Vermont All-Payer ACO Model
Annual ACO Scale Targets and Alignment Report
Performance Year 2 (2019)

Submitted June 30, 2020

Green Mountain Care Board

1. Executive Summary

The Annual ACO Scale Target and Alignment Report, as required by the Vermont All-Payer Accountable Care Organization Model ("All-Payer ACO Model" or "APM") Agreement, 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 2 (PY2, 2019) and an outline of key challenges and opportunities to support further progress.

Progress Toward Achieving Scale Targets

In PY2, four 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; and the University of Vermont Medical Center (UVMMC) Shared Savings ACO Program.

Performance Year 2 results reflect significant growth in attributed lives since PY0 (2017), growing from 29,102 attributed lives to 160,048 in PY2. Most notably, the number of Medicaid beneficiaries attributed under Vermont Medicaid Next Generation ACO Program, which launched in 2017, increased by 45% in PY1 (from 29,102 to 42,342) and nearly doubled again in PY2 to 75,712, with 2020 attribution expected to exceed 100,000 lives.

Figure 1: Attributed Lives by Program to Date

Payer	2017 PY0	2018[1] PY1	2019[2] PY2	2020[3] Preliminary PY3
Medicaid	29,102	42,342	75,712	*103,548*
Medicare	-	36,860	53,973	*50,554*
Commercial	-	30,526	30,363	*69,056*

In PY 2, Vermont achieved **47% Medicare Scale Performance** (target: 75%) and **30% All-Payer Scale Performance** (target: 50%); Vermont did not achieve the Medicare and All-Payer Scale Targets for PY2. The APM Agreement anticipates that scale will increase over the life of the agreement. The gradual ramp up from PY1 is expected and intentional and PY2 attribution shows a marked increase over PY1, though still falling short of the scale targets per the agreement. The GMCB will continue to work with the ACO and other state partners to increase scale, and through its ACO oversight, will monitor new payer programs as they are developed, ensuring that services remain in alignment and qualify as scale target initiatives. Preliminary PY3 (2020) data show continued improvement over PY2.

[1] Attribution count as of January 1, 2018.
[2] Attribution count as of January 1, 2019.
[3] Current estimates based on 2020 revised attribution (6/19/2020).

Challenges Encountered in Achieving Scale Targets

A number of challenges prevented Vermont from achieving scale targets as outlined in the APM Agreement.

1. **The APM Agreement sets ambitious scale targets and includes populations over which the State has no authority.** In particular, the inclusion of self-funded employer plans and Medicare Advantage plans – which together cover nearly 1 in 3 Vermonters – presents an outreach and engagement challenge. In PY1, the population included for APM scale represents 85% of the entire Vermont population. However, the State can impact only 41% of the Vermont population outside of the Agreement (i.e. State employees, Medicaid beneficiaries, and fully insured plans subject to rate review). Medicare covers just under 20% of the remaining population.
2. **In PY2, many Vermont providers are still new to fixed payments.** With new communities coming on board or expanding participation in payer programs in 2019, education continues for the provider community. Prospective (FPP) payments for Medicaid and reconciled all-inclusive population-based payments (AIPBP) for Medicare patients require time and learning to operationalize. Providers differ in their readiness to assume, manage, and monitor that risk.
3. **Challenging dynamics in individual and small group markets.** Vermont has experienced several shifts in its insurance markets since the state negotiated the All-Payer Model, most notably movement from GMCB-regulated fully insured plans to federally-regulated plans (see Figure 2, below). This impacts scale when employers become self-insured or move to a carrier who is not participating with the ACO. In addition, in 2019, due to changes in federal policy relating to association health plans, the state saw a shift from the small group to association plans. Lastly, in the past two years, there has been a shift among the two insurers within the individual and small group markets resulting in lower participation in the ACO program. This shift from BCBSVT to MVP started with a small shift from 2016-2017 and continues through to the 2020-2021 rate filings. The largest shift was noticed from 2018-2019.[4] Now that both carriers in the individual and small group markets are participating in the ACO as of 2020, this should mitigate this last market issue.

