Vermont All-Payer ACO Model
Total Cost of Care Annual Report
Performance Year 5
(January – December 2022)

Submitted May 31, 2024

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 5 (PY5, 2022).

The results presented here will not accurately assess "performance" as outlined in the APM Agreement. Beginning in 2020, the effects of the global pandemic and associated Public Health Emergency (PHE) necessarily and drastically changed care patterns. The PHE redefined short-term health system priorities to meet immediate acute care needs and stabilize the health care system. These necessary changes are likely to have impacted preventive care and health promotion activities. The full effects of the PHE are still developing and may distort trends for many years to come.

The All-Payer TCOC per member per month (PMPM) compounded annual growth rate (CAGR) is 3.7% when compared with 2017. Payer-specific changes ranged from 3.0% (Medicare) to 4.1% (Medicaid) with an observed commercial change of 5.5%. As summarized in Table 1, all payers demonstrated substantial increases in year-over-year expenditures when compared to 2020. This is likely due to a stabilization in care-seeking patterns experienced in 2021 and 2022. The annual percent increase between 2020 and 2021 observed for commercial was the highest of all payers (21.8%). Overall, the compounded annual all-payer growth is within the accepted range per the All-Payer ACO Model Agreement (3.5% - 4.3%) at 3.7%.

Table 1: TCOC Per Beneficiary Annual Growth & CAGR to Date by Type of Payer

	Baseline (2017)	PY1 (2018)	PY2 (2019)	PY3 (2020)	PY4 (2021)	PY5 (2022)	Compounding Growth ('17 to '22)
All-Payer	**$497**	**$515** (3.8%)	**$542** (5.3%)	**$502** (-7.4%)	**$586** (16.5%)	**$596** (1.8%)	**3.7%**
Commercial	$463	$471 (1.8%)	$503 (6.8%)	$473 (-6.1%)	$576 (21.8%)	$606 (5.2%)	**5.5%**
Medicare	$843	$873 (3.6%)	$893 (2.2%)	$819 (-8.3%)	$938 (14.6%)	$976 (4.0%)	**3.0%**
Medicaid	$242	$255 (5.5%)	$265 (3.9%)	$252 (-5.1%)	$300 (19.2%)	$296 (-1.3%)	**4.1%**

Previous estimates of expenditures from 2017 through 2022 have been updated throughout this report. Consequently, annual growth and compounding annual growth rate have been recalculated as well and differ from prior annual reports. There are three reasons for the updates: 1) enhancements to the state's APCD, 2) corrections to the TCOC calculation and 3) recalculation of the Medicaid repricing adjustment. These were necessary changes to provide more valid and reliable estimates. There are no other anticipated changes that would require the historical data to be updated in the future.

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[1] regarding Vermont's performance on Total Cost of Care (TCOC)[2] 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 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 2022.

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.[3]

3. Considerations

3.1. Public Health Emergency/COVID-19

On March 20, 2020, the State of Vermont declared suspension of all non-essential elective surgery and medical and surgical procedures, including dental procedures, pursuant to the Declaration of State of Emergency in Response to COVID-19 Executive Order, in an effort to help protect patients, reduce exposure to healthcare providers and preserve personal protective equipment. In May 2020, limited elective procedures were allowed to resume, however, many were postponed during the second wave of the pandemic starting in October 2020.

Although there was concern of over utilization and capacity of hospitalization due to COVID-19, the 2020 COVID-19 case incidence in Vermont was relatively low, with approximately 5% of Vermont cases requiring hospitalization. An estimated 30% of those hospitalized required intensive care unit (ICU) services, however these costs did not affect TCOC as much as the ***lack*** of healthcare utilization. This underutilization led to expected increases in TCOC expenditures in 2021 and 2022.

Table 2 outlines broad spending categories for consideration and review. Most notably, overall medical utilization increased between 2020 and 2022 across payer types, as expected after a period of lower-than-expected utilization. However, decreases were noted for hospital discharges (inpatient utilization) while utilization for Emergency Services increased substantially across all payer types. Vermont is currently experiencing a severe provider shortage and increased wait times for services, which may contribute to the

[1] 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).
[2] Complete TCOC specifications are available upon request.
[3] 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.

sharp increase in Emergency Department visits. Mixed results were seen for Mental Health and Substance Use services, with modest increases in utilization and a decrease for Medicare in 2022.

