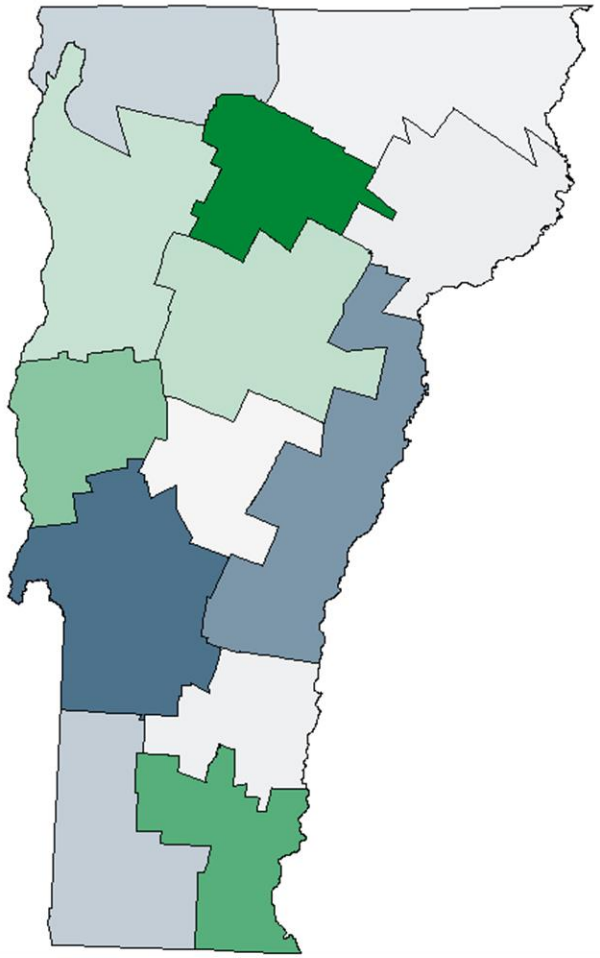


Vermont's ACO Shared Savings Programs: Results and Lessons Learned

2014 - 2016

Sarah Kinsler, Health Policy Advisor, GMCB
Pat Jones, Health Care Project Director, GMCB
Alicia Cooper, Health Care Project Director, DVHA
December 19, 2017

VERMONT
GREEN MOUNTAIN CARE BOARD

Agenda

1. Review Shared Savings Program History and Design
2. 2016 Shared Savings Program Results and Key Takeaways
3. Vermont's Shared Savings Programs in National Context
4. Lessons Learned and Next Steps
5. Additional Resources

ACOs and SSPs

Accountable Care Organizations (ACOs) are composed of and led by health care providers who have agreed to work together and be accountable for the cost and quality of care for a defined population

ACOs can participate in a variety of payment arrangements – including Shared Savings Programs (SSPs)

SSPs are payment reform initiatives developed by health care payers. SSPs are offered to providers (e.g., ACOs) who agree to participate with the payers to:

- Promote accountability for a defined population
- Coordinate care
- Encourage investment in infrastructure and care processes
- Share a percentage of savings realized as a result of their efforts

Participation in ACOs and SSPs is voluntary

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)
- GMCB and BCBSVT administer the Commercial Shared Savings Program (XSSP)
- Design mirrored Medicare SSP (MSSP) launched nationally in July 2012

