OneCare Vermont

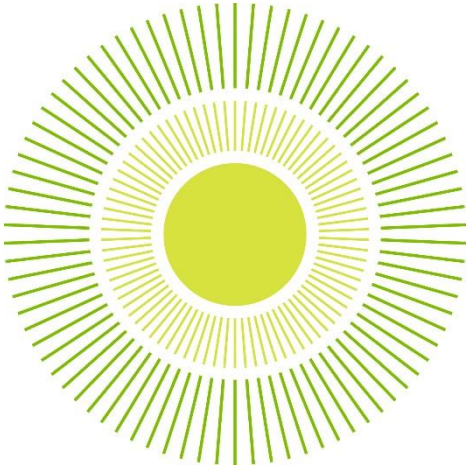
Update
For PY 2018

Joan Zipko Director, ACO Program Operations
Tom Borys Director, ACO Finance

February 27, 2019

OneCareVermont
onecarevt.org

Customer Service to Providers



OneCare Customer Service for *Providers*

Tracking, Monitoring and Reporting

- Customer service inquiries, complaints and grievances are tracked and monitored through resolution
- Reports are provided to payers and GMCB

Primary Drivers for Provider Customer Service

- Patient attribution lists and financial statements
- Prior authorization waiver for VMNG

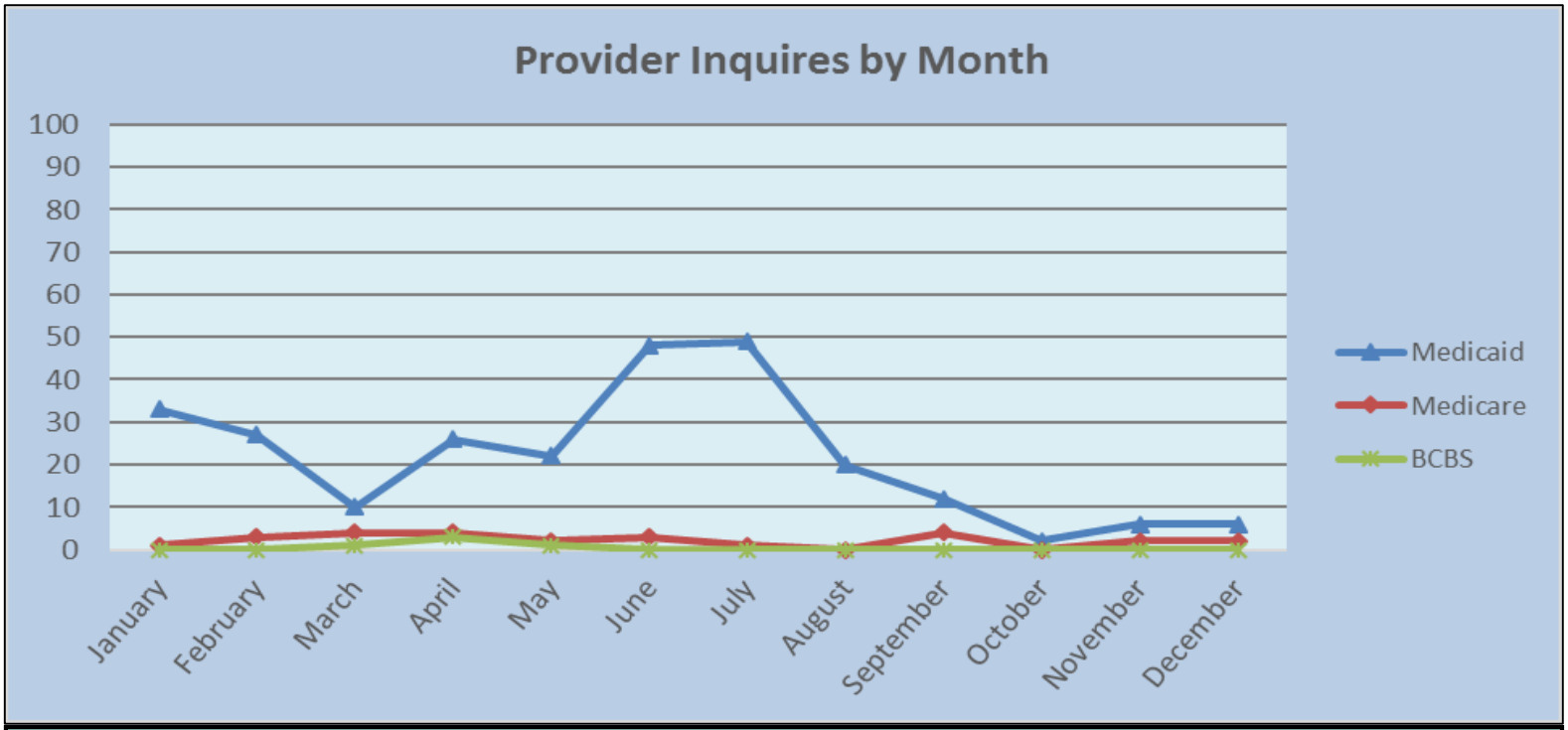
Stats: Inquiries, Complaints and Grievances

