Vermont All-Payer ACO Model
Annual Health Outcomes and Quality of Care Report
Performance Year 4 (2021)

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Green Mountain Care Board

1. Executive Summary

Section 7.e of the APM Agreement, Annual Health Outcomes and Quality of Care Report, requires GMCB to report on performance relative to the statewide health outcome and quality targets described in Appendix 1 of the APM Agreement. The quality framework discussed in this report represents 22 carefully selected measures that aim to support improvement on identified population health goals, building on measurement and long-term health care initiatives underway in Vermont at the time the APM Agreement was signed.

This report outlines progress made for each of the quality metrics as required in Appendix 1 – Statewide Health Outcomes and Quality of Care Targets of the First Amended and Restated Vermont All-Payer Accountable Care Organization Model Agreement ("APM Agreement").[1] These quality metrics include population-level health outcomes, healthcare delivery system quality targets, and process milestones. This report reflects technical changes to quality measures including changes to national measure sets, changes to reflect Vermont-specific reporting mechanisms, and the amended approach to year-over-year "on track" designation, all codified in Amended and Restated APM Agreement.

1.1. Performance Year 4 (2021)

With the conclusion of the fourth performance year (PY4), this report demonstrates that Vermont is currently:

- Improving upon PY3 results in *five of the six* population-level health outcomes targets,
- Improving upon PY3 results in *six of nine reportable* healthcare delivery system quality targets; and
- Improving upon PY3 results in *six of seven reportable* process milestones.

While this report notes improvement in, or progress towards targets, it should be noted that, "[f]or Performance Years 3 and 4, due to the COVID-19 pandemic and its impact on utilization and care patterns, any [applicable increase or] decrease relative to the preceding Performance Year will not be considered in determining a Triggering Event."[2]

While there is still much work to do, there are some encouraging signs of delivery system reform. We expect that as the adoption of prospective population-based payments increases relative to fee-for-service reimbursement, we will only see greater momentum in delivery system reform as a result of more flexible funding streams and the ability for providers to plan and invest resources more wisely. This was born out early in the COVID-19 Public Health Emergency (PHE), as fixed payments made through Vermont's accountable care organization (ACO) programs helped to stabilize health care provider finances prior to the introduction of federal relief funds. Nonetheless, the pandemic posed significant challenges to transformation, as Vermont's health care providers, community, and State partners were focused on response efforts for the duration of the public health emergency (PHE).

1.2. Considerations

Year-over-year comparisons based on available data should be made with extreme caution. This is particularly true in light of the PHE and its impact on care patterns. In some cases, payer-specific attribution has more than doubled within payer populations since 2018. Additionally, methodological changes limit comparability.

[1] Vermont All-Payer Model Amended and Restated Agreement: https://gmcboard.vermont.gov/sites/gmcb/files/documents/APM%20Agreement%202022_VT_fully%20executed.pdf.
[2] Ibid.

Public Health Emergency

The results presented here, beginning in 2020, will not accurately assess "performance" as initially outlined in the APM Agreement. The effects of the global pandemic and associated PHE necessarily and drastically changed care patterns. The PHE redefined short-term health system priorities to meet immediate acute care needs and stabilize the health care system. These necessary changes are likely to have impacted preventive care and health promotion activities. The full effects of the PHE are still developing and may distort trends for many years to come.

Scale Growth

As noted above, the increase in scale across the four PYs further complicates the interpretation of the results outlined in this report.

Scale growth over the life of the Model has caused underlying denominator changes in many measures that are specific to the ACO-aligned population. When more Vermonters enter scale-target qualifying programs, it introduces volatility which impairs our ability to compare data from year to year; more consistent attributed populations will increase our ability to draw conclusions on aligned-beneficiary health and quality over time. The below table shows the scale growth through current performance years, with the overall percent change between 2018 and 2021.

	2018	2019	2020	2021	% Change ('18 – '21)
All-Payer	109,728	163,340	230,765	242,758	121.2%
Medicare	36,860	53,973	53,842	62,392	40.1%

Source: 2021 Scale Targets and Alignment Report.

