Green Mountain Care Board

Medicaid Advisory Rate Case for ACO Services

Review of OneCare Vermont's All-Inclusive Population-Based Payment

Amended Report

JANUARY 31, 2017

ACTUARIAL REPORT

Lewis & Ellis, Inc.

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January 31, 2017

Green Mountain Care Board

Re: AMENDED Actuarial Report on the OneCare Vermont's All-Inclusive Population Based Payment

To the Board:

On December 29, 2016, Lewis & Ellis, Inc. (L&E) provided the Green Mountain Care Board an Actuarial Report outlining its review of the all-inclusive population-based payment arrangement between the Department of Vermont Health Access (DVHA) and OneCare Vermont. L&E was subsequently notified by DHVA's actuary, Wakely Consulting Group, that additional changes had been made to the attributed members. As a result of those changes, L&E now submits this amended report with modifications appearing in the following sections: *Scope of Work*, *Methodology*, *Data Scrubbing*, *Trend*, *ACO Efficiency*, *Risk Arrangement*, and *Conclusions and Recommendations*.

The original report may still be referenced; however, we have made an attempt to clearly identify the changes in the numbers throughout this report.

If you have any questions regarding this report, do not hesitate to contact me.

Sincerely,

Jacqueline B. Lee

Jacqueline B. Lee
Vice President & Principal
Lewis & Ellis, Inc.

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EXECUTIVE SUMMARY

The Green Mountain Care Board (GMCB, Board) is required by the Vermont Legislature[1] to review any all-inclusive population-based payment arrangement between the Department of Vermont Health Access (DVHA) and accountable care organizations (ACOs) effective for Calendar Year 2017. The Board's review shall include the number of attributed lives, eligibility groups, covered services, elements of the per-member, per-month (PMPM) payment, and any other non-claims payments.

GMCB engaged Lewis & Ellis, Inc. (L&E) to provide a review of the payment arrangement between DVHA and the ACO, OneCare Vermont. This report is the documentation of the review and recommendations to the Board that may be passed on to DVHA and its actuary, Wakely Consulting Group, prior to the issuance of the final capitation rates and report. The recommendations presented to DVHA are intended to be advisory and non-binding.

Wakely originally planned to deliver its final report with the certified capitation rates in December 2016; however, in January 2017, it was recognized that the attribution assignments for the cohorts were incorrect. Additionally, since more information was available about the attributed population, assignments as of January 1, 2017 were used. The capitation rates are anticipated to be completed in early 2017.

L&E and GMCB worked with Wakely and DVHA to understand the process they were using and obtain data used to calculate the capitation payments. Based on the individual assumptions and recommendations discussed in the report, L&E has provided an estimated rate calculation for each Medicaid Eligibility Group (MEG).

Capitation Rate Development			
	ABD (A&C)	**Adult**	**Child**
2015 Attributed PMPM	$621.91	$359.94	$109.50
Completion Adjustment (IBNR)	1.009	1.009	1.009
Benefit Adjustment	1.000	1.000	1.000
Adjusted 2015 Attributed PMPM	$627.50	$363.18	$110.49
2 Year Trend Adjustment	1.008	1.028	1.032
Additional Benefit Adjustment	1.000	1.000	1.000
ACO Efficiency Adjustment	0.990	0.990	0.990
Population Adjustment	1.000	1.000	1.000
2017 Projected Cost of Care	$626.21	$369.68	$112.91
Administrative Cost (PMPM)	$6.50	$6.50	$6.50
2017 Capitation Rate	$632.71	$376.18	$119.41

It is important to note that L&E is not recommending that Wakely's calculation or the final rates need to match L&E's estimation. This is L&E's best estimate based on the information and conversations with Wakely and DVHA. L&E recommends that each assumption be compared with the similar assumption used in Wakely's calculation and consider if L&E's development of the assumption is a different approach or accounts for other information that Wakely should further research.

[1] Act 113 (2016) Sec 13

REVIEW OF ALL-INCLUSIVE POPULATION-BASED PAYMENT

Background

On April 7, 2016, DVHA released a request for proposal (RFP) that sought interested Accountable Care Organizations (ACOs) to participate in a population-based payment model similar to the Centers for Medicare & Medicaid Services (CMS) Next Generation ACO Model. As part of this model, the ACO will receive monthly capitation rates for all services covered under this program. As part of this endeavor, DVHA engaged Wakely Consulting Group (Wakely), an actuarial firm, to develop and certify to these capitation rates.

