OneCare Vermont

To: **Alena Berube, Melissa Miles, Marisa Melamed, Sarah Tewksbury, and Michael Barber; Green Mountain Care Board**
CC: **HealthCare Advocate Health Policy Team**
From: **Vicki Loner, CEO OneCare Vermont, Accountable Care Organization, LLC**
Date: **November 22, 2019**
Subject: **Responses to 2nd round of questions from GMCB on the FY 2020 budget submission**

Dear Green Mountain Care Board Team,

Please find below OneCare Vermont's responses to the Green Mountain Care Board's 2nd round of questions regarding our 2020 Budget Submission. Our responses are below the repeated questions. Additionally, we would like to note that we have met with the Healthcare Advocate's health policy team to answer some of their questions. While we have covered some of those questions in the responses below, we also discussed evaluation metrics for RiseVT and the process for Innovation Funding. Those questions are answered in two attachments.

Provider Network & Payer Programs

1. Referring to Question 3 in the GMCB follow-up questions, how would you break out the estimated number of lives per scale strategy using the data you have available? The table in the follow-up questions was developed based on the budget narrative describing 3 scale strategies. If you cannot provide a more detailed breakdown of attribution opportunity in the table format we provided, please describe how these attribution numbers were estimated and what weight we should place on the validity of these estimates.

   The best means available for OneCare to break out the estimated number of lives for scale strategy is to rely upon comparative analyses and historical experience. These estimates are based on available information and the figures should not be used for any concrete analysis of scale under the All Payer Model terms. In an effort to assist the Board, we provide the following.

   <u>Scale Strategy 1: Attribution Methodology</u>
   To estimate this opportunity for the 2020 budget the St. Johnsbury Medicaid geographic attribution pilot provides OneCare with one known data point. The percentage increase within the HSA as a result of this pilot could be applied to other HSAs to roughly estimate gains from this approach. It would not be recommended to employ this same data point across other payer programs. Gains for other programs may be different due to variation in the covered population, variation in attribution churn, and variation in the existing claims-based attribution methodology.

   <u>Scale Strategy 2: Network Participation</u>
   Estimating potential gains on the provider/NPI/TIN level is difficult for OneCare due to the lack of data for non-attributed lives. Reasonable estimates may be generated at the HSA level by comparing across payer programs. For example, because Medicaid participation is widespread across the state, if there are two HSAs with similar Medicaid attribution and one HSA already participates in the

Medicare program, that Medicare attribution figure could be used as an estimate for the community that is not participating in Medicare. This approach fails to incorporate any changes in population demographics or provider makeup, which are significant shortcomings.

<u>Scale Strategy 3: Expanded Payer Program Offerings</u>
Estimating gains from this strategy relies heavily on payer data. Some approaches in the Scale Strategy 2 section above could be used as well if there is a reliable starting data point, but in general OneCare has no way to forecast the potential attribution from a payer without data.

The attribution estimates in the budget submission represented a combination of the approaches above. In aggregate, they are reasonable but each time the data are divided up into more granular components (i.e. HSA-level or practice level) the reliability is sacrificed. Payer data or a more comprehensive statewide dataset would be able to produce much more reliable estimates of attribution opportunity.

2. How is the ACO, in partnership with ACO network providers, identifying efficiencies and scaling best practices to achieve short term savings while we wait for population health investments to pay off?

OneCare has focused on several key strategies to identify efficiencies and scale best practices to achieve short-term savings. These include, but not limited to:

