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2023 Medicare Benchmark Recommendation

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Agenda

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- Staff Recommendations for 2023 Benchmark
- Background
  - All-Payer Model
  - Medicare Benchmark
- Experience to Date
  - Settlements over time
  - OCV results through 2021
  - Prior year Benchmarks and outcomes

Recommendations

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- Staff recommends using the maximum allowable trend for OneCare Vermont's Medicare Benchmarks:
  - 5.2% for Non-ESRD*
  - 3.9% for ESRD*

- Estimates suggest that these trends will allow Vermont to stay on track with its financial accountability targets, accounts for Medicare reimbursement increases, and will help bolster a fragile delivery system.

*ESRD – End Stage Renal Disease

Trade-Offs for Using Maximum Trend

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PROS

- Vermont hospitals are financially fragile, a trend observed nationally.
- The maximum trend will increase the amount of federal dollars available through the current All-Payer Model.
- The maximum trend is estimated to keep the state on track for its financial targets.

CONS

- The maximum trend may endanger the ability of the state to fulfill its financial targets from the APM Agreement.

Maximizing Medicare Benchmark Trend

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There have been comments that the Board has failed to maximize the Medicare trend, and that leaves federal money on the table for Vermont.

- *"We also urge the Board to examine whether there is more Medicare revenue to be realized through the All-Payer Model, and to fully exhaust that potential. We believe that the Board could bring more Medicare funding into the state without any negative impact…" UVMHN Budget Narrative**
- *"maximizing the annual Medicare trend rate to facilitate increased scale and reduce the cost shift" in response to, "What other actions can healthcare stakeholders be taking to support the ACO in achieving the goals of the Vermont All-Payer ACO Model?" OCV Budget Narrative***

*Source: https://gmcboard.vermont.gov/sites/gmcb/files/documents/UVMHN_FY_2023_UVMHN_Budget_Narrative_07-01-2022_-_Final.pdf
**Source: https://gmcboard.vermont.gov/sites/gmcb/files/documents/OCV_FY23-Budget_REDACTED-Narrative-Responses_Sent-09-30-2022.pdf

Previous GMCB Decisions & Trend Limits

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Performance Year	Approved Benchmark Trend Non-ESRD	ESRD	Trend Limits to Date Non-ESRD	ESRD	Notes
2018	3.5%	3.5%	3.5%	3.5%	GMCB elected to use the floor provision of the Agreement (maximum allowable trend)
2019	3.8%	3.1%	3.8%	3.1%	Maximum allowable trends
2020	-7.7%	-2.2%	4.0%	2.9%	Retrospective trends due to COVID-19
2021	17.4%	17.3%	4.4%	2.3%	Retrospective trends due to COVID-19
2022	7.3%	7.3%	10.4%	7.6%	Base experience used imputed values for 2020, which increased the baseline experience value

These trends are combined to set a target for the entirety of the Agreement and additional years (2017-2023): Non-ESRD = 5.2 – 5.5% compounded annual growth; ESRD = 3.9 – 4.2% compounded annual growth

