Vermont ACO Payer Differential

Variation in the Benchmark Rates for Commercial, Medicaid, and Medicare ACOs

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Progress Together

Three payer differential reports prepared under All-payer model requirements

1. Annual change report

- Growth rate in accountable care organization (ACO) benchmarks by payer

2. Assessment report

- Comparison of 2019 ACO benchmarks "payer differential"

3. Options report

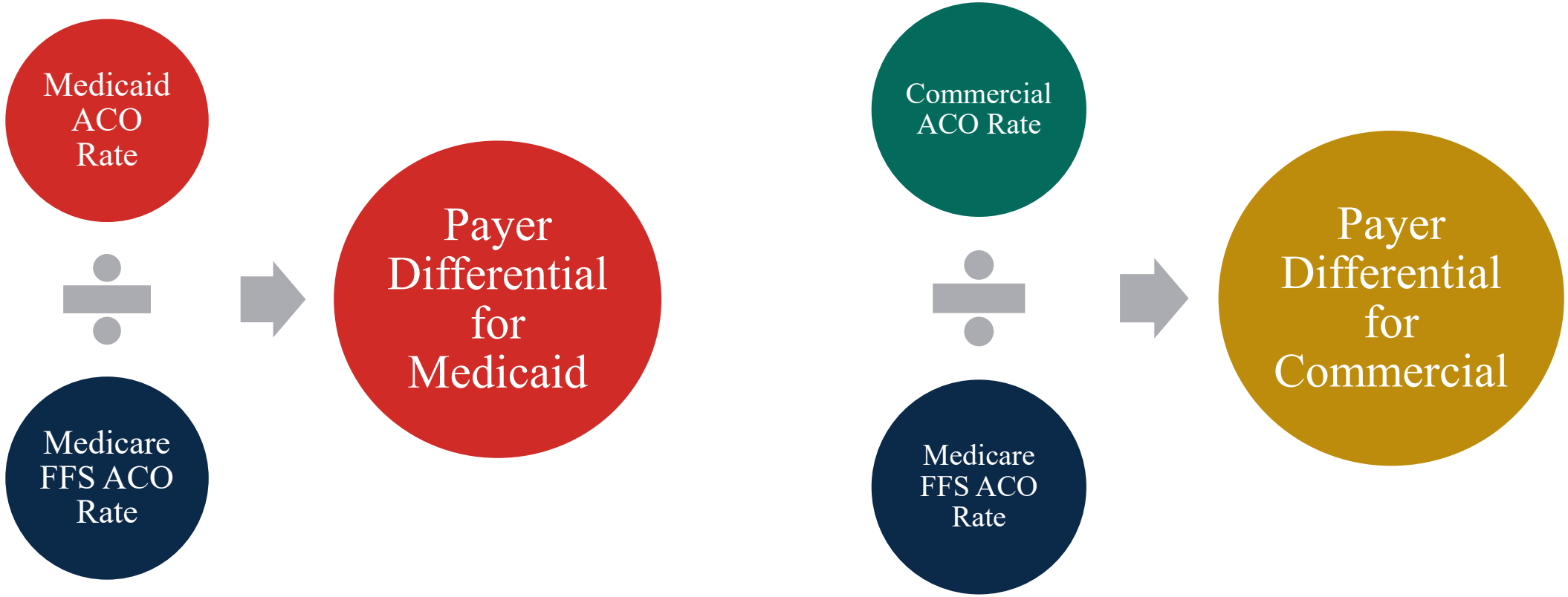
- Reduce the payer differential based on the other two reports

Agenda

- Overview
- Assessment report
  - Methods
  - Results
  - Additional analysis
  - Limitations
- Annual change report
- Options report

