Analytical Framework for State Cost Containment Models: Vermont

Domain #1: Administrative and Clinical Data Collection, Analysis and Reporting	
What types of administrative data does the state collect?	Vermont's Department of Financial Regulation publishes an annual Health Plan report card that provides data on health plan annual performance and performance over time (2012 to 2014). These reports provide information on a health plan performance on a variety of CAHPS and HEDIS measures including: • Members experience of care and service (e.g. call answering, claims handling, rating of overall health plan experience, etc.) • Preventive care (performance on HEDIS measures such as childhood immunizations, breast cancer screening, well child visits, etc.) • Acute illness care (care for adults with acute bronchitis, imaging studies for low back pain, etc.) • Chronic illness care (asthma care, management of medicine for depression, testing for chronic lung disease, etc.) In addition, the Vermont Department of Health publishes an annual statewide comparative report on the state's hospitals with information on quality of care, including healthcare-acquired infection rates, patient safety, nurse staffing levels, financial health, cost for services, and other related information. These statewide reports, referred to as Hospital Report Cards, offer a comparative view of measures reported by Vermont's hospitals. *Source:* *For more information about Vermont's Hospital Report Cards click here.* *For more information about Vermont's Health Plan Report cards click here.*
What types of clinical data does the state collect?	Vermont's Blueprint for Health (the state's PCMH initiative) has developed a process for aggregating clinical data from clinical registries and claims data from the state's APCD. These data are an important component of the Blueprint's reporting capabilities, described in further detail below in Domain #1 – with the aim of improved monitoring of population health within the state. The Blueprint holds primary care practices accountable for four performance measures, applied based on HAS-level performance: o Adolescent Well-Care Visits o Developmental Screening for Children Ages 0-3 Years o Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%) o PQI-92: Chronic Condition Composite The Blueprint also publishes practice profile reports for adult and pediatric patients. In 2015 the Adult Profile Report

Domain #1: Administrative and Clinical Data Collection, Analysis and Reporting	
	reported on 10 measures (breast cancer and cervical cancer screening, three diabetes measures, low back pain imaging, CAHPS Patient Experience access to care results, RUI, and an adjusted utilization measure). The Pediatric Profile Report reported eight such measures. *Sources:* *For a CMS fact sheet on the Vermont All-Payer ACO Model, click here.* *Click here to access a GMCB presentation with additional detail regarding the Model.*
Does the state have an HIT strategy to promote use of clinical and administrative data to promote cost containment initiatives?	Yes. Vermont has created the State Health IT Plan (VHITP) which sets high-level strategy and roadmap for the statewide electronic collection, storage and exchange of clinical or service data in support of improved patient care, improved health of Vermonters, and lower growth in health care costs. In addition, the state's HIE which is operated by Vermont Information Technology Leaders (VITL), collects data from EHRs of physician practices that participate in the state's Blueprint for Health patient centered medical home program; patient data is then transmitted from the EHR to the Blueprint's electronic registry. This system enables providers participating in the Blueprint to access the registry in order "to analyze patient care and identify opportunities for intervention and improvement." *Source:* *For more information about VHITP, click here.* *For more information about VITL, click here.*
Does the state have a centralized agency or entity responsible for collecting, analyzing and reporting health care data?	No, but various agencies and entities do report data. The Green Mountain Care Board (GMCB), the state's independent health care oversight body, for example, is required by statue to submit various reports to the Legislature, including an expenditure analysis that: • establishes a base of health care spending and funding, • examines spending and sources of funds over time, • provides spending from two different perspectives; 1) spending on behalf of Vermont residents, and 2) spending by Vermont providers for both residents and non-residents and, • allows comparison of Vermont spending to National Health Expenditures at CMS. *Source:* *More information about the reports that the Green Mountain Care Board has submitted to the Legislature, click here.*
Does the state have a functioning APCD that it uses to collect data?	Yes. Vermont Healthcare Claims Uniform Reporting and Evaluation System (VHCURES) is Vermont's APCD, first established in 2007. Since 2013, the GMCB has had responsibility for maintaining VHCURES. Medicaid and Medicare data were incorporated into VHCURES in 2013. The GMCB is statutorily charged with six purposes with regards to its maintenance of VHCURES:

