To: Mike Fisher, Chief Healthcare Advocate
From: Todd Moore, CEO OneCare Vermont, Accountable Care Organization, LLC.
Date: October 24, 2017
Subject: OneCare Vermont ACO Responses to Vermont Healthcare Advocate's 2018 Fiscal Year Budget Questions

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Dear Mr. Fisher,

Please find attached OneCare's response to the Vermont Healthcare Advocates Questions regarding our 2018 ACO Fiscal Year Budget Submission to the Mountain Care Board in June. Please note that some of these questions have been answered based on our finalized network and resubmission of our budget to the Green Mountain Care Board last Friday. We are still working to receive or negotiate our full attribution numbers, trends and targets from payers, and therefore this budget continues to rely on our best available projections. 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.

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

1. *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. *What other major assumptions were made in creating this budget?*

      In the earlier budget submission, two major assumptions were made: a) the network makeup and b) the trend rates applied to determine the cost of patient care. Relating to the former, the budget included communities where the home hospital indicated they were interested in participating. However, at the time of budget development no commitments had been made (nor were they expected) and it was assumed that all seven communities will remain in the network. Next, the trend rates were applied using actuarial and APM contract guidance. While thorough and detailed, these trend rates do represent assumptions that affect the cost of care projection and spending target.

   b. *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 Total Cost of Care (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 reductions at this time but may do so in the future in order to set targets for such reductions which can be pursued.

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

      The hospitals are being asked to live within a prospectively set target 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 hospitals are incentivized to promote wellness and prevention, proactively engage with people with chronic illnesses, and avoid unnecessary readmission rates, etc.

   d. *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 Vermont (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 make payer program selections 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. We also still have uncertainty driven by attribution projections and incomplete claims history for that projected attribution. For attribution, we do not know who will remain covered and qualify for attribution into 2018. With regard to projecting trends and targets, for Medicare 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.

2. *What mechanisms do you have in place, or are you considering implementing, to manage fee for service (FFS) care both inside and outside the ACO?*

In July 2017, OneCare launched a Complex Care Coordination program to support the high and very high-risk Medicaid covered lives in the network. This team-based and person-centered approach to care coordination aims to support the patient in identifying and triaging their most important health related goals, which ultimately should result in increased quality and satisfaction while mitigating spend.

OneCare has also significantly stepped up its efforts in 2017 on driving analysis and best practice conversations around episodes of care and chronic conditions. For 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 seriously 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. For chronic disease management, 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 has developed tailored applications that help both internal and external parties monitor quality and financial performance. The application bridges the gap between the clinical service delivery patterns and the overall cost of care provided in the program and helps to highlight both trends and opportunities.

3. *Please describe any funding mechanisms available to OneCare for investment in non-health care expenditures.*

All of OneCare's expenditures are for the purpose of healthcare reform initiatives. The primary areas of focus include: Operations, Clinical/Quality Improvement, Informatics/Analytics, Finance and Program Strategy.

4. *What is the current role of the Vermont Care Organization (VCO) in relation to OneCare's Board of Managers? Please describe how this role has evolved since the creation of the VCO Board.*

OneCare's Board of Managers is separate and independent from the Vermont Care Organization Board of Directors. Other than the powers reserved to the Members in the Operating Agreement, OneCare's affairs are under the exclusive management and control of its Board.

5. *How to you plan to address the high cost of care for people eligible for both Medicare and Medicaid ("dual eligibles")?*

   OneCare's strategy for high-cost/high-needs individuals is centered in our overall care coordination strategy. OneCare uses population segmentation through a prospective risk stratification process to identify patients that are predicted to be high utilizers of the healthcare system in the next 12 months. Through this process each patient receives a risk score and a risk rank. The top 6% are then classified as "very high risk" and the next 10% as "high risk." It is likely that "Dual Eligibles" will have higher than average risk scores which will make them eligible for our complex care coordination program on one of these two levels. High and very high-risk individuals will be eligible for care coordination and the support of a lead care coordinator to facilitate a structured process to support the patient in identifying and triaging his/her most important health-related goals. These are detailed in a shared care plan through OneCare's care coordination software platform, Care Navigator. During the process the patient is asked to select a lead care coordinator among his/her care team and this person serves as a coach and champion, coordinating care among care team members in support of attainment of the patient's stated health goals.

