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

Vermont Medicaid Next Generation Pilot Program 2018 Performance

Department of Vermont Health Access

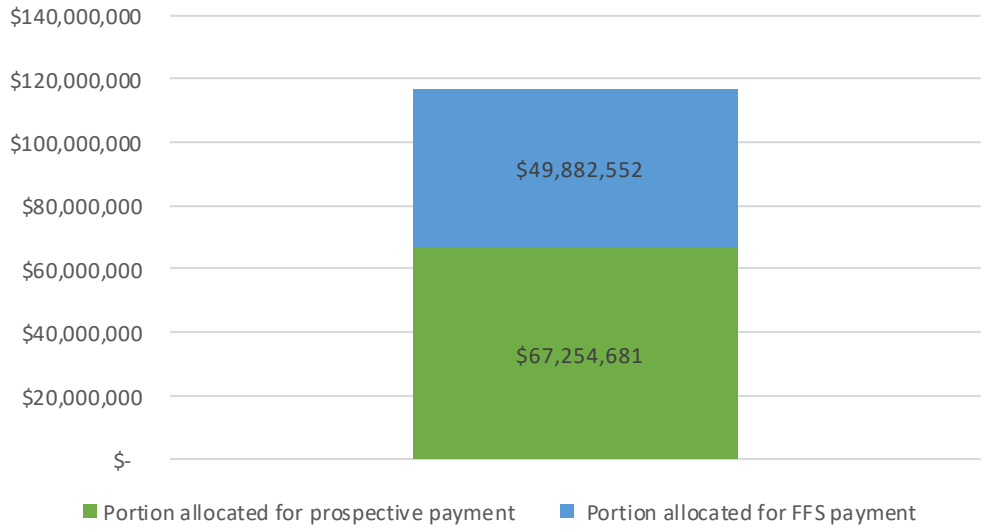
September 20, 2019

The report summarizes program performance in 2018 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 2018 performance year.

Section A: Executive Summary of Vermont Medicaid Next Generation 2018 Results

The Vermont Medicaid Next Generation (VMNG) Accountable Care Organization (ACO) 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 (3% of total price in the 2018 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 on OneCare's behalf through fee-for-service payments to health care providers both in and out of OneCare's network (see Figure 1). Building from the 2017 performance year, the 2018 program results indicate further incremental progress that warrants cautious optimism and a continued commitment to the program.

Figure 1. Agreed Upon Price for Care, 2018 VMNG Contract



Result 1: DVHA and One Care made incremental programmatic improvements.

During the 2018 performance year, DVHA and OneCare implemented several programmatic changes that represented opportunities for incremental improvement. One notable change was the expansion of the waiver of prior authorization in the program to all providers in the Vermont Medicaid network. The waiver still requires the member to be attributed to the ACO and the service to be one for which the ACO is financially accountable. The goal of this modification was to further decrease administrative burden for providers while relying on their clinical expertise to utilize best practices when caring for their patients.

Result 2: The program continues to grow.

Additional providers and communities have joined the ACO network to participate in the program for the 2019 performance year. Additional provider participation is expected for a 2020 performance year. DVHA and OneCare are also discussing the potential to modify the attribution methodology, which would further increase the number of Vermonters connected to the All-Payer ACO Model.

	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		
Unique Medicaid Providers	~2,000	~3,400	~4,300
Attributed Medicaid Members	~29,000	~42,000	~79,000

Result 3: ACO providers and Medicaid shared financial accountability for health care in 2018.

DVHA and the ACO agreed on the price of health care upfront, and the ACO provided approximately $1.5 million in care above the expected price (see Figure 2). Financial performance was within the ±3% risk corridor, which means that OneCare Vermont and its members will pay this amount to DVHA.

