Vermont All-Payer ACO Model
Total Cost of Care Annual Report
Performance Year 2
(January – December 2019)

Submitted April 8, 2021

Green Mountain Care Board

1. Executive Summary

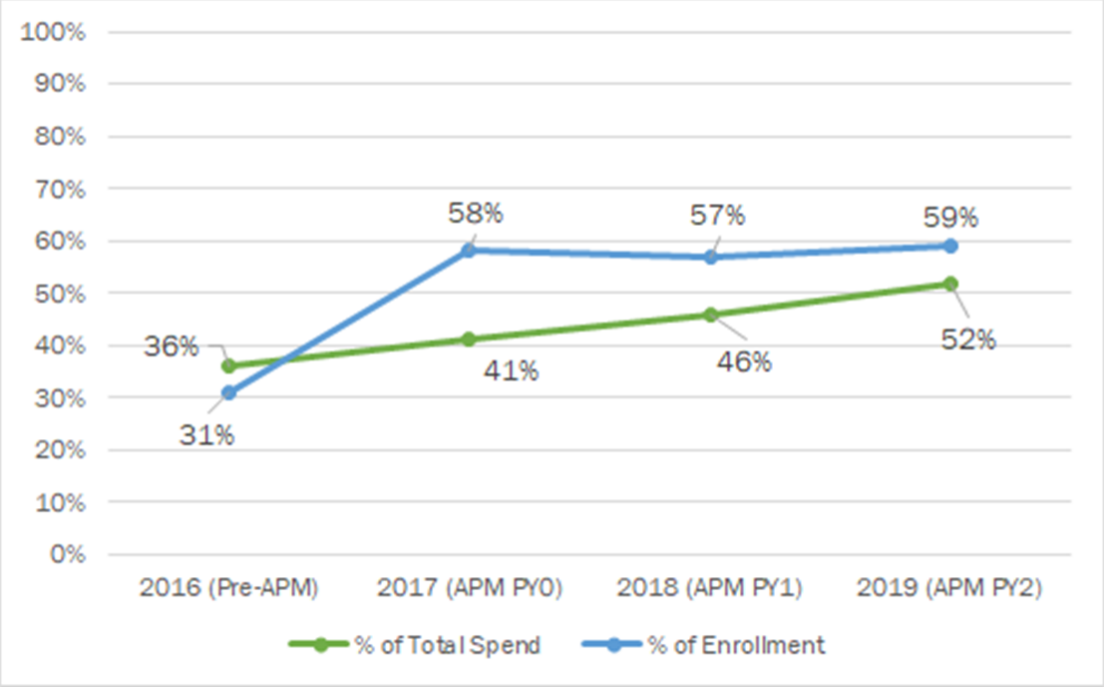
The Annual Total Cost of Care (TCOC) Report, as required by the Vermont All-Payer Accountable Care Organization Model ("All-Payer ACO Model" or "APM") Agreement, illustrates Vermont's progress toward its statewide financial targets, including the All-payer TCOC per Beneficiary Growth Target. Under the Agreement, Vermont's All-Payer TCOC is tied to a historical look at Vermont's economic growth with the goal of bringing health care spending more in line with the Vermont economy. In this vein, the TCOC target included in the Agreement is 3.5%, allowing for growth up to 4.3%. Included in this report are quantitative and qualitative analyses of Vermont's performance on these statewide financial targets in Performance Year 2 (PY2, 2019).

TCOC per member per month (PMPM) increased 4.6% across all payer types in 2019 relative to 2017, which is above the agreed upon range. The highest observed per beneficiary growth occurred for Medicaid at 5.1%, followed by Commercial at 4.5%, and Medicare at 3.0%. The All-Payer TCOC PMPM in 2019 was $548. The PMPMs making up the All-Payer TCOC by payer type were $286 for Medicaid, $504 for Commercial, and $893 for Medicare. The TCOC across all payers in 2019 was $2.9 billion.

