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Findings at a Glance

Vermont All-Payer Model (VTAPM)

Evaluation of the First Two Performance Years: 2018-2019

MODEL OVERVIEW

The Vermont All-Payer Accountable Care Organization Model (VTAPM), launched on January 1, 2017 with an anticipated end date of December 31, 2022, aims to assess whether scaling an Accountable Care Organization (ACO) program across all payers in the state can reduce program expenditures while preserving or improving care quality by generating sufficient incentives and alignment across payers for broad delivery system transformation. In 2017, CMS provided $9.5 million in startup funding to support care coordination activities, establish connections among community-based resources, and support practice transformation for Medicare beneficiaries. The Model builds on nearly two decades of primary care and population health investments in Vermont, strong regulatory oversight, and a statewide culture of reform. Vermont developed a unique multi-layered accountability structure that includes CMS; the state's Agency of Human Services; and the Green Mountain Care Board (GMCB), an independent and nonpartisan governing body.

PARTICIPANTS

Payers opt to participate in the VTAPM.

Hospitals in each health service area (HSA) opt to participate in the Medicare, Medicaid and/or commercial ACO initiatives.

Practitioners within each participating HSAs are eligible.

Patients are prospectively attributed to participating practitioners.

- OneCare Vermont is currently the sole ACO operating in the state. The Model supports risk-sharing arrangements and population-based payments that flow through OneCare Vermont to participating hospitals.
- Participating payers in performance year (PY) 1 (2018) and PY2 (2019) include Medicare, Medicaid, and Blue Cross Blue Shield of Vermont.
- Hospitals in each HSA opt to participate in each ACO initiative; a subset participate in all three.
- The Medicare ACO initiative has limited presence in Vermont's rural areas. Only two of eight critical access hospitals (CAHs) participated in the Medicare ACO initiative.

	PY1 (2018)	PY2 (2019)
Hospitals		
Total # eligible	15	15
Any ACO initiative	67% (10)	87% (13)
All 3 ACO initiatives	40% (6)	53% (8)
Practitioners		
Total # eligible	6,274	6,645
Any ACO initiative	67% (4,188)	74% (4,887)
All 3 ACO initiatives	38% (2,352)	40% (2,630)
Medicare Beneficiaries		
Total # eligible	113,272	113,743
Attributed to VTAPM	33% (36,860)	47% (53,973)

NOTE: Percentage is based on the total number of eligible hospitals, practitioners, or Medicare beneficiaries.

IMPLEMENTATION

- *Payment model*: While Medicaid's fixed prospective payment is widely supported across the state, the Medicare ACO initiative, which uses an all-inclusive population-based payment (AIPBP) reconciled against FFS claims, has limited hospitals' ability to achieve administrative efficiencies due to the lack of predictability around reconciliation .
- *Population health*: The Model allows for continued Medicare funding of existing Blueprint for Health initiatives. OneCare introduced a focus on care coordination for high- and very high-risk patients in particular. Hospitals, now assuming downside financial risk, are investing in additional population health initiatives.
- *Stakeholder collaboration*: The Model provides an important, unifying forum for providers, payers, and state-level stakeholders and is strengthening relationships between providers.

This document summarizes the evaluation report prepared by an independent contractor. To learn more about the VTAPM model and to download Evaluation Report 1, visit https://innovation.cms.gov/innovation-models/vermont-all-payer-aco-model.

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FINDINGS

The VTAPM reduced Medicare spending for beneficiaries in the ACO and statewide.

	Gross Medicare Spending, per beneficiary, per year		Net Medicare Spending, per beneficiary, per year		Net Percent Impact	
	ACO	State	ACO	State	ACO	State
PY1 & PY2	-$607*	-$783*	-$522	-$748***	-4.7%	-6.5%***
PY2	-$793*	-$1,182*	-$742*	-$1,168***	-6.8%*	-9.9%***
PY1	-$360	-$383	-$231	-$328	-2.2%	-2.9%

NOTES: The report only includes impact estimates for Medicare beneficiaries. Gross spending is the impact on Medicare Parts A & B spending; net spending is the impact on Medicare spending after accounting for CMS incentives to providers. *Statistically significant from 0% at p<0.10

- ACO-level results reflect the impact of the all-payer ACO framework beyond payer-specific ACO models that operated prior to VTAPM; state-level results reflect the impact of Vermont's statewide payment and delivery system reform initiatives.
- Observed reductions in Medicare spending reflect rising spending in the comparison groups and relatively flat spending in the VTAPM groups.

Reductions in PY2 hospital utilization contributed to Medicare spending reductions.

ACO		State
-17.9%*	Acute care stays	-9.3%*
-14.7%*	Acute care days	-9.3%*
-12.4%	30-day readmissions	-22.4%*

* Statistically significant from 0% at p<0.10

Specialist evaluation and management (E&M) visits declined in PY2, which may reflect the VTAPM's focus on care coordination along with a shortage of specialists in Vermont.

Use of home health (HH) services decreased, which likely reflects fewer opportunities for post-acute HH due to the decrease in acute care stays.

KEY TAKEAWAYS

- While the Vermont All-Payer Model failed to achieve its all-payer and Medicare scale target goals, in its first two performance years, **the Model achieved statistically significant Medicare gross spending reductions at both the ACO and state levels**, as well as Medicare net spending reductions at the state level.
- There were **declines in acute care stays** (at the ACO and state levels) and in **30-day readmissions** at the state level.
- These decreases in utilization and spending may reflect rising spending in the comparison groups and relatively flat spending in the VTAPM groups that began in the baseline period and continued into the first two performance years.