Vermont All-Payer ACO Model
Annual ACO Scale Targets and Alignment Report
Performance Year 5 (2022)

Submitted September 15, 2023

Green Mountain Care Board

1. Executive Summary

On October 12, 2021, the Center for Medicare and Medicaid Innovation (CMMI) waived enforcement of Vermont All-Payer Accountable Care Organization Model ("All-Payer Model" or "APM") Agreement Scale Targets through the remainder of the current Agreement. The Waiver of Enforcement letter from CMMI to the State of Vermont states that the Scale Targets, as defined in the Vermont APM Agreement, are "unattainable for Vermont based on information not available when the State Agreement was drafted." Vermont continues to pursue increased participation in the model and will continue to report on progress. On March 31,2023, CMMI offered an extension of the current APM Agreement for up to two years, Vermont formally accepted the offer on May 26, 2023; this extension eliminates scale targets for the remainder of the Agreement period due to the concerns cited in the Waiver of Enforcement, though Vermont will continue to report on Model scale.

As required by the Vermont APM Agreement, the Annual ACO Scale Target and Alignment Report developed by the Green Mountain Care Board ("GMCB" or "Board") illustrates Vermont's progress toward achieving Scale Targets and alignment of ACO Scale Target Initiatives. Included in this report are quantitative and qualitative analyses of Vermont's progress in Performance Year 5 (PY5, 2022) as well as alternative measures that provide an opportunity to more thoroughly understand participation in the model.

Progress Toward Achieving Scale Targets

In PY5, five Scale Target ACO Initiatives operated through contracts between payers and OneCare Vermont: the Vermont Medicare ACO Initiative; the Vermont Medicaid Next Generation ACO Program; the BlueCross BlueShield of Vermont (BCBSVT) Commercial Next Generation ACO Program (Qualified Health Plan); the BlueCross BlueShield Primary Program (self-funded plans); and the MVP Qualified Health Plan program.

Performance Year 5 results reflect growth in attributed lives in both the Medicare (+16%) and Commercial (+10%) programs over 2020 program attribution. The attrition noted in 2021 Medicaid scale performance was due to a one year pause in ACO participation by several primary care practices that have since re-joined the ACO for the 2022 performance year.

Figure 1: Scale Qualifying Attributed Lives by Program to Date

Payer	2017 PY0	2018 PY1	2019 PY2	2020 PY3	2021 PY4	2022 PY5
Medicaid[1]	28,593	42,342	79,004	114,335	111,532	126,291
Medicare[2]	-	36,860	53,973	53,842	62,392	62,607
Commercial[3]	-	30,712	30,363	62,588	68,834	71,060

In PY5, Vermont achieved **62% Medicare Scale Performance** (target: 90%) and **50% All-Payer Scale Performance** (target: 70%). Vermont has previously described challenges to achieving scale, both in terms of engaging hard-to-reach payers and in how scale is measured, and in its October 2021 waiver of scale enforcement, CMMI has agreed that the targets are unattainable. The Vermont APM signatories will continue to work with the ACO and other partners to increase scale: the Board's work includes its ACO oversight and monitoring and other regulatory authorities, and the Governor's Administration and Agency of Human Services (AHS) outlined strategies in the APM Implementation Improvement Plan such as including State Employee Health Plan members for attribution to OneCare Vermont in PY5 and education and outreach efforts.[4] The GMCB will also

[1] Medicaid data are prospective and obtained directly from DVHA.
[2] Medicare data are prospective and obtained directly from CMMI.
[3] Commercial data are a combination of all participating programs and are obtained directly from OneCare Vermont.
[4] Implementation Improvement Plan: Vermont All-Payer Accountable Care Organization Model Agreement (November 19, 2020). Vermont Agency of Human Services.

monitor new payer programs as they are developed, ensuring that services remain in alignment and qualify as scale target initiatives.

Alternative Calculations to Scale Target

The GMCB has outlined three alternate measures to describe model participation in Vermont. These metrics diverge from the methodology established by the Agreement but aim to provide a fuller picture of Vermont's progress and the Model's statewide reach given the unattainability of the targets as originally set. There are different considerations for contextualizing All-Payer scale and Medicare scale. When considering the true effect of the model in Vermont's health care delivery system, alternative measures for scale should account for the regulatory leverage accessible by the state and reflect the influence on providers practicing in the state. Three alternative all-payer measures are presented in Section 4 to better assess the objective of statewide participation: adjusted scale, proportion of hospital revenue, and the proportion of providers participating in the APM. One alternative view of Medicare scale, reflecting the members eligible for attribution, is presented in Section 5.

Alternative Measure #1 – Adjusted Scale: The Adjusted Scale measure adjusts the scale denominator to better align with available data and the regulatory influence of the State. This calculation removes health plans which are outside the State's regulatory control, particularly self-funded groups without data available in VHCURES, and the Medicare Advantage populations from the calculation of the scale denominator. **This change in methodology brings the All-Payer achieved rate up to 58%**, still shy of the 70% target set forth in section 6.j.ii of the Agreement. This adjusted scale performance demonstrates that the scale targets are ambitious goals and that the state would have still fallen short in the five reported PYs despite these adjustments. However, the adjustment will continue to be a better reflection of the leverage available to the State and become even more material as beneficiaries increasingly opt to join Medicare Advantage plans.

Alternative Measure #2 – Proportion of Hospital Revenue: This alternative measure estimates all-payer prospective payments to hospitals compared with revenue in scope for APM risk-based arrangements. The aim for this measurement is to provide an estimate of APM penetration at Vermont's hospitals. The Proportion of Hospital Revenue measure estimates how this is changing over time and results differ by hospital. It is calculated through actual financial data submitted to the GMCB by hospitals. The calculation uses hospital discharge data to estimate the proportion of each hospital's net patient revenue that comes from Vermont residents, as Vermont residents are the population eligible for attribution in most ACO programs. Estimates are complete through PY4 (2021) due to delays in hospital discharge data availability for 2022. Completed estimates are anticipated in January 2024.

Alternative Measure #3 – Proportion of Providers Participating: This alternative measure is an estimation of the ACO's network compared with potential participants (licensed and active providers) statewide. Since Vermont residents may attribute to providers practicing out-of-state, this view provides a better gauge for the ACO network penetration in Vermont. The ACO provider network is comprised of primary care providers who can attribute (participants) and other providers within the network seeing patients but who cannot attribute patients to the ACO (preferred). There are two proportions for consideration: the proportion of all ACO network providers (participants and preferred) compared to all active and licensed providers in Vermont, and the proportion of ACO network attributing providers (participants) compared to all active and licensed primary care providers in Vermont. By using estimates derived from the Vermont Department of Health workforce survey data, the 3,896 providers listed in **the 2022 Vermont ACO network represent about 13% of all providers** active and licensed in the state (estimated to be 30,231 for 2022). Of providers estimated to be eligible to attribute patients to the model, **the ACO penetration rate appears to be 65%** (3,215 ACO providers of 4,976 eligible primary care practitioners statewide).

Alignment of Scale Target ACO Initiatives

The five Scale Target ACO Initiatives in 2022 were well aligned on most components. All initiatives used prospective primary care attribution methodologies, included services akin to Medicare Part A and B coverage, worked to use similar sets of quality measures, and included similar approaches to risk. While all payer attribution methodologies are prospective, in 2019 Medicaid piloted an expanded attribution methodology with the ACO in one health service area, St. Johnsbury. Because of the success of this pilot, Medicaid and the ACO continue to offer expanded attribution to their broader program statewide.

