



An Early Look at Vermont's Rollout of Its Value-Based, Multi-Payer "Next Gen" Model to Lower Costs and Improve Population Health

Robin Lunge, JD, MHCDS

Robin Lunge is a member of Vermont's Green Mountain Care Board, which regulates health insurance rates, hospital budgets, and accountable care organizations. In this brief, she explores how Vermont's transformation to a value-based, multi-payer model is faring and its early impact on private-sector accountable care organizations. The views expressed here are her own and not those of the Green Mountain Care Board or the State of Vermont.

Introduction

In October 2016, Vermont signed an [agreement](#) with the [Centers for Medicare and Medicaid Innovation \(CMMI\)](#) to transform its largely fee-for-service payment system to a prospective, value-based, multi-payer reimbursement model with the goals to:

- Reduce health care spending growth to align with state economic growth;
- Meet population health priorities identified by the [State of Vermont](#); and
- Create an integrated delivery system.

The agreement outlines steps to achieve the Institute for Healthcare Improvement's Triple Aim by providing an all-payer health care spending target of 3.5 percent from 2018 through 2022 and a quality framework designed to measure whether the state is increasing access to primary care, reducing deaths caused by suicide and drug overdose, and reducing the prevalence and morbidity of chronic disease. There is an additional financial target for Medicare growth of 0.2 percent less than national trends, which is significant for a state whose Medicare spending has been growing significantly faster than the national rate.

The agreement also allowed Vermont to maintain Medicare participation in its primary care medical home program, called the Blueprint for Health, including initial startup funds and allowing participating accountable care organizations (ACO) to continue Medicare funding after the conclusion of the federal medical home demonstrations. Otherwise, the agreement did not bring additional Medicare dollars into the state. The primary benefits of the agreement is to allow for state-specific flexibility in the Medicare ACO program to increase alignment across all major payers in the state and to take advantage of beneficiary coverage enhancements to allow for greater access to certain care, discussed below.

The vehicle to achieve these goals is a private sector ACO with payment modeled on the [Medicare Next Generation](#) (Next Gen) ACO Model, but with Vermont-specific variations. Medicare's Next Gen model allows ACOs experienced in care coordination for patients to take on more financial risk, which comes with the possibility of greater shared savings, a predictable spending target, and a predictable cash flow. The model also provides key beneficiary enhancements, such as giving patients easier access to nursing home care after a hospital stay, easier home health care referrals, and expanded telehealth services.

The premise of the Vermont ACO model is that in a rural state with a dispersed delivery system and only two geographically distinct, large health systems, this model provides a regional way to coordinate care across a dispersed system of providers. Currently, there is one ACO in Vermont – OneCare Vermont – that has contracts with Vermont Medicaid, Medicare, Blue Cross Blue Shield of VT (BCBSVT), the states' largest commercial insurer, and the University of Vermont Health Network's self-insured employee plan. The agreement also sets up participation targets, called "scale targets," based on the assumption that this ACO model will be more successful at achieving statewide goals if there is sufficient participation across the state.

Vermont has a regulatory system designed to curb spending through review of insurance premiums, hospital budgets, and ACO budgets. The [Green Mountain Care Board](#) is responsible for this system, which may be used, if necessary, to meet the targets. The board is also responsible for reporting to CMMI on cost and quality.

This issue brief examines Vermont's new model, how it is implemented, and early lessons learned for states and private sector ACOs.

Medicare's Building Blocks

Next Generation Accountable Care Organization Model

As noted above, Vermont's model is a state-specific variation on CMMI's Next Gen ACO model. According to CMS, the Next Gen ACO model's core principles include:

- Protecting Medicare fee-for-service beneficiaries' freedom to seek covered items and services from the Medicare-enrolled providers and suppliers of their choice;
- Engaging beneficiaries in their care through benefit enhancements designed to improve patient experience and reward patients who seek appropriate care from providers and suppliers participating in ACOs;
- Creating a financial model with long-term sustainability;
- Utilizing a prospectively-set benchmark that:
 - Rewards quality;
 - Rewards both improvement in and attainment of efficiency; and
 - Ultimately transitions away from using an ACO's recent expenditures for purposes of setting and updating the benchmark;
- Mitigating fluctuations in aligned beneficiary populations and respect beneficiary preferences by supplementing a prospective claims-based alignment process with a voluntary process; and
- Facilitating ACO cash flow and supporting investment in care improvement capabilities through alternative payment mechanisms.

There are many technical details embedded in the design of Next Gen, but two key components are beneficiary enhancements and the payment model. Next Gen offers participating ACOs the opportunity to improve care for Medicare beneficiaries by allowing easier access to nursing home rehabilitation and home health services. Currently, Medicare requires a three-night stay in a hospital before a patient can be admitted to a nursing home for skilled nursing or rehabilitation. Under Next Gen, this rule is [waived](#), allowing for direct referral to a nursing home from a doctor's office, home, or after a shorter nursing home stay, if clinically indicated. In addition, the Next Gen program makes [referrals to home health](#) services easier than under the current Medicare rules, by expanding which providers who can refer for these services. Lastly, the Next Gen program allows ACO participants broader access to [telehealth](#) services than currently allowed in Medicare.

The Next Gen program offers [four payment options](#) for ACOs, ranging from fee-for-service payments with the possibility of shared savings to all-inclusive population based payments (AIPBP), which are PMPM prospective payments, which the Vermont model uses. The AIPBP is a type of capitation. As described by CMMI, the "AIPBP will function by estimating total annual expenditures for aligned beneficiaries and paying that projected amount to the ACO in a per-beneficiary per-month (PBPM) payment with some money withheld to cover anticipated care by providers not participating in capitation." The ACO is then responsible for paying the providers in its network. The AIPBP does not have to include the total cost of care and can be combined with fee-for-service.