The commercial market demonstrated the most *annual* growth from 2018 to 2019 by payer (7.5% compared with 3.7% for Medicaid and 1.7% for Medicare). As required by the APM Agreement, the commercial market includes Medicare Advantage business – a group over which the GMCB and CMMI currently have no regulatory influence. Medicare Advantage demonstrated the most significant annual expenditure growth, increasing by nearly 14%. Historically, Vermont's Medicare Advantage enrollment penetration rate has been quite low as compared with over states, below 10% at the time of negotiations for the APM Agreement. In recent years, the penetration rate increased steadily and took a substantial jump in 2021, in part due to Blue Cross Blue Shield's entrance to the market. As of January 2021, the penetration rate appears to be up to 19%.[1] Vermont and CMMI are currently discussing ways to include Medicare Advantage in the current model. The remainder of the commercial market grew at 4.1%, which reflects the observed medical expenditure trends for the commercial market during this time.

[1] Medicare Enrollment Dashboard data, accessed March 15, 2021 (https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMSProgramStatistics/Dashboard).

Figure 1.a: Influence over time for groups under some regulatory control[2]



As seen in Figure 1.a, the percent of spending under some type of state government influence, such as Medicaid or GMCB regulation, is increasing steadily. By 2019, 52% of the TCOC expenditures and 59% of the market enrollment (in member months) were on behalf of insured groups for which Vermont has some state government influence. Prior to the APM, the State had some control over 36% of TCOC expenditures and 31% of covered lives. Gains in scale for Medicare and commercial plans have expanded these values to 52% of eligible spending (and 59% of Vermonters) in 2019.

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 Accountable Care Organizations (ACOs); these arrangements are tied to quality and health outcomes. This report provides an annual update[3] regarding Vermont's performance on Total Cost of Care (TCOC)[4] per beneficiary growth targets for all payers and for Medicare, as described in Section 9 (Statewide Financial Targets) of the APM Agreement. Section 9.f requires the GMCB to report on the State's performance relative to the TCOC targets quarterly. TCOC

[2]"Some regulatory control" defined as: Medicaid ACO and non-ACO, Medicare ACO (ESRD and ABD); and Commercial Fully Insured.
[3] Per a memo to CMMI dated August 21,2019, Vermont agreed to produce a final, annual report allowing for six months of claims to be paid after the end of the calendar year (i.e. paid runout).
[4] Complete TCOC specifications are available upon request.

results presented in this report include data for Vermont residents based on data from the Vermont Health Care Uniform Reporting and Evaluation System (VHCURES) and non-claims payments for all four quarters of 2019.

Of note, the GMCB employed a variety of techniques to assess the reasonableness of the results. Data available to payers is much different than the data available to the GMCB and therefore results are expected to vary. However, validation efforts revealed the differences to be relatively small.[5]

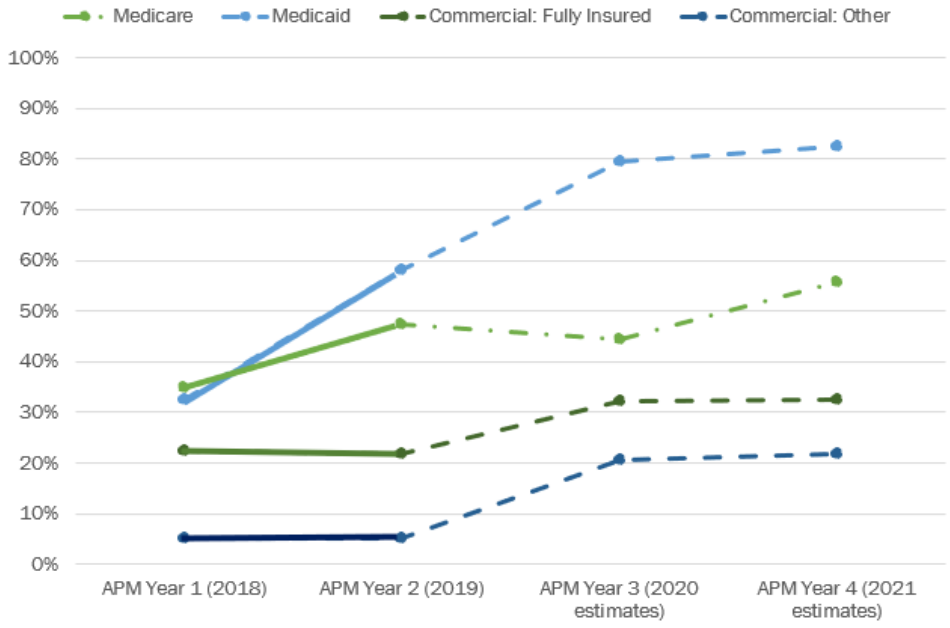
3. Considerations

As this is the second annual TCOC report, many may be eager to draw year over year comparisons based on the two points in time. However, it is imperative that such comparison is done with caution and that consideration is given first to growth and changes amongst payer populations.

