OneCareVermont

HCA Questions

Goals of the ACO Model

1. OCV states in its budget submission that "without adequate trend rates that incorporate early success, spending targets could begin to drop and such disincentives could discourage continued participation." One might interpret this statement as suggesting that if the model succeeds at bending the cost curve downward, that OCV expects providers to stop participating causing model failure. If that is the case, how will the model succeed at long-term cost savings and quality improvement?

   The provider network participating in OneCare programs have shown a commitment to the All Payer Model and its goal to maintain a 3.5% statewide growth rate. However, if the benchmark targets are set in a manner that results in actuarially-projected financial losses, the possibility exists that providers and their boards will decline future participation. With this in mind, the model will succeed at long-term cost savings and quality improvement if the financial models build from the base year at the targeted 3.5% trend rate, and maintain the financial incentives to maintain focus on the goals of the triple-aim.

2. Please clarify the meaning of OCV's statement that "the absence of downside risk drives the focus to population health management (PHM) resources." (p.15)

   This paragraph of the narrative explained the OneCare strategy to build non-hospital community provider participation. These providers are not subject to downside risk, and therefore, the strategic focus tends to shift towards population health management (PHM) resources, balancing clinical independence with an integrated delivery system model, and the community partnerships that may or may not be in place.

Primary Care

3. Does care received at an urgent care center count as primary care for attribution purposes if the Qualified Evaluation and Management (QEM) code qualifies?

   The attribution methodology is different for every Payer Program, but it is based on a member's primary care relationship with a provider participating in the ACO network. An urgent care center can attribute patients if they meet the following criteria: the urgent care center is participating in the ACO network, the urgent care provider is billing with a primary care specialty code, the service being billed is a qualified QEM code, and the majority of the patient's care has been with that provider.

4. Please explain why FQHCs are only participating in 6 of 13 HSAs.

   OneCare represents a voluntary network of providers. All participation choices are individualized and unique to each organization. Therefore, by and large the organizations themselves are in the best position to answer the question about their choice not to participate when their hospital had agreed to be at risk in their community.

5. We recently learned from DVHA that Vermont Chronic Care Initiative (VCCI) case management services are no longer available to Medicaid patients attributed to the ACO.

   a. What is OCV doing to ensure that attributed patients receive services comparable to VCCI?

      The OneCare care coordination model is a community-based model. OneCare believes in building the capacity and skills across communities and organizations by resourcing and supporting community-based providers to enable more robust care teams, as well as by enabling increased access to these supports than existed in the past. There is infrastructure in every community in Vermont to be able to support the complex care coordination needs for attributed members.

      The OneCare community-based model is designed to break down insurance and point-of-entry barriers for individuals needing complex care coordination. Many individuals across OneCare's network do not qualify for VCCI-like complex care coordination services. Through the care coordination payment model, OneCare has invested to build the infrastructure, to provide resources and to provide data that enable a community-based model that is less benefit or resource driven, and provides patients with more access to care, rather than less.

      OneCare has directly resourced organizations for complex care coordination based on an analysis of care team composition for individuals with complex needs. Analysis revealed that these individuals very frequently already receive care and support from a community-based team of organizations including designated agencies, home health, agencies on aging, community health/team social work and MAT staff, who provide complex care coordination and support. Additional resources provided by OneCare allow agencies and providers to adjust their actual staffing models and provides training to expand existing services. By building the skills and resources across communities so that the work is shared by a coordinated team, this model is intended to expand workforce capacity as well as to support workforce retention through staff burnout prevention enabled by team-based care, while simultaneously enabling complex care coordination services to reach more individuals in need.

OneCare recognizes that transforming complex care can take time and it is working intensively with the network to build those services, and to remove barriers across the network such as limits on home visits without a skilled-nursing care need, which allow a variety of existing skilled staff in community-based agencies such as home health and others to reach more of the individuals across populations who could benefit from complex care coordination.

b. What case management services are available to attributed Medicaid recipients who are fired by their primary care provider (PCP)?

OneCare does not support the firing of any patients from a healthcare service/ provider, rather we support finding alternative ways to meet the needs of an individual who has already been fired from primary care and re-connecting the individual to an effective and supportive relationship with a primary care provider. OneCare's care coordination model promotes the availability of resources and practice-based workflow development to proactively connect individuals to additional resources, avoiding cessation of the primary care relationship. This enables what frequently are the social determinant of health, access and system barriers to a relationship with a primary care practice team to be uncovered and addressed, so that all individuals in the OneCare network retain access to the essential care of a primary care provider of their choice.

