To: Kevin Mullin, Chair, Green Mountain Care Board
From: Todd Moore, CEO OneCare Vermont, Accountable Care Organization, LLC
Date: November 14, 2017
Subject: OneCare Vermont's Response to GMCB Questions

Dear Chairman Mullin,

Below you will find OneCare Vermont's responses to GMCB's questions based on our presentation of November 2, 2017 and budget resubmission of October 20, 2017. If you have any questions about our responses, please contact me or Vicki Loner, COO at 847-6255.

Green Mountain Care Board's Questions

1) Your days cash on hand makes a large jump from 2016 to 2017 and remains high in 2018 while the income statement shows a net $0. Please explain.

   The cash on hand reported on the balance sheet forecast is in large part due to the timing of payments from the payers. As noted in the submission, the balance sheet forecast assumed the Medicaid payments continue to be made prospectively. This means that the payment for January 2018 services would be sitting in a cash account as of December 31, 2017. Because this cash is obligated to hospitals, it should not be factored into an analysis of days cash on hand.

2) Please break down the 'Due to Other' liability account on the balance sheet.

   Related to the answer to Question #1, the balance sheet forecast assumed that the Medicaid payment would continue to be paid prospectively. This means that as of December 31, 2017 there is a due to the hospitals accepting fixed payments for the amount they are owed to deliver care in January 2018. The exact amount carried forward into 2018 will be determined by the final split of fixed payments vs. remaining FFS and actual attribution.

3) Expanding on Part 4, Question 5 of your resubmission, please break down the $10.9 million in Population Health Management programs and operations both by account and by hospital.

Initiative	*Value-Based Incentive Fund*	*Basic OCV PMPM*	*Complex Care Coordination Program*	*Community Program Investments*	*CHT Funding Risk Communities*	*PCP Payments Risk Communities*	*Total*
DHH	*$136,874*	*$146,960*	*$100,378*	*$25,000*	*n/a*	*n/a*	*$409,211*
SVMC	*$131,822*	*$141,535*	*$176,552*	*$25,000*	*n/a*	*$96,869*	*$571,779*
CVMC	*$620,277*	*$665,982*	*$524,915*	*$25,000*	*$292,092*	*n/a*	*$2,128,267*
BMH	*$189,492*	*$203,454*	*$187,987*	*$25,000*	*$120,953*	*$35,262*	*$762,150*
UVMMC	*$1,156,620*	*$1,241,845*	*$924,796*	*$75,000*	*$751,015*	*$289,284*	*$4,438,560*
Porter	*$315,061*	*$338,276*	*$279,218*	*$25,000*	*$128,649*	*n/a*	*$1,086,204*
Springfield	*$39,037*	*$41,913*	*$44,879*	*$25,000*	*n/a*	*n/a*	*$150,830*
NMC	*$117,982*	*$126,675*	*$109,377*	*$25,000*	*$173,667*	*$20,415*	*$573,117*
NCH	*$95,673*	*$102,722*	*$134,992*	*$25,000*	*$98,069*	*$76,761*	*$533,216*
MAHHC	*$38,989*	*$41,862*	*$69,824*	*$25,000*	*$73,916*	*$33,638*	*$283,229*
Total	***$2,841,826***	***$3,051,225***	***$2,552,920***	***$300,000***	***$1,638,361***	***$552,229***	***$10,936,561***

4) Please explain how the $7.6 million in payment reform payments will be divided at the community level by provider type.

In essence, the $7.6M net investment is the difference between the hospital gross contributions, less the amount they receive back in the form of PHM/Reform provider payments. The following budget walks through the specific payer revenues, the PHM/reform and operations expenses and both the gross gap funded by hospital commitments and the net hospitals contributions after PHM/reform receipts. (Note: Program TCOC targets are excluded from this budget to more clearly illustrate the way in which PHM/reform programs are funded.)