Domain #1: Administrative and Clinical Data Collection, Analysis and Reporting	
	1. Determining the capacity and distribution of existing resources; 2. Identifying health care needs and informing health care policy; 3. Evaluating the effectiveness of intervention programs on improving patient outcomes; 4. Comparing costs between various treatment settings; 5. Providing information to consumers and purchasers of health care; and 6. Improving quality and affordability of health care. GMCB contracts with OnPoint Health Data to manage the collection, organization and distribution of VHCURES data. *Sources:* *More information about VHCURES may be accessed here and here.*
Does the state report cost and quality to the public?	Yes. The state reports on quality to the public through the state's PCMH initiative (Blueprint for Health), and its ACO Shared Savings Program, as described below. The GMCB also produces reports on Vermont's health care expenditures. *Blueprint Reporting* • Blueprint produces all payer practice profile reports from the state's APCD (VHCURES). These reports compare practices to others in their region and statewide on panel characteristics, risk-adjusted resource utilization and cost and quality (13 HEDIS measures). • Through data use agreements, VHCURES data is being utilized by state agencies, state contractors and academic researchers to support analysis of health care access, spending, utilization, and quality. • In 2015, the Vermont Blueprint for Health released its new Hospital Service Area (HSA) profiles, which contain a broad set of population-based measures from data supplied to the state's APCD. The profiles combine data from all payer types (commercial, Medicaid and Medicare), add ACO payment and reporting measures, integrate data from Vermont's clinical registry (DocSite), measures from the Behavioral Risk Factor Surveillance System (BRFSS), as well as an annual survey conducted by the Vermont Department of Health. *ACO Shared Savings Program Reporting* The GMCB approved measures of quality, patient experience, cost and utilization for each year of the pilot. As data on each year's quality measures are finalized, they are shared with the public by the GMCB. More information about the measure sets collected under the ACO Shared Savings Program is provided at the beginning of this Domain. *Sources*: *To view the Blueprint for Health annual report, click here.*

Domain #1: Administrative and Clinical Data Collection, Analysis and Reporting	
	To view the Blueprint HSA Profiles click here.
Does the state identify and track key cost drivers and high cost providers through analysis of a combination of administrative and clinical data?	Yes. The VHCURES data set enables the state to analyze health care expenditures, cost drivers and health care service use in Vermont.
Does the state monitor health care cost growth?	Yes. Since 1993, Vermont has prepared an annual Health Care Expenditure Analysis that summarizes health spending by resident and by provider. In 2014, Vermont resident total health expenditures were $5.5 billion. *Source:* *The most recent Vermont Health Care Expenditure Analysis may be accessed here.*
Does the state define cost growth targets?	Yes. The Green Mountain Care Board set a target rate for increases in hospital net patient revenue of three percent for FY 2014 through FY 2016. Since establishing this hospital growth rate target, the average rate of growth has been 2.4 percent. Under the state's All-Payer ACO Model, the state commits to limiting the annualized per capita health care expenditure growth for all major payers to 3.5 percent. Under the Model, Vermont also commits to Medicare spending growth that is 0.1 to 0.2 percentage points below that of the national average projected national Medicare growth, across the five year life of the Model, which has a target implementation date of January 2017. *Sources:* *To view the GMCB 2016 annual report, click here.* *For more information about the all-payer model, click here. A CMS fact sheet on the model may be accessed here.*
Is there anything that differentiates this state's data collection, analytic and reporting strategy from those of other states?	Yes. The state pursued a cohesive strategy to spur adoption of electronic health records across the state. This effort began in 2008 when the legislature passed an assessment fee on commercial insurers to establish the Vermont Health IT Fund. The assessments phased out in 2015, but grants made from the fund spurred gains across the state in electronic health record adoption and connectivity – and the availability of data for improved care coordination and quality initiatives. VITL, an independent nonprofit organization, used the Health IT Funds combined with ONC grants to develop the state's HIE, and to enable providers to access the HIE without paying fees. As a result, providers across the state are benefiting from electronic connectivity, allowing for faster transmittal of data between providers.