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

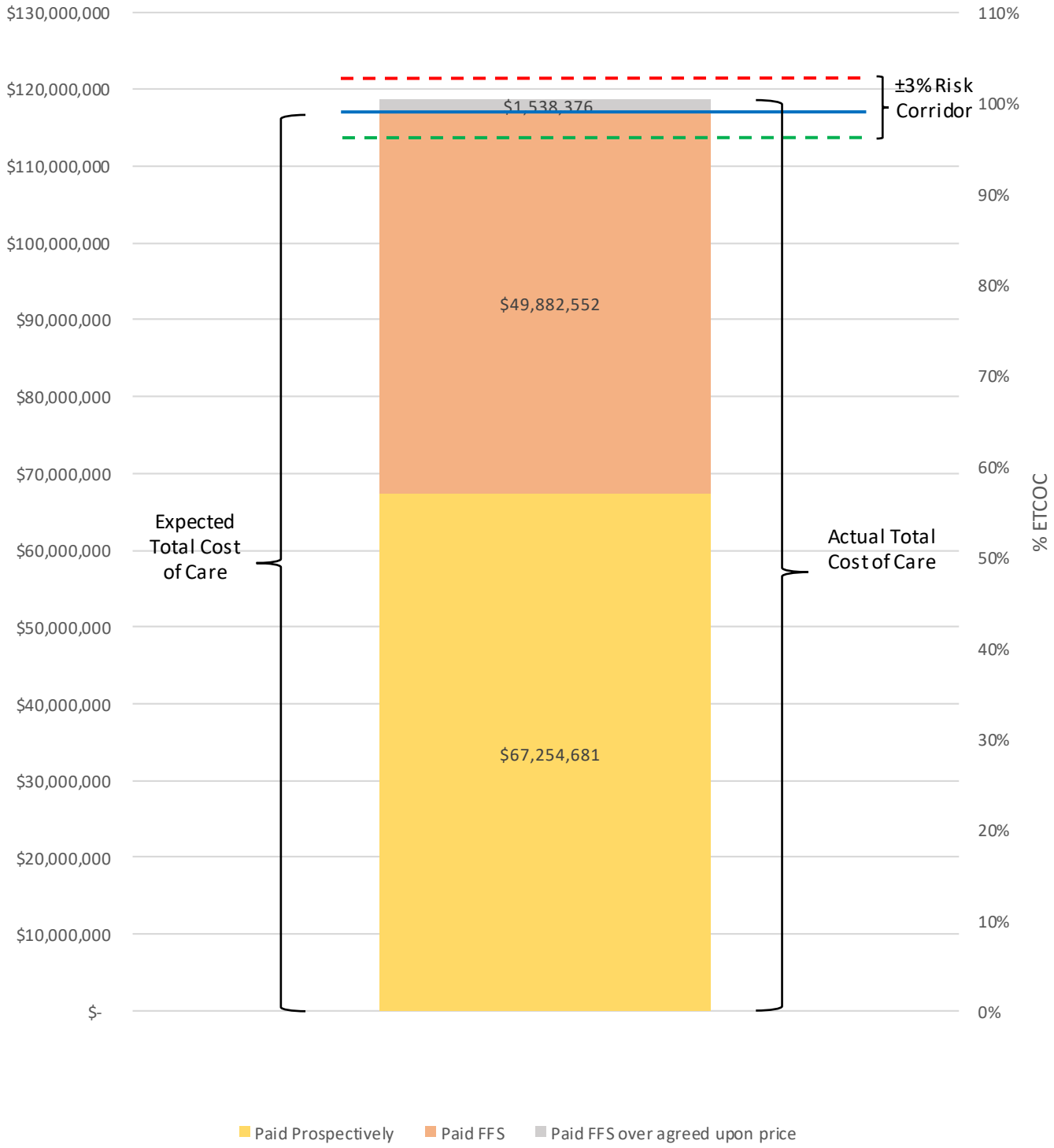
The ACO's quality score was 85% on 10 pre-selected measures. Notably, OneCare's performance exceeded the national 75th percentile on measures relating to developmental screening in the first three years of life and 30 day follow-up after discharge from Emergency Departments for mental health, alcohol, and other drug abuse or dependence. Examining quality trends over time will be important in order to understand the impact of changing provider payment on quality of care.

