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Vermont Medicaid Next Generation ACO Program 2020 Performance

Department of Vermont Health Access

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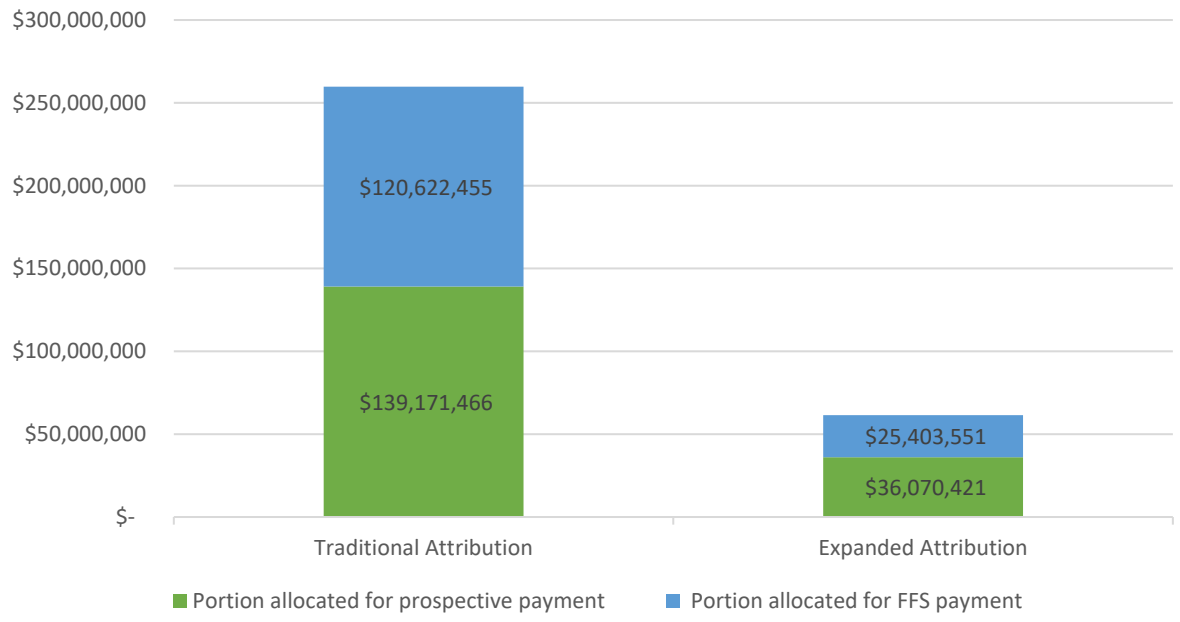
The report summarizes program performance in 2020 and proceeds in three sections. Section A offers an executive summary. Section B provides a brief overview of the program. Section C summarizes financial and quality performance for the 2020 performance year.

Section A: Executive Summary of Vermont Medicaid Next Generation 2020 Results

The Vermont Medicaid Next Generation (VMNG) Accountable Care Organization (ACO) program is a Scale Target 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 where 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 includes pre-payment for the cost of care for this group of attributed Medicaid members. 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 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 performance year 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, 2020 VMNG Contract



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 fourth 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 third performance years in 2020; participation has continued to grow across 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. Additionally, it noted that stakeholders agree that the All-Payer Model provides a unifying forum for providers, payers, and the state to engage in meaningful discussions around health care reform. Additional evaluations are planned for Performance Years 3-5 (2020-2022).

VMNG 2020 Performance - Key Takeaways:

- The program is stable. In 2020, the ACO-attributed Medicaid population increased by 144% over the prior year. This is due both to an increase in the number of communities, health care providers, and people participating in the program, and a modification to the attribution methodology for the VMNG program to expand eligibility for ACO attribution. The program has since stabilized, with attribution remaining relatively consistent in 2021 and 2022 (111,000 and 126,000 attributed Medicaid members, respectively).
- COVID-19 significantly impacted both VMNG financial and quality performance. 2020 saw a decrease in utilization across many components of the health care system due to the COVID-19 pandemic and associated Public Health Emergency (PHE). This 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 its financial and quality programs to hold providers harmless for COVID-19-related impacts to cost, quality, and utilization during the 2020 performance year.
- Fixed Prospective Payments create system stability. As providers saw revenue decrease for elective visits and procedures during 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 withstand the loss of fee-for-service revenue. This underscores the importance of revenue predictability for providers as Vermont looks toward increasing participation in population-based payment models.
- The ACO extended care coordination to more communities and people. There has been a steady increase in the percentage of high-risk and very high-risk attributed Medicaid members who received care coordination interventions under OneCare's Advanced Community Care Coordination model.