Domain #1: Administrative and Clinical Data Collection, Analysis and Reporting	
	Source: *For more information about Vermont's data strategy, click here.*

Domain #2: Medicaid Purchasing and Coverage Strategies to Contain Costs	
Does the state coordinate Medicaid and state employee health plan performance requirements and cost control strategies?	No. The Department of Vermont Health Access (DVHA) manages Vermont's publicly funded health insurances programs, including the state's Medicaid program, its CHIP program, the Marketplace, and Blueprint for Health. The Department of Human Resources administers the state employee health benefit program. While there does not appear to be strong coordination across the Medicaid and state employee programs, all payers – including both Medicaid and the state employees program – participate in the Blueprint for Health Program.
Is the state pursuing an all-payer or Medicare waiver with CMS in order to align cost control strategies?	Yes. In October 2016, CMS approved Vermont's All-Payer ACO Model to test an alternative payment model with the participation of Medicare, Medicaid and the state's commercial payers. The model encourages provider participation in one statewide ACO, plus a funding opportunity for $9.5 million to help providers with care coordination and linkages to community-based providers. Provider and payer participation in the model is voluntary. As described above, the model commits to statewide (all-payer) and Medicare financial targets, limiting annualized per capita health care expenditure growth for all payers to 3.5 percent, and for Medicare beneficiaries in the state to at least 0.1 to 0.2 percentage points below projected national Medicare growth. *Source:* *For a CMS fact sheet on the Vermont All-Payer ACO Model, click here.*
What other waivers, grants or federal demonstrations is Medicaid pursuing to promote cost containment?	At same time as All-Payer Model approval, CMS also approved a five-year extension of Vermont's 1115 waiver demonstration, enabling Medicaid to become a full partner in the Vermont All-Payer ACO Model.
What APMs are being pursued by Medicaid?	All-Payer ACO Model In October 2016, CMS announced approval of the Vermont All-Payer Accountable Care Organization (ACO) model, which will test one alternative payment model for Medicare, Medicaid, and the state's commercial health payers,

Domain #2: Medicaid Purchasing and Coverage Strategies to Contain Costs	
	designed to incentivize value and quality, with a focus on outcomes. The model also features the establishment of one statewide ACO, and is the primary alternative payment model being pursued by the state. Medicaid is participating in the program through its renewed Section 1115 Waiver, but the Green Mountain Care Board is the state entity that pursued this initiative. Key features of the All Payer ACO Model include the following. • The Model establishes statewide targets, including: o ACO Scale Targets that aim to have 70 percent of insured Vermonters participating in ACO programs by 2022. o Financial Targets that limit annualized per capita health care expenditure growth for all major payers to 3.5 percent. Under the Model, Vermont also commits to limit Medicare per capita health care expenditure growth for Vermont Medicare beneficiaries to 0.1 to 0.2 percentage points below projected national Medicare growth. o Quality Targets in four areas identified by Vermont: substance use disorder, suicides, chronic conditions and access to care. The Model establishes three categories of measures within each of these four priority areas (population-level Health Outcomes Measures and Targets, Health Care Delivery System Measures and Target, and Process Milestones). • The Vermont Medicare ACO initiative is the Medicare FFS ACO tailored to Vermont and offered by CMS to Vermont ACOs under the Model; this initiative is largely based on the Next Generation ACO Model. The Vermont Medicare ACO initiative qualifies as an Advanced Alternative Payment Model, enabling providers to potentially qualify for bonus payments under the Advanced Alternative Payment Model requirements under MACRA starting in performance year 2018. • CMS will make $9.5 million in start-up funds available to Vermont in 2017 to support care coordination efforts, including linkages to community-based providers. Vermont is likely to direct at least a portion of these funds to the Blueprint program, which is already engaged in these types of efforts. *Sources:* *Click here for more information about the All Payer Accountable Care Organization agreement.*
What delivery system redesign strategies are being pursued by Medicaid?	Vermont Medicaid program is an important player in the state's delivery and reform initiatives, participating in the All-Payer ACO Model. It also has been a leader in the Blueprint for Health, which is the state's patient centered medical home program, that combines medical homes with community health teams that offer care coordination and connection to support services. In addition, the Medicaid program operates the Support and Services at Home (SASH) program. The SASH program is one which a multidisciplinary health team makes an initial assessment, creates an individualized care plan, and delivers home-based nursing and care coordination.

