OneCareVermont

OneCare 2019 Budget Submission: GMCB Follow-Up Questions

Follow-up from OneCare 10-16-2018 responses

1. I.4.2, Question 38: For the “Due to UVMMC” liability account, please provide a breakdown in dollars of operating expenses, participation costs/receipts, and transactions flowing to UVMMC as founder for both FY18 projections and FY19 budget.

   Functionally, the “Due to UVMMC” account is used for operating expenses (mostly salaries and benefits, building rent, and employee expense reimbursements) and the founder contributions. UVMMC participation costs and other program payments are treated in the same manner as other network participants and flow through the “Due to Other” account. The 2018 projection and the 2019 budget, however, include only the amount for operating expenses. In order to build reserves properly, OneCare is working on the accounting methodology so that founder contributions are handled in a different manner and the submitted schedules reflect this evolution.

2. I.4.3, Question 47: Does OneCare know why imaging, lab, pathology and other services costs have increased on a PMPM basis?

   The 2018 budget model included claims breakdowns produced by Milliman using their proprietary grouper. In 2019 OneCare used a grouper that is available internally as a measure to manage cost and also work within a very tight timeframe. As a result, there were some categorical shifts. Note that the Outpatient Facility group as a total reflects a much more stable year-to-year change.

3. I.4.4, Question 49: In reviewing the ACH Payment Statement submitted as Attachment E, the two types of deductions are combined. Is there a plan to show the two types of deductions on the payment statement so it is clear to hospitals when recording the payment what can be considered an administrative fee and what might be acceptable to deduct from revenue? If no, please explain.

   OneCare plans to show a breakdown of deductions in a manner that allows for proper hospital accounting per guidance from their auditors.

Follow-up from 10-24-2018 presentation

4. Please show, in a table, a reconciliation of your Total Program Target Revenue of $850,713,934 and your Expected Spending Under (Over) Claims Target of $11,073,117 (from your income statement, Appendix 4.2 of your submission) to the

Combined Spending Estimate of $831,583,342 found on slide 26 of your 10-24-2018 presentation.

Total Spend Target	**$850,713,934**
Expected Claims Shared Savings to Network Shared Savings for CHT, PCMH, SASH	$831,583,342 $11,171,567 $7,959,024
Total	**$850,713,934**

5. If OneCare's net income exceeds or falls below the $2.8 million, OneCare indicated it will set aside for its reserve. What is OneCare's plan for any overage and how will OneCare maintain its reserve if the net income falls below the $2.8 million?

   The use of any net income above the $2.8M target will be decided by the OneCare Board of Managers. In the event that it appears OneCare will be unable to build $2.8M in reserves, the Board of Managers will decide whether or not to pursue the full $2.8M and the means by which this is accomplished.

6.
   a. Please show the math for the following statement on slide 30 of your 10-24-2018 presentation: "25% of the total cost of care is distributed to the Network through fixed payments."

      This appears to have been a mistake on the slide. The correct caption should have read 37%.

   b. Please also explain the slight difference between the Medicare Gross Fixed Payment Estimate found on the Summary Tab of Appendix 4.8 of the budget submission ($203,600,119) and the Medicare Gross FPP figure on slide 30 of your 10-24-2018 presentation ($205,746,884).

      Medicare sets the fixed payment amount that OneCare receives and the methodology to determine the amount that OneCare will receive is under review by CMS. The discrepancy noted is the unintentional result of refinements to the model to best estimate the fixed payment amount in light of evolving information.

7. We are having trouble tying the risk tables in OneCare's budget submission to the contract amendments it provided as Attachment A to its 10-16-2018 responses. For example, page 17 of OneCare's budget submission indicates that it is providing $900,000 of risk protection to Brattleboro Memorial Hospital, reducing that hospital's maximum downside risk from $1,660,196 to $760,196. However, the contract amendments state that after all programs have settled Brattleboro Memorial Hospital

"will be responsible for the greater of $900,000 and the first 50% of its aggregate Maximum Risk Limit across all three programs for losses." Please explain how the risk mitigation for Southwestern Vermont Medical Center, Brattleboro Memorial Hospital, and Springfield Hospital would work and how this is reflected in the contract amendments OneCare provided as Attachment A to its 10-16-2018 responses.

