To: **Alena Berube, Melissa Miles, and Marisa Melamed Green Mountain Care Board**
From: **Vicki Loner, CEO OneCare Vermont, Accountable Care Organization, LLC**
Date: **October 25, 2019**
Subject: **Responses to questions to OneCare on the FY 2020 budget submission**

Dear Green Mountain Care Board Team,

Please find below OneCare Vermont's responses to the Green Mountain Care Board's follow up questions regarding our 2020 Budget Submission. Our responses are below the repeated questions.

Section 2: ACO Provider Network

1. Explain your contracting process with providers, including when a signature is or is not required and how changes are communicated to the providers. Explain which aspects of the contract are annual or multi-year.

   OneCare sends individualized contract packages to each organization interested in joining the ACO for the next performance year. The package includes an overview, instructions, and a checklist. OneCare also hosts live contracting webinars and provides contact information for our network operations team to address any questions or concerns.

   Generally, there is a base First Amended and Restated Participant and Preferred Provider Agreement (Base Agreement) that secures general obligations spanning all programs and a Program Addendum for each payer program, such as Vermont Medicaid. There are also Collaborator Agreements for entities that support ACO Activities but are not eligible to be Participants or Preferred Providers. Each contractual document that has been provided states its term, the Base Agreement runs through the end of the APM or December 31, 2022. See a below relating to the terms of the Program Addendums. The Participant and Preferred Provider Agreement and ACO Program Addenda state when signatures are required, which includes for most amendments (those for regulatory compliance do not require signature and the Program of Payment is replaced annually without signature, subject to non-renewal rights). The 2020 Program of Payments has been submitted to the Board.

   a. The program addendums (Part 2 Attachment E) say "2019" in the header for Medicaid and Medicare, confirm these are the correct ACO program addendums for the 2020 year.

      Yes, they are correct. See the Term Provisions in each Program Addendum. The Blue Cross Next Generation Model ACO Program Addendum runs through December 31, 2020; the Vermont Medicare ACO Initiative Program Addendum and the Department of Vermont Health Access Medicaid Next Generation Model ACO Program Addendum both run through December 31, 2022. Note that the 2020 Program of Payments, found as part of the Base Agreement, sets forth the reimbursement model for 2020.

b. Submit the FQHC exemplar contract.

There is no separate FQHC contract, terms relating to FQHCs has been incorporated into the in the First Amended and Restated Participant and Preferred Provider Agreement and its Amendment #1 as well as the 2020 Program of Payments (part of the Base Agreement).

2. How does OneCare determine its outreach strategy to providers, i.e. how does OneCare determine who to send a Solicitation of Interest, as referenced in the Network Development Timeline submitted with certification?

Joining OneCare is a voluntary decision and OneCare remains open to discussing participation with all interested parties whose participation may be secured consistent with the clinical and risk sharing models.

OneCare identifies prospective organizations through various strategies including:

- New organizations interested in joining the ACO complete a "Network Request Form" on the OneCare website.
- In advance of sending the letter of interest, OneCare solicits input from participating hospitals to identify other organizations in their Health Service Area for OneCare to reach out to.
- OneCare identifies non-participating organizations that provide services to attributed patients via claims data.
- Current organizations are invited to continue and increase their participation in OneCare's payer and payment reform programs.

OneCare sends a Letter of Interest to all of the above as identified.

3. In follow-up to question 4a and b, please break out the number of lives estimated in the "Multi-Year Strategy" table on page 15, by using the following table:

OneCare has access to data for attributed lives only. Therefore, the consolidated table provided in the initial budget submission incorporated very high level estimates of attribution opportunity informed solely by past experience. For that reason, OneCare does not have the data to provide the more granular estimate requested. OneCare is willing to meet with the appropriate State officials to determine how it can assist with respect to the State's scale target reporting requirements under the All Payer Model.

OneCare Vermont

Scale Strategy	Estimated # Lives*		
	2020	2021	2022
Geographic Attribution Methodology			
Medicare			
Medicaid			
Commercial-fully ins			
Commercial-SF			
Other Attribution Methodology Changes			
Medicare			
Medicaid			
Commercial-fully ins			
Commercial-SF			
Network Participation			
Medicare			
Medicaid			
Commercial-fully ins			
Commercial-SF			
Expanded Payer Program Offerings			
Medicare			
Medicaid			
Commercial-fully ins			
Commercial-SF			

*Estimates based on scale strategy opportunities presented in the budget submission

4. In part 2, question 4b you state that "OneCare piloted a Medicaid geographic attribution concept with St. Johnsbury HSA [and that] there were a number of key findings that are helping to craft a potential statewide geographic attribution approach in 2020." Please discuss these findings.