Accountability for Quality of Care

6. OCV's Medicare quality results for 2017 are publicly available online. Please submit them or explain why OCV chooses not to include them in its budget submission.

Please find attached the two tables showing OneCare's Quality Measures results for MSSP and BCBSVT in 2017.

7. Can you provide any insight into why OCV's performance on adolescent well visits and child developmental screening are so low and not improving significantly?

OneCare has continued to improve in the adolescent well care visits for the Medicaid and BCBS QHP programs as well as developmental screening in the first three years of life for the Medicaid program. These two quality measures are part of the OneCare clinical priorities and the three payer programs with a large enough pediatric population in 2018.

- *Adolescent Well Care Visits:*

  - *BCBS QHP has remained consistently in the 75th percentile from 2014 to 2017 and is continuing to work towards the national 90th percentile.*
  - *Medicaid has remained consistently in the 50th percentile from 2014 to 2017 and is approaching the 75th percentile. The gap between the Medicaid rate and the 75th percentile in 2014 was over 8%, which was decreased to 2.22% in 2017.*
- *Developmental Screening in the First Three Years of Life:*
  - *This was not a quality measure for BCBS QHP in 2017, however it has been included in the 2018 program. Historical quality measure results from 2015 and 2016 show a stable trend.*
  - *Medicaid has continued to trend upwards above the 75th percentile and has improved from 45.50% in 2014 to 59.74% in 2017.*

8. How is the quality incentive money being used by OCV providers?

   To date, OneCare providers have not yet received the Value-Based Incentive Fund quality incentive dollars. The funding is not distributed to the Network until the program settlement is complete which occurs approximately 6-9 months after the end of a performance year. OneCare is in the process of preparing to distribute the first VBIF funds from the 2017 VMNG program. OneCare does not intend to track the use of the funds within practices as that is at the discretion of the practice to allocate as they see fit.

Commercial ACO Program

9. OCV states that BCBSVT estimates that the impact on trend of the new federal Association Health Plan (AHP) regulations is an increase of 2.3%. (p.24, 25, 27) OCV then asserts that it requires an upward trend adjustment of 2.3% to account for the fact that it will not bear risk for AHPs. OCV also states that it did not include in its requested trend the 1% premium reduction levied by the Board on BCBSVT's 2019 QHP line of business.

   a. Please expand on the apparent contradiction between the different treatment of OCV from BCBSVT documented above and OCV's stated intention to "align and integrate the overall QHP market rates, the hospital budget rate approval process, and the ACO spending target into a uniform system." (p.27)

      While it is OneCare's intent to take on risk for the total cost of care for Vermonters in a manner that is in alignment and integration with overall QHP market rates, the hospital rate approval process and the ACO spending targets, we can only do so if all of the processes and GMCB approvals are in fact aligned and use the All Payer Model (APM) targeted overall growth rate as a parameter. Given the differences in timing and how early we still are in the APM journey, this has unfortunately not occurred to date and complicates the target setting process for OneCare.

It is also important to note that not all factors impacting the QHP premiums affect the expected claims costs for which OneCare is at risk, and will, therefore, not be included in the target setting for OneCare. It is also expected that payers complete their filings in a timely and accurate manner, and that all rate increases filed and approved are actuarially sound. If they are not, OneCare's requirements to take on risk will deviate from our intent of alignment stated above.

OneCare cannot be held responsible for facilitating our provider participants to assume increased risk and costs created by decisions about which we have no control and for which we are not provided funding, even when considered reasonable by the multiple actuaries involved. Ultimately, if OneCare is not provided a fair target, we may decline to take the risk. Given that neither OneCare nor the hospitals who are at risk under the All Payer Model have been provided adequate funding from Medicare or from the commercial payers with whom we contract from which to fully fund required infrastructure, payment reform programs, or create reserves, we must carefully consider every possible impact to the claims cost calculations. Any pre-assumed discounts to commercial risk targets not directly driven by enforcement of the overall APM growth rate, whether required by either a commercial payer or the GMCB, by definition decreases the incentive to providers to assume risk and invest in reform under the APM approach and target growth rate.