Lastly, the Next Gen Model includes a total cost of care benchmark that the ACO is judged against after the performance year. If the ACO saves money and improves quality, it can retain these savings for distribution to its provider network, reinvestment in care coordination, or investment in population health activities. If the ACO exceeds the benchmark, it is responsible for absorbing the excess costs.

MACRA and MIPS

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA, signed into law in 2015, created a Quality Payment Program in Medicare, called the Medicare Incentive Program (MIPS). MIPS requires providers to report quality measures and over time establishes a financial reward and penalty system for their performance. Providers can earn additional revenue by delivering excellent quality care, but also could see their fee-for-service payments reduced for below average quality scores. In addition, there is a bonus for providers participating in advanced alternative payment models. A full discussion of MIPS is outside the scope of this issue brief, but the existence of a fee-for-service quality framework in Medicare establishes an important federal policy framing the environment for providers. Because Vermont's ACO program qualifies as an advance alternative payment model, ACO participants receive assistance from the ACO in the reporting of quality measures and the 5 percent payment increase over Medicare fee-for-service.

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Vermont's Building Blocks

[Blueprint for Health: Advance Practice Medical Homes and Community Health Teams](#)

Vermont has a long history of health care reform, starting with coverage initiatives through Medicaid. In 2003, through an executive order, the former governor established the Blueprint for Health, a unique medical home model with wrap-around supports through a community health team (CHT). The blueprint began as a pilot and was codified into law in 2006 and then became statewide in 2011. In 2016, approximately 85 percent of the 140 primary care practices in Vermont were participating.

The blueprint is a public-private model, with state-funded technical assistance for medical practices to become medical homes and achieve National Committee for Quality Assurance (NCQA) certification. The medical homes are provided with a per member per month payment (PMPM) for attributed patients and are eligible for enhanced payments for higher levels of NCQA certification. Currently, Medicaid, Medicare, commercial insurers, and some self-insured employers participate. In addition, there are all-payer payments to maintain a CHT, which is a regionally organized team of ancillary professionals, such as mental health practitioners, nutritionists, and substance abuse counselors, among others. The CHTs provides the medical homes with an easy way to refer patients who need these supports to meet their health goals. Each region has a fiscal lead – often the hospital, that receives the payments, hires the staff, and coordinates the team. These payments are explored later in this brief.

In addition, the blueprint has expanded to include an opiate disorder treatment program, called the Hub and Spoke and a Women's Health Initiative to improve quality and access to care. (These programs are outside the scope of this issue brief.) The state also provides [community profiles](#) in order for the medical homes and CHTs to understand how their regions (or practice) are doing compared to others, both in terms of cost and quality measures.

[Blueprint for Health: Supports and Services at Home \(SASH\)](#)

SASH coordinates services for seniors with Medicare who live independently at home by providing a Wellness Nurse and a Care Coordinator on-site. The program was developed by Cathedral Square of South Burlington, an affordable, senior housing site, but has been statewide since 2011. SASH was funded by Medicare as part of Vermont's Multi-Payer Advanced Primary Care Practice demonstration through the Blueprint and funding was continued through the All-Payer Model Agreement as noted above. A [federal evaluation](#) released in 2017 estimated a savings of approximately \$1,227 per person per year in Medicare expenditures.

Vermont Health Care Innovation Project

In 2012, Vermont was also fortunate to receive \$45 million from CMS as a State Innovation Model grant that was used to advance delivery system reform goals. With this grant, the state focused on three key areas: provider readiness for reform; health information technology; and testing new payment and delivery system models, specifically ACO shared savings programs. Through the grant, Vermont made significant progress in improving provider readiness for reform by:

- Consolidating the Blueprint for Health regional collaborative and ACO regional efforts;
- Creating learning collaboratives to share best practices among health care providers; and
- Facilitating communities in learning how to connect health care providers and social service providers in order to address the social determinants of health through an [Accountable Health Community](#).

The [results of the shared savings programs](#) were mixed, with improvement in quality, but insignificant financial savings and variations across payers. These results are thought to be the result of weak financial incentives and inadequate tools for tracking quality and cost as well as other technical design flaws in the shared savings model.

Medicaid Global Commitment for Health 1115 Waiver

Vermont also renegotiated its Medicaid Section 1115 waiver while negotiating the All-Payer Model Agreement. This waiver, called the [Global Commitment to Health](#), has been in place since 2005. The negotiation focused on three primary goals:

- Continuing current Medicaid coverage of essential services for Vermont's most vulnerable populations;
- Promoting health care reform by ensuring Medicaid participation and alignment with the all-payer model by providing Vermont with additional financial capacity to invest in health care reform concurrent with the all-payer model; and
- Continuing flexibility in using Medicaid dollars to invest in health care priorities. Without this authority, these investments would require new general fund appropriations or elimination.

As stated in the second goal, the state negotiated the ability to provide up to \$209 million in investments into delivery system reforms consistent with the All-Payer ACO Model Agreement. These investments are subject to the availability of state matching dollars. Given the current fiscal climate in the state, it has had limited ability to tap into this capacity.

Green Mountain Care Board

In 2011, the state legislature created the Green Mountain Care Board to consolidate health care regulatory functions in an independent, transparent, public body consisting of five appointed members and 27 staff. The board members are appointed by the governor, who receives a list of names from a committee, which is appointed by the House and Senate leadership and the governor. Board members have six-year terms and may only be removed for cause. Because all elected officials in Vermont have two-year terms, this results in a board that is insulated from electoral politics. The board is subject to the public records and open meeting laws, which requires notice of any gathering of three or more members as well as public access to documents.

The board's duties consist of insurance premium review, approval of hospital budgets, considering certificate of need applications, ACO budget review, and ACO certification, along with approval of key statewide strategic plans, such as a health information technology plan and health care workforce strategic plan, both of which are produced by the executive branch. The board's duties in relationship to the ACO model are discussed in depth later in this brief.

