First Evaluation Report
Vermont All-Payer Accountable Care Organization (ACO) Evaluation

November 5, 2021

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Agenda

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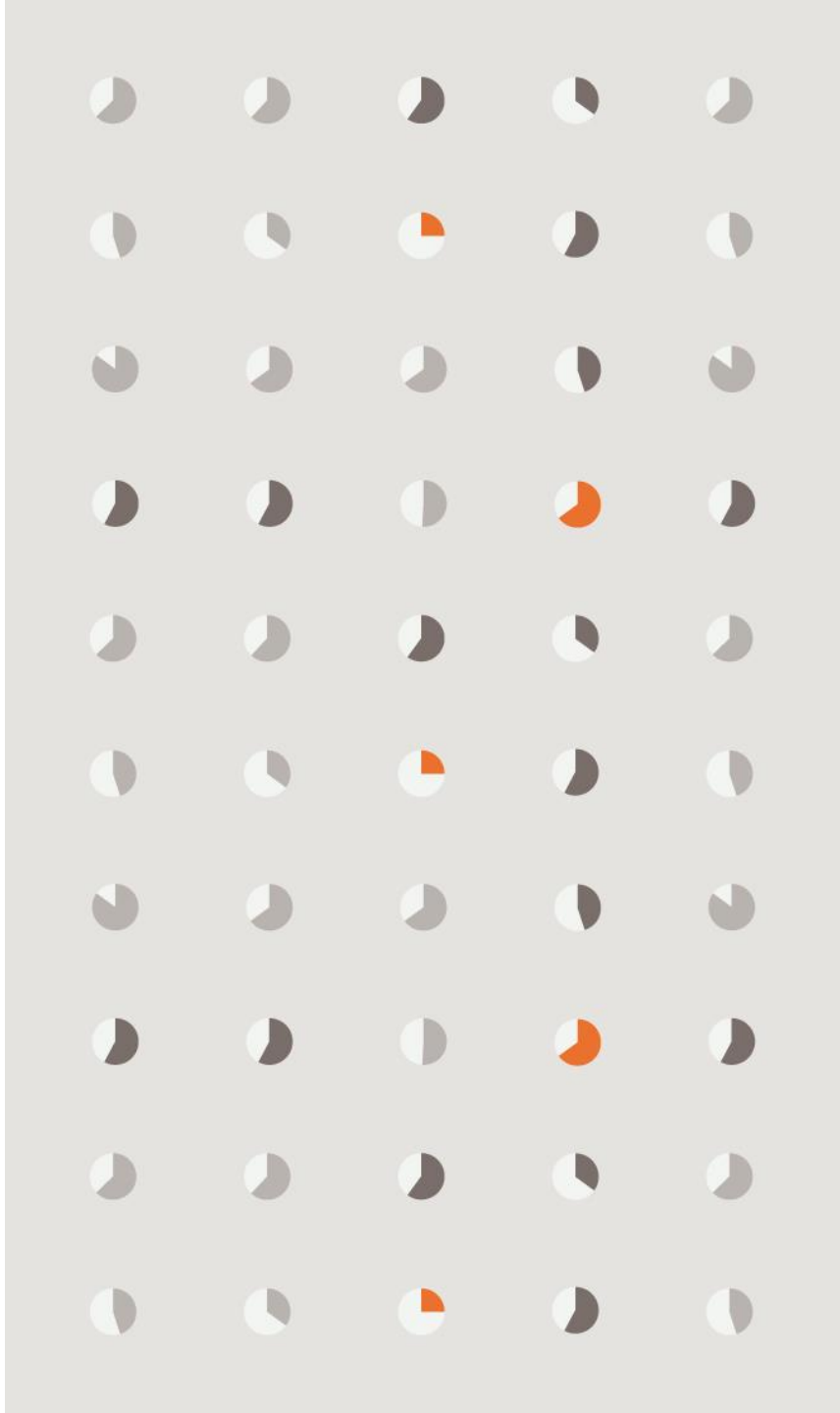