- **292** inquiries resolved to date
- **0** patient complaints received to date
- **0** patient grievances received to date

Escalation

- OneCare has a provider appeals policy should they be dissatisfied with ACO-related resolutions

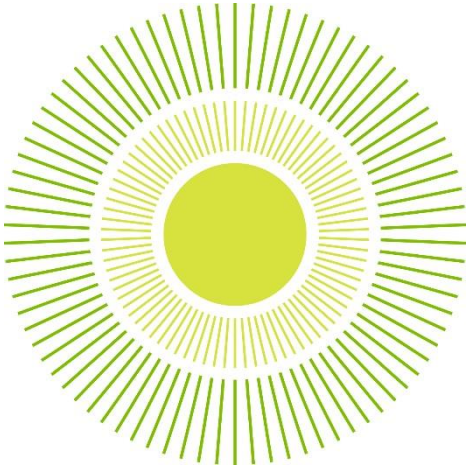
2018 OneCare Provider Inquiries



2018 Primary Drivers for Inquiries:

- Provider inquiries driven by attribution lists and financial statement questions
- Medicaid inquiries are higher due to prior authorization questions specific to that program

Customer Service to Patients



OneCare Customer Service for *Patients*

Tracking, Monitoring and Reporting

- Customer service inquiries, complaints and grievances are tracked and monitored through resolution
- Reports are provided to payers and GMCB