Table 2: Utilization per 1,000 Members

	Payer Type	2020	2021	2022	Percent Change 2021-2022	Percent Change 2020-2022
Total Claims	All-Payer	9,475	10,566	10,344	-2.1%	9.2%
	Commercial	8,363	9,566	9,557	-0.1%	14.3%
	Medicaid	7,184	7,686	7,442	-3.2%	3.6%
	Medicare	13,756	15,848	15,853	0.0%	15.2%
Hospital Discharges	All-Payer	94	86	82	-4.2%	-12.8%
	Commercial	50	49	48	-2.3%	-2.6%
	Medicaid	57	55	52	-4.7%	-8.5%
	Medicare	209	188	188	0.4%	-9.8%
Emergency Department Visits	All-Payer	272	313	347	10.9%	27.7%
	Commercial	169	201	224	11.3%	32.4%
	Medicaid	374	417	468	12.1%	25.2%
	Medicare	335	377	412	9.5%	23.2%
Mental Health and Substance Use	All-Payer	1,373	1,422	1,437	1.1%	4.7%
	Commercial	1,972	2,079	2,088	0.5%	5.9%
	Medicaid	852	866	901	4.0%	5.7%
	Medicare	932	980	956	-2.4%	2.6%

3.2. Medicare Advantage

Vermont is continuing to experience an increasing Medicare Advantage penetration rate. As outlined in the 2019 Annual Total Cost of Care Report,[4] while the APM Agreement explicitly requires Medicare Advantage members to be categorized as commercial, their average expenditures are more like traditional Medicare than standard commercial populations. Table 3 summarizes the PMPMs for Commercial and Medicare subgroups according to the TCOC specified in the APM Agreement.

[4] https://gmcboard.vermont.gov/sites/gmcb/files/documents/ANNUAL_19TCOC%20Report_FINAL_04142021.pdf.

Table 3: APM Total Cost of Care (TCOC) Per Member per Month (PMPM) for Selected Subgroups

	2017	2018	2019	2020	2021	2022	Compounding Growth ('17 to '22)
Full Population TCOC PMPM	**$497**	**$515 (3.8%)**	**$542 (5.3%)**	**$502 (-7.4%)**	**$586 (16.5%)**	**$596 (1.8%)**	**3.7%**
Traditional Medicare	$843	$873 (3.6%)	$893 (2.2%)	$819 (-8.3%)	$938 (8.3%)	$976 (15.7%)	**3.0%**
Commercial	$463	$471 (1.8%)	$503 (6.8%)	$473 (-6.1%)	$576 (21.8%)	$606 (5.2%)	**5.5%**
Fully Insured	*$451*	*$453 (0.5%)*	*$487 (8.1%)*	*$454 (0.7%)*	*$556 (23.4%)*	*$580 (28.8%)*	**5.2%**
Self-Insured	*$456*	*$471 (3.4%)*	*$493 (8.2%)*	*$461 (1.1%)*	*$552 (21.2%)*	*$577 (26.6%)*	**4.8%**
Medicare Advantage	*$625*	*$587 (-6.0%)*	*$649 (3.8%)*	*$609 (-2.6%)*	*$737 (18.0%)*	*$788 (26.0%)*	**4.7%**

Table 4 recategorizes Medicare Advantage with traditional Medicare and shows the commercial growth rate absent the increasing numbers of Medicare Advantage enrollees. The reallocation shows that the "All Medicare" population's PMPM expenditures decreased by nearly 9% (versus 8.3% for traditional Medicare alone) from 2019 to 2020. In 2021, as care patterns began to normalize after the initial onset of Covid-19, the reallocation shows "All Medicare" PMPM expenditures increasing 14.7%, more than five percent higher than traditional Medicare alone. Also, the reallocation of Medicare Advantage out of the Commercial payer group as shown in in Table 3, brings the Commercial growth rate from 5.5% to 5.1%.