Evaluation Approach and Design Considerations

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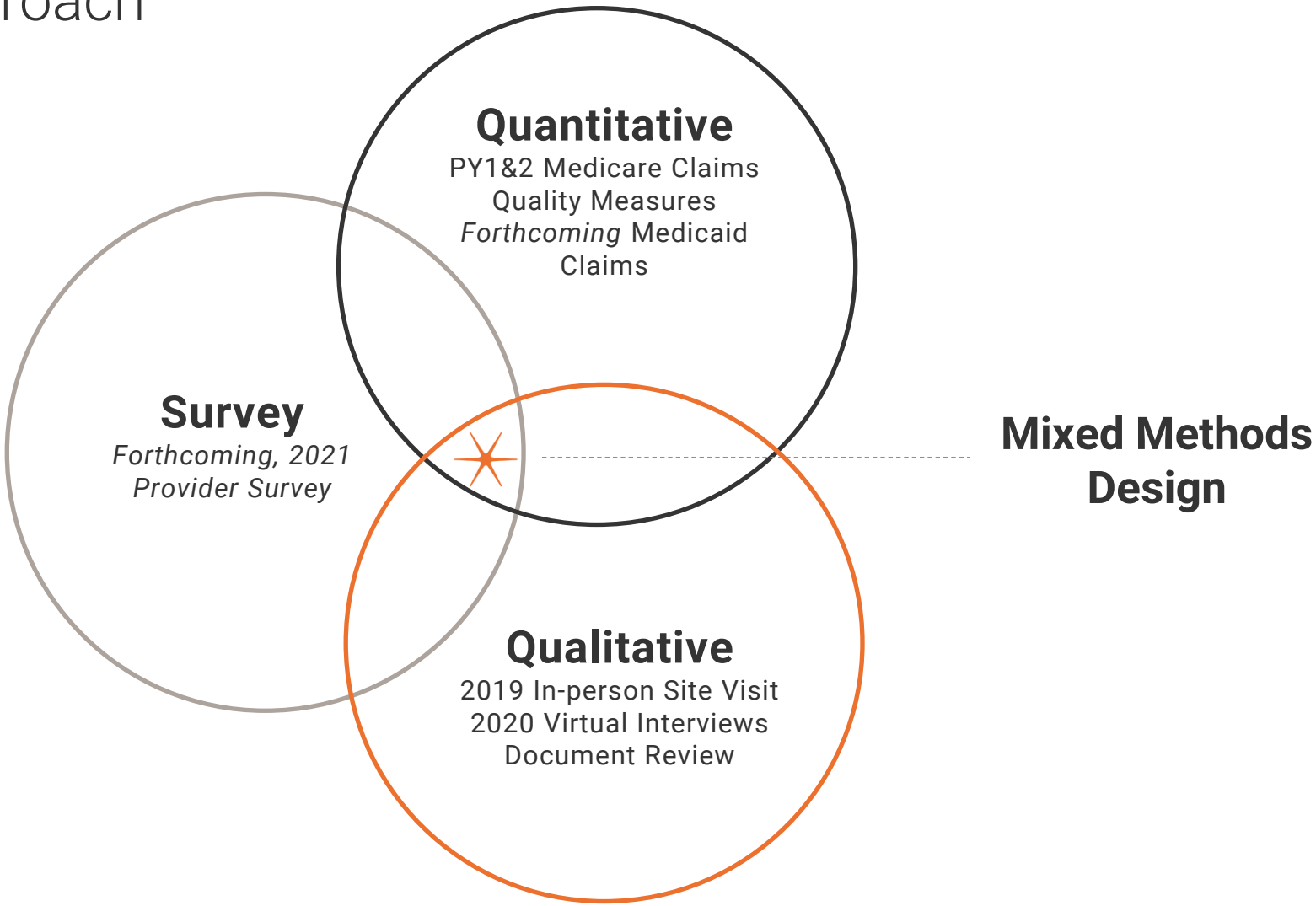
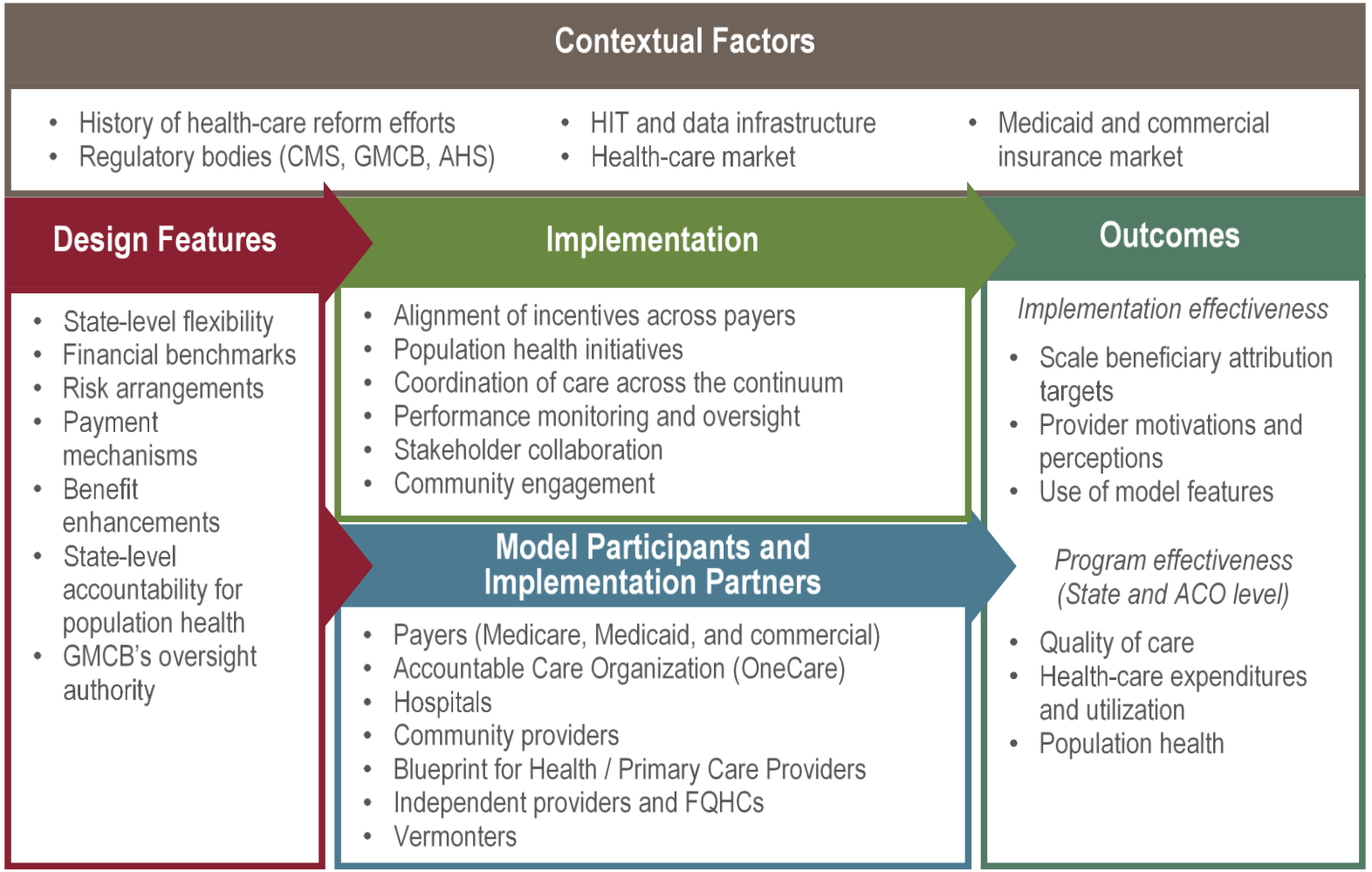
Evaluation Objectives

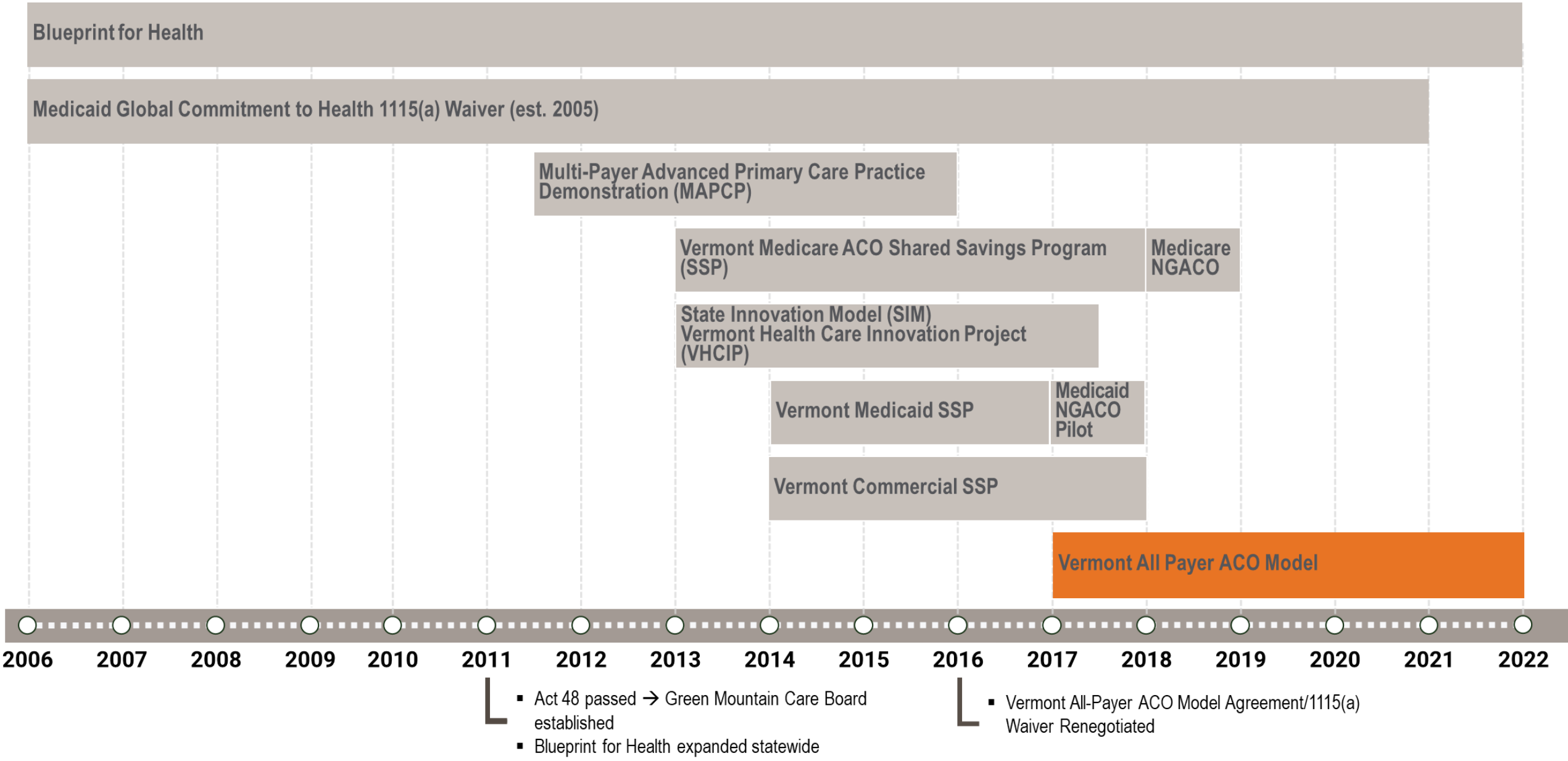
- Impact of the Model on: population health outcomes, statewide spending by payer (Medicare and Medicaid), and other measures of health-care utilization, spending, and quality of care
- Implementation challenges and successes
- Potential replicability in other settings and sustainability over time