Primary Driver for Patient Customer Service

- ACO notification letter questions

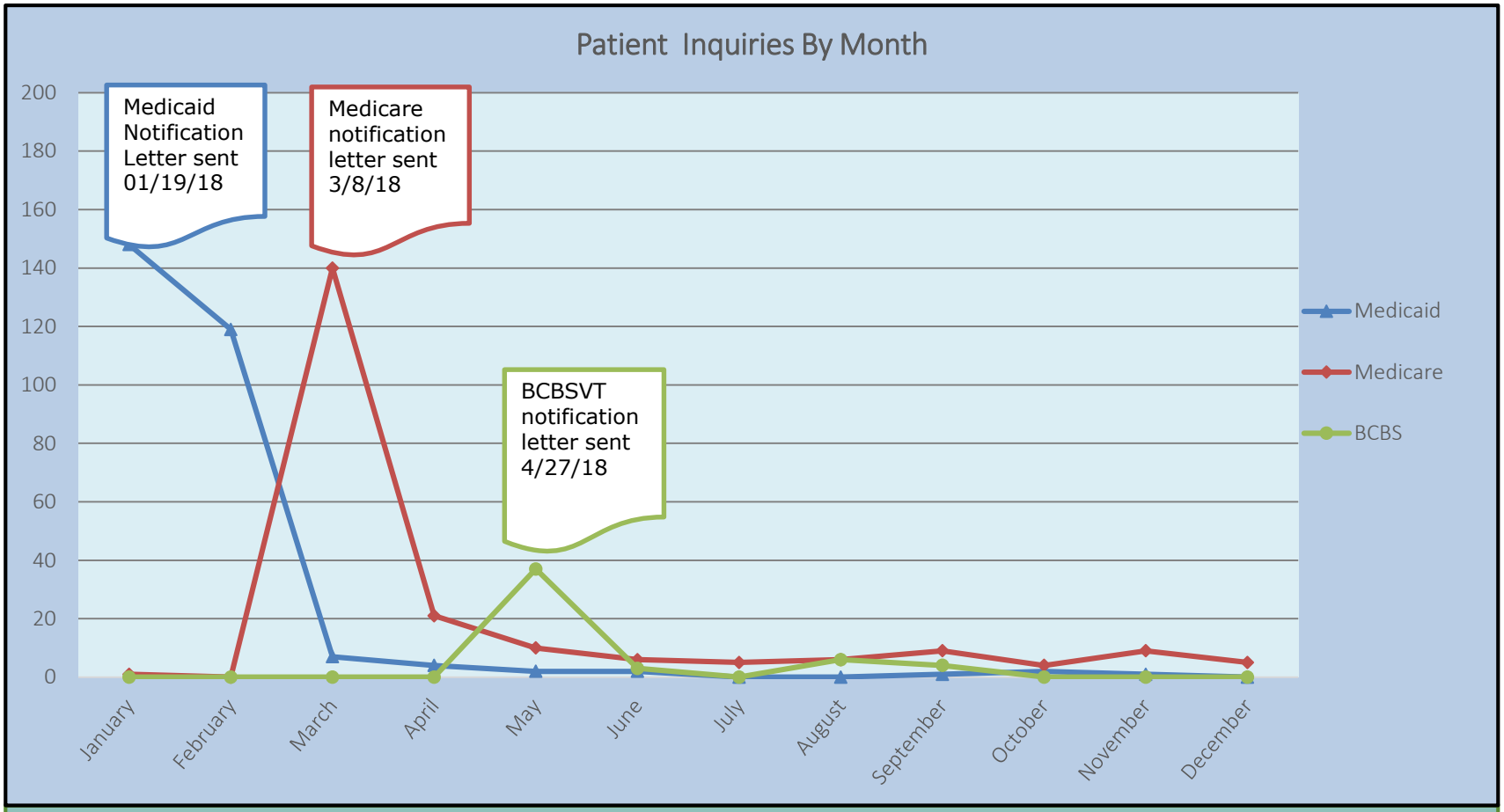
Stats: Inquiries, Complaints and Grievances

- **552** patient inquiries resolved to date
- **19** patient complaints resolved to date
- **0** patient grievances received to date

Escalation

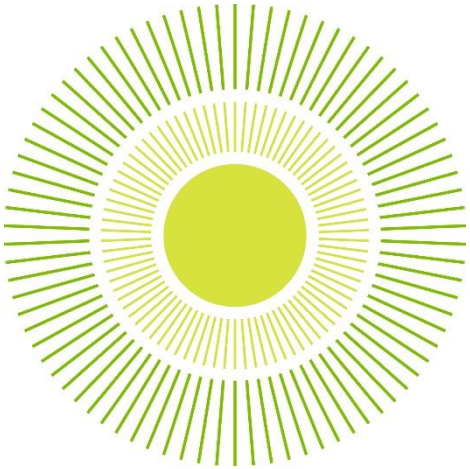
- Patients are offered the option to file a formal grievance if the complaint is not readily resolved to their satisfaction
- Contact information for the Health Care Advocate is provided for additional support to the patient

2018 OneCare Patient Inquiries



Primary Drivers for Patient Inquiries: Education to support the notification letters

