OneCareVermont

OneCare 2019 Budget Submission: GMCB Questions

Part I. Section 2: ACO Provider Network

I.2.1 Description: Provide, as an attachment, a completed 2019 ACO Provider Network Template (Appendix 2.1).

Question:

1. For participation by payer/principal payment type, some payment types are not completed, explain why there are blanks?

   For those providers that do not have a payment type selected payer it is because those organizations, or provider are not participating in that payer program. For example many first time participants this year are only participating in the Vermont Medicaid Next Generation Program. For those communities the hospitals will be checked off as AIPBP while the rest of the providers in the community will be FFS. These providers will have blank categories for all other payers, as they are not participating and the template did not provide a "Not Applicable" selection.

2. Are none of the new network providers, including FQHCs, MAT providers?

   This was an error, and we have corrected it in the revised Appendix 2.1 which is attached. For reference we are only able to verify MAT providers through data that is provided to us by the Blueprint. This is not information we collect on our participants.

3. Why are new hospitals listed as receiving FFS payment?

   This was an error and we have corrected it in the revised Appendix 2.1 which is attached.

I.2.2 Description: 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.

Questions:

4. There are no OB/GYNs listed in some HSAs and low numbers of mental health providers in some communities (Appendix 2.2), do you see this as a problem for your care model?

   OneCare does not restrict an individual's access to any healthcare service or provider regardless of their status with the ACO. OneCare

is working collaboratively with the Blueprint for Health, including their Women's Health Initiative, to support care delivery improvements in practices serving women of childbearing age. OneCare recognizes opportunities to expand mental health providers in our Network and has plans to develop more focused programs to attract these providers during 2019 for possible expansion/implementation in 2020.

5. What is your estimate of the percentage of private practices in the state that are participating in the ACO, and what is your strategy to engage additional private practices?

   We are unable to provide an estimate as it is unclear what OneCare would be using for a denominator and where this data exists. To our knowledge the state has been unable to clearly articulate how many practicing primary care physicians there are in the state, let alone "private practices."

   OneCare's 2020 network development approach is to expand participation in all payer programs by attracting new entrants with patient attribution, developing clear program value propositions and expectations, and enhancing or expanding existing programs and fixed payment arrangements. In early 2019, OneCare will identify potential new independent practices to participate in the ACO network in two ways: 1) leveraging existing association and physician groups such as HealthFirst and Bi-State, and 2) generating an internal report of providers included in ACO claims data that are not currently contracted with the ACO. OneCare will then reach out both directly to the practices and by engaging them through their affiliated associations and groups. Later in the year, OneCare will engage practices in general provider outreach and education prior to the 2020 contracting cycle.

6. The count of attributed lives per PCP in Appendix 2.2 seems low, even in HSAs where the ACO appears to have a high penetration rate (e.g., Bennington, Middlebury, Springfield). What provider types are you including in your definition of PCP?

   The rationale used to determine Primary Care Providers (PCPs) in the PCP category were any providers (including APRNs and PAs) with a Practicing Specialty of Naturopath, Family Medicine, Family Medicine Geriatric Medicine, and Internal Medicine. These provider types were queried by individual NPI number, and organizations in a given Health Service Area (HSA) to determine distinct number of PCP providers in each HSA. This was only the number of PCP providers in each HSA and did not include the number of attributed lives they had. Additionally, please note that the enrollee's category is a combined total across all payers and across all age ranges. The template specifically asks for a separate breakdown of Pediatricians and those, by definition, would be consider PCP's.

Calculating attributed lives per PCP based only on the enrolled category by the PCP category would result in inaccurate number.

I.2.3 Description: Submit, as an Excel spreadsheet (printout not required), your provider list submitted to Medicare for your 2019 Next Generation program.

Questions:

7. Why are some providers not listed as "participant" or "preferred," for example, Mary Hitchcock Memorial Hospital, Community Health Centers of the Rutland Region? Please correct or explain.

   The Green Mountain Care Board asked OneCare to provide them with our Medicare Participant list, which we did. However we also needed to add in those providers that were VMNG and BCBS providers and not Medicare. The "Participant and Preferred Provider" column is not relevant to VMNG and BCBS providers as these two programs do not differentiate between the two classes. They are deemed participants in OneCare. We have removed the "Participant/Preferred Provider" category to minimize the confusion.

I.2.4 Description: 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." 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.

Questions:

8. You did not provide the ACO's targets by year for both providers and attributed lives, and by Health Service Area. Please explain.

   This was an unintentional oversight. However, OneCare has not set specific numerical goals for provider participation and attributed lives by HSA. Instead, goals focus around improving population health, improving the cost of healthcare, and improving the patient experience. Increasing scale may at times be a strategy to achieve the overarching goals of the ACO.

9. Has the ACO assessed its penetration rate by HSA for lives and/or providers? If so, please share that information.

The ACO has not assessed its penetration rate by HSA for lives or providers.

I.2.6 Description: 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 requirements the ACO places on the provider, if any (e.g., reinsurance, reserves).

Questions:

10. Provide detailed descriptions for each heading in Table 2.4 (e.g. clarify FFS in and FFS out).

    Home Hospital Spend*: Spend at the HSA hospital for the lives attributed to the HSA*
    UVMMC*: Spend at UVMMC*
    Dartmouth*: Spend at Dartmouth Hitchcock*
    Other In-State Hospitals*: Spend at other in-state hospitals*
    FFS In*: Spend at non-hospital providers that are part of the OneCare network*
    FFS Out*: Spend at providers that are not part of the OneCare network*

11. The table summarizing OneCare's current estimates for maximum risk and rewards in each program for the 2019 program year leaves off the self-funded programs. Are any estimates available?

    The terms of the self-funded programs are not final and accurate modeling data by HSA is not yet available.

I.2.7 Description: 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).

Questions:

12. What is the basis for the estimated expansion in self-funded lives? Can you explain the discrepancy from Tables 2.3 and 4.5 (172,365 144,407)?

    Table 4.5 includes "revenues" associated with the payer programs. There is a self-funded program in development for which estimated PMPM "revenue" is not yet available. Therefore, the associated attribution has been excluded from Table 4.5 so that the aggregate PMPM "revenue" is not distorted. An overall estimate of attributed lives is available, however, so those lives are included on Table 2.3.

13. Please complete table 2.4 in the following ways:

- Projected 2018 by payer
- Actual 2018 YTD by payer (include paid through date for each program)
- Budget 2019 by payer

14. Confirm attribution is based on average membership (member months/12)

    Generally, initial attribution (i.e. January 1st) is used to show the YTY growth. When estimating provider receipts and other financial factors, however, attribution attrition rates are applied so that expected PHM receipts are not overstated.

I.2.8 Description: Submit copies of each type of your provider contracts and agreements (i.e. risk contracts, non-risk contracts, collaboration agreements).

Questions:

15. How do you plan to address in your provider contracts the $3.9 million in risk that OCV is not delegating to SVMC, Springfield and Brattleboro?

    Please find attached in Attachment A the three risk addendums for SVMC, Springfield and Brattleboro that entails how the $3.9 million in risk is not being delegated to the three respective hospitals.

Part I. Section 3: ACO Payer Programs

I.3.2 Description: 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.

Questions:

16. Please share 2017 MSSP and BCBSVT shared savings quality measure performance.

    Please find attached in Attachment B slides showing OneCare's Quality Measure Performance for MSSP and BCBSVT in 2017. Please note that these results are pending our Board of Managers approval and are not "final"

I.3.3 Description: 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 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: Exclusion or truncation of high-cost outlier individuals (please describe) Payer- provided reinsurance Risk adjustment: age/gender, clinical (identify grouper software); h) Method for setting the budget target; Trended historical experience Percentage of premium Other (please describe).

Questions:

17. Why has OneCare not pursued truncation for Medicaid?

    OneCare negotiates the Medicaid program with DVHA and each side is advocating for terms that are fair and equitable. DVHA does not hold their own reinsurance protection for high-cost cases and therefore adding those terms to the program would imbalance the risk share. That said, one strategy employed to minimize the risk of high-cost cases is to exclude newborns from attribution.

18. Please elaborate on the last two sentences of subsection (h) of the Medicare explanation on pg. 24 (shared savings carryforward) and connect to the budget.

    The way that Medicare ensures a financial connection back to the base year of the All Payer Model is to allow any shared savings earned to be carried forward into the subsequent plan year. OneCare anticipates there will be a carryforward of shared savings applied to the 2019 benchmark, primarily driven by the $7,762,500 of conservatism applied to the target in 2018, and has incorporated this estimate into the budget.

19. Is OneCare talking to BCBSVT about having the AHP participate? If so, why couldn't the ACO have one contract that crosses products?

    OneCare and BCBSVT are no longer in discussion for OCV participating in risk for the AHP product as it would be included in the large group product which is a pool that is diminishing and holds significant risk. OCV offered to engage in a shared surplus agreement for year one (1) with the goal to move to two-sided risk in year two (2) for both of these products. However, BCBSVT stated this was not being considered. Conversation is now focused on the QHP product.

20. Will pharmacy be included in 2019 for BCBSVT?

    OneCare has shared its position with BCBSVT of not taking any risk for pharmacy in 2019. OneCare has little insight, knowledge or experience to take on this risk. BCBSVT insisted this remain part of the program for 2018, however, but it has been communicated that it is OneCare's intention to remove this unless and until we can obtain funding to pay for a Pharm-D and build the expertise to manage this spend. Pharmacy spend has not been included in the submitted budget model.

21. Please provide a weighted calculation of the proposed trend across lines of business.

Program	*2018 Attribution-Adjusted TCOC*	*2019 Budgeted TCOC*	*YTY Growth Rate*
Medicaid	*$192,341,869*	*$193,327,432*	*0.5%*
Medicare	*$462,299,753*	*$467,312,419*	*1.1%*
BCBSVT QHP	*$118,270,446*	*$124,784,779*	*5.5%*
Self-funded	*$61,826,434*	*$65,289,304*	*5.6%*
Total	***$834,738,503***	***$850,713,934***	***1.9%***

22. Regarding the trend used to project 2019 Medicaid TCOC, page 23 of the budget submission states, "Given the positive performance in 2017 and year to date in 2018, we took a modest approach of adding a small trend rate…" Please provide the positive performance that is reference here that was used as the basis for the 0.5% trend rate.

    Please see the quarterly legislative reports produced by DVHA that expound upon the performance of the Medicaid program.

23. Regarding the projection of the 2019 Medicare TCOC, page 24 of the budget submission states, "The budget targets were set primarily using 2018 experience data for the expected network as the base…" Was only the YTD 2018 experience data used? Or was the YTD 2018 experience data used combined with expected costs for the remainder of 2018? If the latter, how was the remainder of 2018 projected, what methodology was used?

    Because Medicare does not supply modeling data, the basis for the 2019 projected PMPM and spending pattern is assembled from multiple sources. For providers participating in the current year, actual spending is incorporated into the model. For new participants, data from past shared savings programs (through either OneCare or CHAC) were used when available, and estimates were used for those with no historical data available at all.

24. Page 25 of the budget submission states, "No truncation for high cost patients is built into the budget model, however there is expected to be a truncation program for all programs." Please elaborate on the expected truncation program for all programs. What is the expected structure of this truncation program? Is this only for self-funded contracts?

    That clause is intended to mean that the submitted budget model does not account for truncation (for example, through reduced spending targets) but OneCare intends to negotiate terms with self-funded plans so that truncation is included in the actual program model.

I.3.5 Description: 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.

Questions:

25. Please explain the basis of OneCare's BCBSVT trend, i.e., how it was calculated. Is there any relationship between the proposed BCBSVT trend and the BCBSVT rate filing? Also, should we understand the proposed trend to be 4.1% plus 2.3%, i.e., 6.4% trend? If not, what is it?

    OneCare made best efforts to mirror the GMCB approved trends that apply to the expected medical cost of care. It is important to note that not all premium adjustments are related to the cost of claims. The trends applied may also relate differently as premium changes reflect changes from 2018 to 2019 (a year to year trend), and the cost of claims changes reflect impacts from 2017 to 2019 (a two year growth).

    Attachment C is a spreadsheet documenting the BCBSVT filing assumptions that OneCare anticipates will affect the cost of claims. We have added additional opinions or details noted by L&E and the GMCB approvals to demonstrate how the OneCare trend has been calculated in the budget submission.

    In summary, BCBSVT initially filed an average 7.4% premium rate increase for its QHP products. An amended filing increased the requested increase to 9.6%. BCBSVT's filings included adjustments to the premium for expected claims costs as well as changes in administrative costs, elimination of corporate taxes/fees, and changes to contribution to reserves. OneCare only considered those items impacting the expected claims costs – and then only for medical services only. No pharmacy trends are included.