Table 4: APM TCOC PMPM with Reallocation of Medicare Advantage from Commercial to Medicare

	2017	2018	2019	2020	2021	2022	Compounding Growth ('17-'22)
All Medicare (Traditional + MA)	$823	$844 (+2.8%)	$863 (+2.3%)	$788 (-8.7%)	$904 (+14.7%)	$939 (+3.9%)	**2.7%**
Commercial (Excluding MA)	$452	$462 (+2.3%)	$490 (+6.0%)	$457 (-6.7%)	$554 (+19.5%)	$579 (+4.5%)	**5.1%**

3.3. Hold Harmless

The Model Agreement establishes an All-Payer TCOC Target of 3.5% over the five performance years of the model. The Model Agreement recognizes that one value of an all-payer model is to address different levels of payments made to providers by payers for similar sets of services. Among other provisions in section 10 (Payer Differential), the Model Agreement establishes that Medicaid reimbursement rate increases that address an existing payer differential or that are intended to ensure greater access should be treated differently than ordinary spending. Section 10.d. provides: *"[i]n order to encourage Vermont to address the Payer Differential, CMS shall make adjustments to the All-payer Total Cost of Care per Beneficiary Growth Target Calculation, as necessary and as specified in this subsection, to recognize that cumulative All-payer Financial Target Services growth may be attributable to efforts by Vermont to increase Vermont Medicaid reimbursement rates to levels comparable to or greater than Medicare reimbursement rates, where a comparable service is*

available, or to rates sufficient to ensure greater access by Medicaid beneficiaries." Year-end percentage reductions that have been applied to prior performance years are shown in Table 5, below.

Table 5: Hold Harmless Reductions 2018 - 2022

	2018	2019	2020	2021	2022
Hold Harmless %	-2.4%	-4.4%	-3.9%	-3.1%	-4.9%

4. Summary of Results

The following tables outline TCOC growth as required per the All-Payer ACO Model Agreement. Table 6a includes the hold harmless adjustment, and table 6b shows the complete TCOC for all reporting years.

Table 6a: All-Payer Total Cost of Care Results, Prior Four Quarters and Year-to-Date (including reduction for excludable Medicaid costs)[5]

		Q1	Q2	Q3	Q4	TCOC Growth YTD (Q1+Q2+Q3+Q4)*
Baseline (CY 2017)	TCOC/Beneficiary (PMPM)	$495.10	$502.84	$485.16	$502.92	$496.51
	Numerator ($)	*$679,450,246*	*$692,235,152*	*$665,677,087*	*$687,931,668*	*$2,725,294,153*
	Denominator (Members)	*457,447*	*458,884*	*457,361*	*455,958*	*457,412*
PY 1 (2018)	TCOC/Beneficiary (PMPM)	$518.32	$519.25	$500.08	$523.93	$515.40
	Numerator ($)	*$717,812,290*	*$717,482,672*	*$687,794,939*	*$719,145,299*	*$2,842,235,201*
	Denominator (Members)	*461,629*	*460,590*	*458,455*	*457,529*	*459,551*
PY 2 (2019)	TCOC/Beneficiary (PMPM)	$546.47	$552.08	$529.80	$541.43	$542.47
	Numerator ($)	*$751,475,170*	*$755,745,804*	*$722,329,075*	*$736,276,652*	*$2,965,826,701*
	Denominator (Members)	*458,383*	*456,300*	*454,463*	*453,292*	*455,609*
PY 3 (2020)	TCOC/Beneficiary (PMPM)	$523.04	$427.46	$540.23	$518.67	$502.42
	Numerator ($)	*$715,098,114*	*$590,340,645*	*$750,983,464*	*$726,784,563*	*$2,783,206,786*
	Denominator (Members)	*455,731*	*460,346*	*463,374*	*467,078*	*461,632*
PY 4 (2021)	TCOC/Beneficiary (PMPM)	$572.90	$589.16	$589.54	$590.51	$585.56
	Numerator ($)	*$795,828,216*	*$821,445,057*	*$825,654,485*	*$831,553,121*	*$3,274,480,880*
	Denominator (Members)	*463,040*	*464,755*	*466,839*	*469,397*	*466,007*
PY 5 (2022)	TCOC/Beneficiary (PMPM)	$576.35	$599.97	$592.32	$616.76	$596.36
	Numerator ($)	*$804,876,061*	*$839,087,421*	*$827,887,323*	*$863,925,610*	*$3,335,776,415*
	Denominator (Members)	*465,503*	*466,184*	*465,900*	*466,919*	*466,127*
Per Beneficiary Growth Rate (2017 to 2021)		***3.1%***	***3.6%***	***4.1%***	***4.2%***	***3.7%***