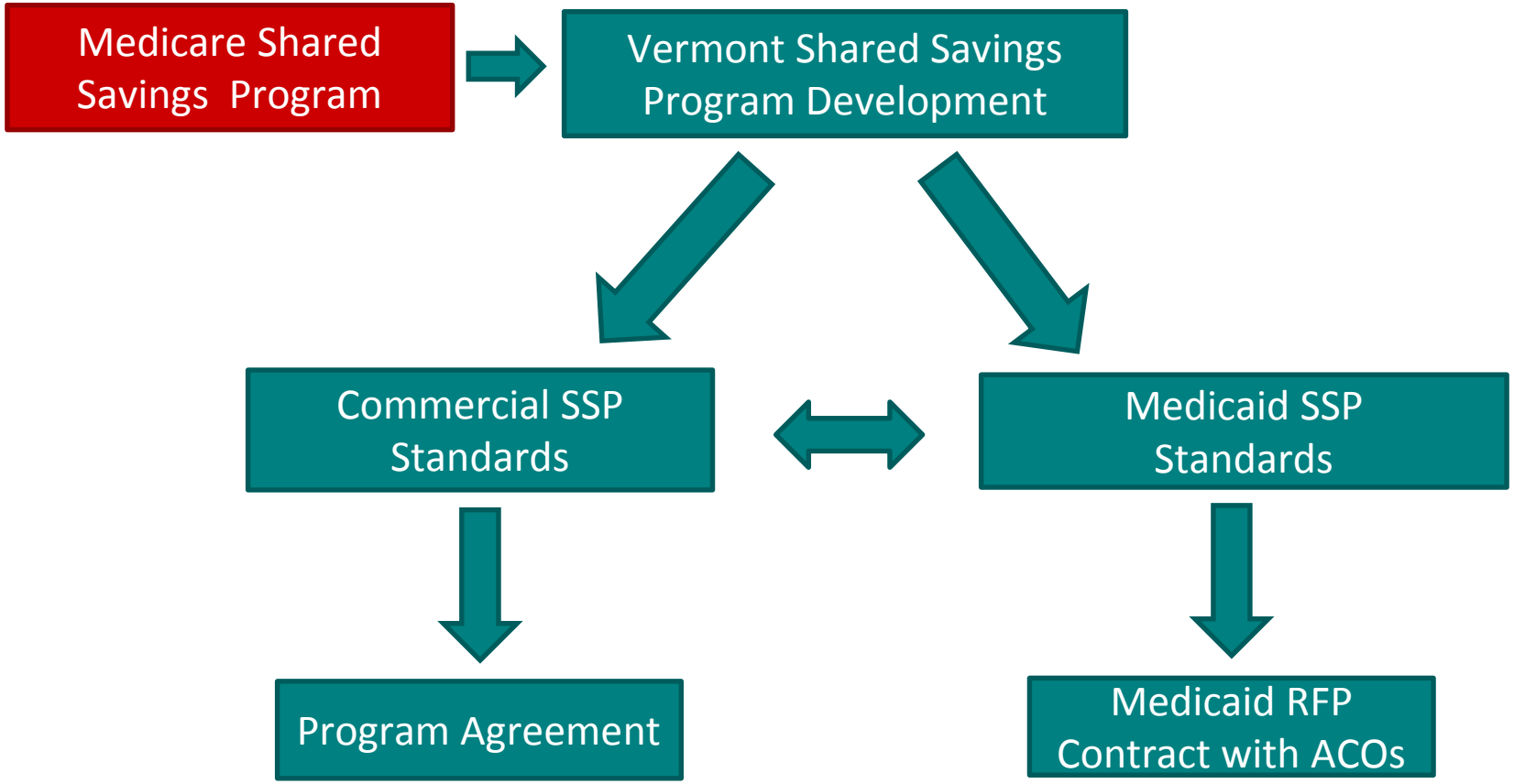
Shared Savings Programs in Vermont

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



VERMONT
GREEN MOUNTAIN CARE BOARD

Beneficiary Attribution to an ACO SSP

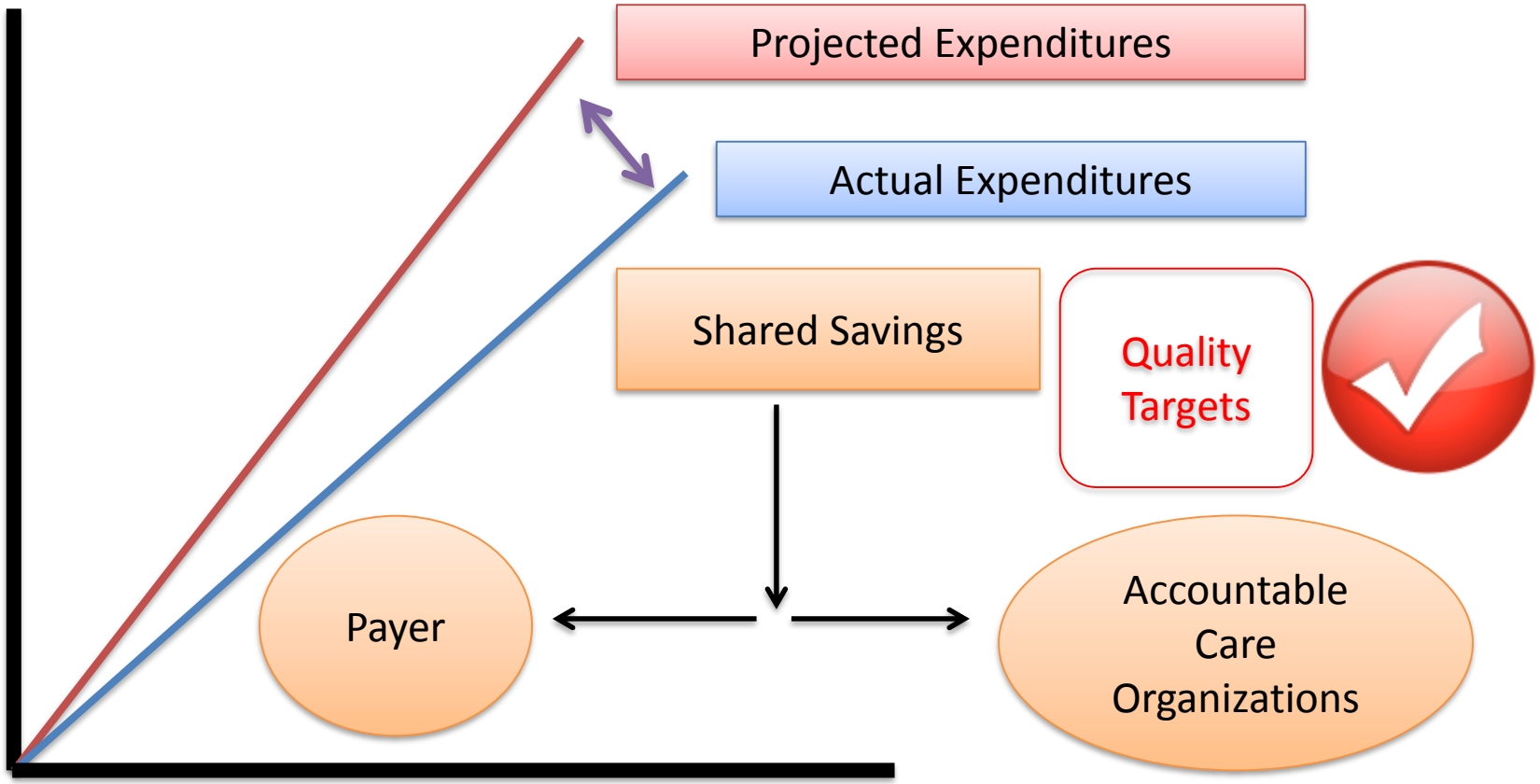
People see their Primary Care Provider (PCP) as they usually do