    The portion of BCBSVT's rate filing related to the expected claims cost impacted the premium from 2018 to 2019 by 9.9% (a one year increase). From this detail and the report from L&E, OneCare calculated the two year trend needed to reflect expected medical claims cost increase moving from the base period in the filing of 2017 to that expected for 2019, which totaled a 14.3% increase in trend (of which the GMCB approved 13.6%). The amended filing added another .1% increase for a total approved trend of 13.7% for the two year period.

    In more detail:

    - *OneCare started the calculation with the 2017 actual claims costs. (We did not add the adjustment BCBSVT used in its rate filings to account for the difference between the 2017 trend and the original filed trend for 2017*

since actual claims costs are being used.)

- *A 5.9% trend for growth in 2018 expected costs was added. BCBSVT initial filed for a trend of 4.7% in its 2018 filing and then added another 1.2% in its 2019 filing as their original estimate for 2018 claims costs growth was too low. (The detail was not readily available to subtract the Rx component of this, which could impact this trend component slightly.)*
- *An increase of 4.1% in trend from 2018 to 2019 was added for the medical portion. BCBSVT filed for a total trend of 5.9%, which included Rx.*
- *An increase in the trend of 2.6% was added for the changes in expected population morbidity from 2018 -2019 as approved by GMCB. (A trend for the actual changes in pool morbidity from 2017 to 2018 has not yet been added, as there are still discussions in setting the 2018 target and it's possible that BCBSVT did not accurately estimate the changes in morbidity due to the significant loss in membership to MVP. This is expected to increase the OneCare target.)*
- *A 1% trend was added due to changes in other factors. (While the filing was for .4% increase, this included a rate reduction for RX decreased rate reimbursement and changes to RX rebates. There were excluded as they don't pertain to the medical claims trend. After eliminating the items not applicable to OneCare, the increase requested was 1.4%. The GMCB reduced the premium increase for this category by .4%, therefore only a 1% increase was added to our trend calculation.)*
- *And lastly OneCare added the .1% additional rate approved by GMCB for the impact of benefit changes filed in BCBSVT's supplemental filing.*

These total a combined 13.7% trend increase from 2017 actual costs to the expected cost of claims for 2019; as approved by the GMCB. An additional 2.3% trend was added for the expected increase for the AHP adjustment bringing the total expected trend rate from 2017 to 2019 of 16% for the small and declining attribution to OneCare of BCBSVT's QHP population.

There were no other additions to the OneCare trend for any other GMCB approved increases or decreases to BCBSVT, including the 1% rate reduction for affordability, changes in CTR, and administrative expenses as they don't impact the expected cost of claims.

26. Regarding the projection of the 2019 Self-Funded TCOC, page 28 of the budget submission states, "The budget model presented applies a 3.5% trend from 2018 to 2019." This seems to imply that 2018 experience and/or expected spend was used as the basis for projecting the 2019 Self-Funded TCOC. Please confirm. If so, was only the YTD 2018 experience data used? Or was the YTD 2018 experience data used combined with expected costs for the remainder of 2018? If the latter, how was the remainder of 2018 projected, what methodology was used? If not, what was the basis? How was the 3.5% trend assumption selected?

Because the self-funded programs are still in development, data are limited. The 3.5% trend rate was derived from historical year-over-year trend rates and represents a reasonable estimate for growth to be expected in 2019. However, factors such as changes in plan design, risk and ultimately which plans join will affect the final PMPMs and the corresponding trend.

Part I. Section 4: ACO Budget and Financial Plan

I.4.1 Description: Submit most recent audited financial statements.

Questions:

27. When is the FY17 audit expected to be complete and available?

    The results of our Audit will likely be completed in November, and we will provide the GMCB with results as soon as it's been completed and reviewed by our Board of Managers.

I.4.2 Description: Complete the GMCB financial statement templates (Appendices 4.1-4.3)

Questions:

28. Please explain the variation in the percentage of service spending through FFS vs. pre-payment (2018 budget vs. projected). What implications does this have for the ACO's business model? How do we reconcile the prepaid hospital payments to Appendix 2.4?

    The variation in the FFS vs. fixed payment as seen between the 2018 budget and the 2018 actual is a result of the BCBSVT QHP program operating on a FFS basis. The 2018 budget model assumed that BCBSVT would be able to offer an acceptable fixed payment model for participating hospitals.

29. What is "OUD Investment Revenue" for 2019?

    This line represents potential funding for work to incorporate opiate use disorder initiatives in 2019. Details of this work are currently in negotiation with payers.

30. Please explain the 75.7% variance between FY2018 budget and FY2018 projections for Health Services Spending.

    It appears that specific variance is in relation to the Payer-Paid FFS line within the Health Services Spending category. The first factor contributing to that variance is the change from a hospital fixed payment model to a FFS model for the BCBSVT QHP program. That shifted some of the health services spending into the FFS category from the fixed payment category. Next, the 2018 projection includes the UVMMC self-funded pilot program. Data for that

program was not available at the time the 2018 budget was submitted.

31. Contracted Services has increased significantly from FY2018 budget to FY2019 budget. Please explain the additions to contracted services, including additional contracted services and expansion of current contracted services.

    A number of factors contribute to this year-to-year increase. Firstly, the RiseVT program is transitioning from an operationally separate program with all cost in the PHM category to being fully incorporated into the OneCare operating budget. This means that some of the contracted expenses shifted from the PHM category to the operations expense in 2019. Next, there is additional expense in the budget for work related to development of the care coordination program to include 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. OneCare is also working with an outside party to explore access to data concerning social determinants of health and how those data can be incorporated into the clinical initiatives. Lastly, costs for legal and actuarial services continue to rise as more programs and communities are added.

32. General Office Expenses is budgeted as zero for FY2019. Please map these expenses from the 2018 budget to the 2019 budget.

    The 2018 budget template didn't have a breakdown of typical operating expenses. To make reporting in 2019 simpler and more transparent, a categorical breakdown was built in to the budget submission. Below is a recast of the 2018 budget in the segmented layout

Category	***2018 Budget***
Salaries and Benefits	*$6,583,992*
Contracted Services	*817,507*
Software	*2,953,726*
Insurance	*79,891*
Supplies	*112,142*
Travel	*78,680*
Occupancy	*321,051*
Other Expenses	*45,671*
Purchased Services	*-*
General Office Expenses	*-*
Reinsurance / Risk Protection	*1,500,000*
Total	***$12,492,660***

33. Software Expense is now a stand-alone account. Is this a contracted service? If not, did the purchases of software fall below capital/depreciation guidelines?

    Most of these software expenses are contracts to use third party software (often licensing fees). Because there is no owned property, whether physical or intellectual, these do not classify as assets that would be subject to capitalization.

34. Does OneCare not have any assets meeting capital/depreciation guidelines? If not, does another party hold any assets used by OneCare that would otherwise fall under capital/depreciation guidelines?

    OneCare does not currently have any assets that are actively depreciating. There is one asset owned by UVMMC that is charged to OneCare.

    Office Renovations
    Total Basis $43,460.94
    Useful life 35 months
    Total Accumulated Depreciation as of 9/30/18 $4,966.97
    Net $38,493.97

35. Is the Innovation Fund listed under PHM/Payment Reform Programs the same as the Community Based Innovation Fund mentioned on page eight of the narrative? If not, please describe the intent of the innovation fund.

    We apologize for any confusion the labeling may have caused, these are the same fund.

36. It appears the Hospital Participation Fee does not include the value-based incentive withhold. Is the Hospital Participation Fee strictly an administrative fee or does this line also include the withhold for the Value-Based Incentive Fund? If any withholds in addition to an administrative fee are being collected in this account, how is this being reported to the hospitals?

    The hospital participation fees include all expected costs related to OneCare programs and operations that are otherwise unfunded by payers or Delivery System Reform dollars. This does incorporate the amounts hospitals pay into Value-Based Incentive Fund. OneCare is currently working with hospitals and auditors to determine the methodology to appropriately report the breakdown of these contributions.

37. Please identify the positions that have been added that increase FTEs from 46.05 in the FY 2018 Projection to 62.63 in the FY 2019 Budget.

The minor changes that have been made have been in support of our growing network of participating providers, additional administrative requirements by the State and Payers, the addition of new payer programs, and the diversity of our population health initiatives that support our inclusive care model. In 2017, we recruited for and hired on in 2018 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. We also filled several vacancies, effectively bringing us to 49.5 budgeted FTEs for the 2018 year. For 2019, the FTE count changes primarily reflect the transitioning of the existing RiseVT employees to FTE counts within OneCare budget - 4 FTEs. The other proposed changes are all staff level employees to support the growing network (clinical, data, operations, and engagement) 6.0 FTEs, expanding administrative oversight requirements 0.48 FTEs and financial oversight and monitoring 0.65 FTEs. We are budgeting 2.0 FTE's for a potential pilot, that will only be filled if we proceed with operationalizing the pilot.

38. Does the Due to UVMMC liability account contain solely the amount due to UVMMC for operational expenses, etc., or are additional items included in this account? Please explain why the FY2018 Projection for this line item is much higher than the FY2018 Budget.

    That account includes both operating expenses, and participation costs/receipts, and any transactions that flow to UVMMC as a founder. The balance sheet projection is a best guess of the timing of events at 12/31/18. The balance projection is put forth in good faith, but no conclusions should be drawn as most variations are related to timing.

39. Please explain the volatility in Accounts Receivable.

    The OneCare receivables are very stable. However, depending on the payment cycle for certain receipts, one month could show a large amount owed and the next it is cleared after the regular payment has been received.

40. What is included in the Due to Other, Unearned Revenue, and Other Current Liabilities accounts?

    The Due to Other account primarily houses payments due to the network including the monthly fixed prospective payments. Other payments to/from third parties can flow through this account as well. The Unearned Revenue account balance is primarily related to the quarterly advanced shared savings from Medicare and the quarterly payments made for PCMH, CHT and SASH. Because the payments made by OneCare are quarterly advances, this account holds the balance that is yet to be recognized on the income statement. Other Current Liabilities contains the loan due to UVMHN that was secured to meet the Medicare financial guarantee criteria.

41. Please clarify how the numbers labeled '[FY]2018 Projected' in Appendices 4.1, 4.2, & 4.3 were calculated. Do these number represent a re-projected of 2018 based on YTD 2018 actuals

    These projections were based on a forecast of the year-end based on both current year-to-date performance as well as known factors that will affect the remainder of the year.

I.4.3 Description: Provide, as an attachment, a completed Appendices 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.

Questions:

42. What does OneCare project for Blueprint, CHT and SASH PMPM by payer for 2019?

    OneCare makes payments for the aforementioned services based on our Boards Direction and the contract(s) that we hold between OneCare and the State. The GMCB has the contract for 2018. We are actively reviewing 2019 projections with the Blueprint (based on refreshed attribution) and our Board of Managers direction.

43. Total Program Target Revenues less Medicare Modified Next Gen – Added equals Health Services Spending Expenses for 2018, but that calculation doesn't work in 2019. Please explain why. Is it due to the 20% withhold going back to Medicare?

    It is due to the 80% risk sharing selection for the Medicare program in 2018. Because of this sharing rate within the 5% risk corridor, it is expected that OneCare will only be able to receive 80% of the $7.5M pre-trended conservatism in the 2018 target as advanced shared savings in 2019. This means that the funding for this will come out of any hospital shared savings earned.

44. The income statement says $15M in PHM/payment reform revenue. Appendix 4.5 says $8.6M – and indicates this is an $8.6M reduction from prior year, which isn't consistent with the income statement. Please explain.

    In this submission this term "revenue" on this tab was interpreted as dollars available to the OneCare network, whether through total cost of care targets or

*PHM payments. The amount in the "Other PHM/Payment Reform Programs (not included above)**" row includes the PHM payments to the network less the amount of the hospital investments. In the 2018 budget the dollars to fund the BluePrint programs were carved out, but because these BluePrint programs are being funded by the hospitals they are now reclassified more appropriately.*

45. Please explain the increase in LAN Category 4B for Medicaid from $117M to $193M.

    The 2019 budget includes growth to the number of communities and providers participating in the Medicaid program. With this growth comes more dollars within the Medicaid total cost of care.

46. What is the activity in Other PHM/Payment Reform Programs in the tab HCP-LAN-APM and corresponding Revenues by Payer tab (Appendix 4.4.)?

    *The amount in the "Other PHM/Payment Reform Programs (not included above)**" row includes the PHM payments to the network less the amount of the hospital investments.*

47. Why are there large increases in the Imaging, Lab and Pathology, and Other Services PMPMs? What is included in Other Services? (Appendix 4.6)? Please explain.

    The data used to populate this tab is based on the actual spending profile for the lives attributed to OneCare. These increase results from more imaging, lab, pathology and other services costs on a PMPM basis as compared to previous years.

I.4.4 Description: Complete all tabs of Part 4.8 Appendix – ACO 2019 Budget Submission Reporting APM for Participating Hospitals for the 2019 budget year.

