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Vermont Medicaid Next Generation ACO Pilot Program

Department of Vermont Health Access

January 18, 2018

- ✓ Improve patient experience of care
- ✓ Improve the health of populations
- ✓ Reduce per capita cost growth

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The Big Goal:

Integrated health system able to achieve the Triple Aim

VT All-Payer Model Agreement

Vermont's contract with CMS to enable ACO Based Reform

CMS provides payment flexibility and local control in exchange for meeting quality, financial, and scale targets and alignment across payers

Sets forth planning milestones for future integration

VT Medicaid Next Generation ACO Pilot Program

The Medicaid component of the All-Payer Model

Program provisions are designed to align with Medicare Next Generation program as much as possible.

Platform for future ACO-based innovation

The Building Blocks of ACO-based Reform

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- Policy choice to focus on paying for value, not volume
  - Vermont has created alternative payment models before, as an employer and payer, though mostly by creating incentives.
  - CMS is moving away from Fee-for-Service(FFS) via MACRA and other innovation programs.
  - ACO model is an opportunity to move a larger portion of spending away from FFS.
- Regulatory design that ensures focus on goals and proper alignment
  - Act 113 of 2016 mandates that AHS and ACOs build an aligned ACO program and work towards an integrated health system.
  - Regulation is new to Medicaid; however, it's normal for hospitals, physicians, FQHCs, and insurers who may own ACOs or offer ACO programs.

Vermont Medicaid Programs for ACOs

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- Since 2014, DVHA has operated the *Vermont Medicaid Shared Savings Program*
  - Participating ACOs can earn “shared savings” incentive payments if Medicaid spending is less than expected for their attributed Medicaid members
- In 2016, DVHA issued an RFP for a new ACO program (based on Medicare’s “Next Generation” ACO Program)
  - Participating ACOs receive All-inclusive population based payments from Medicaid, and they use this money to pay providers for services for attributed Medicaid members
  - Increases provider flexibility, and incentivizes paying for value instead of volume of service

Vermont Medicaid Next Generation ACO Program

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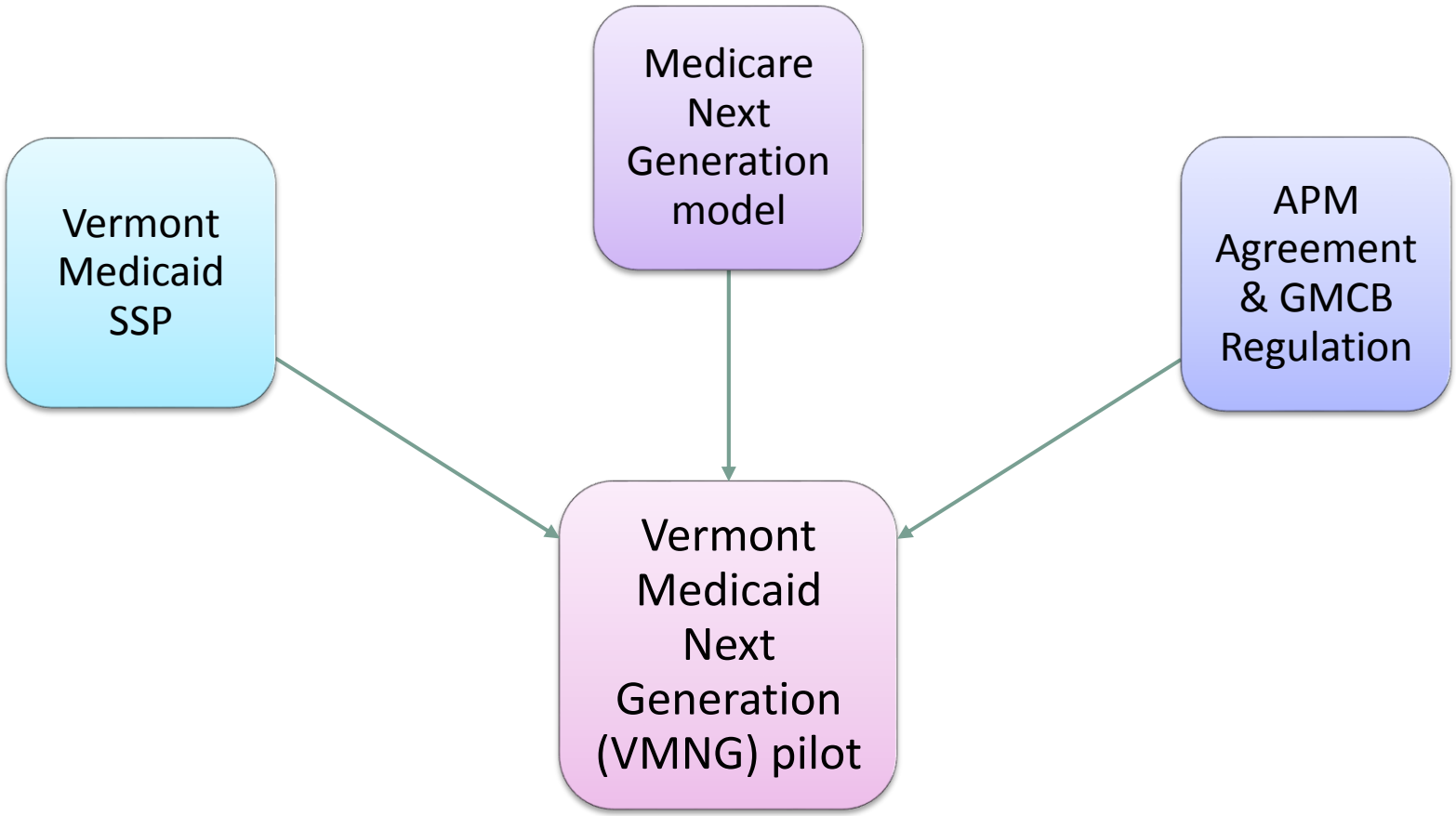