OneCare Vermont was the only successful bidder under the RFP. Therefore, Wakely has been tasked with developing capitation rates for OneCare Vermont for use in performance year (PY) 2017. Wakely originally planned to deliver its final report with the certified capitation rates in December 2016; however, in January 2017, it was recognized that the attribution assignments for the cohorts were incorrect. Additionally, since more information was available about the attributed population, assignments as of January 1, 2017 were used. The capitation rates are anticipated to be completed in early 2017.

Scope of Work

The Green Mountain Care Board is required by the Vermont Legislature[2] to review any all-inclusive population-based payment arrangement between the Department of Vermont Health Access and accountable care organizations effective for calendar year 2017. The Board's review shall include the number of attributed lives, eligibility groups, covered services, elements of the per-member, per-month payment, and any other non-claims payments.

GMCB engaged Lewis & Ellis, Inc. (L&E) to provide a review of the payment arrangement between DVHA and the ACO, OneCare Vermont. L&E has not seen Wakely's final capitation rates or final assumptions. This report is the documentation of the review and recommendations to the Board that may be passed on to DVHA and Wakely prior to the issuance of the final capitation rates and report. The recommendations presented to DVHA are intended to be advisory and non-binding.

L&E provided the GMCB with an Actuarial Report on December 29, 2016 outlining its review of the all-inclusive population-based payment arrangement between DVHA and OneCare Vermont. L&E was subsequently notified by Wakely that additional changes had been made to the attributed members. As a result of those changes, L&E now submits this amended report. Over the course of the first three weeks in January, L&E received several updated versions of the data and model. This report will outline the modified trend study and ranges of results.

Methodology

L&E and GMCB worked with Wakely and DVHA to understand the process they were using and obtain data used to calculate the capitation payments. Wakely provided L&E will the historical claims experience for Base Years (BY) 2013, 2014, and 2015 and with the base model they used to develop the capitation rates. These claim amounts were provided for each Medicaid Eligibility Group (MEG), split between those attributed to OneCare Vermont and those who were not.

[2] Act 113 (2016) Sec 13

L&E received the following information that represents the corrected figures:

Historical Claim Costs PMPM				
MEG	**Cohort**	**BY2013**	**BY2014**	**BY2015[3]**
ABD[4] (Adult & Child)	OneCare VT	$585.10	$603.34	$621.91
	All Eligible	$530.31	$566.76	$580.13
Consolidated Adult	OneCare VT	$302.96	$324.87	$359.94
	All Eligible	$294.41	$309.59	$328.76
Consolidated Child	OneCare VT	$111.15	$121.18	$109.50
	All Eligible	$104.12	$112.96	$111.19
Total	OneCare VT	$222.56	$242.41	$256.14
	All Eligible	$218.40	$238.84	$251.77

Enrollment (Member Months)				
MEG	**Cohort**	**BY2013**	**BY2014**	**BY2015**
ABD[4] (Adult & Child)	OneCare VT	20,976	21,853	22,362
	All Eligible	79,528	83,228	85,710
Consolidated Adult	OneCare VT	79,473	110,848	137,233
	All Eligible	327,212	464,264	579,468
Consolidated Child	OneCare VT	125,614	140,467	152,918
	All Eligible	434,682	477,782	517,553
Total	OneCare VT	226,063	273,168	312,513
	All Eligible	841,422	1,025,274	1,182,731

Risk Scores				
MEG	**Cohort**	**BY2013**	**BY2014**	**BY2015**
ABD[4] (Adult & Child)	OneCare VT	1.8749	1.9821	2.0797
	All Eligible	1.7728	1.8609	1.9117
Consolidated Adult	OneCare VT	1.0607	1.1226	1.2057
	All Eligible	1.0009	1.0702	1.1298
Consolidated Child	OneCare VT	0.3897	0.3886	0.3969
	All Eligible	0.3616	0.3713	0.3865
Total	OneCare VT	0.7634	0.8139	0.8725
	All Eligible	0.7436	0.8087	0.8612

Wakely received detailed claim data that included dates of service, Medicaid Eligibility Group, CPT (Current Procedural Terminology) codes, Categories of Service (COS), paid amounts, dates of birth, Eligibility Start and End dates, and many other fields. L&E received a complete list of the data fields Wakely received for both the claims file and the eligibility file.

