State of Vermont
Department of Vermont Health Access
NOB 1 South, 1st Floor
280 State Drive
Waterbury, Vermont 05671

REPORT TO THE GENERAL ASSEMBLY

Vermont Medicaid Next Generation Pilot Program 2017 Performance

Submitted to
House Committee on Appropriations
House Committee on Human Services
House Committee on Health Care
Senate Committee on Appropriations
Senate Committee on Health and Welfare
Health Reform Oversight Committee
Green Mountain Care Board
Office of the Health Care Advocate
Medicaid and Exchange Advisory Board

Submitted by
Cory Gustafson, Commissioner
Department of Vermont Health Access

Michael Costa, Deputy Commissioner
Department of Vermont Health Access

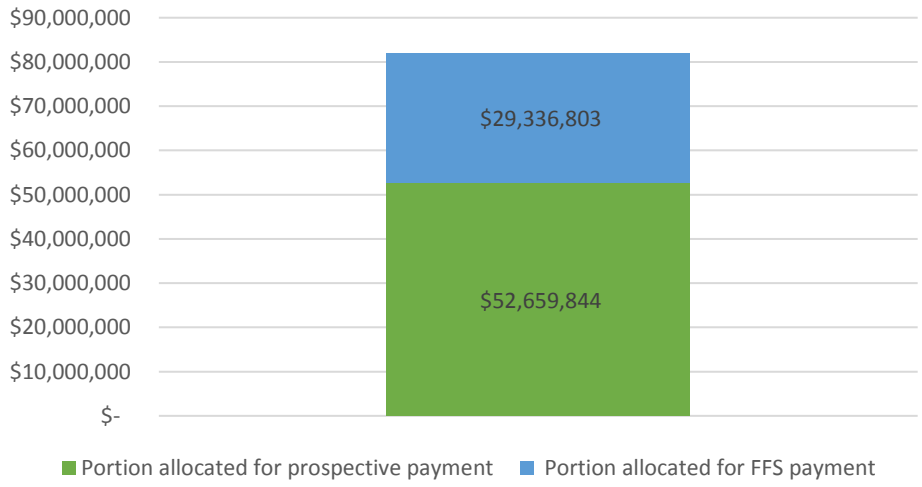
September 20, 2018

This report is submitted as a supplement to the quarterly reports required by Act 124 of 2018, *An Act Relating to Reporting Requirements for the Second Year of the Vermont Medicaid Next Generation ACO Pilot Project*.[1] The report summarizes pilot project performance in 2017 and proceeds in three sections. Section A offers an executive summary. Section B provides a brief overview of the program. Section C summarizes financial and quality performance for the 2017 performance year.

Section A: Executive Summary of Vermont Medicaid Next Generation 2017 Results

The Vermont Medicaid Next Generation (VMNG) Accountable Care Organization (ACO) Pilot program represents Medicaid's participation in the integrated health care system envisioned by the Vermont All-Payer Accountable Care Organization Model agreement with the Centers for Medicare and Medicaid Services (CMS). The Department of Vermont Health Access (DVHA) contracts with an ACO, OneCare Vermont, to pre-pay for the cost of care for a group of Medicaid beneficiaries for a calendar year. OneCare and its network of providers agree to focus on increasing the quality of care and moderating the cost of care for these Vermonters. Additionally, OneCare accepts financial risk if program costs exceed the agreed upon price up to a capped amount of 3% of total price. DVHA makes a fixed prospective payment to OneCare monthly for some of the predetermined amount and pays the rest of the dollars on OneCare's behalf through fee-for-service payments to health care providers both in and out of OneCare's network (see Figure 1). The 2017 program results indicate sufficient, incremental progress that warrants cautious optimism and a continued commitment to the program.

Figure 1. Agreed Upon Price for Care, 2017 VMNG Contract



Result 1: DVHA and One Care launched the program successfully.

