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Vermont Medicaid Next Generation ACO Program 2019 Performance

Department of Vermont Health Access

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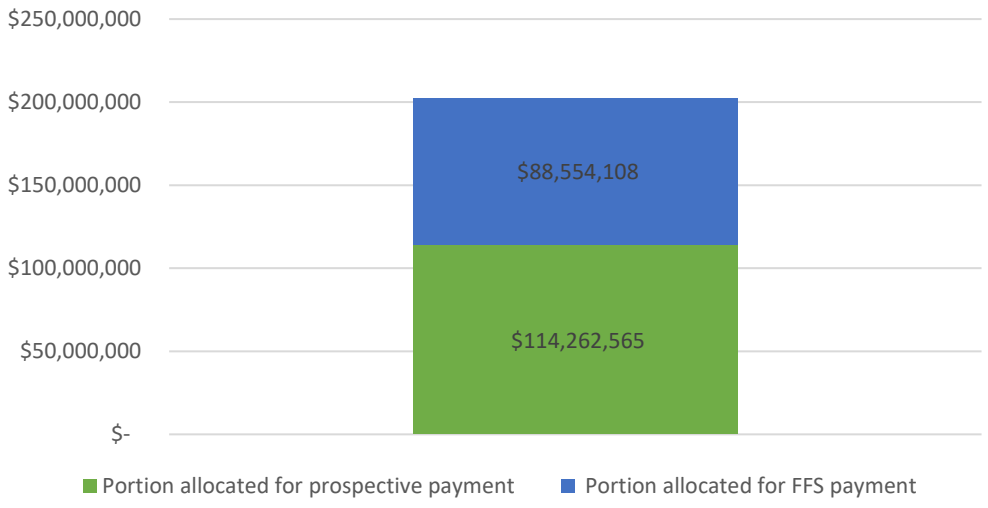
The report summarizes program performance in 2019 and proceeds in three sections. Section A offers an executive summary. Section B provides a brief overview of the program. Section C summarizes financial and quality performance for the 2019 performance year.

Section A: Executive Summary of Vermont Medicaid Next Generation 2019 Results

The Vermont Medicaid Next Generation (VMNG) Accountable Care Organization (ACO) program is a Scale Target ACO Initiative as described in the Vermont All-Payer Accountable Care Organization Model agreement with the Centers for Medicare and Medicaid Services (CMS). This initiative also represents The Department of Vermont Health Access' (DVHA) priority for an integrated health care system where providers accept financial risk for the cost and quality of care. Through a procurement process in late 2016, DVHA offered the opportunity for ACOs to be accountable for the cost and quality of care for a group of Medicaid members during a calendar year. Part of this arrangement includes pre-payment for the cost of care for this group of attributed Medicaid members. OneCare is the only ACO participating in this opportunity. OneCare develops and implements ACO activities with its network of participating providers—these activities are intended to help providers reduce health care cost growth and improve quality for Vermonters. Additionally, OneCare accepts financial risk if health care costs exceed the agreed upon price—in 2019, approximately $203 million—up to a capped amount (4% of total price in the 2019 performance period). DVHA makes a fixed prospective payment to OneCare monthly for some of the agreed upon price and pays the rest of the dollars through fee-for-service payments to health care providers both in and out of OneCare's network (see Figure 1). Building from the 2017 and 2018 performance years, the 2019 program results indicate further incremental progress, offer an opportunity for evaluating potential methodological improvements in the future, and warrant a continued commitment to the program.

As noted above, the VMNG program is specific to Medicaid's contract with OneCare Vermont. The All-Payer Model also encompasses ACO agreements with Medicare and commercial payers. The results summarized in this report pertain to the third year of performance for the Medicaid program only, and these results should not be extrapolated to the All-Payer Model as a whole. Other payer contracts were in their second performance years in 2019; scale has continued to grow across payer programs to date, and the payer contracts have incrementally become more aligned in recent years. However, opportunities for improvement in these areas remain, and any evaluation of the All-Payer Model overall will take these factors into consideration along with more payer-specific results as described in this report.

