Board of Managers Meeting

Thursday, 12/21/2023
4:00 - 6:00 PM ET

1. **PUBLIC: Welcome Board Managers, Invited Guests, and Members of the Public Presented By: Anya Rader Wallack (4:30-4:31)**

2. **PUBLIC: Call to Order and Board Announcements Presented By: Anya Rader Wallack (4:31-4:32)**
   Welcome Judy Peterson

3. **PUBLIC: Consent Agenda Items Presented By: Anya Rader Wallack (4:32-4:33)**
   Motion and Vote to Approve Consent Agenda Items – Majority Required
   3a. 2023-12 Public Consent Agenda Cover Page - Page 3
   3b. 2023-11 OneCare Board Meeting Public Session Minutes - Page 4
   3c. 2023-12 Board Committee Reports - Page 8
   3d. ROI Analysis - Page 9
   3e. Summary of Policy Changes - Page 24
   3f. 01-02 Conflict of Interest - Page 25
   3g. 03-03 Data Use - Page 31
   3h. 05-01 Contract Management - Page 39
   3i. 06-01 Record Retention - Page 43

4. **PUBLIC: Governance Presented By: Anya Rader Wallack (4:33-4:40)**
   Motion and Vote to Approve Resolution Appointing Managers to the Board of Managers– Supermajority Required
   4a. D Courcelle Resume 2023 - Page 45
   4b. Resolution Appointing Managers to the Board of Managers - Page 47

5. **PUBLIC: Waiver Requests Presented By: Carrie Wulfman, Linda Cohen (4:40-4:50)**
   Motion and Vote to Approve SVMC Waiver- Supermajority Required
   Motion and Vote to Approve UVMMC Waiver-Supermajority Required
   5a. SVMC Waiver Request - Page 48
   5b. Resolution to approve Participation Waiver SVMC - Page 50
   5c. UVMMC Waiver Summary - Page 52
   5d. Resolution to Approve UVMMC-Birchwood Participation Waiver - Page 53

6. **PUBLIC: 2023 PHM and Mental Health Screening Initiative Progress and New Primary Care Reports Presented By: Carrie Wulfman (4:50-5:05)**
   6a. 2023 PHM - Page 55
   6b. Mental Health Screening Initiative Progress - Page 57

7. **PUBLIC: Public Comment (5:05-5:10)**

8. **PUBLIC: Move to Executive Session Presented By: Anya Rader Wallack (5:10-5:11)**
   Motion and Vote to Approve Resolution to Move to Executive Session – Majority Required
   8a. 2023-12 Resolution to Move to Executive Session - Page 59

13. **PUBLIC: Votes Presented By: Anya Rader Wallack (6:26-6:29)**
    1. Approve Executive Session Consent Agenda Items - Supermajority Required
    2. Approve 2024 Corporate Goals – Supermajority Required
    3. Approve MVP Term Sheet – Supermajority Required
    4. POTENTIAL VOTE: Approve 2024 Payer Targets – Supermajority Required

14. **PUBLIC: Adjourn Presented By: Anya Rader Wallack (6:30)**

15. **PUBLIC FYI Documents**
    18a. 2023-12 Public Affairs Report - Page 108
    18b. 2023-12 Financial Report Package - Page 110

OneCare Vermont Accountable Care Organization, LLC
Consent Agenda Cover Page

Public Session

December 21, 2023

Agenda Item	Reason for Review and Request for Approval
a. Consent Agenda Cover Page	Reference only.
b. Draft OneCare Public Session Minutes November 14, 2023	Review and approval of prior month's minutes.
c. Board Committee Reports December 2023	Summary of Board subcommittee meetings from the past month.
d. ROI Analysis	Final Report prepared by contractor to meet GMCB Budget Order
e. Summary of Policy Changes **f.** 01-02 Conflict of Interest **g.** 03-03 Data Use **h.** 05-01 Contract Management **i.** 06-01 Record Retention	Review and approval of listed policies; a summary of changes is provided.

OneCare Vermont Accountable Care Organization, LLC
Board of Managers Meeting
November 14, 2023
Public Session Minutes

A meeting of the Board of Managers of OneCare Vermont Accountable Care Organization, LLC ("OneCare") was held remotely via video and phone conference on November 14, 2023. Public access was also available at the OneCare Offices in Colchester, Vermont.

I. Call to Order and Board Announcements

Board Chair Anya Rader Wallack called the meeting to order at 4:49 p.m. She welcomed the newest board manager, Jessica Moschella, to her first meeting. Chair Wallack also reminded the board that there will be two board meetings in December, on the 21st and 28th in order to accommodate end of year business.

II. Welcome Board Managers, Invited Guests, and Members of the Public

Chair Wallack welcomed members of the public in attendance and offered the opportunity to introduce themselves.

III. Public Consent Agenda Items

The Board reviewed consent agenda items including: (1) Draft Public Session Minutes from September 19, 2023; (2) Draft Public Session Minutes from October 19, 2023; (3) Board Committee Reports October 2023; (4) Board Committee Reports November 2023; (5) Q3 CMO Report; (6) Summary of Policy Changes; (7) 04-06 Disbursement Policy; (8) 06-19 Complaints, Grievances, and Appeals for Attributed Lives; (9) 07-03 Privacy; (10) 07-07 Code of Conduct; (11) 07-08 Compliance Communication, Reporting, and Investigation; and (12) 07-09 Security.

An opportunity for discussion was offered.

A Motion to Approve the Consent Agenda Items was made by J. Gilwee, seconded by S. May, and approved by a majority.

IV. Governance

Nominations to the Board of Managers and Finance Committee were presented to the Board.

An opportunity to separate these resolutions was offered.

A Motion to approve the resolution appointing Judy Peterson to the Board of Managers and Bob Laba to the Finance Committee was made by T. Huebner, seconded by S. LeBlanc, and approved by a supermajority.

V. HSA Engagement in Quality Improvement and Health Disparities

Carrie Wulfman, MD, Chief Medical Officer, described HSA consultations conducted this year and how health disparities data were shared and utilized by the network. She presented an overview of OneCare's convening of stakeholders (payers, provider organizations, state government, and practicing providers) around potential alignment towards a standardized social determinants of health screening tool. She encouraged board managers to contact her if they had any interest in participating in these meetings moving forward. Dr. Wulfman also discussed the importance of the quintuple aim in OneCare's work.

VI. 2022 Program Financial Performance Review

Derek Raynes, Director of Payment Reform, provided an analysis of Medicaid performance in 2022 and 2023. In 2022, OneCare beat the fee-for-service target by $9.8M, driven by $13M in savings for adult attributed lives. For the performance by service, total cost of care savings were achieved because the growth in spend from PY21 to PY22 was less than the projected utilization and price growth used to set the target. Mr. Raynes reviewed contributors to spend and described changes from 2022 to 2023. He described several next steps including investigation of high-growth areas, consideration of target-setting approach for pediatric attributed lives, and ongoing network data support. Board discussion considered the impact of access, pent up demand, and acuity on potential future spend trends.

VII. Public Comment

There was no public comment.

VIII. Move to Executive Session

A Motion to Approve the Resolution to Move to Executive Session was made by S. Tester, seconded by S. May, and was approved by a unanimous vote.

IX. Votes from Executive Session

1. Approve Executive Session Consent Agenda Items – **Approved by supermajority via email.**
2. Approve 2023 OneCare Corporate Goal Performance – **Approved by supermajority via email.**
3. Approve Medicare term sheet – **Approved by supermajority via email.**

4. Approve Medicaid term sheet – **Approved by supermajority via email.**
5. Approve Self-Funded Term Sheets – **Approved by supermajority via email.** Jessica Moschella abstained.

X. Adjournment

Upon a Motion, a second, and approval by a unanimous vote, the meeting adjourned at 6:47 p.m.

Attendance:

OneCare Board Managers

Present:

Stuart May	Shawn Tester	Toby Sadkin, MD
Jessica Moschella	Sandy Rousse	Tom Dee
Coleen Condon	Adriane Trout, MD	Teresa Fama, MD
Steve LeBlanc	Jen Gilwee, MD	Judi Fox
Tom Huebner	Anya Rader Wallack	Dan Bennett

Absent:

Leslie Ferrer	Sierra Lowell	Michael Costa
Bob Bick		

S. Tester joined the meeting at 4:55 p.m.

T. Fama joined the meeting at 5:05 p.m.

D. Bennet joined the meeting at 5:45 p.m.

S. Rousse left the meeting at 6:04 p.m.

OneCare Risk Strategy Committee

Absent:

Steve Leffler, MD		

OneCare Leadership and Staff

Present:

Abe Berman	Amy Bodette	Kellie Hinton
Sara Barry	Aaron Perry	Carrie Wulfman
Greg Daniels	Lucie Garand	Tom Borys

Derek Raynes		

OneCare Board of Managers Committee Reports

December 2023

Executive Committee (meets monthly)
The Executive Committee discussed the appointment of a new Designated Agency Manager and renewing the term of the Home Health Manager. There was also discussion about executive committee membership and priorities for 2024. Managers reviewed and discussed the draft 2024 corporate goals. They received an update on the MSSP application, the Green Mountain Care Board budget proceedings, and the AHEAD model. The committee is next scheduled to meet on January 4, 2024.

Finance Committee (meets monthly)
At its December 13th meeting, the committee received updates on the Green Mountain Care Board budget proceedings and Medicaid fixed payments. They approved the MVP term sheet for 2024 and saw a 2024 total cost of care preview for Medicare and Medicaid. The committee approved a deferral of 2023 mental health screening initiative funds and policies related to the Comprehensive Payment Reform program and Federally Qualified Health Centers. The committee is scheduled to meet next on January 10th.

Population Health Strategy Committee (meets monthly)
The committee canceled their meeting on December 11th. The committee is next scheduled to meet on January 8th, 2024.

Patient & Family Advisory Committee (meets monthly)
At its November 28th meeting, the committee heard updates pertaining to the Board of Managers. They discussed membership and introduced guests. The bulk of the meeting included a visit from the Office of the Healthcare Advocate. The meeting finished with recruitment for the Living Fully Supported Workgroup. The committee is next scheduled to meet on January 30, 2024.

Audit Committee (meets quarterly)
The Audit Committee canceled their meeting on October 30th. They conducted electronic votes related to relevant policies and received materials via Directors Desk to review and discuss at the next meeting. The committee is next scheduled to meet on March 4, 2024.

TO:	Sara Barry, Chief Operating Officer and Tom Borys, Chief Financial Officer, OneCare
FROM:	Natalie Graves, Director of Research and Implementation and Jennifer Ricards, Executive Vice President, Cynosure Health
DATE:	November 14, 2023
SUBJECT:	Return on Investment Analysis for OneCare Vermont

Executive Summary

In May 2023, OneCare contracted with Cynosure Health and its subcontractor, Westat Insight, to conduct a mixed methods evaluation of the Community Complex Care Coordination (CCCC) Program, Value-Based Incentive Fund (VBIF), and Comprehensive Payment Reform (CPR) Program, as well as a return on investment (ROI) analysis of OneCare's involvement in the Vermont All-Payer Accountable Care Organization (ACO) Model (VAPM). This memo focuses on the ROI component of the OneCare evaluation.

The Fiscal Year 2023 Green Mountain Care Board ACO Reporting Manual includes a requirement for OneCare to complete an ACO Return on Investment analysis. The reporting manual describes the purpose of the report, stating: "OneCare's administrative expenses must be less than the health care savings, including an estimate of cost avoidance and the value of improved health, projected to be generated through the Model."[1]

In partnership with OneCare, the Cynosure Health and Westat Insight evaluation team operationalized the ROI analysis to include:

1) **Environmental scan** to determine how others have assessed the ROI of ACOs and similar entities, such as integrated health systems.
2) **Proposed methods** for calculating ROI or a similar metric that meets regulatory expectations.
3) **Limitations** to clearly articulate barriers to the proposed approach.
4) **Recommendations** to include future paths of inquiry or methodology to understand OneCare's performance.

Our review of existing literature revealed that no clear or consistent definition currently exists for how to calculate the ROI of a complex, multi-payer health reform intervention. Existing analyses of ACOs or other multistakeholder reform efforts most often evaluate the impacts on cost, quality, or utilization outcomes in separate analyses. These evaluations do not compare those findings to administrative expenses or investments to calculate an ROI metric.

Though we did not identify a widely accepted methodology to calculate the ROI of an ACO, in this memo we describe multiple analytical approaches to explore this objective. For example, we considered how to use results from analyses of OneCare programs program to inform calculations of cost savings or improvements in quality. Our evaluation team completed program evaluations of OneCare's CCCC, VBIF

[1] Green Mountain Care Board. ACO Reporting Manual for FY 2023. Available at: https://gmcboard.vermont.gov/sites/gmcb/files/documents/OCVT_FY23_GMCB_ACO_Reporting_Manual.v.23.3.2_FINAL.pdf

and CPR programs in summer 2023. These analyses may have informed an ROI calculation if they demonstrated changes in population health that could be quantified, either as positive or negative ROI.

Given the programmatic and data limitations under the current evaluation contract, however, we cannot calculate a comprehensive ROI from the standpoint of the state of Vermont as the investor. The barriers to an exhaustive evaluation of these programs precluded the calculation of population-wide benefits. That is, our evaluations do not show causal impacts on cost, quality, or utilization. As a result, we were not able to evaluate a comprehensive set of outcomes to serve as inputs for an ROI calculation.

Programmatic and data limitations include:

- **COVID-19 pandemic.** The timeframes of the CCCC, VBIF, and CPR program evaluations overlapped with the COVID-19 pandemic, a time of significant stress on the health care system. We were not able to disentangle the impacts of the programs from the impacts of the COVID-19 pandemic because they affected the same outcomes. The pandemic also likely obscured potential program impacts on health care utilization outcomes.
- **Data availability.** Our evaluation team had access to limited relevant medical claims and programmatic data to evaluate these programs. Notably, we did not have access to any Blue Cross Blue Shield data given their exit from the model. We also had limited baseline data with little or no data prior to program implementation.
- **Lack of comparisons group.** All OneCare providers participate in the CCCC and VBIF programs, which means no comparison groups are available for these programs. For the CPR program, we explored comparing providers that joined in different years to each other but found that these cohorts were different and therefore could not be used as comparison groups. This limitation precludes causal modeling, especially when combined with the COVID-19 pandemic as a large confounder.

Despite these limitations, we describe in this memo analytic approaches to explore OneCare's impact on cost, quality, and utilization. While each of these approaches includes limitations, collectively they help to look at the question of ROI from different angles. Additionally, given our now detailed understanding of current evaluations, existing data, and OneCare's operations, we propose future paths of inquiry for ROI-like calculations, including cost savings projections based on observed improvements in areas such as care utilization, quality metrics, and/or disease prevalence (for example, based on findings related to the Population Health Model).

We appreciate the opportunity to explore the complexities of such an analysis and look forward to continuing to partner with OneCare to understand and describe their role and value in advancing health reform in Vermont.

Background

The Green Mountain Care Board's ACO Reporting Manual provides context for the ROI analysis, stating that "OneCare's administrative expenses must be less than the health care savings, including an estimate of cost avoidance and the value of improved health, projected to be generated through the Model."[2] In partnership with OneCare's Evaluation Advisory Group, the Cynosure Health and Westat Insight evaluation team operationalized the ROI analysis to include:

1) **Environmental scan** to determine how others have assessed the ROI of ACOs and similar entities, such as integrated health systems.
2) **Proposed methods** for calculating ROI or a similar metric that meets regulatory expectations.
3) **Limitations** to clearly articulate barriers to the proposed approach.
4) **Recommendations** to include future paths of inquiry or methodology to understand OneCare's performance.

Environmental Scan

Currently, no universal or consistent definition exists for how to calculate the ROI of a multi-payer health reform intervention such as the OneCare ACO and the VAPM. Our evaluation team conducted an environmental scan to explore how other researchers have approached this question, to ensure that our proposed methodology builds on and reflects the existing body of knowledge. Our team explored the use of ROI in: (a) individual provider organizations (such as hospitals or primary care), (b) ACOs and similar entities (such as integrated health systems), and (c) the Vermont All-Payer Model and OneCare.

Analyses that use the term "ROI" vary in their definitions of the methodology. The term ROI can encompass different approaches that vary in scope and focus. A traditional ROI analysis focuses primarily on the investor's perspective, with a calculation of the financial investment relative to the resulting financial gain. In contrast, an ROI with underlying methods reflective of a cost-effectiveness analysis or cost-benefit analysis (CBA) would consider a range of benefits from a broader perspective, including societal impact and non-financial gains.[3] The CBA methodology, as compared to the traditional ROI focus on direct monetary benefits, considers important intangible program benefits and may be more appropriate to understand the value of OneCare's efforts. However, a CBA calculation must address the challenge of quantifying the dollar value of non-financial benefits, such as improved provider coordination, reduced administrative burden, or improved care experience. Previous CBA calculations and published research can provide a basis to estimate the non-financial benefits, including an estimate of ranges of uncertainty.

Existing ROI analyses of health care interventions primarily focus on narrowly-defined programs or settings. When applying ROI methods to health system reform, research focuses on specific settings and/or interventions, such as a medication safety program to reduce hospital readmissions. A systematic

[2] Green Mountain Care Board. ACO Reporting Manual for FY 2023. Available at: https://gmcboard.vermont.gov/sites/gmcb/files/documents/OCVT_FY23_GMCB_ACO_Reporting_Manual.v.23.3.2_FINAL.pdf

[3] Thusini, S. T., Milenova, M., Nahabedian, N., Grey, B., Soukup, T., Chua, K. C., & Henderson, C. (2022). The development of the concept of return-on-investment from large-scale quality improvement programmes in healthcare: an integrative systematic literature review. BMC Health Services Research, 22(1), 1492.

review on the impact of evidence-based practices on health care system ROI defined the term ROI as "a performance measure used to evaluate the efficiency of an investment. [ROI] is calculated using a ratio that divides the net profit (or loss) related to the investment cost."[4] In most cases, the financial component of the ROI analysis referenced was focused on health care delivery costs (e.g., reimbursement). In the medication safety example noted above, an ROI analysis would consider the reduction in health care costs associated with reduced readmissions that may have resulted from the investment of implementing a medication safety program.

When analyzing complex and multi-system interventions, such as ACOs, analyses most commonly assess the impact on overall health care spending, utilization, or select quality metrics. Researchers most often analyze these financial, utilization, and quality metrics separately. We reviewed ACO evaluations of Medicare, Medicaid, and commercial ACOs, as well as the Maryland Total Cost of Care Model which has similarities with the Vermont All Payer Model. Table 1 provides examples of financial impact analyses and Table 2 provide examples of assessments of utilization and quality. None of these analyses combine these metrics of health savings and/or improved health outcomes into an ROI-type metric that accounts for investment costs.

Table 1. Example Findings from ACO Evaluations - Financial

Study Group	Example Finding
Medicare	
Medicare - Pioneer ACOs	• "Seventeen of 23 ACOs had positive or neutral financial performance, with 11 earning shared savings above their minimum savings rate, 6 generating savings but not exceeding their minimum savings rate, and 6 generating any loses."[5]
Next Generation ACO (NGACO) Model – Fifth Evaluation Report	• "In its fifth performance year, the NGACO Model was associated with $1.05 billion in gross savings, representing a 1.5 percent reduction relative to similar fee for service beneficiaries in the comparison group." • "Despite these gross spending reductions, the NGACO Model increased cumulative net Medicare spending by $386.5 million."[6]
Medicare Shared Savings Program (MSSP)	• "Our analyses show that estimates of Medicare savings from MSSP are of modest magnitude and sensitive to how switchers are distributed to treatment or comparison groups."[7] • "In this economic evaluation of 15,763 Medicare Advantage and MSSP beneficiaries between 2014 and 2018, spending was

[4] Connor, L., Dean, J., McNett, M., Tydings, D. M., Shrout, A., Gorsuch, P. F., ... & Gallagher-Ford, L. (2023). Evidence-based practice improves patient outcomes and healthcare system return on investment: Findings from a scoping review. *Worldviews on Evidence-Based Nursing*, 20(1), 6-15.

[5] Pham, H. H., Cohen, M., & Conway, P. H. (2014). The Pioneer Accountable Care Organization Model: Improving quality and lowering costs. *JAMA*, 312(16), 1635-1636.

[6] https://www.cms.gov/priorities/innovation/data-and-reports/2022/nextgenaco-fifthevalrpt

[7] https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun19_ch6_medpac_reporttocongress_sec.pdf

Study Group	Example Finding
	22 to 26% higher for MSSP beneficiaries than for MA beneficiaries, even after controlling for detailed clinical risk factors."[8]
Medicaid	
Colorado Accountable Care Collaborative: Medicare-Medicaid Program	• "…the demonstration was not associated with statistically significant savings or additional costs to the Medicare programs."[9]
Minnesota Integrated Health Partnerships	• "In 2014 … all nine providers received a shared savings settlement, ranging from approximately $388,000 to $4.7 million and totaling $23 million." • "Reported savings to the state have increased as more providers have joined the demonstration, from $14.8 million in 2013 to $76.6 million in 2015, for a total three-year savings of $157 million."[10]
Commercial	
Leavitt Partners ACO Database[11]	• Although there are hundreds of ACOs with commercial contracts, researchers reported that few report financial results. One study found that, of the 12 ACOs that did report results, 11 reported savings and "very few of these have reported a dollar figure for savings, but costs were reported to have decreased by between 2 and 12 percent." • Among commercial ACOs, "Successes include one New England ACO that reported a medical cost trend 1.2 percentage points better than its market overall, as well as a large Northeast ACO which shared approximately $2 million in their contract with United Healthcare. Savings aside, the cost of ACO investment was made clear by one Northwestern ACO that reports spending about $1 million on infrastructure and only earning $125,000 in savings in the first year."
Total Cost of Care/All Payer Models	
Maryland Total Cost of Care Model – Quantitative Only Report for the Model's First Three Years	"…substantially reduced rates of all-cause acute care hospital admissions (by 16.1 percent, moderately reduced total Medicare fee-for-service spending by 2.5 percent increased non-hospital spending (by 2.7 percent) but reduced hospital spending by more (6.6 percent), leading to a $781 million reduction in total spending."