Result 5: The ACO expanded implementation of the Advanced Community Care Coordination model to all participating communities.

Building upon early learnings from the 2017 VMNG pilot year, the Advanced Community Care Coordination (A3C) Model expanded from the initial four pilot communities to include eligible community partners in the ten participating hospital service areas in 2018. During the 2018 performance period:

- OneCare distributed approximately $2.7 million in A3C payments to 65 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).
- OneCare trained nearly 700 community care team members in care coordination skills and core competencies, including the use of Care Navigator.
- Care Coordination Core Teams were active in all ten participating communities, tasked with expanding upon best practices, sharing learnings, and implementing team-based care quality improvement projects using Care Navigator.

Figure 2. 2018 VMNG Financial Performance within Expected Total Cost of Care



Section B: Vermont Medicaid Next Generation ACO Pilot Program Overview

Introduction

The Vermont Medicaid Next Generation (VMNG) Accountable Care Organization (ACO) 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).[1] 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 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 2018, DVHA contracted with OneCare Vermont (OneCare) ACO to manage the quality and cost of care for approximately 42,000 Medicaid members in ten 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.[2] DVHA and OneCare elected to exercise one of the four optional one-year extensions permitted by the VMNG contract for a 2018 performance year.[3] In 2018, OneCare Vermont's network of participating providers included ten 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 ten participating communities.

To date, attribution has primarily been 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. When the ACO is aware of the full population for which it is accountable before the first day of the year, the risk-based contract should be a motivation for providers to engage Medicaid members in preventive care, rather than wait for people to come to them. 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:

---

[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 http://dvha.vermont.gov/administration/onecare-32318-am2-final-signed.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. Beginning in 2018, OneCare implemented the Comprehensive Payment Reform (CPR) pilot with three 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 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 the difference between the target and 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—1.5% in 2018—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.

2018 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 2018. Among these was the expansion of the waiver of Medicaid prior authorizations to all Medicaid-enrolled providers (not only providers participating in the ACO network) for ACO-attributed members and for services in the ACO's financial accountability. The prior authorization waiver was also refined to identify a small subset of services for which authorization will *always* be required due to patient care and safety considerations.

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. The organizations have been able to use experience from the first two program years to identify opportunities and develop strategies for continual process improvement as the program evolves and

[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.

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 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 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 and select independent physician practices specifically, are contributing to an overall moderation in DVHA health care spending. Although the 2017 and 2018 program year results alone are insufficient to evaluate the success of the model, the experience from the first two 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, 2018

Financial Performance

Table 1 sets forth ACO financial performance in Calendar Year 2018. 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 and Actual Total Cost of Care as part of the year-end reconciliation process.

Actual expenditures for the program in 2018 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 2018 for the population of prospectively attributed Medicaid members, as detailed in Attachment B of the 2018 VMNG program contract.[5]

OneCare's actual expenditure in 2018 was higher than the expected expenditure for the attributed population in the program year. The fee-for-service payments that DVHA issues on OneCare's behalf 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.

Final financial performance for the 2018 calendar year was 101.31% of the Expected Total Cost of Care, which is within the ±3% risk corridor included in the 2018 contract. As such, OneCare Vermont shall pay to DVHA the difference between the Actual Total Cost of Care and the Expected Total Cost of Care, totaling approximately $1.5 million for the 2018 performance year. Overall, a second year of financial performance within the risk corridor is an early but encouraging signal about the potential for an ACO network to moderate healthcare expenditures for Vermonters relative to a prospectively agreed upon price.

