State Innovation Model

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Overview of Shared Savings Programs (SSPs) and Accountable Care Organizations (ACOs) in Vermont

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Please refer to the Table titled "Details of SSPs and ACOs in Vermont" following this narrative for details about the specific SSP-ACO agreements operating in Vermont, including the ACO's provider networks and the estimated percent of attributed lives within each SSP.

1. *What is an Accountable Care Organization (ACO)?*

An ACO is a network of health care providers, such as doctors, hospitals, home health agencies and mental health providers, who have committed to work together to improve health outcomes at lower costs for a defined group of patients. ACOs are intended to organize providers to better control health care cost growth and shift the focus from providing their separate services to coordinating with each other for the benefit of the people they serve. Currently, reimbursement mechanisms for services by ACO providers have not changed, but the ACO and its providers benefit from "shared savings" arrangements with payers.

There are three ACOs in Vermont: Community Health Accountable Care (CHAC), Accountable Care Coalition of the Green Mountains/Vermont Collaborative Physicians (ACCGM/VCP)[1], and OneCare Vermont (OCV). They include, collectively, all of the State's hospitals, plus Dartmouth-Hitchcock, most of the state's physicians, all of the state's federally-qualified health centers and many of the state's home health and mental health providers. All Vermont ACOs have agreed to participate in shared savings programs with Medicare and Vermont commercial payers. Two are participating in a Vermont Medicaid shared savings program.

2. *What is a Shared Savings Program (SSP)?*

In a shared savings program, the ACO provider network agrees to be tracked on total costs and quality of care for the patients it serves, in exchange for the opportunity to share in any savings achieved through better care management. Provider participants in ACOs essentially have agreed that quality can be improved and health care costs can be reduced, and they will work together toward that goal.

This is different from the current predominantly fee-for-service financial model in American health care, which creates incentives for quantity of service but not necessarily quality of service. Rather, Shared Savings is a middle ground between fee-for-service, which can encourage overuse of care, and a

[1] ACCGM is in the Medicare Shared Savings Program and VCP is in the Commercial Shared Savings Program.

per person amount (capitation), which can encourage underuse. Under shared savings, providers still receive fee for service payments – but the total payments are tracked and provider networks can keep some savings if they meet or exceed quality thresholds and the total payments are less than what was projected at the beginning of the year.

3. Do ACOs and SSPs exist in states other than Vermont?

In other states, ACOs exist or are planned. Specifically, Minnesota, Oregon, New Jersey, Maine and Massachusetts all have, or will have, Medicaid Shared Savings Programs where they contract with ACOs. Commercial payers around the country are also creating Shared Savings Programs. In Vermont they are central to the State's reform plans, and are currently considered to be the best available tool for better coordination of effort across providers, better outcomes for patients and reduced costs. We hope Vermont ACOs can be the foundation for long-term cost and quality accountability, and we will evaluate their success over the next three years to see if that is possible.

Vermont has advantages over other states in using ACOs:

- State oversight of the shared savings programs through the Green Mountain Care Board (GMCB)
- A mix of ACO models:
  - One that is statewide and inclusive of most providers
  - One that is FQHC-based
  - Two that are controlled by independent physicians
- All payer participation in shared savings programs. All-payer participation is essential, because otherwise there will not be sufficient incentives for health care providers to re-organize the system and process of care delivery. Having all payers participate in VT, given its size, increases the likelihood of true transformation on the ground.

4. What are the SSP "Standards"?

In the commercial and Medicaid SSPs, "standards" were developed to offer guidance to ACOs participating in either SSP. Examples of standards include the methodology for attribution of lives and parameters related to the calculation of ACO financial performance and shared savings. Rules regarding the operation of the Medicare SSP were developed by the federal government, and are outlined in the Code of Federal Regulations. These rules cannot be altered by Vermont Stakeholders.

The Medicaid and Commercial shared savings programs were developed as part of Vermont's Health Care Innovation Project. The standards were approved by the Vermont Health Care Innovation Project (VHCIP) Steering Committee, the VHCIP Core Team, and the GMCB. We are testing the shared savings model, as well as two other innovative payment models. All three models will be evaluated over a three-year period for their effectiveness at improving quality and controlling cost growth.

5. What are "attributed lives"?

The term "attributed lives" refers to the health plan beneficiaries whose total cost of care is assigned to an ACO by a payer for purposes of calculating shared savings in accordance with the specific Shared Savings Program (SSP) Standards. Details of the mechanisms used for attribution differ across the three SSPs. However, in general, beneficiaries are assigned to ACOs based on where they received a

preponderance of primary care services during the most recent 12 months (24 months for the Commercial SSP). Since not all primary care providers are part of an ACO network, some Vermonters may not be attributed to an ACO, and therefore their cost of care is not included in financial calculations under an SSP.

a. Can a beneficiary who is attributed to an ACO opt-out?

