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June 30, 2021

Rivka Friedman
Director, State Innovations Group
Acting Director, Prevention and Population Health Group
Center for Medicare and Medicaid Innovation
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD21244-1850

Dear Ms. Friedman,

In its letter to CMMI dated December 10, 2020, the Vermont signatories on the All-Payer Accountable Care Organization Model (APM) Agreement described challenges to achieving the scale targets set out in the Agreement and strategies the state intended to pursue to improve scale performance. This letter provides an update on Vermont's work to increase Model scale and offers some Vermont-developed alternative measures of scale that provide additional insight into the Model's reach.

Scale Strategy Progress Update

1. *Reduced Risk Corridor*: For 2021, the State signatories and CMMI partnered to offer the ACO a reduced risk corridor to support increased rural hospital participation, with reductions in the risk corridor tied to scale. This allowed Rutland Regional Medical Center to join the model in 2021, adding approximately 7,500 Medicare beneficiaries.
2. *CAH Cost Report Guidance*: Vermont requested that CMS offer written guidance or best practices for cost reporting by critical access hospitals (CAHs) that are receiving Medicare prospective payments. CMMI indicated that they will satisfy this request.
3. *Moving Toward True Fixed Payments in Vermont Medicare ACO Initiative*: The State signatories indicated that they would like to partner with CMS to establish a path for the Vermont Medicare ACO Initiative to increase opportunities for flexible, predictable, and sustainable population health payments to providers, building on lessons learned from the Vermont Medicaid Next Generation (VMNG) ACO program. Vermont and Innovation Center staff have discussed this opportunity.
4. *State Employee Health Plan Participation*: Vermont indicated that it would include State Employee Health Plan members for attribution to OneCare Vermont in 2021 (PY4) and this change has occurred. This added 12,675 commercially-insured Vermonters to scale target qualifying initiatives.

5. *Engaging Self-Funded Groups*: Vermont indicated that it would educate non-participating self-funded groups, including hospitals, teachers, and the broader business community about the benefits of participation in a value-based payment and delivery system transformation model. The Agency of Human Services (AHS) will be conducting outreach regarding the benefits of participating in value-based models during summer/fall 2021.
6. *Payer Engagement*: Vermont indicated that it would educate non-participating payers about the benefits of participation in value-based payment and delivery system transformation model. The AHS will lead on educating non-participating payers during summer/fall 2021.
7. *ACO Scale Strategy*: Vermont also indicated that it would continue requiring the ACO to provide updates on their scale strategy, including an update to activities identified in the 2019 Scale Survey and submission of a workplan to achieve goals associated with each activity.
8. *Stabilization Grants*: Finally, the State indicated that it would issue Health Care Provider Stabilization Grants to providers that maintain current levels of participation in value-based payment models. The state issued more than $145 million in health care stabilization funding, all contingent on maintaining current levels of participation in value-based payment. This requirement was enshrined in Vermont statute, Act 136 of 2020.

While the strategies described above are in play and have led to gains in scale, improvement in these areas alone will not make it possible to meet the scale targets as specified in the model Agreement. As we have indicated in the past and as discussed in the body of the report that this letter precedes, the scale targets as specified are unattainable due to numerous factors to include how Vermonters are attributed to the Model for scale.

Alternative Measures of All-Payer Scale for CMMI Consideration

Vermont's December 10, 2020, letter to CMMI also highlighted that the scale target denominator in the Agreement (Section 6.c) holds Vermont Accountable for payers and populations over which the state has limited data and no regulatory control. At that time the State asked that CMMI consider: (1) Removing Medicare Advantage members from the all-payer scale target denominator (approximately 17,700 in 2019); (2) Removing members of self-insured employer plans from the all-payer scale target denominator, with the exception of Vermont's state employee health plan and plans participating in a scale target ACO initiative (approximately 130,000); and (3) Removing Vermonters who receive the preponderance of their care outside of Vermont from the Medicare and all-payer scale target denominators (approximately 20,700 Medicare beneficiaries as of 2018).

In light of the time remaining in the Agreement and the clearance process that would be necessary for any of the changes above, the Vermont signatories do not think that it is worthwhile to amend the Agreement at this juncture, but respectfully request that CMMI consider the alternative scale target assessment strategies developed by the GMCB included in Annual ACO Scale Targets and Alignment Report Performance Year 3 (2020) when evaluating the state's performance in the final years of this agreement.

Summary of Alternative All-Payer Scale Measures

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

Summary of Alternative Medicare Scale Measures

Alternative Measure	Measure Description	Rationale
Adjusted Medicare Scale	Excludes Medicare beneficiaries who are not eligible for attribution.	Adjusts the Medicare scale target denominator to reflect eligible population.

These measures take into consideration the shared goals of a statewide model that moves away from fee-for-service reimbursement while recognizing that some factors that influence whether an individual Vermonter is attributed to the reimbursement model may or may not be within the State's control. For more detail, see Sections 4 and 5 of the full report.