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

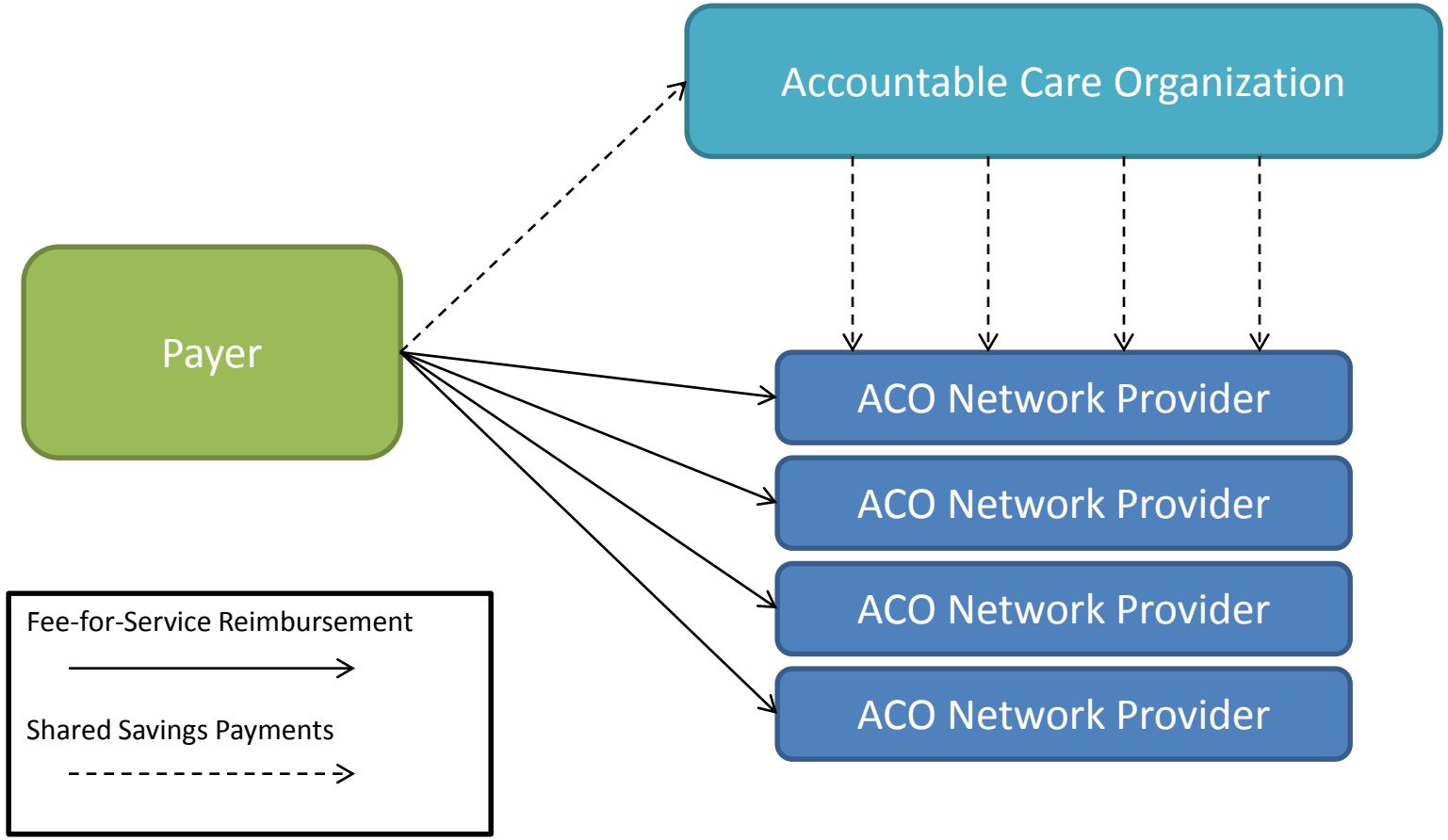
ACO

Providers bill as they usually do

Expenditure Targets in an ACO SSP



How Money Flows in an ACO SSP



VERMONT
GREEN MOUNTAIN CARE BOARD

Vermont's ACO Participation in Shared Savings Programs (SSPs)

ACO Name	2014	2015	2016	2017
Community Health Accountable Care (CHAC)	Commercial SSP Medicaid SSP Medicare SSP	Commercial SSP Medicaid SSP Medicare SSP	Commercial SSP Medicaid SSP Medicare SSP	Commercial SSP Medicare SSP
OneCare Vermont (OneCare)	Commercial SSP Medicaid SSP Medicare SSP	Commercial SSP Medicaid SSP Medicare SSP	Commercial SSP Medicaid SSP Medicare SSP	Commercial SSP DVHA NextGen Medicare SSP
Vermont Collaborative Physicians/Health*first* (VCP)	Commercial SSP Medicare SSP	Commercial SSP	Commercial SSP	

2016 Shared Savings Programs: Results and Key Takeaways

Interpret Financial Results with Caution

- ACOs have different populations and start dates
- 2014 and 2015 Commercial financial targets were based on Vermont Health Connect premiums; actual expenditure calculations were based on paid amounts
- 2016 Commercial calculations:
  - Incorporated 2014 claims experience in targets
  - Relied on allowed amounts (including consumer cost sharing) for actual expenditure calculations
  - These two methodology changes led to larger target and actual expenditures in 2016, so 2016 results can't be compared to 2014 and 2015 results

Detailed 2016 Financial Results: Commercial, Medicaid, and Medicare SSPs

	Medicaid			Commercial			Medicare		
	CHAC	OneCare	VCP	CHAC	OneCare	VCP	CHAC	OneCare	VCP
Actual Member Months	329,661	443,894	N/A	132,175	304,495	104,340	*PMPM Values Not Reported Publicly by CMS*	*PMPM Values Not Reported Publicly by CMS*	N/A
Expected PMPM	$ 181.28	$ 165.47	N/A	$ 498.39	$ 490.24	$ 412.10			N/A
Target PMPM*	N/A*	N/A*	N/A	$ 483.74	$ 478.24	$ 399.20			N/A
Actual PMPM	$ 180.53	$ 168.88	N/A	$ 496.01	$ 496.74	$ 430.01			N/A
Shared Savings PMPM	$ 0.75	$ (3.41)	N/A	$ 2.38	$ (6.50)	$ (17.91)			N/A
Total PMPM Savings Earned	$ - *	$ -	N/A	$ 2.38	$ -	$ -			N/A
Potential ACO Share of Earned Savings	$ -	$ -	N/A	$ 0.49	$ -	$ -			N/A
Expected Aggregated Total	$ 59,760,946.08	$ 73,451,140.18	N/A	$ 65,874,698.25	$ 149,275,628.80	$ 42,998,514.00	$ 122,245,415.00	$ 401,041,933.00	N/A
Target Aggregated Total*	N/A*	N/A*	N/A	$ 63,938,334.50	$ 145,621,688.80	$ 41,652,528.00	N/A*	N/A*	N/A
Actual Aggregated Total	$ 59,513,700.33	$ 74,964,818.72	N/A	$ 65,560,121.75	$ 151,254,846.30	$ 44,867,243.40	$ 142,925,956.00	$ 419,636,813.00	N/A
Shared Savings Aggregated Total	$ 247,245.75	$ (1,513,678.54)	N/A	$ 314,576.50	$ (1,979,217.50)	$ (1,868,729.40)	$ (20,680,541.00)	$ (18,594,820.00)	N/A
Shared Savings Total as % of Expected	*0.41%*	*-2.06%*	N/A	*0.48%*	*-1.33%*	*-4.35%*	*-16.92%*	*-4.64%*	N/A
Total Savings Earned	$ - *	$ -	N/A	$ 314,576.50	$ -	$ -	$ -	$ -	N/A
Potential ACO Share of Earned Savings	$ -	$ -	N/A	$ 64,507.00	$ -	$ -	$ -	$ -	N/A
Quality Score	70%	77%	N/A	74%	88%	88%	90%	97%	N/A
%of Savings Earned	90%**	95%**	N/A	90%	100%**	100%**	90%***	97%***	N/A
Achieved Savings***	$ - *	$ -	N/A	$ 58,056.30	$ -	$ -	$ -	$ -	N/A

* The Medicaid and Medicare SSPs do not use a savings Target. In the Medicaid SSP, in order for an ACO to qualify for savings, it must meet a 2% Minimum Savings Rate (MSR). An ACO may demonstrate savings, yet will not be eligible for payout if the total savings amount falls under the 2% MSR.

**If shared savings had been earned.

*** Savings payouts in the Commercial SSP are contingent on BCBSVT achieving a surplus in its Qualified Health Plan business. As a result, CHAC may not receive payout for savings in 2016.

