# Vermont's All-Payer Model

## Results to Date: Performance Year 1 (2018)

VERMONT
GREEN MOUNTAIN CARE BOARD

## Summary

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 ACO Model Agreement

Vermont's All-Payer Accountable Care Organization Model Agreement is a five-year (2018-2022) arrangement between Vermont and the federal government that 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. The APM Agreement is signed by the federal Center for Medicare and Medicaid Innovation (CMMI), and three distinct parts of Vermont's state government – the Governor's office, Agency of Human Services, and Green Mountain Care Board (GMCB) – to demonstrate our shared responsibility in achieving the goals set forth in this model.

### Increasing Value for Vermonters

The APM allows us to pay for care differently, shifting the health care system away from fee-for-service, toward a value-based model that rewards high performance and good outcomes. 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 helps 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.

### Ensuring Engagement Across the Health Care System

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 it was identified as a promising way to reduce the ever-rising cost of health care nationwide. 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 Accountable Care Organization (OneCare) 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 is the only ACO operating in Vermont, and as such, is the vehicle used

*Green Mountain Care Board*

The purpose of the Green Mountain Care Board is to promote the general good of the State by:

1. Improving the health of the population;
2. Reducing the per-capita rate of growth in expenditures for health services in Vermont across all payers while ensuring that access to care and quality of care are not compromised;
3. Enhancing the patient and health care professional experience of care;
4. Recruiting and retaining high-quality health care professionals; and
5. Achieving administrative simplification in health care financing and delivery.

18 V.S.A. § 9372

to implement the APM. OneCare – and any other ACOs operating in Vermont – are regulated by the GMCB, as required by Act 113 of 2016. Visit GMCB's ACO oversight webpage to learn more.

Our ability to achieve the goals of the APM relies on robust participation from partners across the delivery system — from state agencies, health care providers, payers, employers, and others that support health care transformation. While OneCare is currently the sole Accountable Care Organization in the APM, our success rests on many health system players, working together to align health care delivery in a way that will improve the health outcomes of Vermonters.

## Measuring Success

Tracking quality and cost growth is at the heart of the APM – and will help us determine if we are heading in the right direction. The APM has set ambitious goals and benchmarks that will be measured over 5 years and beyond – including both the targets in the APM Agreement, and goals Vermont has set for itself – knowing that moving the needle on population health is a long-term effort.

As with any health services research or evaluation effort, it is important to remember that data collection and analysis take time. This is particularly true for health care claims data – financial data related to the transactions between insurers and providers – which can take months to adjudicate. Most claims (roughly 95%), are settled within six months of the date the patient received services; this is the standard amount of time researchers wait before they can begin analyzing health care claims data. In addition, data processing and analysis are also time consuming. Most of Vermont's APM targets – in particular, for cost growth and quality – are claims-based measures, which means that results are not available until 12 months after the end of each performance year (PY). In mid-2020, our most recent results are from 2018, PY1 of the APM.

### APM Agreement Targets

There are three primary targets outlined in Vermont's APM Agreement with the federal government:

- **5-Year Growth Target (Total Cost of Care, or TCOC)**
- **Improving Health Care Quality and the Health of Vermonters**
- **Participation (Scale)**

The Agreement requires Vermont to report regularly to CMMI on performance against these APM targets, and other topics. All of GMCB's reports to CMMI are posted to GMCB's APM Reports webpage once final.

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, CMMI is contracting with the non-partisan research organization NORC at the University of Chicago. Unfortunately, results from this evaluation are not timely due to data lag and the time-consuming research, analysis, and report development and the federal clearance process, with final results on the APM expected in Spring 2023. Vermont plans to use federal evaluation findings to inform the APM as they are available; data on the APM's first two performance years (2018 and 2019) are expected in late 2020.

### Ongoing Evaluation and Monitoring

In addition to the Agreement-defined targets described above GMCB is constantly assessing APM successes and challenges through ongoing evaluation and monitoring. Data sources include:

- **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)
- **Materials from GMCB's ACO Oversight** (e.g., 2020 ACO budget and certification submissions and ongoing monitoring)
- **Qualitative stakeholder input** (e.g., a 2019 provider survey to identify barriers to APM participation)

In addition, Vermont has identified some of its own targets for the APM. The GMCB's order approving OneCare's 2019 budget require that "over the duration of the agreement, OneCare's administrative expenses should be less than the health care savings, including cost avoidance and the value of improved health, projected to be generated through the Model."[1] Work is underway to develop such a methodology using data gathered through GMCB's ACO oversight activities.

