State of Vermont
Department of Vermont Health Access
NOB 1 South, 1st Floor
280 State Drive
Waterbury, Vermont 05671

Vermont Medicaid Next Generation ACO Program 2021 Performance

Department of Vermont Health Access

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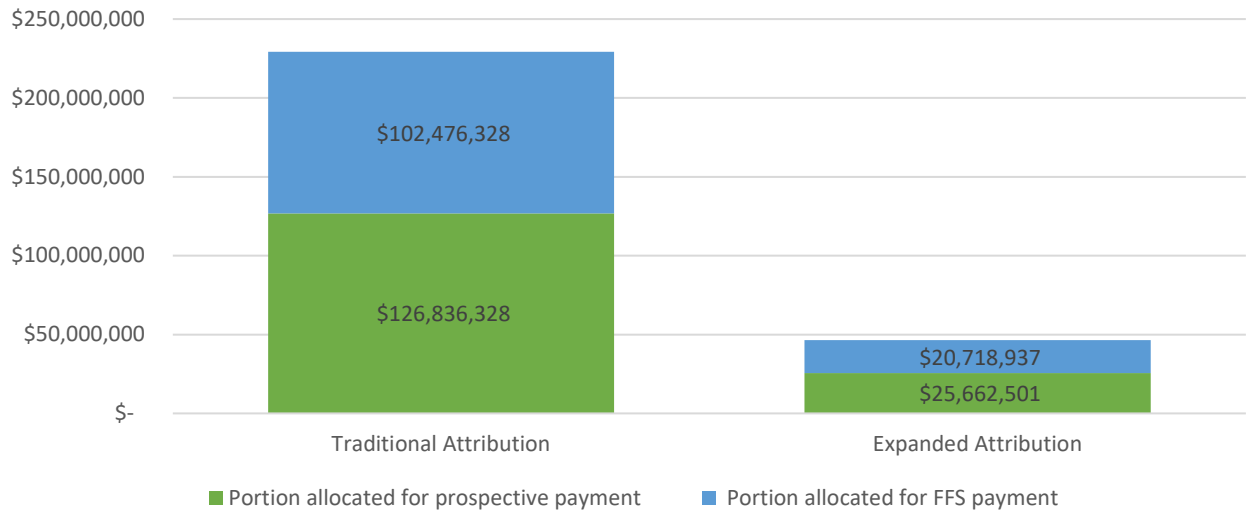
The report summarizes program performance in 2021 and proceeds in three sections. Section A offers an executive summary. Section B provides a brief overview of the program. Section C provides more detailed financial and quality performance results for the 2021 performance year.

Section A: Executive Summary of Vermont Medicaid Next Generation 2021 Results

The Vermont Medicaid Next Generation (VMNG) Accountable Care Organization (ACO) program is an ACO Initiative as described in the Vermont All-Payer Accountable Care Organization Model agreement with the Centers for Medicare and Medicaid Services (CMS). This initiative also represents the Department of Vermont Health Access' (DVHA) priority for an integrated health care system in which providers accept financial risk for the cost and quality of care. Through a procurement process in late 2016, DVHA offered the opportunity for ACOs to be accountable for the cost and quality of care for a group of Medicaid members during a calendar year. Part of this arrangement is pre-payment for the cost of care for this group of attributed Medicaid members. OneCare Vermont (OneCare) is the only ACO participating in this opportunity. OneCare develops and implements ACO activities with its network of participating providers—these activities are intended to help providers reduce health care cost growth and improve health care quality for Vermonters. Additionally, OneCare accepts financial risk if health care costs exceed the agreed-upon price, though downside risk was eliminated for the 2020 and 2021 performance years in alignment with modifications made to ACO programs at the federal level to hold providers harmless for the negative impacts of the COVID-19 pandemic. DVHA makes a fixed prospective payment to OneCare monthly for some of the agreed-upon price and pays the rest of the dollars through fee-for-service payments to health care providers both in and out of OneCare's network (see Figure 1).

Figure 1. Agreed Upon Price for Care, 2021 VMNG Contract (Traditional and Expanded Attribution Cohorts*)



* Details around attribution cohorts and methodology can be found in Section B below

As noted above, the VMNG program is specific to Medicaid's contract with OneCare Vermont. The All-Payer Model also encompasses ACO agreements with Medicare and commercial payers. The results summarized in this report pertain to the fifth year of performance for the Medicaid program only, and these results should not be extrapolated to the All-Payer Model as a whole. Other payer contracts were in their fourth performance years in 2021; participation has continued to grow across most payer programs to date, and the payer contracts have incrementally become more aligned in recent years. An independent evaluation of Performance Years 1 and 2 (2018-2019) conducted by NORC at the University of Chicago found that the All-