   OneCare has worked collaboratively with parties in the St. Johnsbury HSA and at Department of Vermont Health Access (DVHA) to monitor the implementation of the geographic attribution model and together OneCare and DVHA are using these preliminary findings to inform current negotiations for possible expanded attribution to the Medicaid population in 2020. That being said, one of the findings is that there is a material segment of the population that accesses healthcare but has no relationship with a primary care provider. OneCare is interested in exploring ways to incorporate this cohort into a value-based program.

5. Provide a narrative description of the grid depicting "attribution opportunity targets through 2022" on page 13. Describe which strategies may be effective by HSA. In doing so, please also recognize each HSA's starting point (through 2020), as well as their overall "attributable" population (what will still be "left on the table" in 2022 and why?).

   OneCare has access to data for attributed lives only. OneCare would be happy to meet with the appropriate State representatives to determine how it can assist with respect to the State's scale target reporting requirements under the All Payer Model and with progress toward achieving scale targets.

6. Is it correct to understand that OCV estimates that it will carry forward a balance in its "Designated Risk Reserve" of $3.9 million from FY2019 to FY2020? Does OCV anticipate covering any 2019 HSA overruns, and if so, will that result in a lower estimated Designated Risk Reserve entering FY2020 than the $3.9 million identified? If so, do you intend to build the balance back up and how?

   Current forecasts suggest that OneCare will conclude the fiscal year with roughly $4M in reserves net of any contributions that need to be paid to cover risk mitigation arrangements. This forecast is based on partial year claims data and is subject to change as experience and data continue for the rest of the year. If FY2019 program settlements require OneCare to access these reserves, the resulting reserve balance would be reviewed by the Finance Committee and Board of Managers to determine, consistent with regulatory requirements, whether or not additional reserves are needed. OneCare has no reliable means other than hospital dues to generate reserves.

7. Given that $3.7 million of the $3.9 of guaranteed risk protection is for hospitals with a risk mitigation agreement (page 35, question 8c), is it appropriate to assume that the delta is to cover risk specific to OneCare as described on page 16? If so, what is this risk associated with? Please clarify the reference to reserves to "provide general liquidity to manage financial operations." Is this liquidity for OneCare or for hospitals?

   In 2020 the risk mitigation agreements will be changing so that the Founders (University of Vermont Medical Center and Dartmouth Hitchcock) provide the protection rather than OneCare in order to support broad network participation and include hospitals who are not ready, or

able, to bear full risk. Because the Founders have agreed to support the network development in this manner, the reserves that OneCare will carry forward into 2020 are not intended to provide this risk mitigation and are available in their entirety to protect against ACO wide risks. An example of an ACO wide risk is a circumstance in which a participant is unable to pay a settlement obligation.

8. For each risk-bearing hospital and each payer program, submit the final settlement calculations described in OneCare's Program Settlement Policy for performance year 2018.

   OneCare has provided the GMCB with the calculated final settlement previously.

   a. To what extent is the method of distribution communicated to and understood by hospitals up front, and to what extent can the Board of Managers adjust the settlement distribution methodology once the settlement is known? For what reason might the Board of Managers adjust the distribution methodology?

      The method of distribution is explained in detail to the Finance Committee, on which most hospitals are represented, and any risk bearing entities who request additional information are provided with it to the best of OneCare's ability. Settlement reconciliation summaries are also posted to the secure portal. OneCare policies dictate the extent to which the Board of Managers can make adjustment and the participants are bound by the First Amended and Restated Participant and Preferred Provider Agreement, Program Addendums and Program of Payments which also contains the information sought by this question. Generally, the Program of Payments can be changed to add payments, or as a result of material changes in the ACO's circumstances, distribution may be affected by a material change such as a payer not paying shared savings to OneCare.

