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Fact Sheet – Vermont All-Payer ACO Model

All-Payer Growth Financial Target

BACKGROUND

The Vermont All-Payer ACO Model Agreement (***Model Agreement***) allows Vermont to explore new ways of financing health care as part of a strategy to limit the growth of Vermont's total health care spending. The Model Agreement, signed by representatives of Vermont and the federal government, enables Medicare's participation in an all-payer Accountable Care Organization (ACO) delivery model.

One component of the Model Agreement sets Vermont's goal for All-Payer Total Cost of Care per Beneficiary Growth (***All-Payer Growth***). The target All-Payer Growth rate is 3.5%, a level that seeks to align Vermont's increase in health care spending with the state's historic economic growth rate without jeopardizing Vermont's strong provider community.

CALCULATING THE ALL-PAYER GROWTH RATE

Vermont's model will be assessed on how it does relative to the All-Payer Growth rate at the end of the Agreement. All-Payer Growth is calculated as the compound annual growth rate over the five performance years of the Model Agreement (2018-2022). The Green Mountain Care Board (GMCB) will regularly report on Vermont's progress against the 3.5% All-Payer Growth target on a quarterly and annual basis beginning in 2018.

FINANCIAL TARGET SERVICES

The All-Payer Growth calculation includes expenditures on ***financial target services***, as defined by the Model Agreement, for all Vermont residents. The Model Agreement is designed so financial target services are largely comparable across all major payers, including Medicare, Medicaid, commercial insurers, and self-insured plans. In general, most medical, post-acute, and mental health and substance abuse services are included in financial target services.

- **Exclusions:** Financial target services do not include retail prescription drugs or dental care.
- **Medicaid-Specific Exclusions:** The Model Agreement excludes certain specialized services covered by Medicaid, because those services are not typically covered by Medicare or commercial insurance. For example, home and community-based services (HCBS)[ii] and mental health and substance abuse services provided through state agencies are not included.
- **Medicaid Long-Term Institutional Care:** The Model Agreement excludes long-term institutional (nursing facility) care provided by Medicaid for the first three years of the agreement. Beginning in 2021, nursing facility care paid for by Medicaid is included in financial target services.

The table below summarizes financial target services by payer category:

Payer	Included Services	Excluded Services
Medicare	Medicare Parts A and B • Part A: inpatient hospital, skilled nursing, home health and hospice care • Part B: most other professional services, including physicians, durable medical equipment, outpatient hospital, and ambulance care.	Medicare Part D[i] • Part D: retail prescription drugs
Medicaid	Most medical services, including • Hospital and post-acute care • Professional services • Mental health and substance abuse services paid for by DVHA • Durable medical equipment • Long-term institutional services (2021-2022)	• Retail prescription drugs • Dental care • Medicaid home and community-based services (specialized services funded by other state agencies)[ii] • Medicaid mental health and substance abuse services funded by other state agencies (including Designated Agencies) • Long-term institutional services (2018-2020)
Commercial Insurers	Most medical services, including • Hospital and post-acute care • Professional services • Mental health and substance abuse services Durable medical equipment	• Retail prescription drugs • Dental care
Self-Insured Plans	Most medical services, including • Hospital and post-acute care • Professional services • Mental health and substance abuse services • Durable medical equipment	• Retail prescription drugs • Dental care

SPENDING SUBJECT TO THE ALL-PAYER GROWTH FINANCIAL TARGET

The All-Payer Growth calculation includes spending on financial target services for Vermont residents. That means the GMCB is measuring all spending – whether providers are paid through traditional fee-for-service reimbursement mechanisms or through ACO initiatives. As of March 2017, agreements are moving forward for to implement Vermont Medicare and Medicaid ACO initiatives in 2018 that meet the ACO requirements described in the Model Agreement. GMCB is working with Vermont commercial insurers to encourage them to offer ACO initiatives, and additional ACO initiatives are anticipated to develop over time.

ENFORCING THE ALL-PAYER GROWTH FINANCIAL TARGET

Under the Model Agreement, the stated goal for spending growth is 3.5%. However, the Model Agreement allows some flexibility in case of unanticipated factors, such as changes in Medicare law or Vermont-localized health or economic shocks. CMS can only take enforcement action if Vermont's All-Payer Growth is over 4.3%. Enforcement from CMS does not mean Vermont pays any money to CMS. It means that Vermont will need to file a corrective action plan and implement the plan to get on track to achieve the All-Payer Growth financial target.

Endnotes

[i] Medicare Part C is not a separate benefit. It governs Medicare delivered through private health insurance (Medicare Advantage) plans. Spending by Medicare Advantage plans is excluded from all-payer calculations.

[ii] As defined in the Model Agreement, Medicaid home and community-based services (HCBS) means Medicaid reimbursed services delivered in home and community-based settings, including, but not limited to adult day programs, home health aide services, personal care services, and transportation paid for by Vermont Medicaid.