Domain #2: Medicaid Purchasing and Coverage Strategies to Contain Costs	
	Sources: *A March 2013 case study of the Vermont Medicaid program may be found here.* *More information about the SASH program may be found here.*
What benefit designs are being pursued by Medicaid to incentivize good health behaviors and patient responsibility?	The Blueprint for Health program incorporates a variety of self-management programs for beneficiaries. In 2014, the Blueprint program offered 135 workshops across the state on topics such as diabetes prevention and chronic disease self-management. *Sources:* *Click here to access the Blueprint's 2015 annual report.*
Does Medicaid use MMCOs to manage care?	No. Vermont does not use traditional Medicaid Managed Care Organizations. However, the VT Agency of Human Services enlists DVHA (a sub-department) as a managed care entity, paying DVHA a capitated per patient per month (PMPM) rate similar to the way other state Medicaid agencies pay managed care organizations.
What reimbursement policies has Medicaid implemented to promote cost containment?	Under the Blueprint for Health program, PMPM payments are made to providers based on the level achieved by the primary care practice in NCQA-PCMH Recognition standards. In addition, all insurers share the cost for core Community Health Team; this shared costs helps ensure a community-based care support infrastructure for primary care practices and the populations they serve. *Source:* *For more information, click here to access the 2015 Blueprint for Health annual report.*
What initiatives has Medicaid pursued to manage cost of special populations of beneficiaries?	The Vermont Chronic Care Initiative (VCCI) is a legislatively supported, statewide Medicaid health care reform strategy. Enacted in 2007 the VCCI targets Medicaid members at risk for adverse health outcomes for short term, holistic, intensive case management and social support services in order to improve individual and population health -- and related health care costs. Members are identified using claims history, supplemented by risk stratification. The VCCI program is offered by and administered by The Department of Vermont Health Access. The program has demonstrated several successes, including $30.5 million in savings in SFY 2014 – as discussed in more detail in the final section of this document. *Source:* *To read more about the Vermont Chronic care Initiative, click here.*

Domain #3: State Employee Health Plan Coverage and Payment Strategies to Contain Costs

Domain #3: State Employee Health Plan Coverage and Payment Strategies to Contain Costs	
What APMs is the state employee health plan using to control health care costs?	There is no evidence that the state employees' health program is incorporated in the state's health reform activities, although state employees do participate in the Blueprint for Health program.
What benefit design is the state employee health plan using to control health care costs?	No information available.
How does the state believe its purchaser strategy could be strengthened?	No information available.

Domain #4: State Actions to Enhance Competition in the Marketplace	
Does the state certify or otherwise regulate Accountable Care Organizations?	Through collaboration with stakeholders, the GMCB has created standards for ACOs participating in the commercial and Medicaid Shared Savings Programs, and the All-Payer Model.
Does the state collect data regarding the structure of the state's health care market, such as ACO information on number of participating physicians?	Yes, it has done so once before. In 2015, Vermont's Joint Fiscal Office prepared a report to the state legislature on the structure of Vermont's health care market, including an overview of providers and payers. *Source:* *Click here for the Joint Fiscal Office's 2015 report to the Vermont legislature.*
Does the state use the collected data to produce reports to	*Yes, to the extent that the GMCB shares the reports described in Domain #1 with providers – and the public.*

Domain #4: State Actions to Enhance Competition in the Marketplace	
encourage marketplace competition, such as hospital quality and cost report cards, cost impact reports?	
Does the state promote or set limits on consolidation of health care providers of similar services?	No.
Does the state promote or set limits on vertical integration of health care providers of different services?	No.
Does the state promote or limit other types of affiliations among health care providers that impact referral and utilization practices?	No.
What strategies, if any, has the state's insurance department taken to ease insurer entry into the marketplace to enhance insurer competition?	None.
Does the state have consumer protection regulations that promote cost	The state does not have consumer protection regulations that specifically promote cost containment.

Domain #4: State Actions to Enhance Competition in the Marketplace	
containment?	