3.1. Growth Overall

Between PY1 and PY2 of the APM, the ACO aligned eligible population grew 41.9% overall. This was due to increased enrollment statewide and by payer, with the largest change in Medicare Advantage (See Section 3.2). APM TCOC scale includes enrollment aligned with OCVT and those not aligned with OCVT. In PY2, Medicaid ACO-aligned population grew 78.8%, Medicare ACO-aligned population grew 35.9%, and Commercial ACO-aligned decreased slightly by 1.1%.

Figure 1.b: 2018 to 2019 change in ACO-aligned scale by payer type



Note: Commercial Other combines the categories Commercial Self-Funded and Medicare Advantage.

[5] The GMCB continues to improve the data quality and would like to thank Blue Cross Blue Shield of Vermont and MVP for the time they generously volunteered to assist in validating the results.

3.2. Medicare Advantage

Due to the relatively small, though rapidly increasing, size of the Medicare Advantage population, the PMPMs are especially vulnerable to dramatic changes in enrollment. The PMPMs are also sensitive to the risk and spending patterns of the population joining Medicare Advantage. Furthermore, since Medicare Advantage expenditures would be expected to be more in line with traditional Medicare than standard commercial populations, their inclusion can distort patterns of that market. Table 1 summarizes the PMPMs for Commercial and Medicare subgroups according to the TCOC specified in the APM Agreement.

Table 1: APM Total Cost of Care (TCOC) Per Member per Month (PMPM) for Selected Subgroups

	2017	2018	2019	Compounding Growth ('17 to '19)
Full Population TCOC PMPM	**$501**	**$521 (+4.1%)**	**$549 (+5.2%)**	**4.6%**
Traditional Medicare	$841	$878 (+4.4%)	$893 (+1.7%)	3.0%
Commercial	$462	$469 (+1.5%)	$504 (+7.5%)	4.5%
Fully Insured	*$455*	*$451 (-0.2%)*	*$488 (+8.0%)*	*3.8%*
Self-Insured	*$452*	*$470 (+3.4%)*	*$494 (+5.0%)*	*4.2%*
Medicare Advantage	*$619*	*$572 (-7.7%)*	*$651 (+13.9%)*	*2.5%*

Table 2 (below) shows how growth patterns and PMPMs change when Medicare Advantage is included with the traditional Medicare population. The Medicare Advantage population tends to have a lower PMPM as compared with traditional Medicare. When combined, the populations show a lower PMPM than traditional Medicare alone and the compounding growth rate from 2017 to 2019 drops from 3.0% (traditional Medicare) to 2.4%. The reallocation of Medicare Advantage also reduces the PMPMs for the remaining commercial market and results in a lower compounded growth rate (4.1% from 4.5% when including Medicare Advantage). These suggest that the Medicare Advantage is in fact a more expensive population in comparison with other commercial business. Since Medicare Advantage is more like Medicare than it is like other commercial plans and because it's growing relatively quickly, it's changing the populations included in the commercial and Medicare categories. Therefore, changes in the TCOC within these populations may be measuring population changes more than changes in expenditure patterns.

Table 2: APM TCOC PMPM with Reallocation of Medicare Advantage from Commercial to Medicare

	2017	2018	2019	Compounding Growth ('17 to '19)
All Medicare (Traditional + Medicare Advantage)	$823	$846 (+2.8%)	$863 (+2.0%)	2.4%
Commercial (without Medicare Advantage)	$453	$461 (+1.8%)	$491 (+6.4%)	4.1%

3.3. Public Health Emergency/COVID-19

Preliminary information available for Medicare in 2020 suggests a substantial decline in utilization and associated expenditures, resulting from measures implemented in order to reduce the spread of COVID-19. The expected reductions are very likely to bring the compounded growth rate back within the targeted range of 3.5% to 4.3% for 2017 through 2020. However, no sources have yet predicted how utilization might rebound due to delayed care or effects of COVID-19 for years 2021 and 2022. Therefore, we do not yet have insight into how COVID-19 will impact our APM agreement by the end of PY5, 2022.