Overview of Approach



Conceptual Framework




Blueprint for Health
Medicaid Global Commitment to Health 1115(a) Waiver (est. 2005)
Multi-Payer Advanced Primary Care Practice Demonstration (MAPCP)
Vermont Medicare ACO Shared Savings Program (SSP)
Medicare NGACO
State Innovation Model (SIM) Vermont Health Care Innovation Project (VHCIP)
Vermont Medicaid SSP
Medicaid NGACO Pilot
Vermont Commercial SSP
Vermont All Payer ACO Model
2006
2007
2008
2009
2010
2011
2012
2013
2014
2015
2016
2017
2018
2019
2020
2021
2022
Act 48 passed → Green Mountain Care Board established
Blueprint for Health expanded statewide
Vermont All-Payer ACO Model Agreement/1115(a) Waiver Renegotiated

Scope of First Evaluation Report

Program Design

- How ACO program design features compare across payers and to other Medicare ACO programs
- Key issues for the Green Mountain Care Board (GMCB) when setting the trend factor for the benchmark of the modified Next Generation ACO/Vermont Medicare ACO initiative

Implementation

- How the health-care delivery and public health systems are collaborating to reach the population-level health goals
- How the GMCB uses its regulatory authority to influence ACO care management programs and organizational structure
- Influence of the Model's key design features on care delivery transformation; challenges participating providers are encountering
- How program design features impact implementation at the community level

Participation

- Characteristics of beneficiaries and providers in the Model across performance years (PYs)
- How the state, ACO, and payers are working together to reach the statewide ACO targets and barriers they are encountering

Outcomes

- Change in population health measures during the performance period
- Impact of the Model on statewide Medicare spending, utilization, and quality of care outcomes
- Impact of the Model on spending, utilization, and quality-of-care outcomes for ACO-attributed Medicare beneficiaries

Overview of Impact Analysis Design

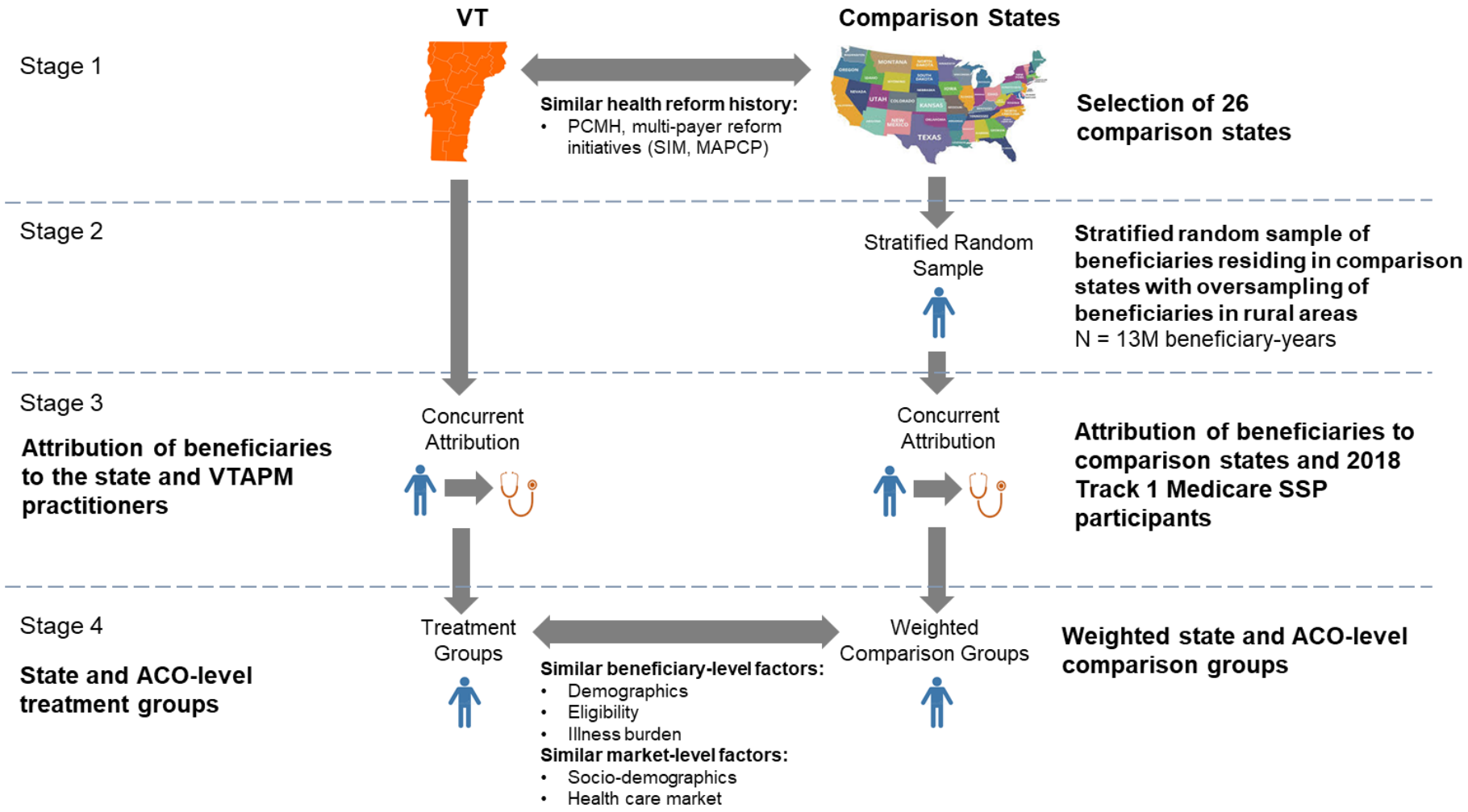
We conducted a quasi-experimental difference-in-difference (DID) analysis to assess impact on Medicare spending, utilization, and quality of care in PY1 (2018) and PY2 (2019).

