Green Mountain Care Board

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PHM Descriptions and Status

- **Population Health Management:** Primary care investments supporting increased focus on population health and high quality care delivery.
  - No changes to this program since FY 2022 Budget submission.

- **Complex Care Coordination Program:** Enables providers across the health care continuum to better manage the care of high risk/high needs individuals attributed to the ACO.
  - Network performance measures and reporting requirements communicated.

- **Value-Based Incentive Fund (VBIF):** Quality inventive program with key priority metrics for children and adults.
  - Change: Medicaid funded a $2M VBIF pool to be paid directly to providers. OneCare will administer the quality evaluation and determine payment amounts and recipients through policy.

- **Comprehensive Payment Reform (CPR) Program:** Designed to transition participating independent primary care practices from FFS to fixed value-based payments across payers.
  - No changes to this program since FY 2022 Budget submission.

- **Specialist/Innovation Funds:** Promotes greater focus on population health and funding for innovative care delivery pilots proposed by participating OneCare providers. Investments in 2022 reflect projects continuing into the fiscal year.
  - No changes to this program since FY 2022 Budget submission.

Updates on Evaluations
(Care Coordination and Variations in Care by HSA)

- **Care Coordination Evaluation**
  - Conducted patient and care coordination staff surveys, analyzing claims data and collecting providers' triennial reports
    - Analytic techniques: descriptive and narrative analysis, trend analysis, patient matching using propensity scores, difference in difference analysis (pre/post intervention), and regression analysis to control for confounders
  - Evaluation completion anticipated summer 2022
- **Data Policy, Reports, and Applications**
  - Data Use Policy updated to facilitate data sharing across ACO network
  - Performance Dashboard report displays variation in care by HSA, distributed to network participants and payers
  - Workbench One App functionality provides users with HSA level performance for comparisons and opportunity identification
- **HSA Consultations**
  - New process in 2022 focused on actionable data
  - Compares HSA performance to others, OneCare total, and predicted values
  - Process continues to evolve, deepening connections across the network
- **Utilization Management Committee**
  - Reviews utilization trends across payers, HSAs

OneCare's Evaluation Contract with UVM

- OneCare is in the process of contracting with the UVM College of Medicine Center for Health Services Research team for support in three areas:
  - **ACO Key Performance Indicators (KPIs)**
    - Key Activities: Literature review; review and refine possible KPIs with OneCare; review data availability; identify a core set of KPIs that can be monitored over time
  - **Network Survey**
    - Key Activities: Identify gaps in available data to support KPIs; design, test, implement, and evaluate a baseline network survey; make recommendations about how to sustain efforts, and incorporate into KPIs
  - **Program Evaluation**
    - Key Activities: Create an evaluation guidance document to advise on evaluation best practices; complete one preliminary evaluation of at least one OneCare program in PY22

ACO Benchmarking Update

- Through the vendor selection process, OneCare learned that none could meet the full scope of the Order, as written, and therefore requested an amendment. Key Changes Requested:
  - Focus benchmark reporting on utilization, cost, and quality; remove patient satisfaction/engagement and evidence-based clinical appropriateness due to lack of available benchmarks.
  - Flexibility to work with selected vendor to identify specific measures (cost, utilization, quality) based on available data; collaborative process with GMCB staff to determine reporting templates.
  - Eliminate requirement for Medicaid and commercial benchmarking as vendors report lack of industry standards, low data availability & consistency, and high costs.

ACO Benchmarking Update cont.

- **Process**:
  - Based on recommendations from GMCB consultant, OneCare performed initial outreach/information gathering and narrowed list of potential vendors from four to two. Based on detailed analysis of the two vendors, OneCare requested a Budget Order modification.
- **Key Considerations**:
  - Vendor experience, size of Medicare data set, ability to benchmark ACOs, data availability, cost, customizability, and ease of integration
- **Limitations**:
  - Very limited/unavailable data on 2 of 5 domains specified in the Budget Order; ~50% of GMCB proposed metrics available with add-on modules
  - Limited marketplace availability of Medicaid and commercial benchmarking; costs in excess of GMCB estimate
  - Cost of ~$150,000 for two data refreshes/year. Cost could be reduced to align with vendor's recommendation for annual benchmark adjustments
- **Next Steps**:
  - OneCare received GMCB approval of selected Medicare benchmarking vendor on April 21, 2022 and is in active contract negotiations.

