State of Vermont
Green Mountain Care Board
144 State Street
Montpelier VT 05620

Report to the Legislature

PRELIMINARY ACO SCALE TARGET PERFORMANCE PER THE ALL-PAYER ACO MODEL AGREEMENT
Performance Year 1 (2018)

In accordance with Act 124 of 2018 (H.914)

Submitted to the
House Committees on Appropriations, on Human Services, and on Health Care, the Senate Committees on Appropriations and on Health and Welfare, the Health Reform Oversight Committee, the Medicaid and Exchange Advisory Committee, and the Office of the Health Care Advocate

Submitted by the
Green Mountain Care Board

August 1, 2018

Legislative Charge

The Green Mountain Care Board (the Board) is submitting this report pursuant to Act 124 of 2018, "An act relating to reporting requirements for the second year of the Vermont Medicaid Next Generation ACO Pilot Project." Section 2 of the Act provides:

> (a) On or before June 15, September 15, and December 15, 2018, the Green Mountain Care Board shall provide to the House Committees on Appropriations, on Human Services, and on Health Care, the Senate Committees on Appropriations and on Health and Welfare, the Health Reform Oversight Committee, the Medicaid and Exchange Advisory Committee, and the Office of the Health Care Advocate written updates on the Board's progress in meeting the benchmarks identified in the Board's Year 1 (2018) All-Payer ACO Model Timeline regarding implementation of the All-Payer Model and the Board's regulation of accountable care organizations.
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> (b) The Board shall also provide to the committees and office described in subsection (a) of this section, to the extent permitted under federal law, the analysis of health care spending required by the Vermont All-Payer ACO Agreement, including:
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> (1) on or before August 1, 2018, information regarding whether the number of attributed lives is consistent with the scale targets in the All-Payer Model ACO Agreement; and
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> (2) on or before November 1, 2018, quality and financial performance information.

2018 Acts and Resolves No. 124, § 2.

Introduction

The Vermont All-Payer Accountable Care Organization Model Agreement (All-Payer ACO Model Agreement or APM Agreement), was signed on October 26, 2016 by Vermont's Governor, Secretary of Human Services, Chair of the Green Mountain Care Board (GMCB), and the Centers for Medicare and Medicaid Services (CMS). It aims to reduce health care cost growth by moving away from fee-for-service reimbursement to risk-based arrangements for ACOs that are tied to quality and health outcomes. The APM Agreement contains targets (Scale Targets) for the percentages of Medicare and All-Payer Scale Target beneficiaries aligned to a qualifying ACO initiative (a Scale Target ACO Initiative) under the model. The ACO Scale Targets are designed to ensure that a critical mass of Vermont's population is engaged in the All-Payer ACO Model Agreement – and hence, that providers can change their care delivery and business models to support value, not volume. If the State fails to meet ACO Scale Targets for two consecutive performance years, the All-Payer ACO Model Agreement requires the GMCB to submit a corrective action plan to support the State in meeting Scale Targets, including a methodology to improve Vermont's Scale performance.

This report describes Vermont's performance on the Scale Targets in Performance Year 1 (calendar year 2018) based on preliminary data. Final results will be available in June 2019, when data for the 2018 calendar year are finalized.

1. Scale Targets Identified in the All-Payer ACO Model Agreement

Section 6 of All-Payer ACO Model Agreement establishes Scale Targets for each of the five performance years, as reflected in Table 1 below:

Table 1: All-Payer and Medicare Scale Targets by Performance Year (PY)

	PY1 (2018)	PY2 (2019)	PY3 (2020)	PY4 (2021)	PY5 (2022)
Vermont Medicare Beneficiaries	60%	75%	79%	83%	90%
Vermont All-Payer Scale Target Beneficiaries	36%	50%	58%	62%	70%

2. Calculating Scale Target Performance

Methodology: Medicare Scale Target

$$\frac{\text{Vermont Medicare Beneficiaries Aligned to a Scale Target ACO Initiative}}{\text{Vermont Medicare Beneficiaries}}$$

Medicare Scale Target Numerator

The Medicare Scale Target numerator includes all Vermont Medicare Beneficiaries aligned to a Scale Target ACO Initiative, as described in Section 6.b of the Vermont All-Payer ACO Model Agreement. In Performance Year 1, OneCare Vermont (OCV) is the sole ACO participating in a Medicare Scale Target ACO Initiative (the Medicare Next Generation ACO Program).