- In 2016, DVHA issued a Request for Proposals (RFP) for a new ACO program based on Medicare's "Next Generation" ACO Program. OneCare Vermont was selected as the Apparently Successful Bidder.
- DVHA conducted a readiness review prior to the launch of the 2017 program year. OneCare Vermont satisfied the majority of requirements before January 1, 2017 and completed all outstanding Readiness Review items prior to the end of the first quarter of 2017.

[1] See https://legislature.vermont.gov/assets/Documents/2018/Docs/ACTS/ACT124/ACT124%20As%20Enacted.pdf.

- DVHA worked with DXC Technologies to change Medicaid payment systems to make fixed prospective payments to OneCare Vermont.
- Processes for ongoing data exchange between DVHA and OneCare have been implemented and are regularly evaluated for potential improvements.
- DVHA and OneCare prepare and maintain an operational timeline to ensure contractually required data sharing and reporting occurs in a timely manner.
- OneCare and DVHA have established a forum for convening operational teams on a weekly basis, and for convening subject matter experts monthly. These forums have allowed the teams to identify, discuss, and resolve multiple operational challenges, and have resulted in several process improvements to date.
- DVHA and OneCare have worked together to monitor and report on program performance on a quarterly basis.

Result 2: The program is growing.

Additional providers and communities have joined the ACO network to participate in the program for the 2018 performance year, and more are expected to do so for the 2019 performance year.

	2017 Performance Year	**2018 Performance Year**	**2019 Performance Year**
Hospital Service Areas	4	10	13
Provider Entities	Hospitals, FQHCs, Independent Practices, Home Health Providers, SNFs, DAs, SSAs	Hospitals, FQHCs, Independent Practices, Home Health Providers, SNFs, DAs, SSAs	Hospitals, FQHCs, Independent Practices, Home Health Providers, SNFs, DAs, SSAs
Unique Medicaid Providers	~2,000	~3,400	~4,300

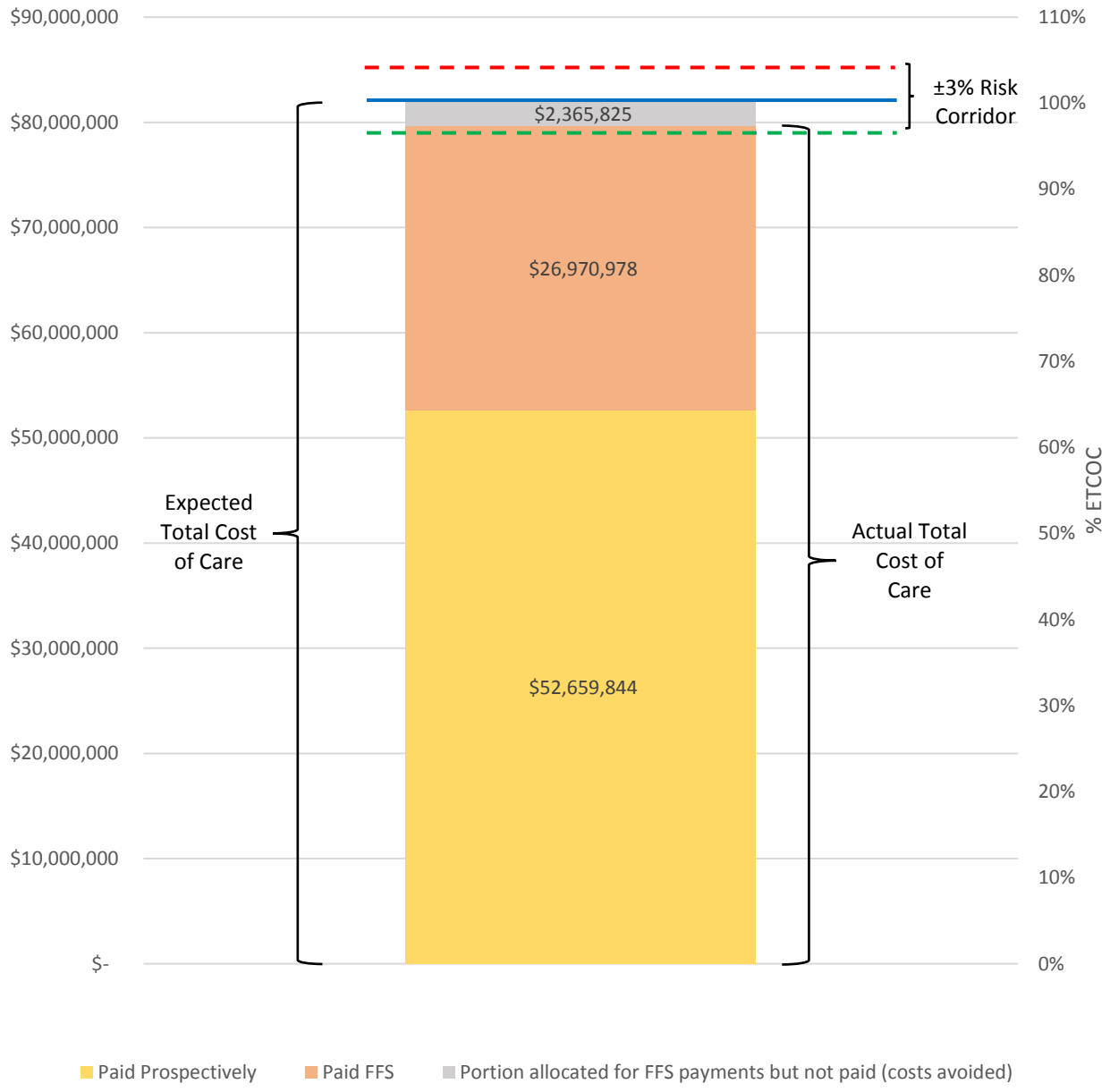
Result 3: The ACO program spent less than expected on health care in 2017.