## Results to Date

### 5-Year Growth Target (Total Cost of Care, or TCOC)

The driving objective of the APM is to align growth in the cost of care with the growth of Vermont's economy over the five years of the Agreement. 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 which are tied to national Medicare spending growth. Vermont and federal partners will be evaluating performance against this goal over 5 years, as we expect health care utilization and costs to fluctuate year-to-year, especially during uncertain times like the COVID-19 public health emergency.

The metric for health care spending Vermont is using to measure growth from year to year – known as **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 according to the terms of the Agreement.

- APM TCOC includes spending on Medicare Part A and B-equivalent services – hospital and physician services – though services vary somewhat by payer type. Payments include health care claims and some non-claims payments (prospective payments, shared savings payments, Blueprint for Health payments, etc.).
- The APM All-Payer TCOC measures spending by all insured Vermonters – NOT just those who are part of the ACO – excluding only those about whom the State has no data: members of plans without a Certificate of Authority from the Vermont Department of Financial Regulation, and members of self-funded employer plans that decline to submit data to the State.
- Cost data and denominator totals are derived from VHCURES, Vermont's All-Payer Claims Database, plus additional information from participating insurers.

The table below shows APM TCOC growth from prior year for 2013-2017 (prior to the start of the APM Agreement performance period), and for 2018 (Performance Year 1 of the APM Agreement).

*APM All-Payer Total Cost of Care Growth from Prior Year, 2013-2018*[2]

| | | *Pre-APM Performance Period* | | | | | *APM Performance Period* | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | **Targets** | **2013** | **2014** | **2015** | **2016** | **2017** *APM Baseline* | **2018 (PY1)** | **2019 (PY2)** | **2020 (PY3)** | **2021 (PY4)** | **2022 (PY5)** |
| **All-Payer Growth** | 3.5% (no more than 4.3%) | 4.7% | 2.5% | 3.4% | 5.0% | 8.5% | 4.1% | *Data Not Yet Avail.* | | | |

It is too soon to tell how Vermont will perform relative to this five-year target. In FY18, the first performance year of the APM, Vermont's all-payer TCOC growth was 4.1%. While this exceeds the 3.5% target, it is a

[1] See FY19 Accountable Care Organization Budget Order for OneCare Vermont, pg. 21.
[2] See Total Cost of Care Annual Report, Performance Year 1 (February 11, 2020) for more information on 2018 performance.

decline from the previous year's growth rate (8.5%), and below the 4.3% threshold. If Vermont were to exceed 4.3% growth in the future, the federal government and Vermont may assess the APM to see if there are changes or improvements to promote cost containment if appropriate. There are no penalties associated with missing the target. For more information on Vermont's performance to date on total cost of care and additional analysis, see the Annual Total Cost of Care Report for PY1.

### Population Health and Quality of Care

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. 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 will continue to assess their approach to quality improvement through our regulatory levers.

Vermont's population health outcome and quality of care measures are broken down into three categories:

(1) Population health outcome measures and targets, which measure the health of all Vermonters, regardless of whether or not they seek care or are ACO participants (see pg. 5);
(2) Health care delivery system quality measures and targets which evaluate ACO performance and quality of care, and for which the population is ACO participants (see pg. 6); and
(3) Process milestones which ensure that the State and provider partners are striving towards improvement (see pg. 7).

For measures that are ACO-specific, 2018 (PY1) serves as the base year. This updated baseline allows for a more accurate comparison through the remaining years of the APM agreement, especially within the ACO population as 2018 was the first year of the Next Generation multi-payer ACO initiative.

The tables below show baselines, targets, and current performance for each of the Agreement's population health outcome and quality of care measures, as well as historical data for the population-level health outcomes targets. **Please note that these tables reflect some changes to the measure set and targets currently included in the APM Agreement, based on mutual understanding of the Vermont APM signatories and Center for Medicare and Medicaid Innovation of the technical changes amendment in progress at the beginning of 2020. Official approval of this amendment has been paused due to the COVID-19 pandemic.**

For more information on Vermont's performance to date on population health outcomes and quality of care targets, and discussion of performance on specific measures, see the Annual Health Outcomes and Quality of Care Report for PY1.