[8] Parikh RB, Emanuel EJ, Brensinger CM, et al. Evaluation of Spending Differences Between Beneficiaries in Medicare Advantage and the Medicare Shared Savings Program. *JAMA Netw Open.* 2022;5(8):e2228529. doi:10.1001/jamanetworkopen.2022.28529

[9] https://www.cms.gov/priorities/innovation/data-and-reports/2021/fai-co-acc-mmp-eval-report

[10] Blewett, L. A., Spencer, D., & Huckfeldt, P. (2017). Minnesota integrated health partnership demonstration: implementation of a Medicaid ACO model. Journal of Health Politics, Policy and Law, 42(6), 1127-1142.

[11] Petersen, M., & Muhlestein, D. (2014). ACO results: What we know so far. *Health Affairs Forefront*.

Study Group	Example Finding
Vermont All-Payer ACO Model	"Cumulatively…we observed a reduction in total Medicare spending of $655.89 (6.0 percent), or $93.8 million overall, before considering CMS's shared savings and other pass-through payouts."

PY = Performance Year

Table 2. Example Findings from ACO Evaluations – Quality and Utilization

Study Group	Example Finding
Medicare	
Medicare - Pioneer ACOs	• "Pioneer ACOs had a mean overall quality score of 84.0% in 2023 compared with 70.8% in 2012. The mean performance score of all Pioneer ACOs improved in 28 of 33 quality measures."
Next Generation ACO (NGACO) Model – Fifth Evaluation Report	• "Cumulatively, the largest percentage reductions in utilization were skilled nursing facility days (6.4 percent in PY5, about 2.5 times the impact seen in PY4). Consistent with reductions in hospital spending, there was a 1.5 percent reduction in acute care hospital stays, nearly twice the size of the impact in the previous PY."
Medicare Shared Savings Program	• "MSSP ACOs improved quality despite their sicker, older population…continued ACO infrastructure development funding, better relationships with PAC facilities and opportunities for diverse ACOs to share their learnings would maximize quality improvement."[12]
Medicaid	
Minnesota Integrated Health Partnerships	• University of Minnesota researchers reported that financial gains for participating providers were linked to quality metrics. Specifically, "performance targets for thirty-two measures of health care processes, health care outcomes, and patient experience."[13]
Commercial	
Leavitt Partners ACO Database	• "As with financial reporting among commercial ACOs, peer-reviewed data on quality and/or utilization are limited. Petersen and Muhlestein reported the following quality and/or utilization metrics for Aetna, Cigna, and United ACOs, including measures such as primary care access, diabetes care

[12] Bleser, W.K., Saunders, R.S., et al. (2018). ACO Quality Over Time: The MSSP Experience and Opportunities for System-Wide Improvement. The American Journal of Accountable Care, 6(1):e1-e5. https://www.ajmc.com/view/aco-quality-over-time-the-mssp-experience-and-opportunities-for-systemwide-improvement

[13] Blewett, L. A., Spencer, D., & Huckfeldt, P. (2017). Minnesota integrated health partnership demonstration: implementation of a Medicaid ACO model. *Journal of Health Politics, Policy and Law*, 42(6), 1127-1142.

Study Group	Example Finding
	management, hospital readmissions, emergency department visits, and preventive care (e.g., screenings)."[14]
Total Cost of Care/All Payer Models	
Maryland Total Cost of Care Model – Quantitative Only Report for the Model's First Three Years	• "(The Maryland Model) substantially reduced rates of all-cause acute care hospital admissions (16.1 percent); improved several quality-of-care measures, including reducing potentially preventable admissions (by 16.1 percent), reducing the likelihood of an unplanned readmission to the hospital (9.5 percent), and increasing timely follow-up after hospital discharge (2.5 percent)."[15]

PY = Performance Year

Our team also reviewed the CMS-funded evaluation reports focused on the VAPM and/or OneCare so that we could layer onto, and not duplicate, existing work. These evaluations, conducted by NORC at the University of Chicago, include results that could be used as inputs for an ROI calculation (for example, cost savings estimates). However, these evaluations are not inclusive of all payers; most only include Medicare data given that CMS procured NORC's services specifically to analyze the Medicare ACO.

Table 3. CMS-funded Evaluations of the VAPM, Conducted by NORC

Report	Key Findings
First Evaluation Report	• "Both statewide and for the Medicare ACO, hospital-based utilization (acute care stays and days) decreased in PY2 (2019). We observed decreases of 17.9 percent and 14.7 percent for acute care stays and acute care days, respectively, for the Medicare ACO initiative." • "Specialty E&M visits significantly declined in PY2, both for the statewide population and for the Medicare ACO, with decreases of 10.2 percent and 7.7 percent, respectively."
Second Evaluation Report	• "Over the first three PYs, the VAPM Medicare ACO initiative achieved statistically significant reductions in cumulative gross spending, totaling $655 per beneficiary per year (PBPY) or 6 percent. After considering shared savings and incentive payments from Medicare, the VAPM Medicare ACO saw a statistically insignificant reduction of $577.13 PBPY." • "Due to influences of the COVID-19 PHE, Medicare utilization saw a steep decline in both the VAPM and comparison groups in PY3. Despite shifts in utilization in care-seeking patterns in PY3, many of the trends observed in PY2 persisted in PY3, including

[14] Petersen, M., & Muhlestein, D. (2014). ACO results: What we know so far. *Health Affairs Forefront*.
[15] Rotter, J., Calkins, K., et al. (2022). Evaluation of the Maryland Total Cost of Care Model: Quantitative-Only Report for the Model's First Three Years (2019-2021). Mathematica. https://www.mathematica.org/publications/evaluation-of-the-maryland-total-cost-of-care-model-quantitative-only-report-for-the-models-first

Report	Key Findings
	decreases in acute care and specialist E&M visits. The decline in specialist E&M visits may be driven in part of specialist shortage in Vermont and long wait time for specialty care." • "In PY3 we observed continued progress toward 2022 performance targets for the majority of the Model's population health and quality of care outcomes. The Model maintained statewide chronic disease prevalence (chronic obstructive pulmonary disease, diabetes, hypertension); increased the Model population's initiation and engagement for treatment for alcohol and other drug dependence and timely follow-up after ED *discharge*; and *almost halved the percentage of Medicare beneficiaries with diabetes experiencing poor HBA1c control*."
Third Evaluation Report	• "The Medicare ACO *reduced cumulative Medicare spending by $686 PBPY over the first four years of performance among attributed beneficiaries (6.2% reduction)*."

PY = Performance Year
E&M = Evaluation & Management

Notably, OneCare also contracted with Milliman in 2021 to establish a benchmarking system to compare its performance to other ACOs, with respect to utilization, cost per capita, quality, patient engagement and satisfaction, and clinical appropriateness. Key findings from this report[16] include:

- The total allowed per member per month (PMPM) cost for OneCare's 2021 attributed population is approximately 9 percent lower than the average of the National Peer ACO Cohort after accounting for differences in risk score and unit cost.
- OneCare's 2021 attributed population is lower cost than the National Peer ACO Cohort, with mixed result when comparing rates for the following specific service categories. Compared to the National Peer ACO Cohort:
    - Inpatient Facility – Medical is approximately 9 percent lower cost. Admission rate is approximately 2 percent higher.
    - Inpatient Facility – Surgery is approximately 11 percent lower cost. Admission rate is approximately 6 percent lower.
    - Outpatient Facility – Surgery is approximately 22 percent lower cost. Visit rate is approximately 36 percent higher.
    - Part B Pharmacy is approximately 15 percent lower cost (across both Outpatient – Pharmacy and Professional – Office Administered Drugs)
    - Office Visits for Primary Care Providers are approximately 27 percent lower cost and Specialist costs are approximately 11 percent lower. The PCP visit rate is approximately 14 percent lower and the visit rate for specialists is approximately 6 percent lower.

[16] OneCare Medicare Benchmarking Report, October 2022. https://gmcboard.vermont.gov/sites/gmcb/files/documents/OCV_FY22-Benchmarking-Report_10-31-22.pdf

- OneCare's population incurs higher costs relative to the National Peer ACO Cohort in a few service categories:
    - Emergency Department: Approximately 32 percent higher costs, driven by 37 percent higher utilization.
    - Post-Acute Care: Approximately 8 percent higher cost for the 2021 attributed population across the post-acute care service lines of Inpatient Facility – Rehabilitation, Skilled Nursing Facility, and Home Health.
- OneCare's 2021 utilization and quality is in overall alignment with the National Peer ACO Cohort.

Finally, the evaluation team identified existing, publicly available reports and analyses from OneCare that describe their financial performance (i.e., shared savings) by year and for each payer (Table 4). Similar to the evaluations catalogued above, these analyses reflect components of what might be included in an overall ROI analysis. The Medicare ACO has achieved shared savings every year in the program, while performance in the commercial contracts has been variable. The Medicaid ACO achieved shared savings 3 out of 4 years.

Table 4. Combined Shared Savings and Losses by Performance Year and Payor, In Millions

	Medicare ACO	Medicaid ACO	BCBSVT	MVP
2018	$13.35	$6.12	-$0.65	--
2019	$11.06	$-1.74	$0.00	--
2020	$16.31	$55.56	$0.13	$1.06
2021	$10.03	$7.12	$-0.11	$0.00

Source: https://www.onecarevt.org/aco-results/

OneCare also internally tracks performance on a set of annual quality metrics that vary by payer and by year. As described in NORC's most recent All-Payer Model Evaluation Report, "despite efforts to align quality improvement metrics across payers, only 7 of the 18 OneCare measures were common across all payers in 2021 and 2022." OneCare reports their quality metric results annually through Quality Measure Scorecards available on their website[17].

Potential Approaches

Our environmental scan revelated no clear precedent for calculating the ROI of a complex, multi-payer health reform initiative but gave us a deep understanding of methodologies to draw on the data that are currently available to be used in any such calculation. We considered multiple approaches, such as:

- Calculating the benefit to providers from investing time and financial resources in implementing the OneCare programs and model (i.e., summing shared savings)
- Calculating a traditional ROI with a focus on investment from the standpoint of the state as the investor (i.e., quantifying improvements in population health outcomes such as primary care visits or improvements in quality metrics)

[17] Quality Measure Scorecards by Payer available here: https://www.onecarevt.org/aco-results/

- Calculating a cost-benefit analysis with a focus on specific outcomes of OneCare initiatives such as the CCCC, VBIF, and CPR program

We assessed the availability and completeness of data for each component of a ROI analysis, including data on administrative expenses, cost savings, and health improvements. Additional detail on the data available for this assessment can be found in the Program Evaluation Brief submitted to OneCare on September 15, 2023. The Cynosure Health and Westat Insight teams had access to:

(1) Data made available for OneCare's program evaluations (including Medicare, Medicaid, and MVP medical claims for select years)
(2) Publicly available data (such as OneCare's administrative expenses, evaluation reports, existing OneCare analyses)

To combine cost and quality metrics into an ROI calculation, we need data consistency across years, payers, and programs. For example, if OneCare's administrative expenses (i.e., the investment portion of the equation) represent the organization's effort across participating payers, the savings portion of the equation should also include all participating payers. We currently do not have access to consistent data by payer, by year to perform an inclusive and holistic analysis.

Calculating "Investment." To assess the investment component of ROI we gathered information on OneCare's administrative expenses from the GMCB's ACO Budget Order.[18] As shown in Table 5, OneCare's administrative expenses have remained relatively stable over time. The administrative expense category is also referred to as operating expenses and includes salaries and benefits, purchased services, software/informatics, occupancy, insurance, assessments, and other expenses (e.g., travel expenses).

Table 5. OneCare Administrative Expenses, 2019-2022

	2019	2020	2021	2022
Administrative Expenses ($)	$15,341,450	$14,044,262	$13,608,546	$15,437,538
Percent of Total	2.3%	1.3%	1.3%	1.1%

Calculating "Value." The GMCB specifies that administrative expenses must be less than the "value of health care savings, including an estimate of cost avoidance and the value of improved health." The evaluation team considered several sources to calculate these components:

- OneCare performance metrics (quality scorecards)
- Quality and utilization metrics (claims data)
- Estimates of cost savings (peer-reviewed literature)

We considered approaches to calculate more specific areas of cost avoidance or value associated with improved health, beyond what the CMS Evaluation Contractor, NORC, has presented in its evaluation reports (described in Table 3). Assuming the relevant data are available to complete these analyses, they would allow for a more understanding of value generated across payers. Given data and program

[18] GMCB. ACO Oversight. Available at: https://gmcboard.vermont.gov/aco-oversight

limitations we cannot currently complete these analyses; however, with additional data we could complete similar analyses in the future.

Cost Savings Example: Shared Savings. One simplistic way to assess OneCare's ROI is to sum the shared savings generated over the life of the model and compare those savings to OneCare's administrative costs. This approach assumes the "investment" portion of ROI is equal to OneCare's administrative expenses, as specified in legislation, and considers the benefit primarily from the perspective of providers (i.e., in the form of shared savings). Using shared savings as a metric of success draws on documented contractual obligations, as negotiated with each payer and provider organizations. It is, therefore, a predetermined and agreed upon metric of success.

Comparing shared savings to administrative expenses from 2019 through 2021 yields a net benefit to providers of $54,128,630. As shown in Table 6, to arrive at this number, we summed shared savings and losses for all participating payers in each year and subtracted total administrative expenses for the same time period.

Table 6. ROI Calculation Using Shared Savings Compared with OneCare's Administrative Expenses

	2019	2020	2021	Total
Shared Savings and Losses*	$9,320,000	$73,060,000	$17,040,000	$99,420,000
Administratiev Expenses	$15,341,450	$14,044,262	$15,905,659	$45,291,370
Net Savings (Row 1-2)	($6,021,450)	$59,015,738	$1,134,342	$54,128,630

*Rounded to the nearest ten thousand

Considering ROI in this way does not quantify other benefits, such as the benefits of improved health outcomes or changes in utilization that may lead to cost savings, nor does it account for various external factors that may impact shared savings. Assessing shared savings as a metric of ACO success is the most common approach we identified in the literature; however, it is an incomplete and simplified assessment of the full impact of an ACO.

Cost Savings Example: Primary Care Visits. One approach to calculating the "value of health care savings" would be to quantify changes in health care utilization (such as primary care visits) and tie those improvements to "costs avoided." For example, researchers have documented a relationship between increased primary care visits and decreased health care costs over time.[19,20,21] The cost savings associated with increased primary care visits were due largely to improved disease prevention and management, as well as avoided utilization such as emergency department visits and hospitalizations.

[19] Gao J., Moran E., Woolhandler S., Toporek A., Wilper A.P., & Himmelstein D.U. (2022). *Primary Care's Effects on Costs in the US Veterans Health Administration, 2016-2019: an Observational Cohort Study*. J Gen Intern Med. 37(13):3289-3294. doi: 10.1007/s11606-021-07140-6

[20] Yanagihara, D. & Hwang, A. (2022). *Investing in primary care: Why it matters for Californians with commercial coverage*. California Health Care Foundation. https://www.chcf.org/wp-content/uploads/2022/04/InvestingPrimaryCareWhyItMattersCommercialCoverage.pdf

[21] Kronman, A.C., Ash, A.S., Freund, K.M. *et al.* (2008). *Can Primary Care Visits Reduce Hospital Utilization Among Medicare Beneficiaries at the End of Life?* J GEN INTERN MED **23**, 1330–1335. https://doi.org/10.1007/s11606-008-0638-5

Given this established relationship between increased primary care visits and decreased costs, if we observe changes in primary care visits among OneCare members, we could project population-wide cost savings. For illustrative purposes, we assume we would observe increases in primary care visits as a benefit of OneCare's programs. To project population-wide cost savings related to any increases in primary care visits, an evaluation team would:

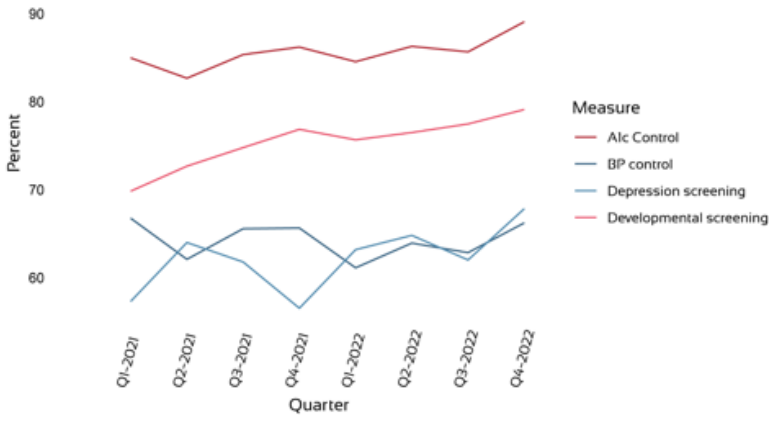
1. Estimate any increase in primary care visits over time among OneCare members.
2. Identify in the literature a range of potential downstream savings estimates associated with increased primary care visits.
3. Multiply savings estimates by the projected increase in primary care visits.

The estimated savings associated with increased primary care use could also be calculated under various scenarios. For example, the evaluation team could estimate what the total savings would be if all patients achieved the estimated mean increase in primary care visits, or if all health service areas achieved as high a primary care visit rate as the highest performing health service area. This would illustrate how achieving different levels of primary care utilization could impact financial gains.

Cost Savings Example: Quality Metrics. OneCare's Quality Scorecards include both claims-based and chart-abstracted measures that reflect various aspects of health care quality and changes in health outcomes associated with downstream cost savings. Similar to the primary care utilization example, we could apply a similar logic as the above primary care savings example for an observed changes in quality metrics: multiplying the projected increase in quality by an associated value of improvement documented in the literature.

However, there are several limitations that preclude current calculations using Quality Scorecard metrics. Quality metrics are not consistent across payers or years, so we cannot analyze improvements in the measures across the lifespan of OneCare's programs. At best, and depending on the availability of underlying data, we may be able to calculate changes in some metrics for some years, as we recently did for the VBIF program from 2021-2022. For example, Figure 1 shows findings from the recent program evaluation for VBIF metrics. We observed increases in 3 of 4 metrics from 2021-2022.

Figure 1. VBIF Measure Rates by Quarter, Q1 2021-Q4 2022



Importantly, use of select Quality Scorecard metrics would represent only specific sources potential savings, given that they represent an incomplete picture of OneCare's program impacts and benefits. Individual quality metrics are not comprehensive, instead they pertain only to specific outcomes or populations (for example, patients with hypertension or pediatric patients). In the VBIF example, the adult metrics only represent savings for patients with hypertension or diabetes; the pediatric metrics only represent savings for pediatric patients. Thus, as with the cost savings example related to primary care use, this approach focused on select quality metrics would provide insight on focused areas of improvement and cost avoidance/savings rather than program-wide comprehensive benefits and savings.

Value Example: Improvement in Chronic Disease Burden

Another approach to estimating specific sources of savings would be to calculate changes in chronic disease incidence or prevalence across the OneCare attributed population over time. To determine potential savings, we would multiply estimates of the cost of care for managing these conditions from the literature by data from the OneCare population on the number of conditions averted and/or diagnosed and then controlled. These savings predominantly stem from decreases in medication use as well as a reduction in acute care utilization, representing the value of the prevention and improved management of these conditions. Examples may include increases in the proportion of patients with controlled diabetes or hypertension across the years for which relevant measures are available. Similar to the analyses above, with access to additional data and/or additional time to observe population health benefits that may accrue over the course of the model, we could test these calculations.

Value Example: Qualitative Analysis

Qualitative data collection and analysis of OneCare's impact could supplement any quantitative calculation of the impact on health care savings or improved health outcomes. For example, we could interview providers about their feedback on programmatic impacts such as standardizing requirements across payers to streamline reporting, reducing administrative burden of contracting with multiple payers, or creating new learning networks that accelerate transformation.

Conversations with the diverse stakeholders in the OneCare network—from hospital administrators to primary care clinicians, to community-based organizations and state agencies—could help the evaluation team better understand the ways in which those stakeholders perceive the value of OneCare and its programs, in both the short and long term. For example, qualitative interviews in the summer of 2023 revealed that multiple primary care practices saw value in OneCare's role as a convener of provider groups and stakeholders, reflecting "where else do you see independent primary care practicing sitting at the same table as senior leaders of the hospitals? It's not often that opportunity happens and that's been coordinated by the ACO." Future interviews with hospital administrators, for example, would provide additional insight into OneCare's impact.