1. Assessment Report Methods

Payer differential compared to Medicare Fee-for-Service (FFS) ACO Benchmark Rate



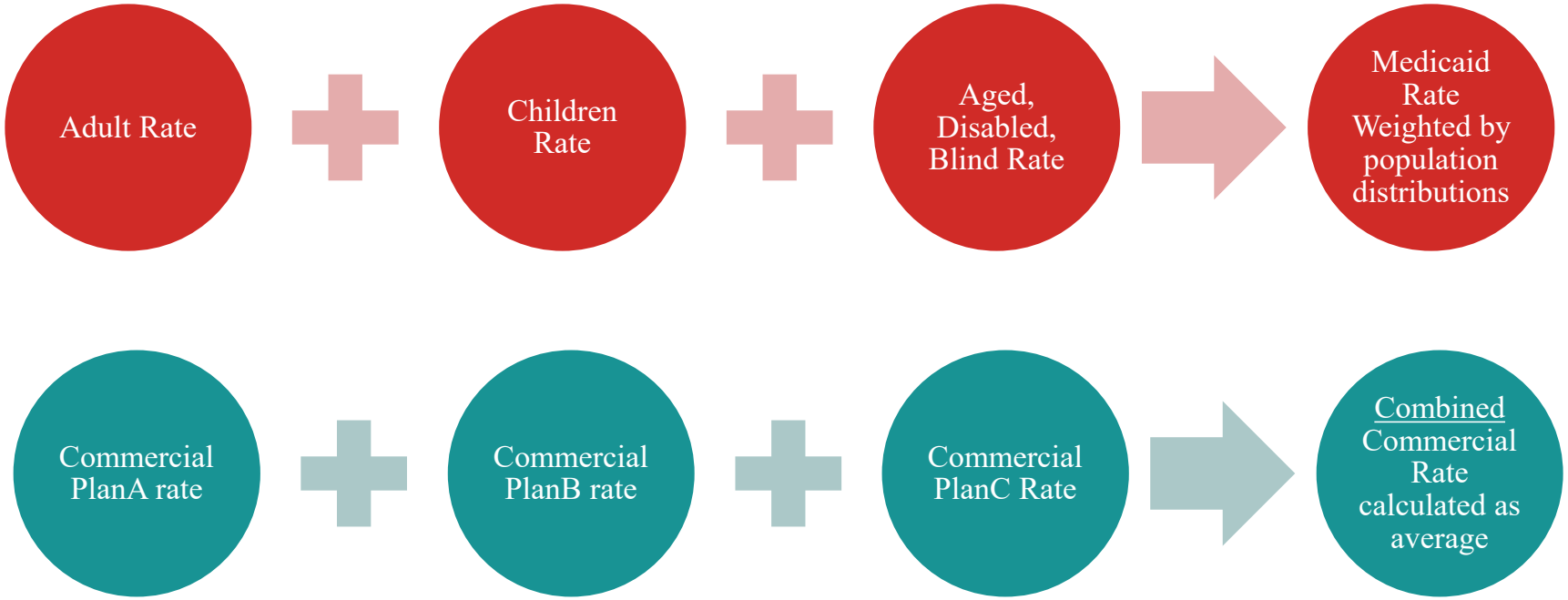
ACO Benchmark Rate/Target Rate

- **Details vary by payer and contract.**
- **Rates for attributed participants for ACO-covered services**
- **Target could be per-member-per year (PMPY) or Per-member-per month (PMPM)**

Medicare FFS	Medicaid	Comparison adjustments
• Paid amount (PMPY) • Shared savings/ loss	• Paid amount (PMPM) • Prospective rate paid to ACO	• Allowed amounts (PMPM) • Use of settlement rates for Medicare and commercial

Aligning ACO Benchmark Rates: Calculating a single rate

/ We need a single rate to compare with Medicare FFS



Covered Services Adjustments

- Covered services and plan designs
  - Payers' covered services, plan designs (for example, patient cost sharing) vary.
  - Some payers include additional payments, such as administrative fees, when determining ACO benchmarks
  - To enhance comparability, we excluded additional payments that varied across payers, such as administrative fees
  - Not able to adjust for plan design differences for example:
    - Covered inpatient/outpatient services
    - Limited benefits etc.

Health status adjustments

Used common risk-adjustment methodology

- The Johns Hopkins Adjusted Clinical Group (ACG) risk adjustment
- Excluded End Stage Renal Disease Rates from Medicare FFS Rates

Adjusted for expected future cost due to disease burden

- Used prospective risk scores
- Used 2017 historical claims to predict expected health care cost in 2018
- Included members with 9 months of continuous 2017 enrollment
- Used Vermont Health Care Uniform Reporting and Evaluation System (VCHURES) medical claims

Account for enrollment changes during ACO implementation

- Included all ACO-aligned members (some may be enrolled for only part of 2018)

