# VERMONT ALL-PAYER ACCOUNTABLE CARE ORGANIZATION MODEL AGREEMENT

The increasing costs of health care are not affordable for Vermonters. Many struggle to access preventive primary care services, and health care outcomes for substance abuse, mental health, and chronic disease need to improve.

Goal

- Limit health care cost growth to no more than 3.5% in aggregate across all payers.
- Increase access to primary care.
- Improve health outcomes for Vermonters.

**All-Payer Model Framework for Transformation**

- Moves from volume-driven fee-for-service payment to a value-based, pre-paid model for Accountable Care Organizations (ACOs).
- Requires alignment across Medicare, Medicaid, and participating Commercial payers.
- Provides a coordinated, system-wide, and integrated reform plan, addressing cost and quality, through 2022.

1. Protect Beneficiaries
   - Medicare and Medicaid beneficiaries keep all their benefits, covered services, and choice of providers, and an ACO cannot narrow their networks.
   - Vermonters with private insurance keep care decisions and provider choice between them and their insurers.

2. Foster Provider-Led Reform
   - Vermont's doctors, hospitals, Federally Qualified Health Centers and community service organizations drive innovation, including the design of reimbursement methodologies, on behalf of their patients and clients.
   - Full choice to participate. The agreement does not require hospitals or doctors to join an ACO.

3. Focus on Health and High Quality Care
   - Three goals, linking the health care delivery system to population health improvement and public health: 1.) Increase access to primary care 2.) Reduce deaths due to suicide and drug overdose 3.) Reduce the prevalence and morbidity of chronic disease.

4. Ensure Accountability
   - State law requires the Green Mountain Care Board (GMCB) to closely regulate ACOs to ensure high quality care, access to services, financial sustainability, and coordination with community-based services.
   - The Model agreement would require the GMCB to set the benchmark for participating Medicare ACOs, review and approve participating commercial plan rates for ACOs, and review Medicaid ACO payment rates.

5. Local Control and Preservation of Successful Programs
   - Extends Medicare participation in the Blueprint for Health, Vermont's nationally recognized initiative for transforming primary care.
   - Continues federal Medicare funding for the Support and Services at Home (SASH) program, which has a track record of saving money while keeping seniors in their homes and out of hospitals.
   - Enables Vermont, through its Medicaid waiver, to support investments in the ACO and in community-based providers.
   - Allows providers to earn incentive payments in Medicare's new payment model in a way that is consistent with the goals of the U.S. Secretary of Health and Human Services, yet customized to Vermont.

6. Phased-In Approach with Ability to Terminate Agreement
   - Provides a phased-in approach for implementation, allowing a "year zero" for preparation in 2017.
   - The percentages of Vermont's all-payer beneficiaries and Medicare beneficiaries who are aligned with an ACO, increase incrementally over the term of the agreement as specified in the table below:

| | By end of 2018 | By end of 2019 | By end of 2020 | By end of 2021 | By end of 2022 |
|---|---|---|---|---|---|
| % of Vermont All-Payer Beneficiaries Aligned with ACO | At least 36% | At least 50% | At least 58% | At least 62% | At least 70% |
| % of Vermont Medicare Beneficiaries Aligned with ACO | At least 60% | At least 75% | At least 79% | At least 83% | At least 90% |

   - Allows the State to terminate the Agreement at any time for any reason with at least 180 calendar days' advance written notice to CMS.