4. Summary of Results

Table 4a: All-Payer Total Cost of Care Results, Prior Four Quarters and Year-to-Date (including reduction for excludable Medicaid costs)[6]

		Q1	Q2	Q3	Q4	TCOC Growth YTD (Q1+Q2+Q3+Q4)*
Baseline (CY 2017)	TCOC/Beneficiary (PMPM)[7]	$502.64	$507.29	$489.25	$504.33	$500.88
	Numerator ($)[7]	*$689,993,655*	*$698,731,179*	*$671,601,466*	*$690,081,212*	*$2,750,407,512*
	Denominator (Members)[8]	*457,581*	*459,126*	*457,569*	*456,100*	*457,594*
PY 1 (2018)	TCOC/Beneficiary (PMPM)[7]	$527.65	$523.14	$504.50	$529.67	$521.25
	Numerator ($)[7]	*$729,656,517*	*$721,362,788*	*$692,943,336*	*$726,074,402*	*$2,870,037,042*
	Denominator (Members)[8]	*460,951*	*459,632*	*457,837*	*456,936*	*458,839*
PY 2 (2019)	TCOC/Beneficiary (PMPM)[7]	$559.70	$558.00	$535.10	$541.12	$548.53
	Numerator ($)[7]	*$769,587,944*	*$763,706,559*	*$729,362,477*	*$735,658,934*	*$2,998,315,915*[9]
	Denominator (Members)[8]	*458,336*	*456,216*	*454,345*	*453,168*	*455,516*
Per Beneficiary Growth Rate		***5.5%***	***4.9%***	***4.6%***	***3.6%***	***4.6%***

*Quarters may not sum due to rounding and different amounts of time for claims runout.

[6] Section 10.d. of the APM Agreement allows All-Payer TCOC growth attributable to Medicaid rate increases to be excluded from the All-Payer TCOC calculations. This table reflects an adjustment of -4.6% for claims payments and Medicaid prospective PBP payments.
[7] Claims-based spending is based on allowed amounts.
[8] Weighted by months enrolled during the measurement period.
[9] Includes additional $268,404 refunded sequestration amount, per final 2019 settlement.

Table 4b: All-Payer Total Cost of Care Results, Prior Four Quarters and Year-to-Date (Total Spending)

		Q1	Q2	Q3	Q4	TCOC Growth YTD (Q1+Q2+Q3+Q4)*
Baseline (CY 2017)	TCOC/Beneficiary (PMPM)[10]	$502.64	$507.29	$489.25	$504.33	$500.88
	Numerator ($)[10]	*$689,993,655*	*$698,731,179*	*$671,601,466*	*$690,081,212*	*$2,750,407,512*
	Denominator (Members)[11]	*457,581*	*459,126*	*457,569*	*456,100*	*457,594*
PY 1 (2018)	TCOC/Beneficiary (PMPM)[10]	$529.55	$524.99	$506.25	$531.36	$523.05
	Numerator ($)[10]	*$732,295,394*	*$723,909,462*	*$695,335,742*	*$728,385,658*	*$2,879,926,257*
	Denominator (Members)[11]	*460,951*	*459,632*	*457,837*	*456,936*	*458,839*
PY 2 (2019)	TCOC/Beneficiary (PMPM)[10]	$562.43	$560.35	$537.40	$543.09	$550.91
	Numerator ($)[10]	*$773,350,290*	*$766,916,057*	*$732,499,731*	*$738,338,956*	*$3,011,330,745[12]*
	Denominator (Members)[11]	*458,336*	*456,216*	*454,345*	*453,168*	*455,516*
Per Beneficiary Growth Rate		***5.8%***	***5.1%***	***4.8%***	**3.8%**	***4.9%***

* Quarters may not sum due to rounding and different amounts of time for claims runout.