VMNG ACO Contract Term

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- The original contract was a one-year agreement (2017) with four optional one-year extensions.
- DVHA and OneCare triggered the first one-year extension for 2018 and has the option of three additional one-year extensions.
- Rates will be renegotiated annually and reconciliation may occur more frequently.

Goals for VMNG in 2018

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- DVHA and OneCare have executed a contract for the 2018 performance year
- Mutual goals for 2018:
  - Minimize programmatic changes from 2017 to 2018
  - Increase the number of providers and communities voluntarily participating in the program
  - Increase the number of Medicaid beneficiaries attributed to the ACO
  - Ensure programmatic alignment between the VMNG, Medicare, and commercial payer programs in 2018

2018 VMNG Programmatic Changes

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- Several modest programmatic adjustments are being made for the 2018 performance year:
  - Expanding the waiver of prior authorizations to all providers (the waiver will still only be available for Medicaid members who are attributed to OneCare, and for services for which the ACO is financially accountable).
  - Removing the ability for specialist providers to attribute members to the ACO (all attribution will be based on an individual's relationship with a primary care provider).
  - Making minor adjustments to the list of quality measures used to evaluate ACO performance (including the addition of patient experience survey measures).

VMNG ACO Provider Network & People

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	2017 Performance Year	2018 Performance Year
Communities	4	10
Provider Entities	Hospitals, FQHCs, Independent Practices, Home Health Providers, SNFs, DAs, SSAs	Hospitals, FQHCs, Independent Practices, Home Health Providers, SNFs, DAs, SSAs
Unique Providers	~2,000	~5,100
Attributed Medicaid Members	29,102	42,342

The Financial Model: The Math & The Money

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Medicaid $$$

DVHA uses actuaries to set All-Inclusive Population Based Payment (AIPBP) for ACO.

ACO is responsible for spending for attributed members for covered services against target. Reconciled after the calendar year.

In 2017, ACO chose to receive a portion of $ in a Fixed Prospective Payment that they largely pay to hospitals.