The Model has multiple layers of accountability and incentives; for this reason, we estimate the Model's impact at two levels:

	ACO-Level	State-Level
Question	Is the Vermont All-Payer Model Medicare ACO initiative achieving spending, utilization, and quality of care, goals *for its attributed Medicare beneficiaries?*	Is Vermont achieving spending, utilization, and quality-of-care goals *for the Medicare population statewide?*
Treatment Group	• Medicare fee-for-service (FFS) beneficiaries • Residing in Vermont • Receiving the plurality of their primary care services **from Model practitioners** during the BYs and PYs	• Medicare FFS beneficiaries • Residing in Vermont • Receiving the plurality of their primary care services **within the state** during the BYs and PYs
Comparison Group	Medicare FFS beneficiaries attributed to Track 1 Shared Savings Program (SSP) ACOs in 26 comparison states with similar histories of health reform as Vermont.	Medicare FFS beneficiaries residing in states that have similar health reform histories as Vermont.

NOTE: BYs= Base Years (2014-2016); PYs = Performance Years (PY1=2018, PY2=2019)

Comparison Group Construction



Vermont's distinct socio-demographics, health-care market, and health-reform history complicate the identification of a comparison group.

Challenge	Mitigation Strategy
Limited pool of comparison beneficiaries similar to Vermonters and reside in regions similar to Vermont	Utilized entropy balancing methods to minimize differences in area- and beneficiary-level characteristics between the Vermont and comparison groups
Lack of common baseline trends	Utilized a flexible DID specification that allows for different baseline trends between the Vermont and comparison groups
Lack of covariate balance on key market-level characteristics	Limited the ACO-level comparison group to Medicare beneficiaries attributed to Track 1 SSP providers; however, sizable differences in Medicare Advantage penetration rate and upside-risk ACO rate remained.
Delayed impacts of baseline initiatives	Selected comparison states with similar health reform initiatives in the baseline; provided context in the report around baseline initiatives and how their delayed impacts may be contributing to early findings.

Qualitative Data

2019 In-Person Site Visit

n = 21

- State-level officials (AHS, BCBS, Blueprint, GMCB, Medicaid)
- OneCare leadership
- Limited interviews with stakeholders in community-based health service areas (HSAs)
- Independent practitioners
- Individuals employed by designated mental health agencies

2020 Virtual Interviews

n = 33

- State-level officials
- OneCare leadership
- Blueprint program managers from 10 HSAs
- Hospital and Federally Qualified Health Center (FQHC) leadership
- Employed and independent practitioners

Document Review

- ACO budget documents
- Hospital budget documents
- GMCB reports and presentations
- Blueprint reports

Participation

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Model Participation Mechanisms

- Payer and provider participation is voluntary
- Hospitals, as the risk-bearing entities, can opt to participate in one or more the Model's payer initiatives
- Other (non-hospital) health care providers are eligible for participation only if the hospital in the health service area (HSA) opts to participate
- Practitioners in the eligible HSA can opt to participate in one or more the Model payer initiatives
- To achieve the scale targets, the Model requires increased participation from hospitals as well as eligible providers with attribution eligible specialties

Payers opt to participate in the Model

Hospitals within each HSA opt to participate in each of the Model's ACO initiatives (Medicare, Medicaid, and/or Commercial)

Practitioners within each participating HSA are eligible

Patients of participating practitioners are prospectively attributed

Payer Participation

- While the Model is designed to include Vermont's major public and commercial insurers, BlueCross and BlueShield of Vermont (BCBSVT) was the only commercial payer in the Model in PY1 (2018) and PY2 (2019)
- While the University of Vermont Medical Center (UVMMC) self-insured plan participated beginning in PY1, the two largest self-insured plans (Vermont teachers' union and the State Employees' Health Care Plan) did not participate in PY1 or PY2

Hospital Participation

- 8 of 15 eligible hospitals participated in all three payer models in PY2
- Critical Access Hospitals (CAHs) were reluctant to participate in the Medicare ACO initiatives due to: (1) concerns about risk, and (2) lack of guidance regarding alignment with cost-based reimbursement.

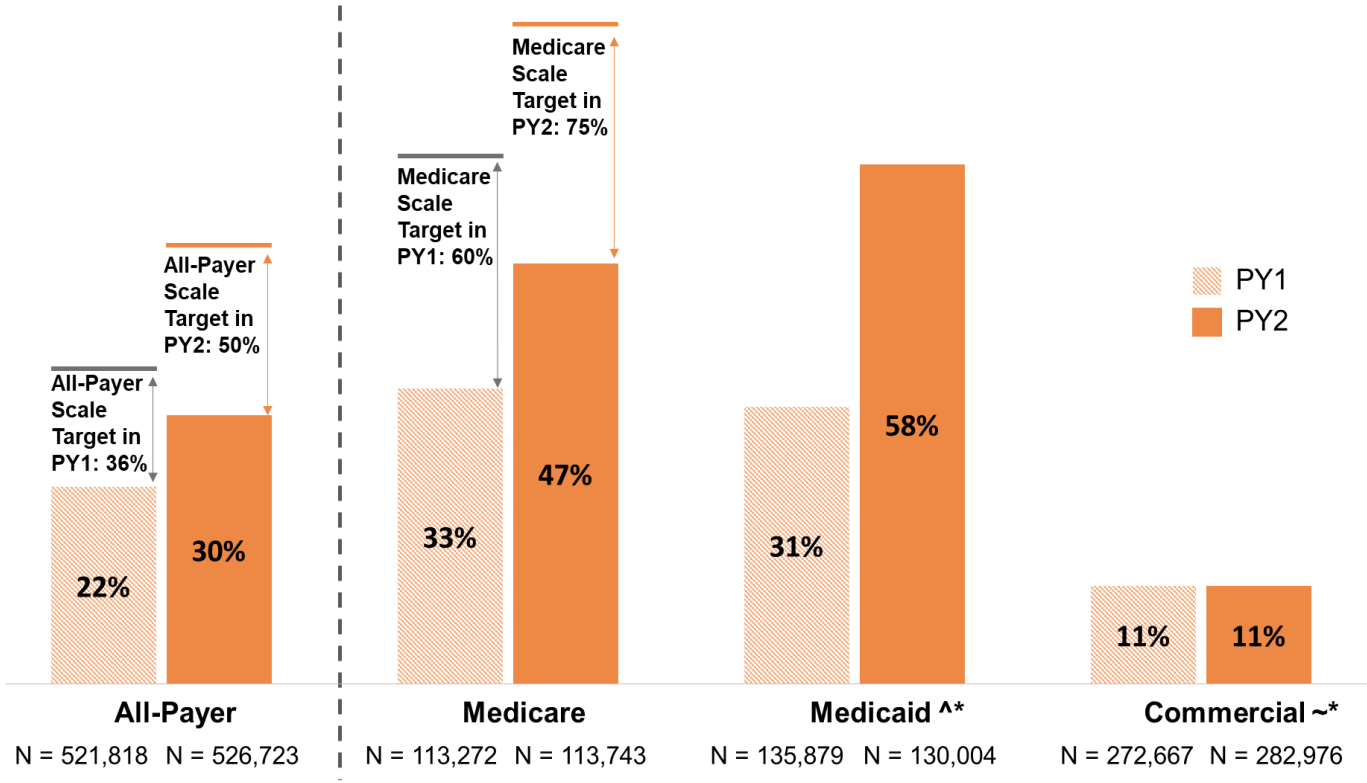
Practice- and Practitioner-Level Participation

- Practitioner participation in the Model increased between PY1 (2018) and PY2 (2019)
- There was only a small increase in the number of practitioners who participated in all participating payer initiatives, mirroring that of the hospitals
- The Medicare ACO initiative has limited presence in the state's more rural areas
- Most providers continue to have a majority of their revenue in FFS, which is an additional barrier to widespread delivery system transformation

Scale Target Performance

- The Model did not meet the All-Payer and Medicare scale targets in PY1 and PY2.
- All-Payer, Medicare, and Medicaid participation increased from PY1 to PY2.
- Commercial participation remained low in PY2.