Questions:

48. Please explain what is contained in the "Other" payer column listed.

    These are PHM receipts or hospital investments that aren't specifically tied to one payer program. Examples include payments related to primary prevention investments, the regional clinical representative payments, and any payments hospitals receive for CHT or PCMH.

49. What are the two different types of Participation Fees that are deducted from Gross Fixed Payments, and what is in those accounts?

    Hospitals contribute towards OneCare initiatives through either fixed payment deductions or invoiced amounts if no fixed payment model is available. Some of

the deductions/invoiced amounts flow back to the hospitals as PHM receipts for their own work towards population health management goals. The remainder is either paid to other community providers (non-hospital) or retained by OneCare as contributions to operations. The template breaks down their investments accordingly so that it's clear how much is the gross deduction as opposed to net cost after factoring in PHM receipts back.

I.4.5. Description: Provide a narrative description of the following elements of the ACO's spending plan: i. Relevant industry benchmarks used in developing the administrative budget; ii. 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. iii. Quantity of Delivery System Reform dollars and associated goals for stated investments; iv. Strategy for planned spending on health information technology, at the ACO level and to support individual providers; v. 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 vi. Anticipated changes in provider network configuration, and the expected impact on service utilization.

Questions:

50. Please explain how the HIT strategy and implementation have evolved since last year's budget submission.

    OneCare has made significant advancements in implementing our population health management analytics platform and support model in the past year. Key strategies include:

    - *Providing data literacy training for staff, Regional Clinical Representatives, and local analysts, care coordinators, and quality improvement facilitators*
    - *Refining the scope and narrowing the focus of new self-service applications to provide more nimble, easier to understand access to meaningful information to drive change*
    - *Increasing and systematizing the collection of end-user feedback for our self-service tools, standard reports, and ad-hoc reports*
    - *Designing and implementing financial reports to address new payment reforms*
    - *Developing a new comprehensive quarterly reporting package, the ANGLER, to provide insights to each HSA on their cost, utilization, and quality data*
    - *Refining OneCare's balanced scorecard (i.e. SQUID) which reports on ACO and HSA-level data including clinical priority areas monthly*

51. Are there any new provider payment incentives tied to ACO performance on quality measures and outcomes?

In 2018, OneCare expanded the Value-Based Incentive Fund (VBIF), a quality withhold from the total cost of care, to all payer programs. These funds are distributed upon program settlement, approximately 6-8 months after the end of a performance year (PY). Thus the funds for PY18 will be distributed summer 2019 once quality measure performance data are finalized. No additional provider payment incentives tied to quality measures have been implemented.

52. Describe any anticipated changes to the VBIF for 2019.

    There are no anticipated changes to OneCare's policy for a 70/30 distribution of VBIF funds for the 2019 performance year. OneCare has worked collaboratively with GMCB and HCA staff to negotiate an aligned set of quality measures for Medicare beginning in 2019. These measures were approved by GMCB in July 2018. In addition, through our clinical committees, OneCare developed a new methodology for the primary care portion of the VBIF which will be pilot tested and refined in 2019 for planned implementation in 2020. This approach creates a variable incentive that distributes funds to primary care based on an organization's performance on a set of quality measures tied to targets and stretch goals. This approach is intended to further incent high quality care and outcomes by providing a more direct impact at the organizational (compared to the ACO) level.

53. The answer regarding relevant industry benchmarks used in developing the administrative budget includes mention of methodology utilized by insurance companies, as well as a MedPAC report. Last year Sherlock was used for industry data. Did OneCare consider additional sources and metrics? If so, what sources were used and what metrics compared? Also, please point the GMCB to the 2% benchmark in the MedPAC June report; we are unable to find it.

    Based on Industry Data combined with the MedPac report analysis of ACO's Nationwide OneCare is comfortable using the 2% administrative costs as a benchmark. We are unaware of any other data or metrics at this time. Please screen shot of 236 of Chapter 8 in Attachment D, which shows the MedPac Report stating that administrative costs for MSSP ACO's are close to $200 PMPM per year. For a link to the entire chapter please click here

I.4.6 Description: 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.

Questions:

54. For which programs are hospitals being invoiced?

    All programs with the exception of Medicare and Medicaid, which offer a fixed payment model and allow for fixed payment deductions.

55. Please diagram timing of payments and distribution of payments, including deduction of hospital payments, and repayment to hospitals.

    General OneCare payments, including the fixed prospective payments, to the network are made on the third Friday of each month. For other arrangements, contract terms will dictate the timing of payments.

I.4.7 Description: 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: 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; 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.); 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; Portion of the risk covered by reinsurance; Portion of the risk covered through any other mechanism (please specify); Any risk management or financial solvency requirements imposed on the ACO payers under ACO program contracts appearing in Part 3.

Questions:

56. Please explain the logic behind the ordering of Layers 2-5.

    The ordering of these layers is intended to result in the fairest methodology to cover risk across the network. Generally, the approach aims to use resources to mitigate risk that would otherwise be cross-covered by other hospitals.

57. Where does the required escrow account sit on your financial statements? What if any requirements are there around its use?

    This amount is in the Other Current Liabilities account. The amount in this account is available to be collected by Medicare if OneCare is unable to fulfill its obligation to pay a program settlement. Else, OneCare will be able to collect the funds from the escrow account after the settlement of the program unless it is

carried forward for a future plan year.

Part I. Section 5: ACO Quality, Population Health, Model of Care, and Community Integration Initiatives

I.5.1 Description: 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.

Questions:

58. How are you tracking implementation of the 11 Community Collaboratives and measuring success within the network? How is OneCare ensuring statewide implementation of improved care in priority areas? Examples provided cite specific communities, but not a statewide approach.

    OneCare tracks the work of the Community Collaboratives and improving care in priority areas in a number of ways. Primarily, OneCare uses monthly (SQUID) and quarterly (ANGLER) reports to monitor progress to the annual clinical priority measures, as well as monitor utilization and spending. These reports are reviewed in multiple leadership meetings, including the Utilization Review Committee (URC) and the Clinical Quality Advisory Committee (CQAC). Based on reviews of the reports, OneCare will outreach to HSAs where significant variation is present to conduct a root cause analysis with community representatives.

    Additionally, the monthly All-Field Team meeting, which is a gathering of community-facing staff at OneCare and the Blueprint for Health, is an opportunity to learn about HSA progress as well as challenges or barriers as they work to address statewide health care priorities, such as suicide prevention, opioid misuse and developmental screening.

59. How does Community Collaborative work interface with ACH work referenced?

    Many of the Community Collaboratives have adopted the Accountable Community for Health (ACH) framework. The ACH framework provides a structure to involving a wider array of community stakeholders in meetings like Community Collaboratives. The ACH framework encourages Community Collaboratives to invite representatives from organizations focused on housing, food security, child welfare and others to meet the varied needs of the community. Together with our partners at Vermont Department of Health and the Blueprint for Health, the ACO is able to monitor the progress of the development of the ACH model in the HSAs through the statewide ACH leadership team and the annual series of ACH Learning Labs, where members of each ACH is invited to deepen their knowledge of the ACH framework and

also learn from each other how to advance the model in their communities.

60. Why will the clinical priorities for 2019 not be finalized until March 2019? Are you expecting changes from 2018? If so, please explain.

    OneCare expects to receive the prospective attribution for 2019, with historical claims information, from all payers by the end of Q1 2019. These data are essential for finalizing the clinical priorities because it allows OneCare and our Network Participants, including new HSAs joining OneCare for 2019, to confirm that the clinical priorities that were relevant to the previous attributed cohorts are still the most important areas of opportunity for the new cohort of individuals. OneCare does not anticipate significant changes in the overarching clinical priority areas from 2018 to 2019; however we plan to use the data received in Q1 2019 to inform the final selection of measures and targets relevant to the 2019 attributed lives. The proposed 2019 clinical priority areas include:

    - *High-Risk Patient Care Coordination*
    - *Episode of Care Variation*
    - *Mental Health and Substance Abuse*
    - *Chronic Disease Management Optimization*
    - *Prevention and Wellness*
    - *Social Determinants of Health*

61. Priorities are focused on Medicare and Medicaid. As you build self-funded business, what are your plans to address the clinical priorities of those populations?

    OneCare is currently in a pilot year with the first self-funded program. Early in 2018 we worked with the employer to identify an aligned set of quality measures and committed to assessing the progress of the pilot and making any necessary changes for future years. As with all of our other payer programs, OneCare tracks monthly performance on key cost, utilization, and quality metrics at the ACO and HSA level. OneCare intends to refine its strategies for quality measures and clinical priorities based on learning from the pilot programs.

I.5.2 Description: 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.

Questions:

62. How is OneCare looking at variation by HSA on these measures?

    OneCare evaluates cost, utilization and quality variation by HSA using claims and manually abstracted clinical data. This information is routinely shared through clinical governance committees, and in HSAs through the Regional

Clinical Representatives, OneCare Clinical Consultants, and in focused educational sessions. In 2018 OneCare revised several of its standard reports to ensure timely access to information on cost, quality, and utilization at the ACO and HSA levels including a monthly report by payer program and a quarterly comprehensive reporting package. These standard reports are supplemented by access to OneCare's self-service analytics tools in WorkBenchOne™ whereby Network Participants can drill deeper into the data to identify areas of opportunity, improve quality and reduce variation among the network.

63. Who is OneCare getting EHR feeds from?

OneCare has direct EHR feeds from University of Vermont Medical Center and Dartmouth-Hitchcock Medical Center.

I.5.3 Description: 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.

Questions:

64. Is OneCare assessing provider satisfaction in any manner aside from committee participation?

OneCare relies on Committee participation, meetings among local providers and their Regional Clinical Representatives and/or Clinical Consultants, and informal outreach to assess provider satisfaction.

65. How many providers have left the ACO from 2018-2019? Does OneCare conduct exit interviews with providers leaving the ACO? If so, what has it learned about why providers have left the ACO?

Eight organizations elected to not renew for the 2019 performance year (seven specialists and one PCP). Although OneCare does not conduct formal exit interviews, we do inquire regarding the reason for non-renewal. The primary reason for non-renewal from 2018 to 2019 is that Preferred Providers do not receive any of the MIPs benefits for participating in an advanced alternative payment model.

I.5.6 Description: 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 :a) The number of active users (i.e. those who use the tool daily by Health Service Area); b) The number of patients with information in the system by Health Service Area; c) The number of patients with shared care plans in the system by Health Service Area; 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); and e) Progress made on the evaluation plan for Care Navigator, as described in your 2018 budget submission.

Questions:

66. Why is the implementation rate for shared care plans (less than 1% [n = 936]) so low? What are the implementation challenges?

    The implementation rate for shared care plans captured in Care Navigator appears to be low due to a variety of factors. First, there is a significant body of work in both system and workflow transformation that has been invested in and is being conducted across OneCare's Network that precedes the demonstration of care plan data in Care Navigator. OneCare is very excited and proud of the work communities and partners have done to create a strong platform for success as the implementation of complex transformation progresses and we expect to see a significant increase in this data point in 2019.

    Second, the shared care plan capture rate in the Care Navigator system is lower than the actual number of care plans that are in development or close to completion because this measure only captures shared care plans in which an individual has created a minimum of two goals with two associated tasks per each goal (and only reflects this end point and not the progressive goal setting towards it). This low number is also is present because the implementation phase of complex transformation is still maturing as communities and agencies work through cycles of process improvement together and continue to adapt models and workflows. Of note, OneCare deliberately established a definition of shared care plan creation at a higher threshold than many other ACOs and/or payer care coordination programs in order to set robust expectations for active patient engagement in care coordination. This makes the bar higher to achieve.

    Additional factors impacting this rate include Network organizational staff turnover and subsequent system re-training needs, effective workflow development, staff time allocation, active leadership support, and system re-design related to complex care coordination model transformation.

    It remains a reality that organizations are still learning how to work as an integrated teams, how to actively reduce barriers to integration that include factors such as differing process, layers and degrees of practice and culture around patient consent and information sharing for example. These are complex issues. The notion of truly integrated teams, while highly and broadly supported, is, in a complete sense, still very new in practice, and this is reflected in the lower numbers of shared care plans seen in the currently as implementation continues to deepen.

67. What made OneCare decide to invest in a mobile app? What is the cost?

    The Care Navigator Mobile App is an included component of our original Care

Navigator contract. It is meant to give care team members access to view and update information about their patients, access their shared care plans and support the implementation of the care model by providing the technological needs of those doing the work. The mobile app supports the needs of on-the-go work and will be the access point for patients in the future.

I.5.7 Description: 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.

Questions:

68. Please explain how time series methodology accounts for regression to the mean, which would be expected. Has OneCare considered a control group, as Medicaid requires?

    The time series analysis OneCare has designed includes a control group to account for regression to the mean. We are using high and very high risk patients not engaged under the care management model but attributed to the ACO for the same timeframe. The model will be analyzed for impact based on improvements in utilization and outcomes relative to those not engaged under the model.