ACO asked DVHA to pay remainder of $ in FFS. ACO is responsible financially for AIPBP, whether $ is paid by ACO or DVHA, within risk corridor.

$$$

Hospitals
Physicians
Health Centers
Other Providers

<u>FFS Spending Continues Outside of the ACO</u>

2018 VMNG ACO Contract Cost and Risk Arrangement

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- **2018 Cost PMPY**: Payments will be made on a PMPM basis by broader Medicaid Eligibility Group (MEG). Estimates below assume 12 full months of attribution for each member. Total cost estimated at approximately $139 million, but this number depends on methodology and potential changes.

MEG	PMPM	PMPY
Aged, Blind, and Disabled	$618.40	$7,420.80
General Adult	$362.93	$4,355.16
General Child	$121.38	$1,456.56
Weighted Composite	**$256.98**	**$3,083.76**

- **2018 Risk Arrangement**:

Expenditures over/under expected TCOC	ACO share	DVHA share
-3% to 3%	100%	0%
<-3% or >3%	0%	100%

2018 VMNG ACO Contract Payment Model Details

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- We are measuring the expected Total Cost of Care (TCOC)
- The expected TCOC is expressed as an All-Inclusive Population Based Payment (AIPBP)
- The AIPBP includes an adjustment for efficiency, the savings due to the model. This is 0.2% in 2018. (Expected to grow in the future.)
- There is a quality withhold of 1.5% that OneCare can only pay out to its members if it hits its quality goals. (Pool size increases in later years.)
- ACO is paid an administrative PMPM of $6.50 and care management fee of $2.50.

	A=B+E+F	B=C+D	C	D	E	F	G=D+E+F
MEG	AIPBP	Risk Corridor Benchmark or Expected TCOC	Allocation for Fee-for-Service*	Allocation for Fixed Prospective Payment*	Admin	PCCM	Monthly Net AIPBP to OCVT
ABD	$618.40	$609.40	$295.14	$314.26	$6.50	$2.50	$323.26
Consolidated Adult	$362.93	$353.93	$137.67	$216.26	$6.50	$2.50	$225.26
Consolidated Child	$121.38	$112.38	$54.02	$58.36	$6.50	$2.50	$67.36

*As of 1/1/18; VMNG contract allows for quarterly updates to the proportional FFS and FPP allocations.

VMNG ACO Contract: Why?

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- **Empower Provider Community**: Gives health care providers the opportunity to take leadership for cost containment and quality rather than the government.
- **Expands Pilot:** The program is expanding in a logical and manageable way, adding 6 additional participating communities and ~13,000 attributed Medicaid members.
- **Create Sustainable Costs:** First step in potentially moderating Medicaid spending in the future by pushing risk down onto providers. Initial data is potentially promising.
- **Test Whether Alignment Matters:** The ACO will begin aligned Medicare and commercial programs on 1/1/18. This is an essential step in determining whether ACO based reform has the potential to transform health care.
- **Promote Value Based Payments**: Continue to move away from Fee for Service payment model and towards payment arrangements based on quality, risk, and accountability.

VMNG ACO Contract: Risks

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- **Still Relatively New:** Like any new program, we cannot guarantee that it will succeed.
- **Accuracy of Numbers:** DVHA's actuaries developed the capitated payments based mostly on fee for service claims experience. It is not clear whether number will be too little or too much. Missing the mark may impact program performance and perceptions of the program.
- **Operations**: DVHA is effectively running two major models for beneficiaries (MCO and ACO) with the same staff. This puts pressure on DVHA's resources and operations.

ACO Contract and APM Alignment

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- The Vermont All-Payer ACO Model Agreement requires an aligned Next Generation program that meets the All-Payer financial, quality, and scale goals. How did we do?
  - *Services*: aligned with Next generation ACO program.
  - *Attribution*: methodology is essentially aligned with the Medicare Next Generation ACO program.
  - *Quality*: the majority of measures in the DVHA contract were drawn from the APM agreement.
  - *Financial:* payment methodology is aligned with the Medicare Next Generation ACO program, but the use of DVHA to pay some Fee-for-Service claims raises interesting questions.
  - *Scale*: program has less than 25% of Medicaid beneficiaries. 70% – 80% of Medicaid beneficiaries would likely need to be in the program by 2022 to reach All-Payer scale targets.

