OneCare Vermont

July 2021 Budget and Monitoring Deliverables:
Budget Order Condition 15 FPP Target, Strategy and Timeline

FY21 OneCare ACO Budget Order Condition #15:
OneCare must work with payers to propose a target for fixed prospective payment levels, a strategy for achieving those levels, and a related timeline, with clear goals, milestones, and targets.

Deliverable:

By July 1, 2021 OneCare must submit a report to the GMCB including:

A. **Targets for percent of contract revenue in fixed prospective payments, by payer program. Include a baseline year, the calculated percent of contract revenue in fixed prospective payments for the baseline year, and achievable targets for FY22 through FY25.**

Payment reform has been identified by the OneCare Board of Managers as a key component of its strategic plan. Currently, Medicaid is the only payer program with a true fixed payment in alignment with OneCare's payment reform strategy. In furtherance of this strategy, OneCare intends to pursue fixed prospective payments for all in-network hospital and core primary care services across all payer programs during the period PY22 through PY25. It is important to note that achieving the targets identified below will, at a minimum, require cooperation on the part of a number of external stakeholders from the public and private sectors, as well as the convergence of favorable market and regulatory conditions.

Current (baseline) contract revenue in the form of fixed prospective payments (FPP), as well as targets for further directing fee-for-service (FFS) contract revenue to fixed prospective payments and important milestones are as follows:

Table 1: Percentage of Contract Revenue in FPPs

Program (TOTAL $)	Hospital FPP	Primary Care FPP	TOTAL Contract Revenue Under FPP*
Medicare ($494M)	0.0%	0.0%	0.0%
Medicaid Traditional ($211M)	49.5%	0.9%	50.4%
Commercial ($129M)	0.0%	0.0%	0.0%

*Program year 2019 utilized as the baseline to avoid the impacts of Covid

Table 2: Targets and Milestones for Contract Revenue in FPPs

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%

Please see Section B, below, for detailed explanation of targets/timing.
Note that these figures are illustrative of targets and milestones based on the 2019 network configuration. Changes to program offerings and network configuration may affect these targets.

B. **A strategy for achieving the targets, by payer, with timelines, clear goals, and milestones. Include discussion of limitations or other factors by payer.**

Medicare

Achieving the stated OneCare target for fixed prospective payments with Medicare centers heavily on CMMI moving away from reconciliation of the FPP to the FFS-equivalent value at year-end. Movement away from the reconciled fixed payment has been a topic of discussion at the statewide level as part of the All Payer Model work group. While the concept is supported by the OneCare network and is specifically endorsed by the work group, achievement of this goal is dependent on when an unreconciled fixed payment will become an available program option. Additionally, there needs to be assurance that Critical Access Hospitals are able to cost-settle under an unreconciled fixed payment. Without this mechanism, moving to true fixed payments may be limited to only PPS hospitals and academic medical centers. Despite the dependence on Medicare to evolve the program offering, the work group is focused on involving the appropriate stakeholders and continuing the conversation about how to maximize the benefits of unreconciled fixed payments, which totaled $254M in PY19, accounting for 52.1% of Medicare program revenue.

Further enhancement of the Comprehensive Payment Reform (CPR) program and expansion of its network of participants will continue to shift health care dollars towards fixed prospective payments for primary care services. OneCare is currently leading a CPR program focus group, comprised of financial and clinical leaders from the network, with the intention of involving network leadership in program design as a means of increasing participation. From the baseline, approximately $9.8M, or 2.0% of Medicare contract revenue is being spent in-network on primary care services, outside the CPR program (in addition to 0.3% currently within the reconciled CPR program moving to unreconciled). The above table reflects this modest growth from PY23 through PY25, to account for incremental participation growth in the CPR program. Note that the CPR program is currently offered to independent primary care. Over the next few years, OneCare aims to expand this program offering to hospital-employed primary care and develop a similar program concept for FQHCs, both of which would be important payment reform milestones.

The above table assumes movement to an unreconciled fixed payment for PY23 and reflects an increase of 53.4% for that program year (52.1% Hospital FPP and 1.3% CPR).