[5] DVHA engaged Wakely Consulting Group to calculate 2018 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, 2018

DVHA Payment to ACO	(A)	*(B) + (C) + (D) + (E1) + (E2)*	$	71,526,371
Fixed Prospective Payment (FPP)	(B)		$	65,552,943
Quality Withhold	(C)		$	1,758,742
Care Coordination Payment (CCP)	(D)		$	1,542,310
Administrative Fee	(E1)		$	1,542,310
Primary Care Case Management (PCCM) Fee	(E2)		$	1,130,065
Total ACO Payments to Providers	(F)	*(B) + (D) + (E2)*	$	68,225,318

Total Expected Shadow FFS	(G)		$	67,254,681
Total Actual Shadow FFS	(H)		$	59,591,372
Shadow FFS Over (Under) Spend	(I)	*(H) – (G)*	$	(7,663,309)

Total Expected FFS	(J)		$	49,882,552
Actual FFS - In Network	(K)		$	24,668,503
Actual FFS - Out of Network	(L)		$	26,752,425
Total Actual FFS	(M)	*(K) + (L)*	$	51,420,928
FFS Over (Under) Spend	(N)	*(M) – (J)*	$	1,538,376

Expected Total Cost of Care	(O)	*(G) + (J)*	$	117,137,233
Actual Total Cost of Care	(P)	*(G) + (M)*	$	118,675,609
Total Cost of Care Over (Under) Spend	(Q)	*(P) – (O)*	$	1,538,376

Total Cost of Care Over (Under) Spend	(Q)		$	1,538,376
Adjustments* Allowed by Contract (if applicable)	(R)		$	2,157
Final Cash Settlement	**(S)**	***(Q) + (R)***	**$**	**1,540,534**

Risk Corridor Upper Bound (103% of ETCOC)		103%	$	120,651,349.72
Risk Corridor Lower Bound (97% of ETCOC)		97%	$	113,623,115.75
ATCOC as Percentage of ETCOC		101.31%		

*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 2018 contract also included two reporting measures; performance on these measures does not impact payment. Table 2 sets forth ACO quality performance in Calendar Year 2018. 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 2018 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 was between the national 50th and 75th percentiles on four measures.
- ACO performance was between the national 25th and 50th percentiles on one measure.
- National benchmarks were unavailable for two measures.

OneCare Vermont was required to withhold some of the prospective payment to providers up-front—1.5% in 2018—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. Of the remaining 15% of withheld payments, the ACO is entitled to retain 50% to reinvest in quality improvement initiatives to support participating communities; the other 50% ($131,906) shall be returned to DVHA.

[6] ACO-level performance was compared to national benchmarks when available. If national benchmarks were not available for the 2018 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. In 2018, the ACO was eligible to receive a bonus point per measure for statistically significant improvement over their 2017 performance; no bonus points were awarded for the 2018 performance year.

Table 2. Overview of VMNG Quality Performance, 2018

Measure Description	NQF #	Numerator	Denominator	Rate	Quality Compass 2018 Benchmarks (CY 2017) 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	72	247	29.15%	10.07	16.26	24.48	32.15	2
30 Day Follow-Up after Discharge from the ED for Mental Health	2605	282	345	81.74%	45.58	52.79	66.25	74.47	2
Adolescent Well Care Visits	N/A	4903	8693	56.40%	45.74	54.57	61.99	66.80	1.5
All Cause Unplanned Admissions for Patients with Multiple Chronic Conditions*	CMS ACO #38 (under NQF review)	11	1078	1.02%	N/A	N/A	N/A	N/A	2
Developmental Screening in the First 3 Years of Life‡	1448	1861	3140	59.27%	17.80	39.80	53.90	N/A	2
Diabetes Mellitus: Hemoglobin A1c Poor Control (>9%)*	0059	122	366	33.33%	46.96	38.20	33.09	29.68	1.5
Hypertension: Controlling High Blood Pressure	0018	223	349	63.90%	49.27	58.68	65.75	71.04	1.5
Initiation of Alcohol and Other Drug Dependence Treatment	0004	494	1271	38.87%	38.62	42.22	46.40	50.20	1
Engagement of Alcohol and Other Drug Dependence Treatment	0004	206	1271	16.21%	9.11	13.69	17.74	21.40	1.5
Screening for Clinical Depression and Follow-Up Plan	418	142	327	43.43%	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	159	424	37.50%	29.61	36.54	45.79	54.13	N/A
Tobacco Use Assessment and Tobacco Cessation Intervention	0028	223	367	60.76%	N/A	N/A	N/A	N/A	N/A

** 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)