Scale Target Performance – GMCB Analysis

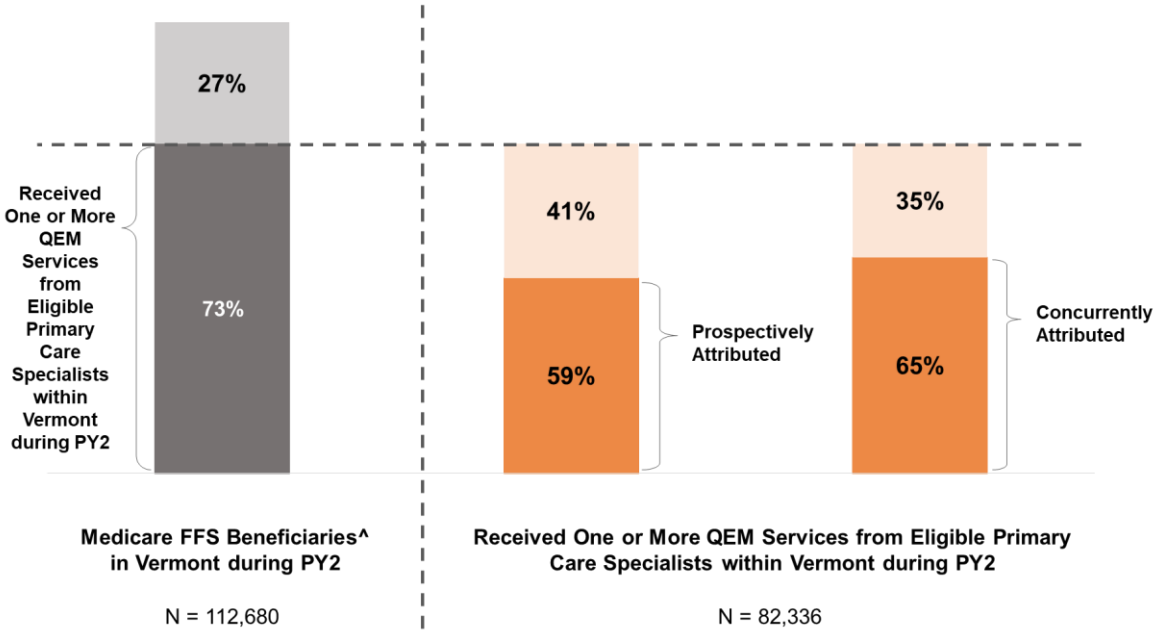


SOURCE: GMCB Vermont All-Payer ACO Model Annual ACO Scale Targets and Alignment PY1 and PY2 Reports.
NOTE: ^ Exclusion of Medicaid recipients with evidence of third-party coverage, limited Medicaid benefits package, or who are dually eligible; ~ Commercially insured members include self-insured employers, fully insured, and Medicare Advantage plans. Members of insurance plans that do not have a Certificate of Authority from Vermont's Department of Financial Regulation are excluded; * Expected Attribution Rate not available. Counts below the labels in graphic represent the total population for each category (denominator).

Medicare Scale Target Performance

- Over 25% of the attribution-eligible Medicare beneficiary population in Vermont did not receive any qualifying evaluation and management (QEM) services within the state.
- NORC assessed the Model's scale target performance after excluding beneficiaries who have no opportunity to be attributed to the Model and assessing the ACO provider network's reach during the performance year.
- The ACO provider network covered about 65% of the eligible Medicare beneficiaries in PY2, still falling short of the Model's scale target goal of 75%.

The Evaluation's Approach to Assessing Medicare Scale Target Performance



SOURCE: NORC analysis of Medicare claims data.
NOTE: ^ FFS Part A & B coverage, no Medicare Advantage coverage during the year, and Medicare was not a secondary payer at any point during the year. Counts below the labels in the graphic represent the total population for each category (denominator).

Implementation

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Implementation of the Payment Model

- The Medicaid ACO initiative's prospective, population-based payment was perceived as innovative, and was widely supported across the state.
  - Stakeholders at all levels suggested that COVID-19 demonstrated value of true capitation as in the Medicaid program.
- Neither state-level stakeholders nor providers understood at the outset that, in contrast to the Medicaid model, the Medicare All-Inclusive Population-Based Payments (AIPBP) was reconciled with FFS claims at the end of the year and does not use full capitation. This has been administratively challenging for hospitals, and a barrier to increasing population health investments.

- State-level stakeholders and hospital leaders underscored the challenge of operating in both FFS and value-based payment models simultaneously.

Improving Population Health

- The model enabled continued funding and administrative support for the Blueprint initiatives (e.g., Patient-Centered Medical Homes, Community Health Teams, Support and Services at Home) that serve the entire community, not only ACO-attributed beneficiaries.
- PY1 and PY2 payments were intended to build capacity for care coordination; however, provider and community organizations were reluctant to hire staff without certainty around the future of the Model.
- The Model is beginning to strengthen relationships between hospitals, community organizations, designated mental health agencies, primary care practices, and other providers.

> "I feel like [the Model has] been an avenue to bring us to the table in a more collaborative way. I feel like the hospital has reached out in a more collaborative way to a variety of partners."
>
> **– Local health department leader**

Provider Engagement

- The Model has not fully engaged CAHs, FQHCs, independent clinicians, and non-hospital providers.

"These programs seem to be happening around us rather than with us. We don't really feel part of the design or the implementation."

– Independent Practitioner

"You don't practice rural medicine because you want to get rich."

- FQHC Administrator

Impact

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The Vermont All-Payer Model reduced Medicare spending for beneficiaries in the ACO and statewide.

- **ACO-level** results may reflect the impact of the all-payer ACO framework beyond payer-specific ACO models that operated prior to the Model.
- **State-level** results may reflect the impact of Vermont's statewide payment and delivery system reform initiatives.
- **Gross spending** is the impact on Medicare Parts A & B spending.
- **Net spending** is the impact on Medicare Parts A & B spending after accounting for CMS incentives to the Model and comparison providers in the baseline and performance periods.