Looking Ahead

Thank you for the opportunity to provide this update. The Vermont signatories to the APM Agreement remain enthusiastically committed to continuing our work with CMMI to drive transformation in health care payment and care delivery and look forward to our continued partnership.

Sincerely,

Michael K. Smith
Secretary

Kevin Mullin
Chair, Green Mountain Care Board

Vermont All-Payer ACO Model
Annual ACO Scale Targets and Alignment Report
Performance Year 3 (2020)

Submitted June 30, 2021

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 3 (PY3, 2020) as well as alternative measures of scale that provide an opportunity to more thoroughly understand performance against the scale measures included in the agreement relative to the goal of a statewide participation in the model.

In addition, the attached cover letter from the Vermont Agency of Human Services (AHS) and Green Mountain Care Board (GMCB) provides an update on Vermont's work to increase Model scale – including both the scale strategies outlined in Vermont's scale warning notice response as well as those in AHS's APM Implementation Improvement Plan – and previews the Vermont-developed alternative measures of scale are discussed further in this report, that provide additional insight into the Model's reach, as requested by CMMI in a letter dated March 5, 2021. The letter highlights AHS's leadership on efforts to engage payers and providers to support increased scale, as well as the GMCB's work to provide additional insight into the Model's statewide reach as the agency responsible for the majority of Vermont's reporting to CMMI under the Model Agreement.

Progress Toward Achieving Scale Targets

In PY3, five Scale Target ACO Initiatives operated through contracts between payers and OneCare Vermont: the Vermont Medicare ACO Initiative; the Vermont Medicaid Next Generation ACO Program; the BlueCross BlueShield of Vermont (BCBSVT) Commercial Next Generation ACO Program (Qualified Health Plan); the BlueCross BlueShield Primary Program (self-funded); and the MVP Qualified Health Plan program.

Performance Year 3 results reflect significant growth in attributed lives in both the Medicaid and Commercial programs. Most notably, the number of Medicaid beneficiaries attributed under Vermont Medicaid Next Generation ACO Program, which launched in 2017, increased nearly 300% since inception and 45% over PY2. Similarly, the commercial participation more than doubled over PY2. The additional increase shown in 2020 is due in part to the growth of Medicaid's expanded attribution model, discussed further in Section 6.

Figure 1: Attributed Lives by Program to Date

Payer	2017 PY0	2018 PY1	2019 PY2	2020 PY3	2021 Preliminary PY4[1]
Medicaid[2]	28,593	42,342	79,004	114,335	*111,532*
Medicare[3]	-	36,860	53,973	53,842	*61,932*
Commercial[4]	-	30,526	30,363	62,588	*96,558*

In PY 3, Vermont achieved **47% Medicare Scale Performance** (target: 79%) and **45% All-Payer Scale Performance** (target: 58%); Vermont did not achieve the Medicare and All-Payer Scale Targets for PY3. The APM Agreement anticipates that scale will increase over the life of the agreement. Vermont has previously described challenges to achieving scale (see the PY1 and PY2 Scale Targets and Alignment

[1] Preliminary attribution based on OneCare Vermont's 2021 revised budget (5/26/2021).
[2] Medicaid data are prospective and obtained directly from DVHA.
[3] Medicare data are prospective and obtained directly from CMMI.
[4] Commercial data are a combination of all participating programs and are obtained directly from OneCare Vermont.

reports and the State's response to CMMI's Warning Notice following the PY2 Scale Targets and Alignment Report), both in terms of engaging hard-to-reach payers and in how scale is actually measured. The Vermont APM signatories will continue to work with the ACO and other partners to increase scale, the Board through its ACO oversight and monitoring and other regulatory authorities, and the Governor's Administration and Agency of Human Services (AHS) through the strategies outlined in the APM Implementation Improvement Plan.[5] The GMCB will monitor new payer programs as they are developed, ensuring that services remain in alignment and qualify as scale target initiatives.

Preliminary PY4 (2021) data show continued improvement over PY3, in particular due to the addition of one of the state's largest hospitals to the Vermont Medicare ACO program, and the addition of Vermont's State Employee Health Plan in the commercial sector. Gains in both payer programs reflect recommendations from the Implementation Improvement plan in action.

Alternative Calculations to Scale Target

As this is the third consecutive year that Vermont has not met scale targets as defined in the Agreement, the GMCB worked to define three alternate measures to show scale progress in Vermont. These metrics diverge from the methodology established by the Agreement but aim to provide a fuller picture of Vermont's progress and the Model's statewide reach, given the barriers Vermont and CMMI have previously identified in achieving the targets as originally set. There are different considerations for contextualizing All-Payer scale and Medicare scale. When considering the true effect of the model in Vermont's health care delivery system, alternative measures for scale should account for the regulatory leverage accessible by the state and reflect the influence on providers practicing in the state. Three alternative all-payer measures are presented to better assess the objective of statewide participation: adjusted scale, proportion of hospital revenue, and the proportion of providers participating in the APM. One alternative view of Medicare scale, reflecting the members eligible for attribution, is presented in Section 5.

