Vermont SIM Initiative

Award
$45 million

Period of performance
October 1, 2013 – June 30, 2017

Pre-SIM Landscape

Medicaid Managed Care
Through its "Global Commitment" 1115 waiver, Vermont functions as the managed care entity for its Medicaid enrollees.

Health Information Exchange
Established in 2007 through the Office of the National Coordinator for Health Information Technology to support meaningful use.

Patient-Centered Medical Home Model
All major commercial and public payers have participated in Blueprint for Health since 2008.

Green Mountain Care Board
Independent entity tasked with expanding health care reform and moderating costs through regulation, innovation, and evaluation.

Accountable Care Organizations
Two ACOs began full-year participation through the Medicare Shared Savings Program in 2013.

Strategies

Symbols represent strategies that build on efforts that pre-date SIM.

Support practice transformation
Vermont supported providers via innovation grants and learning collaboratives.

Expand ACO models
Vermont piloted new Shared Savings Programs for its Medicaid and commercially insured populations, that later evolved into an all-payer ACO model.

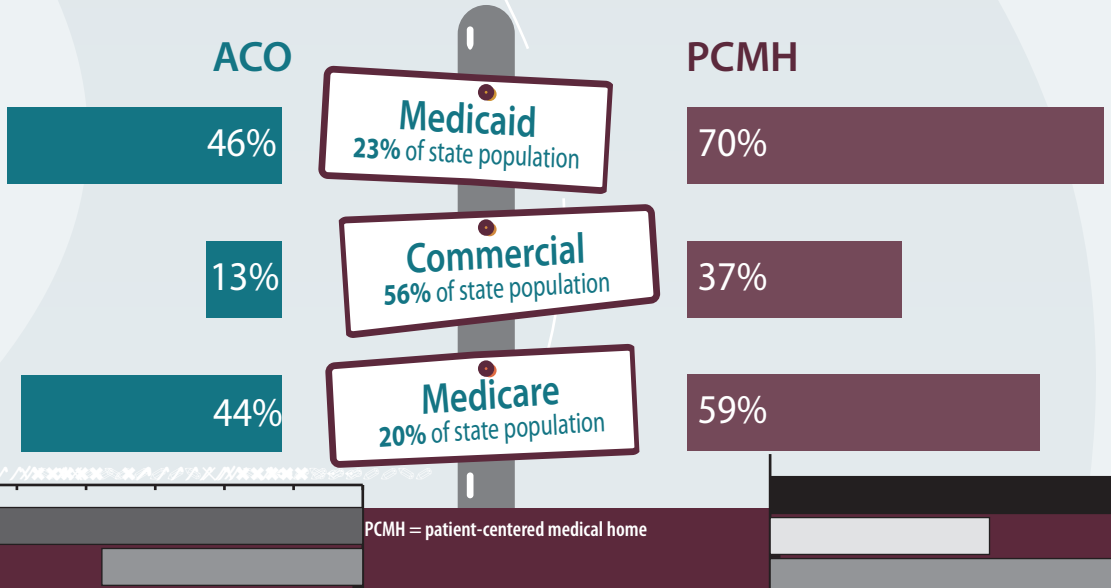
Incentivize quality
Vermont implemented a pay-for-performance program to improve quality and better support Blueprint for Health providers financially.

Strengthen health data infrastructure
Vermont invested in EHR expansion and HIE connectivity and implemented a behavioral health data repository, event notification system, and telehealth pilots.

Reach

as of December 2016

Nearly half (46%) of Vermont's total Medicaid population was served by the state's ACO model.



ACO = accountable care organization; EHR = el PCMH = patient-centered medical home

Impact on Medicaid Population

✔ = Performed better than the CG
✘ = Performed worse than the CG
● = No statistically significant change

Goals

Shared Savings Program

Better Care Coordination

- ✔ Specialty provider visits
  Decreases in specialty care visits could indicate conditions are being managed.
- ● Mental health follow-up visit within 7 days/30 days of mental illness inpatient hospital admission
- ● Primary care provider visits
  The ACO model was expected to increase primary care visits to prevent inappropriate use of higher-cost settings.