Attribution and Finalized Payer Contracts

Attribution – Starting	GMCB Budget	Revised Budget	Change
Medicare	61,788	62,711	923
Medicaid - Traditional	88,784	95,725	6,941
Medicaid - Expanded	28,366	30,563	2,197
BCBSVT QHP	22,212	21,183	(1,029)
MVP QHP *	10,692	10,692	0
BCBSVT Primary - Risk *	45,018	45,018	0
BCBSVT Primary - Non-Risk *	31,004	31,004	0
Total	**287,864**	**296,896**	**9,032**

* Remained an estimate in revised budget submission

- Medicare pre-January 1st attribution came in very close to budget estimate
- Medicaid attribution came in higher than expected
  - Possibility redetermination will resume during 2022, which will affect attrition
- Most commercial attribution updates were not available at the time the revised budget was submitted
  - New data has been received and is in the QA process
  - Total attribution expected to be ~290k

Attribution and Finalized Payer Contracts cont.

Medicaid program negotiations resulted in three notable changes:

1. **PMPM Funding**
   - Reduced from $6.50 to $4.75 for the Traditional Cohort
   - Reduced from $5.00 to $4.75 for the Expanded Cohort
   - PMPM funds cannot be used to support OneCare operations

2. **Care Coordination Outcomes Payments**
   - Medicaid funds base payments but not bonus payments based on practice-specific outcomes

3. **Quality Model**
   - Original budget submission included an All-Payer quality approach with providers; DVHA preferred to instead fund a separate Medicaid-only $2M Value Based Incentive Fund pool to be paid from DVHA directly to providers
     - OneCare will administer the quality evaluation and determine payment amounts and recipients

Revised Final Budget – Revenues

- TCOC totals updated to reflect latest attribution and target estimates
- Payer Program Support reduction reflects lower Medicaid PMPMs
- Other Revenues increase a timing factor related to ongoing PHM programs
- Hospital Participation Fees increased by $927k, largely in response to Medicaid program changes

Revenue Category	2022 GMCB	2022 REVISED	2022 Revision Change
Medicare TCOC	$524,136,820	$498,487,390	($25,649,430)
Medicare - Blueprint Obligation	$9,073,983	$9,073,982	($1)
Medicaid - Traditional TCOC	$245,245,465	$275,105,429	$29,859,964
Medicaid - Expanded TCOC	$47,558,217	$44,959,054	($2,599,163)
BCBSVT QHP TCOC	$159,654,505	$141,553,837	($18,100,668)
MVP QHP TCOC	$66,924,423	$64,219,054	($2,705,370)
BCBSVT Primary - Risk	$277,644,746	$282,922,336	$5,277,590
TCOC Targets Total	**$1,330,238,159**	**$1,316,321,082**	**($13,917,077)**
Payer Program Support	$11,988,969	$10,460,595	($1,528,374)
DSR Funding	$0	$0	$0
Health Information Technology	$0	$0	$0
Fixed Payment Allocation	$3,360,439	$3,360,439	$0
Blueprint Self-Management	$0	$0	$0
Other Revenues	$1,062,121	$2,033,606	$971,486
Hospital Participation Fees	$18,696,155	$19,623,500	$927,344
Total Revenue	**$1,365,345,843**	**$1,351,799,222**	**($13,546,621)**

Revised Final Budget – Expenses

Expense Category	2022 GMCB	2022 REVISED	2022 Revision Change
FFS Spend	$875,282,023	$871,639,451	($3,642,572)
Fixed Payment Spend	$445,882,154	$435,607,649	($10,274,504)
Health Services Spending Total	**$1,321,164,176**	**$1,307,247,100**	**($13,917,076)**
Population Health Mgmt Payment	$9,457,821	$9,512,724	$54,903
Complex Care Coordination Program	$6,150,463	$5,905,659	($244,804)
Value-Based Incentive Fund	$1,000,000	$1,000,000	$0
CPR Program Expense - OCV Funded	$1,331,256	$1,158,877	($172,379)
Primary Prevention Programs - Program Match	$165,000	$120,000	($45,000)
Primary Prevention Programs - Amplify Grants	$50,000	$35,000	($15,000)
Primary Prevention Programs - DULCE	$204,485	$204,485	$0
Longitudinal Care	$399,000	$399,000	$0
Specialist Program - Chronic Kidney Disease	$10,874	$23,165	$12,291
Specialist Program - Mental Health Initiatives	$255,009	$147,550	($107,460)
Innovation Fund	$268,990	$369,434	$100,444
VBIF Reinvestment - Quality Initiatives	$527,247	$1,164,708	$637,461
Blueprint Payments (PCMH)	$1,993,092	$2,062,850	$69,758
Blueprint Payments (CHT)	$2,795,095	$2,725,337	($69,759)
Blueprint Payments (SASH)	$4,285,795	$4,285,795	($0)
Total PHM Pmts	**$28,894,128**	**$29,114,584**	**$220,455**
Salaries, Payroll taxes & Fringe	$9,651,315	$9,368,623	($282,691)
Software/Informatics Tools	$2,516,505	$2,683,279	$166,774
Consulting, legal and purchased services	$1,193,249	$1,366,121	$172,872
Travel, Supplies and Other	$1,926,469	$2,019,514	$93,045
Total Operating Expenses	**$15,287,538**	**$15,437,538**	**$150,000**
Total Expenses	**$1,365,345,843**	**$1,351,799,222**	**($13,546,621)**