Line Item	*Budget*
DVHA	*$6,114,397*
BCBS	*$1,000,000*
Medicare	*$7,762,500*
State/Other	*$6,447,747*
Total Revenue	***$21,324,645***
Basic OCV PMPM	*$4,781,010*
Complex Care Coordination Program	*$7,064,722*
PCP Comprehensive Payment Reform Pilot	*$1,800,000*
Value-Based Incentive Fund	*$4,305,223*
Community Program Investments	*$1,577,600*
Blueprint	*$7,762,500*
Operations	*$12,492,660*
Total Expenses	***$39,783,716***
Gross Hospital Contributions	***$18,459,071***
Hospital PHM/Reform Receipts	*$10,936,561*
Net Hospital Contributions	***$7,522,510***

This perspective highlights that the net contribution towards OneCare Vermont programs represents funding for all initiatives. Said differently, it is not specifically divided at the community level by provider type. Rather, it represents critical funding to ensure that the PHM/reform efforts have the financial resources to further reforms at the community level.

5) Will you have a different Grievance and Appeals Policy for each payer? If not, why?

It is OneCare's intent to leverage the current Vermont Medicaid Next Generation (VMNG) Grievances and Appeals Policy to meet the needs of all payer programs. The continued development of the VMNG policy (with input from the Medicaid process and from the Health Care Advocate) has been instrumental in the creation of a more system-wide approach that creates clear and consistent beneficiary and provider expectations and experience. We will work with BCBSVT and CMMI to share our current VMNG Grievance and Appeals Policy with the intent to continue to leverage one policy for all programs.

<u>Payer</u>

6) Provide additional quantitative and qualitative support of the flow of funds between projected balance sheets and income statements. Provide detailed illustrations of the flow of fund between the parties involved in the operation.

These details are subject to input from OneCare Vermont's auditing firm and the timing of payments, however, in general terms payments from payers will flow to a OneCare cash account. When the time comes to pay the providers per the payment schedule, the revenue will be recorded on the OneCare income statement in addition to an expense for the fixed payments. The difference between these amounts will represent the amount withheld to fund operations and PHM/reform programs. Withholds for the VBIF will remain on the balance sheet as a Due to Other for provider payments to be determine at the end of the program year.

Slide 24 in the submitted presentation provides a visual of the flow as well as estimated payment amounts.

All of the above is subject to review from an audit firm, the final spend targets, and actual attribution.

7) Provide finalized versions of the payer contracts before executed, for review, by November 15th.

Contracts will not be available by November 15th. OneCare is happy to work with the GMCB to help determine alternatives that are agreeable to both parties.

8) Provide detailed calculations of the TCOC targets, including an example from the table on Slide 15 of your OneCare VT November 2, 2017 presentation, and much stronger documentation for actuarial soundness.

Payer Program	*Attribution*	*2016 Spend*	*2016 -2017 Trend*	*2017 Expected*	*2017 - 2018 Trend*	*2018 Expected*
Medicare	*33,474*	*$335,497,851*	*0.00%*	*$335,497,851*	*3.50%*	*$347,240,276*
Medicaid	*40,184*	*$108,204,679*	*3.53%*	*$112,028,840*	*6.07%*	*$118,833,295*
Commercial	*34,943*	*$122,978,233*	*4.50%*	*$128,512,253*	*3.80%*	*$133,395,719*
Total	***108,601***	***$566,680,763***		***$576,038,944***		***$599,469,290***

Budget

9) Please justify why 3.5% was chosen as the growth rate, and how OneCare projects future growth rates in light of the requirements set forth in the All-Payer ACO Model Agreement.

We assume this question refers to the 3.5% trend rate used to take our Medicare 2017 figure to a 2018 projected target. We based this both on our analysis of recent multi-year cost trend rates for OneCare Vermont's Medicare beneficiaries and it's alignment with the All-Payer-Model (APM) Floor negotiated by the State of Vermont.