Result 1: Program participation is stable.

Additional providers and communities have joined OneCare's network to participate in the program for the 2020 performance year and provider participation has remained fairly constant in 2021 and 2022. 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
Hospital Service Areas	4	10	13	14	14	14
Unique Medicaid Providers	~2,000	~3,400	~4,300	~5,000	~4,800	~5,000

As participation increases, the incentives become stronger for providers to modify their care delivery and business practices to be successful under fixed payments. In 2020 DVHA developed an 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 88% of members for whom Medicaid was the primary payer. The attributed population for the VMNG program has held relatively steady for the 2021 and 2022 performance years (with approximately 111,000 and 126,000 attributed members, respectively), indicating that the modified attribution methodology is also helping the model achieve a stable population year-over-year.

Result 2: COVID-19 significantly impacted both quality and financial performance in the VMNG program.

The COVID-19 pandemic and the associated Public Health Emergency (PHE) greatly impacted the health care system, and by extension, the quality and financial performance of the ACO in the VMNG program. 2020 saw a decrease in utilization across many components of the health care system due to the COVID-19 pandemic. This negatively 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 its financial and quality programs to hold providers harmless for COVID-19-related impacts to cost, quality, and utilization during the 2020 performance year.

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

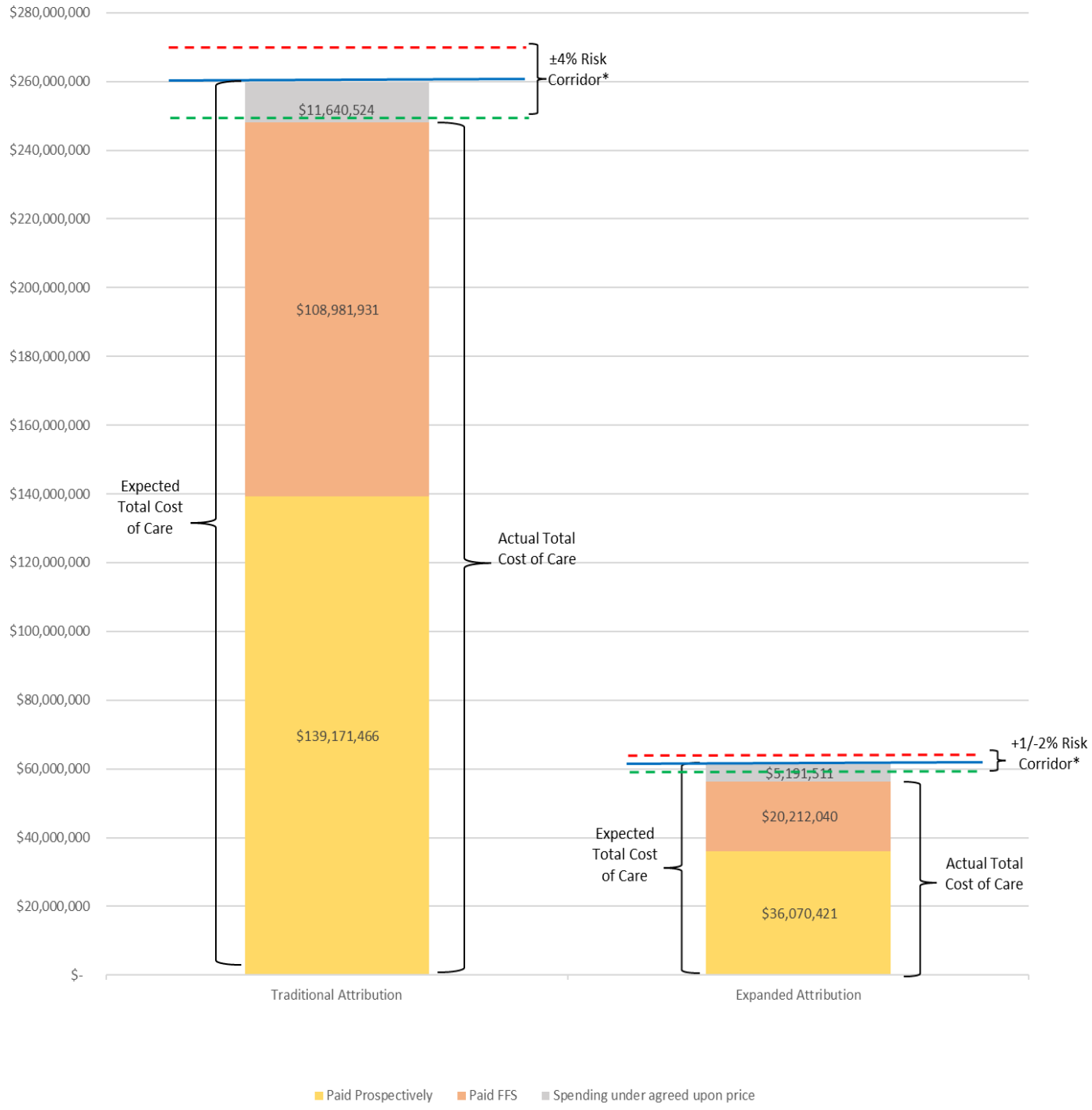
DVHA and OneCare agreed on the price of health care for attributed Medicaid members up-front, which was approximately $260 million for the traditional attribution cohort and $61 million for the expanded attribution cohort in 2020 (see Figure 2). Because 2020 was the first year that OneCare assumed accountability for the expanded attribution cohort, each cohort had a distinct risk arrangement and was reconciled separately. DVHA paid approximately $176 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 providers saw revenue decrease for elective visits and procedures that were on hold during the COVID-19 pandemic, those who received fixed prospective payments in the VMNG program were better able to withstand the loss of fee-for-service revenue for non-Medicaid lines of business.

