2020 Certification Eligibility Verification Form for OneCare Vermont Accountable Care Organization, LLC

Date Issued: July 1, 2019
Submission Due By: September 3, 2019
Submission Date: ***9/3/2019***

I. BACKGROUND

The Green Mountain Care Board (GMCB) is an independent, five-member board charged with overseeing the development and implementation, and evaluating the effectiveness, of health care payment and delivery system reforms designed to control the rate of growth in health care costs; promote seamless care administration and service delivery; and maintain health care quality in Vermont. To complement the GMCB's responsibilities and authorities with respect to health care payment and delivery system reforms, the Vermont Legislature charged the GMCB with certifying accountable care organizations (ACOs).

Once certified, an ACO is required to notify the GMCB of certain matters, such as changes to the ACO's operating agreement or bylaws, within 15 days of their occurrence. GMCB Rule 5.000, § 5.501(c).

Additionally, the GMCB reviews and verifies a certified ACO's ongoing certification eligibility annually. As part of that annual review, each certified ACO must (1) verify that the ACO continues to meet the requirements of 18 V.S.A. § 9382 and Rule 5.000; and (2) describe in detail any material changes to the ACO's policies, procedures, programs, organizational structures, provider network, health information infrastructure, or other matters addressed in the certification sections of 18 V.S.A. § 9382 and Rule 5.000 that the ACO has not already reported to the GMCB. 18 V.S.A. § 9382(a); GMCB Rule 5.000, §§ 5.305(a), 5.503(d). An ACO chief executive, with the ability to sign legally binding documents on the ACO's behalf must verify under oath that the information contained in the ACO's eligibility verification submission is accurate, complete, and truthful to the best of his or her knowledge, information, and belief. *See id.* § 5.305(b). See **Attachment B: Verification on Oath or Affirmation**. In addition to the submission, an ACO may be required to answer questions or provide additional information requested by the GMCB for its review.

Because each ACO is unique and the documentation each ACO submits for certification (and subsequent verifications of eligibility) may differ, the GMCB develops a verification form for each ACO it has certified. This form has been developed for **OneCare Vermont Accountable Care Organization, LLC** (OneCare) for calendar year 2020 (Eligibility Verification Form).

II. REVIEW PROCESS

Within 30 days of receiving a completed Verification of Eligibility Form, the GMCB will notify OneCare in writing if additional information is needed. GMCB Rule 5.000, § 5.305(c). OneCare's certification remains valid while the GMCB reviews its continued eligibility for certification. *Id.* If the GMCB determines that OneCare, its participants, or its providers are failing to meet any requirement of Rule 5.000 or 18 V.S.A. § 9382, the GMCB may, after providing OneCare with notice and an opportunity to respond, take remedial actions, including placing OneCare on a monitoring or auditing plan or requiring OneCare to implement a corrective action plan. *Id.* § 5.504. The GMCB may also, after providing OneCare with written notice and an opportunity for review or hearing, revoke its certification or, if appropriate, refer a potential violation of antitrust law to the Vermont Attorney General. *Id.*; Green Mountain Care Board Guidance re: Referrals of Potential Violations of State or Federal Antitrust Laws to the Vermont Attorney General.

The eligibility verification process does not limit the GMCB's authority to review OneCare's continued compliance with the requirements of Rule 5.000, 18 V.S.A. § 9382, or any orders or decisions of the Board. Such reviews may be performed at any time (e.g., in response to quarterly financial reporting). *Id.* § 5.503.

III. INSTRUCTIONS

OneCare must complete each section of this form and submit an electronic copy of the completed form to, Melissa Miles, Deputy Director of Value-Based Programs and ACO Regulation, at Melissa.Miles@vermont.gov and copy Marisa Melamed, Health Care Policy Associate Director, at Marisa.Melamed@vermont.gov. The form must be received on or before September 1, 2019. ***You must copy the Office of the Health Care Advocate on the filing.*** *See id.* § 5.104. If the OneCare representatives completing this form have any questions, contact Melissa Miles or Marisa Melamed by calling (802) 828-2177, or by sending an email to the addresses above.

IV. DESCRIPTION OF CHANGES AND QUESTIONS FOR ONECARE

1. Submit a complete list of OneCare Policies and Procedures. In the table, include policy name, policy number (if numbered/lettered), date of most recent execution, and next review date. Please label the table "updated as of [date]."

   Please see Appendix 1 for a complete list of our current and executed Policies and Procedures.

2. **FY20 ACO Certification Attachment A: Certification Eligibility Documents for OneCare Vermont ACO** is a list of policies, procedures, and other documents collected by the GMCB to review certification eligibility. Please complete the blank fields in the table. Have there been any material changes to the documents since the most recent filing with the GMCB? If so, provide a brief description of the change(s) and the reason(s) for the change(s) in the last column of the table. If the policies are uploaded in Adaptive, please upload new versions for those policies that have changed.

   Please see the completed Attachment A with the necessary updated information.

3. Since OneCare's certification eligibility was last reviewed, have there been any material changes to OneCare's structure, composition, ownership, governance, and/or management that are not reflected in **FY20 ACO Certification Attachment A**? *See* §§ 5.201-5.203. Please include in your response an update, including expected timeline, on your search for a new CEO.

   Since OneCare's last certification submission in 2018 there have been changes to the OneCare Operating agreement, specifically Section VI. "Management," in which the Board voted to increase the Board of Managers from 19 to 21 seats. The two additional seats are designated as at-large seats. The Board also adopted a provision that set a "term" for Board members at 3 years, with a limit of three terms. The terms will be staggered to limit large turnover at any given time. The Board also adopted a nomination provision for provider associations to put forth a nomination for their representative seat, should an opening occur and for the Board to vote on nominees

   Additionally since 2018, OneCare's former CEO Todd Moore departed for a job opportunity out of state and the OneCare's Board of Managers elected Kevin Stone to serve as interim CEO while a national search for a permanent CEO was conducted. After a lengthy process, Victoria Loner was hired as CEO as of August 1, 2019. When Kevin Stone became interim CEO he resigned his seat as Chair of the Board. Dr. Stephen Leffler assumed the role of Chair of the Board. OneCare's Vice President of Finance and Strategy, whose time was split between OneCare and the Adirondacks ACO, departed OneCare to assume a permanent role at the Adirondacks ACO. This role as well as well as the Vice President of Operations will be backfilled.

4. Provide an update on the mechanisms OneCare employs to obtain consumer input, as compared to the information contained in OneCare's response to the 2019 Verification of Eligibility Form Response #3?

Our Patient and Family Advisory Committee (PFAC) continues to meet bi-monthly, with attendance by members of OCV leadership team and at least one member of the Board of Managers (BOM).

Our patient and family advisors provided valuable feedback on our recently updated website, a proposed Genome project, and how we could better strike the balance of informing them of ACO activities and hearing from them about their health care experiences. We have initiated a standing agenda item, "Report from the Field" where members can share activities, issues and concerns from their communities. Staff from OneCare with various backgrounds present to the PFAC regularly at the meetings during the year. The Committee reports to the full Board of Managers through a committee report which is reflected in the minutes and available on our website. There are also two meetings during the year where Leadership and Board Members present to the full Board on PFAC discussions.

OneCare continues to support Community Collaboratives/Accountable Communities for Health (ACH) which meet in each health service area by engaging Regional Clinical Representatives to facilitate the work, providing data support and other requested support. These community groups allow community stakeholders to discuss pressing local health care issues and implement initiatives to improve the health and the experience of care for their community members. OneCare strongly encourages the inclusion of patients, family members and caregivers. Currently 60% of the Community Collaboratives/ACH include a patient, family member or caregiver in their membership, and efforts continue to add such a member.

OneCare also hosts and contributes to the planning of grand rounds presentations that are open to the public and have a focus on Patient and Family Centered Care. The patient experience is routinely part of these presentations. The Regional Clinical Representatives, who chair the Community Collaboratives, report back to the OneCare clinical team and the Clinical and Quality Advisory Group on their concerns, initiatives, and outcomes.

Specific consumer input activities include:

- *On December 3, 2018 OCV hosted a Patient and Family Centered Care (PFCC) grand rounds and informed invitees that OneCare was willing to facilitate additional training with Dartmouth Hitchcock Medical Center PFCC for any interested organization or practice*

- *OneCare underwent a website redesign that resulted in an enhanced and more easily navigable experiences for users. It is a simpler, and more informative outlet for the*

public and other interested parties to learn more about the ACO. The website continues to have a "Contact Us" page where patients and members of the public can comment or ask questions. We have received and responded to queries posted on this page. Patients and members of the public may submit suggested topics and concerns for the Patient and Family Advisory Committee for general discussion.