Limitations

Our environmental scan and evaluation of OneCare's programs helped to elucidate potential limitations based on program design and data availability, which inform our recommendations for more useful ROI-

like calculations in the future. These limitations currently preclude the accurate calculation of an ROI for OneCare's efforts within the VAPM. However, with our now detailed understanding of the available data, we offer recommendations for analyses that help OneCare, the Green Mountain Care Board, and other stakeholders understand the value of OneCare and its efforts to drive health care reform.

In summer 2023 our evaluation team completed program evaluations of OneCare's CCCC, VBIF and CPR programs, which may have informed an ROI calculation if they demonstrated changes in population health that could be quantified, either as positive or negative ROI. However, barriers to an exhaustive evaluation precluded the calculation of population-wide benefits. This included programmatic and data limitations, as well as the years of study overlapping with the COVID-19 pandemic which likely obscured potential program impacts on healthcare utilization outcomes. As a result, we were not able to evaluate a comprehensive set of outcomes to serve as inputs for an ROI calculation.

Table 7. Limitations for 2023 Program Evaluations and ROI Analysis

Limitation	Implications for Evaluation
Complexity of reform efforts	OneCare is not the only facilitator of transformation activities in the state. Other programs (such as the Blueprint for Health) and agencies (such as the Vermont Department of Mental Health) also influence changes in practice and outcomes.
Loss of BCBS from OneCare	BCBS left OneCare when some programmatic changes for CPR program were being implemented, making it difficult to disentangle the impact of such changes. Loss of this payer also resulted in loss of data during its years of program participation, representing a large number of OneCare members who could not be included in the evaluation.
Overlap of COVID-19 PHE with key years in development and growth of OneCare programs	All analyzed outcomes were severely affected by the COVID-19 PHE during the period of the evaluation of all three programs. Especially because of the lack of a comparison group (discussed below), it was not possible to disentangle the impacts of the programs from the impacts of the COVID-19 PHE because they affected the same outcomes. Therefore, a lack of statistically significant findings or findings contrary to the evaluation team's expectations may be a result of the COVID-19 PHE and not causal impacts of the program.
Lack of a comparison group	This limitation precluded causal modeling, especially when combined with a large confounder that affected the same outcomes in the same period—the COVID-19 PHE. One possible comparison group was not care-managed individuals who were attributed to providers that participated in the CCCC program but were never care managed or providers that never participated in the CPR program. Another type of comparison group is providers that joined the CPR program later than others. However, providers participating in the CPR program and individuals participating in the CCCC program are much different than those who never participated, and providers that joined the CPR program in a certain year (i.e., cohorts) are different than providers that joined the CPR program in any other year. This introduces

Limitation	Implications for Evaluation
	selection bias, which is a challenge for assessing the impacts of the programs on outcomes. Another possible comparison group was individuals or providers from States outside Vermont, but the evaluation team did not have data to facilitate that comparison.
Program changes across time	Changes in design or operation of OneCare programs over time made it challenging to attribute changes in observed outcomes (or lack thereof) to specific program features. For example, the redesign of CCCC in 2020 precluded analysis of the program prior to 2020, so the evaluation team had very limited data over time to make comparisons of program effectiveness.
Limited baseline data	The evaluation team had little or no data prior to the beginning of programs (for CPR) or prior to large changes to programs (for CCCC and VBIF). The lack of baseline data presents a substantial challenge in assessing program impact.

Considerations for Future Analyses to Assess ACO Performance

Specific cost savings estimates are one approach to calculating the tangible value of OneCare's programs. As previously described, this would entail projecting savings based on observed improvements in areas such as care utilization, quality metrics, or disease prevalence. With more data in the coming year, and a focused assessment of the Population Health Management program implementation, the evaluation team could calculate increases in primary care utilization and decreases in acute care utilization and chronic disease burden associated with OneCare participation. Using internal administrative data and/or estimates from the literature, we could then estimate the savings/costs avoided due to these population-wide improvements.

To provide greater context around potential savings, our evaluation team can calculate estimates of uncertainty and variation across different scenarios. Additionally, we can calculate focused estimates among priority populations (for example high risk, high cost members). This will aid OneCare in estimating the financial benefits associated with varying levels of preventive care and population health achievement. While savings/reduced spending estimates tied to specific care quality and health metrics do not represent a comprehensive picture of OneCare's impact on healthcare operations and the health of attributed members, they can serve as concrete illustrations of areas in which OneCare provides both clinical and monetary value to providers, members, and healthcare systems.

Future exploration might also entail additional conversations with stakeholders (including different provider types or state agencies) to develop a more nuanced understanding of the ways in which OneCare adds value. With new insight we might identify opportunities to describe and quantify that value in a way that could be considered as part of a reflection on the ROI of OneCare and the VAPM.

We appreciate the opportunity to explore the complexities of such an analysis and look forward to continuing to partner with OneCare to understand and describe their role and value in advancing health reform in Vermont.

Board of Managers Summary of Policy Changes
Public Session
December 2023

OneCare leadership has reviewed and recommends the following policies for approval by the Board of Managers.

- **01-02 Conflict of Interest**
  - **Purpose:** To provide a comprehensive statement of OneCare's policy for the avoidance, timely identification and resolution of Conflicts of Interest that may adversely affect business or professional decision-making by OneCare or by Interested Persons.
  - **Key Changes:** No substantive changes; all edits are for the purpose of improved clarity.
  - **Committee Endorsement:** N/A

- **03-03 Data Use**
  - **Purpose:** To provide standards and guidelines for the safeguarding, use, sharing, and destruction of: Claims Data provided to OneCare by Payers, Clinical Data provided by various sources, and Other Data.
  - **Key Changes:** The policy was edited to reflect a limited scope of the small cell size rules to Medicare data only, since the rule does not apply to data from other payers. All other edits are for the purpose of improved clarity.
  - **Committee Endorsement:** Audit Committee (12/18/23)

- **05-01 Contract Management**
  - **Purpose:** To establish a uniform policy for drafting, review, approval, execution, management, and retention of contracts involving OneCare to ensure that its contractual arrangements are lawful, consistent with business interests, and comply with Policies and Procedures.
  - **Key Changes:** No substantive changes; all edits are the purpose of improved clarity.
  - **Committee Endorsement:** N/A

- **06-01 Record Retention**
  - **Purpose:** To establish guidelines for the retention and disposal of records that are created and maintained by OneCare.
  - **Key Changes:** No substantive changes; all edits are for the purpose of improved clarity.
  - **Committee Endorsement:** N/A

Policy Number & Title:	01-02 Conflict of Interest
Responsible Department:	Legal
Author:	Aaron Perry, Chief Legal Counsel
Original Implementation Date:	September 4, 2012
Board Approval Date:	December 21, 2023
Revision Effective Date:	December 21, 2023

I. Purpose: The purpose of this policy is to provide a comprehensive statement of OneCare's policy for the avoidance, timely identification and resolution of Conflicts of Interest that may adversely affect business or professional decision-making by OneCare or by Interested Persons. The Policy is intended to supplement, but not replace, any applicable Federal or Vermont law governing conflicts of interest applicable to OneCare, as well as any relevant policies that may also apply.

II. Scope: This policy applies to all of OneCare Vermont's ("OneCare") Officers, Board Members, and any Workforce member who exercises substantial influence over OneCare's business decisions or affairs ("Interested Person(s)").

III. Definitions: Capitalized terms have the same definition as defined in OneCare's *Policy and Procedure Glossary*. For purposes of this Policy, the terms below have the following meanings:

ACO Activities refers to activities engaged in by OneCare to promote accountability for the quality, cost, and overall care for a Payer's Attributed Population, including managing and coordinating care, encouraging investment in infrastructure, and redesigning care processes for high quality and efficient delivery of services, as well as other activities, obligations, or duties required of an ACO under federal or state law.

ACO Program Agreement refers to an agreement between OneCare and a Payer for the performance of ACO Services.

ACO Services refers to services OneCare provides to a Payer's Attributed Population as set forth in an ACO Program Agreement.

Audit Committee means the Audit Committee of the OneCare Board of Managers.

COI Certification Form means a Conflict of Interest questionnaire and certification form, as approved and updated from time to time by the Audit Committee.

COI Advisory Group refers to the group available to OneCare's Chief Legal Counsel for consultation concerning potential Conflicts of Interest as described in this Policy. The working group consists of Chief Legal Counsel, the Chief Compliance and Privacy Officer, the Vice President of Finance, and a Workforce member designated by the Chief Operating Officer who possesses a professional license or certification, or sufficient equivalent professional experience, relating to the tax obligations of non-profit organizations.

Compensation Arrangement means any employment, consulting, or other arrangement involving the receipt of money or other financial benefits during the past three years, or the receipt of gifts or gratuities that is not permitted by a relevant OneCare policy.

Conflict of Interest (COI) refers to any real or perceived barrier, such as a Personal Interest, that would prevent an Interested Person from being impartial and loyal to OneCare's interests.

Controlled Entity means an entity in which an Interested Person has a 35% or greater ownership or beneficial interest.

Disqualified Person has the meaning indicated in section VII(A) below.

Fiduciary Interest means participation as a trustee, director or officer of a Network Member, Subcontractor, or Vendor.

Financial Interest means any direct or indirect ownership interest in a Network Member, Subcontractor, or Vendor.

Immediate Family means an Interested Person's spouse, parent or step parent, children and their spouses, as well as brother(s) and sister(s) and their spouses.

Interested Person(s) has the meaning indicated in the Scope section above.

Network Member refers to any Participant or Preferred Provider that has entered into a Contract with OneCare to provide ACO Services.

Officer means OneCare's Chief Executive Officer, Chief Operating Officer, Chief Medical Officer, Chief Compliance and Privacy Officer, Chief Financial Officer, and Chief Legal Counsel.

Personal Interest means a Financial Interest, Compensation Arrangement, or Fiduciary Interest with or in a Network Member, Subcontractor, or Vendor by the Interested Person, a member of their Immediate Family, their Significant Other, or their Controlled Entity.

Significant Other means a person with whom an Interested Person has a civil union or a similar legal or personal relationship.

Subcontractor means a third party which has entered into a Contract with OneCare delegating the performance of certain ACO Activities.

Vendor means a third party which is doing business or may be seeking to do business with OneCare for the purpose of providing either products or services.

IV. Policy: Interested Persons should at all times: (i) act in a manner that the Interested Person reasonably believes to be in the best interests of OneCare; (ii) comply with the Conflict of Interest disclosure and management procedures set forth in this Policy; (iii) seek to avoid Personal Interests that may create a real or perceived a conflict with the professional obligations or fiduciary duties of the Interested Person or the interests of OneCare and may adversely affect business or professional decisions; and (iv) refrain from participating in operational, strategic, or professional decisions for OneCare in which the Interested Person has a Personal Interest.

In determining the proper management of Personal Interests that may give rise to multiple Conflicts of Interest, consideration will be given to OneCare's participation in the Vermont All-

Payer Accountable Care Organization Model, the regulatory requirement that ACO Boards be composed of a prescribed percentage of Participants and number of Payer-specific Beneficiaries, and its continued ability to meet its obligations as an ACO. For example, should a Personal Interest common to Interested Persons across a category of Participants, such as Board Member employment by hospitals, result in the inability to establish a quorum to vote on whether to approve an ACO Program Agreement, management of such potential Conflicts of Interest must favor OneCare's continued ability to meet its obligations as an ACO.

This Policy shall be administered by the Board of Managers, its Audit Committee, and the Chief Legal Counsel as described below.

V. Disclosure:

A. Disclosure by Interested Persons: Interested Persons shall disclose Personal Interests and any real or potential conflicts of interest that may affect their decision-making, as follows:

1. Initial Disclosure. Each Interested Person shall complete and return a COI Certification Form prior to the commencement of their employment or term of office.

2. Annual Disclosure. Each Interested Person shall complete and return an updated COI Certification Form at least once per calendar year in accordance with a procedure established by the Chief Legal Counsel, and if applicable, will provide additional information requested by the COI Advisory Group, Audit Committee, or Board of Managers regarding any Network Member, Subcontractor, Vendor, or other third party with which they have a relationship or Personal Interest referenced in the COI Certification Form.

3. Interim Disclosure.

   a. By Board Members and Officers. Board Members shall disclose to the Board of Managers, and Officers shall disclose to the Chief Legal Counsel, any Personal Interest involving a Network Member, Subcontractor, Vendor, or other third party, prior to participating in any discussion or decision involving that Network Member, Subcontractor, Vendor, or other third party, and shall refrain from participating in any decision involving that Network Member, Subcontractor, Vendor, or other third party.

   b. By Other Interested Persons. Any other Interested Person shall submit a COI Certification Form (i) if they serve on an ad hoc or established committee the purpose of which is to make purchasing or payment decisions; (ii) if they are a Workforce member with responsibility for recommending purchasing decisions or selecting Subcontractors or Vendors; or (iii) upon request of the Audit Committee or the Chief Legal Counsel, or otherwise at any time they first believe they have a Personal Interest that may give rise to a Conflict of Interest.

B. Disclosure by Subcontractors and Vendors: From time to time, as a condition of doing business with OneCare, the Chief Legal Counsel shall require Subcontractors and Vendors to disclose any Personal Interests of Interested Persons, to the extent of the Subcontractor's or Vendor's knowledge.

VI. Review and Management:

A. **Review by Chief Legal Counsel:** The Chief Legal Counsel shall review all COI certifications at the time they are submitted and report any disclosed Personal Interests or Conflicts of Interest to the Audit Committee for review and, if necessary, a decision as to the appropriate management of the matter consistent with this Policy. The decision will be communicated promptly to the affected Interested Person.

B. **COI Advisory Group Consultation:** For additional input regarding whether a Conflict of Interest exists, appropriate management of the matter, and compliance with Intermediate Sanctions Rules as set forth in Section VII(A), the Chief Legal Counsel, or the Audit Committee in the case of Board Members, may consult with the COI Advisory Group at their discretion. Members of the COI Advisory Group will maintain confidentiality concerning any such consultations unless disclosure is required by law.

C. **Management of Conflicts:** Decisions as to the appropriate management of a conflict of interest include the following:

1. Recusal. In all cases, an Interested Person with a Personal Interest relating to a specific Network Member, Subcontractor, Vendor, or other third party should refrain from voting, or participating on behalf of OneCare, or from exercising influence or control, with respect to decisions or actions affecting or benefiting that Network Member, Subcontractor, or Vendor.

2. Divestiture. If the Personal Interests of an Interested Person is deemed to be of sufficient magnitude to adversely affect the interest of OneCare, the Interested Person may be requested to divest or disassociate from the Personal Interest.

D. **Appeals:** An Interested Person who disagrees with a decision of the Chief Legal Counsel with respect to the management of a Conflict of Interest may appeal to the Audit Committee, and an Interested Person who disagrees with a decision of the Audit Committee may appeal to the Board of Managers.

E. **Report to Audit Committee:** The Chief Legal Counsel shall report all disclosures and related decisions to the Audit Committee at least quarterly.

VII. Transactions Involving "Disqualified Persons":

A. **Compliance with Intermediate Sanctions Rules:** In order to comply with the intermediate sanctions safe harbor contained in Section 4958 of the Internal Revenue Code and underlying rules (the "Intermediate Sanctions Rules"), OneCare shall follow certain special procedures for review and approval of transactions with Board Members, Officers, and any other person who has been in a position to exercise substantial influence over the affairs of OneCare during the five years prior to the transaction, as determined by the Chief Legal Counsel in consultation with the COI Advisory Group. Such persons are considered to be "Disqualified Persons" under the Intermediate Sanctions Rules.

1. **Special Procedures:** The special procedures are as follows:
   Compensation arrangements with Officers and any Disqualified Persons shall be subject

to review by the disinterested members of the Board of Managers in accordance with its Charter.

2. Transactions with a Network Member, Subcontractor, Vendor, or other third party in which a Disqualified Person has a Personal Interest shall be subject to prior approval by majority vote of the Board of Managers, provided no Board Member with a Personal Interest in the transaction votes on the matter.

3. Prior to taking action on the transaction, the Board of Managers must rely on appropriate data, which may include independent expert opinion, as to the fair value and reasonableness of the transaction.

4. The basis for the decision of the Board of Managers must be documented inthe minutes.

VIII. Violations: If the Audit Committee has reasonable cause to believe that an Interested Person has failed to disclose a Personal Interest or otherwise violated this Policy, it shall inform the Interested Person of the basis for such belief in writing and afford the Interested Person an opportunity to explain the alleged violation. If, after hearing the response of the Interested Person and making such further investigation as may be warranted in the circumstances, the Audit Committee determines that the Interested Person has, in fact, failed to disclose a Personal Interest or otherwise violated this Policy, it shall direct that appropriate disciplinary and corrective action, which may include termination of employment and/or appointment, be taken. In cases where such violation results in significant damage to the interests of OneCare, civil action may be initiated if appropriate. Any decision of the Audit Committee may be appealed to the Board of Managers for resolution by majority vote.

IX. Records of Proceedings: Written records shall be maintained of Chief Legal Counsel's determinations, as well as minutes of any meetings and proceedings of the Audit Committee and the Board of Managers, with respect to the management and resolution of Conflicts of Interest in accordance with this Policy.

X. Review Process: This Policy and the COI Certification Form shall be reviewed annually and updated to be consistent with the requirements established by the Board, OneCare Leadership, all applicable laws, and applicable accrediting and review organizations.

XI. References:

- OneCare's ACO Program Agreements with Payers
- OneCare's Policy and Procedure Glossary
- COI Certification Form

XII. Related Policies/Procedures:

- 06-01 Record Retention Policy
- 07-02 Compliance Policy
- 07-07 Code of Conduct Policy

Location on SharePoint: **Department: Policies, Category: Active**

Management Approval:

Chief Legal Counsel	Date
Chief Operating Officer	Date

Policy Number & Title:	03-03 OneCare Data Use Policy
Responsible Department:	Analytics
Author:	Aaron Perry, Chief Legal Counsel
Original Implementation Date:	June 18, 2015
Board Approval Date:	December 21, 2023
Revision Effective Date:	December 21, 2023

I. Purpose: To provide standards and guidelines for the safeguarding, use, sharing, and destruction of: Claims Data provided to OneCare by Payers, Clinical Data provided by various sources, and Other Data.

Additional standards and guidelines for the safeguarding, use, and sharing of Protected Health Information ("PHI") can be found in OneCare's *Privacy* and *Security Policies*.

II. Scope: This Policy applies to OneCare, its Workforce, Participants, Preferred Providers, Collaborators and Business Associate Subcontractors, and any other individual or entity using Claims Data, Clinical Data, or Other Data provided to or by OneCare. These Data are provided to OneCare to further ACO Program goals and to permit ACO to perform ACO Activities and population health management functions.

III. Definitions: Commonly used terms have the same definition as defined in OneCare's *Policy and Procedure Glossary*, available upon request. For the purposes of this Policy, the terms below have the following meanings, to the extent the terms are defined in the glossary, the definitions below will control:

ACO Activities refers to clinical treatment, care management and coordination, quality improvement activities and provider incentive design and implementation.

Claims Data refers to the claims feed and enrollment information for Attributed Lives provided by Payers to OneCare. These data include original data files as well as any subcomponents or subgroups of the original data file. Claims Data does not include Special Data as defined below.

Clinical Data refers to the data elements that describe an individual's condition throughout a medical encounter and includes, for example, data about an individual's symptoms and complaints, physical exam findings, laboratory and radiology results, and assessments and may be obtained through various sources including third party data sources and electronic health records. Clinical Data are separate and distinct from Claims Data, which may include related information such as procedure codes, for example.

Collaborators refers to organizations performing healthcare related or social services who are contracted with OneCare under Collaborator Agreements to further ACO Activities, but who are not Participants or Preferred Providers.

Commercial Payer refers to a nongovernmental organization that provides or administers health insurance products.

Data refers collectively to Claims Data, Clinical Data, De-Identified Data and Other Data.

De-Identified Data refers to data that has been stripped of individual identifiers, including removal of any key or linking data that reasonably could be used to reverse engineer the data back to an individual, and cannot be used to identify an individual. De-identified Data is not PHI Data.

Medicare Claims Data Files means the full set of electronic files with claims and enrollment information sent to OneCare by Medicare under the Vermont All-Payer ACO Medicare ACO Initiative Participation Agreement.

OHCA refers to the Organized Health Care Arrangement of OneCare's Participants and Preferred Providers that, as provided in HIPAA, permits the sharing of PHI Data within the OHCA without requiring a treating relationship with the individual subject of the PHI Data.

Other Data refers to data related to healthcare services or business operations of OneCare or its network that is not PHI Data, Claims Data, Clinical Data or De-Identified Data.

Participant and Preferred Provider refer to health care provider(s) that have entered into a Participant or Preferred Provider Agreement(s) with OneCare to participate in one or more ACO Programs and provide healthcare services to Attributed Lives. For purposes of this Policy, Participants and Preferred Providers are treated as Covered Entities under HIPAA.

