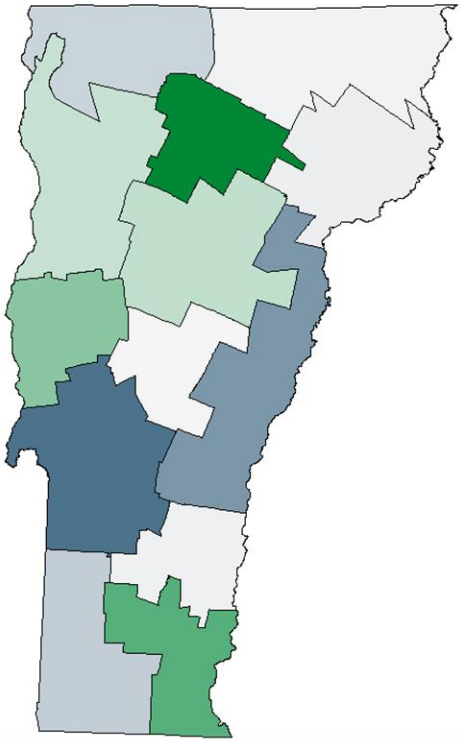

GMCB Review of FY 2019 ACO Budgets and Payer Programs

November 14, 2018

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Agenda

1. Review proposals for quality withhold and operational changes for the 2019 Vermont Medicare ACO Initiative (potential votes).

2. Review revisions to the 2019 ACO budget review and Medicare benchmark timelines.

3. Review requirements of the All-Payer ACO Model Agreement and how they relate to OneCare's 2019 budget.

4. Present preliminary staff observations on OneCare's 2019 budget.

2019 Vermont Medicare ACO Initiative: Quality Framework

Background

- APM Agreement requires Vermont Medicare ACO Initiative to include a linkage between payment and quality of care and/or health of the population (begins in 2019):

> "A Scale Target ACO Initiative is an ACO arrangement offered by . . . Medicare FFS (e.g., Vermont Medicare ACO Initiative, Next Generation ACO Model, Medicare Shared Savings Program) to a Vermont ACO that incorporates, at a minimum, the following:
>
> > iv. **The ACO Benchmark, Shared Savings, Shared Losses, or a combination is tied to the quality of care the ACO delivers**, the health of its aligned beneficiaries, or both (Vermont All-Payer Accountable Care Organization Model Agreement, section 6.b.)."

Progress on Measure Set

- Measure set has been established:
  - GMCB staff worked with OneCare and HCA to develop proposed consensus measure set.
  - CMMI reviewed and approved the proposal.
  - After presentation by GMCB staff and public comment period, the Board voted to approve the measure set on July 11, 2018.

GMCB-Approved Measures for 2019 Vermont Medicare ACO Initiative

Measure	APM	BCBSVT	Medicaid
Tobacco use assessment and cessation intervention	Yes	No	Yes
Screening for clinical depression and follow-up plan	Yes	Yes	Yes
Diabetes: HbA1c poor control (ACO composite)	Yes	Yes	Yes
Hypertension: controlling high blood pressure (ACO composite)	Yes	Yes	Yes
All-cause unplanned admissions for patients with multiple chronic conditions (ACO composite)	Yes	No	Yes
30-day follow-up after discharge from ED for mental health	Yes	Yes	Yes
30-day follow-up after discharge from ED for alcohol or other drug dependence	Yes	Yes	Yes
Initiation of alcohol and other drug dependence treatment	Yes	Yes	Yes
Engagement of alcohol and other drug dependence treatment	Yes	Yes	Yes
Influenza immunization	No	No	No
Colorectal cancer screening	No	No	No
Risk-standardized, all-condition readmission	No	No	No
Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient experience surveys*	Yes	Yes	Yes

Next Steps

Need to develop and approve Medicare quality framework that specifies how quality performance will be linked to payment:

- Which measures will impact payment from Medicare to ACO?
- How will ACO performance on those measures impact the amount of payment from Medicare to the ACO?

