

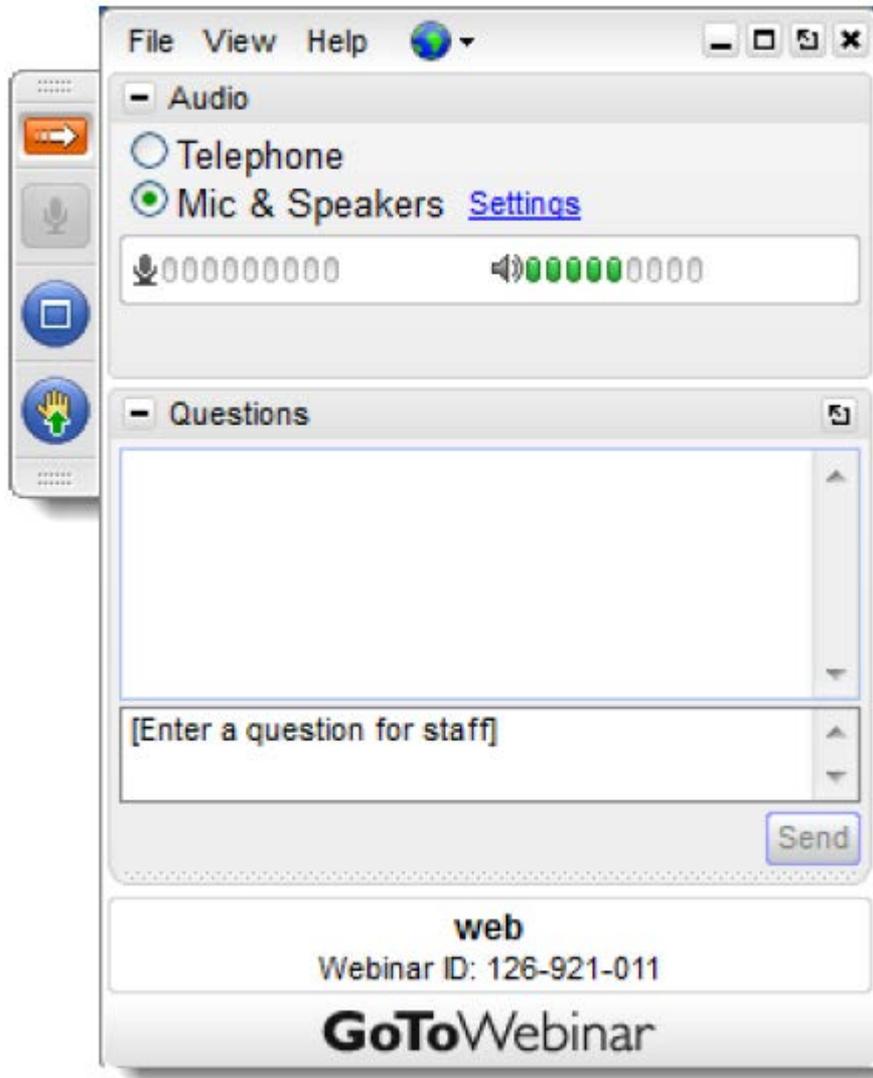
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# Vermont's ACO Shared Savings Programs in a National Context

April 2016

VHCIP Webinar Series

# Before we get started...



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# Before we get started...

- **We've reserved time for Q&A at the end of this event.** Submit questions via Questions pane in webinar control panel.
- **This webinar is being recorded.** Slides and recording will be posted to the VHCIP website following the event: <http://healthcareinnovation.vermont.gov/>
- **Please complete our brief evaluation survey** at the end of the event. We value your feedback!

# Speakers

- Moderator: Georgia Maheras, Director, Vermont Health Care Innovation Project (VHCIP), and Deputy Director of Health Care Reform for Payment and Delivery System Reform, Agency of Administration



- Speaker: Rob Houston, Senior Program Officer, Center for Health Care Strategies (CHCS)

- Speaker: Amy Coonradt, Senior Health Policy Analyst, Department of Vermont Health Access (DHVA)



# Agenda

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- Presentation: Medicaid Accountable Care Organization Design Considerations
- Presentation: Vermont Medicaid Shared Savings Program (VMSSP) Overview
- Q&A