In the Medicare and Medicaid SSPs, ACOs must ensure that the beneficiary has been notified that his/her provider is a participant in the SSP and allow the beneficiary to opt-out of allowing the payer to share his/her medical claims data with the ACO. However, even if beneficiaries opt out of this information-sharing, they will still be attributed to an ACO for purposes of calculating the ACO's Total Cost of Care and potential savings.

b. Are there circumstances where a person attributed to an ACO may receive a different set of services than someone who is not attributed to an ACO?

Attribution to an ACO does not change a beneficiary's access to services. ACOs may provide special clinical interventions to targeted populations who have complex needs or high costs in order to improve their care and control costs. It is likely, however, that these interventions would apply to all individuals served by the providers in an ACO, not just those attributed to the ACO. In addition, ACOs may develop care management models only for individuals attributed to their ACO, in which case these individuals might receive care management differently than someone who is not in an ACO, or someone who is in a different ACO.

c. How does attribution work if an individual has more than one insurance carrier?

Attribution Methodology for Individuals with Multiple Coverage		
Medicare SSP	***Medicaid SSP***	***Commercial SSP***
The purpose of the Medicare SSP is to align incentives between Part A and Part B; as such, the program only attributes a beneficiary to an ACO if the beneficiary has at least 1 month of Part A and Part B enrollment, and the beneficiary cannot have any months of Part A only or Part B only enrollment. • Individuals that have Medicare Part A and have commercial insurance for Part B-like services are excluded from attribution in the Medicare SSP. • Individuals that have both Medicare Part A and Part B, and also has commercial insurance are included in the attribution in the Medicare SSP, as long as they have at least one month of Medicare Part A and Part B enrollment, and do not have any months of Part A only or Part B only enrollment.	The following populations are excluded from attribution to an ACO: • Individuals who are dually eligible for Medicare and Medicaid; • Individuals who have third party liability coverage; • Individuals who have coverage through commercial insurers; • Individuals who are enrolled in Vermont Medicaid but receive a limited benefit package.	Individuals are attributed to an ACO only if the commercial insurer is the primary payer, and the product is available on Vermont Health Connect. • Individuals who have Medicare or Medicaid as primary and a commercial plan as secondary are not included in the Commercial SSP. • Individuals that have Medicare Part A and have commercial insurance for Part B-like services are excluded from attribution in the Commercial SSP. • Individuals that have both Medicare Part A and Part B, and also have commercial insurance are excluded from attribution in the Commercial SSP.

6. ***What providers are in the ACOs' networks?***
An ACO's provider network may differ for each SSP in which they are participating. Please see the "Detail of SSPs and ACOs in Vermont" Table for a list of providers in each ACO's network for each SSP. All three SSP programs are very specific about the kinds of providers that are qualified to have attributed lives and these are the "Network Participants". Network Participants are defined by each payer and are mostly primary care clinicians. "Network Affiliates" are providers who don't have lives attributed to them but do have contracts with the ACO to be part of their provider network.

7. ***Is it possible that a given provider would sign multiple contracts with multiple ACOs?***
Currently there are 8 Agreements between SSP payers and ACOs in which providers could have contracts to participate in an ACO network. This number may grow in the future as ACOs expand their participation in all available SSPs. Providers that have attributed lives can only sign contracts with one ACO within each SSP. (If these providers were associated with more than one ACO, it would be unclear which ACO a beneficiary is assigned to, and consequently, which ACO would get any shared savings arising from the ACO provider's efforts.) Providers in practices that do not attribute any lives can sign contract agreements with multiple ACOs:

Current SSP-ACO Agreements in Vermont				
ACOs	**Shared Savings Programs (SSPs)**			
	Medicare	**Medicaid**	**Commercial BCBS-VT**	**Commercial MVP[2]**
Health*first* ACCGM	X			
Health*first* VT Collaborative Physicians			X	
OneCare Vermont	X	X	X	
CHAC	X	X	X	

8. ***Will providers also continue serving people who are not attributed to any ACO?***
Yes, providers also continue to serve people who are not attributed to an ACO.

9. ***What is "Total Cost of Care"?***
ACOs are eligible to share in the savings if the actual "Total Cost of Care" for their attributed lives is less than the predicted Total Cost of Care for a given year. The benefits included in the Total Cost of Care calculation vary by SSP, and in the case of the Medicaid SSP, will expand throughout the three year program.

