To: **Kevin Mullin, Chair, Green Mountain Care Board**
From: **Todd Moore, CEO OneCare Vermont, Accountable Care Organization, LLC.**
Date: **October 20, 2017**
Subject: **OneCare Vermont ACO 2018 Fiscal Year Budget Resubmission**

Dear Chairman Mullin,

OneCare is pleased to present our revised 2018 annual budget to the Green Mountain Care Board based on our September finalized network. Please note that we are still working to receive or negotiate our full attribution numbers, trends and targets from payers, and therefore this budget relies on our best available projections. As you will see, this budget continues to focus on helping providers and communities move ahead on promoting wellness, coordinating a fragmented system, further improving quality and access, and delivering better care at a more predictable and affordable cost.

Per the GMCB's instructions, please accept OneCare Vermont's Fully Revised 2018 Fiscal Year Budget Package. For additional ease in reading, we have included the GMCB's questions with our response into their respective sections. We have also revised worksheets and attachments as needed while including new attachments at your request.

Section:

1. OneCare Vermont Information, Background & Governance
2. OneCare Vermont Network
3. OneCare Vermont Payer Programs
4. OneCare Vermont Budget and Financial Plan
5. OneCare Vermont Model of Care & Community Integration

My team and I want to extend a special thanks to the staff members at the GMCB. They have all been exceedingly helpful in answering questions and aligning expectations for this re-submission.

If you have any questions please feel free to contact me directly at the number below or Vicki Loner, OneCare's Chief Operating Officer, at (802) 847-6255.

Thank you,

Todd B. Moore, MBA
CEO, OneCare Vermont
(802) 847-1844

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Green Mountain Care Board, 2018 Budget Resubmission

Executive Summary

OneCare Vermont (OneCare) was organized and founded in 2012 by the University of Vermont Medical Center (UVMMC) and Dartmouth Hitchcock Health (DH-H). We are Vermont's largest statewide multi-payer Accountable Care Organization (ACO), currently serving over 100,000 Vermonters.

OneCare currently supports a large statewide network, which includes the majority of hospitals in Vermont and Dartmouth Hitchcock, the largest out-of-state provider of care to Vermonters. Additionally, a majority of the primary care and specialty providers (including hospital employed and private community practices) in the state participate in at least one of our ACO programs. OneCare's current continuum of care provider network consists of 21 SNFs, 9 designated mental health agencies and 10 home health and hospice organizations. Nationally, the unique scope of the OneCare participant network described above is itself a major accomplishment and represents a commitment to statewide collaboration by providers on behalf of its attributed populations.

In 2013, OneCare started participating in the Medicare Shared Savings Program (MSSP) created by the Affordable Care Act. In January of 2014 OneCare became a multi-payer ACO, entering into contracts with the Department of Vermont Health Access (DVHA) for a Medicaid Shared Savings Program (VMSSP) and Blue Cross Blue Shield of Vermont (BCBSVT) for a Commercial Exchange Shared Savings Program (XSSP). In 2015, OneCare was selected to participate in the Medicare Next Generation program, but chose to defer and reapply in 2017 for a January 2018 start to better align with the timing of the All-Payer ACO Model. Lastly, in 2016, OneCare was the sole bidder for the Medicaid Next Generation ACO program, and implemented the program in partnership with the Department of Vermont Health Access on January 1, 2017.

In addition to the ACO Program contracts, in December of 2014 OneCare was awarded a Vermont State Innovation Model contract. The purpose was to further all three (3) ACOs' efforts towards innovative, highly reliable, evidenced-based population health care strategies for Vermonters. The funding is primarily directed to providing support for developing community-learning collaboratives through expanding the role of the Community Collaboratives (Regional Clinical Performance Committees) that serve every health service area (HSA) in Vermont. Because of the successful attainment of contract objectives, the contract was extended through June of 2017.

In 2016, OneCare was also one of only six entities that was awarded a two-year Robert Wood Johnson Foundation grant for Transforming Complex Care. This funding will allow us to strengthen community partnerships by removing barriers and coordinating care for Vermonters with complex health care needs.

OneCare has a track history of improving quality while slowing expenditure growth. For example, in Medicare for Performance Year (PY) 2015, while OneCare did not qualify for shared savings, it was among the highest-value ACOs across the county when mapped on cost per beneficiary and overall

quality score. For Medicaid, OneCare received savings in PY 1 but in 2015 ended up 1.3% above our spending target for the performance year, and therefore did not achieve shared savings. However, OneCare scored in the top benchmark percentile or showed statistically significant improvement in 11 quality measures and increased our quality score from 63% to 73% from 2014 to 2015. For Commercial Exchange Shared Saving Program, our expenditures decreased by 0.1% from 2014 to 2015 but still exceeded the target. The target was based on Blue Cross Blue Shield of Vermont's budgeted medical costs included in its Green Mountain Care Board approved rates for its health plans on the States' Health Exchange and increased by 3% from 2014. OneCare scored in the top benchmark percentile or showed statistically significant improvement in 15 quality measures for the commercial program.

OneCare has made solid progress on quality outcomes and programs to better control illness and deliver care in lower cost settings but we have felt the motivational limitations of a shared savings incentive model on top of a FFS system and against a retrospectively set target. OneCare participants desire a model that provides predictable revenue stability as we strive to meet the Triple Aim. We desire the Next Gen path to capitation to redesign provider payment models to move away from FFS reimbursement. With our involvement in a 2017 Medicaid Risk program, OneCare is well positioned to pursue a fixed payment reform model for all hospitals. We estimate that network hospital providers who wish to be directly rewarded for value and access instead of volume provide a large amount of care, approximately 2/3 for Medicaid and Medicare, to our population.

OneCare holds an important and proactive leadership role in Vermont's transition to value-based reform of its delivery system. We have played a major role in the provider-led transformation processes and collaborated extensively with the other ACOs and the Vermont Blueprint for Health. We are also supportive of the State of Vermont's All-Payer ACO model and its goals to improve the experience of care and the health of the populations while reducing cost growth. Like our founding owners, we are collectively committed to moving from a "Sick Care" to a "Health Care" system by investing in solutions that will promote health and well-being and make care more affordable for Vermonters.

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Part 1: ACO Information, Background and Governance

1. *Date of Application:*
   June 23, 2017

2. *Name of ACO:*
   OneCare Vermont Accountable Care Organization, LLC

3. *Tax ID Number:*
   455399218

4. *Identify and describe the ACO and its governing body, including:*
   a. *Legal status of the ACO (e.g., corporation, partnership, not-for-profit, LLC);*
   b. *Members of the Board and their organizational affiliation (for consumer members, identify whether the member is a Medicaid beneficiary, a Medicare beneficiary and/or a commercial insurance plan member);*
   c. *Board officers;*
   d. *Board committee and subcommittee structure, as applicable;*
   e. *Description of Board voting rules; and*
   f. *Copy of ACO bylaws, or equivalent.*

   OneCare Vermont (OneCare) is a "manager-managed" Not for Profit VT LLC. Other than powers reserved to the Members in the Operating Agreement, OneCare's affairs are under the exclusive management and control of the Board of Managers (BOM). The BOM has responsibility for oversight and strategic direction that is implemented by OneCare's leadership. The BOM appoints a CEO, CCO and CMO to manage the daily affairs. Each reports to the BOM, is accountable for OneCare's activities, and may be removed by the BOM.

   Board committees are accountable to the BOM and include Executive, Finance and Population Health Strategy (PHS) Committees. They provide strategic and organizational recommendations: input on key policies, budget approval, direction on the clinical model and oversight of cost and utilization performance.

   The CEO sets and executes corporate strategy with the support of the CMO, CCO, and COO. The CMO, a board-certified VT MD, directs the non-board level clinical committees and sub-committees to effectively execute on the Clinical Model. The CCO manages the compliance risks providing regular reports to the CEO and BOM. The COO leads and coordinates OneCare's strategic and operational functions.

   To represent the consumer's interests on OneCare's Board of Managers, OneCare has an independent Medicare, Medicaid and Commercial beneficiary representing all three ACO programs.

OneCare works with Vermont's Legal Aid and the Healthcare Advocate to provide advocacy training to our Consumers on our Board and to provide training to our separate consumer advisory group that provides input to the Board of Managers. Each Manager participates in Board meetings with the same level of authority as their fellow Managers.

OneCare's providers are broadly represented in the governing Board of Managers and committees. Of the 18 managers, 15 or 83% represent ACO providers elected by their peers. Both owners elect three (3) Managers and the nine (9) at-large Managers are elected by their peers. This allows for broad input and a substantial voice in ACO governance. Each Manager has one vote. The Operating Agreement provides for supermajority votes of the Board, a 2/3 vote that must include at least one Manager appointed by each owner. This permits owners additional say on significant matters while allowing for ample provider and consumer input. Participating providers and consumers also populate all other committees on the OneCare organizational chart and are active participants in strategy, finance, clinical, and consumer policymaking.

OneCare's current Board of Managers can be found in Attachment A in Part 1 Attachments.

OneCare's Governance Structure including Committees, Subcommittees and Officers can be seen in Attachment B in Part 1 Attachments.

OneCare's By-Laws can be found in Attachment C in Part 1 Attachments.

5. *Identify and describe each member of the ACO's executive leadership team, including name, title, tenure in current position, and qualifications for current position.*

Leadership Team Member and Credentials	Position/Role	Tenure with OneCare VT
Executive Team		
Todd B. Moore, MBA	Chief Executive Officer	5 years
Vicki Loner, RN.C, BS, MHCDS	Vice President and Chief Operating Officer	4 years
Norman Ward, MD, MHCDS	Chief Medical Officer	5 years
Jennifer Parks, JD	Chief Compliance Officer	5 Years
Heather Rozkowski, D.SC., CISSP	Chief Information Security Officer	5 Years
Senior Leadership		
Susan Shane, MD	Medical Director	5 Years
Martita Giard, AS	Director, Programs Strategy & Network Development	5 Years
Sara Barry, MPH	Director, Clinical & Quality Improvement	1 Year
Leah Fullem, MHCDS	Director, Informatics	5 Years
Tom Borys, MBA	Director, Finance	5 Months
Joan Zipko, MHCA	Director, ACO Operations	3 Years
Management Team		
Shawntel Burke, CPC	Manager, ACO Operations	5 Years
Becky Colgan, PhD	Manager, ACO Analytics	4 Years
Theresa Connolly, MSN, RN, CPN	Manager, Clinical and Quality Improvement	3 Weeks

6. *Provide a list of ACO employees, direct or contracted, their titles, and an organizational chart.*

   Please see Attachment D in Part 1 Attachments.

7. *Describe any legal actions taken against the ACO or against any members of the ACO's executive leadership team or Board of Directors related to their duties.*

   No Legal Action has been taken against OneCare Vermont, its leadership team, or its Board of Managers.

8. *With respect to the ACO's executive leadership team or Board members, describe any legal, administrative, regulatory or other findings indicating a wrongful action involving or affecting the performance of his or her duties, or professional fiscal irresponsibility.*

   No Legal, Administrative, Regulatory or other findings including wrongful action has been taken against OneCare Vermont, its leadership team, or its Board of Managers.

9. *If the ACO has been accredited, certified or otherwise recognized by an external review organization (e.g., for NCQA accreditation or payer assessments), submit the review organization's determination letter, associated assessment documents and results. If the ACO is working toward certification, please describe.*

   OneCare has not been accredited or certified by an external review organization.

GMCB Questions for OneCare Vermont
Part 1

1. *Please provide a full set of bylaws, including voting rules.*

   Please see Attachment E Part 1 Attachments for OneCare's Operating Agreement which includes its full bylaws and voting rules.

2. *Please provide more information on how existing staff meets the care coordination needs of the population.*

   OneCare has two full-time staff members dedicated to care coordination, a Care Coordination Program Administrator and a Care Coordination Implementation Specialist. Staff is supported by five full-time OneCare Clinical Consultants whom are deployed to all participating health service areas to support OneCare initiatives and services in local communities. OneCare's care coordination team works in close partnership with the state and local leaders with the Blueprint for Health Program and its partners to align and deploy care coordination strategies to support our community-based care coordination model (Figure 1). In this model, OneCare is advancing the organization of community-based care coordinators from a multitude of care delivery organizations including: Primary Care, Designated Mental Health and Substance Abuse Agencies, Area Agency on Aging, Supports and Services at Home, Home Health Agencies, as well as partners in the Agency of Human Services (e.g. DVHA, VDH, DAIL, DMH) and other community services providers (e.g. housing, transportation, non-profits). OneCare tracks the engagement of care team members though its care coordination software platform, Care Navigator. To date, in the five (5) health service areas currently participating in OneCare's care coordination model, more than 400 care team members are actively connected to patients and caregivers. The number of care team members varies by patient and ranges from one to eight team members. With the introduction of a new payment model in July 2017 (Figure 2), OneCare is supporting community conversations about how best to utilize those funds to identify gaps in care and determine if and where hiring needs to occur; all in an effort to avoid duplication and to facilitate care delivery by appropriately trained staff based on the unique needs identified in each community. OneCare and the Blueprint continue to support care coordination staff competency assessments, trainings, and skill-building to ensure a robust workforce. As we move forward as new opportunities for training are identified, we will deploy them in coordination with guidance and facilitation of local care coordination core team members who serve as our "eyes and ears" on the ground regarding the execution of this model.