Risk Corridor and Advanced Shared Savings

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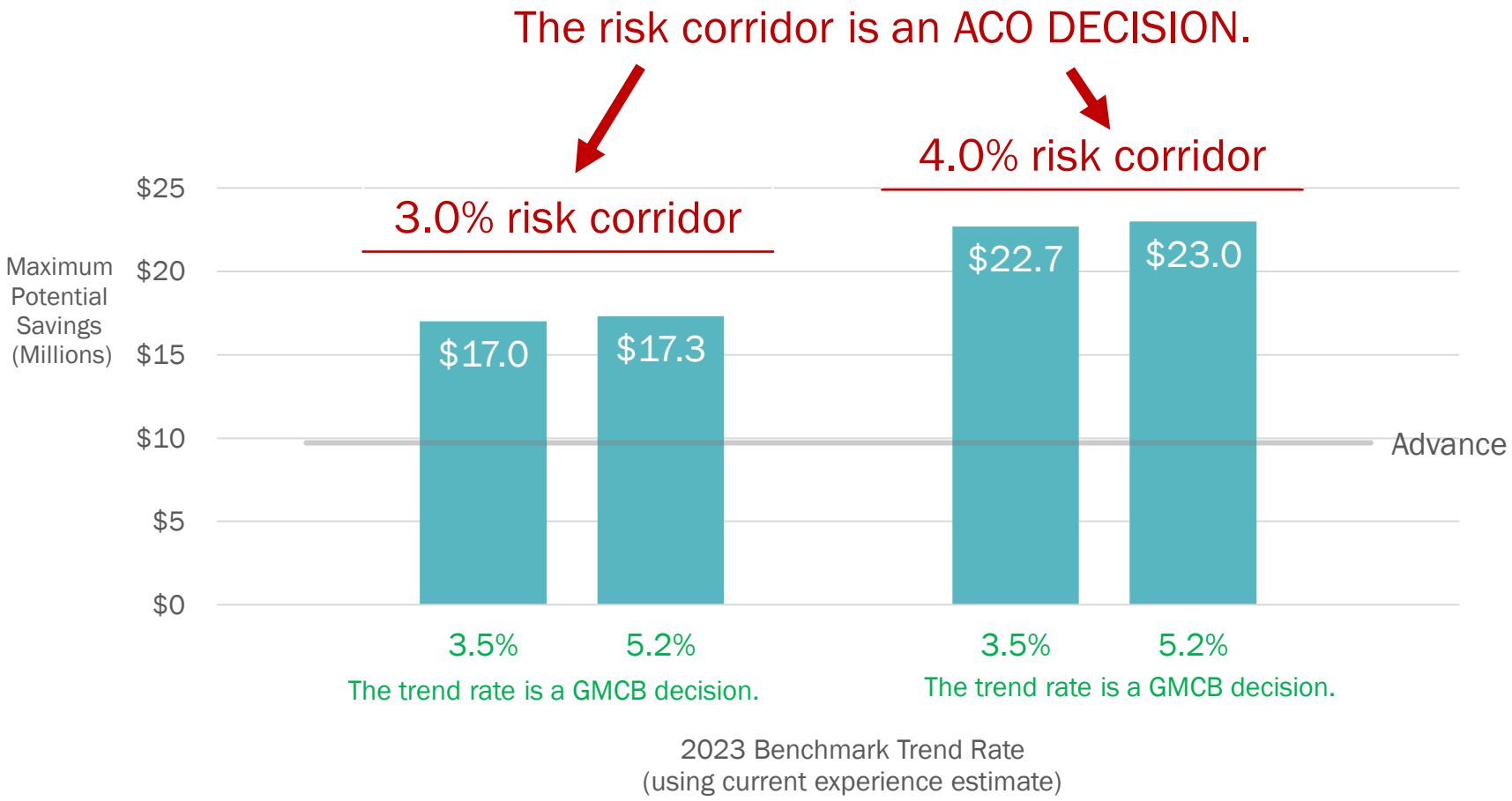

Leveraging Federal Funds

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- GMCB decisions have added federal dollars for Vermont providers.

Benchmark decisions	Additional dollars to OCVT/SOV
Advanced shared savings	$31 million
Using imputed claims for 2020 experience for 2021 Benchmarks	$457 thousand
Floor in 2018	$196 thousand

- Using actual experience and maximum trend for the 2021 Benchmark would have reduced the ACO's Benchmark by $14 million. With the 2% risk corridor, that would have reduced the settlement by $457 thousand.
- As illustrated on previous slide, GMCB's trend decisions are constrained by the ACO's risk corridor.

Leveraging Federal Funds

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- The reduction in risk corridor has had larger impacts on the opportunities for increasing federal dollars. The ACO's gross savings in PY2021 were $22.3 million.

ACO Elected Risk Corridor	PY2021 Maximum Savings	Missed Opportunity
2% (as selected)	$10,026,241	**-$12.3 million**
3%	$15,039,361	-$7.3 million
4%	$20,052,482	-$2.3 million
5%	$25,065,601	Maximum savings realized

Staff Recommendation

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- Use the maximum allowable trend for OneCare Vermont's Medicare Benchmarks:
  - 5.2% for Non-ESRD
  - 3.9% for ESRD

- Request advanced shared savings of $9,545,916 to fund Blueprint for Health Programs and SASH.

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Background

All-Payer Model Agreements

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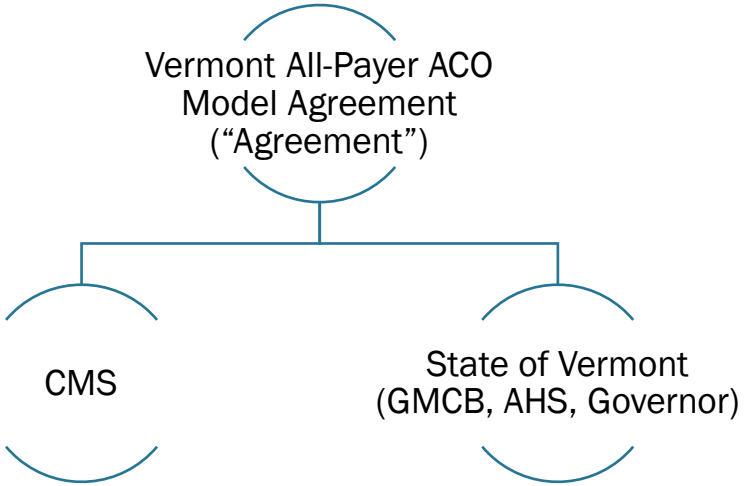