The Medicaid Shared Savings program does not currently include long-term services and supports (LTSS) in the calculation of Total Cost of Care" – the costs on which an ACO can potentially achieve savings. The State will need to make a decision over the next three years about when and how the total costs of care should be expanded to include LTSS.

[2] There are no attributed lives for the Commercial MVP Shared Savings Program.

Benefits included in Total Cost of Care (TCOC) Calculations		
Medicare SSP	**Medicaid SSP**	**Commercial SSP**
Generally comparable to Medicare Part A and Part B services	All 3 years—Services include inpatient hospital, outpatient hospital, professional services, ambulatory surgery center, clinic, federally qualified health center, rural health center, chiropractor, independent laboratory, home health, hospice, prosthetics, orthotics, medical supplies, durable medical equipment, emergency transportation, and dialysis facility. The State has the option to expand the TCOC beginning in Year 2 (January 1, 2015) of the program to include DLTSS or other specialized services. ACOs will have the option to adopt the expanded TCOC in Year 2 and it will be mandatory beginning in Year 3 (January 1, 2016). Medicaid will seek recommendations from VHCIP Work Groups prior to adopting the expanded TCOC definition.	Most benefits offered through exchange insurance plans, with the following exceptions: • Services that are carved out of the contract by self-insured employer customers • Prescription (retail) medications [potential inclusion in the context of shared (upside and downside) risk in Year 3 following VHCIP Payment Models Work Group discussion] • Dental benefits (the exclusion of dental services will be re-evaluated after the Exchange becomes operational and pediatric dental services become a mandated benefit).

10. How does "Shared Savings" work?

If quality and patient experience of care measurement thresholds are met, and there are savings relative to the predicted TCOC for the ACO attributed population, then a portion of those savings is paid to the ACO and the remaining portion goes to the payer. ACOs can increase their share of savings if they perform above the quality and patient experience of care measurement thresholds previously mentioned. Any shared savings payments are in addition to fee-for-service payments already received by health care professionals. The amount of shared savings an ACO will receive depends on: 1) how the savings meet the SSP-defined "Minimum Savings Rate", and 2) how the ACOs perform on SSP-determined quality and performance measures.

Shared Savings Requirements		
Medicare SSP	**Medicaid SSP**	**Commercial SSP**
ACOs must meet a minimum savings rate (MSR) to qualify for savings (which is calculated based on # of attributed lives in the ACO); once this MSR is met, ACOs are eligible to receive up to 50% of the Medicare savings. Actual amount of savings an ACO can receive is determined by ACO's performance regarding reporting on and meeting quality metrics.	ACOs must meet a minimum savings rate (MSR) to qualify for savings (which is calculated based on # of attributed lives in the ACO); once this MSR is met, ACOs are eligible to receive up to 50% of the Medicaid savings. The actual amount of savings an ACO can receive is determined by ACO's performance on certain quality metrics.	ACOs do not need to meet a minimum savings rate to qualify for savings. ACOs can receive up to 25% of savings achieved between the expected amount and the minimum savings rate (MSR) (which is calculated based on # of attributed lives in the ACO), and up to 60% of their savings if they exceed the MSR, with a maximum savings of 10% of their expected expenditures. Actual amount of savings an ACO can receive is determined by ACO's performance on certain quality metrics.
Quality Measures for ACOs to Share in Savings**:** • Currently 33 Measures • Year 1: Only must report on measures • Years 2 and 3: Must report on some measures and meet defined performance metrics on others	Quality Measures for ACOs to Share in Savings**:** • Currently 32 Payment and Reporting Measures, 8 of which are Payment Measures that impact shared savings • Years 1 - 3: Must report on some measures and meet defined performance thresholds on others	Quality Measures for ACOs to Share in Savings**:** • Currently 31 Payment and Reporting Measures, 7 of which are Payment Measures that impact shared savings • Years 1 - 3: Must report on some measures and meet defined performance thresholds on others

11. Are there preconditions on how Shared Savings can be spent by ACOs?

The intent of the SSPs is that a portion of the savings is used by the ACO for administration and other costs, and that the remainder is distributed to the professionals who contributed to the implementation of the improvements that led to the savings. The Medicare SSP only allows ACOs to share their Medicare savings with providers that have a Medicare enrolled provider billing number. ACOs participating in the Vermont Medicaid and Commercial SSPs can share their savings with any provider in their network, but are required to share their written plan for distribution of their shared savings with the State each year. Please refer to the "SSPs and ACOs in Vermont" Table for more detail about how each ACO will share its savings with providers under each SSP. The shared savings formulas are still being determined by some ACOs, but will most likely be different depending on the SSP.