Specification Changes

The 2021 measurement year saw changes in Medicare's methodology for analyzing data from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. Through 2019, benchmarks were calculated as deciles, in 2020 CAHPS surveys were not collected due to the PHE and beginning in 2021 CAHPS benchmarks were calculated based on actual percentiles, creating a significant change in benchmarks. The switch from deciles to performance-based benchmarks leads to more accurate comparisons between providers or provider groups/ACOs. Additionally, OneCare's 2021 and 2022 CAHPS surveys eliminated the use of phone calls – in 2021, this led to a 6% decrease in response rate.

2. Background

Vermont's All-Payer Accountable Care Organization Model Agreement ("APM Agreement") is an arrangement between Vermont and the federal government that allows Medicare to join Medicaid and commercial insurers to pay differently for health care. The APM was originally a five-year agreement (2018-2022); Vermont and CMMI have agreed to extend for two additional performance years (through 2024). The APM Agreement aims to reduce health care cost growth by moving from fee-for-service reimbursement to risk-based arrangements for Accountable Care Organizations (ACOs) that are tied to quality and health outcomes. Section 7.e of the Amended and Restated APM Agreement[3], Annual Health Outcomes and Quality of Care Report, requires GMCB to report on performance relative to the statewide health outcomes and quality targets: *"The GMCB, in collaboration with AHS, shall submit to CMS for its approval, no later than 18 months following Performance*

[3]Ibid.

Year 1 and each subsequent Performance Year, an annual report on the State's efforts to achieve the Statewide Health Outcomes and Quality of Care Targets ("Annual Health Outcomes and Quality of Care Report"). At a minimum, the State shall describe the following in this annual report:

i. *For all Performance Years, Vermont's progress on achieving Statewide Health Outcomes and Quality of Care Targets set forth in Appendix 1;*
ii. *For Performance Years 1 through 5, how Scale Target ACO Initiatives hold Vermont ACOs accountable for quality of care, the health of their aligned beneficiaries (section 6.b.iv), or both; and*
iii. *For Performance Years 1 through 5, how the State holds Vermont ACOs accountable to allocate funding for and invest in community health services to achieve the Statewide Health Outcomes and Quality of Care Targets.*

The quality framework discussed in this report represents 22 carefully selected measures that aim to support improvement on identified population health goals, building on measurement and long-term health care initiatives underway in Vermont at the time the APM Agreement was signed. While selecting measures and developing targets, Vermont consistently advocated for measures that addressed key priority areas in the State, alignment with existing measure sets, consideration of collection burden, and targets that are ambitious but realistically achievable over the performance period. The quality framework encourages health, public health, and community service providers to work together to improve quality and integration of care. This collaboration includes ACOs operating in Vermont and their community partners – while any one ACO is not responsible for these outcomes alone, the GMCB will continue to assess their approach to quality improvement through our regulatory levers.

All changes to the quality framework that were codified in the Amended and Restated Agreement have been reflected in this report.

3. Progress on Achieving Statewide Health Outcomes and Quality of Care Targets

3.1. Domains and Measures Included in Statewide Health Outcomes and Quality of Care Targets Monitoring Report

Measures that are tracked in Vermont's Annual Statewide Health Outcomes and Quality of Care Targets Monitoring Report correspond to three overarching goals: (1) reducing deaths related to suicide and drug overdose, (2) reducing the prevalence and morbidity of chronic disease, and (3) increasing access to primary care. **Tables 3.2 -3.4** outlines the measures included in each domain, including associated goals, baseline performance, performance targets, and the performance for 2018 (PY1), 2019 (PY2), 2020 (PY3) and 2021 (PY4). All measures have been updated to reflect the current APM Agreement, and will differ from prior reports. This report does not comprehensively comment on performance across all 22 quality measures but provides information on selected initiatives and programs in place that are aimed at directly impacting the health of Vermonters.