- *OneCare's Patient and Family Centered Care (PFCC) internal workgroup comprised of OneCare staff continues to promote the concepts of Patient and Family Centered Care within our organization. Some of their implementations include:*

  - *Presenting PFCC principles and our actions plan to the OCV staff as a whole*
  - *Surveying our participating organizations about how they involve patients and families in healthcare operations; then presenting the results at our PFCC Grand Rounds 12.3.18*
  - *Updating and making available an acronym list;*
  - *Continuing to develop PFCC focused language in relation to population health work and discussion of data;*
  - *Integrating the provider and care team perspective into the quadruple aim, and bringing it to leadership for further discussion*
  - *In the process of adding posters in our conference/meeting rooms that state "how will this impact patient, families and providers?"*
  - *Developed training materials to orient new staff to PFCC at OneCare*

- *OneCare remains committed to including a patient, family member or caregiver as one of the presenters in our educational Grand Rounds and Chronic Condition Symposiums. In evaluations, this presentation is consistently noted to be one of the most meaningful and informative.*

- *OneCare continues to submit op-eds and press releases to statewide print publications to help share information about the benefits of OneCare and the impact on Vermont communities. We have also held informational sessions for legislative representatives, stakeholder groups, news outlets, and other interested parties.*

- *OneCare has increased our educational efforts to the public by creating more public-focused materials that describe how OneCare works (e.g., introduction to OneCare, an ACO 101). OneCare is in the process of discussing a centralized WebEx in the coming year for patients, families and caregivers to inform and receive feedback. OneCare has also created more of a social media presence, establishing a Twitter and Linked-In Account and have currently have a full time marketing and communications staff person to help enhance and grow our social media presence as well as create user and consumer friendly materials for public distribution*

5. List and describe any advocacy training that the consumer/enrollee members of OneCare's Board of Managers and the members of OneCare's Patient and Family Advisory Committee have received since 2018 or will receive in 2019.

   There has been no new "training" for the PFAC to date as turnover has been minimal. The HealthCare Advocate will plan to attend the November meeting of the PFAC as they did last year. We are currently in discussions with the HCA around the content of that meeting including providing detail on advocacy training. OneCare also has the ability to utilize the UVMMC Patient and Family Advisory Services who are certified to provide advocacy training.

6. Has OneCare arranged for the members of its Patient and Family Advisory Committee to meet with representatives of the Office of the Health Care Advocate in 2019? If so, when will that meeting take place? *See* § 5.202(h). Did the Office of the Health Care Advocate prepare a report for OneCare following its November 2018 meeting with members of OneCare's Patient and Family Advisory Committee? If so, please attach a copy of the report to your filing.

   As Noted above the meeting with the HCA is scheduled for November 14th and the content and agenda of that meeting is currently being discussed by OneCare and the HCA. The HCA did not prepare a report for OneCare after it met with our PFAC in November of 2018 as they are not required to do so under the provisions of Rule 5.

7. Please provide any updates to OneCare's Medicare benefit enhancement implementation plans and submit any new or updated relevant documentation, e.g. updates to the Three-Day Skilled Nursing Facility (SNF) Rule Waiver Implementation Plan submitted in 2018.

   Please See Appendix 3 and 4 for OneCare's updated Telehealth and Post Discharge Home Visits Waiver Implementation Plans

8. Provide an update and describe any changes related to OneCare's use of WorkBenchOne, or other platforms, that allow providers and OneCare to monitor utilization, costs, and clinical data.

   WorkBenchOne™ (WBO) is the platform that hosts OneCare's self-service analytic applications. The data supporting WBO are made up of claims and clinical data that allows users to query independently in the applications, and supports informed decision making that drives a continuous improvement cycle. OneCare deploys virtual and in person data literacy training to encourage our provider network to perform queries and generate reports on their own.

   In addition, to updating and creating new standard reports for Network participants, OneCare has focused on creating intuitive and easy to use applications that meet unique needs and allow users to examine key performance indicators (KPI's) to facilitate insights into utilization, costs, and clinical data in real time. In response to user feedback, we have worked to simplify the applications and focus them on specific

questions or needs identified by OneCare's Network. For example, OneCare developed an attribution self-service application and made it available to Network members in June 2019. This application assists users in identifying how many attributed lives are in each health service area (HSA) by organization {i.e. Tax Identification Number (TIN)} for all payer contracts, and contains patient lists that can be exported to Excel for ease of use and ingestion into Electronic Health Record (EHR) systems. The data included in the patient lists is comprised of: Johns Hopkins ACG Risk Score, care coordination levels, qualified visit date, condition flags (i.e. Asthma, CAD, COPD, Diabetes, High Risk Pregnancy, Hypertension, Tobacco Use, Anxiety, Depression, Dementia and Bipolar). This application has replaced a previous static attribution report, reducing wait times and providing up-to-date data in an easy to access location.

The Vermont Medicaid Next Generation (VMNG) Utilization application is an internal tool used by OneCare and the Department of Vermont Access (DVHA) to track the utilization of all Prior Authorization (PA) required services. It displays data in run charts and has drill-down capabilities to facilitate the identification of patterns of care delivery. This WBO application was improved in April 2019 to include new codes that were added to the PA waiver and the 2019 cohort. In addition, a new filter was built in the application to allow users to select the current attributed population and patients that have been continuously attributed to OneCare from 2017 to 2019.

The WBO Total Bundled Payment Application analyzes the cost of care for 48 Medicare clinical episodes. These episodes include an initial inpatient stay in a hospital plus the post-acute care of all related services up to 90 days after discharge. Post-acute care consists of skilled nursing facility (SNF), home health, swing bed, inpatient rehab, outpatient observation, emergency room, office visits and other related services. This WBO application was refreshed with the Medicare Next Generation Program data for 2017 and 2018. Post-acute categorization was updated to use the Milliman Health Cost Guidelines (HCG) grouper software. The HCG grouper categorizes medical and pharmacy claims data into healthcare benefit service categories that can be used to analyze and benchmark medical utilization and cost. OneCare has been providing demos of this application at our Network hospitals to highlight improvements and receive user feedback to make improvements.

The new Patient Prioritization for Care Coordination application was developed in WBO to assist in the prioritization of patients who may benefit from engagement in care coordination services. This application uses the Johns Hopkins risk grouper to determine if a patient is likely to have a care coordination gap in care based on the number of unique providers who are treating a patient. Users of the application can gain immediate insight in the total cost of care year-to-date, view a unique count of Emergency Department visits year-to-date, and review the last qualifying evaluation and management visit at the patient's attributed practice. This application provides the care team with an ability to monitor utilization, cost, and clinical data to facilitate OneCare's Care Model.

9. Describe all mechanisms (e.g., website, Patient Fact Sheet) OneCare uses to inform the public about how the ACO works.

   Please see our responses and examples under question 4 above.

10. Have there been any material changes that relate to the requirements of 18 V.S.A. § 9382(a) or Rule 5.000 that are not noted above? If so, please provide a brief description of the change(s).

    There have been no material changes in OneCare Operations or functions that have not been discussed within.

11. Provide a status update on the items the GMCB required for compliance with the new criteria enacted in 2018 Acts and Resolves No. 200 § 15 (mental health access). The response should include a narrative description of OneCare's performance on mental health related quality measures contained in payer contracts, 2019 Quality Improvement Plan, 2019 Clinical Priorities, and any other initiatives that apply to these criteria.

    OneCare, in alignment with Acts and Resolves No. 200 § 15 (2018) is committed to ensuring patients have access to mental health care services at the right time, in the right place according to the patient's needs, just as for other types of health care services. Therefore, OneCare is investing in local community activities to promote integration of mental and physical healthcare services including providing financial resources, tools, and supports to promote community-based integrated care teams inclusive of Designated Agencies (DA) staff, primary care, home health, area agencies on aging and other identified partners. Through these integrated teams, mental health concerns are more readily identified, prioritized, and resourced as part of the shared care plan process. Following are some examples of where our work complies with the new criteria.

    In 2019, Medicare quality measures came into alignment with other payers, allowing OneCare to educate the provider network on a coordinated set of quality measures. Keeping the measures consistent across programs removes administrative burden and provides the opportunity to address gaps in care at each visit regardless of what insurance the patient presents with. OneCare quality measures which are related to mental health or substance use include the following:

    - *Follow-up After Hospitalization for Mental Illness, 7-day Rate*
    - *Depression Remission at 12 Months*
    - *30-Day Follow-Up after Discharge from the ED for Mental Health*
    - *30-Day Follow-Up after Discharge from the ED for Alcohol and Other Drug Dependence*
    - *Initiation of Alcohol and Other Drug Dependence Treatment*
    - *Engagement of Alcohol and Other Drug Dependence Treatment*

These measures represent a significant portion of the ACO's overall quality measure portfolio and are in alignment with Vermont's All Payer ACO Model Population Health Goals. Additionally as OneCare continues to negotiate new contracts, the inclusion of measures related to mental health and substance abuse remain a high priority.

Direct comparison to prior performance years in quality measures is not possible due to the evolving network and changes in the underlying structure of the programs prior to 2019. Early indicators reveal both areas of strength (30 Day Follow-Up after Discharge from the ED for Mental Health) as well as areas for continued focused improvement efforts (Initiation of Alcohol and Other Drug Dependence Treatment). Volatility resulting from small denominators increases the need to improve our ability to access relevant data to drive meaningful change.