Section 3: ACO Payer Programs

9. Why only 0.5% growth in Medicaid from 2019 to 2020 when OneCare's Q2 presentation and Appendix 3.1 Trend Rates suggests that the Medicaid benchmark is lower than the network's total cost of care?

   This modest estimate was incorporated into the budget for two key reasons. The first is that current utilization trends are not suggesting a material increase in service delivery volumes. Second, OneCare does not have the detailed 2020 repricing information that would affect the unit-cost component of the overall trend. Ultimately the actuarial process will determine the actual trend and will supplant this preliminary estimate. In light of the above, a conservative approach was incorporated into the budget model.

   a. Please explain the drivers of the Medicaid 2019 losses being projected in Appendix 4.4 Total Shared Savings/(Loss) ($7,932,988) and break out that which is attributed to Fee-for-Service (FFS) vs. Fixed Prospective Payments (FPP).

      OneCare, DVHA, and contracted actuaries are actively reviewing to understand the root cause.

10. Please explain how you arrive at the 6.04% trend rate for Commercial QHP (Appendix 3.1 Trend Rates) from the GMCB approved rates. Please provide the breakdown between BCBS and MVP for the underlying Base Experience PMPM assumptions.

    The budget assumption was sourced from the approved rate filings and done so in a way to align the approved increases with the set of health care services for which OneCare is accountable as established in its program agreements. These rates are the subject of active contract negotiations and requested information will be included in the final approved and signed contracts.

11. How much churn or turnover is there in the attributed lives (by payer, by year)? What percentage of the lives are consistently attributed over time?

    2018 is the only complete year for the core programs. The amount of "stayers" from year to year varies based on the consistency of the provider network. See the table below for the percentages of churn rate by payer program

	Attribution Year		New Patients in 2019		Patients Attributed in both years		Churn from 2018 to 2019	
	2018	2019	Count	%	Count	%	Count	%
Medicare	39,702	58,782	25,374	43.9%	33,408	84.1%	6,294	15.9%
Medicaid	42,342	79,004	45,552	57.7%	33,452	79.0%	8,890	21.0%
BCBS QHP	20,838	20,362	7,471	36.7%	12,891	61.9%	7,947	38.1%
BCBS SF	9,874	10,145	1,748	17.2%	8,397	85.0%	1,477	15.0%

    a. Please comment on the nature of- and expected drivers of churn. To the extent possible, provide data to support this analysis.

       The payers manage beneficiary/member enrollment and attribution, which limits OneCare's ability to analyze the underlying sources of "churn outside of network composition."

12. Please provide further details that describe the risk-sharing arrangements with Commercial-QHP plans, disaggregated by insurer. Is it correct to understand that estimated FY2020 risk equals $3,626,010 on a base of estimated Commercial-QHP revenue equal to $167,697,435 (2.16%)?

    Yes, this is accurate. The Commercial – QHP program category includes multiple payer contracts with varied risk-sharing terms. The aggregate risk reflects OneCare's current best estimate, but the resulting percentage noted is a blend of separate program designs. The risk-sharing arrangements are the subject of active contract negotiations and not finalized, the requested information will be in final approved and signed contracts.

13. Please provide further details that describe the risk-sharing arrangements with Commercial-Self Insured plans. Is it correct to understand that estimated FY2020 risk equals $1,868,715 on a base of estimated Self-Insured revenue equal to $373,742,964 (0.50%)?

    Yes, this is accurate. The risk-sharing arrangements are the subject of active contract negotiations and not finalized, the requested information will be in final approved and signed contracts.

14. On page 16 of the budget submission, you describe an effort to pursue high-cost case truncation. With which payers does OneCare contemplate exploring such a methodology? What is the status of these conversations, and is the intent to affect distribution of risk in FY2020?

    Truncation is a discussion with most payers. The potential truncation arrangements are the subject of active contract negotiations. The intent of incorporating truncation arrangements is to more clearly distinguish between "incident risk" (ex. bad accident, rare condition) and performance risk. OneCare believes that a reasonable truncation point yields a fairer measurement of performance under a value-based contract.

15. On page 20 of the budget submission, it states that OneCare "was not able to incorporate an estimate of repricing adjustments in the [Medicaid] budget due to inherent complexity." Please clarify how the estimated 2020 Medicaid PMPMs were calculated and whether OneCare anticipates further Medicaid price changes not otherwise captured in OneCare's 2020 budget submission.