What Is Vermont's Next Gen Accountable Care Model?

There is currently one, private-sector, multi-region ACO, [OneCare Vermont](#), formed initially by the state's two main academic medical centers: the University of Vermont Health Network in Burlington, Vermont, and Dartmouth-Hitchcock Medical Center just across the state border in Lebanon, NH. Currently, One-Care Vermont has participation in a majority of health service areas, which includes the participation of both academic medical centers noted above, eight smaller hospitals in Vermont, two federally qualified health centers and rural health centers, 54 independent primary care and specialty practices, eight home health agencies, 19 skilled nursing facilities, six designated mental health agencies, and a handful of other provider types. This provider network currently covers people from 10 out of 14 counties in Vermont, as well as Vermonters seeking care from those counties served by Dartmouth-Hitchcock in NH. Provider participation is voluntary; nonparticipating providers continue to be paid in the same manner as today, largely through fee-for-service. The model has a goal of statewide participation by the end of the five-year agreement. More details about participation targets are contained later in the brief.

Each region, or health service area, is organized into a regional team of providers from the care continuum, who work together to provide care coordination for patients. These regional teams build on a preexisting regional primary care medical home model that includes community health teams, called the Blueprint for Health.

Definitions and Terms

What is an accountable care organization (ACO)? An ACO is a legal entity made up of providers that take responsibility for the total cost of care and the quality of care of a group of patients.

What is a risk corridor? A risk corridor is an amount negotiated between an ACO and a payer that determines the percentage or amount that the ACO may gain or lose if the care provided to patients exceeds or is reduced from the benchmark. The risk in the corridor is sometimes shared with the payer. The exact model varies by payer in the Vermont model based on negotiations between the payer and the ACO.

What is a health service area? A health service area is a geographic region that delineates where most people residing in that area will seek care.

What is an all-inclusive population-based payment? This is an ACO payment model developed by Medicare that pays a monthly prospective payment to an ACO for the estimated total cost of care for their attributed patients. This payment is in lieu of fee-for-service payments.

Vermont's model is based on Medicare's most aggressive payment model in the Next Gen ACO Model, with some negotiated changes to reflect state specific issues and with the opportunity to make changes to the model as time goes on. As in Medicare's Next Gen program, the ACO and each payer negotiate a benchmark amount for the total cost of care for attributed patients. Patients are attributed if their primary care provider is participating in the ACO and based on where most of their care is received in the prior year. One challenge with the current attribution methodology is that healthier patients are excluded because of their lack of utilization of services. This is a potential area that Vermont could explore a new, state-specific approach. The total cost of care consists of the amounts estimated to be paid for patient care and is based on historical spending for those patients. At the end of the year, the actual cost for care is compared to the benchmark to determine if the ACO has achieved savings or exceeded the benchmark.

This model allows a payer to contract with an ACO to pay for attributed patients' care with a mixture of an all-inclusive population-based payment (AIPBP) – which is a prospective PMPM – and fee-for-service. Each payer pays separately. In Vermont's model, the prospective payments for hospital spending are paid directly to the ACO, but fee-for-service payments continue to be paid directly by the payer to other providers. The ACO then pays each hospital a combined, all-payer monthly PMPM payment, which is described below.

The ACO is at risk for the total cost of care provided to attributed patients by any provider, whether the provider is part of the ACO network or not. Patients are not limited to seeing an ACO provider, but have free choice within the payer's network. If there are expenses for patient care over the benchmark, within a negotiated risk corridor, the ACO and its network must pay back that amount to each payer, but the ACO and its providers can keep any savings from better care management, avoiding unnecessary care, or reducing waste. An open network imposes some risk on the ACO to control costs and meet financial targets, because health care providers who are not participating will provide some care for attributed patients. In Vermont, the ACO is managing this risk by requiring sufficient regional participation (described below). In addition, the risk is mitigated by the fact that there are only two academic medical center health systems in the area and care patterns are largely geographically dictated in the state.

The model also provides quality and access metrics to ensure that patient quality and access are not compromised by the prospective payment approach. Quality and access are monitored by the payers and also monitored by the Green Mountain Care Board. Each payer establishes a contractual mechanism for enforcement. The board has enforcement through the ACO budget process.

In 2017, Vermont's Medicaid agency [contracted](#) with OneCare Vermont to pay the ACO an AIPBP as described above for hospital services. Physician services remain fee-for-service. In addition, some Medicaid services are excluded from the ACO program, such as long-term care and certain mental health care payments. Medicaid continued the program into 2018. Vermont, unlike most other states, does not contract with private Medicaid managed care insurers, making its care coordination more streamlined. The state, however, does have a chronic care initiative run by the state agency, which it has had to integrate into the ACO program. Other states with managed care would need to ensure alignment between the managed care contracts and the ACO participation.

Beginning in 2018, OneCare Vermont expanded to include contracts with Medicare through the Next Gen ACO program with BCBSVT, the state's largest commercial insurer, and with the University of Vermont Health Network for its employee health plan. There are approximately 112,000 Vermonters taking part in the ACO program this year across all payers. In 2019, all four payers are expected to continue to participate and there is the potential that OneCare will be successful in recruiting additional self-insured employers.

This table illustrates the number of Vermonters and their estimated total cost of care, as well as the PMPM costs by payer in 2018. The four payers are Medicare, Medicaid, BCBSVT, and the UVMHC self-funded employee program.