We were able to include most ACO-aligned beneficiaries in the analysis

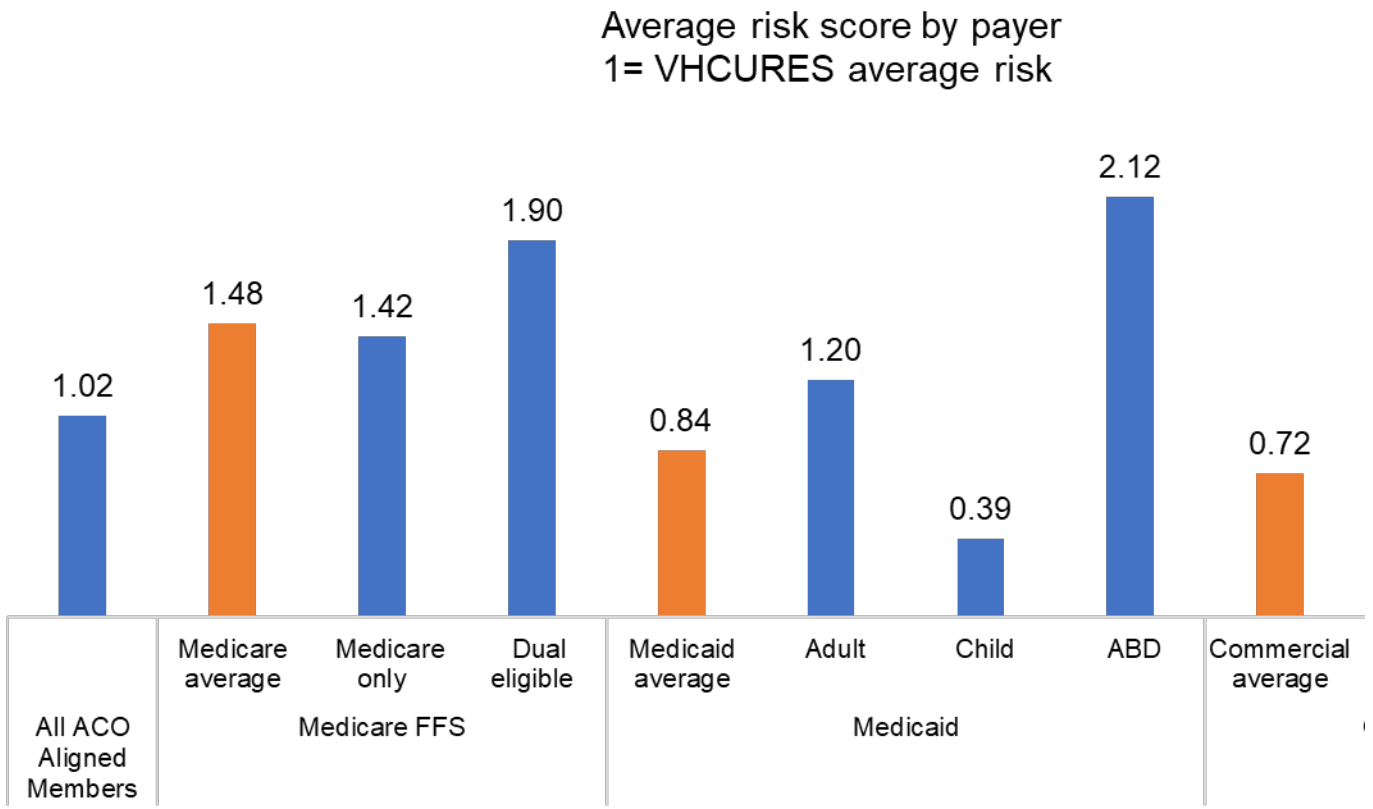
Payer group	Member months included in payer differential report	Member months aligned with ACO in VHCURES	Difference	Percent difference
All members	1,061,658	1,085,530	23,972	2.2%
Medicare FFS[a]	337,597	338,760	1,163	0.3%
Medicaid[b]	456,836	463,597	6,761	1.5%
Commercial Average[c]	267,125	283,147	16,022	5.7%

[a] Excludes ESRD population (<0.1% of population).
[b] Includes the categories non-ABD adult and non-ABD child.
[c] We could not find historical claims for a larger share of commercial ACO-aligned members relative to other payers. This is likely due to commercial payers' attribution methodology in that many new members in qualified commercial health plans may have had fewer than nine months of continuous 2017 enrollment, thus excluding them from our risk-adjusted population.

Risk scores by payer

Compared with the VHCURES average, the ACO-aligned member average risk scores are as follows:

- Overall ACO-Aligned members have 2 % higher risk-scores
- Medicare FFS score is 48% higher
- Medicaid score is 16% lower
- Commercial average score is 28% lower



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1. Assessment Report Results

2018 payer differential results

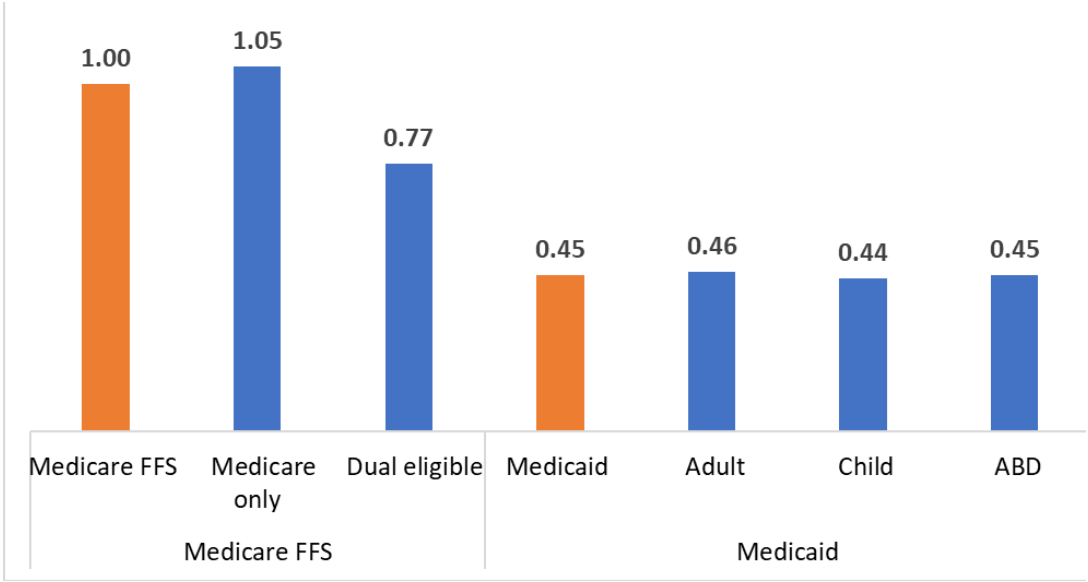
- **Compared with Medicare FFS ACO benchmarks:**
  - Medicaid ACO benchmark is 55% lower
  - Commercial average ACO benchmark is 5% higher