PMPM growth is less meaningful on a quarterly basis. Typically, lower third quarter PMPM costs are observed across all payer groups, with greater annual changes in the first and fourth quarters.

5. Results: Growth in PMPM TCOC

Table 5 displays PMPM costs for all quarters in 2019 by payer group. A 4.6 percent growth in TCOC per member per month across all payers was observed compared to costs in 2017 (per beneficiary growth). The lowest per beneficiary growth was 3.0 percent among Medicare beneficiaries, followed by Commercial at 4.5 percent, and Medicaid at 5.1 percent.[13] As in the base year, Medicare has the highest TCOC PMPM at $893,

[10] Claims-based spending is based on allowed amounts.
[11] Weighted by months enrolled during the measurement period.
[12] Includes additional $268,404 refunded sequestration amount, per final 2019 settlement.
[13] Beneficiaries with multiple sources of coverage are assigned to one payer group according to the following hierarchy: (1) commercial, (2) Medicare, and (3) Medicaid. Beneficiaries dually eligible for Medicare and Medicaid are included in the Medicare population.

followed by Commercial payers at $504 and then Medicaid at $286. The 2019 TCOC PMPM for all payers, adjusted for the hold harmless provision, is $549.

Table 5: All-Payer TCOC calculation for 2017, 2018 and 2019

	Payer	Total Claims Costs	Total Non-Claims	Total Costs	Member Months	Total cost PMPM	Annual Growth	Per Beneficiary Growth
Baseline	All-Payer	$2,666,465,485	$83,942,027	$2,750,407,512	5,491,129	$501	-	-
	Commercial	$1,092,540,992	$17,972,204	$1,110,513,196	2,403,736	$462	-	-
	Medicare	$1,206,568,857	$7,500,000	$1,214,068,857	1,443,055	$841	-	-
	Medicaid	$367,355,635	$58,469,823	$425,825,458	1,644,338	$259	-	-
PY1 (2018)	All-Payer	$2,620,706,085	$249,330,957	$2,870,037,042	5,506,068	$521	**4.1%**	-
	Commercial	$1,124,513,841	$14,785,200	$1,139,299,041	2,429,344	$469	**1.5%**	-
	Medicare	$1,129,993,016	$156,199,070	$1,286,192,086	1,464,835	$878	**4.4%**	-
	Medicaid	$366,199,228	$78,346,687	$444,545,915	1,611,889	$276	**6.5%**	-
PY2 (2019)	All-Payer	$2,998,315,915	$358,292,742	$2,640,023,172	5,466,193	$549	**5.2%**	**4.6%**
	Commercial	$1,226,932,617	$15,506,157	$1,242,438,774	2,464,922	$504	**7.5%**	**4.5%**
	Medicare	$1,100,408,120	$219,874,123	$1,320,282,243	1,478,801	$893	**1.7%**	**3.0%**
	Medicaid	$312,682,435	$122,686,753	$435,369,188	1,522,470	$286	**-2.5%**	**5.1%**

5.1. Commercial

Table 5.1 shows total claims costs and member months by commercial submitter. Commercial plans are grouped into three plan types: fully insured, self-insured, and Medicare Advantage. It is important to reiterate that self-insured results may be less reliable because payers are not required to report data from self-insured plans to VHCURES.

Table 5.1: Total Claim Costs and Member Month Counts by Commercial Payer Group for 2019

Plan type	2019			PMPM Growth PY1-PY2	Compounded Annual Growth	Claim costs percentage of total
	Total claims costs[14]	Total member months	Total cost PMPM			
Commercially Insured (Fully-Insured)	$539,805,133	1,107,114	$488	8.0%	3.8%	43%
Medicare Advantage	$133,478,694	205,044	$651	13.9%	2.5%	11%
Self-Insured	$569,154,946	1,152,764	$494	5.0%	4.2%	46%
Total	**$1,242,438,774**	**2,464,922**	**$504**	**7.5%**	**4.5%**	**100.0%**