- **Developing new analytics tools and reports to aid communities in understanding their performance relative to others as well as self-service tools that allow drill-down data to identify HSA, organization, and provider variations.**
- **Promoting OneCare's complex care coordination program including monthly Care Coordination Core Team meetings in the north and south where data and best practices are shared, barriers and lessons learned are discussed, and planning conducted to bring information and implementation steps back into each community.**
- **Monitoring utilization, quality, and financial data monthly. When variations in care delivery patterns are identified, OneCare clinical and analytics staff outreach to the community to explore the causes for the variation. This has led to improved billing accuracy, new strategies to reduce avoidable emergency department admissions, and identification of high-cost cases with out-of-state claims that the local hospital would otherwise be unaware of.**
- **Using clinical committees, such as the Clinical and Quality Advisory Committee, to share local best practices and lessons learned. At each meeting, one to two Regional Clinician Representatives share highlights from local efforts to improve quality of care and time is spent discussing key lessons learned and tips for implementation.**

OneCare has focused on both reduction in emergency department utilization and inpatient admissions as two key levers to achieving short-term cost savings while also investing in long-term population health strategies such as RiseVT.

3. In your response to GMCB follow-up Question 4, in which OneCare is asked to discuss the number of key findings that came out of the piloted Medicaid geographic attribution concept with St. Johnsbury HSA, you cite only one finding: "that there is a material segment of the population that accesses healthcare but has no relationship with a primary care provider." Is this the only finding from the pilot? If not, please describe the other key findings from the pilot.

   This pilot is still underway. DVHA, the St. Johnsbury community, and OneCare are in the process of developing an implementation manual which should be available in December 2019. OneCare would be happy to share the manual with the Board at the end of the year.

4. For the MVP commercial program, confirm that the quality measures will be in alignment with the other payer programs you are contracting with.

   This is currently under negotiation, however we anticipate that they will be in alignment with other payers.

5. In your response to GMCB follow-up Question 9, and in the budget hearing, you describe 0.5% growth in Medicaid as modest. What assumptions lead you to believe that this is modest? Given your actual growth in expenditures in 2018 and your predicted growth in expenditures in 2019, please compare to the 0.5%, and comment on whether and why this seems like a realistic growth rate.

   When evaluating the early Medicaid performance trend from 2018 to 2019, data suggest a flat or slightly negative overall cost trend for attributed lives. However, one quarter of data is not sufficient to make an assertive assumption that forecasts an ongoing negative trend. Rather, a modest growth assumption that reflects a larger sample of Medicaid utilization increases was incorporated into the budget. Because this information is used to forecast risk for network participants, a more conservative approach is generally preferred.

6. Referring to Question 9a, please provide your best estimate of when OneCare will be able to explain the reasons for the projected 2019 Medicaid loss reflected in your budget.

   OneCare and contracted actuarial support are actively exploring the 2019 year-to-date program results and aim to have a deeper understanding in late December.

7. Please explain how you arrive at the 6.04% trend rate for Commercial QHP (Budget Submission Appendix 3.1 Trend Rates) from the GMCB approved rates. Please provide the breakdown between BCBS and MVP for the underlying Base Experience PMPM assumptions. Acknowledge if any assumptions are related to 2019 projected performance. Provide these projections. While we understand that you do not know how Vermonters will behave, please explain what assumptions you made that led you to predict an 11.1% decrease including but not limited to the following: a) assumptions about Vermonters purchasing MVP versus BCBSVT plans in 2020, and b) assumptions about MVP's attributed population versus their full population reflected in their 2020 QHP rate review filing.

When developing the 2020 budget model OneCare received estimates from the payers on: preliminary attribution, base-year spending, and the GMCB trend factors that are applicable to contracted program design and financial accountability. These data estimates were incorporated into the budget model and resulted in the figures noted in the question. No other assumptions such as market shifts, trend rates, or base year performance were incorporated into the budget. Because the Commercial QHP payers supplied the base year spend data, it is more appropriate for them to answer specific questions about the underlying base experience PMPM assumptions. Overall, OneCare is not predicting an 11.1% decrease. Rather, this is the resulting year over year change to the OneCare Commercial QHP blended PMPM when adding in a new payer.

8. When will your payer contract negotiations be finalized and how certain are you that the assumptions and estimates you've made in your budget will remain accurate?