    We recognize that this is not a randomly selected control group and that the data could be impacted, particularly by patients that may be actively engaged in care coordination but their care not documented in Care Navigator. We plan to continue to monitor the validity of using this control group and refine the design of the study as needed. Limitations will be clearly stated in any reports on findings.

69. How will OneCare engage new network providers including hospitals in Care Navigator and in the care management initiatives of OneCare?

    New Network providers and hospital systems will be engaged in care management initiatives through several avenues, applying OneCare's experience with providers and hospital engagement to date. All new providers and systems receive a comprehensive orientation to the Network and the care management initiatives via multiple in-person discussions to multiple teams by both OneCare leadership and care coordination program staff prior to the beginning of their participation year.

    Engagement with the care management program begins early in the participation year, when new participant and hospital system leaders and care management staff designees join the Care Coordination Core Teams in their appropriate region (Northern and Southern Vermont). These teams meet

monthly and convene members of the OneCare Network with diverse expertise and interest in care coordination in their community on a regular basis to review, share, recommend and/or disseminate a variety of care coordination implementation strategies, workflows, results, 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.

Members include cross-community care coordination key stakeholder representatives from each active participating community. Teams from each community are comprised of individuals with expertise in areas such as Administration/Leadership, Care Coordination and Management, Clinical, Process Improvement/LEAN, Finance, Practice Management, Social Work, Community Health, and Delivery System. Working across communities 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/or other community agencies.

70. What are your measures of success for Care Navigator?

OneCare considers defines measures of success in two domains – software performance and user adoption.

Software Performance

Care Navigator's success is measured on its ability to meet the needs of the OneCare participant Network and community partners. As outlined in our contract, Care Navigator is expected to maintain or exceed 99.5% uptime, meaning the product is continuously available to our users. As the statewide tool is deployed to new users on a regular basis it creates connections across the community who come together to coordinate the care of attributed patients. Care Navigator is successful as a tool when it can be deployed into Health Service area and support the needs of our growing user base. We also measure the success of Care Navigator by evaluating their ability to respond to enhancement requests in a timely manner with high quality outcomes that align with information learned from stakeholder engagement.

OneCare has utilized an iterative release process with Care Navigator to publish changes in incremental phases. This approach allows OneCare to measure the success of Care Navigator by setting the agreed upon release schedule. OneCare will consider the implementation successful if it is released within the thresholds outlined in our scope of work, and supports the needs of the program.

Prior to deploying new features or tools to our participant network, we run an internal pilot cycle to ensure that the full scope has been met. During this process, we are engaging key stakeholders internally to measure their

satisfaction and to run quality assurance checks. These users have a deep understanding of Care Navigator and are able to attest to functionality.

User Adoption

OneCare tracks the number of HSAs in OneCare's Network utilizing Care Navigator as well as the number of trained users, the number of active users, and the number of users serving on care teams and/or as lead care coordinators. Over the past year we have learned to conduct more in-depth orientation and preparatory sessions with potential users to ensure we are identifying the correct individuals in organizations to have access and support care coordination services. For example, early in the process many supervisory-level staff in continuum of care organizations requested training and access to Care Navigator. Through experience we learned that these individuals would benefit from an orientation and overview of the system so that they understood what their staff were expected to do in the system, but often they did not need direct access themselves. Second, we learned to integrate discussions of clinical workflows, care pathways, and common language into the technical training sessions to advance user comprehension and facilitate immediate opportunities to apply what they learned from the training. Learnings such as these have provided opportunities for continuous improvement and more focused efforts to support user identification and adoption.

71. What implementation challenges is OneCare facing with Care Navigator?

Implementation challenges OneCare is facing with Care Navigator include, but are not limited to:

- *The complexity of introducing a new tool that relies on simultaneous complex workflow and system transformation in service delivery across diverse organizations, all in various stages of readiness statewide. OneCare is addressing this challenge through engagement of Care Coordination Core Teams, engagement of senior leaders in participating organizations, and ongoing outreach and education.*
- *Perceived barriers across the Network relating to patient consent and information sharing, such as duplicative or overly layered or complex consent processes, staff and organization concerns about the consent process, and lack of understanding about information sharing in an ACO environment that slow the implementation of integration. OneCare plans to address this barrier through training and existing cross-organizational, network wide workgroups such as the Care Coordination Core Teams.*
- *Fragmentation in systems, and perceived need to 'duplicate' work being done in existing systems is a perceptual barrier to staff and organizational engagement. OneCare's care coordination team continues to develop training materials regarding actual versus perceived expectations for documentation and working in Care Navigator and to develop ways to disseminate them widely to reduce this perceived barrier.*

- *Staff turnover and required re-training and orientation to Care Navigator system slows implementation, and increases training burden. It also can impact care team integration and communication, as well as shared care plan development and other work in the Care Navigator system. OneCare is addressing this through the design of a mobile application to support field-based work in Care Navigator. By design, the mobile application is intuitive to use and does not need extensive training to navigate and begin active use.*

I.5.8 Description: 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.

I.5.9 Question:

72. OneCare reported 20 MAT providers. Please ask the Community Collaboratives for MAT wait time information.

    The Community Collaborates represent a diverse group of organizations working together on implementing community population health priorities, but as a group they are not a servicing provider who has access to wait times. And as previously noted, OneCare does not receive identified data from the payers on any individual who has received substance use services. Servicing providers themselves and perhaps payers would be in the best position to provide wait time data for the entire population, not just those attributed to an ACO.

I.5.10 Description: 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.

Questions:

73. What are the amplify grants?

    Amplify Grants are small grants awarded to community partners to offer programming or initiatives that align with RiseVT's primary prevention mission and vision. There are many high-quality, community-based opportunities for Vermonters to improve their health. Often times, these programs can reach new people or offer more programming with small amounts of funding. The Amplify Grants award a maximum of $1500 to partners to offer programming or make systems change in the community. Examples of initiatives Amplify Grants have funded include water bottle filling stations in schools in St. Albans and Bennington, sponsorship of the Richmond community to host a healthy

scavenger hunt during the July 4th parade, and the adding health components Valley Quest program in Windsor.

74. What are the 10 outcome metrics?

RiseVT has identified 15 outcomes metrics to measure the impact of its work, they include:

***FOOD** (Percentage of):*
Adults eating vegetables three or more times/day
Adults eating fruit two or more times/day
Adolescents eating vegetables three or more times/day
Adolescents eating fruit two or more times/day
Households with Food Insecurity
Adolescents Who Drank At Least 1 Sugar Sweetened Beverage/Day (in the past week)

***ACTIVITY** (Percentage of adults who):*
No time for leisure time activity
Met physical activity guidelines

***HEALTH OUTCOMES** (Percentage of adults with):*
Adult Obesity
Adolescent Obesity
Diabetes
Cardiovascular Disease
High Cholesterol
2 or More Chronic Conditions

I.5.11 Description: 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.

Questions:

75. What is OneCare considering for the specialist payment model?

    The intent of the Specialist Payment Reform program is to improve patient access to specialists, increase patient satisfaction, improve quality and reduce costs in alignment with the OneCare Population Health Management approach. In particular, there is focus on improving access prior to in-person visit; increasing the potential for primary and specialty care integration to improve clinical outcomes and reducing variation in utilization, quality and/or patient satisfaction. The funding covers three categories: 1) Supplemental population-based payments to independent specialists for adhering to annual clinical attestation criteria; 2) Value-Based Incentive Fund allocation to all independent and employed specialists for reporting improvement in one access and one quality measure; and 3) Funding for participation in an alternative access model such as on call or e-consult support for specialists to connect with PCPs and further support of telemedicine consultation.

76. Please clarify SDOH investments, including a breakdown of included programs and amounts.

    OneCare invests in SDoH through local community activities which may occur through complex care coordination activities, enhanced screening in primary care linked to the Basic OCV PMPM and/or PCP Comprehensive Payment Reform Pilot, and Community Program Investments such as RiseVT. OneCare anticipates receiving applications through the Community-Based Innovation funding opportunity in 2019, some of which are likely to involve SDoH investments.

I.5.12 Description: 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.

Question:

77. What percentage of lead care coordinators come from community agencies?

    Of the 3,303 patients across all risk categories with a lead care coordinator, 14% have a lead care coordinator from a community agency. Of the 193 active lead care coordinators, 44% are from community agencies.

I.5.13 Description: 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.

Questions:

78. 25% of primary care spend comes from VBIF. What percentage of the VBIF is the ACO assuming will be distributed and what is the basis for that assumption?

The budget model estimates that 90% of amount accrued in the VBIF will be paid out to the network. This amount was set to be a reasonable yet challenging target for the network in 2019.

Please provide the following documents, or indicate when the document will be available:

1. An example of any supporting documentation sent to hospitals with their monthly fixed prospective payments.

   Please see Attachment E for a sample of our monthly payment statement to a Hospital

2. Any non-risk contracts or collaboration agreements.

   OneCare does not have a separate non-risk contract. All of our participating providers whether they are assuming risk or not, sign the same base contract and payer addendums. We have a collaborator agreement for those community service providers who normally do not bill for medical serves by the payers. That agreement is attached as Attachment F.

3. Year to Date Financial statements.

   Please find attached in Attachment G OneCare's most recent year to date financial statement, our monthly P&L from July.

The submission appears to have several errors that should be corrected. These include:

1. Section I.2.1 –The table lists AIPBP for BCBS.

   At the time of submission it was assumed that AIPBP would be possible for the BCBSVT program in 2019. It is no longer an option at this time

2. Part 1, Attachment A – There are no SNFs listed in Gifford's HSA, but Gifford Hospital has an affiliated SNF.

   It is true that Gifford has an affiliated SNF, however when Gifford decided to contract with us for only the VMNG program in 2019 they stated that their affiliated SNF (under a different TIN) would not be participating as well.

3. Section I.5.6 - P.53 says there are 7,982 patients with data in CN; p.57 says there are 17,541 in CN.

   All OneCare attributed lives across all payer programs are loaded into Care Navigator once risk stratification is complete. This is done to ensure that clinicians have access to their entire attributed population and can use their

knowledge and clinical judgment to determine whether the data-driven risk score accurately reflects an individual's needs and if not, to make adjustments in a separate field to update the care coordination level and document why this was necessary. OneCare pushes data to Care Navigator monthly for all attributed lives to form the foundation of the individual's record. These data include demographic and claims-based information as well as risk score and care coordination level (i.e. low, medium, high, very high risk). The 17,541 individuals described on page 57 indicate the number of ACO attributed lives across payers that were risk stratified as high or very high risk, whereas the 7,982 individuals identified on page 53 indicates the number of individuals who have had additional data manually entered into Care Navigator. Additional data may include completing the "About Me" section, care coordination team members forming a care team, sections of a shared care plan initiated, encounters with care team members and/or community agencies, and/or communication among care team members. These are all early signals of the initial organization and formation of a care team, attempts to engage individuals in active care coordination, and activities and interventions in support of care coordination.

OneCareVermont

356 Mountain View Drive
Suite 301
Colchester, VT 05446
802-847-7220 PHONE
877-644-7176 TOLL-FREE
802-847-6214 FAX
onecarevt.org

AMENDMENT #4 TO THE FIRST AMENDED AND RESTATED ONECARE VERMONT ACCOUNTABLE CARE ORGANIZATION, LLC RISK BEARING PARTICIPANT & PREFERRED PROVIDER AGREEMENT TOGETHER WITH: (1) the VERMONT MEDICARE ACO INITIATIVE PROGRAM ADDENDUM; (2) the DEPARTMENT OF VERMONT HEALTH ACCESS MEDICAID NEXT GENERATION MODEL ACO PROGRAM ADDENDUM AND (3) BLUE CROSS BLUE SHIELD OF VERMONT NEXT GENERATION MODEL ACO PROGRAM ADDENDUM

PARTICIPANT RISK MITIGATION

Legal Business Name: **Brattleboro Memorial Hospital**

Contractual Address:

TIN:

WHEREAS, Participant is a Hospital and a party to the above agreement with OneCare to participate in three Next Generation Model Programs: (1) Medicare, (2) Medicaid and (3) Blue Cross Blue Shield of Vermont (collectively "Programs"); and

WHEREAS, Participant has, for Performance Year 2019 only, been provided with particular payment terms that mitigate Participant's risk in exchange for which Participant will forego a portion of shared savings;

NOW THEREFORE, the Parties agree as follows:

1. After all Programs are settled, Participant will be responsible for the greater of $900,000 and the first 50% of its aggregate Maximum Risk Limit (MRL) across all three Programs for losses; and

2. After all Programs are settled, Participant will be limited to the greater of $900,000 and the first 50% of the aggregate MRL across all three Programs for savings; and

3. After all Programs are settled, OneCare will be responsible for the lesser of $900,000 and the remaining percentage of Participant's aggregate MRL across all Programs; and

4. After all Programs are settled, OneCare will receive the lesser of $900,000 and the remaining percentage of Participant's aggregate MRL across all Programs; and

5. The MRL for each Program will be based on the aggregate Total Cost of Care (TCOC) savings or losses calculated by applying OneCare contracted program risk corridors and sharing percentages to the Healthcare Service Area (HSA) final attributed populations and TCOC targets for each Program. The individual Programs will be settled as to each

of the Program payers according to the payer's timing and methodologies. Those individual Program calculations will then be aggregated to arrive at the All Program MRL that will be the basis for applying the risk mitigation and savings limits set forth above. That is, Participant's aggregate TCOC savings or losses for the Performance Year will be the net of savings and losses of the three Programs.