Payer Contract	Attribution	Total Payer Dollars	Actual PMPM
Medicare Next Generation	39,702	\$408,047,628	\$856.48
Medicaid Next Generation	42,342	\$123,931,647	\$243.91
Commercial Next Generation (BCBSVT)	20,838	\$106,568,866*	\$426.18
Self-Funded (UVMHC)	9,962	TBD	N/A
Total	112,844	\$638,548,140	

**Amount still being finalized*

This multi-payer approach is a key feature to the model and assumes that once a provider, often a hospital, has sufficient volume in fixed prospective payments, it will change its operational focus to expense reduction, efficiency, and providing longitudinal and preventive care that improves the health of Vermonters. This contrasts with the traditional operational focus of productivity, or volume, incentives under fee-for-service to meet revenue targets. Without sufficient volume in the new payment methodology, the hospital or other provider is left in the situation of having one foot in two canoes – one canoe providing an incentive to reduce expenses and waste and the other focused on maintaining sufficient volume. Achieving sufficient volume in the new model would not be feasible without all of a state's major payers participating in a similar payment model using largely the same quality measures and providing the same financial incentives.

A concern often expressed about an ACO model is whether it is simply managed care by another name. There are some key differences between these two models:

Managed Care	Accountable Care
Insurer-based	Provider-based
Utilization management rules direct what care is received from the provider.	Care management is used to reduce unnecessary utilization and increase underused services.
Patients locked into a primary care provider	Patient choice is not limited by the ACO network; an insurer may or may not still have network limits.

Lastly, OneCare Vermont is accepting the risk or benefit of managing to their total cost of care target. The chart below summarizes the risk model by payer in 2018:

Risk Arrangements by Payer		
Payer	Corridor	OneCare's Share
Medicaid	97% - 103%	100%
Medicare	95% - 105%	80%
Commercial	94% - 106%	50%

A risk corridor is a percentage above and below the estimated total cost of care amount within which the ACO will either share savings, if under cost projections, or assume the cost of care if over the amount. This is determined at the end of the performance year when the payer and the ACO reconcile the amounts actually paid on behalf of the attributed population to the estimated total cost of care. For example, the Medicaid contract provides that OneCare Vermont can keep 100 percent of any savings within 3 percent of the total cost of care, but also will not be paid extra for up to a 3 percent overage. In the case of BCBSVT's commercial contract, the risk corridor is bigger – 6 percent up or down – but the savings or overages are split equally between OneCare Vermont and BCBSVT.

OneCare Vermont's risk management model is described below. In addition, the board requires the ACO to reserve \$2.2 million by the end of 2018 to ensure solvency.

How Are Health Care Providers Paid by the ACO?

Hospitals

Under Vermont's model, OneCare Vermont receives a monthly prospective payment from the payer and then contracts with hospitals to provide them, in turn, with a prospective, monthly payment based on estimates of the care necessary for that hospitals' attributed patients. OneCare Vermont expects that the fixed payments to hospitals will represent approximately 65 percent of its overall total cost of care with the remainder in fee-for-service payments. If the hospital care provided to their patients exceeds the fixed payment, the hospital absorbs the cost of delivering that care. If they achieve savings, they can retained it.

The hospitals are only able to participate, however, if there are sufficient primary care providers and community-based providers interested in participating as well. In Vermont, about 60 percent of physicians are typically employed by a hospital, although this varies by the health service area (HSA). The objective is to ensure that there are sufficient primary care providers to attribute patients and to ensure that there is sufficient participation in a health service area to provide a network across the continuum of care for patients. The state also has a significant network of FQHCs and in some HSAs, the FQHC choice to participate or not may impact the hospitals ability to participate.

The payment to OneCare Vermont from the payer is not fully passed onto each hospital, but instead, some of these dollars are redirected to that HSA's primary care providers and community-based providers, such as designated mental health agencies, home health agencies, and others. The purpose of this reallocation of resources is to increase funding to primary care and community-based providers who are involved in prevention and population health management activities. In 2018, over \$25 million was deducted from hospital fixed payments to fund these providers for population health management, care management, and other community investments.

In exchange for this consistent revenue stream, each hospital also agrees to take risk for the total cost of care received by their patients attributed from that HSA, regardless of where that care is provided, up to a maximum amount. Statewide, this has shifted just over \$21 million in risk to 10 hospitals. OneCare Vermont has designed a risk model that limits the risk and potential savings for each hospital to protect the hospitals from an unaffordable loss. Each hospital is expected to reserve or otherwise plan for that risk. The maximum risk is calculated by applying the risk corridors for each payer program to that HSA's total cost of care target. Essentially, this passes the risk from the payer to the ACO to the local hospital. If OneCare Vermont is responsible for repayment of losses to the payer, these losses will be assigned to the hospitals that exceeded their HSA total cost of care. If that amount exceeds the maximum amount set for that hospital, the excess is spread proportionally among the other risk-bearing hospitals. By doing so, each hospital is protected from unaffordable overruns, but may be responsible for covering another hospital's loss.

For critical access hospitals (CAHs), there are concerns about the ability to manage the costs of patient care to the total cost of care target, given that the most expensive care is provided by tertiary care hospitals. Because of this, the state's tertiary care providers have agreed to provide additional risk protection for certain referring CAHs.

Independent Providers and Community-Based Providers

All providers who are not affiliated with a hospital continue to be paid directly by the payer – Medicaid, Medicare, or BCBSVT – using the existing payment model, which is largely fee-for-service in Vermont. These providers are not at risk for the services they provide. In addition, these providers may be eligible for additional payments described below for care coordination and other population health activities.

Starting in 2018, OneCare Vermont is working with three independent primary care practices with at least 500 attributed lives to develop a multi-payer, prospective capitation payment for primary care services with the goal of more flexibility for primary care practices, enhancing their reimbursement, and, potentially, reducing administrative burden. The ACO has invested \$1.8 million additional dollars for this pilot. The model provides monthly PMPM prospective payments to those practices to cover the primary care services delivered to their attributed patients. Both Medicaid and Medicare are participating in the prospective payments in 2018. BCBSVT continues to pay fee-for-service, but the amounts will be included in the end of the year reconciliation of the PMPM estimate for the practices.