   In addition to care coordination, "Dual Eligibles" may benefit from new benefit enhancement waivers such as the waiver of a 3-day inpatient stay before transfer to a skilled nursing facility or additional home health visits post hospital discharge. These serve as critical care transition periods where it is vital that we improve coordination and ensure solid connections to out-patient care.

   Centrally, OneCare monitors utilization metrics and develops and deploys strategies to support optimal care delivery and patient outcomes. This occurs, in part, through our monthly utilization review process and in supporting our clinical priority areas (e.g. reducing unwarranted variations in care in the 48 Medicare "episodes of care bundles" across health service areas, Ambulatory Sensitive Condition Admission reduction, ED use reduction, palliative services promotion, and primary and secondary prevention through increased use of the Medicare Annual Wellness Visits which facilitate identification of health risks or opportunities). Together, these programs all contribute to better quality care at lower cost.

6. *Please provide additional detail about the risk mitigation measures taken by the risk-bearing hospitals to ensure they can cover the downside risk for their communities without asking the Green Mountain Care Board for rate increases.*

   a. *How will OneCare ensure that beneficiaries receive all needed services particularly if a hospital or health service area is at or approaching a cost overrun?*

      High quality patient care is a critical component of the value based incentive fund return to each participant community. Poor performance on the quality measure report card due to low provision of preventive, screening, and chronic care will lead to direct financial

consequences for a particular HSA or provider.

Patient ability to lodge complaints and benefit appeals are retained in the risk paradigm contracts that OneCare is providing to our network. Regular progress meetings with the payer administration will permit action steps to address such concerns. Our WorkbenchOne™ utilization application tracks under as well as over utilization. Our Utilization Review committee monitors this data monthly and can ask the Population Health Strategy Committee and the Board of Managers for directed interventions to address concerning trends.

b. *How will the ACO support hospitals in managing financial risk?*

In July 2017 OneCare 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.

Please refer to the answers in Questions 2 and 5 above.

7. *Please provide additional detail about the methodology used to determine the trends for each payer.*

a. *How did you determine the 2.0% Medicaid trend and what was the reasoning behind this methodology?*

This trend rate was supplied by Milliman, the actuarial firm hired by OneCare to assist with analysis. Their analysis breaks down the historical data into service type groupings and explores trends within each. From there, they aggregate the micro trends up into an overall trend rate for the program. The 2% trend applied in the budget was within the actuarial range supplied.

b. *How did you develop the Medicare trend and what was the reasoning behind this methodology?*

The 2017-2018 Medicare trend was derived from the All-Payer-Model contract. Based on the latest available Medicare FFS cost trend projection from CMS, the 3.5% All Payer Model rate increase floor would apply and the budget was built accordingly.

8. *How were service category Per Member per Month (PMPM) amounts calculated under a capitated agreement (e.g., were these calculated based on amounts the ACO anticipates would have been paid under FFS)?*

Yes, the financial model attempts to predict the mix of services that would have been delivered in a purely FFS model.

a. *Please provide service category utilization in addition to PMPMs.*

The actuarial models used for budget development were based on overall spending trends and did not break down utilization by service category. This process will take place once the final spend targets have been calculated so that we have baseline utilization targets that reconcile to

the overall spend. As we progress with two-sided risk programs, having this utilization baseline will be essential to successful performance.

