Vermont Medicaid Next Generation (VMNG) ACO Program - Overview

Objectives of the Agreement:

- **To take the next step** in redesigning the health care revenue model to reward value, meaning low cost and high quality, rather than volume.
- **To partner** with a risk-bearing Accountable Care Organization (a provider-led and governed organization, with a substantial role for regional clinical leadership) that will assume accountability for the quality and cost of care of ~30,000 Medicaid members in four communities.
- **To pilot** a financial model designed to support and empower the clinical and operational capabilities of the Accountable Care Organization (ACO) provider network in support of the Triple Aim of better care, better health, and lower costs.
- **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. The result will be a health care system that has aligned incentives to improve quality and reduce unnecessary costs, and thereby increase affordability for Vermonters.
- **To launch** the Medicaid component of the integrated health care system envisioned by the All-Payer Model agreement with the federal government.
- **To make Vermont more affordable** by making health care delivery system choices and investments that could moderate health care spending growth in the future.

Financial Arrangement:

- The type of payment provided to the ACO would be a "prospective payment" for hospitals participating with the ACO. This is a monthly fixed prospective payment made in advance of services being performed. Paying prospectively is different from what we do today. Today we pay a fee after a bill is received for each service performed. Fee-for-service payments would continue for all other non-hospital providers in the ACO.
- The ACO is paid for each attributed member by Medicaid Eligibility Group, and the ACO is financially responsible 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 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 savings to 97% of the target. This arrangement provides an incentive to use resources efficiently.
- The ACO will also withhold some of the payment to providers up front-- 0.5% in Year 1 and growing over time. The providers in the ACO can earn this money back through high quality performance. This type of payment incentive is provided to encourage high quality care.

Alignment with the All-Payer Model:

- The program was modeled after the Medicare Next Generation ACO program.
- The services and attribution methodology are aligned with the Medicare Next Generation ACO program.
- The majority of quality measures in the DVHA contract align with the All-Payer Model agreement.
- The payment methodology is tightly aligned with the Medicare Next Generation ACO program, but the risk corridor reflects that the agreement is a pilot project.
- The program will need to scale up substantially by 2022 to reach All-Payer Model scale targets.