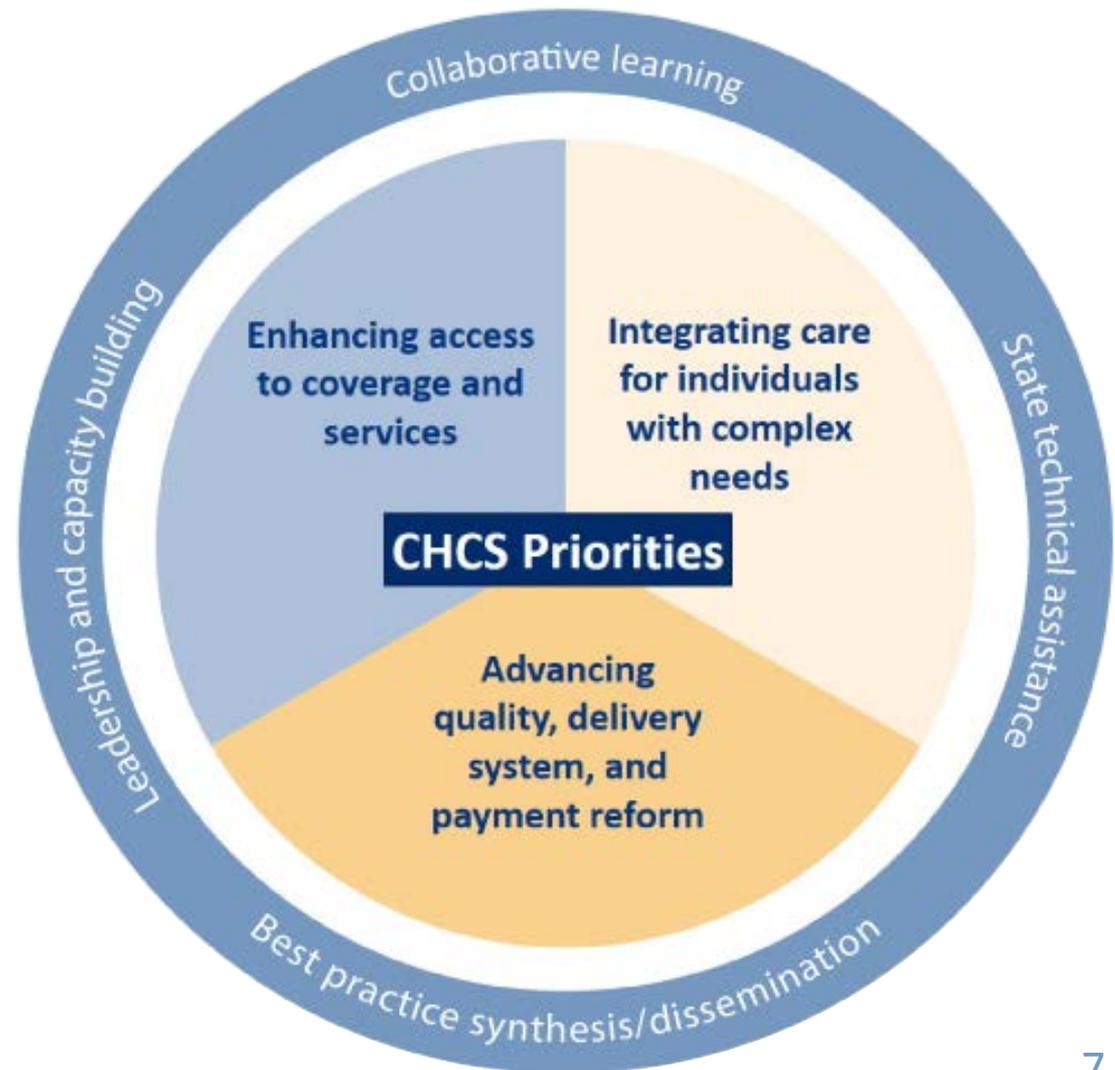


# Medicaid Accountable Care Organization Design Considerations

Rob Houston  
Senior Program Officer  
Center for Health Care Strategies

# About the Center for Health Care Strategies

A non-profit health policy resource center dedicated to advancing access, quality, and cost-effectiveness in publicly financed health care



# Relevant CHCS Initiatives

- **Medicaid ACO Learning Collaborative**  
Working with six states to share ideas and best practices and help design/implement Medicaid ACO programs
- **State Innovation Models (SIM) Initiative**  
Provide technical assistance for CMMI project to design and test state-based models for multi-payer payment and delivery system reform
- **New York DSRIP PPS Learning Collaborative**  
Convene and administer learning network among state and performing provider systems



**CHCS**  
Center for Health  
Care Strategies, Inc.

# Agenda

- Accountable Care Organization Overview
- Key ACO Design Decisions
- ACO Performance Results to Date



# What are Accountable Care Organizations?

- **Accountable Care Organizations (ACOs) are designed to hold providers accountable for improving health outcomes and controlling costs**
- **Key ACO features include:**
  - ▶ Value-based payment incentives
  - ▶ Provider-level financial accountability
  - ▶ Robust quality measurement
  - ▶ Data sharing and analysis
  - ▶ On the ground care management
  - ▶ Provider/community collaboration

The letters 'ACOs' are rendered in a large, 3D, blue font with a slight shadow underneath, positioned on the right side of the slide.