2. Introduction

The Vermont All-Payer Accountable Care Organization Model (All-Payer ACO Model 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 & Medicaid Services (CMS). The All-Payer ACO Model aims to reduce health care cost growth by moving away from fee-for-service reimbursement to risk-based arrangements for ACOs; these arrangements are tied to quality and health outcomes.

This report provides an annual update on the State's performance on the Vermont All-Payer and Medicare beneficiary participation targets (ACO Scale Targets) for Performance Years 1-5 and describes the alignment of key program components of the five Scale Target ACO Initiatives in 2020. This report is required by section 6.j of the APM Agreement, which provides as follows:

i. *"In accordance with section 6.f, the GMCB, in collaboration with AHS, shall submit to CMS for its approval, no later than June 30th of the year following the conclusion of each of the Performance Years 1 through 5, an assessment describing how the Scale Target ACO Initiatives' designs compare against each other on key design dimensions such as services included for determination of the ACO's Shared Losses and Shared Savings as described in section 6.b.iii, risk arrangement, payment mechanism, quality measures, and beneficiary alignment ("Annual ACO Scale Targets and Alignment Report"). This assessment must also describe how the Scale Target ACO Initiatives' designs are aligned across all payers, how they are different, the justification for differences that will remain, and a plan to bridge differences that should not remain."*

ii. *The GMCB shall submit to CMS for its approval, no later than June 30th of the year following the conclusion of each of the Performance Years 1 through 5, the State's performance on the ACO Scale Targets described in sections 6.a, 6.b, and 6.c."*

On October 12, 2021, CMMI waived enforcement of Vermont APM Agreement Scale Targets through the remainder of the current Agreement. The Waiver of Enforcement letter from CMMI to the State of Vermont states that the Scale Targets, as defined in the Vermont APM Agreement, are "unattainable for Vermont based on information not available when the State Agreement was drafted." Vermont continues to pursue increased scale and will continue to report on progress. On March 31,2023, CMMI offered an extension of the current APM Agreement for up to two years, Vermont formally accepted the offer on May 26, 2023; this extension eliminates scale targets for the remainder of the Agreement period due to the concerns cited in the Waiver of Enforcement, though Vermont will continue to report on Model scale.

3. Progress Toward Achieving Scale Targets

Relevant Language:

6.j.ii. "The GMCB shall submit to CMS for its approval, no later than June 30th of the year following the conclusion of each of the Performance Years 1 through 5, the State's performance on the ACO Scale Targets described in sections 6.a, 6.b, and 6.c."

Figure 2, below, shows progress toward achieving All-Payer and Medicare scale targets by performance year, as required by section 6.j.ii of the APM Agreement.

Figure 2: Progress Toward Achieving All-Payer and Medicare Scale Targets by Performance Year

		2018 PY1	2019 PY2	2020 PY3	2021 PY4	2022 PY5
Vermont All-Payer Scale Target Beneficiaries	*Target*	*36%*	*50%*	*58%*	*62%*	*70%*
	Actual	22%	32%	45%	49%	50%
	(Difference)	(-14%)	(-18%)	(-13%)	(-13%)	(-20%)
Vermont Medicare Beneficiaries	*Target*	*60%*	*75%*	*79%*	*83%*	*90%*
	Actual	34%	52%	47%	54%	62%
	(Difference)	(-26%)	(-23%)	(-32%)	(-29%)	(-28%)

Vermont did not achieve the Medicare and All-Payer Scale Targets for PY5, with both measures of scale staying relatively consistent. Sections 4-6 of this report further discuss the factors contributing to the successes and challenges in achieving scale. As previously discussed, in October 2021, CMMI agreed that the scale targets as written in the APM Agreement are unattainable and has waived enforcement of these targets.

3.1. Scale Results

In PY5, the population included for APM scale represents 80% of the entire Vermont population. In PY5, as in prior years, all ACO Scale Target Initiatives used prospective primary care attribution, meaning that additional lives could not be attributed once the PY started. As such, year-end attribution numbers will show a decrease (attrition) from January scale. This decrease is the result of life factors, such as death, change in insurance type, or loss in eligibility for a program. Medicare attrition is largely due to attributed beneficiary deaths throughout the PY.

Figure 3: 2022 Scale Targets and Vermont Population

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Payer	Sub-Category	Included in Denominator?	2022 Vermont Population	2022 Scale Denominator: APM Population	2022 Scale Denominator: % of All Vermonters	2022 Scale Numerator: Participating in Scale Target ACO Initiatives	2022 Scale Achieved
Medicare	*Parts A & B*	Yes	100,952	100,952	16%	62,607	62%
	Part A or B only	No	7,771				
	TOTAL		**108,723**	**100,952**	**16%**	**62,607**	**62%**
Medicaid	*Attributable - Comprehensive Primary coverage - Traditional attribution*	Yes	149,514	149,514	23%	95,727	64%
	Attributable - Comprehensive Primary coverage - Expanded attribution [1]	Yes (2020+)				30,564	20%
	Limited Coverage or Evidence of TPL	No	6,192				
	TOTAL		**155,706**	**149,514**	**23%**	**126,291**	**84%**
Commercial: Self-Funded Employers	*In VHCURES*	Yes	93,378	93,378	14%	33,246	22%
	Not in VHCURES		61,222	61,222	9%		
	TOTAL		**154,600**	**154,600**	**24%**	**33,246**	**22%**
Commercial: Fully Insured	*In VHCURES: COA (plus plans with <200 lives from ASSR)*	Yes	87,766	87,766	14%	37,814	**43%**
	In VHCURES: No COA	No	7,060				
	TOTAL		**94,826**	**87,766**	**14%**	**37,814**	**43%**
No primary comprehensive coverage in VHCURES [2]		No	**41,165**				
Commercial: Medicare Advantage	**TOTAL**	Yes	**41,829**	**25,178**	**4%**	**0**	**0%**
TRICARE	**TOTAL**	No	**14,738**				
FEHBP	**TOTAL**	No	**14,616**				
Uninsured	**TOTAL**	No	**19,367**				
	GRAND TOTAL		**645,570**	**518,010**	**80%**	**259,958**	**50%**
	US Census		**645,570**				

[1] The 2021 Scale Target numerator is the first year to display Medicaid members assigned to the ACO via expanded attribution.

[2] VHCURES reflects a substantial 2021 increase in member with no primary comprehensive coveragedue to the recent addition of members with dental coverage. Because many dental enrollees are likely duplicative of members in other categories, we removed 82,316 dental enrollees from the 'No primary comprehensive coverage' category.

COA = Certificate of Authority from VT Department of Financial Regulation; ASSR = Annual Statement Supplemental Report; VHHIS = VT Household Health Insurance Survey

4. Alternative All-Payer Scale Calculations

The following analyses (Sections 4.1-5) aim to show an alternative picture of scale progress in Vermont. There are different considerations for contextualizing All-Payer scale and Medicare scale. When assessing the true effect of the model in Vermont's health care delivery system, alternative measures for scale should account for data available to the State of Vermont as well as the State's regulatory influence and reflect the influence on providers practicing in the state. Three alternative measures are presented that meet these criteria for All-Payer scale (Figure 4), and one for Medicare Scale (Figure 7).