Domain #5: State Regulatory Actions to Contain Health Care Costs	
Does the state directly (vs indirectly through setting or approving insurer rates) limit price increases by providers?	Yes, the state directly limits hospital price increases via the budget review process undertaken by GMCB. In 2013, GMCB implemented principles for governing the hospital budget review process for FY 2014 through 2016. GMCB set a target rate for increases in hospital net patient revenue (NPR) of 3 percent for FY 2014 through 2016. The All-Payer Model establishes all-payer and Medicare financial targets that limit annualized per capita health expenditures, as described in Domain #2.
Has the state mandated payment and delivery system reform?	Yes. All payers in the state are required to participate in the Blueprint for Health program. The state has not mandated other payment reforms, but has effectively launched payment reform programs, including a statewide all-payer ACO model, through the Green Mountain Care Board. *Sources:* *Green Mountain Care Board 2014 and 2015 Annual Reports. Available here and here.*
Does the state have a Determination or Certificate of Need program or other programs to limit introduction of high cost services?	Yes. Vermont has a Certificate of Need (CON) program that is "intended to prevent unnecessary duplication of health care facilities and services, guide their establishment in order to best serve public needs, promote cost containment, and ensure the provision and equitable allocation of high quality health care services and resources for all Vermonters." State statute specifies that CONs are needed for: • Construction, development, purchase, renovation, of a health care facility, or any capital expenditure exceeding $1.5 million. • A change from one licensing period to the next in the number of licensed beds of a health care facility through addition or conversion, or through relocation from one site to another. • Offering of any home health service. • Purchase, lease or arrangement of diagnostic equipment exceeding $1 million. • The offering of a service or technology with annual operating expense exceeding $500,000.

Domain #5: State Regulatory Actions to Contain Health Care Costs	
	• The construction, development, of an ambulatory surgery center, or of a health care facility exceeding $3 million. GMCB has jurisdiction over projects filed on or after January 1, 2013. In 2015, for example, the GMCB approved eight projects and disapproved one, noting that proposed projects have become increasingly complex. The GMCB review process is transparent with filings posted to website and hearings open to public. Members of the public may attend hearings or submit comments in writing.  GMCB Certificate of Need Regulation.pdf *Sources:* *Click here for more information regarding GMCB oversight of CONs. General rules regarding CONs are specified in state statute. Click here for more information.*
Are there any requirements of commercial payers to provide comparative cost and quality data regarding contracted providers?	No.
Is the state insurance department implementing any strategies to limit provider cost increases?	Until the start of 2014, the GMCB shared responsibility for health insurance rate review with the Department of Financial Regulation (DFR). In 2013, Act 79 expanded the GMCB's authority over health insurance rate increases, making the GMCB the primary reviewer of rates, while the DFR's role was limited to providing the GMCB with analysis and opinion regarding insurer solvency. GMCB works to link hospital budget review process with the health insurance rate review process to ensure slowed growth in both hospital budgets and insurance rates. An independent evaluation found that the GMCB insurance rate review process has saved Vermonters $66 million since 2012. For example, in 2015, the GMCB reduced an 8.6 percent rate increase proposed by Blue Cross and Blue Shield of Vermont to 5.9 percent, and a 3.0 percent increase proposed by MVP Health Plan, Inc. to 2.4 percent. *Sources:* *Green Mountain Care Board 2015 Annual Report available here. Click here to access GMCB's 2016 annual report. More information regarding the Vermont Department of Financial Regulation's annual health plan report card may be found here. For more information about the GMCB's rate review process and associated savings, click here.*
What other strategies, if any, has the state's Insurance department	None, however, it is worth noting the transparency with which the GMCB reviews proposed health insurance rate filing. The GMCB has a rate review website, designed to provide consumer access to

Domain #5: State Regulatory Actions to Contain Health Care Costs	
taken to control health care costs?	Consumers with access to health insurance rate information. The website explains the rate review process and allows consumers to track rate filings and share comments about specific rate filings or the rate review process in general. Vermont's nonprofit health care advocacy organization, the Health Care Advocate, may enter an appearance as a party to the rate review on behalf of Vermont's consumers.