Summary of 2016 Quality Results

Vermont Medicaid Shared Savings Program Quality Performance Summary – 2016 Payment Measures				
ACO Name	Points Earned	Total Potential Points	% of Total Quality Points	% of Savings Earned*
CHAC	21	30	**70%**	90%
OneCare	23	30	**77%**	95%

Vermont Commercial Shared Savings Program Quality Performance Summary – 2016 Payment Measures				
ACO Name	Points Earned	Total Potential Points	% of Total Quality Points	% of Savings Earned*
CHAC	17	23	**74%**	90%
OneCare	23	26	**88%**	100%
VCP	15	17	**88%**	100%

Medicare Shared Savings Program Quality Performance Summary – 2016 Payment Measures		
ACO Name	Quality Score	% of Savings Earned*
CHAC	**90%**	90%
OneCare	**97%**	97%

* if shared savings were earned

VERMONT
GREEN MOUNTAIN CARE BOARD

2016 Medicaid Payment Measure Results

Measure	CHAC Rate / Percentile / Points*	OCV Rate / Percentile / Points*
All-Cause Readmission	15.82/**/2 Points	11.42/**/2 Points
Adolescent Well-Care Visits	48.82/Above 50th/3 Points	51.27/Above 50th/3 Points
Mental Illness, Follow-Up After Hospitalization	39.69/Above 25th/1 Point	52.30/Above 50th/2 Points
Alcohol and Other Drug Dependence Treatment	29.51/Above 50th/2 Points	27.56/Above 50th/2 Points
Avoidance of Antibiotics in Adults with Acute Bronchitis	24.63/Above 50th/2 Points	32.46/Above 75th/3 Points
Chlamydia Screening	44.47/Below 25th/0 Points	50.51/Below 25th/0 Points
Developmental Screening	30.13/**/3 Points	57.15/**/3 Points
Rate of Hospitalization for People with Chronic Conditions (per 100,000)	449.87/**/2 Points	504.12/**/2 Points
Blood Pressure in Control	64.74/Above 75th/3 Points	68.42/Above 75th/3 Points
Diabetes Hemoglobin A1c Poor Control (lower rate is better)	21.52/Above 90th/3 Points	18.77/Above 90th/3 Points

*Maximum points per measure = 3 **No national benchmark; awarded points based on change over time

2016 Commercial Payment Measure Results

Measure	CHAC Rate / Percentile / Points*	OCV Rate / Percentile / Points*	VCP Rate / Percentile / Points*
ACO All-Cause Readmission (lower is better)	1.17/Below 25th/0 Points	0.86/Above 25th/1 Point	0.86/Above 25th/1 Point
Adolescent Well-Care Visits	51.78/Above 75th/3 points	55.91/Above 75th/3 Points	57.18/Above 75th/3 Points
Mental Illness, Follow-Up After Hospitalization	*N/A* *(denominator too small)*	59.26/Above 75th/3 Points	*N/A* *(denominator too small)*
Alcohol and Other Drug Dependence Treatment	23.93/Above 50th/2 Points	26.89/Above 75th/3 Points	32.61/Above 90th/3 Points
Avoidance of Antibiotics in Adults with Acute Bronchitis	33.66/Above 75th/3 Points	34.33/Above 75th/3 Points	44.26/Above 90th/3 Points
Chlamydia Screening	38.34/Above 25th/1 Point	43.87/Above 50th/2 Points	50.75/Above 75th/3 Points
Rate of Hospitalization for People with Chronic Conditions (per 100,000)	99.88/**/2 Points	101.02/**/2 Points	36.15/**/2 Points
Blood Pressure in Control	70.52/Above 90th/3 Points	66.20/Above 75th/3 Points	*Not Provided* *(VCP did not report clinical measures for Year 3)*
Diabetes Hemoglobin A1c Poor Control (lower rate is better)	17.54/Above 90th/3 Points	13.02/Above 90th/3 Points	

*Maximum points per measure = 3, except as noted below ** No national benchmark; awarded maximum of 2 points based on change over time

Summary of SSP Financial Results 2014-2016

	Medicaid								
	Actual PMPM			PMPM Savings (Loss)			Quality Score		
	2014	2015	2016	2014	2015	2016	2014	2015	2016
CHAC	$189.83	$182.06	$180.53	$24.85	$7.03	$0.75	46%	57%	70%
OneCare	$165.66	$171.55	$168.88	$14.93	$(2.18)	$(3.41)	63%	73%	77%
VCP									

	Commercial								
	Actual PMPM			PMPM Savings (Loss)			Quality Score		
	2014	2015	2016	2014	2015	2016	2014	2015	2016
CHAC	$350.03	$369.68	$496.01	$(25.94)	$(14.02)	$2.38	56%	61%	74%
OneCare	$349.01	$348.81	$496.74	$(23.38)	$(13.57)	$(6.50)	67%	69%	88%
VCP	$286.08	$303.95	$430.01	$(19.36)	$(34.62)	$(17.91)	89%	87%	88%

	Medicare (shown as percentage difference from target because PMPM not reported)								
	Actual Aggregate Total			% Difference from Target			Quality Score		
	2014	2015	2016	2014	2015	2016	2014	2015	2016
CHAC	$45,957,103	$56,658,198	$142,925,956	2.36%	-7.83%	-16.92%	*Reporting*	97%	90%
OneCare	$470,417,853	$511,835,661	$419,636,813	-0.89%	-5.56%	-4.64%	89%	96%	97%
VCP	$59,486,632			-4.87%			92%		

NOTE: <u>2016 Commercial SSP PMPM amounts not directly comparable to 2014-2015</u>. Commercial financial calculations in 2014-2015 based on Vermont Health Connect premiums and paid amounts, rather than claims experience. 2016 calculations incorporated 2014 claims and allowed amounts. Also, 2014 and 2015 results based on 6 months of claims runout; 2016 based on 4 months.

Takeaways: 2016 Financial and Quality Results

- **Financial results positive for CHAC in Medicaid SSP; OneCare did not achieve savings**
  - However, CHAC did not receive shared savings because it did not meet 2% Minimum Savings Rate for the Medicaid SSP

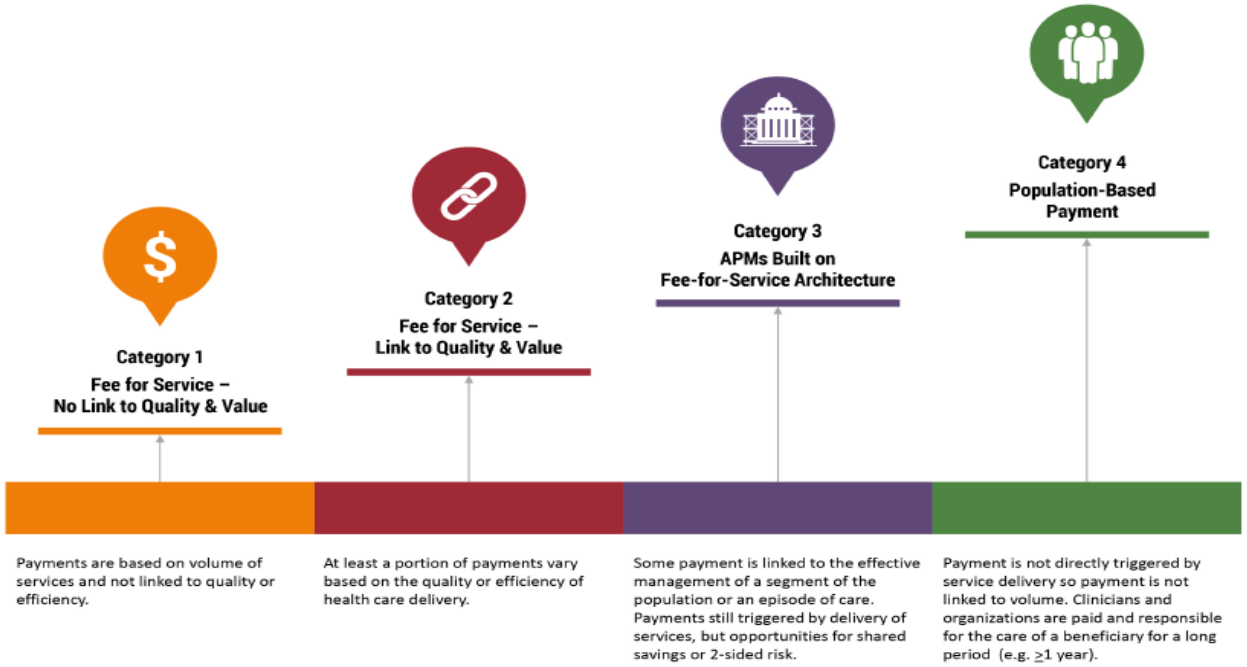
- **CHAC, OneCare, and VCP all showed movement toward Commercial PMPM targets from 2015 and 2016**
  - CHAC did not receive shared savings in 2016; shared savings payments were contingent upon BCBSVT achieving a surplus in Qualified Health Plan business
  - CHAC and OneCare have moved progressively closer to targets since 2014