PHI Data and PII Data are used interchangeably and refer to information, including medical information in Claims Data, Clinical Data, or Other Data that could be used to identify an individual. This includes:

- Full names or last names and initial;
- All geographic identifiers smaller than a State;
- Dates directly related to an individual, such as date of birth;
- Phone numbers including area code;
- Fax numbers;
- Email addresses;
- Social Security Numbers;
- Medical Records Numbers;
- Health Insurance Beneficiary Numbers;
- Bank Account Numbers;
- Certificates/Driver's License Numbers;
- Vehicle identifiers (VIN and license plates);
- Device Identifiers and Serial Numbers;
- Web Uniform Resource Locaters (URLs);
- Internet Protocol (IP) Address Numbers;
- Biometric Identifiers, including fingerprints, retinal, genetic information;
- Full Face Photographs and any comparable images that can identify a person; and
- Any other unique identifying number, characteristic or code, except codes used by OneCare to identify an individual; and
- Reporting of any cell representing 10 or fewer individuals or any use of percentages or other mathematical formulas that could be used to derive or reverse engineer results in the display of a cell representing 10 or fewer individuals.

Special Data refers to Data provided by Payers to OneCare for limited purposes such as financial modeling, or for specific projects subject to a separate agreement(s), amendment(s), or service order(s) between OneCare and a Payer. Special Data must be identified as such by OneCare and is not considered to be Claims Data for purposes of this Policy.

Unauthorized Access refers to any access to Data that is not permitted under this Policy.

IV. Policy

A. Introduction

In alignment with its strategic planning and focus on elevating data and analytics capabilities to support the ACO Network, OneCare's objective is to facilitate the broad sharing of information, data and analysis to the fullest extent permitted consistent with legal and contractual obligations.

OneCare will only access, use and share Data in accordance with the terms set forth by the provider of the Data and applicable law. This includes ACO Program Agreements, Data Use Agreements, HIPAA and other privacy laws. Those authorities provide parameters for the permitted uses and users of the Data, as well as security and destruction requirements as described in this Policy. Data may be subject to several restrictions and each must be followed. For example, in sharing Claims Data that contains individual names from a Commercial Payer the rules for PHI Data and Claims Data must be applied.

B. PHI Data

PHI Data can be contained within Claims Data or Clinical Data regardless of the source, PHI Data must be used and shared under the following rules:

1. **Authorized Users:** PHI Data may be shared with an individual or entity that meets at least one of the following five criteria:
   i. An ACO Participant or Preferred Provider in the ACO Program that provided the PHI Data:

      (a) in a treatment relationship with the individual(s) whose PHI Data is shared; or

      (b) who is a member of the Organized Health Care Arrangement of OneCare network providers;

   ii. A HIPAA Business Associate (BA) of an ACO Participant or Preferred Provider in a treatment relationship with the individual(s) whose PHI Data is shared;

   iii. OneCare's BA who has contracted with OneCare to carry out work on behalf of ACO Participants or Preferred Providers (for example Collaborators or vendors);

   iv. OneCare Workforce within the scope of their work responsibilities; or

   v. A Covered Entity health care provider in a treatment relationship with the individual(s) but who is not a OneCare Participant or Preferred Provider for the purpose of treatment only.

   Potential recipients of PHI Data will be required to provide OneCare with the information necessary to establish that they meet these criteria.

2. **Permitted Purposes for Use:** ACO Activities and sharing under B.1.iv. above.

3. **Limitations on Uses** (in addition to the security, access, breach and destruction requirements below)**:**
   i. Minimum Necessary - All uses and disclosures of PHI Data will follow the HIPAA minimum necessary standards, e.g., OneCare will share or use the minimum PHI Data needed to

accomplish the intended purposes of the sharing or use. The determination of minimum necessary will be made in cooperation with the recipient of PHI Data who must make and describe to OneCare objectively reasonable efforts to limit use and disclosure to the minimum necessary. In addition to monitoring at the time of request, access to Data will be monitored as a compliance function.

ii. Business Associate Agreement – all sharing of PHI shall require a written Business Associate Agreement (BAA) be in place between the OneCare and the recipient of PHI. Participants and Preferred Providers have BAAs in place for the ACO Programs in which they participate as part of their agreements with OneCare.

C. Claims Data

1. **Authorized Users**: Subject to the requirements for PHI Data, Claims Data from Payers (and any analysis derived from that Claims Data) may be used by OneCare's Workforce and ACO Participants, Preferred Providers, Collaborators and OneCare's contracted vendors.

2. **Permitted Purposes for Use:** ACO Activities.

3. **Limitations on Uses** (in addition to the security, access, breach and destruction requirements below):

   i. The amount a Commercial Payer reimburses a provider for health care services is known as commercially sensitive information ("CSI") and is considered a confidential trade secret. As a result, Claims Data from Commercial Payers that contains CSI: (1) may not be released to providers outside the TIN that was paid and (2) may not be used or shared in a manner that could result in the disclosure of the Commercial Payer's confidential information through reverse engineering or otherwise (by way of example, releasing pricing information for two ACO Participants to one ACO Participant would permit reverse engineering and not be allowed).

   ii. Recipients of Claims Data may use it only for the purpose(s) disclosed to OneCare when requesting the Claims Data. Recipients of Claims Data may not copy or reuse any Claims Data without meeting the terms of this Policy and obtaining OneCare's express written consent.

      a. Notwithstanding the above, Participants and Preferred Providers may reuse Claims Data of individuals with whom they have a treating relationship for ACO Activities without prior written authorization from OneCare.

   iii. Use of any Medicare Claims Data absent authorization to access PHI must adhere to CMS's current cell size suppression policy. No cell representing 10 or fewer Medicare beneficiaries may be displayed and no use of percentages or other mathematical formulas may be used if they result in the display of a cell representing 10 or fewer Medicare beneficiaries, or if the results could be used to derive or reverse engineer Data representing 10 or fewer Medicare beneficiaries.

iv. Recipients of Claims Data must maintain it in a manner that ensures it remains distinguishable from all other Data and allows it to be identifiable by the Payer that provided it through the use of access control(s) and firewall(s) as appropriate to limit uses to those that meet this Policy. This is to ensure that all Claims Data can be destroyed or returned to the appropriate Payer when required, as well as aiding in determining whose Claims Data has or may have been compromised in the event of an unauthorized access or breach.

v. Payers retain ownership rights to the Claims Data provided to OneCare. Neither OneCare nor any Authorized User may claim a right or interest in the Claims Data nor may it be sold, rented, leased or loaned.

vi. Claims Data may not be de-identified for use, reuse, or sharing in any way that is inconsistent with this Policy. For example, a Subcontractor, Collaborator, or vendor may not de-identify Claims Data for use, re-use, or sharing in a manner that is inconsistent with the limitations set forth in this Policy or that is inconsistent with the limitations specified for its role as a Business Associate or Business Associate Subcontractor of OneCare or an ACO Network Participant or Preferred Provider.

D. Clinical Data

1. **Authorized Users:** Subject to the requirements for PHI Data above, Clinical Data and analysis derived from that Clinical Data may be used and with OneCare's Workforce and ACO Participants, Preferred Providers, Collaborators and OneCare's contracted vendors.

2. **Permitted Purposes for Use:** ACO Activities.

3. **Limitations on Uses** (in addition to the security and destruction requirements below):

   i. Recipients of Clinical Data may use it only for the purposes shared by OneCare and may not copy or reuse any Clinical Data without meeting the terms of this Policy and obtaining OneCare's express written consent.

E. Special Data Subject to DUA, agreement, amendment, or service order between OneCare and a Payer that relates to its designation as Special Data and to contractual limitations on its use, reuse, or sharing set forth in such DUA, agreement, amendment, or service order, and may not be used in a manner that is inconsistent with such limitations.

F. Other Data

1. Other Data may be subject to contractual use limitations or confidentiality obligations to the extent the provider of the Other Data maintains it as a confidence. Sharing of Other Data must be in accordance with the contractual use and confidentiality requirements of its source.

G. Public Sharing of Data

1. As a regulated entity participating in a cooperative state and federal innovation program, OneCare is often asked to provide Data and analysis in the absence of a contractual relationship with the

recipient(s) or in a manner that may become public. OneCare may share De-Identified Data that does not include confidential reimbursement information (see Section C.3.i.) or any other confidential information in furtherance of ACO Activities with regulators and the public.

H. Data Security

OneCare shall ensure that all Data it maintains and shares is kept in an appropriately secure environment for the nature of the Data.

1. The Medicare Claims Data Files sent to OneCare by CMS must be stored by OneCare and any entity with whom OneCare shares all of those Medicare Claims Data Files using appropriate administrative, technical, and physical safeguards to protect its confidentiality and to prevent unauthorized use or access to it. Medicare Claims Data Files provided by CMS must be in an environment with a level and scope of security that is not less than those requirements established for federal agencies by the Office of Management and Budget (OMB) in OMB Circular No. A-130, Appendix I-Responsibilities for Protecting and Managing Federal Information Resources, as well as Federal Information Processing Standard 200 entitled "Minimum Security Requirements for Federal Information and Information Systems", and NIST Special Publication 800-53 "Recommended Security Controls for Federal Information Systems", or the most recent update of these guidance documents.

2. **PHI Data; Clinical Data; and Claims Data**. PHI Data, Clinical Data and Claims Data other than the Medicare Claims Data Files referred to in (1) above must be stored and used by OneCare and those who receive it from OneCare in compliance with HIPAA security standards and accordance with the terms of Security Policy 07-09, sections B and C.

3. **Other Data** must be stored and used by OneCare and those who receive it in such a manner to that its confidentiality will be preserved and in a manner that is no less stringent that the user maintains for its own data.

I. Unauthorized Access and Breach

1. Recipients of Data must report any Unauthorized Access to that Data to OneCare no later than seventy-two (72) hours after learning of the Unauthorized Access. All reports must identify the Data that was accessed and provide a clear description of the Unauthorized Access.

2. Recipients of Data must report any HIPAA breach of PHI from or derived from the CMS Medicare Claims Data Files within one (1) hour to the CMS Action Desk (410) 786-2850 or by email at cms_it_service_desk@cms.hhs.gov and simultaneously provide notice to OneCare.

3. Recipients of Data must report any HIPPA breach of PHI other than that from CMS referenced above in subsection 2 to OneCare within seventy-two (72) hours of learning of the breach. The report shall identify the Data that was the subject of the breach and provide a clear description of the breach.

J. Return or Destruction

1. **Claims Data**: Claims Data may only be retained until the conclusion or termination of the ACO Program Agreement from which the claims data arose, except for the following circumstances:

   i. Participants and Preferred Providers and Covered Entities may retain Claims Data that has been incorporated into the medical records of individuals that are part of a designated record set under HIPAA after the conclusion or termination of the relevant ACO Agreement.
   ii. Payers may consent to permit OneCare to maintain Claims Data after the end of an ACO Program Agreement. OneCare will notify the recipient if that is the case.
   iii. Within thirty (30) days of the end of an ACO Program Agreement, OneCare and Data recipients shall destroy all other Claims Data and send written certification of the destruction to the Payer (for OneCare) or OneCare (for Data recipients).

V. Individual Consideration of Data Uses or Sharing Requests

This policy is intentionally drafted to permit a uniform interpretation of uses and sharing of Data.

Each individual ACO Program Agreement has detailed, contractual parameters on the use of Claims Data provided by the Payer; some of these parameters may be less stringent than the terms and definitions of this policy. By way of example, ACO Activities is defined differently across ACO Programs, such that more uses or sharing of Clinical Data could be ACO Activities for some Payers but not others. As it is OneCare's intention to maximize the effective use of Data to facilitate the performance of ACO Network Providers, requests for uses or sharing of Data that do not meet the terms of this policy may be reviewed by OneCare's Data Committee (comprised of legal, compliance, Director of Value Based Care and, if needed the Chief Operating Officer and Vice President of Finance) to evaluate those requests on an individual basis and determine if some or all of the contemplated use or sharing could be permissible.

VI. Review Process

This Policy shall be reviewed annually and updated to be consistent with the requirements established by the Board of Managers, applicable laws including HIPAA, ACO Program Agreements, DUAs and Data Use Authorities, and Federal and State regulators.

VII. References:

- OneCare's Policy and Procedure Glossary
- ACO Program Agreements including BAAs and DUAs
- HIPAA Privacy and Security Rules
- OMB Circular No. A-130, Appendix I-Responsibilities for Protecting and Managing Federal Information Resources
- Federal Information Processing Standard 200 entitled "Minimum Security Requirements for Federal Information and Information Systems"
- NIST Special Publication 800-53 "Recommended Security Controls for Federal Information Systems"

Related Policies/Procedures:

- 07-03 Privacy Policy
- 07-09 Security Policy
- Data Sharing Decision Tree
- Data Request Form
- Data Log

Location on SharePoint: Department: Policies, Category: Active

Management Approval:

Director, Value Based Care	Date
Chief Compliance and Privacy Officer	Date
Chief Legal Counsel	Date
Chief Operating Officer	Date

Policy Number & Title:	05-01 Contract Management
Responsible Department:	Contracting
Author:	Martita Giard, Director, ACO Contracting
Original Implementation Date:	July 1, 2020
Board Approval Date:	December 21, 2023
Revision Effective Date:	December 21, 2023

I. **Purpose:** To establish a uniform policy for drafting, review, approval, execution, management, and retention of contracts involving OneCare Vermont Accountable Care Organization, LLC ("OneCare") to ensure that its contractual arrangements are lawful, consistent with business interests, and comply with Policies and Procedures.

II. **Scope:** Applicable to OneCare and its Workforce, and any Contract to which OneCare is a party.

III. **Definitions:** Capitalized terms have the same definition as defined in OneCare's *Policy and Procedure Glossary*. For purposes of this policy, the terms below have the following meanings:

ACO Contracting Director refers to the Director of the Contracting Department for OneCare, with the authority and responsibility to direct, manage, and implement this Policy. ACO Contracting Director shall also be engaged at appropriate times throughout the contracting process to provide business direction and review and sign-off before any Contract is signed by a Responsible Signatory.

ACO Legal Counsel refers to the designated legal representative for OneCare, with the authority and responsibility (through employment or contractual arrangement) to review and approve the legal terms and conditions for a Contract. ACO Legal Counsel shall be engaged at appropriate times throughout the contracting process and must provide Legal Review and sign-off before any Contract is signed by a Responsible Signatory.

Business Lead refers to a representative of the business unit or department requesting the Contract. The Business Lead shall: (i) provide the business, technical and pricing terms, goals and information reasonably necessary for the Contract to reflect the arrangement desired; (ii) liaise with the Contracting Department to secure information, answer questions, provide support for the contracting process; (iii) assist to implement and monitor the Contract and, (iv) provide support for renewal and termination decisions.

Business Review refers to the process by which a Contract is reviewed by the Business Lead, other identified subject matter experts, and the Contracting Department to assure that the terms of the Contract are consistent with the business goals and objectives of OneCare. The Business Review shall be consistent with other applicable Policies of OneCare.

Contract refers to any form of promise or agreement intended to bind OneCare or that may potentially be enforced against OneCare by another party, regardless of its format. This includes, but is not limited to, memorandum of understanding, letter of intent, lease, letter agreement, settlement agreement and amendments to existing agreements.

Contract Liaison refers to a representative of the OneCare Contracting Department responsible for drafting, reviewing, and supporting contracting processes as set forth in this Policy. In no circumstance will the Contract Liaison have the authority to make legal determinations or legal decisions.

Contract Specialist refers to a representative of the OneCare Contracting Department responsible for managing the day-to-day business operations to support contracting processes set forth in this Policy.

Legal Review refers to the process by which Contracts, other than those given exception from this Policy, are reviewed by ACO Legal Counsel, or his/her designee, to assure that the terms of the Contract are consistent with the legal, contractual, and regulatory obligations of OneCare, as well as OneCare's business objectives and strategy.

PCard refers to a credit card provided by UVMMC that allows the approved holder to make purchases for certain delineated items.

PCard List refers to a list of items that have been approved by OneCare's ACO Legal Counsel and Contracting Department to be purchased by using the PCard and without a contract.

Responsible Signatory refers to a representative of OneCare with the authority to contractually bind the organization up to the authorization level set forth in this and other applicable Policies, relevant Board Governance documents, and the current version of OneCare's Operating Agreement. The CEO, COO, and CFO are Responsible Signatories.

IV. Policy: Any Contract to which OneCare is a party must be in writing and shall be drafted, reviewed, approved, executed, managed, and retained in accordance with this Policy. OneCare's Contracting Department, shall have operational responsibility for implementing this Policy as set forth below.

This policy does not apply to PCard purchases of items included on OneCare's PCard List.

A. Initiation and Drafting:

1. Initiation. The Business Lead determines the need for a contract and requests the launch of the contracting process from the Contract Specialist.

2. Drafting. The Contracting Department shall be responsible for drafting Contracts, including engaging and negotiating with other parties when necessary, using standard provisions and templates, to the extent practical.

3. Standard Templates, Clauses, and Provisions. The Contracting Department, under the direction of the ACO Legal Counsel, shall develop and maintain a library of standard contract templates, forms, clauses and provisions to be used and/or included as necessary in Contracts.

B. Required Reviews: Unless an Exception described in this Policy applies, the following reviews are required prior to OneCare's execution of a proposed Contract:

1. Business Review. A Business Review of a proposed Contract will be completed prior to Legal or Compliance Review. To the extent the Business Review raises a business or operational issue(s), the Contracting Department Director or his/her designee will follow up with the appropriate Business Lead to resolve those issues.

2. Legal Review. A Legal Review of a proposed Contract will be completed by the ACO Legal Counsel prior to final review and execution by the Responsible Signatory and/or submission to the Board for any required approvals.

3. Compliance and Privacy Review. A Compliance and/or Privacy Review will be completed by Compliance prior to final review and execution by the Responsible Signatory and/or submission to the Board for any required approvals for any proposed Contract that involves the following subject matter, or upon request of any individual referenced in this Policy.
    a. Involves exchange of anything of value with a Provider or Attributed Life
    b. Involves invoking a Waiver
    c. Involves a potential conflict of interest, either real or perceived
    d. Involves the exchange, storage, use, or sharing of private or protected information such as PHI, PII, IICD, or any other Data subject to OneCare's Data Governance Policy, HIPAA, or any other law or regulation concerning privacy, including as examples: Business Associate Agreements, Business Associate Subcontractor Agreements, and Data Use Agreements

C. Board Approval: Board approval is required for execution of any Contract involving the following: (i) a value-based payment program; (ii) any arrangement that requires a Waiver to be invoked; or (iii) any arrangement for which Board approval is required by the current version of OneCare's Operating Agreement and/or any applicable law or regulation.

D. Execution: Upon completion of the required reviews and receipt of any required Board approval**,** a Responsible Signatory will sign and execute the Contract on behalf of OneCare. The Responsible Signatory may sign any Contract within the scope of their signature authority, or as approved by the Board.

E. Retention and Management:

1. Contract Management System. The Contracting Department shall maintain a searchable computer system for the retention of Contracts subject to this Policy. Procedures governing authorization to access the system and its contents will be developed and maintained in support of this Policy.

2. Retention. Upon signature by the parties, a copy of the fully-executed Contract and its supporting documentation shall be stored and maintained by the Contracting department. The Contract shall be maintained in accordance with OneCare's *Record Retention Policy.*

3. Payment and Accounting. A copy of any Contract involving the exchange of funds or goods will be provided to the OneCare Finance Department upon execution.

4. Termination or Extension. The Contracting Department will advise the Business Lead of the impending expiration of a Contract with sufficient notice for Business consideration of whether to extend, engage in renegotiation, or initiate termination of the Contract.

F. Performance Monitoring: The Contracting Department will notify the Business Lead who owns and is responsible for OneCare's performance of its obligations when a contract has been fully executed. Fully executed contracts will be available in the Contract Management System or by request. The Business Lead and the Contracting Department will maintain regular communication regarding the status of: (i) Contract implementation; (ii) awareness of and meeting of terms and conditions, such as deliverables and deadlines; and, (iii) OneCare's receipt of obligations owed to it under the Contract. The Contracting Department with guidance from the ACO Legal Counsel as appropriate will (iv) address questions or issues about the Contract; and (v) incorporate changes or modifications as needed.

G. Contract Exceptions: Exceptions to this Policy may be made for the following:

a. Contracts related to ongoing litigation or claims for which confidentiality within OneCare is appropriate may be approved with legal and compliance review only;
b. Unaltered templates that have been pre-approved by ACO Legal Counsel or exclusively using standard terms and conditions that have been approved in advance by ACO Legal Counsel
c. Other discrete circumstances requiring an exception to the Policy, including but not limited to: (i) time constraints, (ii) unavailability of an individual responsible for performing a required review, or (iii) inadvertent and/or unauthorized execution of a Contract. In such circumstances, the COO or the CFO may grant an exception upon written request after consultation with the ACO Legal Counsel.

V. Review Process: This Policy will be monitored regularly for any appropriate changes in accordance with needs of the organization.