    OneCare attempted to prospectively replicate the upcoming actuarial process to determine the Medicaid PMPM estimate in the 2020 budget. Existing 2018 actual spend data was used as the base year, and two subsequent annual trends were applied. The first evaluated the difference between the actual 2018 spend and the year-to-date 2019 experience data. This suggested an increase of 2.2%. Then, a very modest estimate of 0.5% was applied for the 2019 to 2020 increase.

    OneCare does not know whether or not there will be further Medicaid price changes.

Section 4: ACO Budget and Financial Plan

16. Please detail how the "State Support" listed under Revenue in Appendix 4.2 Income Statement will be utilized to support Informatics and Delivery System Reform expenditures and what, if any additional funds are used to supplement these investments.

    The "State Support" consists of $3.5M of informatics infrastructure expenses that include enhancements to IT resources, additional expenses related to scale growth, and financial and population health analytics support of OneCare's network. The remaining "State Support" consists of $13.1M in healthcare reform investments, of which $6.0 million are new programs requested over prior years and $1.8 million continues existing programs. The $13.1M also includes $5.3M of OneCare Fixed Payment Care Coordination Allocation, which is fully within the Medicaid global total cost of care, meaning that OneCare is voluntarily shifting funding into this investment category at no additional cost to the state. These Delivery Service Reform (DSR) dollars are foundational to true transformation, including funding initiatives to support increased access to primary care, prevention, mental health, management of chronic illness, and support for OneCare's complex care coordination program. To date, participating hospitals have

prefunded many of OneCare's population health investments and this funding request of the State helps balance these expenditures among hospitals, payers, and the State/Federal contributions to help ensure the All Payer Model's population health objectives are addressed.

a. Please share your application for Delivery System Reform (DSR) funding for 2020. What are the initiatives included? How are these prioritized? If OneCare does not receive $13.1 million in DSR Investments, how will you adjust your program investments or other aspects of the budget?

OneCare does not submit applications to CMS for DSR funding; that is the purview of DVHA and AHS. Possible initiatives address: access to primary care, prevention, mental health, management of chronic illness, and support for OneCare's complex care coordination program. Should some or all of the funding fail to materialize, the entire budget will undergo re-review by OneCare's relevant Committees and the entire Board of Managers to make appropriate adjustments as needed. Of the $13.1M in healthcare reform investments, $6M is a request for new programs and $1.8M for continuation of existing funding. The DSR funds are eligible for federal match as memorialized in the All Payer Model Agreement. Match rates vary, but OneCare estimates approximately half of these new funds ($3M) would come from State investment and the remainder from federal funds.

b. Which of the Population Health Management (PHM) programs are dependent on the current 2019 DSR dollars/Health Care Reform Investments? Why is DULCE not listed as a PHM Program for 2020?

Current 2019 healthcare reform investments (which may or may not include DSR funds) as determined by the State, include: RiseVT, informatics infrastructure, and complex care coordination support. DULCE is funded through the complex care coordination program in 2019. All 2020 healthcare reform investments are currently being considered and, until memorialized in contract, they are subject to change.

17. Provide a variance analysis for each line item in the income statement (Appendix 4.2) over or under 10% (across any of the variance categories), be sure to break out changes due to volume versus rate.

Line	**Variance Analysis**
Medicare - Claims	Updated benchmark; includes volume and rate changes
Medicare - Blueprint Obligation	Updated projection; includes volume and rate changes
Medicaid	Overall growth; updated benchmark; includes volume and rate changes
Commercial - QHP	Overall growth; includes volume and rate changes
Commercial - Self-Funded	New program design; includes volume and rate changes
VMNG PMPM General Revenue	Overall growth; volume change
VMNG PHM Program Pilot - Complex CC	Reclassified to a different line
Commercial - QHP Program Reform Pilot Support	Overall growth; volume change