Result 4: The ACO continued to support implementation and expansion of the Advanced Community Care Coordination model in all participating communities.

In 2020, implementation and expansion of the Advanced Community Care Coordination (A3C) Model continued in all participating health service areas. During the 2020 performance period:

- There was a steady increase throughout 2020 in the percentage of high-risk and very high-risk attributed Medicaid members who received a wide range of care coordination interventions under the Care Coordination Model. Notably, in 2020 OneCare exceeded the target of 15% of high and very high risk traditionally-attributed Medicaid members who are care managed (which includes assignment of a lead care coordinator, creation of a care team, and creation of a shared care plan).

Figure 2: 2020 VMNG Financial Performance relative to Expected Total Cost of Care



* No downside risk in 2020 due to COVID-19 Public Health Emergency

- OneCare distributed approximately $3.9 million in A3C payments to 78 community partner organizations (including primary care practices, Designated Mental Health Agencies, Area Agencies on Aging, and Visiting Nurse Associations).
- OneCare continued to support and implement the Developmental Understanding and Legal Collaboration for Everyone (DULCE) model in four pediatric practices. DULCE is an intervention that takes place within a pediatric care office to address social determinants of health in infants, newborn to 6 months of age, and provides support for their parents.
- Care Coordination Core Teams were active in all thirteen participating communities, connecting health service areas to share good clinical practices, innovations, and important information related to the Care Coordination Model.
- OneCare implemented an electronic learning platform to provide training opportunities for community care team members in care coordination skills and core competencies. Seven self-serve training modules were developed, on topics such as planning for effective care team conferences, social risk assessment to support population health management, and person-centered care. OneCare also conducted Care Management Certification educational workshops and live webinars on motivational interviewing.
- To support providers in identifying process improvement opportunities and members who could benefit from care coordination, OneCare analyzed and shared data, calculated social risk scores for all attributed members, and conducted provider assessments and targeted outreach.

2017-2020: Observations and Model Potential

Having four 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 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; as the program has increased in size, payments for attributed members have become more predictable year-over-year. Likewise, the risk corridor ensures there are both incentives to control costs and protections—for providers and the Medicaid program—in place for 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 enabled the program to stabilize the health system in periods of revenue unpredictability.