Figure 1. OneCare Care Coordination Model

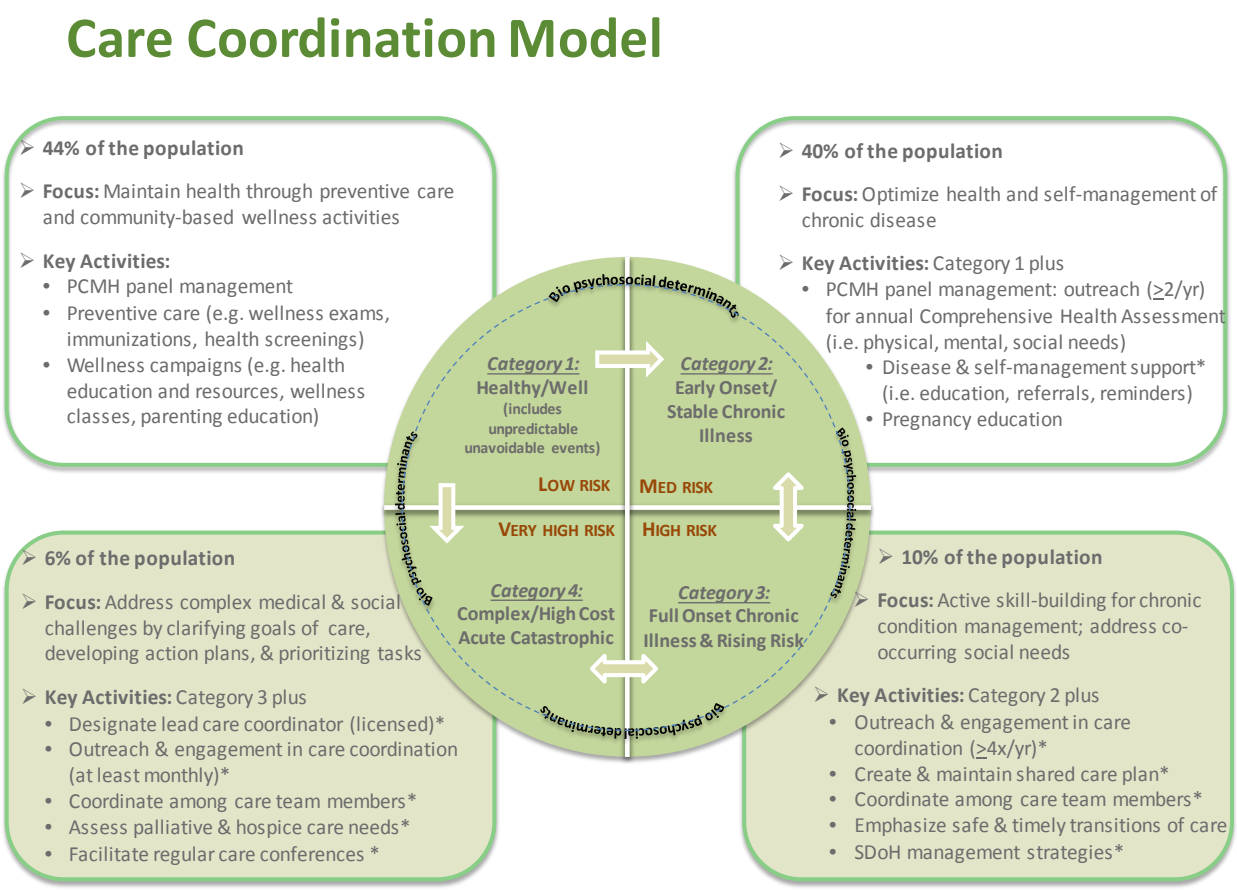
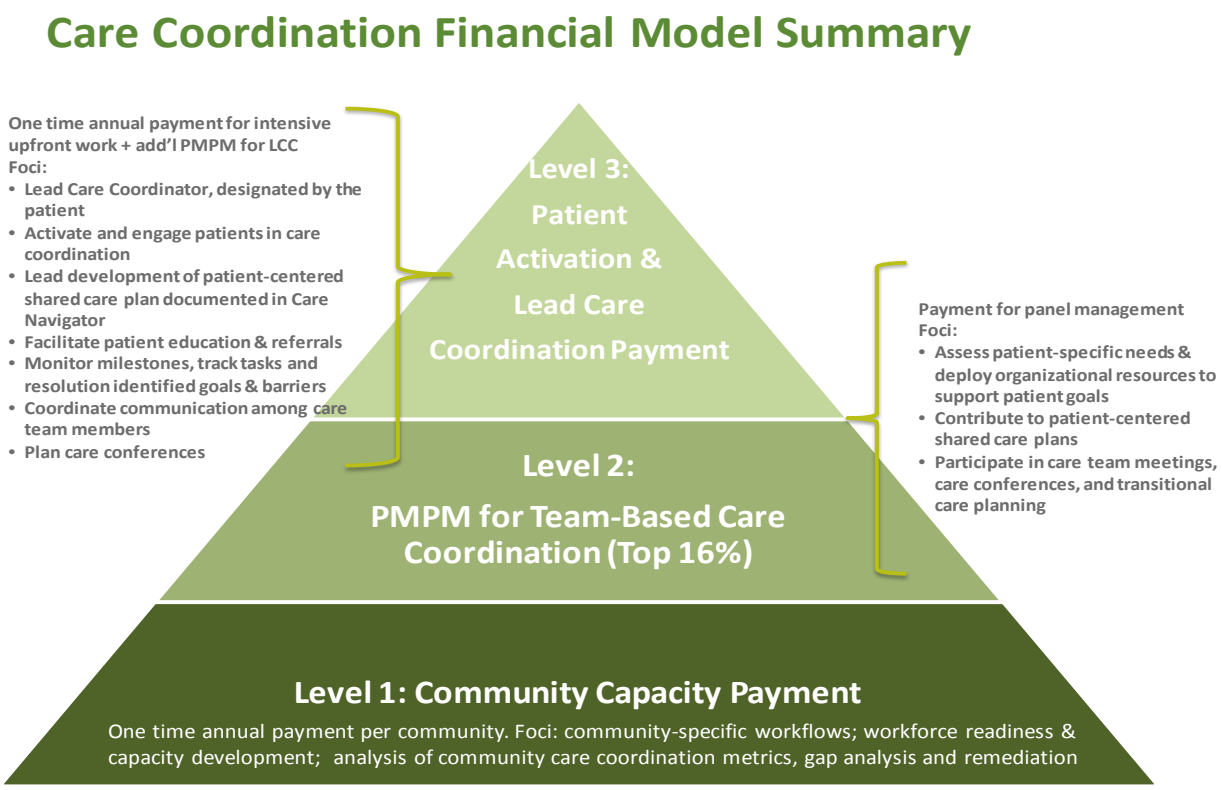


Figure 2. OneCare Care Coordination Payment Model



3. *Who, of your staff, oversees provider reimbursement and network management?*

   The Operations department, led by Joan Zipko, handles network management to include the planning, execution and tracking of participant contracts to our network. The Finance Team headed up by Tom Borys is responsible for making sure the monthly provider reimbursements are paid and that the providers are supplied monthly statements of funds they are receiving, which is uploaded to the Provider Portal by the Operations department.

Part 1
Attachments

Attachment A – OneCare Vermont Board of Managers

Attachment B – OneCare Vermont Governance Structure

Attachment C – OneCare Vermont By-Laws

Attachment D – OneCare Vermont Staff Organizational Chart

Attachment E – OneCare Vermont Operating Agreement and By-Laws

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Part 2: ACO Provider Network

1. *Provide, as an attachment, a completed **Appendix A1 – ACO Provider Network Template** which will include*:*
    a. *Name*
    b. *Provider type: (e.g., academic medical centers; critical access, sole community and other hospital types; federally qualified health centers; independent physician office practices; mental health and substance use treatment providers; home health providers, skilled nursing facilities, community long-term services and supports providers; facility post-acute care providers, SASH providers, Blueprint for Health Community Health Teams.)*
    c. *Contract type and payment model: Payer-defined and administered fee-for-service (FFS); ACO- defined FFS; ACO capitation, including all-inclusive population-based payment (AIPBP); global budget; shared savings; shared risk, or as otherwise defined.*

    Please see Attachment A in Part 2 attachments titled "Complete Physician Network" for a complete list of the OneCare's Provider Network across all three payer programs.

    Please see Attachment B in Part 2 attachments titled "Summary of Provider Network by Provider Type" for a Summary list of the OneCare's Provider Network across all three payer programs by provider type.

2. *Provide, as an attachment, a completed **Appendix A2 – Summary ACO Provider Network Template** which will include*:*
    a. *Count of providers by provider type and specialty, by county*

    Please see Attachment B in Part 2 attachments titled "Summary of Provider Network by Provider Type" for a summary list of the OneCare's Provider Network across all three payer programs by provider type.

    Please see Attachment C in Part 2 attachments titled "Summary Provider Network by HSA/County by Provider Type" for a Summary list of the OneCare's Provider Network across all three payer programs by provider type and county.

3. *For provider contracts for which the provider is assuming risk, describe the ACO's current contract with the provider:*
    a. *The percentage of downside risk assumed by the provider, if any;*
    b. *The cap on downside risk assumed by the provider, if any, and*
    c. *What risk mitigation requirements the ACO places on the provider, if any (e.g., reinsurance, reserves).*

    OneCare as the ACO ultimately holds the risk for the VMNG contract which has a symmetrical 3% risk corridor with 100% risk sharing. The downside risk is also capped at this 3% level. The four (4) risk-bearing hospitals, through their contractual agreement with

OneCare, have committed to a maximum 3% of target risk exposure corridor for their community, which is prorated by the NPSR.

To provide evidence that OneCare has sufficient financial resources for the risk associated with the DVHA VMNG Risk program, OneCare has obtained a letter of credit from the University of Vermont Health Network in order to cover any losses above and beyond what it is capable of covering. For 2018, when OneCare has risk for 3 payer programs, we are exploring re-insurance.

4. *Submit provider contracts as requested by the GMCB.*

Please see Attachment D in Part 2 Attachments titled OneCare Provider Base Risk Contract with Medicare, Medicaid and Commercial Rider.

GMCB Questions for OneCare Vermont
Part 2

1. *The Medicare and Medicaid provider contract templates submitted by OneCare state that "losses will be paid by the ACO and Participants in a manner consistent with ACO strategy and approved by the Board of Governors."*
    a. *Please clarify what distinguishes a Participant from an Affiliate.*

        Participants are providers that attribute while affiliates do not attribute. Both are part of the network and eligible for OneCare PHM payments if applicable. Risk is being borne by hospitals only, all of which are Participants.

    b. *What strategy has the Board of Governors ("Board of Managers", yes?) adopted? Elsewhere in the submission, there is an indication that UVMMC has agreed to fund any 2017 Medicaid losses. Is that correct?*

        OneCare Vermont is an LLC, and as such its governing body is technically called a "Board of Managers." Please see the attached OneCare Savings/Losses Policy for the board-approved risk sharing model. The 2017 risk management model pools all savings or overruns and spreads the revenue/expense based on 2015 NPSR. To facilitate contracting with DVHA in 2017, UVMMC provided a separate letter of credit to be the guarantor of the downside risk prior to the Board-approved 2017 model.

2. *You did not explicitly list any Medication Assisted Treatment (MAT) providers in your network. Please explain.*

    OneCare does have providers in our network that are able to prescribe Medication assisted treatment. As an ACO we contract with providers that are already credentialed with payers; thus we do not gather XDEA information on providers.

3. *Please describe OneCare's involvement with and support of the Hub and Spoke model, including at the participating provider level.*

    OneCare Vermont (OCV) is highly collaborative with the Blueprint for Health and its Hub and Spoke medication assisted treatment (MAT) model. The vast majority of OCV clinicians are Blueprint participants. OCV is active at promoting training for both MDs to obtain their appropriate MAT DEA designation and advocating for advanced practice providers to obtain similar scope of practice. The UVMMC primary care practices (general internal medicine, family medicine, pediatrics, obstetrics) (one third of our attributed lives) have actively promoted integration of appropriate patients into spoke primary care practice settings with MAT wrap around services. The HSA Community Collaboratives across the OneCare network and OneCare Vermont's Regional Clinician Representatives also seek local promotion of provision of MAT. The new Vermont Department of Health opiate prescribing rules and regulations beginning July 1, 2017 have reinforced increased awareness of the critical nature of Vermont's opiate epidemic. The Vermont All Payer Model process milestone goals include specific mention of

increased rates of adherence to the use of the Vermont Prescription Monitoring System. OneCare has identified improving our network's adherence to the All Payer Model Health Care System Goal of "within 30 day ambulatory setting follow-up after an Emergency Department visit for either substance abuse or mental health issues" as one of our five overarching clinical priorities for 2017 (as endorsed by our Clinical and Quality Advisory Committee and Board of Managers.)

OneCare Vermont is also committed to piloting a payer agnostic primary capitation model that could be designed to further promote provision of sufficient resources to increase the numbers of MAT patients I the primary care spoke setting.

OneCare would be willing to explore methods to reduce waiting lists for MAT with a goal of "on demand" real time response. This would require increased support and capacity of both the hub and spoke treatment venues. The 1115 Waiver Medicaid state/federal matching funds (so called "Transformation Funds") could be used to enhance this capacity.

4. *Provide your most recent payer contracts. If the 2018 contracts are not complete, please update Template #1: Revenue by Payer (Sect 4. Attachment C-1) to reflect any changes, and provide a narrative on your payer negotiations.*

   The Medicaid/DVHA and Commercial/BCBSVT payer contracts are still being negotiated. Both negotiations have been very collaborative and are beginning to transition into the phase where actual contracts are drafted. There have been no material changes to the general concepts of the programs since the first submission, but much progress has been made to discuss operational refinements that will help make these programs a success in 2018 and beyond.

   For Medicare, all of the Next Generation submissions were delivered on time. We now await data around our initial attribution and spend targets for the 2018 plan year. At present we have not seen a draft contract for review.

5. *Provide a copy of the letter of credit that is in place to cover 2017 Medicaid VMNG contract losses.*

   Please see Attachment E in Part 2 Attachments for the letter of credit.

6. *Provide contracts for risk-bearing entities. If the contracts are the same throughout your network, you may submit one and note.*

   Please see a revised Attachment D in Part 2 Attachments for our provider contracts which now includes the BCBSVT Rider Contract. All provider contracts are the same throughout the network and there is not a separate contract for risk-bearing entities.

   Also, for ease, please see attachment F in part 2 attachments which is a simple high-level summary of OneCare's 2018 network showing the breakdown by HSA and provider type.

Part 2
Attachments

Attachment A – Complete Physician Network

Attachment B – Summary of Provider Network by Provider Type

Attachment C – Summary Provider Network by HSA by Provider Type

Attachment D – OneCare Provider Base Risk Contract with Medicare, Medicaid and Commercial Rider

Attachment E – OneCare Letter of Credit

Attachment F – OneCare 2018 Network Grid

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Part 3: ACO Payer Programs

1. *Provide copies of existing agreements or contracts with payers. If 2018 contracts not available, please submit as an addendum when signed*.*

   To view OneCare Vermont's Vermont Medicaid Next Generation Contract (VMNG) with the Department of Vermont Health Access, please visit the following links:

   Link to DVHA VMNG Contract "Attachment A and B":
   http://dvha.vermont.gov/administration/onecare-aco-32318-final-searchable.pdf

   Link to DVHA VMNG Contract Exhibit 1 (Complete list of included and excluded service codes)
   http://dvha.vermont.gov/administration/exhibit-1-to-attachment-a-service-codes-final.pdf

   Link to DVHA VMNG Contract Exhibit 2 (Attribution Technical Specifications)
   http://dvha.vermont.gov/administration/exhibit-2-to-attachment-a-evaluation-managment-services-final.pdf

   OneCare currently only participates in the Shared Savings Program with Medicare and does not have a risk-based Next Generation contract with Medicare at this time. It is anticipated, upon being awarded participation in the Next Gen Program sometime in August 2017, that a contract will be signed later in the fall of 2017.

   OneCare currently is finalizing negotiations with Blue Cross and Blue Shield of Vermont for a risk-based program to be effective in 2018. Upon completion of negotiations and the execution of a contract, OneCare will provide a copy of the contract to the GMCB.

2. *Provide a completed **Appendix B – 2018 ACO Program Elements by Payer** template which will include*:*
   a. *Payer and line of business with which the ACO has agreements:*
      i. *Medicaid*
      ii. *Medicare*
      iii. *Commercial: Individual and Small Group (Vermont Health Connect)*
      iv. *Commercial: Large Group*
      v. *Commercial: Self-insured*
      vi. *Commercial: Medicare Advantage*
   b. *Attributed lives by payer and line of business*
   c. *Projected spending associated with attributed lives by payer and line of business*
   d. *Projected percentage growth rate or projected PMPM for 2018 for All-Payer ACO Model targets. If not available, please use prior years' data and describe.*

Please see Attachment A in Part 3 attachments titled ACO Program Elements by Payer for the 2018 Program Elements by Payer.

3. *If applicable, by payer and line of business, describe program arrangement(s) between the payer and the ACO including**
    a. *Full risk, shared risk, shared savings, other (please specify);*
    b. *The use of a minimum savings rate, minimum loss rate, or similar concept;*
    c. *The percentage of downside risk assumed by the ACO;*
    d. *The cap on downside risk assumed by the ACO, if any;*
    e. *The cap on upside gain for the ACO, if any;*
    f. *Risk mitigation provisions in the payer contract:*
        i. *Exclusion or truncation of high-cost outlier individuals (please describe)*
        ii. *Payer-provided reinsurance*
        iii. *Risk adjustment: age/gender, clinical (identify grouper software)*
    g. *Method for setting the budget target;*
        i. *Trended historical experience*
        ii. *Percentage of premium*
        iii. *Other (please describe)*

The following synopsis represents the current planned approach for the 2018 contract year as negotiations with payers, reinsurance brokers, and the provider network are ongoing:

Please also Attachment B in Part 3 attachments titled ACO Program Arrangements between ACO and Payer.