Table 6a Notes: Quarters may not sum due to rounding and different amounts of time for claims runout; claims-based spending is based on allowed amounts; weighted by months enrolled during the measurement period.

[5] 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 -4.9% for claims payments and Medicaid prospective PBP payments in 2022.

Table 6b: 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)	$495.10	$502.84	$485.16	$502.92	$496.51
	Numerator ($)	*$679,450,246*	*$692,235,152*	*$665,677,087*	*$687,931,668*	*$2,725,294,153*
	Denominator (Members)	*457,447*	*458,884*	*457,361*	*455,958*	*457,412*
PY 1 (2018)	TCOC/Beneficiary (PMPM)	$520.12	$521.07	$501.83	$525.70	$517.19
	Numerator ($)	*$720,301,204*	*$720,005,684*	*$690,196,073*	*$721,573,152*	*$2,852,076,112*
	Denominator (Members)	*461,629*	*460,590*	*458,455*	*457,529*	*459,551*
PY 2 (2019)	TCOC/Beneficiary (PMPM)	$549.82	$555.43	$533.14	$544.69	$545.79
	Numerator ($)	*$756,082,830*	*$760,327,476*	*$726,871,391*	*$740,717,135*	*$2,983,998,832*
	Denominator (Members)	*458,383*	*456,300*	*454,463*	*453,292*	*455,609*
PY 3 (2020)	TCOC/Beneficiary (PMPM)	$531.33	$430.16	$543.27	$521.62	$506.65
	Numerator ($)	*$726,431,152*	*$594,068,973*	*$755,213,305*	*$730,910,185*	*$2,806,623,615*
	Denominator (Members)	*455,731*	*460,346*	*463,374*	*467,078*	*461,632*
PY 4 (2021)	TCOC/Beneficiary (PMPM)	$595.60	$613.12	$615.81	$616.53	$610.30
	Numerator ($)	*$827,352,357*	*$854,853,922*	*$862,449,359*	*$868,190,726*	*$3,412,846,364*
	Denominator (Members)	*463,040*	*464,755*	*466,839*	*469,397*	*466,007*
PY 5 (2022)	TCOC/Beneficiary (PMPM)	$602.48	$627.12	$620.92	$645.33	$623.98
	Numerator ($)	*$841,363,062*	*$877,066,703*	*$867,856,766*	*$903,947,329*	*$3,490,233,860*
	Denominator (Members)	*465,503*	*466,184*	*465,900*	*466,919*	*466,127*
Per Beneficiary Growth Rate (2017 to 2021)		***4.0%***	***4.5%***	***5.1%***	***5.1%***	***4.7%***

Table 6b Notes: Quarters may not sum due to rounding and different amounts of time for claims runout; claims-based spending is based on allowed amounts; weighted by months enrolled during the measurement period.

The ACO Agreement requires adding Medicaid Long Term Care (LTC) payments to TCOC in performance year 4 (PY4) (2021). Medicaid pays LTC costs for Medicaid members, including duals who are assigned to Medicare by the TCOC algorithm. To incorporate these associated costs, the GMCB and AHS worked together to identify applicable category of service codes, adding a total of $124.9 million Medicaid dollars to the 2021 annual costs and $132.3 million in 2022. Table 6c shows the 2021 and 2022 PMPM costs by payer including the addition of LTC costs. The overall change in per member expenditures from 2017 to 2022 was 3.7%. However, because of the addition of LTC expenditures, Medicaid's percent increase is inflated (without LTC expenditures, Medicaid PMPM 2020-2022 would have stayed about the same). We omit the annual change overtime for Medicaid from Table 6c as the total PMPM is calculated differently with the addition of Long-Term Care expenditures (Appendix C).