Commercial - Self-Funded Programs Revenue	Overall growth; volume change
Primary Prevention Revenue	Reclassified to a different line
OUD Investment Revenue	Did not move forward
Informatics Infrastructure Support	Change in contract amount; rate change
Hospital Participation Fee	Updated to reflect 2020 budget model
Payer-Paid FFS	Overall growth; includes volume and rate changes
Fixed Prospective Payments	Overall growth; includes volume and rate changes
Expected Spending Under (Over) Claims Target	None anticipated in 2020 budget
Salaries and Benefits	Overall growth; includes volume and rate changes
Contracted Services	Updated spending estimates; change in chart of accounts; includes volume and rate changes
Software	Updated spending estimates; change in chart of accounts; includes volume and rate changes
Insurance/Risk Protection	Expanded coverage; includes volume and rate changes
Supplies	Updated spending estimates; change in chart of accounts; includes volume and rate changes
Travel	Change in chart of accounts; expense management; includes volume and rate changes
Occupancy	Additional space; includes volume and rate changes
Other	Updated spending estimates; change in chart of accounts; includes volume and rate changes
Reinsurance / Risk Protection	Based on Medicare benchmark; includes volume and rate changes
Basic OCV PMPM	Overall growth; volume change
Complex Care Coordination Program	Overall growth; includes volume and rate changes
Value-Based Incentive Fund - Total	Overall growth; includes volume and rate changes
Comprehensive Payment Reform Program	Changes based on participation; includes volume and rate changes
Primary Prevention	Overall growth
Specialist Program	Change in scope
Innovation Fund	Change in scope
RCRs	Payment exchange excluded from budget model

18. Provide an estimate of FTEs you expect to require (by number, staffing category, and dollar amount) once the model has reached scale.

    The 2020 OneCare budget model is scaled appropriately in relation to its current network, programs and number of attributed lives. OneCare's staffing needs are also impacted by regulatory requirements. The amount of FTEs that will be required in future years, has not been, but will be evaluated by the Board of Managers to ensure that OneCare is meeting the needs of its network participants and fulfilling its contractual obligations by payer programs and submitted in future budgets.

19. For programs (payer or provider) or financial incentives that have been discontinued (such as the Regional Clinical Representatives funding), please explain why you discontinued the program. Similarly, for new programs or financial incentives, please explain why you choose to invest in this program (include any evidence basis you considered). How do you monitor progress and return on investment?

    Regional Clinical Representatives (RCR) facilitate information sharing and communication bi-directionally with each Health Service Area. RCRs will continue to function in this way; however the funding mechanism is being refined at the request of OneCare's Finance Committee to be direct hospital expenditures.

    OneCare's Population Health Strategy Committee monitors programs and evaluation of their impact as well as recommending new programs and discontinuation of programs. In 2020, OneCare is exploring the addition of an embedded clinical pharmacy program in primary care. Research was conducted in national literature, OneCare consulted with other health systems to evaluate the clinical and financial outcomes and the information looks favorable for a positive potential ROI. A good example is from Fairview Health System where they achieved reductions in 30-day readmissions, improved cholesterol, diabetes and hypertension control, decreases in tobacco use and improved asthma control along with demonstrating a significant reduction in overall healthcare costs (https://www.ncbi.nlm.nih.gov/pubmed/29437537).

20. Explain any recent grant funding you have received or are applying for.

    OneCare was awarded a two year grant from the Center for Health Care Strategies (CHCS) funded by Robert Wood Johnson Foundation for a project entitled Advancing Integrated Models. This grant focuses on improved data sharing to inform the community based complex care coordination program regarding patients who may have indicators of social complexity. Please see the attached press release from CHCS regarding the launch of the grant.

21. Industry benchmarks: If no appropriate industry benchmarks exist, as stated on page 25, what metrics does OneCare use to evaluate financial performance? Acknowledge the advantages/limitations of these measures.

    OneCare monitors its financial performance through a monthly review of the income statement and balance sheet. These financial statements are presented to the Finance Committee and Board of Managers each month. OneCare is not able to catalog all of the advantages and disadvantages, but provides these examples in response. An advantage of this model is that the method is consistent across most organizations. A disadvantage is that financial statements require a baseline financial acumen and understanding of value-based care accounting to fully comprehend.

22. Utilization: Provide data to support service utilization assumptions and identify any driving factors. What are the 2019 utilization patterns you observed – what do you expect to be different, if anything in 2020 – and how does this inform your budgetary assumptions?

    OneCare does not make service utilization assumptions when developing the budget model. Please see Part 4 Question 4f of the budget submission for a more thorough description of the budget approach regarding utilization.