3.2. Summary Results

Table 3.2: Summary Results for Population-Level Health Outcomes Targets

Goal	Measure	Baseline	2022 Target	2018 (PY1)	2019 (PY2)	2020 (PY3)	***Current***	2022 (PY5)
Population-Level Health Outcomes Targets				*Rate*	*Rate*	*Rate*	***Rate***	*Rate*
Reduce Deaths Related to Suicide and Drug Overdose	Opioid-related deaths among Vermonters/100,000 (Statewide)	17.6 (2017)	10% Reduction from Baseline	20.8/100k	18.3/100k	25.3/100k	***33.7/100k***	
Reduce Deaths Related to Suicide and Drug Overdose	Deaths Related to Suicide (Statewide)	17.2/100,000 (2016)	16 per 100k VT residents or 20th highest rate in US	18.8/100k	15.3/100k	17.6/100k	***20.3/100k (13th in US)***	
Reduce Chronic Disease	COPD Prevalence (Statewide)	6% (2017)	Increase ≤1%	6%	7%	6%	***7%***	
Reduce Chronic Disease	Diabetes Prevalence (Statewide)	8% (2017)	Increase ≤1%	9%	9%	8%	***9%***	
Reduce Chronic Disease	Hypertension Prevalence (Statewide)	26% (2017)	Increase ≤1%	25%	26%	25%	***25%***	
Increase Access to Primary Care	Percentage of Adults with Personal Doctor or Care Provider (Statewide)	87% (2017)	89%	86%	86%	85%	***90%***	

Measure specifications and Sources can be found in Appendix A.

Table 3.3: Summary Results for Healthcare Delivery System Quality Targets

Goal	Measure	Baseline	2022 Target	2018 (PY1)	2019 (PY2)	2020 (PY3)	***Current***	2022 (PY5)
Healthcare Delivery System Quality Targets				*Rate*	*Rate*	*Rate*	*Rate*	*Rate*
Reduce Deaths Related to Suicide and Drug Overdose	Initiation of Alcohol and Other Drug Dependence Treatment (Multi-Payer ACO)	38.9% (2018)	40.8%	38.9%	40.1%	39.4%	***42.2%***	
Reduce Deaths Related to Suicide and Drug Overdose	Engagement of Alcohol and Other Drug Dependence Treatment (Multi-Payer ACO)	13.3% (2018)	14.6%	13.3%	17.1%	18.6%	***16.5%***	
Reduce Deaths Related to Suicide and Drug Overdose	30-Day Follow-Up After Discharge from ED for Mental Health (Multi-Payer ACO)	84.4% (2018)	60%	84.4%	89.8%	78.1%	***81.0%***	
Reduce Deaths Related to Suicide and Drug Overdose	30-Day Follow-Up After Discharge for Alcohol or Other Drug Dependence (Multi-Payer ACO)	28.2% (2018)	40%	28.2%	27.6%	31.6%	***33.2%***	
Reduce Deaths Related to Suicide and Drug Overdose	Growth Rate of Mental Health and Substance Abuse-Related ED Visits (Statewide)[4,5]	5.3% (2016 - 2017)	5%	6% (2017-2018)	5% (2018 – 2019)	-16% (2019 – 2020)	***9%*** ***(2020-2021)***	
Reduce Chronic Disease	Diabetes HbA1c Poor Control (Medicare ACO)	58.02% [6] (2018)	70th-80th percentile (national Medicare benchmark)	Measurement change – result available in 2018 report	13.49% (Medicare 80th percentile)	13.65% (Medicare 80th Percentile)	***9.98%*** **(Medicare 90th percentile)**	
	Controlling High Blood Pressure (Medicare ACO)	68.12% (2018)	70th-80th percentile (national Medicare benchmark)	68.12% (Medicare 60th percentile)	71.46% (Medicare 70th Percentile)	65.32% (Medicare 60th Percentile)	***71.48%*** **(Medicare 70th percentile)**	
	All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions (Medicare ACO)[7]	63.84% (2018)	70th-80th percentile (national Medicare benchmark)	63.84% (Medicare 30th percentile)	60.04% (Medicare 40th percentile)	30.11% (Medicare 90th Percentile)	***31.61%*** ***(Percentile N/A)***	
Increase Access to Primary Care	ACO CAHPS Composite: Getting Timely Care, Appointments and Information (Medicare ACO)	84.62% (2018)	70th-80th percentile (national Medicare benchmark)	84.62% (Medicare 80th percentile)	82.48% (Medicare 80th Percentile)	N/A Medicare CAHPS measures were not collected in 2020 due to PHE	***82.95%*** ***(Medicare 40th percentile)***	

Measure specifications and sources can be found in Appendix A.