ONECARE VERMONT ACCOUNTABLE CARE ORGANIZATION, LLC

By: _____ Date: _____

Todd B. Moore
Chief Executive Officer

PARTICIPANT/PREFERRED PROVIDER

By: _____ Date: _____

Authorized Signature

Print Name: _____
Title: _____
Legal Business Name:
TIN:

OneCareVermont

356 Mountain View Drive
Suite 301
Colchester, VT 05446
802-847-7220 PHONE
877-644-7176 TOLL-FREE
802-847-6214 FAX
onecarevt.org

AMENDMENT #4 TO THE FIRST AMENDED AND RESTATED ONECARE VERMONT ACCOUNTABLE CARE ORGANIZATION, LLC RISK BEARING PARTICIPANT & PREFERRED PROVIDER AGREEMENT TOGETHER WITH: (1) the VERMONT MEDICARE ACO INITIATIVE PROGRAM ADDENDUM; (2) the DEPARTMENT OF VERMONT HEALTH ACCESS MEDICAID NEXT GENERATION MODEL ACO PROGRAM ADDENDUM AND (3) BLUE CROSS BLUE SHIELD OF VERMONT NEXT GENERATION MODEL ACO PROGRAM ADDENDUM

PARTICIPANT RISK MITIGATION

Legal Business Name: **Springfield**

Contractual Address:

TIN:

WHEREAS, Participant is a Hospital and a party to the above agreement with OneCare to participate in three Next Generation Model Programs: (1) Medicare, (2) Medicaid and (3) Blue Cross Blue Shield of Vermont (collectively "Programs"); and

WHEREAS, Participant has, for Performance Year 2019 only, been provided with particular payment terms that mitigate Participant's risk in exchange for which Participant will forego a portion of shared savings;

NOW THEREFORE, the Parties agree as follows:

1. After all Programs are settled, Participant will be responsible for the greater of $1,000,000 and the first 50% of its aggregate Maximum Risk Limit (MRL) across all three Programs for losses; and

2. After all Programs are settled, Participant will be limited to the greater of $1,000,000 and the first 50% of the aggregate MRL across all three Programs for savings; and

3. After all Programs are settled, OneCare will be responsible for the lesser of $1,000,000 and the remaining percentage of Participant's aggregate MRL across all Programs; and

4. After all Programs are settled, OneCare will receive the lesser of $1,000,000 and the remaining percentage of Participant's aggregate MRL across all Programs; and

5. The MRL for each Program will be based on the aggregate Total Cost of Care (TCOC) savings or losses calculated by applying OneCare contracted program risk corridors and sharing percentages to the Healthcare Service Area (HSA) final attributed populations and TCOC targets for each Program. The individual Programs will be settled as to each

of the Program payers according to the payer's timing and methodologies. Those individual Program calculations will then be aggregated to arrive at the All Program MRL that will be the basis for applying the risk mitigation and savings limits set forth above. That is, Participant's aggregate TCOC savings or losses for the Performance Year will be the net of savings and losses of the three Programs.

ONECARE VERMONT ACCOUNTABLE CARE ORGANIZATION, LLC

By: _____ Date: _____

Todd B. Moore
Chief Executive Officer

PARTICIPANT/PREFERRED PROVIDER

By: _____ Date: _____

Authorized Signature

Print Name: _____
Title: _____
Legal Business Name:
TIN:

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AMENDMENT #4 TO THE FIRST AMENDED AND RESTATED ONECARE VERMONT ACCOUNTABLE CARE ORGANIZATION, LLC RISK BEARING PARTICIPANT & PREFERRED PROVIDERAGREEMENT TOGETHER WITH: (1) the VERMONT MEDICARE ACO INITIATIVE PROGRAM ADDENDUM; (2) the DEPARTMENT OF VERMONT HEALTH ACCESS MEDICAID NEXT GENERATION MODEL ACO PROGRAM ADDENDUM AND (3) BLUE CROSS BLUE SHIELD OF VERMONT NEXT GENERATION MODEL ACO PROGRAM ADDENDUM

PARTICIPANT RISK MITIGATION

Participant/Preferred Provider Name:
Contractual Address:

Participant/Preferred Provider TIN:
Attention To:

WHEREAS, Participant is a Hospital and a party to the above agreement with OneCare to participate in three Next Generation Model Programs: (1) Medicare, (2) Medicaid and (3) Blue Cross (collectively "Programs"); and

WHEREAS, Participant has, for Performance Year 2019 only, been provided with particular payment terms that mitigate Participant's risk in exchange for which Participant will forego a portion of shared savings;

NOW THEREFORE, the Parties agree as follows:

1. The Maximum Risk Limit (MRL) for each Program will be based on the aggregate Total Cost of Care (TCOC) savings or losses calculated by applying OneCare contracted program risk corridors and sharing percentages to the Healthcare Service Area (HSA) final attributed populations and TCOC targets for each Program.

2. The individual Programs will be settled as to each of the Program payers according to the payer's timing and methodologies. Those individual Program calculations will then be netted to arrive at the aggregate MRL for all Programs (All Programs MRL) that will be the basis for applying the risk mitigation and savings limits set forth here.

3. After all Programs are settled:

    a. OneCare will be responsible for any losses beyond the midpoint (50%) of the Participant's All Programs MRL but not to exceed $2,000,000. Any losses in excess of the $2,000,000 maximum covered by OneCare will be the responsibility of the Participant; and

b. OneCare will retain any savings beyond the midpoint (50%) of the Participant's All Programs MRL but not to exceed $2,000,000. Any savings in excess of the $2,000,000 maximum covered by OneCare will be paid to the Participant.

ONECARE VERMONT ACCOUNTABLE CARE ORGANIZATION, LLC

By: _____ Date: _____
Todd B. Moore
Chief Executive Officer

PARTICIPANT/PREFERRED PROVIDER

By: _____ Date: _____
Authorized Signature

Print Name: _____
Title: _____

BCBS QHP 2017 Quality Measure Results

Draft Results pending Board of Managers Review and Approval

	OneCare Vermont Quality Measures						2017 PPO/EPO Benchmarks				Quality Points		
	2015 Rate	2016 Rate	2017 Denominator	2017 Numerator	2017 Expected Rate	2017 Final Rate	25th Percentile	50th Percentile	75th Percentile	90th Percentile	2017 Performance	Points Earned	Points Available
Payment Measures													
ACO All-Cause Readmissions	0.99^	0.86^	464	42	44.97	**0.9340**	0.7767	0.7337	0.6740	0.6132	<25th Percentile	-	3
Adolescent Well-Care Visits	57.20%	59.50%	2,160	1,289		**59.68%**	35.82%	43.51%	51.43%	64.69%	75th Percentile	3	3
Avoidance of Antibiotic Treatment for Adults with Acute Bronchitis*	31.60%	32.90%	254	171		**32.68%**	22.38%	25.52%	30.70%	35.02%	75th Percentile	3	3
Chlamydia Screening in Women	50.50%	46.50%	820	412		**50.24%**	38.14%	43.14%	48.63%	58.83%	75th Percentile	3	3
Controlling High Blood Pressure#	70.70%^	66.20%^	411	285		**69.34%**	48.49%	53.00%	60.05%	68.81%	90th Percentile	3	3
Diabetes Mellitus: Hemoglobin A1c Poor Control (<9%)#	15.13%^	13.02%^	411	82		**19.95%**	45.74%	37.06%	31.37%	26.09%	90th Percentile	3	3
Follow-Up After Hospitalization for Mental Illness: 7-Day	62.80%	66.70%	44	24		**54.55%**	42.80%	50.64%	57.33%	63.64%	50th Percentile	2	3
Initiation and Engagement for Substance Abuse Treatment: Initiation			289	93		**32.18%**	Benchmarks not available						
Initiation and Engagement for Substance Abuse Treatment: Engagement			289	44		**15.22%**							
Initiation and Engagement for Substance Abuse Treatment: Initiation and Engagement (Composite)	19.60%	20.60%	289			**23.70%**	21.02%	23.08%	25.59%	28.78%	50th Percentile	2	3
Prevention Quality Chronic Composite (AHRQ PQI #92)**	95.10^	101.02^	0.20614	74		**358.98**	Benchmarks not available					-	2
											TOTAL	**19**	**26**
Reporting Measures													
Diabetes Mellitus: Evidence of Eye Exams#			411	280		**68.13%**	40.43%	46.87%	54.15%	60.69%	**90th Percentile**		

*Avoidance of Antibiotic Treatment for Adults with Acute Bronchitis is an inverted measure.
**The eligible population for PQI92 is 20,614. It is displayed as 0.20614 in order to calculate the rate per 100,000 as done in previous years.
2017 Hybrid rates were not able to be verified
^ Hybrid, PCR and PQI historic rates were calculated by the Lewin Group

Available Points: 26.00

Points Earned: 19.00

Percentage of Possible Points: 73.07%

OneCareVermont

OneCare Vermont
2017 Quality Measure Scores: Medicare
Performance Year 5: Reporting and Performance Measures
Draft Results pending Board of Managers Review and Approval

			OneCare Vermont			Quality Improvement Detail*					Final Scores	
Domain	Number of Measures	Total Measures for Scoring	Points Possible	Points Scored	Domain Score	Measures Eligible for QI Points	Net Improvement	Domain Improvement Score	Quality Improvement Points	Points Scored with QI added	Domain Scores with QI Points	Domain Weight
Patient/ Caregiver Experience	8	8 survey module measures	16	13.55	84.69%	8	0	0.00%	0	13.55	84.69%	25%
Care Coordination/ Patient Safety	10	10 measures, EHR measure double-weighted	22	18.40	83.64%	6	-1	-16.67%	0	18.40	83.64%	25%
Preventive Health	8	9 measures	16	14.05	87.81%	8	+1	15.50%	0.48	14.53	90.81%	25%
At-Risk Population	5	4 measures, 2-component diabetes measure	8	7.40	92.50%	5	0	0.00%	0	7.40	92.50%	25%
Total in all Domains	**31**	**30**	**62**	**53.40**	**87.16%**						**87.91%**	**100%**

*Quality Improvement Calculation Detail	
Step 1	Calculate the change in performance for each eligible measure, eligible measures are defined as any measure with scores for both 2016 and 2017
Step 2	Determine, for each measure, whether the change in performance was statistically significant at a 95% confidence level (done by CMS)
Step 3	Calculate Net Improvement for each domain: **Net Improvement = # of significantly improved measures - # of significantly dedined measures** *Note: In the event that an ACO shows a statistically signficiant dedine in a measure from one year to the next, but still scores above 90 percent (or above the 90th percentile benchmark in the case of certain daims-based measures) in both years, CMS will consider this change as a "no change" in performance instead of a signficant dedine in performance when calcuating the domain improvement score*
Step 4	Calculate Domain Improvement Score: **Domain Improvement Score = Net Improvement/ Eligible Measures * 100**
Step 5	Use the scoring ladder provided to determine points awarded for each domain

CMS QI Scoring Ladder	
Improvement Measure Score	Quality Improvement Points
90+ percent	4.0 points
80+ percent	3.56 points
70+ percent	3.12 points
60+ percent	2.68 points
50+ percent	2.24 points
40+ percent	1.8 points
30+ percent	1.36 points
20+ percent	0.92 points
10+ percent	0.48 points
<10 percent	No points