Figure 1. Agreed Upon Price for Care, 2019 VMNG Contract



VMNG 2019 Performance - Key Takeaways:

- The program is still growing. In 2019, the ACO-attributed Medicaid population increased by 88% over the prior year. The number of communities, health care providers, and people participating in the program increased from 2019 to 2020 and is expected to grow again in 2021.
- Spending on health care services for ACO-attributed members was more than expected in 2019. DVHA and OneCare agreed on the price of health care upfront, and actual spending was more than expected (see Result 2). Because OneCare shares financial risk with Medicaid, OneCare and its provider network has to pay for a portion of this spending over the agreed upon price.
- Fixed Prospective Payments are showing promise. For the third year in a row, providers receiving prospective payments have spent less than expected on services within their control, highlighting the potential of changing financial incentives in this model.
- The ACO performed well against its quality targets. OneCare's quality score was 95% on pre-selected performance measures, and OneCare demonstrated statistically significant year-over-year improvement on five measures.
- The ACO extended care coordination to more communities and people. There has been a steady increase in the percentage of high-risk and very high-risk attributed Medicaid members who received care coordination interventions under OneCare's Advanced Community Care Coordination model.

Result 1: The program continues to grow.

Additional providers and communities have joined OneCare's network to participate in the program for the 2020 performance year. As most Vermont communities are already participating in the VMNG program, only modest additional provider participation may be expected for a 2021 performance year.

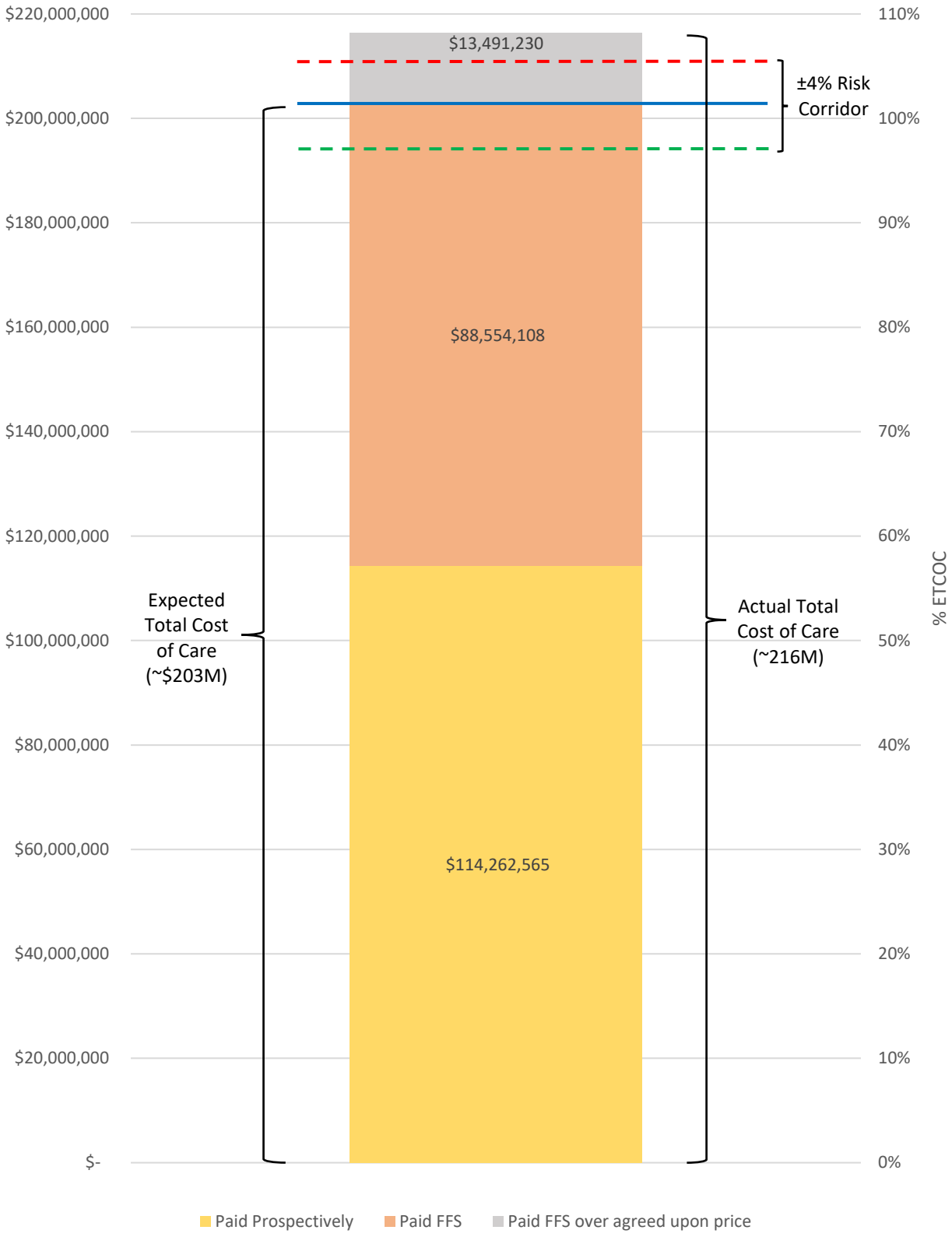
	2017 Performance Year	2018 Performance Year	2019 Performance Year	2020 Performance Year
Hospital Service Areas	4	10	13	14
Provider Entities	Hospitals, FQHCs, Independent Practices, Home Health Providers, SNFs, DAs, SSAs			
Unique Medicaid Providers	~2,000	~3,400	~4,300	~5,000