Medicaid

a. The 2018 OneCare budget plans for a full risk arrangement with Medicaid.
b. There is no minimum savings rate or minimum loss rate for this arrangement.
c. 100% of the downside risk is assumed by OneCare.
d. The downside risk is capped at 3% of the total cost of care (TCOC).
e. The upside savings potential is capped at 3% of the total cost of care (TCOC).
f. Risk mitigation provisions include:
    i. No truncation for Medicaid high-cost outliers.
    ii. The OneCare budget plan does include a commercial reinsurance expense. The details of this reinsurance plan are currently being explored. Possible models include pooled risk capitation as well as provider-specific capitation offered through OneCare.
    iii. No risk adjustments were included in the budget model.
g. The budget targets were set using 2016 actual spend data for the expected network and attributed population as the base and trended forward with the best OneCare actuarial guidance available at the time of the budget development. For Medicaid, OneCare has set its budget using a 3.53% trend for 2016 to 2017 and another 6.07% for 2017 to 2018. These trends will be negotiated and fall within a range supported by two actuarial firms. The 2017 to 2018 trend also includes an estimated factor to adjust for anticipated changes to the reimbursement structure for services provided at Dartmouth.

Medicare

a. Our budget includes a shared risk model under the Medicare Modified Next Generation Program. Although the OneCare budget plans for this 80% shared risk arrangement with Medicare, we may shift to a 100% risk arrangement for 2018 at a later date. It is at the Medicare Next Generation ACO's discretion to select either an 80% or a 100% risk-sharing arrangement prior to starting the performance year.
b. There is no minimum savings rate or minimum loss rate for this arrangement.
c. 80% of any downside loss is assumed by OneCare.
d. The downside risk is capped at 5% of the total cost of care (TCOC). It is at the Medicare Next Generation ACO's discretion to choose anywhere from a 5% to 15% "corridor" for which to cap savings or losses. OneCare has selected 5%. Within that 5% downside risk exposure, 80% is assumed by OneCare and 20% is assumed by Medicare. In effect, the total downside risk for the ACO is capped at 4% of TCOC based on a 5% overrun.
e. The upside savings potential is symmetric and is capped at 5% of the total cost of care (TCOC) and the same 80% sharing model for the downside risk applies to savings. In effect, the total upside savings potential for the ACO is capped at 4% based on 5% total savings.
f. Risk mitigation provisions include:
    i. Individual beneficiary expenditures capped by Medicare at the 99th percentile of expenditures to prevent substantial impacts by outliers.
    ii. The OneCare budget plan does include a commercial reinsurance expense. The details of this reinsurance plan are currently being explored. Possible models include pooled risk capitation as well as provider-specific capitation offered through OneCare.
    iii. No risk adjustments were included in the budget model.
g. The budget targets were set using 2016 data for the expected network as the base and trended forward to generate a 2017 projection and then trended forward again to project a 2018 target. OneCare used the best estimates available at the time of the budget development. For Medicare, a trend rate of 0.0% was applied for 2016 to 2017 based on OneCare analysis and actuarial review to establish a projection for 2017 actual expenditures as the "base year" for the All-Payer-Model's Modified Next Generation ACO program. To project a target for 2018 under that program, OneCare again applied a 3.5% trend rate from 2017 to 2018 but for different reason. OneCare applied the APM terms with best available information which indicates that the 3.7% trend rate floor and a 0.2% discount rate would apply for APM, and which we propose should be the term granted to OneCare.

Blue Cross Blue Shield of Vermont

IMPORTANT NOTE: OneCare Vermont and BCBSVT are in ongoing discussions on the nature and details of an expected 2018 risk program contract. Many elements remain in discussion and any assumptions made below and elsewhere by OneCare for budgeting purposes are subject to change, and it cannot be assumed that BCBSVT has agreed to these program assumptions.

a. The 2018 OneCare budget plans for a shared risk arrangement (50%) with Blue Cross Blue Shield of Vermont of Vermont.
b. For the purposes of budgeting, we have assumed there is no minimum savings rate or minimum loss rate for this arrangement.

c. Fifty percent (50%) of the downside risk is assumed by OneCare.
d. The downside risk is capped at 6% of the total cost of care (TCOC). Of that 6% downside risk exposure, 50% is assumed by OneCare and 50% is assumed by Blue Cross Blue Shield of Vermont. In effect, the total downside risk for the ACO is capped at 3% of TCOC.
e. The upside savings potential is symmetric and capped at 6% of the total cost of care (TCOC) and the same 50% sharing model for the downside risk applies to savings. In effect, the total upside savings potential for the ACO is capped at 3% of TCOC.
f. Risk mitigation provisions include:
    i. No truncation for high cost patients is assumed in the budget, but ongoing discussion with BCBSVT may add such risk protection provided by BCBSVT.
    ii. The OneCare budget plan does include a commercial reinsurance expense. The details of this reinsurance plan are currently being explored. Possible models include pooled risk capitation as well as provider-specific capitation offered through OneCare.
    iii. No risk adjustments were included in the budget model.
g. The budget targets were set using 2016 data for the expected network as the base and trended forward with the estimates developed in cooperation with BCBSVT and based on their overall Medical Expense Trend (MET) figures for their Qualified Health Plan (QHP) rate filings. These factors are 4.5% for 2016 to 2017 and 3.8% for 2017 to 2018. The actual contracted factors for the OneCare-attributed population to determine 2018 targets will be determined later in 2017 through actuarially-supported negotiations.

4. *By payer, describe proposed categories of services included for determination of the ACO's savings or losses, and if possible, projected revenues by category of service and type of payment model (e.g., FFS, capitation or AIPBP).*

Medicaid: For a summary of covered services included and excluded in the VMNG program for determination of the AIPBP payments to hospitals and the Total Cost of Care Spend please Section 3 (pages 22-25) at the following link. DVHA VMNG Contract Attachment A and B
http://dvha.vermont.gov/administration/onecare-aco-32318-final-searchable.pdf

For a list of Service Categories included and excluded in the VMNG program for determination of the AIPBP payments to hospitals and the Total Cost of Care Spend please see the following link. DVHA VMNG Contract Exhibit 1:
http://dvha.vermont.gov/administration/exhibit-1-to-attachment-a-service-codes-final.pdf

Medicare: Service categories included and excluded are in accordance with those outlined in the Medicare's Next Generation agreement, generally described as Part A and B services for aligned beneficiaries.

BlueCross Blue Shield of Vermont Service: Categories are still being determined as part of contract negotiations.

5. *By payer, describe how the proposed ACO benchmark, capitation payment, AIPBP, shared savings and losses, or any other financial incentive program are tied to quality of care or health of aligned beneficiaries*.*

   Please see Attachment B in Part 3 Attachments for a copy of OneCare Vermont's Value Based Quality Incentive Fund Policy.

6. *By payer and line of business, provide a comprehensive list of ACO quality measures that will, or are proposed to, affect payment or be monitored, according to the terms of the agreement with the payer. For public payers, the applicant may provide a link to publicly-available materials. Provide the most recent annual ACO quality reports for measures included in agreements with payers*.*

   Medicaid: For a comprehensive list of the ACO quality measures that are required by VMNG please see pages 85-91 in Section J of Attachment B at the following link. DVHA VMNG Contract Attachment A and B:
   http://dvha.vermont.gov/administration/onecare-aco-32318-final-searchable.pdf

   Medicare: The Next Generation ACO Model Quality Measures and Narrative Specifications can be found at the following link:
   https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/2017-Reporting-Year-Narrative-Specifications.pdf

   Blue Cross Blue Shield of Vermont: The Risk Based Program quality measures are currently being discussed as part of negotiations.

7. *By payer and line of business, describe the current or proposed methodology used for beneficiary/member alignment (also known as attribution). If these differ significantly by payer, please describe. Complete a master table in template to be provided of attribution for each program and by Health Service Area (HSA)*.*

   Medicaid: To see the Attribution Methodology for the VMNG program, please see Section 1 (pages 4-9) at the following link:
   http://dvha.vermont.gov/administration/onecare-aco-32318-final-searchable.pdf

   To see the Attribution Technical Specifications for the VMNG program please visit the DVHA VMNG Contract Exhibit 2:
   http://dvha.vermont.gov/administration/exhibit-2-to-attachment-a-evaluation-managment-services-final.pdf

   Medicare: The Next Generation Program Beneficiary Alignment can be found on pages 20-24 at the following link:
   https://innovation.cms.gov/Files/x/nextgenaco-rfa2018.pdf

Blue Cross Blue Shield of Vermont: The Risk Based Program Attribution Methodology is currently being discussed as part of negotiations.

GMCB Questions for OneCare Vermont
Part 3

For answers to questions for Sections 3 and 4, please see Section 4

Part 3
Attachments

Attachment A – ACO Program Elements by Payer

Attachment B – ACO and Payer Program Arrangements

Attachment C – OneCare Vermont Value Based Quality Incentive Fund Policy

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Green Mountain Care Board, 2018 Budget Resubmission

Part 4: ACO Budget and Financial Plan

1. *Submit most recent audited financial statements and profit and loss statement, including balance sheet, that show at a minimum: assets, liabilities, reserves, sources of working capital and other sources of financial support*.*

   Prior to the 2017 VMNG contract, OneCare was not required to undergo an annual financial audit. In conjunction with that contract, OneCare will face an audit for the 2017 fiscal year. The results of that audit can be provided to the GMCB after completion.

   The 2016 final financial statements and balance sheet summary have been included with this submission. Please see Attachment A Part 4 Attachments.

2. *Submit financial data on 2016 performance under any contracted shared savings, shared risk or full risk payer contracts, inclusive of medical and administrative expenses, by payer. If 2016 performance data is not available, please submit 2015 and supplement with 2016 when available*.*

   The latest available 2016 shared shavings results for Medicaid and Commercial have been included with this submission. Please see Attachment B in Part 4 Attachments.

3. *Answer a or b, according to your type of contractual agreements with payers*:*

   a. *For ACOs who have fewer than 10,000 attributed lives or who are not taking risk, in aggregate forecast for July 1, 2018 across all lines of business, submit the ACO's medical expense and administrative expense budget for 2018.*

   b. *For ACOs with 10,000 or more attributed lives or taking risk in aggregate forecast for July 1, 2018 across all lines of business, provide, as an attachment, a completed* ***Appendix C – 2017 and 2018 ACO Projected Cost and Revenue Data Templates****. This will ask the ACO, by payer and line of business, to provide information on projected revenues and expenses to flow through the ACO financial statements (including payer revenues, participating provider dues, and grant funding), medical costs and administrative costs (including contracted services, community investments and contribution to reserves), in total dollars and per member per month (PMPM) dollars when applicable. The GMCB may request additional information or copies of grants or agreements as part of the review.*

      These templates have been included with the submission. Please see Attachment C "Complete ACO Projected Cost and Revenue Data Package" in Part 4 Attachments.

4. *Provide a narrative description of the following elements of the ACO's spending plan.*
    a. *ACO industry benchmarks used in developing the administrative budget;*
    b. *The methodology determining the qualification and amount of eligible provider incentive payments;*
    c. *Planned spending on SASH and Blueprint for Health by payer (including practice payments and Community Health Team payments), in comparison with 2016 and 2017 spending levels;*
    d. *Strategy and spending on community investments (e.g. early childhood development, housing, mental health, substance use, and other services that address social determinants of health);*
    e. *Strategy for planned spending on health information technology, at the ACO level and to support individual providers;*
    f. *Budget assumptions related to service utilization, including anticipated changes from prior years' utilization, including anticipated changes in care delivery including but not limited to new and innovative services, service mix, value-based payment model adoption (including risk assumption); and*
    g. *Anticipated changes in provider network configuration, and the expected impact on service utilization.*

    a. At present, the OneCare administrative budget is based on the requirements to achieve its strategy as a risk-bearing, multi-payer, statewide ACO. OneCare's Finance Committee and Board of Managers, which consists of participants from OneCare, approve the annual budget and any material changes occurring mid-year. We provide benchmarks in two ways:
        - First, we review managed care "per member per month" (PMPM) operations benchmarks from Sherlock Company, the national leader in such benchmarking. Based on our proposed budget for 2018, the OneCare total PMPM for operations (excluding budgeted reinsurance policy expense) is $7.47 PMPM. OneCare's analysis shows the Sherlock Company expected range to be $6 PMPM to $8 PMPM based on ACO-applicable categories for medical management, provider network management, and administration including finance and information systems. In addition, OneCare is currently engaged with the Sherlock Company and other ACOs to pilot an ACO-specific administrative cost benchmark study.
        - As a second benchmark exercise, we apply a "percent of premium" approach. In this approach we divide OneCare administrative expense into the total of our payer risk targets plus those administrative expenses. Based on our proposed budget for 2018, we calculate the OneCare percent of premium as 1.8%. This is less than one tenth of the ACA-mandated limit of 15% based on a minimum medical loss ratio of 85%. Those guidelines apply to health insurers who have many more requirements and processes than an ACO, but those plans are also allowed to account for quality improvement activities as Medical expense rather than as administrative expense. If OneCare were to do the same, the 1.8% would shrink further. Our conclusion is that our expenses are well within, and likely below, an expected "percent of premium" range for a risk-bearing ACO of our size.

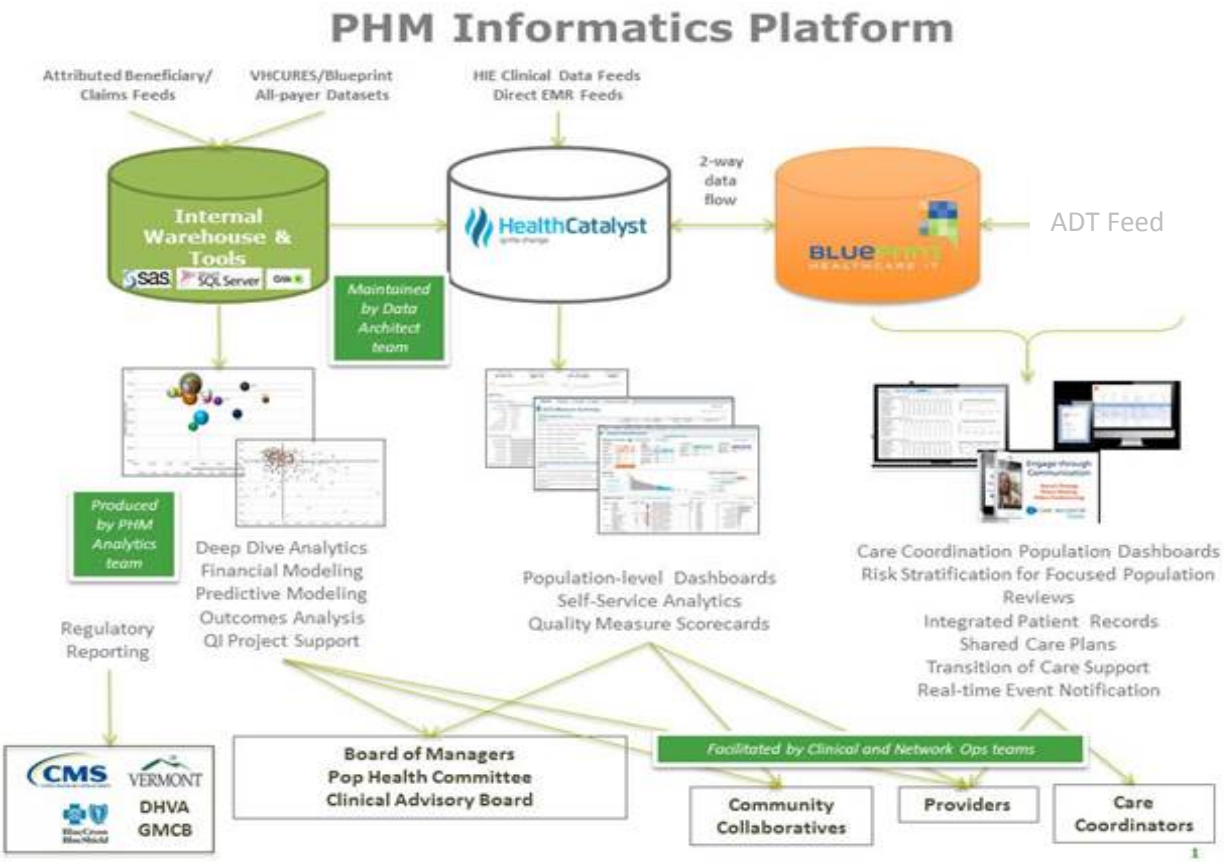
b. Please see attached quality incentive payment policy for Medicaid that will be used for all other government and commercial payers. This policy once expanded will need to be amended and approved by our Board of Managers.
c. For Medicare, OneCare, as the risk bearing ACO, intends to continue to fund SASH and Blueprint payments (CHT and practice-level) at the 2017 levels plus an inflationary rate of 3.5%.
d. All of OneCare's investments, which we believe should include our Population Health Management programs with aligned payment reform, must be reviewed by the OneCare Finance and Population Health Strategy Committees and ultimately approved by our Board of Managers. We have attached to this document our list of planned initiatives and a table below outlining the full financial value of each. These programs for 2018 support population management activities from prevention to chronic illness to high risk poly-chronic patients, and provide for support (both clinical and financial) to the full continuum of care, from primary care to designated agencies.

