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HCA Questions – OneCare Vermont 2021 ACO Budget Review

1. OneCare's fixed prospective payments (FPPs):
    a. OneCare's FPPs were not designed for circumstances like COVID-19, when care was largely unavailable to patients. Is it a general goal for providers to get predictable payments regardless of the care provided (e.g., even if their offices are closed and no care is provided)?
    b. There is an apparent conflict between the goal of giving providers stable payments with consistent increases and the goal of lowering costs for Vermonters. How do you see FPPs fulfilling each of these goals?
    c. Do FPPs help insulate providers from shifts in payer mix?
2. How did OneCare determine that the cut-off for provision of care management was a blended 15% of high risk and very high risk patients?
    a. Is this a budgetary decision or based on a certain level of acuity where care coordination would be expected to have the biggest impact?
        i. If it is the latter, was this established internally or based on external recommendations?
    b. Is there variation by payer on how you apply the metrics to establish which patients receive care coordination?
3. OneCare's 2019 Medicare quality scores are notably low for two payment measures as compared to national benchmarks: Risk Standardized, All Condition Readmissions (50th percentile) and All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions (40th percentile). These measures appear to be directly aligned with OneCare's primary goals.
    a. Please describe in detail what OneCare intends to do to improve performance in these areas.
4. OneCare's 2019 Medicare quality scores are notably low for two reporting measures: Follow-up After ED Visit for Alcohol and Other Drug Abuse or Dependence within 30 Days (19.9%; 11% with follow-up within 7 days) and Engagement of Alcohol and Other Drug Dependence Treatment (5%). We note that 30 days is a low standard for follow-up (i.e., far too long after discharge for effective follow-up).
    a. What are you doing to improve these metrics compared to your past performance?
    b. What, if anything, are you doing to encourage providers to follow up in a significantly shorter time period than 30 days for both substance use and mental health ED visits?
5. Does switching ACO risk to the network (i.e. state) level present new issues? We understand that presently due to low population and/or attribution, normal random variation in spending could drive outcomes.
    a. If risk is shifted to a state-wide level, is ACO risk essentially driven by UVMMC performance given the proportion of the total population in that HSA?
    b. If ACO performance is driven by UVMMC, is it reasonable to assume that smaller HSAs might not change their practices since they would have a negligible impact on ACO risk outcomes?
    c. Does this dynamic incentivize OneCare to prioritize UVMMC's services for its population health investments?
    d. How do expanded/geographic attribution and the shift to state-level risk interact in terms of payer, ACO, and provider risk exposure?

6. Please describe in additional detail how the variable population health management (PHM) payments will be calculated for each practice. (They are described as tied to both "ACO and local health service area (HSA) financial results." Narrative, pg. 11.)
    a. Does this methodology account for differences in the underlying patient population by HSA?
7. You mentioned that the expansion of telemedicine is promising. What, if anything, are you doing to educate your participating providers on how to provide quality care through telemedicine?
8. Has OneCare considered offering to negotiate supply costs for its participating providers in order to leverage the combined size?
9. What is the reason for the improvement on your quality scores - Is it motivation to receive the payments? Education? Data? Focusing on these particular issues? To what extent can these practices be used to expand the areas OneCare improves?
10. OneCare noted in its patient example the difficulty faced by patients who are unable to access dentures. This is a serious systemic health care access issue that the HCA has been aware of for many years. Please describe what OneCare did to acquire dentures for this patient, and whether this kind of benefit is offered for other patients.
11. OneCare was directed to provide "the methods for establishing new or continued investment" for population health and payment reform investments. In Table 10 on pages 58 through 63, OneCare listed six population health or payment reform investments. Of the five items that OneCare intends to continue in 2021, OneCare stated that the financial sustainability of the program depends on continued investments from partners in the column "Methods for establishing new or continued investment." Please clarify whether OneCare's method for making new or continued population health or payment reform investments is solely that OneCare has the available money, as suggested by OneCare's reference to financial sustainability, or whether OneCare has a different method to decide where to invest available monies. If such a method exists, please provide it for each population health or payment reform investment listed in Table 10.
12. Please provide a detailed description of each of the following programs (expanding on the information provided in Table 10), and provide any related contracts and/or protocols:
    a. Primary Prevention: Self-Management Program
    b. Specialist: Chronic Kidney Disease (CKD) program
    c. Specialist: Mental Health Program
13. In reference to page 53 of your narrative, is it correct that "most prevalent high cost conditions" was interpreted as "most prevalent conditions for high cost individuals? In other words, the condition may not be high cost? This information does not appear to answer the question that was asked.
14. Please explain how the patients attributed through the Medicaid expansion methodology in 2020 will be attributed (or not attributed) in 2021.

Please reach out to hcapolicystaff@vtlegalaid.org with any questions.