Growth in the number of participating communities, providers, and attributed members in the VMNG program contributes to the state's overall progress toward the scale targets in the All-Payer ACO Model agreement. As scale increases, the incentives become stronger for providers to modify their care delivery and business practices to be successful under fixed payments. In the 2019 performance year, approximately 79,000 Medicaid members were attributed to OneCare, representing approximately 60% of members for whom Medicaid was the primary payer. In 2020, the number of prospectively attributed members increased to approximately 114,000, representing approximately 88% of members for whom Medicaid was the primary payer.

Result 2: ACO providers and Medicaid shared financial accountability for health care in 2019.

DVHA and OneCare agreed on the price of health care for attributed Medicaid members up-front, and spending for ACO-attributed members was approximately $13.5 million more than the expected price (approximately $203 million, see Figure 2).

Figure 2. 2019 VMNG Financial Performance relative to Expected Total Cost of Care



- ACO-participating providers who were paid prospectively (instead of fee-for-service) spent $8.2M *less than* expected on the services within their control. Conversely, providers who were paid fee-for-service (both within and outside of OneCare's network) spent $13.5M *more than* expected. This highlights how two different changing financial incentives might impact the delivery and cost of health care.
- The ACO-attributed population nearly doubled from 2018 to 2019. This significant change introduced relatively more uncertainty into the rate setting process than in prior years.
- Overall utilization trends increased for the entire Medicaid-enrolled population between 2017 (the base year that was used for rate development) and 2019 (the performance year). 2019 utilization was more similar to 2018 utilization, but the agreed-upon price was based on lower 2017 utilization.

Because financial performance exceeded the agreed-upon price, OneCare is liable for the full amount within the 4% risk corridor—approximately $8.1 million. After application of other necessary adjustments, OneCare Vermont will pay approximately $6.7 million to DVHA. If DVHA and OneCare did not have this risk-sharing arrangement, the Vermont Medicaid program would pay the entirety of the amount in excess of the expected price.

Result 3: The ACO met or exceeded most of its quality targets.

OneCare's quality score was 95% on 10 pre-selected measures. Notably, OneCare's performance exceeded the national 90th percentile on measures relating to diabetes mellitus hemoglobin A1c poor control, 30-day follow-up after discharge from Emergency Departments for mental health and for alcohol and other drug dependence. OneCare's performance exceeded the national 75th percentile on measures relating to developmental screening in the first three years of life and engagement of alcohol and other drug dependence treatment. Also notably, OneCare demonstrated significant improvement over prior year performance for measures relating to adolescent well care visits, diabetes mellitus hemoglobin A1c poor control, developmental screening in the first three years of life, 30 day follow-up after discharge from Emergency Departments for mental health and for alcohol and other drug dependence, and Screening for Clinical Depression and Follow-Up Plan. Examining quality trends over time will be important in order to understand the impact of changing provider payment on quality of care, and results will become increasingly meaningful as OneCare achieves scale in provider participation in its Medicaid program.