PHM/Payment Reform Prgm.	**Investment Amount**
Value-Based Incentive Fund	$ 4,305,223
Basic OCV PMPM	$ 4,781,010
Complex Care Coordination Program	$ 7,064,722
PCP Comprehensive Payment Reform Pilot	$ 1,800,000
Community Program Investments	$ 1,577,600
CHT Funding Risk Communities	$ 1,771,057
CHT Funding Non-Risk Communities	$ 747,841
SASH Funding Risk Communities	$ 2,364,691
SASH Funding Non-Risk Communities	$ 905,263
PCP Payments Risk Communities	$ 1,255,720
PCP Payments Non-Risk Communities	$ 717,929
Total	**$ 27,291,056**

Also please see Attachment D "Population Health Programs Grid" in Section 4 Attachments for more information.

e. OneCare has and will continue to invest in health information technology in order to support participants in their desire to enter into contracts that hold them accountable for the cost, quality and experience of care. The Informatics capabilities are provided through partnerships with Health Catalyst, BluePrint HIT's Care Navigator, VITL and the BluePrint for Health to deliver best in class solutions. The informatics platform provides a mechanism for combining claims and clinical data from all ACO participants to perform advanced analytics and support clinical decision making. Reporting tools and skilled analysts can deliver cost, utilization and quality information in an actionable and timely manner to develop new

models for reimbursement of services. In 2017 and to be expanded in 2018, OneCare is shifting to a deployed toolset for network self-service in addition to our central support capabilities. The OneCare PHM Platform provides full-scale informatics and analytic services to our network. (See the following diagram)



f. There are no assumptions built into the budget model. We believe our program targets will be actuarially sound and represent the expected spend in 2018. We hope our programs and the strength of the incentives under the risk programs will lead to successful efforts on prevention and wellness, avoidance of waste, and innovation on lower cost care delivery. We felt no basis to accurately predict the success of those efforts, and with the fixed revenue models would have no direct impact to our revenue budget as proposed and such savings would accrue to network members as the central theme of population-based payment reform.

g. In May, OneCare requested that providers submit to OneCare a Letter of Interest (LOI) if they wanted to pursue a risk based program contract through OneCare in 2018. The LOI was non-binding. Participants will have until September 8, 2017 to declare if they would like to withdraw from the risk bearing program(s). To best project our budget for the 2018 Medicaid and BCBSVT programs with a network consisting of those submitting the LOI, we requested and received planning data sets representing the attributed members of those providers. For Medicare, we used existing Medicare Shared Savings Program data with selected assumptions where necessary for the presumed 2018 network.

NOTE: Review of multi-year, historic OneCare financial models included in the budget spreadsheets will include the shifts in OneCare's provider network and the resulting financial and utilization variability over time and into 2018.

5. *Provide a narrative description of the flow of funds in the system. The description should include the flow of funds from payers to the ACO, and from the ACO to its providers. The description should demonstrate the ability of the ACO to maintain sufficient funds to support its administrative operations and meet provider payment obligations.*

   The budgeted programs with payers are budgeted to include a two-part funds flow from payers and to providers. The approach is based on the All-Inclusive, Population-Based-Payment (AIPBP) method included in the Medicare Next Generation Program. In this approach, the ACO can select one or more ACO-contracted participant providers (identified at the TIN level) to be included in a monthly prospective payment stream. All other providers, whether contracted with the ACO or not, will receive regular payer-administered, fee-for-service (FFS) payments. We have assumed in our budget that the AIPBP model is available for all three programs, although discussion with BCBSVT is still assessing their operational readiness for the model in 2018. Our budget further includes the assumption that we will only include the ACO-participating **hospitals** in the prospective payment system from the three payers, with all others remaining FFS. Final decisions on which providers to include in the prospective payment will be made later in 2017. Our budget projects that for those hospitals included in the prospective payment system, OneCare will pay each a calculated component of that payer payment stream applicable to their individual hospital. This payment shall represent a fixed "pre-payment" for all services rendered to the OneCare-attributed populations during that month. Such a model represents the sharpest incentive for hospitals to move away from volume-based FFS optimization.

   The prospective payment concept is designed to meet the cash flow requirements of both the providers and OneCare. It is anticipated that the payer-provided payments will be made in a timely enough fashion to not harm the revenue cash flow to the hospitals included. In the current VMNG program, DVHA make payments to OneCare in advance of the month for which the payment is made and OneCare, in turn, distributes the fixed prospective payment and any other payments due to providers shortly thereafter. Any dues or quality incentive components can be withheld from these payments and will be distributed by OneCare in accordance with the Board-approved programs and provider contract terms.

6. *Provide a quantitative analysis with accompanying narrative to demonstrate how the ACO would manage the financial liability for 2018 through the risk programs included in Part 3 should the ACO's losses equal i) 75% of maximum downside exposure, and ii) 100% of maximum downside exposure. As part of the narrative response, describe your full risk mitigation plan to cover this liability and the mitigation plan for any contracted providers to which risk is being delegated or with which risk is being shared. This response is to include, but is not limited to:*
   a. *Portion of the risk covered by reserves, collateral, or other liquid security whether established as a program contractual requirement or as part of the ACO's risk management plan;*

b. *Portion of the risk delegated through fixed payment models to ACO-contracted providers;*
c. *Portion of the risk covered by ACO providers through mechanisms other than fixed payment models (e.g., withholds, commitment to fund losses at annual settlement, etc.);*
d. *Portion of the risk covered by reinsurance;*
e. *Portion of the risk covered through any other mechanism (please specify);*
f. *Any risk management or financial solvency requirements imposed on the ACO by third-party health care payers under ACO program contracts appearing in Part 3.*

Payer	Fixed Hospital Payments	Remaining FFS	Total Cost of Care	75% Maximum Downside Risk	100% Maximum Downside Risk
Medicare	$227,035,651	$120,204,625	$347,240,276	$10,417,208	$13,889,611
Medicaid	$80,313,840	$38,519,455	$118,833,295	$2,673,749	$3,564,999
BCBSVT	$99,118,828	$34,276,890	$133,395,719	$3,001,404	$4,001,872
Total	**$406,468,319**	**$193,000,971**	**$599,469,290**	**$16,092,361**	**$21,456,481**

Providers participating in the risk programs are not currently required to maintain any collateral reserves. In the 2018 budget model, 68% of the Total Cost of Care (TCOC) risk is delegated through the hospital prospective payment model as described in the previous section. Hospitals, by contract, will deliver services to the OneCare attributed population under this fixed model, and will absorb the cost of any excess utilization required which to the hospital will be at the true variable cost to deliver such care. This model shields the ACO from any losses on the majority (68%) of the spending target. For the remaining amount which remains Fee-For-Service (FFS), it would then take a 7.2% overrun on those services to reach 75% risk liability, and a 9.5% FFS overrun is required to reach 100% risk liability. We believe it unlikely to approach outcomes in this range, but we must have additional plans to fulfill the obligation if owed. To do this, our budgeted risk model assumes the Health Service Area's (HSA's) hospital also bears all risk for the FFS spending on the attributed population of that HSA, regardless of which provider attributed the lives in that community. Ultimately, each contracted hospital must be willing to accept the risk for their actual HSA FFS overrun up to the maximum risk corridor. Throughout the year, OneCare will monitor actual results against spending targets and provide risk-bearing hospitals the information necessary to manage both their financial statements and reserves as needed. To lower the maximum downside risk, a reinsurance premium estimate is included in the OneCare budget to protect its risk-bearing hospitals. The details of this reinsurance protection are currently being explored, but may include large-case coverage and/or reinsurance coverage of an upper-level band of the maximum risk on the total cost of care.

7. *Provide actuarial certification that the risk-bearing arrangements between the ACO and payers are not expected to threaten the financial solvency of the ACO.*

OneCare has enlisted Milliman to provide the actuarial guidance for budget modeling. However, due to the number of remaining variables at play, it is premature to seek actuarial certification. After the provider network is finalized and final trend analysis has been produced and negotiations are complete with payers, OneCare can update the GMCB with any actuarial certifications for 2018.

GMCB Questions for OneCare Vermont
Part 4

1. *OneCare is expecting certain hospitals to assume a significant amount of the ACO's risk in 2018 and a budget of $467M in total.*
    a. *Are all the hospitals bearing the same amount of risk? If not, please explain in detail which are and by how much.*

    Each hospital is subject to a risk level calculated by applying the risk corridor to their specific TCOC for each payer program to the attributed lives in that hospital's Healthcare Service Area (HSA). The dollar amount of risk exposure does vary depending on the size and payer mix of the hospital/HSA, but the same methodology is used to determine their maximum risk level. Please see the attached OneCare Savings/Losses Policy for further details relating to the sharing of risk.

    b. *Are the risk-bearing hospitals yet able to assess how they are doing financially in 2017 for the Medicaid contract? If so, what are they finding?*

    Yes. Each month OneCare produces a financial report that shows total VMNG performance, hospital fixed payments compared to shadow claims, and non-hospital FFS compared to budget targets. These reports are shared at the OneCare finance committee meetings, which have representatives from all risk-bearing hospitals. Thus far hospitals are seeing that they are doing well under the fixed payment model and the payments remaining FFS under the TCOC is over target.

    c. *Page 29 of the submission indicates that hospitals will be at risk for all FFS spending in their HSA. Is this included in the $467M projection? Why does OneCare believe that the hospitals will be able to manage this risk?*

    The hospitals bear two segments of risk. One is under the Fixed Prospective Payment for the services they deliver to the local attributed population. In this part of the risk model, they may either deliver fewer services than expected or more. This risk however is based on the actual variable cost to deliver those services, therefore utilization overruns are much less painful, although the variable cost for the extra utilization will affect margin since there is no corresponding increased revenue. The second segment of risk is covering the FFS spending under the TCOC for the locally-attributed population. This includes a combination of local providers who remain FFS and out of area providers both within Vermont and outside of Vermont. In this risk, the hospital is responsible for the FFS claims expense for any excel utilization up to the maximum risk level. The budget model projects that each HSA lands exactly on their spending target, and we do not assume any savings or losses driven by utilization being either lower or higher than the projected TCOC. The actuarial TCOC targets are based on OneCare's best estimate of where their actual spend would land in a "pure FFS model" and we do not budget for any expected shared savings or losses.

    d. *It appears that the 2018 maximum exposure to the ACO is $27.5M maximum. Of that, $16.8M is to be borne by hospitals. There are no risk mitigation requirements that OneCare*

has placed on providers assuming downside risk to ensure the affected providers are protected in the event of the maximum possible contractual loss. Why?

In the OneCare Savings/Losses Policy the hospitals are subject to the full $27.5M of risk. The strategy to ensure that hospitals are protected in the event their HSA has a poor year against the spending target, each hospital's risk maximum is calculated by applying the risk corridor to their specific TCOC for each payer program. This model keeps the worst-case payback scenario affordable for hospitals and is not expected to jeopardize their solvency.

e. *Please provide evidence that the network hospitals are financially capable to absorb the TCOC risk delegated through the hospital prospective payment model AND the additional FFS downside risks. Page 29 of the submission document says reinsurance will be utilized to protect risk-bearing hospitals. Can you explain what you are planning?*

OneCare has been transparent with the budget models and maximum risk estimates, which allows individual hospitals to assess the possible impact of a worst-case scenario of downside risk payback. OneCare is pursuing reinsurance to cover losses at an attachment point to-be-determined in top half of ACO-level risk in the event of widespread overruns. However, since the reinsurance applies to ACO-wide performance, HSA-level maximum risk still applies since only one HSA may have maximum poor performance but isn't enough to trigger reinsurance coverage. Please see the attached OneCare Savings/Losses Policy for further details relating to the sharing of risk.

f. *OneCare reports exploring "pooled risk capitation" and "OCV-offered provider-specific capitation" for reinsurance. Can you explain these options?*

In the context of reinsurance, pooled risk capitation refers to ACO-level coverage for the blend of all overspending, regardless of which HSA(s) exceeded targets. Provider specific coverage would protect each HSA individually. Our efforts to place HSA-level coverage have been unsuccessful.

Note, the question is similar to the Health Care Advocate's first question from their July 6, 2017 memo:

2. *In your budget narrative, you state that there are no assumptions built into the budget model. Please explain what this means (i.e., did you assume spending would continue as would have been expected under fee for service?).*
    a. *Do you anticipate service changes such as a reduction in emergency department use and/or an increase in use of primary care? If so, does this budget take any such changes into account?*

The budget model projects that each HSA lands exactly on their spending target, and we do not assume any savings or losses driven by utilization being either lower or higher than the projected TCOC. The actuarial TCOC targets are based on OneCare's best estimate of where their actual spend and utilization would land in a "pure FFS" model and we do not budget for any expected shared savings or losses. However,

we do fund primary care and community-based payment reform by redirecting a portion of the expected spending on hospital-based acute care services, thereby creating an incentive for hospitals to capture cost savings in these services to keep the same margin. The primary care and community-based payment reforms are designed to drive prevention and patient engagement, which can lower acute care utilization. We have not budgeted such reductions at this time but may do so in order to set targets for such reductions which can be pursued.

b. *What differences in care processes do you anticipate as you move from shared savings to capitation?*

The hospitals are being asked to "live within their means" in a capitated model. This paradigm shift is starting to change the thinking from a volume-based approach to a value-based strategy where wise care-delivery choices are critical to success. This means that hospital are incentivized to pay attention to lower cost settings of care, wellness and prevention, proactive engagement with those with known illnesses, referral patterns, sub-acute care strategies, readmission rates, facility efficiencies, etc..

