Medicaid ACO Programs: Promising Results from Leading-Edge States

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I. Welcome and Introductions

II. Medicaid ACO Landscape

III. Medicaid ACOs: Results from Leading-Edge States
   - Minnesota’s Integrated Health Partnerships
   - Oregon’s Coordinated Care Organizations
   - Vermont’s Medicaid Shared Savings Program

IV. Question & Answer Session
Today’s Speakers

Tricia McGinnis, Vice President, Programs, Center for Health Care Strategies

Pamela Riley, Assistant Vice President, Delivery System Reform, The Commonwealth Fund

Matthew Spaan, Manager, Care Delivery and Payment Reform, Minnesota Department of Human Services

Chris DeMars, Director of Systems Innovation, Transformation Center, Oregon Health Authority

Alicia Cooper, Health Care Project Director, Department of Vermont Health Access
A non-profit policy center dedicated to improving the health of low-income Americans
Pamela Riley
Assistant Vice President
Delivery System Reform

commonwealthfund.org
Medicaid ACO Landscape

Tricia McGinnis, Vice President, Programs
Center for Health Care Strategies
What is an Accountable Care Organization?

- Accountable care organization (ACOs) are designated entities held accountable for the financial and quality outcomes of a defined population.
- ACOs were developed to move the U.S. health care system toward the goals of the Triple Aim.
- ACOs were first adopted in Medicare under the Affordable Care Act of 2010.
- First Medicaid ACO Program launched in 2011.
- ACOs have since become a leading payment and delivery reform model across all payers.
What is the Current ACO Market?

- Rapid expansion across payers
  - Over 800 ACOs in the United States

- Over 25 million covered lives
  - Commercial: 17.2 million
  - Medicare: 8.3 million
  - Medicaid: 2.9 million

- Widespread penetration
  - ACO service areas in all 50 states and the District of Columbia
ACOs are a key vehicle in the industry-wide shift from fee-for-service to value-based purchasing.

Providers are increasingly likely to seek opportunities to join “advanced” alternative payment models (including certain types of ACOs) under MACRA.*

ACOs tend to show greater focus on population health, wellness, and disease prevention.

Many ACOs have shown cost reductions and quality improvement.

HHS Value-Based Payment Goals

<table>
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<tr>
<th>Year</th>
<th>Goal</th>
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<tr>
<td>2016</td>
<td>30% of Medicare payments tied to alternative payment models, such as ACOs or bundled payments (HHS met this goal)</td>
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<tr>
<td>2018</td>
<td>50% of Medicare payments tied to alternative payment models</td>
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What Does an ACO Look Like in Medicaid?

While there is no uniform definition of a Medicaid ACO, key features are:

- Value-based purchasing
- Quality measurement
- Data sharing and integration
- On-the-ground care management
- Provider and community collaboration
- Social determinants of health
Medicaid ACO models vary greatly, but we generally see three models:

**Provider-driven**
- Provider establishes collaborative networks and assumes accountability for cost of care

**MCO-driven**
- MCOs retain financial risk but implement new payment model and partnerships with providers

**Regional/Community Partnership-driven**
- Regional/community organizations form care teams with providers and receive payments
States pursuing Medicaid ACO programs

- WA
- OR
- CO
- NM
- MO
- NC
- LA
- UT

States with active Medicaid ACO programs

- NY
- PA
- VT
- RI
- CT
- NJ
- DE
- MD
- DC

**Current Medicaid ACO Landscape**
# Future of Medicaid ACOs

## Version 1.0
- Fee-for-service payment models (shared savings or P4P)
- Physical health only
- Medicaid only
- Many quality measures
- Payment tied to quality reporting / performance on process measures

## Version 2.0
- Capitated or global payments
- Behavioral health, LTSS, dental, pharmacy, social services
- Multi-payer
- Fewer, more aligned quality measures
- Payment tied to quality outcomes and care coordination metrics
The Medicaid ACO Learning Collaborative

- National initiative designed to help states plan and launch Medicaid ACO programs
  - Offer peer-to-peer learning and technical assistance
  - Have helped 13 states develop/design their ACO programs and 10 of those states launch ACOs

- Medicaid ACO Resource Center
  - Practical resource to help states interested in designing a Medicaid ACO program
Minnesota’s Medicaid ACOs:
Integrated Health Partnerships

MINNESOTA DEPARTMENT OF HUMAN SERVICES
JANUARY 2017
The Context – Minnesota’s Medicaid Program

- 1 million enrollees, approx. $11 billion annual expenditures (FY16)
- Families and Children and Adults without children: 800,000
  - Medicaid and MinnesotaCare
- Seniors 65+ with MLTSS: 52,000 enrollees
  - MSHO (voluntary-integrated with Medicare D-SNPs)
  - MSC+ (mandatory default)
- People with Disabilities 18-65: 52,000 enrollees
  - Special Needs Basic Care (opt out, does not include LTSS)
  - Some plans are integrate D-SNPs
- Remaining 100,000 (approx.) enrollees are people with disabilities opting out of managed care, other smaller populations, and short-term FFS months
- IHP includes under 65, non-dual eligible in both Managed Care and FFS
Approach to MN Medicaid ACO development