Result 4: The ACO continued expansion of the Advanced Community Care Coordination model in all participating communities.

In 2019 the Advanced Community Care Coordination (A3C) Model continued to grow and expand in all participating health service areas. During the 2019 performance period:

- OneCare distributed approximately $5.2 million in A3C payments to 84 community partner organizations (including primary care practices, Designated Mental Health Agencies, Area Agencies on Aging, and Visiting Nurse Associations).
- Key performance indicators showed incremental increases in care team activity in OneCare's care coordination software (Care Navigator).
- Care Coordination Core Teams were active in all thirteen participating communities, tasked with expanding upon best practices, sharing learnings, and implementing team-based care quality improvement projects using Care Navigator.
- There was a steady increase in the percentage of high-risk and very high-risk attributed Medicaid members who received a wide range of care coordination interventions under the Advanced Community Care Coordination model. Notably, in 2019 OneCare came very close (14.5%) to

reaching the target of 15% of high and very high risk members who are care managed (which includes assignment of a lead care coordinator and creation of a shared care plan with at least 2 goals and 2 tasks).

- OneCare prepared for implementation of an electronic learning platform to provide training opportunities for community care team members in care coordination skills and core competencies, including the use of Care Navigator.
- OneCare developed programs and supports for primary prevention to improve population health and reduce the long-term social and economic burden of chronic disease through the RiseVT model in 14 additional communities for a total of 35 communities with active RiseVT wellness campaigns.
- OneCare began to implement the Developmental Understanding and Legal Collaboration for Everyone (DULCE) model in four pediatric practices. DULCE is an intervention that takes place within a pediatric care office to address social determinants of health in infants, newborn to 6 months of age, and provides support for their parents.

Result 5: DVHA and One Care made incremental programmatic improvements.

During the 2019 performance year, DVHA and OneCare implemented several programmatic changes that represented opportunities for incremental improvement. One notable change was a pilot in the St. Johnsbury Health Service Area (HSA) to study an alternative attribution methodology based on a Medicaid member's residence rather than their primary care utilization. The pilot sought to focus on provider accountability for the entire community of Medicaid members, rather than just those who had accessed primary care historically. It additionally tested whether alternative attribution methodologies could be operationalized and built upon in future years of the program, and lessons learned from this pilot were incorporated into the VMNG's expanded attribution methodology for the 2020 performance year.

2017-2019: Observations and Model Potential

Having three years of performance results—both within and outside the risk corridor, and both greater than and less than the agreed-upon price—has allowed DVHA and the Agency of Human Services to more fully assess the opportunities associated with having a risk-sharing contract with an ACO. Foremost, contracting with OneCare for multiple years has given the Vermont Medicaid program more certainty in budgeting than it would have had absent this arrangement, particularly as the attributed population has grown over time. This arrangement also allows for more revenue predictability for the providers participating in OneCare's network. Likewise, the risk corridor ensures there are both incentives to control costs and protections—for providers and the Medicaid program—in place for when actual spending is different than expected. Payment predictability and risk-sharing work together to build system stability over time. This contract also represents DVHA's largest initiative to move away from fee-for-service reimbursement and toward value-based payments. For three years in a row, providers participating in the VMNG program who are being paid prospectively have spent less than expected; for two years in a row, providers being paid fee-for-service have spent more than expected. While not conclusive, this is a pattern of interest that signals the potential of changing financial incentives. All the while, there have been incremental improvements in quality performance and changes in the delivery and coordination of care. For these reasons, DVHA and AHS believe that this model should continue to be tested, at least through the term of the All-Payer ACO model agreement.