OneCare's Clinical Priority areas are selected in addition to the quality measures and are chosen based upon data that is available to OneCare. Suppressing of data related to mental health and/or substance abuse has the potential to limit our ability to identify insight and engage with the provider network to drive change and improvement activities. Clinical priorities are monitored through the OneCare Performance Dashboard. Improvement targets for the Clinical Priorities are set per payer, and tracked using claims data. OneCare is tracking the following clinical priority areas across the ACO Network in 2019 that may address mental health:

- *Increase percent of Medicaid and Commercial patients with developmental screening*
- *Decrease acute inpatient admission rate for high and very high risk cohorts*
- *Decrease emergency department visit rate for high and very high risk cohorts*
- *Increase percent of high and very high risk patients engaged in care coordination*

OneCare's complex care coordination program continues to provide significant funds to increase capacity by providing resources to add additional personnel in participating organizations to join care teams, to coordinate care across organizational boundaries, and to support person-centered goal setting and progress. This funding adds positions and reallocates current staff to address the needs of patients with mental health and substance use disorder. OneCare continues to support the coordination of care across the continuum by investing time and resources in adapting Care Navigator to support patients with mental health conditions. Care team members from all participating sites have access to information on individual's shared care plans, and receive admissions, discharges, and transfer information in- and out-of-state. Care Navigator contains patient panels, including mental health diagnoses such as Anxiety, Depression, and Bipolar Disorder. OneCare has deployed enhanced mobile and desktop applications across the network to strengthen the ability of care team members to reach patients. Later in 2019 a version of the mobile application will be made available to patients and

provide the ability to view their shared care plan and communicate securely with members of their care team.

OneCare continues to incentivize mental health providers in its network by providing substantial funding to Designated Mental Health Agencies (DAs) through per-member per-month disbursements for high and very high-risk individuals attributed in each health service area (HSA). Lead care coordinators and care team members are responsible for frequent and meaningful outreach to patients, participation in care conferences, and addressing patient goals while working to improve the physical and mental health of individuals. Decision making on the utilization of the funds that are provided remains the responsibility of the receiving organization and process metrics are tracked by OneCare to measure the impact of the investment.

As identified in the 2019 Quality Improvement work plan OneCare increased the manual collection of clinical data from medical records across the Network beyond the required yearly collection that determines performance on specific quality measures. Types of data collected include depression screening with follow up for clinical depression and follow-up plan. These manually collected data are supplemented by claims-based data on measures such as 30-day follow-up from the emergency department for mental health or substance use disorders (two distinct measures). The collection of additional data allows OneCare to provide more timely information to inform clinical workflow redesign and ultimately, to better serve patients. The output of this work results in OneCare producing quality measure scorecards, which are provided to practices on a health service area-level and provide feedback on areas where they are performing well and areas of opportunity. Data continue to be collected throughout the year and improvement is measured and reported back to the practice. OneCare submitted all required data on time for each payer program as described in the Quality Improvement plan.

OneCare has continued to invest in and collaborate with the Howard Center and SASH to embed a full-time mental health clinician in two Burlington congregate housing locations where SASH has on-site programs to improve access and utilization of mental health services by residents in low-income housing. The embedded clinician hosts groups and meets with residents one-on-one. The clinician also joins staff meetings and team discussions on SASH participants. Staff have become more comfortable addressing and preventing crisis and appreciate the warm hand-offs to the clinician. Residents continue to use the services and provide positive feedback on their experience with this opportunity.

OneCare also works closely with the Vermont Blueprint for Health (the Blueprint) to provide education and tools to both the Blueprint and OneCare field staff by arming these teams with information and resources to support patients with mental health needs during monthly All Field Team meetings. Themes covered include the Rapid Access to Treatment program out of Central Vermont Medical Center (CVMC), a deep dive into

the follow up quality measures related to mental health, and a suicide prevention gatekeeper training.

Since early 2018, OneCare has participated in a performance improvement project (PIP) with DVHA's clinical and quality improvement team. The focus of this PIP is to improve the rates for initiation and engagement specifically for Medicaid patients, though the interventions of the PIP, including education and outreach to mental health providers on how to use telemedicine to improve access, has collateral benefits beyond the Medicaid population.

OneCare has established new mechanisms in 2019 including the Innovation Fund and the Specialty Payment Reform programs to implement evidence-based and promising practices to support progress towards healthcare reform goals. Both programs encourage cross-organizational collaborations with opportunities to focus on the mental health needs of individuals and groups. Through the spring 2019 Innovation Fund, OneCare selected a unique partnership between United Counseling Service (UCS) and Southwestern Vermont Medical Center (SVMC) to implement a child psychiatric urgent care center as an intensive behavioral support program that will serve as an alternative to the emergency department for children presenting at school with an urgent mental or behavioral health issue. The pilot begins in September 2019 and UCS will give quarterly updates on progress towards goals throughout the project term. Information learned from this pilot will be shared in an effort to scale this intervention beyond the current geographic boundaries as a result of the positive outcomes. Additional programs and investments are in the contracting phase and will be shared publically later this fall.

In summary, OneCare Vermont complies with and supports the new criteria enacted in 2018 Acts and Resolves No 200 § 15 as part of our mission to join providers and communities together to improve the health of Vermonters. Mental Health is an important component of one's overall health. We have reflected it directly as such within our clinical priority areas and indirectly by absorbing it as a healthcare priority into data collection, care coordination, incentives, contracts, committee work and work within the community.

12. Provide an update on the items the GMCB required for compliance with the new criteria enacted in 2018 Acts and Resolves No. 167 § 13a (payment parity). The response should include the current status of the 2018 CPR Pilot, the 2019 CPR program (reports required Q2 and Q3 2019), and any other initiatives that apply to these criteria.

The ACO model provides OneCare and its network with the ability to transform existing payments mechanisms in ways that facilitate more efficient delivery of care, place incentives on value rather than quantity, and redirect funding towards initiatives aimed at wellness. At the OneCare ACO level, the funding currently available is built upon the existing payer fee schedules, billing codes and utilization rates experienced in a fee-for-service (FFS) system. This is due to the current position of the payers with whom

OneCare contracts, and is something we are working to evolve over time. While this is a reasonable place from which to begin a transition to true value-based care, it means that the ACO has limited funds at its disposal; and only from those payers willing to shut off the fee-for-service payment mechanism to the providers and instead pay the ACO in a monthly fixed payment, from which we can implement value based payment systems and reform models designed to achieve ACO objectives. From a practical standpoint, this results in a zero-sum scenario for the Network outside of payer-paid FFS. Because aggregate funding is limited, at this time the ACO is only able to shift dollars between providers and is not able to generate new sources of revenue from payers to enable more significant changes to payment methodologies (outside the investments in population health initiatives).

While the long-term strategy aims to incorporate payment reform models that place additional emphasis on value, OneCare is taking a measured approach for multiple reasons. All provider payments currently made by the ACO, including hospital fixed payments and payments to independent primary care practices participating in the comprehensive payment reform (CPR) program are built upon historical fee-for-service levels as a means to transition into a PMPM reimbursement paradigm. This makes for a smoother conversion into a fixed payment reimbursement model and allows providers the requisite time to adjust both operations and strategy. New in 2019, however, is the beginning of a process to incorporate community hospital fixed payments and CPR payments. This is being incorporated by blending historical FFS with a risk-adjusted HSA spend to transition to a population-based payment methodology. Secondarily, OneCare is also taking this initial approach as Medicaid is the only program in which the fixed payments are not reconciled back to the fee-for-service equivalent level. For all other payers, any dollars paid to providers in excess of what was generated in fee-for-service billings have to be paid back to the payers; truly limiting the ACO's ability to more substantially change the payment and incentive models and reimbursement rates until there is a change from the payer's perspective.

In 2019, OneCare will be making payments to providers in three ways: fixed payments to hospitals, fixed payments to CPR practices, and population health management program payments. Within each category, there are no differences in the payment methodologies among comparable participating providers across all practice settings.

Hospital Fixed Payments
The hospitals' fixed payments are determined in aggregate by the payers, and then divided between the hospitals based on a blend of historical FFS spending and a risk-adjusted spend on a PMPM basis by OneCare. This means that the ACO has limited funds to work with, but does have the ability to reallocate between the hospitals. To facilitate a smoother transition away from FFS, however, the fixed payments are designed to replace the historical cash flow generated from FFS billing. Because of the fixed payment approach, hospitals are now financially incentivized to improve health

and wellness, minimize potentially preventable utilization and deliver high-quality care. The methodology used to generate the payment amounts is the same for each hospital.

Comprehensive Payment Reform Payments
The 2019 Comprehensive Payment Reform (CPR) program generates a payer-blended PMPM reimbursement model for independent primary care practices. The overarching goal is to reimburse these practices through a fixed payment model that provides appropriate financial resources and facilitates innovative and fluid care delivery models. Mechanically, the approach combines payer-paid fixed payment dollars with supplemental investments from OneCare. These additional investments are designed to incorporate the PMPM receipts these practices would otherwise receive as OneCare providers, and supplement further to encourage innovative practice delivery and care models. In the end, the financial model aims to calculate an appropriate risk/panel adjusted reimbursement and erase some of the inequities created by a FFS system. Each of the practices participating is subject to the identical methodology. In 2019, a "partial cap" CPR model was offered to smaller practices as a warm-up year to transition into the full capitation CPR model. The practices continue to receive FFS payments from the payers but are eligible for a CPR supplemental payment to encourage practice innovations.

Population Health Management Program Payments
OneCare makes payments to network providers to encourage participation in initiatives designed to further the population health goals of the ACO. These payments are designed to supplement, not replace, the existing claims-based reimbursements providers currently receive. In all cases, the amounts paid to each provider type within the network are based on the identical methodology.

13. Provide an update on the items the GMCB required for compliance with the new criteria enacted in 2018 Acts and Resolves No. 204 § 7 (addressing childhood adversity). This should include an updated narrative of activities in the plan to address childhood adversity submitted Q1 2019.