Our experience on "total cost of care" based on OneCare Vermont data under the Medicare Shared Savings Program indicates a five-year compound annual growth rate of 3.7%. This analysis is based on our four fully-settled performance years in the program from 2013 through 2016 and a modeled 0% cost increase factor from 2016 full year spending as our 2017 projection. In total, this means our proposed 3.5% is below the historic trend rate. Additionally, this calculated five year trend rate of 3.7% is significantly impacted (i.e. it is lower) due to the 0% applied for 2016 to 2017. We have no

way of knowing with certainty where 2017 will actually end up, and whether the 2016 to "early 2017" trend is an anomaly or is indeed indicative of a new expected trend. As another major factor, we have a significant number of new attributing providers joining OneCare in 2018 for the first time. That means for those providers we have no base attribution or historic claims information from any period for analysis, and we have included assumptions and extrapolations in our budget based on the information we do have available. We believe these attribution numbers are likely high enough that the GMCB cannot assume any level of precision or accuracy on our Medicare budget models. We advise that the OneCare budget be treated as a "plan" or "projection" based on best available information and assumptions, with expected adjustment or variance reporting as actual information becomes available.

Also, as we move into risk-based programs and the much sharper incentives which include financial penalties for excess spending, we believe that initial targets should have a general methodology of applying current base spending plus relevant trend rates "leftover" from the fee-for-service era in order to facilitate a smooth transition. Artificially reduced targets in Year 1 of our APM risk programs, which already include significant "assumed savings" against previous growth rates, are unrealistic and unwise. We believe that taking such an approach may actually jeopardize access and quality, and may cause OneCare to reevaluate the budgeted investments in population health management programs that are critical to success in two-sided risk programs. Making these investments under the 3.5% first year Medicare growth target effectively generates a more limited year-to-year revenue increase (under 2%) to OneCare hospitals in order to fund the population health transformation. Given the state's very limited use of the Delivery System Reform (DSR) funds included in the Vermont 1115 Global Commitment Waiver and designed to directly assist in these expenses, maintaining the ability for OneCare to implement these programs, which focus on primary care and community efforts, is even more important.

We believe it is avoiding this effect that contributed to the State of Vermont negotiating the 3.5% Medicare floor in the first place, i.e. for the case that the go-forward APM standard of the national FFS rate of growth was lower than the relevant growth rate projection for Vermont's Medicare beneficiaries as we initiate the APM. The published CMS figure from April 2017 indicated a 2018 national projected FFS rate of growth of 2.73% which we believe is still suppressed by low growth in higher spending, more populous regions of the United States which have "low hanging fruit" opportunities on cost and quality, but remain measurably worse on both than Vermont. We therefore believe this figure is neither appropriate nor required under APM for use in determining OneCare's 2018 target. We find it defensible and prudent to apply the State's floor of 3.5% to OneCare. In future years, without any recurring floor protection, we anticipate the GMCB will apply the projected national FFS rates of growth as outlined in the APM in setting OneCare's future annual targets. In recent years, CMS multi-year projections on expected national FFS trends have had very mixed accuracy and therefore we have no concrete multi-year expectations on future Medicare growth rates to be applied to OneCare under APM.

10) Provide additional quantitative and qualitative support for items that have changed since the last budget submission (e.g. VMNG PHM Program Pilot - Complex CC).

All of the changes between the first and second submissions were due to the incorporation of the latest available data. The primary drivers affecting change were updates to the expected attribution and spend targets. Because many of the PHM/reform budget amounts are derived from either of these figures, the budget estimates changed accordingly. There was no change to overall

methodology for determining these budgets and the calculations remained consistent with the way they were explained during the budget presentation and in the suppled materials.

Risk Mitigation Strategy

11) Please explain why you have categorized the Medicare and Commercial payer programs as "Full Risk."

Per the budget presentation, both programs are budgeted to move to two-sided risk configurations in 2018. This is a change from 2017 when they are upside only (i.e. no risk).

12) There is a solvency concern for OneCare if a big Health Service Area (HSA) generates a huge loss at the HSA's MRL but the other HSAs generate small savings. This would result in an overall loss for OneCare, and it is unclear if the pooling mechanism is effective in mitigating the risk in this situation. Please provide an example where there is equitable gains and losses among the HSAs and an example where multiple, larger HSAs have losses.

