**To:** Alena Berube, Melissa Miles, Marisa Melamed, Green Mountain Care Board, and Healthcare Advocate Policy Team
**From:** Vicki Loner, CEO OneCare Vermont, Accountable Care Organization, LLC
**Date:** October 25, 2019
**Subject:** Health Care Advocate Questions for OneCare Vermont, October 11, 2019

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Dear Green Mountain Care Board and Healthcare Advocate Teams,

Please find below OneCare Vermont's responses to the HealthCare Advocate's follow up questions regarding our 2020 Budget Submission. Our responses are below and in italics.

***Follow-up on HCA Guidance Question***

1. In our 2020 guidance questions, the HCA asked, "*During the Vermont Health Connect 2020 rate review process, Blue Cross Blue Shield of Vermont stated that taking both the care coordination fee and projected savings into account, Blue Cross projects a slight increase in rates due to its relationship with OneCare in 2020…**When** does OneCare believe Blue Cross and its members will experience overall savings due to its relationship with OneCare?"*

   OneCare responded, *"Currently OneCare only has a QHP contract with BCBSVT, which is a small portion of their business/membership. QHP rates have had premium growth rates based on actual utilization. Should other commercial populations be added into the All Payer Model, OneCare would expect its commercial trend could diminish. OneCare is actively working to expand our footprint into the BCBSVT self-funded market. The goal is to develop a model that qualifies for scale targets, achieves clinical alignment, and incorporates payment reform."*

   It is not clear from the response ***when*** OneCare believes BCBSVT will realize saving due to its relationship with OneCare taking into account both the care coordination fee and projected savings. Please respond to the question posed by specifying whether OneCare believes that BCBSVT's QHP program will at some point save more money on the OneCare program than it is spending on the OneCare program. If OneCare believes this will happen, how soon does it project it to happen? If OneCare does not believe that the BCBSVT QHP program will "save" BCBSVT money, please explain this belief.

   Making such an estimate requires access to information internal to Blue Cross that OneCare does not have. OneCare refers the HCA to Blue Cross's rate review materials and testimony in which they addressed this question.

***BCBSVT and MVP QHP***

2. Please provide additional details on your QHP programs as described below. For reference, Appendix 3.1 details a 6.04% PMPM trend for Commercial QHP 2018-2020 and a -11.1% trend between 2019 projected and 2020.

   The budget assumption was sourced from the approved rate filings and done so in a way to align the approved increases with the services for which OneCare is accountable. These rates are the subject

of active contract negotiations and requested information will be included in the final approved and signed contracts.

a. Please provide your 2019 projected shared savings for BCBSVT QHP.

   See response to GMCB Question 36a.

b. How does OneCare's 2019 BCBSVT QHP budget, as detailed in your 2019 contract with BCBSVT, compare to OneCare's 2019 projection detailed in the 2020 budget submission?

   OneCare does not understand this question sufficiently to make comparisons. There is no budget detail in a contract with BlueCross.

c. Please provide a narrative description, supported by data, of the variation between the 2019 budget and 2019 projection for the BCBSVT QHP population.

   OneCare has not performed this analysis due to data limitations (see response to 7a below) and because the performance is currently close to target.

d. Please provide the hypothesized causes of any observed differences between the 2019 BCBSVT QHP budget and 2019 projection.

   Current data suggest that performance is very close to the 2019 benchmark. Therefore there are there no hypothesized causes to discuss as part of the 2020 budget process.

e. It is our understanding that the table in Appendix 3.1 combines MVP and BCBSVT QHP populations.
   i. Please confirm whether our understating is correct.

      Your understanding is correct.

   ii. Please explain OneCare's prediction of an 11% decline between 2019 projected and 2020 budget. Please include in the explanation a discussion of how OneCare expects the MVP and BCBSVT trends to move individually

      The projected decline is the result of incorporating an entirely new population into the OneCare's Commercial QHP program line. Please see the BCBSVT and MVP QHP rate filings submitted to the GMCB for a detailed analysis of their rate trends and the contributing factors.

f. Please explain any facts and/or assumptions that OneCare relied on to establish the 11% decline from 2019 to 2020. For example, to what extent is the decline due to an expectation that healthier individuals with lower projected claims will join the pool with MVP participation?