VMNG 2017 UPDATE

2017 VMNG Update

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- 2017 performance year concluded 12/31/2017
  - Because of the claims-lag, it is not yet possible to fully evaluate 2017 financial and quality performance
  - Final 2017 results are expected mid-2018
- Financial information from the first three quarters* of 2017 indicates that actual spending has been fairly consistent with expected spending
- June 15, September 15, and December 15 VMNG legislative reports contain more detailed information

*Subject to additional claims run-out and ongoing validation

2017 VMNG Attribution

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Attributed Medicaid Members*	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
% of 29,102	100.00%	99.72%	98.54%	97.04%	93.17%	92.11%	91.07%	89.29%	86.58%	84.67%	83.61%	82.60%
Total	29,102	29,021	28,676	28,240	27,115	26,806	26,503	25,985	25,197	24,642	24,332	24,038
Aged, Blind, Disabled	1,910	1,907	1,906	1,878	1,819	1,808	1,790	1,791	1,773	1,764	1,755	1,742
General Adult	12,987	12,933	12,754	12,525	11,980	11,845	11,646	11,331	10,764	10,512	10,326	10,164
General Child	14,205	14,181	14,016	13,837	13,316	13,153	13,067	12,863	12,660	12,366	12,251	12,132

*Defined after February 1, 2017 as number of individuals for whom a monthly prospective payment was made.

- Attribution of Medicaid members to the ACO occurs prospectively, at the start of the program year.
- No members can be added during the course of a program year, but prospectively attributed members *may* become ineligible for attribution during the course of the program year.
- Between January and December, approximately 77.7% of prospectively attributed members remained continuously eligible for ACO attribution.

2017 VMNG Provider Participation

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Participating Providers in OneCare's 2017 VMNG Network				
	CY '17 Quarter 1	CY '17 Quarter 2	CY '17 Quarter 3	CY '17 Quarter 4
Primary Care Providers	529	518	533	542
Specialists	1,521	1,508	1,566	1,555
TOTAL	2,050	2,026	2,099	2,097

- OneCare supplies DVHA with Network Composition reports on a quarterly basis.
- Provider participation remained fairly constant throughout the 2017 pilot year.