Since the last report, OneCare has focused activities in several areas including: educational opportunities for our Network, data sharing with AHS, advancing the pediatric complex care coordination program, expansion of the DULCE program, and continued alignment and education around related quality measures and clinical priority areas.

OneCare is hosting an Interdisciplinary Grand Rounds session on adolescent health and well visits in October 2019 with two network providers participating as presenters. Interdisciplinary Grand Rounds bring together providers, continuum of care and/or community-based organizations, and patient/caregiver representatives to discuss strategies that have been employed locally to improve alignment and integration of

care. They lead to robust dialog across provider types and among different areas of the state to facilitate dissemination of best practices.

Leaders from OneCare and the AHS are exploring possibilities to build a data and systems-driven collaboration to develop the legal and operational pathways to integrate social needs data within OneCare to develop collaborations across medical and human services providers. This will allow our network to better identify individuals that could benefit from enhanced services and supports, reduce duplication and enhance individual's experience of care, and align and integrate health and human services supports in local communities. OneCare and AHS responded to a national requests for proposals to support this work in early summer and were recently notified that we are finalists. Site selection will occur in September.

The cornerstone of OneCare's Care Model is a strong relationship between the patient/caregiver and his/her patient centered medical home. The care model promotes outreach and engagement of individuals in primary care, identification and segmentation of the population by risk, and community-based care teams that can support individuals and families in the identification of person-centered goals of care then documented and supported in a shared care plan tool. OneCare's four-quadrant Care Model currently has a pediatric-friendly shared care plan tool that was enhanced in 2018 through input from pediatric-serving healthcare providers and care team members. In the pediatric population, there is a need to address two-generational approaches to the identification of risk, such as stressors in the family that may lead to adverse childhood outcomes. Currently, care team members use tools such as Camden Cards and Eco Maps to identify social, economic, legal, or other risks as well as to map an individual/family's strengths (e.g. relationships, resources, social connections in the community). At the request of OneCare's Pediatric Subcommittee, we are exploring possible adaptations to the pediatric complex care coordination program for 2020 and have formed a work group that is meeting through the summer to inform program changes for 2020 implementation. Adaptations under consideration include risk stratifying the pediatric population separate from the adult population for each payer program; using a claims-based pediatric medical complexity risk stratification tool instead of the Johns Hopkins ACG tool; testing of other social determinant of health screening tools (e.g. Hunger Vital Signs, CMS 10); carving out specific funding in the complex care program for pediatrics, among others. OneCare is also exploring expanded collaborations with other state partners such as the School Nurse Liaison of the Vermont Department of Health (VDH). Through feedback from participating Health Service Areas (HSA), OneCare has identified a desire to bring school nurses closer to the care teams supporting high and very high-risk individuals in our care model. Currently operational challenges in addressing this request (e.g. legal requirements for information sharing) must be overcome. In the meantime, we are expanding collaborations around areas of

mutual interest such as addressing the needs of children and adolescents with Attention Deficit Disorder and tobacco exposure.

OneCare is also collaborating with the VDH and Vermont Legal Aid to spread the Developmental Understanding & Legal Collaboration for Everyone (DULCE) model to four additional sites through a partnership among local patient centered medical homes and Parent Child Centers. Project DULCE's purpose is to insure that newborns and their families receive quality medical care as well as all the social services and community support they need during the first six months of the newborns life. Families participating under the DULCE program will receive comprehensive social determinant of health screening with a unique emphasis on the legal needs that might cause family stress or uncertainty. These four sites represent one more than originally planned in OneCare's Population Health Management investments and was made possible through creative collaboration with VDH to fund a fourth site. Through the DULCE implementation, OneCare supported 15 local team members to participate in a national training in Washington DC where the focus was on reducing toxic stress in early childhood through proactive screening, outreach, and connection to community services. DULCE family specialists serve as referral agents, care coordinators and embrace a holistic approach to the infant and family's needs. They also meet with families at their infant's routine healthcare visits, provide home visits, offer information on child development, and parenting support. Through this initiative, OneCare is providing connections and incentives to existing community services for preventing and addressing the impact of childhood adversity.

The ACO collaborates with its network on a set of quality measures for use by primary care providers who work with children and families and fosters collaboration among care coordinators, community service providers, and families. In OneCare's 2018 Medicaid program, the network achieved the highest benchmark possible in developmental screening. OneCare continues to track progress on the percent of patients with developmental screening as one of its quality measures, and ongoing Clinical Priority focus areas. Data show that the network continues to track favorably towards high performance.

OneCare works through its clinical committees to identify and track clinical priority areas of focus across the ACO Network. In 2019, Clinical Priorities that address childhood adversity include:

- *Emergency department visit rates for pediatric patients with asthma*
- *Emergency department rates for high and very high risk cohorts*
- *Engagement of high and very high risk patients in care coordination*
- *Medicaid and Commercial patients age 12-21 with a well-care visit within 12 months*

- *Medicaid and Commercial patients with developmental screening*
- *Engagement of three pediatric-serving practices in the DULCE program*

OneCare continues to educate its Network around the quality measure specifications, current performance and benchmarks (as available) and targets. OneCare conducted several deep-dive trainings on the quality measures with the All Field Team staff, particularly focused on the Blueprint Practice Facilitators and the ACO Clinical Consultants to make sure that these community-facing staff are aligned in their knowledge, expectations, and resources available to support improvement activities within and across organizations and HSAs.

In summary, OneCare Vermont complies with and fully supports the new criteria enacted in 2018 Acts and Resolves No 204 § 7 as part of our mission to improve the health of Vermonters. Preventing and addressing the impact of childhood adversity is foundational to population health outcomes and effective healthcare reform efforts will supported by fostering collaboration between families and community service providers. We have demonstrated it directly in our community investments, educational offerings, quality measures, Clinical Priorities, committee work and work within the community.

V. NOTIFICATION OF POTENTIALLY ANTICOMPETITIVE CONDUCT

1. Does OneCare share pricing information (e.g., reimbursement rates paid by commercial insurers or other negotiated fee information) with participants in its network? Does OneCare employ any measures not already described in its Data Use Policy (03-03) to protect such information?

   OneCare does not share pricing information with participants in its network.

2. Does OneCare engage in any of the conduct described in paragraphs 2-5 of the Green Mountain Care Board Guidance re: Referrals of Potential Violations of State or Federal Antitrust Laws to the Vermont Attorney General?[1] If yes, please describe.

   OneCare does not engage in any of the conduct as listed in paragraphs 2-5 in the Green Mountain Care Board's Guidance re: Referrals of Potential Violations of State or Federal Antitrust Laws to the Vermont Attorney General.

VI. VERIFICATION UNDER OATH

Please complete and attach the requisite verifications under oath (**Attachment B: Verification on Oath or Affirmation**).

Please see the attachment immediately preceding this document.

[1] Available at: https://gmcboard.vermont.gov/sites/gmcb/files/GMCB%20Guidance%20re%20AGO%20Referrals_05.01.18.pdf.

OneCare Vermont

Appendix 1

Policy #	Policy Title	Last BOM Review	Last OneCare Review	OneCare Review 2019	2020 Review
02-01	OneCare VMNG Prior Authorization Waiver	12/18/2017	2/1/2019	9/27/2019	8/28/2020
02-02	Advance Community Care Coordination Payments	12/18/2017	3/27/2019	9/27/2019	3/27/2020
02-03	BCBSVT Primary Attribution & Payment Methodolgy	7/1/2019	6/17/2019	6/17/2019	3/27/2020
02-04	Dues	7/1/2019	7/1/2019	6/17/2019	3/27/2020
02-05	Participant Fixed Payment	7/1/2019	7/1/2019	6/17/2019	3/27/2020
02-06	H.S.A Benchmark	7/1/2019	7/1/2019	6/17/2019	3/27/2020
03-01	OCVT Privacy and Security	12/18/2017	1/16/2019	9/27/2019	8/28/2020
03-03	OneCare Vermont Data Use	12/18/2017	2/20/2018	9/27/2019	8/28/2020
03-04	Data Destruction	12/18/2017	2/20/2018	9/27/2019	8/28/2020
04-01	Party of Interest Transaction Reporting	12/18/2017	1/26/2018	9/27/2019	8/28/2020
04-02	Certification of Data and Reporting Submitted to DVHA	12/18/2017	1/26/2018	9/27/2019	8/28/2020
04-03	OneCare Program Settlement 2019	8/10/2018	8/10/2019	9/27/2019	Archive
04-04	OneCare Member Payment Liability	1/19/2018	1/19/2018	9/27/2019	8/28/2020
04-05	Primary Care Alignment Strategy	12/18/2017	2/21/2018	9/27/2019	8/28/2020
04-06	OneCare Disbursement Authority	9/18/2018	9/18/2018	9/27/2019	8/28/2020
04-07	OneCare Program Settlement 2020	7/25/2019	7/25/2019	7/25/2019	3/27/2019
05-02	OneCare Conflict of Interest	1/19/2018	1/19/2018	9/27/2019	8/28/2020
05-03	OneCare Code of Conduct	1/19/2018	1/19/2018	9/27/2019	8/28/2020
05-06	OneCare Beneficiary Grievances and Appeals	2/21/2018	2/21/2018	9/27/2019	8/28/2020
06-01	OneCare Maintenance of Records	2/19/2018	2/19/2018	9/27/2019	8/28/2020
06-02	OneCare Policy on Policy Management	1/19/2018	1/19/2018	9/27/2019	8/28/2020
06-06	OneCare Network Support and Access		1/16/2019	9/27/2019	8/28/2020
06-07	OneCare Subcontractor Management	1/19/2018	1/19/2018	9/27/2019	8/28/2020
06-09	OneCare Provider Education and Outreach	12/18/2017	2/19/2018	9/27/2019	8/28/2020
06-12	OneCare Participant Appeals	8/16/2018	8/16/2018	7/25/2019	3/27/2020
06-14	OneCare Compliance Plan	12/18/2017	1/19/2018	9/27/2019	8/28/2020
06-16	OneCare Value Based Incentive Fund 2019	8/16/2018	8/16/2018	9/27/2019	Archive
06-16	OneCare Value Based Incentive Fund 2020	7/1/2019	7/1/2019	7/1/2019	3/27/2020
06-17	Core Program Exemptions PY 2019 Only	8/16/2018	8/16/2018	9/27/2019	Archive
06-18	OneCare Risk Program Participation PY 2020 ONLY	5/7/2019	5/7/2019	5/7/2019	3/27/2020
07-01	OneCare Governance	3/27/2019	3/27/2019	3/27/2019	8/28/2020
08-01	Board of Managers Nomination Policy, Designated Managers	3/12/2019	3/12/2019	3/12/2019	8/28/2020