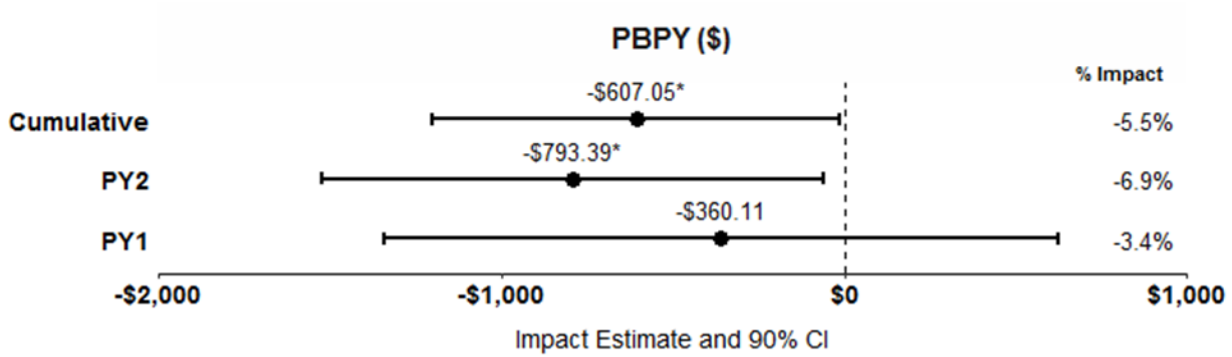
	Medicare Spending, PBPY		Net % Impact
	Gross	Net	
ACO			
PY1 & PY2	-$607*	-$522	-4.7%
PY2	-$793*	-$742*	-6.8%*
PY1	-$360	-$231	-2.2%
State			
PY1 & PY2	-$783*	-$748***	-6.5%***
PY2	-$1,182*	-$1,168***	-9.9%***
PY1	-$231	-$328	-2.9%

NOTES: PBPY = Per Beneficiary Per Year. *p<0.10; **p<0.05; ***p<0.05.

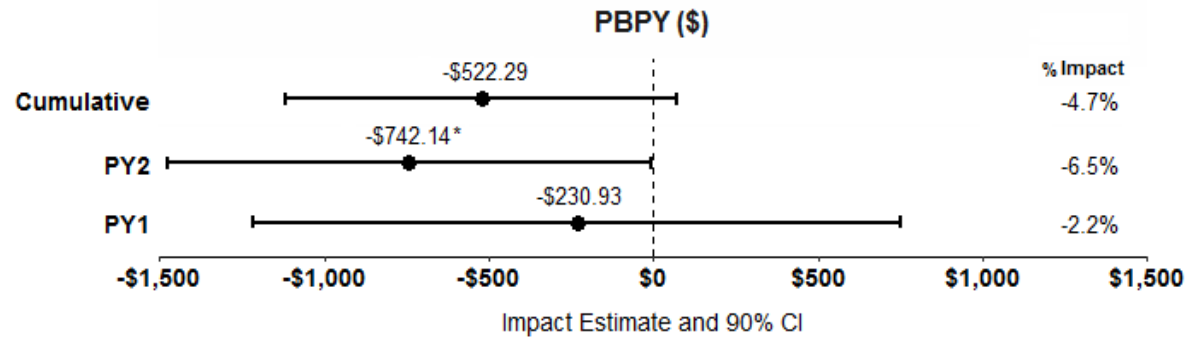
Gross Medicare spending decreased across PY1 and PY2 for beneficiaries in the ACO and statewide, and net Medicare spending decreased for the statewide population.