2017 VMNG Inquiries, Complaints, Grievances, and Appeals – Medicaid Members

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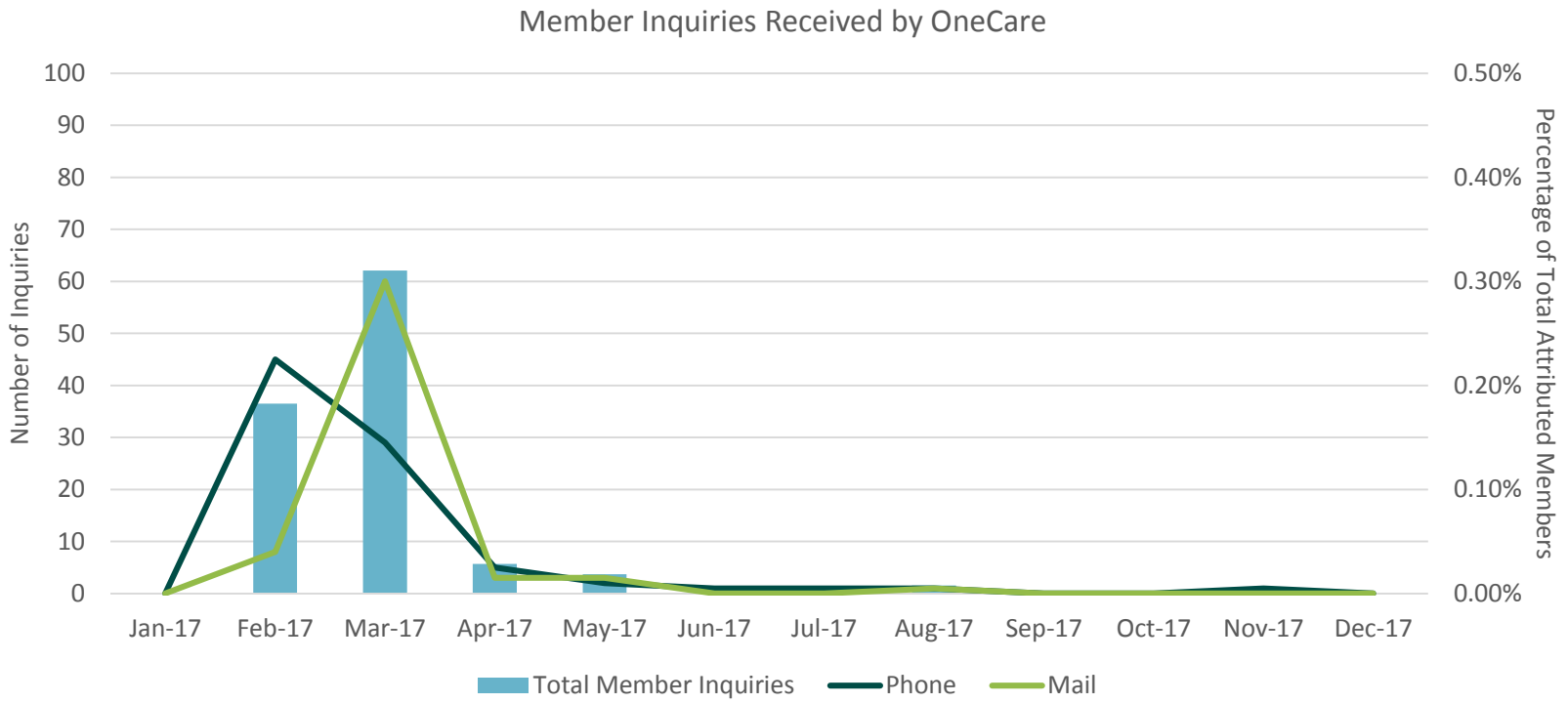

- All but one member and provider communications have been categorized as inquiries; OneCare has received one member complaint. No grievances or appeals were filed in 2017.
- In 2017, all member inquiries but one have related to the process by which members may opt out of having their Medicaid claims data shared with OneCare.