- Care Coordination expense reduced due to Medicaid negotiations
- VBIF Reinvestment change reflects timing of initiatives
- Operations budget increased by $150k for the ordered benchmarking tool

Hospital Participation Fees

Hospital Support	GMCB Budget	Revised Budget	Change
Hospital Par Fees – Base	$18,696,155	$19,623,500	$927,345
Hospital Par Fees – Reserves	$0	$0	$0
Category Total	**$18,696,155**	**$19,623,500**	**$927,345**

Par Fees	GMCB Budget	Revised Budget	Change
SVMC	$1,372,980	$1,446,792	$73,812
CVMC	$2,478,905	$2,570,973	$92,068
BMH	$734,053	$738,823	$4,770
UVMMC	$8,483,255	$9,092,141	$608,886
DH	$1,110,943	$1,215,030	$104,087
Porter	$590,285	$619,886	$29,601
Copley	$158,210	$169,082	$10,872
NCH	$568,120	$598,943	$30,823
Gifford	$107,154	$115,080	$7,926
RH	$1,167,706	$1,265,004	$97,298
Springfield	$107,687	$112,541	$4,854
NMC	$992,337	$812,572	($179,765)
NVRH	$450,398	$487,425	$37,027
Mt. Ascutney	$374,123	$379,207	$5,084
Total	**$18,696,155**	**$19,623,500**	**$927,345**

- Participation Fees increase by $927k primarily due to Medicaid contract negotiations

Total Risk & Risk Model

- Despite updates to attribution and TCOC targets, total shared loss potential remains $16.2M
  - Shared savings potential remains $17.5M due to the upside only program

- Other Variables of Note:
  - Continued extension of the federal Public Health Emergency status will reduce downside potential in the Medicare program
  - If the Medicaid redetermination process begins, it could result in material attribution attrition and thus less savings/loss potential overall

- There were no other changes to the risk model relative to the initial budget submission

Progress on Commercial Fixed Payments

Previously Submitted Milestones/Targets – FPP as a % of contracted TCOC

Program	Baseline	PY22	PY23	PY24	PY25
Medicare	0.0%	0.0%	53.4%	53.9%	54.4%
Medicaid	50.4%	50.7%	58.2%	58.5%	58.8%
Commercial	0.00%	2.9%	23.9%	44.9%	65.9%

2022 Targets vs. Actual

Program	PY22 Target	PY22 Actual
Medicare	0.0%	0.48% *
Medicaid	50.7%	52.24%
Commercial	2.9%	0.16% *

* For CPR only, hospitals cover reconciliation making it a true fixed payment for those participants.

- Actual 2022 results are relatively close to the established targets, however, we have not received indications suggesting Medicare is ready to convert to a true fixed payment in 2023 (which would result in a material variation)
- Commercial unreconciled fixed payments were not secured in 2022
- OneCare and the commercial partners continue to discuss an unreconciled fixed payment concept for potential implementation in 2023
  - Main focus remains on hospitals and independent primary care, but OneCare is open to other provider types as well (ex. FQHCs)

Sources of Funds for PHM Programs

- The payments OneCare can make to its participants are funded through two main sources:
  - Payer contract revenues
  - Hospital Participation Fees
- In some cases each program will have funds from both sources
- A more comprehensive table can be found in the submitted budget Excel workbooks

PHM Expense	Total Expense	Payer Contract Revenue	Hospital Participation Fees (Current Year)	Hospital Participation Fees (Prior Year)	Shared Savings OR Hospitals
Basic OCV PMPM	$9,512,724	$7,566,390	$1,946,334	$0	$0
Complex Care Coordination Program	$5,905,659	$1,987,665	$3,917,994	$0	$0
Value-Based Incentive Fund	$1,000,000	$0	$1,000,000	$0	$0
CPR Program (Supplemental)	$1,158,877	$906,540	$0	$252,337	$0
Primary Prevention	$359,485	$0	$359,485	$0	$0
Longitudinal Care	$399,000	$0	$399,000	$0	$0
Specialist / Innovation	$540,149	$0	$0	$540,149	$0
VBIF Reinvestments	$1,164,708	$0	$0	$1,164,708	$0
PCMH	$2,062,850	$0	$0	$0	$2,062,850
CHTs	$2,725,337	$0	$0	$0	$2,725,337
SASH	$4,285,795	$0	$0	$0	$4,285,795
Total	**$29,114,584**	**$10,460,595**	**$7,622,813**	**$1,957,194**	**$9,073,982**

Questions