   Payer contract negotiations will conclude iteratively over the next few months. Some will be complete prior to January 1st 2020, but some may extend beyond that date as details are finalized. OneCare provides the GMCB with the best information it has available at the time of submissions (see Verifications), and even with program agreements in place, budgets by their forecasting nature are not "certain."

9. In follow-up to Board Member Pelham's hearing question about the QHP benchmark plan, does OneCare plan to engage in any conversations with DVHA about the benchmark plan design to better understand how the plan design might better align with ACO programs and incentives?

   OneCare does not currently impact benefit plan design for any payer. We are open to considering this in the future once we have more experience and consistency in operationalization of payer programs.

10. Please provide a complete answer to Question 12 from the GMCB's follow-up questions. Provide further details that describe the risk-sharing arrangements with Commercial-QHP plans, disaggregated by insurer (i.e. what is the percentage of the arrangement that will be at risk?).

    The risk sharing arrangements remain subject to active negotiation and are not final. Matters in active negotiation are exempt from public disclosure. 1 V.S.A. § 317(b)(15). The final arrangements will be included in final program agreements, which will, as in the past, be provided to the GMCB.

11. Please provide a complete answer to Question 13 from the GMCB's follow-up questions. Please provide further details that describe the risk-sharing arrangements with Commercial-Self Insured plans.

    The risk sharing arrangements remain subject to active negotiation and are not final. Matters in active negotiation are exempt from public disclosure. 1 V.S.A. §

317(b)(15). The final arrangements will be included in final program agreements, which will, as in the past, be provided to the GMCB.

Risk Plan

12. Please give us a timeline by which you will be able to share your final risk mitigation plans for 2020. Have you identified specific criteria for offering risk mitigation to certain hospitals and what are they? Please describe any assumptions underlying the $4M of remaining risk reserves at OneCare and how this reserve amount was determined to remain appropriate. Please comment on your goals for your risk mitigation strategy and how you plan to balance hospital sustainability without over-reserving the system? You acknowledge in your presentation that you plan to improve your monitoring of hospitals in FY20, describe how you plan to do this.

    It is generally preferable to finalize payer contracts prior to finalizing risk mitigation contracts with applicable participants (see question 8 for the payer contract timeline). While there are some general criteria that determine eligibility, the flexibility to work with and respond to the unique needs of each provider and/or community has been more successful. The goals of these risk mitigation arrangements are to generate new participation, sustain existing participation, allow for an on-ramp period (which is especially relevant when entering a risk program without an upside-only lead-in year), and reflect the individual financial circumstances of entities bearing risk. The decision to maintain the ~$4M in reserves reflected the shift in the risk mitigations back to the Founders and also the opinion that liquidating reserves at this point in OneCare's growth would be unwise. Using the word "monitoring" in this context likely did not accurately reflect the intent. Rather, OneCare aims to continuously improve the data and reports available to network hospitals to help them succeed under the financial model and enhance the quality of care.

13. Given current program settlement projections, please answer GMCB follow-up question 6, "Is it correct to understand that OneCare estimates that it will carry forward a balance in its
    "Designated Risk Reserve" of $3.9 million from FY2019 to FY2020? Does OneCare anticipate covering any 2019 HSA overruns, and if so, will that result in a lower estimated Designated Risk Reserve entering FY2020 than the $3.9 million identified? If so, do you intend to build the balance back up and how?"

    Current estimates suggest OneCare will conclude 2019 with approximately $4.0M in reserves. This number is subject to change. Current estimates also suggest that a modest amount (roughly $500k) may be needed to cover risk protection agreements, but that figure will vary based on final performance outcomes. Combined, these inputs suggest that OneCare will be able to carry forward a reserve amount roughly equal to the 2019 budget order into 2020. If the risk protection estimate were to change materially, the OneCare Finance Committee and Board would need to evaluate the magnitude and determine whether or not hospital dues, the only means available to OneCare, should be increased to build reserves. OneCare will update the GMCB should there be any material changes.