23. Please explain the significant growth in Maximum Risk of APM amount year over year (Appendix 4.6) for Northwestern Medical Center: 2019 risk amount of $2,973,505 vs. 2020 risk amount of $4,303,405.

    The St. Albans maximum risk amount for 2019 is $3,975,976. The increase to $4,303,405 is driven by overall increases to benchmarks, the addition of a new risk program, and a modest attribution increase estimate. The St. Albans maximum risk is calculated in the same manner as all of the other communities.

24. Explain any differences between Appendix 2.4, home hospital spend, and Appendix 4.6, Fixed Prospective Payment, for local lives, for Medicare.

    Medicare does not zero-pay all of the claims that providers accepting a fixed payment bill. Any claims protected by 42 CFP Part 2, claims related to care for data opt-out beneficiaries, and add-ons such as IME and DSH continue to pay fee-for-service. The budget model factors in the proportion of claims that will zero-pay accordingly, which results in the difference noted in the question.

25. Please explain the specific factors that determined the current distribution of risk between participating hospitals (with focus on criteria such as size, financial ability to take on risk, percentage of care received outside the HSA). What other distribution arrangements were considered but disregarded? What specific criteria qualifies an HSA for risk mitigation arrangements?

    The 2020 budget includes a continuation of the HSA-accountability model. This was selected leading up to the 2018 performance year to instill a population-based concept with segmentation around each of the participating communities. Alternate risk/reward sharing strategies are discussed often and any future modifications will be decided-upon by the Board of Managers. Risk mitigation arrangements are decided upon individually and require agreement from the Finance Committee, Board of Managers and other parties to the arrangement(s). Generally these arrangements are in place to accommodate the unique needs of OneCare participants and ensure continued or first-time participation.

26. Why are 2019 deferred revenues in the 2020 income statement (Appendix 4.2)? Are there corresponding deferred expenses? Does the budget exclude any 2020 revenues or expenses that may defer into 2021?

    2019 programs such as the Innovation Fund and Specialist program include multi-year financial commitments made by OneCare. While the funds have been obligated in 2019, some of the spending will occur in 2020 and beyond. To align with the timing of expenses, the budget model includes the deferral of some participation fees, the source of funding for these initiatives, to be recognized in 2020.

27. Is it correct to understand that the downside and upside risk arrangement adjustments with the Bennington, Brattleboro, and Morrisville HSAs are “asymmetrical,” such that a total of up to

$3,770,158 downside risk is held by One Care Vermont for these HSAs, whereas, in an upside scenario, up to $1,885,079 million in upside potential could be paid to One Care Vermont's founding hospitals? What is the rationale for OCV holding the downside risk potential whereas the founding hospitals would hold a portion of the upside risk potential? Of the $1,885,079 in upside risk potential for the founding hospitals, how would these funds be split between the parties?

The asymmetrical construct noted is correct, but the Founders are the counterparty on both the upside and the downside. This model was developed to ensure fairness to participants, and reviewed and approved by the Finance Committee and Board of Managers. Final contracts with the Founders are not yet in place to determine the split.

28. On page 35 of OCV's budget submission, OCV states that "one hundred percent of the risk is covered by means other than the fixed payments." Please clarify whether this statement applies to all payers or a subset of payers. Please clarify whether this statement should be understood to apply to Medicaid All-Inclusive Population Based Payments (AIPBP).

    For all payers offering a fixed payment, the fixed payments themselves do not cover risk. Even in a capitated fixed payment model, which is preferred, the OneCare network needs to be prepared for the full risk payment for each program (i.e. the risk corridor is not limited or affected by the fixed payment within). The fixed payment model remains an opportunity to change the underlying way in which healthcare is reimbursed. Even if in a value-based program, if claims are reimbursed on a fee-for-service basis focus needs to remain on utilization and volumes to ensure financial sustainability of the providers.

29. Why are your Population Health Investments not growing proportionally to your population (decrease of 4.0% to 3.0% from 2019 to 2020 after excluding SASH, Blueprint, and Community Health Teams)?

    Not all of the Population Health Investments are based on attribution. Some are more closely linked to the number of participating communities, and wouldn't be expected to grow significantly with a relatively similar network configuration. It's also important to note that hospitals have shouldered the majority of funding for reform through the payment of dues. Each budget season comes with a careful review of the existing population health initiatives and the cost to the participant hospitals. Continued reliance on hospital dues to fund the reforms required by the State's All Payer Model contract with CMS remains a significant risk for all parties.