[4] Vermont Residents only. Shown as a percent change from previous year.
[5] This measure uses a phased approach. The goal is to reduce the growth rate of mental health and substance abuse-related ED visits to 5% in PY 1-2, 4% in PY 3-4 and 3% by PY5.
[6] The baseline and 2018 result shown is a Medicare composite of ACO #27 (A1c poor control) and ACO #41 (diabetes eye exam) per Medicare Shared Savings Program reporting standards. Beginning in 2019, the result is for ACO #27 only. A lower rate is indicative of better performance on this measure.
[7] A lower rate is indicative of better performance on this measure.

Table 3.4: Summary Results for Process Milestones

Goal	Measure	Baseline	2022 Target	2018 (PY1)	2019 (PY2)	2020 (PY3)	***Current***	2022 (PY5)
Process Milestones				*Rate*	*Rate*	*Rate*	*Rate*	*Rate*
Reduce Deaths Related to Suicide and Drug Overdose	Number of opioid analgesic morphine milligram equivalents (MMEs) dispensed per 100 residents	61,300 (2017)	Decrease in Rate	52,535	43,782	40,507	***37,083***	
Reduce Deaths Related to Suicide and Drug Overdose	Adults Receiving Medication Assisted Treatment (MAT) (Statewide, Ages 18-64)[8] Rate per 10,000 Vermonters	215 per 10,000 Vermonters (2018)	150 per 10,000 Vermonters (or up to rate of demand)	215 per 10,000	236 per 10,000	235 per 10,000	***238 per 10,000***	
Reduce Deaths Related to Suicide and Drug Overdose	Screening for Clinical Depression and Follow-Up Plan (Multi-Payer ACO)	50.23% (2018)	70th-80th percentile (national Medicare benchmark)	50.23% (Medicare 50th percentile)	54.47% (Medicare 50th Percentile)	48.62% (Percentile N/A)	***56.64%*** ***(Percentile N/A)***	
Reduce Chronic Disease	Tobacco Use Assessment and Cessation Intervention (Multi-Payer ACO)	70.56% (2018)	70th-80th percentile (national Medicare benchmark)	70.56%[9]	84.94% (Medicare 70-80th percentile)	78.95% (Medicare 70th - 80th percentile)	***88.27%*** ***(Medicare 80th – 90th percentile)***	
Reduce Chronic Disease	Asthma Medication Ratio: Percentage of Vermont Residents with an Asthma Medication Ratio of 0.50 or Greater (Multi-Payer ACO)	49.3% (2020)	Monitoring	Measure change – see prior reports for corresponding PY results		49.3%	***67.1%***	
Increase Access to Primary Care	Percentage of Medicaid Children & Adolescents with Well-Care Visits (Statewide Medicaid)	51.2% (2020)	Monitoring	Methodology change – see prior reports for corresponding PY results		51.2%	***56.5%***	
Increase Access to Primary Care	Percentage of Medicaid Enrollees Aligned with ACO (Statewide Medicaid)	31% (Jan 2018)	≤15 percentage points below alignment rate for Vermont Medicare beneficiaries	31% (Medicaid) 35% (Medicare)	58% (Medicaid) 47% (Medicare)	92% (Medicaid) 47% (Medicare)	***79%*** ***(Medicaid)*** ***54%*** ***(Medicare)***	

Measure specifications and sources can be found in Appendix A.

[8] Q4 results for all Performance Years.

[9] No national Medicare benchmark is available for CY 2018.

3.3. Discussion: Statewide Efforts to Address APM Quality Framework

This report does not comment on individual measure performance, rather aims to provide information on selected statewide initiatives in place that are aimed at directly impacting the health of Vermonters. These initiatives and programs are outlined in sections 3.3.1 – 3.3.3 below and are bucketed by the overarching population health goal as outlined in the APM Agreement.

