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Findings at a Glance

Vermont All-Payer ACO Model

Evaluation of the First Five Performance Years (2018-2022)

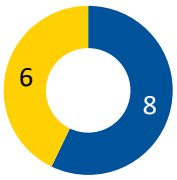
MODEL AND EVALUATION OVERVIEW

The Vermont All-Payer Accountable Care Organization (ACO) Model (VTAPM) tests how a state-specific, all-payer ACO program can incentivize broad delivery system transformation to reduce statewide spending and improve population health outcomes. The model was originally scheduled to end in 2022 but has been extended.

This evaluation report focuses on the impact of the model on the Medicare ACO-attributed population—as well as implementation progress and challenges across the state—in its first five performance years (PYs), from 2018 through 2022.

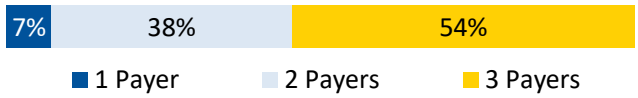
PY 5 (2022) PARTICIPATION

8 of 14 participating hospitals engaged in all three ACO payers (Medicaid, Medicare, and commercial)



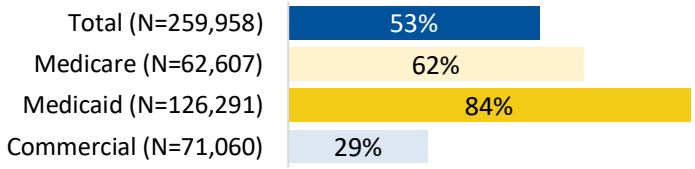
- Of the 6 hospitals that did not participate in the Medicare ACO, 5 were critical access hospitals (CAHs)
- Funds from each payer flow through OneCare (the only ACO participating in the model), which distributes payments to participating hospitals

Over half of the 5,452 clinicians in the model contracted with all three ACO payers



- Clinicians are eligible to participate in the model only if the hospital in their health service area is participating

Approximately half of eligible Vermonters were attributed to the model



- Almost one quarter of Vermonters attributed to the model are Medicare beneficiaries
- The Medicaid ACO had the widest reach, with 84% of eligible members covered by the model

SPENDING

The VTAPM Reduced Gross and Net Total Medicare Spending for ACO-Attributed Beneficiaries Through PY 5 (2018-2022)

	$ PBPY Impact	% Impact
Gross Spending	-$789**	-6.6%**
Net Spending	-$758**	-6.3%**

NOTES: PBPY = per beneficiary per year.
**Statistically significant at p<0.05.

- ***Gross spending*** *shows total Medicare spending change for the VTAPM relative to changes in the comparison group of Shared Savings Program beneficiaries.*
- ***Net spending*** *shows gross spending after adding shared savings payments to VTAPM and comparison providers.*

Statewide since the introduction of the VTAPM, **gross and net spending for all Vermont Medicare beneficiaries decreased**, regardless of whether they were attributed to the VTAPM (savings of $1,227 and $1,196 PBPY, respectively), potentially due to spillover effects of the model.

We observed a **decline in unadjusted per-member Medicaid spending** for ACO-attributed members from $4.5k in 2017-2019 to $3.3K in 2020-2021, likely due in part to the Medicaid ACO expanding its eligibility criteria to attribute members based on enrollment status instead of historical utilization starting in 2020.

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

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UTILIZATION, QUALITY, & POPULATION HEALTH OUTCOMES

Utilization & Quality

- OneCare and model participants initiated, expanded, and strengthened initiatives to **increase population health management capacity** and **reduce avoidable hospital utilization**.
- The **decrease in hospital utilization** for beneficiaries in the Medicare ACO may reflect the collective impact of many ongoing efforts, including model programs and external initiatives.
- **Specialty care visits decreased** during the COVID-19 pandemic and had yet to recover, which may be due to documented shortage of specialty care providers, increasing demand, and insufficient patient volume in rural areas to support a full-time specialty practice.

PY 5 (2022) Medicare ACO Impacts

- ↓ **Acute Care Stays***
- ↓ Acute Care Days
- ↑ ED Visits & Observation Stays
- ↓ Total E&M Visits
- ↑ Primary Care Visits
- ↓ **Specialty Care Visits***

Related Programs and Initiatives

- OneCare Complex Care Coordination Program
- OneCare Comprehensive Payment Reform Program
- Blueprint for Health and associated care coordination and community health teams
- Support and Services at Home
- More primary care access points
- Initiatives to connect frequent ED users with primary care
- Telehealth adoption/expansion

NOTES: E&M = evaluation and management. *Statistically significant at p<0.1.

Population Health

- Providers emphasized the value of the model in providing a **focal point for collaborative work** around care delivery transformation and population health initiatives.
- Vermont reported achieving its targets for addressing diabetes, hypertension, chronic obstructive pulmonary disease, asthma, and tobacco cessation—in line with ongoing **investments and collaboration across the state to reduce chronic disease**.
- State and local initiatives to address mental health and substance use disorder (SUD) contributed to reported improvements in initiation and engagement in treatment of alcohol and other drug dependence and follow-up after discharge from the ED for mental health.
- For attribution-eligible Medicaid enrollees, we observed **increases in SUD diagnoses and treatment** since 2016. However, a **decrease over time in the percentage of enrollees diagnosed with an SUD receiving treatment** indicates that the need for SUD treatment services may be outpacing the availability of services.

> "If you don't have a collectivist model, it doesn't work. You can't opt in and opt out. We're all in this together or it doesn't work… You need to change thinking, and you're not going to do that unless everybody is moving together on the same thing…"
>
> - CAH Leader

KEY TAKEAWAYS

- The VTAPM builds on the state's history of health reform and parallel reform efforts to drive progress on spending, utilization, and population health goals; as such, results should be interpreted considering these efforts over the last two decades and likely reflect longer-term effects of those efforts, in addition to effects from this model.
- VTAPM participants focused on preventing avoidable acute care, which likely contributed to reduced hospital admissions.
- Statewide and community-level population health initiatives may have contributed to the state meeting many of the VTAPM's quality performance targets. Contributing efforts may not have been funded or otherwise determined by the model or OneCare.
- The model has faced challenges in scaling value-based care due to limited model participation in all three payer ACO initiatives and variation in payment mechanisms across payers. Financial constraints, administrative burden, and access to timely data were barriers to population health efforts.
- Overall, the model improved understanding and acceptance of value-based care among providers and inspired collaborative population health initiatives.