Opportunity to Align Medicare Quality Framework with Medicaid and Commercial Frameworks

"CMS, in collaboration with Vermont, shall design and launch the Vermont Medicare ACO Initiative to begin on January 1, 2019, and its performance period will align with Performance Years 2 through 5 of this Agreement…**The GMCB may propose modifications to the Initiative to better align the Initiative with ACO programs operated by Vermont Medicaid, Vermont Commercial Plans, and participating Vermont Self-Insured Plans.** CMS may accept such proposals at its sole discretion." *(Emphasis added)*

Progress on Quality Framework

Process similar to Medicare measure set development used to develop Medicare quality framework:

- GMCB staff worked with OneCare and HCA to develop proposed quality framework.
- CMMI has reviewed and approved the proposal.
- Now seeking Board review and approval of proposal.

Key elements of proposed quality framework include:

- Withhold percentages for Value-Based Incentive Fund
- Identification of payment measures
- Scoring performance on payment measures
- Distribution of VBIF based on quality score

Proposed VBIF and Withhold Percentages

Establishes Medicare Value-Based Incentive Fund (VBIF) that aligns with Medicaid and Commercial programs:

- Withhold at percentages outlined in below table
- Funds distributed from VBIF based on quality scores
- Unearned funds to be reinvested in performance improvement activities to address gaps in care

Performance Year	Payment Period	Quality Withhold Percentage
PY2: 1/1/19-12/31/19	Summer 2020	0.5%
PY3: 1/1/20-12/31/20	Summer 2021	1.0%
PY4: 1/1/21-12/31/21	Summer 2022	*
PY5: 1/1/22-12/31/22	Summer 2023	**

*To be set in PY2

** To be set in PY3

Identification of Payment Measures

Quality Measure	Performance Years 2-3	Performance Years 4-5
Tobacco use assessment and cessation intervention	Payment	Payment
Screening for clinical depression and follow-up plan	Payment	Payment
Diabetes HbA1c poor control	Payment	Payment
Hypertension: controlling high blood pressure	Payment	Payment
All-cause unplanned admissions for patients with multiple chronic conditions	Payment	Payment
30-day follow-up after discharge from ED for mental health	Reporting	Payment
30-day follow-up after discharge from ED for alcohol or other drug dependence	Reporting	Payment
Initiation of alcohol and other drug dependence treatment	Reporting	Payment
Engagement of alcohol and other drug dependence treatment	Reporting	Payment
Influenza immunization	Payment	Payment
Colorectal cancer screening	Payment	Payment
Risk-standardized, all-condition readmission	Payment	Payment
Patient Experience		
CAHPS: Getting Timely Care, Appointments and Information	Payment	Payment
CAHPS: How Well Your Providers Communicate	Payment	Payment
CAHPS: Patients Rating of Provider	Payment	Payment
CAHPS: Access to Specialists	Payment	Payment
CAHPS: Health Promotion and Education	Payment	Payment
CAHPS: Shared Decision Making	Payment	Payment
CAHPS: Health Status/Functional Status	Reporting	Reporting
CAHPS: Stewardship of Patient Resources	Reporting	TBD

Scoring Performance on Quality Measures

- Each payment measure is scored individually and carries equal weight in scoring methodology; reporting measures will not be scored.
- OneCare's performance is compared to national Medicare percentile benchmarks when available. OneCare may earn up to two (2.0) points per measure.
- The total possible points will be calculated as the number of payment measures multiplied by a maximum of two points per Payment Measure.
- Beginning in PY3 (2020), OneCare may earn points for improvement over the prior year's performance.
- OneCare may not earn more than the total possible points for performance and improvement combined.

	PY 2	PY 3	PY 4 & 5
Percent of Base Payment Allocated to Quality Incentive Pool	0.5%	1.0%	TBD
Total Possible Points	28	28	36 or 38
Improvement Points Available?	No	Yes	Yes

Impact of Performance on Scoring

ACO Performance Compared to National Benchmark	Points Per Measure Awarded in Performance Years 2-3	Points Per Measure Awarded in Performance Years 4-5
90th+	2.0	2.0
80th+	1.75	1.75
70th +	1.5	1.5
60th +	1.25	1.25
50th +	1.0	1.0
40th +	0.75	0.5
30th +	0.5	0
20th +	0	0
10th +	0	0

Distribution of VBIF Based on Quality Score

Excerpt from detailed tables in proposal:

Earned Points (Max 28)	Quality Payment Withhold Available for Distribution to Network Providers	Quality Payment Withhold Available for Reinvestment in QI Initiatives
14	0.2500400%	0.249960%
14.25	0.2545050%	0.245495%
14.5	0.2589700%	0.241030%
14.75	0.2634350%	0.236565%

Next Steps

Current Decision Points:

- Board approval of quality framework proposal, including withhold percentages for the VBIF, identification of payment measures, scoring of ACO performance on quality measures, and distribution of the VBIF based on the ACO's quality score.