VI. References:

- OneCare's Policy and Procedure Glossary

VII. Related Policies/Procedures/Forms:

- 04-06 Disbursement Authority Policy
- 05-05 Signature Authority Policy
- 06-01 Record Retention Policy
- UVMMC FINCE3 Levels of Authorization Policy
- Recommended and Prohibited Contract Provisions
- OneCare PCard List
- Intake Form
- Legal & Business Review Form
- Contract Exception Form

Location on SharePoint: Department: Policies, Category: Active

Management Approval:

Director, ACO Contracting	Date
Assistant General Counsel for Contracting and Innovation	Date
Chief Operating Officer	Date

Policy Number & Title:	06-01 Record Retention
Responsible Department:	Operations
Author:	Joan Zipko, Director, ACO Planning and Operations
Original Implementation Date:	January 1, 2017
Board Approval Date:	December 21, 2023
Revision Effective Date:	December 21, 2023

I. **Purpose:** To establish guidelines for the retention and disposal of records that are created and maintained by OneCare.

II. **Scope:** Applicable to records that are created or maintained by OneCare.

III. **Definitions:** Capitalized terms have the same definition as defined in OneCare's *Policy and Procedure Glossary*. For purposes of this policy, the terms below have the following meanings:

Records means any written, electronic or other medium on which information is stored. "Records" include, among other things, paper documents, electronic mail, computer files, images, spreadsheets, CDs, discs, tapes, computer back-up tapes and files, calculations and records of payments.

IV. **Policy:** It is the policy of OneCare to retain and dispose of records for the period required by applicable federal, state, and local laws, rules and regulations, ACO Program Agreements, and contractual obligations.

A. Retention Guidelines:
All Records shall be maintained for a period of ten (10) years. Any Records that are the subject of an external audit, evaluation, inspection, or investigation, or are involved in a litigation or contested proceeding, shall be maintained for ten (10) years from the date such event(s) are completed, settled, or otherwise resolved, as determined by the Chief Legal Counsel. Records may be retained either in paper or electronic format, as appropriate, and may be stored at remote locations if on-site retention is not needed for administrative convenience.

B. Disposal Guidelines:
Records may be disposed of after ten (10) years in accordance with the Retention Guidelines. Records should be disposed of in a manner that safeguards any HIPAA protected, confidential, sensitive or proprietary business information contained in the records.

C. Litigation and Audit Hold Guidelines:
The OneCare Chief Legal Counsel and Chief Operating Officer should be notified immediately if a OneCare employee receives notification of any claim or complaint that could lead to litigation or a government investigation or an audit of an ACO Program. Upon receipt of notice of a claim, pending or future litigation or audit of an ACO Program, the recipient of the information will advise the Chief Legal Counsel and will communicate with affected persons to assure that evidence and records relating to the litigation or investigation are preserved and maintained until the litigation or investigation is concluded. A litigation or audit hold takes precedence over the regular disposal of records and records that meet the hold should not be disposed.

V. **Review Process:** This policy shall be reviewed annually and updated to be consistent with revisions in laws, regulations and contractual requirements.

VI. References:

- OneCare's Policy and Procedure Glossary
- OneCare's Program Agreements with Payers
- OneCare's Risk Bearing Participant and Preferred Provider Agreement
- GMCB Rule 5.000: Oversight of Accountable Care Organizations

VII. Related Policies/Procedures:

Location on SharePoint: Department: Policies, Category: Active

Management Approval:

Director, ACO Planning and Operations	Date
Chief Legal Counsel	Date
Chief Operating Officer	Date

DICK COURCELLE
802-770-2730 (mobile)
dcourcelle@rmhsccn.org

PROFESSIONAL EXPERIENCE

Community Care Network 2007-present
Rutland Mental Health Services, Inc.
Rutland Community Programs, Inc.

CHIEF EXECUTIVE OFFICER. 2015-present. Executive leadership of two not-for-profit health and human services organizations with 300-plus employees and annual revenues of $40 million located in Rutland, Vermont. Overall accountability, responsibility and authority for the management of the business and affairs of the two corporations in accordance with the strategic plan and objectives adopted and approved by the Boards of Directors and subject to oversight by the Boards. Develop strategic direction and ensure effective operations.

PROGRAM DIRECTOR. 2007-2015. Leadership and administration of federally-funded programs; assisted senior executives with special projects and marketing. Principal duties and responsibilities included developing short and long-term program plans and strategies; budget development and fiscal monitoring; supervising program managers; developing staffing models for optimal results and efficiencies; grant writing; federal and state regulatory monitoring and compliance; developing and negotiating vendor contracts and collaborative agreements.

Vermont Achievement Center, Inc. 2002-2007

CHIEF FINANCIAL OFFICER. Responsible for administering all financial and IT functions for a not-for-profit social service and education agency. Served as corporate Treasurer. Principal duties and responsibilities included fiscal control and budget development; accounting, payroll, benefits and insurance; food services; future planning and research; facilities management; information technology and related systems; grants management. Led and coordinated business development.

Central Vermont Public Service Corporation 1999-2002
The Home Service Store, Inc. (Subsidiary)

MARKET DEVELOPMENT STAFF CONSULTANT- (2001-2002). Developed business expansion and marketing plans for a corporate subsidiary of electric utility. Assessed market potentials for new products and services. Developed financial forecast models. Evaluated financial viability for new products. Identified and held meetings with dealer sales reps and contractors to establish distribution and promotion channels. Assisted management in evaluating and modifying operational systems, policies and procedures.

DIRECTOR OF RELATIONSHIP MARKETING- The Home Service Store, Inc. (1999-2001). Responsible for direct marketing and customer communication programs for a corporate subsidiary operating in 100-plus markets nationwide. Created membership marketing acquisition and retention program. Developed field sales and trade show support program, including collateral and presentation materials. Developed and produced membership magazine periodicals. Launched public relations program that included syndicated editorial content for The Associated Press. Hired and managed direct marketing agency, integrated marketing agency and communications consultant. Supervised direct marketing and communications staff.

Downtown Development Corporation 1990-1999
(d/b/a Downtown Rutland Partnership)

EXECUTIVE DIRECTOR. Administered a marketing and management agency for a retail and professional downtown district. Responsible for annual business plans and budgets, and financial administration. Developed advertising campaigns, promotional programs, and special events. Developed and produced print and electronic advertising, brochures, newsletters and direct mail. Coordinated and promoted fundraising and grant programs, generating significant funds for the organization. Regularly represented organization to civic, business and government organizations and associations. Taught workshops in marketing and sales promotions to retail and professional businesses and associations.

EDUCATION

MPA- University of Vermont.
BA, Psychology- Castleton University.
Professional Certificate in Leadership and Management- University of Vermont.
Finance and Accounting graduate coursework- St. Michael's College.

OTHER PROFESSIONAL ACTIVITIES

- Board of Directors- Rutland Regional Medical Center. 2020-Present.
- Board of Commissioners- Rutland (City) Redevelopment Authority. 2023-Present.
- Rutland City Board of School Commissioners. 2006-2020.
- Graduate Faculty in Administration and Management (Adjunct). St. Michael's College. 1995-1998.
- University of Vermont Council of Community Advisors. 1990-1998.

OneCare Vermont

OneCare Vermont Accountable Care Organization Board of Managers Resolution Appointing Board Managers December 21, 2023

BE IT RESOLVED by the Board of Managers (the "Board") of OneCare Vermont Accountable Care Organization, LLC ("OneCare") as follows:

The Board, having reviewed and discussed the recommendations of the Nominating Committee and the qualifications of the candidate, hereby elects to seat the following Managers:

A. Dick Courcelle, Designated Agency Manager, for a three-year term ending on January 31, 2027; AND

B. Sandy Rouse, Home Health Manager, for a three-year term renewal ending on January 31, 2027.

Participation Waiver Request:

Southwestern Vermont Medical Center ("SVMC") and Rescue Inc. will cooperate to transport patients from Vermont and New Hampshire hospitals and emergency departments to SVMC for inpatient care where the placement is recommended by Dartmouth Hitchcock Medical Center's Capacity Coordination Center, SVMC hospitalists, and agreed to by the patient. SVMC will pay Rescue Inc. a capacity fee to be available for transport and mileage fees attendant to transports.

There are two groups of eligible patients: (1) Attributed Lives; and (2) Vermont residents.

Why: Inefficiencies in the current system.

a. Reliance on local EMS. The traditional use of local EMS for transportation from emergency departments to inpatient care is inefficient and can result in increased length of stay in the emergency department.
    i. Local EMS often lacks capacity to be out of their community service area for transports.
    ii. Insurance reimbursement for mileage, including the component the patient is responsible for, often does not meet the costs of transport.
b. Coverage. Health care coverage is often limited for transport to the nearest facility.
c. Discharge processes. Traditionally case managers contact potential accepting hospitals individually and can have difficulty finding an inpatient bed with adjunctive medical services. Case Managers often seek and secure placements at multiple hospitals simultaneously while transport is secured and then leave hospitals reserving beds for patients that never arrive, creating inefficiencies in the healthcare delivery system.

These three forces can result in transfer of patients to tertiary hospitals when quality care could be rendered at a lower acuity hospital and lower cost of care.

How: Solutions to inefficiencies.

a. Establish a dedicated, regularly available transport team without community EMS responsibilities.
    i. SVMC and Rescue, Inc. contract will include a base on-call payment that will be used to establish a dedicated, on-call transport team with an advanced life support (ALS) trained paramedic and a vehicle available weekdays 10-6.
    ii. SVMC will also pay a transport fee that is related to the distance/time between Rescue Inc's home base in Brattleboro and the ED or hospital, the ED or hospital and SVMC, and for the return from SVMC to the Rescue Inc. home base
        a. Return fee waived if ambulance picks up a transport from SVMC.
b. Coverage – Rescue Inc. will bill insurers and collect coinsurance from patients.

c. Discharge processes – Dartmouth Hitchcock Medical Center's Capacity Coordination Center, staffed with RNs and other professionals, will communicate with origination EDs about admissions to SVMC. The Capacity Coordination team would evaluate and approve for admission to SVMC and determine the most appropriate placement for a patient balancing the available system resources. Patient consent will be obtained for all placements.

ACO Activities: The arrangement must be reasonably related to one or more (full list in the Resolution).

- Promoting Accountability for Quality and Cost of Care
- Managing and coordinating care
- Encouraging investment in re-designed care processes for high quality and efficient services delivery

Notes: Similar to the approved concept for Rescue Inc to partner with the Brattleboro Retreat on discharges from ED which is going vey well and is in the process of expanding.

Aligned with January 2022, Board guidance about focusing waiver use on discharge facilitation, including transportation, post-discharge drugs at SNFs and patient needs at home.

Patient Engagement Incentive Waiver: Potential request, but no Board action required.

Those patients who choose to be transported to SVMC, even though it is beyond their insurance coverage for transport to the closest available facility, will not pay more out of pocket than their insurance coverage assesses. SVMC's compensation to Rescue, Inc. covers the rest of the trip so there is potential that a regulator may consider the patient to be receiving in-kind transport for part of the ride to SVMC. This is being evaluated for a potential request for a patient engagement incentive waiver.

OneCare Vermont Accountable Care Organization Board of Managers Resolution Invoking Participation Waiver for Transport from Hospitals and Emergency Departments to Participant Southwestern Vermont Medical Center for Inpatient Treatment December 21, 2023

WHEREAS, OneCare participates in the Vermont All Payer ACO Model Vermont Medicare ACO Initiative and the Vermont Medicaid Next Generation Program. The Secretary of the Department of Health and Human Services by and through CMS, and the Department of Vermont Health Access, have provided certain waivers of federal and state fraud and abuse laws in connection with the Vermont All Payer ACO Model ("APM"), the Fraud and Abuse Waiver Notice for Vermont ACO Initiative.

WHEREAS, Vermont hospitals are experiencing high emergency department utilization as well as high inpatient census at some hospitals and often patients, remain in the emergency departments for lack of safe transport for continuing care; and

WHEREAS, processes to identify appropriate hospitals for continuing care are influenced by reimbursement rules favoring transport the closest facility and limited coordination amongst discharging providers and potential accepting hospitals; and

WHEREAS, to date local EMS providers have been unwilling or unable based on capacity to provide transport for qualifying patients from emergency departments and hospitals beyond the closest hospital; and

WHEREAS, these factors often result in patients waiting longer in emergency departments for available beds at the closest hospital than if they were transferred to another appropriate, but farther hospital; and

WHEREAS, patients remaining in the emergency department limits the ability of the emergency departments to provide treatment to new patients presenting for emergent care needs and detriments the patients' treatment; and

WHEREAS, OneCare's goals (shared with the entire health care delivery system) for cost and quality and patients' needs are best served by eliminating time boarding in emergency departments and moving expeditiously to the appropriate and referred treatment venue; and

WHEREAS, The Participation waivers are available when, among other things, the governing body of the ACO has reviewed and determined that the arrangements are reasonably related to ACO Activities. ACO Activities include:

- Promoting accountability for quality of care;

- Promoting accountability for cost of care;
- Promoting accountability for overall care;
- Managing and coordinating care;
- Encouraging infrastructure investment;
- Encouraging investment in re-designed care processes for high quality and efficient services delivery;
- Carrying out any obligation or duty under the Vermont ACO Initiative or the Vermont Medicaid NextGen Program (together "Programs");
- Direct patient care;
- Promoting evidence based medicine;
- Promoting patient engagement;
- Reporting on quality and cost measures;
- Coordinating care with telehealth, remote monitoring and other technologies;
- Establishing and improving ACO clinical systems;
- Establishing and improving ACO administrative systems;
- Meeting Programs quality standards;
- Evaluating patient health;
- Communicating clinical knowledge;
- Communicating evidence-based medicine; and
- Developing standards for patient access and communication including to medical records.

BE IT RESOLVED by the Board of Managers (the "Board") of OneCare Vermont Accountable Care Organization, LLC ("OneCare") as follows:

The OneCare Board of Managers has duly authorized the arrangement below and made a bona fide determination the arrangement is reasonably related to one or more of the above ACO Activities, including managing and coordinating care and accountability for quality, cost and overall care. The Board wishes to extend the protections afforded under the ACO Participation Waiver to the arrangement described below.

1. ACO Participant SVMC will contract Rescue Inc., a Vermont ambulance company, to be available to with a staffed ambulance to transport Attributed Lives and Vermont residents from emergency departments and hospitals to SVMC for inpatient treatment, M-F 10am-6pm.

   Eligible patients will be identified by Dartmouth Hitchcock Medical Center's Capacity Coordination Center, staffed by professionals able to assess patients' medical needs and appropriate medical placement. All patients will consent to their inpatient provider.

   SVMC will pay Rescue Inc. a base payment annually to maintain this capacity. Additionally, SVMC will pay Rescue Inc. a mileage fee for the miles they drive from Brattleboro to the patient, to SVMC with the patient and back to Brattleboro. Rescue, Inc. will, in addition to the availability and mileage fees, bill patients or their insurers for the transportation provided.

2. The invocation of this Participation Waiver does not, in any respect, indicate that the arrangement is not compliant with applicable regulations.

UVMMC Waiver Summary

This Participation Waiver request falls within the previously approved category of hospitals paying for medications at skilled nursing facilities to promote medically appropriate discharges from inpatient hospitalizations. Here, UCMMC will pay Birchwood Terrace the costs of an IV pump and two IV medications for up to 14 days to facilitate discharge of an Attributed Life from inpatient at UVMMC to Birchwood for care.

OneCare Vermont Accountable Care Organization Board of Managers Resolution Invoking Participation Waiver for UVMMC to Provide Prescribed Antibiotics for Patient Discharged to Birchwood Terrace Skilled Nursing Facility

WHEREAS, OneCare participates in the Vermont All Payer ACO Model Vermont Medicare ACO Initiative and the Vermont Medicaid Next Generation Program. The Secretary of the Department of Health and Human Services by and through CMS, and the Department of Vermont Health Access, have provided certain waivers of federal and state fraud and abuse laws in connection with the Vermont All Payer ACO Model ("APM"), the Fraud and Abuse Waiver Notice for Vermont ACO Initiative; and

WHEREAS, Vermont hospitals are experiencing high inpatient census, which includes patients who do not require acute care, but who remain in inpatient settings as a result of non-medical barriers to discharge; and

WHEREAS, patients remaining in inpatient beds limits the ability of hospitals to provide treatment to new patients presenting with acute care needs and detriments the patients' treatment; and

WHEREAS, OneCare's goals (shared with the entire health care delivery system) for cost and quality as well as patients' needs are best served by transferring patients no longer in need of acute care out of acute care settings and to settings that delivery the medically appropriate level of care; and

WHEREAS, The Participation waivers are available when, among other things, the governing body of the ACO has reviewed and determined that the arrangements are reasonably related to ACO Activities. ACO Activities include:

- Promoting accountability for quality of care;
- Promoting accountability for cost of care;
- Promoting accountability for overall care;
- Managing and coordinating care;
- Encouraging infrastructure investment;
- Encouraging investment in re-designed care processes for high quality and efficient services delivery;
- Carrying out any obligation or duty under the Vermont ACO Initiative or the Vermont Medicaid NextGen Program (together "Programs");
- Direct patient care;
- Promoting evidence based medicine;
- Promoting patient engagement;
- Reporting on quality and cost measures;
- Coordinating care with telehealth, remote monitoring and other technologies;
- Establishing and improving ACO clinical systems;

- Establishing and improving ACO administrative systems;
- Meeting Programs quality standards;
- Evaluating patient health;
- Communicating clinical knowledge;
- Communicating evidence-based medicine; and
- Developing standards for patient access and communication including to medical records.

BE IT RESOLVED by the Board of Managers (the "Board") of OneCare Vermont Accountable Care Organization, LLC ("OneCare") as follows:

OneCare, in furtherance of its strategic goals and in pursuit of ACO Activities, and with an intention to assist in the response to high patient census in acute inpatient settings, is assisting its network of providers in implementing delivery system innovations. The OneCare Board of Managers has duly authorized the arrangement below and made a bona fide determination that it is reasonably related to one or more of the above ACO Activities. In invoking these waivers, no determination has been made that the arrangement is prohibited by any law regulation. The description of the arrangement is set forth below for the purpose of OneCare and its network availing themselves of the protections afforded under the ACO Participation Waiver.

1. The University of Vermont Medical Center ("UVMMC"), an ACO Participant, will pay the cost of up to two weeks (fourteen days) of two IV medications and the cost of the IV pump for a patient discharged from UVMMC inpatient status to Birchwood skilled nursing facility who will administer the medications on site.

2023 PHM Results

Measurement Level	Measure	Baseline	Q1	Q2	Q3	
Practice Level	Child and Adolescent Well Visits	38/88 (43%)	33/88 (38%)	32/88 (36%)	35/88 (40%)	↓
	Developmental Screening	31/88 (35%)	32/88 (36%)	38/88 (43%)	35/88 (40%)	↑
	Diabetes A1c Poor Control	NA [2]	NA [2]	94/99 (95%)	96/99 (97%)	↑
	Annual Wellness Visit 40+ [1]	NA [3]	8/72 (11%)	6/72 (8%)	14/72 (19%)	↑
HSA Level	Annual Wellness Visit 40+ 1, 4	NA 3	0/10 (0%)	0/10 (0%)	0/10 (0%)	–
	Potentially Avoidable ED Revisits	NA [3]	1/14 (7%)	5/14 (36%)	6/14 (43%)	↑
	Initial Hypertension	NA [3]	1/14 (7%)	1/14 (7%)	1/14 (7%)	–
	Routine Hypertension	NA [3]	1/14 (7%)	5/14 (36%)	5/14 (36%)	↑

1. Practices with more than 300 members in the denominator as of the baseline period were evaluated at the practice level for this measure. All others were evaluated at the HSA level.

2. The Diabetes A1C measure was not evaluated in the Baseline or Q1 performance periods

3. AWV 40+, ED Revisits and the 2 hypertension measures used a compare to self target - 10% lower than baseline - and therefore have no result in the baseline period

4. Only 10 of 14 HSAs have any practices that are evaluated at the HSA level for Annual Wellness Visits

PHM Performance Data through Q3 2023

	Inverse Measures					
	Practice Level Measures			HSA Level Measures		
Year	Child and Adolescent Visits	Developmental Screening	Age 40+ Annual Well Visits	Emergency Department Re-Visits	Initial Hypertension Follow-Up	Routine Hypertension Follow-Up
2021	60.1%	55.6%	57.0%	35.5%	61.9%	21.6%
2022	60.6%	53.9%	54.2%	33.1%	63.2%	21.8%
2023 *	60.4% Target: 57.4%	57.2% Target: 57.5%	53.2% Target:10% Improvement	33.0% Target: 10% Improvement	63.9% Target: 10% Improvement	22.4% Target: 10% Improvement

*Claims through 4/30/2023 with at least 3 months of runout for all payers

Mental Health Screening Initiative

December 2023 results

- 80% of network primary care practices participated
- Number of qualifying patient visits=203,873
- Total number of patients screened=121,793 (60%)
- Total rate of positive qualifying screens=11%
- Number of those positive who had qualifying follow-up=56%
- Total initiative dollars paid for reporting through December=$1,105,310 ($532,830 remainder)

Mental Health Screening Initiative

2024 Evolution

- OneCare and Blueprint for Health collaborating
- Program design discussions now, plan to finalize a policy by January
- Possible initiative changes include:
- Payment for improving rate of screening by prescribed amount
- Payment directed toward IT improvements that allow for electronic reporting of these data
- Payment that covers virtual mental health care for people who screen positive (pilot practice/s)

OneCare Vermont

OneCare Vermont Accountable Care Organization

Board of Managers Resolution to Move to Executive Session

December 21, 2023

BE IT RESOLVED by the Board of Managers (the "Board") of OneCare Vermont Accountable Care Organization, LLC ("OneCare") as follows:

> The Board will now move into executive session in order to discuss subjects that are outside of the scope of the ACO's public meetings. For this meeting those include: (1) subjects that are or use trade secret information; (2) status of ongoing contract negotiations; and (3) confidential attorney-client communications.