Payer group	Member months	Average rescaled risk score	ACO benchmark rate	Risk-adjusted benchmark rate[a]	Differential ratio compared with Medicare
All members	1,061,558	1.016	$485.84	$501.69	
Medicare FFS	**337,597**	**1.483**	**$806.82**	**$645.21**	**1.00**
Medicaid	**456,836**	**0.842**	**$245.82**	**$292.52**	**0.45**
Commercial Average	**267,125**	**0.724**	**$490.66**	**$678.01**	**1.05**

[a] Medicare and Medicaid risk-adjusted benchmark rates divided by paid-to-allowed ratio; the "all members" row equals the average of Medicare FFS, Medicaid, and commercial, weighted by member months.

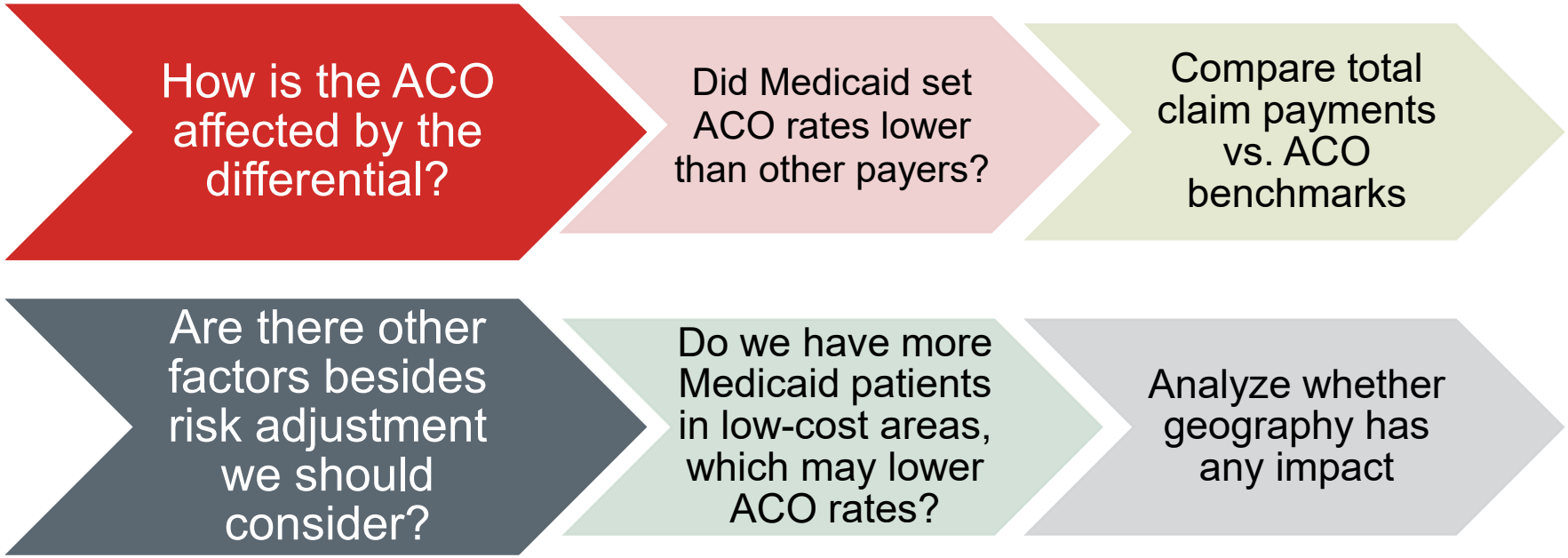
Differential ratios by subgroup

- **Medicare dual-eligible ratio is lower because Medicare FFS sets an average ACO benchmark**
- **Medicaid subgroup ratios are similar due to different ACO benchmark rates by subgroups**
- **Medicaid sub-group rates do not have an impact on the payer differential**



1. Assessment Report
Additional Analysis and Limitations

Explaining the payer differential



Comparing claim-based cost in 2018 to ACO benchmarks

- **The cost-to-benchmark ratio compares benchmark rates to the actual costs as measured by claim-based payments accrued during the year**
- **Benchmarks are adjusted for alignment; total costs are also aligned with ACO-covered services**
- **Caveat: The cost-to-benchmark ratio should be considered a general data point because:**
  - The ratio is affected by ACO performance (a lower ratio may mean that an ACO effectively managed the population to lower costs)
  - Costs may have changed since the baseline calculations due to member attrition or other factors
  - Enrollment changes, e.g. higher mortality or percentage of dually-eligible, may impact costs
  - We would need a more robust analytical approach to understand these ratios

Did Medicaid set ACO rates lower than other payers compared to claim-based costs in 2018?