Payer Model's Medicare ACO Initiative has seen favorable impacts, including statistically significant gross spending reductions in total Medicare Parts A & B spending during the evaluation period, as well as decreases in acute care stays and days in 2019 and decreases in specialty evaluation and management (E&M) visits in 2019. In its evaluation of Performance Year 3 (2020), NORC noted more modest declines in utilization and spending relative to the comparison group, with acknowledgment that the COVID-19 PHE and the November 2020 cyberattack at the University of Vermont Health Network (UVMHN) posed unprecedented challenges and disruptions to hospitals and providers in Vermont, and concluded that the model is evolving and may realize benefits in the long term.[1] Additional evaluations are planned for Performance Years 4-5 (2021-2022). Key takeaways for the 2021 performance year are outlined below with additional detail on the following pages.

VMNG 2021 Performance - Key Takeaways:

- The program is stable. In 2021, the ACO-attributed Medicaid population decreased slightly over the prior year, due to fewer providers participating in the VMNG program in 2021. Attribution has remained consistently high between 2020 and 2023 and has included around 80% of attribution-eligible members, signaling that the program may have achieved statewide scale once its expanded attribution methodology was implemented.
- COVID-19 likely continued to impact both VMNG financial and quality performance. 2021 saw volatility in patterns of utilization across many components of the health care system, likely due to the continued COVID-19 pandemic and associated Public Health Emergency (PHE). This had implications for both the ACO's financial performance and quality performance in the VMNG program. In alignment with programmatic adjustments at the federal level, DVHA modified certain program features to hold providers harmless for COVID-19-related impacts to cost and utilization during the 2021 performance year.
- Fixed Prospective Payments support system stability. As the health system continued to experience utilization and revenue volatility due to the ongoing impacts of the COVID-19 pandemic, providers who received fixed prospective payments as part of the VMNG program for some portion of their business were better able to weather volatility in fee-for-service revenue. This underscores the importance of revenue predictability for providers as Vermont looks toward increasing participation in population-based payment models.

Result 1: Program participation is stable.

The number of providers and communities in OneCare's network who are participating in the VMNG program has remained fairly constant in 2021, 2022, and 2023. As most Vermont communities are already participating in the VMNG program, only modest additional provider participation may be expected for future performance years.

Performance Year	2017	2018	2019	2020	2021	2022	2023
Hospital Service Areas	4	10	13	14	14	14	14
Unique Medicaid Providers	~2,000	~3,400	~4,300	~5,000	~4,800	~5,000	~5,100

[1] See https://innovation.cms.gov/data-and-reports/2023/vtapm-2nd-eval-full-report for further information.

As participation increases, the incentives for providers to modify their care delivery and business practices to be successful under fixed payments become stronger. In 2020 DVHA developed an expanded attribution methodology that would qualify members who didn't have a history of primary care utilization to be attribution-eligible. This resulted in significant program growth in the 2020 performance year, with approximately 86,000 members attributed through the traditional methodology and approximately 28,000 members attributed through the expanded methodology, totaling approximately 114,000 attributed members, or 85% of members for whom Medicaid was the primary payer. The attributed population for the VMNG program has held relatively steady for the 2021, 2022, and 2023 performance years (with approximately 111,000 or 77% of members with Medicaid as primary payer, 126,000 or 79% of members with Medicaid as primary payer, and 142,000 attributed members or 86% of members with Medicaid as primary payer, respectively), indicating that the modified attribution methodology is also helping the model achieve a stable population year-over-year.