9. *According to Appendix A3: Summary ACO Provider Network there will be an average of about 176 people attributed per primary care physician including adult and pediatric PCPs. This would represent about 12% of a typical primary care provider's patient panel (1,500). Please discuss how practices would change under a mix of capitation and FFS.*

   There are several factors that impact this calculation. First, included in the 779 primary care specialty practitioners are clinicians functioning as hospitalists and not in a position to manage an attributed population. Secondly, many of our primary care providers do not have panels of patients near 1,500 patients. Many faculty physicians are part time with educational, research and other service obligations. This mix of capitated/risk beneficiaries with fee-for-service patients provides a graded experience "on ramp" for practices to pilot operational changes to better serve patients in the new paradigm. In subsequent years and with the addition of self-insured accounts to the population health methods, these percentages will increase substantially.

   a. *What are the key changes you have made or plan to make to address FFS "motivational issues" mentioned in the narrative, given that patients under a capitated agreement will remain a minority?*

      We submit that the capitated/prepaid patients will benefit from the willingness of clinicians to meet their care needs with innovative non face-to-face methods such as telephone, video conferencing, EMR portal responses, virtual visits (store/forward/reply) and multidisciplinary care conferences. OneCare's care model provides for provisions of additional financial resources to engage in care coordination activities at the practice level and using our Care Navigator tool to better communicate with community agencies. These methods can improve access and convenience for patients in that they decouple care decisions from RVU generating office visit priorities. Clinicians can interact with a larger number of patients in the same or shorter time. Clinician compensation models will need to adapt to incent excellent performance on mixed panels of patients, pending a much larger percentage of patients covered under a fixed payment model.

   b. *How will provider contracts change to manage the mixed incentives of FFS and capitation?*

      The incentives of the two payment systems will coexist for a period of time. Clinician compensation models will evolve to place an increasing emphasis on quality and productivity metrics needed to effectively serve patients. This will be true for both primary care and specialty care clinicians. Data analysis of practice level and provider level performance managing both types of patients will influence clinician compensation models – with patient satisfaction and adherence to standardized evidence-based disease management protocols as major components. Specialists and primary care clinicians will need to communicate in ways that improve access to specialty care advice to expedite diagnostic pathways/laboratory testing/imaging and design of appropriate treatment plans. It is likely that specialists will be incented to provide facilitated interactions with primary care clinicians before face-to-face

specialty consultations thus speeding the process of getting the patient an accurate diagnosis and still benefiting from face-to-face interaction with the specialist.

10. *Why are different enrollment numbers used for calculating revenue and cost PMPMs in 2016 and 2017? It appears that the 2018 enrollment numbers were used for all three years on the cost side. Please explain the reasoning for this.*

    The financial models project forward the lives expected to be in the network in 2018, and then look back at their spend over the previous years. This "closed cohort" approach quiets noise from changes in the network providers, which impacts spend characteristics, risk scores, and general population shifts.

11. *When comparing revenue (T1 [omitted in public version], OneCare Projected Cost and Revenue Data Package) and costs (T3, OneCare Projected Cost and Revenue Data Package) by payer for 2016, 2017, and 2018 there appear to be significant losses in 2016 actual ($97 million) and 2017 ($172 million). In 2018, Medicaid and Commercial break even and Medicare makes a small profit (before Admin). Is this an artifact of how reporting is done?*

    The spending targets are presented as "revenue" in the GMCB templates, but those were not actually dollars that passed through OneCare. Rather, they were illustrative of the scope of the spending for the population projected to be in the network in 2018 and the overall accountability of the ACO.

12. *The 2017 Lewis and Ellis Medicaid Advisory Rate Case for ACO Services estimated that OneCare would have had about 26,000 lives in Base Year 2015, with a PMPM of $256. Per the most recent DHVA report to the legislature, actual attributed lives as of January, 2017 were 29,102. The 2016 budget numbers are very different (enrollment of 37,000 based on revenue and 55,000 based on costs; PMPM of $169 based on revenue, $261 based on costs).*

    a. *Why are the cost PMPM trends so consistent (2%-5% per year, depending on year and payer) while the revenue PMPM trends are so erratic? For example, the Medicaid revenue PMPM jumps by almost 54% from 2016 to 2017, Medicare revenue trend is -9.3% from 2016 to 2017 and 17% from 2017 to 2018. Is this the effect of non-care revenue?*

    In reference to Appendix C tab T1, there are two perspectives displayed. The top represents the spend history for only the lives expected to be attributed in 2018. The actual 2016 cost of care for these lives are then trended forward to 2017 and 2018 based on either actuarial analysis or contractual language.