- **CHAC and OneCare did not achieve savings in Medicare SSP in 2016**

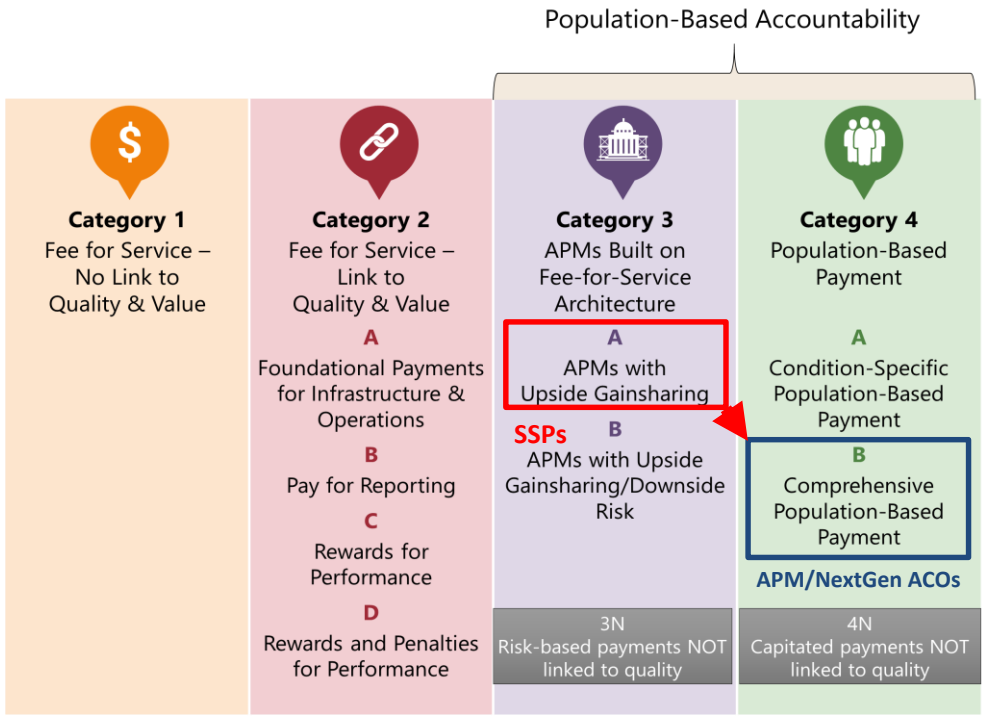
- **Progressive improvements in overall quality scores for CHAC and OneCare in the Medicaid and Commercial SSPs, with continued high performance for VCP**

National Context:
Shared Savings Program Performance

CMS Alternative Payment Model Framework



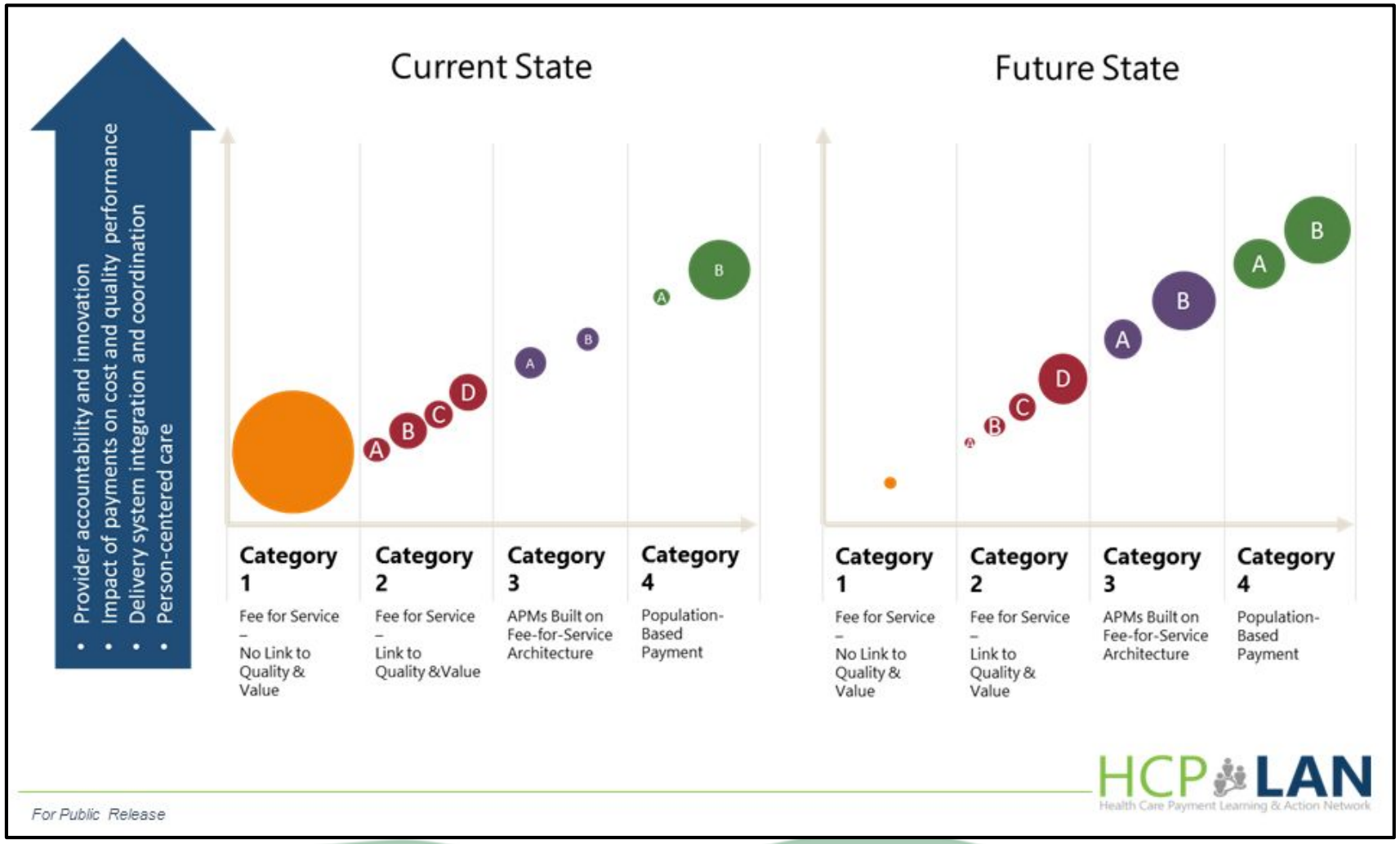
The CMS Framework assigns payments from payers to health care providers to four Categories, such that movement from Category 1 to Category 4 involves increasing provider accountability for both quality and total cost of care, with a greater focus on population health management (as opposed to payment for specific services).