DVHA and the ACO agreed on the price of health care upfront, and the ACO spent approximately $2.4 million less than the expected price (see Figure 2). Financial performance was within the ±3% risk corridor, which means that OneCare Vermont and its members are entitled to save those dollars.

Result 4: The ACO met most of its quality targets.

The ACO's quality score was 85% on 10 pre-selected measures. Notably, OneCare's performance exceeded the national 75th percentile on measures relating to diabetes control and engagement with alcohol and drug dependence treatment. Examining quality trends over time will be important in order to understand the impact of changing provider payment on quality of care.

Figure 2. 2017 VMNG Financial Performance within Expected Total Cost of Care

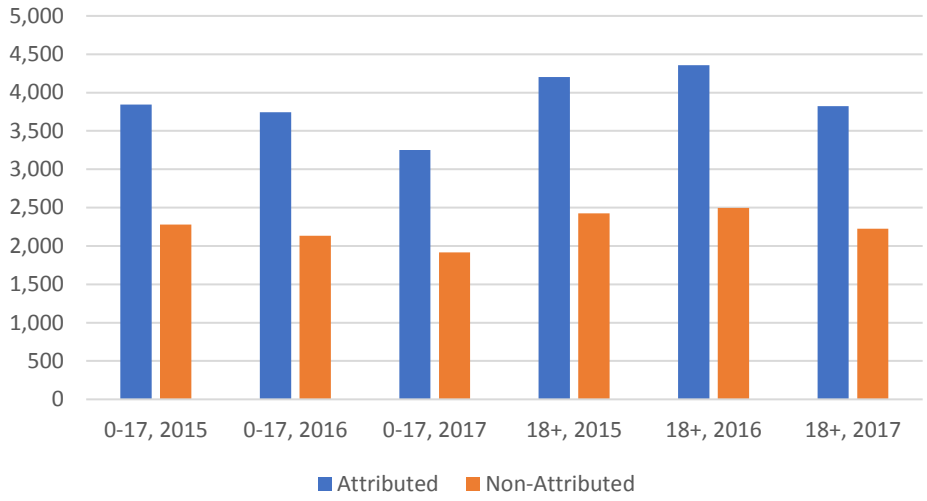


Result 5: DVHA is seeing more use of primary care among ACO-attributed Medicaid members.

