VERMONT

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To: Vicki Loner, CEO, OneCare Vermont
Cc: Spenser Weppler, OneCare Vermont
From: Green Mountain Care Board ACO oversight staff
Date: October 14, 2019
Subject: Round 1 questions to OneCare on the FY2020 budget submission

The Green Mountain Care Board ACO oversight team prepared the following questions in response to OneCare's FY20 budget submitted October 1, 2019. In addition, we are attaching questions for OneCare prepared by the Office of the Health Care Advocate and submitted to the Green Mountain Care Board.

Please prepare written responses to the questions by October 25, 2019 and submit them to the GMCB ACO team, copying the Health Care Advocate on your responses. Submit responses to:

Berube, Alena Alena.Berube@vermont.gov; Miles, Melissa Melissa.Miles@vermont.gov; Melamed, Marisa Marisa.Melamed@vermont.gov; Tewksbury, Sarah Sarah.Tewksbury@vermont.gov; Barber, Michael Michael.Barber@vermont.gov; hcapolicystaff@vtlegalaid.org

Section 1: ACO Information and Background

No questions.

Section 2: ACO Provider Network

1. Explain your contracting process with providers, including when a signature is or is not required and how changes are communicated to the providers. Explain which aspects of the contract are annual or multi-year.
    a. The program addendums (Part 2 Attachment E) say "2019" in the header for Medicaid and Medicare, confirm these are the correct ACO program addendums for the 2020 year.
    b. Submit the FQHC exemplar contract.

2. How does OneCare determine its outreach strategy to providers, i.e. how does OneCare determine who to send a Solicitation of Interest, as referenced in the Network Development Timeline submitted with certification?

3. In follow-up to question 4a and b, please break out the number of lives estimated in the "Multi-Year Strategy" table on page 15, by using the following table:

Scale Strategy	**Estimated # Lives***		
	2020	**2021**	**2022**
Geographic Attribution Methodology			

Medicare			
Medicaid			
Commercial-fully ins			
Commercial-SF			
Other Attribution Methodology Changes			
Medicare			
Medicaid			
Commercial-fully ins			
Commercial-SF			
Network Participation			
Medicare			
Medicaid			
Commercial-fully ins			
Commercial-SF			
Expanded Payer Program Offerings			
Medicare			
Medicaid			
Commercial-fully ins			
Commercial-SF			

*Estimates based on scale strategy opportunities presented in the budget submission

4. In part 2, question 4b you state that "OneCare piloted a Medicaid geographic attribution concept with St. Johnsbury HSA [and that] there were a number of key findings that are helping to craft a potential statewide geographic attribution approach in 2020." Please discuss these findings.

5. Provide a narrative description of the grid depicting "attribution opportunity targets through 2022" on page 13. Describe which strategies may be effective by HSA. In doing so, please also recognize each HSA's starting point (through 2020), as well as their overall "attributable" population (what will still be "left on the table" in 2022 and why?).

6. Is it correct to understand that OCV estimates that it will carry forward a balance in its "Designated Risk Reserve" of $3.9 million from FY2019 to FY2020? Does OCV anticipate covering any 2019 HSA overruns, and if so, will that result in a lower estimated Designated Risk Reserve entering FY2020 than the $3.9 million identified? If so, do you intend to build the balance back up and how?

7. Given that $3.7 million of the $3.9 of guaranteed risk protection is for hospitals with a risk mitigation agreement (page 35, question 8c), is it appropriate to assume that the delta is to cover risk specific to OneCare as described on page 16? If so, what is this risk associated with? Please clarify the reference to reserves to "provide general liquidity to manage financial operations." Is this liquidity for OneCare or for hospitals?

8. For each risk-bearing hospital and each payer program, submit the final settlement calculations described in OneCare's Program Settlement Policy for performance year 2018.
    a. To what extent is the method of distribution communicated to and understood by hospitals up front, and to what extent can the Board of Managers adjust the settlement distribution methodology once the settlement is known? For what reason might the Board of Managers adjust the distribution methodology?

Section 3: ACO Payer Programs

9. Why only 0.5% growth in Medicaid from 2019 to 2020 when OneCare's Q2 presentation and Appendix 3.1 Trend Rates suggests that the Medicaid benchmark is lower than the network's total cost of care?
    a. Please explain the drivers of the Medicaid 2019 losses being projected in Appendix 4.4 Total Shared Savings/(Loss) ($7,932,988) and break out that which is attributed to Fee-for-Service (FFS) vs. Fixed Prospective Payments (FPP).

10. Please explain how you arrive at the 6.04% trend rate for Commercial QHP (Appendix 3.1 Trend Rates) from the GMCB approved rates. Please provide the breakdown between BCBS and MVP for the underlying Base Experience PMPM assumptions.

11. How much churn or turnover is there in the attributed lives (by payer, by year)? What percentage of the lives are consistently attributed over time?
    a. Please comment on the nature of- and expected drivers of churn. To the extent possible, provide data to support this analysis.

12. Please provide further details that describe the risk-sharing arrangements with Commercial-QHP plans, disaggregated by insurer. Is it correct to understand that estimated FY2020 risk equals $3,626,010 on a base of estimated Commercial-QHP revenue equal to $167,697,435 (2.16%)?

13. Please provide further details that describe the risk-sharing arrangements with Commercial-Self Insured plans. Is it correct to understand that estimated FY2020 risk equals $1,868,715 on a base of estimated Self-Insured revenue equal to $373,742,964 (0.50%)?

14. On page 16 of the budget submission, you describe an effort to pursue high-cost case truncation. With which payers does OneCare contemplate exploring such a methodology? What is the status of these conversations, and is the intent to affect distribution of risk in FY2020?