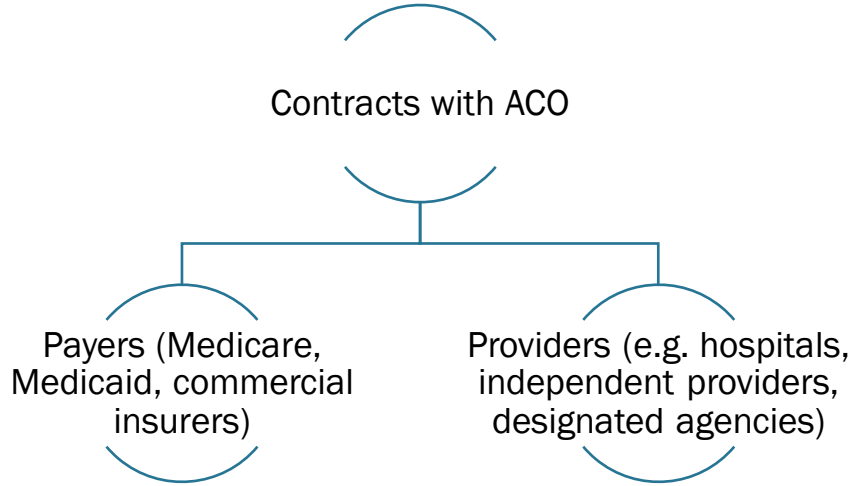

Agreement requires GMCB to set Benchmarks for ACO's Medicare program. Benchmarks must be approved by CMS prior to performance year.

How We Measure the APM

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- The APM has three (3) areas of performance that we (GMCB) monitor and report on for our federal partners.
  - TCOC is the financial yard stick by which we measure performance.
  - Scale, or the proportion of the population aligned to an ACO, is a second yard stick.
  - Quality is the third yard stick, measuring the state's trajectory toward improving patients' and providers' outcomes.

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  - TCOC is the financial yard stick by which we measure performance.
    - The Medicare ACO-aligned population is the State's entry point to regulating healthcare for Medicare beneficiaries.
    - Also, Medicare Benchmark is how we fund the Medicare piece of Blueprint for Health and Support Services at Home (SASH).
  - Scale, or the proportion of the population aligned to an ACO, is a second yard stick.
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APM Financial Targets

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State of VT Accountability

All-Payer TCOC Per Capita Growth
(3.5 to 4.3% average from 2017 to end of Agreement)

Medicare TCOC Per Capita Growth
(Average from 2017 to end of Agreement from -0.2 to +0.1 percentage points of national projections)

GMCB Duty

ACO Medicare Benchmarks
(Annual Growth targets for Medicare beneficiaries attributed to the ACO)

ACO Financial Targets

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- Medicaid and commercial payers negotiate annual financial targets with the ACO
  - The GMCB uses its ACO oversight to monitor how these targets relate to the APM financial yard sticks.
- Medicare relies on GMCB to propose annual financial targets for the ACO on its behalf
  - The Agreement includes certain criteria the proposals must meet.
  - CMMI approves or may request modification of the proposal.