Section B: Vermont Medicaid Next Generation ACO Pilot Program Overview

Introduction

The Vermont Medicaid Next Generation (VMNG) Accountable Care Organization (ACO) program is a Scale Target ACO Initiative as described in the Vermont All-Payer Accountable Care Organization Model agreement with the Centers for Medicare and Medicaid Services (CMS).[1] ACOs are provider-led and -governed organizations 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 program pursues this goal by 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 2019, DVHA contracted with OneCare Vermont (OneCare) ACO to manage the quality and cost of care for approximately 80,000 Medicaid members in thirteen communities, representing an 88% increase over the 2018 Medicaid attributed population. Together, DVHA and OneCare are piloting a financial model designed to support and empower the clinical and operational capabilities of the 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.[2] DVHA and OneCare elected to exercise the second of the four optional one-year extensions permitted by the VMNG contract for a 2019 performance year.[3] In 2019, OneCare Vermont's network of participating providers included thirteen hospitals along with their employed physicians and providers; Federally Qualified Health Centers; independent practices; home health providers; Designated Agencies; Area Agencies on Aging; and skilled nursing agencies in the participating communities.

Until 2019, attribution had primarily been based on a Medicaid member's relationship with a primary care provider who has elected to participate in OneCare's network. Based on the learnings of a geographic attribution pilot in St. Johnsbury in 2019, program-wide modifications to attribution were implemented for the 2020 performance year, resulting in a methodology that does not solely rely on a members' past primary care utilization. Attribution of Medicaid members to OneCare occurs prospectively, at the start of the program year. In this way, OneCare 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

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[1] See http://gmcboard.vermont.gov/sites/gmcb/files/documents/10-27-16-vermont-all-payer-accountable-care-organization-model-agreement.pdf.
[2] See http://dvha.vermont.gov/administration/onecare-aco-32318-final-searchable.pdf.
[3] See https://dvha.vermont.gov/sites/dvha/files/documents/Administration/1onecare-aco-32318-3-final-signed-with-exhbits.pdf. .

members may become ineligible for attribution during the course of the program year. Members may become ineligible for attribution due to:

- 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 contract, DVHA pays OneCare a monthly fixed prospective payment (FPP) for services provided by hospitals (and hospital-owned practices) in OneCare's network. This is a monthly, per member payment made in advance of the services being performed. Beginning in 2018 and continuing in 2019, OneCare implemented the Comprehensive Payment Reform (CPR) pilot with four independent physician practices that also elected to be paid the FPP for their ACO-attributed members. Medicaid fee-for-service payments continue for all other non-hospital and non-CPR providers in OneCare's network, for all providers who are not a part of OneCare's network, and for all services that are not included in the fixed prospective payment. OneCare is accountable 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. OneCare has agreed to a risk-based spending target for the full attributed population during the performance year. If OneCare exceeds its spending target for the Performance Year, it is liable for expenses up to 104% of the target; if OneCare spends less than its target, it may retain the difference between the target and 96% of the target. This arrangement provides an incentive to use resources efficiently. OneCare is also required to maintain a fund equal to a percentage of the expected health care costs—2% in 2019—to support a quality incentive program. The providers in OneCare's network can earn a share of this money 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.

2019 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 continued to implement incremental programmatic improvements in 2019. Among these was a pilot in the St. Johnsbury Health Service Area (HSA) to study a geographic attribution methodology, which was based on a Medicaid member's residence rather than their primary care utilization. The pilot sought to test whether alternative attribution methodologies could be implemented within the VMNG program and whether lessons learned could be used for program modifications in future years. Based on experience with the 2019 geographic attribution pilot, an expanded attribution methodology was developed and implemented for the VMNG program's 2020 performance year.

[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.

DVHA and OneCare are committed to fostering stability within the model while making targeted, incremental improvements in both the implementation of the program and in evaluating performance. Both parties have been able to use experience from the first three program years to identify opportunities and develop strategies for continual process improvement as the program evolves and includes more providers and Medicaid beneficiaries over time. DVHA and OneCare have also seen the VMNG program as an opportunity to align certain programmatic features with the Medicare and commercial payer ACO programs; in other areas the VMNG program has allowed DVHA and OneCare to pilot innovative ideas (for example, developing and testing new attribution methodologies) in hopes that they could be areas for multi-payer alignment in future program years.