# What Types of ACOs Exist?

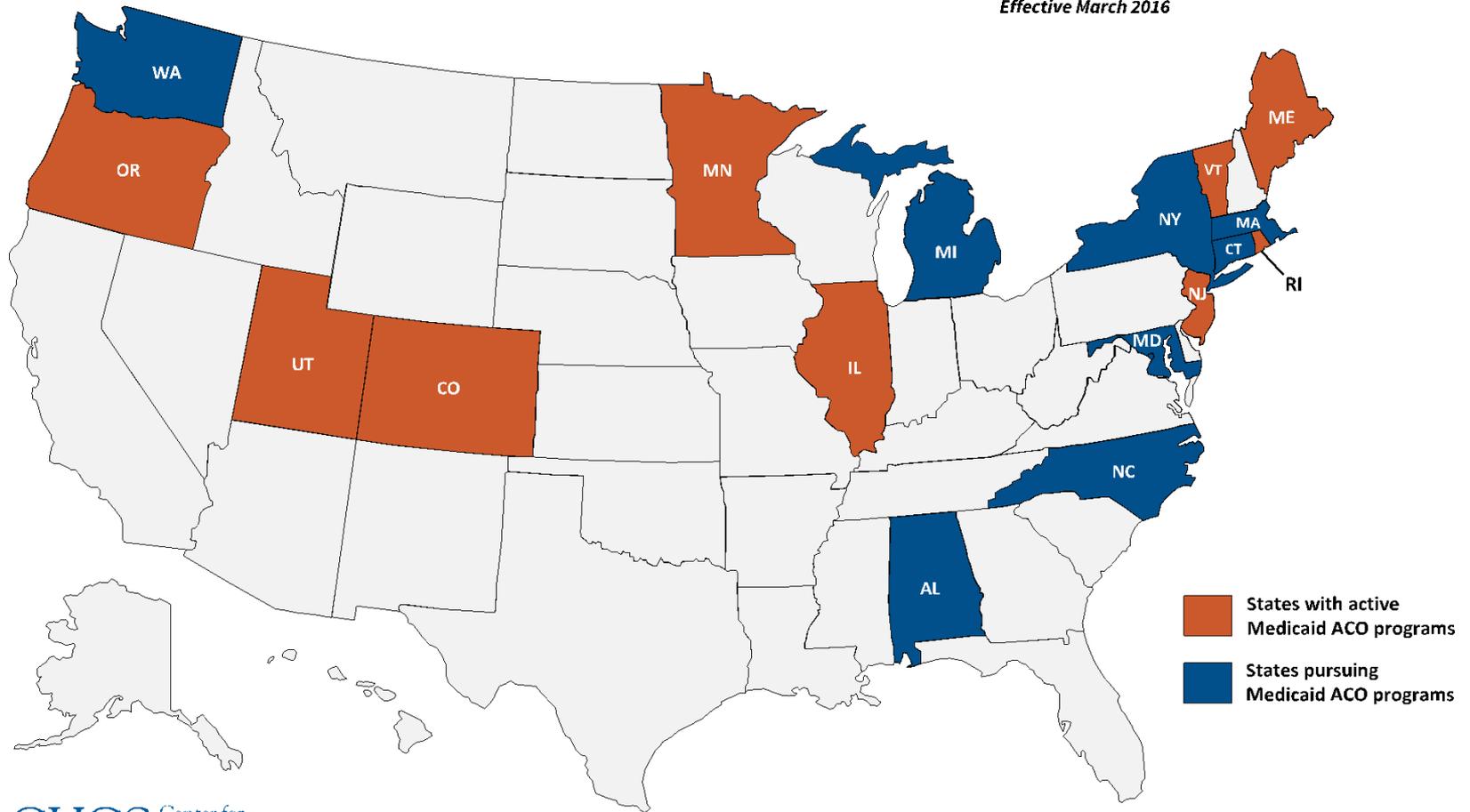
- **Medicare ACOs**
  - ▶ Pioneer ACOs
  - ▶ Medicare Shared Savings ACOs
  - ▶ Next Generation ACOs
- **Medicaid ACOs**
  - ▶ 9 States with active Medicaid ACO programs
  - ▶ At least 8 others pursuing programs
- **Commercial ACOs**
  - ▶ “The wild wild west”
  - ▶ Largely led by health plans and integrated hospital systems
- **Many ACOs have shown cost reductions and quality improvements**



# Medicaid ACO Activity to Date

## State-Based Medicaid Accountable Care Organizations

Effective March 2016



# Designing a Medicaid ACO program



- **States perform these three steps when designing a Medicaid ACO program**
  - ▶ While these steps will not be conducted uniformly across states, they do provide a helpful guideline for the process

# Evaluate the Current Environment

- **Provider readiness**
  - ▶ Ability to perform ACO financial and care management
- **Market dynamics**
  - ▶ Managed care?
  - ▶ Dominant payers or providers?
- **Existing programs**
  - ▶ Can ACOs be built on existing efforts?
- **Political factors**
  - ▶ Where impetus of program originates can influence its formation and attributes



# Define Program Goals/Framework

- **Think about program goals**
  - ▶ Should be clear, measurable, and achievable
  - ▶ Should address identified problems
- **Define scope of the model**
  - ▶ Will it be a pilot or statewide effort?
- **Should the program be prescriptive or flexible?**
- **Are there any “must have” structural elements?**



# 8 Key Design Questions to Develop a Structural Model

1. Who will lead the ACOs?
2. Whom will the ACOs serve?
3. How will patients be attributed?
4. What services will ACOs provide?
5. How will the payment model be structured?
6. How will quality be measured?
7. How will data be collected and analyzed?
8. How will MCOs be involved (if applicable)?



# Design Questions Walkthrough

## 1. Who will lead the ACOs?

- ▶ Providers or payers?
- ▶ Another entity or partnership?

## 2. Whom will the ACOs serve?

- ▶ Full population or sub-population?
- ▶ Include Medicare-Medicaid enrollees?

## 3. How will patients be attributed?

- ▶ Retrospectively or prospectively?
- ▶ By utilization or geographically?



# Design Questions Walkthrough

## 4. What services will ACOs provide?

- ▶ States have included physical health, behavioral health, long-term supports and services, oral health, pharmacy, non-emergency medical transport

## 5. How will the payment model be structured?

- ▶ Pay-for performance
- ▶ Shared savings/risk
- ▶ Global or capitated payments

## 6. How will quality be measured?

- ▶ How many/which metrics will be used?
- ▶ How will metrics be tied to payment?



# Design Questions Walkthrough

## 7. How will data be collected and analyzed?

- ▶ Insource or outsource?
- ▶ How will contractors be utilized (if at all)?

## 8. How will MCOs be involved (if applicable)?

- ▶ Will MCOs be part of an ACO, the ACO itself, or not involved?
- ▶ What responsibilities will ACOs have relative to MCOs and vice versa?