Care Coordination Payments

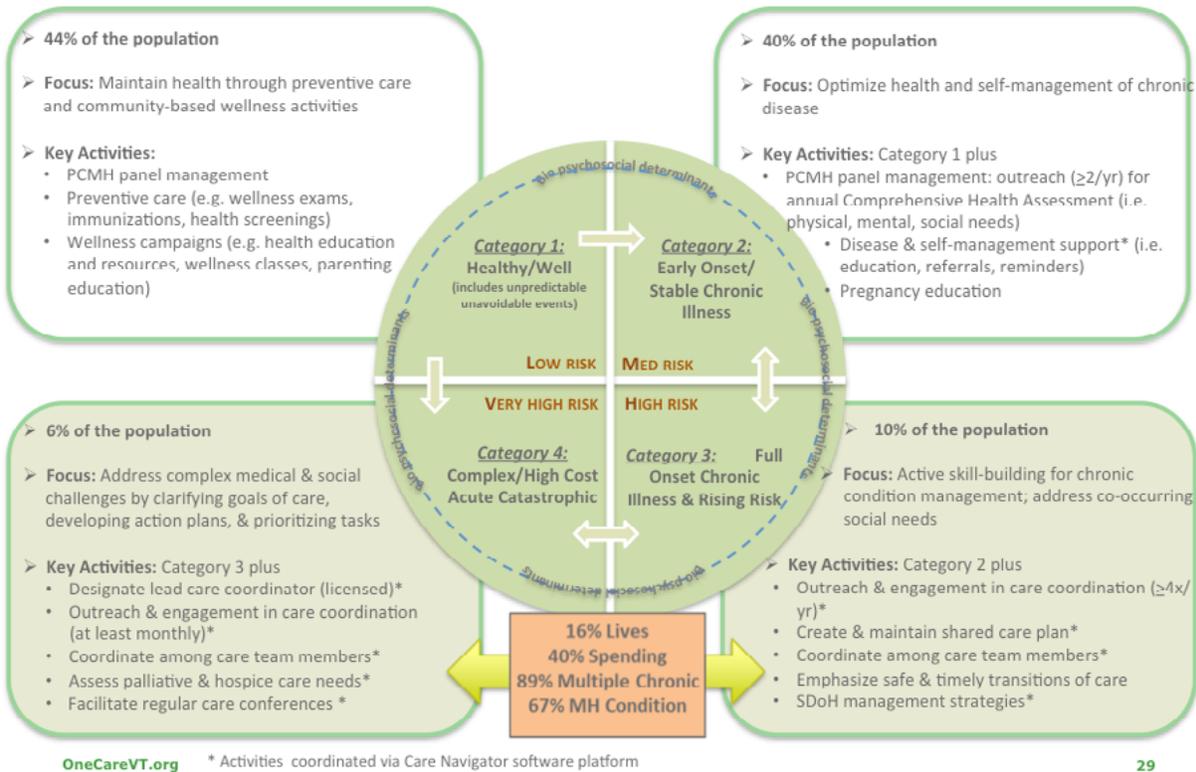
OneCare Vermont has created new payments for providers to enhance the ability to engage in care coordination, prevention, and population health activities. These new payments for ACO network providers are in addition to the state's Blueprint for Health medical home and community health team payments, which existed prior to the ACO programs as explained above. The following table illustrates the payment streams to primary care providers and community-based providers regardless of source.

Source of Funds	Description	Provider Type	Amount
Medicaid & Blue Cross Blue	<i>Blueprint for Health Primary Care Medical Home (PCHM)</i>	Primary care	\$3 per member per month (PMPM); up to 50 cents more PMPM for quality performance
Shield of VT	<i>Blueprint for Health Community Health Team (CHT)</i>	Regional financial administrator for the health service area (HSA)	\$2.77 PMPM
OneCare Vermont	<i>Medicare Contribution to Blueprint Medical Home</i>	Primary care	\$2 PMPM
	<i>Medicare Contribution to Blueprint CHT</i>	Regional financial administrator for HSA	\$2.45 PMPM
	<i>Medicare Funding for Services and Supports at Home (SASH)</i>	Care coordination at senior housing	\$57.16 PMPM
	<i>Basic Care Coordination Payment</i>	Primary Care	\$3.25 PMPM
	<i>Complex Care Coordination Payment: For the 16% of patients with the most complex needs</i>	Primary care, Designated Mental Health and Substance Abuse Agencies (DA), Home Health (HH), Area Agency on Aging (AAA)	\$15 PMPM to each agency
	<i>Lead Care Coordinator Payment: Creates shared care plan and leads the team of providers</i>	Lead chosen by patient; could be DA, HH, PCMH, or AAA	\$10 PMPM; plus \$150 one-time payment to lead agency
	<i>HSA Capacity Payment: community-specific workflows; workforce readiness; analysis of community care coordination metrics, gap analysis and remediation</i>		\$25,000 one-time payment

For the OneCare Vermont network, the investments in these programs total over \$25 million reinvested from hospital services to primary care and community-based providers.

OneCare Vermont also established a Value-Based Incentive Fund that will serve as a way to distribute savings -- if savings are achieved by meeting payer quality measures. Seventy percent of the savings will go to primary care practices based on attribution and the remainder will go to other providers based on their percentage of total eligible expenditures. This distribution recognizes that the preponderance of quality measures relies on primary care and that these providers are the cornerstone to its population health and care coordination strategies. Moving forward, OneCare Vermont is developing payments to providers tied to their quality scores. In addition, as explained above, this model qualifies as an Advanced Alternative Payment Model under Medicare's Merit-based Incentive Payment System (MIPS), which means the ACO will support providers with the required data submissions in 2018 resulting in the providers receiving a 5 percent payment increase from Medicare in 2020.