   OneCare has no way to predict which Vermonters will purchase which insurance through the QHP market. Please see the BCBSVT and MVP QHP rate filings submitted to the GMCB for a detailed analysis of their rate trends and the contributing factors.

***BCBSVT ASO/LG***

3. On page 55 of the 2020 budget narrative (Narrative), OneCare states that BCBSVT's 2019 ASO and large group self-funded program, which included $3.25 PMPM and $100 PMPY payments to primary care providers who met certain requirements, did not qualify as a scale target ACO initiative. On page 6, you state that the 2020 program will qualify as scale target.

   OneCare will be contracting with Blue Cross directly and actively working on the design and documentation of a program for Blue Cross's self-funded clients and large groups. Blue Cross will hold agreements with its administrative services clients and large groups. The questions involving the relationships between Blue Cross and its customers (3a, 3c and 3d) are properly directed to Blue Cross.

   a. To fulfill the scale target initiative shared savings requirements, is OneCare's plan for the individual self-insured businesses to directly share savings and losses with OneCare or will shared savings and losses be settled with BCBSVT and only passed down to the business members through actual FFS claims and/or through a per member per month fee?

      See Above

   b. Are any other details of the structure of the program known that aren't included in OneCare's 2020 budget submission such as monthly fees?

      No, the budget includes the latest understanding, but contract negotiations are ongoing.

   c. Will ASO groups and large groups be informed that they are joining OneCare? If yes, when?

      See Above

   d. Is ACO participation mandatory for ASO and/or large groups (e.g. a contractual obligation) or do they opt-in to the program on a case by case basis?

      See Above

***Medicare***

4. In 2018, based on appendix 4.4 "Total Shared Savings / (Loss)," Medicare appears to be successful with a $13 million savings.
   a. Please itemize specific actions which led to this $13 million savings.

      The result is achieved through a totality of coordinated efforts that range from data collection and analysis to Care Team meetings to the design of a reimbursement and risk sharing methodology.

   b. Please estimate the amount of savings realized due to factors outside of OneCare's control such a random volatility or macro trends in utilization?

Because OneCare has only one year of experience in the Medicare risk program linked to the Vermont All Payer Model, sufficient data are not available to accurately assess the impact factors outside of OneCare's control that contributed to the 2018 result.

***Health Service Areas***

5. Please complete the below provided table.

   OneCare's quality scores are determined at the ACO-level, not the HSA-level, based on attributed lives provided by the payers. As part of the quality scoring process, Payers calculate the claim-based measures at the ACO-level and include data such as opt-outs and confidential claims which are unavailable to OneCare, thus OneCare is unable determine an overall quality score at the HSA-level. Similarly clinical measures samples are determined by payers at the ACO-level and thus may not be valid approximations at the HSA-level due to small or varying sample sizes from year-to-year. See additional information provided in OneCare's response memo to the GMCB. Similarly, "Shared Savings" are earned at the ACO level. OneCare then utilizes a methodology set forth in policy to calculate an amount owed to or from network participants. These settlement figures include a number of components such as risk corridor constraints, HSA maximum risk limits, cross-HSA pooling, sharing terms with payers, and risk mitigation arrangements. Therefore they do not represent the singular shared savings figure requested.

| Health Service Area | 2018 Actual Medicaid Shared Savings | 2018 Actual Medicare Shared Savings | 2018 Actual Commercial Shared Savings | 2018 Medicaid Quality Score |
|---|---|---|---|---|
| Bennington | | | | |
| Berlin | | | | |
| Brattleboro | | | | |
| Burlington | | | | |
| Lebanon | | | | |
| Middlebury | | | | |
| Newport | | | | |
| Randolph | | | | |
| Rutland | | | | |
| Springfield | | | | |

| St. Albans | | | | |
|---|---|---|---|---|
| St. Johnsbury | | | | |
| **Total** | | | | |

***Quality Results***

6. We are interested in how changes in attribution impact OneCare's year to year quality scores and what that can tell us about the challenges Vermont faces in different health service areas.

   a. Please estimate to what extent the lower quality scores for your Medicaid program between 2017 and 2018 were due to changes in patient and provider attribution. Please provide evidence to support your response.

