REVIEW OF THE ACO BUDGET

GREEN MOUNTAIN CARE BOARD

DATE: NOVEMBER 6, 2017

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 funds 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.**
- OneCare claims that the program targets are "actuarially sound" (page 34). OneCare has provided an explanation and demonstration of the TCOC targets in the November 2, 2017 presentation. We would like a better explanation in writing with an example. **We request detailed calculations of the TCOC targets, including an example from the table on Slide 15, and much stronger documentation for actuarial soundness.**

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.
- The Medicare growth rate is set at 3.5%, which is the floor. **Please justify why 3.5% was chosen as the growth rate, and how OneCare projects future growth rates in light of the requirements set forth in the APM contract.**
- 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.
- 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. **Please provide an example where there is equitable gains and losses among the HSAs and an example where multiple, larger HSAs have losses.**

We understand that in the event of multiple large hospitals lose money, then other hospitals are supposed to help provide funds. **If the other hospitals cannot or choose not to help out, then we would like to know who the responsibility falls to. Is OneCare responsible or do the hospital face the risk entirely? If the responsibility falls on OneCare, is the reinsurance great enough to cover this?**

We recommend that OneCare consider 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.

Reinsurance

Currently, there is inconsistent information on whether OneCare will have reinsurance in 2018. We would like to know the anticipated parameters that have been assumed with the $1.5M premium expenses. **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.
- 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. It appears to be a solvency concern that OneCare does not have enough money to purchase reinsurance to cover potential losses, such as the high cost outlier individuals.

Settlement

For Medicare and Commercial, there will be a separate, yet simultaneous, settlement of the hospital fixed payment and the actual costs. The fixed payment will be reconciled to the shadow FFS, and the settlement instantly generates. This will occur in the summer of 2019 to allow enough time for runout. **While it is common practice for there to be sufficient runout before calculating settlements, how will OneCare ensure that they have enough cash flow in the event of a shortfall due to a poor initial estimate?**

Shared Saving Experience

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.**