Benchmark Components

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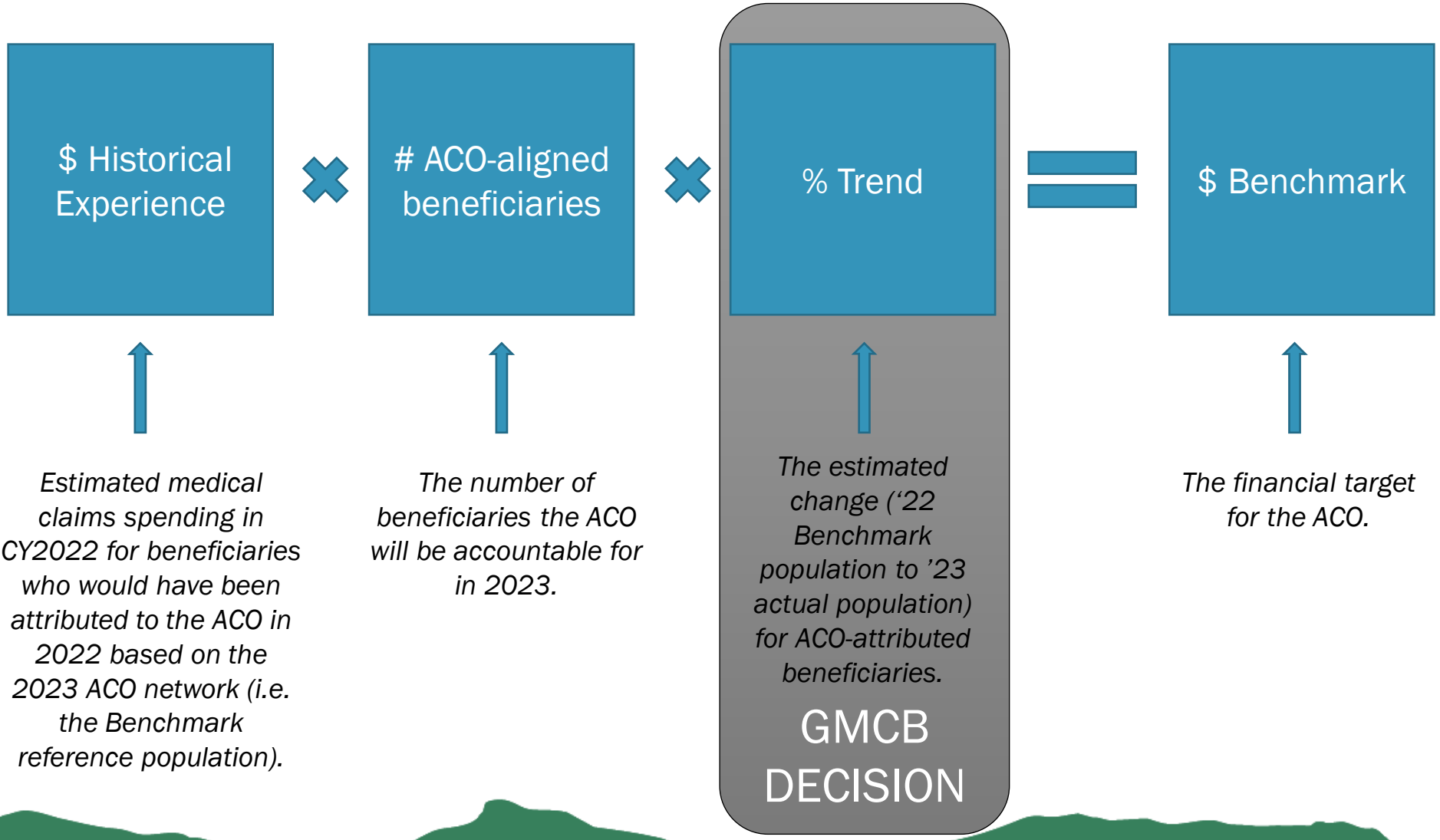

Allowable Benchmark Trends

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- Per the Agreement, trends set by the GMCB must meet certain criteria:
  - One of the criteria is that the trend set is at least 0.2% lower than the projected growth for Medicare fee-for-service (FFS) nationally.
- National projections are from the Medicare Advantage Call Letter, released annually around April preceding the performance year.
- Example: for 2023 the trend for Non-ESRD FFS Medicare expenditures was 5.4%. Vermont's maximum trend, per the Agreement, is 5.2%.

Baseline Experience
OneCare Vermont Concern

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We appreciate and support the GMCB staff recommendation to utilize the maximum allowable trend rate when computing the 2023 Medicare benchmark. However, we are very concerned with the calculation of the 2022 base spend upon which that trend is applied, and believe much more work and analysis should be undertaken to assure it is sufficient. We believe there are alternatives to ensure the base is accurately set to reflect actual cost of care and would want to see that memorialized in writing. If the 2022 base spend numbers shared by the GMCB on December 16, 2022 are utilized, the 2023 target will be 0.1% higher than the 2022 target, which falls well short of inflationary trends at a point when our network providers are facing extreme financial stress. Part of the value of the all-payer model agreement was to ensure adequate Medicare payments to Vermont providers. Under-shooting on our Medicare target negates this benefit.

- OneCare Vermont letter to GMCB (12/16/2022)

Baseline Experience

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- Each year, the GMCB reviews the baseline estimate and works with OneCare and CMMI to ensure it's accurate. Adjustments have been made in prior years.
- The GMCB is coordinating a meeting between to help identify reasons for differences between CMMI and OneCare estimates.
- Historically, OneCare VT has overestimated its final PMPM at this time of the year:

PY	OCV estimate	CMMI
2021	$838 to $858 ($17 to $37 over actual)	$821 (actual)
2022	$867	~$820 (current estimate)
2023		$829 (benchmark estimate)

Baseline vs Targets

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While the targets between 2022 and 2023 are close, that's largely due to the **trend rate**. The baseline experience estimate increased by 2.5%.