The first alternative measure, adjusted scale, is the simplest, adjusting for the calculation to better align with available data and the regulatory influence of the State. This calculation removes self-funded groups without data available in VHCURES and the Medicare Advantage populations from the calculation of the scale denominator. **This change in methodology brings the All-Payer achieved rate up to 54%**, just shy of the 58% target set forth in section 6.j.ii of the Agreement. However, this adjusted Scale performance demonstrates that the scale targets are still ambitious goals and that the state would have still fallen short in the first three PYs despite these adjustments. However, the adjustment will continue to be a better reflection of the leverage available to the state and be more material as more beneficiaries join Medicare Advantage plans.

A second alternative, estimates the prospective payments to hospitals compared with revenue in scope for APM risk-based arrangements. The aim for this measurement is to provide an estimate of APM penetration at Vermont's hospitals. Any prospective payments made to hospitals at this time represent provider-based risk and therefore represent material changes to the way hospitals are reimbursed for care. The Proportion of Hospital Revenue measure estimates how this is changing over time and differs by hospital. It is calculated through actual financial data submitted to the GMCB by hospitals. The calculation uses hospital discharge data to estimate the proportion of hospital's net patient revenue comes from Vermont residents, as Vermont residents are the population eligible for attribution in most

[5] https://gmcboard.vermont.gov/sites/gmcb/files/documents/APM%20Implementation%20Improvement%20Plan%20Final%2011.19.20.pdf.

ACO programs. As summarized in Section 4, **revenue steadily grew from 2017 (2% of system revenue in the year piloted by DVHA) to 2020 (16%)**.

Finally, the proportion of providers participating in the APM is an estimation of the ACO's network compared with potential participants (licensed and active providers) statewide. Since Vermont residents may attribute to providers practicing out of state, this view provides a better gauge for the ACO network penetration in Vermont. The ACO provider network is comprised of primary care providers who can attribute ("participants") and other providers within the network seeing patients but who cannot attribute patients to the ACO ("preferred"). There are two proportions for consideration: the proportion of all ACO network providers (participants and preferred) compared to all active and licensed providers in Vermont; and, the proportion of ACO network attributing providers (participants) compared to all active and licensed primary care providers in Vermont. By using estimates derived from Vermont Department of Health workforce survey data, the 4,178 providers listed in the 2020 ACO network represent about 17% of all providers active and licensed in the state (estimated to be 24,980 for 2020). Of providers estimated to be eligible to attribute patients to the model, **the ACO penetration rate appears to be 90%** (3,398 ACO providers of 3,796 eligible primary care practitioners statewide).

Alignment of Scale Target ACO Initiatives

The five Scale Target ACO Initiatives in 2020 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 an expanded attribution methodology with the ACO in one health service area, St. Johnsbury. Because of the success of this pilot, Medicaid and the ACO 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 five Scale Target ACO Initiatives in 2020. This report is required by section 6.j of the APM Agreement, which provides as follows:

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

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

3. Progress Toward Achieving Scale Targets

Relevant Language:

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

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

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

		PY1 (2018) Final	PY2 (2019) Final	PY3 (2020) Final	PY4 (2021) Preliminary [6]	PY5 (2022)
Vermont All-Payer Scale Target Beneficiaries	*Target*	*36%*	*50%*	*58%*	*62%*	*70%*
	Actual	22%	31%	45%	*57%*	
	(Difference)	(-14%)	(-19%)	(-13%)	*(-5%)*	
Vermont Medicare Beneficiaries	*Target*	*60%*	*75%*	*79%*	*83%*	*90%*
	Actual	33%	47%	47%	*52%*	
	(Difference)	(-27%)	(-28%)	(-32%)	*(-31%)*	

While Vermont did not achieve the Medicare and All-Payer Scale Targets for PY3, marked improvement was made over PY2, with an increase realized in the All-Payer calculation. Medicare beneficiary scale remained flat between PY2 and PY3. Preliminary 2021 (PY4) attribution shows another large increase in attribution in the All-Payer category, in particular due to the addition of one of the state's largest hospitals to the Vermont Medicare ACO program, and the addition of Vermont's State Employee Health Plan in the commercial sector. 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. Sections 4-6 of this report further discuss the factors contributing to the successes and challenges in achieving scale.

[6] 2021 preliminary estimates utilize the 2020 population and are subject to change with official 2021 report.

3.1. Scale Results

In PY3, the population included for APM scale represents 80% of the entire Vermont population. Figure 3 summarizes Vermont's scale estimates for 2020. In PY3, as in prior years, all ACO Scale Target Initiatives used 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. Medicare attrition is largely due to attributed beneficiary deaths throughout the PY.