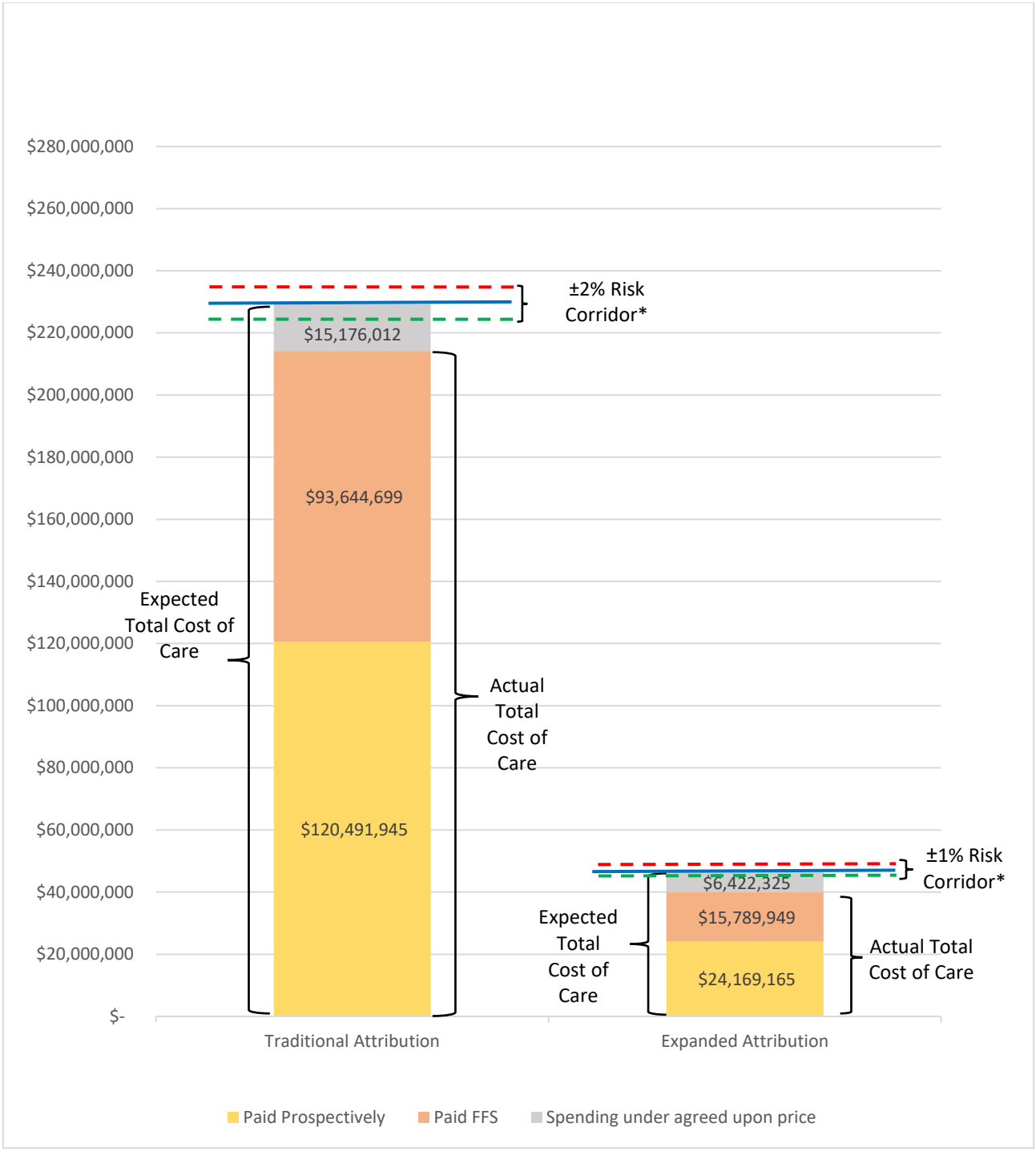
Result 2: COVID-19 likely continued to impact both quality and financial performance in the VMNG program.

The COVID-19 pandemic and the associated federal Public Health Emergency (PHE) likely continued to impact the health care system, and by extension, the quality and financial performance of the ACO and its participating providers in the VMNG program in 2021. Utilization and revenue across the health care continuum have been volatile as the system continues to address and begins to emerge from the COVID-19 pandemic. This volatility in turn likely impacted both the ACO's financial performance and quality performance in the VMNG program. In alignment with programmatic adjustments at the federal level, DVHA modified certain program features to hold providers harmless for continued COVID-19-related impacts to cost and utilization during the 2021 performance year.

Result 3: The VMNG payment model supported stability in the healthcare system.

DVHA and OneCare agreed on the price of health care for attributed Medicaid members up-front, which was approximately $230 million for the traditional attribution cohort and $46 million for the expanded attribution cohort in 2021 (see Figure 2). Because the expanded attribution cohort remained a relatively new population to OneCare (2021 was the second year that OneCare assumed accountability for this cohort), each cohort had a distinct risk arrangement and was reconciled separately. DVHA paid approximately $144.5 million of the total price in fixed prospective payments to OneCare over the course of the performance year and retained the remainder to pay fee-for-service claims for ACO-attributed members on behalf of OneCare during the year. As the health system continued to experience utilization and revenue volatility due to the ongoing impacts of the COVID-19 pandemic, those providers who received fixed prospective payments in the VMNG program were better able to weather the disruption in fee-for-service revenue for non-Medicaid lines of business.