OneCare Vermont

Public Affairs Report | December 2023

Media Coverage

OneCare wrongful termination lawsuit settles out of court

December 9, 2023, VTDigger
December 12, 2023, Valley News
Coverage of Robert Hoffman wrongful termination lawsuit being settled out of court.

Jury draw begins in OneCare whistleblower case

November 15, 2023, WCAX
Announcement of jury draw for Robert Hoffman wrongful termination lawsuit. At the time, the trial was slated for January 2024.

Government Relations

State Legislative Update

The Health Care Reform Oversight Committee met on November 30 to hear updates from the GMCB and AHS. The GMCB provided an update on the Hospital Transformation and community engagement process as required by Act 167 as well as providing an update on the recent hospital budget process and current financials of the hospital system. The Director of Healthcare Reform from the Agency of Human Services provided an update on healthcare reform activities in Vermont as well as provided an overview of the recently released AHEAD model by CMMI which the state is considering applying for. The Legislature is set to reconvene for their 2nd session of the Biennium on January 3.

Green Mountain Care Board

On November 8, OneCare Executive team spent the day presenting and answering questions on their PY 2024 budget to the GMCB. YouTube videos of the hearing can be found here (part 1) and here (part 2).

On November 15, Vytalize Health 9 presented their Medicare Only ACO budget to the GMCB. The GMCB was also provided a strategic plan update on the VHIE by AHS, GMCB and VITL. Also on November the GMCB hosted their Primary Care Advisory Workgroup which was provided an update on healthcare reform by the Director of Healthcare Reform at the AHS as well as a discussion around the AHEAD model.

The GMCB staff provided their review of the Medicare Only ACO budgets (Lore Health and Vytalize Health) on November 20 and on November 29 the 2022 All Payer ACO results were presented by GMCB, DVHA, BCBSVT, MVP and OneCare VT.

On December 6 the GMCB voted to approve the Medicare Only ACO Budgets that were submitted by Lore Health and Vytalize Health 9 as recommended by GMCB Staff with conditions. The staff also provided their review of the OneCare VT 2024 budget and the board asked preliminary questions and plan to continue to deliberate OneCare VT's budget at its December 13 meeting with approval and budget orders being scheduled for a vote on December 20.

Outreach and Advocacy

Events, Shares, Articles, and Resources

On September 22, 2023, a new initiative through Vermont Medicaid began covering automatic blood pressure monitors through the pharmacy benefit. Members meeting medical necessity can obtain home blood pressure monitors with a primary care provider prescription from their local pharmacy. Learn more here.

Abe and Dr. Jacobs presented at the Data-Driven Health Care session at the UVM Health Equity Summit in late October. The recording of their presentation: Leveraging the Unique Role of an Accountable Care Organization to Advance Health Equity, is now available to watch on the UVM DEI YouTube channel.

Follow Us

You can keep up with OneCare on our blog, LinkedIn, and Twitter (@OnecareVermont) and YouTube. We would greatly appreciate it if you like and share our content to help spread awareness.

Questions? Contact OneCare Public Affairs using the Contact Us form on our website or email us at public@onecarevt.org.

2023 All Payers Summary Monthly Statement

OneCare Vermont

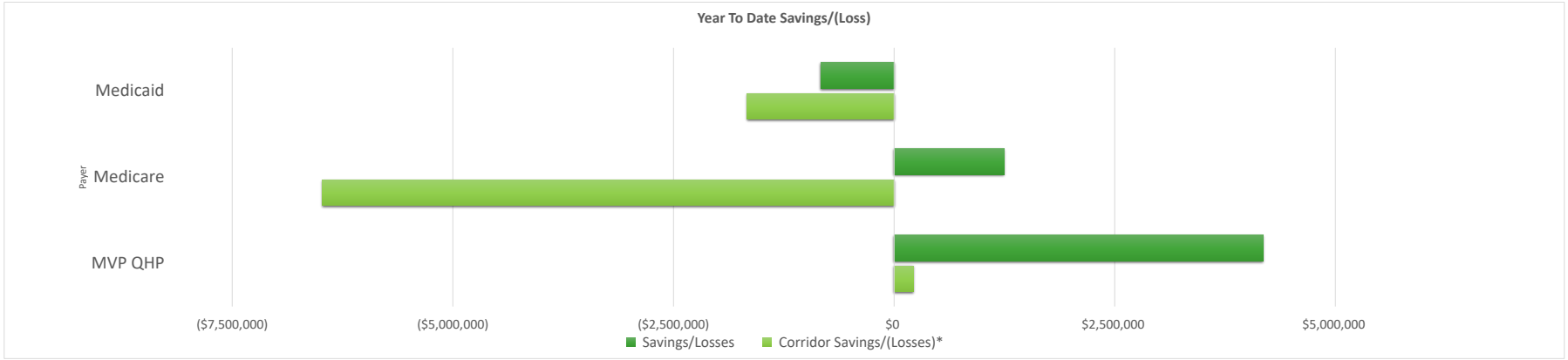
September 2023 PY Monthly Financial Peformance Report

January - September 2023 PY Year To Date, May Current Month (Includes IBNR and Forecast)

Current Month	Payer	Medicaid		Medicare		Self-Funded		MVP QHP		Total
		PMPM	Total	PMPM	Total	PMPM	Total	PMPM	Total	
	Savings/(Losses)	$3.09	$361,043	($81.70)	($3,927,310)	Pending	Pending	$125.94	$855,747	**($2,710,520)**

Year To Date	Payer	Medicaid		Medicare		Self-Funded		MVP QHP		Total
		PMPM	Total	PMPM	Total	PMPM	Total	PMPM	Total	
	Savings/Losses	($0.74)	($829,535)	$2.84	$1,244,571	Pending	Pending	$64.38	$4,180,774	**$4,595,809**
	Corridor Savings/(Losses)*	($1.48)	($1,668,201)	($14.78)	($6,477,545)	Pending	Pending	$7.08	$217,954	**($7,927,792)**

Full Year Forecast	Payer	Medicaid		Medicare		Self-Funded		MVP QHP		Total
		PMPM	Total	PMPM	Total	PMPM	Total	PMPM	Total	
	Savings/(Losses)	$0.84	$1,228,795	$3.33	$1,934,352	Pending	Pending	$58.75	$4,978,990	**$8,142,138**
	Corridor Savings/(Losses)	$0.10	$139,515	($14.38)	($8,362,452)	Pending	Pending	$7.08	$284,432	**($7,938,505)**



*Corridor is prorated to reflect the limitations on savings/(loss) through the current month

OneCare Vermont

September 2023 PY Monthly Financial Peformance Report

January - September 2023 PY Year To Date, May Current Month (Includes IBNR and Forecast)

Current Month Shared Savings/(Losses)

OCV Actual Monthly PMPM	$240.02
Target PMPM	$243.11
Savings/(Losses) PMPM	**$3.09**

OCV Actual Total Cost	$28,057,006
Target Total Cost	$28,418,049
Savings/(Losses)	**$361,043**

Year To Date Shared Savings/(Losses)

OCV YTD PMPM	$240.65
Target PMPM	$239.92
Savings/(Losses) PMPM	**($0.74)**
Corridor Limited Savings/(Losses) PMPM**	**($1.48)**

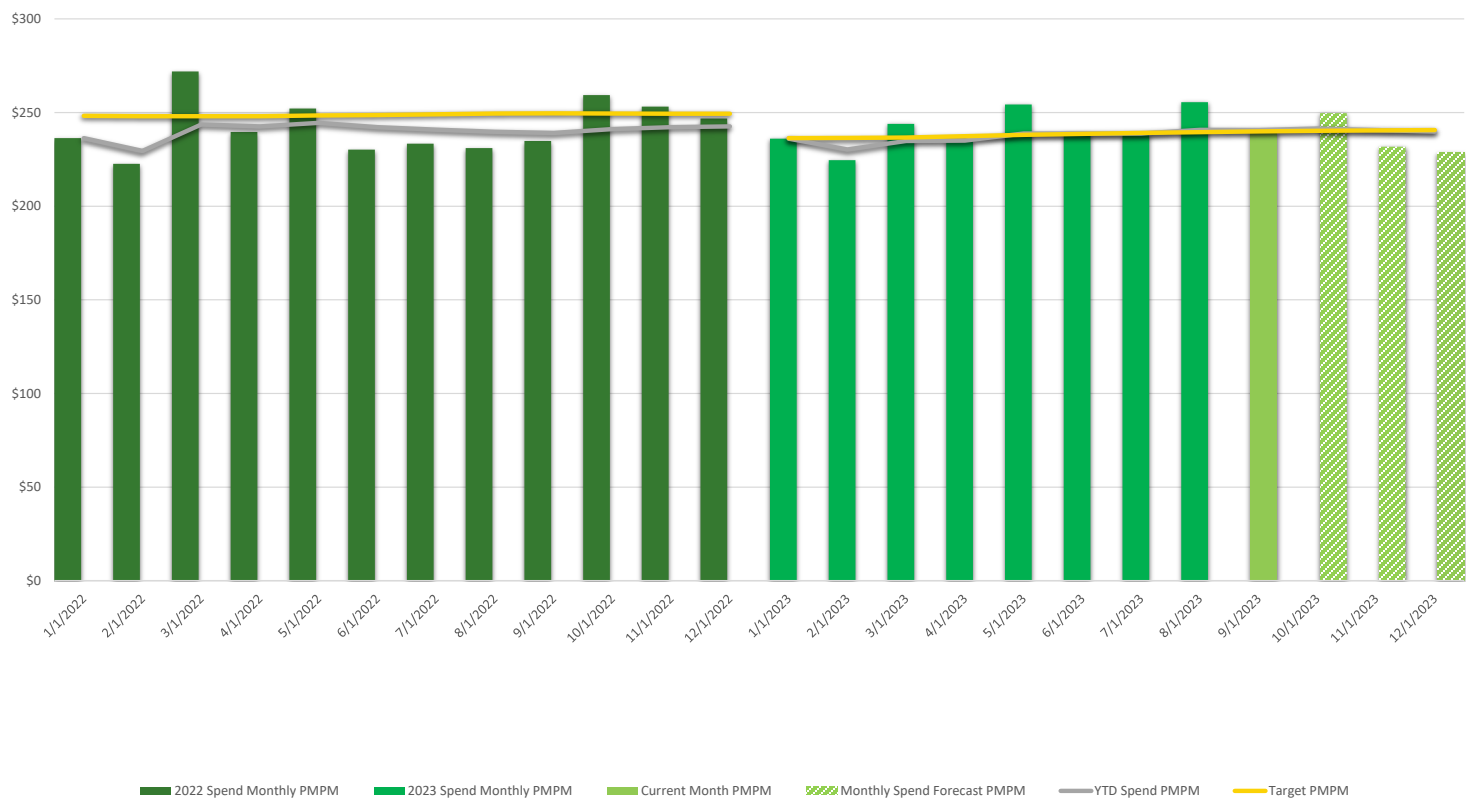
OCV YTD Total Cost	$271,366,821
Target Total Cost	$270,537,285
Savings/(Losses)	**($829,535)**
Corridor Limited Savings/(Losses)**	**($1,668,201)**

Full Year Forecast Shared Savings/(Losses)

OCV Full Year Forecast PMPM	$239.79
Target PMPM	$240.63
Savings/(Losses) PMPM	**$0.84**
Corridor Limited Savings/(Losses) PMPM**	**$0.10**

OCV Full Year Forecast Total Cost	$350,151,898
Target Total Cost	$351,380,693
Savings/(Losses)	**$1,228,795**
Corridor Limited Savings/(Losses)**	**$139,515**

2022-2023 Medicaid Performance History



*IBNR, COVID and Truncation included in the calculations for the TCOC

**Includes Blueprint and quality score impact

OneCare Vermont

2023 Medicare Summary Monthly Statement

OneCare Vermont

September 2023 PY Monthly Financial Peformance Report

January - September 2023 PY Year To Date, May Current Month (Includes IBNR and Forecast)

Current Month Shared Savings/(Losses)

OCV Actual Monthly PMPM	$1,007.29	OCV Actual Total Cost	$48,419,978
Target PMPM	$925.59	Target Total Cost	$44,492,669
Savings/(Losses) PMPM	**($81.70)**	**Savings/(Losses)**	**($3,927,310)**

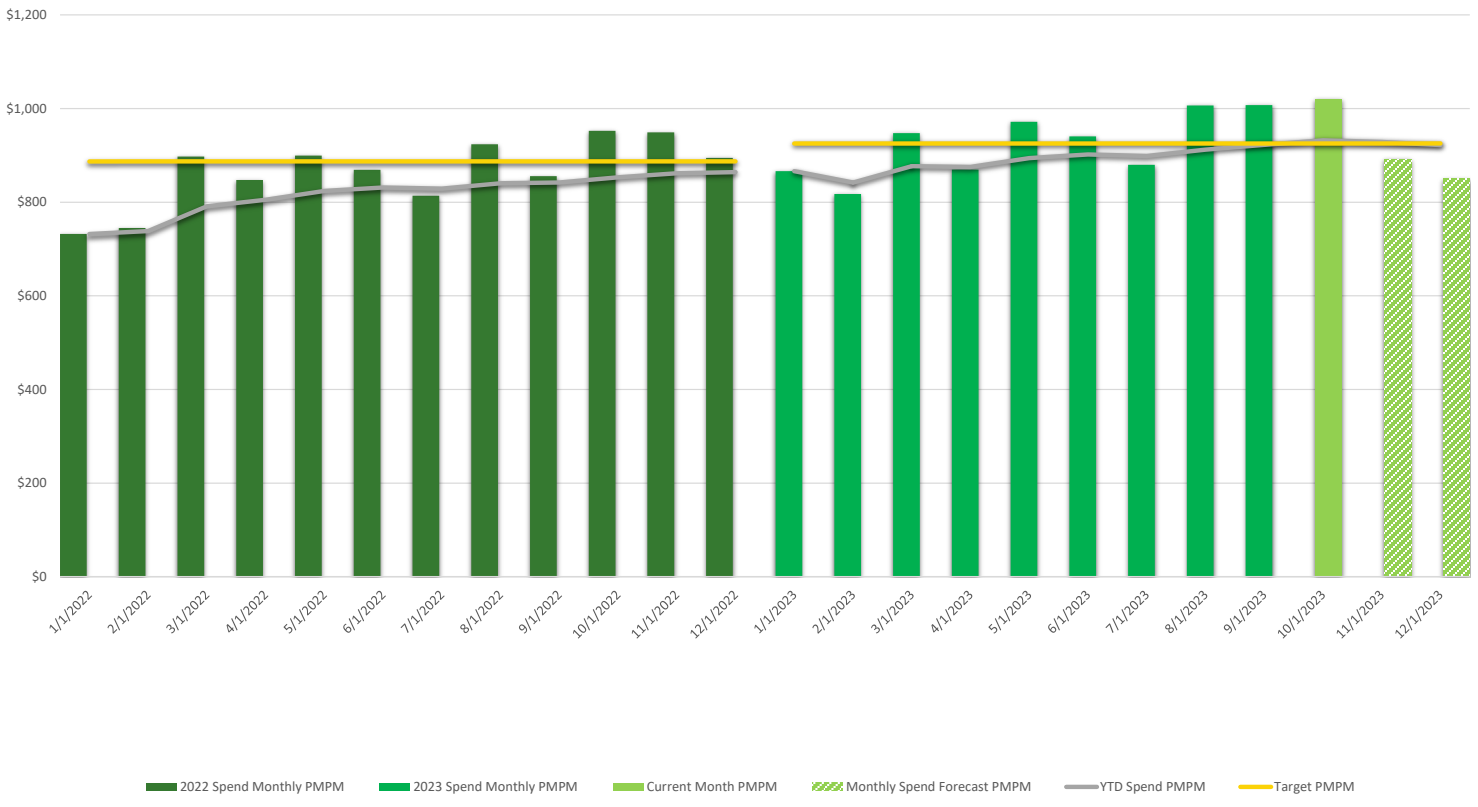
Year To Date Shared Savings/(Losses)

OCV YTD PMPM	$922.53	OCV YTD Total Cost	$404,349,176
Target PMPM	$925.37	Target Total Cost	$405,593,747
Savings/(Losses) PMPM	**$2.84**	**Savings/(Losses)**	**$1,244,571**
Corridor Limited Savings/(Losses) PMPM**	**($14.78)**	**Corridor Limited Savings/(Losses)****	**($6,477,545)**

Full Year Forecast Shared Savings/(Losses)

OCV Full Year Forecast PMPM	$922.13	OCV Full Year Forecast Total Cost	$536,252,684
Target PMPM	$925.45	Target Total Cost	$538,187,036
Savings/(Losses) PMPM	**$3.33**	**Savings/(Losses)**	**$1,934,352**
Corridor Limited Savings/(Losses) PMPM**	**($14.38)**	**Corridor Limited Savings/(Losses)****	**($8,362,452)**

2022-2023 Medicare Performance History



*IBNR, COVID and Truncation included in the calculations for the TCOC

**Includes Blueprint and quality score impact

OneCare Vermont

September 2023 PY Monthly Financial Peformance Report

January - September 2023 PY Year To Date, May Current Month (Includes IBNR and Forecast)

Current Month Shared Savings/(Losses)

OCV Actual Monthly PMPM	$582.14	OCV Actual Total Cost	$3,955,656
Target PMPM	$708.08	Target Total Cost	$4,811,404
Savings/(Losses) PMPM	**$125.94**	**Savings/(Losses)**	**$855,747**

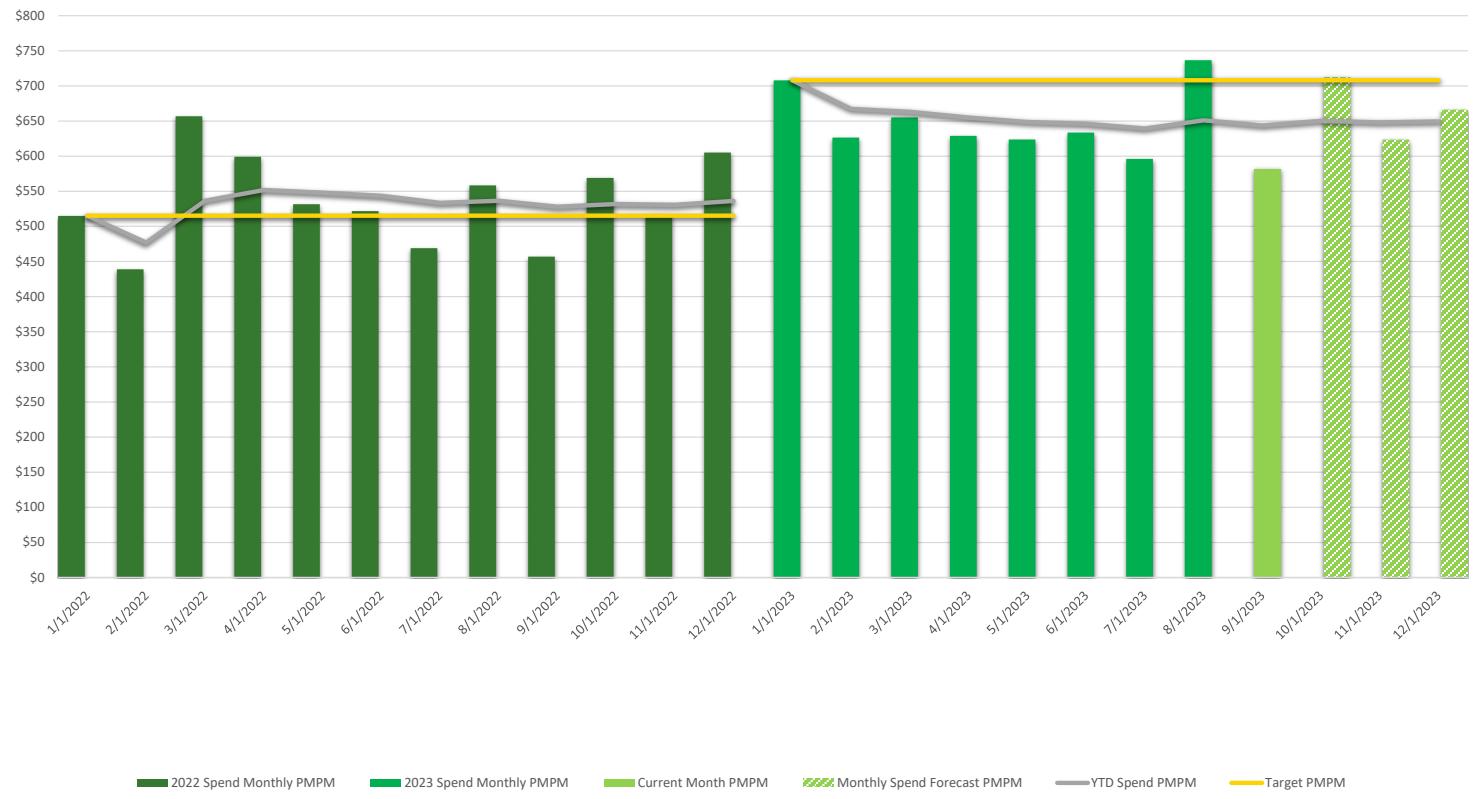
Year To Date Shared Savings/(Losses)