Figure 3: Scale Targets and Vermont Population

			Scale Denominator		Scale Numerator		
Payer	**Sub-Category**	**2020 Vermont Population**	**APM Population**	**% of All Vermonters**	**Participating in Scale Target ACO Initiatives**	**2020 Scale Achieved**	**Data Sources**
Medicare	*Parts A & B*	115,496	115,496	18%	53,842	47%	CMMI/VHCURES
	Part A or B only	7,677	0	0%	-	-	
	TOTAL	**123,173**	**115,496**	**18%**	53,842	**47%**	
Medicaid	*Attributable*	124,069	124,069	19%	114,335	92%	DVHA/VHCURES
	Limited Coverage or Evidence of TPL	5,203	0	0%	-	-	
	TOTAL	**129,272**	**124,069**	**19%**	114,335	92%	
Commercial: Self-Funded Employers	*In VHCURES*	97,340	97,340	15%	25,834	27%	VHCURES
	Not in VHCURES	68,091	68,091	11%		-	ASSR
	TOTAL	**165,431**	**165,431**	**26%**	25,834	16%	
Commercial: Fully Insured	*COA*	90,613	90,613	14%	36,754	41%	VHCURES
	No COA	6,101	0	0%	-	-	VHCURES
	No evidence of comprehensive, primary coverage	52,981	0	0%	-	-	ASSR
	TOTAL	**149,695**	**90,613**	**14%**	36,754	41%	
Commercial: Medicare Advantage	**TOTAL**	**19,924**	**19,924**	3%	-	-	VHCURES
TRICARE	**TOTAL**	**13,154**	0	0%	-	-	TRICARE Website
FEHBP	**TOTAL**	**14,687**	0	0%	-	-	ASSR
Uninsured	**TOTAL**	**27,741**	0	0%	-	-	VHHIS
	GRAND TOTAL	**643,077 (Census)**	**515,533**	**80%**	**230,765**	**45%**	

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

4. Alternative All-Payer Calculations

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

Figure 4: Summary of Alternative All-Payer Scale Measures

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

4.1. Adjusted Scale

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

Medicare Advantage plans are administered by private insurers in partnership with the federal government. The program already involves substantial care management and uses capitated payments from Medicare to manage this population's benefits. This program is more challenging to incorporate into Vermont's ACO model and to do so would likely require active assistance from CMS. As more and more beneficiaries in Vermont opt for Medicare Advantage plans, the question will have broader impact than measuring scale.

Self-funded groups no longer reporting data after the *Gobeille v. Liberty Mutual* decision remain an extremely elusive population. Under ERISA, the State has no authority to regulate non-governmental self-funded groups; however, the State has chosen to model the Adjusted Scale measure excluding only the estimated population belonging to self-funded groups who do not report to Vermont's all-payer claims database (VHCURES). While the State can provide high-level estimates about the size of this population, outreach efforts are substantially

compromised by the limited information available. Note that self-insured groups who continue to report data to VHCURES remain in the denominator.

Figure 5: Adjusted Denominator

	2018 (PY1) Final	2019 (PY2) Final	2020 (PY3) Final	2021 (PY4) Preliminary
All-Payer Scale Denominator	550,806	526,723	515,533	TBD
Medicare Advantage	*11,749*	*17,745*	*19,924*	
Self-Funded Lives Not in VHCURES	*85,000*	*75,000*	*68,091*	
Adjusted Denominator	**454,060**	**433,978**	**427,518**	
Adjusted All-Payer Scale Performance	25%	37%	54%	68%[7]
Difference from All-Payer Scale Target	*-11%*	*-13%*	*-4%*	*+6%*

This change in perspective results in a 9% increase in scale performance, bringing the achieved rate up to 54%, just shy of the 58% target set forth in section 6.j.ii of the Agreement. However, this adjusted Scale performance demonstrates that the scale targets are still ambitious goals and that the state would have still fallen short in the first three PYs despite these adjustments. However, the adjustment will continue to be a better reflection of the leverage available to the state and be more material as more beneficiaries join Medicare Advantage plans.

4.2. Proportion of Hospital Revenue

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

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

Any prospective payments made to hospitals at this time represent provider-based risk and therefore represent material changes to the way hospitals are reimbursed for care. The Proportion of Hospital Revenue measure estimates how this is changing over time and differs by hospital. It is calculated through actual financial data submitted to the GMCB by hospitals.

$$\text{Proportion of Hospital Revenue} = \frac{\text{Prospective payments + Other reform payments}}{\text{Prospective payments + Other reform payments + Net Patient Revenue (estimated share from VT residents)}}$$ [8]

The calculation uses hospital discharge data to estimate the proportion of hospital's net patient revenue comes from Vermont residents, as Vermont residents are the population eligible for attribution in most ACO programs.

[7] Preliminary 2021 performance estimates are based on the 2020 Vermont population and are subject to change.
[8] Other reform payments include SASH, Blueprint for Health, and Community Health Team payments.

As summarized in Figure 6, revenue steadily grew from 2017 (2% of system revenue in the year piloted by DVHA) to 2020 (16%).