Figure 2: 2021 VMNG Financial Performance relative to Expected Total Cost of Care



* No downside risk in 2021 due to COVID-19 Public Health Emergency

2017-2021: Observations and Model Potential

Having five years of performance results—both within and outside the risk corridor, and both greater than and less than the agreed-upon price—has allowed DVHA and the Agency of Human Services (AHS) to more fully assess the opportunities associated with having a risk-sharing contract with an ACO. Foremost, contracting with OneCare for multiple years has given the Vermont Medicaid program more certainty in budgeting than it would have had absent this arrangement, particularly as the attributed population has grown over time. This arrangement also allows for more revenue predictability for the providers participating in OneCare's network because as attribution to the program has increased, a larger portion of Medicaid payments have become more predictable year-over-year. Likewise, the risk corridor ensures there are incentives to control costs and protections for both providers and the Medicaid program in place when actual spending is different than expected. Payment predictability and risk-sharing work together to build system stability over time. Moreover, the VMNG financial model has enabled the program to stabilize the health system in periods of revenue unpredictability. Even as we begin to emerge from the COVID-19 Public Health Emergency, the health care environment continues to be complex and dynamic, with factors such as workforce challenges and health care inflation impacting service delivery and financial stability. A predictable payment model can continue to support the health care system during such uncertain times.

This contract is DVHA's largest initiative to move away from fee-for-service reimbursement and toward value-based payments. Although the COVID-19 Public Health Emergency affected the utilization and quality of care in 2020 and in 2021, there were promising early financial and quality results prior to that time, and programs nationwide continue to be similarly affected. For these reasons, DVHA, AHS and CMS believe that this model should continue to be tested through 2024, the full term of the Vermont All-Payer ACO Model agreement extension. Additionally, the model will provide valuable learning to inform future value-based payment models.

Section B: Vermont Medicaid Next Generation ACO Pilot Program Overview

Introduction

The Vermont Medicaid Next Generation (VMNG) Accountable Care Organization (ACO) program is an ACO Initiative as described in the Vermont All-Payer Accountable Care Organization Model agreement with the Centers for Medicare and Medicaid Services (CMS).[2] ACOs are provider-led and -governed organizations that have agreed to assume accountability for the quality, cost, and experience of care. The model's goal is an integrated health care system that has aligned incentives to improve quality and reduce unnecessary costs. The VMNG ACO program pursues this goal by transitioning the health care revenue model from fee-for-service payments to value-based payments. This transition is meant to focus health care payments on rewarding value - meaning low cost and high quality - rather than volume of services provided.

The VMNG program allows DVHA to partner with a risk-bearing ACO. For Calendar Year 2021, DVHA contracted with OneCare Vermont (OneCare) ACO to manage the quality and cost of care for approximately 111,000 Medicaid members in fourteen communities. Together, DVHA and OneCare are testing a financial model designed to support and empower the clinical and operational capabilities of the provider network in support of the "Triple Aim" of better care, better health, and lower costs. Primary goals of the program are

[2] See http://gmcboard.vermont.gov/sites/gmcb/files/documents/10-27-16-vermont-all-payer-accountable-care-organization-model-agreement.pdf.

to increase provider flexibility and to support health care professionals to deliver the care they know to be most effective in promoting and managing the health of the population they serve.

OneCare Vermont ACO Network & Attribution

In February of 2017, DVHA contracted with OneCare to participate in the Vermont Medicaid Next Generation ACO Pilot program for the 2017 calendar year with four optional one-year extensions.[3] DVHA and OneCare elected to exercise the final of the four optional one-year extensions permitted by the VMNG contract for a 2021 performance year.[4] In 2021, OneCare Vermont's network of participating providers included fourteen hospitals along with their employed physicians and providers; Federally Qualified Health Centers; independent practices; home health providers; Designated Agencies; Area Agencies on Aging; and skilled nursing agencies in the participating communities.

Until 2019, attribution had primarily been based on a Medicaid member's relationship with a primary care provider who had elected to participate in OneCare's network. Based on the learnings of a geographic attribution pilot in St. Johnsbury in 2019, program-wide modifications to attribution were implemented beginning in the 2020 performance year, resulting in a methodology that does not solely rely on members' past primary care utilization. Attribution of Medicaid members to OneCare occurs prospectively, at the start of the program year. In this way, OneCare is aware of the full population for which it is accountable at the program's outset and can use that information to identify and engage members most effectively. Although no members can be added during the course of a program year, some of the prospectively attributed members may become ineligible for attribution during the course of the program year, at which point Medicaid no longer makes payments to OneCare for those members. Members may become ineligible for attribution due to:

- Becoming ineligible for Medicaid coverage[5]
- Switching to a limited Medicaid benefits package (e.g., pharmacy-only benefits)
- Gaining additional sources of insurance coverage (e.g., commercial or Medicare)
- Death

Financial Model

Through the VMNG contract, DVHA pays OneCare a monthly fixed prospective payment (FPP) for services provided by hospitals (and hospital-owned practices) in OneCare's network. This is a monthly, per member payment made in advance of the services being performed. Beginning in 2018 and continuing through 2021, OneCare implemented the Comprehensive Payment Reform (CPR) pilot with independent physician practices that also elected to be paid the FPP for their ACO-attributed members. The pilot has grown from four participating practices in 2018 to 11 practices for the 2021 performance year. Medicaid fee-for-service payments continue for all other non-hospital and non-CPR providers in OneCare's network, for all providers who are not a part of OneCare's network, and for all services that are not included in the fixed prospective payment. OneCare is accountable for both the cost and quality of care for each attributed member. This is true whether that person uses little or no care or whether they require services consistently throughout the year.