Patient Notification Letter
Opt Outs and Improvements



Patient Notification and Opt-Out

- Newly attributed patients receive a letter at the start of the performance year to notify them that their provider participates with OneCare
- Patients may opt-out of having their claims data shared with OneCare but may not opt-out of being attributed to OneCare
- If a patient opts-out of data sharing:
  - OneCare remains accountable for the patient's costs and quality of care
  - Limited data sharing may still occur for improvement purposes (e.g., quality measure reporting)

Patient Notification and Opt-Out by Payer

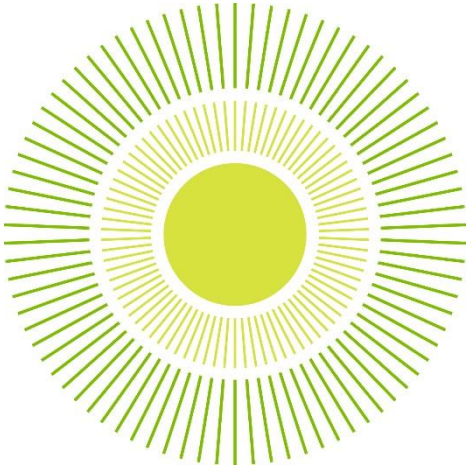
	Medicaid	Medicare	BCBSVT
Timing	Mailed January 4, 2019	Mailed February 8, 2019	April 2019 (Anticipated)
Opt-out Offered in Letter?	Yes, letter explicitly states that the patient has the right to opt-out of data sharing	No, letter does not provide opt-out information. Opt-out info is provided in the Medicare Benefits Manual that patients receive yearly	Yes, letter explicitly states that the patient has the right to opt-out of data sharing
2018 Patient Opt-Out Rates	1.12%	0.85%	0.04%

Optimizing Patient and Provider Communication

- **Improved Patient Communication**
  - **Wide Collaboration:** Worked with payers, providers, Health Care Advocate and patients to improve comprehension for the patient notification letter
  - **All Payer:** Provided a patient notification that aligns across payers, written in 6th grade language
  - **New ACO Fact Sheet:** Supported by a clear fact sheet that covers most patient questions and concerns
  - **Communication**: Proactively shared the letter and fact sheet with our providers to better support patient questions

- **Improved Provider Notification**
  - Proactively shared the final letter and patient fact sheet in advance of patient mailing to all network providers via:
    - **Network News** – sent monthly to all network providers and organizational contacts
    - **Email** – sent to Executive, Operational, and Financial contacts at each organization
    - **Provider Portal** – available to all network providers

Reference



OneCare Customer Service Definitions

Inquiry:

- A routine communication requesting information that is within the general scope requesting a routine action

Complaint:

- A communication that requires the ACO to take an action to resolve concerns. Examples of ACO complaints include data sharing, an ACO Policy, etc.