Table 6c: All-Payer TCOC calculation for 2017-2022

	Payer	Total Claims Costs	Total Non-Claims	Long Term Care Costs	Total Costs	Member Months	Total cost PMPM	Annual Growth	Per Beneficiary Growth
Baseline	All Payer	$2,644,433,037	$80,861,116		$2,725,294,153	5,488,949	$497	-	-
	Commercial	$1,095,349,845	$17,972,204		$1,113,322,048	2,405,236	$463	-	-
	Medicaid	$342,607,004	$55,388,912		$397,995,916	1,644,022	$242	-	-
	Medicare	$1,206,476,189	$7,500,000		$1,213,976,189	1,439,691	$843	-	-
PY1 (2018)	All Payer	$2,604,038,101	$246,400,092		$2,850,438,193	5,514,606	$517	**4.0%**	**4.0%**
	Commercial	$1,131,879,986	$14,785,200		$1,146,665,186	2,433,437	$471	**1.7%**	**1.7%**
	Medicaid	$344,036,473	$75,462,682		$419,499,155	1,610,813	$260	**7.4%**	**7.4%**
	Medicare	$1,128,121,641	$156,152,210		$1,284,273,851	1,470,356	$873	**3.6%**	**3.6%**
PY2 (2019)	All Payer	$2,624,902,229	$354,091,191		$2,978,993,420	5,467,312	$545	**5.4%**	**4.7%**
	Commercial	$1,226,002,775	$15,508,240		$1,241,511,015	2,466,233	$503	**6.8%**	**4.2%**
	Medicaid	$298,495,285	$118,486,689		$416,981,973	1,522,406	$274	**5.4%**	**6.4%**
	Medicare	$1,100,404,170	$220,096,262		$1,320,500,432	1,478,673	$893	**2.3%**	**2.9%**
PY3 (2020)	All Payer	$2,408,691,541	$383,402,668		$2,792,094,209	5,539,587	$504	**-7.5%**	**0.5%**
	Commercial	$1,152,882,543	$14,798,430		$1,167,680,973	2,470,476	$473	**-6.0%**	**0.7%**
	Medicaid	$229,721,030	$177,245,643		$406,966,672	1,581,821	$257	**-6.2%**	**2.0%**
	Medicare	$1,026,087,968	$191,358,595		$1,217,446,563	1,487,290	$819	**-8.3%**	**-1.0%**
PY4 (2021)	All Payer	$2,746,516,649	$415,552,469	$121,053,658	$3,283,122,776	5,592,089	$587	**16.5%**	**4.2%**
	Commercial	$1,385,628,775	$13,979,676		$1,399,608,451	2,431,356	$576	**21.8%**	**5.6%**
	Medicaid	$268,679,177	$158,961,442	$121,053,658	$548,694,277	1,747,416	$300	-	**5.5%**
	Medicare	$1,083,566,800	$242,611,351		$1,326,178,151	1,413,317	$938	**14.5%**	**2.7%**
PY5 (2022)	All Payer	$2,778,873,963	$431,175,039	$125,727,412	$3,335,776,415	5,593,518	$596	**1.5%**	**3.7%**
	Commercial	$1,482,244,350	$10,785,247		$1,493,029,597	2,464,989	$606	**5.2%**	**5.5%**
	Medicaid	$259,119,863	$178,953,919	$125,727,412	$563,801,194	1,817,936	$296	-	**4.1%**
	Medicare	$1,037,509,751	$241,435,873		$1,278,945,624	1,310,593	$976	**4.1%**	**3.0%**

From table 6c, we observe that there was especially high growth in Commercial and Medicare between 2020-2021. Continued commercial TCOC growth into 2022 is likely a combination of increased volume of care, the continuous increase in MA penetration (grouped into Commercial), and rate increases post-Covid-19 PHE. The PMPM for Medicare shows a return to pre-pandemic expenditure growth trends. Overall Vermont's TCOC CAGR remains within the bounds of the Agreement.