      OneCare achieved an overall quality score of 85.0% in the Medicaid program for both 2017 and 2018. The patient and provider attribution increased substantially from 2017 to 2018 with the addition of six new HSAs. Examining individual quality measure scores, variation was approximately 1% for most measures. This represents a small number of patients, often less than 10. As OneCare's network gains scale, year-over-year comparisons will become more valid as long as measures and their definitions remain stable as well.

   b. Is the difference in quality scores attributable to the HSAs that joined in 2018? Please provide evidence to support your response.

      As noted above, the quality score remained consistent in the Medicaid program from 2017 to 2018. Please see responses to GMCB questions for further information.

***Attribution***

7. We are interested in better understanding the barriers to entry/participation that OneCare details on Narrative page 14.

   a. OneCare lists multiple barriers that impeded expansion of the ACO in 2019 and which will need to be addressed for expansion to be realized in the future. One of these barriers is "payer data availability/accuracy/timeliness." Please provide the specific issues related to payer data availability, accuracy, and timeliness including, but not limited to, which payer(s) the issue(s) applies to.

      One challenge affecting network recruitment is that OneCare does not have final attribution or benchmark data at the time participation decisions are due. OneCare continues to work collaboratively with payers to ensure accurate data are available as soon as possible. Additionally, each year of programs participation adds valuable data that can help stabilize projections and advance timing. In addition, Blue Cross transitioned to a new operating system in 2019 which caused claims processing issues and resulted in delayed data flow to OneCare. Blue Cross and OneCare believe they have resolved the issues.

b. That same list of barriers impeding expansion includes "hospital board education." Please list the activities OneCare has planned for the budget year to educate hospital boards about OneCare and ACO participation options. Please also provide the top 5 issues that you believe need to be included in effective hospital board education.

   OneCare, at the request of its participant organizations, has already begun active board education to help ensure the governing bodies of network participants are informed and have the opportunity to ask questions and provide insight. Common discussion topics include general ACO program understanding, downside risk and risk mitigation strategies, funding for reform efforts, statewide commitment to the All Payer Model, and future risks and challenges to the State's All Payer Model agreement.

8. Narrative page 13 includes a growth chart which shows variation in attribution "opportunity" by health service area. Has OneCare assessed how changes in population mix due to increasing attribution will impact its risk contract results and if there will be financial impacts due to OneCare's expanded geographic footprint?

   Changes in population mix can have material impacts on spending benchmarks. These are analyzed each year as part of the actuarial process that determines the appropriate spending targets. Despite changes to the underlying population of attributed lives, the OneCare network remains committed to the All Payer Model state wide population health approach and achieving scale targets by growing the network.

***Affordability***

9. OneCare states on Narrative page 8 that "OneCare's providers have become innovators driving toward…. affordability."

   a. Please provide the definition of "affordability" as used in the above cited sentence.

      OneCare is working as a vehicle to support the goals under the ACO-APM that was signed by the State of Vermont and CMS.

   b. Please provide empirical support for the proposition that OneCare providers are driving affordability.

      OneCare's Budget narrative stated, in full: "OneCare's providers have become innovators driving toward excellence in healthcare quality, person-centeredness, and affordability", not that they are "driving affordability." In furtherance of these goals, OneCare providers have entered into two-sided value-based contracts and taken on financial accountability for the healthcare cost of Vermonters. These types of value based contracts have the potential to curb increases to healthcare costs systemically and on the individual level.

   c. Please describe how OneCare providers are addressing "affordability" from a consumer's perspective (i.e. costs experienced by the patient as opposed to aggregate affordability measures at the system-scale).

