

2018 OneCare Vermont Progress Update

Green Mountain Care Board

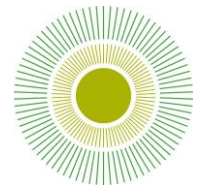
April 11th, 2018



OneCareVermont

OneCareVT.org

Budget Presentation Components



1. 2018 Budget Update

- a) Attribution
- b) Total Cost of Care
- c) Risk
- d) Population Health Management Spending
- e) Impact to Budget Orders

2. Quality and other population-based management initiatives

3. 2019 Network Development

Attribution



Program	GMCB Budget	Actual *	Change	Change Rate
Medicare	33,474	39,702	6,228	19%
Medicaid	44,211	42,342	(1,869)	-4%
BCBSVT QHP	34,943	20,838	(14,105)	-40%
Self-Funded	9,962	9,962	0	0%
Total	122,590	112,844	(9,746)	-8%

* As of January 1st

- **Medicare**

- Actual attribution started the year higher than the estimate used in the budget model
 - Budget model included a mix of actual data from the historical shared savings program and estimates for providers that weren't previously part of the OCV network
- CMS data projects final year-end attribution to be roughly 35k lives after attrition

- **Medicaid**

- Attribution was slightly lower than the projection, but within a range that is reflective of typical attribution churn
- We expect the attrition rate to be similar to the 2017 experience (roughly 1.7% per month) and end around 35k lives

- **BCBSVT QHP**

- Attribution was substantially lower than what was included in the budget model
- We will be monitoring attrition, but estimates are that we'll finish with roughly 18k lives

- **Self-Funded**

- We are still using an estimated figure and expect a rerun mid-April

Total Cost of Care Estimates



GMCB Budget	Attribution	Blended PMPM	TCOC
Medicare	33,474	\$864.45	\$347,240,276
Medicaid	40,184*	\$246.44	\$118,833,295
BCBSVT	34,943	\$318.13	\$133,395,719
Total			\$599,469,290

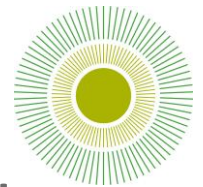
Recast Budget	Attribution	Blended PMPM	TCOC
Medicare	35,460*	\$856.48	\$364,451,924
Medicaid	38,563*	\$243.91	\$112,873,027
BCBSVT	20,004*	\$426.18	\$102,306,619
Total			\$579,631,570

Net Change	Attribution	Blended PMPM	TCOC
Medicare	1,986	(\$7.97)	\$17,211,648
Medicaid	-1,621	(\$2.52)	(\$5,960,268)
BCBSVT	-14,939	\$108.06	(\$31,089,099)
Total			(\$19,837,719)

* Includes an attrition factor

- Based mainly on attribution changes, the expected TCOC has decreased when compared to the budget model
- The original budget model used the attribution “high water mark” for modeling the total cost of care for Medicare and BCBSVT
 - Medicaid incorporated an attrition rate per actuarial input
- The recast budget incorporates an estimated attrition rate for all payers to more accurately project the TCOC at final settlement

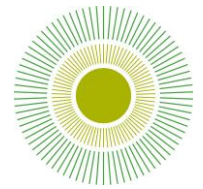
Risk



- Because the TCOC has changed, the expected max risk has changed accordingly
- Functionally, there are two angles to max risk
 - The “quoted” max risk is the true ceiling we will not exceed
 - This is built by applying the program risk corridors to the product of January 1st attribution and preliminary benchmark PMPMs
 - These amounts will be included in contract addendums
 - The “expected” max risk is the estimated ceiling based on forecasted attrition and, thus, is lower than the “quoted” amount
 - Because the TCOC is dependent on attribution, as we experience attrition the actual annual TCOC will decrease
 - The program risk corridors will be applied to the final TCOC to determine the actual max risk

Max Risk	GMCB Budget	Quoted	Estimated
Medicare	\$13,889,611	\$16,321,936	\$14,578,077
Medicaid	\$3,564,999	\$3,780,003	\$3,386,191
BCBSVT	\$4,001,872	\$3,947,009	\$3,069,199
Total	\$21,456,481	\$24,048,948	\$21,033,466

