VERMONT

Green Mountain Care Board
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MEMO
RE: Medicare Trend Factor and OneCare Vermont Votes
To: Green Mountain Care Board Members
From: Green Mountain Care Board Staff
Date: December 21, 2017

Background

Per Act 113, the Green Mountain Care Board (the Board) is charged with reviewing, modifying, and approving the budgets of Accountable Care Organizations (ACOs)[1] with attributed lives in Vermont. Fiscal Year 2018 (FY18) ACO budgets are the first to be subject to Board review. Secondly, per the All-Payer Accountable Care Organization Model Agreement, the Board must prospectively develop the Vermont Medicare ACO Initiative Benchmark (Medicare Trend Factor below) for Performance Year 1 of the Agreement.

Please find below the following items we are requesting you provide a vote on today. For your reference, the Board received initial recommendations during a presentation on December 12, 2017. Recommendations that have been added since that time may be found in bold.

Medicare Trend Factor Vote

We recommend the Board submit to CMMI for approval:

1) A 3.5% trend factor for the Vermont Modified Next Generation ACO Program Medicare Benchmark. This provides for investments at the start of the Performance Period that may be essential to achieving savings in later years. And, it is a significantly lower rate of growth per capita than the trend suggested by preliminary data for aligned beneficiaries.
2) Use pay-for-reporting approach to quality in 2018, consistent with first year approach in Medicare Next Gen ACO program and prior CMMI initiatives. If ACO successfully reports on quality measures, it would receive full payment.

OneCare Vermont Budget Vote

We recommend approving OneCare Vermont's FY18 budget subject to the following conditions:

Overall Budget

1) By the end of the month following the close of each quarter, OneCare must submit to the Board the actual year-to-date FY18 operating results for the quarter. OneCare must comply with any other monitoring and/or reporting requirements implemented by the Board.

[1] An "Accountable care organization" or "ACO" is defined in 18 V.S.A. § 9571 as "an organization of health care providers that has a formal legal structure, is identified by a federal Taxpayer Identification Number, and agrees to be accountable for the quality, cost, and overall care of the patients assigned to it."

Payer Contracts

2) OneCare must submit each payer contract, Medicare, Medicaid, Commercial, to the Board promptly after it is executed.

3) No later than the end of the first quarter of 2018, OneCare must submit a written report to the Board demonstrating to the Board's satisfaction that the BCBSVT and UVMMC programs qualify as Scale Target ACO Initiatives under section 6.b. of the APM Agreement.

4) No later than the end of the first quarter of 2018, OneCare must submit a report to the Board that describes how its contracts with BCBSVT and UVMMC align with the Medicare contract in the areas of total cost of care; attribution and payment mechanisms; patient protections; provider reimbursement strategies; and quality measures, and that explains the rationale for any differences in these areas.

Rates of Growth

5) 3.5% for Medicare

6) 3.5% for Commercial

7) 6.1% for Medicaid (1.5% after All-Payer TCOC calculation exclusions)

8) OneCare must submit to the Board an updated P&L after attribution has been finalized and the benchmarks for all payer programs have been calculated.

Risk Levels

9) The maximum amount of risk OneCare may assume for 2018 is the sum of the following: 4% of the Medicare benchmark; 3% of the Medicaid benchmark; and 3% of the commercial benchmark. OneCare must request and receive an adjustment to its budget prior to executing a contract that would cause it to exceed these risk levels.

Risk Delegation Strategy

OneCare must implement the delegated risk model it described in its budget proposal, except that it must:

10) Provide the Board by January 15, 2018, contracts that obligate each of the risk-bearing hospitals to OneCare's risk sharing policy;

11) Provide the Board by January 15, 2018, a policy approved by OneCare's Board of Managers which delegates risk to the risk-bearing hospitals in the manner described in OneCare's budget filings;

12) Provide the Board with irrevocable letters of credit from OneCare's founders committing to cover risk-share for Brattleboro Memorial Hospital and Springfield Hospital;

13) Establish reserves of at least $1.1 million by July 1, 2018 and at least $2.2 million by December 31, 2018; and,

14) Notify the Board promptly regarding its intent to purchase aggregate total cost of care reinsurance for 2018.

Primary Care and Population Health Investments

15) OneCare must fund SASH and Blueprint for Health payments (CHT and PCP) at 2017 levels plus an inflationary rate of 3.5% in both risk and non-risk communities, as described in the proposed budget.

16) 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 Rise VT—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.

17) No later than the end of the second quarter of 2018, OneCare must submit a payment differential report that describes its Comprehensive Payment Reform Pilot's payment methodology and analyzes how the capitated payments for primary care services under its program compare to the payments hospitals make to primary care providers that are not participating in the pilot. The report should also address how the Comprehensive Payment Reform pilot reduces administrative burden for primary care providers.

18) No later than the end of the second quarter of 2018, OneCare must report to the Board on the number of Medication Assisted Treatment providers in its network and update the Board on its network's capacity for substance use disorder treatment at all levels of care (including preventive care).

Administrative Expenses

19) OneCare must ensure that its administrative expenses are appropriately allocated by state (i.e., between VT and NY).

20) 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.

21) OneCare's administrative expenses should be less than health care savings generated through the All-Payer Accountable Care Organization Model.

Consumer Protections

22) OneCare must consult with the Office of the Health Care Advocate to establish a grievance and appeals process consistent with Rule 5.000 and submit to the Board a final policy that applies to all aligned beneficiaries.

23) In consultation with GMCB staff, identify a pathway by which potential savings from this model will be returned to participating commercial premium rate payers, initially focusing on those individuals with qualified health plan (QHP) coverage through Vermont Health Connect.