Medicaid (Traditional)

Currently, Medicaid is the only OneCare program with an unreconciled FPP option. Accordingly, the Medicaid program operates from a baseline of 50.4% (49.5% Hospital FPP and 0.9% CPR).

The area ripest for expansion of fixed payments within the Medicaid program would be in-network primary care currently being reimbursed FFS ($17.8M, 8.4%). Of this amount, roughly eighty-five percent (~$15M, 7.2%) is being paid to Federally Qualified Health Centers. Developing a fixed payment program for FQHCs is part of the OneCare strategic plan and is actively being modeled and designed now, with a goal to launch a pilot program in PY22. Realistically, FQHC fixed payments on a larger scale will most likely come into focus for PY23. The remaining ~1.2% will be converted to fixed payments via CPR Program expansion (similar to Medicare, 0.3% incremental increases annually). These amounts are reflected in Table 2.

Commercial

There is significant opportunity for conversion to fixed payments within commercial payer hospital services, which currently represents 55.8% of the total spend. At present, only one OneCare network hospital participates in a hospital fixed payment with a commercial plan due to the reconciled nature of the offering. The pilot has been largely successful thus far from an operational standpoint and could possibly serve as a basis for further expansion into hospital fixed payments, either by expansion of the participants with the same commercial payer or by involving other payers in similar hospital fixed payment programs. Table 2 reflects this growth opportunity and associated goals in three equal increments of 18.6%, in line with the expectation that expansion of hospital FPPs will come incrementally, such as additional pilot programs within the Network, as opposed to Network-wide expansion into hospital fixed payments by payer program. Because this is a reconciled fixed payment model the baseline for fixed payments is 0.0%.

As is the case with Medicare and Medicaid, further enhancement of the CPR program and expansion of its network of participants will continue to shift commercial health care dollars towards fixed prospective payments for primary care services. From the baseline, approximately $1.8M, or 1.4% of commercial contract revenue is being spent in-network on primary care services (in addition to 0.5% currently within the reconciled CPR program moving to unreconciled). Accordingly, the above table reflects an increase of 0.4% annually from PY22 through PY25, to account for incremental participation growth in the CPR Program, in addition to the 0.5% moving to unreconciled in PY22. The FQHC program design mentioned above represents another area of opportunity. While initial focus will be on the Medicaid reimbursement conversion, future iterations of this program may include commercial fixed payments as well.

Table 2 reflects additional conservative, incremental growth of 2.0% annually, beginning in PY22, in addition to the 0.4% annual growth projected for the CPR program generally. This conservative projection reflects the expectation that expansion will come incrementally, such as additional pilot programs within the Network, as opposed to Network-wide expansion into fixed payments by payer program.

Achieving all of these goals requires partnership with commercial insurers and the State. OneCare is currently participating in a series of group discussions with these parties to identify shared goals and opportunities. Private discussions with commercial insurers are also ongoing as programs are negotiated.

C. **A description of how OneCare calculates the percent of revenue in fixed prospective payments, using the LAN definitions below. Fixed prospective payments are those that fit the definitions found within the shaded box. OneCare must break out the payment types according to those categories.**

Based on feedback from participating providers generated over the first few years of operations, a fixed payment that reconciles back to FFS should not be classified as a true fixed payment. Operationally, providers are required to manage their accounting and revenue cycle in ways that are much more akin to FFS, which dilutes the underlying purpose of the payment reform. As such, the Medicaid FPP represents the only true fixed payment offering for providers in the OneCare network.

Considering the above, the FPP with FFS reconciliation and Shared Savings and Losses (Medicare fixed payment) is not reflected among the fixed payment percentages in Table 1, above. It is, however, recognized in Table 2 as an achievable fixed payment target.

In regard to the LAN categories, OneCare considers the Medicare program, and any commercial programs with a reconciled fixed payment, to be a hybrid between “FFS with Shared Savings and Losses” and “Fixed prospective payment (FPP) with FFS reconciliation and Shared Savings and Losses.” The Medicaid program is considered a hybrid between “FFS with Shared Savings and Losses” and “FPP with Shared Savings and Losses.” In both cases, OneCare is able to convert in-network spend to a fixed payment (whether reconciled or unreconciled) while the payer continues to pay FFS for all other care. Because OneCare isn’t structured to pay claims to non-network providers, this hybrid approach is expected to continue.