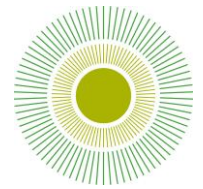
PHM Spending Estimates



- **Investments in population health management is largely driven by attribution**
 - Because attribution has been updated, so too has the modeled PHM spending breakdown
- **Two changes worthy of note:**
 - The engagement rate for the Complex Care Coordination program has been reduced to account for additional ramp-up time
 - The model for the Blueprint payments has been updated by the Blueprint (i.e. not a change made by OneCare)

Investment	GMCB Budget	Recast Budget	\$ Change	% Change
Value-Based Incentive Fund	\$4,305,223	\$4,116,546	(\$188,677)	-4%
Basic OCV PMPM	\$4,781,010	\$4,041,185	(\$739,825)	-15%
Complex Care Coordination Program	\$7,064,722	\$6,186,837	(\$877,886)	-12%
PCP Comprehensive Payment Reform Pilot	\$1,800,000	\$1,800,000	\$0	0%
Community Program Investments	\$1,577,600	\$1,583,143	\$5,543	0%
CHT Funding Risk Communities	\$1,771,057	\$1,400,887	(\$370,170)	-21%
CHT Funding Non-Risk Communities	\$747,841	\$844,966	\$97,125	13%
SASH Funding Risk Communities	\$2,364,691	\$2,572,500	\$207,809	9%
SASH Funding Non-Risk Communities	\$905,263	\$1,131,900	\$226,637	25%
PCP Payments Risk Communities	\$1,255,720	\$875,328	(\$380,392)	-30%
PCP Payments Non-Risk Communities	\$717,929	\$954,936	\$237,007	33%
Total	\$27,291,056	\$25,508,227	(\$1,782,829)	-7%

Impact to Budget Orders



- **Order H: OneCare must fund PHM at no less than 3.1% of its overall budget**
 - Based on the revised data, we do not anticipate any core budget-model concerns. However, some of the spending will vary based on network engagement and program ramp-up. We will monitor this ratio throughout the year.
- **Order K: OneCare must ensure that its administrative expenses are appropriately allocated by state (i.e., between VT and NY)**
 - There are no current concerns with our ability to comply with this order as a result of the changes to attribution and total cost of care estimates.
- **Order L: OneCare's administrative expense ratio must be consistent with its proposed budget**
 - Because the total cost of care is a moving number (both between budget approval and go-live and also throughout the plan year), maintaining a consistent administrative expense ratio is not possible even if OneCare administrative expenses end up exactly on budget. Attribution and TCOC changes of this magnitude do not result in administrative efficiencies.
- **Order M: OneCare's administrative expenses should be less than the health care savings generated through the All-Payer Accountable Care Organization Model**
 - Because gross savings potential is linked to attribution and total cost of care, the health care savings potential is affected. However, based on the magnitude of these changes there are no present concerns.

Highlights: Population Health & Quality Initiatives



• Diabetes Prevention & Management Learning Collaborative

- OneCare partnering with Blueprint, VDH, SASH, QIN/QIO
- 16 teams across eight health service areas
- Monthly technical assistance + four in-person sessions:
 - 4/20: Standards of Care & Patient Panels
 - 6/1: Self-management and Motivational Interviewing
 - 9/14: Pharmacology and Medication Management
 - 1/11/19: Screening and Referrals for Mental Health and Social Determinants of Health
- Assess: vital signs, diabetes poor control, self management care plans, referrals, dilated eye exams, primary care visits, depression screening

• Clinical Education and Training Series

- Interdisciplinary Grand Rounds
- Interdisciplinary Chronic Condition Symposia
- Enduring Materials

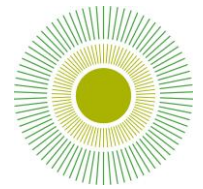
Grand Rounds Topic Areas:

- Medicare Annual Wellness Visits (2017)
- Palliative Care (2017)
- Suicide Screening & Intervention (2017)
- Dementia Care in Vermont (2018)
- End Stage Renal Disease (2018)
- Pediatric Topic TBD (2018)
- Patient/Family-Centered Care (2018)

Symposia Topic Areas:

- Diabetes & Pre-Diabetes (2017)
- Chronic Obstructive Pulmonary Disease (2018)

Highlights: Population Health & Quality Initiatives



- **Data Collection & Reporting**

- New partnership with Blueprint & Capital Health Associates to improve quality of clinical data from VITL
- BCBS to begin sending quarterly aggregate data on substance use claims-based quality measures
- Manually collected data on >5,000 patient records for 2017 performance year quality measurement reporting
- Redesigned annual quality measure reporting to display HSA-level comparisons and historical performance
- Negotiations with GMCB, HCA, CMMI regarding alignment of Medicare quality measures for 2019 under All Payer Model agreement