Medicare Scale Target Denominator
The Medicare Scale Target denominator includes all Vermont Medicare Beneficiaries, including those dually eligible for Medicare and Medicaid, but excluding Medicare Advantage enrollees.

Methodology: All-Payer Scale Target

$$\frac{\text{Vermont All-Payer Scale Target Beneficiaries Aligned to a Scale Target ACO Initiative}}{\text{Vermont All-Payer Scale Target Beneficiaries}}$$

All-Payer Scale Target Numerator
The All-Payer Scale Target numerator includes all Vermonters aligned to a Scale Target ACO Initiative as described in Section 6.b of the Vermont All-Payer ACO Model Agreement. In Performance Year 1, OCV is the sole ACO participating in Scale Target ACO Initiatives, including the Medicare Next Generation ACO Program, Vermont Medicaid Next Generation ACO Program, BCBSVT Commercial Next Generation ACO Program, and UVMMC Shared Savings ACO Program.

All-Payer Scale Target Denominator
The Vermont All-Payer Scale Target denominator includes the following groups:

Table 2: All-Payer Scale Target Denominator Groups

Payer	Subcategory
Medicare	All Vermont Medicare Fee-For-Service (FFS) enrollees, including those dually eligible for Medicare and Medicaid
Medicaid	All Vermont Medicaid enrollees (see below for exceptions)
Commercial	All Vermont Members of Fully Insured Health Plans, Self-Funded Health Plans, and Medicare Advantage Plans

The following groups are excluded from the All-Payer Scale Target denominator:

- Members of Federal Employee Health Plans (FEHBP) and Military Health Plans (TRICARE)
- Non-ACO Eligible Medicaid Enrollees (e.g., individuals with evidence of third-party coverage, and individuals who receive a limited Medicaid benefit package)
- Members of Insurance Plans without a Certificate of Authority from Vermont's Department of Financial Regulation
- Uninsured Individuals

3. Preliminary Scale Target Performance in Performance Year 1

In 2017 and 2018, payers and providers in Vermont made notable progress adopting alternative payment methodologies consistent with the All-Payer ACO Model.[1] OCV holds four payer contracts in 2018 that have been evaluated by the Green Mountain Care Board to qualify as Scale Target ACO Initiatives.[2]

- For Performance Year 1, the four Scale Target ACO Initiatives operating through contracts between payers and OCV are:
  - Medicare Next Generation ACO Program
  - Vermont Medicaid Next Generation ACO Program[3]
  - BCBSVT Commercial Next Generation ACO Program
  - UVMMC Shared Savings ACO Program
- 9 of Vermont's 14 hospitals, plus Dartmouth Hitchcock Medical Center, participated in the ACO for at least one payer program.
- 837 primary care providers participated in the ACO for at least one payer program, including 703 general practice, internal medicine, and family practice primary care providers and 134 pediatric providers.

Table 3, below, summarizes Vermont's Scale calculations for Performance Year 1 (2018). This table reflects **preliminary** data from payers, OCV, and other sources; final data collection and reconciliation for PY1 will occur in June 2019, and numbers are expected to change.

[1] For more information on All-Payer Model implementation, see GMCB's Report to the Legislature – Progress in Meeting All-Payer ACO Model Implementation Benchmarks (June 15, 2018): https://legislature.vermont.gov/assets/Legislative-Reports/GMCB-All-Payer-ACO-Model-Update-to-Legislature-FINAL-6-15-2018.pdf.

[2] For more information, see staff presentation to GMCB (June 27, 2018): http://gmcboard.vermont.gov/sites/gmcb/files/Scale%20Target%20and%20Alignment%20Presentation_6.27.18%20%28FINAL%29%202.1.pdf.