OneCare Vermont

Appendix 1 Continued

Procedure #	Procedure Title	Last OneCare Review	2019 OneCare Review
C02-01	Early Periodic Screening, Diagnosis & Treatment (EPSDT) for Children and Pregnant Women	12/31/2018	11/31/2019
C02-02	Compliance with Vermont Advanced Directives	12/31/2018	11/31/2019
C02-04	Training for Annual Quality Measure Collection and Inter-rater Reliability	12/11/2018	11/31/2019
C02-05	Care Coordination and Disease Management Program within an Integrated Care Delivery Model	3/31/2018	11/31/2019
C02-06	Care Coordination Training and Responsibilities	11/15/2018	11/31/2019
C02-07	Quality Performance Measurement Management	12/31/2018	11/31/2019
C02-08	ACO Quality Improvement	12/31/2018	11/31/2019
C02-09	ACO Utilization Review	1/1/2019	11/31/2019
C02-10	Patient and Family Advisory Committee Reimbursement	10/30/2018	11/31/2019
C02-11	EIDM/QRMS Annual License Recertification	12/11/2018	11/31/2019
C02-12	Medicare Reattribution Process	3/21/2019	11/31/2019
C02-13	Monthly Quality Data Abstraction	7/11/2019	11/31/2019
C02-14	Medicare Benefit Enhancement Waivers Data Collection Tool Submission	1/30/2019	11/31/2019
F04-01	OneCare Vermont Value Based Incentive Fund Calculation & Distribution Process	11/30/2018	11/31/2019
F04-02	VMNG Primary Care Alignment Strategy	11/30/2018	11/31/2019
FO4-03	OneCare Vermont Shared Savings Calculation & Distribution Process	11/30/2018	11/31/2019
F04-05	OneCare Vermont VMNG Fixed Prospective Payment Distribution	11/30/2018	11/31/2019
F04-06	Accounts Payable For OneCare Vermont	11/30/2018	11/31/2019
F04-07	Deposits for OneCare Vermont	11/30/2018	11/31/2019
F04-08	OneCare Vermont Primary Care Case Management and Care Coordination Payment Distribution	11/30/2018	11/31/2019
F04-09	OneCare Vermont Blueprint for Health (Medicare) Payment Distribution Process	11/30/2019	11/31/2019
N01-08	OCV Secure Web Portal Documents Usage and Maintenance	10/30/2018	11/31/2019
N01-09	OneCare Vermont Secure Portal User Additions	10/30/2018	11/31/2019
N01-11	Annual Compliance Training Distribution and Tracking	4/30/2018	11/31/2019
N01-12	Regional Clinician Representative Contracting Process	10/30/2018	11/31/2019
N01-17	OneCare Vermont Network Audits	7/1/2018	11/31/2019
O05-07	VMNG Beneficiary & Participant Servicing	12/31/2018	11/31/2019
O05-08	Beneficiary Notification & Opt Out Process	12/31/2018	11/31/2019
O05-09	Payer Marketing Material Distribution to Beneficiaries	12/31/2018	11/31/2019
O05-28	Provider/Practice Information Change Form	10/30/2018	11/31/2019
O05-32	Meditract/Contract Management and Document Retention	10/30/2018	11/31/2019
O05-35	Provisioning and Maintenance of Workbench One Users	10/30/2018	11/31/2019
O05-36	Care Navigator User Addition and Maintenance	11/30/2018	11/31/2019
O05-39	OneCare Contract Management and Monitoring	10/30/2018	11/31/2019
O05-40	Payer Program Atrribution Notification	10/30/2018	11/31/2019
O05-41	Vermont Next Generation Program Payments Distribution and Notification	10/30/2018	11/31/2019
O05-44	OneCare Inquiries, Complaints, Grievances and Appeals	2/28/2018	11/31/2019
O05-48	OneCare Vermont Secure Portal, Care Navigator, and Workbench One Bi-Annual Compliance User	10/30/2018	11/31/2019
O05-52	Vermont Medicaid Next Generation Prior Authorization Process	10/30/2018	11/31/2019
O05-54	Care Navigator Patient Record Access Audit	5/28/2019	11/31/2019
O05-56	Contract Distribution Process	3/21/2019	11/31/2019
O05-57	BCBSVT, Medicare and Medicaid Phone Call Tracking and Escalation	1/9/2019	11/31/2019
O05-58	New User CN Access	6/21/2019	11/31/2019
O05-59	Care Navigator Training Registration	3/19/2019	11/31/2019
OO5-60	Monthly Network Provider Updates	10/15/2019	11/31/2019
005-61	Letter of Interest	3/19/2019	11/31/2019
005-62	Medicare Provider File Process	4/3/2019	11/31/2019
005-63	Complex Care Coordination Level 3 Validation and Statements Creation	5/16/2019	11/31/2019
005-64	Monthly Phone Reporting	6/21/2019	11/31/2019
O05-65	Medicare Vetting Process	5/27/2019	11/31/2019
O05-66	Verification of Tax Identification Number (TIN)	5/21/2019	11/31/2019

FY20 ACO Certification Attachment A: Certification Eligibility Documents for OneCare Vermont ACO

GMCB Rule 5.000 Section		In Adaptive* (Y/N)?	Dated	Last Filed	Changed (Y/N)?	Brief description of the change(s) and reason(s) for change(s)
5.201	**Legal Entity**					
	Certificate of Good Standing from the Vermont Secretary of State	Y	1/29/18	2/21/18	N	Currently in Good Standing with the Vermont Secretary of States office and does not need to Renewed until 2022
5.202	**Governing Body**					
	OCV Operating Agreement	Y	1/15/19	6/18/19	N	
	OCV Board of Managers (BOM) Roster	Y	3/20/19	4/30/19	Y	See Updated BOM Roster in Adaptive reflecting new Board Members current as of August 2019.
	Patient and Family Advisory Committee Charter (also 5.206)	N		10/1/18	N	
	OCV Conflict of Interest Policy (Policy 05-02)	Y	1/19/18	2/21/18	N	Up for review in Q4 2019
	Full Organizational Chart	N	n/a	10/1/18	Y	See Updated Organization Chart in Adaptive. Changed to reflect new CEO as well as updated leadership
	Leadership Team Table	N	n/a	10/1/18	Y	See Updated Organization Chart in Adaptive. Changed to reflect new CEO as well as updated leadership
5.203	**Leadership and Management**					
	OCV Compliance Plan (Policy 06-14)	Y	2/21/18	2/21/18	N	Up for review in Q4 2019
5.204	**Solvency and Financial Stability**					
	OCV Quarterly Operating Results / Quarterly P&L	Y	n/a	4/30/19	Reported Quarterly to the GMCB.	
	OCV Finance Committee Charter	N	please submit		N/A	Please find Committee Charter Attached as Attachment B
5.205	**Provider Network**					
	OCV Policy 06-06 Network Support and Access Policy	Y	1/1/17	2/21/18	N	Policy was updated to make format consistent and this has been uploaded to Adaptive
	OCV Policy 06-12 Provider Appeals Policy	Y	3/20/18	3/21/18	N	
5.206	**Population Health Management and Care Coordination**					
	OCV Policy C02-05 Care Coordination & Disease Management	Y	2/19/18	2/21/18	N	Up for review in Q4 2019
	OCV Policy C02-06 Care Coordination Training & Responsibilities	Y	2/19/18	2/21/18	N	Up for review in Q4 2019
	OCV Utilization Management Plan (also 5.207(c))	Y	2/21/18	2/21/18	N	Up for review in Q4 2019
5.207	**Quality Evaluation and Improvement**					
	OCV Policy C02-08 Quality Improvement Procedure	Y	2/19/18	2/21/18	N	Up for review in Q4 2019
5.208	**Patient Protections and Support**					
	Patient Complaint and Grievance Policy (05-06)	Y	2/21/18	2/21/18	N	Up for review in Q4 2019
5.209	**Provider Payment**					
	OCV FPP Distribution Procedure (F04-05)	Y	2/20/18	2/21/18	N	Up for review in Q4 2019
	OCV PCCM and PHPM Distribution Procedure (F04-08)	Y	2/20/18	2/21/18	N	Up for review in Q4 2019
	VMNG Advanced Community Care Coordination Payments (02-02)	Y	8/19/17	2/21/18	Y	New Version uploaded to Adaptiv. Policy was updated to include the requirements for Participants, Preferred Providers, and Collaborators to receive funding under the complex care coordination program in 2020. The new payments move from a capacity building model to payments tied to value (i.e. effective engagement in care coordination programming).
5.210	**Health Information Technology**					
	Data Use Policy (03-03)	Y	2/20/18	2/21/18	N	Up for review in Q4 2019
	OCV Privacy and Security Policy (03-01)	Y	2/19/18	2/21/18	N	Up for review in Q4 2019

Notes:
* Adaptive is the GMCB platform for reporting budget data and sharing reports. The GMCB is testing use of Adaptive to store current policies and procedures submitted by OneCare through the regulatory process.