The model is designed so that no HSA/hospital will be subject to a payback (or savings) above their calculated Maximum Risk Limit (MRL). If an HSA's calculated overrun were to exceed the MRL, the excess is pooled and shared across the network. This protection ensures that no one HSA will exceed their limit, but does mean that an HSA that met or beat their target could have to contribute to cross-cover the excess loss for another. In the event a reinsurance claim attaches, the claim contributions will first cover any excess overruns above an HSA's MRL to minimize the need for pooling. Please refer to the submitted OneCare Vermont Risk Sharing/Savings policy for more detail.

13) If the other hospitals cannot or choose not to help out if there are overages, is OneCare responsible or do the hospital face the risk entirely? If the responsibility falls on OneCare, is the reinsurance great enough to cover this?

Hospitals will be contractually obligated to contribute towards ACO-level losses up to their calculated MRL and per the methodology outlined in the OneCare Vermont Risk Savings/Losses Sharing Policy. A reinsurance claim may or may not be a factor depending on the outcome of the performance year.

14) L&E recommends that OneCare consider adding a risk adjustment process to the claim costs to take into account the health status differences between:
    - The HSAs, or
    - The actual and target populations.

Please describe if you will take L&E's following recommendation into account in your planning. If not, please explain why.

The targets are set based on either the methodology of the payer program or through negotiations. For Medicare, the final target is assumed to be retrospectively risk adjusted per standard CMS methodology. For Medicaid, the risk score trend was factored into the actuarial analysis and weighed into the rate negotiations accordingly. For BCBS, the rate negotiations are underway and the way in which risk scoring is incorporated will be determined collaboratively between OneCare Vermont and BCBSVT.

It's important to note that the payer targets are all set on the ACO level. In other words, the Medicare, Medicaid and BCBSVT targets are not broken down by HSA. Rather, there are separate ACO-level

PMPMs for the population category groupings outlined in the submitted presentation materials. Within the network, each providers fixed payment will be calculated based on their historical FFS billing, which does incorporate the past risk of their population.

15) Please provide a formal reinsurance quote or agreement. If this will not be provided by November 15, 2017, please explain why.

Negotiations with potential reinsurance underwriters are ongoing. No formal or binding proposal has been reached as of the submission of this response. The final agreement will be based on an agreed-upon approach that incorporates the latest available spending targets and the corresponding maximum risk.

16) Based on the Shared Savings results and the fee-for-service spending in the 2017 Medicaid Contract, please explain how the steps you are taking now and in future years are expected to be effective in controlling your increasing costs and utilization.

Due to the January 1, 2017 start of the program and claims runout requirements, it has only been in recent weeks that initial 2017 data is meaningful and capable of driving conclusions and areas of focus. One of the immediate, and in our opinion constructive conclusions supported by the performance, is the need for the network to truly focus on the "remaining FFS" spending. We are currently researching explanations for that performance including which providers and where, which types of services and which Medicaid enrollment populations. As VMNG becomes a continuing program, more ongoing longitudinal analysis and patterns will be available for new population health programs and patient engagement strategies.

Regarding specific changes mid-year, in July 2017, OneCare Vermont launched the Complex Care Coordination program which targets the high and very high risk Medicaid covered lives attributed to the program. This was pre-planned rather than a reaction to early performance, but does focus on supporting our highest complexity and cost enrollees in ways which may mitigate spending through more proactive and preventative care with less waste and duplication. We will be monitoring the impact to utilization and/or spending through the remainder of 2017 to assess overall programmatic impact. This evaluation will help to inform program expansion for the larger population across the three payer programs in 2018.

OneCare has also significantly stepped up its efforts in 2017 on driving analysis and best practice conversations around episodes of care and disease states. On episodes of care, OneCare has built and deployed an analytic tool focused on the CMS-defined set of 48 specific clinical episodes which are selected for focus based on an acute care inpatient stays but which typically also has significant pre and post-acute care delivery. The OneCare network has taken the significant variation in episode spending patterns to heart with at least one large HSA implementing a specific focus on post-acute care which has decreased use of more expensive follow-up when not clinically required. On disease states, OneCare has created and facilitated statewide activities and clinician-to-clinician best practice sharing on hypertension, diabetes and CHF.