Figure 6: Systemwide Proportion of Value-Based Hospital Revenue from Vermont Residents[9]

	2017 (PY0)	2018 (PY1)	2019 (PY2)	2020 (PY3)
Total Revenue	$2,378,721,942	$2,520,075,138	$2,597,288,054	$2,444,037,937
Estimated VT Resident Revenue	$2,234,000,656	$2,329,290,531	$2,401,820,237	$2,238,229,808
Prospective Payments + Other Reform Payments	$43,510,957	$231,893,481	$299,908,013	$351,471,909
Proportion of Revenue	**1.9%**	**10.0%**	**12.5%**	**15.7%**

4.3. Proportion of Providers Participating in the APM

The third and final look at all-payer scale performance is the Proportion of Providers Participating in the APM measure compares the ACO network to all providers practicing in the state. Section 6.i. of the Agreement states that *"CMS and Vermont expect that the majority of providers and suppliers operating in Vermont and participating in Vermont ACOs will chose to participate in a VMA ACO or a Vermont Modified Next Generation ACO."* The ACO provider network is comprised of primary care providers who can attribute ("participants") and other providers within the network seeing patients but who cannot attribute patients to the ACO ("preferred"). There are two proportions for consideration: the proportion of all ACO network providers (participants and preferred) compared to all active and licensed providers in Vermont; and, the proportion of ACO network attributing providers (participants) compared to all active and licensed primary care providers in Vermont. The most challenging aspect of these measures is estimating the numbers of active and licensed providers practicing in Vermont who might be eligible to participate in the model.

In 2020, the ACO network had 4,178 providers. Of providers estimated to be eligible to attribute patients to the model, the ACO penetration rate appears to be 90% (3,398 ACO providers of 3,796 eligible primary care practitioners statewide). Of note, because our measures represent Vermont residents cared for by Vermont providers, we do not include Dartmouth-Hitchcock providers in the ACO network counts. Note that this measure uses licensure data derived from the Vermont Department of Health workforce survey which measures the number of individual providers, not provider practices or organizations.

5. Alternative Medicare Scale Calculations

When considering Medicare beneficiaries, the program's attribution methodology is the most relevant factor. There are two considerations for accurately measuring scale as implemented to date: limiting to the population that meets attribution criteria and estimating beneficiaries who attribute to providers practicing out of state. Medicare scale depends on the attribution method employed by the Medicare ACO program. Beneficiaries must meet certain criteria to be eligible for attribution. Approximately 20% of Vermont Medicare beneficiaries are not eligible for attribution to the ACO program due to exclusions in the attribution methodology (Figure 7, following page).

[9] Totals exclude Springfield Hospital for all years due to missing information for 2017-2019.

Figure 7: Vermont Medicare Beneficiaries Eligible for Attribution to ACO

	2019 (PY2)	2020 (PY3)
VT Medicare Scale Target Beneficiaries	113,743	115,496
Subpopulation Eligible for Attribution	93,871	93,550
Difference	*-18,972*	*-21,946*
Scale Performance for Eligible Beneficiaries	**57%**	**58%**
Difference from Medicare Scale Target	*-18%*	*-21%*

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

The remaining challenge with Medicare's attribution methodology is for those Vermont Medicare beneficiaries whose primary care relationships are with out-of-state providers. GMCB attempted to model this issue in the past and found that around 20,000 Vermont Medicare beneficiaries would have attributed to an out-of-state provider and that if every Vermont provider were participating in the ACO, only 75,000 beneficiaries statewide would attribute to the model.[10] However, GMCB has since learned that replicating the attribution algorithm is a known challenge and is working with CMMI to better model the maximum attribution realized if all Vermont providers were participating.

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

6. Factors Influencing Progress Toward Scale Targets

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

6.1. Provider Network

Successes of the provider network are shown through increased participation in the Vermont Medicaid Next Generation Model and the Comprehensive Payment Reform (CPR) program. In PY3, the provider network saw increased participation in both Medicaid and commercial payers (BCBSVT), as well as independent providers joining the network. Though the network saw these increases, the changes were minimal from 2019 to 2020 and similar challenges seen in the first two years of the APM were seen in PY3. 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.

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

6.2. Payer Participation

The APM is premised on the inclusion of the major payers present in Vermont. In addition to Medicaid and Medicare, Vermont has three major commercial insurance payers: BCBSVT, MVP, and Cigna. BCBSVT and MVP offer plans in both the merged individual and small group market and the large group market. 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. All three payer types have been represented in the first three performance years. Both the payers and ACO have been able to draw on their experiences in the Medicare, Vermont Medicaid, and Vermont commercial shared savings programs (SSPs) from 2014-2016/2017 to help ease the transition to the APM. Challenges to payer participation include that Vermont is preempted by federal law from influencing self-funded employer groups' choices regarding health insurance. Furthermore, engaging hundreds of employers individually would be difficult for an ACO to scale without unsustainably growing administrative personnel.

6.3. 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. Successes include refinements and improvements to attribution methodology through the Vermont Medicaid Next Generation ACO Program and through the work DVHA continues to implement, including an expanded attribution methodology (Figure 8, below). The goal of expanded attribution is to support a whole-population (panel) approach to implementation of OneCare's Care Management Model to help account for some of the challenges presented by standard attribution methodologies.