OneCare Vermont

Appendix 2

Finance Committee Charter

Charge: The Finance Committee is a standing committee of the OneCare Vermont Accountable Care Organization, LLC ("OneCare") Board of Managers. The Finance Committee is charged with reviewing and providing input into the financial aspects of OneCare programs and operations and making recommendations to the Board of Managers to ensure that the financial operations enable OneCare's purpose of achieving high quality, coordinated, and efficient health care delivery across the OneCare beneficiary population.

Committee Leadership and Member Appointment: The Finance Committee will be chaired by a member of the Board of Managers appointed by the Board of Managers. The Chair will preside over each meeting. In the absence of the Chair, the Vice-Chair will act as Chair. If neither the Chair nor the Vice-Chair can attend, the Chair will appoint a member of the committee or management to preside over the meeting. The Finance Committee will be comprised of members based on the composition outlined below. The Board of Managers will appoint members to the Finance Committee based on nominations by the Executive Committee. The Finance Committee may be comprised of a majority of non- manager members, because the Finance Committee's scope of work may benefit from the perspective of finance officers and other leaders not represented on the OneCare Board of Managers.

Committee Composition: The Finance Committee shall be comprised of no more than thirteen (13) voting members with each member having one (1) vote. The Finance Committee composition shall be based on the following guidelines:

- One (1) Chair who shall be a member of the Board of Managers
- One (1) Vice-Chair who shall also be a member of the Board of Managers
- One (1) additional member of the Board Managers
- One (1) representative of University of Vermont Medical Center
- One (1) representative of Dartmouth Hitchcock Medical Center
- One (1) Chief Executive Officer of a hospital participating in all core OneCare risk programs
- Three (3) Chief Financial Officers (or equivalent) of hospitals participating with OneCare
- Four (4) "at large" executives/finance leaders from other provider organizations participating with OneCare

In addition, members of the Budget Advisory Group (BAG) will be invited to participate in the meetings on a non-voting basis. The BAG is comprised of up to two (2) representatives from each risk-bearing hospital participating in OneCare risk programs. At the discretion of the Chair or by majority vote, all or part of the meeting may be closed to the BAG members. OneCare management will be responsible for maintaining the roster of BAG members on behalf of the Finance Committee.

Accountabilities: The Finance Committee reports to the Board of Managers. The primary role of this committee is review and provide input to and support the financial operations of OneCare. The Finance Committee is limited to making recommendations to the Board of Managers.

OneCare Staff Support: The Finance Committee will be assisted, as necessary, by OneCare staff.

Scope: The principle responsibility of the Finance Committee is to review and provide input to the financial aspects of OneCare programs and operations and make recommendations to the Board of Managers.

This will require the following activities:

1. Recommend an annual operating budget to the Board of Managers.
2. Engage key stakeholders in support of financial decision making.
3. Provide input and recommend policies to the Board of Managers that maintain and improve the financial health and integrity of the organization.
4. Review and make recommendations of adoption of a long-range financial plan to the Board of Managers.
5. Review annual operating and capital budgets for consistency with the long range financial plan for the organization.
6. Review the financial aspects new programs and services, and proposals to discontinue programs or services.
7. Monitor the financial performance of the organization against approved budgets, long-term trends and industry benchmarks.
8. Provide input into the risk sharing policy and methodologies used to share costs across the participants.
9. Review Value Based Incentive Fund distribution models.
10. Participate in and oversee audits and periodic financial performance assessments which will include receiving reports from staff on audit progress, reviewing and approving final reports, and making recommendations to the Board of Managers and staff.

Frequency of Meetings: The Finance Committee will meet at six (6) times per year. Notices of meetings and related materials will be distributed to members at least three (3) business days prior to the meeting date. Members will be allowed to participate via teleconference. Minutes will be taken at each meeting.

OneCare Vermont

Vermont All Payer Model ACO Participation Agreement
Telehealth Expansion Implementation Plan

I. General Information

a) Describe how expanding telehealth services will help lower total Medicare expenditures and improve the care of your Next Generation beneficiaries.

The OneCare Vermont (OneCare) network is statewide over a large rural geography, which poses many challenges with respect to access and proximity to healthcare facilities. Expanding permissible telehealth services into Chittenden, Franklin and Grand Isle county communities and the homes of Vermont All-Payer Model Accountable Care Organization (VTAPM ACO) beneficiaries will assist in achieving appropriate care delivery, expanding access to specialty and subspecialty care, while decreasing personal risks from travel for elderly, frail or homebound post-operative patients. Timely assessment and intervention provided by telehealth will create greater stability in the beneficiary's health status thereby reducing avoidable advancement of illness, unnecessary emergency room visits, inpatient admissions, and high cost emergent interventions, leading to increased health equity.

The accessibility of specialist consults via telehealth services in rural areas, where specialty care may be limited, will support proper diagnosis and help clarify the need for appropriate transfers and time sensitive interventions while allowing for local provision of complex care. This is particularly true for asynchronous telehealth for tele-dermatology and teleophthalmology. "Store and forward" capabilities will allow for primary care consultations to these specialists who are often unavailable in rural areas.

b) Describe any prior experience furnishing telehealth services in which a patient was located in a non-rural and/or home setting.

Both OneCare founders, the University of Vermont Medical Center (UVMMC) and Dartmouth Hitchcock Medical Center (DHMC) have extensive experience with live telehealth consultation services for trauma care, stroke care, emergency room care, neurology, psychiatry evaluations, PACS radiology review services, dermatology, palliative care, genetics consultation, and others. Additional services in development include ALS care, post-operative surgical care (neurology, orthopedics), and pharmacy consultation. Telehealth affiliations include the Northeast Telehealth Resource Center (NETRC), American Telemedicine Association (ATA), and Center for Telehealth and e-Health Law (CTel). OneCare Providers utilizing telehealth services are permitted to use the telehealth vendor of their choice. The Vermont Radiology Association has

promoted beneficiaries obtaining CT or MRI imaging in their local community using standardized imaging techniques and permitting distance review by consultative clinicians. Both UVMMC and DHMC have provided hardware to regional hospitals to promote telehealth services and both have administrative or medical directors devoted to advancing these capabilities. For example, UVMMC services 5 VT and 5 NY emergency departments, 7 mobile units in both VT and NY, and 50 telemedicine carts/Polycom setups in its regional offices.

The Visiting Nurse Association of Vermont (VNA) has extensive experience with deploying home physiological monitoring systems in beneficiaries' homes to promote better care of high-risk conditions (CHF, COPD, CAD, arrhythmia, etc.). Such devices permit more efficacious triage of these chronic conditions in addition to promoting self-management of care at home. Both wireless and land line devices have been utilized depending on beneficiaries' location. Clinician performance of physiological monitoring or a virtual visit may result in scheduling another virtual visit, a prompt face to face visit or a revision of current treatment plan. Reduction in emergency room visits and hospitalizations should result from this timely access.

c) Project the expected annual number of unique beneficiaries that will utilize telehealth services under this waiver.

All Vermont hospitals enrolled in the OneCare Network engage in some form of telehealth services (i.e. administration, education, patient consult.) The technology is available anywhere there is internet service and patient and provider interest in telehealth services is increasing daily. The Telehealth Benefit Expansion Waiver services will be available to all VTAPM Medicare beneficiaries. We estimate that approximately 75-100 unique beneficiaries or less will utilize the telehealth waiver at hospitals, primary and specialty care offices offering telehealth/telemedicine services currently, who are able to add to and bill for the Telehealth Expansion Waiver codes and services in addition to their standard Telehealth practice.

II. Telehealth Management Plan

a) Identify the individual(s) who will be primarily responsible for the implementation of this benefit enhancement and the position/role of such individuals(s) in the organization.

The implementation team is led by the Chief Medical Officer (CMO) of OneCare. Since our initial implementation plan, we have hired a Clinical Project Coordinator who serves as the Medicare Waiver Program Administrator, with the primary focus of that position being administering the Medicare Waivers, including Telehealth as well as the 3-Day SNF Rule and Post Discharge Home Visits (PDHV)Waivers. The hiring of this position allowed OneCare to dedicate a resource to be steadfast in the implementation and expansion of these Waivers throughout the OneCare Network. ACO Clinical Consultants, established in each HSA, the Assistant Director of Value Based Care Assistant Director, Clinical Program Manager, and Clinical and Quality Committees also are included in the OneCare team that has oversight and interest in the Medicare Waiver program.