15. On page 20 of the budget submission, it states that OneCare "was not able to incorporate an estimate of repricing adjustments in the [Medicaid] budget due to inherent complexity." Please clarify how the estimated 2020 Medicaid PMPMs were calculated and whether OneCare anticipates further Medicaid price changes not otherwise captured in OneCare's 2020 budget submission.

Section 4: ACO Budget and Financial Plan

16. Please detail how the "State Support" listed under Revenue in Appendix 4.2 Income Statement will be utilized to support Informatics and Delivery System Reform expenditures and what, if any additional funds are used to supplement these investments.
    a. Please share your application for Delivery System Reform (DSR) funding for 2020. What are the initiatives included? How are these prioritized? If OneCare does not receive $13.1 million in DSR Investments, how will you adjust your program investments or other aspects of the budget?
    b. Which of the Population Health Management (PHM) programs are dependent on the current 2019 DSR dollars/Health Care Reform Investments? Why is DULCE not listed as a PHM Program for 2020?

17. Provide a variance analysis for each line item in the income statement (Appendix 4.2) over or under 10% (across any of the variance categories), be sure to break out changes due to volume versus rate.

18. Provide an estimate of FTEs you expect to require (by number, staffing category, and dollar amount) once the model has reached scale.

19. For programs (payer or provider) or financial incentives that have been discontinued (such as the Regional Clinical Representatives funding), please explain why you discontinued the program. Similarly, for new programs or financial incentives, please explain why you choose to invest in this program (include any evidence basis you considered). How do you monitor progress and return on investment?

20. Explain any recent grant funding you have received or are applying for.

21. Industry benchmarks: If no appropriate industry benchmarks exist, as stated on page 25, what metrics does OneCare use to evaluate financial performance? Acknowledge the advantages/limitations of these measures.

22. Utilization: Provide data to support service utilization assumptions and identify any driving factors. What are the 2019 utilization patterns you observed – what do you expect to be different, if anything in 2020 – and how does this inform your budgetary assumptions?

23. Please explain the significant growth in Maximum Risk of APM amount year over year (Appendix 4.6) for Northwestern Medical Center: 2019 risk amount of $2,973,505 vs. 2020 risk amount of $4,303,405.

24. Explain any differences between Appendix 2.4, home hospital spend, and Appendix 4.6, Fixed Prospective Payment, for local lives, for Medicare.

25. Please explain the specific factors that determined the current distribution of risk between participating hospitals (with focus on criteria such as size, financial ability to take on risk, percentage of care received outside the HSA). What other distribution arrangements were considered but disregarded? What specific criteria qualifies an HSA for risk mitigation arrangements?

26. Why are 2019 deferred revenues in the 2020 income statement (Appendix 4.2)? Are there corresponding deferred expenses? Does the budget exclude any 2020 revenues or expenses that may defer into 2021?

27. Is it correct to understand that the downside and upside risk arrangement adjustments with the Bennington, Brattleboro, and Morrisville HSAs are "asymmetrical," such that a total of up to $3,770,158 downside risk is held by One Care Vermont for these HSAs, whereas, in an upside scenario, up to $1,885,079 million in upside potential could be paid to One Care Vermont's founding hospitals? What is the rationale for OCV holding the downside risk potential whereas the founding hospitals would hold a portion of the upside risk potential? Of the $1,885,079 in upside risk potential for the founding hospitals, how would these funds be split between the parties?

28. On page 35 of OCV's budget submission, OCV states that "one hundred percent of the risk is covered by means other than the fixed payments." Please clarify whether this statement applies to all payers or a subset of payers. Please clarify whether this statement should be understood to apply to Medicaid All-Inclusive Population Based Payments (AIPBP).

29. Why are your Population Health Investments not growing proportionally to your population (decrease of 4.0% to 3.0% from 2019 to 2020 after excluding SASH, Blueprint, Community Health Teams)?

Section 5: ACO Quality, Population Health, Model of Care, and Community Integration Initiatives

30. Further explain your 2018 quality scores. When applicable, explain when variance over prior year is due to population change versus intervention or unanticipated consequences.

31. Provide a breakdown, by HSA, of which clinical priorities each HSA is focusing on.

32. Provide a copy of the primary care engagement toolkit referred to on page 55.

33. If possible (and statistically meaningful), please share the cost and quality results for the four HSAs that have been in the VMNG program the longest.

34. Please provide an analysis of the Medicaid most prevalent conditions presented in Part 5, question 11c by age groups (0-10, 11-17, 18+).

35. On page 48, in your Complex Care Coordination description, you mention a reduction in Emergency Department visits as a result of an intervention. Please describe the intervention and provide any data as evidence to these findings

36. In Part 5, Attachment A, 2019 Clinical Priority Areas:
    a. Why is no commercial data represented in 2019?
    b. Recognizing that many analyses are still early in 2019, please resubmit the table with your actual performance rates.

37. Part 5, Attachment B, ACO Quality Activities:
    a. Why is the Blueprint learning collaborative on hold (as noted in the VPMS measure)?
    b. Provide a variation analysis for the Medicaid adolescents with well-care visits measure—relatively low performance for VMNG and BCBSVT populations—and discuss improvement plans.

38. Provide the 2019 HSA variation of care and ACO dashboard report referenced on page 46.

39. Please complete the attached Excel workbook "2018-2020 Care Navigator Enrollment" and provide inclusion/exclusion criteria as you move from columns B-E, starting with when patient data are loaded into Care Navigator. Describe changes in how patient data are loaded into Care Navigator from 2018 to 2019.

40. Please describe whether and how RiseVT is integrated with OneCare's care coordination model.