Frequently Asked Questions

Vermont's All-Payer Model and GMCB ACO Oversight

VERMONT
GREEN MOUNTAIN CARE BOARD

Last Updated: February 2021

Questions: *To skip to a question, click on a question and hit the Enter key.*

1. What is Vermont's All-Payer Accountable Care Organization Model Agreement?

Vermont's All-Payer Model (APM) is changing the way health care is delivered and paid for, with the goal of keeping the state's health care spending in check and improving the quality of care Vermonters receive.

The **All-Payer Accountable Care Organization Model Agreement** (sometimes referred to as the All-Payer Model, APM, or the "Agreement") is a five-year (2018-2022) agreement between Vermont and the federal government that allows Medicare to join Vermont's Medicaid agency and commercial insurers to pay for health care in a different way. New payment models change incentives to reward improved provider communication and patient outcomes to improve the lives of Vermonters, by paying for value in health care rather than volume. The goal of the APM is to shift from a fee-for-service system to a population-based payments system while improving population health outcomes for Vermonters and limiting the health care cost growth to state economic growth.

Vermont's All-Payer Model Agreement aims to align health care cost growth with the growth of the Vermont economy and to improve the health of Vermonters over time. It has set ambitious goals and benchmarks that will be measured over 5 years and beyond. The outcomes we are trying to achieve require significant upfront investment, effective management, robust engagement, ongoing tracking, and adjustments and improvements along the way.

The APM Agreement identified three types of targets for the State (more information and early results in Question 8):

1) **5-Year Growth Target**. The driving objective of the APM is to align health care cost growth with the growth of the Vermont economy. The APM will track health care spending across 5 years, with the goal of keeping the average increase in costs to 3.5% – and no more than 4.3% – between 2018 and 2022. We will continue evaluating our goal over the course of the 5-year agreement as we expect health care utilization and costs to fluctuate year-to-year, especially during uncertain times like the COVID-19 public health emergency.
2) **Improving Health Care Quality and the Health of Vermonters.** One of the most ambitious goals of the APM is to improve the health of Vermonters over time. Specifically, the APM aims to increase access to primary care, reduce deaths from suicide and drug overdose, and lower prevalence of chronic disease, knowing that moving the needle on population health is a long-term effort.
3) **Participation (Scale).** For the APM to succeed, the majority of Vermonters must be included, which means we must have the majority of providers and insurers be part of the effort. As the Model grows, participating providers should see a greater proportion of their business tied to value, rather than volume, which will help ensure that health care delivery in Vermont is aligned with improving health outcomes.

Additional Resources:
Vermont All-Payer Model Agreement. Signed October 2016.

All-Payer Model. GMCB.

Vermont All-Payer ACO Model. Centers for Medicare & Medicaid Services (CMS).

2. What is an Accountable Care Organization? What is OneCare Vermont's role in the APM?

An Accountable Care Organization (ACO) is a group of health care providers that agree to be accountable for the care and cost of a defined population of patients. The Affordable Care Act (ACA) included incentives for creating Medicare ACOs because the ACO model was identified as a promising way to reduce the ever-rising cost of health care nationwide. For a brief article explaining ACOs, see Kaiser Health News, "Accountable Care Organizations, Explained."

Vermont's APM was designed to change health care payment models, curb health care cost growth, maintain quality of care, and improve the health of Vermonters, using the ACO model as a chassis.

Vermont law requires the GMCB to oversee ACOs through two key ACO regulatory processes:

(1) *Certification*. Certification ensures that ACOs seeking to receive payments from Vermont Medicaid and commercial payers have the systems in place to do the work required of an ACO.
(2) *Budget Review*. The annual ACO budget review process provides an opportunity to assess the ACO's programs, which are expected to facilitate Vermont's shift toward value-based care, as well as the cost of administering these programs.

To learn more, see Accountable Care Organizations (ACOs) and GMCB's ACO Oversight.

Vermont's APM was designed to change health care payment models, curb health care cost growth, maintain quality of care, and improve the health of Vermonters, using the ACO model as the primary vehicle for delivery system reform. An Accountable Care Organization is a voluntary network of health care and social services providers that have joined together to be accountable for the health of a population and work toward the goals of the APM.