Figure 4: Summary of Alternative All-Payer Scale Measures

Alternative Measure	Measure Description	Rationale
Adjusted Scale	Removes self-funded groups without data available in VHCURES and the Medicare Advantage populations from scale target denominator calculation	Adjusts the scale target calculation to better reflect data available to the State of Vermont as well as the State's regulatory influence
Proportion of Hospital Revenue	Estimates proportion of prospective payments to hospitals compared with hospital revenue in scope for APM risk-based arrangements	Estimates APM penetration at Vermont's hospitals
Proportion of Providers Participating in the APM	Compares ACO's network with potential participants (licensed and active providers) statewide	Provides a better gauge for the ACO network penetration in Vermont since Vermont residents may attribute to providers practicing out-of-state

4.1. Adjusted Scale

Adjusted Scale removes populations for which the State has no data or has no authority to regulate, particularly self-funded employer plans and Medicare Advantage plans. Figure 5 models removing these groups from the scale denominator to show progress towards Scale goals where the State has data and/or regulatory influence.

Medicare Advantage plans are administered by private insurers in partnership with the federal government. The program uses capitated payments from Medicare and includes care management to manage enrollee benefits. This program is more challenging to incorporate into Vermont's ACO model and to do so would likely require active assistance from CMS. As an increasing number of Medicare beneficiaries in Vermont opt for Medicare Advantage plans, the impact on scale becomes broader. Additionally, there have been submitter-end VHCURES reporting challenges that don't allow for an accurate picture of the full Medicare Advantage population, again limiting the data available to the State. We see this reflected in Figure 3, which shows that only about 60% of Medicare Advantage beneficiaries are currently captured in VHCURES.

Self-funded groups, no longer required to report data to VHCURES after the *Gobeille v. Liberty Mutual* decision, remain an extremely elusive population. Under the Employee Retirement Income Security Act of 1974 (ERISA), the State has no authority to regulate non-governmental self-funded groups. However, the State only has estimated data about the total size of this population. The State's Adjusted Scale measure excludes the estimated population belonging to self-funded groups who do not report to Vermont's all-payer claims database

(VHCURES); self-insured groups who continue to report data to VHCURES remain in the denominator. Outreach efforts to this population are substantially compromised by the limited information available.

Figure 5: Adjusted Scale Denominator

	2018 PY1	2019 PY2	2020 PY3	2021 PY4	2022 PY5
All-Payer Scale Denominator	550,806	526,723	515,533	530,469	518,010
Medicare Advantage	*11,749*	*17,745*	*19,924*	*27,640*	*25,178*[5]
Self-Funded Lives Not in VHCURES	*85,000*	*75,000*	*68,091*	*65,251*	*61,222*
Adjusted Denominator	**454,060**	**433,978**	**427,518**	**437,578**	***431,610***
Adjusted All-Payer Scale Performance	**25%**	**37%**	**54%**	**55%**	**60%**
Difference from All-Payer Scale Target	*-11%*	*-13%*	*-4%*	*-7%*	-10%
Difference from Non-Adjusted Scale Performance	*+3%*	*+16%*	*+9%*	*+9%*	+10%

This change in measurement using Adjusted Scale results in a 10% increase in scale performance, bringing the achieved rate up to 60%. This Adjusted Scale performance demonstrates that the scale targets are ambitious goals and that the State would have still fallen short for all reported PYs even with these adjustments. Still, the adjustment will continue to be a better reflection of the leverage available to the State and be more material as more beneficiaries join Medicare Advantage plans.

4.2. Proportion of Hospital Revenue

The All-Payer Model is premised on the idea that providers will alter behavior based on payment incentives. In Vermont's APM, the hospitals operating in the state are taking on most of the risk. One method to measure how much the model is penetrating the delivery system is to measure how much hospital revenue is shifting from traditional fee-for-service (FFS) reimbursement to value-based arrangements across all payers.

One important note is that the APM alone does not include any mandates associated with having fixed prospective payment (FPP). Further, there are no fixed payments occurring directly from payers to hospitals in the ACO's model. The ACO entity, OneCare, receives lump payments from participating payers and distributes them to hospitals. The methods of determining performance and reconciling the financial risk under these contracts are managed by the ACO.

The Proportion of Hospital Revenue measure estimates how this is changing over time and differs by hospital. It is calculated through actual financial data submitted to the GMCB by hospitals.

[5] CMS data estimates 41,829 Medicare Advantage beneficiaries in Vermont in 2022. However, due to challenges collecting Medicare Advantage data, VHCURES only includes 25,178 MA beneficiaries in 2022. This is an additional challenge for Scale.

$$\text{Proportion of Hospital Revenue} = \frac{\text{Prospective payments + Other reform payments}}{\text{Prospective payments + Other reform payments + Net Patient Revenue (estimated share from VT residents)}}$$[6]

The calculation uses hospital discharge data to estimate the proportion of hospitals' net patient revenue that comes from Vermont residents, as Vermont residents are the population eligible for attribution in most ACO programs. Any prospective payments made to hospitals at this time represent provider-based risk and therefore represent material changes to the way hospitals are reimbursed for care. Notably, all-payer prospective payments and other reform payments are a subset of total dollars at risk for cost and quality through total cost of care targets included ACO payer programs.

As summarized in Figure 6, all-payer prospective revenue steadily grew from 2017 (2% of system revenue in the year piloted by DVHA) to 15.4% in 2021, with a peak shown in 2020. Of note PY4 includes an estimated $340 Million in COVID relief funds. Estimates in Figure 6 are complete through PY4 (2021) due to delays in hospital discharge data availability for 2022. Completed estimates and an updated report are anticipated in January 2024.

Figure 6: Systemwide Proportion of All-Payer Prospective Hospital Revenue from Vermont Residents[7]

	2017 (PY0)	2018 (PY1)	2019 (PY2)	2020 (PY3)	2021 (PY5)	2022 (PY5)
Total Revenue	$2,378,721,942	$2,511,925,956	$2,571,060,326	$2,393,616,068	$2,821,452,357	*Not Yet Available*
Estimated VT Resident Revenue	$2,067,602,136	$2,146,086,206	$2,205,578,491	$2,065,917,715	$2,417,831,059	*Not Yet Available*
Prospective Payments + Other Reform Payments	$43,510,957	$230,974,869	$308,716,669	$358,829,804	$372,972,156	*Not Yet Available*
Proportion of Revenue	**2.1%**	**10.8%**	**14.0%**	**17.4%**	**15.4%**	*Not Yet Available*

Vermont hospitals have stated that the challenges of pandemic response and related financial uncertainty have been barriers to returning to pre-pandemic risk levels in their payer contracts. Moving forward, Vermont hopes to continue to partner with CMMI to identify areas where joint state-federal efforts can further shift hospital revenue from traditional fee-for-service reimbursement to value-based arrangements.

4.3. Proportion of Providers Participating in the APM

The third alternative measure of all-payer scale performance is the Proportion of Providers Participating in the APM measure that compares the ACO network to all providers practicing in the state. Section 6.i. of the Agreement states that *"CMS and Vermont expect that the majority of providers and suppliers operating in Vermont and participating in Vermont ACOs will chose to participate in a VMA ACO or a Vermont Modified Next Generation ACO."* The ACO provider network is comprised of primary care providers who can attribute ("participants") and other providers within the network seeing patients but who cannot attribute patients to the

[6] Other reform payments include SASH, Blueprint for Health, and Community Health Team payments.
[7] Totals exclude Springfield Hospital for all years due to missing information for 2017-2019.