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[3] See http://dvha.vermont.gov/administration/onecare-aco-32318-final-searchable.pdf.

[4] See https://dvha.vermont.gov/sites/dvha/files/documents/Administration/VMNG%20OCVT%20Amendment%208%20Final%20Signed.pdf

[5] If a member has lost Medicaid coverage but later becomes eligible for Medicaid again during the performance year, they may also become eligible for attribution again at that time.

One of the key goals of the prospective payment model is to give providers and Medicaid certainty and predictability regarding revenue for a pre-identified population of Vermonters. This should lead to better incentives and provider investments that improve the quality of care for Vermonters. Prior to the COVID-19 pandemic, OneCare had agreed to a risk-based spending target for the full attributed population during the performance year and would have been liable for expenses up to 102% of the target. This liability was eliminated in order to align with federal COVID-19-related program adjustments for ACO models. Because DVHA and OneCare agree upon a price prior to the start of the performance year, OneCare is also entitled to retain the difference between the target and 98% of the target if spending is less than the target. Additionally, OneCare is required to maintain a fund equal to a percentage of the expected health care costs—1% in 2021—to support a quality incentive program. The providers in OneCare's network can earn a share of this money through high quality performance on targeted quality measures. This type of payment incentive is provided to encourage high quality care.

2021 Performance Overview

Since piloting the Vermont Medicaid Next Generation contract in February of 2017, DVHA and OneCare Vermont collaborated in the launch and ongoing implementation of the program. DVHA and OneCare are committed to fostering stability within the model while making targeted, incremental improvements in both the implementation of the program and in evaluating performance. Both parties have been able to use experience from the first five program years to identify opportunities and develop strategies for continual process improvement as the program evolves and includes more providers and Medicaid members over time. DVHA and OneCare have also seen the VMNG program as an opportunity to align certain programmatic features with the Medicare and commercial payer ACO programs; in other areas the VMNG program has allowed DVHA and OneCare to pilot innovative ideas (for example, developing and testing new attribution methodologies beginning in the 2020 performance year) in hopes that if successful, they could be areas for multi-payer alignment in future program years.

Overall, the focus of the VMNG program is on improving health and delivering high quality health care while creating a financial model capable of producing predictable and sustainable health care costs. DVHA will continue to analyze the operational, financial, and quality performance of the program to determine its efficacy and to determine whether the VMNG program generally, and the fixed prospective payments to hospitals and select independent physician practices specifically, are contributing to an overall moderation in DVHA health care spending. Although results to date alone are insufficient to evaluate the success of the model and the impacts of COVID-19 have made it difficult to compare 2020 and 2021 to prior performance years, the experience from the first five years of VMNG implementation has provided a foundation for continued implementation and program evolution.

Section C: Vermont Medicaid Next Generation ACO Financial and Quality Performance: January 1 – December 31, 2021

COVID-19-related Program Adjustments

The COVID-19 pandemic and associated federal Public Health Emergency (PHE) impacted many components of Vermont's health care system, including financial and quality performance in the VMNG program. In alignment with programmatic adjustments at the federal level, DVHA modified certain contractual provisions to hold providers harmless for COVID-19-related impacts to cost and utilization during the 2021 performance year by decreasing the downside risk corridor proportionally to the

proportion of months in 2021 that were in an active federal PHE (12 out of 12 months, thus reducing downside risk to 0%), and removing COVID-19 episodes of care from Actual Total Cost of Care calculations.

Financial Performance

Tables 1a and 1b set forth ACO financial performance in Calendar Year 2021 for the traditional and expanded attribution cohorts respectively. The tables include several components:

- Funds paid prospectively to OneCare by DVHA (paid on a monthly basis).
- Zero-paid "shadow claims" that are submitted by providers, used to understand what services were delivered and to calculate the cost of services delivered (according to the Medicaid fee-for-service fee schedule) that were covered by the prospective payment from DVHA to OneCare.
- Fee-for-service claims paid by DVHA on behalf of OneCare (claims for services received by ACO-attributed Medicaid members from providers in OneCare's network who have elected to continue to be reimbursed on a fee-for-service basis, and from providers outside OneCare's network).
- Adjustments made to the Expected and Actual Total Cost of Care as part of the year-end reconciliation process.