The main changes from the original data set and these amended figures was seen in the Aged, Blind, and Disabled (ABD) MEG. The PMPMs increased by roughly 30% in each base year, the enrollment assigned

[3] Includes a completion factor adjustment.
[4] Aged, Blind, & Disabled

to this MEG reduced by about 40%, and the risk scores for ABD increased significantly by 70% to 80%. The other MEGs had more moderate shifts in the PMPMs, enrollment, and risk scores. The total enrollment and overall PMPMs changes because the original report utilized eligibility as of November 2016. With the calculation of the capitation rates changing, it was decided to use eligibility as of January 2017. This removed any potential need for an adjustment to better reflect the actual population to be covered because it is now reflected entirely in this updated eligibility run.

Data Scrubbing

The historical figures were adjusted to reflect the anticipated population and covered services for 2017. The adjustments made to the original data Wakely received included:

- Attributees
- Covered Services
- Completion of Claims for BY2015

ATTRIBUTEES

Wakely grouped the claims data and enrollment based on which individuals would be attributed to OneCare Vermont and those who would not in 2017. This attribution process uses the attribution years to assign members to the ACO. L&E has relied on Wakely to work with the health policy vendor, Burns and Associates, Inc.[5] (Burns) and the ACO to correctly assign the appropriate members to the ACO. This prospective process alleviates the need to project potential changes in the population. Due to the prospective attribution process, there is no need for an adjustment to account for the anticipated 2017 population because it is generally known and would not produce a material impact.

Wakely adjusted the base year data to only include the claim and enrollment data on attributed members. These attributed members were influx throughout the last part of 2016 as OneCare Vermont was finalizing its provider networks. Therefore, L&E did not have an opportunity to review or audit Wakely's categorization of the attributed members, though L&E reviewed and agreed with Wakely's overall methodology.

As of the amended report, the attribution process was using individuals eligible as of January 1, 2017.

COVERED SERVICES

Similar to the population, the anticipated covered services were well defined in the RFP. Since Wakely had detailed claims data, it was able to remove any services included in the base year data set that were not to be covered by the ACO. The RFP included a list of CPT codes that were covered. L&E received a detailed listing of the CPT codes, and the list is available upon request. Therefore, since the covered services were known and the base data was adjusted to reflect only the covered services, there is no additional adjustment needed for changes to benefits anticipated for PY2017. Because of the tight timeline, L&E did not audit Wakely's assignment of the covered services to the base data, though L&E reviewed and agreed with Wakely's overall methodology.

COMPLETION OF CLAIMS FOR BY2015

Typically, health claims can take up to 12 or 18 months to be fully reported and paid. Because the run out on the BY2015 is through June (or 6 months), an adjustment factor needed to be applied to the BY2015

[5] http://www.burnshealthpolicy.com/

to estimate completed claims for the base year. For six months of run out, L&E anticipates an increase of paid claims between 0.5% and 2.0% to estimate fully reported and paid claims. L&E believes that Wakely's adjustment of 0.8% is appropriate, as if falls within L&E anticipated range.

Projection

The base period data was projected to calculate 2017 capitation rates. The projection factors included:

- Trend
- Benefit Changes
- ACO Efficiency
- Population Adjustments
- Administrative Expenses
- Risk Charges

TREND

In order for the historical experience to be representative of costs in the projection year, the data needed to be trended forward to account for changes in utilization and unit cost of the services provided. Wakely provided claim costs on a PMPM basis, risk score, risk-adjusted PMPM, and membership, each split out between the various cohorts (e.g. OneCare Attributed Adult, Blind, & Disabled). These figures were provided for Base Years 2013 through 2015. The data was normalized to only reflect the anticipated covered population.

Using this data, L&E was able to calculate the change in costs over the two-year time period by cohort. Ultimately, L&E decided to use the risk-adjusted PMPMs to calculate the historical annual trends experienced by each cohort. Risk-adjusted PMPMs provide more credible results because the risk-adjustment removes some variability captured in the PMPM. Therefore, L&E determined that the risk-adjusted trend produced a better estimate than the unadjusted trends.