Future Work:

- During PY 2 and PY 3, GMCB staff will facilitate discussions with CMMI, OneCare, and the Health Care Advocate and provide a proposal to the Board to:
    - Establish the PY 4 and PY 5 withhold percentages for the VBIF.
    - Establish the distribution of the VBIF based on the ACO's quality score.

Public Comment & Potential Vote

2019 Vermont Medicare ACO Initiative: Program Changes

2019 Vermont Medicare ACO Initiative: Program Changes

- On June 25, 2018, OneCare sent a memo to the Board requesting several operational changes to the Medicare Next Generation Program as part of the 2019 Vermont Medicare ACO Initiative.
  - Governance
  - CMS Readiness Review
  - Descriptive ACO Materials
  - Beneficiary Notice

- On August 1, 2018, the Board approved a plan to transmit OneCare's memo to CMMI.

- OneCare wants to make two changes, one to the governance requirements and the other to the beneficiary notice.

2019 Vermont Medicare ACO Initiative: Program Changes

- **Governance:**
  - New Medicare Language: "Governing Body will be comprised of at least 75% of participants and preferred providers or their designated representatives in its network."
  - Current Medicare Language: "At least 75 percent control of the ACO's governing body shall be held by Next Generation Participants or their designated representatives."

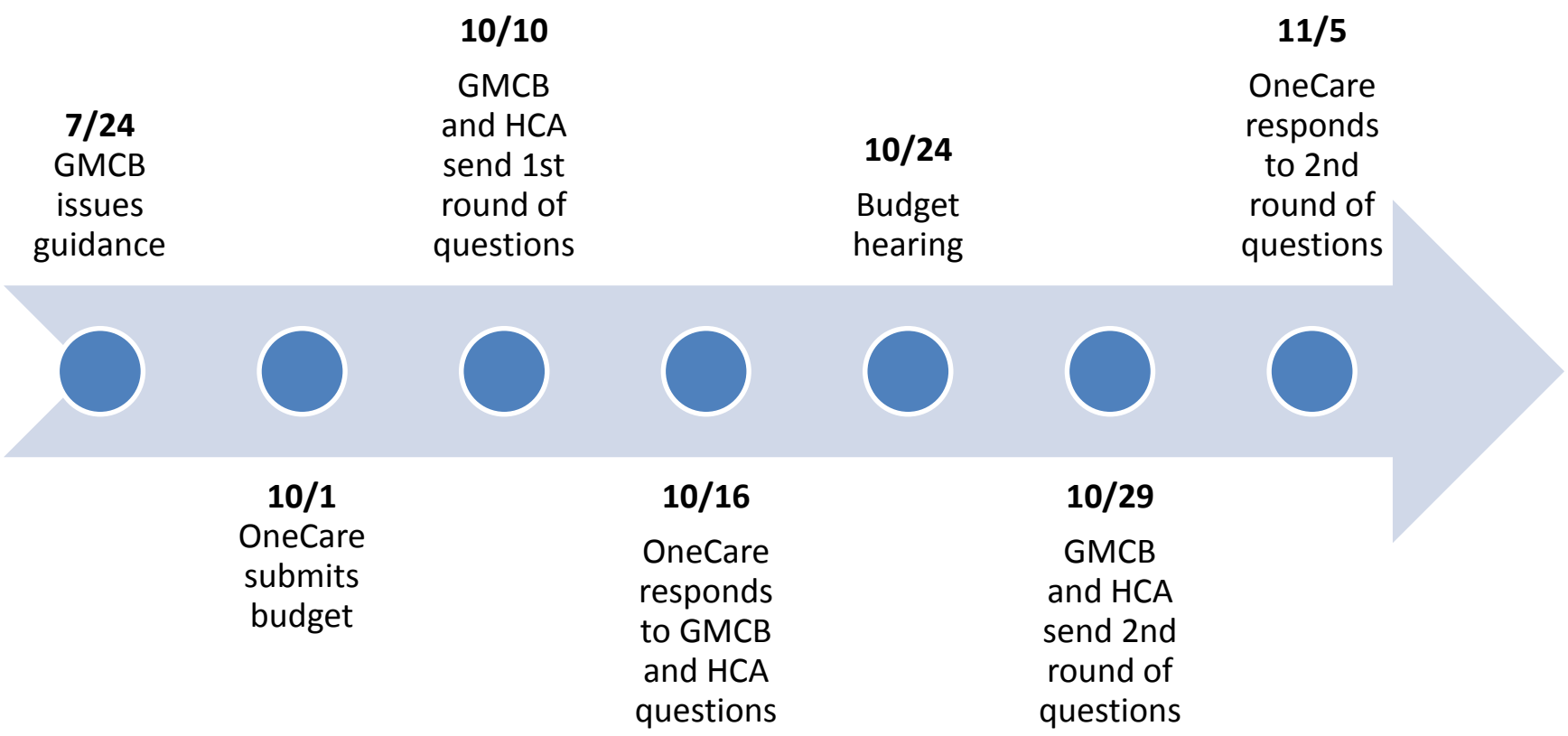
- **Beneficiary Notice and Patient Fact Sheet:** Changes to improve readability and understandability based on input from Medicare beneficiaries. Maintains basic format/coverage of prior version.