Actual health care expenditure for the attributed population in 2021 is compared to expected expenditure as an indicator of financial performance. The Expected Total Cost of Care is derived based on actuarial projections of the cost of care in 2021 for the population of prospectively attributed Medicaid members, as detailed in Attachment B of the 2021 VMNG program contract.[6] Because the rate development process relied on data from 2019 as a baseline, COVID-19-related costs were not factored into the Expected Total Cost of Care, and COVID-19 episodes of care in 2021 were subsequently identified and removed from the Actual Total Cost of Care calculation, as noted above.

The actual health care expenditure in 2021 was lower than the expected expenditure for both the traditional and expanded attribution cohorts in the program year. Both the fee-for-service payments that DVHA issues and the zero-paid shadow claims for services included in the prospective payment were lower than expected, at least in part due to the effects of the COVID-19 pandemic on utilization of health care services.

Final financial performance for the 2021 calendar year was 93.4% of the Expected Total Cost of Care for the traditional attribution cohort and 86.2% of the Expected Total Cost of Care for the expanded attribution cohort, both of which fall outside of the 2% (for the traditional attribution cohort) and 1% (for the expanded attribution cohort) risk corridors included in the 2021 contract. As such, OneCare Vermont is entitled to the difference between the Actual Total Cost of Care and the Expected Total Cost of Care within the risk corridor—approximately $6.9 million for the traditional attribution cohort and $589,000 for the expanded attribution cohort. After applying other necessary adjustments, OneCare is entitled to a total of approximately $7.1 million from DVHA for the 2021 performance year, which is distributed in its entirety to OneCare's network based on the risk-sharing arrangements it has in place with its participating providers.

OneCare Vermont experienced financial performance within the risk corridor in the 2017 and 2018 performance years, and financial performance outside the risk corridor in the 2019, 2020, and 2021 performance years (above the risk corridor in 2019 and below the risk corridor in 2020 and 2021).

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[6] DVHA engaged Wakely Consulting Group to calculate 2021 ACO rates, including the Expected Total Cost of Care. These rates were also reviewed by OneCare and the Green Mountain Care Board, and by the actuarial firms with which they contracted at the time (Milliman and Lewis & Ellis, respectively).

Table 1a. VMNG 2021 year-end reconciliation calculations (Traditional Attribution Cohort)

Year-End Reconciliation Calculations – Traditional Attribution Cohort			**VMNG 2021**
DVHA Value-Based Care Payment to ACO	(A)	*(B) + (C)*	$ 130,812,593
Fixed Prospective Payment (FPP)	(B)		$ 124,466,052
Administrative Fee (including Population Health Program Funds)	(C)		$ 6,346,542
Population Health Program Funds Distributed by ACO	(D)		$ 3,173,271
Total ACO Payments to Participating Providers	(E)	*(B) + (D)*	$ 127,639,323
Total Expected Zero-Paid Claims	(F)	*(B)*	$ 126,836,328
Total Actual Zero-Paid Claims	(G)		$ 127,499,279
Zero-Paid Claims Over (Under) Spend	(H)	*(G) – (F)*	$ 662,951
Total Expected FFS	(I)		$ 102,476,328
Actual FFS - In Network	(J)		$ 49,404,820
Actual FFS - Out of Network	(K)		$ 48,508,943
Total Actual FFS	(L)	*(J) + (K)*	$ 97,913,763
FFS Over (Under) Spend	(M)	*(L) – (I)*	$ (4,562,565)
Expected Total Cost of Care	(N)	*(F) + (I)*	$ 229,312,656
Actual Total Cost of Care	(O)	*(F) + (L)*	$ 214,136,644
Total Cost of Care Over (Under) Spend	(P)	*(O) – (N)*	$ (15,176,012)
Year-End Reconciliation of Value-Based Care Payment*	(Q)		$ (2,365,033)
Financial Liability Before Risk Corridor	(R)	*(P) + (Q)*	$ (17,541,045)
Risk Corridor Upper Bound (100% of ETCOC)		100%	$ 229,312,656
Risk Corridor Lower Bound (98% of ETCOC)		98%	$ 224,726,403
ATCOC as Percentage of ETCOC			93.4%
Financial Liability After Risk Corridor	(S)	*[(O)-(O)*0.98] + (R)*	$ (6,951,286)
Year-End Reconciliation of Unearned VBIF Payments	(T)		$ 358,301
Year-End Reconciliation of Undistributed Population Health Program Funds	(U)	(C)/2-(D)	$ -
Final Settlement Amount Owed to OneCare	**(V)**	***(S) + (T) + (U)***	**$ (6,592,985)**

*Adjustments are required in instances where DVHA paid a prospective payment for an attributed member according to a Medicaid Eligibility Group (MEG) assignment that was not current for that month. For example, if a payment was issued to OneCare for a General Child, but the attributed member had aged into the General Adult group, an adjustment would be made for the difference. Adjustments are also required when DVHA paid a prospective payment for a member who was no longer Medicaid eligible. For instance, if a payment was issued to OneCare for a member who had passed away, any dollars paid to OneCare for that month would be recouped through such an adjustment.