Source: Health Care Payment Learning and Action Network

VERMONT
GREEN MOUNTAIN CARE BOARD

Evolution Over Time



From the Health Care Payment Learning and Action Network (HCP LAN):
The values presented in the above "current state" graphic are based on available data on private plans from Catalyst for Payment Reform and Medicare FFS allocations. This graphic is meant to represent recommendations for how the health care system should change, and it accounts for the likely impact of Medicare's Quality Payment Program and private initiatives. Values displayed in the graphic are not precise and will depend on delivery capabilities. The size of the various circles represents spending across various types of payment models. Payments are expected to shift over time from Categories 1 and 2 into Categories 3 and 4. Additionally and over time, APMs within a particular category will increase the extent to which payments are linked to provider accountability, enable more innovation in care, make a greater impact on quality and cost performance, increase coordination in delivery systems, and result in more value-based care.

VERMONT
GREEN MOUNTAIN CARE BOARD

Medicare Shared Savings Programs (MSSP) Track 1 vs. Advanced Alternative Payment Models (2016 Results)

Track 1 SSP (First 4 Years)	Track 2 SSP (First 4 Years)	Track 3 SSP (First Year)	Next Generation ACO (First Year)
Track 1 ACOs had overall **net costs** to Medicare relative to their aggregate benchmark. However, Medicare savings were achieved on beneficiary services relative to benchmark, but total bonus payments to eligible MSSP ACOs exceeded these savings. **Nearly one third of MSSP ACOs achieved enough savings to receive Medicare shared savings payments in 2016.**	Track 2 ACOs, which comprise a small fraction of MSSP ACOs, achieved modest net savings relative to their aggregate benchmark in the first three years, but nearly doubled net savings between the third and fourth years. **All Track 2 ACOs achieved enough savings to receive Medicare shared savings payments in 2016.**	Track 3 ACOs, which comprise a small fraction of MSSP ACOs, achieved modest net savings relative to their aggregate benchmark in the first year. **Over half of Track 3 ACOs achieved enough savings to receive Medicare shared savings payments in 2016.**	Next Generation ACOs achieved $63 million in net Medicare savings overall relative to benchmark levels. These net savings incorporate discounted benchmarks. **Of 18 ACOs, 11 received shared Medicare savings and 7 owed Medicare due to 2016 spending results.**

Source: Kaiser Family Foundation Side-by-Side Comparison: Medicare Accountable Care Organization Models
http://files.kff.org/attachment/Evidence-Link-Side-by-Side-ACOs-20171110

Lessons Learned

- **While financial results were mixed, quality improved** (or remained very high) across all ACOs and all programs**.**

- **Vermont's SSP performance fits within a national context** of payment reform and innovation, and was a critical step in preparing Vermont (providers, ACOs, and the State) for the All-Payer Model.

- **The All-Payer Model addresses some challenges of the SSPs.** Compared to the SSPs, the All-Payer Model has stronger financial incentives to encourage high-quality, coordinated, efficient care for ACO members. Incentives continue to be aligned across payers due to multi-payer approach.

- **Vermont's SSP experience was critical to supporting provider and payer readiness for the All-Payer Model.** Vermont Medicaid Next Generation ACO Pilot launched in January 2017.

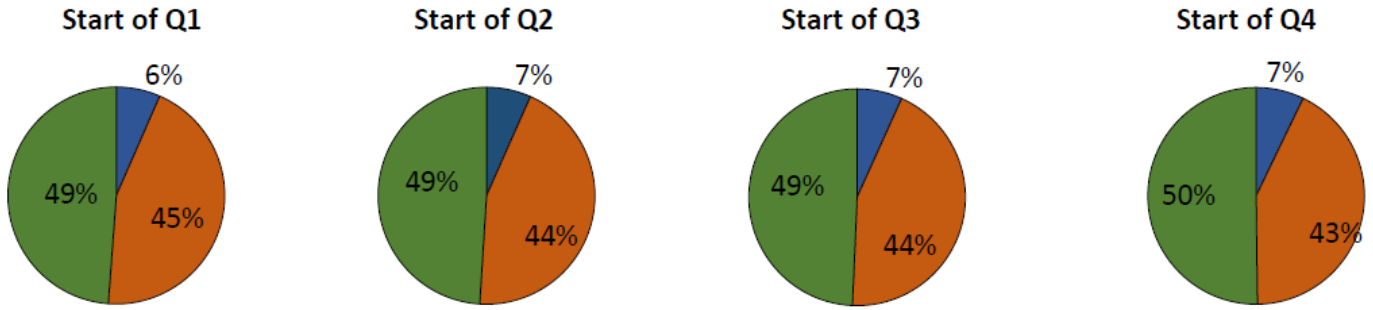
Vermont Medicaid Next Generation ACO Pilot

- 2017 performance year
  - Setting up operations following 2016 procurement
  - Developing monitoring and reporting strategies
- Submission of June 15, September 15, and December 15 VMNG legislative reports
- DVHA and OneCare have engaged in contract negotiations for a 2018 performance year
- Mutual goals for 2018 are to:
  - Minimize programmatic changes from 2017 to 2018
  - Increase the number of providers and communities voluntarily participating in the program
  - Increase the number of Medicaid beneficiaries attributed to the ACO
  - Ensure programmatic alignment between the VMNG, Medicare, and commercial payer programs in 2018