- **Decision Point:** May staff send OneCare's revised memo to CMMI with the new governance language and a new beneficiary notice and patient fact sheet?

Public Comment & Potential Vote

Timeline:
ACO Budget Review and Medicare Benchmark

Timeline: Completed



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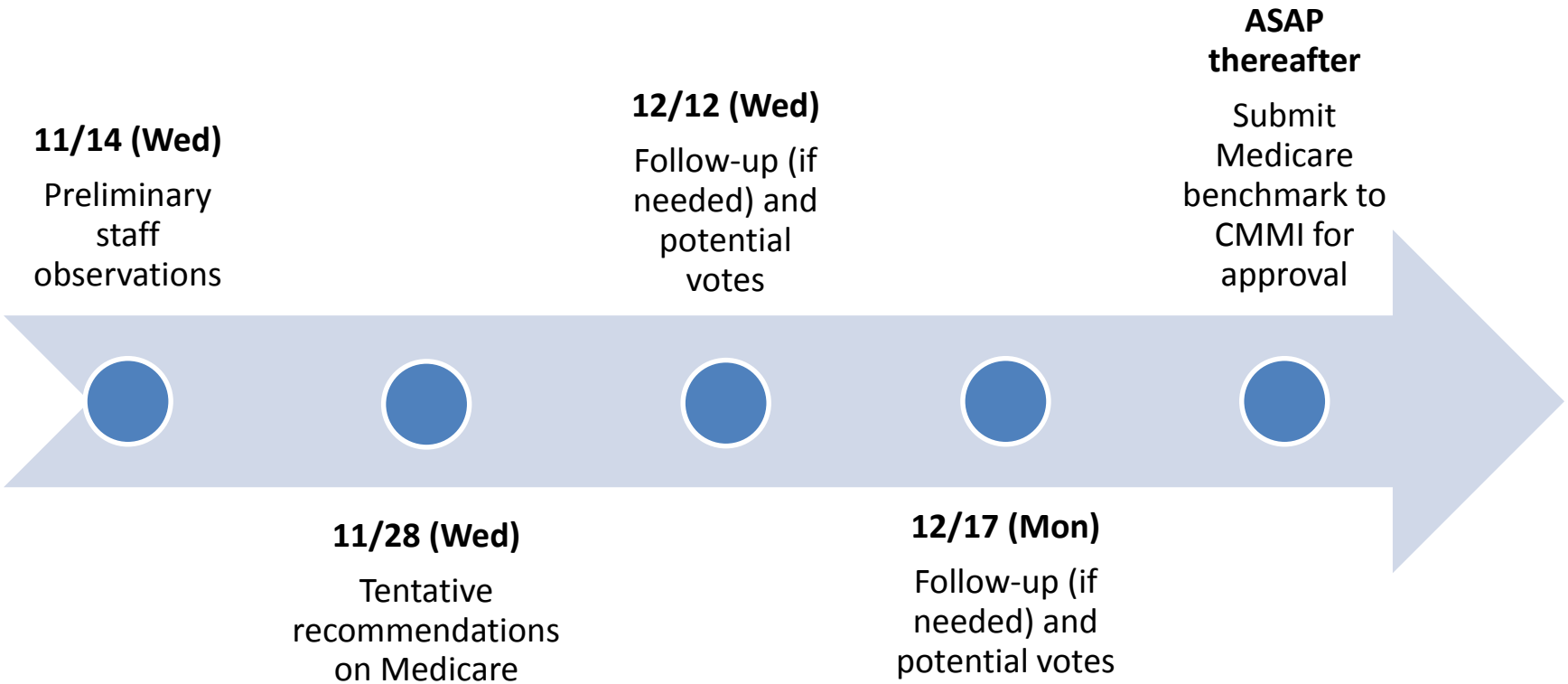
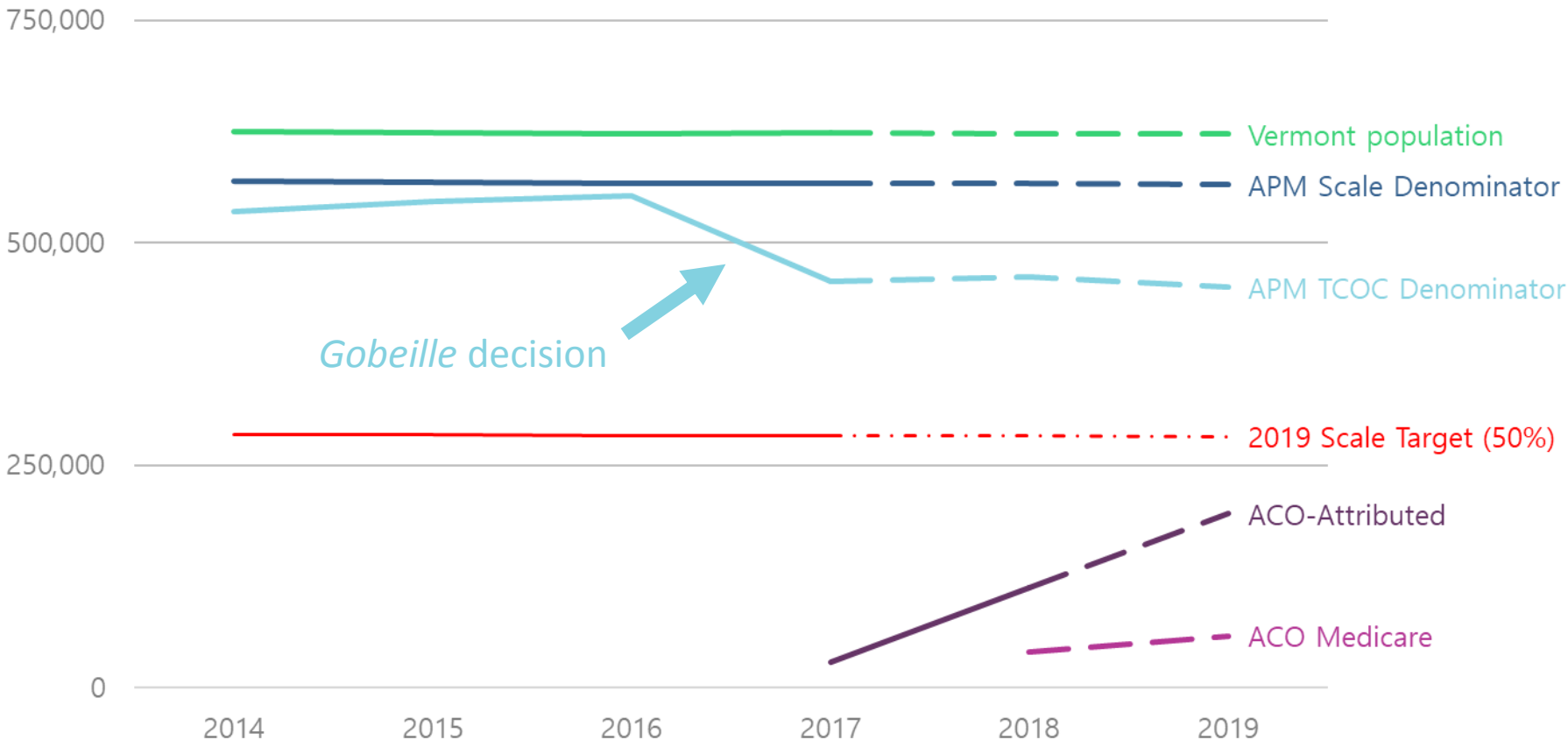
Timeline: Remaining