In tandem, OneCare Vermont's clinical initiatives focus on the highest risk, and therefore most costly, lives in the network. A core strategy to manage network-wide spend is to "wrap" around those highest risk lives and incorporate all continuum of care providers through shared care planning and case management. This approached aims to better manage the patient's health, and thus reduce both short and long-term cost.

c. *How confident are you in your budget projections? Where are the areas of greatest uncertainty?*

Overall, the budget projections represent reasonable expectations for the 2018 plan year. The area of greatest uncertainty for the initial submission was the network composition. In the spring of 2017 OneCare asked statewide healthcare delivery providers for their interest in being modeled in the budget. With this came no commitment; these providers would ultimately have the option to join the network and for which payer programs at a later date (after the initial GMCB budget submission). If a substantial portion of the network decided not to move forward with OneCare in 2018, it would have a material impact on the overall OneCare budget and network-wide risk exposure. Additionally, we have uncertainty driven by attribution projections and incomplete claims history for that projected attribution. On attribution, we do not know who will remain covered and qualify for attribution into 2018. On projecting trends and targets, we are especially concerned with Medicare where we do not have any claims history for the attributed lives from new OneCare attributing providers. Although we have made some educated assumptions on attribution and spending patterns, Medicare does not provide prospective planning data sets to ACOs.

Please explain the following from the financial table submissions:

3. *Appendix C projected medical costs PMPM by line of business are not consistent with actual CY16 experience for Medicaid and commercial. Can you help us understand the basis for the projections if not CY16 experience?*

   We chose to show the trend for just the expected ***2018*** OneCare lives on the budget forms. Mechanically, after projecting the 2018 attribution we look back and pull the actual cost of care for these lives in the base year (2016). Then, that figure is trended forward per actuarial guidance or contract terms. Presenting the data in this manner more clearly highlights the TCOC trends OneCare is applying.

   In actuality, the prior years had upside-only programs in place with a different network composition. In aggregate, comparing those programs to the 2018 two-sided programs and a materially different provider network would not provide a consistent evaluation. The comparison of spend in this manner adds a moving part that clouds the overall trend analysis.

4. *The Vermont All-Payer Accountable Care Organization Model Agreement states: During the baseline year of 2017, CMS will include $7.5M in the Vermont Medicare Total Cost of Care per Beneficiary Growth and All-payer Total Cost of Care per Beneficiary Growth calculations, approximately the sum of Medicare payments made to Vermont providers in 2016 as part of the Multipayer Advanced Primary Care Practice demonstration. The $7.5 million Medicare Infrastructure payments should be included in your 2017 baseline benchmark, consistent with the language above. Tables should be adjusted to represent the 3.5% percentage growth you are requesting for Medicare as opposed to 5.3%. Please make this change throughout templates in Appendixes B and C.*

   We made a judgment call on how to best portray this. With no actuarial claims in our 2017 base model for the $7.5M since the MAPCP payments from Medicare ended in 2016, we chose to start with actual expected Medicare claims spend for 2017. We will shift to including the $7.5M in the base and then apply the 3.5% since that appears above to be the GMCB preference.

5. *Appendix B-2 was modified and displays -$17,450,770 in population-based prospective payment revenue. Please explain what this represents.*

   Note: I believe this question refers to Appendix C-2 instead of B-2 and the response is answered thusly.

   The $17.5M figure represents the deductions from hospital fixed payments to fund the OneCare Vermont population health management/reform programs and operations. However, while the hospitals are contributing $17.5M to these reform initiatives, they are also recipients of funding from these programs. After factoring in the dollars flowing back to hospitals as a result of their participation, the net investment in OneCare is reduced to $7.5M

6. *Appendix B-3 shows the following:*

a. *There are only professional SUD treatment payments in Medicaid, and not commercial or Medicare. Why? Do you have plans for investment in SUD treatment programs?*

The distribution of these funds is based on the historical spend profile by payer and is not a representation of OneCare care-delivery investment choices. Also noteworthy is that federal health information privacy laws place restrictions access on SUD claims data. As a result, OneCare's access to detailed SUD data is very limited.

OneCare would like to be a contributing partner in the statewide effort to address substance use. This issue can be well-integrated with the population health management approach OneCare aims to implement and success in this arena would both benefit Vermonters and help the OneCare network succeed in in two-sided risk programs.

b. *There are $1.7M in incentive payments to "Continuum of Care". What does this represent?*

These are dollars from OneCare population health management programs that will flow to non-hospital and non-primary care providers such as DAs, home health agencies, area agencies on aging, etc. The initiatives directing dollars to these entities are the Complex Care Coordination Program and the Value Based Incentive Fund.

7. *Appendix B-5 depicts the administrative budget.*
   a. *There is no expense for claims administration. How is that function being funded?*

OneCare will not be adjudicating or paying any FFS-type claims. Rather, all providers will submit claims to the payers (Medicaid, Medicare, BCBSVT) as they ordinarily would and if the claim is captured under a fixed payment the adjudicated claim will remit as usual but with no plan payment dollars flowing with it. OneCare and the payers will monitor these zero pay claims against the spending targets to evaluate program performance. For all other providers, the payers (not the ACO) adjudicate and pay the claims as usual under FFS, and such payments are accrued against our overall population cost targets.

   b. *What is "ACO Programs Team"?*

This team is responsible for ensuring all the requirements of the Next Generation style programs (for Medicare, Medicaid, and BCBSVT) are met. This includes coordination of all reporting, compliance, communications, and other requirements that are part of these initiatives.

   c. *For Informatics, $2.9M is to be spent on contracted services, including $1M to Health Catalyst and $.9M to VITL. How is the remaining $1M to be spent?*

This $1M includes a number of comparatively smaller expenses. There are license fees for software tools such as the John's Hopkins ACG grouper, Qlik, 3M PPE Groupers, and Network Navigator. Also included in this amount is planned spending on upgrades to the Health

Catalyst platform to help with our transition to Next Generation style two-sided risk programs and support a risk-bearing network.

d. *Are there any planned major capital expenditures not captured in the report templates?*

OneCare has no planned major capital expenditures in 2018.

8. *Please describe the nature of the liabilities listed that are due to each partner, D-H H and UVMMC. Please specifically address the $1.4M negative liability of "Due to D-H H - CY16" shown in Statement of Assets, Liabilities & Equity 12/31/16 of A. 2016 OneCare Final Financial Statement and Balance Summary Sheet.pdf.*

In the formative years of OneCare, the founders contributed to operations as "services in kind" and then quantified and split between the founders on a due-to/due-from basis. The amount owed to/from DHH and UVMMC for 2016 has since been settled/aid and is no longer reflected on the OneCare balance sheet.

Additionally, as a means to manage cost and create efficiencies, OneCare leverages some of the existing UVMMC systems resources such as payroll, accounts payable, accounts receivable, etc. Because of this arrangement, UVMMC pays the OneCare payroll (along with some other expenses) and those charges are booked as a Due To UVMMC. Periodically UVMMC and OneCare process cash transfers to reconcile.

9. *It is unclear whether the sources of working capital (UVM MC, D-H H and participants) are committed to sustaining operations. Would you please speak to plans for 2018?*

UVMMC and DHH are both committed owners. That said, OneCare's aim is to operate in a self-sufficient manner that does not require ongoing capital investment or working capital from the founders (with the operational efficiencies discussed in Question 7 excluded). The 2018 OneCare budget relies on revenues from payers and the ACO monthly prospective payment cash flow from the payers for hospital services. We have chosen with advice and consent of the OneCare hospitals, to take deductions from the hospital fixed payments to fund budgeted programs and operations "off the top" rather than pay the hospitals only to immediately invoice them for required contribution or fees.

10. *Please provide total operating expenses and annual depreciation for 2016.*

2016 Operating Expenses: $9,284,101
2016 Depreciation: $0

11. *Please describe why your debt ratio shown in your The Statement of Assets, Liabilities & Equity 12/31/16 (calculated as total liabilities/total assets) does not indicate a potential organizational solvency concern.*

OneCare Vermont has no long-term debt obligations. The liabilities on the balance sheet represent only timing-based short-term debts owed to either providers or the founders.

12. *"Vermont Medicaid ACO Shared Savings Achievement and Distribution - Year 3" of "B. 2016 Shared Savings Results for Medicaid and Commercial Programs.xlsx" showed that the actual spending for year 3 is larger than the expected spending.*
    a. *What are the primary drivers that led the actual spending to exceed the expected spending in Year 3 for Medicaid ACO savings?*

       Analysis shows an increase in utilization rates for Outpatient Facility services PKPY and High Cost Imaging PKPY and an increase in costs for Professional Specialty Care from 2014-2016 primarily drove the 2.06% overrun.

    b. *What programs or changes have been or will be put in place to aim toward a shared savings payment in 2017 and beyond?*

       In July 2017 OneCare Vermont launched the Complex Care Coordination program and targets the high and very high risk Medicaid covered lives in the network. By wrapping around these complex cases, the program aims to mitigate spend through more proactive and preventative care.

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

       In addition to clinical programs, OneCare Vermont has developed tailored applications that help both internal and external parties monitor financial performance. The application bridges the gap between the clinical service delivery patterns and the overall cost of care provided in the program. Having access to this type of data helps to highlight both trends and opportunities.

13. *"Vermont ACO Pilot Calculation of Commercial ACO Savings - Year 3 Calculation of Actual Medical Expenses" of "B. 2016 Shared Savings Results for Medicaid and Commercial Programs.xlsx" showed that there are no Year 3 Commercial ACO Savings.*
    a. *What are the primary drivers that lead the actual spending to exceed the expected spending in Year 3 for Commercial ACO savings?*

At this point in time the 2016 Commercial ACO program results are still being vetted in collaboration with OneCare, BCBSVT and the GMCB. After the data has been reconciled a final analysis of results will be prepared.

b. *What programs or changes have been or will be put in place to aim toward a shared savings payment in 2017 and beyond?*

In 2017 OneCare Vermont and BCBSVT began quarterly quality, clinical initiative and utilization review meetings. These meetings bring together the CMOs of both OneCare and BCBSVT, clinical program leaders from both organizations, and key members of the analytics and quality teams. This forum provides the opportunity to partner with BCBSVT to review performance trends during the performance year, opportunities for improvement, and setting specific improvement areas for both organizations to prioritize and monitor progress.

Also, the efforts described under the Medicaid program question above around episodes of care and disease states have been applied in an "all payer" approach. This will offer the same benefits to BCBSVT attributed populations.

Also worthy of note is that the Complex Care Coordination program being piloted with Medicaid in 2017 will be expanded in 2018 to include the high and very high risk lives in the BCBSVT covered population of the OneCare Vermont network.

14. *Please comment on the future availability of the other revenue sources listed in "T6 ACO Other Revenue" of Appendix C.*

That category has a mix of funding streams expected to continue into future years and those which are/were time-limited awards. OneCare is continuously working with payer partners including DVHA to source additional resources to fund evidence-based population health management programs which drive value through lower utilization, higher quality, or both.

15. *Please include 2016 budget numbers in Appendix C.*

The 2016 budget numbers have been added to tab T5 in Appendix C.

16. *Please further explain why OCV believes the program targets to be actuarially sound.*

OneCare Vermont employs the expertise of Milliman to evaluate trends in our program spending patterns. Their analysis segments historical costs by service types using their proprietary methods and develops micro trends within the dataset that aggregate to an overall trend rate for each payer. Because their analysis looks at only the expected OneCare Vermont population, their trends represent a tailored analysis. Both OneCare and Milliman analysis however is limited to available data and must include some required assumptions on final 2018 attribution. For Medicare, we do not have any base data for attribution and spending/claims history for new providers joining OneCare in 2018.

Additionally, in collaboration with our payer partners, the attribution and targets will be revised via iterative processes through the 2018 performance year go live to ensure that benchmarks are set based on the latest available data, and reflect beneficiaries/enrollees/members with continued coverage.

17. *Regarding the trend rates to project 2016 spend to 2018 for the three lines of businesses, please describe if the following items have been considered while setting the trend rates:*
    a. *Adjustment for significant changes in attributed lives?*

       The spending targets are reflective of projected 2018 attribution for the network which signed contracts to proceed in 2018 programs. Where claims data for analysis and planning does not exist, we must make informed assumptions on some populations.

    b. *Adjustment for historical changes in population clinical risk?*

       The actuarial trend analyses used to inflate from the 2016 base year do consider an evaluation of risk scores and an adjustment if actuarially recommended. However, there are no prospective adjustments for expected changes in risk profile across the network in the 2018 model.

    c. *Adjustment for changes in provider rates and/or service coverage?*

       The actuarial trend analyses used to inflate from the 2016 base year do consider rate adjustment factors separately from utilization. Additionally, any known changes in provider/payer rates are separately built into the TCOC targets as adjustments.

    d. *Adjustment for high-cost patient outliers?*

       The Medicare Next Generation program comes with individual patient spent truncation if their annual cost exceeds the national 99th percentile. This is factored into the process to set the 2018 benchmark. There is no truncation for Medicaid or BCBSVT under current expectations for our 2018 contracts. OneCare is still exploring the possibility of buying high-cost case reinsurance or negotiating truncation into the Medicaid and BCBSVT program terms for the 2018.

18. *What are the differences between "Revenue Trend for Just Lives in 2018 Budget Model" and "Actual OCV Programs (Multiple Moving Parts)" in "T1 ACO Revenues by Payer" tab of Appendix C?*

    The former provides an isolated breakdown for the lives OneCare expects to be in the 2018 network. For those lives, the 2016 actual and 2017 projection represents the actual spend and projection *only for those specific lives*, which more clearly illustrates the trends used in the budget model. This methodology projects trends and targets for those beneficiaries/enrollees/ members with expected continued coverage into 2018. Those who no longer have coverage will

not be eligible for attribution for 2018 and therefore their spending history is largely irrelevant to the budget exercise to project the 2018 targets.

The second section is the 2016 actual and 2017 projection for the actual OneCare operations in those years, representing the networks participating and their attributed lives who had coverage at that time. This does not provide a basis for fair comparison because the network configuration and patient enrollment was different than what is expected in 2018.

19. *Please further describe the projected 2018 PHM / Payment Reform Programs of -$17,450,770 (cell AM39) and $5,559,260 (cell S39) of "T2 ACO Costs by HCP-LAN APM" tab.*

The $17.5M figure represents the deductions from hospital fixed payments to fund the OneCare Vermont population health management/reform programs and operations. Included in this amount is funding for the OCV participation basic PMPM ($3.25), the complex care coordination program, the value based incentive fund, the comprehensive primary care pilot, and general operations.

The $5.5M figure is the redistribution of the value based incentive fund. Prefunded from hospital fixed payment deductions, OneCare will have a $5.5M pool of dollars to distribute based on the outcome of quality measures and report cards defined by our payer programs. Because these measures are highly impacted in the primary care setting, the majority of the value based incentive fund will be distributed to primary care providers.

20. *What are the projection assumptions in "T3 ACO Medical Costs by Service"?*

This breakdown is reflective of the historical spending distribution and does not incorporate any assumed changes at this time. The 2016 spend distribution is then trended forward using the payer-specific trends to populate this view.

21. *Why does cell BY52 of "T4 ACO Medical Costs by APM" not match cell AM41 of "T2 ACO Costs by HCP-LAN APM"?*

This was due to a different interpretation of what was being requested, and based on a good faith decision on how best to populate our initial GMCB budget. On tab T2 ("ACO Payments by HCP-LAN Alternative Payment Model") the figures reflect the actual budgeted ACO payments to providers by category. On tab T4 ("ACO Medical Costs, by Service Type, by HCP-LAN Alternative Payment Model") only the medical costs are reported. Because of this change in perspective the numbers neither tie in aggregate nor in those particular cells.

In the revised version the perspectives has been aligned so that these cells now reconcile.

22. *For Medicare, please describe the nature and structure of the existing "Medicare Shared Savings Program data" being used and the development of the selected assumptions as stated on page 27 and 28 of "GMCB ACO Budget Submission Final.docx".*

The Medicare data currently flowing through OneCare is used to try to replicate the methodology CMS will use to set the ACO PMPM target. There are no assumptions for changes to service utilization or care delivery incorporated into the global spending target. OneCare's analysis and projections for Medicare are severely hampered by being limited to providers and beneficiaries who were previously under OneCare ACO programs. We have no data for possible attribution or cost for new participating providers in 2018, and we have relied on informed assumptions for a material part of our Medicare budget model.