Population Health Approach to Care Coordination



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For healthy patients, this takes the form of screening, education, and wellness initiatives, such as [RiseVT](#). RiseVT is a public health model integrating wellness and prevention into health care delivery, by providing health coaching as well as wellness activities. For patients with chronic health needs, the focus is on providing more intensive care coordination and building on the existing Blueprint for Health efforts.

As noted in the graphic above, 16 percent of the people who receive 40 percent of the spending have high or very high chronic health needs. These patients are the focus of the care coordination programs with the enhanced payments described above, as well as other community-specific pilots and priority areas. The complex care coordination program enables providers to work with patients to develop shared care plans. OneCare Vermont provides tools for providers' use in the care plan development process, such as "Camden Cards." Camden Cards are paper tools designed by Jeff Brenner's [medical home initiative](#) in Camden, NJ. A provider or health coach uses these cards with a patient to identify

Mental Health Wellness Pilot

OneCare Vermont is partnering with Supports and Services at Home (SASH) and Howard Mental Health to explore ways to improve the quality of mental health and substance abuse services for residents of two Chittenden County housing communities. SASH provides care coordination and services for seniors and those with special needs through a model that brings those services to the senior housing community. Howard Mental Health is a locally-designated mental health agency. This pilot explores ways to promote mental health wellness through resident group education and other supports offered where people live.

the patient's health goals and priorities as well as the obstacles to achieving these goals. The purpose of the cards is to facilitate the identification of the real issues in the patient's life that inhibit self-care or improved health. OneCare Vermont also provides care coordination software, called Care Navigator, to support cross-organization communication and coordination of care. The software is used by the ACO network providers to access patient-level information and work together for the patient. OneCare plans to expand the functionality to incorporate event notification of admissions and discharges, deliver reminders, and trigger specific tasks.

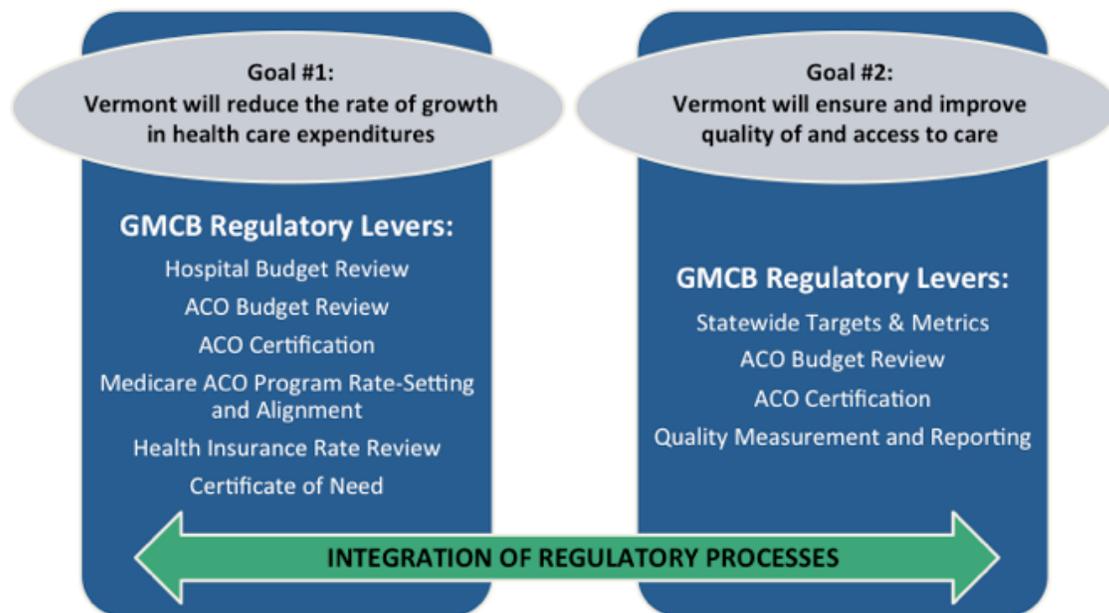
OneCare Vermont and the Blueprint for Health collaborate regionally across provider types to tackle specific regional goals, such as reducing emergency department admissions or increasing certain screenings, and to provide trainings on best practices for certain diseases or conditions. There are additional quality improvement initiatives underway by OneCare Vermont, such as a hypertension project, improving pediatric quality measure screening results, training for primary care medical homes, among others. For more information about the care management structure, see [The Commonwealth Fund's Case Study, Vermont's Bold Experiment in Community-Driven Health Care Reform](#).

How Is the State Involved?

Vermont's model is premised on using a private sector ACO to reduce the growth of health care costs over five years and to meet population health goals by increasing access to primary care, reducing deaths due to suicide and drug overdose, and reducing the prevalence of and morbidity from chronic disease. The state, however, is involved both as a Medicaid payer and as a regulator. As a payer, the state is committed to building its Medicaid Next Gen program in alignment with Medicare, with appropriate modifications for the Medicaid population and with the knowledge that there will be the ability to seek modifications of its Medicare program for 2019 and later. The All Payer ACO Model Agreement between the state and Medicare allows Vermont to apply for state-specific changes to the Next Gen program to improve operational efficiency or address state-specific needs. One example of a potential customization is modifying the ACO-level quality and performance measures currently required in the Medicare Next Gen program to allow for increased alignment across payers and reduce administration burden for providers. The Medicare Next Gen program currently uses 31 nationally-recognized quality measures in four domains: patient/caregiver experience, care coordination/patient safety, clinical care for at-risk populations, and preventive health. Click [here](#) for more details on the 2018 measures.