      See "A" above

***Population Health Management***

10. In the same format as the table on Narrative pages 56 through 58, please provide the top five most expensive conditions as measured by unit price multiplied by utilization. Please provide this data by payer and by HSA.

    OneCare does not produce these analyses.

11. Based on the information presented on Narrative page 27, it appears that under 25% of the budget is going to clinical programs.

    a. As OneCare establishes its information technology infrastructure, what are its long term goals of increasing clinical program investments?

       Clinical investments are critically important to success within the APM and OneCare's goals are to increase investments in those programs. At the same time, high quality data are always necessary to monitor performance and drive change and even established IT infrastructure requires significant fixed costs (see b below). Additional, non-hospital funding is needed to maximize clinical program investments. OneCare reviews the portfolio of population health investments on an ongoing basis through its Finance Committee, Population Health Strategy Committee and the full Board of Managers as part of the annual budgeting process. One of the core objectives is for the long term strategy is to integrate clinical supports and data analytics for the overall population attributed to OneCare.

    b. Does OneCare expect to be able to spend less on software and analytics and, due to that, more on direct services and/or community support to ACO members in the future?

       Many of OneCare's IT expenses represent fixed costs under existing lifecycles while others are subject to increases as expenses are tied to the number of attributed lives under OneCare's population health management programs. Thus, we anticipate that some IT expenses will increase as more Vermonters are aligned to the APM, but not necessarily in proportion to attribution growth.

12. On Narrative page 47, OneCare presents the table Encounters by Type.

    a. Please provide the number of patients for each care coordination level of severity.

       We interpret this question to ask the number of patients in each level of OneCare's population health model. We have provided this information by payer.

OneCare Vermont

| Patient Count by Payer and Risk Level | | | | | |
|---|---|---|---|---|---|
| **Payer** | **Very High Risk** | **High Risk** | **Medium Risk** | **Low Risk** | **Total** |
| Medicare | 3,442 | 5,771 | 23,235 | 26,334 | 58,782 |
| Medicaid | 4,729 | 7,898 | 31,596 | 34,781 | 79,004 |
| BCBS | 1,200 | 2,000 | 8,035 | 8,844 | 20,079 |
| **Total** | **9,371** | **15,669** | **62,866** | **69,959** | **157,865** |

b. Please provide the total number of individuals OneCare has engaged in care coordination and active care management by payer.

Note: these rates change daily; the table below represents updates since OneCare's initial 2020 Budget submission, thus the totals are higher than the original submission and represent the ongoing growth in care coordination supports for Vermonters.

| Payer | Patients Engaged in Care Coordination (defined as any activity in Care Navigator | Patients Actively Care Managed |
|---|---|---|
| Medicare | 5,308 | 1,166 |
| Medicaid | 5,388 | 1,665 |
| BCBSVT QHP | 530 | 92 |
| OneCare Total | 11,226 | 2,923 |

13. On Narrative page 48, OneCare states that it has ceased using mental health and substance use metrics due to data tracking and timeliness issues. Given that mental health issues were identified as a top issue in each HSA, that the opioid epidemic continues to play a major role in Vermont, and that the All Payer Model requires progress in substance use treatment and suicide prevention, does OneCare have current plans to develop new metrics or other ways of tracking progress towards the All Payer Model's mental health and substance abuse treatment goals?

The narrative on page 48 referenced OneCare's lack of ability to use mental health and substance use metrics as clinical priority area metrics that it tracks and measurers itself. However, those same metrics are core metrics under OneCare's quality measurement performance with payer contracts for which the data are gathered and reported annually by each payer in aggregate across the ACO network. OneCare has increased its focus on mental health and substance use in 2019 and has used our innovation fund mechanism to address a number of mental health and substance use programs in health service areas in Bennington, Brattleboro, and Burlington. In collaboration with Vermont Care Partners, OneCare is in the process of contracting for additional supports in four more health service areas. We anticipate these additional programs will begin in December 2019. Each of these programs has specific metrics that will be monitored over time at the local level with aggregate reporting to OneCare.