Thoughts on 2019 All Payer Model and Hospital Budget Guidance

Green Mountain Care Board

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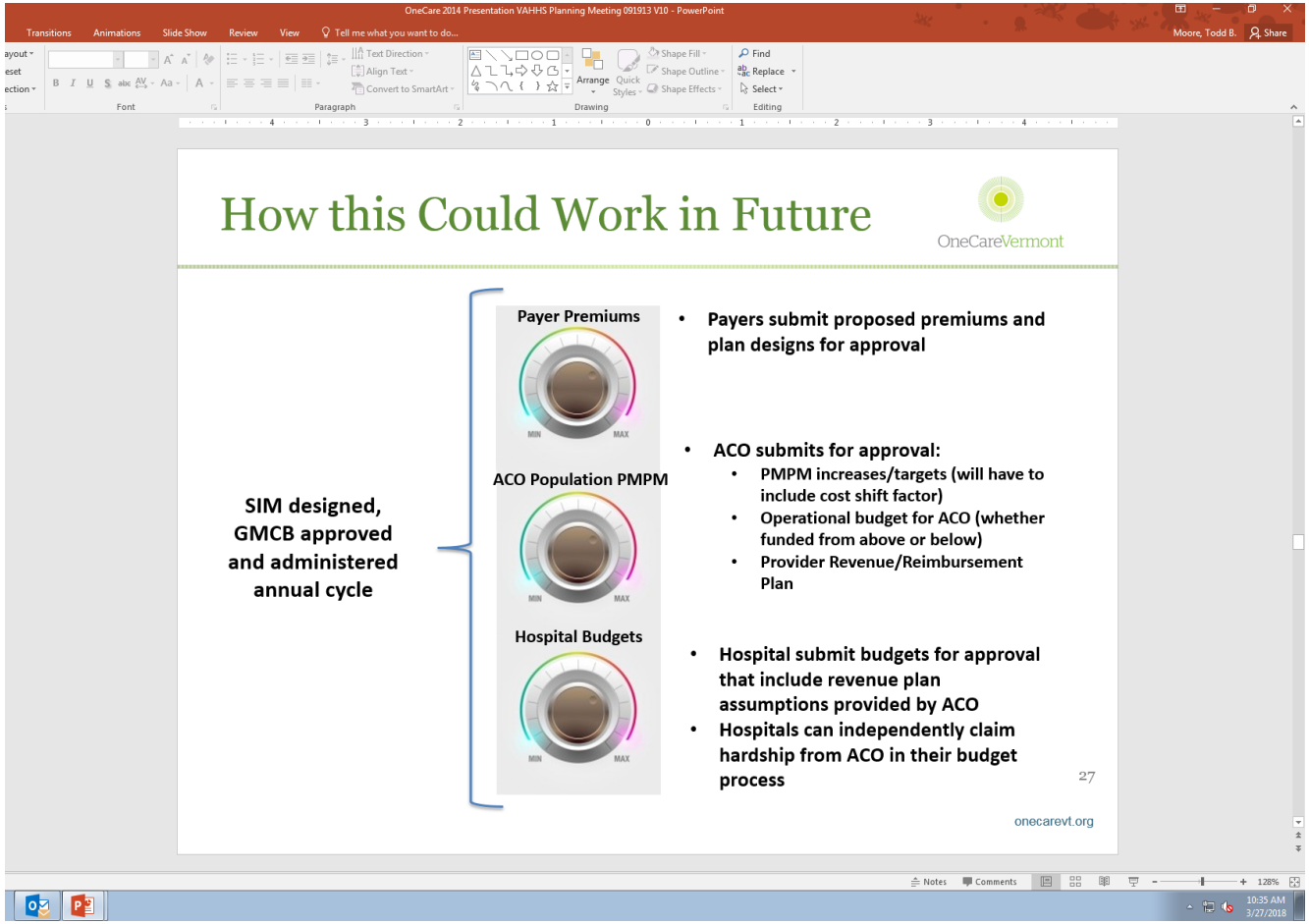
OneCareVermont

The Future has Arrived



Actual Slide from OneCare Presentation to VAHHS on September 19, 2013 (4.5 Years ago)

Context for Today's Appearance

- **ACO Interest in GMCB aligned financial and budget models**
  - Hospital Budgets, Insurance Rates, ACO Budgets (including ACO Program PMPM Targets)
  - These all relate both directly and indirectly to each other, and all relate to APM targets and commitments
  - These need to be in alignment (or avoid misalignment) since parameters set in one area as seemingly sound may jeopardize ability to set sound parameters and avoid significant unintended consequences in the others
- **Belief that the 3.5% growth target should be a central focus point, especially in these early years of APM**
  - Developed to be an appropriate target for sustainable, smoothly implemented affordability through risk-based ACO programs and GMCB models (would be unprecedented five year growth rate)
  - But also designed for balancing both provider and payer participation, while maintaining hospital solvency and access to services
  - If proves to be over-adequate, can tighten in years 3-5
- **Recognition that OneCare APM risk contracts with hospitals are still new and fragile**
  - Good start but at crucial early juncture of the first year-to-year cycle within APM period
  - Hospitals are funding majority of transformation including community-based payment reform and infrastructure costs; very little of expected Delivery System Reform (DSR) funds made available
  - The assumption of population spending risk by hospitals may be underappreciated as all early budget models assume on-target performance, but which in reality could add additional costs to absorb or pay back negative risk performance