ACO ("preferred"). There are two proportions for consideration: the proportion of all ACO network providers (participants and preferred) compared to all active and licensed providers in Vermont; and the proportion of ACO network attributing providers (participants) compared to all active and licensed primary care providers in Vermont. The most challenging aspect of these measures is estimating the numbers of active and licensed providers practicing in Vermont who might be eligible to participate in the model.

In 2022, the ACO network had 3,896 providers in Vermont.[8] By using estimates derived from Vermont Department of Health (VDH) workforce survey data, the providers listed in the 2022 ACO network represent about 13% of all providers active and licensed in the state (estimated to be 30,231 for 2022). Of providers estimated to be eligible to attribute patients to the model, the ACO participation rate appears to be 65% (3,215 ACO providers of 4,976 eligible primary care practitioners statewide). Because our measures represent Vermont residents cared for by Vermont providers, we do not include Dartmouth-Hitchcock providers in the ACO network counts. This adjusted scale measure uses licensure data derived from the Vermont Department of Health workforce survey which measures the number of *individual* providers, not provider practices or organizations. Also of note, the ACO network (numerator) grew steadily over the five years of the Agreement while the total active and licensed provider population (denominator) estimates varied significantly between 2018-2022. This was due to the PHE pausing health administration activities which includes conducting these provider surveys. For that reason, the proportion of ACO penetration varies over time between reports but not due to any decreases in ACO network or provider engagement.

5. Alternative Medicare Scale Calculations

When considering scale related to Medicare beneficiaries, the program's attribution methodology is the most relevant factor. There are two key considerations for accurately measuring Medicare scale as currently defined: limiting to the population that meets attribution criteria and estimating beneficiaries who attribute to providers practicing out of state.

Program Exclusions: In 2022, under Medicare's current attribution methodology for the Vermont Medicare ACO Initiative, approximately 7% of Vermont Medicare beneficiaries were not eligible for attribution to the ACO program due to exclusions.

Figure 7: Vermont Medicare Beneficiaries Eligible for Attribution to ACO

	2019 (PY2)	2020 (PY3)	2021 (PY4)	2022 (PY5)
VT Medicare Scale Target Beneficiaries	113,743	115,496	116,270	100,952
Subpopulation Eligible for Attribution	93,871	93,550	89,894	93,940
Difference	*-18,972*	*-21,946*	*-26,376*	*-7,012*
Scale Performance for Eligible Beneficiaries	**57%**	**58%**	**69%**	**67%**
Difference from Medicare Scale Target	*-18%*	*-21%*	*-14%*	*-23%*

[8] The full ACO network includes DHMC and affiliated providers, for a total of 5,109 providers overall (participating and preferred) and 4,428 primary care providers (participating).

Adjusting the denominator to reflect Medicare beneficiaries eligible for attribution improves scale performance, though it still falls below targets.

Vermont Medicare Beneficiaries whose Primary Care Relationships are with Out-of-State Providers: GMCB attempted to model this issue in the past and found that around 20,000 Vermont Medicare beneficiaries would have attributed to an out-of-state provider and that if every Vermont provider were participating in the ACO, only 75,000 beneficiaries statewide would attribute to the model.[9] However, GMCB has since learned that replicating the attribution algorithm is a known challenge and is working with CMMI to better model the maximum attribution realized if all Vermont providers were participating.

Medicare scale should ideally reflect the population eligible for attribution. If scale were measured for beneficiaries eligible for attribution and who have primary care relationships with Vermont providers, the State's Medicare scale performance could potentially improve dramatically and better reflect the factors within the State's control.

6. Factors Influencing Progress Toward Scale Targets

As discussed in previous sections of this report, there are several factors which contribute to achieving scale. Alignment to a Scale Target ACO Initiative is contingent on provider participation, specifically primary care providers participating in the ACO network; the payers engaging in agreements with the ACO; and the methodology used for attribution. Each of these factors is discussed below.

6.1. Provider Network

The ACO provider network did not change drastically from PY4 to PY5. The ACO continues to pursue independent practice participation through its Comprehensive Payment Reform (CPR) program, though this avenue will yield minimal increased attribution with each additional practice.

Barriers to expanding the Medicare ACO provider network include that Medicare ACO participation presents significant risk, particularly to the state's smaller, rural hospitals where risk may be greater than or equal to total operating margin. In service areas where the hospital and FQHC are not jointly owned, there can be additional challenges in garnering cooperation between these entities and distributing risk. In addition, the inclusion of funding for the Blueprint for Health and Support and Services at Home (SASH) program in the Medicare ACO benchmark, paid as Advanced Shared Savings, is perceived by providers to limit the potential for providers to earn shared savings through participation. Because risk and potential for savings are currently low (bidirectional 2% in 2022), if savings are earned most would go to recouping the Advanced Shared Savings amount.

6.2. Payer Participation

The APM is premised on the inclusion of the major payers present in Vermont. In addition to Medicaid and Medicare, Vermont has three major commercial insurance payers: BCBSVT, MVP, and Cigna. BCBSVT and MVP offer plans in both the merged individual and small group market and the large group market (markets were unmerged beginning in plan year 2022). Cigna is only present in the large group market. In addition, all three payers offer third-party administration to self-insured employers along with Aetna, among others. As shown in Figure 3 above, Vermont has a robust self-insured market and small membership in several federal sources of coverage, including Medicare Advantage plans, though Medicare Advantage enrollment is quickly growing. The GMCB will continue to explore new strategies to attract these plan types into the Model. Medicare, Medicaid,

[9] Vermont All-Payer ACO Model Annual Scale Targets and Alignment Report Performance Year One (2018).

and commercial payers have been represented in the five performance years. Both the payers and ACO have been able to draw on their experiences in the Medicare, Vermont Medicaid, and Vermont commercial shared savings programs (SSPs) from 2014-2016/2017 to help ease the transition to the APM.

Challenges to payer participation include that Vermont is preempted by federal law from influencing self-funded employer groups' choices regarding health insurance, including submission of plan data to the state's all-payer claims database. Furthermore, engaging hundreds of employers individually would be difficult for an ACO to undertake without unsustainably growing administrative personnel.

Of note, effective February 2023, Blue Cross and Blue Shield of Vermont withdrew the remaining voluntarily submitted self-funded lives from VHCURES. Although this did not impact the first five years of the Agreement, this withdrawal resulted in an estimated 8,000 beneficiaries' data lost, approximately 10% reduction to the already incomplete self-funded population in VHCURES. This further demonstrates that without significant administrative investment or federal change, the self-funded data loss will continue to pose measurement challenges for multi-payer population-level reform initiatives.

Figure 8: Total Commercial Self-Funded Population in VHCURES, PY1 through Extension Year 1.

	2018 PY1	2019 PY2	2020 PY3	2021 PY4	2022 PY5	*2023 PY6*
Population in VHCURES	96,996	96,794	97,340	93,906	93,378	*85,320*
% Change over PY1		-.02%	-0.4%	-3.2%	-3.7%	*-12.0%*

6.3. Attribution Methodology

Attribution methodology influences which Vermont patients are eligible to become attributed to the ACO, driven by the patients' relationships with primary care providers. Despite the apparent simplicity of this exercise, many Vermont patients may not attribute to the ACO due to a lack of primary care utilization, receiving care from non-qualifying specialists, or seeking most of their primary care outside of Vermont. Some of these factors are outside the control of the State and ACO, necessitating some potential refinements to attribution methodologies. Successes include refinements and improvements to attribution methodology through the Vermont Medicaid Next Generation ACO Program and through the work DVHA continues to implement, including an expanded attribution methodology (Figure 8, below). The goal of expanded attribution is to support a whole-population (panel) approach to OneCare's Care Management Model to help account for some of the challenges presented by standard attribution methodologies.