Figure 2: Vermont Market Shift

	2013	2018	Change, 2013-2018
Total Insured Market (GMCB regulated)	151,752	94,415	▼ 37.8%
Individual & Small Group	*35,509*	*73,064*	▲ *105.8%*
Large Group	*116,243*	*21,351*	▼ *81.6%*
Total Self-Insured Market	157,047	208,439	▲ 32.7%
Total Other	41,191	12,135	▼ 70.5%
TOTAL COMMERCIAL MARKET	349,990	314,989	▼ 10.0%
Medicaid	127,342	150,375	▲ 21.7%
Medicare	111,954	133,915	▲ 22.0%
TOTAL GOVERNMENT COVERAGE	239,396	284,290	▲ 21.8%
TOTAL UNINSURED	37,344	19,800	▼ 47.0%

Together, Vermont and CMMI have the opportunity to alleviate some of these challenges to increasing scale, as we work to incentivize population health and delivery system reform:

1. Consideration of alternate attribution methodologies (e.g. geographic);

[4] Market shifts are based on rate filings and may not match actuals at year end.

2. Improvement of timelines and clarity of data provided to participants;
3. Denominator that the State has influence over (allowing the potential for 100% scale achievement); and,
4. Risk models that reflect challenges faced by small rural hospitals.

Looking ahead to PY3 (2020), the four Scale Target ACO Initiatives in place in since 2018 have continued to mature with two hospitals adding additional risk programs and one additional hospital joining the network.[5] All four payer programs were renewed in 2020, with the launch of an additional commercial payer program which added an additional 9,944 lives[6]. Currently, the GMCB estimates an approximate increase in attributed lives of 60,000 in PY3 (2020).

Alignment of Scale Target ACO Initiatives

The four Scale Target ACO Initiatives in 2019 were well aligned on most components. All initiatives used prospective 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 geographic attribution with the ACO in one health service area, St. Johnsbury. Because of the success of this pilot, Medicaid and the ACO rolled this out to their broader program statewide in 2020.

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 four Scale Target ACO Initiatives in 2019. 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. CMS has the sole discretion to approve or disapprove the State's assessment. If CMS disapproves the State's assessment, it may qualify as a Triggering Event as described in section 21."

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."

[5] In 2020, Springfield Hospital decreased its participation from all risk programs to Medicaid and BCBS only.
[6] Revised attribution as of 6/19/2020.

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 3, 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 3: Progress Toward Achieving All-Payer and Medicare Scale Targets by Performance Year

		PY1 (2018) Final	PY2 (2019) Interim	PY3 (2020)[7] Preliminary	PY4 (2021)	PY5 (2022)
Vermont All-Payer Scale Target Beneficiaries	*Target*	*36%*	*50%*	*58%*	*62%*	*70%*
	Actual	22%	30%	42%*		
	(Difference)	(-14%)	(-20%)	(-16%)		
Vermont Medicare Beneficiaries	*Target*	*60%*	*75%*	*79%*	*83%*	*90%*
	Actual	35%	47%	44%*		
	(Difference)	(-25%)	(-28%)	(-35%)		

While Vermont did not achieve the Medicare and All-Payer Scale Targets for PY2, marked improvement was made over PY1, with increases realized in both the All-Payer and Medicare calculations. Preliminary 2020 (PY3) attribution shows another large increase in attribution in the All-Payer category, with the Agreement anticipating continued scale growth over the remaining agreement term. Allowing scale targets to gradually increase over the course of the APM takes into consideration the practical realities of operational change at the provider level and allows time for providers to successfully change the way they deliver care. Section 4 of this report further discusses the factors contributing to the successes and challenges in achieving scale.

[7] 2020 preliminary estimates are based on revised attribution as of 6/19/2020 and utilize 2019 population estimates.

3.1. Scale Results

The APM Agreement sets ambitious scale targets and includes populations over which the state has no authority. In particular, the inclusion of self-funded employer plans and Medicare Advantage plans – which together cover nearly 1 in 3 Vermonters presents an outreach and engagement challenge. In PY2, the population included for APM scale represents 85% of the entire Vermont population. However, the State can impact only 41% of the Vermont population outside of the Agreement (i.e. state employees, Medicaid beneficiaries, and fully insured plans subject to rate review). Medicare covers just under 20% of the remaining population. These factors make achieving scale challenging. Figure 4, below, summarizes Vermont's scale estimates for 2019.