- All three payer results indicate a close relationship between benchmarks and costs in 2018
- Payer differential results seem to be related to underlying FFS payment differences rather than to differences in ACO benchmarking methods

Payer group	Risk-adjusted PMPM cost	Risk-adjusted benchmark	PMPM cost to benchmark ratio
All members	$498.84	$501.69	0.99
Medicare FFS	$635.14	$645.21	0.98
Medicaid	$298.89	$292.52	1.02
Commercial average	$668.52	$678.01	0.99

Geographic variation

- **The geographic distribution of Medicaid ACO members appeared to have no impact on the differential**

Hospital Service Area	Ratios of risk-adjusted actual costs to risk-adjusted benchmarks		Percentage of ACO members	
	Medicaid adult	Medicare	Medicaid total	Medicare FFS
Burlington	0.92	0.94	24%	42%
Barre	1.00	0.99	13%	19%
St Albans	1.00	0.91	12%	7%
Bennington	0.91	0.93	12%	2%
Newport	0.91	1.41	9%	0.1%
Brattleboro	0.85	1.16	7%	7%
Middlebury	1.09	0.96	7%	10%
Springfield	1.23	1.11	6%	9%
White River Jct	0.77	1.15	5%	0.4%
Rutland	1.11	1.00	3%	2%
Morrisville	0.79	0.88	1%	1%
Randolph	0.99	0.84	1%	1%
St Johnsbury	0.77	0.90	0.5%	0.2%
Vermont total	**0.96**	**0.98**	**100%**	**100%**

Limitations

- ACG risk adjustment accounts for some but not all variation in risk
- Did not examine differences between service sites—for example:
  - Do Medicare patients use hospital-based outpatient clinics more than Medicaid patients do?
- Plans vary in benchmark construction and plan design
- There are factors external to ACO that affect benchmark rates (e.g., Medicaid's more robust coverage of high-cost services, such as long-term care)

2. Annual Change Report

Annual change report

- **Growth rate in accountable care organization (ACO) benchmarks by payer**
- **Risk adjusted ACO benchmarks (same methodology as assessment report**
- **Calculated two growth rates**
  - Annual change in ACO benchmark rates
  - "Update factor" difference between ACO benchmark rate and estimated baseline FFS payments

Annual change in ACO benchmarks

- **Annual changes in risk adjusted ACO benchmark rates were similar for public payers.**
- **Annual changes in risk adjusted benchmarks are a function of baseline cost changes due to newly attributed members and newly aligned providers.**

Payer	Change in ACO benchmark rates in 2019 vs. 2018
Medicaid	-2.4%
Medicare	-2.0%

Note: Medicaid rate is weighted by 2018 ACO membership distribution. All benchmarks are risk adjusted using VHCURES ACG risk-adjustment scores.

Annual update factor in ACO benchmarks in 2019 vs. 2018

- "Update Factor" looks at the rate of increase in ACO benchmarks compared to estimated baseline cost for the same attributed members and ACO network.
- 2019 factors were similar while 2018 had a larger increase for Medicaid.

Payer	Update to 2019 factor	Update to 2018 factor
Medicaid	2.2%	5.1%
Medicare	2.2%	3.5%

3. Options Report

Option Reports

- Payer differential reports are limited to evaluating ACO benchmarks, which showed the ACO benchmark setting did not substantially change the underlying payer differentials in Vermont.
- We did not analyze the cost of providing services nor differences in fee-schedules of different types of providers, which was not in-scope for this report.
- Focusing on ACO benchmarks, we developed the options discussed in this report in close collaboration with the GMCB and Department of Vermont Health Access (DHVA).