Figure 9: Medicaid Traditional and Expanded Attribution Over Time

	2017 PY0	2018 PY1	2019 PY2	2020 PY3	2021 PY4	2022 PY5
Traditional	28,593	42,342	79,004	85,937	83,685	95,727
Expanded	-	-	-	28,398	27,847	30,564
TOTAL	28,593	42,342	79,004	114,335	111,532	126,291

Challenges include that ACO attribution is provider-driven and that there can be a disconnect between where people live (i.e., Vermont residents) and where they seek care (i.e., provider locations). The GMCB and CMS continue to discuss these challenges as they pertain to the Medicare program, since the initial analyses suggest

that achieving scale for Medicare may be impossible due to the attribution design. Analyses for the Medicaid population yielded similar findings, which is part of the reason DVHA is utilizing alternate attribution techniques.

7. Scale Target ACO Initiative Designs

The APM Agreement is premised on the assumption that alignment between payer programs is desirable because it will create more robust provider incentives to change care delivery and ease provider administrative burden. This is reflected in section 6.f of the Agreement, which requires Vermont to ensure that Scale Target ACO Initiatives reasonably align in their design (e.g., beneficiary alignment methodology, ACO quality measures, payment mechanisms, risk arrangements, and services included) with the Vermont Modified Next Generation ACO in PY1 and with the Vermont Medicare ACO Initiative in subsequent performance years. As noted above, the Agreement requires Vermont to submit an 'Annual ACO Scale Targets and Alignment Report' beginning in 2019, for Performance Years 1-5. This section provides a comparison, using definitions from the Agreement, of what elements are incorporated in OneCare Vermont's 2021 Scale Target ACO Initiatives. Reasonable alignment does not require uniformity and allows for some variation among payer programs to reflect legitimate differences, such as those due to different populations (e.g., the elderly versus children).

Figure 9 below provides examples of relevant programmatic information on key design dimensions of the Medicare Next Generation ACO Initiative, the Medicaid Next Generation ACO Initiative, the Commercial Next Generation ACO Program Agreement between BCBSVT and OneCare, the Primary Population-Based ACO Program Agreement between BCBSVT and OneCare, and the Commercial Next Generation ACO Program Agreement between MVP Health and OneCare. Following the table is an analysis of these key features.

Relevant language:

> *6.f "Vermont shall ensure that Scale Target ACO Initiatives offered by Vermont Medicaid, Vermont Commercial Plans, and participating Vermont Self-insured Plans reasonably align in their design (e.g., beneficiary alignment methodology, ACO quality measures, payment mechanisms, risk arrangements, and services included for determination of the ACO's Shared Losses and Shared Savings as described in section 6.b.iii) with the Vermont Modified Next Generation ACO in Performance Year 1 and with the Vermont Medicare ACO Initiative in Performance Years 2 through 5."*

> *6.j.i "In accordance with section 6.f, the GMCB, in collaboration with AHS, shall submit to CMS for its approval, no later than June 30th of the year following the conclusion of each of the Performance Years 1 through 5, an assessment describing how the Scale Target ACO Initiatives' designs compare against each other on key design dimensions such as services included for determination of the ACO's Shared Losses and Shared Savings as described in section 6.b.iii, risk arrangement, payment mechanism, quality measures, and beneficiary alignment ("Annual ACO Scale Targets and Alignment Report"). This assessment must also describe how the Scale Target ACO Initiatives' designs are aligned across all payers, how they are different, the justification for differences that will remain, and a plan to bridge differences that should not remain."*

Figure 10: Crosswalk: Key Design Features of 2022 Scale Target ACO Initiatives

	Medicare Next Generation ACO	Vermont Medicaid Next Generation ACO	BCBSVT (QHP)	BCBSVT (Primary)	MVP (QHP)
Services Included for Shared Savings/Losses ***See Appendix A for crosswalk of TCOC services***	Parts A & B services for aligned beneficiaries	Generally, A & B services. Exceptions: 1. Pharmacy 2. Nursing facility care 3. Psychiatric treatment in a state psychiatric hospital 4. Level 1 inpatient psychiatric stays (as defined in the Department of Mental Health's Designated Hospitals Manual and Standards) in any hospital when paid for by DVHA 5. Services provided by the Brattleboro Retreat 6. Dental services billed on professional claims 7. Non-emergency transportation (ambulance transportation is not part of this category) 8. Smoking cessation services 9. Services provided by Designated Agencies (DAs) and Specialized Service Agencies (SSAs)	Generally, A & B services. Exceptions: 1. Services carved out from primary insurer	Generally, A & B services. Exceptions: 1. Services carved out from primary insurer	Generally, A & B services. Exceptions: 1. Services carved out from primary insurer

	Medicare Next Generation ACO	Vermont Medicaid Next Generation ACO	BCBSVT (QHP)	BCBSVT (Primary)	MVP (QHP)
		10. Graduate Medical Education (GME) payments 11. Electronic Health Record (EHR) incentive payments 12. Disproportionate Share Hospital (DSH) payments			
Risk Arrangement	Two-sided risk arrangement, no minimum savings or loss rate. 2% TCOC risk corridor, 100% share. No payer-provided reinsurance, no risk adjustment (aside from separate ESRD Benchmark).	Two-sided risk arrangement, no minimum savings or loss rate. Truncation of total claims during PY of $200,000 or $100,000 per member depending on member's eligibility group, no payer-provided reinsurance, no risk adjustments. Traditional Attribution: 2% TCOC risk corridor, 100% share. Expanded Attribution: 1% TCOC risk corridor, 100% share.	[redacted]	[redacted]	[redacted]
Payment Mechanism from Payer to ACO	AIPBP for eligible participants (e.g. hospitals), FFS for non-eligible	Value-Based Care Payments, which include FPP, administrative fee based on attribution cohort, and population health	FFS	FFS	FFS

	Medicare Next Generation ACO	Vermont Medicaid Next Generation ACO	BCBSVT (QHP)	BCBSVT (Primary)	MVP (QHP)
		investment; FFS for non-participating			
Quality Measures ***See Appendix C for 2022 measure crosswalk***	Financial arrangement tied to quality of care for health of aligned beneficiaries. 2020 utilized a pay-for-reporting and pay-for-performance approach. Quality measures were selected through stakeholder process and accepted by CMMI in 2018. Majority of the measures now align with the APM Agreement.	Financial arrangement tied to quality of care for the health of aligned beneficiaries. Utilizes Value-Based Incentive Fund (VBIF). Majority of the quality measure align with the APM Agreement.	Financial arrangement tied to quality of care or the health of aligned beneficiaries. Subset of the APM Agreement; Overlaps with Medicaid.	Financial arrangement tied to quality of care or the health of aligned beneficiaries. Subset of the APM Agreement; Overlaps with Medicaid.	Financial arrangement tied to quality of care or health of aligned beneficiaries. Quality score determines share of savings ACO may be eligible for. Subset of the APM Agreement; Overlaps with Medicaid.
Beneficiary Alignment	Prospective attribution, claims-based evaluation	1) Traditional Attribution: Prospective attribution, claims-based evaluation 2) Expanded Attribution: Prospective attribution, includes Medicaid beneficiaries with no claims paid during attribution period and no other insurance	Prospective attribution, if health plan requires PCP selection, patient is attributed to selected PCP, otherwise claims-based evaluation to determine primary care relationship.	Prospective attribution, if health plan requires PCP selection, patient is attributed to selected PCP, otherwise claims-based evaluation to determine primary care relationship.	Prospective attribution, claims-based evaluation.