5. Conclusion

The results presented here will not accurately assess "performance" as outlined in the APM Agreement. Beginning in 2020, the effects of the global pandemic and associated Public Health Emergency (PHE) necessarily and drastically changed care patterns. The PHE redefined short-term health system priorities to meet immediate acute care needs and stabilize the health care system. These necessary changes are likely to have impacted preventive care and health promotion activities. The full effects of the PHE are still developing and may distort trends for many years to come.

Following the fifth performance year, we are beginning to see some normalization of trends in spending following the PHE. Overall, compounding all-payer growth is within the accepted range per the All-Payer ACO Model Agreement (3.5% - 4.3%) at 3.7% for 2022.

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 through 5 of the APM, using 2017 as a baseline (adjusted in PY1 with MAPCP, and shared savings/loss adjustment). From Section 9.a.i of the Agreement:

$$\left(\frac{\left(\frac{Vermont\ all-payer\ TCOC_{2022}}{Vermont\ all-payer\ beneficiaries_{2022}}\right)}{\left(\frac{Vermont\ all-payer\ TCOC_{2017}}{Vermont\ all-payer\ beneficiaries_{2017}}\right)}\right)^{\frac{1}{5}} - 1 \leq 0.035$$

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[6], 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.

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.

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

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 2022. Medicaid claims payments and Medicaid all-inclusive population based payments (PBPs)[7] were adjusted downward by 4.9 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 2022, 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 -4.9% for excludable price increases under the terms of the APM Agreement.[8] 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 2022 shared savings payments totaling $9,574,335, of which $9,073,982was advanced to the ACO to promote continued funding of the Blueprint for Health and SASH, leaving $490,346of net savings in the Medicare program for 2022.[9]

[7] PBPs are also known as Fixed Prospective Payments (FPPs).
[8] The Medicaid repricing factor is also applied to 2022 claims payments. See Vermont All-Payer Accountable Care Organization Model Agreement, Section 10.d.
[9]https://gmcboard.vermont.gov/sites/gmcb/files/documents/PY%202022%20VTAPM%20Final%20Shared%20Savings%206M%20GMCB%281%29.pdf

Appendix C: Long-Term Care TCOC calculations

Background

The ACO Agreement requires adding Medicaid LTC payments to TCOC in performance year 4 (PY4) (2021). Medicaid pays LTC costs for Medicaid members, including duals who are assigned to Medicare by the TCOC algorithm. Medicaid might also pay LTC for members with secondary Medicaid coverage with primary commercial coverage—who are assigned to the commercial category in TCOC logic—and members with secondary Medicaid coverage who are excluded from TCOC logic.

Incorporating LTC costs presents methodological challenges due to how members are assigned to payer groups in TCOC logic. The key challenge is calculating per member per month costs without double counting members with secondary Medicaid coverage. Beginning with 2022 reporting, LTC costs and members were incorporated directly into the TCOC data file from VHCURES.

Method to add LTC spending to PMPM costs

To mitigate the risk of double counting members with secondary Medicaid in PMPM costs requires adding LTC PMPM costs to existing PMPMs. The method to calculate LTC PMPM differs for the all-payer and Medicaid populations.

All Payer TCOC PMPM

All Payer TCOC PMPM = All Payer PMPM with no LTC + All Payer PMPM with LTC

Where All Payer PMPM with no LTC = All non LTC costs/unduplicated all payer member months

And All Payer PMPM with LTC = All LTC costs/(all payer primary member months+excluded Medicaid member months)

Where Excluded Medicaid members are in TCOC stepdown tables in the “excluded, secondary Medicaid” category

Medicaid TCOC PMPM

Medicaid TCOC PMPM = Medicaid PMPM with no LTC + Medicaid PMPM with LTC

Where Medicaid PMPM with no LTC = All non LTC costs/Medicaid primary member months

And Medicaid PMPM with LTC = All LTC costs/(Medicaid primary member months + Medicaid secondary member months)

Where Medicaid secondary member months =

Medicare primary\Medicaid secondary member months +

commercial primary\Medicaid secondary member months +

excluded Medicaid secondary member months