Overall, the focus of the VMNG 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 VMNG program generally, and the fixed prospective payments to hospitals and select independent physician practices specifically, are contributing to an overall moderation in DVHA health care spending. Although results to date alone are insufficient to evaluate the success of the model, the experience from the first three years 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, 2019

Financial Performance

Table 1 sets forth ACO financial performance in Calendar Year 2019. 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 ACO-attributed Medicaid members from providers in OneCare's network who have elected to continue to be reimbursed on a fee-for-service basis, and from providers outside OneCare's network).
- Adjustments made to the Expected and Actual Total Cost of Care as part of the year-end reconciliation process.

Actual health care expenditures for the attributed population in 2019 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 2019 for the population of prospectively attributed Medicaid members, as detailed in Attachment B of the 2019 VMNG program contract.[5]

The actual health care expenditure in 2019 was higher than the expected expenditure for the attributed population in the program year. The fee-for-service payments that DVHA issues were higher than expected; conversely, zero-paid shadow claims for services included in the prospective payment total to less than the expected amount. This latter observation 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. Similar patterns were observed in the 2018 performance year.

Final financial performance for the 2019 calendar year was 106.7% of the Expected Total Cost of Care, which is outside of the ±4% risk corridor included in the 2019 contract. As such, OneCare Vermont is liable to DVHA the difference between the Actual Total Cost of Care and the Expected Total Cost of Care within the risk corridor—approximately $8.1 million. After applying other necessary adjustments, OneCare's total liability to DVHA is approximately $6.7 million for the 2019 performance year.

In both the 2017 and 2018 performance years, OneCare Vermont experienced financial performance within the risk corridor. As experience was outside of the risk corridor in 2019, both DVHA and OneCare Vermont engaged in additional analyses to understand some of the drivers of these financial results. One contributing factor was the near-doubling of the population of attributed Medicaid members (from approximately 42,000 in 2018 to nearly 80,000 in 2019), and the corresponding expansion in the number and types of provider organizations participating in OneCare's network in 2019. An additional contributing factor appears to have been related to utilization trends increasing for the entire Medicaid-enrolled population between 2017 (the base year that was used for rate development) and 2019 (the performance

[5] DVHA engaged Wakely Consulting Group to calculate 2019 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).

year). In other words, some of the increased utilization observed in 2019 represented a continuation of trends that had already been established in 2018, and that therefore could not be directly influenced by the OneCare provider network *during* the performance year.

In addition to these factors, there were further utilization patterns observed within the 2019 performance year that contributed to the actual expenditure in excess of the Expected Total Cost of Care. In both 2018 and 2019, there were shifts in utilization patterns of 2019 attributed Medicaid members toward higher-cost facilities (including hospitals not receiving prospective payments both within and outside OneCare's network of providers) and higher-cost services (including more complex inpatient Diagnosis Related Groups and more costly outpatient surgical procedures). In 2019, the OneCare network also included additional Federally Qualified Health Centers (FQHCs) which are reimbursed differently (and often at a higher rate) than other primary care providers for professional services. Relative to 2017 and 2018, the overall 2019 health care expenditure for the ACO-attributed population was more greatly affected by FQHC service utilization as a result of this increased FQHC participation.

The analysis of the 2019 VMNG financial performance gave both DVHA and OneCare the opportunity to consider some of the benefits and limitations of the rate development methodology that has been used for each of the VMNG contract years to date. In essence, this methodology identifies the attributed population of Medicaid members for a performance year (for instance, 2019), looks at actual historic service utilization and costs for those specific members during a base year (2017 was the base year for 2019), and then makes a number of assumptions about how utilization and provider payments are expected to change between the historic base year and the future performance year in order to estimate what services will cost for that population during the future performance year. This methodology is generally consistent with how rates are set for other ACO and managed care programs nationally. However, predictive models rely on assumptions about how what has happened in the past relates to what will happen in the future, and there can be exceptional years that deviate from what otherwise may have been expected. Because of this potential uncertainty, the VMNG model (like many other payer models) has employed a risk corridor to limit the provider network's exposure to financial risk in the event of higher-than-expected costs and utilization, and to limit the potential financial gain in the event of lower-than-expected costs and utilization.