Figure 4: Scale Targets and Vermont Population

			Scale Denominator		Scale Numerator		
Payer	**Sub-Category**	**2019 Vermont Population**	**APM Population**	**% of All Vermonters**	**Participating in Scale Target ACO Initiatives**	**2019 Scale Achieved**	**Data Sources**
Medicare	*Parts A & B*	113,743	113,743	18%	53,973	47%	CMMI/VHCURES
	Part A or B only	7,402	0	0%	-	-	
	TOTAL	**121,145**	**113,743**	**18%**	53,973	**47%**	
Medicaid	*Attributable*	130,004	130,004	21%	75,712	58%	VHCURES
	Limited Coverage or Evidence of TPL	5,635	0	0%	-	-	
	TOTAL	**135,639**	**130,004**	**21%**	75,712	58%	
Commercial: Self-Funded Employers	*In VHCURES*	96,794	96,794	16%	10,021	6%	VHCURES
	Not in VHCURES	75,000	75,000	12%		0%	ASSR
	TOTAL	**171,794**	**171,794**	**28%**	10,021	6%	
Commercial: Fully Insured	*COA*	93,437	93,437	15%	20,342	22%	VHCURES
	No COA	5,697	0	0%	-	-	VHCURES
	No evidence of comprehensive, primary coverage	20,000	0	0%	-	-	ASSR
	TOTAL	**119,134**	**93,437**	**15%**	20,342	22%	
Commercial: Medicare Advantage	**TOTAL**	**17,745**	**17,745**	3%	0	0%	VHCURES
TRICARE	**TOTAL**	**13,166**	0	0%	-	-	TRICARE Website
FEHBP	**TOTAL**	**14,687**	0	0%	-	-	ASSR
Uninsured	**TOTAL**	**24,988**	0	0%	-	-	VHHIS
	GRAND TOTAL	**618,298 (Census)**	**526,723**	**85%**	**160,048**	**30%**	

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

3.2. Attribution

In PY2, all ACO Scale Target Initiatives continued to use prospective 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. Of note, changes in coverage among those enrolled in Medicaid or Qualified Health Plans (QHP) resulted in greater attrition rates than the self-insured and Medicare populations. The Medicare attrition is largely due to attributed beneficiary deaths throughout the performance year.

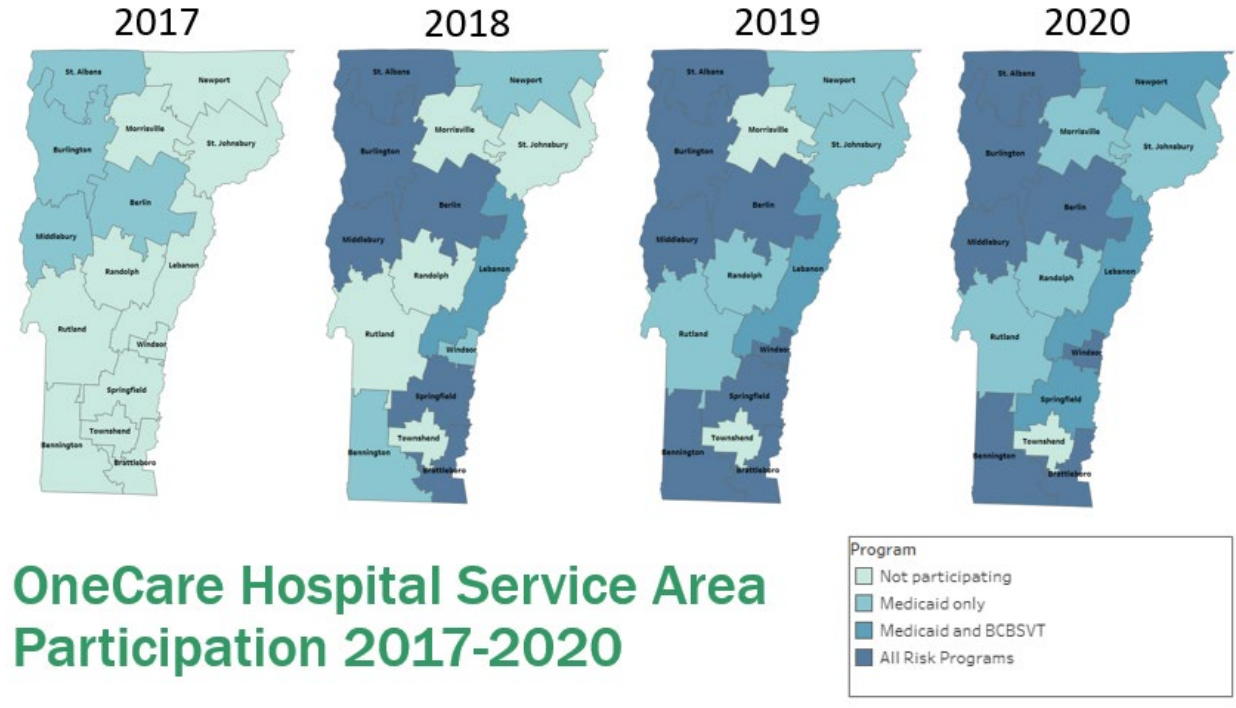
4. Factors Influencing Progress Toward Scale Targets