Domain #6: Payment Reform and Delivery System Reform	
What entities are driving payment and delivery system reform in the state?	The Governor, the state legislature and the Green Mountain Care Board are the primary entities driving reforms in the state, and also the Department of Vermont Health Access (DVHA). Vermont's executive and legislative branches have long been active in shaping health care policies for the state. The state legislature has given state-based agencies and the GMCB wide authority to promote and enforce health care delivery reforms. • In 2011, the state legislature gave the GMCB authority to design and test new ways of paying for and delivering high quality health care. The GMCB has exercised this authority in three ways: o Shared Savings Program pilot o All-payer model o Pilots focused on smaller payment and delivery system reform innovations (for example a pilot to support oncology care in St. Johnsbury, Vermont). • Launched in 2003 as a Governor's initiative, the Blueprint for Health serves the majority of Vermonters, providing them with primary care via Patient Centered Medical Homes (PCMHs), support services through Community Health Teams (HTs), and self-management support programs. All major insurers in Vermont participate in the Blueprint. The Blueprint initiative gives primary care practices support programs and helps facilitate continuous improvements in participating practices. Vermont has worked hard to build connections between the Blueprint and Shared Savings Program pilot, by integrating ACO representatives into the Blueprint's Regional Community Collaboratives, adding ACO performance measures to the Blueprint practice profiles, and planning for future incorporation of Blueprint into the All-Payer Model. DVHA is responsible for Medicaid, Blueprint – its PCMH, the exchange and the Medicaid shared savings ACO pilot. DVHA has a matrix relationship with VITL – the state's HIE.

Domain #6: Payment Reform and Delivery System Reform	
	Source: *For more information about the GMCB, click here.*
What support has the state received to promote payment and delivery system reform?	In October 2016, CMS approved Vermont's All-Payer ACO Model, which will include the participation of all significant payers and the majority of the delivery system in redesigning care delivery across the state. The Model offers Vermont a $9.5 million funding opportunity in terms of start-up investments to help providers with care coordination and designing linkages with community-based providers. The Model is described in detail in Domain #2. In February 21, 2013, Vermont was awarded a $45 million Round One State Innovation Model (SIM) Design Award Grant from the Center for Medicare and Medicaid Innovation (CMMI) . This grant funds activities inside and outside of state government over the next four years to expand and integrate innovative health care provider payment and health information technology that supports more effective and efficient care delivery. Vermont has named the project that will utilize the SIM grant funds the Vermont Health Care Innovation Project (VHCIP). *Sources:* *To read more about Vermont's All-Payer ACO Model, click here.* *To read more about the Vermont Health Care Innovation Project (VHCIP), click here.*

Domain #7: Environmental Context for the Cost Containment Strategies	
Does the state's culture promote cost reform?	Vermont benefits from a collaborative environment where parties with different interests come together to try to forge agreement through compromise. This culture provides a stable foundation from which to affect system change.
What are/were the governmental facilitators?	The key governmental facilitator is the Green Mountain Care Board. The GMCB is a group of five Vermonters nominated by a broad-based committee and appointed by the Governor. GMCB is charged with ensuring that changes in the health system improve quality while stabilizing costs. GMCB has three broad responsibilities: 1) regulation (hospital budgets, payer premiums, CON applications; 2) innovation (e.g., payment reform models); and 3) evaluation (e.g., evaluate innovations). *Source: Click here for more information about the GMCB.*
Are there any key insurers that are driving cost containment	In Vermont, BCBSVT is the dominant insurer with 88 percent market share. BCBSVT is actively and consistently engaged in working with the state on its health reform agenda.