OCV YTD PMPM	$643.70	OCV YTD Total Cost	$41,801,021
Target PMPM	$708.08	Target Total Cost	$45,981,795
Savings/(Losses) PMPM	**$64.38**	**Savings/(Losses)**	**$4,180,774**
Corridor Limited Savings/(Losses) PMPM**	**$7.08**	**Corridor Limited Savings/(Losses)****	**$217,954**

Full Year Forecast Shared Savings/(Losses)

OCV Full Year Forecast PMPM	$649.33	OCV Full Year Forecast Total Cost	$55,027,772
Target PMPM	$708.08	Target Total Cost	$60,006,763
Savings/(Losses) PMPM	**$58.75**	**Savings/(Losses)**	**$4,978,990**
Corridor Limited Savings/(Losses) PMPM**	**$7.08**	**Corridor Limited Savings/(Losses)****	**$284,432**

2022-2023 MVP QHP Performance History



*IBNR, COVID and Truncation included in the calculations for the TCOC

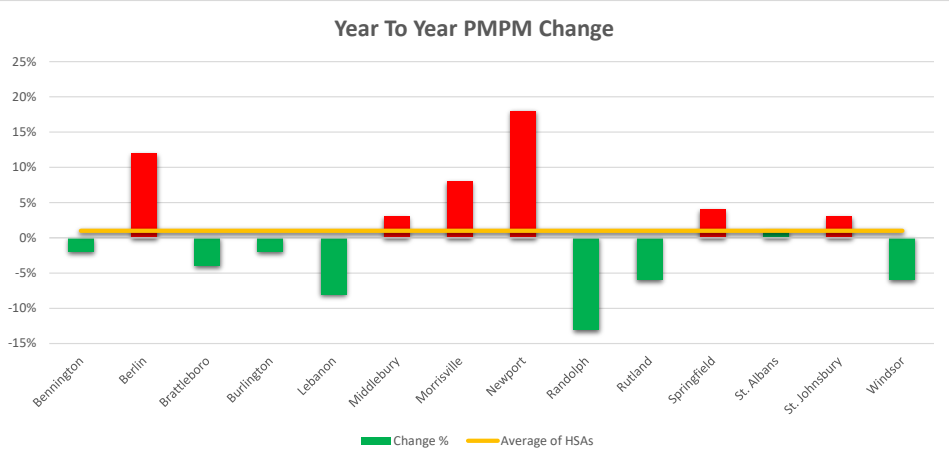
**Includes Blueprint and quality score impact

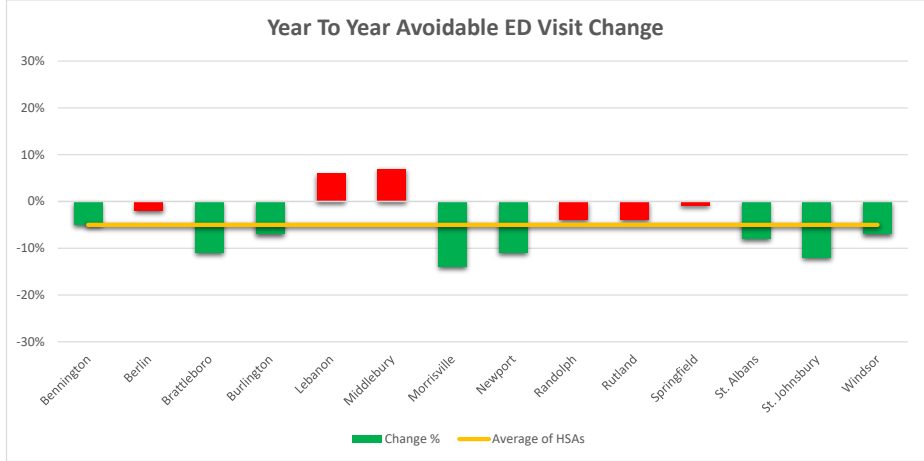
OneCare Vermont

September 2023 PY Monthly Financial Peformance Report

January - September 2023 PY Year To Date, May Current Month (Includes IBNR and Forecast)

Medicaid													
HSA	Year To Year PMPM Change					Year To Year Avoidable ED Visits PKPY Change					Combined Score PIP Earned	% of PIP	PIP Payout
	2022	2023	Change %	Average of HSAs	PIP Earned*	2022	2023	Change %	Average of HSAs	PIP Earned			
Bennington	$168.96	$166.15	-2%	1%	Y	248	235	-5%	-5%	Y	2	13%	$0
Berlin	$201.77	$226.24	12%	1%	N	293	286	-2%	-5%	N	0	0%	$0
Brattleboro	$186.20	$178.42	-4%	1%	Y	234	209	-11%	-5%	Y	2	13%	$0
Burlington	$219.90	$216.32	-2%	1%	Y	238	222	-7%	-5%	Y	2	13%	$0
Lebanon	$224.78	$206.34	-8%	1%	Y	278	294	6%	-5%	N	1	6%	$0
Middlebury	$191.50	$196.38	3%	1%	N	438	468	7%	-5%	N	0	0%	$0
Morrisville	$207.62	$224.11	8%	1%	N	306	265	-14%	-5%	Y	1	6%	$0
Newport	$200.34	$235.40	18%	1%	N	407	364	-11%	-5%	Y	1	6%	$0
Randolph	$239.74	$208.91	-13%	1%	Y	317	305	-4%	-5%	N	1	6%	$0
Rutland	$253.47	$238.81	-6%	1%	Y	312	300	-4%	-5%	N	1	6%	$0
Springfield	$226.75	$235.40	4%	1%	N	373	371	-1%	-5%	N	0	0%	$0
St. Albans	$201.91	$203.37	1%	1%	Y	347	321	-8%	-5%	Y	2	13%	$0
St. Johnsbury	$211.82	$217.91	3%	1%	N	327	288	-12%	-5%	Y	1	6%	$0
Windsor	$204.30	$192.35	-6%	1%	Y	343	317	-7%	-5%	Y	2	13%	$0
Average of HSAs	**$209.93**	**$210.44**	**1%**			**319**	**303**	**-5%**			**16**	**100%**	**$ -**



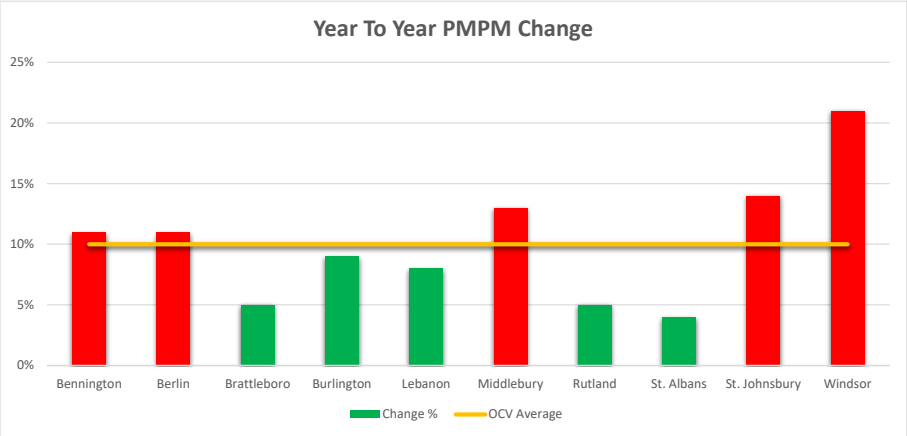


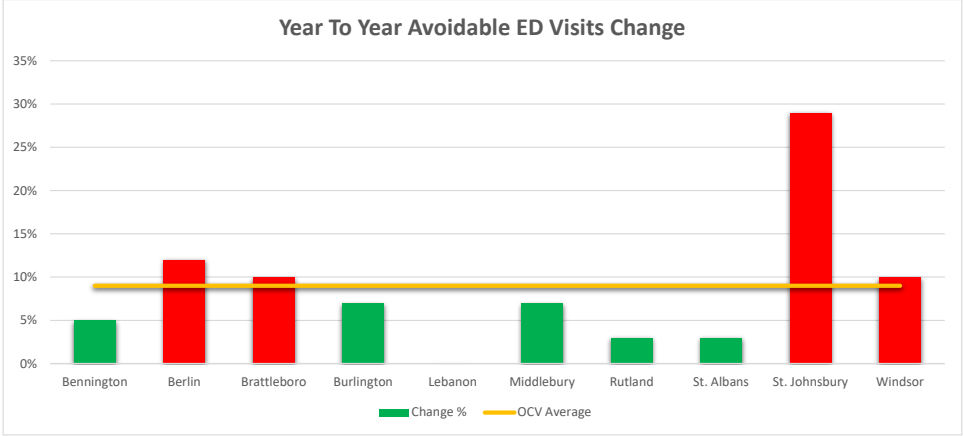
OneCare Vermont

September 2023 PY Monthly Financial Peformance Report

January - September 2023 PY Year To Date, May Current Month (Includes IBNR and Forecast)

Medicare													
HSA	Year To Year PMPM Change					Year To Year Avoidable ED Visits PKPY Change					Combined Score PIP Earned	% of PIP	PIP Payout
	2022	2023	Change %	Average of HSAs	PIP Earned	2022	2023	Change %	Average of HSAs	PIP Earned			
Bennington	$771.69	$854.85	11%	10%	N	260	273	5%	9%	Y	1	9%	$0
Berlin	$770.00	$853.57	11%	10%	N	232	260	12%	9%	N	0	0%	$0
Brattleboro	$766.38	$803.44	5%	10%	Y	208	229	10%	9%	N	1	9%	$0
Burlington	$777.05	$850.70	9%	10%	Y	222	237	7%	9%	Y	2	18%	$0
Lebanon	$695.94	$748.43	8%	10%	Y	141	141	0%	9%	Y	2	18%	$0
Middlebury	$718.85	$813.40	13%	10%	N	355	378	7%	9%	Y	1	9%	$0
Morrisville													
Newport													
Randolph													
Rutland	$944.97	$989.23	5%	10%	Y	281	291	3%	9%	Y	2	18%	$0
Springfield													
St. Albans	$764.69	$794.31	4%	10%	Y	347	357	3%	9%	Y	2	18%	$0
St. Johnsbury	$790.84	$902.57	14%	10%	N	234	300	29%	9%	N	0	0%	$0
Windsor	$813.44	$983.74	21%	10%	N	260	287	10%	9%	N	0	0%	$0
Average of HSAs	**$781.38**	**$859.42**	**10%**			**254**	**276**	**9%**			**11**	**100%**	**$ -**



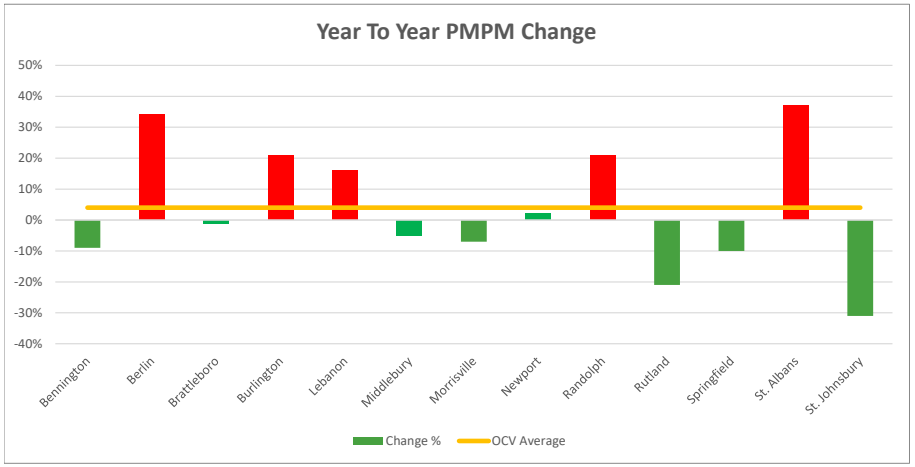


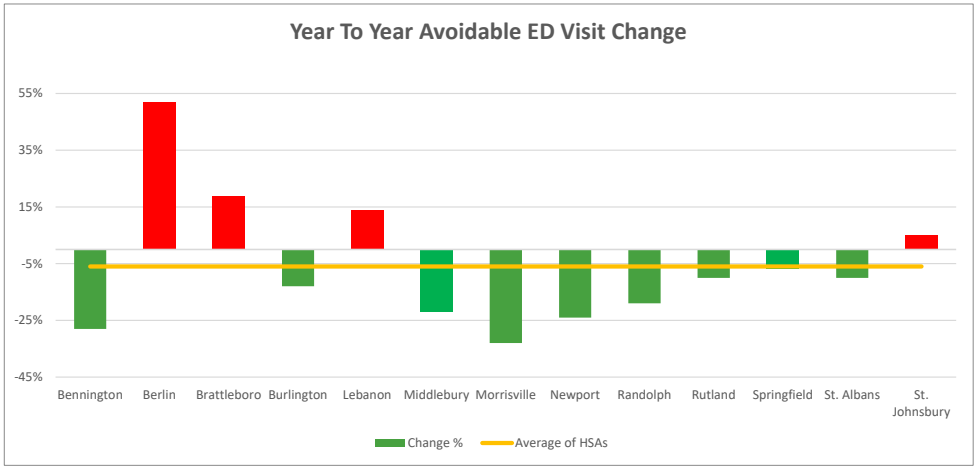
OneCare Vermont

September 2023 PY Monthly Financial Peformance Report

January - September 2023 PY Year To Date, May Current Month (Includes IBNR and Forecast)

MVP QHP													
HSA	Year To Year PMPM Change					Year To Year Avoidable ED Visits Change					Combined Score PIP Earned	% of PIP	PIP Payout
	2022	2023	Change %	Average of HSAs	PIP Earned	2022	2023	Change %	Average of HSAs	PIP Earned			
Bennington	$763.28	$695.16	-9%	4%	Y	178	127	-28%	-6%	Y	2	12%	$2,564
Berlin	$536.65	$720.44	34%	4%	N	66	100	52%	-6%	N	0	0%	$0
Brattleboro	$448.43	$445.91	-1%	4%	Y	98	117	19%	-6%	N	1	6%	$1,282
Burlington	$453.86	$548.29	21%	4%	N	67	59	-13%	-6%	Y	1	6%	$1,282
Lebanon	$624.93	$725.16	16%	4%	N	112	128	14%	-6%	N	0	0%	$0
Middlebury	$487.45	$461.51	-5%	4%	Y	86	67	-22%	-6%	Y	2	12%	$2,564
Morrisville	$689.15	$638.64	-7%	4%	Y	128	85	-33%	-6%	Y	2	12%	$2,564
Newport	$748.86	$766.60	2%	4%	Y	198	150	-24%	-6%	Y	2	12%	$2,564
Randolph	$533.10	$643.21	21%	4%	N	155	126	-19%	-6%	Y	1	6%	$1,282
Rutland	$908.37	$715.42	-21%	4%	Y	147	132	-10%	-6%	Y	2	12%	$2,564
Springfield	$938.93	$849.70	-10%	4%	Y	144	134	-7%	-6%	Y	2	12%	$2,564
St. Albans	$554.38	$759.80	37%	4%	N	135	122	-10%	-6%	Y	1	6%	$1,282
St. Johnsbury	$550.59	$378.07	-31%	4%	Y	103	108	5%	-6%	N	1	6%	$1,282
Average of HSAs	$732.86	$740.78	4%			260	112	-6%			17	100%	$ 21,795.37





OneCare Vermont

2023 Year to Date Total Shared Savings/(Losses)

September 2023 PY Monthly Financial Peformance Report

January - September 2023 PY Year To Date, May Current Month (Includes IBNR and Forecast)

HSA_Savings/(Losses) Statement

OneCare		Medicare	Medicaid	MVP	Self-Funded	Total
OneCare Total Savings/Losses		($6,477,545)	($1,668,201)	$217,954	Pending	($7,927,792)
HSA_Level		**Medicare**	**Medicaid**	**MVP**	**Self-Funded**	**Total**
Bennington	Base Shared Savings/(Loss)	($571,499)	($105,417)	$26,696	Pending	($650,219)
	Incentive Pool Earned	$0	$0	$2,564	Pending	$2,564
	Total	**($571,499)**	**($105,417)**	**$29,261**	**Pending**	**($647,655)**
Berlin	Base Shared Savings/(Loss)	($999,003)	($142,908)	$11,918	Pending	($1,129,993)
	Incentive Pool Earned	$0	$0	$0	Pending	$0
	Total	**($999,003)**	**($142,908)**	**$11,918**	**Pending**	**($1,129,993)**
Brattleboro	Base Shared Savings/(Loss)	($306,543)	($66,570)	$5,136	Pending	($367,977)
	Incentive Pool Earned	$0	$0	$1,282	Pending	$1,282
	Total	**($306,543)**	**($66,570)**	**$6,418**	**Pending**	**($366,695)**
Burlington	Base Shared Savings/(Loss)	($2,051,567)	($417,365)	$57,752	Pending	($2,411,180)
	Incentive Pool Earned	$0	$0	$1,282	Pending	$1,282
	Total	**($2,051,567)**	**($417,365)**	**$59,034**	**Pending**	**($2,409,898)**
Lebanon	Base Shared Savings/(Loss)	($119,551)	($58,281)	$7,289	Pending	($170,543)
	Incentive Pool Earned	$0	$0	$0	Pending	$0
	Total	**($119,551)**	**($58,281)**	**$7,289**	**Pending**	**($170,543)**
Middlebury	Base Shared Savings/(Loss)	($417,176)	($83,147)	$13,805	Pending	($486,518)
	Incentive Pool Earned	$0	$0	$2,564	Pending	$2,564
	Total	**($417,176)**	**($83,147)**	**$16,369**	**Pending**	**($483,954)**
Morrisville	Base Shared Savings/(Loss)	$0	($77,908)	$9,831	Pending	($68,076)
	Incentive Pool Earned	$0	$0	$2,564	Pending	$2,564
	Total	**$0**	**($77,908)**	**$12,396**	**Pending**	**($65,512)**
Newport	Base Shared Savings/(Loss)	$0	($95,811)	$5,508	Pending	($90,304)
	Incentive Pool Earned	$0	$0	$2,564	Pending	$2,564
	Total	**$0**	**($95,811)**	**$8,072**	**Pending**	**($87,739)**
Randolph	Base Shared Savings/(Loss)	$0	($66,001)	$4,921	Pending	($61,080)
	Incentive Pool Earned	$0	$0	$1,282	Pending	$1,282
	Total	**$0**	**($66,001)**	**$6,203**	**Pending**	**($59,798)**
Rutland	Base Shared Savings/(Loss)	($769,759)	($178,351)	$22,546	Pending	($925,564)
	Incentive Pool Earned	$0	$0	$2,564	Pending	$2,564
	Total	**($769,759)**	**($178,351)**	**$25,110**	**Pending**	**($923,000)**
Springfield	Base Shared Savings/(Loss)	$0	($88,688)	$8,673	Pending	($80,015)
	Incentive Pool Earned	$0	$0	$2,564	Pending	$2,564
	Total	**$0**	**($88,688)**	**$11,237**	**Pending**	**($77,451)**
St. Albans	Base Shared Savings/(Loss)	($460,326)	($141,702)	$15,626	Pending	($586,403)
	Incentive Pool Earned	$0	$0	$1,282	Pending	$1,282
	Total	**($460,326)**	**($141,702)**	**$16,908**	**Pending**	**($585,121)**
St. Johnsbury	Base Shared Savings/(Loss)	($570,061)	($118,844)	$6,458	Pending	($682,448)
	Incentive Pool Earned	$0	$0	$1,282	Pending	$1,282
	Total	**($570,061)**	**($118,844)**	**$7,740**	**Pending**	**($681,166)**
Windsor	Base Shared Savings/(Loss)	($212,058)	($27,209)	$0	Pending	($239,268)
	Incentive Pool Earned	$0	$0	$0	Pending	$0
	Total	**($212,058)**	**($27,209)**	**$0**	**Pending**	**($239,268)**
Total HSA Savings/(Loss)		**($6,477,545)**	**($1,668,201)**	**$217,954**	**Pending**	**($7,927,792)**

HSA Savings/(Losses) Statement

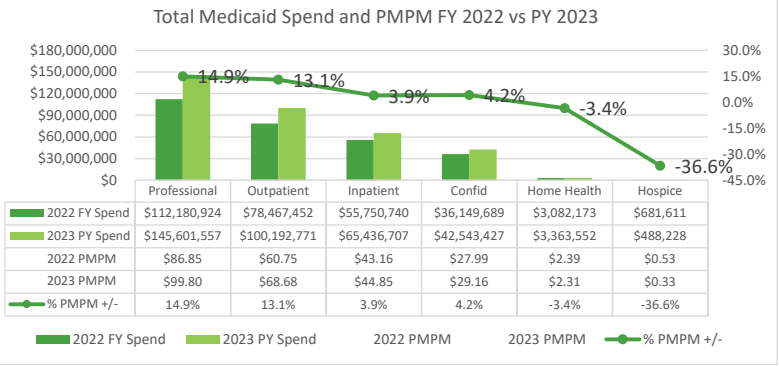
*For practices that deferred accountability contribution, deferral not accounted for in the numbers above.