3.3.1 Reduce Deaths Related to Suicide and Drug Overdose

1115 Waiver

The Vermont Department of Health, Division of Substance Use Programs is working on several initiatives through the 1115 Global Commitment waiver designed to enhance and expand substance use disorder treatment and recovery services for Vermonters. Notably, the Substance Use Disorder Community Intervention and Treatment (SUD CIT) program expands access to SUD treatment services for uninsured and underinsured individuals with an SUD diagnosis whose incomes are above Medicaid limits – from 133% FPL up to 225% FPL. Benefits of the SUD CIT will include case management, recovery support, psychoeducation, residential treatment, withdrawal management, counseling, and skilled therapy services. According to the Agency of Human Services, Vermont is the first state to create an eligibility group targeted towards uninsured and underinsured individuals with SUD whose incomes are above the Medicaid limits. Peer Recovery and Withdrawal Management services provided to beneficiaries will also be eligible for reimbursement through Medicaid.

Blueprint Expansion

In 2023, the Vermont Legislature included an appropriation of funds for a two-year pilot program aimed at expanding the Blueprint for Health's Hub and Spoke Program. This pilot is intended to improve access to mental health and substance use disorder services through increased integration with primary care. Expanded funding from Medicaid for Vermont Blueprint for Health Community Health Teams (CHTs) supports implementation of a two-year pilot program for primary care practices in providing the following services:

- Universal screening for mental health, substance use disorder, and social determinants of health,
- Brief intervention within the practices when there are positive screening results, and
- Navigation to additional community-based services when warranted.

The funding will be used to hire a licensed or unlicensed Psychologist, Social worker, Community Health Worker, or Counselor(s) as a member of the primary care team embedded in the practice.

Zero Suicide

Vermont currently has three different "tracks" of Zero Suicide implementation which are supported through the Department of Mental Health and the Vermont Department of Health. Tracks include implementation in Designated Agencies (DAs), primary care practices, and emergency departments. Each track is described in more detail below.

Vermont has ten Designated Agencies (DA) engaging in the Zero Suicide Initiative. There have been agencies using the Zero Suicide framework for many years that have been able to implement the framework more completely and are able to share lessons learned for the agencies more recently introduced to this framework. In addition, they have been partnering with PCMHs on the *Suicide Safer Care Mini Grant Project*, led by the

Center for Health and Learning. DAs have been supportive of their staff receiving training in Collaborative Assessment and Management of Suicidality (CAMS), Counseling on Access to Lethal Means (CALM), and Columbia Suicide Severity Risk Scale (CSSRS) amongst others. In 2023, Vermont also launched a youth-focused Zero Suicide Academy and Community of Practice to support Zero suicide implementation at the Brattleboro Retreat and other youth mental health treatment programs in Chittenden, Rutland, Bennington, and Windham counties.

Patient-Centered Medical Homes (PCMH) have been participating in a Zero Suicide Initiative called the *Suicide Safer Care Mini Grant Project*. PCMHs are where numerous people receive their primary care. Currently there are seven PCMHs engaging in this project, which partners them with the DA serving their catchment area to build a suicide safe pathway from one setting to another without losing continuity of care.

VDH is partnering with the Vermont Program for Quality in Health Care (VPQHC) and Vermont's 14 hospitals to improve suicide care in emergency departments (ED) for individuals experiencing suicidality. Each of the fourteen Hospital Emergency Departments in Vermont are participating in the Emergency Department Project, which entails a Zero Suicide organizational self-study, an identified Quality Improvement project of their choosing, and CALM training for staff.

3.3.2 Reduce Prevalence and Morbidity of Chronic Disease

Self-Management Programs

The Blueprint for Health, in concert with the Vermont Department of Health work together to provide Self-Management Programming statewide. Program offerings include: Blood Pressure Management, Chronic Disease Management, Chronic Pain Management, Diabetes Self-Management Program, Diabetes Prevention Program, and the Quit Smoking Program.[10]

3-4-50 Campaign

The premise of 3-4-50 is that three behaviors (no physical activity, poor diet, and tobacco use) lead to four diseases (cancer, heart disease & stroke, type 2 diabetes, and lung disease) which result in more than 50% of deaths in Vermont. Partners of the program include worksites, schools, faith communities, service organizations, and towns, and agree to collect and report on wellness measures.