Budget and Financial Plan

14. Describe any cash flow and balance sheet concerns. When is your lowest projected point of cash availability during the year and what is the amount? What are your contingency plans if one of the payers is late on reimbursement and they need to pass through funds to the hospitals? You discussed that if a hospital does not pay their settlement OneCare may pay. Explain how OneCare would fund this and what would be the approvals by the Board of Managers?

    There are currently no cash flow concerns to report. The lowest projected point of cash availability is conceptually in mid-summer after the Value Based Incentive Fund distribution, but the timing and direction of program settlements can also mean this is a time with significant cash availability. Like all providers, failure to receive payment from a payer or insurer, whether a OneCare fixed payment or fee-for-service batch, can create significant cash flow challenges. If a payer payment to OneCare were late OneCare would work with that payer to evaluate the nature and expected length of the delay. Possible interventions would include accessing OneCare reserves and/or collaborating with the payer to restart fee-for-service reimbursement. If a risk-bearing entity fails to pay a settlement obligation it will require a conversation with the Board to determine the appropriate response. Reserves would certainly be considered, but the magnitude and overall circumstance would need to be factored into the process.

15. Slide 8 of the October 30 presentation describes your financial results from 2018. What are the main drivers of your 2018 savings? How do you plan to achieve results going forward?

    The main drivers of 2018 savings included:

    - **Entering into value-based care contracts that invert the financial incentive structure to reward efficient high-quality care rather than volume.**
    - **Facilitating a care coordination program for high risk patients that includes technological tools, best practice guidance, data, and access to other OneCare providers.**
    - **Providing capitation payments for hospitals that shift reimbursement away from a fee-for-service methodology**

    OneCare plans to achieve results going forward by continuing to enter into value-based contracts and executing the population health strategies outlined in the budget submission.

16. What is the total salary and benefits dollars associated with vacancies identified in your organizational chart?

    The 2020 budget submission includes 0 total salary and benefits dollars associated with vacancies identified in the organizational chart.

17. Slide 12 shows that 35% of OneCare's provider reimbursement reflects a capitated payment. What is the maximum percentage of the total provider reimbursements that you estimate could be a capitated payment? What is OneCare's plan to achieve greater uptake of capitated payments?

Theoretically, 100% of the provider reimbursement could be converted to a capitation payment, however, this would require OneCare to pay claims to providers not in the OneCare network which is not a function the organization is designed to facilitate. OneCare's plan to achieve greater uptake of capitated payments is to work with payers to ensure the models are operationally and actuarially sound, components such as cost reporting are appropriately configured to align with the capitation approach, program design encourages expanded hospital participation, and capitation models are developed for programs not currently offering a fixed payment option.

18. If the structure of your revenues change, how will you restructure the population health programs? Identify any reallocation of resources, including the elimination of any programs?

    The nature of any change to the structure of revenues will largely dictate any restructuring of population health programs. Some revenues are tied to specific initiatives and may result in a correlated population health adjustment while other revenues have programmatic flexibility and changes would necessitate decisions from the OneCare Board. If decisions are needed, changes would be intended to minimize programmatic impact on network participants and financial impact on hospitals dues.

19. How much are you getting for the Robert Wood Johnson Foundation Grant and how does it factor into your budget?

    The Robert Wood Johnson Foundation Grant is for $150,000 over two years. Due to the timing of the grant application and the budget deadline, it was not incorporated into the submitted budget.

20. Provide details on your plans for "new programs" that will be paid for with $6 million of state support dollars mentioned in your October 25, 2019 response to Board Question #16.

    OneCare's plan for new programs paid for with Delivery System Reform funds (combination of state and federal funds), subject to modification, includes investments in primary care prevention, mental health, management of chronic illness, and expansion of our care coordination programs including support for longitudinal care, pediatrics, and clinical pharmacy supports. OneCare- and its provider participants- believe these investments are needed to continue making progress under the APM care model goals- expanding access, decreasing harmful impacts of mental health and substance use, and decreasing prevalence of chronic disease.