2017 VMNG Inquiries, Complaints, Grievances, and Appeals - Providers

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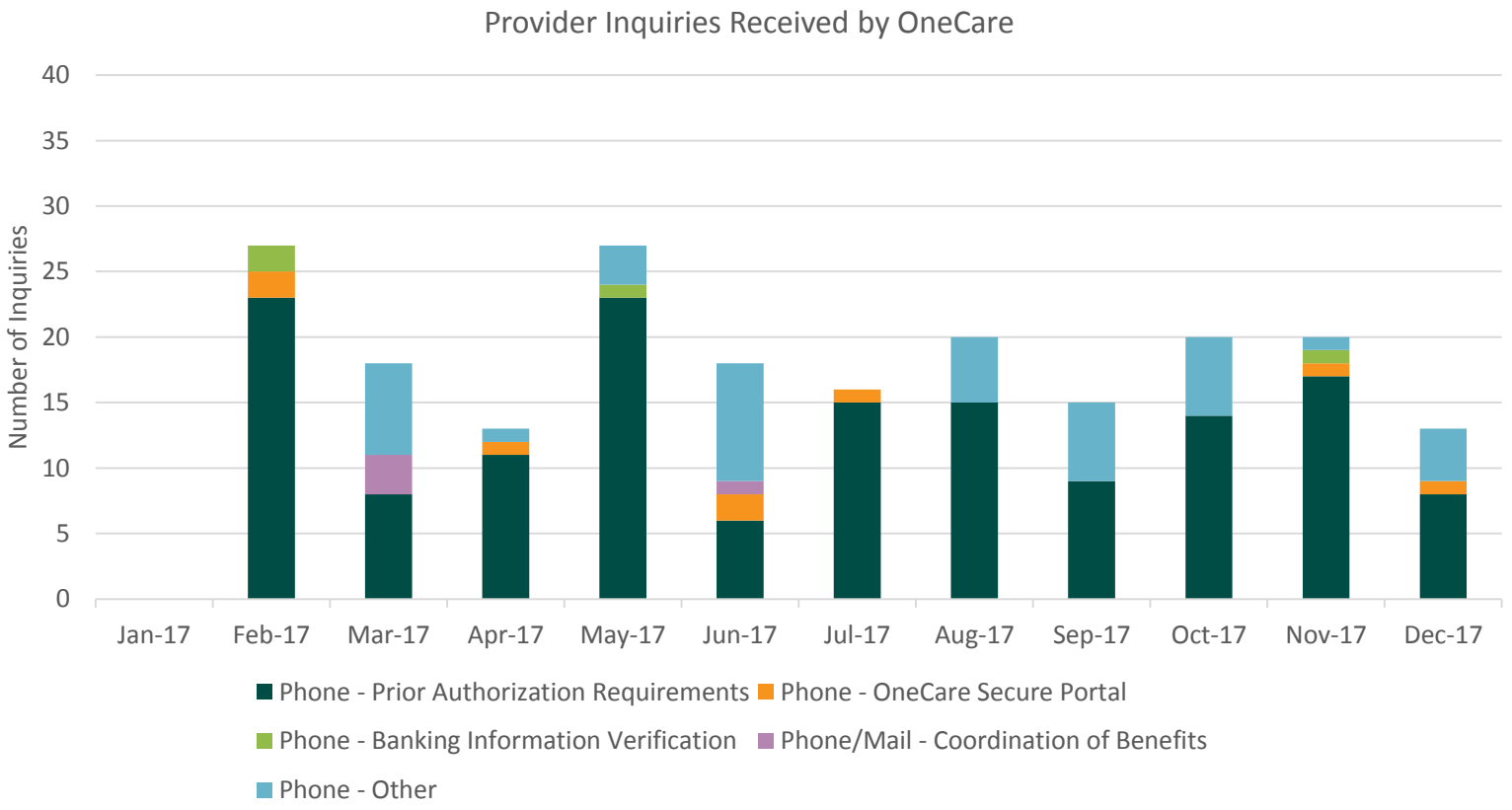

- The majority of provider inquiries in 2017 focused on prior authorization requirements as waived by the Vermont Medicaid Next Generation program.

2017 VMNG Service Utilization, Ages 0-17

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Utilization of Health Care Services by Service Category and Age Group for Members Attributed to the ACO and Members Not Attributed to the ACO						
Population Counts: Nine Month Average						
	VMNG Attributed Members			Members Eligible for Attribution but not Attributed		
	CY '15 Q1 – Q3	CY '16 Q1 – Q3	CY '17 Q1 – Q3	CY '15 Q1 – Q3	CY '16 Q1 – Q3	CY '17 Q1 – Q3
Ages 0-17	14,198	14,783	13,703	35,533	36,252	34,656
Ages 18+	12,335	13,775	13,227	37,573	41,900	41,723
Total	26,532	28,558	26,930	73,106	78,152	76,379
Ages 0-17: Rate per 12,000 member months						
Hospital Inpatient	44	37	18	49	41	19
Hospital Outpatient ED	426	406	382	547	532	491
Hospital Outpatient non-ED	564	602	721	622	666	747
Home Health and Hospice	139	172	129	86	101	81
Physician Services and other Professional Fees						
PCP Office Visit	3,846	3,745	3,253	2,279	2,133	1,918
Non-PCP Office Visit	453	475	423	447	450	401
DME/Supp/Prosth/Orth	627	602	614	555	578	570
Mental Health^	8,146	8,604	9,779	5,455	5,966	6,513
Diagnostic X-ray	387	396	355	444	458	423
Diagnostic Lab	571	605	758	699	662	703
Ambulance	37	34	32	35	35	31
Dental*	1,699	1,712	1,801	1,549	1,567	1,604
Pharmacy/Medications*	5,362	5,354	5,392	5,572	5,596	5,476
^Mental Health category includes a combination of services for which the ACO is and is not financially responsible (i.e. includes all fund sources, and Designated Agency utilization).						
***Services for which ACO is not financially responsible.**						