UVMMC via the UVM Health Network (UVMHN) Telehealth Department has led the way in implementing this waiver within their telehealth provider network, with program assistance by OneCare. The UVMHN Telehealth Department has disseminated information about the expansion benefits under the Waiver to their affiliated telehealth providers and added the HCPS codes for telehealth waiver, as included in the telehealth Frequently Asked Questions (FAQ) as made available by CMS/CMMI, into their billing system. This has allowed their current telehealth providers to offer the expanded services offered under the Waiver with ease. A data analysis of these codes in late July 2019 discovered that two UVMHN primary care sites billed for telehealth services under the way in the first half of this year.

b) Describe how the ACO will develop and disseminate standard protocols for use of this benefit enhancement.

Current telehealth service delivery has a written protocol developed in conjunction with clinical and administrative resources where the service is located. Expansion into three additional HSAs with the use of asynchronous telehealth services for teledermatology and teleophthalmology and into the home setting will require review and possible revision of the protocols. Where new telehealth services are employed protocols will be developed and reviewed with primary care providers and staff, specialty care physicians and staff, Skilled Nursing Facility staff, Services and Supports at Home (SASH), Visiting Nurses Association (VNA), Home Health and any ancillary staff during training sessions prior to beginning the new program. Workflows specific to this benefit enhancement can be created and incorporated into new pilot site protocols as well. Changes or updates to these protocols will be disseminated via email, webinars, written materials, and hospital, PCMH or facility medical staff meetings or at monthly Health Service Area Community Collaborative Committee meetings, as well as uploaded to the OneCare secure portal.

c) Describe how the ACO will provide education and technical assistance to VTAPM participants and preferred providers furnishing telehealth services.

In mid-2019, a Telehealth Waiver Guidance Document was created for use by the One Care Network. This guidance document contains valuable information on the Waiver, including an overview of the program, provider and patient eligibility, how to check beneficiary attribution to OneCare, a checklist of criteria to guide our network participants in providing these services, a comprehensive list of OneCare resources, including data and care coordination software programs and a list of ACO Clinical Consultants and contact information.

Education to participants about telehealth visits will include direct communication with primary care providers, specialists and hospital personnel, and facility education programs (SNF, SASH). Provider acceptance and promotion of this service is crucial. Technical assistance to new telemedicine sites will be provided through the UVMHN Telehealth Department, as mentioned above.

d) Please identify and describe any third party entities/vendors with which the ACO and its VTAPM Participant has or plans to have arrangements to assist in furnishing telehealth services to beneficiaries.

Multiple vendors offer videoconferencing expertise, specific names would depend on which service supplier is chosen by the provider; UVMNH telehealth uses Cisco software. As expansion of the Waiver continues through the OneCare Network, we will gather information on use of third-party vendors as necessitated. All are encryption of protected health information (PHI) would be HIPAA compliant.

III. Patient Engagement

a) How will the ACO inform beneficiaries about telehealth services and their options with respect to such services?

OneCare sends a Medicare beneficiary letter to attributed beneficiaries annually as required by CMS. In this letter, OneCare provides information on the Benefit Enhancement Waivers offered, including the Telehealth Waiver. While OneCare does not provide direct patient education on the Waiver, we do encourage patients to connect with their primary care provider to learn more about the program. Attributed beneficiary's primary care physicians and patient centered medical homes can provide education regarding telehealth options. Hospital personnel can incorporate telehealth service information with discharge education. OneCare's Clinical Consultants meet with their health service area hospital staff, community agencies and PCMH primary care office staff regularly and can transmit updates on the expansion of this benefit enhancement in those forums.

b) How will the ACO answer patient questions and handle potential complaints about telehealth services?

VTAPM ACO participating providers (hospitals, primary care medical homes, community service agencies) serve as a primary resource for patients to provide information and resources, and answer questions about the Telehealth Waiver. Patients with questions or complaints may contact OneCare directly through our toll free phone number, or through private messaging on our website.

c) How will the ACO ensure that telehealth services furnished under this waiver comply with applicable Federal and state laws regarding the privacy and security of patient data and communications?

All protected health information (PHI), data, and other information produced, obtained, and/or transmitted as part of the Telehealth Waiver program will comply with applicable Federal and state laws regarding privacy and security of beneficiary information, including HIPAA and the Privacy and HI-TECH security rules. OneCare has signed Business Associate Agreements

(BAA) with our provider network, our preferred providers, and our software/data vendors which require privacy and breach safeguards and protections be maintained. In addition, UVMMC's collaborative Polycom videoconference infrastructure meets the same healthcare guidelines. The review of privacy requirement of these standards will be communicated in the planning stages of implementation of this waiver enhancement benefit.

IV. Self-Monitoring Plan

a) Describe the ACOs plan to ensure compliance with the terms of this waiver, and describe the individual(s) responsible for overseeing compliance.

OneCare's CMO, the Medicare Waiver Program Administrator, and the Data Analytics Department, as supported by the Clinical & Quality Advisory Committee, will track SNF Waiver usage to identify trends, usage change with the expanded benefit enhancement and total cost of care. The Medicare Waiver Program Administrator and OneCare's Chief Privacy and Compliance Officer will be responsible for reviewing and monitoring the Medicare Waiver program to maintain compliance with state and federal and state regulations. Any program integrity concerns will be referred to CMS.

b) Describe safeguards the ACO will have in place for preventing or correcting the use of telehealth services when in-person visits are more clinically appropriate.

By providing education and training prior to implementation and regular program updates, OneCare Participants and Preferred Providers will have a clear understanding of the Waiver program rules. These program rules are also included in the Guidance Document and FAQ that is provided for education, as well as a Medicare Waiver overview provider education module available to the Network on our Secure Portal. OneCare will regularly monitor use of the Telehealth Waiver through our data analytics platform. If patterns of inappropriate utilization are identified, we will engage the providers in a dialogue about the purpose of the waiver and provide education and training to clarify the appropriate care pathways based on clinically identified need.

Appendix 4

OneCare Vermont

Vermont All Payer Model ACO Participation Agreement
Post-Discharge Home Visits Implementation Plan

I. General Information

a) Describe how use of post-discharge home visits will help lower total Medicare expenditures and improve the care of your VTAPM Beneficiaries.

OneCare Vermont (OneCare) will partner with our preferred home health providers to implement the Post-Discharge Home Visits Benefit Enhancement Waiver (PDHV or PDHV Waiver) in a coordinated fashion to improve the care of attributed beneficiaries while simultaneously reducing the total cost of care. Patient Centered Medical Homes (PCMH), VTAPM ACO preferred providers (i.e. Area Agency on Aging (AAA), Home Health Agencies (HHA), Supports and Services at Home (SASH), and Community Health Teams (CHTs) have a longstanding history of collaboration in support of effective transitions of care from hospital to community settings. In general, post-acute care is well coordinated and services are accessible to patients and families. However, we recognize that this period can be a time of significant stress for patients as there are often changes in caregiver roles, new medications, and new self-care strategies needed that can increase the risk for readmissions, missed care coordination opportunities, and as a result, a sub-optimal environment for healing and a return to health for the patient may be created.

This benefit enhancement seeks to address the identified needs by providing timely assessment and implementing in-home supports through home health agency staff to conduct home health visits, provide education on self-care, perform medication reconciliation, assess social supports/needs, and assess changes in health risk status that, without appropriate intervention, could result in avoidable re-admissions or a costly emergency room visit. By proactively assessing, educating, and supporting post-discharge patients, we can help them achieve their health goals while remaining at home.

b) Describe any prior experience in furnishing post-discharge home visit services.

In our previously submitted PDHV Implementation Plan, OneCare discussed the extensive experience some of OneCare's preferred partners have providing home visit services to support patients during a post-acute period. These preferred providers include Bayada Home Health Care (Bayada), Supports and Services at Home (SASH), the Visiting Nurses Associations (VNA), and the University of Vermont Health Network Home Health & Hospice (HH&H) who all have extensive experience using evidence-based medication reconciliation programs to conduct home

visits. This experience provided the necessary knowledge to update the PDHV Waiver implementation plans for 2018.

In late 2019, OneCare executed a PDHV Waiver pilot program agreement with the University of Vermont Medical Center's (UVMMC) Colchester Family Practice (primary care practice) and the University of Vermont Health Network Home Health and Hospice (HH&H). OneCare decided to implement this Waiver with a small test site pilot in order to closely monitor how the program was working – the positives and lessons learned, so the parties could work closely together to fine-tune the program to make it the most successful for all parties –most importantly the attributed beneficiaries who will receive care.

It is our intention to expand this Waiver pilot in additional health service areas (HSAs) participating in the VTAPM Medicare program, including potential partnerships with preferred provider sects of the VNAs of Southwestern Vermont; a home health agency with extensive background and experience in home-health and nursing care.

c) Project the expected annual number of unique beneficiaries that will utilize post-discharge home visits under this waiver.