Additionally, L&E utilized both the 2014/2013 and 2015/2014 annual trends and all members to estimate the future trends. In the estimation, L&E tested using different weights between the two annual trend figures, such as 50% of each or 40% of the 2014/2013 and 60% of the 2015/2014. Because the ACO had nearly 313,000 member months in BY2015 (representing roughly 26% of all member months), L&E also wanted to weight the ACO's population with all members' data to provide further stability. It was determined that a weighting of 50% of the 2014/2013 and 50% of the 2015/2014 was the most appropriate. For the blend between the attributed members and all members, L&E used a 70% weighting for the attributed members and 30% weighting for all members.

Risk-Adjusted Trends (OneCare Vermont)				
MEG	**Cohort**	**2014/2013**	**2015/2014**	**Projected 2017, Weighted**
ABD (Adult & Child)	OneCare VT	-4.2%	-0.9%	0.0%[6]
Adult	OneCare VT	-0.5%	4.1%	1.8%
Child	OneCare VT	14.8%	-10.7%	2.1%
Total	OneCare VT	6.9%	-4.0%	1.8%

Risk-Adjusted Trends (All Members)				
MEG	**Cohort**	**2014/2013**	**2015/2014**	**Projected 2017, Weighted**
ABD (Adult & Child)	All Members	0.6%	0.6%	1.3%
Adult	All Members	-4.3%	1.4%	0.4%
Child	All Members	4.9%	-4.5%	0.4%
Total	All Members	0.5%	-1.5%	0.5%

The trends above are quite volatile, which challenges the projected trend analysis. The ABD and Child cohorts experienced positive trends for 2014/2013 and then negative trends for 2015/2014 for both OneCare attributed members and all members. The Adult cohort saw opposite trend swings.

Blended Risk-Adjusted Trends		
MEG	**Blend (OneCare/All)**	**Projected 2017, Blended**
ABD (Adult & Child)	70/30	0.4%
Adult	70/30	1.4%
Child	70/30	1.6%
Total	70/30	1.4%

L&E also reviewed DVHA's Budget Document for State Fiscal Year 2017 to determine the overall reasonableness of the trends seen in the data provided. While this document provides general support of these lower trends, it was determined that the covered services differed enough from the covered services for the ACO that the comparison would not be appropriate.

L&E estimated ranges for each cohort based on different weightings between each blended annual trend. The range's bookends were determined by using the 50/50 weighting of the 2014/2013 and 2015/2014 annual trends and by using the 10/90 weighting of the 2014/2013 and 2015/2014 annual trends. L&E's estimate of the capitation rate was set using the trends below, using a 50/50 weighting. The results below

[6] Because the trends for 2014/2013 and 2015/2014 for ABD are both negative, the initial resulting projected 2017 trend was negative; however, it was decided that the projected 2017 trend be set at 0.0% to be conservative and would produce a trend that is more likely sustainable.

show inconsistent recommended trends because of the opposing trend swings previously observed, but L&E used a consistent methodology to determine the ranges and recommended trends.

Risk-Adjusted Trends (OneCare Vermont)			
MEG	**Low**	**High**	**Recommended**
ABD (Adult & Child)	0.3%	0.4%	0.4%
Adult	1.4%	2.8%	1.4%
Child	-6.7%	1.6%	1.6%

Benefit Changes

When projecting historical PMPMs forward, a typical practice includes adjusting for anticipated benefit changes. The RFP outlined the CPT codes to be covered by the ACO; therefore, the anticipated benefits have been accounted for in the historical data. L&E does not anticipate an adjustment for benefit changes that would need to be captured outside of the trend assumption.

ACO Efficiency

One of the responsibilities of the ACO is to achieve cost savings through high quality coordinated care[7]. Another adjustment to the base period experience includes accounting for the anticipated cost savings for the ACO that is not accurately reflected in the base period experience. L&E asked Wakely if they had any documentation or conversations that lead to an adjustment for the ACO Efficiency, and they stated that they anticipated minor savings that would help to keep trend moderated due to the care management of the ACO and the informatics platforms. Additionally, Wakely informed L&E that the data analytics group at Burns provided a summary of the savings opportunities of the group to be covered under the ACO. Wakely provided L&E with the summary from Burns after the first report was issued. According to L&E's interpretation of the analysis, the report shows that OneCare could potentially have maximum savings opportunities between 10% and 15%. This additional information did not impact L&E's initial recommendation because L&E is unaware of OneCare's intentions on achieving savings as the report indicates. Additional savings would be L&E believes that an adjustment between 0% and 3% would be an achievable amount for the ACO as a reasonable expectation for the ACO's first year given Burns' analysis. L&E is making an adjustment of 1% for the ACO Efficiency, which would represent an estimate on the low end.