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

30. Further explain your 2018 quality scores. When applicable, explain when variance over prior year is due to population change versus intervention or unanticipated consequences.

    The BCBS QHP and Medicare risk programs began in 2018 and therefore did not receive a quality score in 2017. OneCare achieved the same quality score of 85.0% for the Medicaid program in both 2017 and 2018, resulting in no variance over the prior year. Medicaid denominators for claims based measures increased with the addition of six new Health Service Areas joining OneCare in the 2018 performance year. Please see response to question 33 below for additional analysis on the VMNG program.

31. Provide a breakdown, by HSA, of which clinical priorities each HSA is focusing on.

    As described in the narrative page 51, OneCare remains informed of progress towards the Clinical Priorities from Regional Clinical Representative (RCR) report outs at the Clinical Quality Advisory Committee meetings where RCRs rotate sharing information about local activities. This model preserves local decision making and each HSA uses data to determine their own focus areas and community priorities. OneCare does not track the full compendium of projects that are occurring throughout the HSA to address the Clinical Priorities, instead it focuses on measuring population health in the communities. ACO performance is tracked centrally at OneCare and reported out monthly based on available data in the ACO Performance Dashboard. This report is produced at the OneCare and HSA level. These reports are posted to the Secure Portal for network participants to review performance, identify progress, as well as opportunities for new improvement efforts.

32. Provide a copy of the primary care engagement toolkit referred to on page 55.

    Please find a copy of the primary care engagement toolkit attached.

33. If possible (and statistically meaningful), please share the cost and quality results for the four HSAs that have been in the VMNG program the longest.

    OneCare performs the annual manual data abstraction for the clinically based quality measures and therefore has the underlying data to support a review of the progress from 2017 to 2018 at the HSA level. The final claims based measure results are provided in aggregate by Medicaid and are based upon a complete dataset, including patients who have opted out of data sharing and substance abuse claims, that OneCare does not have access to, thus OneCare cannot replicate these analyses.

    From 2017 to 2018, among the four communities participating in both years of the VMNG program and where OneCare has sufficient clinical data to report, OneCare notes:

    - two out of the four HSAs had a positive improvement in the diabetes A1c measure;
    - three out of four HSAs had a positive improvement in the hypertension control measure; and
    - two out of four HSAs had a positive improvement in screening for depression and follow-up.

The fourth clinical measure, tobacco use assessment and cessation intervention was added in 2018, thus no comparison group is available. In addition, it is important to note that for each of the clinical measures, there was significant variability in sample size at the HSA-level across years (e.g. a sample of 45 patients in 2017 and 28 in 2018 or 94 to 40 across years). This is due to the random sampling methodology employed by all payers and the growing number of participating providers in OneCare's network. Thus, comparisons are only intended to be made on ACO-wide quality performance.

34. Please provide an analysis of the Medicaid most prevalent conditions presented in Part 5, question 11c by age groups (0-10, 11-17, 18+).

    Please see the table below for the top five most prevalent conditions in the Medicaid population by ages requested.

OneCare Medicaid Most Prevalent Conditions by Age Group					
0-10 years	Acute upper respiratory tract infection 13.1%	Otitis media 8.73%	Developmental disorder 6%	Viral syndromes 5.6%	Adjustment disorder 3.55%
11-17 years	Acute upper respiratory tract infection 5.8%	Adjustment disorder 4.4%	Refractive errors 4%	Anxiety 3.8%	Attention deficit disorder 3.8%
18+ years	Anxiety 12.05%	Depression 10.54%	Tobacco 9.51%	Hypertension 8.31%	Acute upper respiratory tract infection 8.17%

35. On page 48, in your Complex Care Coordination description, you mention a reduction in Emergency Department visits as a result of an intervention. Please describe the intervention and provide any data as evidence to these findings.

    For this outcome analysis, members are considered to be in the intervention group if they are under active care management as defined in OneCare's complex care coordination model. In brief, this includes having a designated lead care coordinator on the patient's care team and the patient having a shared care plan containing at least two goals with two associated tasks. The date that this care managed status is reached is used as the intervention date in the pre and post analysis. OneCare has noted a 33% reduction (3,146 PKPY to 2,098 PKPY; P<.001) in ED utilization among Medicare beneficiaries active in OneCare's care coordination program for at least six months and a 13% reduction (1,774 PKPY to 1,534 PKPY; P<.001) in ED utilization in the corresponding Medicaid population.