D. **The report from OneCare may also include discussion of other payment models OneCare is implementing to reduce reliance on fee-for-service and achieve the goals of value-based care to reduce costs and improve quality of care. OneCare may include a calculation of the percent of revenue in other alternative payment models, using the definitions below. However, the revenue in fixed prospective payments is the focus of the report and must be clearly defined and calculated.**

   - Discussion may include: What types of payments work best for different provider types? What other provider types does it make sense to evolve the payment models to, e.g., FQHCs? What other payment types are out there?

All of the fixed payment reforms OneCare offers to its participants are in spirit of moving away from a FFS model, and helping to provide financial stability and predictability. There are a number of other payment models, such as episode bundles, but OneCare is currently not resourced to facilitate more than the hospital and primary care initiatives.

GMCB-Provided Reference Information:

Health Care Payment Models:

Definitions adapted from the Learning Action Network's Alternative Payment Model Framework.

Fee-for-service (FFS) – Traditional, no link to Quality/Value: payments are made to providers to deliver a service without providing an incentive to improve quality or reduce costs.

Fee-for-service (FFS) – link to Quality/Value: uses traditional FFS payment but adds incremental incentives or disincentives for performance on quality, patient satisfaction, efficiency, or for participation in activities that could improve care. Examples include FFS supplemented with care coordination/HIT payments, pay for reporting, and pay for performance.

Alternative Payment Models (APM)

FFS with Shared Savings: uses traditional FFS payment but holds savings "at risk" for performance on quality and total cost of care

FFS with Shared Savings and Losses: uses traditional FFS payment but holds provider "at risk" for savings as well as losses associated with the total cost of care versus the established budget, as well as for performance on quality.

Fixed prospective payment (FPP) with FFS reconciliation and Shared Savings and Losses: pays a fixed prospective payment, often monthly, with a year end reconciliation against the FFS equivalent, and holds the provider "at risk" for savings as well as losses associated with the total cost of care versus the established budget, as well as for performance on quality (e.g. Vermont Medicare ACO Initiative)

FPP with Shared Savings and Losses: pays a fixed prospective payment, and holds the provider "at risk" for savings as well as losses associated with the total cost of care versus the established budget, as well as for performance on quality (e.g. Vermont Medicaid Next Generation)

Population-Based Payment: prospective payment to providers for "all care", with quality incentives playing a central role.

(*Definitions adapted from the Learning Action Network's Alternative Payment Model Framework.)

Other Population Health or Health Care Reform Payments:

Care Coordination Payment: Payments for the organization of patient care activities, including information sharing among a patient's care team, in order to achieve safer and more effective care with the goal of improving a patient's health outcomes.

ACO Population Health Management (PHM): PHM payments delivered through the ACO are intended to maximize health outcomes, and support value-based care objectives. PHM payments can be fixed or variable, depending on whether a recipient assumes risk during participation. OneCare has a variable population health management payment program for risk-based programs.

Blueprint for Health: OneCare administers payments to Blueprint for Health participating providers for two key programs: Primary Care Medical Home (PCMH) and Community Health Teams (CHT). The only program that receives PCMH payments is Medicare and eligibility is based on attribution. The payment for FY21 PCMH is $2.05 PMPM. The FY21 CHT payments are $2.56 PMPM and is paid through the Medicare program directly to the Blueprint entity within that HSA.

ACO Shared Savings/Losses: Shared savings and losses is a payment strategy that incentivizes providers to reduce health care costs for their patient population in which the ACO offers providers a portion of net savings for their efforts to reduce spending for their population, or losses if spending ends up being more than expected. This payment methodology is designed to tie payment to ACO or provider performance.

Other Value Based Infrastructure Payments: Payments or incentives to providers to invest in infrastructure expected to improve patient care (e.g. EMR/HIT investments).