7.1. Areas of Difference Between Scale Target ACO Initiative Designs

The 2022 Scale Target ACO Initiatives continue to be reasonably aligned across participating payers. As noted above, uniformity is not required and some variation is permitted among payer programs to reflect legitimate differences, such as those due to different populations (e.g., older adults versus children). This section highlights the differences between the key design features described above and indicates where these differences are justified and where additional work is needed.

Services Included for Shared Savings/Losses

The services included for shared savings and losses in PY5 were reasonably aligned across payers and largely aligned with the APM Total Cost of Care.

Justification:

The Agreement does not require that each payer program include only the same services as the TCOC, recognizing that each payer covers different populations with different medical needs.

Monitoring:

The GMCB will continue to monitor any changes to ensure that services remain reasonably aligned and will review any new payer programs as they are developed. It should be noted that the State does not have the legal authority to require self-insured employers to accept alignment of their ACO program design due to the constraints under ERISA.

Risk Arrangements

The risk arrangements are reasonably aligned across payers in PY5. Medicare, Medicaid, and BCBSVT each offered a two-sided risk-based initiative. The variation among these programs was the risk corridor and how the savings were split between the ACO and the payer. BCBSVT decreased the risk sharing percentage from 100% in PY2 to [redacted] in PYs 3-5, which differs from the Medicaid and Medicare 100% risk sharing.

Justification:

Medicaid Next Generation Personal Services Agreement: The smaller risk corridor (2%) reflects the Medicaid population, which includes the most vulnerable Vermonters with poor social determinants of health. The 2% corridor provided value to the Medicaid program, provided sufficient incentives for providers, and reflected the financial risk associated with this population. Risk is two-sided with a 100% share.

Medicare ACO Initiative: In PY5, the Medicare cohort was contracted at 2% risk, in a two-sided arrangement with a 100% share.

BCBSVT: A [redacted] sharing arrangement ensures that [redacted] any PY5 savings are returned to the carrier to increase the affordability of coverage [redacted]. The ACO and payer state that this arrangement provided value to the carrier and its customers while also ensuring that the provider network has a financial incentive to contain costs; that said, [redacted]

MVP: A [redacted] sharing arrangement ensures that [redacted] any PY5 savings are returned to the carrier to increase the affordability of coverage [redacted] This arrangement provided value to the carrier and its customers while also ensuring that the provider network has a financial incentive to contain costs.

Monitoring:

GMCB will continue to monitor any changes to ensure that risk arrangements remain reasonably aligned and will review any new payer programs as they are developed. It should be noted that the State will not have the authority to require self-insured employers to accept alignment with the APM.

Payment Mechanism from Payer to ACO

The payment mechanisms are reasonably aligned for the public payers, but the commercial sector remained fee-for-service (FFS). In 2022, the Medicare and Medicaid contracts continued to offer an All-Inclusive AIPBP, or Value-Based Care Payment in the case of Medicaid, to the ACO, which represents fixed payments to certain providers who selected that payment mechanism. This allowed providers, at the TIN level, to select a 100% fee reduction on claims in exchange for a fixed payment. Each of the Commercial plans remained FFS.

Justification:

Commercial plans remained FFS during the COVID-19 pandemic, which continued into 2022.

Monitoring:

GMCB will continue to monitor progress through review of payer contracts and ACO updates.

Quality Measure Alignment

As seen in Appendix C, PY5 quality measures differ across payers in terms of the number of measures required, and include differences in measured population (e.g. older adults versus children) but do not substantially differ in substance from those measures included in the All-Payer ACO Model Agreement (Appendix 1 – Statewide Health Outcomes and Quality of Care Targets). Throughout 2018, the GMCB, OneCare and the Health Care Advocate worked to create a measure set that aligned with the All-Payer ACO Model Agreement, per the Vermont Medicare ACO Initiative[10] to begin in 2019 and run through the duration of the Model, to include any extension years. This resulted in a reduction in the total Medicare measures and allowed for better alignment with other ACO programs operating in Vermont.

Justification:

Current variation is appropriate, given the differing populations served and the clinical priorities of each payer.

Monitoring:

The GMCB will continue to monitor the quality programs to ensure that they remain in alignment and will review quality measures of any new payer programs as they are developed. It should be noted that the State will not have the authority to require self-insured employers to accept quality measures in alignment with the APM.

Beneficiary Alignment/Attribution

Attribution is primarily based on a member's primary care relationship with a provider participating in the ACO network. The Attribution Element Table found below (Figure 11, following page) compares the following four categories by payer: provider types, look-back period, qualifying claims, and alignment based on selection of PCP. As was discussed in previous sections of this report, the state may want to consider changes to attribution in the future to improve scale performance. At this time, the program variation is acceptable and justifiable given the issues raised earlier.

[10] Vermont All-Payer Accountable Care Organization Agreement: Section 8.

Figure 11: Attribution Elements

Attribution Element	Medicare	Medicaid	BCBSVT (QHP)	BCBSVT (Primary)	MVP
Provider Types	Primary Care and select specialists	Primary Care or Expanded Attribution	Primary Care	Primary Care	Primary Care
Look-Back Period	24 months (ending 6 months from beginning of PY)	33 months (more recent months weighted more heavily; ending 2 months from beginning of PY)	Most recent 30 months	Most recent 30 months	Most recent 24 months
Qualifying Claims (and tie breakers)	Greatest number of weighted claims (most recent visit)	Greatest number of weighted claims (most recent visit)	Greatest number of claims (most recent visit)	Greatest number of claims (most recent visit)	Greatest number of claims (most recent visit)
Alignment Based on Selection of PCP	No	No	Yes	Yes	No

Justification:

The Medicaid and Medicare attribution are largely aligned; the Medicaid attribution was intentionally built from the Medicare attribution model. Of note, for 'Provider Types', Medicaid only allows primary care providers to attribute while Medicare includes select specialists. This variation is appropriate, as some Medicare beneficiaries receive the majority of their care from a specialist, which differs from the Medicaid program. The 'Look-Back period' and 'Qualifying claims' largely align among all five payers. In the 'Alignment based on selection of PCP', neither Medicare nor Medicaid require the selection of PCP, while two of the three Commercial plans participating in the current program do require PCP selection. This variation is also appropriate, as it is inherent in the way the programs are designed.

Monitoring:

The GMCB will continue to monitor the attribution alignment and progress towards Scale Targets with the addition of expanded attribution in the Medicaid population.

8. Conclusion and Lessons Learned to Date

Throughout the initial term of the Agreement, model targets provided opportunities for the state to study and improve its healthcare provider network and to understand important aspects of insurance market dynamics. In the prior four reports, we have discussed successes and challenges with the Scale targets and measurement methodology in each year. In this fifth report, completing the initial term of the Agreement, we offer conclusions and lessons learned from PYs 1-5. Notwithstanding the PHE in PYs 3-5, and waiver of targets in PY4, Vermont has continued to monitor scale progress while compiling lessons learned for future models: population alignment, primary care prospective attribution model, and self-funded data loss.