CMMI's most recent estimate for PY2022 experience is ~$820 PMPM, which would result in OneCare maximizing their potential savings.

	Baseline	Trend	Target
PY2022	$809	7.3%	$868
PY2023	$829	5.2%	$872
Annual Change	*2.5%*	*-2.0%*	*0.5%*

End Stage Renal Disease vs. Non

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- The Medicare Benchmark is set separately for beneficiaries who are eligible due to End Stage Renal Disease (ESRD) and the remaining population (i.e. beneficiaries eligible due to age and/or disability).
- There are very few beneficiaries eligible due to ESRD, but their average expenditures are much greater than the remaining population.

Benchmarks & The AIPBP

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A Common Point of Confusion

- Medicare offers prospective payments called All-Inclusive Population Based Payment (AIPBP).
- These payments are designed as a cash flow mechanism to provide more stability to providers during the year.
- Ultimately AIPBP is reconciled to the *what would-have been paid* on behalf of attributed beneficiaries.

Medicare ACO TCOC = FFS payments + AIPBP claims

- Medicare's AIPBP is calculated separately and reconciled independently from the Benchmark.

Benchmarks vs AIPBP Reconciliation for OneCare

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	2019	2020	2021
AIPBP	$0 (0%)*	-$36 m (19%)	-$7 m (2.8%; awaiting finalization)
Full settlement	$11 m	$16 m	$10 m
Settlement less advance	$5 m	$8 m	$ 1 m

* A hospital signed up for AIPBP but was not eligible due to its participation in an existing Medicare program, which represented ~12.2 million. It was identified early, and OneCare held onto the funds.

The AIPBP was disrupted in 2020 due to the pandemic and has been relatively close since. This AIPBP reconciliation is *separate from* the Benchmark settlement.

AIPBP = cash flow
Benchmark = performance

Advanced Shared Savings

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- Medicare's investments in the Blueprint for Health Programs ended in 2016, i.e.
  - Primary Care Medical Home (PCMH)
  - Community Health Team (CHT)
  - Support and Services at Home (SASH)
- The Agreement included provisions to allow for their continued funding by Medicare.
- The funding is attached to the Medicare Benchmark but does not represent *performance risk*.
- The advance is reconciled at settlement.

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Experience to Date

OneCare Vermont Medicare Participation

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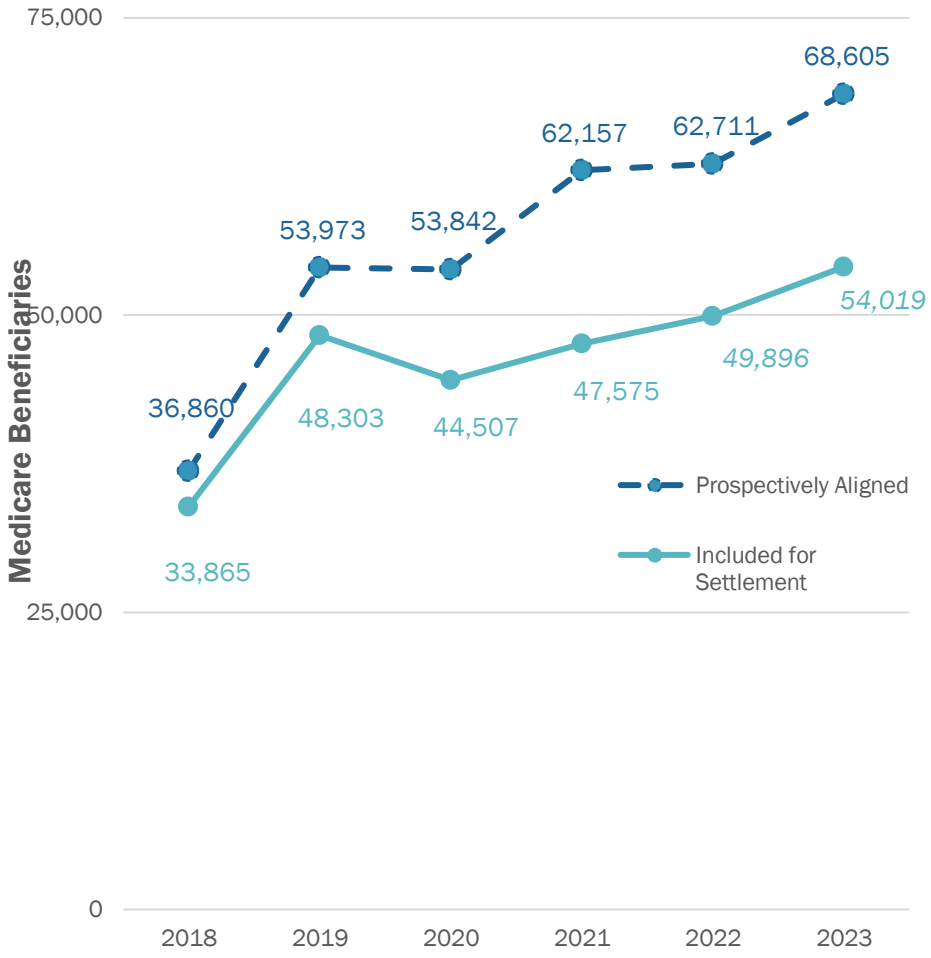
- The Vermont Medicare ACO program limits which beneficiaries are included in the financial settlement.
- Beneficiaries must:
  - Maintain eligibility for the entire performance year (or until they pass away)
  - Receive 50% or more of their primary care services in the ACO's service area
- As more people opt for Medicare Advantage plans, substantially more beneficiaries are losing eligibility.