[3] For more information, see DVHA's most recent report to the Legislature on the Vermont Medicaid Next Generation Pilot Program (submitted June 15, 2018): https://legislature.vermont.gov/assets/Legislative-Reports/ACT-124-VMNG-Report-to-Legislature-June-15-2018.pdf.

Table 3: Preliminary Scale Target Performance – Performance Year 1 (2018)

			Scale Denominator	**Scale Numerator**			
Payer	**Sub-Category**	**Vermont Population** (2018 Data)	**APM Population** (2018 Data)	**Participating in Scale Target ACO Initiatives** (PY 1 – 2018)	**PY1 Scale Progress**	**Performance Year 1 Scale Target**	**Denominator Data Source**
Medicare	*Parts A & B*	115,029	115,029	**39,702**	**35%** *Medicare*	**60%** *Medicare*	CMMI
	Part A or B only	11,477	0				
	MEDICARE TOTAL	**126,506**	**115,029**				
Medicaid	*Primary Coverage*	136,407	136,407	**42,342**			VHCURES
	Non-Primary Coverage	836	0				
	MEDICAID TOTAL	**137,243**	**136,407**				
Commercial: Self-Funded Employers	*In VHCURES*	97,151	97,151	9,874			VHCURES
	Not in VHCURES	85,000*	85,000				ASSR
	Self-Funded Sub-Total	***182,151***	***182,151***				-
Commercial: Fully Insured	*COA*	105,473	105,473	20,838			VHCURES
	No COA	2,593	0				VHCURES
	Not in VHCURES	3,000*	0				ASSR
	Fully-Insured Sub-Total	***111,066***	***105,473***				-
Commercial: Medicare Advantage	***Medicare Adv. Sub-Total***	***11,749***	***11,749***	0			VHCURES
	COMMERCIAL TOTAL	**304,966**	**299,373**	**30,712**			-
TRICARE	**TRICARE TOTAL**	**13,405**	**0**	**-**			TRICARE
FEHBP	**FEHBP TOTAL**	**14,594**	**0**	**-**			ASSR
Uninsured	**UNINSURED TOTAL**	**22,994***	**0**	**-**			Census Data
	ALL-PAYER TOTAL	**619,708**	**550,809**	**112,756**	**20%** *All-Payer*	**36%** *All-Payer*	

NOTES: **All data included in Table 3 are preliminary; final data collection and reconciliation for PY1 will occur in June 2019.** ASSR = Annual Statement Supplemental Report; CMMI = Center for Medicare and Medicaid Innovation; COA = Certificate of Authority from Vermont Department of Financial Regulation; FEHBP = Federal Employee Health Benefit Plan; VHCURES = Vermont Health Care Uniform Reporting and Evaluation System. *Counts of individuals who are members of self-funded and fully insured plans not submitting to VHCURES are estimates, as is the number of uninsured individuals in Vermont.

Strengths: Preliminary Scale Target Performance in Performance Year 1

Vermont is a national leader in designing and implementing a new way to deliver and pay for health care. Though preliminary analyses indicate that Vermont did not achieve Performance Year 1 scale targets, the four Scale Target ACO Initiatives listed above represent significant progress, particularly in light of the complexities of program launch and early implementation:

- *Medicare Next Generation ACO Program*: OCV is one of two Medicare Next Generation ACOs in the country that elected to receive an All-Inclusive Population Based Payment (AIPBP) from Medicare in 2018. This is a complex payment model which requires significant financial and operational readiness to successfully implement.
- *Vermont Medicaid Next Generation ACO Program*: The Department of Vermont Health Access (DVHA) was the first risk-based contract for OCV (starting in 2017, Performance Year 0), which uses a prospective payment model. From 2017-2018, Medicaid lives attributed to OCV increased by 45% (from 29,102 in 2017 to 42,342 in 2018) as the program expanded from four Health Service Areas (HSAs) to nine across the state. This gradual ramp-up allowed time for Vermont payers, providers, and the ACO to become familiar with the new payment design and to plan for implementation.
- *Commercial ACO Programs*: In 2018, Blue Cross Blue Shield launched its first risk-based contract for members of its Qualified Health Plans. UVMMC also added the state's first self-insured, employer-based ACO shared savings program. Each contract includes complex mechanisms for payment, attribution, and quality measurement, all of which require significant collaboration and testing to successfully operationalize.