Population Adjustments

It is also common practice to adjust historical experience for anticipated changes in population. Due to the attribution process, there will not be any new entrants during the projection year. Initially, newborn babies of covered mothers were going to be included and counted as the only allowable new entrants. However, during negotiations and discussions, it was determined that newborns would not be covered under the ACO rate. Since there are no new entrants, there is no population adjustment.

Administrative Expenses

As of the writing of this report, DVHA and OneCare Vermont have agreed to $6.50 PMPM to pay for general administrative expenses, care coordination, provider contracting, call center, and the informatics

[7] CMS Definition of ACO: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/index.html?redirect=/aco/

platform. DVHA provided L&E with its draft report of the readiness review[8] to provide additional insight into the services OneCare Vermont will be providing. For the general administrative, OneCare will be supporting staff and member services, including member communication, marketing and outreach materials, and member policies. DVHA's review was positive regarding the staff's experience and capabilities of being able to support the members of the ACO. Due to the experience of OneCare Vermont, the team will be efficient and not have a steep learning curve that would increase the cost and time to perform the general administrative tasks.

For care coordination, the ACO will use their care coordination model. OneCare Vermont appears to be organized and have the methodology well thought out and documented. The care plan team assigned to members is readily available online to continue efficiencies. These efforts should result in reduced costs for the ACO.

The provider contracting to be performed by the ACO is limited in nature because the contracts are mostly in place due to the DVHA contracts. There is an addendum to incorporate the specifics of this arrangement.

The informatics platform is highly sophisticated and a strength of OneCare Vermont. OneCare Vermont will be utilizing WorkbenchOne, Care Navigator, and REDCap to help with data report and analysis and to identify opportunity gaps. Available and organized data will greatly help DVHA and the ACO when determining how the medical services are being utilized and know in quick time where issues are and improvements that can be made.

L&E spoke with Wakely who used publicly available data to determine a reasonable range for the general administrative expense assumption. L&E relied on Wakely for their commentary with DVHA and OneCare Vermont on the administrative expenses because L&E was not part of the negotiation discussions. L&E's experience and research revealed that administrative expenses for ACOs tended to be less than $10.00 PMPM. The negotiations between DVHA and OneCare Vermont resulted in an administrative rate of $6.50 PMPM. As indicated above, the ACO's administrative functions are currently being used by the company and the administrative services are limited in nature. Since this amount falls within Wakely's range and under L&E's researched figure, L&E believes that the agreed upon administrative rate does not appear to be excessive. L&E recommends that the administrative expenses of the ACO be monitored closely to ensure that the ACO is falling in line with these expectations.

Risk Arrangement

In the original RFP and the beginning negotiations, DVHA and OneCare Vermont discussed having a truncation strategy to handle the risk of having large claims and to cap expenditures. However, Wakely reviewed the detailed claims data to determine the frequency of these large claims and determined that large claims were not common historically. Wakely explained that the lack of large claims was expected because of the nature of DVHA's facility contracts. Wakely advised against the truncation approach to handling risk. Because of the uncertainty of this new arrangement, DVHA and OneCare agreed to a risk corridor arrangement to handle profits and losses that would mitigate the risk to the ACO. The arrangement was modified after the initial report was completed. This arrangement would hold OneCare responsible for any profits or losses within 3% of the target. DVHA would be responsible for any

[8] Assessment of the Readiness of OneCare Vermont to Fulfill Requirements under the Department Of Vermont Health Access' Contract to Serve as a Medicaid Accountable Care Organization, dated December 15, 2016.

additional payments in the event of more than 3% of losses and would require OneCare to pay back a portion of the capitation rate in the event of profits in excess of 3%.

Risk Corridor Arrangement Shares		
Expenditures over/under target	**OneCare VT**	**DVHA**
-3% to 3%	100%	0%
> 3% or < -3%	0%	100%

L&E did not have the time or data to perform an analysis on this risk arrangement; however, this structure eliminates potentially great losses by having lower shares for OneCare Vermont. Most of the concern surrounding new capitated arrangements is whether the rate is sufficient to cover all required services. This risk corridor protects OneCare Vermont from large losses.