• Integrated Health Partnership (IHPs) demonstration authorized in 2010 by MN Statutes, 256B.0755

• Builds on a long history of reform in Minnesota
  - Health Care Homes
  - E-health Initiative
  - Encounter Data Collection
  - Standardized Quality Measures
  - Community Care Teams
  - Strong Collaborative Partnerships

• Define the “what” (better care, lower costs), rather than the “how”

• Create a common framework of accountability for patient’s total cost and quality of care, while ensuring flexibility
IHP Model Components

- **Eligible recipients**
  - Non-dual, under-65, across both FFS and all Medicaid MCO enrollees
  - Attributed using past encounters/claims

- **Provider requirements**
  - Voluntary contracts under model options “Virtual” (shared savings only) and “Integrated” (negotiated gain/loss sharing) based on size and structure
  - Flexibility in governance structure and care models

- **Payment and quality model**
  - Defined **core set of services**, IHP may elect to include additional services
  - Existing payments persist with **gain-/loss-sharing payments made annually** based on risk-adjusted TCOC performance, **contingent on quality performance (SQRMS)**

- **Provider supports**
  - Data analytics and reporting feedback (monthly and quarterly files)
  - Learning collaboratives
IHP Successes: Growth and Savings

Minnesota ACOs: Integrated Health Partnerships (IHPs)

- Currently 21 ACOs covering over 460,000 lives
- Goal: by 2018 to have 500,000 enrollees covered
  - No providers have dropped out of the demonstration – first two rounds have renewed for additional 3-year cycles

- Results:
  - Significant savings in first three years
  - 14 percent reduction in inpatient admission and 7 percent reduction in ER visits
  - IHPs are achieving quality goals of improvement or meeting/beating statewide benchmarks; receiving 85%+ of payments at risk for quality
IHP Successes: Growth and Savings

MN Integrated Health Partnerships Growth & Savings

- IHPs are helping to bend the cost curve. In first three years of project, they achieved an estimated savings of nearly **$156 million** compared to trended targets.
Participation can **accelerate care delivery innovations** that had already begun, such as movement towards team-based care, community partnerships, a “super-utilizer” focus, etc.

**BUT...** Long-term sustainability is an open question. Innovations can be costly, and potential shared savings may be years away. Continued shared savings isn’t always possible.

**Data and reports have been essential**, providing a “source of truth” and a view of patients not readily available elsewhere.

**BUT...** Data rich, but sometimes still **information poor**. Variations in capacities across IHPs, not always able to use the data effectively. Timing of data can make it’s use difficult

**Flexibility of model is key** - every population is different; everything is local.

**BUT...** Not all provider models fit well into the current demonstration.

**Partnerships are critical** to the success of the model longer term – pushing IHPs to reach out to unaffiliated providers and community partners is important.

**BUT...** Partnerships tend to be informal in nature, and there isn’t a formal mechanism to ensure partners are involved in the value arrangement and risk models.
What’s Next? - IHP 2.0 Key Design Elements

- Include a population-based flexible **prospective payment**.
- Support exchange of **electronic clinical event notifications** between IHPs and providers.
- Incorporate IHP contract incentives that **strengthen partnerships** with community supports and social service organizations.
- Ensure a track for IHPs that are **not able to take on risk**, but are still accountable for patient care.
- Develop an advanced track where higher capacity systems can take on **increased accountability** for patient population health outcomes.
- Strengthen alignment with Health Care Homes (MN’s PCMH model), MACRA, and other programs.
Health System Transformation in Oregon

Chris DeMars, M.P.H.
Director of Systems Innovation
Transformation Center
Oregon’s health reform timeline

• **2011**: Oregon Legislature passed a bi-partisan bill proposing a statewide system of coordinated care organizations (CCOs)
  – CCOs are networks of all types of health care providers (physical health, addictions and mental health, and dental care) who work together to serve Oregon Health Plan (Medicaid) members through implementing the Coordinated Care Model.

• **2012**: State legislation created CCOs; CCOs launched; Medicaid waiver approved
Oregon’s Coordinated Care Model

- Best Practices to manage and coordinate care
- Paying for outcomes and health
- Transparency in price and quality
- Sustainable rate of growth
- Shared responsibility for health
- Measuring Performance

Better Health, Better Care, Lower Costs
## Oregon’s Coordinated Care Model within Coordinated Care Organizations

<table>
<thead>
<tr>
<th>Before CCOs</th>
<th>With CCOs</th>
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<tbody>
<tr>
<td>Fragmented care</td>
<td>Coordinated care: physical/behavioral/oral health</td>
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<tr>
<td>Disconnected funding streams with unsustainable rates of growth</td>
<td>One global budget with a fixed rate of growth</td>
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<tr>
<td>No incentives for improving health (payment for volume, not value)</td>
<td>Metrics with incentives to improve quality and access</td>
</tr>
<tr>
<td>Health care services paid for</td>
<td>Flexible services beyond traditional medical care may be provided to improve health</td>
</tr>
<tr>
<td>Health care delivery disconnected from population health</td>
<td>Community health assessments and improvement plans</td>
</tr>
<tr>
<td>Limited community voice and local area partnerships</td>
<td>Local accountability and governance, including a community advisory council</td>
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Transformation Center

- Launched in 2013 via State Innovation Model Grant

- **Mission:** The Transformation Center is the hub for innovation and quality improvement for Oregon’s health system transformation efforts to achieve better health, better care, and lower costs for all.
  - The Transformation Center identifies, strategically supports, and shares innovation at the system, community, and practice levels. Through collaboration, we promote initiatives to advance the coordinated care model.