OneCare Vermont (OneCare) is the only ACO operating in Vermont.

3. What does the All-Payer Model do for Vermonters?

Vermont's All-Payer Model (APM) is changing the way health care is delivered and paid for, with the goal of keeping the state's health care spending in check and improving the health of Vermonters. The APM gives health care providers the flexibility to deliver services like telehealth, group visits, and coordination with fellow providers that were previously not billable. And it holds insurers and providers jointly accountable for the quality and cost of care they provide to Vermonters.

The Vermont All-Payer Accountable Care Organization Model Agreement allows Medicare to join Medicaid and commercial insurers to pay for health care more efficiently. The goal of the APM is to shift payments from a fee-for-service system that rewards volume to a payment system based on value while improving the health of Vermonters and limiting health care cost growth.

This change in incentives helps Vermonters connect to the right care, at the right place, at the right time. By shifting the focus to preventive care, the APM urges providers to catch and treat small health problems before they turn into big issues. The APM also encourages increased communication and coordination between health care and social service providers, especially those who are caring for the sickest or highest-risk patients, to drive better health outcomes and enhance the quality of care. By working with providers and payers to align quality measures, models of delivery, payments, and more, we can help improve care for all Vermonters.

Because of the APM's flexible payments, population health investments, and incentive structure, hospitals and surrounding communities are shifting resources toward activities known to improve overall health, including primary care, lifestyle medicine, health education and prevention, mental health counseling, and nutrition. The APM is changing incentives to push toward to increased access to primary care and social services and increased efficiency across the system. Under the APM, Vermonters continue to receive their health insurance coverage and benefits; neither the APM nor the ACO limit the benefits or provider choice available under patients' insurance plans. Payer and provider participation in the APM through the ACO may enhance the benefits of insurance plans in some cases. As population

health initiatives are funded by the ACO, Vermonters receive greater access to programs they can benefit from, such as care coordination and telehealth. Vermonters should see an increase in services known to improve overall health, such as preventive care, and services that address social determinants of health.

It is important to remember that improvements in population health take time and are not simple to measure. Improvements will also need scale, meaning more patients included in the APM. Providers are more likely to alter investments and change behavior when the majority of their reimbursements are driven by value, not volume. It will take time to add more patients to the APM and to shift more payments away from fee-for-service. The APM involves long term investments in improving health and it will take years before researchers can assess the impact of the APM on population health outcomes in any statistically meaningful way.

4. Why did Vermont decide to pursue the All-Payer Model? How were Vermonters informed?

The Vermont health care system and State government have been laying the foundation for statewide payment reform since the early 2000s. The APM builds on these successful reform efforts that have evolved through several administrations and legislative sessions (see "A Brief History of Health Care Reform"):

- The Blueprint for Health was created by legislation in 2006 and expanded statewide in 2013. The Blueprint builds upon the Patient Centered Medical Home (PCMH) model with an important focus on complex care coordination.
- From 2013-2017, the federal government awarded Vermont a $45 million dollar State Innovation Model (SIM) grant to develop value-based payments for Vermont providers, assist providers with their readiness for practice transformation under new payment models, including health data infrastructure, and provide evaluation of investments and policy decisions. SIM tested an early ACO payment model known as the Shared Savings Program, and without waiting for results of the formal evaluation, there were indicators that this payment model was not a strong enough incentive for change.

These efforts put the building blocks in place for the federal government to enter into an All-Payer Model Agreement with Vermont, shifting to a more aggressive risk model and different payment types. The Agreement was negotiated from 2015-2016. During this time, the GMCB held at least 16 public Board meetings to discuss the details of the proposal. The GMCB also participated in public informational meetings held around the state in partnership with the Administration to present details of the proposal and answer questions from the public. The Vermont Legislature took testimony and debated implementation of the APM and oversight of ACO's in Vermont, passing Act 113 of 2016, "An act related to implementing an all-payer model and oversight of accountable care organizations."