Vermont All-Payer ACO Model Agreement Requirements

All-Payer Model (APM) Populations



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Model Agreement Requirements: Scale *Estimates*

Payer	2018 (Performance Year 1)			2019 (Performance Year 2)		
	APM Pop.	Pop. in Scale Target Initiatives	Scale Performance (Target)	APM Pop.	Pop. in Scale Target Initiatives	Scale Performance (Target)
Medicare	115,029	39,702	36% (60%)	~120,000	58,782	~50% (75%)
Medicaid	136,407	42,342		~140,000	79,150	
Commercial Self-Funded	182,151	9,874		~170,000	35,984	
Commercial Fully Insured	105,473	20,838		~110,000	22,502	
Commercial Medicare Advantage	11,749	0		~14,000	0	
All-Payer Total	550,809	112,756	20% (35%)	~554,000	196,418	~35% (50%)

Model Agreement Requirements: All-Payer Total Cost of Care (TCOC) per Beneficiary Growth

$$\left(\frac{Vemont\ All{-}Payer\ TCOC\ per\ person\ in\ 2022}{Vermont\ All{-}Payer\ TCOC\ per\ person\ in\ 2017}\right)^{\frac{1}{5}}\text{-}1$$

The TCOC does *not* include all spending

- Dental services, retail pharmacy, and many services provided through Medicaid (e.g. Home and Community Based Services) are excluded.

Model Agreement Requirements: All-Payer TCOC per Beneficiary Growth

- The Agreement sets targets based on the **compounding target to date.**
  - Vermont is expected to maintain a compounding growth rate of 3.5% or less over the course of the agreement.
  - Corrective action would not be triggered unless the compounding growth rate were to exceed 4.3%.

- The All-Payer TCOC is computed based on a combination of claims and non-claims based spending.
  - Non-claims spending includes population-based payments, any savings or losses achieved by the ACO, as well as the Blueprint for Health and Community Health Team payments.
  - Claims spending uses the allowed amounts for a member's primary payer for the month.

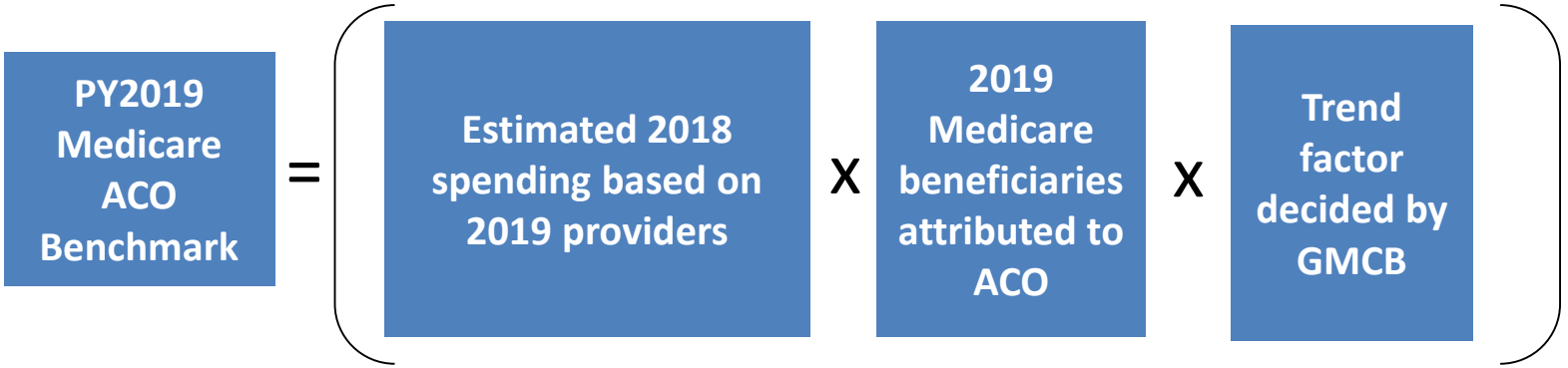
Model Agreement Requirements: Medicare TCOC per Beneficiary Growth

- The Agreement sets targets based on the **compounding target to date.**
    - Vermont is expected to maintain a compounding growth rate that is 0.2% or less than national projections.
    - Corrective action would not be triggered unless the compounding growth rate were to exceed 0.1% of national projections.