Payer differential analysis summary

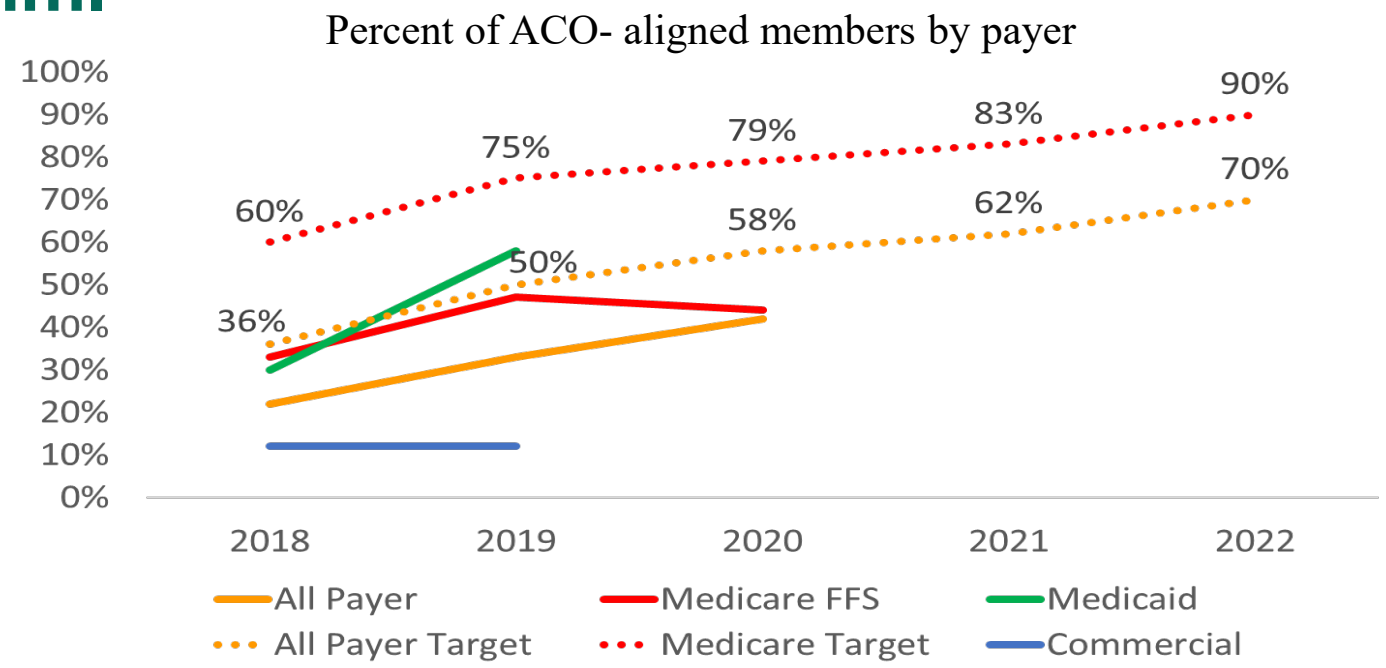
- Assessment report confirmed that there is a significant difference between Medicare and Medicaid ACO benchmarks and the difference originates from historical utilization and cost differences in payment rates.

Options

1	2	3
• Shift the focus on the scale target	• Uncouple benchmark calculation from FFS based claims	• Expand the payer differential assessment to full benefits

1. Shift the Focus on ACO Scale Targets

- **While percent of Medicare FFS ACO-aligned beneficiaries declined in 2020, Medicaid ACO-aligned beneficiaries surpassed 50 percent as a result of changes in Medicaid's attribution algorithm.**



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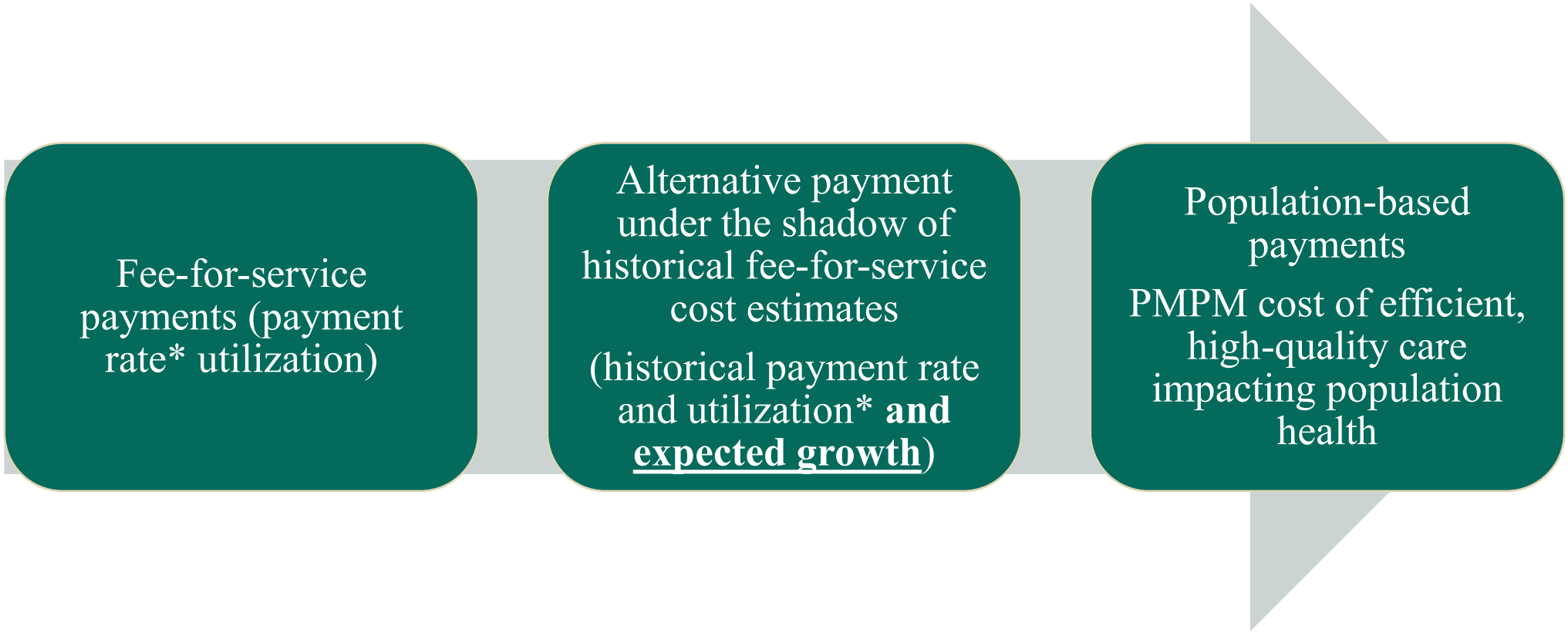
Medicaid provider participation in ACO