Conclusions and Recommendations

Based on the individual assumptions and recommendations above, L&E has provided an estimated rate calculation for each MEG. Both charts have been updated for the amended report.

Capitation Rate Development			
	ABD (A&C)	**Adult**	**Child**
2015 Attributed PMPM	$621.91	$359.94	$109.50
Completion Adjustment (IBNR)	1.009	1.009	1.009
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2017 Capitation Rate Ranges			
	ABD (A&C)	**Adult**	**Child**
Best Estimate	$632.71	$376.18	$119.41
Low Estimate	$618.84	$368.72	$99.79
High Estimate	$632.71	$386.46	$119.41

The range was developed based on the high and low estimates of the individual assumptions. The ABD and Child cohorts' best estimates represent the high end of the range mainly due to the trend assumption discussed within the trend section.

It is important to note that L&E is not recommending that Wakely's calculation or the final rates need to match L&E's estimation. This is L&E's best estimate based on the information and conversations with Wakely and DVHA. L&E recommends that each assumption be compared with the similar assumption

used in Wakely's calculation and consider if L&E's development of the assumption is a different approach or accounts for other information that Wakely should do more research on.

Data Reliance

Wakely, DVHA, and the Board provided all data and information utilized by L&E during this analysis. L&E heavily relied on Wakely's assistance in order to understand the negotiation process that directly impacted the final rates. DVHA and Wakely have been working with OneCare Vermont for months, discussing most components of the rates in great detail that L&E was not part of. Therefore, L&E spent a significant amount of time discussing overall methodologies with Wakely. Wakely provided prompt and thorough responses and was readily available via phone call on short notice multiple times. Below will outline the various assumptions that were impacted by these conversations.

L&E relied on Wakely's attribution methodology to produce the results above. Wakely and L&E discussed their methodology during a phone call. The data size was very large, and Wakely spent a large amount of time to scrub the data and ensure that only the appropriate claim records were included in the experience.

For the general administrative expenses and risk corridor arrangement, L&E relied on Wakely's data analysis and presence at negotiations to provide insight into the figures and arrangements agreed upon by both parties.

L&E was presented with several challenges during the review. In order to better understand the methodology of the review, it is important to outline the challenges first:

- L&E had the first call with DVHA and Wakely at the beginning of September 2016. During this call, Wakely informed L&E and GMCB that they had already spent in excess of 400 hours scrubbing the data. With a deadline of the end of the year, it was determined that L&E would not be auditing or performing an independent scrubbing of the data. Instead, L&E discussed Wakely's methodology and process of setting the rate.
- OneCare Vermont and DVHA were in active negotiations during most of Wakely's analysis time and, therefore, L&E's analysis time.
- L&E received the last data file on December 15, 2016 and received answers to questions on December 20, 2016. Therefore, L&E's review time was limited and constrained to the information that was provided.
- For the amended report, L&E received the last data file on January 20, 2017 and received the Burn's Savings file on January 26, 2017. Therefore, L&E's review time was limited and constrained to the information that was provided.

Limitations

The contents of this report are intended for the Green Mountain Care Board to advise the Department of Vermont Health Access (DVHA) and its actuaries before the use of the all-inclusive population-based payment arrangement effective in 2017. The Board may distribute this report to those parties stated above, in which case it will be provided in its entirety including all assumptions, caveats, and limitations. In addition, we request that the Board or any recipient notify Lewis & Ellis, Inc. to whom it was distributed.

Any distribution of this report should be made in its entirety. In addition, any third party with access to this report acknowledges, as a condition of receipt, that L&E does not make any representations or

warranty as to the accuracy or completeness of the material. Any third party with access to these materials cannot bring suit, claim, or action against L&E, under any theory of law, related in any way to this material.

To the best of our knowledge, our determinations were made in accordance with generally accepted actuarial principles and practices. The American Academy of Actuaries (Academy) requires its members to perform professional services only when qualified to do so, and to meet certain qualification standards. The Academy prescribes qualification standards for individuals who issue prescribed statements of actuarial opinion. This report is not a prescribed statement of actuarial opinion. I certify that I am a member of the Academy, that I am qualified to review this work, but this report and any recommendations should not be considered an actuarial opinion.