36. In Part 5, Attachment A, 2019 Clinical Priority Areas:
    a. Why is no commercial data represented in 2019?

       In 2019, Blue Cross transitioned its operating system which resulted in unexpected claims processing issues that impeded the flow of data to OneCare. Working together, OneCare and Blue Cross believe they have resolved the issues and are moving forward with data exchange.

    b. Recognizing that many analyses are still early in 2019, please resubmit the table with your actual performance rates.

       OneCare does not have "actual performance rates" for 2019, with two thirds of the year's data remaining, it would be premature to deem any rate as actual.

37. Part 5, Attachment B, ACO Quality Activities:
    a. Why is the Blueprint learning collaborative on hold (as noted in the VPMS measure)?

       Blueprint would be best suited to address their decision to place their chronic pain management learning collaborative on hold.

    b. Provide a variation analysis for the Medicaid adolescents with well-care visits measure—relatively low performance for VMNG and BCBSVT populations—and discuss improvement plans.

       According to Medicaid.gov, from all states who report on the Adolescent Well-Care measure the median rate is 45%, Vermont achieved 51%. OneCare's 2018 Medicaid rate was 56.4% achieving the 50th percentile, and the 2018 BCBS rate was 62.62% corresponding to the 75th percentile. For Medicaid the 2018 denominator was 8,693. In order to achieve the 90th percentile an additional 904 adolescents ages 12-21 needed to have at least one comprehensive well-care visit with a primary care provider or obstetrical/gynecological provider during the measurement year. For BCBS QHP the 2018 denominator was 1,977 and an additional 41 adolescents ages 12-21 needed to have at least one comprehensive well-care visit with a primary care provider or obstetrical/gynecological provider during the measurement year.

       OneCare has created gaps in care reports including those adolescents who meet the denominator criteria in order for the practices to outreach to these patients and bring them in for a qualifying visit. OneCare hosted an Interdisciplinary Grand Rounds session in October 2019 on the topic of Adolescent Well-Care and created enduring material to remain available and eligible for CME/CEU credits. In addition OneCare recently hosted a think tank of local experts in the areas of adolescent well-care and quality improvement to create provider and patient tools and resources that will over time improve the rate of adolescents who receive high quality well-care.

38. Provide the 2019 HSA variation of care and ACO dashboard report referenced on page 46.

    Please find templates of the HSA Variation of Care and ACO Performance Dashboard reports attached. Both reports contain mock data. The data should not be interpreted for any purpose; the reports are provided as examples of the types of reports OneCare provides to its network participants.

39. Please complete the attached Excel workbook "2018-2020 Care Navigator Enrollment" and provide inclusion/exclusion criteria as you move from columns B-E, starting with when patient data are loaded into Care Navigator. Describe changes in how patient data are loaded into Care Navigator from 2018 to 2019.

    In 2018 and 2019 all OneCare attributed patients for the Medicare, Medicaid, and BCBSVT QHP programs were loaded into Care Navigator upon receipt of data from each payer. Differences in total attribution versus patients loaded into Care Navigator are due to the UVMMC Self- Funded program data delays. OneCare tracks multiple process measures related to the process of care coordination engagement. The metrics GMCB requested in the Excel file could add confusion rather than clarify this process. In brief, the outcome of "care managed" is the initial endpoint of the engagement process and thus the key metric OneCare reported on. As of the original 2020 budget submission, OneCare had 2,446 patients actively care managed.

    If further information is desired, OneCare requests a conversation with GMCB staff to clarify the request to ensure appropriate information is provided.

40. Please describe whether and how RiseVT is integrated with OneCare's care coordination model.

    RiseVT is a OneCare primary prevention program and as such, represents a significant investment in promoting health and wellbeing across participating communities. RiseVT aligns with quadrant one of OneCare's care model, while OneCare's complex care coordination program focuses on the high and very high risk populations (quadrants three and four). OneCare is seeking new opportunities in 2020 to link these activities through enhanced supports for individuals in quadrant two of OneCare's population health model.