The exhibits supplied do not incorporate the risk mitigation arrangements for Springfield, Brattleboro and Southwestern. This view is important in that the total maximum risk for the ACO is unaffected by these risk arrangements. In other words, if the entire OneCare network maximizes downside risk, the number shown is the amount that would be due to payers. The risk mitigation arrangements simply mean that if the HSAs corresponding to the hospitals with the arrangements reach the point at which the risk mitigation arrangement takes hold, OneCare will still invoice the hospital per the terms of that arrangement (i.e. with the lower maximum risk provided) and use reserves or other mechanisms to fund the remainder. The "greater of" term simply means that OneCare's risk reduction offer will not exceed 50% of what the actual maximum risk ends up to be for the affected hospital. If the maximum risk ends up being higher than projected in this budget, the hospital must contribute more than the projected amount.

8. With respect to OneCare's 10-16-2018 response to question 53, please calculate OneCare's budgeted administrative expenses as a PMPY figure.

   This PMPY will be very dependent on three factors: final payer programs (i.e. which programs are fully implemented in 2019 and when they go into effect), initial attribution, and attribution attrition rate. Note that we are interpreting this question to include all centrally budgeted and expended clinical, technical, and financial expenses of the OneCare Vermont Organization itself. Please know that many of these expenses in other contexts of health care including the Affordable Care Act rules on medical versus administrative expense ratios, would not be classified as "administrative".

   With these thoughts in mind, the following represents reasonable ranges for the administrative expense PMPY figures:

   <u>All Budgeted Programs Implemented</u>
   Low: $95.19
   High: $98.13

   <u>Core Budgeted Programs Implemented but Delay to Self-Funded Expansion</u>
   Low: $111.76
   High: $115.21

9. If OneCare is required to provide a financial guarantee for the Medicare program, would this change its plans to build $5 million in reserves?

   It is expected that OneCare will be required to provide a financial guarantee for the Medicare program, which really represents a securitized deposit against a portion of what hospitals would need to pay against Medicare losses under OneCare's risk-sharing policy if losses are accrued. OneCare intends to also build its general cash reserves for a variety of possible scenarios, including as available resources to meet the risk obligations under Medicaid and Commercial contracts not related to the Medicare instrument. If it turns out that the Medicare guarantee is not required, OneCare would reevaluate the reserve strategy with ultimate decisions coming from the Board of Managers, and subject to any required review and/or budget order amendment from the GMCB.

10. Is the difference between the cost of care expected to be delivered to an HSA's locally-attributed population by a network hospital other than the home hospital subject to that home hospital's maximum risk limit? For example, looking at Appendix 2.4, if the fee-for-service value of care provided by UVMMC to patients that are attributed to OneCare by providers practicing in the Newport HSA were to greatly exceed $1,133,048, would North Country Hospital be protected by its maximum risk limit of $452,664 with respect to this difference, or is the FPP reconciliation separate?

    The intent of the MRL is to protect hospitals from a risk payback that could harm the financial solvency of the hospital. The hospital risk model includes accountability for above-target spending of the local population when care is rendered in other hospitals and providers whether they are OneCare participants or not, including out of state providers. OneCare has implemented, with the approval of participating hospitals, a model where even the "shadow FFS" value of care rendered by other FPP-receiving hospitals will be reconciled by OneCare against targets and be included in risk settlement calculations for the "home hospital" for its local attributed lives. However, OneCare will also include in that calculation the value of any above-target spending at a hospital when delivering services to lives from other service areas. Overall, this will net to zero for the whole of OneCare under the FPP model, but individual hospitals may be "net winners" or "net losers" on these two factors. If a hospital is a "net loser" and therefore owes money to OneCare for this internal network financial transfer, that paid amount would accrue toward the MRL payment limit by that hospital.