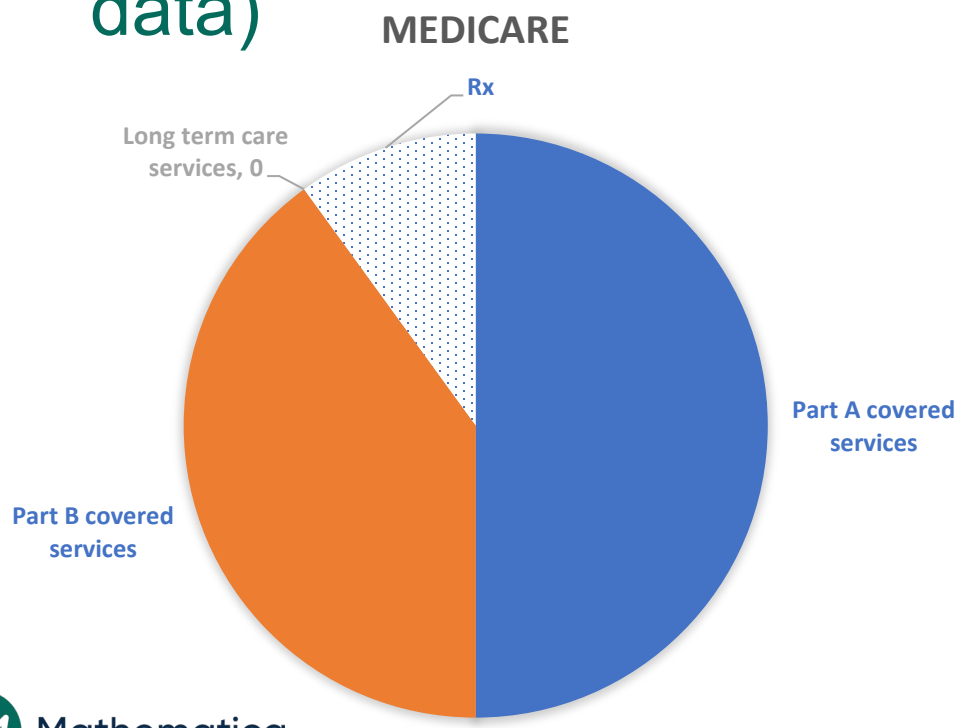
Researching providers' perspectives may also help contextualize the payer differential. Specifically, analyzing the fraction of Medicaid and Medicare providers who participate in the ACO over time would provide information about the status quo from the provider perspective.

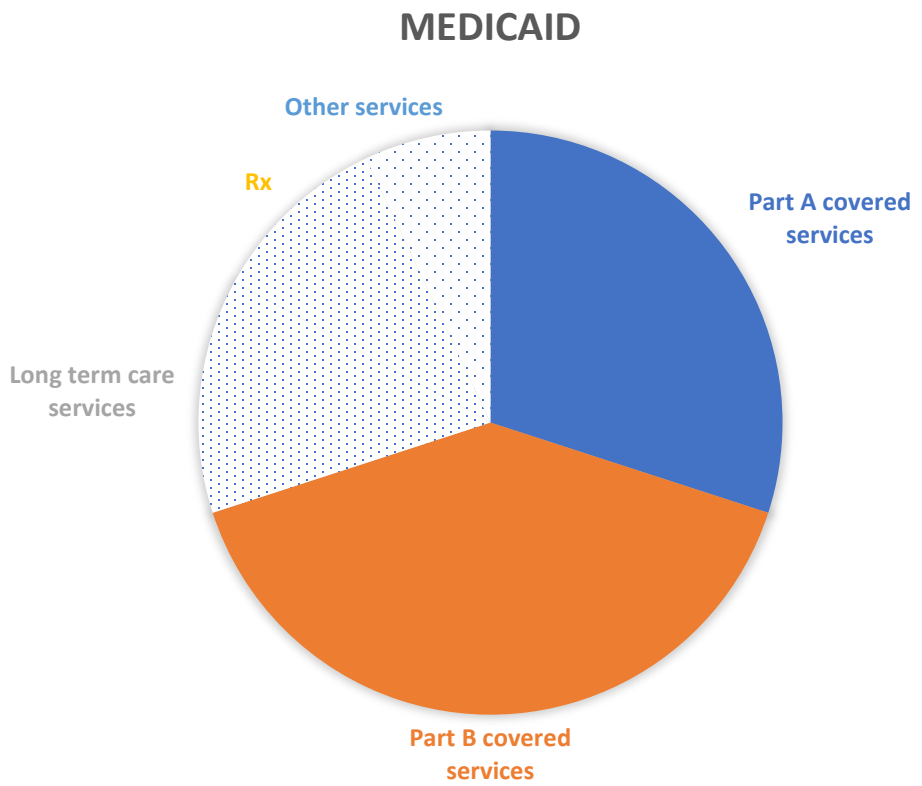
Option 2. Uncouple benchmark calculation from fee for service claims