OneCare Recommendations: 2019 GMCB Hospital Budget Guidance

1. Incorporate the fact that APM and OneCare payment models have 2017 actual experience as the “base year” going forward
2. Let the statewide, multi-payer APM “math” at 3.5% help drive other factors and expectations, especially as we get started in first years of program
3. Employ a single allowed NPSR growth limit for hospitals in FY2019 budgets rather than two different growth allowances for ACO/APM and non-ACO/APM revenue
4. Allow hospital commercial NPSR budgets and their related rate structures to reflect the APM models and the allowed NPSR growth factor

Appendix

Rationale for Recommendations

OneCare Recommendations - Rationale

1. **Incorporate the fact that APM and OneCare payment models have 2017 actual experience as the "base year" going forward**

   - APM Agreement calls out 2017 as the base year
     - All APM measures, financial and otherwise, start with a 2017 base
   - OneCare's payment models to hospitals in 2018 were based on 2017 actual performance, which will remain a relevant base point going forward
   - Not rebasing for GMCB hospital budget approach risks OneCare's actual payment models being misaligned with budget guidance and expectations
     - Trying to avoid position of rationally-designed OneCare hospital payments under APM contracts possibly looking like excess NPSR, or being inadequate for a hospital in actually achieving its allowed budget
     - May still be ways to protect and adjust for those adversely affected by rebasing
   - As APM proceeds, OneCare revenue will increasingly be a material portion of the participating hospitals' budget – likely too much for this "base year" misalignment to persist over the long term

OneCare Recommendations - Rationale

2. **<u>Let the statewide, multi-payer APM "math" at 3.5% drive other factors and expectations, especially as we get started in first years of program</u>**

- Early years of APM may be most important to establish the 3.5% and feel its effect
  - Successful initial year-to-year cycles, along with smoothness over time, may be as important as trying to "bank" excess savings below 3.5% out of the gates
- The potential savings to ACO and providers under fair population-based targets is the bedrock of non-FFS payment reform incentives
  - Taking initial discounts from 3.5% really amounts to a change in the target
  - Incentive for realistic savings needs to be there, and if achieved, not taken back until it reaches high levels
- OneCare encourages the GMCB to build an all-payer 3.5% growth model for 2019 at full-system level
  - Medicare allowed growth factor under APM – to be known in April
  - Medicaid factor to be consistent with state budget, as expected from 2019 contract between DVHA and OneCare
  - Commercial to be independent variable, meaning its targeted growth rate is calculated to achieve the 3.5% and would be expected basis of OneCare proposed budget

OneCare Recommendations - Rationale

3. Employ a single allowed NPSR growth factor for hospitals in 2019 rather than two different growth allowances for ACO/APM and non-ACO/APM revenue

- Idea has been considered for higher allowed growth rate on ACO revenue than non-ACO revenue
  - First issue is that under APM model "math", the natural growth for OneCare would actually be *lower* due to payer mix differences (OneCare has less commercial mix than statewide)
- Separate growth targets may also have challenges and unintended policy consequences
  - Conceptually bad if set higher revenue growth on ACO revenue
    - More attractive to providers but *makes ACO reform model the "high cost option" for payers*, employers and individuals policy holders
  - Method of implementation may be challenging
    - Implementing at ACO-attributed population PMPM level to drive savings (since target would be well above expected "shadow" FFS) would risk contract impasse, and add challenge for insurer to set rates and could even be at odds with ACA
    - Implementing via two different underlying FFS models is administratively burdensome (if not impossible) for both payers and providers
- Single hospital NPSR growth allowance best aligns with OneCare budget approach where hospitals use overall resources to help fund the substantial reform included in the ACO-attributed population
  - This then expands in an affordable, step-wise fashion over time as more attribution and service revenues shift into the ACO model

OneCare Recommendations - Rationale

4. **Allow hospital commercial NPSR budgets and their related rate structures to reflect consistency with the APM models and allowed NPSR growth factor**

- Will mean value of the APM statewide growth rate limit is baked in hospital rates for both ACO and non-ACO payers and services
- Promotes alignment with ACO payer contracts and actuarial models under the 2017 base-year models
  - Avoids risk and noise of ACO population targets and underlying provider payment models including the "shadow FFS" being too far apart (important in early years of APM)
- Makes hospital budget approach and analysis more clear and simple, leading to better understanding by GMCB and better ability for hospitals to analyze joining OneCare or expanding their current OneCare risk footprint
- Sets right basis for the rest of the five year model of APM "math" and ACO risk as the most important method of preventing excess cost growth system-wide
  - If going forward there is true excess population-level utilization and cost growth under APM, it will be the APM "math" and risk-based ACO contracts which should be the source of implementing discipline and capturing this excess for distribution to payers