The Vermont All-Payer Model Agreement was signed in October 2016 by the federal government and Vermont's Governor, Secretary of Human Services, and Chair of the Green Mountain Care Board. In addition to bringing Medicare to the table as a payer in a Vermont-specific ACO model, it also continues Medicare's investment into the Blueprint for Health and Support and Services at Home (SASH) program for seniors – both long-running home-grown programs with demonstrated success in improving care and lowering costs – which otherwise would have lost Medicare funding after 2016.

Additional Resources:
Carbee, J; Langweil, N. Vermont: A Brief History of Health Care Reform. 2019.

The Commonwealth Fund. Vermont's Bold Experiment in Community-Driven Health Care Reform. 2018.

5. What is the role of GMCB in health care reform, the APM, and in regulating ACOs (including OneCare)?

GMCB's role in health care reform focuses on the regulation of some private health care entities in support of the state's broader health care reform goals of (1) curbing health care cost growth and (2) improving quality and population health outcomes. The GMCB also serves as a steward of health care data and provides analytics for public consumption and for policymakers, supporting a transparent, statewide view of cost and quality across Vermont's health care system.

In the All-Payer Model, the GMCB exercises its regulatory and data analytic capabilities to support the Model's goals. For example, the GMCB establishes health care spending targets for Medicare, and recommends modifications to Medicare's ACO initiative in Vermont so that it may better align with other Vermont health care reform efforts. The APM Agreement is signed by the Governor, the Secretary of the Agency of Human Services, and the GMCB Chair. These "APM

signatories" work together to implement the Agreement: the GMCB is primarily responsible for monitoring and reporting on progress toward achieving the APM goals.

The GMCB also regulates Vermont ACOs, as required by Vermont law, through two key processes: (1) certification and (2) budget review (see 18 V.S.A. § 9382 and GMCB Rule 5.000). The certification process ensures appropriate governance, policies, and procedures necessary to operate an ACO, while budget review and approval provides oversight over ACO revenues, expenses, and risk mitigation.

Under this oversight structure, national experts have called Vermont's ACO one of the most highly regulated ACOs in the nation. The GMCB and its staff spend hundreds of hours on ACO oversight annually and review thousands of pages of ACO documents to ensure that Vermont's ACO meets State standards for operation, and that its budget supports Vermont's health reform goals. In the past few years, GMCB's oversight has resulted in conditional certification and budget approvals which in turn require the ACO to demonstrate that it continues to strive for improvement and transparency. The GMCB's ACO oversight also aligns with other regulatory duties, most notably hospital budget review.

6. Do any other states have models like Vermont's All-Payer ACO Model Agreement?

According to an article published in the journal Health Affairs in 2019, there were 995 active ACOs nationwide, with 1,588 contracts with public and private insurers, and including 44 million assigned beneficiaries. While ACOs are not unique to Vermont, Vermont's all-payer approach and focus on population health are highly innovative. Two other states – Maryland and Pennsylvania – also have All-Payer Models with the federal government, which bring Medicare to the table as a payer in state-designed programs.

Additional Resources:
Spread of ACOs and Value-Based Payment Models in 2019. *Health Affairs* Blog. October 21, 2019.

States the Reported Accountable Care Organizations in Place (SFY2015-SFY2015). Kaiser Family Foundation. 2019.

State 'Accountable Care' Activity Map. National Academy for State Health Policy. 2019.

Maryland All-Payer Model. Centers for Medicare & Medicaid Services.

Pennsylvania Rural Health Model. Centers for Medicare & Medicaid Services.

7. How do we know if the All-Payer Model is working?

The All-Payer Model aims to control the cost of care so that it does not outpace growth in Vermont's economy and to improve the health of Vermonters over time. It sets ambitious goals and benchmarks that will be measured over 5 years and beyond. The outcomes Vermont is trying to achieve require significant upfront investment, effective management, robust engagement, ongoing tracking, and may require adjustments to the model along the way.