The commercially insured group of 205,410 average members includes those purchasing individual and small group plans, large group plans, and Medicare Advantage plans. The 3.8% growth rate for fully-insured commercial lives noted in Table 5.1 should not, therefore, be compared to the insurance premium increases for the 2019 plan year. Insurance premiums consist of several components: medical trend, pharmacy trend, taxes and fees, reserves, and administrative costs. The only relevant component of the premium increase is the medical trend. Medical trend for insurance premiums is established by using actual claims from 2 years prior to the filing year (e.g. 2017 for 2019 plans) in order to ensure that the claims are complete. Those claims are then adjusted for population changes (enrollment and demographic), benefit changes and other relevant factors, then trended forward by two years using actuarial estimates – the BCBSVT QHP medical trend, the only ACO-participating sub-group in 2019, was 4.1% (2.7% in unit cost changes, 1.4% in utilization and intensity changes). The 3.8% trend included in this analysis is based on actual 2017 to actual 2019 claims while the medical trend premium increases for the 2019 plan year of 4.1% are based on actuarial estimates.

[14] Claims costs are based on allowed amount. Results exclude non-claims costs.

5.2. Medicare

Table 5.2 shows the distribution of Medicare PMPM across claims and non-claims costs.

Table 5.2: Medicare Fee-For-Service Claims and Non-Claims Cost Trends

Cost type	2019			Prior Year Cost PMPM	Annual Change in PMPM
	Total costs	Total member months	Total cost PMPM		
Total	**$1,320,550,647**	**1,478,801**	**$892.99**	**$878.05**	**1.7%**
Claims costs[15]	$1,100,408,120	1,478,801	$744.12	$771.41	-3.5%
Non-claims: Advanced Shared savings[16]	$6,342,236	1,478,801	$4.29	$5.31	-19.2%
Non-claims: Net Shared Savings	$4,943,260	1,478,801	$3.34	$3.80	-12.1%
Non-claims: Aged & Disabled PBP[17]	$208,060,344	1,478,801	$140.70	$97.08	44.9%
Non-claims: ESRD[18] PBP	$753,993	1,478,801	$0.51	$0.45	13.3%

5.3. Medicaid

Medicaid claims payments and Medicaid non-claims ACO payments were adjusted by -4.6 percent in 2019 to reflect the Medicaid rate increases that are excluded from All-payer TCOC per Beneficiary Growth.[19] The adjustment reduced the Medicaid TCOC PMPM from $295 to $285, reducing the Medicaid TCOC per Beneficiary growth rate by 3.0 percentage points. Medicaid claims costs decreased by 9.6 percent while non-claims costs collectively increased 65.8 percent (not shown). This shift is driven by an increase in scale from 2018 to 2019 (refer to Figure 1.b.). Most Medicaid non-claims costs are Vermont Medicaid Next Generation (VMNG) ACO program capitated payments, which increased 70.5

[15] Claims costs are based on allowed amount.
[16] A portion of shared savings were advanced to fund SASH and Blueprint payments.
[17] PBP = All-Inclusive Population Based Payments. These payments to the ACO are distributed to hospitals as fixed perspective payments.
[18] ESRD = End Stage Renal Disease.
[19] The adjustment factor was calculated by GMCB staff. We applied this factor to claim-based payment amounts and ACO Hold Harmless non-claim-based amounts.

percent between 2018 and 2019 (Table 5.3.a). The impact of the Medicaid ACO payment adjustment reduced all payer TCOC PMPM from $551 to $549, reducing the growth rate by 0.36 percentage points (Tables 4.a & 4.b).

Table 5.3.a: Medicaid Claims and Non-Claims Cost Trends

Cost type	2019			2018 cost PMPM	2019 Annual change in PMPM
	Total costs	Total member months	Total cost PMPM		
Total	**$435,369,188**	**1,522,470**	**$285.96**	**$275.79**	**3.7%**
Claims costs[20]	$312,682,435	1,522,470	$205.38	$227.19	-9.6%
Non-claims: FPP[21]	$112,669,552	1,522,470	$74.00	$43.39	70.5%
Non-claims: PCMH	$5,525,802	1,522,470	$3.63	$2.39	51.9%
Non-claims: CHT	$3,395,441	1,522,470	$2.23	$2.19	1.8%
Non-claims: WHI	$1,095,958	1,522,470	$0.72	$0.64	12.5%

[20] Claims costs are based on allowed amount.
[21] 2019 capitated non-claims payments include a rate adjustment of -4.6%. The large increase shows is driven by scale as noted in the text.