Based on preliminary analyses of utilization, the cohort of attributed members has had higher utilization of primary care office-visits than the cohort of members who are eligible for attribution but not attributed (see Figure 3). As further information about utilization becomes available, DVHA will conduct

more robust analyses to determine whether differences between cohorts are statistically significant, and to understand the impact of the program on utilization patterns over time.

Figure 3. Primary Care Visits Per 1,000 Member Years by Age and Year



Section B: Vermont Medicaid Next Generation ACO Pilot Program Overview

Introduction

The Vermont Medicaid Next Generation (VMNG) Accountable Care Organization (ACO) Pilot program represents the initial phase of Medicaid's participation in the integrated health care system envisioned by the Vermont All-Payer Accountable Care Organization Model agreement with the Centers for Medicare and Medicaid Services (CMS).[2] ACOs are provider-led and -governed organizations, with a substantial regional clinical leadership role, that have agreed to assume accountability for the quality, cost, and experience of care. The model's goal is an integrated health care system that has aligned incentives to improve quality and reduce unnecessary costs. The VMNG ACO Pilot program pursues this goal by taking the next step in transitioning the health care revenue model from Fee-for-Service payments to Value-Based payments. This transition is meant to focus health care payments on rewarding value, meaning low cost and high quality, rather than volume of services provided.

The VMNG program allows the Department of Vermont Health Access (DVHA) to partner with a risk-bearing ACO. For Calendar Year 2017, DVHA contracted with OneCare Vermont (OneCare) ACO to manage the quality and cost of care for approximately 29,000 Medicaid members in four communities. Together, DVHA and OneCare are piloting a financial model designed to support and empower the clinical and operational capabilities of the ACO provider network in support of the Triple Aim of better care, better health, and lower costs. Primary goals of the program are to increase provider flexibility and support health care professionals to deliver the care they know to be most effective in promoting and managing the health of the population they serve. This will contribute to improving the health of Vermonters and moderating health care spending growth in future.

OneCare Vermont ACO Network & Attribution

In February of 2017, DVHA contracted with OneCare to participate in the Vermont Medicaid Next Generation ACO Pilot program for the 2017 calendar year with four optional one-year extensions.[3] In 2017, OneCare Vermont's network of participating providers included the University of Vermont Medical Center, Central Vermont Medical Center, Northwestern Medical Center, and Porter Hospital along with their employed physicians and providers; two Federally Qualified Health Centers; independent practices; home health providers; Designated Agencies; Area Agencies on Aging; and skilled nursing agencies in the four participating communities.

Attribution is primarily based on a Medicaid member's relationship with a primary care provider who has elected to participate in the ACO network. Attribution of Medicaid members to the ACO occurs prospectively, at the start of the program year. In this way, the ACO is aware of the full population for which it is accountable at the program's outset and can use that information to identify and engage members most effectively. Although no members can be added during the course of a program year, some of the prospectively attributed members may become ineligible for attribution during the course of the program year. Members may become ineligible for attribution due to:

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[2] See http://gmcboard.vermont.gov/sites/gmcb/files/documents/10-27-16-vermont-all-payer-accountable-care-organization-model-agreement.pdf.

[3] See http://dvha.vermont.gov/administration/onecare-aco-32318-final-searchable.pdf.

- Becoming ineligible for Medicaid coverage[4]
- Switching to a limited Medicaid benefits package (e.g. pharmacy-only benefits)
- Gaining additional sources of insurance coverage (e.g. commercial or Medicare)
- Death

Financial Model

Through the VMNG, DVHA pays OneCare a monthly fixed prospective payment (FPP) for services provided by hospitals (and hospital-owned practices) participating with the ACO. This is a monthly, per member payment made in advance of the services being performed. Medicaid fee-for-service payments continue for all other non-hospital providers in the ACO, for all providers who are not a part of the ACO, and for all services that are not included in the fixed prospective payment. The ACO is responsible for both the cost and quality of care for each attributed member. This is true whether that person uses little or no care or whether they require services consistently throughout the year.