Under the same logic that OneCare not accept an artificially "underwater" target for the attributed lives for its attributed QHP population, OneCare took note that BCBSVT filed a rate increase for its QHP products for the anticipated claims cost increase resulting from healthier, lower cost small group enrollees moving to an AHP product and away from the QHP population. L&E supported this expectation of a 2.3% increase in QHP costs as a reasonable assumption because BCBSVT demonstrated the lower expected claims for the AHP population that drove this calculation.

The GMCB, however, denied the rate increase due to a number of factors, none of which are relevant to OneCare's business model and proposed target setting based on expected claims costs:

- *BCBSVT filed this request late in the process, thus GMCB doubted the necessity of the increase. OneCare believes this to be a real effect which will leave us with a higher risk QHP attributed population.*
- *BCBSVT testified they expected to shift membership from its own QHP to its AHP products. Therefore, they expect to retain the margin from these enrollees contributing to its reserves, albeit in a different product line. OneCare will not be contracting for this line of business and will not have the same ability to offset the additional cost and resulting losses.*
- *BCBSVT's expected AMT refund, which was not factored into a rate*

reduction, can be used to absorb any additional costs. OneCare has no such "back end" protection if we end up with a higher risk population and therefore our target and its adjustment methodology is our only lever.

It is important to note that OneCare also does not receive specific funding through BCBSVT to build reserves, nor have hospital budgets been approved which allow building of total cost of care reserves there. We believe it is reasonable to suggest that OneCare should either have its target approved under our approach to full claims projection adequacy or OneCare or its hospitals should be provided resources for building reserves if there is an expectation we will assume a target which projects a high but perhaps not certain expected risk of a loss against the target.

Regarding the second item in the question, the GMCB's reduction to BCBSVT's premium of 1% for affordability, this has no bearing on the expected claims costs and trends, which drive our proposed target. This in combination with the fact that OneCare is provided inadequate funding from BCBSVT for our operational costs for many of our payment reform programs implemented for their attributed population, which includes the Value Based Incentive Fund, nor provided any amount from which to build reserves, leaves us in a challenging position for continued provider support for the BCBSVT contract. Therefore, our targets must be focused on adequacy and fairness, tied directly to OneCare's expected claims costs, while still ensuring alignment with the APM targets.

Although we are expecting the OneCare reforms and programmatic innovations to bend the cost curve below 3.5% on an all payer basis, that differential is precisely the financial incentive OneCare has told providers was the basis for participating and investing in the model. Unless an "affordability reduction" for commercial rates is driven by and directly connected to the overall 3.5% rate of growth called for in the APM, we are concerned that the 3.5% target is being effectively reduced as the target for affordability while we at the same time must invest in improving quality, coordination, and access to services within the health care system.

In summary, OneCare is taking on risk for the total cost of care for attributed members. It is engaging significant efforts, mostly at its own expense, to help ensure commercial premiums and premium equivalents for self-funded plans fit within the 3.5% targeted growth rate under APM.

b. Please explain why the 1% disregard is appropriate given that it will make it harder for BCBSVT to benefit from its participation in the ACO while simultaneously making it easier for OCV to achieve its targets.

As answered above, the 1% reduction in premium is not tied to expected claims costs or cost trends. We do not have a percent of premium model. We

have a historical claims cost plus trend model. The 1% premium reduction should therefore not be factored into OneCare's target, unless OneCare is provided the comparative advantage BCBSVT has which includes, but is not limited to, receiving funding for operations, funding to build reserves, and a share of the AMT refund – all of which the GMCB has stated is available for BCBSVT to offset this premium reduction.

c. Please expound on the requested trend adjustment of 2.3% for AHPs in light of the fact that the Board stated in its BCBSVT QHP decision that the impact of the new AHP regulation is "speculative" and that the Department of Financial Regulation stated in its explanation of the economic impact of the emergency AHP rule that it is "impossible to quantify the impact that fully-insured AHPs will have on premiums in VHC."

While the GMCB stated that the impact of the new AHP regulation is "speculative," both BCBSVT's actuary and L&E agreed that a 2.3% increase in rates "were reasonable." Since OneCare is bearing the risk of the claims cost and does not have the ability to offset these costs in the many ways 0 already outlined, OneCare must ensure an adequate target is set or we will be unable to take the risk being asked of us.

d. Have any assumptions been made about changes in BCBSVT's pool morbidity due to member shifts from BCBSVT QHPs to MVP QHPs?