2015 Final Score	2016 Final Score	2017 Final Score	Percent Change
96.10%	96.88%	87.91%	-9.26%

Attachment C

BCBSVT 2019 Rate Filing Data for QHP
OCV
09.24.18

	Filed Impact to premium	From L&E summary Impact to claims cost	Approved by GMCB Impact to claims cost		Comment
1. 2017 Actual/Projected Claims Experience					
	-0.50%	0.00%	0.00%		If we use actual claims, no need to adjust for the change in actual v/s projected
2. Difference in trend from 2017 to 2018					
	1.20%	5.90%	5.90%		4.7% was anticipated for 2017 to 2018 trend increae in the 2018 rate filing. This projection was 1.2% too low. Actual trend was 5.9%
3. Estimate Trend from 2018 to 2019					
	5.90%	4.10%	4.10%		Medical portion 4.1%. Did not factor in RX component as we are not taking RX risk
4. Changes to Population Morbidity Adjustment					
	2.90%	2.90%	2.60%		GMCB reduced by .3%
				2.40%	Changes in pool morbidity
				-0.10%	Impact of health status of new members
				0.20%	Change in definition of small group
				0.40%	Impact of different benefit plans
				2.90%	Subtotal
5. Changes to Other Factor					
	0.40%	1.40%	1.00%		GMCB reduced by .4% for the est of the removal of penalty for individual mandate. (removed reductions for RX as we will not have risk for RX)
				2.00%	Removal of penalty for ind mandate
				0.00%	change in demographics
				0.00%	Changes in RX contract - no rx risk filed .9% reduction
				-0.70%	Impact of plan selection
				0.00%	RX rebates, Blue Print, ITS fees, Vaccine payments and net cost of reinsurance - no rx risk - filed for -.1% reduction
				0.10%	VHC retro adjustments
				1.40%	sub total
Subtotal of initial filing	9.90%	14.30%	13.60%		
GMCB reduced BCBSVT's premium	-1%		0.00%		Reduced for affordability - no impact on expected claims cost for OCV
Impact of small groups migrating to AHP plans			2.30%		BCBS estimated impact of 2.3%. Was not included in original filing and numbers above. Disallowed by GMCB because they filed it too late and can use their AMT tax refund and savings in AHP plans to offset the additional QHP costs
Add impact of late benefit changes			0.10%		approved by GMCB in late filing
			16.00%		
			$ 573.97		Risk adjusted (potential outcome) $494.80 from 2017 settlement X 1.16

Attachment E

OneCareVermont

ACH Payment Statement:September 2018

[redacted]

Description	Quantity / Attribution	Rate / PMPM	Payment Amount
Fixed Prospective Payment - Medicare			$870,682.79
Fixed Prospective Payment Deduction - Medicare			($28,598.54)
Fixed Prospective Payment - Medicaid			$496,470.31
Fixed Prospective Payment Deduction - Medicaid			($31,092.27)
OCV Population Health Management Payment - Medicare	1,155	$3.25	$3,753.75
OCV Population Health Management Payment - Medicaid	351	$3.25	$1,140.75
OCV Population Health Management Payment - BCBS	527	$3.25	$1,712.75
OCV Population Health Management Payment - UVMMC SF	300	$3.25	$975.00
Complex Care Coord Level 2: Team-Based - Medicare	210	$15.00	$3,150.00
Complex Care Coord Level 2: Team-Based - Medicaid	81	$15.00	$1,215.00
Complex Care Coord Level 2: Team-Based - BCBS	14	$15.00	$210.00
Complex Care Coord Level 2: Team-Based - UVMMC SF	6	$15.00	$90.00
Complex Care Coord Level 3: Lead Care Coord - Medicare	20	$10.00	$200.00
Complex Care Coord Level 3: Lead Care Coord - Medicaid	12	$10.00	$120.00
Primary Care Case Management - Medicaid	351	$2.20	$772.20
Total Payment:			**$1,320,801.74**

Thursday, September 20, 2018

in ACOs by specialists and whether the degree of specialists' participation affects ACOs' performance.

Are ACOs only a transition step to MA?

The ACO program is large, continues to expand, and continues to evolve. However, some suggest that MA plans are the more efficient model and that, eventually, ACOs should evolve into MA plans. As a matter of policy, the question is whether all ACOs should be encouraged to become MA plans or whether there are circumstances in which it is better for ACOs to remain ACOs (Medicare Payment Advisory Commission 2016b).

In the past, the Commission has discussed how no one model is the low-cost model in all parts of the country (Medicare Payment Advisory Commission 2014c). In some markets, the tools that MA plans have to manage service use result in substantial savings. In other markets, ACOs or FFS is the lower cost model. For analytical purposes, that report synchronized the benchmarks at 100 percent of FFS spending for all three models. In fact, in 2018 we estimate MA benchmarks (including quality bonuses) will average 107 percent of FFS spending.

One particularly important factor is that, although MA plans have more tools to control service use, they also have higher administrative costs. Data from the major insurance companies indicate that, on average, administrative costs in MA plans are approximately $1,300 per beneficiary. Among those costs are costs for marketing, both directly to beneficiaries and through brokers; enrolling members; negotiating with providers; paying claims; and providing other insurance functions, such as prior authorization. MA plans also have to qualify as state-licensed insurers, which could entail considerable costs and financial resources.

Our discussions with ACOs suggest their administrative costs, in contrast to those of MA plans, are close to $200 per beneficiary per year. ACOs do not have the costs of advertising, enrolling, negotiating contracts, and paying claims. Their administrative costs include the expense of setting up and managing the ACO, which should include data analysis and reporting quality measures. However, some companies can provide those services under contract, and some ACOs are using that approach.

Therefore, which model will generate greater savings depends on whether the MA plan's reduction in spending on medical services offsets its higher administrative cost relative to an ACO's spending and costs. There are two basic possibilities:

- If MA health care spending reductions compared with ACO health care spending reductions are greater than $1,100, then MA plans would be expected to be the lower cost model.
- If MA health care spending reductions compared with ACO health care spending reductions are less than $1,100, then ACOs would be expected to be a lower cost model than MA.

The amount of service use that MA plans will be able to reduce relative to FFS Medicare and ACO use will depend on several factors. One may be the initial level of service use and fraud in the market. Data suggest MA plans can generate substantial savings in some high-use markets such as Miami. However, if there is less than $1,300 of unnecessary spending to cut, then FFS Medicare could be a lower cost model. Second, ACO savings could be affected by the ACO's providers' position in the market. One conceptual advantage of MA plans is their ability to lock beneficiaries into a defined provider network. If an ACO's participants constitute the dominant health system in a market, then the ACO model with its lower costs may be more efficient because the ACO should have a similar ability to control utilization.

However, benchmarking could still be an issue even if an ACO is in a dominant market position. Under a historically based benchmark, a regionally based benchmark (based on regional FFS spending), or a blend, an ACO with a dominant market position would have to improve on its own performance over time because its benchmark will reflect its own performance. In contrast, MA benchmarks are based on FFS spending, not MA spending. Thus, MA plans do not face the issue of their own historical performance dictating their benchmark. In addition, MA benchmarks are adjusted so that they are a higher percentage of FFS spending if the county has lower FFS spending relative to the national level. In some counties, MA benchmarks are 115 percent of the FFS average (see the Commission's MA *Payment Basics* document, available at http://medpac.gov/-documents-/payment-basics, for a fuller discussion).

Thus it is not clear a priori whether ACOs are in all circumstances a stepping stone to MA or should remain as ACOs. The challenge going forward is to set MA and ACO benchmarks in such a way that the models can compete and the most efficient model can gain market share in each individual market.

COLLABORATION AGREEMENT

BETWEEN

ONECARE VERMONT ACCOUNTABLE CARE ORGANIZATION, LLC ("ACO")

AND

<xcd_contract_desc>

This Collaboration Agreement (the "Agreement") is made as of the date it has been signed by OneCare Vermont Accountable Care Organization, LLC's Chief Executive Officer, and indicated on the signature page of the agreement (the "Effective Date"), by and between **OneCare Vermont Accountable Care Organization, LLC** ("ACO"), organized under the laws of the State of Vermont, and <xcd_contract_desc> ("Collaborator"), with the tax identification number ("TIN") listed on the signature page hereto (collectively, the "Parties" and each, individually a "Party").

WHEREAS, ACO is participating in the All Payer Model, including Medicare NextGeneration, Medicaid NextGeneration and Commercial NextGeneration Blue Cross programs and may participate in other value based payment arrangements (collectively, the "Programs");

WHEREAS, Collaborator is an entity that provides for, arranges for or manages health care services and/or social support services in the ACO service area or otherwise supports the activities and goals of the ACO and desires to engage in functions or services with the ACO related to ACO activities;

WHEREAS, ACO and Collaborator are committed to improving the quality, cost and overall care of individuals attributed under the Programs and while Collaborator will not attribute individual lives to ACO, it desires to assist ACO to successfully meet its goals of better health, better healthcare, and reduced healthcare cost growth; and

WHEREAS, the sharing of de-identified data relating to quality and utilization is a necessary part of the Parties' ability to meet the goals of this Agreement.

NOW, THEREFORE, the Parties agree as follows:

1.0 COLLABORATOR SERVICES

1.1 Collaborator shall support and assist ACO and ACO related activities which includes, but is not limited to: participating in Community Collaborative Committees; assisting ACO in a collaborative fashion to accomplish its triple aim; supporting and assisting with care coordination; supporting and assisting in the development, maintenance and implementation of the Clinical Model; supporting and assisting with applicable ACO case

management protocols and ACO Policies and Procedures; and supporting or assisting with other mutually defined goals.

1.2 Collaborator shall comply with all applicable laws, regulations and payment program requirements that are applicable to its services. This includes, but is not limited to, federal laws such as the False Claims Act, Anti-Kickback Laws, Civil Monetary Penalties Laws, HIPAA, Stark and anti-discrimination. The provisions of this Section 1.2 shall survive termination of this Agreement for any reason.

1.3 Collaborator shall hold confidential all confidential and proprietary information and all Data provided to or shared with it by ACO during the performance of this Agreement and will comply with the terms of the Business Associate Agreement attached hereto as **Exhibit 1**, the Data Use Agreement Addendum attached hereto as **Exhibit 2** (originally applicable to MSSP & VMSSP data, and now applicable to Medicare and Medicaid NextGen data as required in those program agreements), and ACO's Data Use Policies and Procedures. Collaborator may not disseminate or share any Data with any person or entity other than ACO employees; ACO Participants and/or ACO Affiliate Participants in the ACO Program from which the Data originated. The terms of this Section 1.3 shall survive termination of this Agreement for any reason.

1.4 Collaborator may not create or distribute any marketing or other materials that reference ACO, or Collaborator's participation in any ACO Program without ACO's express, written consent.

1.5 Collaborator acknowledges that CMS, DHHS, the Comptroller General, the federal government or its designees, DVHA or GMCB have the right under various ACO Programs to monitor, investigate, audit, inspect or evaluate any books, contracts, records, documents or other evidence of services or functions related to ACO Programs. Collaborator agrees to cooperate and assist those parties and ACO in connection with any such activity, including allowing reasonable access to records and facilities to regulators with authority.

1.6 Collaborator agrees to maintain for ten (10) years from the final date of this Agreement all books, contracts, records, documents or other evidence of the performance of services or functions related to ACO activities. If there is a termination, dispute or allegation of fraud or similar fault against the Collaborator, Collaborator agrees to maintain such materials for an additional six (6) years (or sixteen (16) years total).

2.0 TERM & TERMINATION

2.1 The term of this Agreement shall commence on the Effective Date and shall continue in effect until one Party gives notice of intention to terminate no less than ninety (90) days before the effective date of termination.

3.0 GENERAL PROVISIONS

3.1 Amendments. This Agreement may be amended or modified in writing as mutually agreed upon by the Parties, or as provided in this Agreement. In addition, ACO may unilaterally modify any provision of this Agreement and its Exhibits, Attachments and Riders upon thirty (30) days prior written notice to Collaborator, or immediately upon receipt by Collaborator if such modification is made to comply with federal or state laws or other regulatory bodies.

3.2 Independent Contractor Relationship. None of the provisions of this Agreement between or among ACO, Collaborator, or Payors create a relationship other than that of independent entities contracting solely for the purposes of effecting the provisions of this Agreement.

3.3 No Third-Party Beneficiaries. Except as specifically provided herein by express language, no person or entity shall have any rights, claims, benefits, or powers under this Agreement, and this Agreement shall not be construed or interpreted to confer any rights, claims, benefits or powers upon any third party.

3.4 Notices. Notices and other communications required by this Agreement shall be deemed to have been properly given if mailed by first-class mail, postage prepaid, or hand delivered to the following address:

OneCare Vermont Accountable Care Organization, LLC
356 Mountain View Drive, Suite 301
Colchester, VT 05446
Attn: Director of Contracting

Collaborator
<send_full_address>
Attention: _____

3.5 Counterparts, Signatures. This Agreement may be executed in multiple counterparts, each of which shall be deemed an original, but all of which shall constitute one and the same instrument and shall be effective when OneCare Vermont has executed its counterpart. Any signature delivered by facsimile machine, or by .pdf, .tif, .gif, .peg or other similar attachment shall be treated in all manner and respects as an original executed counterpart and shall be considered to have the same binding legal effect as if it were the original signed version thereof delivered in person.

3.6 Applicable Law. This Agreement, together with all of the respective rights of the parties hereto, shall be governed by and construed and enforced in accordance with the laws of the State of Vermont.

IN WITNESS WHEREOF, the Parties have caused this Agreement to be executed by the duly authorized officers to be effective as of the Effective Date indicated above.

