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REVIEW OF THE ACO BUDGET

GREEN MOUNTAIN CARE BOARD

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REPORT

Lewis & Ellis, Inc.

JACQUELINE B. LEE, FSA, MAAA
LARRY CHOI, ASA, MAAA

ACO Budget Review

Recommendations and Findings

Lewis & Ellis, Inc., Actuaries and Consultants, (L&E) was engaged by the Green Mountain Care Board (GMCB) to review the budget submission from the Accountable Care Organization (ACO), OneCare Vermont (OneCare). L&E received all documents from the original submission, dated June 23, 2017, and the revised submission, dated October 20, 2017. L&E was also asked to review the risk mitigation strategy for OneCare and assess any solvency risks.

ACO Budget

L&E focused its review on Part 3 – ACO Programs and Part 4 – ACO Budget and Financial Plan. During the review, L&E submitted questions to OneCare via the GMCB. L&E reviewed both the original submission and the resubmitted documents. L&E's key findings and observations are as follows. For ease, we have bolded the requests we have for OneCare.

Payer

- There is lack of clarity in the documentation of the flow of money between the payers, OneCare, and the various participating and affiliated providers. **Provide additional quantitative and qualitative support of the flow of fund between projected balance sheets and income statements. Provide detailed illustrations of the flow of fund between the parties involved in the operation.**
- Budget is difficult to evaluate without reviewing final payer contracts. **We request finalized versions of the payer contracts before executed for our review no later than November 15th.**
- The information provided in the "Actual OCV Programs (Multiple Moving Parts)" table in "T1 ACO Revenues by Payer" tab of Appendix B: ACO Revenue and Cost Data is confusing without adequate support. **OneCare needs to further explain what the "multiple moving parts" are and how they impact the budget.**
- OneCare claims that the program targets are "actuarially sound" (page 34). OneCare has not adequately explained how the TCOC targets are set, stating that Milliman's methodology is proprietary. **We request detailed calculations of the TCOC targets and much stronger documentation for actuarial soundness.**
- We recommend adding a risk adjustment process to the claim costs to take into account the health status differences between:
  - The HSAs, or
  - The actual and target populations.

Budget

- There are several assumptions in the budget regarding the Medicaid contract and rates. L&E will be looking to validate these assumptions in the finalized contracts and information provided to the Board by DVHA.
- **Provide the actual and projected membership.**
- The administrative expense percentage (2% of revenue) is lower than national average even after including $1.5M of reinsurance premium. If the reinsurance premium is excluded, the percentage drops to 1.8%. With a projected net income of $0, there is concern that if admin projections end up higher than expected, it could result in a deficit for OneCare.

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- There is lack of support in the self-funded line of business shown on "B1ACO Program Elements by Payer" tab of "A-B. Payer Program Elements.xlsx". **Provide additional explanation and support for this line item.**
- There is lack of support in the projected other revenue in CY 2018. **Provide additional quantitative and qualitative support for items that have changed since the last budget submission (e.g. VMNG PHM Program Pilot - Complex CC).**
- We recommend the "C. Complete OneCare Projected Cost and Revenue Data Package" be redesigned so that there is an additional page to list all the assumptions used in the projection. The projected values are all tied back to the assumption page by formula. It would enhance the traceability significantly.

Risk Mitigation Strategy

L&E assessed the risk mitigation strategy of OneCare. This section will briefly explain the risk mitigation components and L&E's observations.

The risk sharing description in "B2 Program Arrangements" of "A-B. Payer Program Elements.xlsx" is misleading since OneCare does not assume the full risk of the Medicare and Commercial programs. **Please explain why these payers are classified as "Full Risk."**

Risk Corridor

In 2018, OneCare is limiting its shared savings and losses with a risk corridor arrangement. The parameters vary by payer and are modified each year. The 2018 parameters are outlined below:

Payer	Corridor	OneCare's Share
Medicare	95% - 105%	80%
Medicaid	97% - 103%	100%
Commercial	94% - 106%	50%

The participating hospitals bear the risk of losses and receive savings on the spend for the lives attributed to the providers in their Health Service Area (HSA) up to a Maximum Risk Limit (MRL). MRL is based on the aggregate Total Cost of Care (TCOC) savings or losses calculated by applying the risk corridors and sharing percentages to each HSA population regardless of overall ACO performance. This allows the savings to a provider for local HSA performance in the absence of OneCare' savings earned from the payer.

There is a solvency concern for OneCare if one big HSA generates a huge loss at the HSA's MRL but the other HSAs generates small savings. This would result in an overall loss for OneCare, and it is unclear if the pooling mechanism is effective in mitigating the risk in this situation.

Reinsurance

Currently, there is inconsistent information on whether OneCare will have reinsurance in 2018. **L&E requests that a formal reinsurance quote or agreement be provided.**

Additional concerns on the lack of confirmed reinsurance:

- The "B2 Program Arrangement" tab of "A-B. Payer Program Elements" indicated there's no payer-provider reinsurance. The absence of reinsurance increases OneCare's solvency risk.

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- It was stated that truncation of high cost outlier individuals is not present for Medicaid and Commercial. We recommend adding truncation of high cost outlier individuals for Medicaid and Commercial. The truncation is already in place for Medicare.

Settlement

For Medicare and Commercial, there will be a separate, yet simultaneous, settlement of the hospital fixed payment and the variable component (i.e. "remaining FFS"). The fixed payment will be reconciled to the shadow FFS, and the settlement instantly generates.

There is a lack of clarity in documentation of the settlement mechanics of the risk mitigation program. OneCare should provide illustrations of the whole settlement process and how the shadow FFS works. **Please answer the following questions:**

- Define the selection criteria of claims going into the shadow FFS.
- How do you ensure the accuracy and completeness of the shadow FFS?
- How frequently should the shadow FFS report be compiled and distributed to all parties involved?

Other Strategies

A letter of credit was provided that is likely outdated because the amount in the letter of credit ($2.8M) does not appear to be adequate in insulating OneCare from solvency risks since the maximum downside risk. Currently, this amount is projected at about $21.5M according to page 47 of GMCB ACO Budget Submission Round 2 Final.docx. **Please provide an updated letter of credit or an updated estimate of the anticipated credit line.**

OneCare provided a table on p.47 providing detailed calculations of the maximum downside risk ($21.5M total). The results are different than what is reported on p.38 ($27.5M). **Please explain the variance.**

The "Due to UVMMC – CY17" amount is close to $4M, which exceeds the amount in the Letter of Credit ($2.8M) (source: 9/30/2017 balance sheet in OCV Supplemental Data for GMCB - Balance Sheet Forecast.xlsx). This is a solvency concern.

The shared saving experience in 2016 further worsens. Commercial spending exceeded target by 4.4%. Medicaid spending exceeded target by 3.8%. **OneCare needs to demonstrate the steps they are taking in 2017 and the future years are effective in controlling the increasing costs and utilization.**

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