2017 VMNG Service Utilization, Ages 18+

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Utilization of Health Care Services by Service Category and Age Group for Members Attributed to the ACO and Members Not Attributed to the ACO						
Population Counts: Nine Month Average						
	VMNG Attributed Members			Members Eligible for Attribution but not Attributed		
	CY '15 Q1 – Q3	CY '16 Q1 – Q3	CY '17 Q1 – Q3	CY '15 Q1 – Q3	CY '16 Q1 – Q3	CY '17 Q1 – Q3
Ages 0-17	14,198	14,783	13,703	35,533	36,252	34,656
Ages 18+	12,335	13,775	13,227	37,573	41,900	41,723
Total	26,532	28,558	26,930	73,106	78,152	76,379
Ages 18+: Rate per 12,000 member months						
Hospital Inpatient	120	123	108	127	128	115
Hospital Outpatient ED	878	847	773	951	902	805
Hospital Outpatient non-ED	2,640	2,942	3,136	2,559	2,729	2,707
Home Health and Hospice	342	379	443	345	402	467
Physician Services and other Professional Fees						
PCP Office Visit	4,204	4,359	3,824	2,424	2,498	2,226
Non-PCP Office Visit	1,506	1,536	1,367	1,453	1,431	1,179
DME/Supp/Prosth/Orth	727	773	783	654	700	688
Mental Health^	5,787	5,763	5,730	4,441	4,628	4,537
Diagnostic X-ray	1,651	1,673	1,493	1,560	1,604	1,437
Diagnostic Lab	3,430	3,596	2,830	3,076	3,535	2,967
Ambulance	133	148	137	141	144	149
Dental*	972	1,011	1,006	834	895	872
Pharmacy/Medications*	20,410	21,179	21,222	18,543	19,121	19,517
^Mental Health category includes a combination of services for which the ACO is and is not financially responsible (i.e. includes all fund sources, and Designated Agency utilization). ***Services for which ACO is not financially responsible.**						

2017 VMNG Service Utilization

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- Comparison of the two cohorts over time does not reveal trends that vary notably for most service categories.
- Across all years and both age groups, the cohort of attributed members has had higher utilization of PCP office-visits, mental health visits, and dental visits than the cohort of members who are not attributed.
- Adults in the cohort of attributed members have also had more pharmacy prescriptions than adults in the cohort of members who are not attributed.
- As complete information about utilization in the 2017 performance year is available, DVHA will work with OneCare to conduct more robust statistical analyses to determine whether any of these differences between cohorts are significant, and to determine whether 2017 was significantly different than 2015 or 2016 for either cohort.

VMNG 2017 Financial Performance: January - November

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- Exercise caution when interpreting early financial results. The data is preliminary and subject to change because there is not yet sufficient claims run out to meaningfully assess the program.
- In combination, the claims lag and fixed prospective payment will both understate the cost of care, and tend to make the ACO appear better-off financially than it is until the final reconciliation.
  - Disproportionate impact of the claims lag on the most recent months of performance.

VMNG 2017 Financial Performance: January - November

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- Through November, OneCare's actual expenditure to date is approximately $860,000 less than expected.
- Currently, the program is within approximately 1% of its estimated 2017 Total Cost of Care.
- DVHA will continue to analyze the financial, clinical, and quality performance of the program to determine its efficacy and to determine whether the ACO program generally, and the fixed prospective payments to hospitals specifically, are contributing to an overall moderation in DVHA health care spending.