Figure 8: Medicaid Traditional and Expanded Attribution Over Time

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

On the other hand, challenges to attribution include that ACO attribution is provider-driven and that there can be a disconnect between where people live (i.e., Vermont residents) and where they seek care. The GMCB and CMS continue to discuss these challenges as they pertain to the Medicare program, since the initial analyses suggest that achieving scale for Medicare may be impossible due to the attribution design. Analyses for the Medicaid population yielded similar findings, which is part of the reason DVHA is utilizing alternate attribution techniques.

7. Scale Target ACO Initiative Designs

The APM Agreement is premised on the assumption that alignment between payer programs is desirable because it will create more robust provider incentives to change care delivery and ease provider administrative

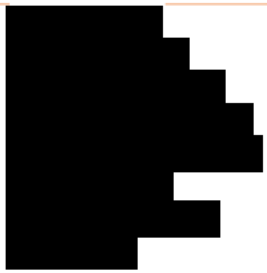
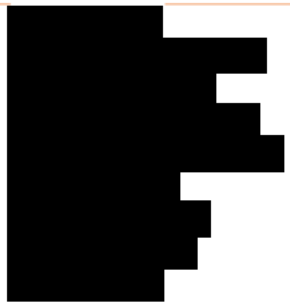
burden. This is reflected in section 6.f of the Agreement, which requires Vermont to ensure that Scale Target ACO Initiatives reasonably align in their design (e.g., beneficiary alignment methodology, ACO quality measures, payment mechanisms, risk arrangements, and services included) with the Vermont Modified Next Generation ACO in PY1 and with the Vermont Medicare ACO Initiative in subsequent performance years. As noted above, the Agreement requires Vermont to submit an 'Annual ACO Scale Targets and Alignment Report' beginning in 2019, for Performance Years 1-5. This section provides a comparison, using definitions from the Agreement, of what elements are incorporated in OneCare Vermont's 2020 Scale Target ACO Initiatives. Reasonable alignment does not require uniformity and allows for some variation among payer programs to reflect legitimate differences, such as those due to different populations (e.g., the elderly versus children).

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

Relevant language:

> *6.f "Vermont shall ensure that Scale Target ACO Initiatives offered by Vermont Medicaid, Vermont Commercial Plans, and participating Vermont Self-insured Plans reasonably align in their design (e.g., beneficiary alignment methodology, ACO quality measures, payment mechanisms, risk arrangements, and services included for determination of the ACO's Shared Losses and Shared Savings as described in section 6.b.iii) with the Vermont Modified Next Generation ACO in Performance Year 1 and with the Vermont Medicare ACO Initiative in Performance Years 2 through 5."*
>
> *6.j.i "In accordance with section 6.f, the GMCB, in collaboration with AHS, shall submit to CMS for its approval, no later than June 30th of the year following the conclusion of each of the Performance Years 1 through 5, an assessment describing how the Scale Target ACO Initiatives' designs compare against each other on key design dimensions such as services included for determination of the ACO's Shared Losses and Shared Savings as described in section 6.b.iii, risk arrangement, payment mechanism, quality measures, and beneficiary alignment ("Annual ACO Scale Targets and Alignment Report"). This assessment must also describe how the Scale Target ACO Initiatives' designs are aligned across all payers, how they are different, the justification for differences that will remain, and a plan to bridge differences that should not remain."*

Figure 9: Crosswalk: Key Design Features of 2020 Scale Target ACO Initiatives

	Medicare Next Generation ACO	Vermont Medicaid Next Generation ACO	BCBSVT (QHP)	BCBSVT (Self-Insured)	MVP (QHP)
Services Included for Shared Savings/Losses ***See Appendix A for crosswalk of TCOC services***	Parts A & B services for aligned beneficiaries	Generally, A & B services. Exceptions: • 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 • Hospice (room and board) • Skilled Nursing Facilities • Selected CPT/HCPCS codes (list varies by year) • Categories of Service: 2201, 2901, 501, 502, 2701, 2702, 2703, 2713, 2717, 3301, 3304, 3501, 3507, 3602, 3703, 3705, 3707, 3709, 801, 802, 806, 807	Generally, A & B services Exceptions: 1. Services carved out from primary insurer	Generally, A & B services. Exceptions: 1. Services carved out from primary insurer	Generally, A & B services. Exceptions: 1. Services carved out from primary insurer
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. Truncation of total claims during PY of $200,000 or $100,000 per member depending on member's eligibility group, no payer-provided reinsurance, no risk adjustments. Expanded Attribution Pilot: Two-sided, 2% upside risk			