8.1. Scale Population versus TCOC Population

Using different populations for each of the three APM goals made interpreting results together or holistically more difficult. The APM agreement included three separate, related goals each with their own respective measures:

- **financial targets, measured by all-payer and Medicare total cost of care**
- **population scale targets, measured by all-payer and Medicare's percent of each payers' eligible beneficiaries aligned to the ACO**
- **quality of care targets, measured by a collection of statewide and ACO-attributed population(s)[11]**

When framing the results for TCOC per beneficiary per month (PBPM) or per beneficiary per year (PBPY) over time, it is important to understand the total insured, APM-eligible, and ACO-aligned populations. Differences in populations across these measures made it difficult to understand population and cost dynamics together. Some notable differences between the scale target populations and the TCOC populations are included in the chart below.

Figure 12: Comparing criteria for TCOC and Scale

	Total Cost of Care (TCOC) Criteria	Scale Criteria
Attribution	Does not limit to provider groups or attributions beyond payer attribution	Requires contact with a primary care provider or ACO-attributing provider in the prior lookback period
ACO-alignment	Not limited to ACO-alignment, includes both ACO-aligned and non-ACO-aligned	ACO-aligned and participating in Scale Target initiatives
Geography	All payments to providers regardless of location so long as the services align with Medicare Part A and B but the members are required to be Vermont residents based on zip code	ACO-aligned Vermonters regardless of where their providers are, so the beneficiaries could be non-residents and getting care out of state
Lookback Period	Member months for the current PY, always delayed because of runout	Prospective estimate as of January of the PY and based on historical utilization (see Attribution)
Dual Eligible	Excludes in PYs 1-3, then includes Duals as Medicaid-primary for Long-Term Care calculations in PY4 and PY5	Includes as Medicare, excludes from Medicaid
Medicare Advantage	Includes Medicare Advantage in Commercial	Includes Medicare Advantage in Commercial, if participated.
Self-funded	Excludes self-funded not in VHCURES	Excludes self-funded not in VHCURES

Below is a table demonstrating the two populations, Scale and TCOC, for all five years of the agreement. We can see these populations are not only contextually different, but the numbers vary widely. There had been hope that by bringing together scale targets, financial targets, and other targets such as quality, Vermont could focus

[11] With respect to quality measures, it is appropriate that different measures have different populations. For example, the beneficiary population for the adolescent well-care visit measure is necessarily different from the population for controlled HbA1c, and neither could be measured against the whole population of Vermont beneficiaries.

on these holistically. But these differences have made interpreting insurance market, state regulatory authority, and financial dynamics more challenging for policymakers.

Figure 13: Scale population versus TCOC population, PY1-5

		PY1 (2018)	PY2 (2019)	PY3 (2020)	PY4 (2021)	PY5 (2022) Preliminary
Medicaid	*Scale•*	42,342	79,004	114,355	111,532	126,291
	TCOC°	134,234	126,867	131,818	151,343*	156,087*
Medicare	*Scale*	39,072	58,782	53,842	62,392	62,607
	TCOC	122,530	123,223	123,941	124,748	125,321
Commercial	*Scale*	30,712	30,363	72,588	67,850	71,060
	TCOC	202,786	205,519	205,873	201,718	205,697

• Scale is defined as the population eligible & participating in ACO Scale Target initiatives

° TCOC is defined as the population eligible & with payer as primary for TCOC

** Beginning in PY4, Medicaid included Duals and Commercial eligible members who used Medicaid for Long-Term Care. We count both Medicaid primary and Medicaid secondary without overlap with Medicare/Comm.*

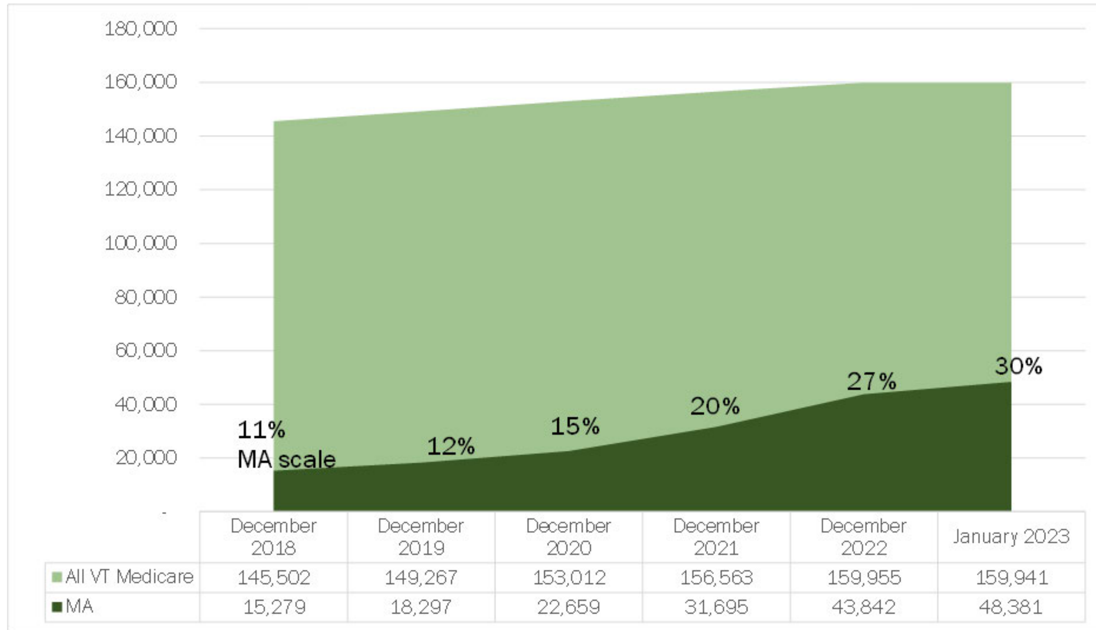
One potentially helpful change would be to use alternative measures for scale and targets that include more of the same eligibility criteria as those used for financial accountability. This could look like: limiting scale eligibility in terms of insured populations over which states have some regulatory influence, defining scale eligibility with populations for which there is available data, and/or using the same runout and eligibility anchor dates for both scale and TCOC.

8.2. Working with a Primary Care-Based, Prospective Attribution Model

The prospective attribution methodology used across Scale-qualifying ACO programs both leverages and incentivizes a strong primary care network, as well as counting the Vermonters over whom providers and payers have some level of influence. However, in practice, this constrains the scale population. Two groups which are most impacted by the constraint on prospective primary care attribution are Medicare and Medicaid.

For Medicare, a prospective attribution for Medicare does not account for members who would be eligible in the year ahead but then opt for Medicare Advantage (we illustrate the significant shift from traditional Medicare to Medicare Advantage in Figure 3 of this report). Figure 13 (below) also demonstrates the percent of beneficiaries electing for Medicare Advantage in Vermont, in terms of total Medicare eligible population.

Figure 14: Medicare Advantage as a percentage of all Medicare eligible12, by year



	December 2018	December 2019	December 2020	December 2021	December 2022	January 2023
All VT Medicare	145,502	149,267	153,012	156,563	159,955	159,941
MA	15,279	18,297	22,659	31,695	43,842	48,381

An additional factor for the Medicare population is the increased likelihood that Medicare beneficiaries will die within the performance year. The TCOC accounts for this difference with a year-end reconciliation, which we do not have for Scale.