Settlements

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	2018	2019	2020	2021
Gross Savings / (Losses)	$ 17,022,114	$ 11,285,496	$ 27,002,622	$ 22,318,060
Cap on Savings / (Losses)	$ 20,634,180	$ 24,790,486	$ 20,391,839	$ 10,026,241
Capped Savings / (Losses)	$ 17,022,114	$ 11,285,496	$ 20,391,839	$ 10,026,241
Quality Adjustment	$ -	$ (196,758)	$ -	$ -
ACO Risk Arrangement	80%	100%	80%	100%
Adjusted capped savings / (Losses)	$13,345,337*	$11,285,496*	$ 16,313,471	$10,024,813*
Advanced Shared Savings	$ 7,776,760	$ 6,342,236	$ 8,401,660	$ 8,767,133
Net Settlement Adjusted for Advanced Shared Savings	**$ 5,568,578**	**$ 4,943,260**	**$ 7,911,811**	**$ 1,233,926**

* Includes deduction for sequestration

Takeaways: over the last 4 years of the APM, VT providers have received $31.1 million, and the ACO has netted $20 million.

Concerns: Future models may not be as beneficial for Vermont.

OneCare Risk Results

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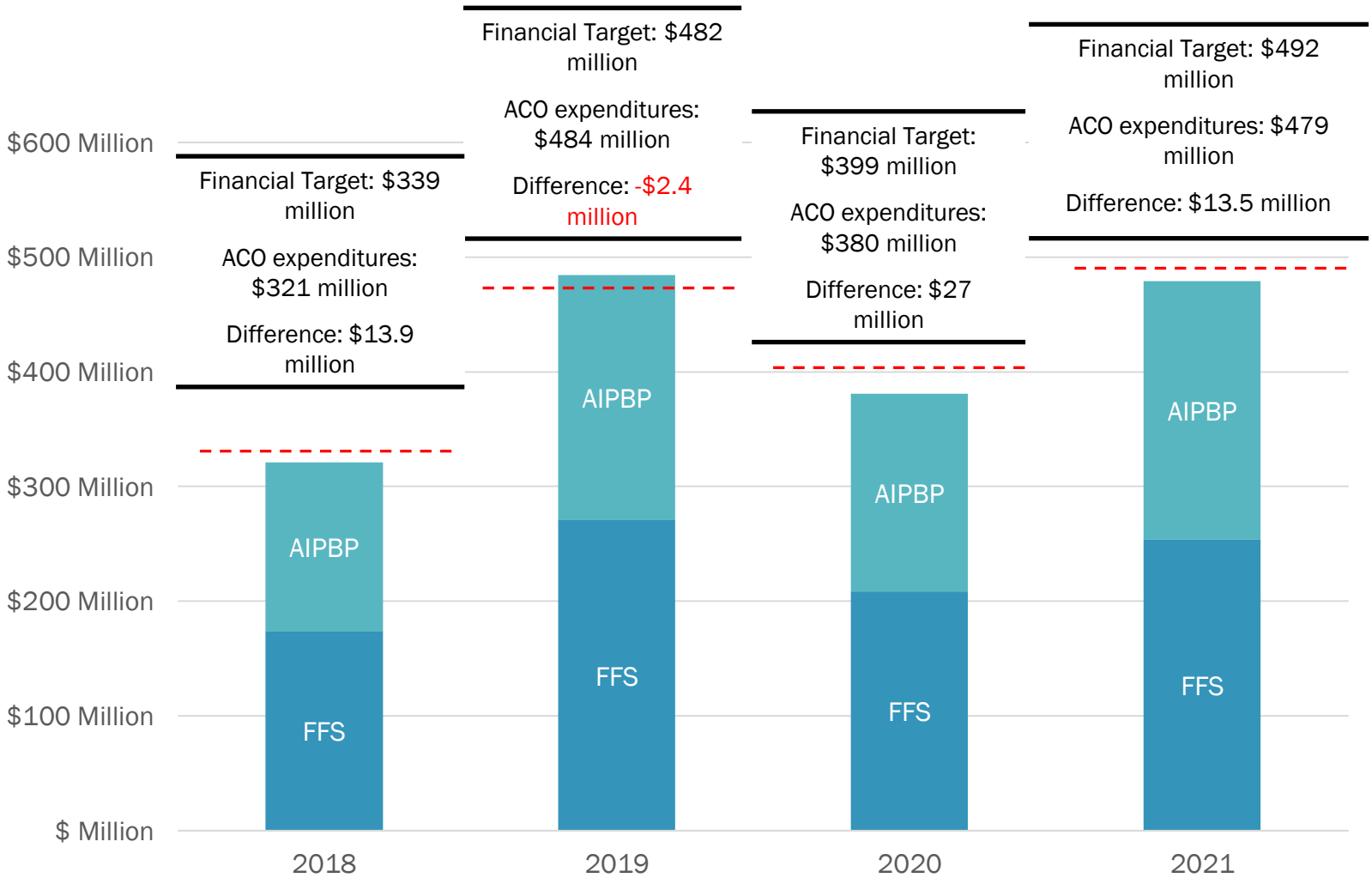

