreasonably delay this benefit and materially hinder the population health work that these data analytics capabilities support.

21. Has OneCare had any communication with CMS, CMMI, or any other federal agency regarding the data analytics transition?

Yes. OneCare notified CMS via letter dated October 4, 2022, regarding the data analytics transition to UVMHN and the designation of a UVMHN representative as the data custodian. OneCare has not received an objection in response to this communication.

22. How does OneCare's new data analytics arrangement improve patient care, improve access to health care, increase efficiency, or reduce cost?

OneCare's new data analytics arrangement is materially similar in structure to arrangements that have existed since its inception. There is a need for software and tools to protect, store, and organize claims data and for staffing resources to analyze data and provide for reporting that can help providers assess current care delivery patterns, measure quality, and identify opportunities to maintain or improve care. Collectively these resources (tools, software, staff), when organized through an ACO arrangement, cost less than they would if each provider organization sought to install them independently. OneCare's contracting arrangement through the UVMHN Data Management Office, when fully implemented, will result in savings due to operational efficiencies as well as a more ACO-oriented analytics tool that will automate manual tasks that are resource intensive for existing personnel.

By providing actionable data and reporting, this arrangement will support provider- led advancements in care delivery transformation and payment reform – goals that both providers and the state agree upon under the APM agreement. As CMS recognized when making claims data more accessible to ACOs, health care providers are able to obtain a fuller picture of patients care delivery, outside of the information in their electronic health records. For example, under ACO arrangements providers are accountable for total cost of care, which includes services provided outside their organization. It is therefore important for providers' to understand how care is delivered and how well it is being managed. OneCare uses data and analytics to inform actions at the individual patient level as well as collectively at the Health Services Area (HSA) level and at the organizational level. Individual patient interactions improve quality of care and access and reduce cost on the granular level and can accumulate to the wider spread goals that are listed. The availability of high quality analytics provides actionable information to allow OneCare to have a more systemic impact.

First, it allows providers to more effectively manage their patient populations, identify high risk individuals, monitor appropriate utilization of services (reducing waste and improving preventive care), close care gaps, and track their financial accountability. The goals of providing data and tools is to help practicing providers better understand their attributed populations in hopes that they can meet the aims of an ACO: 1) improve experience, 2) demonstrate high value, and 3) reduce total cost of care. Thus, if a patient of Dr. Smith in HSA A visits three different emergency departments for a total of five times in a three-month window, the provider could be alerted to this utilization pattern. Dr. Smith could determine its clinical appropriateness, and outreach to the individual to attempt to reengage them with primary care and/or other community supports (such as housing, food, care coordination).

OneCare also uses data analytics at an intermediate level, i.e. the Health Services Areas level, in their regular consultations to identify trends that impact patient care, quality, efficiency and cost. Often that focus is on quality measure performance and avoidable emergency room department visits are a quality measure. OneCare can use data to help identify patterns of patients seeking avoidable emergency care. At the HSA consult, OneCare would share the data and ask for input from the group to plan responses. Perhaps, if an urgent care closed, making off-hours primary care visits more available would help reduce emergency department utilization. Maybe some health equity data reporting could shed light on environmental factors such as housing instability, indicating that patients could be moving between HSAs often. This collective effort at improving patient care and access which should lead to cost reductions by lessening avoidable emergency department visits.

Finally, the ACO as a whole uses data to make the same kind of inquiries as the HSAs and to evaluate the potential for implementing effective solutions ideas across HSAs.

High quality data analytics, deployed by an ACO coordinating provider efforts, builds the healthcare improvement effort from the individual patient level to the macro population health level.