12. What is downside risk and how does it work?

Downside risk is designed to address concerns that shared savings is "one-sided" since there are no consequences if the financial calculations actually yield higher costs, or if no care improvement is seen. As such, the Medicare SSP includes the possibility of both upside and downside risk, or both shared savings and penalties. In this two-sided model, ACOs receive shared savings for managing costs and meeting quality and satisfaction benchmarks, but also will be liable for expenses that exceed spending targets (i.e., downside risk). If an ACO agrees to take downside risk, they typically also share in a higher percentage of any savings that are attained.

Risk Parameters		
Medicare SSP	**Medicaid SSP**	**Commercial SSP**
Upside Risk Only for 3 Years, with Up and Downside Risk starting Year 4 if the ACO decides to continue in the Shared Savings Program	ACOs were asked to select from two tracks (one-sided or two-sided model) for contract years one through three of the program. In the case of the one sided model, the maximum sharing rate is 50%; and in the case of the two-sided model, the maximum sharing rate is 60%. To date, all ACOs participating in the Medicaid SSP have chosen one-sided risk model which includes upside Risk Only for 3 Years. All three programs are currently exploring options for inclusion of downside risk after the initial three years of the contract.	Upside Risk Only for 2 Years; Upside and Downside Risk in Year 3; no decisions made regarding Downside Risk after Year 3

13. ***What protections exist for beneficiaries if their provider is negatively impacted by the ACO arrangement for down-side risk (i.e., provider folds because they perform poorly and are required by the ACO to help pay back funds to CMS)?***

The Medicare and Medicaid Shared Savings Programs do not restrict beneficiary access to providers in any way – beneficiaries retain freedom of choice to see the providers they want to see. The commercial Shared Savings Program does not restrict beneficiary access except according to benefit design limitations.

Because the ACO structure is an agreement between the provider and the ACO, the beneficiary will not be directly impacted by their provider's decision to leave an ACO. That said, beneficiaries may notice positive impacts regarding their care delivery because of their provider's participation in an ACO, and therefore a beneficiary may want to seek out another provider who is in the same ACO. A beneficiary's choice of provider is not at all restricted, and they can go to another provider at any time they choose. The state will be monitoring patient experience in several ways to ensure that beneficiaries are getting the necessary care, including a patient experience survey and monitoring appeals and grievances for beneficiary complaints.

14. What is the governance and advisory structure of the ACOs in Vermont?

ACO	Governing Body	Formal Advisory Groups
Health*first* - Accountable Care Coalition of the Green Mountains (ACCGM)	ACCGM Management Committee: Comprised of physician participants, Executive Director and Medicare beneficiary. This committee meets quarterly. The ACCGM Management Committee governs the affairs of ACCGM and has broad authority to act on behalf of and execute the functions of the ACO.	Care Coordination and Quality Improvement Sub-Committee: Comprised of Physician Participants, Executive Director and Clinical Manager of ACCGM. Meets quarterly to review clinical data and make recommendations to the Management Committee for implementation of policies and programs. Compliance and Clinical Implementation Committee: Comprised of participating practice administrators, Executive Director, Clinical Manager and Network Administrator. Meets every other month and reviews compliance and operational aspects of the ACO. Recommendations are made to the Management Committee for adoption/approval.
Health*first* - - Vermont Collaborative Physicians (VCP)	VCP Management Committee: Comprised of physician participants, Executive Director and consumer representative. This committee will meet quarterly and will govern the affairs of VCP.	Clinical Quality and Care Coordination Committee: This Committee will be responsible to the Management Committee for: (1) performance monitoring and improvement; (2) care management and coordination; and (3) protocol adaptation and implementation.
OneCare Vermont (OCV)	The OCV Governing Body includes a beneficiary representative from each of the three Shared Savings Programs, and representatives of the ACO hospitals, physicians and other OCV network providers, including mental health and substance abuse providers and post-acute and long-term care and support services providers.	Clinical Advisory Board (CAB): Comprised of OCV physicians and other providers from across Vermont representing expertise appropriate to the attributed beneficiaries; CAB membership is expanding to include additional providers and specialties to reflect the needs of the broader Medicaid and Commercial populations. Consumer Advisory Group: Will be comprised of representatives from communities served by OCV. Meets at least quarterly, with meeting reports shared at OCV board meetings. Purpose of the Group is to ensure consumers' input and comments are heard, considered, and reported to OCV's board.
Community Health Accountable Care (CHAC)	The CHAC Board includes a beneficiary representative from each of the three Shared Savings Programs, a representative from each FQHC and a representative from Bi-State. Seats are open for representation from a hospital, from behavioral health, and from long-term supports and services. There are two additional at large seats.	The Clinical Committee is responsible for producing clinical guidelines to be used in the care of CHAC patients as well as a network annual quality improvement plan, which prioritizes areas where CHAC overall could improve its performance against its own clinical standards and guidelines as well as against Shared Savings Program goals. The Clinical Committee is also responsible for conducting quarterly performance updates. The Beneficiary Engagement Committee serves to engage beneficiary input into the design of CHAC programs and strategies. The Committee will seek input from a broader set of CHAC beneficiaries than are able to sit on the Governing Board, and will review all feedback from beneficiaries and their representatives to make recommendations to the Governing Board about how to best ensure that patients are represented in CHAC's decision making.