BCBSVT made assumptions about the pool morbidity in its filings, and OneCare has requested the corresponding increase in our trend as approved by the GMCB. Furthermore, OneCare is working to include risk-adjustment mechanisms as part of the settlement process under our BCBSVT QHP contract to better adjust targets to account for any material differences in actual risk versus projected risk of the OneCare attributed population, such as for new members with no claims history available to neither BCBSVT nor OneCare. Again, BCBSVT itself can absorb that potential risk through reserves (funded and maintained over time with a portion of premium) as well as Affordable Care Act mechanisms, which protect them, neither of which have been made available to OneCare.

10. OCV states that BCBSVT is unable to implement a fixed payment system for 2019. (p.37)

a. Please describe whether this is due to one or both parties not being interested in exploring a fixed payment system or whether both parties are interested but have been unable to agree upon a fixed price.

OneCare has pushed all payers to implement one of our key payment reform mechanisms, which is a fixed prospective payment model. BCBSVT has informed us they are still unable to implement this change in their claims

processing system for 2019, which means the remaining option is a manual process for each of the participating providers, which would represent an additional administrative burden. This is an important capability and the primary mechanism for OneCare to manage the risk.

b. Please also describe what efforts OCV has taken in 2018 and intends to take in 2019 to encourage BCBSVT to implement a fixed payment system.

OneCare has been in active negotiations with BCBSVT and will consider to explore contract options for getting to an acceptable fixed payment system.

11. The 2018 Exchange PMPM increased substantially from budget ($318.13) to projected ($451.53).

a. Was this driven by utilization? If so, in what areas? If not due to utilization, please explain the other factor(s) that drove the increase.

The increase is related to a confidential claims data issue that affected the initial 2017 budget. As presented in testimony on April 11th, the expected paid PMPM is higher than the number initially submitted as part of the 2018 budget.

b. Please explain why in 2018 Exchange attribution drops by about half but the total spend drops by only 33%.

As presented in testimony on April 11th, actual 2018 attribution was substantially lower than initially projected. This decline, combined with the PMPM increase explained in question 11a, results in the outcome noted.

OCV Initiatives

12. OCV describes a large number of initiatives to decrease costs, increase quality, and address social determinants of health.

a. Please clarify whether OCV provides direct financial support for all of the initiatives referred to in its budget narrative. If not, please provide a list of all projects mentioned in the narrative not receiving direct financial support from OCV.

Yes, OneCare provides direct financial support for all of the initiatives referred to in the budget narrative as described in Appendices 5.4-5.5.

b. What is OCV doing to track and replicate successful programs so that each HSA will not need to work in isolation to test potential solutions to the same issues? As a part of your answer, please explain the extent to which this type of work is done by the various OCV committees described on page 52 and the committees' criteria for evaluating program effectiveness.

OneCare learns about and shares information on successful programs in the Network's HSAs through a variety of venues. The primary venue for this feedback loop is at the bi-monthly Clinical Quality Advisory Committee (CQAC), where our Regional Clinical Representatives (RCRs) report on the work happening in their HSAs. This is an opportunity for OneCare leadership to learn what is happening the HSAs, but simultaneously the RCRs and other community representatives hear from each other and have an opportunity to take ideas back to their communities. Additionally, the OneCare Clinical Consultants attend the HSA leadership bodies, such as the Accountable Community for Health (ACH), Regional Clinical Performance Committee (RCPC) and Community Collaborative (CC) meetings. The Clinical Consultants often have more than one HSA they participate in, which allows for a natural flow of information among those communities, but the Clinical Consultants also share in weekly clinical team meetings at OneCare work that is happening in their communities.

The Clinical Consultants also write Network Success Stories on successful programs in their HSAs and help the HSAs create posters detailing their improvement process for events such as the Jeffords Institute Quality Forum. The Clinical Consultants also participate in the monthly All-Field Team (AFT) meetings, organized as a joint meeting for community-facing staff members of OneCare and the BluePrint for Health. The feedback loop at the AFT happens at multiple levels. The organizing committee chooses topics and bring speakers from around Vermont to highlight state and regional efforts to improve the healthcare delivery system. In a recent AFT meeting on the opiate epidemic, the organizing committee invited a representative from the Barre/Berlin HSA to speak to their emergency room initiation of medication assisted treatment for opiate use dependence. On another level, the organizing committee builds in time for the teams from each HSA to discuss what they will take away from the AFT as well as build in time to allow for the HSA teams to network.

c. Please explain what it means to say that a specific HSA implemented a program. How are these decisions made, funding secured, and work produced?