Using this methodology has given both the state and participating ACO providers more predictability around Medicaid expenditures and revenue, respectively, and in the first two years of program performance, the actual cost of services has been close (within the risk corridor) to the expected cost that was estimated using this approach to rate development. However, the parties have also now observed the 2019 performance year, for which assumptions about utilization changes did not match what actually occurred. This highlights a limitation of the methodology when there is volatility beyond what might have been reasonably assumed. The 2019 performance year is also the first that highlights the utility of the risk corridor in limiting OneCare's and providers' financial liability.

Although the 2019 financial performance was higher than expected and outside of the risk corridor, the drivers described above offer both opportunities for focus going forward and a lens for understanding why 2019 was somewhat unique relative to 2017 and 2018. As such, both DVHA and OneCare remain committed to the ongoing implementation and testing of this model. Moreover, because of these learnings from the 2019 performance year, DVHA and OneCare will be working with their respective actuaries to consider and evaluate potential modifications to the rate setting methodology that could allow for additional year-over-year predictability in future.

Table 1. VMNG 2019 year-end reconciliation calculations

Year-End Reconciliation Calculations			VMNG 2019
DVHA Payment to ACO	(A)	*(B) + (C) + (D) + (E)*	$ 118,045,872
Fixed Prospective Payment (FPP)	(B)		$ 108,592,432
Quality Withhold	(C)		$ 4,056,333
Care Coordination Payment (CCP)	(D)		$ 2,698,553
Administrative Fee	(E)		$ 2,698,553
Total ACO Payments to Providers	(F)	*(B) + (D)*	$ 111,290,985
Total Expected Shadow FFS	(G)		$ 114,262,565
Total Actual Shadow FFS	(H)		$ 106,016,700
Shadow FFS Over (Under) Spend	(I)	*(H) – (G)*	$ (8,245,865)
Total Expected FFS	(J)		$ 88,554,108
Actual FFS - In Network	(K)		$ 54,783,813
Actual FFS - Out of Network	(L)		$ 47,261,524
Total Actual FFS	(M)	*(K) + (L)*	$ 102,045,338
FFS Over (Under) Spend	(N)	*(M) – (J)*	$ 13,491,230
Expected Total Cost of Care	(O)	*(G) + (J)*	$ 202,816,673
Actual Total Cost of Care	(P)	*(G) + (M)*	$ 216,307,903
Total Cost of Care Over (Under) Spend	(Q)	*(P) – (O)*	$ 13,491,230
Reconciliation of Prospective Payments (if necessary)	(R)		$ (1,607,374)
Recoupment of Unearned VBIF Payments	(S)		$ 101,408
Financial Liability Before Risk Corridor	(T)	(Q) + (R) + (S)	$ 11,985,264
Risk Corridor Upper Bound (104% of ETCOC)			$ 210,929,340
Risk Corridor Lower Bound (96% of ETCOC)			$ 194,704,006
ATCOC as Percentage of ETCOC			106.7%
Financial Liability After Risk Corridor	**(U)**	**[(O)*1.04-(O)] + (R) + (S)**	**$ 6,606,702**
Recoupment of Undistributed 2019 A3C Payments	(V)		$ 78,308
Final Settlement Amount Owed to DVHA	**(W)**	***(U) + (V)***	**$ 6,685,010**

*Adjustments are required in instances where DVHA paid a prospective payment for an attributed member according to a Medicaid Eligibility Group (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 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, any dollars paid to OneCare for that month would be recouped through such an adjustment.

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 2019 contract also included three reporting measures; performance on these measures does not impact payment. Table 2 sets forth ACO quality performance in Calendar Year 2019. 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 earned based on 2019 performance.[6]

OneCare can earn up to 2 points for each measure based on its performance relative to national or multi-state benchmarks (if available). OneCare is also eligible to earn up to 1 bonus point per measure for improvement over its own prior year performance (bonus points are not available for measures with no benchmarks). In combination, points earned for performance relative to benchmarks and year-over-year improvement cannot exceed a maximum of 2 points multiplied by the number of payment measures. For example, if there are 10 payment measures, the maximum total possible points is (2 points * 10 measures) = 20 possible points.