As data for each subsequent year of the APM becomes available, we will track against these benchmarks, carefully evaluate our progress, and make adjustments as we learn what works along the way, knowing that moving the needle on population health is a long-term effort. We will also transparently share results with the public as they are available.

*Health Outcomes and Quality of Care Results, 2013-2018: Population-Level Health Outcomes Targets*

As noted above, Vermont has a preliminary agreement with CMMI to update the base years to reflect data that is relevant to the model's performance years. At the time the Agreement was signed, the base year reflected the most recent data available. In an effort to more accurately measure performance across the population, the data has been updated to utilize 2017 (PY0) as a base where applicable.

**Final performance results for PY1 show Vermont currently meeting three of the six population-level health outcomes targets.**

| | | | | *Pre-APM Performance Period* | | | | | *APM Performance Period* | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Goal** | **Measure** | **Baseline** | **2022 Target** | **2013** | **2014** | **2015** | **2016** | **2017 (PY0)** | **2018 (PY1)** | **2019 (PY2)** | **2020 (PY3)** | **2021 (PY4)** | **2022 (PY5)** |
| Population-Level Health Outcomes Targets | | | | | | | | | | | | | |
| Reduce Deaths Related to Suicide and Drug Overdose | Deaths Related to Drug Overdose (Statewide)[3] | 124 (2017) | Reduce by 10% (112) | 105 | 102 | 103 | 132 | 124 | 117[4] | *Data Not Yet Avail.* | | | |
| Reduce Deaths Related to Suicide and Drug Overdose | Deaths Related to Suicide (Statewide)[5] | 17.2/ 100,000 (2016) | 16 per 100k VT residents or 20th highest rate in US | 16.9 per 100k | 18.7 per 100k | 14.5 per 100k | 17.2 per 100k | 18.3 per 100k | 18.3/100k 19th in US (2017, most recent avail.) | *Data Not Yet Avail.* | | | |
| Reduce Chronic Disease | COPD Prevalence (Statewide)[6] | 6% (2017) | Increase ≤1% | 6% | 6% | 6% | 6% | 6% | 6% | *Data Not Yet Avail.* | | | |
| Reduce Chronic Disease | Diabetes Prevalence (Statewide)[6] | 8% (2017) | Increase ≤1% | 8% | 8% | 8% | 8% | 8% | 9% | *Data Not Yet Avail.* | | | |
| Reduce Chronic Disease | Hypertension Prevalence (Statewide)[7] | 26% (2017) | Increase ≤1% | 27% | - | 25% | - | 26% | 25% | *Data Not Yet Avail.* | | | |
| Increase Access to Primary Care | Percentage of Adults with Personal Doctor or Care Provider (Statewide)[6] | 87% (2017) | 89% | 87% | 87% | 88% | 88% | 87% | 86% | *Data Not Yet Avail.* | | | |

[3] See Drug-Related Fatalities Among Vermonters. Vermonters who die in Vermont (i.e. excludes out-of-state residents' deaths and Vermonters who die in other states). Baseline data has been updated to reflect one additional death since publication of the 2018 Statewide Health Outcomes and Quality of Care report, this update is included in this table in the baseline and target columns.
[4] Preliminary 2018 data; January-October.
[5] See Vermont Department of Health, Intentional Self-Harm and Death by Suicide (December 2019). Death rate is age-adjusted per 100,000 population. For comparison to other states, see National Center for Health Statistics, Stats of the State of Vermont.
[6] Vermont Behavioral Risk Factor Surveillance Survey. Data collected annually.
[7] Vermont Behavioral Risk Factor Surveillance Survey. Data collected in odd years through 2017, annually through the duration of the Agreement.

Data are updated to utilize 2017 as a base where applicable. For those measures that are ACO-specific, 2018 (PY1) will serve as the base year. This updated baseline allows for a more accurate comparison through the remaining years of the APM agreement, especially within the ACO population as 2018 was the first year of the Next Generation multi-payer ACO initiative.