# A Final Consideration

**States should be mindful of future iterations when designing their Medicaid ACO program**

Colorado and Minnesota are currently seeking to update their programs to “Version 2.0” in 2017

# Program Design Considerations for Medicaid Accountable Care Organizations

- CHCS issue brief outlining findings from the Medicaid Accountable Care Organization Learning Collaborative
- Insights on designing a Medicaid ACO model
- Input from 8 states with active Medicaid ACO programs
  - ▶ CO, IL, ME, MN, NJ, OR, UT, VT
- [Download from the CHCS website](#)



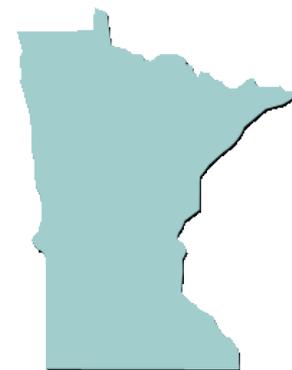
# Colorado's Accountable Care Collaborative

- **Colorado's Accountable Care Collaborative established seven Regional Care Coordination Organizations (RCCOs) charged with improving care coordination**
  - RCCOs receive care coordination payments between \$8 and \$10 and a P4P bonus for performance on quality metrics
  - RCCOs receive data and analytics support from the State Data and Analytics Contractor (SDAC)
  - Program has saved \$77 million in net savings over four years



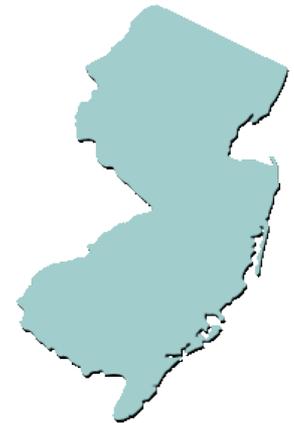
# Minnesota's Integrated Health Partnerships

- **Integrated Health Partnerships (IHPs) build on existing patient-centered medical home (PCMH) initiative and are modeled on the Medicare Shared Savings Program**
- **Two-track approach:**
  - ▶ “Virtual” providers participate on an upside-only basis, receiving 50% of shared savings
  - ▶ Fully integrated providers bear two-sided risk, and shared losses are gradually incorporated
- **Providers can choose to participate, but MCOs must share savings with ACOs**
- **Program saved \$76.1 million in 2 years and all IHPs have improved quality**



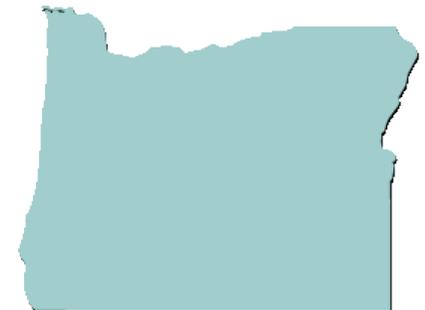
# New Jersey's ACO Demonstration Project

- **A regional/community partnership model**
- **ACOs are nonprofit provider organizations that cover a self-defined geographic area**
  - ▶ ACOs are required to have the written support of all hospitals, 75% of providers, and 4 behavioral health providers in the designated area
- **MCO participation is not required**
- **An upside-only gainsharing arrangement with no minimum savings rate is recommended**
  - ▶ ACOs and MCOs negotiate this payment arrangement themselves, but is subject to state approval
- **ACO performance is measured on physical and behavioral health performance metrics**



# Oregon's Coordinated Care Organizations

- **An MCO-driven model**
- **Regional CCOs cover 16 defined geographic areas of the state**
  - ▶ MCOs apply for CCO contracts through a selective procurement process
- **CCOs are paid through a global payment**
  - ▶ Payment is capped at a 2% annual growth rate
- **CCOs cover physical health, behavioral health, and dental services for all Medicaid beneficiaries, including Medicare-Medicaid enrollees**



# ACO Results to Date

- **Pioneer ACOs**
  - ▶ 9 leading-edge integrated delivery systems (down from 32)
  - ▶ Saved \$196.32M in its first 2 years (\$92.15M in Y1, \$104.1M in Y2)
  - ▶ Resulted in establishment of Next Generation ACO model
- **Medicare Shared Savings Program (MSSP ACOs)**
  - ▶ 338 participants in 47 states (4.9M attributed beneficiaries)
  - ▶ Saved \$372M in its first 2 years
- **Medicaid ACOs**
  - ▶ Colorado reported \$77M in savings in its first three years
  - ▶ Minnesota's IHP program saved \$76.3M in two years
  - ▶ Vermont saved \$14.6M in its first year
  - ▶ Oregon showed a decrease in inpatient admissions and ED usage
- **Commercial ACOs**
  - ▶ Models vary widely, but many have shown promise and savings
- **All models have shown evidence of quality improvement**



# What is the Future of ACO models?

- **We are seeing a sea-change toward value-based payment, led by ACO models**
- **Emerging topics of ACO discussion include:**
  - ▶ Population-based models
    - Geographic areas
  - ▶ Specialized models for specific subpopulations
    - High need, high cost populations; pediatrics
  - ▶ Increased provider risk
    - Phasing in risk toward a capitated model
  - ▶ Multi-payer ACOs
    - Medicare; Medicaid; commercial;  
Medicare-Medicaid enrollees; state employees



# Visit CHCS.org to...

- **Download** practical resources to improve the quality and cost-effectiveness of Medicaid services
- **Subscribe** to CHCS e-mail updates to learn about new programs and resources
- **Learn** about cutting-edge efforts to improve care for Medicaid's highest-need, highest-cost beneficiaries

[www.chcs.org](http://www.chcs.org)

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# Vermont Medicaid Shared Savings Program (VMSSP) Overview