As noted above, 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.

4.1. Provider Network

Figure 5, below, outlines the ACOs growing network from 2017 - 2020.

Figure 5: OneCare Vermont Network Growth



4.1.1. Successes

DVHA's Medicaid program piloted a capitated payment model in 2017, which helped prepare the provider network for the All-Payer participation in PY1 and beyond. Provider participation in Medicaid's program included all but two hospitals in 2019. In addition, a majority of participating hospitals maintained commitments with all three payer programs (Medicaid, Medicare, and commercial programs through BlueCross BlueShield of Vermont) in 2019.

Many hospitals expanded their participation after starting with the Vermont Medicaid Next Generation Program. Hospitals have reported that beginning with Medicaid eases their operational adjustment from fee-for-service to value-based payment and delivery systems without as much risk as starting in the Medicare program. With success in managing the fixed payments in Medicaid, hospital leadership supports taking on additional risk and patient populations, while changing the hospital's operational and care delivery infrastructure to support this new paradigm.

In addition, PY2 also saw continued growth in the Comprehensive Payment Reform (CPR) program. Participating independent physician practices agree to receive fixed prospective payments for their attributed lives through a full or partial capitation model. These practice sites continue to be the first non-hospital entities in the state opting to receive payments outside of the fee-for-service structure.

4.1.2. Challenges

Providers in Vermont are still new to fixed payments and require ample time to adjust to taking on risk and make the operational changes needed to manage to that risk. In addition, challenges in Medicare's implementation of new payment methodologies has created uncertainty and some financial challenges, particularly for Vermont's vulnerable critical access hospitals. Providers report that APM participation presents an enormous 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 the entities and distributing risk.

In a 2019 survey of hospitals and FQHCs, providers indicated that in order to increase participation and achieve scale targets, hospitals and FQHCs must believe the payment structure is transparent, predictable, and sustainable.[8] Payments must offset any added administrative burden, including new reporting requirements, and must incentivize population health and delivery reform. Survey respondents suggested both external and internal use of existing regulatory and/or policy levers to help alleviate some challenges, including:

1. Improving communication throughout CMS regarding Vermont's model,
2. Clarifying the interaction between the FPP and Medicare Cost Reports,
3. Improving timeliness and clarity of data from all payers,
4. Considering alternate attribution methodologies,
5. Enhancing information available when considering Medicare risk, such as a trial period with shadow attribution before moving into the risk model, and

[8] See Appendix B.

6. Alignment of ACO participation requirements to existing state and federal rules in place (FQHC, Critical Access Hospitals, Patient Centered Medical Homes, etc.).

Outside of this survey, some non-participating providers have also indicated that the reconciliation of the Medicare fixed prospective payment to the fee-for-service equivalent has been a deterrent to their participation. It is possible that if this payment were truly fixed in nature, akin to the Medicaid program, that the ACO may be more successful in recruiting such providers to participate.

The most common and significant challenge for hospitals has been the Medicare payment errors in payment in 2018 and 2019 which required CMS to recoup funds from participating providers who received both FPP and fee-for-service payments. The federal payment errors exacerbated hospitals' concerns that they did not have a reliable, understandable method to track financials associated with their Medicare patients.

4.2. 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. 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. The GMCB will continue to explore new strategies in an effort to attract these plan types into the Model.

4.2.1. Successes

All three payer types were represented in the initial performance year. Both the payers and ACO were 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. GMCB is pleased that the state's largest commercial insurer, BCBSVT, continued to participate on behalf of its Qualified Health Plan business (20,342 attributed lives). In addition, BCBSVT continued its program for the self-funded plan covering the University of Vermont Medical Center employees (10,021 attributed lives).