**Final 2018 data show Vermont moving toward achievement on seven of the nine healthcare delivery system quality targets.**

| Goal | Measure | Baseline | 2022 Target | Current | 2018 (PY1) | 2019 (PY2) | 2020 (PY3) | 2021 (PY4) | 2022 (PY5) |
|---|---|---|---|---|---|---|---|---|---|
| Health Care Delivery System Quality Targets | | | | *2018* | *Num/Denom* | *Num/Denom* | *Num/Denom* | *Num/Denom* | *Num/Denom* |
| Reduce Deaths Related to Suicide and Drug Overdose | Initiation of Alcohol and Other Drug Dependence Treatment (Multi-Payer ACO) | 38.9% (2018) | 40.8% | 38.9% | *807*<br>*2,073* | *Data Not Yet Avail.* | | | |
| Reduce Deaths Related to Suicide and Drug Overdose | Engagement of Alcohol and Other Drug Dependence Treatment (Multi-Payer ACO) | 13.3% (2018) | 14.6% | 13.3% | *276*<br>*2,073* | *Data Not Yet Avail.* | | | |
| Reduce Deaths Related to Suicide and Drug Overdose | 30-Day Follow-Up After Discharge from ED for Mental Health (Multi-Payer ACO) | 84.4% (2018) | 60% | 84.4% | *910*<br>*1,078* | *Data Not Yet Avail.* | | | |
| Reduce Deaths Related to Suicide and Drug Overdose | 30-Day Follow-Up After Discharge for Alcohol or Other Drug Dependence (Multi-Payer ACO) | 28.2% (2018) | 40% | 28.2% | *149*<br>*528* | *Data Not Yet Avail.* | | | |
| Reduce Deaths Related to Suicide and Drug Overdose | Growth Rate of Mental Health and Substance Abuse-Related ED Visits (Statewide)[8,9] | 5.3% (2016 - 2017) | 5% in PY 1-2<br>4% in PY 3-4<br>3% in PY5 | 6.9% (2017-2018) | *14,433*<br>*13,506* | *Data Not Yet Avail.* | | | |
| Reduce Chronic Disease | Diabetes HbA1c Poor Control (Medicare ACO)[10] | 58.02% (2018) | 70th-80th percentile (national Medicare benchmark) | 58.02% (Medicare 80th percentile) | *152*<br>*262* | *Data Not Yet Avail.* | | | |
| | Controlling High Blood Pressure (Medicare ACO) | 68.12% (2018) | 70th-80th percentile (national Medicare benchmark) | 68.12% (Medicare 60th Percentile) | *250*<br>*367* | *Data Not Yet Avail.* | | | |
| | All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions (Medicare ACO)[11] | 63.84% (2018) | 70th-80th percentile (national Medicare benchmark) | 63.84% (Medicare 30th percentile) | - | *Data Not Yet Avail.* | | | |
| Increase Access to Primary Care | ACO CAHPS Composite: Getting Timely Care, Appointments and Information (Medicare ACO) | 84.62% (2018) | 70th-80th percentile (national Medicare benchmark) | 84.62% (Medicare 80th Percentile) | -<br>*269* | *Data Not Yet Avail.* | | | |

[8] Shown as a percent change from previous year.
[9] Vermont residents only.
[10] The result shown is a Medicare composite of ACO #27 (A1c poor control) and ACO #41 (diabetes eye exam) per Medicare Shared Savings Program reporting standards.
[11] A lower rate is indicative of better performance on this measure.

*Health Outcomes and Quality of Care Results, 2018: Process Milestones*

Data are updated to utilize 2017 as a base where applicable. For those measures that are ACO-specific, 2018 (PY1) will serve as the base year. This updated baseline allows for a more accurate comparison through the remaining years of the APM agreement, especially within the ACO population as 2018 was the first year of the Next Generation multi-payer ACO initiative.

