Request for Information—DVHA

1. A searchable copy of contract #32318
   Please see attached searchable contract.

2. A breakdown of attributed members in each MEG

MEG (as of 01/01/17)	**Number (%) of Attributed Members**
Aged, Blind, or Disabled (ABD) Adult & Child	1,910 (6.56%)
Consolidated Adult	12,988 (44.63%)
Consolidated Child	14,205 (48.81%)
Total	***29,103***

3. The trend factors applied to each MEG for calculation of the ETCOC and any explanatory documents
   Please see attached actuarial report (p. 17, *D. Trends*, and p. 36, *Appendix B.3 – Capitation Rate Development (Final AIPBP)*) for detail on the trend factors applied and a description of the approach used to derive the trend factors.

4. The total number of OneCare providers and how many of those are primary care providers

Participating Provider Specialty (as of 01/01/17)	**Number (%) of Providers**
Primary Care	678 (36.93%)
Specialist eligible for Attribution	128 (6.97%)
Specialist not eligible for Attribution	1,030 (56.10 %)
Total	***1,836***

5. The total number of attributed Medicaid members and how many of those are attributed to primary care providers

Attributing Provider Specialty (as of 01/01/17)	**Number (%) of Attributed Members**
Primary Care	28,580 (98.20%)
Specialist	523 (1.80%)
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6. A copy of OCVT's network contracts (where contracts are duplicative, one copy will suffice, and attachments with standard language are unnecessary)
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      Data from SFY 2015-16 were used.
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    The Actual Total Cost of Care will be calculated using the sum of FFS payments on behalf of attributed members and the sum of adjusted and reconciled fixed prospective payments (the net AIPBP minus admin and PCCM fee).

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    DVHA intends to utilize the WHPP amounts captured for the zero-paid claims in order to understand what would have been spent on services for attributed members absent the prospective payment to the ACO. The total WHPP amount will be compared to the total amount prospectively paid during the year. The WHPP amounts will also be considered in setting ACO rates in future years (i.e. trending forward CY 2017 expenditure to set rates for CY 2019).

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14. Explain if or how Blueprint activities and Patient-Centered Medical Homes (PCMH) are integrated into this contractual arrangement:
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    a. For instance, will OneCare's network of primary care providers continue working on Blueprint initiatives? If so, is the cost of this work included in the amount of the contract?
       Yes, we anticipate OneCare's network will continue to work on Blueprint initiatives. The ACO contract does not contain terms that would definitively

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b. Do cost savings from those activities and support networks accrue to OneCare, and will they no longer be considered in Blueprint's ROI?
DVHA's goal is to understand savings and ROI related to the ACO and Blueprint separately to judge each program on its actual performance.
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    a. Please confirm that the maximum amount of the contract includes both the net AIPBP payments made directly to OneCare and the FFS payments made by DVHA directly to providers (both affiliated and non-affiliated) for attributed members.
    Yes, the maximum contract amount includes both the Net AIPBP payments to OneCare and the FFS payments made by DVHA for attributed members. The maximum contract amount was calculated by assuming all attributed members would have the weighted average Total Cap payment made on their behalf for each of the months of the year:
    $267.32 PMPM * 29,103 members * 12 months = $93,357,767.52
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    Please see attached 'Exhibit 1' documents (accompanying the OneCare Provider Base Agreement and Medicaid Addendum) for each of the 4 hospitals that will be receiving prospective payments from OneCare. These describe the mechanism by which prospective payments will be made per each hospital's contract with OneCare. DVHA has the authority to audit actual payments throughout the program year.
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Request for Information—DVHA

1. A searchable copy of contract #32318
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2. A breakdown of attributed members in each MEG

MEG (as of 01/01/17)	**Number (%) of Attributed Members**
Aged, Blind, or Disabled (ABD) Adult & Child	1,910 (6.56%)
Consolidated Adult	12,988 (44.63%)
Consolidated Child	14,205 (48.81%)
Total	***29,103***

3. The trend factors applied to each MEG for calculation of the ETCOC and any explanatory documents
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4. The total number of OneCare providers and how many of those are primary care providers

Participating Provider Specialty (as of 01/01/17)	**Number (%) of Providers**
Primary Care	678 (36.93%)
Specialist eligible for Attribution	128 (6.97%)
Specialist not eligible for Attribution	1,030 (56.10 %)
Total	***1,836***

5. The total number of attributed Medicaid members and how many of those are attributed to primary care providers

Attributing Provider Specialty (as of 01/01/17)	**Number (%) of Attributed Members**
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   a. If FY2014-15 data were used, please explain why more recent data were not chosen for attribution, especially given the distortions due to delayed redeterminations.
      Data from SFY 2015-16 were used.
   b. Did DVHA's actuary estimate the total cost of care if the attributed population was based on FY2016? If so, please provide.
      The TCOC estimates were based on CY 2015 (the most recent full calendar year of data) and were trended forward to 2017. Please see attached actuarial report for additional detail.

