



2019 Vermont Medicare ACO Initiative Benchmark for OneCare Vermont

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OneCare Vermont's FY 2019 Budget and Payer Programs

December 17, 2018

2019 Vermont Medicare ACO Initiative Benchmark for OneCare Vermont

Follow-up from 12/12: Vermont Medicare TCOC per Beneficiary Growth

Target

Based on national projections
in advance of performance
year

$$\begin{aligned} &= (1.037 * 1.040)^{\frac{1}{2}} - 1.002 \\ &= 3.7\% \end{aligned}$$

Performance (ACO-only)

Based on ACO actuals
compared with hypothetical
comparison population (based
on same provider network)

$$\begin{aligned} &= (0.984 * 1.038)^{\frac{1}{2}} - 1.00 \\ &= 1.1\% \end{aligned}$$

Follow-up from 12/12: Vermont Medicare TCOC per Beneficiary Growth

$$\sqrt{0.984 * 1.038} - 1 = 1.1\%$$

Estimated ACO
spending in 2018
(through June)
versus estimated
hypothetical
comparison
population in 2017.

If ACO were to
grow at 3.8% when
comparing actual
2019 spending to
hypothetical
population in 2018.

2019 Vermont Medicare ACO Initiative

Benchmark for OneCare Vermont

- Staff recommend approving the 2019 Vermont Medicare ACO Initiative benchmark for OneCare using trend rates of 3.8% for the Aged and Disabled component and 3.1% for the End-Stage Renal Disease component.
 - The recommended rates are within parameters set by the All-Payer ACO Model Agreement and, based on our best estimates, would not cause the State to exceed the Medicare growth target.
 - Savings generated in early years of the model could help offset the additional risk that would come with increasing scale or allow for investments in care transformation.
 - With the high levels of risk in the Medicare program, early successes may help increase participation.

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Follow-up from 12/12: Public Comments

- 33 Public comments received. Themes included
 - Support for continued ACO investments in prevention, primary care, home health, mental health and other services provided in communities;
 - Suggestions for alternatives to the All-Payer Model (e.g., single payer) and criticisms of accountable care organization programs;
 - Requests related to continued monitoring of ACO programs and expenses, including administrative costs, tools (e.g., Care Navigator), quality measures, and total cost of care;
 - Suggestions for evaluation of ACO programs and the All-Payer Model;
 - Recommendations for modifications to specific payer programs, in particular the Medicaid ACO program;
 - Consider relationship between QHP rate filing and ACO commercial trend; and
 - Ensure transparency.

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Staff recommend approving OneCare Vermont's FY2019 budget on the terms, and subject to the conditions, set forth below:

- 1) No later than 30 days after end of Q1 2019, OneCare must submit a written report to the Board which demonstrates to the Board's satisfaction that its payer programs (other than the Vermont Medicare ACO Initiative) qualify as Scale Target ACO Initiatives under section 6.b. of the All-Payer ACO Model Agreement, and which describes (a) how these programs align with the Vermont Medicare ACO Initiative in the areas of attribution methodologies, quality measures, payment mechanisms, services included in determining shared savings and losses, patient protections, and provider reimbursement strategies and (b) the rationale(s) for any differences in these areas. Thereafter, OneCare must update this report no later than 15 days after entering a new payer program covering any portion of 2019.
- 2) At times specified by the Board, OneCare must submit documents or summary information needed to prepare reports required by the All-Payer ACO Model Agreement (e.g., the Payer Differential Report).

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- 3) Approve the following 2019 benchmark trend rates
 - **Medicare:** 3.8% (3.8% for A/D and 3.1% for ESRD).
 - **Medicaid:** Within the Wakely range.
 - **Commercial:** OneCare must provide the Board with (a) actuarial certifications for each of its commercial (including self-funded) benchmarks stating that the benchmark is adequate but not excessive; (b) an explanation of how its overall rate of growth across all payers fits within the overall all-payer target rate of growth and, if its overall rate of growth exceeds the target, how it plans to achieve the target for the term of the All-Payer Model ACO Agreement (2017 to 2022); and (c) a revised budget based on the finalized benchmarks.

- 4) In developing the 2019 benchmark for the Blue Cross Blue Shield of Vermont (BCBSVT) QHP program, OneCare must base its trend figures on the ACO-attributed population and, if it is relying on the BCBSVT filing, data supporting the trend should be drawn from BCBSVT's final, ordered filing.

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- 5) The maximum amount of risk OneCare may assume for 2019 is the sum of the following: 5% of the Medicare benchmark; 4% of the Medicaid benchmark; 3% of the commercial Blue Cross Blue Shield QHP benchmark; and 1.8% of the commercial self-funded program benchmark(s). OneCare must request and receive an adjustment to its budget prior to executing a contract that would cause it to exceed these risk levels.
- 6) OneCare must provide the Board contracts that obligate each of the risk-bearing hospitals to OneCare's risk sharing policy.
- 7) OneCare must hold at least \$3.9 million in reserves by the end of 2019.
- 8) OneCare must inform the Board whether it has secured aggregate total cost of care protection for Medicare or any other payer programs in 2019.

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- 9) OneCare's administrative expense ratio must be consistent with its proposed budget. If the expense ratio increases by more than one percent (1%) from the budget, OneCare must promptly inform the Board.
- 10) OneCare must ensure that its administrative expenses are appropriately allocated by state.
- 11) OneCare must submit its audited financial statements as soon as they are available and must submit information as required by the Board to monitor OneCare's performance.

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- 12) OneCare must fund the population health management and payment reform programs/investments described in its submission at no less than 3.6% of its overall budget (i.e., within 0.5 percentage points of the targeted ratio of 4.1%) and must fund the SASH and Blueprint for Health (PCMH and CHT) investments at 2018 Medicare levels plus an inflationary rate of 3.8% in risk and non-risk communities. If the percentages are projected to be less than those required by this order by the end of 2019, OneCare must promptly alert the Board.
- 13) No later than 30 days after the end of Q3 2019, OneCare must submit a final report on its 2018 Comprehensive Payment Reform Pilot that (a) compares the 2018 quality outcomes of the pilot cohort with the non-pilot cohort; (b) analyzes how the capitated payments received by primary care practices in 2018 under the pilot compared to payments hospitals make to primary care providers that did not participate in the pilot; and (c) describes practices' experiences with the pilot (e.g., impacts on administrative burden and any clinical innovations allowed by increased flexibility and/or resources).
- 14) No later than 30 days after the end of Q2 2019, OneCare must submit an interim financial report on the 2019 Comprehensive Payment Reform Program that describes changes made to the program in 2019 and analyzes how the capitated payments received by primary care practices under the program are comparing to payments hospitals make to primary care providers not participating in the pilot.

Conditions: Programs & Investments

- 15) No later than 30 days after the end of Q3 2019, OneCare must submit a written report describing its progress in testing and implementing a variable component to the VBIF distribution methodology for 2020.
- 16) No later than 30 days after the end of Q3 2019, OneCare must submit implementation and evaluation reports for the specialist payment pilot and the community innovation fund. OneCare must work with GMCB staff regarding the subjects to be covered by the reports, which may include, for example, how the innovation fund investments balance a state-wide approach that considers regional innovation and community needs, and how the specialist pilot relates to OneCare's care model and clinical priorities.