One of the key goals of the prospective payment model is to give providers and Medicaid certainty and predictability regarding revenue for a pre-identified population of Vermonters. This should lead to better incentives and provider investments that improve the quality of care for Vermonters. The ACO has agreed to a risk-based spending target for the full attributed population during the performance year. If the ACO exceeds its spending target for the Performance Year, it is liable for expenses up to 103% of the target; if the ACO spends less than its target, it may retain savings to 97% of the target. This arrangement provides an incentive to use resources efficiently. The ACO also withheld some of the payment to providers up front—0.5% in 2017—to support a quality incentive program. The providers in the ACO can earn this money back through high quality performance on targeted quality measures. This type of payment incentive is provided to encourage high quality care and is expected to grow over time.

2017 Performance Overview

Since executing the Vermont Medicaid Next Generation contract in February of 2017, DVHA and OneCare Vermont collaborated in the launch and ongoing implementation of the pilot program. OneCare, its network of providers, and DVHA demonstrated the ability to stand up the VMNG ACO pilot program in 2017, including:

- Operationalizing fixed prospective payments from Medicaid to an ACO and switching to predictable and reliable revenue stream for participating hospitals.
- Operationalizing a waiver of prior authorization for providers participating in the VMNG program to address provider administrative burden.
- Developing and refining approaches to financial monitoring and reporting to understand program performance.

DVHA and OneCare are committed to ongoing improvement in implementation of the program and in evaluating performance. The two organizations have been able to use 2017 experience to identify opportunities and develop strategies for continual process improvement as the program evolves and includes more providers and Medicaid beneficiaries over time.

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[4] If a member has lost Medicaid coverage but later becomes eligible for Medicaid again during the performance year, they may also become eligible for attribution again at that time.

Overall, the focus of the ACO program is on improving health and delivering high quality health care while creating a financial model capable of producing predictable and sustainable health care costs. DVHA will continue to analyze the operational, financial, 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. 2017 program year results alone are insufficient to evaluate the success of the model, but the experience from the first year of VMNG implementation has provided a foundation for continued implementation and evaluation.

Section C: Vermont Medicaid Next Generation ACO Financial and Quality Performance: January 1 – December 31, 2017

Financial Performance

Table 1 sets forth ACO financial performance in Calendar Year 2017. The table includes several components:

- Funds paid prospectively to OneCare by DVHA (paid on a monthly basis).
- Zero-paid "shadow claims" that are submitted by providers, used to understand what services were delivered and to calculate the cost of services delivered (according to the Medicaid fee-for-service fee schedule) that were covered by the prospective payment from DVHA to OneCare.
- Fee-for-service claims paid by DVHA on behalf of OneCare (claims for services received by Medicaid members attributed to the ACO from providers in the ACO network who have elected to continue to be reimbursed on a fee-for-service basis, and from providers outside the ACO network).
- Adjustments made to the Expected Total Cost of Care as part of the year-end reconciliation process.

Overall, actual expenditures for the program in 2017 are compared to expected expenditure as an indicator of financial performance. The Expected Total Cost of Care is derived based on actuarial projections of the cost of care in 2017 for the population of prospectively attributed Medicaid members, as detailed in Attachment B of the 2017 VMNG program contract.[5]

OneCare's actual expenditure in 2017 was lower than the expected expenditure for the attributed population in the program year. This is true with respect to both the fee-for-service payments that DVHA issues on OneCare's behalf and the prospective payments made by DVHA to OneCare—zero-paid shadow claims for services included in the prospective payment total to less than the expected amount. This is consistent with the intent of the incentives of the payment model, and results in a smaller loss against the true delivery expense to deliver the services. This will help ensure provider commitment to the predictable model, and improvements in access and quality for Medicaid enrollees.

