Frequently Asked Questions

Vermont All-Payer Model and GMCB ACO Oversight

VERMONT
GREEN MOUNTAIN CARE BOARD

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 APM is working to ensure the cost of care does not outpace growth in Vermont's 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 **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.

The APM Agreement identified three types of targets for the State (for more information and results to date, see Q8):

1) **5-Year Growth Target**. The driving objective of the APM is to ensure the cost of care does not outpace growth in Vermont's 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).

Report to the Legislature: Evaluation of Social Service Integration with ACOs. GMCB. December 2019.

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. OneCare Vermont Accountable Care Organization (OneCare) is the only ACO currently operating in Vermont. 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. The OneCare provider network works together to improve the health of Vermonters by providing the right care, at the right place, at the right time. OneCare is also the mechanism through which predictable payments are made to providers in exchange for caring for a population of Vermonters.

As described in past budget submissions, OneCare works to improve care and reduce cost through:

1) *Care coordination.* OneCare supports improved communication among health care and social service providers who are caring for the sickest or most at-risk patients. Care coordination is shown to improve patient outcomes for the highest risk patients.
2) *Information.* OneCare provides data analytics on care delivery patterns and patient outcomes. OneCare shares data with health care providers who then use the information to improve care and invest in population health programs to address patient and community needs.
3) *Innovation*. OneCare supports innovative pilot projects that are developed in communities and can be scaled more broadly if shown to be successful.
4) *Investment dollars*. Hospital participation fees and state funding make up the investment dollars that support the programs available to participating providers. Investment dollars, which are focused on primary care, care coordination, and prevention, are distributed to providers within the network to best care for patients. This results in a shift of dollars from hospitals to community providers.

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

The All-Payer Model gives health care providers the flexibility to provide 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 APM pays for care based on value not volume, with the hopes of driving improved outcomes and enhancing the quality of care. It encourages increased communication and coordination between health care providers, especially those who are caring for the sickest or highest-risk patients. It helps ensure Vermonters are connected to the right care, at the right place, at the right time. And by shifting the focus to preventive care, the APM helps patients catch and treat small health problems before they turn into chronic issues.

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 benefits Vermonters by providing incentives to increase access to primary care and social services, improve access to services not always covered by insurance, and promote 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.

The APM seeks to limit the rate of growth in health care costs (measured over the 5-year Agreement from 2018-2022), as well as increase access to services that address primary and preventive care. The most vulnerable and high-needs populations should see increased care coordination and better access to social services. Vermonters should see an increase in services known to improve overall health, such as preventive care, and services that address social determinants of health.

The APM is built on Vermont's existing health care delivery foundation and its success depends on collaboration among the full delivery system to achieve the statewide population health goals, not just ACO efforts alone. The ACO works with state agencies, the Blueprint for Health, hospitals, primary care and specialty providers, community and social service providers, mental health, home health, housing, and others to achieve the goals of the APM.

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.

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 the APM and in overseeing OneCare?

Vermont law requires GMCB oversight authority over Vermont ACOs 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 furthers 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.

The GMCB's responsibilities under the APM Agreement include Medicare ACO growth rate setting and reporting to the federal Center for Medicare and Medicaid Innovation (CMMI). The Vermont Agency of Human Services is a partner in the APM Agreement and carries out its responsibilities through the Department of Vermont Health Access (DVHA) and the Vermont Department of Health (VDH). DVHA oversees the Vermont Medicaid Next Generation ACO Program contract with OneCare and associated reporting to CMMI.

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 is working to ensure the cost of care doesn't outpace growth in Vermont's 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're trying to achieve require significant upfront investment, effective management, robust engagement, ongoing tracking, and adjustments and improvements along the way.

Tracking quality and cost growth is at the heart of the APM – and will help us determine if we're heading in the right direction. But it takes time to coordinate quality data collection in a model as ambitious and far-reaching as this. That means that although we are in Year 3 of the APM, we are currently analyzing data for Year 1 (2018). 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. We're tracking performance by:

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 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 late 2020) 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 that the APM cohort (lives attributed to OneCare under the APM) has exhibited positive shifts related to appropriate network utilization. For example, in its 2020 budget hearing, OneCare noted that it has seen a 33% reduction in emergency department (ED) utilization among care managed Medicare patients and a 13% reduction in ED utilization among care managed Medicaid patients.

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 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%). If Vermont were to exceed the 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.

Improving Health Care Quality and the Health of Vermonters. The APM Agreement evaluates statewide health outcomes and quality of care through 20 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 will continue to assess their 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) 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%*		

While Vermont has not yet achieved Scale Targets, we have made marked improvements in Medicare Scale and All-Payer Scale since PY1 for. 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.

Additional Resources:
Vermont All-Payer ACO Model Total Cost of Care Annual Report, Performance Year 1 (2018)

GMCB Staff Presentation on FY2018 Total Cost of Care Results

Vermont All-Payer ACO Model Annual Health Outcomes and Quality of Care Report, Performance Year 1 (2018)

Vermont All-Payer ACO Model Annual ACO Scale Targets and Alignment Report, Performance Year 1 (2018)
(Note: Year 2 (2019) Scale report to be released by June 30, 2020. All reports can be found here.)