Amy Coonradt, MPH

Payment Reform

Department of Vermont Health Access

April 13, 2016

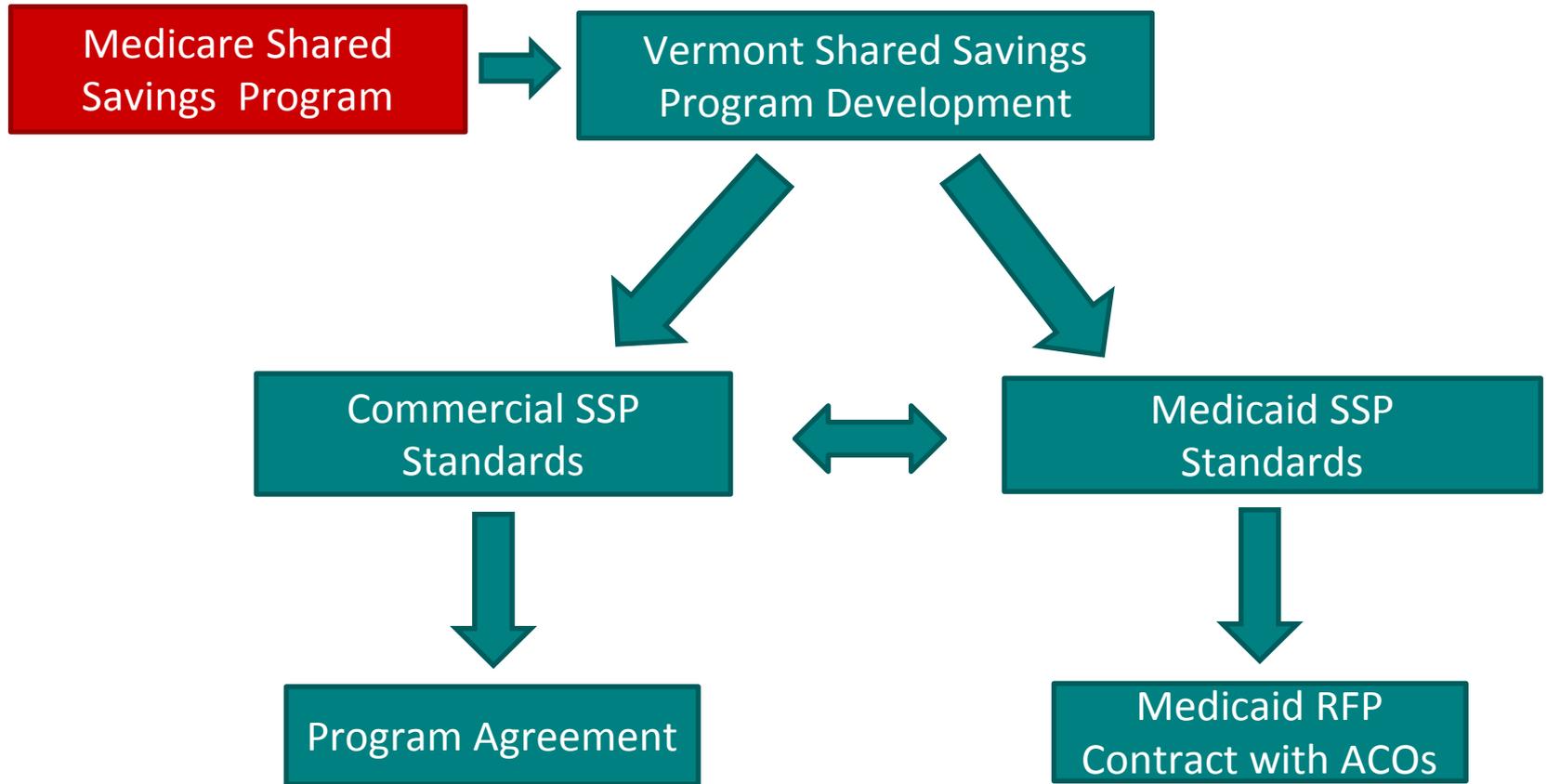
# State Innovation Model Testing Grant

- 2013: VT Awarded \$45 million SIM Testing Grant from CMMI
  - Vermont Health Care Innovation Project
- Design, Implement, and Evaluate alternative multi-payer payment models in support of the Triple Aim
- 2014: Launched commercial and Medicaid Shared Savings Programs (SSPs)
  - DVHA administers the Vermont Medicaid Shared Savings Program (VMSSP)