Final financial performance for the 2017 calendar year was 97.11% of the Expected Total Cost of Care, which is within the ±3% risk corridor included in the 2017 contract. As such, OneCare Vermont is entitled to retain the savings between the Actual Total Cost of Care and the Expected Total Cost of Care, totaling approximately $2.4 million for the 2017 performance year.

[5] DVHA engaged Wakely Consulting Group to calculate 2017 ACO rates, including the Expected Total Cost of Care. These rates were also reviewed by OneCare and the Green Mountain Care Board, and by the actuarial firms with which they contracted at the time (Milliman and Lewis & Ellis, respectively).

Table 1. Overview of VMNG Financial Performance, 2017

DVHA Payment to ACO	$ 50,651,871.21	(A)	*(B) + (C) + (D) + (E) + (F)*
Fixed Prospective Payment (FPP)	$ 47,435,653.23	(B)	
Quality Withhold	$ 412,059.98	(C)	
Primary Care Case Management (PCCM) Fee	$ 726,387.50	(D)	
Care Coordination Payment (CCP)	$ 1,038,885.25	(E)	
Administrative Fee	$ 1,038,885.25	(F)	
Total ACO Payments to Providers	$ 49,200,925.98	(G)	*(B) + (D) + (E)*
Total Expected Shadow FFS	$ 52,659,843.59	(H)	
Total Actual Shadow FFS	$ 44,531,294.27	(I)	
Shadow FFS Over (Under) Spend	$ (8,128,549.32)	(J)	*(I) – (H)*
Total Expected FFS	$ 29,659,883.84	(K)	
Actual FFS - In Network	$ 5,617,338.69	(L)	
Actual FFS - Out of Network	$ 21,353,639.38	(M)	
Total Actual FFS	$ 26,970,978.07	(N)	*(L) + (M)*
FFS Over (Under) Spend	$ (2,688,905.77)	(O)	*(N) – (K)*
Expected Total Cost of Care	$ 82,319,727.43	(P)	*(H) + (K)*
Actual Total Cost of Care	$ 79,630,821.66	(Q)	*(H) + (N)*
Total Cost of Care Over (Under) Spend	$ (2,688,905.77)	(R)	*[(H) + (N)] – [(H) + (K)]*
Adjust ETCOC Downward for MEG Adjustments*	$ 276,945.36	(S)	
Adjust ETCOC Downward for AIPBP Payments Made for Months when Member was No Longer Eligible for Medicaid^	$ 46,135.32	(T)	
Total ETCOC Reduction	$ 323,080.68	(U)	*(S) + (T)*
Adjusted Expected Total Cost of Care	$ 81,996,646.75	(V)	*(P) – (U)*
Actual Total Cost of Care	$ 79,630,821.66	(Q)	
Adjusted Total Cost of Care Over (Under) Spend	**$ (2,365,825.09)**	(W)	*(Q) – (V)*

*Medicaid Eligibility Group (MEG) adjustments are required in instances where DVHA paid a prospective payment for an attributed member according to a MEG assignment that was not current for that month. For example, if a payment was issued to OneCare for a General Child, but the attributed member had aged into the General Adult group, an adjustment would be made to the Expected Total Cost of Care for the difference.

^Adjustments are also required when DVHA paid a prospective payment for a member who was no longer Medicaid eligible. For instance, if a payment was issued to OneCare for a member who had passed away, the Expected Total Cost of Care would be adjusted downward and any dollars paid to OneCare for that month would be recouped.

Quality Performance

The VMNG ACO contract includes measures that are used to evaluate the quality of care for the population of attributed Medicaid members. ACO-level quality is evaluated based on performance on 10 measures that impact payment. In addition to payment measures, the 2017 contract also included two reporting measures; performance on these measures does not impact payment. Table 2 sets forth ACO financial performance in Calendar Year 2017. The table includes several components:

- Measure name and National Quality Forum (NQF) number (or other number if the measure is not currently endorsed by the NQF);
- Measure numerator (the number of attributed members meeting the criteria for the measure), denominator (the number of attributed members eligible for inclusion in the measure population), and rate (a percentage derived from dividing the numerator by the denominator);
- National benchmarks (where available); and
- The number of points the ACO earned based on their 2017 performance.[6]

OneCare Vermont earned 17 of 20 total possible points. Therefore, the ACO's overall quality score was 85%, combining performance on all 10 payment measures. To the extent possible, quality measures included in the VMNG contract were selected to align with measures included in the Vermont All-Payer ACO Model agreement. Many of these measures were identified because they represented an opportunity for improvement statewide.