VMNG 2017 Attribution

*Attributed Medicaid Members**	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
% of 29,102	**100.00%**	**99.72%**	**98.54%**	**97.04%**	**93.17%**	**92.11%**	**91.07%**	**89.29%**	**86.58%**	**84.67%**	**83.61%**	**82.60%**
Total	29,102	29,021	28,676	28,240	27,115	26,806	26,503	25,985	25,197	24,642	24,332	24,038
Aged, Blind, Disabled	1,910	1,907	1,906	1,878	1,819	1,808	1,790	1,791	1,773	1,764	1,755	1,742
General Adult	12,987	12,933	12,754	12,525	11,980	11,845	11,646	11,331	10,764	10,512	10,326	10,164
General Child	14,205	14,181	14,016	13,837	13,316	13,153	13,067	12,863	12,660	12,366	12,251	12,132

- Aged, Blind, Disabled
- General Adult
- General Child



VERMONT
GREEN MOUNTAIN CARE BOARD

Preliminary 2017 VMNG Results

- Presently in the final month of the 2017 performance year
  - Because of the claims-lag, it is not yet possible to fully evaluate 2017 financial and quality performance
  - Final 2017 results are expected mid-2018
- Financial information from the first three quarters of 2017 indicates that actual spending has been fairly consistent with expected spending.*
- Exercise caution when interpreting early financial results. The data is preliminary and subject to change because there is not yet sufficient claims run out to meaningfully assess the program.
- In combination, the claims lag and fixed prospective payment will both understate the cost of care, and tend to make the ACO appear better-off financially than it is until the final reconciliation.
  - Disproportionate impact of the claims lag on the most recent months of performance.

*Subject to ongoing validation

VMNG Financial Performance, January - November 2017

VMNG ACO CY 2017 Total Cost of Care (TCOC) Estimate Compared to Actual	
Cumulative Paid through 12/01/17	
Expected Total Cost of Care	$76,168,623
Actual Total Cost of Care	$75,306,123
Difference Btw Expected TCOC and Actual TCOC	**($862,499)**
Fixed Prospective Payment from DVHA to ACO	$46,500,674
Incl. in Fixed Prospective Payment Admin & PCCM Fees paid by DVHA to ACO	$2,587,832
In Network Fee For Service paid by DVHA on behalf of ACO*	$9,565,678
Out of Network Fee For Service paid by DVHA on behalf of ACO	$21,204,956
Total ACO Payment made by DVHA to date	$77,271,307

VMNG Financial Performance, January - November 2017

	January	February	March	April	May	June	July	August	September	October	November	Q1	Q2	Q3	Year-to-Date
Attribution^	29,102	29,021	28,676	28,240	27,115	26,806	26,503	25,985	25,197	24,642	24,332				
DVHA Payment to ACO*	$ 189,170	$ 5,057,828	$ 5,000,517	$ 4,918,984	$ 4,720,509	$ 4,670,045	$ 4,607,387	$ 4,514,450	$ 4,352,537	$ 4,263,747	$ 4,205,500	$ 10,247,515	$ 14,309,538	$ 13,474,373	$ 46,500,674
Total Expected Shadow FFS	$ -	$ 4,796,639	$ 4,742,352	$ 4,664,824	$ 4,476,474	$ 4,428,791	$ 4,368,859	$ 4,280,585	$ 4,125,764	$ 4,041,969	$ 3,986,512	$ 9,538,991	$ 13,570,089	$ 12,775,208	$ 43,912,769
Total Actual Shadow FFS	$ -	$ 4,231,151	$ 4,126,396	$ 4,353,496	$ 4,056,891	$ 3,615,256	$ 3,444,461	$ 3,441,072	$ 3,359,831	$ 3,001,474	$ 1,086,392	$ 8,357,546	$ 12,025,644	$ 10,245,363	$ 34,716,420
Shadow FFS Over (Under) Spend	$ -	$ (565,488)	$ (615,956)	$ (311,328)	$ (419,583)	$ (813,534)	$ (924,399)	$ (839,513)	$ (765,933)	$ (1,040,495)	$ (2,900,120)	$ (1,181,445)	$ (1,544,445)	$ (2,529,845)	$ (9,196,350)
Total Expected FFS	$ 7,522,630	$ 2,701,638	$ 2,671,062	$ 2,627,395	$ 2,521,309	$ 2,494,452	$ 2,460,696	$ 2,410,977	$ 2,323,774	$ 2,276,578	$ 2,245,342	$ 12,895,330	$ 7,643,156	$ 7,195,447	$ 32,255,853
Actual FFS - In Network	$ 4,393,596	$ 610,198	$ 630,904	$ 597,909	$ 613,828	$ 554,967	$ 454,776	$ 489,489	$ 481,024	$ 531,550	$ 207,438	$ 5,634,698	$ 1,766,704	$ 1,425,289	$ 9,565,678
Actual FFS - Out of Network	$ 2,639,429	$ 1,978,305	$ 2,049,273	$ 2,046,081	$ 2,192,078	$ 1,943,762	$ 1,991,154	$ 2,055,638	$ 1,910,554	$ 1,715,095	$ 683,587	$ 6,667,007	$ 6,181,920	$ 5,957,347	$ 21,204,956
Total Actual FFS	$ 7,033,025	$ 2,588,503	$ 2,680,176	$ 2,643,990	$ 2,805,905	$ 2,498,728	$ 2,445,930	$ 2,545,127	$ 2,391,578	$ 2,246,645	$ 891,025	$ 12,301,705	$ 7,948,623	$ 7,382,636	$ 30,770,634
FFS Over (Under) Spend	$ (489,605)	$ (113,135)	$ 9,114	$ 16,595	$ 284,596	$ 4,276	$ (14,766)	$ 134,151	$ 67,805	$ (29,933)	$ (1,354,317)	$ (593,625)	$ 305,467	$ 187,189	$ (1,485,219)
Expected Total Cost of Care	$ 7,522,630	$ 7,498,277	$ 7,413,414	$ 7,292,219	$ 6,997,783	$ 6,923,243	$ 6,829,556	$ 6,691,562	$ 6,449,538	$ 6,318,547	$ 6,231,854	$ 22,434,321	$ 21,213,245	$ 19,970,655	$ 76,168,623
Actual Total Cost of Care	$ 7,655,673	$ 7,385,142	$ 7,422,600	$ 7,308,814	$ 7,282,379	$ 6,927,519	$ 6,814,790	$ 6,825,712	$ 6,517,342	$ 6,288,614	$ 4,877,537	$ 22,463,415	$ 21,518,712	$ 20,157,844	$ 75,306,123
Total Cost of Care Over (Under) Spend	$ 133,043	$ (113,135)	$ 9,186	$ 16,595	$ 284,596	$ 4,276	$ (14,766)	$ 134,151	$ 67,805	$ (29,933)	$ (1,354,317)	$ 29,094	$ 305,467	$ 187,189	$ (862,499)

^ Defined after February 1, 2017 as number of individuals for whom a monthly prospective payment was made.

*Includes funds for cost of care, administrative fees, care coordination support, and Primary Care Case Management (PCCM) fees.

Note 1: Additional claims run-out is expected for all months of 2017; however, the impact of the claims-lag is particularly pronounced for the months of July and August.