# Shared Savings Programs in Vermont

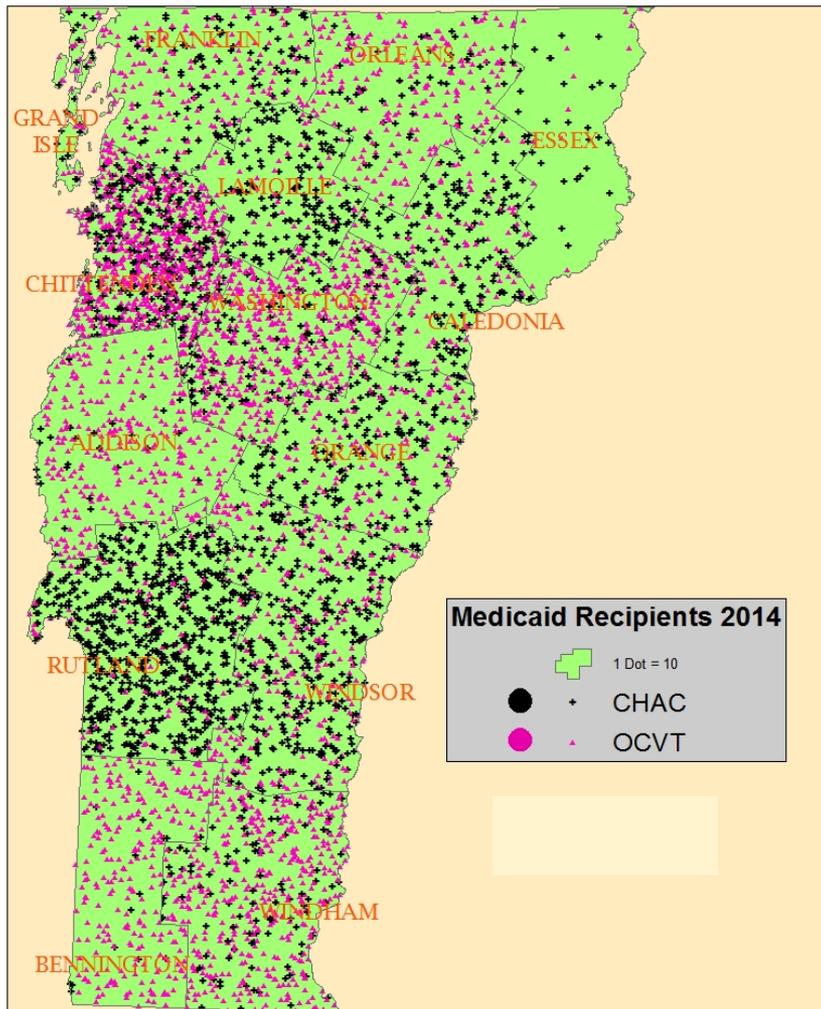
- Shared Savings Program standards in Vermont were developed as a result of collaboration among payers, providers, and stakeholders, facilitated by the State
- Designed ACO SSP standards that include:
  - Attribution of Patients
  - Establishment of Expenditure Targets
  - Distribution of Savings
  - Impact of Performance Measures on Savings Distribution
  - Governance

# Development of Vermont's SSPs



# VMSSP Participation

ACO Distribution by County



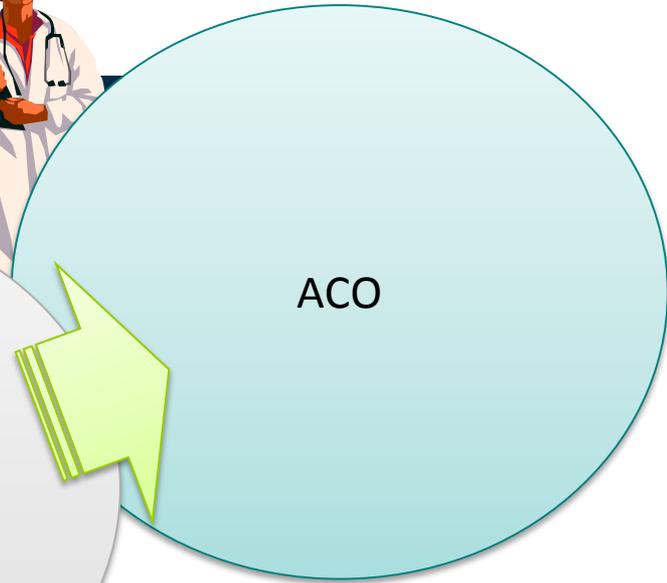
- Two ACOs signed contracts with DVHA to participate:
  - OneCare Vermont
  - Community Health Accountable Care (CHAC)
- In first program year (CY2014):
  - **37,929** Medicaid beneficiaries attributed to OneCare
  - **26,587** Medicaid beneficiaries attributed to CHAC
- In the second program year (CY 2015):
  - **50,809** Medicaid beneficiaries attributed to OneCare
  - **28,898** Medicaid beneficiaries attributed to CHAC

# Beneficiary Attribution to an ACO

People see their Primary Care Provider (PCP) as they usually do



If their PCP belongs to an ACO, the ACO can share savings based on the cost and quality of services provided to that person