	Medicare Next Generation ACO	Vermont Medicaid Next Generation ACO	BCBSVT (QHP)	BCBSVT (Self-Insured)	MVP (QHP)
		corridor and 1% downside risk corridor, 100% ACO risk for TCOC within risk corridor.			
Payment Mechanism from Payer to ACO	AIPBP for eligible participants (e.g. hospitals), FFS for non-eligible	Value-Based Care Payments, which include FPP, administrative fee based on attribution cohort, and population health investment; FFS for non-participating	FFS	FFS	FFS
Quality Measures ***See Appendix C for 2019 measure crosswalk***	Financial arrangement tied to quality of care for health of aligned beneficiaries. 2019 utilized a pay-for-reporting and pay-for-performance approach. Quality measures were selected through stakeholder process and accepted by CMMI in 2018. Majority of the measures now align with the APM Agreement.	Financial arrangement tied to quality of care for the health of aligned beneficiaries. Utilizes Value-Based Incentive Fund (VBIF). Majority of the quality measure align with the APM Agreement.	[redacted]	[redacted]	[redacted]
Beneficiary Alignment	Prospective attribution, claims-based evaluation	1) Traditional attribution: Prospective attribution, claims-based evaluation 2) Expanded Attribution: Prospective attribution, includes Medicaid beneficiaries with no claims paid during attribution period and no other insurance	[redacted]	[redacted]	[redacted]

7.1. Areas of Difference Between Scale Target ACO Initiative Designs

The 2020 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 PY3 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 PY3. 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 self-insured and commercial QHP programs have a smaller risk corridor ([redacted]% and [redacted]% risk corridor, respectively) than the other payers. BCBSVT decreased the risk sharing percentage from 100% in PY2 to [redacted]% in PY3, which differs from the Medicaid and Medicare 100% risk sharing.

Justification:

Medicaid Next Generation Personal Services Agreement: 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. Risk is two sided with a 100% share.

Medicare ACO Initiative: In PY3, the Medicare cohort was contracted at 5% risk, in a two-sided arrangement with a 100% share.

BCBSVT: A [redacted]% sharing arrangement ensures that [redacted] of any PY3 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.

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 2020, the Medicare and Medicaid contracts continued to offer an All-Inclusive AIPBP, or Value-Based Care Payment in the case of Medicaid, to the ACO, which represents fixed payments to certain providers who selected that payment mechanism. This allowed providers, at the TIN level, to select a 100% fee reduction on claims in exchange for a fixed payment. Each of the Commercial plans remained fee-for-service (FFS).

Justification:

Commercial plans remained FFS during the COVID-19 pandemic. The State is engaging with commercial plans to develop fixed payment mechanisms.

Monitoring:

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

Quality Measure Alignment

As seen in Appendix C, PY3 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[11] 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 priorities of each payer.

Monitoring:

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

Beneficiary Alignment/Attribution

Attribution is primarily based on a member's primary care relationship with a provider participating in the ACO network. The Attribution Element Table found below (Figure 10, following page) compares the following four categories by payer: Provider types, look-back period, qualifying claims, and alignment based on selection of PCP. As was discussed in previous sections of this report, the state may want to consider changes to attribution in the future to improve scale performance. At this time, the program variation is acceptable and justifiable given the issues raised earlier.

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

Figure 10: Attribution Elements

Attribution Element	Medicare	Medicaid	BCBSVT (QHP)	BCBSVT (Self-Insured)	MVP
Provider Types	Primary Care and select specialists	Primary Care or Expanded Attribution	Primary Care	Primary Care	Primary Care
Look-Back Period	24 months (ending 6 months from beginning of PY)	33 months (more recent months weighted more heavily; ending2 months from beginning of PY)	Most recent 30 months	Most recent 30 months	Most recent 24 months
Qualifying Claims (and tie breakers)	Greatest number of weighted claims (most recent visit)	Greatest number of weighted claims (most recent visit)	Greatest number of claims (most recent visit)	Greatest number of claims (most recent visit)	Greatest number of claims (most recent visit)
Alignment Based on Selection of PCP	No	No	Yes	Yes	No

Justification:

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

Monitoring:

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

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: Warning Notice of Vermont's Non-Compliance with ACO Scale Targets for Two Consecutive Performance Years

DEPARTMENT OF HEALTH& HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICARE & MEDICAID INNOVATION

September 14, 2020

Susan J. Barrett, J.D.
Executive Director
Green Mountain Care Board
144 State Street
Montpelier, Vermont 05602

SUBJECT: Warning Notice of Vermont's Non-Compliance with Accountable Care Organization (ACO) Scale Targets for Two Consecutive Performance Years

Dear Ms. Barrett,

On July 2, 2020, the Green Mountain Care Board (GMCB) submitted the 2019 Scale Targets and Alignment Report, per Section 6.j of the State Agreement. We are writing to inform the GMCB that it has failed to achieve the ACO Scale Targets described in sections 6.a, 6.b, and 6.c of the Vermont All-Payer Accountable Care Organization Model Agreement (the "State Agreement") for two consecutive Performance Years (Performance Year (PY) 1 and PY 2). Under Section 6.a of the State Agreement, "Vermont shall ensure that the percentage of Vermont Medicare Beneficiaries and the percentage of Vermont All-payer Scale Target Beneficiaries aligned to a Scale Target ACO Initiative, as defined in section 6.b, meet or exceed" certain specified percentages for each PY. Those percentages, as well as the achieved percentage of Vermont Medicare Beneficiaries and the achieved percentage of Vermont All-payer Scale Target Beneficiaries aligned to a Scale Target ACO Initiative for PY1 and PY2, are specified in the following table:

