To: **Alena Barube, Melissa Miles, and Marisa Melamed Green Mountain Care Board**
From: **Vicki Loner, CEO OneCare Vermont, Accountable Care Organization, LLC**
Date: **October 16, 2019**
Subject: **Responses to 2020 Continued Certification Follow-up Questions**

Dear Alena, Melissa and Marisa,

Please find below OneCare Vermont's responses to the Green Mountain Care Board's follow up questions regarding our 2020 continued Certification. Our responses are below and in italics.

1. Are new educational materials posted online or does OneCare plan to post these materials e.g. Intro to OneCare, ACO 101, acronym list? The submission states, "OneCare has increased our educational efforts to the public by creating more public-focused materials that describe how OneCare works…" how are you making materials available to the public (p.5)?

   OneCare has revamped its website to include new and better organized information accessible to the public. Additions include a OneCare Glossary, a Value of OneCare chart, and a printable version of the Introduction to OneCare. In addition, there is a new blog intended to increase awareness about ongoing projects and contributions to healthcare delivery reform. OneCare also shares informational materials at community meetings, public events, and conferences. OneCare also provides patient fact sheets to the provider network and clinical consultants. Please note that, as part of contractual obligation to Medicare, there are limitations in public materials that may be published and are required to seek prior approval of public materials involving Medicare

2. Submit a full organizational chart for OneCare with position titles for all employees (individual names are not required below the leadership/governance level as provided in the previously submitted governance chart).

   Attached is a full organization chart with position titles.

3. Submit resumes for the Executive Team. When the two vacant Executive Team positions are filled (VP and Chief Operating Officer and VP of Revenue and Strategy), please submit resumes for those positions as well.

   Attached are resumes for OneCare's Chief Executive Officer, Chief Medical Officer, and Chief Compliance and Privacy Officer.

4. Does OneCare prepare a financial risk assessment for its Board of Managers (BOM)? If yes, please describe the process that OneCare follows to produce and present the assessment, including the frequency with which this assessment is done and presented to the BOM. Has OneCare presented a 2019 and/or 2020 risk analysis to the BOM? If so, please provide.

   This question seems to imply that there is one item that is a "financial risk assessment" which is an inaccurate assumption. Every decision that the Board makes related to payments and programs is supported by financial analysis that originates with OneCare staff, is shared with the appropriate

committees such as Finance or Population Health and/or Executive, is revised (if necessary) according to the guidance of the committees and is then presented to the Board in meeting materials and then considered at a Board meeting. In other words, financial risk assessments are a part of most Board decision making.

5. What checks or controls are in place to maintain the required functionality for the accurate and timely administration payments on behalf of enrollees?

   OneCare is unsure of the meaning of "administration payments" and "required functionality" and does not perceive it is making payments on behalf of enrollees. Given this uncertainty, OneCare has interpreted this question as inquiring about the processes and controls in place to ensure that payments to network participants are made timely and accurately and responds accordingly.

   OneCare makes the routine payments to network participants each month. This process is coordinated and facilitated by the Accounting and Financial Management team within the Finance Department. The latest monthly attribution update file from the payers is the primary source of information used to prepare the payment batch. These attribution files go through a thorough internal quality assurance (QA) process to ensure accuracy. After attribution file QA, the data are delivered to the Accounting and Financial Management Team, which is the group within the Finance Department responsible for network payments. This team produces the initial calculations for these attribution-based payments. For payments that are not based on attribution, a cross-functional team generates required clinical data, care navigator data, and financial data to prepare the initial calculations and communicates the results to the Accounting and Financial Management Team to be incorporated into the master payment batch file.

   After completing the batch build, an analysis is prepared that tests the payment calculations, and compares the payment amounts to those made in the prior month across both payment type and recipient. Any variances are investigated and the resulting findings are noted.

   A batch approval memo is then circulated to leadership in accordance with the Payment Disbursement Policy. This memo contains all the backup information for the payment batch as well as the results of the comprehensive analysis.

   After final signatures and leadership approvals are secured, the Accounting and Financial Management Team loads the payment batch for ACH transfer to the network. This is cross-reviewed within the team. Two approvals are required to release the final batch.

6. For any payment distribution policy that points to a distribution methodology approved by the board (e.g. VBIF distribution policy), for each policy please explain the extent to which the actual method of distribution approved by the board may differ from that which is described in the policy. Please cite any relevant prior year examples.

   None. The combination of payment policies and procedures is the Program of Payments and is developed with the best information available at the time, vetted through Board committees and then the entire Board. The Programs of Payments and the Participant Agreements are provided to the network during the contracting process with the best information at that point in time. Given the dynamic nature of the programmatic elements, and the fact that many key aspects are not

determined when contracting is required by payers, the Board reserves the right to amend the Program of Payments during the Program Year and the Participants (who enjoy at least 75% representation on the Board and are necessary for the supermajority required to modify the Program of Payments) contractually agree to that process. If the Board votes on a matter within the Program of Payments in a manner that makes modification(s), that is a contractually permitted amendment of the policy(ies) by the Board.