Option 3: Expand the scope of included services and recalculate the payer differential

- ACO covered services exclude a significant portion of Medicaid covered services. (Charts are illustrative not based on actual data)





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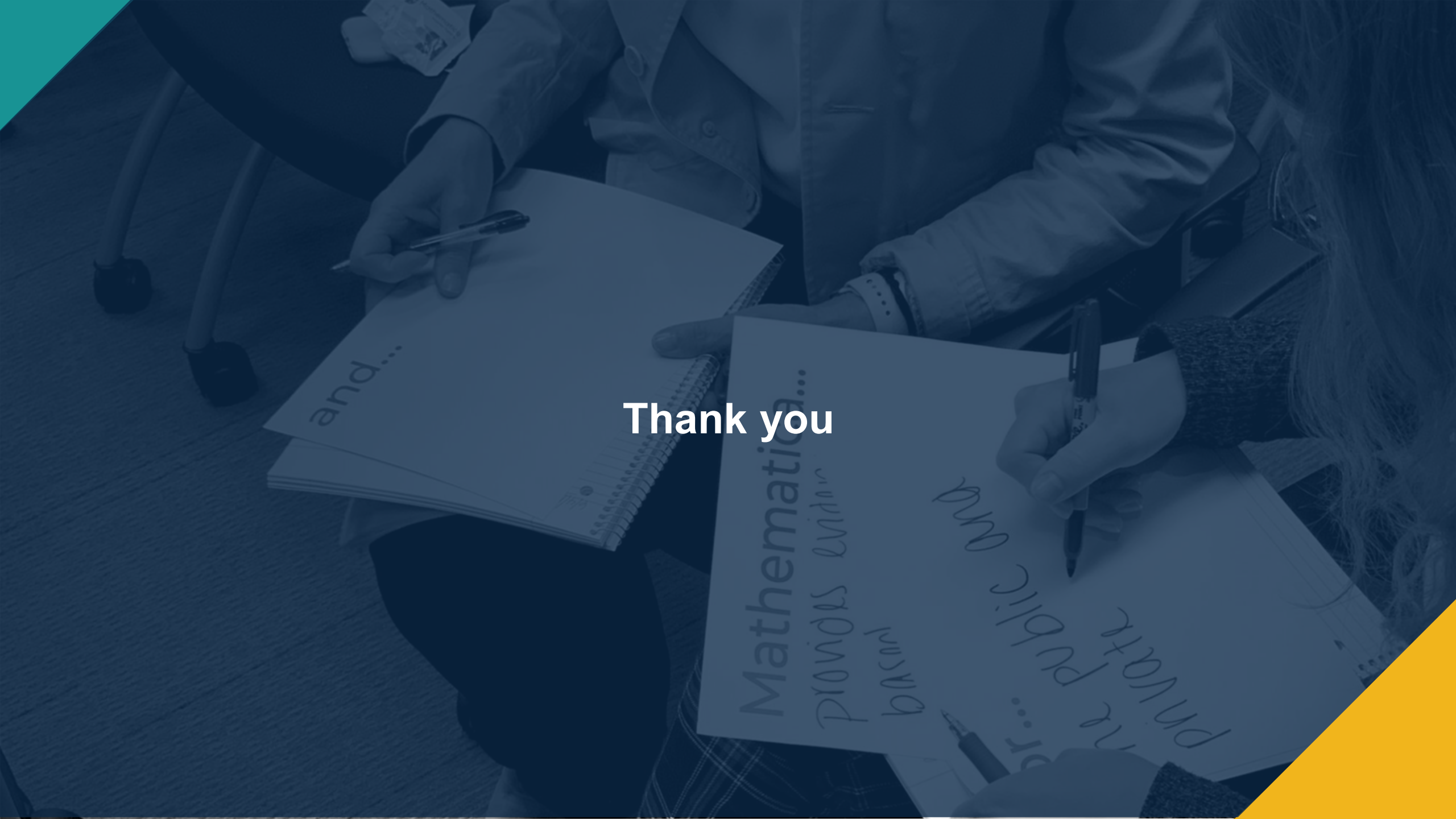
Provider-based cost, utilization, and payment differentials

- Fee-schedule differences vs. utilization differences
- Office visits vs. hospital outpatient visits
- Payment rates for the same providers and cost assessments
  - What is the cost of providing a service? Salaries, supplies etc.
  - What is the payment rate for each payer? Medicaid, Medicare, Commercial
  - Payer differential as a difference of payment/cost



Thank you