Model Agreement Requirements: Medicare TCOC per Beneficiary Growth Targets

	2018 Per Member Per Month (PMPM)	2019 PMPM	Annual Growth Rate	Compounded Growth Rate	Financial Target to Date
Aged and Disabled	$856.41	$891.07	4.0%	3.9%	3.7%
End Stage Renal Disease	$7,586.28	$7,833.28	3.3%	3.5%	3.3%
Blended Growth Rate	$880.64	$916.06	4.0%	3.9%	3.7%

Model Agreement Requirements: Medicare Benchmark



The Benchmark is calculated separately for:

- Aged and Disabled
- End Stage Renal Disease

Once combined, the Benchmarks are further adjusted by any ACO shared savings or losses.

Shared Savings or Losses

- The Benchmark is adjusted for any savings or losses realized by the ACO.
- In 2019, the ACO expects to realize savings. If so, the ACO will be eligible to keep up to 80% of them, due to the risk arrangement they elected for 2018.
- Any savings included in the Benchmark **count as spending** for Medicare and All-Payer TCOC calculations.

Scale Target ACO Initiatives

Four Requirements:

- Possibility of Shared Savings for achieving goals related to quality of care or utilization.
- The ACO's Shared savings, as a percentage of its expenditures less than the benchmark, is at minimum 30%; if the ACO is also at risk for Shared Losses, its Shared Losses, as a percentage of its expenditures in excess of the benchmark, is at minimum 30%.
- Services comparable to, but not limited to, the All-payer Financial Target Services and their associated expenditures are included for determination of the ACO's Shared Losses and Shared Savings;
- The ACO Benchmark, Shared Savings, Shared Losses, or a combination is tied to the quality of care the ACO delivers, the health of its aligned beneficiaries, or both.

Scale Target ACO Initiatives

Potential Changes to Existing Programs in 2019: None we think would disqualify the programs from being Scale Target ACO Initiatives.

- Medicare
  - increasing gain/loss share from 80% to 100%
  - VBIF quality framework to align with other payers
- Medicaid
  - increasing VBIF withhold as percentage of benchmark
  - increasing gain/loss corridor from 3% to 4%
- BCBSVT QHP
  - removing non-specialty pharmacy
- Self-Funded
  - Savings only → risk (6% corridor and 30% share)

Potential New Self-Funded Program: Still being negotiated. Not described in sufficient detail to allow us to determine whether it would qualify, although OneCare states that this is its intent.

Alignment with Medicare Program

Potential 2019 Changes to Existing Programs

- **Alignment/Attribution Methodologies:**
  - Potential changes to Medicaid methodology in 2019. No changes anticipated for other payers.
- **Quality Measures:**
  - Changes to Medicare measures. Increasing alignment.
- **Payment Mechanisms:**
  - No changes. Medicaid and Medicare will be the only payers using the all-inclusive population-based payment mechanism.
- **Risk Arrangements:**
  - Symmetrical shared risk arrangements. Levels in Medicare and Medicaid getting closer (e.g., 3%→4% and 80%→100%).
- **Services Included in Determining Savings and Losses:**
  - Potential loss of non-specialty pharmacy in commercial (increases alignment).

OneCare's 2019 Investments and Financial Observations

Investments

ACO budget statute (18 V.S.A. § 9382) requires consideration of:

- Efforts to prevent duplication of high-quality services and integration of efforts with Blueprint and its regional care collaboratives.
- Incentives for investments to strengthen primary care (strategies for recruiting more providers, providing resources to expand capacity in existing primary care practices, and reducing administrative burden).
- Incentives for investments in social determinants of health, such as developing support capacities that prevent hospital admissions and readmissions, improve population health outcomes, reward healthy lifestyle choices, and improve the solvency of and address the financial risk to community-based providers in ACO's network.
- Incentives for integration of community-based providers in the ACO's care model or investments to expand capacity in existing community-based providers, to promote coordination across the continuum.
- Incentives for preventing and addressing the impacts of adverse childhood experiences.