    The bottom section represents historical OneCare shared savings programs. The variation in PMPM is an excellent example of the way that network configuration can dramatically affect the overall cost of care. This is why the OneCare budget approach uses the fixed cohort of lives and examines the trends for these patients in isolation.

13. *The enrollment numbers reported in the most recent DHVA report to the legislature show that the number of attributed lives is declining by an average of about 500 per month. How will this affect the budget, assuming this pattern continues (as a result of retrospective attribution)?*

The initial budget submission assumed that all lives will participate throughout the year. This essentially sets the high mark for spend, and allows typical attribution attrition to draw down the spending target throughout the plan year.

a. *Do you anticipate that those who do not remain attributed for the full year will be sicker or healthier than those who do remain attributed? How do you anticipate this will affect the budget?*

   Based on the actuarial analysis provided, the lives that fall off tend to cost less, but there is some variability within eligibility aid categories. For the Medicaid program, this has been factored into the rate analysis provided by the actuarial firms.

14. *Please provide additional detail about the pharmacy and mental health services that are included in this budget.*

a. *Do you anticipate including pharmacy coverage for Medicare and commercial lives? There is significant PMPM spending for outpatient pharmacy for both payers.*

   There is no Part D pharmacy spend included in the Medicare Next Generation program.

   The current negotiation with BCBSVT does include Part D pharmacy spend for non-specialty drugs. The risk arrangement can only reduce earned savings on the medical spend and does not add any addition downside risk for the network.

b. *Why is the professional mental health PMPM substantial for Medicaid ($17.49 2016 actual), moderate for Medicare ($6.05), and minimal for commercial ($0.43)?*

   This variation is likely due to both the payer reimbursement models and the populations served. The OneCare budget submitted projects forward historical spend distributions and does not build any adjustments to level-set between payers.

15. *Does the Sherlock Company's operations benchmark range include utilization management?*

The Sherlock benchmarking tool looks at administrative costs by category and level sets against attribution figures. The tool does not look at network utilization trends.

OneCare monitors utilization in a number of different forums. Firstly, the Utilization Review Committee meets monthly to review reports, trends and collectively explore progress and patterns within the network. In addition, the OneCare Finance Committee receives regular reports on the performance of the VMNG program, which includes a utilization review by providing hospital and attributing HSA.

In addition to the tailored reports, the OneCare analytics platform offers providers a self-service tool to investigate their own service delivery and cost trends. This strategy engages providers in their own performance within the two-sided risk paradigm.

a. *Does OneCare plan to perform utilization management services for any of its contracted payers?*

*If so, please provide a detailed description of how OneCare plans to conduct utilization management.*

The vast majority of clinicians perform in a normative fashion. Therefore, the challenge is identifying those hospitals, agencies, or individual clinicians who display outlier characteristics. OneCare's data analytics will permit practice and provider level analysis on categories of utilization and care (complex imaging rates, hospital length of stays, readmission rates, emergency department utilization, therapy services, specialty referral rates, skilled nursing facility post-acute utilization and length of stays, etc.). This data will be reviewed regularly by the Utilization Review Committee, processed by the Population Health Strategy Committee for recommended action steps and reported to the BOM for implementation when unwarranted variation is identified. WorkBenchOne™ provides applications to view population and provider level cost and utilization analysis. Our Episodes of Care Application provides a valuable tool to assess variation for utilization of hospital acute services as well as the gamut of 90-day post-acute service usage. Since hospital and post-acute services make up such a large proportion of total cost of care, this tool greatly facilitates statistical analysis of clinical variation that can be communicated to each HSA for their own process improvement interventions with ACO monitoring of post-intervention trends.