Table 1b. VMNG 2021 year-end reconciliation calculations (Expanded Attribution Cohort)

Year-End Reconciliation Calculations – Expanded Attribution Cohort			VMNG 2021
DVHA Value-Based Care Payment to ACO	(A)	*(B) + (C)*	$ 26,748,358
Fixed Prospective Payment (FPP)	(B)		$ 25,536,868
Administrative Fee (including Population Health Program Funds)	(C)		$ 1,211,490
Population Health Program Funds Distributed by ACO	(D)		$ 605,745
Total ACO Payments to Participating Providers	(E)	*(B) + (D)*	$ 26,142,613
Total Expected Zero-Paid Claims	(F)	*(B)*	$ 25,662,501
Total Actual Zero-Paid Claims	(G)		$ 22,208,729
Zero-Paid Claims Over (Under) Spend	(H)	*(G) – (F)*	$ (3,453,772)
Total Expected FFS	(I)		$ 20,718,937
Actual FFS - In Network	(J)		$ 8,002,870
Actual FFS - Out of Network	(K)		$ 9,026,575
Total Actual FFS	(L)	*(J) + (K)*	$ 17,029,445
FFS Over (Under) Spend	(M)	*(L) – (I)*	$ (3,689,492)
Expected Total Cost of Care	(N)	*(F) + (I)*	$ 46,381,438
Actual Total Cost of Care	(O)	*(F) + (L)*	$ 39,959,113
Total Cost of Care Over (Under) Spend	(P)	*(O) – (N)*	$ (6,422,325)
Year-End Reconciliation of Value-Based Care Payment*	(Q)		$ (124,764)
Financial Liability Before Risk Corridor	(R)	(P) + (Q)	$ (6,547,089)
Risk Corridor Upper Bound (100% of ETCOC)		100%	$ 46,381,438
Risk Corridor Lower Bound (99% of ETCOC)		99%	$ 45,917,624
ATCOC as Percentage of ETCOC			86.2%
Financial Liability After Risk Corridor	(S)	*[(O)-(O)*0.98] + (R)*	$ (588,578)
Year-End Reconciliation of Unearned VBIF Payments	(T)		$ -
Year-End Reconciliation of Undistributed Population Health Program Funds	(U)		$ -
Final Settlement Amount Owed to OneCare	**(V)**	***(S) + (T) + (U)***	**$ (588,578)**

*Adjustments are required in instances where DVHA paid a prospective payment for an attributed member according to a Medicaid Eligibility Group (MEG) assignment that was not current for that month. For example, if a payment was issued to OneCare for a General Child, but the attributed member had aged into the General Adult group, an adjustment would be made for the difference. Adjustments are also required when DVHA paid a prospective payment for a member who was no longer Medicaid eligible. For instance, if a payment was issued to OneCare for a member who had passed away, any dollars paid to OneCare for that month would be recouped through such an adjustment.

Quality Performance

The VMNG ACO contract includes measures that are used to evaluate the quality of care for the population of attributed Medicaid members. ACO-level quality is typically evaluated based on performance on 10 measures that impact payment along with three reporting-only measures (performance on which does not impact payment).

Prior to 2020, quality results in the VMNG program were encouraging. Unfortunately, beginning in early 2020 the unprecedented COVID-19 pandemic had a significant impact on the delivery of health care in

Vermont, and nationally, as elective visits and procedures were curtailed to reduce transmission of the virus. One of the many tragic consequences of the pandemic is that important care was deferred. Consequently, health care providers' quality results - which measure things like whether preventive visits have occurred - declined, including in Vermont. This trend continued into 2021. It will take time to fully understand the impact on health outcomes.

Table 2 sets forth ACO quality performance in Calendar Year 2021. The table includes several components:

- Measure name and National Quality Forum (NQF) number (or other number if the measure is not currently endorsed by the NQF);
- Measure numerator (the number of attributed members meeting the criteria for the measure), denominator (the number of attributed members eligible for inclusion in the measure population), and rate (a percentage derived from dividing the numerator by the denominator) for both the traditional and expanded attribution cohorts;
- 2020 performance (for reference only); and
- The number of points assigned based on 2021 performance for payment measures.