9. Sec. 10 appears to provide a process for monthly adjustment of PMPM payments based on current Medicaid status. Is this correct and does the adjustment include all three components of the net AIPBP monthly payment? Does the Medicaid ACO PMPM File contain only active members?
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10. Sec. 10.2.2 states that DVHA's fiscal agent will continue to receive all claims from VT Medicaid providers and that all claims will continue to be processed through DVHA's edits and audits. However, 10.4.6 refers to a ACO non-claims response file containing payments to providers not reported at a claim level. Please explain.
    Providers are required to submit claims as they have previously, and DVHA's fiscal agent will continue to process those as they have previously. However, claims for providers electing to receive a prospective payment from the ACO will be zero-paid by DVHA's fiscal agent upon processing. Through the 'ACO Non-Claims Response File', the ACO will detail payments that it makes to any providers being paid prospectively. It is expected that the ACO will make monthly fixed prospective payments to providers regardless of how many claims they submit.

11. Will the year-end reconciliation process to compute the actual cost of care utilize data from FFS claims, zero-based claims and WHPP claims amount or will the calculation be a sum of FFS payments and monthly (adjusted and reconciled) net AIPBP payments?
    The Actual Total Cost of Care will be calculated using the sum of FFS payments on behalf of attributed members and the sum of adjusted and reconciled fixed prospective payments (the net AIPBP minus admin and PCCM fee).

12. If the latter, will DHVA perform an analysis of actual cost of care for attributed population based only on claims data (actual and estimated)?
    DVHA intends to utilize the WHPP amounts captured for the zero-paid claims in order to understand what would have been spent on services for attributed members absent the prospective payment to the ACO. The total WHPP amount will be compared to the total amount prospectively paid during the year. The WHPP amounts will also be considered in setting ACO rates in future years (i.e. trending forward CY 2017 expenditure to set rates for CY 2019).

13. Sec. 7.0 of the contract (attachment A), states that VCCI will no longer be engaged in care management for the ACO-attributed Medicaid population. Please provide the number of Medicaid members that were receiving care management from VCCI and now have care management assigned to OneCare.
    63 Medicaid members who were being case-managed by VCCI at the start of the contract period are now in the process of being transitioned to OneCare for management going forward. The VCCI and OneCare teams have been coordinating to ensure an individualized approach and a 'warm hand-off' for each member. It is expected that this process will be ongoing for the next several weeks.

14. Explain if or how Blueprint activities and Patient-Centered Medical Homes (PCMH) are integrated into this contractual arrangement:
    The Blueprint and PCMH activities are not integrated in the contract. The ACO and Blueprint collaborate presently, as they have during the multi-payer shared savings programs during the past several years. Until the ACO has more people enrolled, the Blueprint will likely continue to serve state government to facilitate and encourage practice transformation across the whole population rather than solely the ACO program attributed lives. This is consistent with Blueprint's traditional role focusing on multi-payer health care reform.
    a. For instance, will OneCare's network of primary care providers continue working on Blueprint initiatives? If so, is the cost of this work included in the amount of the contract?
       Yes, we anticipate OneCare's network will continue to work on Blueprint initiatives. The ACO contract does not contain terms that would definitively

change the relationship between providers and the Blueprint. Furthermore, the cost of Blueprint related activities is not included in the contract amount.

b. Do cost savings from those activities and support networks accrue to OneCare, and will they no longer be considered in Blueprint's ROI?
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c. Will OneCare's primary care providers receive the PCCM payment that is part of the net AIPBP?
Yes, OneCare primary care providers will continue to receive the PCCM payment. This is a pass-through payment that does not affect the calculation of the AIPBP.

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a. Please confirm that the maximum amount of the contract includes both the net AIPBP payments made directly to OneCare and the FFS payments made by DVHA directly to providers (both affiliated and non-affiliated) for attributed members.
Yes, the maximum contract amount includes both the Net AIPBP payments to OneCare and the FFS payments made by DVHA for attributed members. The maximum contract amount was calculated by assuming all attributed members would have the weighted average Total Cap payment made on their behalf for each of the months of the year:
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