ACO Level

GROSS IMPACT

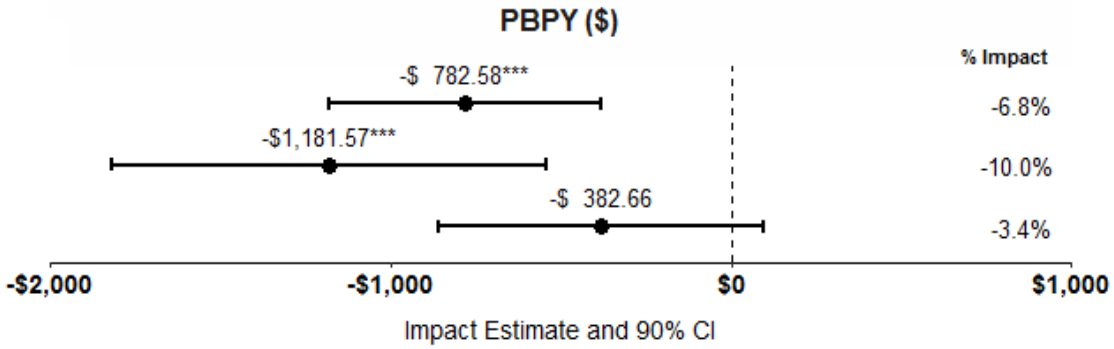


NET IMPACT

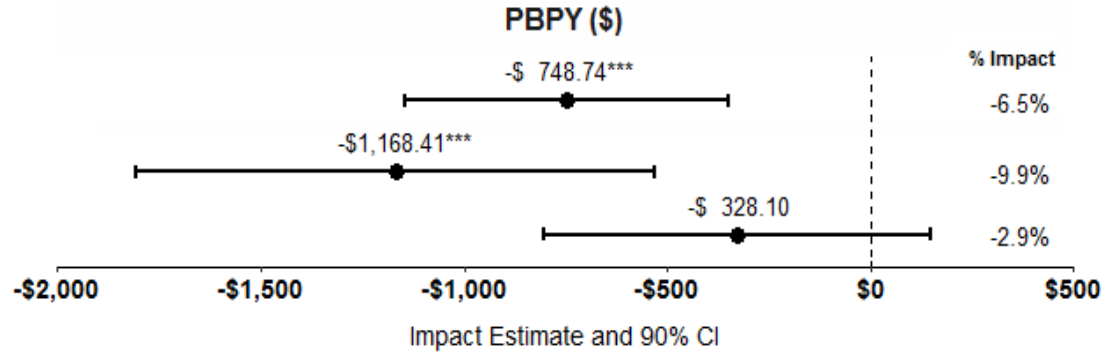


State Level

GROSS IMPACT



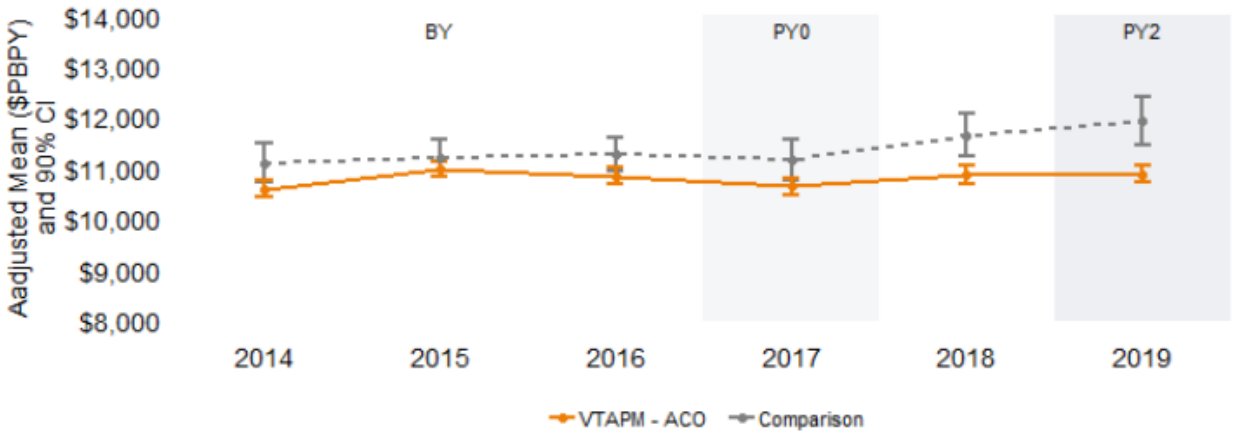
NET IMPACT



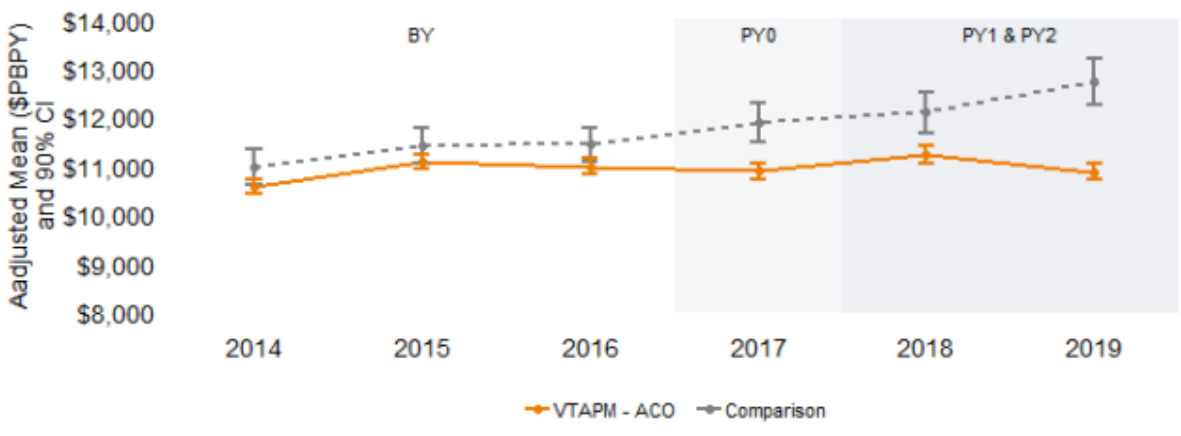
SOURCE: Analysis of Medicare claims data by NORC.
NOTE: Impacts are presented per beneficiaries per year (PBPY). Asterisks denote significance at *p<0.10, **p<0.05, ***p<0.01.

Observed reductions in Medicare spending reflect rising spending in the comparison groups and relatively flat spending in the Model groups during the first two PYs.

ACO Level



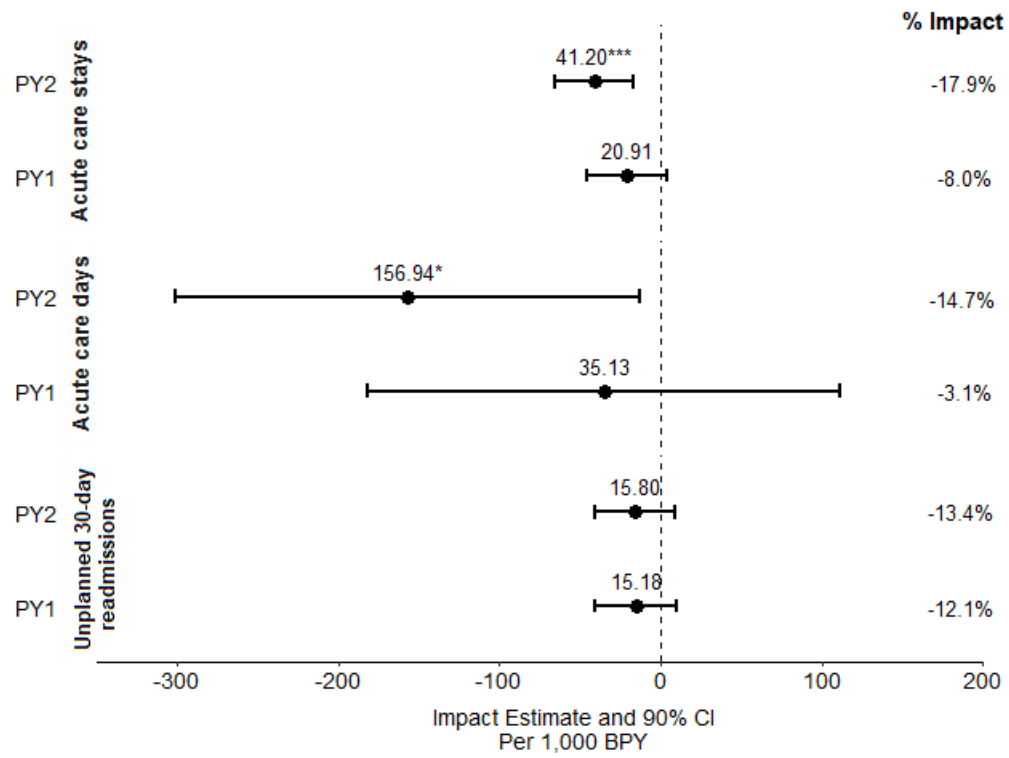
State Level



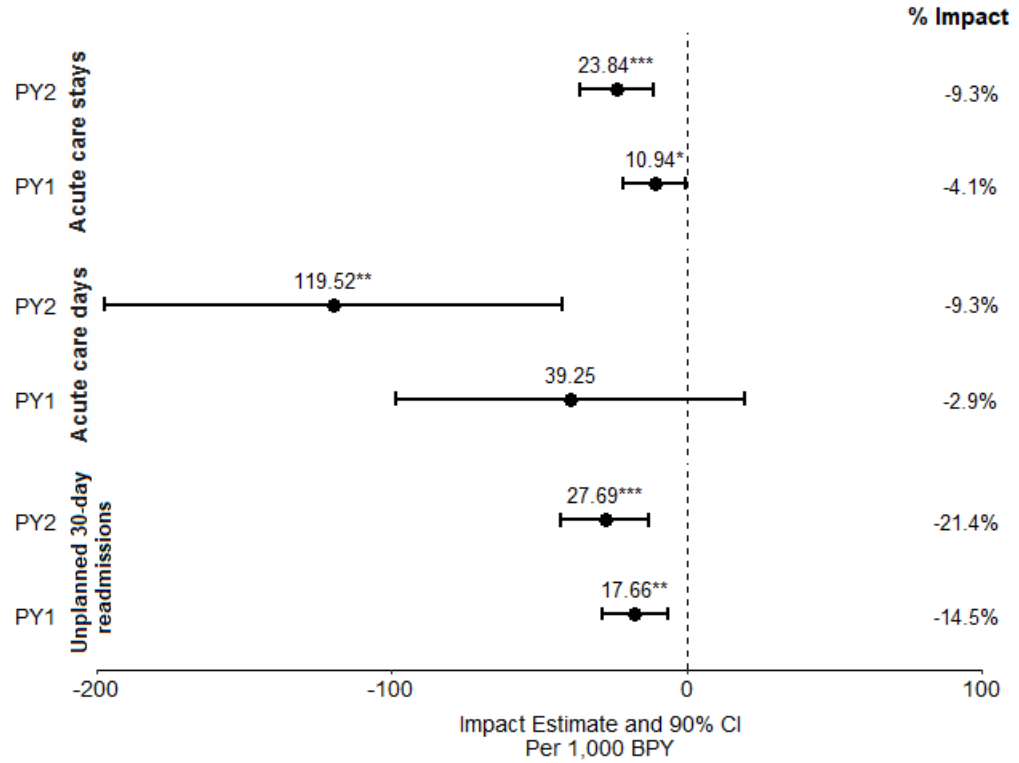
SOURCE: Analysis of Medicare claims data by NORC.
NOTE: Impacts are presented per beneficiaries per year (PBPY). Asterisks denote significance at *p<0.10, **p<0.05, ***p<0.01.