Advanced Shared Savings in the Medicare Benchmark

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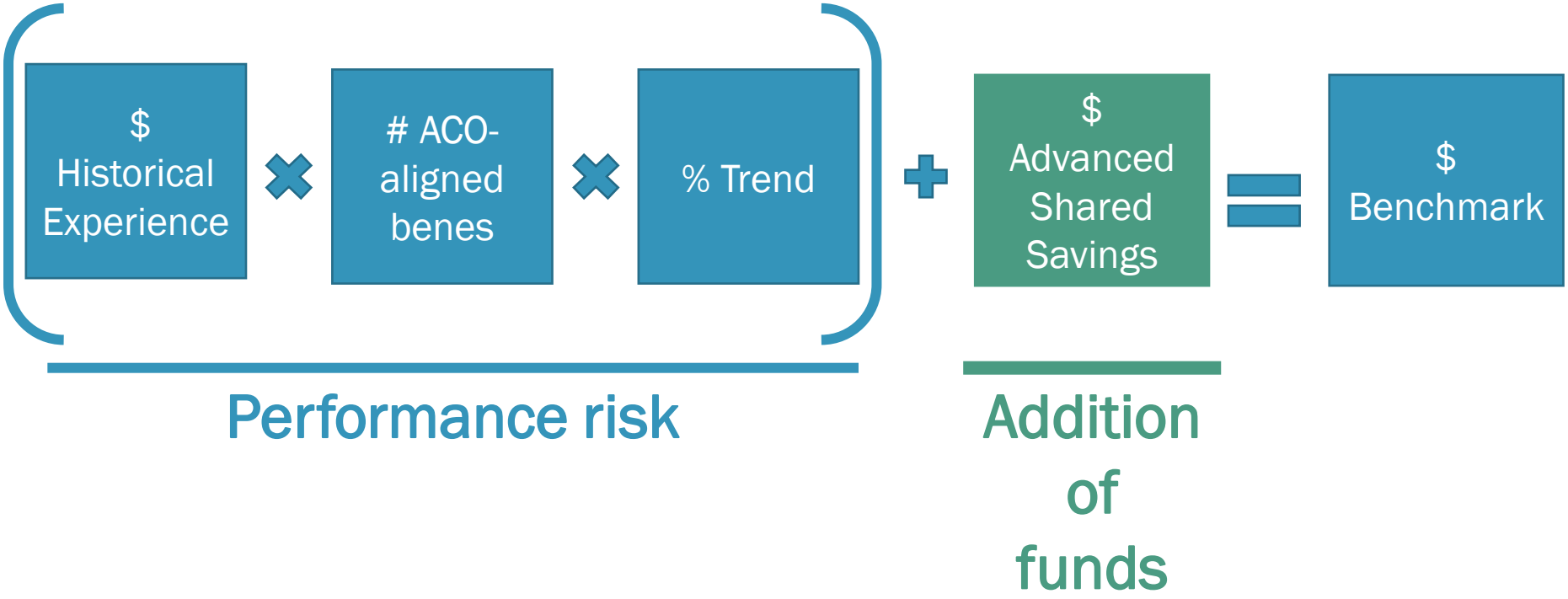

