OneCare Vermont

Policy Number & Title:	02-06 HSA Benchmark Policy
Responsible Department(s):	Finance
Author:	Tom Borys
Date Implemented:	January 1, 2019
Date Reviewed/Revised:	June 2, 2019
Next Review Date:	June 30, 2021

Purpose: To define the methodology used to calculate each Health Service Area (HSA) benchmark. Benchmarks are used to evaluate financial spending performance within a Program's Performance Year in alignment with the terms of the Program Agreements and Program Settlement Policy.

Scope: This is applicable to all OneCare Participants that are Risk Bearing Entities (RBEs).

Policy

1) Preliminary HSA- Benchmarks will be calculated in a manner that recognizes the specific circumstances of each HSA (ex. risk score of the population) and reconciles to the aggregate benchmarks contained in the OneCare Program Agreements. Final HSA- benchmarks for programs with benchmarks adjusted at the time of settlement will be recalculated to reconcile with the final aggregate benchmark using a similar methodology to the preliminary HSA- benchmarks.
2) HSA- benchmarks will be calculated to align with any population segmentation found in the Program Agreements.
3) Population segments can be subject to either an Aggregate ACO Pooling or HSA-Specific Accountability methodology.
    a) Aggregate ACO Pooling
        i) There will be no HSA Benchmarks, rather, any aggregate (i.e. ACO wide) gains or losses will be spread to all RBEs based on member months of attribution of assignment to their respective HSA for the specific population segment.
    b) HSA-Specific Accountability
        i) A benchmark will be calculated for each HSA and any gains or losses (subject the terms of the Program Settlement Policy) will be the responsibility of the RBE for the HSA for the specific population segment.
4) The population segments will be treated in the following manner:
    a) Medicare
        i) End Stage Renal Disease (ESRD): Aggregate ACO Pooling
        ii) Non-ESRD: HSA-Specific Accountability
    b) Medicaid
        i) Aged Blind Disabled (ABD): Aggregate ACO Pooling
        ii) Consolidated Adult: HSA-Specific Accountability
        iii) Consolidated Child: HSA-Specific Accountability
    c) BCBS QHP

i) Single Cohort: HSA-Specific Accountability

d) Other

i) Per decision from the Board of Managers

5) HSA-Specific Accountability benchmarks will be determined for each population segment separately by blending the Historical FFS PMPM with the Risk-Adjusted PMPM with a 75% weight applied to the Historical FFS PMPM and a 25% weight applied to the Risk-Adjusted PMPM.

a) The Historical FFS PMPMs will be determined by capping the prior year cost of any individual member annual spend at amounts approved by the Board of Managers (if any)*, calculating the FFS and FFS-equivalent spending PMPM for the lives that attribute for the Performance Year, and applying an upward or downward percentage adjustment so that the aggregate PMPM reconciles to the OneCare contracted benchmark for the corresponding population segment.

b) The Risk Adjusted PMPMs will be calculated by applying the renormalized HSA-specific risk score from the Johns Hopkins Adjusted Clinical Grouper to the OneCare contracted benchmark in the Program Agreement for the corresponding population segment.

6) HSA-Specific Accountability benchmarks will be broken down into components for:

a) Home Hospital Spend: costs for lives receiving care at the hospital within the HSA to which they are attributed or assigned.

b) Other Hospital Spend: costs for lives receiving care at a OneCare participant hospital outside the HSA to which they are attributed to assigned.

c) Fee-for-Service (FFS): all other costs.

7) If a Program contains a mechanism by which performance from prior years is carried into the current Performance Year, each HSA will have an adjusting amount factored into its Program benchmark in a manner that aligns as closely as possible to the prior year settlement.

a) If any portion of this amount has been obligated by the Board of Managers in the OneCare budget process, this amount will be spread to all HSAs using a fair basis.

b) Any remaining balance will then be allocated to only those HSAs that participated in the prior Performance Year.

c) The amount of this adjustment will not be finalized until the prior year program final settlement. Any estimates will be replaced by these final amounts.

Ongoing Review

8) Some Program Agreements allow for review of the results well after the final settlement has concluded. In the event that a payer initiates this subsequent review, the results will be brought to the Finance Committee and Board of Managers for review and a decision in regard to the best way to manage the circumstance. The Board's actions may supersede any/all methodologies outlined in this policy.

* No truncation amounts we approved for Performance Year 2019.

Related Policies/Procedures: N/A

Location on Shared Drive:
S:\Groups\Managed Care Ops\OneCare Vermont\Policy and Procedures\Policies

Management Approval:

Director, ACO Finance & Analysis — Date: 6/27/19

7.10.19

Date

CHIEF OPERATING OFFICER

Board of Manager Approval:

7/1/19

Chair, OneCare Board of Managers (Required) Date