    At its November meeting, the OneCare Board of Managers agreed to decision criteria for delaying investments absent state/federal funding. The decision criteria is guided by the goal of minimizing programmatic and financial impact on network participants. The criteria include:
    1. Sustain existing OneCare programs.
    2. Sustain committed funding to network participants.
    3. Target initiatives with significant operational resource demands.
    4. Prioritize initiatives with potential short-term financial and clinical benefits.

21. Please provide a complete answer to Question 21 from the GMCB's follow-up questions. If OneCare does not use industry benchmarks because they do not exist, how does OneCare monitor its financial performance monthly? What metrics do you look at and how do you determine the financial health of OneCare?

    OneCare facilitates value-based programs on behalf of its contracted providers. Evaluating financial health therefore focuses on determining a) whether or not the budget model enables operationalization of the planned activities and b) whether or not the budget plan is being appropriately executed. The former is done as part of the annual budget build process and the latter is done through monthly financial statement review with the Finance Committee and Board. Elements such as PHM spending by program, operational spending, revenue accruals, receivable balances, payable balances, and overall bottom line status are components of this monthly review.

Population Health and Quality

22. The 100% Quality result for Medicare is scored for reporting. What was the actual performance? If you are not able to calculate, please explain why. What worked well, what didn't work, and what did you learn about improving or maintaining quality across all payers?

    The GMCB staff testimony on November 20, 2020, gave their estimated quality result as 82.4%. OneCare believes this to be a gross estimate as it does not take into consideration the quality point's analysis that Medicare applies after comparing the raw rate to the benchmark percentile. Medicare's quality point's algorithm is a black box and we have not been able to replicate it in past years. Based on historical performance, it is likely that in a year-to-year comparison it would adjust the overall score up from 82.4%.

    Much of the focus for OneCare's provider network in 2018 was on becoming familiar with the new APM quality measures and learning that many of the measures have no accessible data source for ongoing monitoring. For example, the clinical measures require cumbersome manual data gathering from many unique EHRs which causes burden on the practices. In addition, OneCare is precluded from receiving claims with substance use codes attached, thus we have no way to approximate many of the mental health and substance use quality measures throughout the year. One strategy we are working on with payers is trying to obtain de-identified reports throughout the year that can serve as better approximations of ongoing quality performance in these areas. An additional focus has been to test proxy measures (e.g. # diabetic patients without a lab test in the current performance year) for manually collected data. These proxy measures may provide signals of changes in performance that could be detectable before the clinical outcome can be fully realized or measured on an annual basis.

    With respect to areas that did not work well, in 2018, the Medicare quality measures did not yet align with the APM quality measures and thus we found some practices chose to focus on improvement projects in clinically important areas that will no longer be measured in 2019 (e.g. body mass index).

23. How do provider network changes year over year affect quality outcomes given a shifting population?

There are several impacts that a changing provider network can have on quality outcomes including:

- **Diluting potential improvements as the denominator of patients eligible for a measure increases.**
- **Clinical measures are drawn from an ACO-wide random sample of patients eligible for the measure. Because it is random, shifts in the sample selected can materially impact the quality score for that measure. This impact is minimized when looking for trends over time. This is why most cost, utilization, and quality data OneCare reviews and reports are presented on run charts or control charts rather than as point-to-point estimates.**
- **As noted in prior responses, OneCare has seen significant patient churn from year-to-year. This can impact the stability of the estimates as well.**
- **OneCare's and Vermont's population is getting older and with a higher illness burden. These two factors can make benchmark comparisons challenging as they become less apples-to-apples comparisons (see BCBSVT's November 20, 2019 testimony to GMCB on changes in population profiles from 2017 to 2018 for the QHP population).**
- **In future years as providers continue to make delivery system changes that move away from traditional fee-for-service billing codes, it may become more challenging to meet the measure specifications due to the type or location of documentation rather than whether the service, test, or procedure occurred.**