The board has a role as the regulatory body in Vermont that certifies [ACOs](#) entering into the market. It oversees ACOs budgets and programs for consistency with legislated policy goals and parameters, reviews and approves rates of growth for hospitals through a budget process, and approves insurance premiums. It also manages the state's all-payer claims database, called the Vermont Healthcare Claims Uniform Reporting and Evaluation System (VHCURES). Through these regulatory processes and with the available data, the board is responsible for managing and reporting on total cost of care and quality metrics. In addition, the board has the authority to set the Medicare growth rate for the ACO payments. The payments, as noted above, are compared to national growth in Medicare and the all-payer growth target of 3.5 percent as described below.

The illustration below explains how the Green Mountain Care Board (GMCB) uses its regulatory oversight to facilitate cost containment and quality improvement in alignment with the goals articulated in the All Payer Model Agreement.



Total Cost of Care

Vermont has agreed to a goal of reducing health care spending on hospital and physician services to 3.5 percent compounded annual growth over the five-year period of the agreement. This goal was negotiated based on analysis of the state's 10- and 15-year economic growth, with the goal that health care spending growth should be in line with the state's economy in order to make it more affordable to Vermonters over time. There is an additional financial target for Medicare growth of 0.2 percent less than national trends, which is significant for a state that has been growing faster than the national Medicare growth rate.

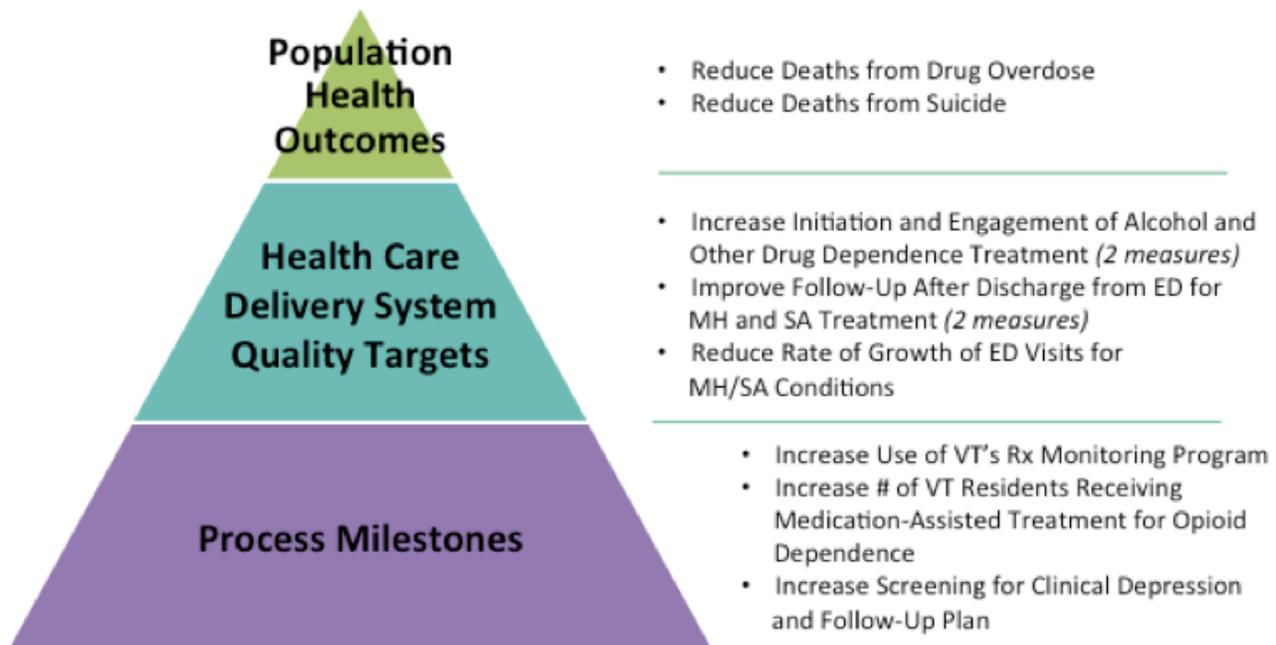
If spending grows faster than 4.3 percent, the state is subject to a corrective action plan with CMMI and could lose the flexibility to tailor the Medicare program to state-specific needs. There are no financial penalties, however, and the state or the federal government may withdraw from the program with sufficient notice if necessary. If the federal government withdraws, Vermont would return to the standard fee-for-service Medicare program and providers would be subject to MIPS incentives and penalties. Because of claims lag issues, the first quarterly report on total cost of care is scheduled to be received by the board in the last quarter of 2018, with annual results from the first year expected in the third quarter of 2019.

Quality Framework

Vermont prioritized three population health goals and built a quality framework around those goals:

- Increase access to primary care;
- Reduce deaths due to suicide and drug overdose; and
- Reduce the prevalence and morbidity of certain chronic diseases.

There is strong consensus in the state that improved access to primary care, with an enhanced focus on preventive services, can improve health care quality and the health of the population, and help reduce growth in health care costs. The other two goals were identified using the State Health Improvement Plan, called Healthy Vermonters 2020, and key areas where the state could improve. The graphic below illustrates the three tiers of Vermont's quality framework in the agreement using the population health goal of reducing deaths due to suicide and drug overdose.



Overall, the quality framework consists of 22 measures across all payers and took the intentional approach of focusing on existing measures currently required by the Blueprint for Health or a national quality program, such as the Healthcare Effectiveness Data and Information Set (HEDIS), in order to minimize new administrative burden for primary care professionals. These measures determine whether the state is meeting the terms of the agreement for quality. First year results on the measures will be reported to CMMI in the third quarter of 2019.