OneCare is also beginning to explore comparisons of the payer's assessment of utilization with the OneCare data set. This process will serve as a double check on assuring that data definitions are congruent and that observed trends are verifiable in both data sets.

16. *Hospitals often charge significantly more than the actual cost of providing certain services in order to fund other needed services. This dynamic places the burden of paying for hospitals' "fixed costs" on individuals who need particular services, and likely impedes innovation that could offer some services at better quality and lower cost. What is OneCare's strategy for addressing this dynamic?*

OneCare plans to primarily address this through our hospital fixed prospective payment (FPP) model where health plan payments will not be made under fee for service (FFS) payments to in-network hospitals. They will instead be paid by OneCare under a "global budget" style approach where the hospitals are pre-paid monthly for any and all services provided to the OneCare population.

a. *What are the strengths and weaknesses of the strategy?*

The largest strength of the model is how clearly the hospital incentives shift away from FFS where what is charged (or received or negotiated as reimbursement) on individual services and service lines is central to financial budgeting. One weakness is that this model will only apply to attributed patients, which under the initial years of the all payer ACO model (APM) will be fewer than those still covered and paid under FFS. That is a driving reason behind the APM "scale targets" which work to ensure that incentives truly drive new thinking. Also, we need to ensure that the measures of access, quality, and patient satisfaction included in APM and OneCare's ACO programs are monitored and reported, with strong inclusion in the value-based financial model.

b. *If global hospital budgets are part of your strategy, please explain how this payment methodology will address within-hospital cost shifting and align consumer costs with the costs of the services*

*provided.*

Again, the very nature of global budgets greatly deemphasizes individual service or service line financial optimization. For serving attributed populations in 2018, hospitals will need to determine the basis for allocating revenue to service lines from the FPP. Although some may choose to simply use the FFS-equivalent initially, we expect this to shift rapidly to one based on true costs and the clearer picture of population-based health care economics it offers.

As for aligning consumer costs, OneCare does not set Medicare nor Medicaid models of patient "out-of-pocket" (OOP) cost-sharing or the underlying reimbursement it may be based upon. For commercial contracts, however, the shift in incentives will significantly lower barriers to hospitals working with OneCare and commercial payers on more rational models of underlying reimbursement for attributed patients to better align patient OOP costs with the cost of the actual services provided. This will be challenging territory due to the models of plan "actuarial value" where the ratio of plan-paid versus patient-paid is the central concept. Changes in out-of-pocket models are typically implemented very carefully as relationships exist between utilization and patient OOP expenses. It is worth noting that one major element of the new hospital incentives under OneCare's ACO risk programs is better focus on ensuring patients do not defer necessary care which could cost more later. In a FFS system, this drives additional revenue, but doesn't in a risk-based ACO model. Hospitals will want to understand where OOP costs might be keeping patients from receiving necessary preventive care, diagnostics, therapies or services.

17. *There is significant concern that ACOs simply add an extra layer of administrative cost to the health care system. There is also a hope that ACOs can streamline health care payment systems and other processes to reduce the burden on providers. How is OneCare planning to help reduce provider administrative costs and resources? Please provide an estimate of how much money this will save and/or any other benefits that will result.*

An ACO like OneCare is more accurately described as part of the existing layer of financial and care management administration seen in government payers and commercial health plans. The administrative expense to the system shall increasingly shift from payer programs to OneCare's model of supporting true population health management through enabling providers and communities already touching the attributed lives with supportive processes and tools. Since OneCare intends to apply an "all payer" approach and infrastructure to what is now fragmented across many payers, OneCare should end up with a lower cost model for its administrative role with greater scale of lives than any individual program or payer under the current system. OneCare has no standing to ensure cost savings are achieved on the program/payer side, but if fully captured such savings could be 1% to 2% of the premium equivalent, which at scale drives significant savings.