23. *Please describe how the providers' planning data sets, the Medicare Shared Savings Program data and selected assumptions are applied to project the anticipated changes in provider network configuration and the expected impact on service utilization.*

The available planning data is first filtered to include only the providers expected to participate in the 2018 programs. Milliman is then employed to break down the data into service categories and apply micro trends that aggregate to a total trend for the Medicare program. This effectively accounted for and incorporated the impact on service utilization trends on the budgeted spending benchmark. We have no data for possible attribution or cost for new participating providers in 2018, and we have relied on informed assumptions for a material part of our Medicare budget model.

24. *Please provide additional support for the calculation of the 75% and 100% maximum downside risk for Medicare, Medicaid and BCBS programs provided in the quantitative analysis.*

Payer	Total Cost of Care	Risk Corridor	Share within Corridor	Max Risk	75% Maximum Downside	100% Maximum Downside
Medicare	$347,240,276	5%	80%	$13,889,611	$10,417,208	$13,889,611
Medicaid	$118,833,295	3%	100%	$3,564,999	$2,673,749	$3,564,999
BCBS	$133,395,719	6%	50%	$4,001,872	$3,001,404	$4,001,872
TOTAL	**$599,469,290**			**$21,456,481**	**$16,092,361**	**$21,456,481**

25. *Of note, GMCB is expecting OneCare to submit an actuarial certification when your certification application is due.*

Milliman is willing to review our final benchmarks and consider a certification based on their actuarial opinion and expertise. Because at this point in time the spending targets have not been finalized with the payers, we have not yet sought this certification.

Part 4
Attachments

Attachment A – 2016 OneCare Final Financial Statements and Balance Sheet Summary

Attachment B – 2016 Shared Savings Results for Medicaid and Commercial

Attachment C – Complete ACO Projected Cost and Revenue Data Package

Attachment D – Population Health Programs Grid

Attachment E – Concept P & L for Entire Budget

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Green Mountain Care Board, 2018 Budget Resubmission

Part 5: ACO Model of Care and Community Integration

1. *Describe the ACO's Model of Care, including but not limited to how it may address:*
    a. *Support for person-directed care;*
    b. *Support for appropriate utilization;*
    c. *Seamless coordination of care across the care continuum, including specialty medical care, post-acute care, mental health and substance abuse care and disability and long-term services and supports, especially during care transitions;*
    d. *Integration efforts with the Vermont Blueprint for Health, regional care collaboratives and other state care coordination initiatives;*
    e. *Identification of, and care coordination interventions for, high risk and very high risk patients; and*
    f. *Use of comprehensive integrated/shared care plans and interdisciplinary care teams.*

    Please see response to this question as well as questions 2, 3, 4, and 5 in the narrative below.

2. *Describe new strategies for bringing primary care providers into the network*

    Please see response to this question in the narrative below.

3. *Describe strategies for expanding capacity in existing primary care practices, including but not limited to reducing administrative burden on such practices.*

    Please see response to this question in the narrative below.

4. *Describe the participation and role of community-based providers that are included in the ACO, including any proposed investments to expand community-based provider capacity and efforts to avoid duplication of existing resources*

    Please see response to this question in the narrative below.

5. *Describe the ACO's population health initiatives, including programs aimed at preventing hospital admissions or readmissions, reducing length of hospital stays, providing benefit enhancements resulting from delivery system flexibility, improving population health outcomes, addressing social determinants of health (e.g. Adverse Childhood Events), and supporting and rewarding healthy lifestyle choices. Describe how the ACO will measure success of these initiatives, and what will constitute success.*

    MODEL OF CARE AND COMMUNITY INTEGRATION: Health care system reform is one of the most pressing and complicated challenges we face, both locally and nationally. The ultimate goal in health care reform is to optimize the health system performance in pursuit of the Triple Aim:

to improve patient experience (quality, access and reliability), improve the health of defined populations and control per capita costs. As a statewide Accountable Care Organization (ACO) focused across the full continuum of care, OneCare Vermont (OneCare) is positioned to achieve the Triple Aim by acting as the "macro-integrator" capable of and committed to accepting responsibility for all three legs of the Triple Aim for a defined population. Our role as an ACO is to support our frontline systems such as primary care medical homes, community-based continuum of care providers, hospitals, specialists, etc., by providing them with the systems and resources necessary to redesign care delivery. We will also work with the State and Payers to design innovative financial models that support the clinical model. OneCare is a strong proponent of the three goals the State of Vermont negotiated under the All Payer Model Waiver: improving access to primary care, reducing deaths due to suicide and drug overdose, and reducing the prevalence and morbidity of chronic disease. As providers, we recognize this is a unique opportunity to shape the future. In partnership with the State of Vermont, Green Mountain Care Board, Blueprint for Health, and our payers, we can direct the transformation necessary for Vermont to deliver on its ambitious goal of creating a high-value health care system for all Vermonters, regardless of employer, employment status, or income.

Population Health Management (PHM)

The Affordable Care Act and the advent of ACOs has drawn the attention of policy makers, health care providers, public health professionals, and other interested parties to assess and manage the health of whole populations as a framework to improve health outcomes and reduce cost growth. More specifically, it calls upon stakeholders to look beyond the traditional boundaries of the healthcare delivery system to identify social determinants of health and recognizes the impact of these factors on the burden of disease at the individual, family, community, and health systems levels. In addition, PHM emphasizes wellness and prevention rather than focusing solely on "illness care" within the population. OneCare's PHM approach embraces a set of diverse but interconnected activities that address preventive and chronic needs of every Vermonter in the ACO. These activities include but are not limited to: addressing upstream social determinants of health to prevent disease, supporting primary care practices through practice redesign, improving coordination between primary and specialty care, risk stratification and identification of high-risk individuals that could benefit from enhanced care coordination which includes the integration of care delivery with community partners. To support these activities, OneCare will be the vehicle to help disseminate success and lessons learned and will provide access to high-quality and reliable data as well as consultants to facilitate change and improvement activities. OneCare has recently focused on numerous initiatives to address effective population health management, including but not limited to the following:

- Developing and implementing a controlling hypertension quality improvement project in partnership with the Blueprint for Health, Health Department, and other community partners.
- Promoting preventive/wellness care through local community initiatives such as RiseVT and the 3-4-50 campaign.

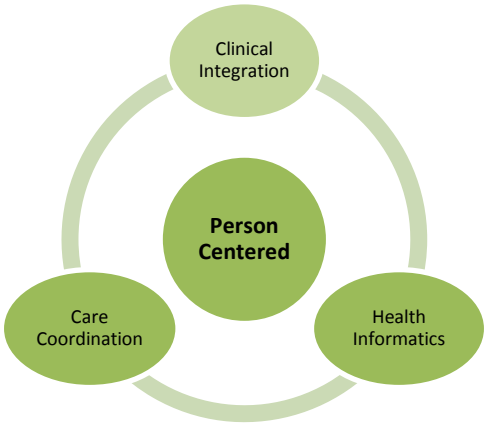
- Collaborating with the Vermont Child Health Improvement Program (VCHIP) to support 22 pediatric and family medicine practices in a quality improvement collaborative to improve pediatric quality measures of developmental screening and the adolescent well visit.
- Engaging in and promoting Accountable Communities for Health to advance Community Collaborative foci beyond traditional boundaries of clinical care to embrace broader definitions of population health and improve partnerships with various human service organizations (e.g. housing, food, economic services, and childcare).
- Partnering with The Permanent Fund for Vermont's Children to investigate opportunities to promote health for children and families through the door of early care and education settings.
- Examining opportunities to promote team-based care in primary care settings (e.g. care coordination, embedded behavioral health).
- Researching and planning for the first disease management focused patient resource library to be developed and embedded in Care Navigator, OneCare's shared care coordination software tool.
- Developing partnerships to investigate social determinant of health screenings in primary care settings (e.g. ACES, food insecurity, and maternal depression).
- Providing training for primary care medical homes on effective panel management to identify sub-populations that could benefit from enhanced care planning.
- Implementing a new risk stratification algorithm, the John's Hopkins Adjusted Clinical Grouper, to identify prospective risk for all attributed patients.
- Providing intensive education and training for the network on the use of risk stratification, OneCare's Care Coordination model, and expectations for team-based care.
- Implementing a waiver of prior authorization for a specific set of services under the Medicaid risk contract that reduces the administrative burden on providers; simultaneously developing an analytic application to monitor utilization and identify any unwarranted variation in services.
- Organizing, evaluating, and obtaining feedback on current and proposed ACO quality measures under the All Payer ACO Model Waiver to identify efficiencies and align priorities with gaps in care that are actionable for change and improvement.
- Facilitating the development and deployment of best practices for congestive heart failure, reducing readmission rates, and high emergency room utilization.

Integrated Care Delivery Model Promotes Person-Centered Care

OneCare supports a tightly integrated clinical delivery system that delivers Population Health Management (PHM) across the continuum of care using a cohesive community health systems approach to achieve the Triple Aim. Community integration starts with a sustainable governance and operations that assures strategic planning and execution on initiatives, matching capacity and demand for health care and social services across areas. It also includes the development of evidence-based care pathways; use of shared information technology platforms with appropriate interoperability; predictive models and risk assessment that take into account situational factors, medical history as well as utilization use; and a system for ongoing learning and improvement.

OneCare is enabling the transition from a volume- to a value-based structure allowing resources to be used for care coordination, self-management, prevention, and health promotion. OneCare's PHM model focuses on core activities across the continuum from prevention and wellness to high-risk populations that generate the majority of health costs. OneCare's PHM model supports strong: clinical governance, local decision making through Community Collaboratives, Person-Centered Medical Homes/Neighborhoods inclusive of community-based health care services, definition and stratification of populations, identification of care gaps, consumer engagement and promotion of shared decision-making, adoption/implementation of evidenced-based guidelines, access to and efficient use and coordination of specialist, inpatient and outpatient hospital services, and care transitions through care coordination. At the foundation of our model is the person-centered approach that compels and empowers participants to provide care for the whole person. (See Diagram A below)

Diagram A: Person Centered Approach



OneCare has demonstrated its commitment to delivering on a fully integrated community-based approach. Our work over the last three years on the Vermont Health Care Innovation Project (VHCIP) grant is one such example of OneCare's leadership in supporting the forward momentum (transition) to a more effective health care delivery system. With support of the VHCIP grant, and in partnership with the Blueprint for Health and the other ACOs, OneCare led the development of fourteen (14) regional multi-disciplinary teams statewide — each with a formalized governance structure focused on improving the health of their communities. These multi-disciplinary teams, called Community Collaboratives, are redesigning the way care is delivered locally and demonstrating measurable improvements in clinical priority areas brought forth through OneCare's clinical committees. For example, the Burlington Health Service Area (HSA) selected hospice care as one of their focus areas and has achieved a 156% improvement in utilization of hospice benefits in a sample of people with dementia as well as corresponding 66% increase among people with congestive heart failure, and 23% increase among people diagnosed with cancer.

As part of its long-term business planning, OneCare identified six core strategies to meet our mission and vision of creating an Accountable Care Community health system based on a PHM model that meets the Triple Aim, including: governance, community-based integration, support for primary care, care coordination, testing innovations, and quality improvement. Together, these strategies support an integrated community-based care delivery model that will transform the system of care from an often fragmented "place-based" model of care delivery to one that is integrated and "person-based."

Clinical Governance

OneCare has developed a clinical governance structure that ensures broad representation from our members and community partners including both leadership of these organizations and direct care providers who interact with patients and families on a day-to-day basis. This diverse representation facilitates organizing, testing and evaluating innovations, and deploying resources to support clinical integration and population health management. OneCare Vermont is managed by a Board of Managers (BOM). Committees of the Board of Managers are accountable to the BOM and include Executive, Finance, Population Health Strategy Committees and Clinical Advisory Board. Additional committees are the Consumer Advisory Group, Quality Improvement Committee, Informatics Committee, Pediatric Sub Committee, Lab Sub Committee, and a soon-to-be formed Primary Care Sub Committee. Each HSA in OneCare's network organizes and convenes regular meetings called Community Collaboratives, which serve as local organizing bodies to advance population health strategies and improve health care delivery and outcomes. The committees provide strategic and organizational recommendations, input on key policies, direction on the clinical model and oversight of cost and utilization performance.

Clinical committees are supported by the Chief Medical Officer, Medical Director, and staff of the Clinical and Quality Department within OneCare. Externally, OneCare has contracted with a Regional Clinical Representative (RCR) in each HSA within our network. The RCRs provide local content expertise and support to the Community Collaboratives to assist them in identifying clinical priority areas, identifying opportunities for improvement, and encouraging a data-driven focus on achieving identified quality improvement goals. The RCRs are active participants in OneCare's clinical governance committees, bringing fresh ideas and perspectives back to the ACO, and facilitate shared learning and spread of successful change strategies across HSAs. Robust Operations as well as Informatics and Analytics Departments within OneCare support the work of the Clinical and Quality Improvement Department as well as the entire network of providers.

Clinical and Quality Improvement

OneCare is committed to developing an integrated, community-based care delivery model that supports optimal health for Vermonters. We have made significant advancements towards this model by supporting advanced community integration, care coordination, and creating a very nimble health informatics platform, while keeping individuals and their families at the center. Community integration starts with a sustainable governance and operations that assures

strategic planning and execution on initiatives, matching capacity and demand for health care and social services across areas. It also includes the development of evidence-based care pathways; use of shared information technology platforms with appropriate interoperability; predictive models and risk assessment that take into account situational factors, medical history as well as utilization use; and a system for ongoing learning and improvement.

Quality Measurement: OneCare's PHM informatics platform supports system levels metrics and ultimately the provision of person-centered care by facilitating access to high-quality, timely data that can be used to monitor the effectiveness and efficiency of care and drive decision making. It supports benchmarking against regional and national peers, guides strategic decision making about performance priority areas, provides mechanisms to monitor quality and experience measures, and guides quality improvement initiatives. Each of OneCare's payer programs require annual collection of quality data tied to the experience of care, preventive services, management of selected chronic conditions, safety, coordination of care, and utilization of resources. Over the past four years, OneCare's Clinical and Quality Improvement and Operations Departments have developed expertise in defining, collecting, and interpreting the measure sets for each program. OneCare dedicates extensive time and resources in training the network and providing resources for data abstraction. We collaborate with the other Vermont ACOs to deliver a unified interpretation of the measures set and share our trainings and our collection tools with the other ACOs. Our team of Clinical Consultants travels statewide each winter to review medical record data and to abstract the needed data elements. Internally, our Operations team, consisting of certified coders, aids in data collection and a highly skilled data analytics team aids in cleaning, submitting, analyzing, and interpreting the data and transforming it into information that is actionable for change and improvement. Once the data is compiled and validated ACO and HSA level data is shared with participants and the OneCare Boards and Committees.

