GMCB 2017 Test Year ACO Budget Review
Questions for OneCare Vermont
August 4, 2017

I. ACO Information and Background (Part 1)

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

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

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

II. ACO Provider Network and Provider Risk Assumption (Parts 2 and 3)

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

2. 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.
    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?

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

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

5. 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.

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

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

III. ACO Payer Programs and ACO Budget and Financial Plan (Parts 3 and 4)

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

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. 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?
    b. What differences in care processes do you anticipate as you move from shared savings to capitation?
    c. How confident are you in your budget projections? Where are the areas of greatest uncertainty?

Please explain the following from the financial table submissions:

2. 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?

3. 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.

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

5. 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?
    b. There are $1.7M in incentive payments to "Continuum of Care". What does this represent?

6. Appendix B-5 depicts the administrative budget.
    a. There is no expense for claims administration. How is that function being funded?
    b. What is "ACO Programs Team"?
    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?
    d. Are there any planned major capital expenditures not captured in the report templates?

7. 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.

8. 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?

9. Please provide total operating expenses and annual depreciation for 2016.

10. 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.

11. "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?
    b. What programs or changes have been or will be put in place to aim toward a shared savings payment in 2017 and beyond?

12. "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?
b. What programs or changes have been or will be put in place to aim toward a shared savings payment in 2017 and beyond?

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

14. Please include 2016 budget numbers in Appendix C.

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

16. 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?
    b. adjustment for historical changes in population clinical risk?
    c. adjustment for changes in provider rates and/or service coverage?
    d. adjustment for high-cost patient outliers?

17. 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?

18. 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.

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

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

21. For Medicaid and BCBSVT programs, please describe the nature and structure of the planning data sets received from the Letters of Interest (LOI) from the providers. Please also provide a summary of the data collected.

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".

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.

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.

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

IV. ACO Model of Care and Community Integration (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?

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?

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?

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?
   - 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)?
   - 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)?
   - 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?
   - 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)?
   - 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)?
- 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)?
- 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?

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.

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.

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