24. How do you ensure that you are not duplicating efforts with the Blueprint for Health?

OneCare and Blueprint leadership have monthly meetings to discuss what is working, challenges, and upcoming opportunities for collaboration. In addition, OneCare and Blueprint central staff co-plan monthly All Field Team meetings to ensure alignment of priorities and messaging with field-based staff. As this partnership has grown, OneCare has looked for innovative ways to leverage and build upon reform work efforts. For example, OneCare pays Level 1 Community Capacity Payments to the organization in each HSA that holds the Blueprint for Health contract. The contract supports Blueprint program managers to help convene and coordinate the complex care coordination program in their local community. OneCare clinical consultants support these efforts by providing access to data on progress, identifying training opportunities, facilitating onsite Care Navigator supports, and serving as bi-directional spokespeople for local opportunities and successes.

At Blueprint's request, OneCare and Blueprint have entered into an exploratory process to consider further integration of programming into OneCare and enhanced alignment with the care model. Blueprint introduced this strategy at its November 20, 2019 Blueprint Executive Committee with OneCare in attendance. Early discussions are focused on tighter integration of QI and patient self-management programs. This is in early development phase and more details on feasibility will be available in early 2020.

25. In the answer to GMCB follow-up Question 33, you described trends and data on a partial set of Medicaid measures for the four communities that participated since 2017. For these four communities, please provide the numerator and denominators for all Medicaid clinical measures for 2017 and 2018.

HSA	2017		2018	
	Numerator	Denominator	Numerator	Denominator
Diabetes Mellitus: HbA1c Poor Control *(inverse measure – lower rate is better)*				
HSA 1	26	94	10	40
HSA 2	24	92	11	42
HSA 3	51	126	31	109
HSA 4	15	56	11	24
Hypertension: Controlling High Blood Pressure				
HSA 1	67	92	30	36
HSA 2	61	95	38	51
HSA 3	76	124	49	90
HSA 4	26	45	18	28
Screening for Clinical Depression and Follow-Up Plan				
HSA 1	22	47	16	36
HSA 2	30	42	17	19
HSA 3	55	124	58	133
HSA 4	10	34	11	24
Tobacco Use Assessment and Tobacco Cessation Intervention *(new measure in 2018)*				
HSA 1	N/A	N/A	32	42
HSA 2	N/A	N/A	23	41
HSA 3	N/A	N/A	81	116
HSA 4	N/A	N/A	15	21

26. In the answer to Question 29 from GMCB follow-up questions, OneCare states, "Not all Population Health Investments are based on attribution." We acknowledge that may be the case for some programs; however, the GMCB FY19 ACO budget order requires OneCare to maintain a minimum PHM investment ratio proportional to total revenue. How will OneCare maintain, or even increase, the PHM ratio as it increases scale?

    OneCare investments in programs that have the potential to improve population health and foster success under value-based care contracts. OneCare neither intends to increase nor decrease the PHM ratio mentioned. On an annual basis OneCare evaluates its clinical priority areas, available funding, and operational expenses to develop a budget, inclusive of investments. The budget is considered in the context of the cost to participants, who are largely funding, and whether or not the amount is appropriately scaled. Investments or other expenses may be scaled back if participant investments are overly burdensome.

27. Please explain whether your FY20 PHM investments take into consideration any potential lag in spending into the next fiscal year due to the time it takes to award the grants, hire staff, and bring the pilots to fruition. Which line items in your budget are impacted by this timing issue? Based on your submission, we have identified $1.4 M in

the Specialist program and $618 K in the innovation fund that were FY19 dollars that will be spent in FY20. Are these the only programs that spillover across fiscal years? If there are further spillovers, please identify the line items and how much of the budgeted FY19 investments are projected to be spent in FY20 and if all these dollars are reflected in your budget.