15. Are there other ways ACOs must address beneficiary engagement?

The "Governance" section of the Medicaid SSP contracts between DVHA and ACOs includes the following provisions:

D. 2. Devote an allotted time at the beginning of each in-person governing body meeting to hear comments from members of the public who have signed up prior to the meeting and providing public updates of the ACO's activities.

D. 4. Post summaries of ACO activities provided to ACO's consumer advisory board on the ACO's website.

G. The ACO's governing body must include at least one consumer member who is a Medicaid beneficiary. Regardless of the number of payers with which the Contractor participates, there must be at least two consumer members on the Contractor governing body. Consumer members shall have some prior personal, volunteer, or professional experience in advocating for consumers on health care issues. The Contractor shall not be found to be in non-conformance with this provision if the Contractor has in good faith recruited the participation of qualified consumer representatives to its governing body on an ongoing basis and has not been successful.

H. Members of the ACO's management and the governing body must regularly attend consumer advisory board meetings and report back to the ACO's governing body following each meeting of the consumer advisory board. Other consumer input activities shall include but not be limited to hosting public forums and soliciting written comments. The results of other consumer input activities shall be reported to the ACO's governing body at least annually.

16. What is the relationship between ACOs and users and providers of human services and long-term services and supports?

The Medicaid Shared Savings Program gives rise to issues that the Medicare and commercial insurer programs don't face. Because Medicaid pays for a broader array of services than other payers, and serves vulnerable populations with very specific needs, we need to carefully consider and make decisions about the scope of the program within Medicaid.

The State is taking a very careful approach to integrating long-term services and supports and specialized disabilities services in shared savings programs. The State, the ACOs and long-term services and supports providers are in the early stages of discussions about whether and how ACOs could bridge health care and human services delivery in a positive way.

17. What will happen to the commercial and Medicaid SSPs after the three year contract is up?

It is understandable that some providers and some consumers may be worried about what the development of the ACOs means for them. The VHCIP Core Team, the Agency of Human Services and the GMCB are committed to continuing a process whereby concerns can be expressed and emerging issues are addressed.

The VHCIP project will be an important avenue of input into the evolution and evaluation of ACOs. Work groups that are part of the project will make recommendations in the coming months about such issues as:

- How to assure that quality measures on which ACOs report reflect the needs of Vermonters, especially those with disabilities;
- Whether and how to expand the scope of total costs to include LTSS;

- How to coordinate care management activities between acute and long-term services providers, and institutional and community-based providers, for the maximum benefit of the people they serve, and assuring that person-directed care is not compromised.

Recommendations from those work groups will be reviewed by the VHCIP Steering Committee, which includes a broad array of health, human services and disability stakeholders, and the VCHIP Core Team. The final recommendations will inform AHS and the GMCB regarding further design of ACO payment programs and long-term ACO oversight.

Details of Shared Savings Programs (SSPs) and Accountable Care Organizations (ACOs) in Vermont