Quality Improvement: OneCare has several years of experience executing on performance improvement activities in support of our clinical priority areas and directed towards achieving the Triple Aim. These quality improvement activities take place within specific clinical settings (e.g. hospital unit or primary care site) and across HSAs through the Community Collaboratives. OneCare has collaborated extensively with the Blueprint for Health and beginning in late2015, OneCare and Blueprint staff have participated in regular structured "All Field Team" monthly meetings and trainings. Led by ACO and Blueprint leadership, these trainings provide an opportunity to strengthen and align quality efforts by providing a mechanism for shared learning as well as an avenue to identify areas of concern or opportunity that could benefit from enhanced supports. OneCare has also collaborated with the Vermont Health Care Innovation Project (VHCIP) to enhance community-based infrastructure through the deployment of Clinical Consultants and Regional Clinical Representatives within each HSA in our network. OneCare joined VHCIP leadership in planning and conducting the Integrated Communities Care Management Learning Collaborative (ICCMLC) and is building on its success by further resourcing and supporting communities' care coordination activities. Currently, OneCare is partnering with the Vermont Department of Health, Blueprint for Health, and others to plan and

execute a learning collaborative to improve the proportion of people with high blood pressure that have their blood pressure under control. Early in 2017 OneCare identified this as a gap in care, noting that across payers, only 70% of patients with hypertension demonstrated sufficient blood pressure control. Partnering with the Department of Health to refine and finalize a toolkit of evidence-based strategies and co-mingling community-based resources with Blueprint for Health, yielded a robust project team and a structured, focused quality improvement initiative to rollout to all interested HSAs. Currently 10 practices and one home health & hospice organization have enrolled in this intensive eight-month project. Participants will convene in three in-person trainings and be supported through regular coaching and measurement to facilitate testing, implementing, and sustaining changes in their clinical practice and workflows that support high-quality, person-centered care for people diagnosed with hypertension.

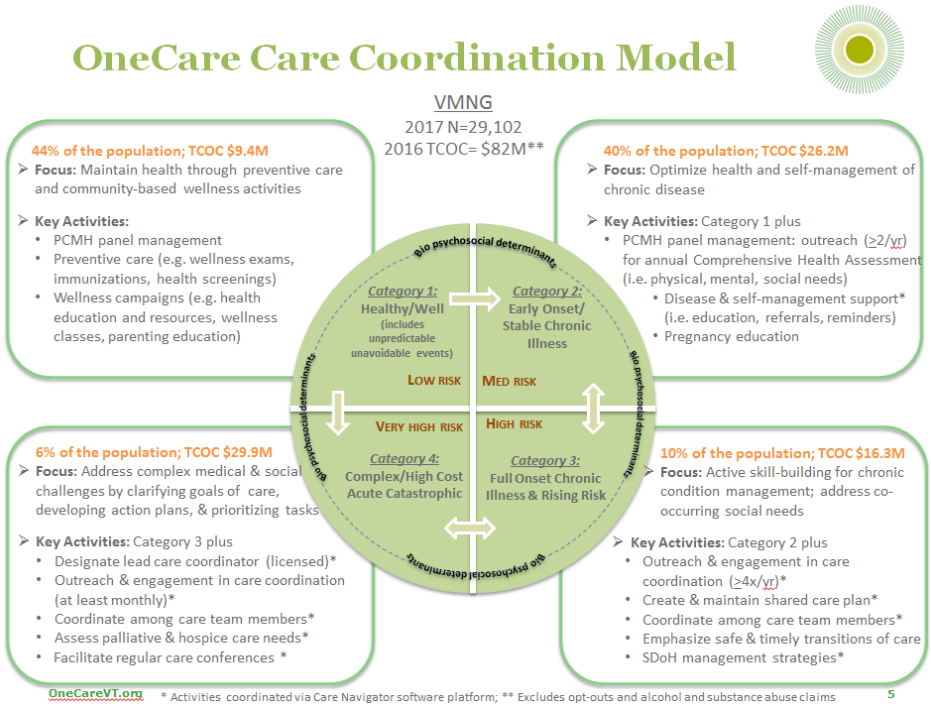
OneCare is committed to facilitating quality improvement efforts throughout the State. Our Clinical Consultants work within their assigned communities and statewide to assist with project selection, design, and management in each HSA. The Clinical Consultants bring data to these teams to inform and guide their focused quality initiatives as well as to monitor performance across a dashboard of quality metrics over time. Over the past year OneCare has been rolling out a software program, WorkBenchOne (WBO), to our participants to support monitoring of utilization, cost, and clinical data in a timely manner. The software provides a HIPAA compliant, web-based platform that provides summary data (e.g. across the ACO or across the HSA) and allows users to drill down to the individual facility, provider, and/or patient level (as allowed based on user security and configuration to protect patient information). OneCare strongly believes that the investment in WorkBenchOne will lead to better quality through the increased ease of access to actionable data that can be stratified to identify specific populations of concern, providing a new mechanism to conduct gap analysis and inform quality initiatives. OneCare's past four years of collaboration with local community teams, including supporting the formation and development of Community Collaboratives, has been very instructive in guiding our learning about how best to support these teams in designing very simple rapid cycle improvement strategies. These teams have begun to demonstrate visible improvements in their clinical priority areas and quality improvement projects. OneCare highlights these successes and lessons learned through brief, focused "Network Success Stories" that illuminate the key action steps, results, and translatable activities that other facilities and/or communities can adopt or adapt to their specific circumstances. OneCare facilitates additional learning opportunities for our participants including synchronous and asynchronous trainings and events; "story-telling" sessions; skill-based sessions; in-person trainings such as learning sessions;, written materials (e.g. clinical charters); web-based postings to a secure portal; and access to customized data displayed in a variety of ways.

Care Coordination: As part of our larger population health management model, OneCare has a core clinical strategy to improve care coordination for people at high risk. In order to advance this strategy, OneCare has focused on developing rigorous processes and systems to identify high-risk individuals in each community and support a tightly integrated health care delivery model that provides effective communication and coordination of care for these individuals and

their family. OneCare has been an active partner working with the Blueprint for Health and VHCIP in the Integrated Communities Care Management Learning Collaborative (ICCMLC) over the past several years. OneCare's Clinical Consultants participated in the Train-the-Trainer program and have planned and facilitated local community skill-based trainings, helping to disseminate the use of evidence-based and/or evidence-informed tools and practices. Early in this process, OneCare volunteered to create and host a Care Coordination Toolkit and make it readily available on our website. Based on the work of the ICCMLC, OneCare leadership recognized a unique opportunity to support our primary care, specialty care and continuum of care providers to improve communication and collaboration in support of person-centered care by investing in and deploying Care Navigator (CN). CN is a care coordination software platform to promote the use of standardized shared care plans by interagency care teams. A unique feature of this software is that all care team members interacting with a patient can share information with one another in one place and can update tasks associated with the patient's stated care plan goals, thus reducing duplication and fragmentation. As of May 2017, OneCare has deployed this software in five HSAs to more than 225 unique users.

Care coordination, centered on individuals and their families, encourages shared decision making by way of intentional processes that actively engage each individual in creating a shared plan of care. Effective care coordination requires timely identification of individuals who could benefit from coordinated service delivery and transitions of care, and engaging them in a systematic approach to care coordination in the context of strong community-based linkages among clinical and non-clinical services. Over the past nine months, OneCare has developed and refined a Care Coordination Model (see Diagram B) that is inclusive of the entire attributed population. The model uses population segmentation to identify key focus areas and activities based on prospective risk stratification and informed by clinical knowledge and decision making. The model quantifies risk from low through very high and promotes a strong foundation within primary care for effective panel management, preventive care, outreach and engagement, education, self-management support, referrals, and effective coordination of care with all members of a person's care team regardless of organization. Further, the model requires regular outreach to engage people in care as well as specific tools and supports such as the identification of a lead care coordinator, the creation and maintenance of shared care plans, and person-centered care conferences as needed.

Diagram B. OneCare's Care Coordination Model



In the coming months OneCare will be deploying additional resources to primary care and continuum of care partners to further align and integrate team-based care and provide care coordination tools and supports to meet people's needs and desires to improve their health and wellbeing. During this same period, OneCare also plans to continue to evolve our care coordination software platform, Care Navigator, to expand capacity to engage individuals and caregivers directly through the software such as through the use of a resource library, event notification, and other features. Finally, OneCare will create a care coordination impact and outcomes analysis application in WorkBenchOne to support community participants in monitoring key utilization and outcome measures to provide input on progress made, gaps in services, and outcomes achieved.

6. *Provide a copy of your grievance and complaint process.*

   Please see Attachment A in Part 5 Attachments "OneCare Vermont ACO Grievance and Appeals Policy."

7. *Provide a completed* ***Appendix D – ACO initiatives to address All-Payer ACO Model Quality Measures*** *to briefly describe ACO initiatives to address measures.*

   Please See Attachment B in Part 5 Attachments "ACO initiative to address All-Payer ACO Model Quality Measures."

GMCB Questions for OneCare Vermont
Part 5

1. *OneCare's provider payment models do not appear to include strong provider incentives for quality improvement. Also, providers do not appear to be rewarded for their own performance, but rather for the performance of the ACO network. Can you explain how the payment model will provide both support and motivation to attain improvement in the APM targets and in contractual quality measures to which OneCare is subject?*

   At the recommendation of our provider community, we are taking a step-wise approach to creating new incentives for quality improvement. In 2017, we began by responding to our Network's request to reduce administrative burdens on primary care and have identified and implemented strategies such as waiving prior authorization and renegotiating both Medicaid and Commercial quality measures to reduce the number of measures and take bold steps to bring them into alignment with the State's All Payer Model Measures. This work is ongoing and we anticipate continued discussions with GMCB and payers about measure alignment.

   Our second step, implemented in January 2017, was to design and implement a Value-Based Incentive Fund (VBIF) to reward OneCare participants for delivering high quality care. Currently in place for the Medicaid program, OneCare intends to expand the VBIF to all payer programs in 2018. During 2017 and 2018, the VBIF is designed to reward ACO-level performance with 70% returning to primary care based on attribution – this is in recognition of the fact that the preponderance of quality measures relies on primary care and they are a cornerstone to a successful population health management strategy. The stability of this two-year VBIF implementation allows providers to gain familiarity with a set of new APM quality measures and recognizes that, in order to succeed, we need to address community-wide systems of care, not only what happens within the walls of a primary care office. By 2019, OneCare intends to refine the VBIF to add a variable component for performance at an organizational level. The 2019 ACO VBIF measure set, with the variable component, will likely vary from the ACO-level quality performance measures and will need significant exploration and discussion among OneCare participants and collaborators to identify and align key measures and drivers of cost, utilization, and quality that are within our ability to impact change and improvement.

   In addition to the VBIF, OneCare is actively using performance data at the ACO, health service area, site-of-care, provider, and patient level to identify opportunities for improvement. OneCare's self-service analytics tools provide both actionable data and a comparative framework (provider to provider; community to community) which can tap into the friendly competition of individuals wanting to improve relative to their peers. Together we feel these levers will continue to facilitate improvement and allow OneCare to produce the consistently high-quality results that we have demonstrated to date while also allowing us to address new areas of need as identified through the APM.

2. *While OneCare has board and advisory committee central planning functions for population health, clinical care and quality improvement, the ACO has adopted a highly de-centralized QI model that lets communities pick their projects.*

   - *How will this structure support ACO accountability on APM and individual payer measures?*
   - *What will OneCare do to change care delivery across its network?*

   OneCare uses a two-prong strategy that both supports local control and decision-making about what and how to drive change in local health service areas with a structured approach that drives focus on specific areas of need. For example, in the current performance year, OneCare worked with its provider network to identify a set of five clinical priority areas from a list of more than 70 topics proposed. For each priority area, there was discussion and agreement on a specific measure and a goal. These priority areas were then disseminated to our network participants and collaborators via clinical governance committee meetings, using our clinician representatives (i.e. Regional Clinical Representatives) in each community, and through active discussions at "All Field Team" meetings, which consist of Blueprint and ACO staff and partners that support local community efforts. In addition, OneCare conducted an in-depth analysis early in 2017 and identified a quality measure that had sub-optimal performance across payer programs – controlling hypertension – and worked collaboratively with the Blueprint for Health, Vermont Department of Health, the QIN/QIO, SASH, and CHAC to design and execute a quality improvement learning collaborative. Currently 10 primary care and one home health agency are actively participating in the collaborative which takes place through December of 2017.

   In 2018, we plan to continue to deploy this two-pronged strategy and will work to align local and ACO efforts with the APM goals and measures. We are also actively working with GMCB and DVHA to obtain key de-identified data that will be necessary to drive change and improvement in the delivery of mental health care (e.g. claims that can track progress on the 30-day follow-up from the emergency department for mental health and substance use measures for which OneCare is precluded from receiving direct, identifiable data).

3. *There are a large number of quality improvement initiatives happening in the state, among varying organizations that include VCHIP, VPQHC, and CHAC. How do you coordinate with these other quality improvement initiatives to coordinate and ensure there is not duplication?*

   The Clinical and Quality team at OneCare conducts environmental scans to identify existing activities as well as those in the planning stages and then we outreach to develop partnerships and collaborative efforts where all organizations can benefit from alignment and contributions of resources such as staff time, recruitment methods, identification of best practices, and execution strategies. In addition to the controlling hypertension learning collaborative described in question 2 above, OneCare has partnered with VCHIP on their CHAMP Learning Collaborative to improve pediatric ACO measures. We helped recruit 22 OneCare practices to participate in this quality improvement project and have provided data and content expertise in the project's execution. OneCare will also be partnering with VCHIP on the 2018 project around social determinants of health, specifically screening for food insecurity and depression. OneCare continues to meet regularly with SASH, VPQHC, CHAC, Blueprint, QIN/QIO, VDH, and others to

keep abreast of new priority areas among our partners and to seek opportunities to work together.

4. *OneCare's response to Section 5.1 of the Budget Review Guidance submission document included limited detail about the ACO's Model of Care. Please describe strategies in the following areas:*

   - *How will the ACO work with its network to support person-directed care?*

     OneCare promotes shared-decision making strategies that support timely and effective patient/provider conversations that elicit the patient's needs and desires for their health. For example, OneCare has begun offering quarterly "Grand Rounds" for network participants. These 90-minute sessions highlight a clinical topic or area of concern to the network and facilitate a panel-based discussion of best practices, insights from providers demonstrating success in the area, and open space for conversations and questions about how others can change/improve. For example, a June Grand Rounds focused on the Medicare Annual Wellness Visit benefit and several nurse-based care delivery models that have demonstrated high patient engagement and satisfaction in the early stages. Through qualitative data, patients shared that they felt they had more time with the nurse to share their concerns, to ask questions, and address preventive care and it allowed them to then focus on follow-up appointments for specific chronic conditions or other patient-driven topics. In addition, OneCare's care coordination model is centered around a person-directed approach to identifying areas of concern, prioritizing them, developing a shared care plan (in the patient's own words) and then identifying the tasks or milestones along the way to attainment of the health-related goals. Finally, OneCare participates in annual patient surveys and shares that information with its network to facilitate dialogue and improvement opportunities.

   - *How will the ACO work with its network to support appropriate utilization (e.g., to reduce overuse and misuse of services and protect against underuse)?*

     OneCare routinely tracks utilization data and reports it to our Board and participants through monthly reports and through direct access to our self-service analytics platform, WorkBenchOne™. In addition, OneCare has formed an internal team consisting of a medical director, nurse, coder and data analyst that meet regularly to monitor utilization (over and under) and has developed a detailed policy to address instances of unwarranted variation. The policy includes deeper case review and analysis, interviews with provider, and development of remediation strategies and recommendations to our Population Health Strategy Committee of our Board of Managers.

   - *How will the ACO work with its network to support seamless coordination of care across various providers in the care continuum, especially during care transitions (e.g., facilitate timely communication across ACO and non-ACO providers)?*

     OneCare has invested in Care Navigator, our care coordination platform, as the primary mechanism to support communication and coordination of care across the continuum of care. All ACO participants and collaborators can access patient-level information based on

appropriate permissions. We will be expanding Care Navigator functionality this fall to incorporate event notification so that care team members can receive timely notifications of admissions, discharges, and can outreach to support patients to ensure effective transitions of care during this period of vulnerability. Further, Care Navigator allows care team members to store information about other non-ACO providers in notes fields so that the care team is fully informed and can proactively address communication needs. Much of this work is led by the lead care coordinator, who is a care team member identified by the patient to take the "team lead" role. In addition, OneCare is facilitating monthly cross-community meetings of core care-coordination leaders to develop and refine community-specific workflows that can address unique opportunities and challenges in the local care delivery system. For example, the workflow development discussion might lead to the recognition that a key community partner is not part of the ACO and the core team can outreach and engage that organization in a conversation about how best to bring them into the communication and coordination and then document this in a workflow followed by training for local care team members. Care Navigator can also be customized to deliver reminders and trigger specific tasks for care team members and patients based on specific parameters set in advance – for example, sending a patient a reminder it's time to fill a prescription or schedule a next appointment with their specialist.