- **Care Coordination**

- Risk stratified all attributed patients; identified individuals that may benefit from complex care coordination
- Expanded model into five additional HSAs
- Formed a Care Coordination Core Team in the southern region of Vermont
- Facilitated community workflow development/refinement
- Trained >200 individuals since January on core skills, advanced topics, and/or sr. leader engagement

Highlights: Population Health & Quality Initiatives



• Partnership with RiseVT



- RiseVT is a unique public health movement that integrates wellness and prevention into the healthcare delivery system.
- An initiative in northwest VT that was recently formalized into a new state level organization to make the program available statewide.
- Partnering on an integrated approach to primary prevention, and OneCare also functions as the administrative partner for the RiseVT organization offering employment, support, and space for the new organization and its leaders.

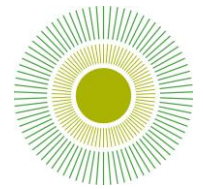
• SASH/Howard Mental Health Pilot

- Major investment in an innovative pilot program to improve the quality of mental health and substance use treatment services for residents of two Burlington area housing communities specializing in the coordination of care and services for older adults and those with special needs.
- Unique focus on prompting a culture of mental wellness through resident group education and staff support.

• Community Network Success Stories

- Controlling Hypertension (spotlight on PCHP-St. Albans)
- Improving Hospice Utilization (Brattleboro)
- Diabetes Prevention Program (Springfield Medical Care System)
- Reduction in SNF Utilization after Total Joint Surgery (Berlin)
- Integration of Behavioral Health Care (St. Albans)

OneCare 2019 Network Development



Current Provider Types

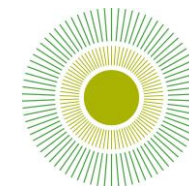
- **Hospitals**
 - Existing hospital participants will be expected to move to all programs offered, with approval to defer that requirement by management on an exception basis
 - If a hospital is new to risk, OneCare will offer participation in either all programs or start with VMNG only for one year (and expectation to move to all programs in 2020)
- **Independent Primary and Specialty Care, FQHC, Home Health, Designated Agencies, Skilled Nursing Facilities:**
 - Provider types only have the option to participate in the same program selections as their Health Service Area hospitals
 - If a provider is new or was only in one program in the past, expectation is to participate in all programs that their hospital is participating in for the year, with approval to defer that requirement by management on an exception basis

OneCare 2019 Network Development



- **Continue to Seek Willing Providers:**
 - To meet All Payer Model scale targets, OneCare seeks to increase the number of people in population health management programs under value-based payment arrangements
- **Key Elements of the 2019 Network Development Plan:**
 - Welcome new entrants with patient attribution
 - Develop clear program value proposition and expectations
 - Enhance or expand existing programs and fixed payment arrangements
 - Begin to engage with new provider types in late 2018- early 2019 to develop specific value-add programs in 2020 (PT, OT, ST, Chiropractic, Home Infusion Vendors etc.)
 - Border Hospitals will be deferred until 2020 to assess if there are alternate risk platforms that they can enter into with OneCare
- **New Program Offerings**
 - Any new programs to include additional financing and population health support will be vetted and recommended by the Population Health Committee and Finance Committee, with approval by the Board of Managers

2019 Network Development Timeline



		2018 Milestones in Preparation for 2019			
		Q1	Q2	Q3	Q4
1	Determine Program Offerings and Strategy for Network Development	February-March			
2	Define Budget Assumptions Send Solicitation of Interest to Hospital, PCP's and FQHC's	March-April			
3	Receive Response on 2019 Interest by Hospitals, PCPs and FQHCs		April		
4	Financial Modeling Based on Attributing Providers Interested Network		May-June		
5	Send LOI to all other Continuum or Care Providers in HSA's where Hospitals have expressed interest		May		
6	Preliminary Full Budget Models and Initial Approval by BOM		June		
7	Provider Outreach on 2019 Programs/Contracts/Payments/Budget			July-August	
8	Contract and Program Riders Returned (Provider Commitment)			August	
9	Approval by BOM of Final Network and GMCB Budget Submission			September-October	
10	Provide Final Rosters to Payers Confirm 2019 Program Participation Refine Budget as Necessary			September-October	