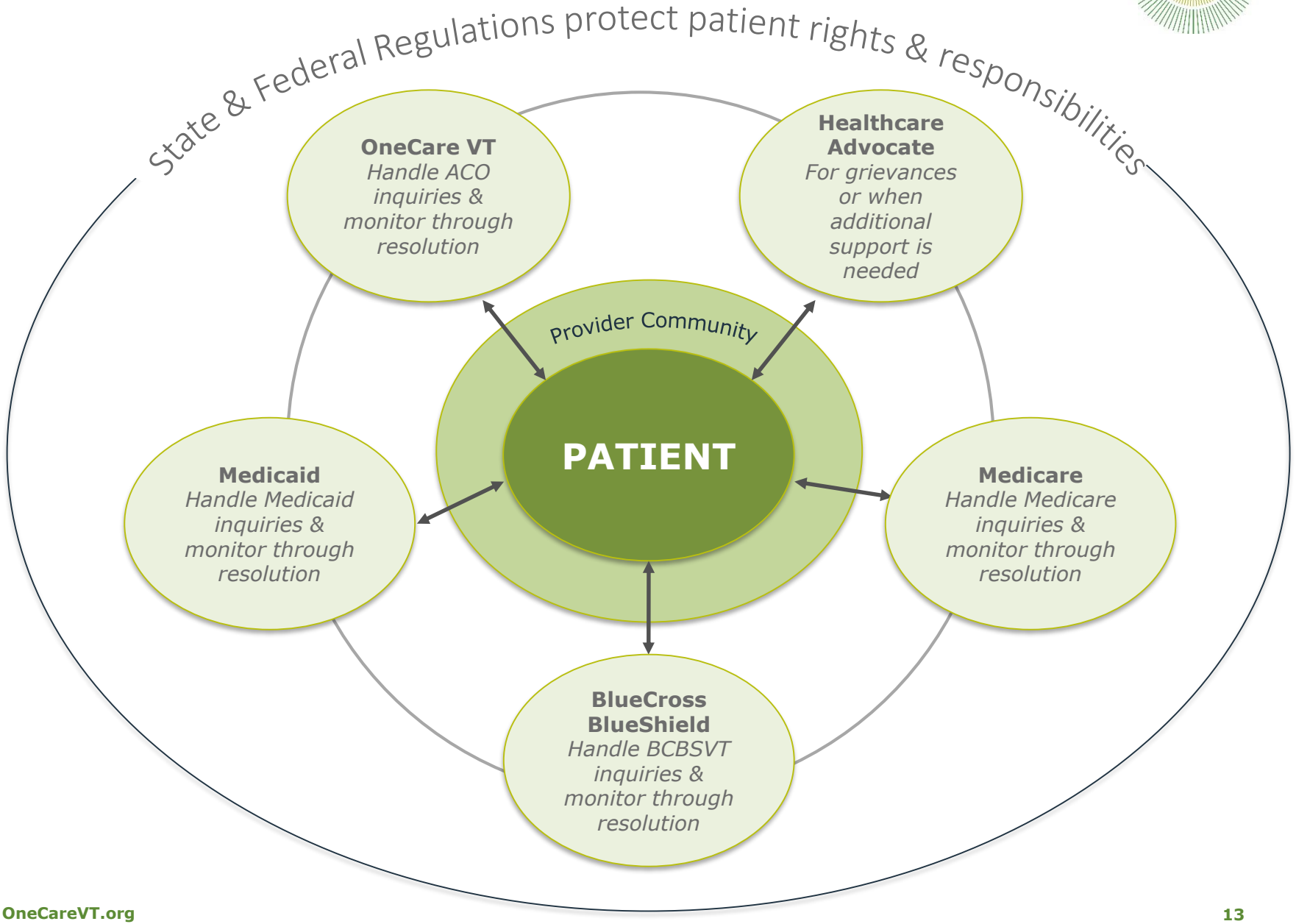
Grievance:

- A complaint that is not resolved through discussion with the ACO when first presented, and is elevated to senior leadership of the ACO, the payer, and/or the Health Care Advocate

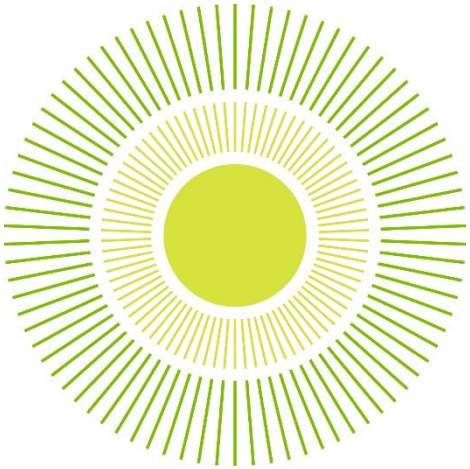
Appeal:

- Since OneCare is not an insurance company, there is no Appeals process for patients at the ACO when overturning decisions such as benefits or coverage. Patients would work with payers and/or HCA to appeal
- For providers, there is an appeals policy and process should they be dissatisfied with ACO-related resolutions