Medicare Growth Rate Setting

Under the agreement, the board has the authority to set the Medicare growth rate for participating ACOs, based on the Medicare Advantage United States Per Capita Costs Projections, annually issued in April. This authority allows the state more flexibility to determine the right growth rate over time with the goal of achieving a total cost of care that is 0.2 percent less than national growth. The board has set this rate only once to date, in December 2017 for 2018. This responsibility is logical in a state with an existing regulatory body in charge of private sector regulation of cost, in particular because the state had been growing faster than the national average. It is not, however, a necessary component to an agreement. Because Vermont had the capacity, it was attractive to obtain the local control for growth rates.

How Is the State Involved?

As with any new program reliant on claims data to measure the results, this model will take 18 months before the first year of data is complete and results are reported. The board will be receiving periodic updates at its meetings from OneCare Vermont to monitor implementation, hear about challenges in implementation, and get feedback from the public. Currently, OneCare Vermont [estimates](#) that the Medicaid program in 2017 will be within 1 percent of its target. During the first nine months of the Medicaid program, OneCare is reporting an increase in primary care visits among those with early- to late-stage diseases and a reduction in emergency department visits as well as fewer hospital admissions.

There are some early lessons learned for states and for private-sector ACOs interested in this type of a model, particularly those considering the model's design and incentives for changing provider and patient behavior.

Model Design Considerations

- As a private sector-led model, states need to find a balance between oversight and allowing payers and providers to make their own arrangements. The state as a payer, however, needs to be engaged and willing to work with other payers to create a system that provides consistent incentives to the provider community.
- This model is complex. It could be hard for non-clinicians, including many policymakers, to grasp some of its delivery reforms and implications or understand the operational challenges for providers. Operational change is slow and , unlikely to show immediate results preferred by some policymakers. On the other hand, the model has the potential to shift resources to prevention, wellness, and primary care without state intervention in ways that providers and payers support while improving the lives and health of patients.
- The total cost of care is estimated based on historical spending of the patients whose providers are in the ACO. The patients included in a payer's cost of care typically decline over the course of the year as people move between payers, die, or lose eligibility (in the case of Medicaid). This results in the total cost of care and total financial risk changing over the year as well. This makes it hard to pin down spending and is not the type of regulation or monitoring that most state agencies are accustomed to.
- The model does not explicitly address cost shifting between payers, which is the result of payment differences among Medicaid, Medicare, and commercial insurers. Many providers assert that public programs underpay, resulting in increased pressures on commercial payers. In Vermont's agreement, however, the state is encouraged to address Medicaid payment differentials and is held harmless from any increases because increases may be excluded from the total cost of care calculations. In other words, growth in Medicaid resulting from increasing reimbursements does not count in the growth trend for determining success of the model.

Incentives for Change

- Multi-payer reform with alignment between payers is key to operational change at the provider level. Without consistent incentives across payers, reform is more difficult to achieve.
- Sufficient attribution is a key factor for provider behavior change, but also needs to be attained over time to ensure the program is working well. Without a certain volume of payments made in the new way, the financial incentives will not be enough of an incentive for providers to make operational changes. For most states, in order to achieve sufficient scale in this model, self-insured employers will need to be convinced that the model is fiscally prudent and good for their employees. States cannot regulate or coerce employers into participating due to legal restrictions in the Employee Retirement Income Security Act of 1974 (ERISA). On the other hand, change at too fast a pace imperils providers' ability to restructure care in patient's best interests.
- Engaging patients is necessary for care coordination models to be successful. With a complex model that is largely focused on provider incentives and behaviors, it is difficult to engage patients. Many patients will fear the rationing in managed care systems. Participating providers will need to increase engagement with patients who need it to ensure that care coordination is successful.
- Bringing and keeping the provider community together in a voluntary model is also challenging. Finding common interests between small, critical-access hospitals and large academic medical center systems is a challenge.

The Vermont ACO model may be uniquely suited for states with small populations, more concentration in insurance markets, and dispersed delivery systems, such as rural states. But, this model does not have to be implemented as a statewide system. The key ingredients are:

- Local or regional collaborations by health care providers and others in an HSA based on usage patterns by patients;
- Participation by academic medical centers and health systems in the locality or region, because these often are where the highest-priced care is provided;
- One or more ACO provider organizations used to systematize care coordination between unaffiliated providers;
- A set of tools and data resources to be used by providers to facilitate keep information on cost and quality flowing among providers in a consistent fashion; and
- Sufficient payer participation in the locality or region with the willingness to align payment methods and quality measures across all payers (Medicaid, Medicare, and commercial insurers) to provide consistent incentives to the health care providers who participate.

This model could be further adapted for use by cities, counties, or regional areas in a larger state, depending on that state's unique delivery system and payer profiles. In addition, states interested in pursuing this type of model will need to understand whether the state's Medicare spending is growing faster or slower than national Medicare growth, because this will inform negotiations with CMMI and the types of state-specific modifications that may be desirable. Lastly, state Medicaid programs are necessary partners and can provide leadership by looking for ways to align with Medicare, where appropriate.

Acknowledgements:

Robin Lunge, JD, MHCDS, has served on the Green Mountain Care Board since November 2016. Prior to joining the board, she served for nearly six years as Vermont's Director of Health Care Reform in Gov. Peter Shumlin's administration. Her experience includes working as a nonpartisan staff attorney at the Vermont Legislative Council, where she drafted legislation and provided support to members of the Vermont legislature relating to health and human services matters, and at the Center on Budget and Policy Priorities in Washington, DC, as a senior policy analyst on public benefits issues. Lunge's areas of expertise are federal and state public benefit programs, health care, and health care reform. Robin holds a BA from the University of California Santa Cruz, a JD from Cornell Law School, and a Masters of Health Care Delivery Science from Dartmouth College. Her term continues to Sept. 30, 2022. The views expressed here are her own and not those of the Green Mountain Care Board or the State of Vermont.

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