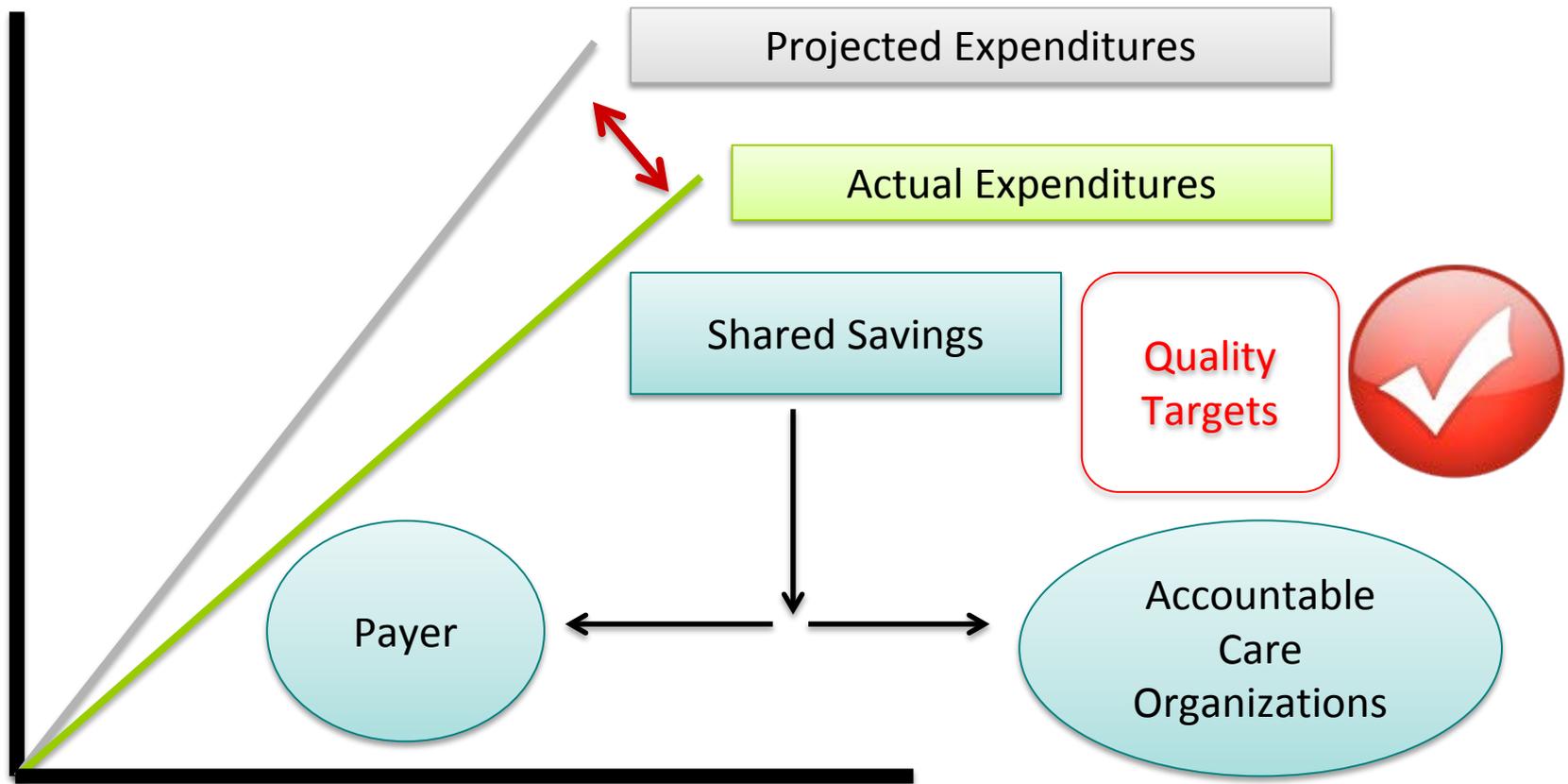


Providers bill as they usually do

# VMSSP: Beneficiary Attribution

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

# VMSSP: Expenditure Targets



# VMSSP: Core Services – Total Cost of Care

- Core Service Expenditures
  - Inpatient, outpatient, and professional services
  - Laboratory, home health, hospice, prosthetic/orthotics, medical supplies, durable medical equipment, emergency transportation
- Non-Core Service Expenditures
  - Personal care, pharmacy, dental, non-emergency transportation
  - Services administered by the Department of Mental Health, Division of Alcohol and Drug Abuse Programs, Department of Disabilities, Aging and Independent Living, Department for Children and Families, and Department of Education

# VMSSP: Quality Measurement

Payment measures are collected at the ACO level. ACO responsible for collecting clinical data-based measures. How ACO performs influences amount of shared savings.

## PAYMENT

Reporting measures are collected at the ACO level. ACO responsible for collecting clinical data-based measures. How the ACO performs does NOT influence the amount of shared savings.

## REPORTING

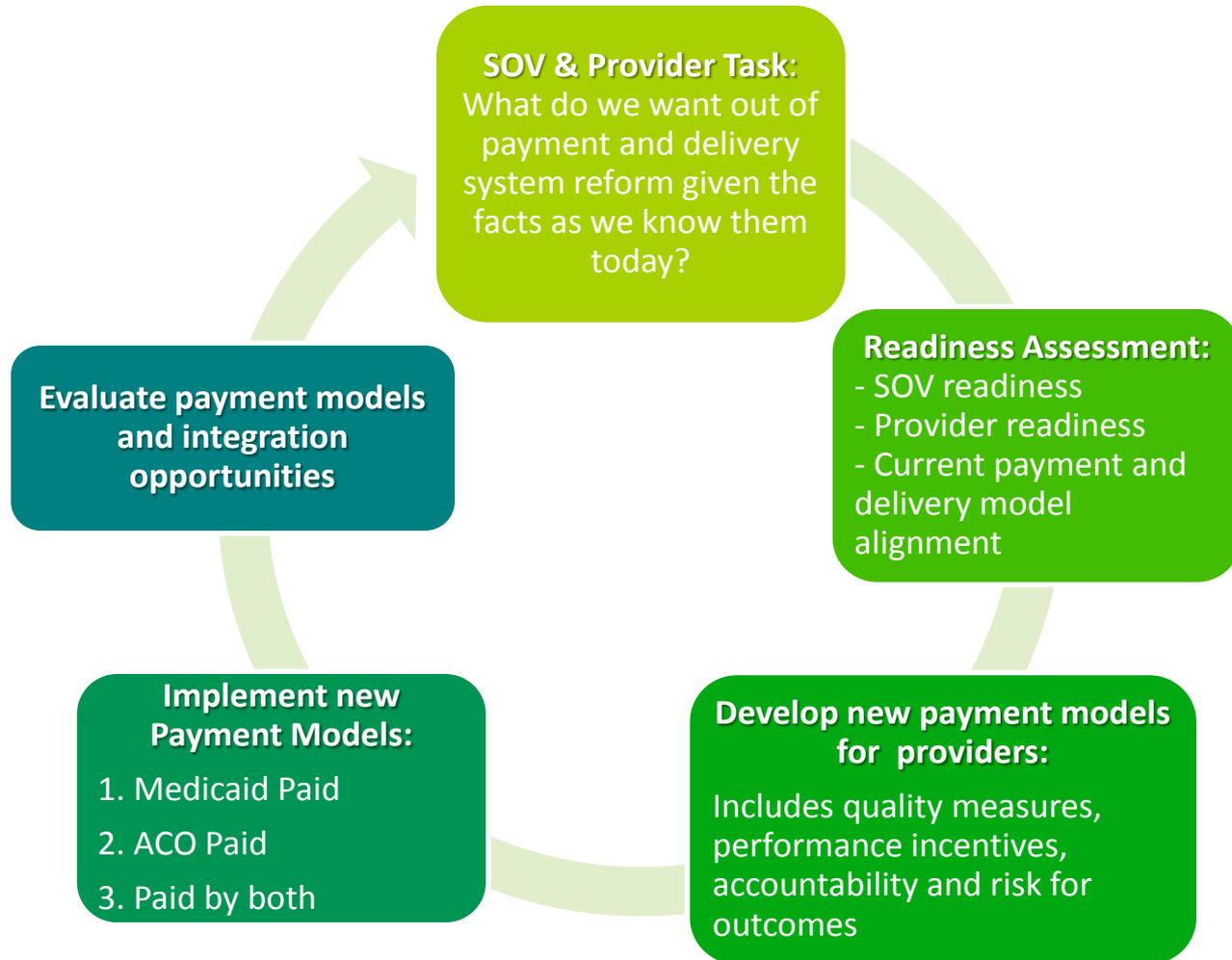
Monitoring measures are collected at the State or Health Plan levels; cost/utilization measures at the ACO level. ACO not responsible for collecting these measures. How the ACO performs does NOT influence the amount of shared savings.

