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July 6, 2017

Kevin Mullin, Chair
Green Mountain Care Board
3rd Floor City Center
89 Main Street
Montpelier, VT 05620-3601

Re: HCA Pre-Hearing Questions – OneCare Vermont FY18 Test Year Budget Review

Dear Chair and Members of the Green Mountain Care Board:

Thank you for the opportunity to participate in the Green Mountain Care Board (the Board)'s fiscal year 2018 Accountable Care Organization (ACO) budget review.

Per Act 113 of 2016, beginning in 2018 the Office of the Health Care Advocate (HCA) may receive copies of all materials related to any ACO budget review, ask questions of the Board related to the budget review, submit written questions that the Board will ask the ACO in advance of budget review hearings, submit written comments for the Board's consideration, and ask questions and provide testimony in budget review hearings. We appreciate the opportunity to participate in this FY18 ACO budget review test year.

Please find below pre-hearing questions from the HCA for OneCare Vermont (OneCare). Thank you for sending these questions to OneCare in time for OneCare to prepare its presentation for the July 13, 2017 hearing. We understand that the timeframe for this review process is extremely short. OneCare may submit written answers after the hearing, if necessary, to questions they are unable to answer before the hearing.

1. In your budget narrative you state that there are no assumptions built into the budget model. Please explain what this means (i.e., did you assume spending would continue as would have been expected under fee for service?).
    a. What other major assumptions were made in creating this budget?
    b. Do you anticipate service changes such as a reduction in emergency department use and/or an increase in use of primary care? If so, does this budget take any such changes into account?
    c. What differences in care processes do you anticipate as you move from shared savings to capitation?
    d. How confident are you in your budget projections? Where are the areas of greatest uncertainty?

2. What mechanisms do you have in place, or are you considering implementing, to manage fee for service (FFS) care both inside and outside the ACO?

3. Please describe any funding mechanisms available to OneCare for investment in non-health care expenditures.

4. What is the current role of the Vermont Care Organization (VCO) in relation to OneCare's Board of Managers? Please describe how this role has evolved since the creation of the VCO Board.

5. How to you plan to address the high cost of care for people eligible for both Medicare and Medicaid ("dual eligibles")?

6. Please provide additional detail about the risk mitigation measures taken by the risk-bearing hospitals to ensure they can cover the downside risk for their communities without asking the Green Mountain Care Board for rate increases.
    a. How will OneCare ensure that beneficiaries receive all needed services particularly if a hospital or health service area is at or approaching a cost overrun?
    b. How will the ACO support hospitals in managing financial risk?

7. Please provide additional detail about the methodology used to determine the trends for each payer.
    a. How did you determine the 2.0% Medicaid trend and what was the reasoning behind this methodology?
    b. How did you develop the Medicare trend and what was the reasoning behind this methodology?

8. How were service category Per Member Per Month (PMPM) amounts calculated under a capitated agreement (e.g., were these calculated based on amounts the ACO anticipates would have been paid under FFS?)
    a. Please provide service category utilization in addition to PMPMs.

9. According to Appendix A3: Summary ACO Provider Network there will be an average of about 176 people attributed per primary care physician including adult and pediatric PCPs. This would represent about 12% of a typical primary care provider's patient panel (1,500). Please discuss how practices would change under a mix of capitation and FFS.
    a. What are the key changes you have made or plan to make to address FFS "motivational issues" mentioned in the narrative, given that patients under a capitated agreement will remain a minority?
    b. How will provider contracts change to manage the mixed incentives of FFS and capitation?

10. Why are different enrollment numbers used for calculating revenue and cost PMPMs in 2016 and 2017? It appears that the 2018 enrollment numbers were used for all three years on the cost side. Please explain the reasoning for this.

11. When comparing revenue (T1 [omitted in public version], OneCare Projected Cost and Revenue Data Package) and costs (T3, OneCare Projected Cost and Revenue Data Package) by payer for 2016, 2017, and 2018 there appear to be significant losses in 2016 actual ($97 million) and 2017 ($172 million). In 2018, Medicaid and Commercial break even and Medicare makes a small profit (before Admin). Is this an artifact of how reporting is done?

12. The 2017 Lewis and Ellis Medicaid Advisory Rate Case for ACO Services estimated that OneCare would have had about 26,000 lives in Base Year 2015, with a PMPM of $256. Per the most recent DHVA report to the legislature, actual attributed lives as of January, 2017 were 29,102. The 2016 budget numbers are very different (enrollment of 37,000 based on revenue and 55,000 based on costs; PMPM of $169 based on revenue, $261 based on costs).
    a. Why are the cost PMPM trends so consistent (2%-5% per year, depending on year and payer) while the revenue PMPM trends are so erratic? For example, the Medicaid revenue PMPM jumps by almost 54% from 2016 to 2017, Medicare revenue trend is -9.3% from 2016 to 2017 and 17% from 2017 to 2018. Is this the effect of non-care revenue?

13. The enrollment numbers reported in the most recent DHVA report to the legislature show that the number of attributed lives is declining by an average of about 500 per month. How will this affect the budget, assuming this pattern continues (as a result of retrospective attribution)?
    a. Do you anticipate that those who do not remain attributed for the full year will be sicker or healthier than those who do remain attributed? How do you anticipate this will affect the budget?

14. Please provide additional detail about the pharmacy and mental health services that are included in this budget.
    a. Do you anticipate including pharmacy coverage for Medicare and commercial lives? There is significant PMPM spending for outpatient pharmacy for both payers.
    b. Why is the professional mental health PMPM substantial for Medicaid ($17.49 2016 actual), moderate for Medicare ($6.05), and minimal for commercial ($0.43)?

15. Does the Sherlock Company's operations benchmark range include utilization management?
    a. Does OneCare plan to perform utilization management services for any of its contracted payers? If so, please provide a detailed description of how OneCare plans to conduct utilization management.

16. Hospitals often charge significantly more than the actual cost of providing certain services in order to fund other needed services. This dynamic places the burden of paying for hospitals' "fixed costs" on individuals who need particular services, and likely impedes innovation that could offer some services at better quality and lower cost. What is OneCare's strategy for addressing this dynamic?
    a. What are the strengths and weaknesses of the strategy?
    b. If global hospital budgets are part of your strategy, please explain how this payment methodology will address within-hospital cost shifting and align consumer costs with the costs of the services provided.

17. There is significant concern that ACOs simply add an extra layer of administrative cost to the health care system. There is also a hope that ACOs can streamline health care payment systems and other processes to reduce the burden on providers. How is OneCare planning to help reduce provider administrative costs and resources? Please provide an estimate of how much money this will save and/or any other benefits that will result.

18. How will OneCare address patient requests for appeal when there is no dispute over insurance coverage for the service (e.g., if a patient is denied a service by a provider or ACO that is medically necessary and covered by the patient's health insurance plan)?

Please feel free to contact me with any questions.

Sincerely,

\s\ Julia Shaw
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