MEDICARE SHARED SAVINGS PROGRAM (MSSP)								
ACO Name	Start Date in Program	Geographic Area	ACO Network Participants[1,2] (Providers with attributed lives)	ACO Network Affiliates[1] (Providers without attributed lives)	ACO Shared Savings Distribution with Provider Network[3]	Estimated Medicare Attributed Lives		
						# and % of Total VT Medicare Enrollees (Total N=126,081)[4]	# and % of VT MSSP Eligible Enrollees (Total N=117,015)[5]	# and % of Dual Eligibles within Attributed Lives (Total N=21,670)
Health*first* - Accountable Care Coalition of the Green Mountains (ACCGM)	Jan 1, 2013	Approved Statewide; current network available in Greater Burlington and North Central Vermont	• 30 Physicians – 10 Primary Care	Committee working on Collaborative Care Agreements (CCAs) with practitioners, including: • Specialists • Other specific entities (e.g., Visiting Nurses Association)	• 50% of shared saving distributed to Healthfirst Network Participants and CCA Practitioners o Collaborative Care Agreements (CCAs) will specify responsibilities of CCA Practitioners in order to share in these savings, including patient and network engagement • 50% of shared savings to Collaborative Health Systems[6]	7,446 6%	7,446 6%	583 3%
OneCare Vermont (OCV)	Jan 1, 2013	Statewide	• 2 Academic Medical Centers (FAHC and DHMC) • All other VT hospitals • Brattleboro Retreat • 4 Federally Qualified Health Centers (FQHCs) • 4 Rural Health Centers • 300+ Primary Care Physician FTEs • Most of VT Specialty Care Physicians	• 28 of 40 Skilled Nursing Facilities • All but one Home Health and Hospice Agency • All 9 Comprehensive Mental Health (MH)/Developmental Service (DS) Designated Agencies (DA), the 1 MH-only DA, no DS-only DA, no Children's MH Specialized Service Agency (SSA), and no DS SSAs	• 90% of shared savings distributed to OCV Network Participants; 10% retained by OCV • Separate Incentive Plan Provision for OCV Network Affiliates • Both depend on reporting and performance metrics	52,265[7] 41%	52,265[7] 45%	13,066[8] 61%
Community Health Accountable Care (CHAC)	Jan 1, 2014	8 of 14 Counties (Chittenden, Grand Isle, Franklin, Orleans, Caledonia, Essex, Orange, Washington)	• 5 FQHCs and Bi-State Primary Care Association - 24 FQHC practice sites (includes dental and school based sites) - 97 Primary Care Providers	• 9 VNA / Home Health and Hospice Agencies (1 is under umbrella of FQHC) • 8 of 9 Comprehensive MH/DS DAs, the 1 MH-only DA, no DS-only DA, the 1 Children's MH SSA, and 1 of 4 DS SSAs • 4 hospitals (2 of these are under umbrella of FQHC)	Distribution methodology to be determined.	5,980 4.7%	5,980 5.1%	unknown
TOTALS			~427 Primary Care Providers ~ 67% of 634 Primary Care Providers statewide[9]			65,691 52% of all VT Medicare enrollees	65,691 56% of all VT MSSP Eligible enrollees	At least 13,649 At least 63% of all VT Duals

VERMONT MEDICAID SHARED SAVINGS PROGRAM (VMSSP)								
ACO Name	**Start Date in Program**	**Geographic Area**	**ACO Network Participants[10],[11] (Providers with attributed lives)**	**ACO Network Affiliates[9] (Providers without attributed lives)**	**ACO Shared Savings Distribution with Provider Network[12]**	**Estimated Medicaid Attributed Lives**		
						# and % of Total VT Medicaid Enrollees (Total N= 153,315)[13]	# and % of VT VMSSP Eligible Enrollees (Total N=95,000)[14]	# and % of Dual Eligibles within Attributed Lives (Total N=21,670)
ACCGM/VCP	NA	NA	NA	NA	NA	NA	NA	NA
OneCare Vermont (OCV)	Jan 1, 2014	Statewide	• 2 Academic Medical Centers (FAHC and DHMC) • All but 2 other VT hospitals • Brattleboro Retreat • 0 Federally Qualified Health Centers (FQHCs) • 3 Rural Health Centers • 300+ Primary Care Physician FTEs • Most of VT Specialty Care Physicians	• 22 of 40 Skilled Nursing Facilities • All but one Home Health and Hospice Agency • All 9 Comprehensive Mental Health (MH)/Developmental Service (DS) Designated Agencies (DA), the 1 MH-only DA, the 1 DS-only DA, the 1 Children's MH Specialized Service Agency (SSA), and all 4 DS SSAs	• 90% of shared savings distributed to OCV **Network Participants and Affiliates**; 10% retained by OCV • Provider amount depends on reporting and performance metrics	29,000 19%	29,000 31%	0
Community Health Accountable Care (CHAC)	Jan 1, 2014	13 of 14 Counties (with sites in or significant service to all counties except Bennington)	9 FQHCs and Bi-State Primary Care Association • 49 FQHC practice sites • 233 Primary Care Providers	• 9 VNA / Home Health and Hospice Agencies (1 is under umbrella of FQHC) • 8 of 9 Comprehensive MH/DS DAs, the 1 MH-only DA, the 1 DS-only DA, the 1 Children's MH SSA, and all 4 DS SSAs • 5 hospitals (2 of these are under umbrella of FQHC)	Distribution methodology to be determined.	21,000 14%	21,000 22%	0
TOTALS			~533Primary Care Providers **~84% of 634 Primary Care Providers statewide[15]**			Approximately 50,000 or Approximately 33% of all current VT Medicaid enrollees	Approximately 50,000 or Approximately 53% of all VMSSP Eligible enrollees	0 **0% of all VT Dual Eligibles**

