# BUILDING AN INTEGRATED HEALTH SYSTEM:

## *IMPLEMENTING THE VERMONT ALL-PAYER ACCOUNTABLE CARE ORGANIZATION MODEL*

## *THE VERMONT MEDICAID NEXT GEN ACO PILOT CONTRACT*

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## The Big Goal:

Integrated health system able to achieve the Triple Aim

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

### 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



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# The Building Blocks of ACO-based Reform

- Experience with ACO-based reform
  - The program builds on current ACO Shared Savings Program.

- 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.
  - This requires AHS/DVHA to be good faith partners with the GMCB and other payers.

# ACO Contract: Who?
## *Provider Network & People*

- **ACOs Network**: OneCare Vermont, with participation of UVMMC, CVMC, NMC, Porter and additional participation from FQHCs/independent practices, home health providers, Designated Agencies, and skilled nursing agencies in the four communities.

- **Providers**: 1,836 unique providers are participating.

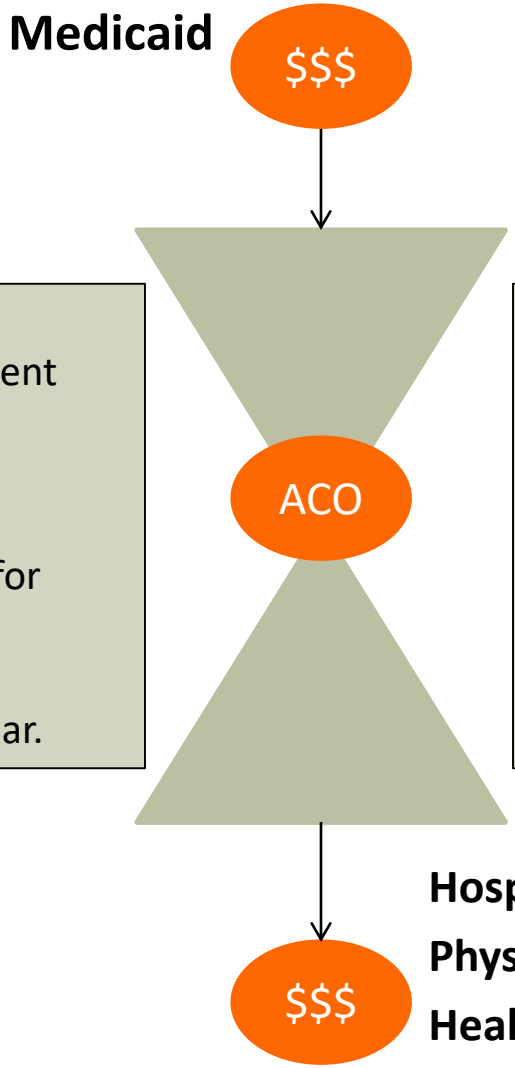
- **People**: 29,103 Vermonters are attributed in the current analysis, about 20% of potentially eligible Medicaid population.

# ACO Contract: What?
## *Services*

**Services:** DVHA aligned its model with the Medicare/CMS Next Generation model.

| Services for which ACO is accountable | Services for which ACO is not accountable |
|---|---|
| • **Inpatient hospital services**<br>• **Outpatient hospital services**<br>• **Physician services, primary care and specialty**<br>• **Nurse practitioner services**<br>• **Ambulatory surgical center services**<br>• **Federally Qualified Health Center and Rural Health Clinic services**<br>• **Home health services**<br>• **Hospice services (room and board excluded)**<br>• **Physical, occupational and speech therapy services**<br>• **Chiropractor services**<br>• **Audiology services**<br>• **Podiatrist services**<br>• **Optometrist and optician services**<br>• **Independent laboratory services**<br>• **Mental health and substance abuse services funded by DVHA and not funded by other State Departments (excluding DA & SSA services)**<br>• **Ambulance transport – emergent/non-emergent**<br>• **Durable medical equipment, prosthetics and orthotics (eyewear excluded)**<br>• **Medical supplies**<br>• **Dialysis facility services**<br>• **Preventive services** | • Pharmacy<br>• Nursing facility care<br>• Dental services<br>• Non-emergency transportation (ambulance transportation is not part of this category)<br>• Psychiatric treatment in a state psychiatric hospital<br>• Level 1 (involuntary placement) inpatient psychiatric stays in any hospital<br>• Smoking cessation services<br>• Services provided by the Designated Agencies or Specialized Service Agencies. (Note: These providers are part of the ACO network, and they may be involved in the care of ACO attributed members, but DVHA is not converting any of its current payments to these providers into the payment to an ACO.) |

# The Financial Model: The Math & The Money




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.