4.2.2. Challenges

Vermont is preempted by federal law from influencing self-funded employer groups' choices regarding health insurance. Furthermore, engaging hundreds of employers individually would be difficult for an ACO to scale without unsustainably growing administrative personnel. OneCare is working with insurers to develop programs that allow employers to join through their third-party administrator to minimize this burden, as seen with the UVMMC participation.

Medicare Advantage presents additional challenges, because this business is growing in Vermont, with participation exceeding 17,000 in January of 2019. This was not the case at the time the APM Agreement was negotiated (enrollment was less than 10,500 at that time) and presents an unanticipated challenge. The federal government is in a better position to encourage participation by these plans.

4.3. Attribution Methodology

Attribution methodology influences which Vermont patients are eligible to become members of 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 (or any) 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 appropriate methodologies.

4.3.1. Successes

The Vermont Medicaid Next Generation ACO Program has made incremental refinements and improvements to its attribution methodology for each performance year after 2017, to both better reflect relationships between members and their primary care providers, and (beginning in 2019) to design and pilot a different approach to attribution with select populations. For the 2019 performance year, DVHA and OneCare piloted geographic attribution in one area for Medicaid beneficiaries where notable differences in patients' patterns of care-seeking made them especially difficult to attribute. The pilot program used the member's residence to attribute them to OneCare, instead of claims associated with primary care. The goal of geographic attribution is to support a whole-population (panel) approach to implementation of OneCare's Care Management Model to help account for some of the challenges presented by standard attribution methodologies. DVHA is continuing to implement improvements to its attribution methodology based on findings from the 2019 performance year.

4.3.2. Challenges

Traditional ACO attribution is provider-driven and there can be a disconnect between where people live (i.e., Vermont residents) and where they seek care. Initial exploration in 2018 indicated that even if all Vermont primary care providers had been participating in the OneCare network in 2018, fewer than 75% of Vermont Medicare beneficiaries would have attributed to the ACO due in part to the large number of Vermonters who seek regular care in border states, or who reside in other parts of the country for some portion of the year. 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.

5. Scale Target ACO Initiative Design Alignment

5.1. 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 2019 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 6 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, and the Self-Insured ACO Program Agreement between UVMMC 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. CMS and Vermont will work together to explore modifications to the Vermont Medicare ACO Initiative in order to facilitate design alignment. In accordance with section 8, Vermont may propose such modifications to the Initiative, and CMS may accept such proposals for modifications at its sole discretion."*
>
> *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. CMS has the sole discretion to approve or disapprove the State's assessment. If CMS disapproves the State's assessment, it may qualify as a Triggering Event as described in section 21."*

Figure 6: Crosswalk: Key Design Features of 2019 Scale Target ACO Initiatives

	Vermont Medicare ACO Initiative	Vermont Medicaid Next Generation ACO	BCBSVT (QHP)	UVMMC (Self-Insured)
Services Included for Shared Savings/Losses	Parts A & B services for aligned beneficiaries	Generally, A & B services. Exceptions: • Psychiatric treatment in state psychiatric hospital or Level-1 (involuntary placement) inpatient stays in any hospital when paid for by DVHA • Spend at Designated Agencies/Specialized Service Agencies • Skilled Nursing Facilities • Categories of Service with the following two-digit prefixes: 08, 22, 29, 35, 05, 27, 33, 36, 37 • Services paid for by the state departments other than DVHA	Generally, A & B services Exceptions: • Retail Pharmacy	Generally, A & B services. Exceptions: • Pharmacy • Behavioral Health • Non-Medical dental or vision
Risk Arrangement	Two-sided risk arrangement, no minimum savings or loss rate. 5% 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. 4% TCOC risk corridor, 100% share. No truncation, no payer-provided reinsurance, no risk adjustments. Geographic attribution pilot had no associated risk.	Two-sided risk arrangement, no minimum savings or loss rate. 6% TCOC risk corridor, 50% share. No payer-provided reinsurance, end-of-year risk adjustment.	One-sided risk arrangement, eligible for savings after program costs covered, 10% TCOC upside risk corridor, 30% share. No downside risk.
Payment Mechanism from Payer to ACO	AIPBP for eligible participants (e.g. hospitals), FFS for non-eligible.	FPP for eligible participants (e.g. hospitals), FFS for non-eligible.	FFS.	FFS.
Quality Measures ***See Appendix C for 2019 measure crosswalk***	Financial arrangement tied to quality of care for the health of aligned beneficiaries. Utilizes Value-Based Incentive Fund (VBIF). Majority of the measures align with the APM Agreement.	Financial arrangement tied to quality of care for the health of aligned beneficiaries. Utilizes VBIF. Majority of the quality measures align with the APM Agreement.	Financial arrangement tied to quality of care for the health of aligned beneficiaries. Utilizes VBIF. Majority of the quality measures align with the APM Agreement.	Financial arrangement tied to quality of care for the health of aligned beneficiaries. Utilizes VBIF. Majority of the quality measures align with the APM Agreement.
Beneficiary Alignment	Prospective attribution, claims-based evaluation.	Prospective attribution, claims-based evaluation.	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.