ONECARE VERMONT ACCOUNTABLE CARE ORGANIZATION, LLC

By: _____
Todd B. Moore
Chief Executive Officer

Effective Date: _____

<xcd_contract_desc>

By: _____
Authorized Signature

Print Name: _____

TIN: <xcd_tin>

Date: _____

EXHIBIT 1

BUSINESS ASSOCIATE AGREEMENT

This Business Associate Addendum (the "Addendum") is entered into by and between **OneCare Vermont Accountable Care Organization, LLC** ("ACO") and Collaborator ("Business Associate").

RECITALS

ACO and Business Associate are parties to this Collaboration Agreement (the "Agreement") pursuant to which Business Associate provides certain services to ACO and, in connection with those services, ACO discloses to Business Associate certain Protected Health Information ("PHI") that is subject to protection under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and Title XIII, The Health Information Technology for Economic and Clinical Health Act ("HITECH"), of the American Recovery and Reinvestment Act ("ARRA").

The parties desire to comply with the requirements set forth in the Privacy and Security Regulations and HITECH concerning the privacy of PHI.

The purpose of this Addendum is to comply with the requirements of the Privacy Rule, the Security Rule, HITECH and, if applicable, 42 CFR Part 2 including but not limited to the Business Associate Requirements at 45 C.F.R. Section 164.504(e).

Therefore, in consideration of the mutual promises and covenants contained herein, the parties agree as follows:

SECTION I – DEFINITIONS

1.1 Definitions. Unless otherwise provided in this Agreement, capitalized terms shall have the same meaning as set forth in the HIPAA regulations, 45 C.F.R. Sections 160 and 164, and HITECH and its related regulations or under 42 CFR Section 2.11.

SECTION II – OBLIGATIONS OF BUSINESS ASSOCIATE

2.1 Use/Disclosure of PHI. In connection with its use and disclosure of PHI, Business Associate agrees that it shall use and/or disclose PHI only as permitted or required by this Addendum or as otherwise required by law.

2.2 Safeguards for Protection of PHI. Business Associate agrees to use reasonable and appropriate safeguards to prevent the use or disclosure of PHI other than as provided in this Addendum.

2.3 Compliance with HITECH Act and Regulations. Business Associate will comply with the requirements of HITECH, codified at 42 U.S.C. §§ 17921-17954, which are applicable to Business Associate, and will comply with all regulations issued by the Department of Health and Human Services to implement these referenced statutes, as of

the date by which Business Associate is required to comply with such referenced statutes and HHS regulations.

2.4 General Reporting. Business Associate shall report to ACO any use or disclosure of PHI which is not provided for by this Agreement of which Business Associate becomes aware.

2.5 Reporting of Breaches of Unsecured Protected Health Information. Business Associate will report in writing to ACO's Privacy Officer any breach of unsecured PHI, as defined in the breach notification regulations, within ten (10) business days of the date Business Associate learns of the incident giving rise to the breach. Business Associate will provide such information to ACO as required in the regulations. Business Associate will reimburse ACO for any reasonable expenses ACO incurs in notifying individuals of a breach caused by Business Associate or Business Associate's subcontractors or agents, and for reasonable expenses ACO incurs in mitigating harm to those Individuals. Business Associate also will defend, hold harmless and indemnify ACO and its employees, agents, officers, directors, members, contractors, and subsidiary and affiliate entities, from and against any claims, losses, damages, liabilities, costs, expenses, penalties or obligations (including attorneys' fees) which ACO may incur due to a breach caused by Business Associate or Business Associate's subcontractors or agents.

2.6 Mitigation. Business Associate shall make reasonable efforts to mitigate, to the greatest extent possible, any harmful effects arising from any improper use and/or disclosure of PHI.

2.7 Subcontractors. Business Associate shall ensure that any agents, including any subcontractor, to whom it provides PHI, shall agree to the same restrictions and conditions that apply to Business Associate with respect to PHI.

2.8 Access by Individuals. Business Associate shall allow individuals who are the subject of the PHI to inspect and copy their PHI in the possession of Business Associate if ACO does not also maintain such information.

2.9 Access by Department of Health and Human Services. Business Associate shall make its internal practices, books, and records relating to the use and disclosure of PHI available to the Secretary of the Department of Health and Human Services for purposes of determining ACO's compliance with the HIPAA privacy regulations.

2.10 Access by ACO. Upon reasonable notice, Business Associate shall make its internal practices, book, and records relating to the use and disclosure of PHI available to ACO for purposes of determining Business Associate's compliance with the terms of this Agreement and Business Associate's compliance with HIPAA and HITECH.

2.11 Accountings of Disclosures. If Business Associate discloses any PHI, Business Associate shall make available to ACO the information necessary for ACO to provide an accounting of disclosures to any individual who requests such an Accounting, or, in the

alternative, Business Associate shall provide an accounting of disclosures directly to the requesting individual, if requested by ACO.

2.12 Amendment of PHI. Business Associate agrees to make any amendment(s) to PHI in a designated record set that ACO directs or agrees to pursuant to ACO's obligations under the Privacy Rule.

SECTION III – PERMITTED USES AND DISCLOSURES

2.1 General. Except as otherwise limited in this Addendum, Business Associate may use or disclose PHI to perform functions, activities, or services for, or on behalf of, ACO as specified in the Agreement, provided that such use or disclosure would not violate the Privacy Rule if done by ACO.

SECTION IV – SECURITY

4.1 Compliance with Security Rule. Business Associate agrees to implement the Security Rule (security standards as set out in 45 C.F.R. parts 160, 162 and 164), Administrative, Physical and Technical Safeguards that reasonably and appropriately protect the Confidentiality, Integrity, and Availability of the electronic PHI that Business Associate creates, receives, maintains, or transmits on behalf of the Covered Entity.

4.2 Reporting. Business Associate agrees to report to Covered Entity any security incident of which it becomes aware.

4.3 Agents Compliance with Business Associate Addendum. Business Associate agrees to ensure that any agent, including a subcontractor, to whom it provides PH I received from, or created or received by, Business Associate on behalf of ACO agrees to the same restrictions and conditions that apply through this Addendum to Business Associate with respect to such information.

4.4 Agents Compliance with Security Rule. Business Associate will ensure that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement the Security Rule, Administrative, Physical and Technical Safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI.

4.5 Records Availability. Business Associate agrees to make its policies, procedures, and documentation relating to the safeguards described herein available to the Secretary, for purposes of the Secretary determining ACO's compliance with the Security Rule.

SECTION V – TERM & TERMINATION

5.1 Term and Termination. This Addendum shall be effective as of effective date of the Agreement and shall terminate when all of the PHI provided by ACO to Business Associate, or created or received by Business Associate on behalf of ACO, is destroyed or returned to ACO. The parties acknowledge and agree that the terms and conditions

stipulated in this Agreement shall apply to any future written or oral agreements between ACO and Business Associate which require the disclosure of PHI, whether or not this Agreement is incorporated by reference into future agreements executed between the parties. This Agreement shall terminate in accordance with the termination provisions in the Agreement.

5.2 Effect of Termination. Upon termination of the Agreement, for any reason, Business Associate shall, if feasible, return or destroy all PHI that Business Associate still maintains in any form and shall not retain any copies of such PHI. If such return or destruction is not feasible, Business Associate shall extend the protections of this Agreement to the PHI and shall limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible.

SECTION VI – MISCELLANEOUS

6.1 Amendment. This Addendum shall be deemed to amend automatically, by force of law and without further act of the parties, if necessary to bring the Agreement into compliance with any changes in HIPAA, HITECH or any related regulations that are made after the date of execution of this Agreement.

6.2 Interpretation. Any ambiguity in this Addendum shall be resolved in a manner that brings the Addendum into compliance with the then most current version of HIPAA and the HIPAA privacy regulations.

6.3 No Third Party Beneficiaries. Nothing express or implied in this Addendum is intended to confer, nor shall anything herein confer, upon any other person other than the parties and their respective successors or assigns, any rights, remedies, obligations or liabilities whatsoever.

EXHIBIT 2

DATA USE AGREEMENT

A. General

1. Subject to the limitations discussed in this Agreement, and in accordance with applicable law, in advance of the Start Date and at any other time deemed necessary by CMS, CMS will offer the ACO an opportunity to request certain data and reports, which are described in Sections VI.B, VI.C, and Appendix D of this Agreement.
2. The data and reports provided to the ACO under the preceding paragraph will omit individually identifiable data for Next Generation Beneficiaries who have opted out of data sharing with the ACO, as described in Section VI.D. of thisAgreement. The data and reports provided to the ACO will also omit substance use disorder data for any Next Generation Beneficiaries who have not opted into substance use disorder data sharing, as described in Section VI.E. of this Agreement.

B. Provision of Certain Claims Data

1. CMS believes that the care coordination and quality improvement work of the ACO (that is acting on its own behalf as a HIPAA covered entity ("**CE**") or who is a business associate ("**BA**") acting on behalf of its Next Generation Participants or Preferred Providers that are HIPAA CEs) would benefit from the receipt of certain beneficiary-identifiable claims data on Next Generation Beneficiaries. CMS will therefore offer to the ACO an opportunity to request specific beneficiary-identifiable claims data by completing the HIPAA-Covered Disclosure Request Attestation and Data Specification Worksheet (Appendix D). All requests for beneficiary-identifiable claims data will be granted or denied at CMS' sole discretion based on CMS' available resources, the limitations in this Agreement, and applicable law.
2. In offering this beneficiary-identifiable claims data, CMS does not represent that the ACO or any Next Generation Participant or Preferred Provider has met all applicable HIPAA requirements for requesting data under 45 CFR § 164.506(c)(4). The ACO and its Next Generation Participants and Preferred Providers should consult with their own counsel to make those determinations prior to requesting this data from CMS.
3. The beneficiary-identifiable claims data available is the data described in Appendix D.
4. The parties mutually agree that, except for data covered by Section VI.B.13 below, CMS retains all ownership rights to the data files referred to in Appendix D, and the ACO does not obtain any right, title, or interest in any of the data furnished by CMS.
5. The ACO represents, and in furnishing the data files specified in Appendix D

CMS relies upon such representation, that such data files will be used solely for the purposes described in this Agreement. The ACO agrees not to disclose, use or reuse the data except as specified in this Agreement or except as CMS shall authorize in writing or as otherwise required by law. The ACO further agrees not to sell, rent, lease, loan, or otherwise grant access to the data covered by this Agreement.

6. The ACO intends to use the requested information as a tool to deliver seamless, coordinated care for Next Generation Beneficiaries to promote better care, better health, and lower growth in expenditures. Information derived from the CMS files specified in Appendix D may be shared and used within the legal confines of the ACO and its Next Generation Participants and Preferred Providers in a manner consistent with paragraph 7 below to enable the ACO to improve care integration and be a patient-centered organization.

7. The ACO may reuse original or derivative data without prior written authorization from CMS for clinical treatment, care management and coordination, quality improvement activities, and provider incentive design and implementation, but shall not disseminate individually identifiable original or derived information from the files specified in Appendix D to anyone who is not a HIPAA CE Next Generation Participant or Preferred Provider in a treatment relationship with the subject Next Generation Beneficiary(ies); a HIPAA BA of such a CE Next Generation Participant or Preferred Provider; the ACO's BA, where that ACO is itself a HIPAA CE; the ACO's sub-BA, which is hired by the ACO to carry out work on behalf of the CE Next Generation Participants or Preferred Providers; or a non-participant HIPAA CE in a treatment relationship with the subject Next Generation Beneficiary(ies). When using or disclosing PHI or personally identifiable information ("**PII**"), obtained from files specified in Appendix D, the ACO must make "reasonable efforts to limit" the information to the "minimum necessary" to accomplish the intended purpose of the use, disclosure or request. The ACO shall further limit its disclosure of such information to the types of disclosures that CMS itself would be permitted make under the "routine uses" in the applicable systems of records listed in Appendix D.

   Subject to the limits specified above and elsewhere in this Agreement and applicable law, the ACO may link individually identifiable information specified in Appendix D (including directly or indirectly identifiable data) or derivative data to other sources of individually-identifiable health information, such as other medical records available to the ACO and its Next Generation Participants or Preferred Providers. The ACO may disseminate such data that has been linked to other sources of individually identifiable health information provided such data has been de-identified in accordance with HIPAA requirements in 45 CFR § 164.514(b).

8. The ACO agrees to establish appropriate administrative, technical, and physical safeguards to protect the confidentiality of the data and to prevent unauthorized use or access to it. The safeguards shall provide a level and scope of security that

is not less than the level and scope of security requirements established for federal agencies by the Office of Management and Budget (OMB) in OMB Circular No. A-130, Appendix I--Responsibilities for Protecting and Managing Federal Information Resources (https://www.whitehouse.gov/omb/circulars_default) as well as Federal Information Processing Standard 200 entitled "Minimum Security Requirements for Federal Information and Information Systems" (http://csrc.nist.gov/publications/fips/fips200/FIPS-200-final-march.pdf); and, NIST Special Publication 800-53 "Recommended Security Controls for Federal Information Systems" (http://nvlpubs.nist.gov/nistpubs/SpecialPublications/NIST.SP.800-53r4.pdf). The ACO acknowledges that the use of unsecured telecommunications, including the Internet, to transmit directly or indirectly identifiable information from the files specified in Appendix D or any such derivative data files is strictly prohibited. Further, the ACO agrees that the data specified in Appendix D must not be physically moved, transmitted or disclosed in any way from or by the site of the custodian indicated in Appendix D other than as provided in this Agreement without written approval from CMS, unless such movement, transmission or disclosure is required by a law.