ACO chose to receive 2/3 $ in a Fixed Prospective Payment that they will largely pay to hospitals. Including hospital owned physician practices.

ACO asked DVHA to pay 1/3 $ (estimated) in FFS. ACO is responsible financially for AIPBP, whether $ is paid by ACO or DVHA, within risk corridor.

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

# ACO Contract: What?
## *Cost and Risk Arrangement*

- **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 $93 million reflecting a reasonable guess within the actuary's acceptable range. Final number depends on actual spending, risk payment or recoupment, and final number of member months for attributed lives during CY 17.

| MEG | PMPM | PMPY |
|---|---|---|
| **Aged, Blind, and Disabled** | $616.07 | $7,392.84 |
| **General Adult** | $376.49 | $4,517.88 |
| **General Child** | $120.97 | $1,451.64 |
| **Weighted Composite** | $267.32 | $3,207.84 |

- **Risk Arrangement**:

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



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# ACO Contract: What?

## *Details of the Payment Model*

- 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 2017. (Expected to grow in the future.)
- There is a quality withhold of 0.5% that OneCare can only pay out to its members if it hits its quality goals. (Pool size increases in later years.)
- ACO is paid a$6.50 admin PMPM and passes through a care management fee of $2.50.

| | A | B=C+D | C | D | E | F | G=D+E+F |
|---|---|---|---|---|---|---|---|
| **MEG** | **AIPBP** | **Risk Corridor Benchmark or Expected TCOC** | **Allocation of FFS** | **Allocation towards AIPBP or FPP** | **Admin** | **PCCM** | **Monthly Net AIPBP to OCVT** |
| | | | **36.03%** | **63.97%** | | | |
| **ABD** | **$616.07** | **$607.07** | **$218.73** | **$388.34** | **$6.50** | **$2.50** | **$397.34** |
| **Consolidated Adult** | **$376.49** | **$367.49** | **$132.41** | **$235.08** | **$6.50** | **$2.50** | **$244.08** |
| **Consolidated Child** | **$120.97** | **$111.97** | **$40.34** | **$71.63** | **$6.50** | **$2.50** | **$80.63** |

# ACO Contract: When?

- **Term:** One-year agreement with four optional one-year extensions.  Rates will need to be renegotiated annually and reconciliation may occur more frequently.

# ACO Contract: Where?

- **Oversight led by DVHA's Payment Reform Team**
  - Alicia Cooper is the program's day to day leader reporting to DVHA Commissioner's Office.

- **DVHA Operational Readiness**: The DVHA Payment Reform Team is prepared to be point of contact for the ACO and coordinate activities across DVHA.
  - Procedure manuals and operational timelines have been developed.
  - DVHA, via Hewlett-Packard Enterprise, is classifying payments as ACO FFS/ACO Capitation/Non-ACO (regular FFS) per contract specifications.
  - Hewlett-Packard Enterprise is paying a monthly capitation payment.

- **OneCare Operational Readiness**: DVHA conducted a readiness review with OneCare in November and December. Most areas (76%) rated satisfactory during the review. Remaining areas are prioritized for completion in Q1 2017 via monthly meetings between DVHA and OneCare.

# ACO Contract: Why?

- **Supporting Provider-Led Care Transformation**: ACO structure allows doctors, nurses, community service leaders, and consumers significant input, along with strong voice in governance and the development of clinical and quality programing.

- **Supporting a Learning Health Systems Approach**: The pilot program with four participating communities and ~30,000 attributed Medicaid members allows for small changes to be implemented and refined (for both Medicaid and OneCare) prior to more broad-based participation in subsequent years.

- **Re-designing the Revenue Model**: First step in redesigning the revenue model is to reward value, meaning low cost and high quality, rather than volume.  Redesigning payments ultimately supports the new care model.

# ACO Contract: Risks?

- **New:** Like any new program, we cannot guarantee that it will succeed.

- **Financial Projections:** Numbers are being developed without experience. Not clear whether number will be too little or too much. Missing the mark may impact program performance and perceptions of the program.

- **Operations**: Implementation challenges are likely to occur in the first months of any new program. Such challenges can affect public perception of the program, and may poison the well for other statewide readiness activities during Year 0 of the APM agreement.

- **Integration:** AHS will need to be a willing partner in transformative change.

# ACO Contract and APM Alignment

- 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: The covered services are aligned with the Medicare Next Generation program.
  - Attribution: Methodology is 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. The risk arrangement features upside and downside risk like the Medicare Next Generation program.
  - Scale: Program will need to scale up substantially by 2022 to reach All-Payer Model scale target

# Questions?

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