COMMERCIAL SHARED SAVINGS PROGRAM (XSSP) – Blue Cross Blue Shield of Vermont (BCBS-VT) and MVP Health Care (MVP)

ACO Name	Start Date in Program	Geographic Area	ACO Network Participants[16] (Providers with attributed lives)	ACO Network Affiliates[15] (Providers without attributed lives)	ACO Shared Savings Distribution with Provider Network[17]	Estimated Commercial Plan Attributed Lives		
						# and % of Total VT Commercial Plan Enrollees (Total N=155,479)[18]	# and % of VT XSSP Eligible Enrollees (Total N=70,000)[19]	# and % of Dual Eligibles within Attributed Lives (Total N=21,670)
Health*first* - - Vermont Collaborative Physicians (VCP)	Jan 1, 2014	Statewide	• 69 Physicians – 24 Primary Care Practices	Committee working on Collaborative Care Agreements (CCAs) with practitioners, including: • Specialists • Other specific entities (e.g., Visiting Nurses Association)	• PCP's to retain the majority of shared savings • VCP to retain a portion for administration and reserves • Collaborative Care Agreements (CCAs) will specify responsibilities of CCA Practitioners in order to share in these savings, including patient and network engagement	7,200 (BCBS only) 5%	7,200 (BCBS only) 10%	0
OneCare Vermont (OCV)	Jan 1, 2014	Statewide	• 2 Academic Medical Centers (FAHC and DHMC) • All but 3 other VT hospitals • Brattleboro Retreat • 1 FQHC • 2 Rural Health Centers • 300+ Primary Care Physician FTEs • Most of VT Specialty Care Physicians	• 23 of 40 Skilled Nursing Facilities • All but two Home Health and Hospice Agencies • All 9 Comprehensive Mental Health (MH)/Developmental Service (DS) Designated Agencies (DA), the 1 MH-only DA, no DS-only DA, the 1 Children's MH Specialized Service Agency (SSA), and 1 of 4 DS SSAs	• 90% of shared savings distributed to OCV Network Participants; 10% retained by OCV • Separate Incentive Plan Provision for OCV Network Affiliates • Both depend on reporting and performance metrics	18,400 (BCBS Only) 12%	18,400 (BCBS Only) 26%	0
Community Health Accountable Care (CHAC)	Jan 1, 2014	12 of 14 Counties (with sites in or significant service to all counties except Bennington and Lamoille)	8 Federally Qualified Health Centers (FQHCs) and Bi-State Primary Care Association • 45 FQHC practice sites • 218 Primary Care Providers	• 9 VNA / Home Health and Hospice Agencies (1 is under umbrella of FQHC) • 8 of 9 Comprehensive MH/DS DAs, the 1 MH-only DA, no DS-only DA, the 1 Children's MH SSA, and no DS SSAs • 5 hospitals (2 of these are under umbrella of FQHC)	Distribution methodology to be determined.	8,900 (BCBS Only) 6%	8,900 (BCBS Only) 13%	0
TOTALS			~587 Primary Care Providers ~ 93% of 634 Primary care Providers statewide[20]			34,500 22% of all VT Commercial Plan enrollees	34,500 49%of all VT XSSP Eligible enrollees	0 0% of all VT Dual Eligibles

ACRONYMS

ACCGM:	Accountable Care Coalition of the Green Mountains
ACO:	Accountable Care Organization
BAA:	Budget Adjustment Act
BCBS-VT:	Blue Cross Blue Shield of Vermont
CCA:	Collaborative Care Agreements
CHAC:	Community Health Accountable Care
CHS:	Collaborative Health Systems
DA:	Designated Agency
DHMC:	Dartmouth-Hitchcock Medical Center
DS:	Developmental Services
DVHA:	Department of Vermont Health Access
ESI:	Employer-Sponsored Insurance
ESIA:	Employer-Sponsored Insurance Assistance
FAHC:	Fletcher Allen Health Care
FQHC:	Federally Qualified Health Center
FTEs:	Full-time Equivalents
MH:	Mental Health
MSR:	Minimum Savings Rate
MSSP:	Medicare Shared Savings Program
MVP:	MVP Health Care
NA:	Not Applicable
OCV:	OneCare Vermont
SSA:	Specialized Service Agency
SSP:	Shared Savings Program
TBD:	To Be Determined
VCP:	Vermont Collaborative Physicians
VHAP:	Vermont Health Access Program
VMSSP:	Vermont Medicaid Shared Savings Program
VT:	Vermont
XSSP:	Commercial Shared Savings Program

