

SUMMARY: PROPOSED MEDICAID SHARED SAVINGS ACO PROGRAM REQUIREMENTS

BACKGROUND: For the past 10 months, DVHA has been working closely with the Green Mountain Care Board and the ACO Standards Work Group to develop standards for its Medicaid Shared Savings Program (SSP) that align with the commercial SSP. In some cases, there are differences between the Medicaid and commercial SSP due to the nature of the populations served or other considerations of the payers that will be participating in the SSPs. The work group recommendations regarding programmatic standards for both the Medicaid and Commercial SSPs have been presented to the SIM Steering Committee on various occasions over the past several months, and feedback on these recommendations has been incorporated into the most recent versions.

Following is a summary of those standards of concern, and how they were addressed in the RFP:

ACO Governance: At least 75% of a Medicaid ACO's governing body must be held by ACO participants, including the following: a) a participant representative of the mental health and substance abuse community of providers; and b) a participant representative of the post-acute care (such as home health or skilled nursing facilities) or long term care services and supports community of providers. Sub-specialty providers are also strongly encouraged to participate on ACO clinical advisory boards. Additionally, the ACO's governing body must include at least one consumer member who is a Medicare beneficiary (if the ACO participates with Medicare), at least one consumer member who is a Medicaid beneficiary (if the ACO participates with Medicaid), and at least one consumer member who is a member of a commercial insurance plan (if the ACO participates with one or more commercial insurers).

The ACO must have a regularly scheduled process for inviting and considering consumer input regarding ACO policy, including the establishment of a consumer advisory board that meets on (at least) a quarterly basis. Members of ACO management and the governing body must regularly attend consumer advisory board meetings and report back to the ACO. Finally, this governing body must have a transparent process including but not limited to the following: publishing the names and contact information of members; devoting an allotted time at the beginning of each in-person meeting to hear comments from the public; make meeting minutes available to the ACO's provider network upon request; and posting summaries of ACO activities to the consumer advisory board on the ACO's website.

Financial Risk: Similar to the Medicare Shared Savings Program (MSSP) ACO's will have the choice between two "tracks" reflecting different levels of potential exposure to financial risk. Track one, the one-sided (up-side only) model, does not expose the ACO to any financial liability; however, this option offers a lower Maximum Sharing Rate (MSR) of 50% (percentage of savings that will be returned to the ACO) as a trade-off. Track two (the two-sided model), on the other hand, offers up to a 60% MSR along with the phase in of down-side risk over the three years of the program (5% in Year 1, 7.5% in Year 2 and 10% in Year 3). Following is a chart comparing the key differences between the two tracks (generally speaking these differences reflect the MSSP model).

Design Element	One-Sided Model	Two-Sided Model
Minimum Number of Attributed Lives	5,000	5,000
Maximum Sharing Rate	Up to 50%	Up to 60%
Quality Scoring	[awaiting feedback from work group]	[awaiting feedback from work group]
Minimum Savings Rate (MSR)	Varies by population size	Flat 2% regardless of size
Minimum Loss Rate (MLR)	Not applicable	Flat 2% regardless of size
Maximum Sharing Cap	10% of ACO's benchmark	15% of ACO's benchmark
Shared Savings	First-dollar sharing once MSR is met or exceeded	First-dollar sharing once MSR is met or exceeded
Shared Losses	None	One minus final sharing rate applied to first-dollar losses once MLR is met or exceeded; shared losses not to exceed 60%
Loss Sharing Limit	None	Cap on the amount of losses to be shared is phased in over three years starting at 5% in Year 1, 7.5% in Year 2, and 10% in Year 3

Total Cost of Care (TCOC): In addition to the two-track model surrounding financial risk, Medicaid ACOs will also have options for how they approach the calculation of the TCOC. In Year One of the program, all ACOs are responsible only for those costs deemed to be “Core” (essentially Medicare Part A&B services). In Year Two of the program, regardless of the financial track an ACO has chosen (as described above), each ACO will have the opportunity to increase their sharing potential by 10% if it agrees to expand the TCOC calculation to include all additional costs excluded from the Year One “Core” costs. By Year Three of the program, all ACOs will be required to expand the TCOC to include all costs excluded from the Year One “Core” costs, however, only those ACO’s who were “early adopters” will continue to receive a 10% enhanced sharing rate.

Eligible Populations: DVHA has defined six populations among all Medicaid eligibles that may be considered for attribution in its ACO model: Aged, Blind or Disable (ABD) Adult; General Adult; New Adult; Blind or Disabled (BD) Child; General Child; and SCHIP Child. Additionally, a number of Medicaid eligibility categories have been excluded from consideration in the ACO, most notable being individuals who are dually eligible for Medicare and Medicaid, as well as individuals who have third party liability coverage, individuals who are eligible for enrollment in Vermont Medicaid but have obtained coverage through commercial insurers, and individuals who are enrolled in Vermont Medicaid but receive a limited benefit package.

Attribution: According to baseline calculations, 99.1% of eligible members are attributable to an ACO provider participant using the following methodology:

Step 1: Determine all beneficiaries who were enrolled for at least 10 months in the study year and assign the beneficiary to the enrollment category where he/she appeared last in the study year.

Step 2: Follow the blueprint model for attribution by using CPT codes.

Step 3: For eligible beneficiaries not attributed in Step 2, assign the beneficiary to his/her primary care provider that was either selected or auto-assigned to in the study year.

Calculation of Historical/Expected Total Cost of Care

- Retrospective Calculation of Actual Total Cost of Care
- Annual Financial Reconciliation Calculation (One and Two-Sided Models)
- Annual Quality Performance Assessment:
- Distribution of Shared Savings Payments
- Repayment of Shared Losses