5.2. Areas of Difference Between Scale Target ACO Initiative Designs

The 2019 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., the elderly 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 PY2 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. This is demonstrated in the Agreement by the inclusion of additional services for Medicaid in later years.

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 the Employee Retirement Income Security Act of 1974 (ERISA).

Risk Arrangements

The risk arrangements are reasonably aligned across payers in PY2. 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. The Medicaid program has a smaller risk corridor (4% in traditional attribution cohort; 2% upside, 1% downside in expanded attribution cohort [St, Johnsbury Pilot]) than the other payers. BCBSVT increased the risk sharing percentage from 80% in PY1 to 100% in PY2, in line with both Medicaid cohorts. Lastly, the UVMMC self-insured employer contract was the only program without downside risk.

Justification:

Medicaid Traditional Attribution: The smaller risk corridor (4%) reflects the Medicaid population, which includes the most vulnerable Vermonters with poor social determinants of health. The 4% corridor provided value to the Medicaid program, provided sufficient incentives for providers, and reflected the financial risk associated with this population.

Medicaid Expanded Attribution (St. Johnsbury HSA Pilot): In PY2, this cohort did not have any risk associated.

BCBSVT: A 50% sharing arrangement ensures that half of any PY2 savings are returned to the carrier to increase the affordability of coverage. This arrangement provided value to the carrier and its customers while also ensuring that the provider network has a financial incentive to contain costs.

UVMMC self-insured: Whereas OneCare's two-sided risk programs with Medicare, Medicaid, and BCBSVT in 2019 were preceded by several years of shared savings experience, OneCare and UVMMC entered into their first agreement in 2018, allowing the parties to enter a shared

savings program and measure the population's needs, this program continued into 2019. Due to the legal complications surrounding sufficient risk, it may take time for the parties to develop an ERISA-compliant risk arrangement that includes a downside component. The State, however, cannot compel a self-insured employer to modify their risk arrangement as noted above.

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 2019, the Medicare and Medicaid contracts continued to offer an All-Inclusive AIPBP 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 fee-for-service (FFS).

Justification:

The Commercial plans stated that they had limitations in their claims processing system to be able to make the transition from FFS to AIPBP and fixed payments. In 2019, BCBSVT implemented new claims processing technology, which was a complex and arduous process. Moving forward, BCBSVT is expecting the operational capability that would allow implementation of fixed prospective payments.

Monitoring:

BCBSVT and OneCare have stated that the parties will commit best efforts to implement a system whereby the BCBSVT will make fixed prospective payments for medical services to the ACO for designated ACO Participants by January 1, 2020. The parties have, in fact, implemented a pilot in 2020.

GMCB will continue to monitor progress towards this mutual goal.

Quality Measure Alignment

As seen in Appendix C, PY2 quality measures differ across payers in terms of the number of measures required, and include differences in measured population (e.g. elderly 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[9] to begin in 2019 and run through the duration of the Model. 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 priority areas 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

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

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 7) 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, in line with the Medicaid programs attribution algorithm set out in 2019 and carried into 2020 on a statewide basis. At this time, the program variation is acceptable and justifiable given the issues raised earlier.