In 2019, OneCare Vermont earned 19 of 20 total possible points. Therefore, OneCare's overall quality score was 95%, 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. In summary:

- ACO performance exceeded the national 90th percentile on three measures.
- ACO performance exceeded the national 75th percentile on one measure for which there was no 90th national percentile.
- ACO performance was between the national 75th and 90th percentiles on one measure.
- ACO performance was between the national 50th and 75th percentiles on two measures.
- ACO performance was between the national 25th and 50th percentiles on one measure.
- National benchmarks were unavailable for two measures.
- ACO performance showed statistically significant improvement from prior year performance on five measures, including one of the measures with no benchmarks.[7]

OneCare Vermont was required to withhold some of the prospective payment to providers up-front—2% in 2019—to support a quality incentive program. The providers in OneCare's network 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, OneCare will

[6] ACO-level performance was compared to national benchmarks when available. If national benchmarks were not available for the 2019 performance year, ACO performance on a given measure was compared to prior year performance. In instances where neither national benchmarks nor prior year performance are available, OneCare is awarded 2 points for performance.

[7] Statistical significance is defined on the VMNG contract by a p-value of 0.1 using a one-way ANOVA test.

distribute 95% of withheld payments to participating OneCare providers. Of the remaining 5% of withheld payments, OneCare is entitled to retain 50% to reinvest in quality improvement initiatives to support participating communities; the other 50% ($101,408) shall be returned to DVHA.

Table 2. Overview of VMNG Quality Performance, 2019

Measure Description	NQF #	Numerator	Denominator	Rate	Quality Compass 2018 Benchmarks (CY 2017) National Medicaid Percentiles				Points awarded	Bonus points awarded
					25th	50th	75th	90th		
Payment Measures										
30 Day Follow-Up after Discharge from the ED for Alcohol and Other Drug Dependence	2605	227	611	37.15%	10.07	16.26	24.48	32.15	2	1
30 Day Follow-Up after Discharge from the ED for Mental Health	2605	532	622	85.52%	45.58	52.79	66.25	74.47	2	0
Adolescent Well Care Visits	N/A	8789	15,326	57.35%	45.74	54.57	61.99	66.80	1	0
All Cause Unplanned Admissions for Patients with Multiple Chronic Conditions*	CMS ACO #38 (under NQF review)	17	1940	0.88%	N/A	N/A	N/A	N/A	1^	N/A
Developmental Screening in the First 3 Years of Life‡	1448	3107	5003	62.10%	17.80	39.80	53.90	N/A[8]	2	1
Diabetes Mellitus: Hemoglobin A1c Poor Control (>9%)*	0059	95	371	25.61%	46.96	38.20	33.09	29.68	2	1
Hypertension: Controlling High Blood Pressure	0018	233	372	62.63%	49.27	58.68	65.75	71.04	1	0
Initiation of Alcohol and Other Drug Dependence Treatment	0004	806	1977	40.77%	38.62	42.22	46.40	50.20	0.5	0
Engagement of Alcohol and Other Drug Dependence Treatment	0004	400	1977	20.23%	9.11	13.69	17.74	21.40	1.5	1
Screening for Clinical Depression and Follow-Up Plan	418	159	306	51.96%	N/A	N/A	N/A	N/A	2	N/A
								Total Points Earned	**15**	**4**
Reporting Measures[9]										
Follow-Up after Hospitalization for Mental Illness (7 Day Rate)	0576	306	749	40.85%	29.61	36.54	45.79	54.13	N/A	N/A
Tobacco Use Assessment and Tobacco Cessation Intervention	0028	312	372	83.87%	N/A	N/A	N/A	N/A	N/A	N/A

** denotes measures for which a lower rate indicates higher performance*

‡ denotes measure that does not have national benchmarks in Quality Compass but that does have multi-state benchmarks with 26 states reporting (FFY 2016)

^denotes measure for which scoring was based on a comparison of 2019 ACO performance to 2018 ACO performance

Key: Performance Compared to National Benchmarks
Equal to and below 25th percentile (0 points)
Above 25th percentile (0.5 point)
Above 50th percentile (1 point)
Above 75th percentile (1.5 points)
Above 90th percentile (2 points)

[8] Because national 90th percentile benchmarks are not available for this measure, OneCare was awarded the full two points for exceeding the national 75th percentile for their performance.

[9] The VMNG includes composite scores of survey results from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey as an additional reporting measure.