The Specialist Program and Innovation fund are unique in that funding is obligated within the fiscal year but some spending will occur in subsequent years. This pattern for these initiatives should be expected in 2020 and beyond. The care coordination program is one other initiative that is subject to material ramp-up. In addition, the payment model for this program is evolving in 2020 to pay for active engagement rather than capacity. To alleviate some of the ramp-up effect, OneCare rolled out the revised payment methodology close to a year in advance of the scheduled payment methodology change. The result is that the ramp-up phase is already underway, which has the potential to deliver a more seamless transition in 2020.

28. In response to GMCB follow-up Question 19, you state, "OneCare's Population Health Strategy Committee monitors programs and evaluation of their impact as well as recommending new programs and discontinuation of programs." What is your monitoring and evaluation plan for each program, including a description of any metrics?

In 2019, The Population Health Strategy Committee (PHSC) has focused on monitoring cost, quality, and utilization through receipt of regular reports from OneCare's Utilization Review Committee. The Committee received reports on the implementation of the complex care coordination program including the key process metrics shared previously with the Board as well as outcome metrics around cost (PMPM) and utilization (ED visits, IP admits, preventive care). These metrics are tracked through the WorkBenchOne care coordination progress and outcome metrics applications. New in 2019, the PHSC developed a set of "areas of interest" and publicized them through the two rounds of innovation fund requests for proposals. A selection committee of the PHSC evaluated each proposal using objective criteria which considered its degree of innovation, its ability to be sustainable, scalable, and its overall impact to the ACO's cost, quality, and healthcare goals, among others. The Selection Committee made its recommendations to the full PHSC and then, in turn, to the OneCare Board of Managers. Each approved project had a preliminary set of process and outcome measures they proposed tracking and they were asked what data and/or analytics support they may need from OneCare to evaluate their program. Each award recipient has a final set of evaluation measures due at the end of Q1 of their project and OneCare works closely with the awardees to support their efforts. Many projects will take 1-2 years to begin to show results.

29. How did OneCare choose its risk stratification strategy across payers? Why does BCBS VT have a lower rate of engagement in care management than other payers?

OneCare established its approach to population segmentation through iterative feedback from our provider network during 2016-2017. Providers wanted to be sure and focus not only on the traditional top 3% or 5% of most expensive patients, but also dive deep into the "rising risk" population they defined as the next 10% of the population with high

needs. They also recognized that the needs may be physical, mental, or social in nature and that many people will have a complex interplay of two or all three types of needs. During this period in shared savings programs, OneCare was using the Hierarchal Condition Category grouper, typically used for Medicare populations. It was deemed insufficient, particularly for younger patients. OneCare researched alternatives and selected the John's Hopkins Adjusted Clinical Grouper as a tool that seemed to work well across payer populations. Currently each payer program is risk stratified separately and risk ranks are applied to each member within a payer cohort. Thresholds are drawn at the top 6%, 10%, 40% and 44% per our population health segmentation approach.

BCBSVT has a lower rate of engagement in care management, in part, because of the delay in receipt of claims data to OneCare resulted in significant delays in our ability to risk stratify and identify the populations for the care coordination staff to make outreach and engagement.

30. Please share the breakdown of specific population health investments, by amount and specific program, separately for each service area. Then, please show, again by HSA, how OneCare's specific population health investments 1) align with the clinical priorities of each HSA and 2) how these specific investments work to reduce the relative disparities in **cost** and/or **quality** as evidenced in OneCare's variations in care analyses. Please submit the most recent variations of care analysis to support your assessment.