Percent (%)	**By end of PY1 (2018)**	**By end of PY2 (2019)**
Vermont All-Payer Scale **Target** Beneficiaries	36%	50%
Vermont All-Payer Percentage **Achieved** Beneficiaries	22%	30%
Vermont Medicare Scale **Target** Beneficiaries	60%	75%
Vermont Medicare Percentage **Achieved** Beneficiaries	33%	47%

CMS considers Vermont's failure to meet the ACO Scale Targets for two consecutive PYs a "Triggering Event" under Section 6.k and Section 21.d.iv of the State Agreement. Section 21.a of the State Agreement provides that, if CMS determines that a Triggering Event has occurred, CMS will provide a Warning Notice, no later than six (6) months after a determination by CMS that a Triggering Event has occurred, notifying the GMCB or AHS, as applicable, that Vermont is not meeting a requirement of the State Agreement with an explanation and data supporting its determination. This letter serves as a Warning Notice of Vermont's failure to meet the ACO Scale Targets for two consequtive PYs. As required under

Section 21.a of the State Agreement, the State must submit a written response to this Warning Notice within ninety (90) days of receipt of the Warning Notice.

CMS will review the State's response in accordance with Section 21.a within ninety (90) days of receipt and will either accept the response as sufficient, taking into account the totality of the circumstances, including whether a factor unrelated to the Agreement caused the Triggering Event or require the State to submit a CAP. If the State fails to timely and successfully implement a required CAP, CMS reserves the right to rescind or modify aspects of the Model, or to terminate the State Agreement.

We appreciate your dedication to improving health outcomes under the Model. We look forward to receiving your response to this Warning Notice so we may continue to work with the State to implement the goals of the Model in accordance with the terms of the State Agreement. If you have any questions or require additional information, please contact Fatema Salam at Fatema.Salam1@cms.hhs.gov.

Sincerely,

Pierre Yong

Pierre L. Yong, MD, MPH, MS
Acting Director
State Innovations Group, Center for Medicare and Medicaid Innovation (CMMI)
Centers for Medicare and Medicaid Services

cc:

Ena Backus, Director of Health Care Reform
Vermont Agency of Human Services

Katherine J. Sapra, PhD, MPH, Deputy Division Director
Division of All-Payer Models, State Innovations Group, CMMI

Fatema Salam, MPH, Health, Insurance Specialist
Division of All-Payer Models, State Innovations Group, CMMI

Appendix C: Quality Measure Crosswalk

Measure	Vermont All-Payer ACO Model	2020 Vermont Medicaid Next Gen	2020 Vermont Medicare Initiative	2020 BCBSVT	2020 MVP
% 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	X
Initiation of alcohol and other drug dependence treatment [12]	X	X	X	X	X
Engagement of alcohol and other drug dependence treatment[10]	X	X	X		
30-day follow-up after discharge from emergency department for mental health	X	X	X	X	X
30-day follow-up after discharge from emergency department for alcohol or other drug dependence	X	X	X	X	X
% of Vermont residents receiving appropriate asthma medication management	X				
Screening for clinical depression and follow-up plan (ACO-18)	X	X	X	X	
Tobacco use assessment and cessation intervention (ACO-17)	X	X	X		
Deaths related to suicide	X				
Deaths related to drug overdose	X				
% of Medicaid enrollees aligned with ACO	X				
# per 10,000 population ages 18-64 receiving medication assisted treatment for opioid dependence	X				
Rate of growth in mental health or substance abuse-related emergency department visits	X				
# of queries of Vermont Prescription Monitoring System by Vermont providers (or their delegates) divided by # of patients for whom a prescriber writes prescription for opioids	X				
Hypertension: Controlling high blood pressure	X[13]	X	X[11]	X	X
Diabetes Mellitus: HbA1c poor control		X		X	X
All-Cause unplanned admissions for patients with multiple chronic conditions		X			
Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient experience surveys[14]	X	X	X	X	X
ACO all-cause readmissions (HEDIS measure for commercial plans)				X	X
Risk-standardized, all-condition readmission (ACO-8)			X		
Influenza immunization (ACO-14)			X		
Colorectal cancer screening (ACO-19)			X		
Developmental screening in the first 3 years of life		X		X	
Follow-up after hospitalization for mental Illness (7-Day Rate)		X		X	X

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

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

[14] Surveys vary by program. Vermont Medicare ACO Initiative includes ACO CAHPS Survey composite of timely care, appointments and information for ACO-attributed Medicare beneficiaries. Vermont Medicaid Next Generation includes multiple CAHPS PCMH composites for ACO-attributed Medicaid beneficiaries. BCBCBS Next Generation includes care coordination composite and tobacco cessation question from CAHPS PCMH for ACO-attributed BCBSVT members.

Appendix D: Resource List

1. *QHP Rate Filings*
   BCBSVT

   MVP

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

   Performance Year 2 (PY2, 2019)

   Performance Year 3 (PY3, 2020)

   Performance Year 4 (PY4, 2021)

   Performance Year 5 (PY5, 2022)

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

   Performance Year 2 (PY2, 2019)