2018 and 2019
OCV Population Health Investments

PHM/Payment Reform Programs	2018 Approved	2019 Submitted
Basic OCV PMPM	$4,781,010	$5,935,530
Complex Care Coordination Program	$7,064,722	$9,181,362
Value-Based Incentive Fund	$4,035,223	$7,537,231
Comprehensive Payment Reform Program	$1,800,000	$2,250,000
Primary Prevention	$1,577,600	$910,720
Specialist Program Pilot	-	$2,000,000
Innovation Fund	-	$1,000,000
RCRs *(in 2018 was included in Primary Prevention line item; $300,000)*	-	$375,000
PCMH Legacy Payments	$1,973,649	$1,830,264
CHT Block Payment	$2,518,898	$2,411,679
SASH	$3,269,954	$3,815,532
Total	**$27,291,056**	**$37,247,319**

What are OCV's 2019 New Initiatives

- Comprehensive Payment Reform Program Expansion
- Payment Reform Pilot(s) for Specialists
- Primary Prevention and Adverse Childhood Events Pilot
- Community Based Innovation Funds
- St. Johnsbury Accountable Community for Health Pilot Study
- Expansion of RiseVT

OCV Blueprint for Health and Primary Care Investments

Direct Investments

- Continuing the Medicare Blueprint For Health PCMH Payments to support primary care practices, SASH and CHT Block Payments
- Basic OCV PMPM
- Complex Care Coordination Program
- Regional Clinical Representatives
- Comprehensive Payment Reform program
- New Specialist Program

Indirect Investments

- Offering quarterly grand rounds for providers
- Piloting telemedicine project to increase access to specialists
- Waiving prior authorizations in the Medicaid contract
- OCV Clinical Consultants engaged in Community Collaboratives
- Collaborated with GMCB and the Health Care Advocate to align and reduce measures in the 2019 Medicare Next Generation Program by half

Community Provider Investments

Direct Investments

- Complex Care Coordination Program
  - Community Support Care Coordination Payments
  - Patient Activation Payment
- SASH
- CHT
- Innovation Fund

Indirect Investments

- Implementation of the NextGen Medicare Waivers
- HSA data to engage partners in quality improvement
- Care Navigator
  - Increasing the patient educational modules in Care Navigator
- Care Coordination Cross-Community Core Teams
- Universal Consent Collaboration with DAs

OCV Social Determinants of Health and Adverse Childhood Experiences Investments

Direct Investments

- RiseVT Expansion
- PHM Payments
- Complex Care Coordination Program
- SASH/Howard Center Pilot

Indirect Investments

- Pediatric household-derived risk model
- Pediatric Shared Care Plan
- Food insecurity survey for network
- DULCE

Investments: Areas for Recommendations

What areas can you expect staff to make recommendations on?

- Percent of Total Budget tied to Population Health Management Programs.
- Funding for SASH and Blueprint payments (CHT and primary care practice).
- Full-year quality and financial reporting on 2018 CPR Pilot and 2019 changes to / expansion of the pilot.
- Reporting on implementation and evaluation plan for the Specialist pilot and Innovation Fund.
- Reporting on progress towards implementing variable component to the VBIF distribution formula.
- Providing 2019 Clinical Priority Areas when complete.

Financial Observations

	2018 Budget Approved	2018 Budget Projected	2019 Budget Submitted
Admin Expense Ratio	1.95%	1.72%	1.77%
PHM & Payment Reform Spending to Revenues Ratio	3.1%	2.3%	3.5%

- Highlights Based on the 2019 Submitted Budget:
  - Administrative expense ratio is projected and budgeted for 2019 at below the approved 2018 level.
  - PHM and payment reform expenses to total revenues ratio fell below the required level for the 2018 projection due to high initial attribution and ramp up of some of the PHM spending.
  - The Salaries and benefits expense line increased 34.7% from the 2018 budget to 2019 budget due in part to OneCare bringing RiseVT's staff in house as well as staff additions to reflect their growing network.

Proposed Next Steps

Presentations and Votes:

- November 28 (tentative): Staff Recommendations Medicare benchmark trend rate and ACO budget (presentation).

- December 12: Follow up (if needed) and potential votes.

- December 17 (Mon): Follow up (if needed) and potential votes.

Public comment:

- October 1st – December 10th

Questions?