Figure 7: Attribution Elements

Attribution Element	Medicare	Medicaid	BCBS Next Gen	UVMMC Shared Savings
Provider Types	Primary Care and select specialists	Primary Care or Geographic Attribution (pilot in St. Johnsbury)	Primary Care	Primary Care
Look-Back Period	24 months (ending 6 months prior to the start of PY)	30 months (ending 6 months prior to the start of PY)	24 months (ending immediately prior to the PY)	24 months (ending immediately prior to the PY)
Qualifying Claims *(and tie breakers)*	Highest weighted allowed amount *(most recent visit)*	Highest weighted allowed amount *(most recent visit)*	Patient-selected PCP; otherwise greatest number of claims *(most recent visit)*	Patient-selected PCP; otherwise greatest number of claims *(most recent visit)*
Alignment Based on Selection of PCP	No	No	Yes	Yes

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 four payers. In the 'Alignment based on selection of PCP', neither Medicare nor Medicaid require the selection of PCP, while 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 geographic attribution in the Medicaid population. In addition to looking for alignment, we may be evaluating whether some attribution methodologies are more likely to result in the state achieving scale targets.

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 B: Scale Memo

MEMORANDUM

TO: Green Mountain Care Board

FROM: Susan Barrett, Executive Director, Green Mountain Care Board
Ena Backus, Director of Health Care Reform, Agency of Human Services

CC: Scale Survey Participants
DATE: August 16, 2019
SUBJECT: Insights from Hospital/FQHC Scale Survey: Results and Reactions

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In April of 2019, the Green Mountain Care Board and the Director of Health Care Reform of the Agency of Human Services conducted a survey with Vermont hospitals and federally qualified health centers (FQHCs) to assess how the state can increase provider participation in the Vermont All-Payer ACO Model. The goal of the survey was to identify barriers to scale and potential strategies to improve the Model.

Section 6 of the All-Payer ACO Model Agreement ("Agreement") includes annual scale targets. These are included below with Vermont's final PY1 and preliminary PY2 scale performance.

Table 1: All-Payer ACO Model Scale Targets

		PY1 (2018)	PY2 (2019)	PY3 (2020)	PY4 (2021)	PY5 (2022)
Vermont All-Payer Scale Target Beneficiaries	*Target*	*36%*	*50%*	*58%*	*62%*	*70%*
	Actual	22%	30%-40%*			
Vermont Medicare Beneficiaries	*Target*	*60%*	*75%*	*79%*	*83%*	*90%*
	Actual	35%	52%			

*PY2 Commercial Self-Funded numbers are preliminary. Ranges represent approximate totals across these contracts and potential impact on All-Payer Scale.

Source: Vermont All-Payer ACO Model Annual ACO Scale Targets and Alignment Report, Performance Year 1 (2018), submitted June 28, 2019. Available at: https://gmcboard.vermont.gov/payment-reform/APM.

Vermont did not achieve the PY1 Scale Targets. However, the Agreement anticipates continued increases in scale over the life of the model, with a more significant growth trajectory after PY1.

Results from the survey suggest that in order to increase participation in the Model and achieve the scale targets described above, hospitals and FQHCs must believe the All-Payer ACO Model's payment structure is *transparent, predictable, and sustainable*. Payments from the ACO and participating payers must offset additional administrative and reporting requirements (*reduce burden*) and incentivize delivery reform, with a greater emphasis on prevention and health improvement (*incentivize population health*).

The table on pages 2 [following page] summarizes key takeaways from the survey; action steps taken in response to survey results; and next steps to improve participation.

Table 2: Issues Identified in Hospital/FQHC Survey Regarding Participation in the Vermont All-Payer ACO Model