ACO Customer Service Support System for Patients



2018 Budget Order Amendment Request



Context

- 2018 – first year of the All-Payer Model (APM) and the first ACO budget submission to the GMCB
- Budget submission included significant overall growth and evolution of programs across multiple payers
- The timing and availability of accurate data was a significant challenge when developing the 2018 budget (especially in the first year of the APM)
- Overall, 2018 operations were executed in alignment with the approved budget model, but some numbers did change

Order F.4.: Reserves

Order F.4. Establish reserves of $1.1 million by July 1, 2018 and $2.2 million by December 31, 2018

- The budget model presented to the GMCB did not incorporate a reserve component (modeled as break-even)
- Budget also didn't foresee the Medicare financial guarantee of $4.125M
- Due to some changes to attribution/program rollout, modeling suggested the possibility of complying without invoicing hospitals additional par fees to fund the reserve
- Met the July 1st milestone without the need for a separate invoice to hospitals
- Margins declined in the second half
  - Increased legal and actuarial costs (commercial program negotiations)
  - Ramp up of RiseVT
  - Attribution attrition
  - Interests costs related to Medicare financial guarantee

Order F.4.: Reserves

Request: Amend reserve requirement to $1.4M by December 31, 2018

- Avoids the need to invoice the hospitals for the remaining balance
  - Sensitive to asking for additional funding
  - The 2019 budget included a reserve component in the estimated participation fees, which allowed for more appropriate planning/budgeting
- 2019 reserve requirement will provide for adequate protection and fulfillment of risk mitigation arrangements
- 2019 will also require a Medicare financial guarantee

Order H: PHM Ratio

Order H. OneCare must fund its other population health management and payment reform programs—Value-Based Incentive Fund, Basic OneCare PPM, Complex Care Coordination Program, PCP Comprehensive Payment Reform Pilot, and RiseVT—at no less than 3.1% of its overall budget. The Board will monitor this ratio throughout the year to ensure it does not decrease below 3.1%. If the percentage decreases, OneCare must promptly alert the Board.

- All programs have been rolled out in the design of the budget presentation, however, for a number of reasons the actual PHM spending ratio has been lower
  - Currently projecting ~2.5%

Order H: PHM Ratio

- Measurement is calculated based on the overall budget, which includes TCOC benchmarks (also a variable)
- Blueprint replacement funding is excluded from the eligible PHM expenses
- Current Pre-Audit Estimates:
  - Total overall budget - $626,816,000
  - Total eligible PHM expense - $15,481,260

Investment	YTD Actual	YTD Budget	$ Var	% Var
Basic OCV PMPM	$3,990,100	$4,781,010	$790,911	16.5%
Care Coordination Program	$5,633,580	$7,064,722	$1,431,142	20.3%
Comprehensive Payment Reform Pilot	$715,806	$1,800,000	$1,084,194	60.2%
Value-Based Incentive Fund	$4,243,973	$4,305,223	$61,250	1.4%
Community Program Investments	$897,801	$1,577,600	$679,799	43.1%
Total	**$15,481,260**	**$19,528,555**	**$4,047,295**	**20.7%**

Order H: PHM Ratio

- **Care Coordination**
  - Reduction in spending driven by two primary factors
    - Lower than expected attribution
    - Delay to the start of the UVMMC self-funded program
- **Comprehensive Payment Reform Pilot**
  - Budget was developed to accommodate 10 sites
  - Three joined (two of which were the biggest in the modeling set)
  - Budget variance reflects the reduced number of practices
- **Value Based Incentive Fund**
  - On budget – driven by program contract terms
- **Community Program Investments**
  - Includes HC/SASH program, Regional Clinical Representative Payments, and RiseVT
  - Budget variance driven by the ramp-up of the statewide RiseVT roll-out
    - Timing of community-based program coordinators
    - Escalation of Amplify Grants

Order H: PHM Ratio

Request: Amend PHM Ratio to 2.5% with a variance materiality threshold

- All programs have been operationalized in alignment with the budget submission
- Changes to attribution, participation, and the timing of program roll-out resulted in some variance to budget
- In some cases, savings contributed to reserves, thus avoiding increases to hospital invoices