Increased Quality of Care

- ✔ Young child developmental screenings
- ● Adolescent well-care visits
- ● Initiation/engagement of treatment after episode of alcohol and other drug dependence

Appropriate Utilization of Services

- ✔ ED visits
  ACOs targeted reducing unnecessary use of the ED to help control costs.
- ✔ Inpatient admissions
- ● 30-day readmissions

Lower Total Spending

- ✔ Inpatient PBPM spending
- ✔ Professional PBPM spending
- ✔ Total PBPM spending
  While total and inpatient facility PBPM spending increased, the increase was lower for Medicaid patients in the Medicaid SSP group than the comparison group.

Improved Population Health

Vermont explored the Accountable Communites for Health model, whch focuses on all patients' health within a geographic area. The state included population health measures in its new All-Payer ACO Model.

Limitations

Because the Medicaid SSP builds on and complements Vermont's strong existing health reform initiatives, including the Blueprint for Health, positive results cannot be attributed solely to ACO and SIM Initiative efforts.

Attributing comparison group providers who participated in the commercial SSP could bias the results to the null. Attributing comparison group providers who chose not to participate in any ACO could bias the results away from the null.

Population changes (e.g., Medicaid expansion) may have affected the Medicaid SSP and comparison groups differently. This was mitigated through propensity score weighting of the samples each year to balance on key characteristics.

Lessons Learned

- ☑ Vermont's efforts were accelerated by the prior foundation of reforms and the existing infrastructure.
- ☑ Wide-scale, state-based reforms require willingness to adapt to evolving priorities and needs.
- ☑ Stakeholder engagement requires significant staff resources and is critical to gaining buy-in and sustaining momentum for reforms.

ACO = accountable care organization; CG = comparison group; ED = emergency department; PBPM = per beneficiary per month; SSP = Shared Savings Program

Table ES-1. Summary of outcomes for payment and delivery models reaching Medicaid beneficiaries during the SIM Initiative

Model name (in order of greatest to fewest positive outcomes)	Years of post-period data used for analysis	Utilization measures	Expenditure measures	Quality measures
 Vermont SSP (ACO model)	3	+	+	+
 Maine Accountable Communities (ACO model)	2	+	NS	NS
 IHPs (Minnesota-specific Medicaid ACO model)	3 (expenditures) 4 (utilization)	+ and -	NS	+ and -
 Arkansas Upper Respiratory Infection Episodes of Care	2	-	[No data]	+
 Arkansas Perinatal Episodes of Care	2	+ and -	[No data]	Most +
 Oregon PCPCH (PCMH model) [a, b]	>2 for majority of practices	NS	NS	Few +
 Massachusetts PCPRI (PCMH model) [a,c]	2	-	-	NS

ACO = accountable care organization; AR = Arkansas; IHP = Integrated Health Partnership; MA = Massachusetts; ME = Maine; MN = Minnesota; OR = Oregon; PCMH = patient-centered medical home; PCPCH = Patient-Centered Primary Care Home; PCPRI = Primary Care Payment Reform Initiative; SSP = Shared Savings Program; VT = Vermont.

+ / green box = Changes were statistically significant in the expected direction (relatively lower emergency department and inpatient utilization and total expenditures, relatively better performance on quality of care measures).

- / light red box = Changes were statistically significant in the unexpected direction (relatively higher emergency department or inpatient utilization and total expenditures, relatively worse performance on quality of care measures).