This contract continues to represent DVHA's largest initiative to move away from fee-for-service reimbursement and toward value-based payments. Throughout implementation there have been incremental improvements in quality performance and changes in the delivery and coordination of care. Although the COVID-19 Public Health Emergency affected the utilization and quality of care in 2020, programs nationwide were (and continue to be) similarly affected. For these reasons, DVHA and AHS believe that this model should continue to be tested, at least through the term of the All-Payer ACO model agreement.

Section B: Vermont Medicaid Next Generation ACO Pilot Program Overview

Introduction

The Vermont Medicaid Next Generation (VMNG) Accountable Care Organization (ACO) program is a Scale Target ACO Initiative as described in the Vermont All-Payer Accountable Care Organization Model agreement with the Centers for Medicare and Medicaid Services (CMS).[1] 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 the Department of Vermont Health Access (DVHA) to partner with a risk-bearing ACO. For Calendar Year 2020, DVHA contracted with OneCare Vermont (OneCare) ACO to manage the quality and cost of care for approximately 114,000 Medicaid members in fourteen communities, representing a 144% increase over the 2019 Medicaid attributed population. Together, DVHA and OneCare are piloting 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 to increase provider flexibility and 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. This will contribute to improving the health of Vermonters and moderating health care spending growth in future.

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.[2] DVHA and OneCare elected to exercise the third of the four optional one-year extensions permitted by the VMNG contract for a 2020 performance year.[3] In 2020, 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 has 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 for 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

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[1] See http://gmcboard.vermont.gov/sites/gmcb/files/documents/10-27-16-vermont-all-payer-accountable-care-organization-model-agreement.pdf.
[2] See http://dvha.vermont.gov/administration/onecare-aco-32318-final-searchable.pdf.
[3] See https://dvha.vermont.gov/sites/dvha/files/documents/Administration/OneCare%2032318-4%20Final%20Signed.pdf.

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[4]
- 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 in 2019 and 2020, OneCare implemented the Comprehensive Payment Reform (CPR) pilot with four independent physician practices that also elected to be paid the FPP for their ACO-attributed members. 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.

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 104% of the target. This liability was eliminated in order to align with COVID-19-related program adjustments for ACO models at the federal level. 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 96% 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—2% in 2020—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 and is expected to grow over time.

2020 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. OneCare, its network of providers, and DVHA continued to implement incremental programmatic improvements in 2020 including a modified attribution methodology based on learnings from a 2019 pilot of the methodology in the St. Johnsbury Health Service Area (HSA). The pilot sought to test whether alternative attribution methodologies could be implemented within the VMNG program and whether lessons learned could be used for program modifications in future years. Based on experience with the 2019 geographic attribution pilot, an expanded attribution methodology was developed and implemented for the VMNG program's 2020 performance year, leading to a significant increase in the number of attributed lives in the program.

[4] 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.

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 four 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) in hopes that 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 to prior performance years, the experience from the first four years of VMNG implementation has provided a foundation for continued implementation and evaluation.

Section C: Vermont Medicaid Next Generation ACO Financial and Quality Performance: January 1 – December 31, 2020

COVID-19-related Program Adjustments

The COVID-19 pandemic and associated 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, quality, and utilization during the 2020 performance year by making 2020 a reporting-only year for the VMNG quality measure set, decreasing the downside risk corridor proportionally to the proportion of months in 2020 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 the calculations of the Actual Total Cost of Care.

Financial Performance

Tables 1a and 1b set forth ACO financial performance in Calendar Year 2020 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 2020 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 2020 for the population of prospectively attributed Medicaid members, as detailed in Attachment B of the 2020 VMNG program contract.[5] Because the rate development process relied on data from 2018 as a baseline, COVID-19-related costs were not factored into the Expected Total Cost of Care, and COVID-19 episodes of care in 2020 were subsequently identified and removed from the Actual Total Cost of Care calculation, as noted above.

The actual health care expenditure in 2020 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 2020 calendar year was 95.5% of the Expected Total Cost of Care for the traditional attribution cohort and 91.6% of the Expected Total Cost of Care for the expanded attribution cohort, both of which fall outside of the 4% (for the traditional attribution cohort) and 2% (for the

[5] DVHA engaged Wakely Consulting Group to calculate 2020 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).

expanded attribution cohort) risk corridors included in the 2020 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 $10.3 million for the traditional attribution cohort and $1.2 million for the expanded attribution cohort. After applying other necessary adjustments, OneCare is entitled to a total of approximately $15.3 million from DVHA for the 2020 performance year.