Current Projections for APM TCOC PMPM through 2023

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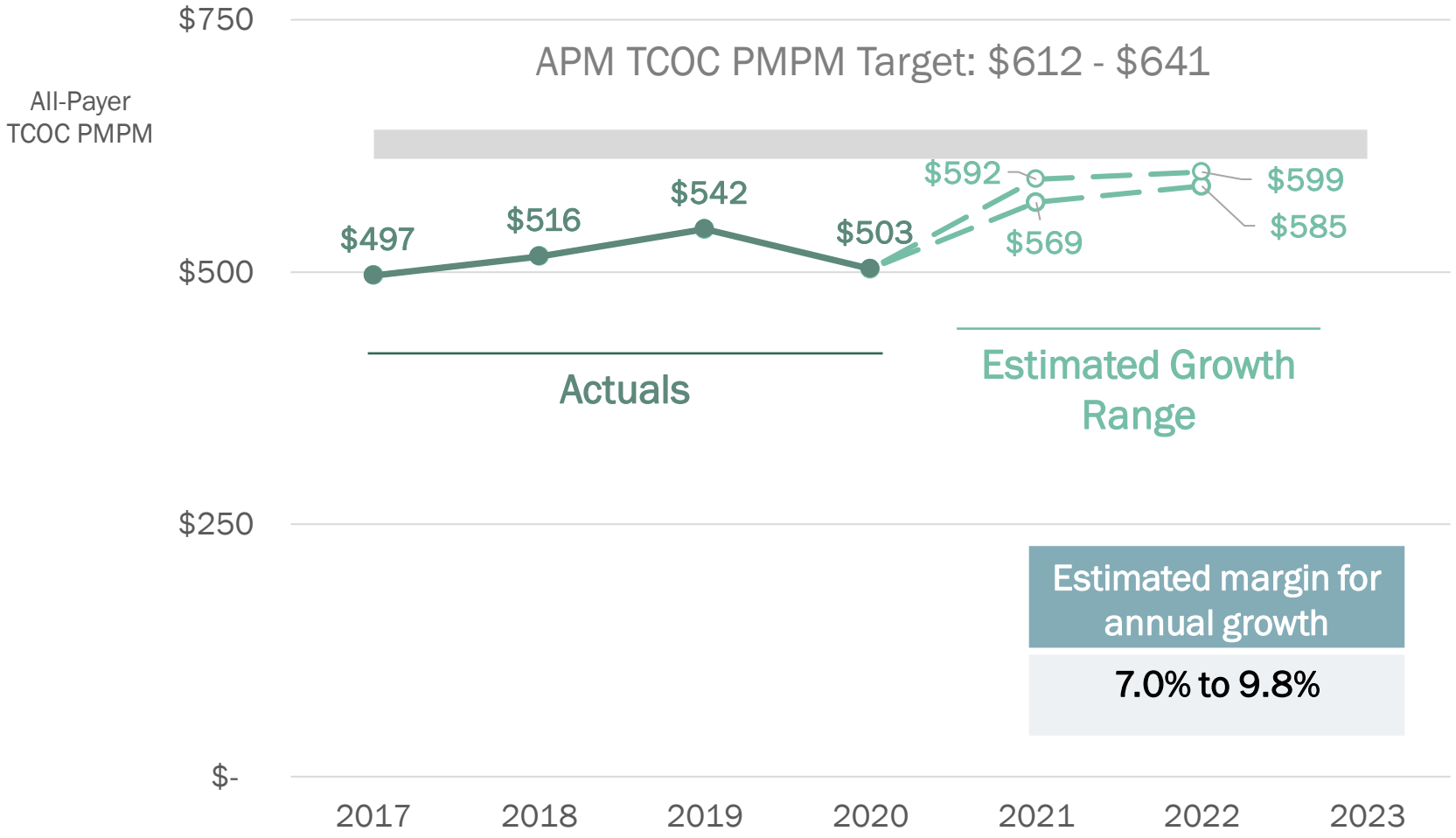

Estimated margin for annual growth
7.0% to 9.8%

Staff Recommendation

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