- *How will the ACO work outside of its network to coordinate care, improve quality and manage costs? Will any tools be provided to out of network providers?*

  OneCare is very cognizant of the care delivered to ACO-attributed patients outside of our Network, particularly in some border communities. OneCare is beginning to monitor that "leakage" and share information with communities on when and where it is occurring so that they can explore "why" it is happening. Over time we expect this will lead to increased conversations and planning about referral networks, local workforce needs/gaps, and enhancements to patient education and outreach. OneCare continues to support out-of-network providers through the Community Collaborative structures in place between OneCare and the Blueprint that facilitate local quality improvement efforts, including care coordination. OneCare provides data, quality improvement support and tools to facilitate local change in recognition that by supporting non-ACO providers it will help improve care for the entire population.

- *How will the ACO support integration efforts with the Blueprint, RCCs, and other state care coordination activities (e.g., how will these activities be integrated into ACO strategy and operations)?*

  OneCare has been meeting biweekly with Blueprint for Health and other ACO leadership to align strategies including financing, care models, and quality improvement activities. One area of mutual development over the past year has been how to evolve the Community Collaboratives (formerly called UCCs or RCPCs) so that they become "accountable communities for health" (ACH) – moving to a true, whole population focus, while retaining their focus on clinical priority areas. Together this spring we successfully transitioned this

pilot ACH work from its initial SIM funded scope into an enduring model by taking on co-leadership of statewide training sessions and working together to align the Blueprint Health Service Area contracts with ACO priorities and the ACH framework. Initial feedback from communities has been very positive and we anticipate continuing this work and building on it together moving forward. A second example was the close partnership that emerged between OneCare and the Blueprint in evolving the Integrated Communities Care Management Learning Collaborative framework into a complex care coordination model that could expand initial capacity and provide a structured approach to spread care coordination strategies statewide. Blueprint and OneCare continue to co-sponsor care coordination training events, facilitate community dialogue at "All Field Team" meetings and we will continue to work collaboratively to monitor utilization and make adjustments in the model and associated payment methodology.

- *How will the ACO work with its network to provide care coordination interventions for high risk and very high-risk patients (e.g., development and provision of consistent and effective care management services for these patients)?*

  Building on existing capacity and expertise in local communities, OneCare developed a care coordination model and strategy to address the needs of all patients, with a particular focus on high and very high-risk patients. This model requires the identification of care team members with knowledge of a patient and the identification of an initial lead care coordinator to conduct outreach to engage the patient into a care coordination process. Once engaged, time is spent supporting the patient to identify his/her goals and creating a shared care plan. This person-centered tool guides the conversation to identify what is most important to the patient and then supports the creation of patient-narrated goals and specific next steps, or tasks, which will facilitate attainment of those goals. Standardized tools developed through previous statewide collaboratives are being utilized such as shared care plans, Eco Maps, Camden Cards, as well as new tools OneCare is providing such as risk stratification data, identification of disease panels, identification of opportunities to re-engage the patient with primary care through panel management, as well as assessments and, in the coming months, patient education materials. OneCare is developing care coordinator competency assessment tools and facilitating ongoing discussions and training sessions where gaps are identified. Further work on community-specific workflows will highlight local variations based on community provider access and will allow communities to customize workflows to maintain their strengths while identifying and addressing barriers or potential areas of duplication of services.

- *How will the ACO work with its network to support use of comprehensive integrated/shared care plans and interdisciplinary care teams (e.g., implementation of shared care plan and support for interdisciplinary care team conferences with high risk patients)?*

  See questions above. In addition, OneCare has built fields into Care Navigator to track the Camden Card domains (e.g. legal, education, and housing) that align with the patient-

narrated goals in order to capture these data systematically for use in local community planning as well as ACO-wide gap analysis and remediation planning.

- *How will the ACO work outside of its network to coordinate care, improve quality and manage costs? Will any tools be provided to out of network providers?*

  Please see sub-bullet #4 above.

5. *OneCare's response to Section 5.2 and 5.3 of the Budget Review Guidance submission document included limited detail about new strategies for bringing primary care providers into the network, and strategies to expand capacity in existing primary care practices. For example, with respect to the latter, the ACO could describe strategies that allow primary care practices to:*

   - *decrease the time they have to spend on service authorization, documentation, or reporting, and/or*
   - *see more patients and see patients at new times, and/or*
   - *care for patients through new modalities (e.g., e-visits, telemedicine), and/or*
   - *augment primary care practice teams, and/or*
   - *other strategies of OneCare's choosing.*

   OneCare Vermont's complex care coordination model delivers significant financial resources to all participating primary care practices to help defray the cost of care coordination services imbedded in the PCMH. These resources significantly augment existing supports provided by the Blueprint practice payments and Community Health Team.

   Hospital-owned primary care practices under OneCare's new financial model are already capitated for their attributed lives since the fixed hospital payments include historical expenditures for hospital inpatient, outpatients and physician services (including primary care services.) Thus, the preponderance of primary care clinicians can immediately adopt and grow more facile with innovative non face-to-face clinical care – telephone discussion, video visits, virtual (e.g., store/forward/reply) visits, EMR portal responses, active use of Care Navigator to promote better complex care coordination activities, interdisciplinary care planning conferences, and others. OneCare will be targeting network provider education to promote these innovative methods of care.

   Starting in 2018, OneCare intends to pilot a payer agnostic primary care capitation model for independent practices of at least 500 attributed patients to promote similar innovative approaches. Practices are being recruited for this pilot and focus groups have begun.

   OneCare has successfully negotiated relief from prior authorization and utilization review for the Vermont Medicaid Next Generation program for part A and B services which is a bona-fide demonstration of reducing practice and hospital burden of personnel time and expense for these activities. The OneCare Utilization Review Committee monitors data for over and underutilization but the majority of our participants will experience a real reduction in administrative burden. While we do not have risk for pharmaceutical spending in current contracts, taking on some future financial risk for drug spending will likely result

in reduced resources needed to comply with pharmacy benefit manager formulary authorization rules.

In the new paradigm, “Seeing more patients” will become an outdated phrase since it emphasizes the fact that face-to-face billable office visits are essential elements in a fee-for-service world. “Meeting the care needs of patients conveniently, expertly, and in the communication format that they desire” will become the more appropriate characterization of future patient care. Norms of documentation will evolve but the current need to bill in a compliant fashion (federal documentation criteria, National Coverage Decisions, Local Cover Decisions, payer benefit limits) that also meets the needs of professional licensing and medico-legal considerations will offer few immediate major changes.

As discussed above, OneCare has prioritized reducing the burdens of quality measure reporting by emphasizing claims-based measures that do not require painstaking human data gathering in charts.

OneCare Vermont also recognizes that current requirements for NCQA certification as a Patient Centered Medical Home to qualify for Blueprint practice payments and attribution is considered a significant burden by many primary care practices. Despite some recent simplifications to the NCQA re-certification methods, our network has not yet been able to assess how much reduction in time and opportunity-cost investments practices will experience. The OneCare network is willing to explore alternative methods to assure practices have essential operational capabilities to effectively serve patients in a population health paradigm.

OneCare is promoting the use of registered nurses to expand the primary care workforce by involving them in performance of the Medicare Wellness Visit. This compliant strategy frees up physician and APP level clinicians to manage other acute and chronic illness patients. Patients benefit from having more time to discuss their health concerns with the nurse and have those concerns addressed immediately (e.g., Advanced Directive completion, immunization updating) or recorded for future follow up (e.g., new symptoms or complaints.)

The Vermont All Payer Model paves the way for new benefit waivers in the Medicare Next Generation program as well as in Medicaid Next Generation and the Commercial Exchange Next Generation programs. The standard Medicare waivers in 2018 will help primary care by providing for better supported hospital discharge transitions of care home health agency home visits, permitting both billable telemedicine visits (contemporaneous video/audio communication) and non-billable telemedicine interactions with patients in their home, and making nursing home (sub-acute rehabilitation) services available to patients without the burden of the current three-day hospital stay requirement. These waivers support primary care in significant ways to provide care more flexibly and conveniently. Recommendations for additional waivers to be considered for our three programs are currently being assembled for analysis and negotiation with the Green Mountain Care Board and payer partners.

OneCare is optimistic that the transformed health system consisting of prepaid financial models, stronger community continuum of care communications, less administrative burden, patients more engaged in their health, Blueprint supports being maintained in the form of ongoing Community Health Team support services, SASH activities, and payment streams to primary care office based care coordination will usher in a favorable future for primary care practice in Vermont. In addition, skilled nursing facility dedicated medical staff models ("SNF-ists") represent improved care of complex sub-acute rehabilitation patients and long-term care nursing home patients. More emphasis on expert and reliable transitions of care from hospital to home or SNF, SNF to home, and home health to independent living, will contribute to improved quality of care and a more favorable primary care clinician experience.

OneCare is also involved in promotion of innovative models of integrated mental health services in primary care settings to help address the significant contribution of mental illness on the outcome and resource use for physical health care. These models include deployment of designated agency personnel in the PCMH setting and increased use of primary clinician/psychiatric consultation direct communication for improved diagnosis and medication management. Such interventions can rely on "consultants on retainer" compensation models (at first within the hospital-owned practices) made possible by the fixed hospital payments in the OneCare financial model.

6. *OneCare's response to Section 5.4 of the Budget Review Guidance submission document included limited detail about the participation and role of community-based providers that are included in the ACO. Please describe planned ACO investments in community-based provider capacity, efforts to include community-based providers in decision-making and policy development, and efforts to avoid duplication of resources.*

OneCare's population health management strategy requires active participation of the full continuum of care to improve care delivery and health outcomes. Community-based providers are represented at all levels of OneCare's governance, from the Board of Managers to our Clinical and Quality Advisory Committee. As such they have a direct impact on the development and execution of our ACO vision and strategy. For example, community providers had direct influence on the selection of OneCare's clinical priority areas which contributed to the selection of a priority area on reducing skilled nursing facility length of stay as well as a priority on wellness and prevention. One of the most visible areas of collaboration across the continuum was in OneCare's creation of a payment model to support our community-based care coordination strategy. Early in the process, OneCare established a goal of ensuring that community partners that provide care coordination supports and services would be compensated. This led to discussions and a focus on providing payments for team-based care coordination. As conversations evolved it became apparent that the Designated Agencies, Home Health, and Area Agencies on Aging needed resources to be active care team members and if a patient desired to become the lead care coordinator. This payment model facilitates alignment of community resources, reduces duplication, and recognizes the varying expertise of community-based providers in meeting the needs of patients and families.

Community-based providers are also recognized in OneCare's Value Based Incentive Fund, described previously, with 30% of the earned incentive being shared across Network participants based on the health service area's performance. Beginning in 2018, community-based providers such as home health will engage in OneCare's benefit enhancement waivers as we work together to optimize transitions of care. Finally, OneCare is interested in continuing conversations with community providers about how to design future payment models that align care delivery in more efficient and effective ways.

7. *OneCare's response to Section 5.5 of the Budget Review Guidance submission document often did not respond directly to the following areas of GMCB interest in terms of population health initiatives. Please provide information on the ACO's programs in the following areas, including how the ACO will measure success and what will constitute success:*
    - *preventing hospital admissions or readmissions*
    - *reducing length of hospital stays*
    - *providing benefit enhancements resulting from delivery system flexibility*
    - *improving population health outcomes*
    - *addressing social determinants of health (e.g. Adverse Childhood Events)*
    - *supporting and rewarding healthy lifestyle choices*

    OneCare's four-quadrant population health model provides a framework to address the GMCB's areas of interest. The overarching goal of our model is to ensure all Vermonter's in the ACO have access to primary care and the community-based supports and services that can aid them in maintaining health, managing disease, and avoiding preventable hospitalizations. To accomplish this goal, OneCare uses analytics tools to segment the population into four categories from healthy/well through acute/catastrophic care. OneCare is working to develop and refine strategies in each quadrant to ensure a balanced portfolio of evidence-based strategies to support our beneficiaries. Beginning with the healthy/well population, OneCare is supporting and rewarding healthy lifestyle choices by investing in RiseVT, a community-wide collective impact model that supports healthy lifestyles by bringing together disparate sectors of the community (e.g. municipalities, businesses, schools, healthcare) to align strategies and resources that can impact service delivery, land use planning, education/outreach, among others. Currently RiseVT exists in Franklin County, but though mutual investments of OneCare, hospitals, and other stakeholders, there is momentum to spread RiseVT statewide over the next few years. OneCare intends to begin by investing $1.2M in 2018 to support the first spread phase and will, under the direction of the RiseVT Board, hire and support the statewide RiseVT Executive Director and Program Manager.

    Vermonters in quadrant two whom are often experiencing one or more chronic conditions care benefit from self-management skills, regular connection with primary care, and screening to assess their physical, mental, and social needs. OneCare, through its provider network, promotes referrals to Community Health Teams to support self-management education. In addition, through our care coordination software platform, Care Navigator,

ACO participants can monitor utilization data and patient cohorts (e.g. patients with COPD or CHF) to identify gaps in care.

In quadrant three and four, representing the top 10 and 6% of high-risk/high-needs individuals respectively, OneCare is deploying a comprehensive care coordination model that facilitates team-based care that is person-centered and flexible to meet the goals the patient identifies. This model requires the use of shared care plans, shared-decision making, and appropriate communication and coordination by diverse care team members to support patient attainment of health-related goals. It is likely that these high risk patients are the ones most likely to benefit from the three benefit enhancement waivers OneCare intends to deploy in 2018 – a post-acute discharge waiver allowing for home health visits for patients not currently eligible for these services, a waiver of the 3-day inpatient stay requirement before a patient can be discharged to a skilled nursing facility, and the removal of the rural geographic requirement for telehealth services which will allow their expansion into Chittenden, Franklin, and Grand Isle counties. OneCare intends to closely track these benefit enhancement waivers and related investments to assess patient outcomes and will continue to work with GMCB and payers to explore future benefit enhancement waivers for 2019 and beyond. Together our care coordination and transitions of care strategies along with our data-driven approach to identifying high-risk individuals and cohorts will facilitate improvement in inpatient length of stay and our focus on health and wellness and identification of "rising risk" populations will directly impact preventable hospital admissions and readmissions.

Finally, OneCare is committed to refining and improving our use of data to segment the population, focusing on building community partnerships to facilitate the systematic collection and sharing of social determinant of health data to improve our collective understanding of whom is at risk and how best to coordinate care and service delivery to optimize patient outcomes. This is a long-term strategy that will begin with a planning process in 2018 to gather information on existing resources, gaps, and opportunities. In the meantime, other efforts are underway to address social determinants of health including piloting the use of screening tools for patients in care coordination (VT Self Sufficiency Outcomes Matrix), use of Camden Cards to identify the lifestyle factors of most concern to patients and then support of their shared care plan development, screening in pediatric-service primary care practices for food insecurity and parental depression, and other emerging innovative pilot projects occurring in local communities.

Part 5
Attachments

Attachment A – OneCare Vermont ACO Grievance and Appeals Policy

Attachment B – ACO Initiative to Address All-Payer ACO Model Quality Measures