Challenges to Achieving Scale Targets in Performance Year 1 and Beyond

- *Program launch and early implementation.* As described above, program launch and early implementation across payer programs requires significant operational and financial readiness for OCV, providers, payers, and government. A gradual ramp up within and across payer programs allows all partners to develop and test new processes.
- *Challenges associated with attribution methodologies.* The attribution methodologies used to link members of participating insurance plans with the ACO may exclude individuals who are newly insured, use few medical services, or whose insurance coverage changes during the Performance Year.
- *Challenges associated with scale calculation*. Vermont's scale denominator – defined by the All-Payer ACO Model Agreement – includes some insurance types and populations over which the State has limited regulatory control. For example, approximately 3 in 10 Vermonters are insured by federally-regulated self-funded employer plans. The inclusion of large federally-regulated populations in the All-Payer ACO denominator presents an outreach and engagement challenge. If Association Health Plans join Vermont's insurance market in future years and pull a significant number of Vermonters away from the state's Qualified Health Plan market, this could provide an additional challenge.

Opportunities for Increasing Model Scale in Performance Years 2-5

All-Payer ACO Model partners, including GMCB, the Agency of Human Services/Department of Vermont Health Access, OCV, and Vermont health care providers, are planning or considering actions that could increase scale performance in future years. These include:

- *Increasing provider participation in the Scale Target ACO Initiatives.* OCV is actively seeking willing health care providers who may be interested in joining the ACO in Performance Year 2 for some or all payer programs.
    - OCV focuses recruitment efforts at the HSA level, seeking to engage local hospitals, primary care practices, and other local providers (e.g., Home Health, Designated Agencies, Skilled Nursing Facilities, and specialists) simultaneously; in order for providers to join OCV's financial risk model, an HSA's "home" hospital must be willing and able to take financial risk for the HSA's ACO population.[4]
    - However, hospital participation alone cannot achieve scale targets. Because individuals are attributed to ACOs based on their primary care provider relationship, increasing primary care participation in the ACO network is critical. This includes engaging Federally Qualified Health Centers (FQHCs) and independent primary care practices, in addition to hospital-owned primary care practices. ACOs and payers have developed incentives for increasing primary care participation through payment enhancements, payment changes to increase provider flexibility, and policy changes to reduce administrative burden. These include a payment enhancement for primary care providers and other community organizations performing complex care coordination; a primary care capitation payment model, piloted with three independent primary care practices in 2018 to promising results; and a waiver of Medicaid prior authorization requirements for ACO providers working with ACO-attributed individuals.
    - There are several large health service areas and FQHCs who are not currently in the model but are considering 2019 participation. OCV's 2019 provider network will be finalized in September 2018. In addition, several hospitals entered OCV's risk-based model for Medicaid only in 2018, allowing their community time to ramp-up; several have indicated plans to increase their participation to additional payer programs in 2019.[5]
- *Potential for new contracts between OCV and payers*. OCV is discussing expanding its Scale Target ACO Initiatives with current and new payers, including commercial payers and large Vermont employers with self-funded plans. Engaging new commercial market segments (e.g., additional BCBSVT business beyond Qualified Health Plan participants; large self-funded employers like hospitals, Vermont's state employee and retiree health plans, or teacher health plans) could significantly increase All-Payer Scale Performance.
- *Technical changes to increase attribution*. DVHA is currently considering modifying attribution methodologies to include more patients in the model.

Appendix 1 summarizes Scale Target calculations and preliminary PY1 performance.