- ACO performance exceeded the national 75th percentile on three measures.
- ACO performance exceeded the national 50th percentile on two measures.
- ACO performance was below the national 25th percentile on one measure.
- National benchmarks were unavailable for four measures.

OneCare Vermont was required to withhold some of the prospective payment to providers up-front—0.5% in 2017—to support a quality incentive program. The providers in the ACO are able to earn this money back through high quality performance on targeted quality measures. This type of payment incentive is provided to encourage high quality care. Because of the overall quality score, the ACO will distribute 85% of withheld payments to participating ACO providers. The ACO will reinvest the remaining 15% of withheld payments in quality improvement initiatives to support participating communities.

[6] ACO-level performance was compared to national benchmarks when available. If national benchmarks were not available for the 2017 performance year, the ACO was awarded two points. In future years, ACO performance will be compared to prior year performance when national benchmarks are unavailable.

Table 2. Overview of VMNG Quality Performance, 2017

Measure Description	NQF #	Numerator	Denominator	Rate	Quality Compass 2017 Benchmarks (CY 2016) National Medicaid Percentiles				Points awarded
					25th	50th	75th	90th	
Payment Measures									
30 Day Follow-Up after Discharge from the ED for Alcohol and Other Drug Dependence^	2605	49	162	30.25%	N/A	N/A	N/A	N/A	**2**
30 Day Follow-Up after Discharge from the ED for Mental Health^	2605	157	194	80.93%	N/A	N/A	N/A	N/A	**2**
Adolescent Well Care Visits	N/A	3335	5800	57.50%	43.06	50.12	59.72	68.06	**1.5**
All Cause Unplanned Admissions for Patients with Multiple Chronic Conditions*	CMS ACO #38 (under NQF review)	13	880	1.48%	N/A	N/A	N/A	N/A	**2**
Developmental Screening in the First 3 Years of Life‡	1448	1205	2017	59.74%	15.70	36.00	50.50	N/A	**2**
Diabetes Mellitus: Hemoglobin A1c Poor Control (>9%)*	0059	116	368	31.52%	48.57	41.12	35.52	29.07	**2**
Hypertension: Controlling High Blood Pressure	0018	230	356	64.61%	47.69	56.93	64.79	71.69	**1.5**
Initiation of Alcohol and Other Drug Dependence Treatment	0004	287	811	35.39%	35.79	40.72	45.13	50.00	**0**
Engagement of Alcohol and Other Drug Dependence Treatment	0004	143	811	17.63%	7.98	12.36	16.25	21.31	**2**
Screening for Clinical Depression and Follow-Up Plan	418	117	247	47.37%	N/A	N/A	N/A	N/A	**2**
								Total Points Earned	**17**
Reporting Measures									
Follow-Up after Hospitalization for Mental Illness (7 Day Rate)	0576	67	181	37.02%	34.00	46.36	56.22	65.01	N/A
Timeliness of Prenatal Care	1517 (No Longer Endorsed)	221	315	70.16%	77.66	83.56	88.59	91.67	N/A

^ denotes first-year HEDIS measures for which benchmarks are not yet available
** denotes measures for which a lower rate indicates higher performance*
‡ denotes measure with multi-state benchmarks: 26 states reporting (FFY 2016)

Key: Performance Compared to National Benchmarks
Equal to and below 25th percentile (0 points)
Above 25th percentile (1 point)
Above 50th percentile (1.5 points)
Above 75th percentile (2 points)
Above 90th percentile (2 points)