The Board has agreed to pay Lewis & Ellis, Inc. a fee for preparing this report. Other than with regard to that contract, L&E is financially and organizationally independent from the Board and any entity or individual related to the Board. There is nothing in our relationship with the Board that would impair or seem to impair the objectivity of our work.

EXHIBIT 1: ASOP 41 DISCLOSURES

The Actuarial Standards Board (ASB), vested by the U.S.-based actuarial organizations[9], promulgates actuarial standards of practice (ASOPs) for use by actuaries when providing professional services in the United States. Each of these organizations requires its members, through its Code of Professional Conduct[10], to observe the ASOPs of the ASB when practicing in the United States.

The ASOPs are not narrowly prescriptive and neither dictates a single approach nor mandates a particular outcome. ASOPs are intended to provide actuaries with a framework for performing professional assignments and to offer guidance on relevant issues, recommended practices, documentation, and disclosure. Each ASOP articulates a process of analysis, documentation, and disclosure that, in the ASB's judgment, constitutes appropriate practice within the scope and purpose of the ASOP.

ASOP 41 provides guidance to actuaries with respect to actuarial communications and requires certain disclosures which are contained in this Exhibit.

Identification of the Responsible Actuary

The responsible actuary is Jacqueline B. Lee, FSA, MAAA, Vice President and Principal of Lewis & Ellis, Inc. This actuary is available to provide supplementary information and explanation.

Identification of Actuarial Documents

The date of this document is January 31, 2017, its subject is the estimation and recommendation regarding the 2017 all-inclusive population-based payment arrangement (capitation rate) for OneCare Vermont, and the document version identification is Version #1 (1/31/2017 3:45 PM).

Disclosures in Actuarial Reports

- The contents of this report are intended for the Green Mountain Care Board.
- The purpose of this engagement is to provide the Green Mountain Care Board with an estimation, recommendation, and guidance on the 2017 all-inclusive population-based payment arrangement (capitation rate) for OneCare Vermont.
- The responsible actuary identified above is qualified as specified in the *Qualification Standards* of the American Academy of Actuaries.
- The projections included in this report involve estimates of historical PMPMs, trends, benefit changes, ACO efficiency adjustments, population adjustments, and administrative expense. Actuarially determined amounts are subject to continual revision as actual results are compared to past expectations and new estimates are made about the future. The results are not to be used for any

[9] The American Academy of Actuaries (Academy), the American Society of Pension Professionals and Actuaries, the Casualty Actuarial Society, the Conference of Consulting Actuaries, and the Society of Actuaries.
[10] These organizations adopted identical *Codes of Professional Conduct* effective January 1, 2001

purpose other than to provide the Board with guidance and recommendations to send to the Department of Vermont Health Access (DVHA) regarding the 2017 capitation rates for OneCare Vermont. These communications should not be relied upon for any other purpose.

- The Green Mountain Care Board has agreed to pay Lewis & Ellis, Inc. a fee for preparing this report. Other than with regard to that contract, we are financially and organizationally independent from the Board. There is nothing in our relationship with the Board that would impair or seem to impair the objectivity of our work.

- The Green Mountain Care Board, Department of Vermont Health Access and Wakely Consulting provided the claims data, enrollment, and other information used to prepare our report. We have reviewed the data for reasonableness, but have not audited it. To the extent that there are material inaccuracies in the data, our results may be accordingly affected.

- The date through which data or other information has been considered in developing the findings included in this report is June 30, 2016.

- We are not aware of any subsequent events that may have a material effect on the actuarial findings.

- The various documents comprising this actuarial report are contained within the document to which these disclosures are attached.

Actuarial Findings

The actuarial findings of the report can be found in the body of this report, as well as the attached exhibits.

Methods, Procedures, Assumptions, and Data

The methods, procedures, assumptions and data used by the actuary can be found in body of this report, as well as the attached exhibits.

Assumptions or Methods Prescribed by Law

This actuarial memorandum was prepared in accordance with generally accepted actuarial principles.

Responsibility for Assumptions and Methods

The actuary does not disclaim responsibility for material assumptions or methods.

Deviation from the Guidance of an ASOP

The actuary has not deviated materially from the guidance set forth in an applicable ASOP.