VMNG 2017 Financial Performance: January - November

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	Q1	Q2	Q3	Year-to-Date
DVHA Payment to ACO*	$ 10,247,515	$ 14,309,538	$ 13,474,373	$ 46,500,674
Total Expected Shadow FFS	$ 9,538,991	$ 13,570,089	$ 12,775,208	$ 43,912,769
Total Actual Shadow FFS	$ 8,357,546	$ 12,025,644	$ 10,245,363	$ 34,716,420
Shadow FFS Over (Under) Spend	$ (1,181,445)	$ (1,544,445)	$ (2,529,845)	$ (9,196,350)
Total Expected FFS	$ 12,895,330	$ 7,643,156	$ 7,195,447	$ 32,255,853
Actual FFS - In Network	$ 5,634,698	$ 1,766,704	$ 1,425,289	$ 9,565,678
Actual FFS - Out of Network	$ 6,667,007	$ 6,181,920	$ 5,957,347	$ 21,204,956
Total Actual FFS	$ 12,301,705	$ 7,948,623	$ 7,382,636	$ 30,770,634
FFS Over (Under) Spend	$ (593,625)	$ 305,467	$ 187,189	$ (1,485,219)
Expected Total Cost of Care	$ 22,434,321	$ 21,213,245	$ 19,970,655	$ 76,168,623
Actual Total Cost of Care	$ 22,463,415	$ 21,518,712	$ 20,157,844	$ 75,306,123
Total Cost of Care Over (Under) Spend	**$ 29,094**	**$ 305,467**	**$ 187,189**	**$ (862,499)**

*Includes funds for cost of care, administrative fees, care coordination support, and Primary Care Case Management (PCCM) fees.
Note: DVHA and OneCare are working together to ensure all program year claims—whether fee-for-service claims or zero-paid shadow claims—were processed correctly and consistently with VMNG program design. OneCare has identified a subset of fee-for-service claims paid to the four risk-bearing hospitals, and is working with DVHA and DXC to determine whether those claims were appropriately classified as fee-for-service claims (according to program design and system logic), or whether those claims ought to have been covered by the prospective payments issued to these hospitals by OneCare, and therefore zero-paid. The process for evaluating this subset of claims at a detailed level is ongoing. DVHA and OneCare will continue to monitor program expenditures to resolve this and any future questions regarding the classification of claims, and it is expected that such activities will continue until the summer of 2018 when the 2017 pilot year expenditures are examined as part of the final year-end reconciliation.

VMNG ACO Contract

APPENDIX – GENERAL INFORMATION

Attribution Methodology Overview

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- Prospective and based on two years of historic data
  - Requires active Medicaid eligibility at start of performance year
- It assigns beneficiaries to ACOs based on the plurality of qualified E&M services they received in that timeframe.
  - Using total expenditure rather than number of claims
- ACO participating providers are identified by their tax identification numbers (TIN)

Attribution Eligibility

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- Eligible members:
  - General Adult
  - General Child
  - Aged, Blind or Disabled Adult & Child
- Excluded members:
  - Individuals dually eligible for Medicare and Medicaid
  - Individuals with coverage through commercial insurers or other third party insurers
  - Individuals who are enrolled in Medicaid but receive a limited benefits package

Services Covered in the ACO Payment (AIPBP)

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- Examples of services *included:*
  - Inpatient hospital services
  - Outpatient hospital services
  - Physician services
  - Nurse practitioner services
  - FQHC
  - Home Health Services
  - Hospice
- Examples of services *excluded:*
  - Pharmacy
  - Nursing facility care
  - Dental services
  - Non-emergency transportation
  - Services delivered through Designated Agencies and other Departments within the Agency of Human Services

VMNG ACO Contract: Information Systems

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- Providers will continue to submit claims as they do today
- DVHA/HPE will process all claims following current processes
- Prior to paying claims, DVHA/HPE will determine if the service is one that is included in the ACO prospective payment
- Claims related to services included in prospective payment will be forwarded to ACO for determination of payment and amount
- Claims related to services not included in prospective payment will be paid by DVHA utilizing current processes