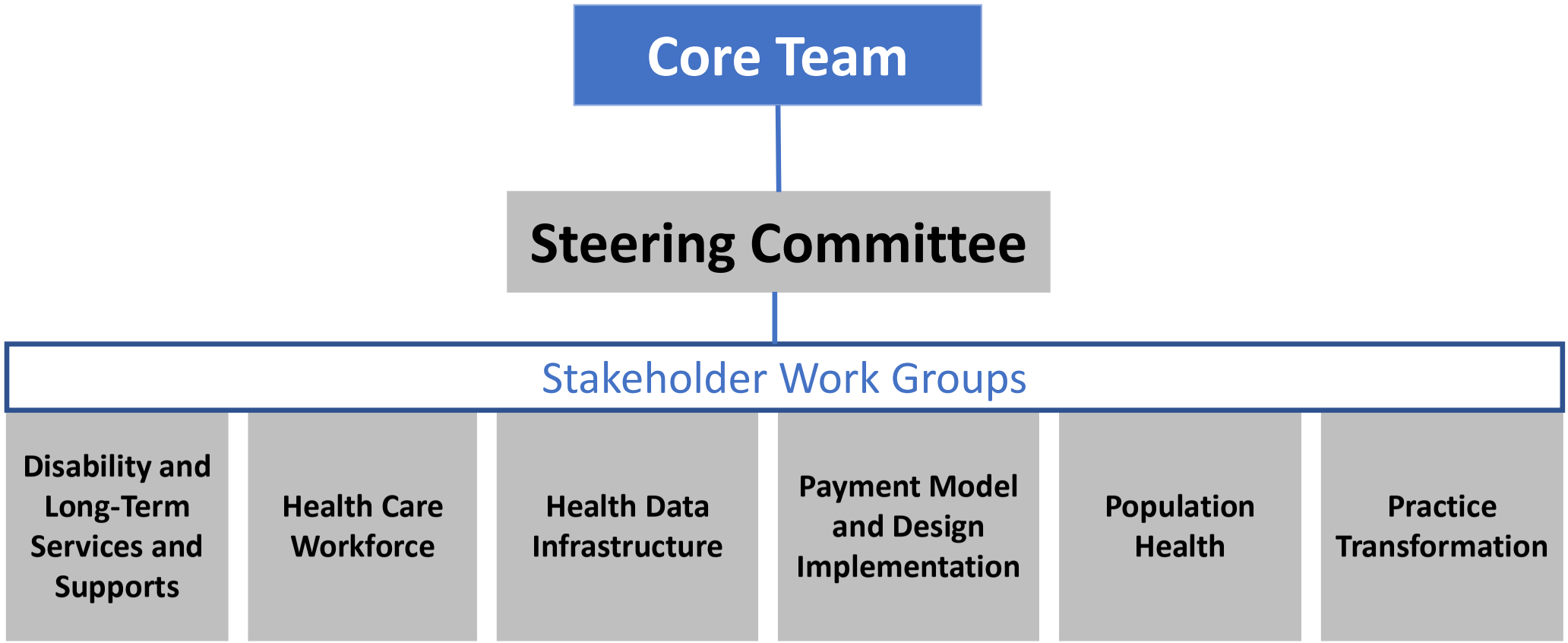
+ and - / yellow box = Statistically significant changes, some in expected direction and some in unexpected direction.

NS / gray box = Nonsignificant changes.

[a] The analyses in Massachusetts and Oregon were presented in the Year Four Annual Report (RTI International, 2018).

[b] Although the Oregon analysis includes four payers, we focus on the Medicaid results in this table because more than half of Medicaid Coordinated Care Organizations made incentive payments to PCPCHs during the period of analysis for this report.

[c] We classify the PCPRI model as a PCMH model because it is a primary care–based model. However, the model does have aspects of an ACO model also because it holds providers accountable for total cost of care (one-sided risk) and non–primary care services (two-sided risk).


Core Team
Steering Committee
Stakeholder Work Groups
Disability and Long-Term Services and Supports
Health Care Workforce
Health Data Infrastructure
Payment Model and Design Implementation
Population Health
Practice Transformation