Table 5.3.b: Medicaid PMPM ACO Claims-Based Trends

Year	ACO	Adjusted Claims Payments (*includes -4.6% adjustment in 2019*)	Adjusted non-claims (ACO capitation) Prospective Payments [22] (*Includes -4.6% reduction in 2019*)	Member Months	PMPM (*excludes Blueprint non-claims payments*)	Blueprint non-claims PMPM[23] (*PCMH, CHT, WHI*)	Final PMPM	PMPM Annual Change
2017	**Total**	**$425,825,458**	**$50,452,882**	**1,644,338**	**$258.96**	**$4.88**	**$254.01**	
	No	$337,479,322		1,337,980	$252.23	$4.88	$246.75	
	Yes	$88,346,136	$50,452,882	306,358	$288.38	$4.88	$285.74	
2018	**Total**	**$444,545,915**	**$69,941,022**	**1,611,889**	**$275.79**	**$5.21**	**$275.79**	**8.6%**
	No	$315,776,314		1,148,292	$275.00	$5.21	$275.00	11.4%
	Yes	$128,769,601	$69,941,022	463,597	$277.76	$5.21	$277.77	-2.8%
2019	**Total**	**$435,369,188**		**1,522,470**	**$285.96**			
	No	$208,902,782		705,280	$296.60			
	Yes	$226,466,406		817,190	$277.13			

In general, the Medicaid program experienced higher utilization (and therefore total expenditure) in 2019 than in the previous two years of the model. While the overall Medicaid TCOC grew per beneficiary by 5.1 percent from 2017 to 2019, that was primarily driven by growth in TCOC for Medicaid members who were not attributed to the ACO and the shift to fixed perspective payments on behalf of ACO-aligned members. In terms of annual change from 2018, total Medicaid expenditures decreased 2.1 percent, with the decrease of 33.8% on behalf of Non-ACO-aligned members; whereas total expenditures increased 75.9% for ACO-aligned members in the same period. Again, Figure 1.b. demonstrates how the Medicaid ACO-aligned population saw the highest growth of all payers in the model. Specifically, growth in member months aligned with the ACO was 76.3% (not pictured), which ties to the 75.9% increase in total expenditures for this population between 2018 and 2019.

[22] ACO capitation payments are entirely attributed to ACO-aligned members.
[23] Blueprint PMPM payments are calculated by dividing total annual Blueprint payments by total member months. The PMPM cost is added to both ACO and non-ACO aligned members.

Appendix A: Total Cost of Care Per Beneficiary Growth Calculation

Vermont All-Payer Total Cost of Care per Beneficiary Growth:

Vermont All-Payer TCOC per Beneficiary Growth will be calculated by Vermont and CMS in aggregate as a compounded annualized growth rate (CAGR) across Performance Years 1 and subsequent Performance Years of this Model, using 2017 as a baseline (adjusted in PY1 with MAPCP, and shared savings/loss adjustment). Vermont's performance on the All-payer Total Cost of Care per Beneficiary Growth Target will be calculated by the following formula, where "20xx" is the Performance Year for which the All-payer Total Cost of Care per Beneficiary is being calculated, and "z" is the total number of Performance Years. From Section 9.a.i of the Agreement:

$$\left(\frac{\left(\frac{Vermont\ all-payer\ TCOC_{20xx}}{Vermont\ all-payer\ beneficiaries_{20xx}}\right)}{\left(\frac{Vermont\ all-payer\ TCOC_{2017}}{Vermont\ all-payer\ beneficiaries_{2017}}\right)}\right)^{\frac{1}{z}} - 1 \leq 0.035$$

Appendix B: Methodology

All-Payer Total Cost of Care per Beneficiary

The methodology for calculating All-Payer TCOC per Beneficiary does not vary across Performance Years.