9. The ACO agrees to grant access to the data and/or the facility(ies) in which the data is maintained to the authorized representatives of CMS or DHHS Office of the Inspector General, including at the site of the custodian indicated in Appendix D, for the purpose of inspecting to confirm compliance with the terms of this Agreement.

10. The ACO agrees that any use of CMS data in the creation of any document concerning the purpose specified in this section and Appendix D must adhere to CMS' current cell size suppression policy. This policy stipulates that no cell (e.g., admittances, discharges, patients, services) representing 10 or fewer beneficiaries may be displayed. Also, no use of percentages or other mathematical formulas may be used if they result in the display of a cell representing 10 or fewer beneficiaries.

11. The ACO agrees to report any breach of PHI or PII from or derived from the CMS data files, loss of these data or improper use or disclosure of such data to the CMS Action Desk by telephone at (410) 786-2850 or by email notification at cms_it_service_desk@cms.hhs.gov within one hour. Furthermore, the ACO agrees to cooperate fully in any federal incident security process that results from such improper use or disclosure.

12. The parties mutually agree that the individual named in Appendix D is designated as Custodian of the CMS data files on behalf of the ACO and will be responsible for the observance of all conditions of use and disclosure of such data and any derivative data files, and for the establishment and maintenance of security arrangements as specified in this Agreement to prevent unauthorized use or disclosure. Furthermore, such Custodian is responsible for contractually binding any downstream recipients of such data to the terms and conditions in this Agreement as a condition of receiving such data. The ACO agrees to notify CMS

within fifteen (15) days of any change of custodianship. The parties mutually agree that CMS may disapprove the appointment of a custodian or may require the appointment of a new custodian at any time.

13. Data disclosed to the ACO pursuant to Appendix D may be retained by the ACO until the conclusion or termination of this Agreement. The ACO is permitted to retain any individually identifiable health information from such data files or derivative data files after the conclusion or termination of the Agreement if the ACO is a HIPAA CE, and the data has been incorporated into the subject Beneficiaries' medical records that are part of a designated record set under HIPAA. Furthermore, any HIPAA CE to whom the ACO provides such data in the course of carrying out the Model initiative may also retain such data if the recipient entity is a HIPAA CE or BA and the data is incorporated into the subject Beneficiaries' medical records that are part of a designated record set under HIPAA. The ACO shall destroy all other data and send written certification of the destruction of the data files and/or any derivative data files to CMS within 30 days following the conclusion or termination of the Agreement. Except for disclosures for treatment purposes, the ACO shall bind any downstream recipients to these terms and conditions as a condition of disclosing such data to downstream entities and permitting them to retain such records under this paragraph. These retention provisions survive the conclusion or termination of the Agreement.

C. De-Identified Reports

CMS will provide the following reports to the ACO, which will be de-identified in accordance with HIPAA requirements in 45 CFR § 164.514(b):

1. Monthly Financial Reports

   These reports will include monthly and year-to-date information on total Medicare expenditures and expenditures for selected categories of services for Next Generation Beneficiaries. This aggregate information will not include individually identifiable health information and will incorporate de-identified data from Next Generation Beneficiaries who have opted out of data sharing.

2. Quarterly Benchmark Reports

   CMS will provide quarterly benchmark reports ("**BRs**") to the ACO to monitor ACO financial performance throughout the year. The BRs will not contain individually identifiable data. The design and data source used to generate the BRs is also used for the final year-end settlement report, as described in Section XIV.C. In the event that data contained in the BRs conflicts with data provided from any other source, the data in the BRs will control with respect to settlement under Section XIV.B of the Agreement.

D. Beneficiary Rights to Opt Out of Data Sharing

1. The ACO shall provide Next Generation Beneficiaries who inquire about or wish to modify their preferences regarding claims data sharing for care coordination and quality improvement purposes with information about how to modify their data sharing preferences via 1-800-MEDICARE. Such communications shall note that, even if a Next Generation Beneficiary has elected to decline claims data sharing, CMS may still engage in certain limited data sharing for quality improvement purposes.
2. The ACO shall allow Next Generation Beneficiaries to reverse a data sharing preference at any time by calling 1-800-MEDICARE.
3. CMS will maintain the data sharing preferences of Beneficiaries who elect to decline data sharing in this Model or who have previously declined data sharing under the MSSP or the Pioneer ACO Model.
4. The ACO may affirmatively contact a Next Generation Beneficiary who has elected to decline claims data sharing no more than one time in the Performance Year to provide information regarding data sharing. Such contact includes mailings, phone calls, electronic communications, or other methods of communicating with Next Generation Beneficiaries outside of a clinical setting.
5. In the event that a Next Generation Professional is terminated from the ACO for any reason, if that departing Next Generation Professional is the sole Next Generation Professional in the ACO to have submitted claims for a particular Next Generation Beneficiary during the 12-month period prior to the effective date of the termination, CMS will administratively opt the Next Generation Beneficiary out of all claims data-sharing under this Section VI within 30 days of the effective date of the termination, unless—
    (a) The Next Generation Beneficiary affirmatively consents to continued data sharing of such claims with the ACO through an authorization that meets the requirements under 45 CFR § 164.508(b); or
    (b) The Next Generation Beneficiary has become the patient of another Next Generation Professional participating in the ACO.
6. Notwithstanding the foregoing, an ACO shall receive claims data regarding substance use disorder treatment only if the Next Generation Beneficiary has not elected to decline data sharing or otherwise been opted out of data sharing and has also submitted a CMS-approved form pursuant to Section VI.E of this Agreement.

E. Beneficiary Substance Use Disorder Data Opt-In

1. The ACO may inform each newly-aligned Next Generation Beneficiary, in compliance with applicable law:
    (a) That he or she may elect to allow the ACO to receive beneficiary-identifiable data regarding his or her utilization of substance use disorder services;
    (b) Of the mechanism by which the Next Generation Beneficiary can make

this election; and

(c) That 1-800-Medicare will answer any questions regarding sharing of data regarding utilization of substance use disorder services.

2. A Next Generation Beneficiary may opt in to substance use disorder data sharing only by submitting a CMS-approved substance use disorder opt in form to the ACO. The ACO shall promptly send the opt-in form to CMS

OneCare Vermont

Statement of Assets, Liablilities and Equity
July 31, 2018

	Current Month	Previous Month	Change
Cash - Unrestricted	$ 182,740	$ 6,190,913	$ (6,008,173)
GMCB - Required Reserve Funding	$ 1,100,000	$ 1,100,000	$ -
Additional Reserve Funding (CMS)	$ 4,130,213	$ 4,128,008	$ 2,205
VBIF Funding	$ 2,527,435	$ 2,172,169	$ 355,266
Advance Funding - VMNG	$ 5,799,075	$ 5,885,731	$ (86,656)
Accounts Receivable	$ 4,060,279	$ 3,116,295	$ 943,984
Prepaid Expense	$ 1,458,908	$ 219,846	$ 1,239,062
Total Assets	**$ 19,258,649**	**$ 22,812,962**	**$ (3,554,313)**
Unearned Revenue	$ 1,546,824	$ 253,708	$ 1,293,116
Accrued Expenses	$ 55,053	$ 405,320	$ (350,267)
Due to Other	$ 7,692,984	$ 8,753,963	$ (1,060,979)
Due to UVMHN - CMS Reserve Funding	$ 4,124,849	$ 4,124,849	$ -
Due to UVMMC - CY17	$ 0	$ 5,090,908	$ (5,090,908)
Due to UVMMC - CY18	$ 3,774,101	$ 3,365,866	$ 408,235
Due to DHH - CY18	$ 2,014,838	$ 768,349	$ 1,246,490
Total Liabilities	**$ 19,208,649**	**$ 22,762,962**	**$ (3,554,313)**
Capital Contribution UVMMC	$ 25,000	$ 25,000	$ -
Capital Contribution D-H H	$ 25,000	$ 25,000	$ -
Total Equity	**$ 50,000**	**$ 50,000**	**$ -**
Total Liabilities and Equity	**$ 19,258,649**	**$ 22,812,962**	**$ (3,554,313)**

NOTE: This statement is created for the benefit of the member organizations of OneCare Vermont and is not representative of a GAAP Balance Sheet.

OneCare Vermont

2018 P&L

July 31, 2018

	Annual Budget	YTD Budget	OCV YTD Actual	$ Variance Fav/(Unfav)	% Variance Fav/(Unfav)	Rise VT YTD Actual	Adk ACO YTD Actual
VMNG Revenue	$ 3,134,352	$ 1,828,372	$ 1,864,187	$ 35,815	2.0%	$ -	$ -
VMNG PHM Program Pilot - Complex CC	$ 2,980,045	$ 1,738,359.58	$ 1,679,070	$ (59,289)	-3.4%	$ -	$ -
BCBSVT Reform Pilot Support	$ 1,000,000	$ 583,333.33	$ 447,678	$ (135,656)	-23.3%	$ -	$ -
Self-Funded Pilot Revenue	$ 1,075,896	$ 627,606	$ 342,576	$ (285,030)	-45.4%	$ -	$ -
CMS Medicare Blueprint Replacement	$ 7,762,500	$ 4,528,125	$ 4,536,443	$ 8,318	0.2%	$ -	$ -
SOV PHM Program Pilot - Primary Prevention	$ 1,500,000	$ 875,000	$ -	$ (875,000)	-100.0%	$ -	$ -
Informatics Infrastructure Support	$ 3,500,000	$ 2,041,666.67	$ 2,041,667	$ 0	0.0%	$ -	$ -
Other Grants/Contracts - RWJ	$ 51,851	$ 30,246.42	$ -	$ (30,246)	-100.0%	$ -	$ -
Other Grants/Contracts - Adirondack	$ 216,000	$ 126,000	$ 126,000	$ -	0.0%	$ -	$ -
Other Grants/Contracts - Cigna	$ 104,000	$ 60,666.67	$ 81,252	$ 20,585	33.9%	$ -	$ -
Other Revenue	$ -	$ -	$ 454,951	$ 454,951	0.0%	$ 238,144	$ 466,138
Participation Fees	$ 18,459,071	$ 10,767,791.42	$ 10,149,613	$ (618,179)	-5.7%	$ -	$ -
Total Income	**$ 39,783,715**	**$ 23,207,167**	**$ 21,723,436**	**$ (1,483,731)**	**-6.4%**	**$ 238,144**	**$ 466,138**
Basic OCV PMPM	$ 4,781,010	$ 2,788,922.50	$ 2,354,134	$ 434,788	15.6%	$ -	$ -
Care Coordination	$ 7,064,722	$ 4,121,087.83	$ 3,294,562	$ 826,526	20.1%	$ -	$ -
PCP Comprehesive Payment Reform Pilot	$ 1,800,000	$ 1,050,000	$ 422,503	$ 627,497	59.8%	$ -	$ -
VBIF	$ 4,305,223	$ 2,511,380.08	$ 2,527,435	$ (16,055)	-0.6%	$ -	$ -
Community Program Investments	$ 1,577,600	$ 920,266.67	$ 432,477	$ 487,790	53.0%	$ -	$ -
Blueprint	$ 7,762,500	$ 4,528,125	$ 4,538,635	$ (10,510)	-0.2%	$ -	$ -
Salaries/Fringe	$ 6,583,992	$ 3,840,662	$ 3,609,354	$ 231,308	6.0%	$ 157,655	$ 429,620
Purchased Services	$ 845,766	$ 493,363.50	$ 344,249	$ 149,115	30.2%	$ 11,500	$ -
Contract & Maintenance	$ 2,925,467	$ 1,706,522.42	$ 1,473,616	$ 232,907	13.6%	$ -	$ -
Lease & Rental	$ 321,051	$ 187,279.75	$ 98,276	$ 89,004	47.5%	$ -	$ -
Utilities	$ -	$ -	$ 47,752	$ (47,752)	0.0%	$ 963	$ -
Other Expenses	$ 1,816,384	$ 1,059,557	$ 1,073,848	$ (14,291)	-1.3%	$ 68,026	$ 36,518
Total Expenses	**$ 39,783,715**	**$ 23,207,167**	**$ 20,216,840**	**$ 2,990,327**	**12.9%**	**$ 238,144**	**$ 466,138**
Net Income / (Loss)	**$ -**	**$ -**	**$ 1,506,596**	**$ 1,506,596**		**$ -**	**$ -**