OneCareVermont

To: **Representative William J. Lippert, Chairman, Vermont House Committee on Health Care**
From: **Vicki Loner VP, COO, OneCare Vermont, Accountable Care Organization, LLC**
Cc: **Todd Moore, CEO OneCare Vermont**
Date: **February 13, 2018**
Subject: **OneCare Vermont ACO Questions**

Dear Chairman Lippert,

As requested, please find attached our written responses to the OneCare specific questions that were posed by the Committee Members during the 2/8 testimony by DVHA Deputy Commissioner, Michael Costa, and GMCB Chief of Health Care Policy, Ena Backus, about "Vermont's Accountable Care Organizations and the VT All-Payer ACO Model Agreement."

Thank you for the opportunity to provide additional detail about our programs as well as to clarify any misperceptions about our operations and legal status. If you have any additional questions please feel free to contact me directly at (802) 847-6255.

Respectfully,

Victoria E Loner

Vicki Loner, RN.C, MHCDS
Vice President and COO, OneCare Vermont

Attachments:

A. Value Based Incentive Fund Payments
B. Waiver Criteria
C. Comprehensive Payment Reform Pilot Program and Clinical Benefits

1. *Is OneCare Vermont a For-Profit Organization?*

Answer: OneCare is a pass through entity of non-profit organizations. It is an accountable care organization ("ACO") and a limited liability company. Although its two members are non-profit, tax-exempt organizations that provide health care services and participate in OneCare in furtherance of their tax-exempt statuses, under Vermont law OneCare could not be a non-profit organization.

ACOs are designed to be provider led organizations. Only providers and suppliers of health care services to Medicare patients can form ACOs that participate in federal programs (MSSP, NextGen). Program rules and Rule 5 require that at least 75% of the Board of an ACO be representatives of health care provider participants. No more than 49% of a Vermont non-profit's Board can have a financial interest, which includes an indirect compensation interest, in the non-profit's business. This has been interpreted to mean that an ACO could not be a Vermont non-profit.

Companies can only organize in the forms that the State creates, and there is no non-profit, limited liability company.

2. *What is OneCare's Quality Incentive Program and how is it paid out?*

Answer: The Value Based Incentive Fund (VBIF) is the quality performance incentive funding that is paid out by the ACO after the performance year to network participants based on the ACO's quality performance. VBIF is calculated for each program separately and is funded through withholding a portion of our own ACO-wide claims target to be paid to the provider network based upon achieved quality. This is one of the big commitments by our participating providers in moving payment incentives from volume to value. The total accrued VBIF available across all payers will be divided into two pools with 70% going to the primary care pool and the remaining 30% going to general participant pool. The primary care pool is set at a level to represent the strong focus on primary care related measures in our quality scorecards and the required efforts by primary care for measurement and improvement. The primary care pool is apportioned for payment to each Tax Identification Number (TIN) based on the number of attributed lives. The general distribution pool is based on the percentage of total eligible expenditures by all other provider types. In 2018, the VBIF will be funded at 0.5% of the Medicare and Commercial total cost of care (TCOC) and 1.5% of Medicaid TCOC. This occurs through revenue reductions from the participating hospitals as part of their fixed payments to support the fund. There is expected to be ~$4.6 million in available funding for the VBIF 2018. For a breakdown of available funding by region please refer to Attachment A.

3. *What Federal Waivers is OneCare Actively Rolling out?*

Answer: OneCare intends to pilot all three of the currently available federal waivers (skilled nursing facility waiver, post discharge and telehealth) in 2018. Attachment B provides the Committee with the criteria for each of the waivers, if we have already identified a pilot site and the timeframe for active roll out of the waivers. Please note that for the post-discharge and telehealth waivers that we have been in active communications with our network and identified interested sites that will look to commit within the next few weeks. In 2019, we will look to deploy the waivers on a statewide basis.

