Frequently Asked Questions

VERMONT
GREEN MOUNTAIN CARE BOARD

Vermont's All-Payer Model and GMCB ACO Oversight

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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. The goal of the APM is to shift payments from a fee-for-service system that rewards the delivery of high-volume high-cost services, to a payment system based on value, high quality care and good health outcomes at a lower cost.

Vermont's All-Payer Model Agreement has set ambitious targets and benchmarks that will be measured over the duration of the model. 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 Q8):

1) **Cost Growth Target**. The key objective of the APM is to align health care cost growth with the growth of the Vermont economy. In accordance with the APM, health care spending will be tracked over the full term of the agreement, with the goal of keeping the average increase in costs to 3.5% – and no more than 4.3% – over that time period. The GMCB evaluates the state's progress annually relative to the model's goal, expecting 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**. Another one of the APM's ambitious goals 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

* In December 2021, Vermont submitted a request to extend the model for one year, through 2023. The federal response to this request, in April 2022, indicated that Vermont's federal partners are working to offer a one-year extension for 2023 plus a transition year in 2024 to prepare for a potential longer-term subsequent model. Vermont and federal partners are currently in discussions about this proposal.

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 voluntary network 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. OneCare Vermont (OneCare) is currently the only multi-payer ACO operating in Vermont, though the APM does not preclude more than one ACO from operating in the state.

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.

Additional Resources:
Guide to GMCB's ACO Oversight.

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. This change in incentives helps Vermonters connect to the right care, at the right place, at the right time, and 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. 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.

The Vermont All-Payer Accountable Care Organization Model Agreement (APM 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.

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. 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 below, "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 Shumlin 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 patient centered medical home/population health programs 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's Vermont ACO program, 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 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.

National experts have called Vermont's ACO model one of the most highly regulated ACO models 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 any ACO subject to regulation 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 activities also align 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 national 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 that Reported Accountable Care Organizations in Place (SFY2015-SFY2019). Kaiser Family Foundation. 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?

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 sets ambitious goals and benchmarks that will be measured over the life of the model. The outcomes the APM sets out to achieve require significant upfront investment, effective management, robust engagement, ongoing tracking, and possible model adjustments and improvements along the way.

The GMCB is primarily responsible for monitoring and reporting on progress toward achieving the APM goals. 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 receive and analyze health care claims data, we are beginning to analyze data for Year 4 (2021), though we are in Year 5 (2022) of the APM. This early data gives us a starting point from which to build as we collect and average data from the full duration of 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 Q1), 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 performance on the APM targets; this will be the most robust evaluation of the APM's impact, focusing its quantitative analysis on Medicare's participation and Medicare beneficiaries. In August 2021, the first evaluation report (summary) was released, covering the first two years of the Model (2018-2019). Findings included reduced Medicare

spending in Vermont compared to other states. The report also notes that the APM is supporting collaboration across the health care system around shared goals. The report also found positive effects for the full Vermont population because many of the Model's population health initiatives serve Vermonters regardless of insurance or ACO participation, highlighting Vermont's long history of investment in primary care and population health, culture of reform, and strong hospital and ACO regulation. The report also identifies areas for improvement, many of which echo AHS's fall 2020 APM Implementation Improvement Plan (see Q8).

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?

For the most up-to-date summary of Vermont's progress toward achieving the All-Payer Model Agreement targets, see **Vermont's All-Payer Model Performance Summary Dashboard**.

Cost Growth Target: A key objective of the APM is to align the growth in the cost of care to the growth of Vermont's economy. In accordance with the APM, health care spending will be tracked over the full term of the agreement, with the goal of keeping the average increase in costs to 3.5% – and no more than 4.3% – over that time period; 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.

GMCB evaluates the state's progress annually relative to the model's goal, expecting health care utilization and costs to fluctuate year-to-year, especially during uncertain times like the COVID-19 public health emergency. It is too soon to tell how Vermont will perform relative to this long-term target, however the growth in health care costs was 4.1% in Year 1 (2018), 4.6% in Year 2 (2019), and 0.4% in Year 3 (2020). The decline in compounding growth is mostly due to the lack of health care utilization during the COVID-19 public health emergency.

Improving Health Care Quality and the Health of Vermonters. Another one of the APM's ambitious goals is to improve the health of Vermonters over time. 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 period of the model. 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.

As of Year 3, Vermont is seeing improvement in the majority of the 22 reported measures – and meeting or exceeding five of the Agreement's six population health outcome targets. As data for each subsequent year of the APM becomes available, we will track against these benchmarks, carefully evaluate our progress, knowing that moving the needle on population health is a long-term effort. In line with the Board's purpose to provide transparency, we will share results on the state's progress with the public as they become available.

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)	PY5 (2022) *Preliminary
All-Payer Scale Target	*Target (waived)*	*36%*	*50%*	*58%*	*62%*	*70%*
	Actual	22%	31%	45%	46%	50%*
Medicare Scale Target	*Target (waived)*	*60%*	*75%*	*79%*	*83%*	*90%*
	Actual	33%	47%	47%	54%	54%*

In October 2021, the federal government waived enforcement of the APM Agreement Scale Targets through the remainder of the current Agreement, stating that the Scale Targets, as defined in the Vermont APM Agreement, are "unattainable for Vermont based on information not available when the State Agreement was drafted." Vermont continues to pursue increased scale and will continue to report on progress. While much of the data discussed above suggests Vermont is heading in the right direction, the State has also identified room to improve APM performance. In November 2020, the Agency of Human Services released an APM Implementation Improvement Plan, developed in partnership with GMCB staff, aimed at achieving the goals of the APM. The plan includes ideas for getting the most out of Vermont's special relationship with the federal government under the APM Agreement; improvements that AHS and GMCB can make in their implementation and oversight; and strengthening OneCare Vermont's leadership strategy.

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

GMCB Website – Vermont's All-Payer Model Performance Summary Dashboard

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 may 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. This uncertainty will make it difficult to understand changes in cost growth over the full duration 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.

Because of the impact of the COVID-19 public health emergency on data and on providers' and State officials' ability to engage in planning, Vermont submitted a request to extend the model for one year, through 2023, to allow more time for planning and stakeholder engagement around a longer-term APM Agreement renewal. The federal response to this request, in April 2022, indicated that Vermont's federal partners are working to offer a one-year extension for 2023 plus a transition year in 2024 to prepare for a potential longer-term subsequent model. Vermont and federal partners are currently in discussions about this proposal.

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