Please see attached "PHM Breakout_Q30" for a breakdown of specific population health investments by program and amount. The distribution methodology (e.g. attribution, spend, contract) is noted for each investment type. Note that the Value Based Incentive Fund (VBIF) distribution assumes an 80% earned quality score and is then spread based on OneCare VBIF policy. In addition the Specialist, Innovation Fund, and VBIF Quality Initiatives are labeled as to-be-determined because these allocations will occur in 2020. All investments are projections and actual distributions will vary with final attribution, contracts awarded, provider engagement, and other related variables. Each organization and local HSA determines its own programs and focus areas per OneCare's decentralized model. OneCare supports this decision making by sharing data to identify opportunities and monitor progress. OneCare does not maintain a list of activities in each organization or HSA supporting the clinical priority areas. OneCare's Regional Clinician Representatives share highlights and examples of projects from their local communities at the Clinical and Quality Advisory Committee meetings to facilitate dissemination of lessons learned and best practices. When OneCare identifies a particularly promising practice, the story is shared through network success stories and/or it could become the backbone for an interdisciplinary clinical education session open to OneCare's entire network.

Please see attached the "HSA Variation report" for an example of the data produced for OneCare's network to examine cost outliers. The data are for January – June 2019 with runout through September and the HSAs have been randomized differently in each report. The purpose of this report is to compare cost data for targeted clinical focus areas and identify areas of strength and potential opportunity. The report should not be used to forecast aggregate performance or settlement results. Also, note that these represent new reports for OneCare and until trend data are available they should be reviewed with significant caution. Small numbers can

inhibit drawing any conclusions from these early data, instead, they are intended to provide the network of signals to explore within cost, utilization, and quality data within their organization and HSA.

Certification Questions

1. How does OneCare provide education to its Board members on the ACO regulatory process, particularly to its Enrollee members? 5.202(d)

   All new Board members receive an orientation that covers the regulatory process. The regulatory process is discussed at Board meetings, particularly around certification and the annual budget submission.

2. In OneCare's responses to the GMCB follow-up questions for certification (10/16/19), OneCare states, "*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.*" If OneCare does not produce a financial risk assessment or risk analysis as a report, please explain how you can report any findings of your risk analysis process to the GMCB, are these assessments available in the BOM meeting minutes posted online? 5.204(a)(b)

   OneCare is reporting to the GMCB through its Certification submission and responses to questions, neither of which require any single document, rather risk is evaluated on an ongoing basis through regular performance reporting, planning for new internal programs and processes and internal programming. Risk assessment and related information would not be part of the public portion of Board meetings, and the assessments would not be available in the public meeting minutes.

3. Please provide the Hospital risk addendum for Porter Medical Center and any others that need to be updated in GMCB records.

   The 2019 Medicare Benchmark was recently updated to reflect the final shared savings carryover from 2018. Revised addendums were sent to all Medicare risk bearing entities and signed copies will be sent to the GMCB as soon as possible.

4. How are you working with AHS to ensure that the investments made by OneCare to social service providers (e.g. Designated Agencies) are complimentary to broader state initiatives?

   OneCare has regular meetings with AHS leadership across the Secretary's office, DVHA, and VDH. OneCare meets ad hoc with DMH leadership and staff on topics of mutual interest – for example, we recently invited DMH staff to present on their suicide prevention strategies to our Population Health Strategy Committee (November meeting) and discuss areas of mutual interest and opportunity. In addition, OneCare and DMH leaders met several

times in 2019 to learn about reform efforts underway with the Designated Agencies and to share ideas and lessons learned from each of our experiences to date with reforms.

5. What are the priorities for 2019 and 2020 for the Pediatric Subcommittee?

   The primary foci for 2019 have included implementation of DULCE, monitoring progress on social determinant of health data analysis and testing of algorithms, and significant ongoing engagement about potential changes to the complex care coordination program to better meet the needs of children and families. It is anticipated that all three foci will continue into 2020.

   a. Do subcommittees have charters?
      The Pediatric Subcommittee has a charter which includes the following accountability: *The Pediatric Subcommittee, as a subcommittee of the OCV CQAC, will deliberate on OCV clinical policy pertaining to pediatric age individuals (0-21 years) including, but not limited to, data analysis of utilization, cost, trends, care coordination and integration with, and transitions to, adult age care.*

Attachments

1. HSA Variation Grid
2. PHM Breakout
3. RiseVT evaluation methods
4. Innovation Fund Process