OneCare uses HSA designations to capture the work happening within a community as it relates to participation in our Network. Within the HSA, however, the look of a program implementation in an HSA varies depending on the organization or organizations involved. Through our Clinical Quality Advisory Committee (CQAC) our Regional Clinical Representatives (RCRs) report on the work happening in their HSAs. In their reports, they include initiatives identified, funded and implemented by individual hospitals, designated agencies and other HSA organizations. They also report on initiatives undertaken by their HSA's leadership bodies, such as an

Accountable Community for Health (ACH), Regional Clinical Performance Committee (RCPC), and/or Community Collaborative (CC). The HSAs, through their leadership body, or bodies, will use the Community Health Needs Assessment, utilization/claims data and population statistics, to identify key issues facing their communities. Workgroups of key stakeholders are formed to dig deeper into the issue, looking at resources currently available in the community as well as funding opportunities to enhance current work. The workgroups oversee the initiatives and provide regular reports to the HSA leadership bodies on progress.

Initiatives undertaken by the leadership bodies may be funded by a member organization or organizations, or grants made available through the regional, state or national groups such as the Vermont Department of Health or the Robert Wood Johnson Foundation. Alternatively, there can be initiatives that are formed and funded by other means. For example in the Burlington HSA, there is a multiyear initiative to increase public awareness and adoption of advance care planning in Chittenden and Grand Isle counties. The funding is through The University of Vermont Medical Center, but the initiative is managed and produced by a steering committee made up of the OneCare, Vermont Ethics Network, Bayada Hospice, Age Well, Howard Center, UVMMC, and others.

d. How do the HSAs work on process improvement?

Process improvement within an HSA happens on many levels. Each of the HSAs has at least one leadership body, such as an Accountable Community for Health (ACH), Community Collaborative (CC) or Regional Clinical Performance Committee (RCPC). These bodies often take up process improvements that benefit the HSA. Additionally, the HSAs, often through those leadership bodies, choose to take on statewide efforts in process improvement, such as adopting best practices recommended at the statewide ACH Learning Lab meetings. Additionally, hospitals and independent practices choose to participate in regional and statewide process improvement programs, such as the Diabetes Prevention and Management Learning Collaborative or the Women's Health Initiative.

e. How closely do OCV's HSAs geographically align with HSAs defined by the state? For example, OCV refers to a Berlin HSA but the state does not. Does OCV's Berlin HSA geographically align with the state's Barre HSA?

OneCare's HSAs align with the Dartmouth Atlas of Health Care model for HSAs. The geographical alignment is close to those designated by the state, but not exact. The Dartmouth Atlas of Health Care model designates hospital services areas as local health care markets for hospital care. In this model the HSA is a collection of ZIP codes whose residents receive most of their

hospitalizations from the hospitals in the area. HSAs were defined by assigning ZIP codes to the hospital area where the greatest proportion of their Medicare residents were hospitalized. Minor adjustments were made to ensure geographic contiguity. This process resulted in 3,436 HSAs nationwide; with 14 in Vermont plus Lebanon, NH which is split by the Vermont/New Hampshire border.

Provider Training and Education

13. Please provide the number of both 2018 Care Navigator trainings and active Care Navigator users by Health Service Area.

    OneCare hosted 31 unique trainings in 2018 across the participant network. The cumulative number of active Care Navigator users is 547. The breakdown of users across Health Service Areas can be found below:

Health Service Area	Active Users
Bennington	77
Berlin	107
Brattleboro	33
Burlington	176
Lebanon	5
Middlebury	24
Newport	13
Springfield	39
St. Albans	49
Windsor	24
Total	**547**

14. We have heard from Vermont Medicaid recipients that they are being required to sign agreements to assume financial liability for covered procedures when OCV has waived the prior authorization. What is OCV doing to educate providers and insurers so that this does not continue to occur?

    This scenario was a unique occurrence by a OneCare participant who misunderstood the VMNG prior authorization waiver. OneCare worked with Medicaid and the Health Care Advocate to educate the participant about the waiver and the participant is no longer requesting that patients sign a financial liability agreement. OneCare and Medicaid have collaborated to further simplify the prior authorization waiver rules for 2019 and there will be increased education to support participants and therefore patients.