**Final 2018 results show Vermont making progress toward six of the seven process milestones.**

| Goal | Measure | Baseline | 2022 Target | Current | 2018 (PY1) | 2019 (PY2) | 2020 (PY3) | 2021 (PY4) | 2022 (PY5) |
|---|---|---|---|---|---|---|---|---|---|
| Process Milestones | | | | *2018* | *Num/Denom* | *Num/Denom* | *Num/Denom* | *Num/Denom* | *Num/Denom* |
| Reduce Deaths Related to Suicide and Drug Overdose | Percentage of Vermont Providers Checking Prescription Drug Monitoring Program Before Prescribing Opioids (Statewide) | 2.19 (2017) | 1.80 | 3.10 | *225,041* / *72,494* | *Data Not Yet Available* | | | |
| Reduce Deaths Related to Suicide and Drug Overdose | Adults Receiving Medication Assisted Treatment (MAT) (Statewide, Ages 18-64) | 257 per 10,000 Vermonters (2018) | 150 per 10,000 Vermonters (or up to rate of demand) | 257 per 10,000 Vermonters | - | *Data Not Yet Available* | | | |
| Reduce Deaths Related to Suicide and Drug Overdose | Screening for Clinical Depression and Follow-Up Plan (Multi-Payer ACO) | 50.23%[12] (2018) | 70th-80th percentile (national Medicare benchmark) | 50.23% (Medicare 50th percentile) | *493* / *983* | *Data Not Yet Available* | | | |
| Reduce Chronic Disease | Tobacco Use Assessment and Cessation Intervention (Multi-Payer ACO) | 70.56%[13] (2018) | 70th-80th percentile (national Medicare benchmark) | 70.56%[14] | *241* / *389* | *Data Not Yet Available* | | | |
| Reduce Chronic Disease | Percentage of Vermont Residents Receiving Appropriate Asthma Medication Management – 50% compliance (Multi-Payer ACO) | 72.5% (2018) | 65% | 72.5% | *882* / *1,217* | *Data Not Yet Available* | | | |
| Increase Access to Primary Care | Percentage of Medicaid Adolescents with Well-Care Visits (Statewide Medicaid) | 47.8% (2017) | 53% | 49.9% | *12,483* / *24,998* | *Data Not Yet Available* | | | |
| Increase Access to Primary Care | Percentage of Medicaid Enrollees Aligned with ACO (Statewide Medicaid) | 31% (Jan 2018) | ≤15 percentage points below alignment rate for Vermont Medicare beneficiaries | 31% (Jan 2018) | *42,342* / *136,407* | *Data Not Yet Available* | | | |

[12] Weighted result based on ACO Medicare, Medicaid and Commercial Qualified Health Plan (QHP) performance in calendar year (CY) 2018.
[13] Weighted result based on ACO Medicare and Medicaid performance in CY 2018.
[14] No national Medicare benchmark is available for CY 2018.

### 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 and not with the number of services provided. The APM Agreement assesses this through **ACO Scale**.

ACO Scale is the percentage of eligible 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) Final | PY2 (2019) Interim | PY3 (2020) Preliminary | PY4 (2021) | PY5 (2022) |
|---|---|---|---|---|---|---|
| **All-Payer Scale Target** | *Target* | *36%* | *50%* | *58%* | *62%* | *70%* |
| | Actual | 22% | 30% | 42%* | | |
| **Medicare Scale Target** | *Target* | *60%* | *75%* | *79%* | *83%* | *90%* |
| | Actual | 33% | 47% | 44%* | | |

*Preliminary 2020 scale calculated based on 2019 Vermont population estimates and preliminary ACO attribution; subject to change.

While Vermont has not yet achieved Scale Targets, we have made marked improvements in Medicare Scale and All-Payer Scale since PY1. Preliminary 2020 (PY3) data shows another large increase in attribution in the All-Payer category. 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.

## Conclusion

Vermont will continue to collect data to report on APM progress to the public and to our federal partners. In the meantime, results from PY1 (2018) are promising: Provider participation steadily increased throughout Year 1. The growth in health care costs was 4.1% in Year 1, representing a decline from the previous year's growth rate (8.5%). As more providers come on board, and the changes to their business models begin to take hold, we expect to see continued progress towards our 5-year growth target of 3.5%.

Vermont is also seeing 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. Early data also suggest that the APM cohort (lives attributed to OneCare under the APM) has exhibited positive shifts related to appropriate network utilization. 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.

As the APM progresses, we are dedicated to sharing data reflecting its impact in a way that is transparent, accessible, and timely. We will also continue to track the APM's short-term progress, analyze opportunities for long-term growth and adjust as needed to reach our shared goals.

## Additional Resources

Vermont All-Payer Model Agreement (signed October 2016)

GMCB Website – All-Payer Model

GMCB Website – All-Payer Model Reports

GMCB Website – Vermont All-Payer Model Frequently Asked Questions

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

*Last Updated: July 2020*