## MONITORING & EVAL

Pending measures are considered to be of interest, but are not currently collected.

## PENDING

# Medicaid Pathway: Payment and Delivery System Reform Continuous Cycle



# Stay tuned!

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## VHCIP Webinar Series May 2016 Event:

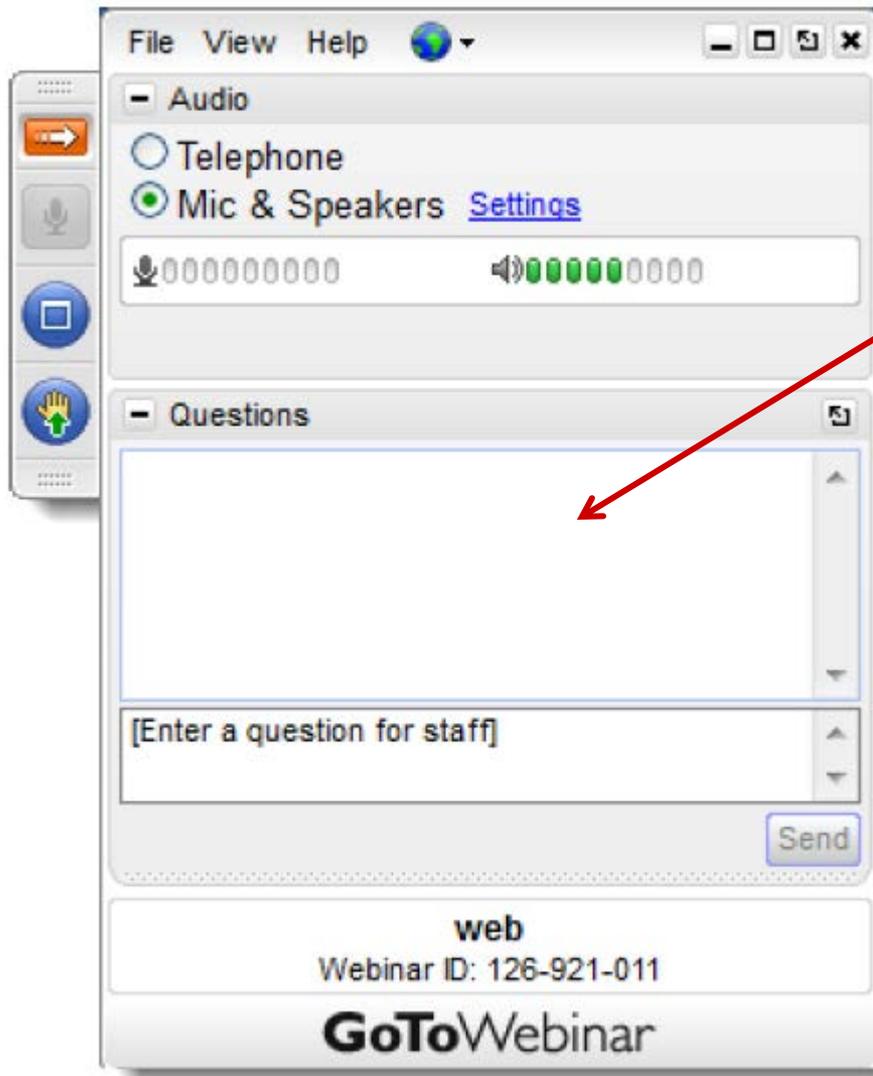
### Deep Dive into Vermont's Year 1 Medicaid and Commercial ACO Shared Savings Program Results

Wednesday, May 11

12:00-1:00pm

To Register: <http://healthcareinnovation.vermont.gov/node/879>

# Questions?



- Enter questions in Questions pane of GoToWebinar control panel.

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# Thank you!