Note 2: DVHA and OneCare are working together to ensure all program year claims—whether fee-for-service claims or zero-paid shadow claims—were processed correctly and consistently with VMNG program design. OneCare has identified a subset of fee-for-service claims paid to the four risk-bearing hospitals, and is working with DVHA and DXC to determine whether those claims were appropriately classified as fee-for-service claims (according to program design and system logic), or whether those claims ought to have been covered by the prospective payments issued to these hospitals by OneCare, and therefore zero-paid. The process for evaluating this subset of claims at a detailed level is ongoing. DVHA and OneCare will continue to monitor program expenditures to resolve this and any future questions regarding the classification of claims, and it is expected that such activities will continue until the summer of 2018 when the 2017 pilot year expenditures are examined as part of the final year-end reconciliation.

Proposal

- Vote to formally close out GMCB Payment Reform Pilots related to the Shared Savings Programs.

Additional Resources:
2016 SSP Reporting Measure Results
2016 SSP Patient Experience Measure Results

2016 Medicaid Reporting Measures

Reporting Measures	CHAC Rate/ Percentile	OCV Rate/Percentile
COPD or Asthma in Older Adults	340.87/No Benchmark	459.70/No Benchmark
Cervical Cancer Screening	57.10/Above 50th	64.74/Above 75th
Tobacco Use Assessment & Cessation	89.08/ No Benchmark	97.82/No Benchmark
Pharyngitis, Appropriate Testing for Children	83.89/Above 75th	84.35/Above 75th
Childhood Immunization	38.11/Above 50th	50.27/Above 90th
Weight Assessment and Counseling for Children/Adolescents	61.52/Above 25th	69.46/Above 50th
Optimal Diabetes Care Composite	39.39/No Benchmark	43.47/No Benchmark
Colorectal Cancer Screening	56.81/No Benchmark	63.04/No Benchmark
Screening for Clinical Depression & Follow-Up Plan	47.20/No Benchmark	46.60/No Benchmark
Body Mass Index Screening & Follow-Up	70.61/No Benchmark	71.74/No Benchmark

2016 Medicaid Reporting Measures: Strengths and Opportunities

Strengths:

- For measures with benchmarks, 7 of 8 ACO results were above the national 50th percentile
- 4 of 8 ACO results for measures with benchmarks were above the 75th percentile, and 1 of 8 was above the 90th percentile

Opportunities:

- 1 of 8 ACO results for measures with benchmarks were below the national 50th percentile
- Even when performance compared to benchmarks is good, potential to improve some rates
- Some variation among ACOs
- Lack of benchmarks for some Medicaid measures hindered further analysis

2016 Commercial Reporting Measures

Reporting Measures	CHAC Rate/ Percentile	OneCare Rate/Percentile	VCP Rate/ Percentile
Developmental Screening	28.33/No Benchmark	53.25/No Benchmark	74.23/No Benchmark
Hospitalizations for COPD or Asthma in Older Adults (lower is better)	46.79/No Benchmark	70.58/No Benchmark	18.53/No Benchmark
Pharyngitis, Appropriate Testing for Children	82.22/Above 50th	87.18/Above 50th	93.75/Above 90th
Immunizations for 2-year-olds	*N/A* *(denominator too small)*	60.87/Above 90th	*Not Provided* *(VCP did not report clinical measures for Year 3)*
Weight Assessment and Counseling for Children/Adolescents	72.49/Above 90th	73.74/Above 90th	
Colorectal Cancer Screening	66.67/Above 75th	72.09/Above 90th	
Depression Screening and Follow-Up	56.72/No Benchmark	48.07/No Benchmark	
Adult BMI Screening and Follow-up	74.11/No Benchmark	75.20/No Benchmark	
Cervical Cancer Screening	71.21/Above 25th	79.26/Above 90th	
Tobacco Use Assessment and Cessation	92.15/No Benchmark	98.09/No Benchmark	
Diabetes Composite	45.23/No Benchmark	52.08/No Benchmark	

2016 Commercial Reporting Measures: Strengths and Opportunities

Strengths:

- For measures with benchmarks, 9 of 10 ACO results were above the national 50th percentile
- 7 of 10 ACO results for measures with benchmarks were above the 75th percentile, and 6 of 10 were above the 90th percentile

Opportunities:

- For measures with benchmarks, 1 of 10 ACO results were below the national 50th percentile
- Even when performance compared to benchmarks is good, potential to improve some rates
- Some variation among ACOs
- Lack of benchmarks for some Commercial measures hindered further analysis
- VCP did not report clinical measures for Year 3.

2016 Combined Commercial/Medicaid Patient Experience Results: CHAC and OneCare

Adult Patient Exp. Composite	CHAC Rate/Percentile (Commercial + Medicaid)	OneCare Rate/Percentile* (Commercial + Medicaid)
Access to Care	58%/Above 25th	51%/Below 25th
Communication	79%/Below 25th	83%/Above 25th
Shared Decision-Making	65%/At 50th	62%/Above 25th
Self-Management Support	55%/At 75th	48%/Above 25th
Comprehensiveness	62%/Above 75th	59%/Above 75th
Office Staff	75%/Below 25th	72%/Below 25th
Information	69%/No Benchmark	68%/No Benchmark
Coordination of Care	73%/No Benchmark	72%/No Benchmark
Specialist Care	49%/No Benchmark	47%/No Benchmark
LTSS Care Coordination	54%/No Benchmark	51%/No Benchmark

2016 Combined Commercial/Medicaid OneCare Patient Experience Results for UVMMC Practices*

Adult Patient Exp. Composite: Visit-Based Survey	UVM Medical Center/OneCare Top Score Rate/Percentile (Commercial + Medicaid)
Access to Care	63%/At 50th
Communication	91%/Above 25th
Shared Decision-Making	67%/No Benchmark
Self-Management Support	42%/No Benchmark
Comprehensiveness	48%/No Benchmark
Office Staff	88%/Below 25th th
Information	53%/No Benchmark
Coordination of Care	74%/No Benchmark
Specialist Care	45%/No Benchmark

* OneCare rate does not include UVMMC practice results. UVMMC-owned practices voluntarily fielded a visit-based survey that was similar to the annual survey used for ACOs; survey differences prevent direct comparison.

2016 Combined Patient Experience Measures: Strengths and Opportunities

Strengths:

- Most ACO primary care practices chose to participate
- State funding (VHCIP and Blueprint) and vendor management reduced burden on practices
- Use of same survey for Blueprint and ACO evaluation reduced probability of multiple surveys to consumers
- 4 of 12 ACO results for measures with benchmarks were at or above the national 50th percentile

Opportunities:

- 8 of 12 ACO results for measures with benchmarks were below the national 50th percentile; 3 of 12 were below the national 25th percentile
- Lack of benchmarks hindered further analysis
- VCP did not have adequate denominators for reporting
- National all-payer benchmarks might not be comparable to CHAC/OneCare combined Commercial/Medicaid results