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[4] For more information, see OCV presentation to GMCB (Nov. 2, 2017): http://gmcboard.vermont.gov/sites/gmcb/files/files/meetings/presentations/OCV%202018%20Revised%20Budget%20Presentation%20GMCB%20110217.pdf.

[5] For more information, see OCV presentation to GMCB (April 11, 2018): http://gmcboard.vermont.gov/sites/gmcb/files/OneCare%202018%20GMCB%20Presentation%20-%204.11.18%20Final.pdf.

APM SCALE TARGET SUMMARY

ACO Scale is the percentage of Vermonters who are attributed to a Scale Target ACO Initiative.

ACO Scale Targets

The All-Payer ACO Model Agreement includes All-Payer and Medicare Scale Targets for each year.

	PY1 (2018)	PY2 (2019)	PY3 (2020)	PY4 (2021)	PY5 (2022)
All-Payer Scale Target	36%	50%	58%	62%	70%
Medicare Scale Target	60%	75%	79%	83%	90%

ACO Scale Targets are designed to ensure that a critical mass of Vermont's population is engaged in the All-Payer ACO Model – and hence, that providers can change their care delivery and business models to support value, not volume.

Calculating All-Payer Scale

$$\frac{\text{Vermont All-Payer Scale Target Beneficiaries Aligned to a Scale Target ACO Initiative}}{\text{Vermont All-Payer Scale Target Beneficiaries}}$$

- The Vermont All-Payer Scale Target denominator includes:
  - *Medicare*: All Vermont Medicare fee-for-service enrollees, including dual eligibles.
  - *Medicaid*: All Vermont Medicaid enrollees (excludes third-party coverage or limited benefit).
  - *Commercial*: All Vermont members of fully insured plans, self-funded employer plans, and Medicare Advantage plans (excludes members of Federal Employee Health Benefit Plans, TRICARE, and plans without a Certificate of Authority from Vermont Dept. of Financial Regulation; also excludes uninsured).

Calculating Medicare Scale

$$\frac{\text{Vermont Medicare Beneficiaries Aligned to a Scale Target ACO Initiative}}{\text{Vermont Medicare Beneficiaries (including dual eligibles, excluding Medicare Advantage)}}$$

Performance Year 1 (2018) – Preliminary Scale Performance

In PY1, four Scale Target ACO Initiatives operate through contracts between payers and OneCare Vermont: Medicare Next Generation ACO Program; Vermont Medicaid Next Generation ACO Program; BCBSVT Commercial Next Generation ACO Program; and UVM Medical Center Shared Savings ACO Program.

	PY1 Scale Targets	Preliminary PY1 Performance
All-Payer Scale	36%	20%
Medicare Scale	60%	35%

Notes on Preliminary Performance Year 1 Scale Performance

- Vermont did not achieve Medicare and All-Payer Scale Targets specified for PY1. However, the Scale Targets anticipate continued increases over the life of the program, with a more significant growth trajectory after PY1. Program launch is challenging and requires significant operational and financial readiness from the ACO, payers, and providers; a gradual ramp up from PY1 is expected and intentional. A corrective action plan is only triggered if scale targets are not met in two consecutive PYs.
- Preliminary PY1 performance reflects major improvements since PY0 (2017). This is the first year of implementation for the Medicare and BCBSVT Next Generation ACO programs and for the UVMMC Shared Savings ACO Program. The Vermont Medicaid Next Generation ACO Program, launched in 2017, increased in size by 45% from 2017-2018.
- Scale calculation and attribution methodologies make achieving targets challenging. In particular, the inclusion of federally-regulated self-funded employer plans and Medicare Advantage plans – which together cover nearly 1 in 3 Vermonters – in the All-Payer Scale denominator presents an outreach and engagement challenge.
- All-Payer ACO Model partners, including GMCB, the Agency of Human Services/Department of Vermont Health Access, OneCare Vermont, and Vermont health care providers, are planning and considering actions that would improve scale performance in future performance years. These include increasing provider participation in ACO initiatives, developing new payer-ACO contracts, and adjusting attribution methodologies.