Acute care stays and days decreased in PY2 for the Model's Medicare ACO and statewide Medicare populations, as did 30-day readmissions for Vermont beneficiaries in both PYs.

ACO Level



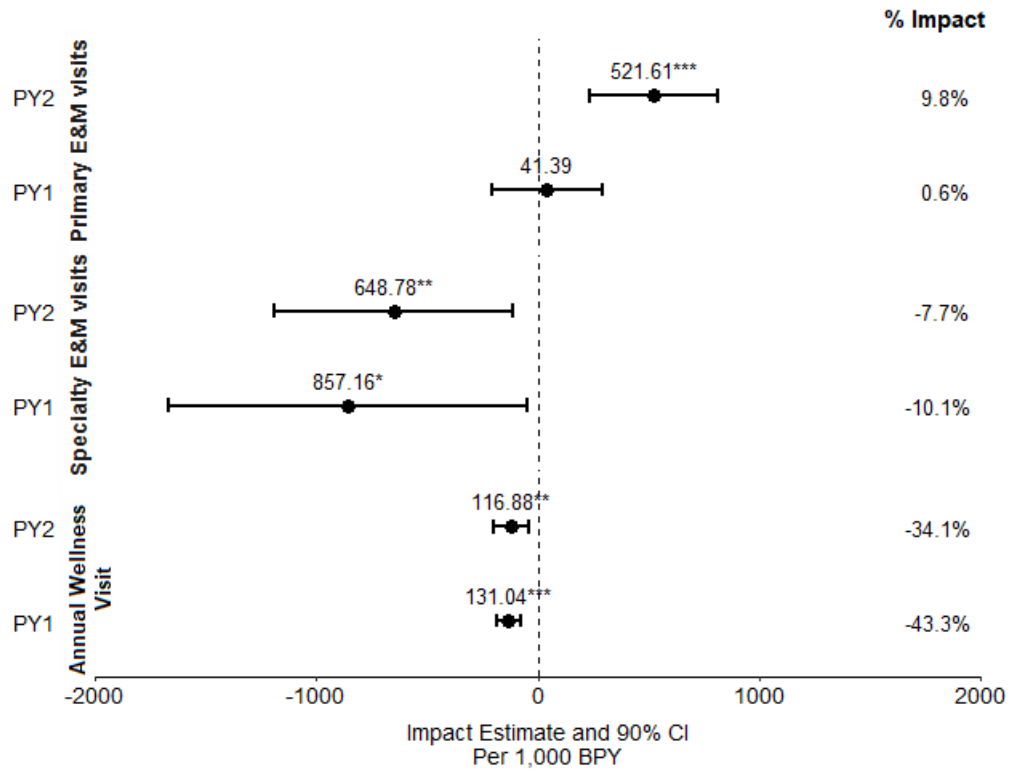
State Level



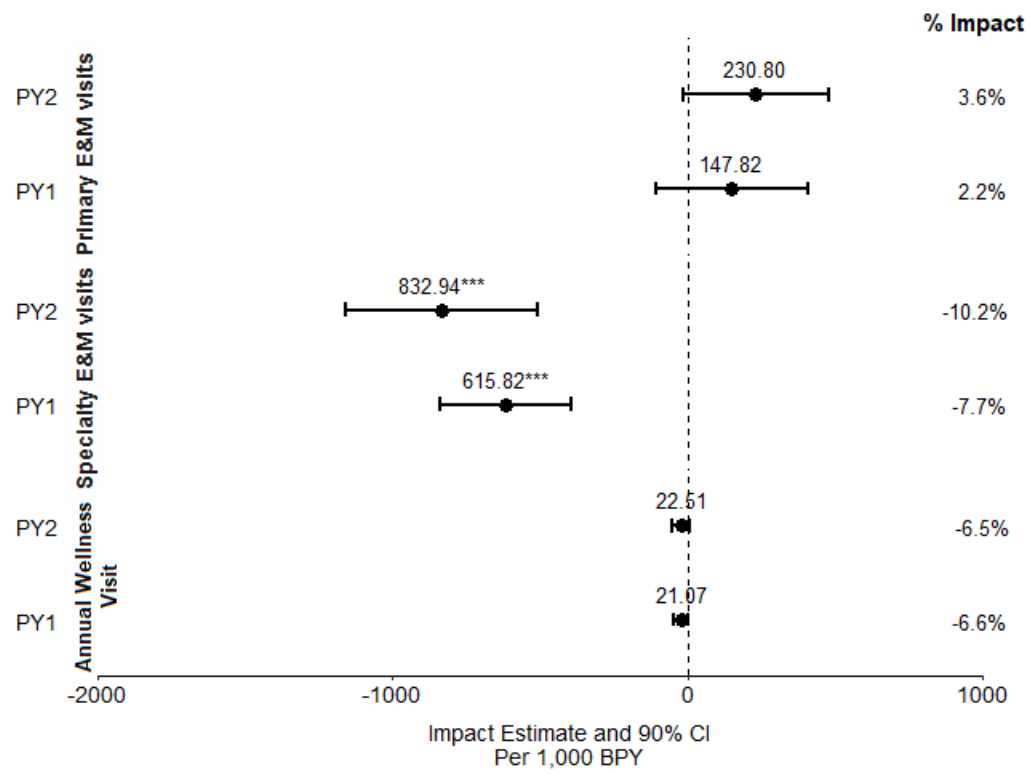
SOURCE: Analysis of Medicare claims data by NORC.
NOTE: Impacts are per 1,000 beneficiaries per year (BPY). Asterisks denote significance at *p<0.10, **p<0.05, ***p<0.01.

Specialty Evaluation and Management (E&M) visits decreased for the Model's Medicare ACO and statewide Medicare populations; annual wellness visits decreased for the Medicare ACO population.

ACO Level



State Level



SOURCE: Analysis of Medicare claims data by NORC.
NOTE: Impacts are per 1,000 beneficiaries per year (BPY). Asterisks denote significance at *p<0.10, **p<0.05, ***p<0.01.

Summary of Key Findings

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Key Findings

- Despite achieving limited scale, the Model reduced Medicare spending during the first two performance years.
- Lack of widespread understanding of the Model, perceived lack of transparency, and distrust have contributed to challenges engaging practitioners and the public.
- The model provides an important, unifying forum for providers, payers, and the state to engage in meaningful discussions about health-care reform and setting goals.
- Transformation will require a more comprehensive transition to value-based payment and a focus on upstream investments that address social determinants of health (SDOH).

Thank you.

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