On reducing administrative burden to providers, the shift to a more coordinated and proactive system of care which also rewards access, quality and satisfaction will continue to involve new processes and systems. OneCare will continue to be a facilitative partner with our providers and communities to see payment reform programs, process redesign, team-based care, and innovation as the primary antidotes to the ever increasing challenge of operating in a more value-based, coordinated and proactive care delivery system. For 2018 we are establishing a primary care multi-payer capitation pilot to test a monthly payment model for primary care services. It is designed to

enable innovative practice processes, organizational models, and panel management approaches for more efficiency and effectiveness. Although new provider payment streams like this are intended to be simpler and more predictable than fee for service (FFS), claims must still be submitted to payers for many important reasons even if they are not the source for payments.

To help ease the burdens of quality measurement in a value-based system, OneCare has been a clear leader in Vermont on aligning quality measures across payer programs. OneCare has worked strongly with the Green Mountain Care Board since 2014 to design and manage quality measures across ACO programs. When OneCare worked with the Department of Vermont Health Access (DVHA) on the Vermont Medicaid Next Generation (VMNG) program for 2017, negotiations resulted in a reduction in the number of proposed measures, and an increase in the number tied to claims, resulting in less interruption for practices and easier monitoring of quality goals during the performance year. OneCare also brings highly developed quality data collection and support resources and tools to our network. Our systems include live ACO Gateway connectivity to VITL which is starting to enable automated collection of quality indicators even when requiring clinical information. Also worth noting is that for Medicare, ACO participation also eliminates additional Medicare Incentive Payment System (MIPS) reporting requirements.

Another way OneCare helps ease provider burdens is through simplifying or eliminating payer-side controls. Payers have traditionally sought to limit claims costs through program controls such as Prior Authorization. OneCare seeks to have these programs reduced or removed as we assume the risk for claims spending. They are burdensome for patients, providers, and payers but have unfortunately been a necessary "Band-Aid" remedy to drive some level of claims cost awareness by providers who had no other such incentives in a purely FFS system. We are already removing Prior Authorization requirements under the VMNG program and are discussing a similar approach with Blue Cross Blue Shield of Vermont (BCBSVT). Additionally, some rules for Medicare are waived under the Next Generation program to better streamline getting Medicare beneficiaries care through telemedicine, home health, and more rapid SNF access.

OneCare has also been a leader in aligning the ACO model with the Blueprint for Health program to avoid competing approaches and priorities. OneCare and Blueprint leadership work closely on community-based models and deploy shared resources as truly integrated and aligned programs. We continue to discuss jointly whether the Blueprint and OneCare might partner to propose relieving primary care practices in OneCare's risk-based programs of the required NCQA medical home certification but still remain in the Blueprint program and eligible for payments.

18. *How will OneCare address patient requests for appeal when there is no dispute over insurance coverage for the service (e.g., if a patient is denied a service by a provider or ACO that is medically necessary and covered by the patient's health insurance plan)?*

In the VMNG program, if a beneficiary initiates a complaint with OneCare disputing denial of service related to their insurance coverage, OneCare will provide the member with the contact information for DVHA's grievances and appeals unit. If the beneficiary decides to submit a formal grievance, DVHA will inform the patient of the grievance and appeals process (to include the provision of the Health Care Advocate contact information). OneCare will track all complaints, grievances and appeals that originated at OneCare and work with DVHA to ensure that they are resolved.

If, in this example, the member initiates a complaint regarding a quality of care concern on behalf of

an OneCare-participating provider, OneCare will offer its own similar grievances and appeals process to the beneficiary, with the option of a second grievance review by DVHA if resolution is not attained in working with the ACO. OneCare will track all complaints, grievances and appeals that originated at OneCare and continue to provide monthly reports to DVHA for transparency and shared resolution. OneCare will work with BCBS-VT to institute similar protocols for patients attributed through commercial programs.