Domain #7: Environmental Context for the Cost Containment Strategies	
strategies?	
Do health plans promote use of high-quality, low cost providers in their plan designs?	No evidence of such approaches.
Have health plans implemented alternative payment models with providers?	BCBSVT has been an active participant in reforms and APMs pursued by the state, including Blueprint, the ACO Shared Savings Pilot, and the All-Payer Model.
How have health plans promoted delivery system transformation?	All of the payers in the state are required to participate in the Blueprint for Health program. The exception is self-insured employers – though, many have chosen to participate. The payers pay on a FFS basis, plus a per member per month payment to support primary care practice transformation, and traditionally unfunded services. In addition to the base payment there is a small performance based component that rewards high value care. Payers pay for the care coordination work of the community health teams based on the proportion of members in each HSA.
Are there any multi-stakeholder coalitions facilitating cost containment strategies?	The GMCB is the primary driver of payment reforms and cost containment strategies in the state. Other multi-stakeholder groups include Partners for Health Care Reform and the Vermont Business Roundtable. • Partners for Health Care Reform is a group of health care providers, employers, and a health plan provider interested in research-based analyses to shape effective reform of Vermont's health care system. • Vermont Business Roundtable is a non-partisan organization comprised of 115 CEOs from among the state's most successful private sector and not-for-profit employers. The Roundtable is a member of Partners for Health Reform, a multi-stakeholder group that includes representation of payers, providers and the business community concerned with the success of health reform.
Is there a strong employer purchaser coalition in the market facilitating cost containment strategies?	No.
Are there any individual employers that are driving cost control discussions and actions within the state?	No. But IBM and the state employees both participate in the Blueprint for Health program.
Does the state have a centralized agency or designated work group responsible for	Yes. The Green Mountain Care Board and its staff serve this function as described above – and DVHA plays a central role as well. The GMCB will play a lead role in administering the Vermont All-Payer ACO Model.

Domain #7: Environmental Context for the Cost Containment Strategies	
overseeing/driving health care cost strategies?	
Has the state or any of its executive branch agencies adopted a formal cost control strategy or roadmap?	Vermont does not have a formal cost control strategy or roadmap, but rather pursues cost containment, largely under the direction of the Green Mountain Care Board. *Source:* *To access the GMCB's 2015 annual report, click here.*
Does the state have any funding mechanism to support cost containment initiatives by unaffiliated providers such as independent primary care practices, small community hospitals or safety-net hospitals?	The Blueprint for Health program provides a supplemental per member per month payment to support improved care coordination.
Does the state have any resources and program initiatives to assist health care providers to increase quality and efficiency?	No.

What has been the effectiveness of state strategies on cost control according to formal evaluation activity, including independent party evaluations and self-reported studies?	
Key Findings	**Summary and citation**
1. A CMS report that measured Medicare savings from Vermont's Blueprint for Health and similar reform programs in seven other states found that Vermont's savings were the highest. Further, Blueprint was one of only two reform efforts that resulted in slower growth in total Medicare spending. The report found that Vermont's savings resulted from improvements in care coordination that lowered the need for hospitalizations, for example. **2. A DVHA report on the Support and Services at Home (SASH) program, which is part of the Blueprint for Health, found that "SASH participants cost Medicare an average of**	The Blueprint has been effective in slowing growth in expenditures when compared to non-Blueprint practices, according to two studies. *Source:* *Click here for more information about the Blueprint evaluation reports.*

What has been the effectiveness of state strategies on cost control according to formal evaluation activity, including independent party evaluations and self-reported studies?	
$1,756 less per member per year than non-SASH-enrolled Vermonters and an average of $2,197 less per member per year than non-SASH-enrolled New Yorkers."	
1. An independent evaluation of Vermont's use of federal Cycle II Rate Review Grant found that Vermont's insurance premium rate review process has saved approximately $66 million since 2012, equal to three percent of total proposed premiums. **2. Since establishing hospital growth rate targets in 2013, the average rate of growth for hospitals has been 2.4 percent. In the prior six years, hospitals grew at an average rate of 6.3 percent. One percentage point is equal to approximately $20 million of health system costs.**	An independent evaluation found that the state's insurance premium rate review process resulted in savings of $66 million between 2012 and 2016. The GMCB reported on this evaluation in its 2016 annual report. *Source:* *Click here to access GMCB's 2016 annual report.*
In SFY 2014, the state reported the following achievements for the Vermont Chronic Care Initiative: **1. Net savings of $30.5 million to Vermont Medicaid program;** **2. 15 percent decrease in avoidable emergency department visits;** **3. 30 decrease in inpatient hospitalizations; and** **4. 31 percent decrease in hospital readmissions (30-day).**	The Vermont Chronic Care Initiative, described in more detail in Domain #2 has experienced several a number of successes as reported by the state. The program assists Medicaid members at risk for adverse health events by targeting intensive case management and providing social support services. The program is offered on a statewide basis and was first enacted in 2007. *Source:* *For more information about the VCCI and its successes, click here.*