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 and 2020 performance years (above and below the risk corridor, respectively).

Table 1a. VMNG 2020 year-end reconciliation calculations (Traditional Attribution Cohort)

Year-End Reconciliation Calculations – Traditional Attribution Cohort			**VMNG 2020**
DVHA Value-Based Care Payment to ACO	(A)	*(B) + (C) + (D) + (E)*	$ 142,813,100
Fixed Prospective Payment (FPP)	(B)		$ 131,392,795
Quality Withhold	(C)		$ 5,195,878
Care Coordination Payment (CCP)	(D)		$ 3,112,213
Administrative Fee	(E)		$ 3,112,213
Total ACO Payments to Providers	(F)	*(B) + (D)*	$ 134,505,008
Total Expected Zero-Paid Claims	(G)		$ 139,171,466
Total Actual Zero-Paid Claims	(H)		$ 102,114,521
Zero-Paid Claims Over (Under) Spend	(I)	*(H) – (G)*	$ (37,056,945)
Total Expected FFS	(J)		$ 120,622,455
Actual FFS - In Network	(K)		$ 62,378,944
Actual FFS - Out of Network	(L)		$ 50,416,970
Total Actual FFS	(M)	*(K) + (L)*	$ 108,981,931
FFS Over (Under) Spend	(N)	*(M) – (J)*	$ (11,640,524)
Expected Total Cost of Care	(O)	*(G) + (J)*	$ 259,793,921
Actual Total Cost of Care	(P)	*(G) + (M)*	$ 248,153,397
Total Cost of Care Over (Under) Spend	(Q)	*(P) – (O)*	$ (11,640,524)
Year-End Reconciliation of Value-Based Care Payment*	(R)		$ (1,437,824)
Financial Liability Before Risk Corridor	*(S)*	*(Q) + (R)*	*$ (13,078,347)*
Risk Corridor Upper Bound (100% of ETCOC)		100%	$ 259,793,921
Risk Corridor Lower Bound (96% of ETCOC)		96%	$ 249,402,164
ATCOC as Percentage of ETCOC			95.5%
Financial Liability After Risk Corridor	*(T)*	*[(O)-(O)*0.96] + (R)*	*$ (11,829,581)*
Recoupment of Unearned VBIF Payments	(U)		$ -
Final Settlement Amount Owed to OneCare	**(V)**	***(T) + (U)***	**$ 11,829,581**

*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 2020 year-end reconciliation calculations (Expanded Attribution Cohort)

Year-End Reconciliation Calculations – Expanded Attribution Cohort			VMNG 2020
DVHA Value-Based Care Payment to ACO	(A)	*(B) + (C) + (D) + (E)*	$ 35,293,243
Fixed Prospective Payment (FPP)	(B)		$ 34,085,408
Quality Withhold - *Not Applicable for Expanded Attribution Cohort*	(C)		$ -
Care Coordination Payment (CCP)	(D)		$ 422,742
Administrative Fee	(E)		$ 785,093
Total ACO Payments to Providers	(F)	*(B) + (D)*	$ 34,508,150
Total Expected Zero-Paid Claims	(G)		$ 36,070,421
Total Actual Zero-Paid Claims	(H)		$ 20,273,637
Zero-Paid Claims Over (Under) Spend	(I)	*(H) – (G)*	$ (15,796,784)
Total Expected FFS	(J)		$ 25,403,551
Actual FFS - In Network	(K)		$ 11,666,313
Actual FFS - Out of Network	(L)		$ 9,339,144
Total Actual FFS	(M)	*(K) + (L)*	$ 20,212,040
FFS Over (Under) Spend	(N)	*(M) – (J)*	$ (5,191,511)
Expected Total Cost of Care	(O)	*(G) + (J)*	$ 61,473,972
Actual Total Cost of Care	(P)	*(G) + (M)*	$ 56,282,461
Total Cost of Care Over (Under) Spend	(Q)	*(P) – (O)*	$ (5,191,511)
Year-End Reconciliation of Value-Based Care Payment*	(R)		$ (2,337,800)
Financial Liability Before Risk Corridor	*(S)*	*(Q) + (R)*	*$ (7,529,311)*
Risk Corridor Upper Bound (100% of ETCOC)		100%	$ 61,473,972
Risk Corridor Lower Bound (98% of ETCOC)		98%	$ 60,244,493
ATCOC as Percentage of ETCOC			91.6%
Financial Liability After Risk Corridor	*(T)*	*[(O)-(O)*0.98] + (R)*	*$ (3,567,280)*
Recoupment of Unearned VBIF Payments - *Not Applicable for Expanded Attribution Cohort*	(U)		$ -
Final Settlement Amount Owed to OneCare	**(V)**	***(T) + (U)***	**$ 3,567,280**