In 2020, OneCare Vermont received 13.75 of 20 total possible points for an overall quality score of 68.75%. To the extent possible, quality measures included in the VMNG contract were selected to align with measures included in the Vermont All-Payer ACO Model agreement. Many of these measures were identified because they represented an opportunity for improvement statewide. Of note:

- Quality performance exceeded the national 90th percentile for 4 measures, exceeded the 75th percentile for 1 measure, exceeded the 50th percentile for 4 measures, and was below the 25th percentile for 1 measure;
- Statistically significant improvement from 2020 was seen for 2 measures while statistically significant decline from 2020 was seen for 3 measures; and
- Quality results for the expanded attribution cohort were limited to claims-based measures.

OneCare Vermont was required to maintain a percentage of the Expected Total Cost of Care—1% in 2021—as a fund to support a quality incentive program. The providers in OneCare's network are able to earn this money back through high quality performance on targeted quality measures. This type of payment incentive is provided to encourage high quality care. Because of the overall quality score, OneCare will distribute 68.75% of this fund, or $1,576,525 to participating OneCare providers.

Table 2. Overview of VMNG Quality Performance, 2021

			TRADITIONAL COHORT			EXPANDED COHORT									
Item #	Measure Description	NQF #	Numerator	Denominator	2021 Rate	Numerator	Denominator	2021 Rate	2020 Rate (for reference, traditional cohort)	2020 Rate (For reference, expanded cohort)	Quality Compass® 2021 Benchmarks (CY 2020) National Medicaid (ALOB) Percentiles				Points awarded
											25th	50th	75th	90th	
1	30 Day Follow-Up after Discharge from the ED for Alcohol and Other Drug Abuse or Dependence	2605	199	605	32.89%	50	147	34.01%	32.68%	29.13%	10.75	21.31	26.22	32.6	2
2	30 Day Follow-Up after Discharge from the ED for Mental Health	2605	463	567	81.66%	83	112	74.11%	79.36%	72.78%	45.48	53.54	64.65	73.56	2
3	Child and Adolescent Well Care Visits (ages 12-17)	N/A	8,543	13,869	61.60%	512	1406	36.42%	57.93%*	35.82%*	39.45	45.06	54.04	62.45	1.75
4	All Cause Unplanned Admissions for Patients with Multiple Chronic Conditions	CMS ACO #38 (under NQF review)	16	2,012	0.80%	2	106	1.89%	0.92%	4.17%	N/A	N/A	N/A	N/A	1
5	Developmental Screening in the First 3 Years of Life	CMS Child Core CDEV	3,282	5,850	56.10%	325	711	45.71%	58.69%	39.44%	27.10	35.60	57.40	N/A	1
6	Diabetes Mellitus: Hemoglobin A1c Poor Control (>9%)	0059	119	372	31.99%	N/A	N/A	N/A	38.98%	N/A	51.98	43.3	38.44	34.06	2
7	Hypertension: Controlling High Blood Pressure	0018	232	372	62.37%	N/A	N/A	N/A	56.87%	N/A	50.61	55.47	62.53	66.42	1
8	Initiation of Alcohol and Other Drug Abuse or Dependence Treatment	0004	739	2,013	36.71%	230	535	42.99%	41.07%	47.93%	40.96	44.85	48.85	54.13	0
9	Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	0004	315	2,013	15.65%	104	535	19.44%	19.07%	25.29%	9.38	13.99	17.86	22.83	1
10	Screening for Clinical Depression and Follow-Up Plan	418	146	269	54.28%	N/A	N/A	N/A	45.82%	N/A	N/A	N/A	N/A	N/A	2
														Total	13.75
11	Follow-Up after Hospitalization for Mental Illness (7 Day Rate)	0576	277	544	50.92%	50	119	42.02%	50.45%	40.94%	30.87	38.99	47.75	57.81	N/A
12	Tobacco Use Assessment and Tobacco Cessation Intervention	0028	319	345	92.46%	N/A	N/A	N/A	80.81%	N/A	N/A	N/A	N/A	N/A	N/A
13	Patient Centered Medical Home (PCMH) Consumer Assessment of Healthcare Providers & Systems (CAHPS®) Survey Composite Measures Collective by DVHA		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Notes: *1) For HbA1C Poor Control and All Cause Unplanned Admission measures, a lower rate indicates higher performance.*
2) Benchmarks for Developmental Screening in 1st 3 years of Life are multi-state benchmarks: 30 states reporting (FFY 2020)
* Showing rate for ages 12-17 for 2020 in order to compare to 2021 rate

Key: Performance Compared to National Benchmarks
Equal to and below 25th percentile (0 points)
Above 25th percentile (0.25 point)
Above 50th percentile (1.0 points)
Above 75th percentile (1.75 points)
Above 90th percentile (2 points)