Tracking quality and cost growth is at the heart of the APM – and will help us determine if the state is heading in the right direction. Because of the time it takes to procure, scrub, and analyze claims data, which are essential to analyzing progress in a model as ambitious and far-reaching as this, we are currently analyzing data for Year 2 (2019), though we are in Year 4 of the APM. This early data gives us a starting point from which to build as we collect and average the full five years of data from the APM.

All-Payer Model Agreement Targets and Reporting. The Agreement requires Vermont to report regularly to CMMI on performance against the APM targets (see Question 1), and other topics. All of GMCB's reports to CMMI are available to the public once they're finalized, posted to the APM Reports page of GMCB's website.

Evaluation and Monitoring. The GMCB is continually assessing APM successes and challenges generally, through:

- APM Reports to CMMI on scale, quality, and cost (described above, posted to the GMCB website)
- Payer-specific evaluations (e.g., 2018 contractual results presented to GMCB in November 2019)
- Qualitative stakeholder input (e.g., a 2019 provider survey to identify barriers to APM participation)

In addition, a formal independent evaluation of the APM is required by federal law and will include an analysis of the state's five-year performance on APM total cost of care, quality, and scale. To conduct this evaluation, the Center for Medicare and Medicaid Innovation (CMMI) is contracting with the non-partisan research organization NORC at the University of Chicago. Unfortunately, due to data availability, the final results of this evaluation will not be available in

time to inform further implementation of the APM nor the development of a potential subsequent agreement ("APM 2.0"); final results are expected in Spring 2023. GMCB intends to leverage any relevant findings from reports on the APM's early performance years (e.g., 2018 and 2019 which are expected to be available in Q1 of 2021) to inform APM 2.0, if possible. There is no formal state-funded evaluation of the APM of this caliber, but if one were to be initiated, it would suffer from the same data lag as the federal evaluation.

Though the complete federal APM evaluation results will not be available for some time, there are some promising signs of delivery system reform: hospitals are increasing their investments in primary prevention and the social determinants of health; traditionally siloed providers are finding new ways to coordinate care and reduce duplication of services across the care continuum; and advances in data analytics are helping to reduce unnecessary spending and identify high risk patients who would benefit most from early intervention and complex care coordination. While delivery system reform is by no means complete, we recognize that major transformation requires both time and patience, and the reallocation of resources towards population health is reassuring.

Early data suggest positive shifts related to appropriate network utilization among lives attributed to the APM through OneCare. For example, in its 2021 budget submission, OneCare noted a 26% reduction in inpatient admissions and a 20% reduction in emergency room utilization among participants in its Longitudinal Care Program. OneCare reported making significant progress in reducing emergency department utilization and inpatient admissions for high and very high-risk individuals in 2018 and 2019 across all payers. Though overall, more work is needed in addressing ambulatory sensitive conditions including COPD, CHF, and asthma, performing A1C checks among Medicare and commercial patients with diabetes, and increasing well-care visits among Medicare patients and Medicaid and commercial adolescents.

GMCB will continue to monitor APM and ACO performance as data become available, and once trend data are established, and populations become more stable, will be able to dig into results to perform more robust analyses.

8. What results do we have so far?

5-Tear Cost Growth Target: Vermont's All-Payer Model Agreement aims to align health care cost growth with the growth of the Vermont economy. Based on historical growth rates, the APM Agreement targets 3.5% growth for a subset of the state's health care costs over the term of the Agreement but allows for growth up to 4.3%; there are separate targets for Medicare cost growth as well. APM Total Cost of Care differs from other measures of health system cost such as ACO spending per beneficiary, total Vermont health care expenditures, and hospital net patient revenue; it is limited to a specific population and set of services and excludes costs like most pharmaceuticals, most mental health spending, and more. Cost data and denominator totals are derived from VHCURES, Vermont's All-Payer Claims Database. It is too soon to tell how Vermont will perform relative to this five-year target, however in FY18, the first performance year of the APM, Vermont's all-payer TCOC growth reached 4.1%, and while this exceeds the 3.5% target, it is a decline from the previous year's growth rate (8.5%). Data are currently delayed due to the COVID-19 Public Health Emergency, the GMCB anticipates releasing Year 2 (2019) results in Q1 2021. (See Question 9 for more information on the impact of COVID-19 on the APM.)