Strategy	Lead	Status
Improve communication between federal partners regarding VT's All-Payer ACO Model	SOV	CMMI is interested in increasing coordination between CMMI, other CMS divisions, HRSA, and other federal agencies. GMCB and CMMI continue to discuss this issue.
Provide ACO-participating Critical Access Hospitals (CAHs) with guidance on federal cost report submission	SOV	CMMI is working with GMCB to provide guidance for ACO-participating CAHs. GMCB and CMMI continue to discuss this issue; GMCB is continually updating CAHs.
Improve processing of the Medicare payments (including the All-Inclusive Population Based Payments) to ensure that the ACO has a predictable Medicare revenue stream	CMMI	CMMI is hiring a new contractor to process Medicare payments. GMCB and CMMI continue to discuss this issue.
Improve the process for the ACO to receive Medicare benchmarking and attribution data	SOV	GMCB is researching how GMCB and CMMI can collaborate further on the Vermont Medicare ACO Initiative benchmarking process for 2020-2022.
Provide greater clarity on hospital risk and reserves	SOV	GMCB is seeking an expert opinion from a national contractor to support hospital and ACO regulation.
Offer a multiple risk models based on hospital size and readiness	OCV	OneCare Vermont is currently working on a modified model that will include a mechanism for reserving risk and will include further definition for hospital auditors. The ACO will continue dialog with founders, GMCB, and CAHs to create an aligned plan.
Continue to improve Care Navigator to allow use for all patients (not just ACO-attributed) and reduce burden of duplicate record-keeping by allowing uploads from existing EMR systems	OCV	OneCare Vermont is working with each health service area in the ACO network to educate and engage providers on the new care coordination payment model, which includes incentives to use Care Navigator. The ACO continues to work on integration opportunities with EMRs as part of a longer-term strategy and is currently working to identify short-term goals on site with key stakeholders.
Offer interested hospitals/FQHCs one year of shadow attribution without payment changes in advance of joining the ACO	OCV	In early consideration.
Improve hospital understanding of payer reconciliation	OCV	OneCare Vermont is seeking recommendations from a consultant on this issue.
Improve attribution and performance data clarity and timeliness for both Medicaid and Commercial programs	OCV/ payers	OneCare Vermont and payers continue to improve processes, alignment on methodology, and accuracy of data. Some improvements have already been made, including earlier contracting to allow the ACO to receive attribution files sooner and deliver them earlier to the network than in past years.
Improve clarity of contracts with FQHCs (e.g., expectations, deliverables, attribution methodology)	OCV	Completed for 2019. OneCare Vermont added more detail around expectations to FQHC contracts following feedback from FQHCs and other providers. Information about attribution, as well as other readiness education materials, are available to providers via a secure portal.
Develop FQHC-specific contract with more primary care funding and incentives to ease provider burden	OCV	OneCare Vermont's new payment model provides stronger incentives for care management and quality. OneCare continues to work with DVHA to expand the prior auth waiver and will engage with BCBSVT to partner on a similar waiver. OneCare is considering additional contracting strategies for future years.
Offer option for primary care to join without hospital partner	OCV	Currently, hospitals take on risk for the entire health service area's population and costs; under this model, OneCare Vermont is unable to provide this contract option, though other models may be considered.
Offer or facilitate network-based telehealth opportunities to smaller providers	OCV	OneCare Vermont offers innovation programs and grant opportunities to its provider network and would welcome proposals about telehealth and about meeting the specific needs of smaller providers.
Expand outreach to providers, including FQHCs, about benefits of joining	OCV	OneCare Vermont conducts outreach to all FQHCs as part of its network development during contracting, and will work to increase outreach in the future.
Change attribution methodology	OCV	DVHA and the ACO are currently developing a broader geographic attribution methodology, building on the St. Johnsbury attribution pilot initiated in 2019.

Appendix C: Quality Measure Crosswalk

Measure	Vermont All-Payer ACO Model	2019 Vermont Medicaid Next Gen	2019 Vermont Medicare Initiative	2019 BCBSVT Next Gen
% 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 adolescents with well-care visits	X	X		X
Initiation of alcohol and other drug dependence treatment	X	X	X	X[10]
Engagement of alcohol and other drug dependence treatment	X	X	X	
30-day follow-up after discharge from emergency department for mental health	X	X	X	X
30-day follow-up after discharge from emergency department for alcohol or other drug dependence	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		X

[10] BCBSVT Next Generation treats these measures as a single composite measure; Vermont Medicare ACO Initiative and Vermont Medicaid Next Generation treat them as separate measures.

Measure	Vermont All-Payer ACO Model	2019 Vermont Medicaid Next Gen	2019 Vermont Medicare Initiative	2019 BCBSVT Next Gen
Diabetes Mellitus: HbA1c poor control	X[11]	X	X[11]	X
All-Cause unplanned admissions for patients with multiple chronic conditions		X		
Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient experience surveys[12]	X	X	X	X
ACO all-cause readmissions (HEDIS measure for commercial plans)				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

[11] Per a mutual agreement between CMMI and the GMCB, these measures will be reported separately moving forward.
[12] 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)

3. *OneCare Vermont Attribution Update (6/19/2020)*
   Budget Order Item #9

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