**Does not include fixed payment recon

In case of losses

Medicaid 2023 PY Drivers

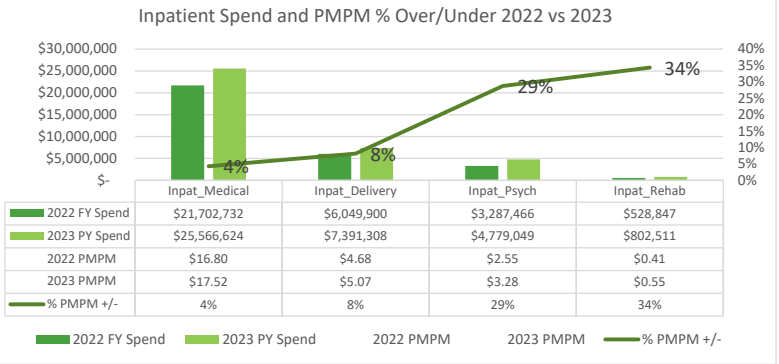
Medicaid Total Spend and %PMPM Change 2022-2023



	Professional	Outpatient	Inpatient	Confid	Home Health	Hospice
2022 FY Spend	$112,180,924	$78,467,452	$55,750,740	$36,149,689	$3,082,173	$681,611
2023 PY Spend	$145,601,557	$100,192,771	$65,436,707	$42,543,427	$3,363,552	$488,228
2022 PMPM	$86.85	$60.75	$43.16	$27.99	$2.39	$0.53
2023 PMPM	$99.80	$68.68	$44.85	$29.16	$2.31	$0.33
% PMPM +/-	14.9%	13.1%	3.9%	4.2%	-3.4%	-36.6%

>The Spend projections graph shows the impact of redetermination that resumed in the summer of 2023. Spend is high in Q1,Q2 and beginning of Q3 with unseasonably high August.
>Some of the main cost drivers are Chemo drugs , Mental Health Services across service lines

Inpatient 2022-2023



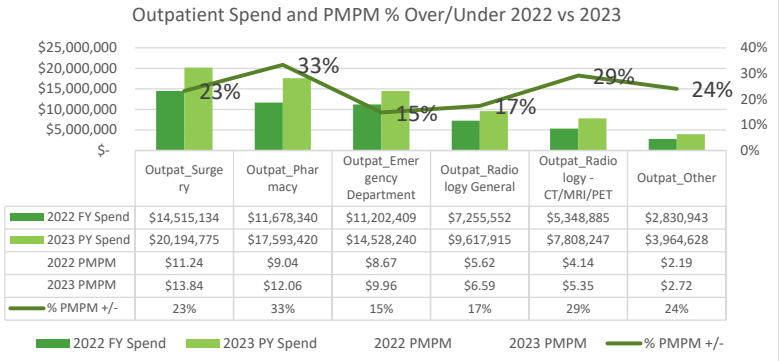
	Inpat_Medical	Inpat_Delivery	Inpat_Psych	Inpat_Rehab
2022 FY Spend	$21,702,732	$6,049,900	$3,287,466	$528,847
2023 PY Spend	$25,566,624	$7,391,308	$4,779,049	$802,511
2022 PMPM	$16.80	$4.68	$2.55	$0.41
2023 PMPM	$17.52	$5.07	$3.28	$0.55
% PMPM +/-	4%	8%	29%	34%

> Inpat_Medical increased for (septicemia or severe sepsis up 16%, pulmonary edema & respiratory failure up 23%)

> Inpat_Surgical increased the most for (major small & large bowel procedures up 107%, cardiac valve & oth maj cardiothoracic procedures up 543% but no major financial impact, less then 600K)

> Inpat_Psych increased the most for (Psychoses up 28%).

Outpatient 2022-2023



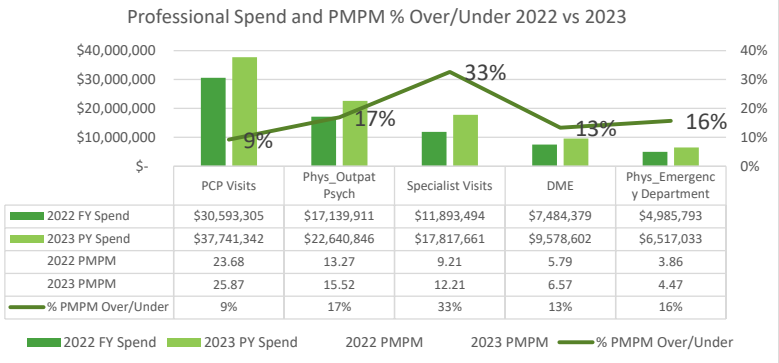
	Outpat_Surgery	Outpat_Pharmacy	Outpat_Emergency Department	Outpat_Radiology General	Outpat_Radiology - CT/MRI/PET	Outpat_Other
2022 FY Spend	$14,515,134	$11,678,340	$11,202,409	$7,255,552	$5,348,885	$2,830,943
2023 PY Spend	$20,194,775	$17,593,420	$14,528,240	$9,617,915	$7,808,247	$3,964,628
2022 PMPM	$11.24	$9.04	$8.67	$5.62	$4.14	$2.19
2023 PMPM	$13.84	$12.06	$9.96	$6.59	$5.35	$2.72
% PMPM +/-	23%	33%	15%	17%	29%	24%

> Outpatient surgery increased for (42820-remove tonsils and adenoids up 215%, 27447-total knee arthroplasty up 131% and 69436-create eardrum opening up 127%)

> Outpatient pharmacy increased the most for chemotherapy drugs (J9271 up 75%, J9299 up 189%). New drugs being used (J1300 and Q5310 starting 2023)

> Outpatient Radiology increased the most for (77385- (IMRT) up 98% and 77412-radiation treatment delivery 68%).

Professional 2022-2023



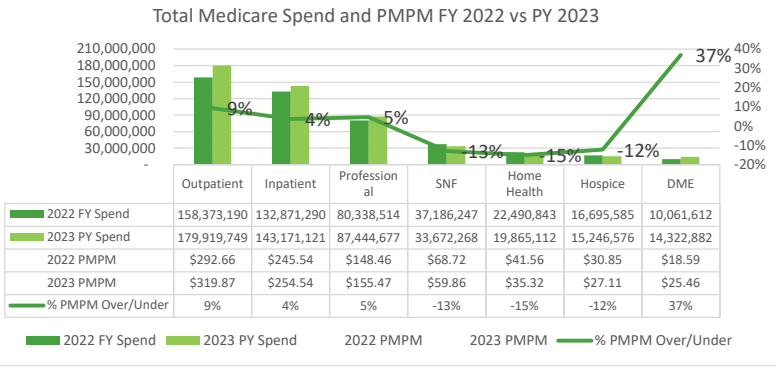
	PCP Visits	Phys_Outpat Psych	Specialist Visits	DME	Phys_Emergency Department
2022 FY Spend	$30,593,305	$17,139,911	$11,893,494	$7,484,379	$4,985,793
2023 PY Spend	$37,741,342	$22,640,846	$17,817,661	$9,578,602	$6,517,033
2022 PMPM	23.68	13.27	9.21	5.79	3.86
2023 PMPM	25.87	15.52	12.21	6.57	4.47
% PMPM Over/Under	9%	17%	33%	13%	16%

> Phys_Outpat Psych increased for (90837-Psychoterapy up 19% and 90791-psych diagnostic evaluation up 32%)

> Specialist visits increased the most for pediatric medicine, licensed clinical mental health counselor, licensed psychologist/social worker

Medicare 2023 PY Drivers

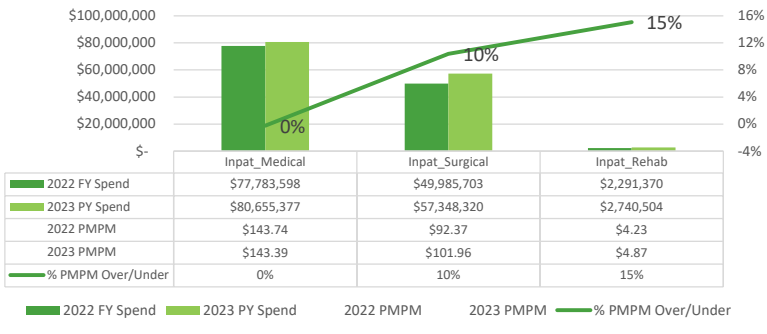
Medicare Total Spend and %PMPM Change 2022-2023



	Outpatient	Inpatient	Professional	SNF	Home Health	Hospice	DME
2022 FY Spend	158,373,190	132,871,290	80,338,514	37,186,247	22,490,843	16,695,585	10,061,612
2023 PY Spend	179,919,749	143,171,121	87,444,677	33,672,268	19,865,112	15,246,576	14,322,882
2022 PMPM	$292.66	$245.54	$148.46	$68.72	$41.56	$30.85	$18.59
2023 PMPM	$319.87	$254.54	$155.47	$59.86	$35.32	$27.11	$25.46
% PMPM Over/Under	9%	4%	5%	-13%	-15%	-12%	37%

>Spend in the first half of 2023 is tracking closely to the benchmark amount. OneCare's forecast models suggest we will end the year very close to target and forecasts an uptick in the second half of the year spend for 2023

Inpatient 2022-2023



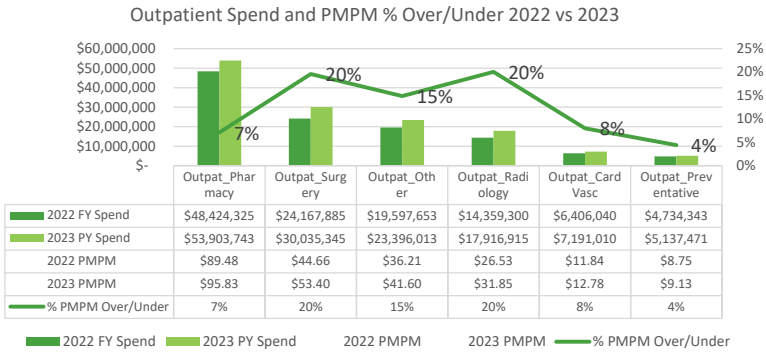
	Inpat_Medical	Inpat_Surgical	Inpat_Rehab
2022 FY Spend	$77,783,598	$49,985,703	$2,291,370
2023 PY Spend	$80,655,377	$57,348,320	$2,740,504
2022 PMPM	$143.74	$92.37	$4.23
2023 PMPM	$143.39	$101.96	$4.87
% PMPM Over/Under	0%	10%	15%

> Inpat_Medical increased by 8% for (septicemia or severe sepsis)

> Inpat_Surgical increased the most for endovascular cardiac valve replacement by 52% and supplement procedures, and by 40% for major small and large bowel procedures

> Inpat_Rehab increased the most for aftercare, musculoskeletal system and connective tissue by 77%. Also on the rise where degenerative nervous system disorders up by 16%

Outpatient 2022-2023



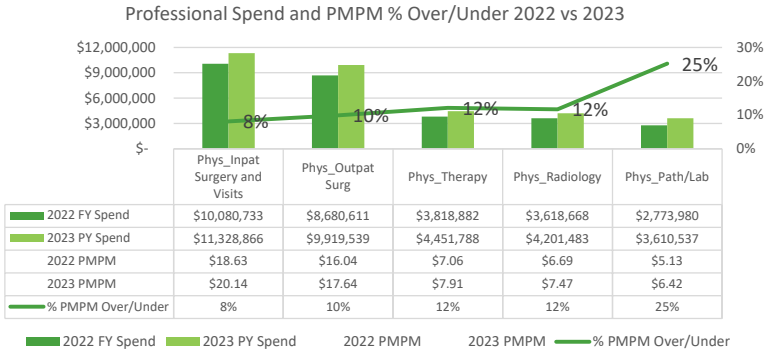
	Outpat_Pharmacy	Outpat_Surgery	Outpat_Other	Outpat_Radiology	Outpat_Card Vasc	Outpat_Preventative
2022 FY Spend	$48,424,325	$24,167,885	$19,597,653	$14,359,300	$6,406,040	$4,734,343
2023 PY Spend	$53,903,743	$30,035,345	$23,396,013	$17,916,915	$7,191,010	$5,137,471
2022 PMPM	$89.48	$44.66	$36.21	$26.53	$11.84	$8.75
2023 PMPM	$95.83	$53.40	$41.60	$31.85	$12.78	$9.13
% PMPM Over/Under	7%	20%	15%	20%	8%	4%

> Outpatient surgery increased for total knee arthroplasty up 65% , total hip arthroplasty up 34% and reconstruct shoulder joint up 41%

> Outpatient pharmacy increased the most for chemotherapy drugs (J9271 up 8%, J1303 up 119%, J1944 up 24%). New drug being used (J1569) starting 2023

> Outpatient Radiology increased the most for radiation treatement delivery up 14% and diagnostic radiology abdomen up 20%. A new code has been introduced in use in 2023: A9607-Radiopharmaceutical agent

Professional 2022-2023



	Phys_Inpat Surgery and Visits	Phys_Outpat Surg	Phys_Therapy	Phys_Radiology	Phys_Path/Lab
2022 FY Spend	$10,080,733	$8,680,611	$3,818,882	$3,618,668	$2,773,980
2023 PY Spend	$11,328,866	$9,919,539	$4,451,788	$4,201,483	$3,610,537
2022 PMPM	$18.63	$16.04	$7.06	$6.69	$5.13
2023 PMPM	$20.14	$17.64	$7.91	$7.47	$6.42
% PMPM Over/Under	8%	10%	12%	12%	25%

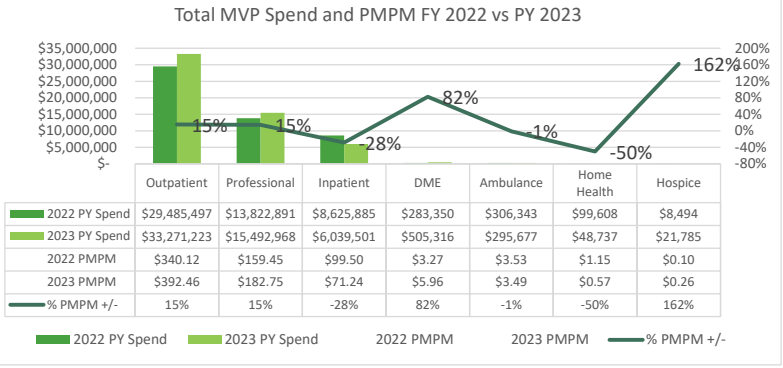
> Phys_Outpat_Surgery increased for (66984-Intraocular Lens Procedures up 7%, 27447-total knee arthroplasty up 38%, 17311-Mohs Micrographic Surgery up 45%)

> Phys_Therapy increased the most for 97530-therapeutic activities up 38%, 97112-neuromuscular reeducation up 36%

> Phys_Radiology increased the most for 74117-diagnostic radiology abdomen up 22%

MVP 2023 PY Drivers

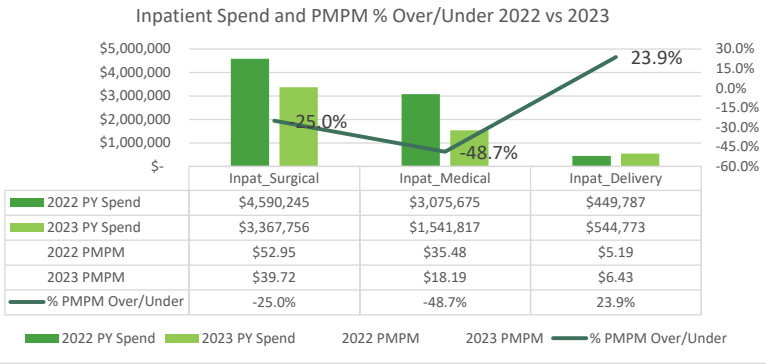
MVP Total Spend and %PMPM Change 2022-2023



	Outpatient	Professional	Inpatient	DME	Ambulance	Home Health	Hospice
2022 PY Spend	$29,485,497	$13,822,891	$8,625,885	$283,350	$306,343	$99,608	$8,494
2023 PY Spend	$33,271,223	$15,492,968	$6,039,501	$505,316	$295,677	$48,737	$21,785
2022 PMPM	$340.12	$159.45	$99.50	$3.27	$3.53	$1.15	$0.10
2023 PMPM	$392.46	$182.75	$71.24	$5.96	$3.49	$0.57	$0.26
% PMPM +/-	15%	15%	-28%	82%	-1%	-50%	162%

>Currently, the program spend is below the target and a small amount of shared savings is projected for the year. Currently, inpatient spend is tracking at a lower PMPM than in the base period, driven by lower medical/surgical spend. Outpatient surgery spend is also trending lower and contributing to the savings projection. The growth rate of allowed PMPM in MVP's Vermont QHP business for members not attributed to OneCare is higher than the growth rate for members attributed to OneCare.

Inpatient 2022-2023

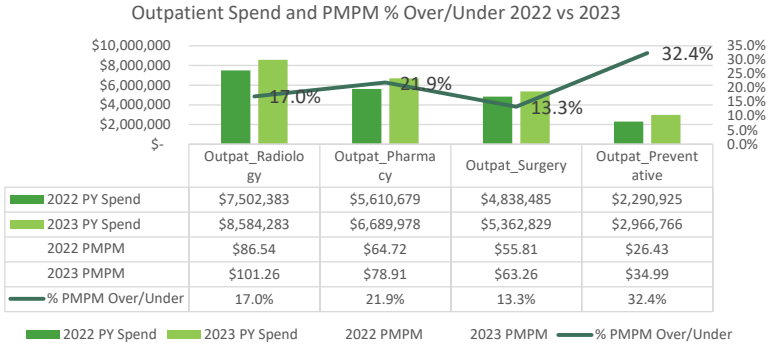


	Inpat_Surgical	Inpat_Medical	Inpat_Delivery
2022 PY Spend	$4,590,245	$3,075,675	$449,787
2023 PY Spend	$3,367,756	$1,541,817	$544,773
2022 PMPM	$52.95	$35.48	$5.19
2023 PMPM	$39.72	$18.19	$6.43
% PMPM Over/Under	-25.0%	-48.7%	23.9%

> Inpat_Surgical decreased for (cardiac valve and cardiothoracic, intracranial vascular procedures with hemorrhage down , small and large bowel procedures down

> Inpat_Medical decreased the most for (chimeric antigen receptor and other immunotherapies, diabetes and renal failure down)

Outpatient 2022-2023

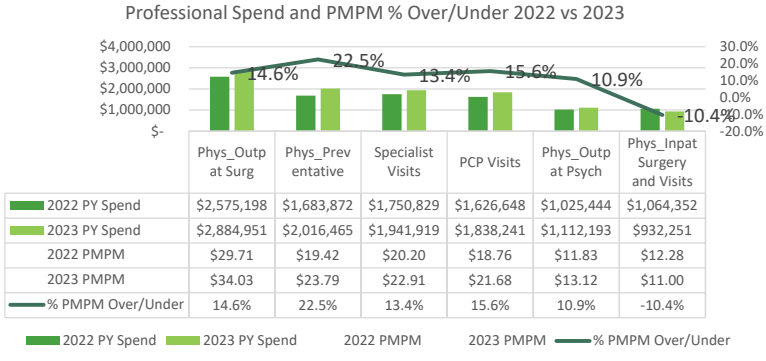


	Outpat_Radiology	Outpat_Pharmacy	Outpat_Surgery	Outpat_Preventative
2022 PY Spend	$7,502,383	$5,610,679	$4,838,485	$2,290,925
2023 PY Spend	$8,584,283	$6,689,978	$5,362,829	$2,966,766
2022 PMPM	$86.54	$64.72	$55.81	$26.43
2023 PMPM	$101.26	$78.91	$63.26	$34.99
% PMPM Over/Under	17.0%	21.9%	13.3%	32.4%

> Outpatient Radiology increased for (computed tomography, abdomen and pelvis up 47% and intensity modulated radiation treatment delivery up 10%)

> Outpatient pharmacy increased the most for chemotherapy drugs (J2350 up 34%, J9271 up 124%, J9914 up 22%). New drug being used (J1569) starting 2023

Professional 2022-2023



	Phys_Outpat Surg	Phys_Preventative	Specialist Visits	PCP Visits	Phys_Outpat Psych	Phys_Inpat Surgery and Visits
2022 PY Spend	$2,575,198	$1,683,872	$1,750,829	$1,626,648	$1,025,444	$1,064,352
2023 PY Spend	$2,884,951	$2,016,465	$1,941,919	$1,838,241	$1,112,193	$932,251
2022 PMPM	$29.71	$19.42	$20.20	$18.76	$11.83	$12.28
2023 PMPM	$34.03	$23.79	$22.91	$21.68	$13.12	$11.00
% PMPM Over/Under	14.6%	22.5%	13.4%	15.6%	10.9%	-10.4%

> Phys_Outpat Surg increased for (arthroplasty, knee up 144% and mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue up 121%)

> Phys_Office Administered Drugs increased the most for (J1745 up 2166%, J2182 up 63%, J0585 up 62%) all chemo drugs