- Broad range of support: value-based payment, CCO incentive metrics, behavioral health integration, community health, and the Patient-Centered Primary Care Home program.
  - 100+ learning collaborative meetings/large convenings
  - 270+ episodes of technical assistance to CCOs
CCO Performance
OHA Accountability & CCO Incentives

State Performance Measures
• Annual assessment of statewide performance on 33 measures.
• Financial penalties to the state if quality goals are not achieved.

CCO Incentive Measures
• Annual assessment of CCO performance on 17 measures.
• Quality pool paid to CCOs for performance.
• Compare current performance against prior baseline year.
Better outcomes, lower costs

Percentage of members enrolled in a patient-centered primary care home, statewide.

Data source: CCO quarterly reporting

- 2012: 51.8%
- 2013: 78.6%
- 2014: 81.0%
- 2015: 87.5%
- Sep 2016: 90.6%

Goal: 60.0%
Better outcomes, lower costs

Avoidable emergency department utilization, statewide.

Data source: Administrative (billing) claims
Rates are per 1,000 member months

(Lower is better)

2011: 14.2
2013: 8.6
2014: 7.4
2015: 7.1
mid-2016: 6.7
Better outcomes, lower costs

Dental sealants for children ages 6-14, statewide.

Data source: Administrative (billing) claims
Benchmark source: Metrics and Scoring Committee consensus

2014: 11.2%
2015: 18.5%
Mid-2016: 20.1%
2016 Benchmark: 20.0%
Savings to the state resulting from CCOs

Results:

• Oregon’s innovations have held down costs to 3.4 percent growth in the past five years.

• Health transformation has avoided costs of $1.3 billion since 2013 and is projected to save a total of $10.5 billion by 2022.

• Oregon’s growth is below the 4.5%-5.5% national average for Medicaid increase.

• Oregon will hold cost growth to 3.4 percent through 2020.
Lessons Learned

- Importance of leadership
  - from the top
  - from health system, community members, Medicaid members

- Incorporate financial incentives
  - Incentive measures drive behavior change

- Allow for flexibility & experimentation

- Foster culture of innovation
  - Incorporate relationship-building and improvement science

- Build on work already happening
  - E.g., Patient-centered Primary Care Homes, which preceded CCOs, are a foundational element of Oregon’s health reform efforts
Vermont Medicaid:
Evolving ACO-Based Health Care Reform

Alicia Cooper, MPH, PhD
Department of Vermont Health Access

January 17, 2017
2014-2016: The Vermont Medicaid Shared Savings Program
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)
  - Three year program (2014-2016)
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
Attribution Eligibility

- **Eligible members:**
  - General Adult
  - General Child
  - Aged, Blind or Disabled Adults and Children

- **Excluded members:**
  - Individuals dually eligible for Medicare and Medicaid
  - Individuals with coverage through commercial insurers
  - Individuals with third party liability coverage
  - Individuals who are enrolled in Medicaid but receive a limited benefits package
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
Examples of services included:
- Inpatient hospital services
- Outpatient hospital services
- Physician services
- Nurse practitioner services
- FQHC
- Home Health Services
- Hospice

Examples of services excluded:
- Pharmacy
- Nursing facility care
- Dental services
- Non-emergency transportation
- Services delivered through Designated Agencies and other Departments within the Agency of Human Services
VMSSP Expenditure Targets

Projected Expenditures

Actual Expenditures

Shared Savings

Quality Targets

Accountable Care Organizations

Payer
# VMSSP 2014-2015 Results

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<tr>
<td>CHAC</td>
<td>$189.83</td>
<td>$182.06</td>
<td>$24.85</td>
<td>$7.03</td>
<td>$7.8M</td>
<td>$2.4M</td>
<td>46%</td>
<td>57%</td>
</tr>
<tr>
<td>OneCare Vermont</td>
<td>$165.66</td>
<td>$171.55</td>
<td>$14.93</td>
<td>($2.18)</td>
<td>$6.8M</td>
<td>($1.3M)</td>
<td>63%</td>
<td>73%</td>
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- Two year net aggregate savings of $15.7M
- Two-year improvement in quality scores
- ~79,000 Medicaid members impacted
2017 Onward: Medicaid Next-Generation ACO Model
A Medicaid Next Generation Model

- ACO will be paid a prospective all-inclusive, population based payment for the array of services provided
- Program is based on Medicare’s Next Generation ACO model but has Vermont- and Medicaid-specific modifications
- Builds on the current Vermont Medicaid Shared Savings Program
- The goal of this partnership is to improve the quality and value of the care provided to the citizens served by the State of Vermont’s public health care programs
Question & Answer
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