[1] Current Network Participants and Network Affiliates as of April, 2014; may change over time
[2] ACO Participants can only be in the network of one ACO because they could have lives attributed to them to calculate Medicare performance and savings; Outcomes for each "life" can only relate to a single ACO.
[3] Under the Medicare SSP, ACOs must meet a minimum savings rate (MSR) to qualify for savings (which is calculated based on # of attributed lives in the ACO); once this MSR is met, ACOs are eligible to receive up to 50% of the Medicare savings; Actual amount of savings an ACO can receive is determined by ACOs performance regarding reporting on and meeting quality metrics
[4] Source: www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Downloads/2014/Mar/State-County-Penetration-MA-2014-03.zip
[5] MSSP does not include Medicare enrollees in Medicare Advantage Plans. In March 2014, 9,036 Vermonters were enrolled in these Plans. Source: www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Downloads/2014/Mar/State-County-Penetration-MA-2014-03.zip
[6] Healthfirst partnered with Collaborative Health Systems (CHS), a subsidiary of Universal American Corp., to form ACCGM for the Medicare SSP. CHS has partnered with 34 Independent Practice Associations across the country to form Medicare SSP ACOs and provides care coordination, analytics and reporting, technology and other administrative services for the ACOs.
[7] Number of attributed lives is an estimate.
[8] Based on estimated attribution numbers as of June 30, 3014.
[9] PCP Statewide total from Paul Harrington, Vermont Health Care Reform Update, Health*first* Annual Meeting, November 2, 2013
[10] Current Network Participants and Network Affiliates as of April, 2014; may change over time
[11] ACO Participants can only be in the network of one ACO because they could have lives attributed to them to calculate Medicaid performance and savings; outcomes for each "life" can only relate to a single ACO.
[12] Under the Medicaid SSP, ACOs must meet a minimum savings rate (MSR) to qualify for savings (which is calculated based on # of attributed lives in the ACO); once this MSR is met, ACOs are eligible to receive up to 50% of the Medicaid savings; Actual amount of savings an ACO can receive is determined by ACOs performance regarding reporting on and meeting quality metrics
[13] Based on DVHA SFY'15 Budget Document Insert 2, using SFY '14 BAA enrollment figures; excludes Pharmacy Only Programs and VHAP ESI, Catamount, ESIA, Premium Assistance For Exchange Enrollees < 300%, and Cost Sharing For Exchange Enrollees < 350% (i.e., all programs that financially assist individuals to enroll in commercial products)
[14] Number provided in DVHA's VMSSP RFP; the following populations are excluded from being considered as attributed lives: Individuals who are dually eligible for Medicare and Medicaid; Individuals who have third party liability coverage; Individuals who are eligible for enrollment in Vermont Medicaid but have obtained coverage through commercial insurers; and Individuals who are enrolled in Vermont Medicaid but receive a limited benefit package.
[15] PCP Statewide total from Paul Harrington, Vermont Health Care Reform Update, Health*first* Annual Meeting, November 2, 2013
[16] Current Network Participants and Network Affiliates as of April, 2014; may change over time
[17] Under the Commercial SSP, ACOs can receive up to 25% of savings achieved between the expected amount and the minimum savings rate (MSR) (which is calculated based on # of attributed lives in the ACO), and up to 60% of their savings if they exceed the MSR, with a maximum savings of 10% of their expected expenditures. Actual amount of savings an ACO can receive is determined by ACOs performance regarding reporting on and meeting quality metrics
[18] Vermont residents covered in Private Insurance Market, 2012; Source: 2011 Vermont Health Care Expenditure Analysis, Green Mountain Care Board, page 14. Only includes individuals who have a Commercial plan as their primary insurance.
[19] The XSSP eligible population for attribution to an ACO includes individuals who have obtained their commercial insurance coverage through products available on the VT Health Connect Exchange (obtained through the exchange website or directly from the insurer).
[20] PCP Statewide total from Paul Harrington, Vermont Health Care Reform Update, Health*first* Annual Meeting, November 2, 2013