Medicaid attribution was also constrained by a prospective primary care attribution model because a large enough proportion of their membership did not have relationships with primary care through which to be attributed. To enroll as many Medicaid beneficiaries as possible, Medicaid implemented their own expanded attribution pilot program in PY3 which, after providing successful, was applied to the entire state for PYs 4 and 5 (see Section 6.3).

Furthermore, the most uniform and comprehensive data available to policy makers is largely resident based, while we know that Vermont providers serve a broader population. State data sources are often missing important details (such as provider identities or associations, detailed insurance affiliations, and financial data). Consequently, it has been difficult to connect these two populations for a comprehensive cause-and-effect analysis.

These challenges would be lessened in a facility-based or provider-based reform model, though Vermont anticipates that some of the same data issues could persist.

8.3. Importance of Self-Funded Data and Regulatory Oversight

The ruling from *Gobeille v. Liberty Mutual* limited data collected in VHCURES and other state APCDs. With Blue Cross Blue Shield of Vermont's recent decision to withdraw data for its remaining self-funded plans from VHCURES, the total number will again decrease by about 8,000 individuals. If other commercial payers also withdrew the remaining voluntarily submitted self-funded beneficiaries, VHCURES could lose up to another 20,000 commercially covered beneficiaries (based on 2022 estimates). The net result would reduce the APCD to

[12] Source: Medicare enrollment dashboard, Accessed July 2023.

including less than half of the total commercial market. Refer to Figure 8 above for the total number of self-funded beneficiaries currently captured in VHCURES.

Vermont has seen higher participation in Scale Qualifying ACO programs among commercial payers over which the state has regulatory authority.

Figure 15: Scale populations grouped by state regulatory authority

Vermont Residents, PY5 (2022)	ACO Eligible		ACO Aligned	
	Number	Column Percentage	Number	Row Percentage
Included in Scale Target	562,904	87%	259,958	46%
Within State regulatory authority	338,232	52%	226,712	**67%**
Medicaid primary	149,514	23%	126,291	84%
Commercial fully insured with COA	87,766	14%	37,814	43%
Medicare FFS ACO-Aligned	100,952	16%	62,607	62%
Outside of State regulatory authority	224,672	35%	33,246	**15%**
Commercial Self-funded	153,378	24%	33,246	22%
Medicare Advantage	25,178	4%	0	0%
Medicare FFS Non-Aligned	46,116	7%	0	0%
Excluded from Scale Target	82,666	13%	0	0%

Potential solutions to bring more Vermont beneficiaries into a future model would be to work with self-funded plan providers and Medicare Advantage providers to demonstrate return on investment for participating in such a model. Vermont has now completed its five-year APM agreement, with three of the five years analyzed so far having shown savings for Medicare.[13] Additionally, the federal government could consider incentives or other levels to encourage participation by Medicare Advantage, the Federal Employee Health Benefit Plan, or TRICARE, or other non-state regulated payers.

[13] https://innovation.cms.gov/data-and-reports/2023/vtapm-3rd-eval-full-report

Appendix A: Methodology

All-Payer Scale Target

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

All-Payer Scale Target Numerator

The All-Payer Scale Target Beneficiary numerator includes all Vermonters aligned to a Scale Target ACO Initiative as described in Section 6.b of the APM Agreement.

All-Payer Scale Target Denominator

The Vermont All-Payer Scale denominator includes:

Payer	Subcategory
Medicare	All Vermont Medicare FFS enrollees
Medicaid	All Vermont Medicaid enrollees (see below for exceptions)
Commercial	Fully Insured
	Members of Self-Insured Health Plans
	Medicare Advantage Plans

The following groups are excluded from the Scale Target denominator:

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

Estimates are provided for primary coverage for comprehensive major medical insurance as of January of the performance year.

Medicare Scale Target

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

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 APM Agreement.

Medicare Scale Target Denominator

The Medicare Scale Target denominator includes all Vermont Medicare Beneficiaries with Parts A and B coverage enrolled at the beginning of the performance year

Appendix C: 2022 Quality Measure Crosswalk

Measure	Vermont All-Payer ACO Model	Vermont Medicaid Next Gen *(Traditional Attribution)*	Vermont Medicare Initiative	BCBSVT QHP	MVP QHP
% of adults with a usual primary care provider	X				
Statewide prevalence of Chronic Obstructive Pulmonary Disease	X				
Statewide prevalence of Hypertension	X				
Statewide prevalence of Diabetes	X				
% of Medicaid child & adolescents with well-care visits[14]	X	X		X	X
Initiation of alcohol and other drug dependence treatment [15]	X	X	X	X	X
Engagement of alcohol and other drug dependence treatment[10]	X	X	X		
30-day follow-up after discharge from emergency department for mental health	X	X	X	X	X
30-day follow-up after discharge from emergency department for alcohol or other drug dependence	X	X	X	X	X
% of Vermont residents receiving appropriate asthma medication management	X				
Screening for clinical depression and follow-up plan (ACO-18)	X	X	X	X	
Tobacco use assessment and cessation intervention (ACO-17)	X	X	X		
Deaths related to suicide	X				
Deaths related to drug overdose	X				
% of Medicaid enrollees aligned with ACO	X				
# per 10,000 population ages 18-64 receiving medication assisted treatment for opioid dependence	X				
Rate of growth in mental health or substance abuse-related emergency department visits	X				
# of queries of Vermont Prescription Monitoring System by Vermont providers (or their delegates) divided by # of patients for whom a prescriber writes prescription for opioids	X				
Hypertension: Controlling high blood pressure	X[16]	X	X[11]	X	X
Diabetes Mellitus: HbA1c poor control		X		X	X
All-Cause unplanned admissions for patients with multiple chronic conditions		X			
Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient experience surveys[17]	X	X	X	X	X
ACO all-cause readmissions (HEDIS measure for commercial plans)				X	X
Risk-standardized, all-condition readmission (ACO-8)			X		
Influenza immunization (ACO-14)			X		
Colorectal cancer screening (ACO-19)			X		
Developmental screening in the first 3 years of life		X		X	
Follow-up after hospitalization for mental Illness (7-Day Rate)		X		X	X

[14] The Agreement specifies Medicaid adolescents, other commercial payers measure their specific population.
[15] BCBSVT and MVP Programs treat these measures as a single composite measure; Vermont Medicare ACO Initiative and Vermont Medicaid Next Generation treat them as separate measures.
[16] Per a mutual agreement between CMMI and the GMCB, these measures will be reported separately moving forward.
[17] Surveys vary by program. Vermont Medicare ACO Initiative includes ACO CAHPS Survey composite of timely care, appointments and information for ACO-attributed Medicare beneficiaries. Vermont Medicaid Next Generation includes multiple CAHPS PCMH composites for ACO-attributed Medicaid beneficiaries. BCBCBS Next Generation includes care coordination composite and tobacco cessation question from CAHPS PCMH for ACO-attributed BCBSVT members.

Appendix D: Resource List

1. *QHP Rate Filings*
   BCBSVT

   MVP

2. *OneCare Vermont Budget Submission*
   Performance Year 1 (PY1, 2018)

   Performance Year 2 (PY2, 2019)

   Performance Year 3 (PY3, 2020)

   Performance Year 4 (PY5, 2021)

   Performance Year 5 (PY5, 2022)

3. *ACO Scale Targets and Alignment Report(s)*
   Performance Year 1 (PY1, 2018)

   Performance Year 2 (PY2, 2019)

   Performance Year 3 (PY3, 2020)

   Performance Year 4 (PY4, 2021)