During implementation discussions for the PDHV Waiver pilot, the consensus of the participants was that we will begin with 1-2 attributed beneficiaries seen per week for the first few months, with an increase expected as workflows and processes are fine-tuned, including identifying moderate and high risk attributed beneficiaries who do not meet criteria for home health care, but could benefit from some form of home health supports as provided by the Waiver. As the PDHV Waiver program is expanded to other sites within the OneCare Network, the plan is to start those expansion sites off with a small number of patients per week like the pilot, 1-2 patients per week, and expand after sites feel comfortable with workflows, processes, and procedures, but most importantly seeing a positive outcomes for their patients. Annual projection is approximately 50-75 patients annually. Billing rules imposed have resulted in a delay related to legal and contractual agreements that need to be in place related to incident to billing requirements.

II. Post-Discharge Home Visits Management Plan

a) Identify the individual(s) who will be primarily responsible for the implementation of this benefit enhancement and the position/role of such individual(s) in the organization.

The implementation team is led by the Chief Medical Officer (CMO) of OneCare. Since our initial implementation plan, we have hired a Clinical Project Coordinator who serves as the Medicare Waiver Program Administrator, with the primary focus of that position being administering the Medicare Waivers, including PDHV as well as the 3-Day SNF Rule and Telehealth Benefit Expansion Waivers. The hiring of this position allowed OneCare to dedicate a FTE to be steadfast in the implementation and expansion of these Waivers throughout the OneCare Network. ACO Clinical Consultants, established in each HSA, along with the OneCare internal Clinical and Quality Teams and the Value Based Care Assistant Director and Clinical

Program Manager also are included in the OneCare team that has oversight and interest in the Waiver program.

b) Describe how the ACO will develop and disseminate standard protocols for use of this benefit enhancement.

OneCare worked extensively with the pilot program partners (UVMMC and HH&H) to create a PDVH Waiver Guidance Document. This document contains valuable information on the Waiver, including an overview of the program, provider and patient eligibility, how to check beneficiary attribution to OneCare, provides standing home-health orders from the medical home as an example, reviews what documentation should be captured during home health visits, provides a list of program codes agreed upon for billing purposes, and a comprehensive list of OneCare resources, including data and care coordination software programs and a list of ACO Clinical Consultants and contact information. This guidance document also includes a sample workflow for the pilot program, which can be used as a template for future expansion of the program across the OneCare network.

During the implementation of the pilot, we found that the development of workflows helped to provide role clarity and process overview. These workflows were discussed in detail and outlined in hard-copy, with some portions of these workflows incorporated into the UVMMC medical record system which will allow for seamless multi-directional communication and coordination of care for PDHV Waiver beneficiaries. As workflows and processes are fine-tuned during the pilot program, the Guidance Document will updated with these materials and it will be disseminated to current and future sites.

c) Describe how the ACO will provide education and technical assistance regarding this benefit enhancement to Next Generation Participants and Preferred Providers.

In addition to the Guidance Document referred to above, OneCare also utilizes the APM Participation Agreement PDHV Appendix section and the CMS produced FAQ on the PDHV Waiver to provide education and technical assistance to the pilot site participants, and also potential sites who express interest in the Waiver. These documents have been successfully received by recipients who have expressed interest in the Waiver.

In addition, after an initial monitoring period of the pilot site, the Medicare Waiver Program Administrator plans to create a training presentation in order to provide education to potential sites who may be interested in implementing this benefit enhancement. This training will be provided in-person and via WebEx/Skype, depending on the location and length of the training. Regular program updates will also be provided by the Medicare Waiver Program Administrator via email and the OneCare Network News, which is sent Network wide monthly. Program updates will also be shared with regional clinical representatives who champion the work of

OneCare in their HSAs, ACO clinical consultants so they can provide information directly to the providers in the communities they serve, as well as community stakeholders and payer partners.

d) Describe how the ACO will integrate the waiver into its operational processes.

Potentially eligible beneficiaries will be identified prior to discharge by the care team member (i.e. hospital discharge planners, care coordinators) and screened for eligibility using a standardized screening protocol. Once eligibility is determined, beneficiaries will be offered the benefit enhancement in the form of a first post-discharge home visit. Home visits will be offered to the identified eligible beneficiary by a home health agency staff member that is contracted with that beneficiary's primary care provider. In this way the home health staff member will be introduced as an extension of the PCMH care team. The first home visit will most likely take place during the first 1-5 days post-discharge. We anticipate that primary care post-discharge visits will be scheduled within 7 days. Care during this transition period will be closely managed and coordinated across the care team and supported by a web-based care coordination patient management software solution, Care Navigator. This tool will allow care coordinators to track and monitor patient's progress and to anticipate situations of potentially rising risk for the patient. We anticipate there may be times when, at the first home visit, the home health nurse determines the patient is eligible for and would benefit from a full home care skilled care episode. In this case, the nurse will coordinate with the primary care provider and ACO to admit the patient to the home health agency and bill and appropriate source outside of the Next Generation waiver. Eligibility for additional home visit within 90 days post-discharge will be determined through the use of a screening process conducted either by the home health staff member during the first home visit or by the PCMH care team (inclusive of their designated care coordinator). In this way, the entire community-level VTAPM ACO provider network effectively manages care for patients under this waiver benefit.

III. Patient Engagement

a) How will the ACO inform beneficiaries about post-discharge home visit services and their options with respect to such services?

OneCare sends a Medicare beneficiary letter to attributed beneficiaries annually. In this letter, OneCare provides information on the Benefit Enhancement Waivers offered, including PDHV. Depending on the success of the pilot and planned expansion of the program throughout the Network, OneCare may develop a CMS approved communication plan for direct outreach to beneficiaries, including posting PDHV Waiver information on our public-facing website. OneCare also relies on providers and case managers to inform and educate patients on the availability of the Waiver, at our pilot site. We will rely on the same staff roles to provide patient education in expansion sites in 2020.

b) How will the ACO answer patient questions and handle potential complaints about post-discharge home visit services?

VTAPM ACO participating providers (hospitals, primary care medical homes, community service agencies) serve as a primary resource for patients to provide information and resources, and answer questions about the post-discharge waiver enhancement program. Patients with questions or complaints may contact OneCare directly through our toll free phone number, or through private messaging on our website.

c) How will the ACO ensure that the post-discharge home visit services are appropriate for beneficiaries?

Determination of whether the post-discharge home visit is appropriate for a beneficiary will depend on meeting baseline criteria that has been developed. Baseline criteria include being an OneCare attributed patient, discharged to home setting, and at moderate to high risk for readmission.

Determination of eligibility related to high risk for readmission will likely include the following criteria, which is included in our Guidance Document:

A. Diagnosed with a condition such as: CAD, CHF, COPD, Diabetes, Sepsis, Dementia, Frailty, Major Depression, Falls, Delirium during hospitalization and/or Pneumonia;
B. Polypharmacy (≥4 medications) or a high-risk medication, such as an anti-coagulant;
C. Primary language other than English;
D. Concern regarding low health literacy;
E. Cognitive impairment;
F. Inadequate support at home;
G. Patient or caregiver anxiety; and/or
H. Clinical judgment by a medical professional that indicates the need for a home health visit.

The need for a second and additional home visits will be balanced against the systemic or environmental barriers to initiating follow-up care, including transportation, food insecurity, concerns with living situation.

d) How will the ACO ensure that post-discharge home visits furnished under this waiver comply with applicable Federal and state laws regarding the privacy and security of beneficiary data and communications?

All protected health information (PHI), data, and other information produced, obtained, and/or transmitted as part of the PDHV Waiver program will comply with applicable Federal and state

laws regarding privacy and security of beneficiary information, including HIPAA and the Privacy and HI-TECH security rules. OneCare has signed Business Associate Agreements (BAA) with our provider network, our preferred providers, including HH&H, and our software/data vendors which require privacy and breach safeguards and protections be maintained.

IV. Self-monitoring Plan

a) Describe the ACO's plan to ensure compliance with the terms of this waiver, and describe the individual(s) responsible for overseeing compliance.

OneCare's CMO, and his designee - the Medicare Waiver Program Administrator will track post-discharge home visits to identify trends in utilization of home visits, re-admission rates, emergency department utilization, and total cost of care. The Medicare Waiver Program Administrator and OneCare's Chief Privacy and Compliance Officer will be responsible for reviewing and monitoring the post-acute discharge waiver benefit enhancement program to maintain compliance with federal and state regulations.

b) Describe safeguards the ACO will have in place for preventing post-discharge visits when alternate sites of care, including hospitalization, are more clinically appropriate.

Through use of our robust data analytics platform, OneCare will examine ACO- and community-level data to identify potential inappropriate utilization of post-discharge home visits when alternative sites of care are more clinically appropriate. If patterns of inappropriate utilization are identified, we will engage the providers in a dialog about the purpose of the PDHV Waiver and provide education and training to clarify program rules and appropriate care pathways for post-discharge patients based on clinically identified need (i.e. referral to a skilled nursing facility, re-admission).

c) Describe the ACO's plan to ensure Participant and Preferred Providers furnish post-discharge home visit services no more than nine times in the 90 days following discharge.

By providing education and training prior to implementation and regular program updates, OneCare Participants and Preferred Providers will have a clear understanding of the Waiver program rules including the number of visits allowed. These program rules are also included in the Guidance Document and FAQ that is provided for education, as well as a Medicare Waiver overview provider education module available to the Network on our Secure Portal. OneCare will regularly monitor use of the PDHV Waiver through our data analytics platform and check-ins with Waiver participants. If patterns of inappropriate utilization are identified, we will engage the providers in a dialogue about the purpose of the waiver and provide education and training to clarify the appropriate care pathways based on clinically identified need.