4. *How much is OneCare investing in primary care in 2018 and what are the specific Program investments?*

Answer: In 2018, OneCare is investing approximately $14 million to support primary care. Investments include:

- OneCare Vermont Population Health Per Member Per Month (PMPM) of $3.25 for every patient attributed to the practice
- Complex care coordination PMPMs
  - $15 PMPM for every attributed patient in the High and Very High risk cohorts (16% Medicare/Medicaid, 3% Commercial)
  - Lead Care Coordinator ($10 PMPM if selected)
  - Shared Care Plan creation ($150)
- Value Based Incentive Fund (VBIF) payments: 70% to primary care
- Preserved Medicare Blueprint practice payments $2.00 PMPM
- Preserved Medicare Blueprint CHT funding $2.47 PMPM

In addition to OneCare investments, OneCare primary care providers will be eligible for the federal Advanced Alternative Payment Model (APM) 5% Part B bonus payments beginning 2020 since OneCare qualifies as an Advanced APM.

5. *Who are the practices participating in the independent pilot, what is it, and how is it working?*

Answer: The OneCare Vermont 2018 Primary Care Comprehensive Payment Reform Pilot (CPR Pilot) is a voluntary payment model offered to eligible OneCare practices who participate in all offered risk programs in 2018 and have a combined panel size of at least 500 attributed patients across programs. It is designed to demonstrate an approach that can be expanded to other practices in 2019. The program is based on payer-blended, risk-adjusted capitation payments to cover primary care services delivered by a practice to OneCare-attributed panel members. Payments are made on a per member per month (PMPM) basis and will be calculated and measured based on the risk level of attributed members. The program is designed to support a team based approach and budgeted with added financial resources beyond what are available now under a fee-for-service system (FFS) to ensure higher revenue models than participating practices would otherwise expect to receive in this pilot year. For a listing of program and clinical benefits, please refer to Attachment C. Currently three organizations (Thomas Chittenden Health Center, Cold Hollow Family Practice, and Primary Care Health Partner sites), who combined represent six practice sites, are participating in the pilot. The organizations and OneCare leadership meets monthly to review progress and will provide a report on successes and challenges to date to the Green Mountain Care Board by mid-year. OneCare and the participants will also look to engage Vermont Program for Quality in Health Care (VPQHC) in the future to support practices in designing and evaluating innovate delivery changes that improve effectiveness.

6. *How will providers bear risk relative to OneCare?*

Answer: The OneCare model is based on each participant hospital bearing two levels of risk: (i) accepting a pre-set fixed monthly model for all services delivered to attributed

patients from their service area, and (i) those same hospitals accepting the risk (and receiving any shared savings) on the all remaining fee-for-service spending for those locally-attributed lives up to a Maximum Risk Limit (MRL). Once any hospital exceeds its MRL, the other participating hospitals will, by OneCare policy, contribute some or all of their own MRL to cover those losses. This approach means that hospitals cover 100% of OneCare's risk (net of any applicable contributions from reserves or reinsurance) in any situation. In 2018, for hospitals entering risk programs for the first time and participating in all risk programs will only be responsible for the first 50% of their MRL for losses and be limited to 50% of MRL for savings. OneCare's corporate owners will be responsible for the other 50% for those new hospitals. In the OneCare risk sharing approach and policy, no other provider types have risk beyond the quality "upside incentive" of the VBIF where they might not receive the full amount of their eligibility.

Attachment A

Value Based Incentive Fund Payments

HSA	Attribution	PCMH (70%)	Other HSA Providers (30%)	Total
Bennington	6,083	$164,015	$45,903	$209,918
Berlin	17,846	$481,179	$221,090	$702,269
Brattleboro	7,834	$211,227	$84,640	$295,867
Burlington	53,251	$1,435,799	$609,753	$2,045,552
Lebanon	2,850	$76,844	$36,013	$112,857
Middlebury	10,741	$289,608	$146,020	$435,628
Newport	3,920	$105,694	$17,998	$123,693
Springfield	7,107	$191,625	$115,164	$306,789
St. Albans	9,109	$245,605	$102,133	$347,738
Windsor	1,071	$28,877	$5,776	$34,653
Total	**119,812**	**$3,230,473**	**$1,384,489**	**$4,614,962**

- 70% of the value based incentive fund is paid to primary care based on attribution
- The remaining 30% of the fund is paid out to other HSA providers based on proportion of spend
- Distribution of these funds will happen after conclusion of the plan year