Performance Years 1-5:

$$\frac{\textit{Vermont All-Payer TCOC}}{\textit{Vermont All-Payer TCOC Beneficiaries}}$$

All-Payer TCOC per Beneficiary Numerator:

The Vermont All-Payer TCOC per Beneficiary numerator includes:

- Claims and fee-for-service equivalent payments from consolidated data in VHCURES, submitted by payers.
- Non-claims supplemental data submitted by Medicare, Medicaid, and large commercial insurers.

All-Payer TCOC per Beneficiary Denominator:

The Vermont All-Payer TCOC per Beneficiary denominator includes:

- All Vermont Medicare enrollees.
- All Vermont Medicaid enrollees, with the exception of non-eligible populations described below.
- Members of fully insured health plans, with the exception of non-eligible populations described below.
- Members of self-insured health plans, with the exception of non-eligible populations described below.
- Members of Medicare Advantage Plans (considered Commercial plans under the All-Payer Model Agreement).

The Vermont All-Payer TCOC per Beneficiary denominator excludes:

- Members of Federal Employee and Military Health Plans.
- Medicaid Enrollees who are not eligible for the Medicaid ACO program (e.g., individuals dually eligible for Medicare and Medicaid[24], individuals with evidence of third-party coverage, and individuals who receive a limited Medicaid benefit package).
- Members of self-insured health plans who decline to voluntarily submit data to VHCURES.
- Members of insurance plans without a Certificate of Authority from Vermont's Department of Financial Regulation.
- Uninsured individuals.

[24] Beneficiaries covered by both Medicare and Medicaid are included in the Medicare population to avoid double counting.

Detailed specifications for Medicaid payments, commercial and self-insured payments made through claims, and commercial and self-insured non-claims payments are available upon request.

Vermont All-Payer Total Cost of Care per Beneficiary Growth:

Vermont All-Payer TCOC per Beneficiary Growth will be calculated by Vermont and CMS in aggregate as a compounded annualized growth rate across Performance Years 1 through 5 of this Model, using 2017 as a baseline.

Data sources

VHCURES data was used to calculate claims payments in the numerator and the number of Vermont residents in the denominator for commercial, Medicaid, and Medicare payer groups in 2019. Medicaid claims payments and Medicaid all-inclusive population based payments (PBPs)[25] were adjusted downward by 4.6 percent to account for price increases excluded from the TCOC pursuant to section 10.d of the All-Payer ACO Model Agreement, which allows for the exclusions of cost growth attributable to price increases intended to bring Medicaid reimbursement rates to levels comparable to or greater than Medicare reimbursement rates or to ensure greater access for Medicaid beneficiaries. The All-Payer TCOC per Beneficiary Growth is reported with and without the price adjustment in Section 4. VHCURES data were used for Medicare fee-for-service equivalent amounts. These fee-for-service equivalents represent the amount that Medicare would have paid through traditional reimbursement for services paid for prospectively with Medicare's PBP. For remaining non-claims payments in the numerator, including shared savings/losses made to providers and payments outside of claims reporting, we used data from multiple sources:

1. Two commercial payers, Blue Cross Blue Shield of Vermont and MVP, provided GMCB with non-claims payments amounts for 2019, including capitation and risk settlement payments. Blueprint payments for Patient-Centered Medical Homes (PCMH) and Community Health Teams (CHT) were also included. To calculate non-claims payments for commercial payers, payer-reported capitation and risk settlement payments were added to PCMH and CHT payments as reported by the Blueprint for Health.
2. Non-claims Medicaid payments include Blueprint payments as well as the Medicaid PBP paid prospectively to the ACO. As previously mentioned, the PBP payments from Medicaid include an adjustment of -4.6% for excludable price increases under the terms of the APM Agreement.[26] Blueprint payments include PCMH, Core CHT, and Women's Health Initiative (WHI) payments as reported by the Blueprint for Health.
3. In addition to the PBPs reported to VHCURES, Medicare non-claims costs include 2019 shared savings payments totaling $11,285,496, of which $6,342,236 was advanced to the ACO to promote continued funding of the Blueprint for Health and SASH, leaving $4,943,260 of net savings in the Medicare program for 2019.

[25] PBPs are also known as Fixed Prospective Payments (FPPs).
[26] The Medicaid repricing factor is also applied to 2019 claims payments. See Vermont All-Payer Accountable Care Organization Model Agreement, Section 10.d.