*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 very 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 had to be deferred. Consequently, health care providers' quality results, which measure whether things like preventive visits have occurred, declined, including in Vermont. It will take time to fully understand the impact on health outcomes.

As a result, the VMNG program's 2020 quality measure set was modified so that all measures are reporting-only and performance on the measures does not impact payment. In doing so, Vermont has followed the lead of the Federal government in determining how to assess 2020 quality results. The Center for Medicare and Medicaid Innovation (CMMI) has also decided to link payment to reporting rather than performance in 2020, in recognition that care was delayed or forgone during the pandemic.

Table 2 sets forth ACO quality performance in Calendar Year 2020. 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;
- 2019 performance (for reference only); and
- The number of points assigned based on 2020 performance for reporting-only measures.

In 2020, OneCare Vermont received 20 of 20 total possible points (as 2020 was a reporting-only year for quality measure performance) for an overall quality score of 100%. 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:

- ACO performance declined on 9 out of 10 measures, with statistically-significant decline on 5 of those measures;
- National benchmarks were not available for the 2020 performance year; 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—2% in 2020—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 100% of this fund to participating OneCare providers.

Table 2. Overview of VMNG Quality Performance, 2020

Item #	Measure Description	NQF #	Numerator Traditional Attribution Cohort	Denominator Traditional Attribution Cohort	2020 Rate Traditional Attribution Cohort	Numerator Expanded Attribution Cohort	Denominator Expanded Attribution Cohort	2020 Rate Expanded Attribution Cohort	2019 Rate (for reference, *Traditional Attribution Cohort ONLY*)	Points awarded	Bonus points awarded
1	30 Day Follow-Up after Discharge from the ED for Alcohol and Other Drug Abuse or Dependence	2605	216	661	32.68%	37	127	29.13%	37.15%	2	N/A
2	30 Day Follow-Up after Discharge from the ED for Mental Health	2605	473	596	79.36%	115	158	72.78%	85.53%	2	N/A
3	Adolescent Well Care Visits	N/A	9668	17751	54.46%	1483	5767	25.72%	57.35%	2	N/A
4	All Cause Unplanned Admissions for Patients with Multiple Chronic Conditions	CMS ACO #38 (under NQF review)	21	2282	0.92%	7	168	4.17%	0.88%	2	N/A
5	Developmental Screening in the First 3 Years of Life	CMS Child Core CDEV	3238	5517	58.69%	424	1075	39.44%	62.10%	2	N/A
6	Diabetes Mellitus: Hemoglobin A1c Poor Control (>9%)*	0059	145	372	38.98%	N/A	N/A	N/A	25.61%	2	N/A
7	Hypertension: Controlling High Blood Pressure	0018	211	371	56.87%	N/A	N/A	N/A	62.63%	2	N/A
8	Initiation of Alcohol and Other Drug Abuse or Dependence Treatment	0004	853	2077	41.07%	290	605	47.93%	40.77%	2	N/A
9	Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	0004	396	2077	19.07%	153	605	25.29%	20.23%	2	N/A
10	Screening for Clinical Depression and Follow-Up Plan	418	115	251	45.82%	N/A	N/A	N/A	51.96%	2	N/A
									Total	20	0
11	Follow-Up after Hospitalization for Mental Illness (7 Day Rate)	0576	337	668	50.45%	70	171	40.94%	40.85%	N/A	N/A
12	Tobacco Use Assessment and Tobacco Cessation Intervention	0028	299	370	80.81%	N/A	N/A	N/A	83.87%	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

*indicates a measure where a lower score means better performance.