Improving Health Care Quality and the Health of Vermonters. The APM Agreement evaluates statewide health outcomes and quality of care through 22 measures, each with specific targets and tied to three population health goals: to improve access to primary care; to reduce deaths due to suicide and drug overdose; and to reduce prevalence and morbidity of chronic disease. The measures included in the quality framework were carefully selected in collaboration with providers, advocates, and others to support improvement on identified population health goals, building on measurement and long-term health care initiatives underway in Vermont at the time the Agreement was signed. While selecting measures and developing targets, Vermont consistently advocated for measures that addressed key priority areas in the State, aligned with existing measure sets, and minimized provider data collection burden. Vermont also fought for targets that are ambitious but realistically achievable over the five-year period. The framework encourages health, public health, and community service providers to work together to improve quality and integration of care. This collaboration includes the ACO and its community partners – while the ACO is not responsible for these outcomes alone, the GMCB seeks to understand the ACO's approach to quality improvement through our regulatory levers.

Participation (**Scale**). ACO scale is the percentage of Vermonters who are included in the APM – meaning that the patient's provider and insurance program choose to participate in the ACO. Inclusion in the APM does not change any of the benefits of a patient's insurance plan or a patient's choice of doctor or medical provider. The All-Payer ACO Model

Agreement includes All-Payer and Medicare scale targets for each year, which are designed to ensure that Vermont engages a critical mass of its population in the APM so that providers can change their care delivery and business models to support value, not volume.

The table below shows progress toward achieving All-Payer and Medicare scale targets by performance year.

		PY1 (2018)	PY2 (2019)	PY3 (2020)	PY4 (2021) *Preliminary	PY5 (2022)
All-Payer Scale Target	*Target*	*36%*	*50%*	*58%*	*62%*	*70%*
	Actual	22%	30%	42%	46%*	
Medicare Scale Target	*Target*	*60%*	*75%*	*79%*	*83%*	*90%*
	Actual	35%	47%	44%	56%*	

While Vermont has not yet achieved Scale Targets, we have made marked improvements in Medicare Scale and All-Payer Scale since PY1. The Agreement anticipates continued scale growth over the 5-year period. Allowing scale targets to gradually increase over the course of the APM allows time for providers to successfully change the way they deliver care.

Additional Resources:
GMCB Website – All-Payer Model Reports and Federal Communications

9. How does the COVID-19 public health emergency impact the All-Payer Model?

While the COVID-19 pandemic and public health emergency have not changed Vermont's goals for transitioning from fee-for-service health care payment to models that pay for value, it has had an enormous impact on Vermont's health care providers and will impact the APM going forward.

In 2020, Vermont requested federal flexibility related to the APM Agreement's performance targets, and flexibility in the contract between Medicare and Vermont's ACO. This is because the impact of COVID-19 on 2020 performance against these targets is not predictable and is likely to be outside of providers' control. The Board worked with federal partners to limit providers' potential risk for shared losses for 2020; to waive financial penalties related to quality to allow providers to focus on the COVID-19 response; and to extend the deadline for providers to decide whether to participate in the Medicare ACO program in 2021. In addition, the State is likely to request and receive flexibility related to performance on overall health care cost growth (known as Total Cost of Care under the APM Agreement) and potentially other model targets. We continue to measure providers' performance and will continue reporting to our federal partners as outlined in the APM Agreement.

The COVID-19 public health emergency is also impacting Vermont's ability to measure the impact of the APM. For example, we are still waiting for data on how COVID-19 has impacted patient care patterns, but providers have reported that COVID-19 caused a dramatic reduction in use of health care services (often called "utilization") in the early part of the pandemic. We expect that this will also cause a significant reduction in cost growth in 2020. This uncertainty will make it difficult to understand changes in cost growth over the full 5 years of the All-Payer Model. Vermont will need to work with providers, our federal partners, and health care evaluators to better understand the impacts of COVID-19 on the Model when more data are available.

Additional Resources:
GMCB Website – All-Payer Model Reports and Federal Communications