Attachment B

2018 Benefit Enhancement Waivers

	Three-Day Skilled Nursing Facility (SNF) Waiver	Post-Discharge Home Visit Waiver	Telehealth Expansion Waiver
Criteria for Pilot	• Pilot sites in OneCare Network • SNF 3 Star rating • Hospital & SNF have established relationship and in close physical proximity • Medical Directors of Hospital and SNF engaged • Prior experience with waiver • Organizations are willing to help operationalize benefit enhancement details and have the staff in place to support education and training	• Pilot sites in OneCare Network • Primary Care & HHA have an established working relationship • Attributed patient volume is sufficient to test waiver • An agreement for "incident to" billing and payment processing can be established soon • Organizations are willing to help operationalize benefit enhancement details and have the staff in place to support education and training	• Pilot site in OneCare Network • Telehealth equipment available which utilizes HIPAA compliant technology • Electronic medical record can store appropriate documentation (e.g. photos, videos, documents) • Organizations are willing to help operationalize benefit enhancement details and have the staff in place to support education and training
Pilot Site	Porter Medical Center/Helen Porter Rehabilitation and Nursing	TBD	TBD
Timeline	• January – ACO information gathering • February – Pilot Site plan development and education • Early Spring – Pilot Site implementation of Waiver • Future– Education and implementation within Network	• January – ACO information gathering and 2nd content expert meeting • February – Identification of Pilot Site. Development of billing plan. • Late Spring – Pilot Site implementation of Waiver • Future– Education and implementation within Network	• January – ACO information gathering and Pilot Site identification • February – Pilot Site plan development and education • Early Spring – Pilot Site implementation of Waiver • Future– Education and implementation within Network

Attachment C

Primary Care CPR
Program Clinical Benefits

Clinical Benefits:

- Quality Measures:
  - Alignment and Limiting of Quality Measures across payer programs in accordance with the APM
- OneCare Quality Support:
  - Strong quality measurement and improvement tools and support capabilities designed to greatly minimize practice staff efforts
- Care Coordination:
  - Self-service analytics and care coordination tools helps improve your existing efforts on panel management/segmentation, disease registries/disease management and care coordination
- MIPS/MACRA for Medicare:
  - Through participation, much of your MIPS reporting is covered
- NCQA Certification:
  - OneCare plans to negotiate or change the need for NCQA PCMH certification to benefit payment reform resources

Primary Care CPR
Program Benefits

Program Benefits:

- Prior Authorizations:
  - PAs are not required for your attributed Medicaid patients.
  - We expect to take similar steps in the commercial arena in 2019.
- OneCare and Blueprint leadership working in close alignment to identify priorities and deploy shared resources as a truly integrated and aligned program.
- Program Waiver Enhancements:
  - Implementing current and future benefit waivers to improve access, efficiency, effectiveness, and timeliness of care for patients.
  - Medicare waivers for 2018 include:
    - Paid home visits post-discharge
    - Removal of 3-day acute stay burden for a SNF placement
    - Enhancement of telemedicine access

Attachment C (continued)

Primary Care CPR
Program Payment Overview and Benefits

- Medicaid and Medicare Payments:
  - Combining multiple revenue streams into a single cash flow model
  - Payer-blended, risk-adjusted capitation payments to cover primary care services delivered by a practice to OneCare-attributed panel members.
  - Payments will be made on a per member per month (PMPM) basis and calculated based on the risk level of attributed members.
  - Budgeted with additional financial resources beyond what are available now under the Fee-for-Service (FFS) system to ensure higher revenue than participating practices would otherwise expect to receive.
- BCBSVT Payments:
  - BCBSVT is unable to accommodate the monthly population-based payments to OneCare for primary care practice revenue in 2018. This means:
    - CPR Pilot practices will still receive BCBSVT FFS claims payments supplemented by an additional PMPM cash stream under the CPR Pilot and
    - The practice can expect to yield the same total revenue across the entire multi-payer pilot as they would have if BCBSVT had been able to make such population payments for primary care through OneCare Vermont.