3.3.3 Increase Access to Primary Care

Health Care Workforce Development Strategic Plan

As of the writing of this report, several of the activities in the Health Care Workforce Development Strategic Plan are accomplished or underway. Coronavirus State Fiscal Recovery funds are being deployed to increase the health care workforce in Vermont including additional loan repayment opportunities for physician assistants and primary care providers. The State also implemented several rounds of hazard pay and premium pay grant opportunities that were available to primary care practices between PY2020 and PY2023. Approximately $8.9 million in hazard pay funding was awarded to federally qualified health centers and health care facilities, including primary care practices and an additional $4.4 million in premium pay was awarded to primary care practices. The GMCB will continue to monitor primary care access through its regulatory processes, including its Primary Care Advisory Group and its review of the Vermont Health Care Workforce Development Strategic Plan.

[10] 2022 Annual Report on Blueprint for Health. https://blueprintforhealth.vermont.gov/sites/bfh/files/doc_library/2022%20Annual%20Report%20Draft%20Jan%2031%202023%20%28006%29.pdf.

Blueprint for Health

The Blueprint for Health is an established program to integrate high-quality primary and community-based care. Through the Blueprint, providers are encouraged to take a long-term, whole person approach to care—one that addresses medical, social, and mental health needs and provides access to a range of supportive services—in an integrated fashion. The Blueprint supports PCMHs and CHTs to promote care coordination, panel management, and integrated care for mental health and substance use disorders. PCMHs supported by CHTs are also intended to support people who need additional resources to address health-related social needs such as case management, housing, economic services, food insecurity, transportation, and long-term placement.

4. Vermont ACOs' Role in the All-Payer ACO Model Agreement

The APM Agreement leverages the ACO model to support innovation and transformation in pursuit of the Agreement's statewide cost and quality targets. It allows the State to adapt the Medicare Next Generation ACO program to promote alignment across payer programs and to set the Medicare ACO benchmark.

The GMCB also has state regulatory levers over ACOs operating in Vermont. In 2016, the legislature enacted Act 113, which granted authority to the Board to regulate ACOs. The GMCB's ACO regulatory process includes certification, annual budget and program review, and monitoring of the budget order throughout the year. In order to receive payments from Medicaid or commercial insurers, Vermont ACOs must obtain and maintain, on a yearly basis, certification from the GMCB.[11] OneCare Vermont ("OneCare"), the only ACO operating in Vermont in 2020, received their initial certification in 2018, with an extensive compliance review of the GMCB Rule 5.000 certification elements. Each calendar year an ACO with attributed lives in Vermont must submit a budget for the coming year that includes a description of their projected network, anticipated payer contracts, operational budget as well as estimates of health service expenditures for which the ACO will be accountable, and population health programs. An ACO is required to present their budget and programs in a public hearing before the GMCB. Vermont's Office of the Health Care Advocate is also a party to the budget process.

The quality framework in the APM Agreement encourages health, public health, and community service providers to work together to improve quality and integration of care. This collaboration includes OneCare and its community partners – while OneCare is not responsible for these outcomes alone, a major component of the ACO budget review process is GMCB's review of OneCare's quality improvement efforts.

In response to the state's performance to date on APM scale, in November of 2020 AHS issued an assessment of progress and recommendations for improving performance in Vermont's model for health care reform. This report outlined a number of implementation risks and opportunities that could be leveraged by each stakeholder to ensure Vermont's continued progress toward the goals of the APM Agreement. Among successes, the plan highlights OneCare's success in quality framework alignment:

> *"High performing ACOs maximize alignment of measures across payer contracts to amplify focus on improvement and to reduce administrative burden. OneCare Vermont's ACO-level quality measures are highly aligned with the Agreement's quality framework and across payer contracts, reflecting years of ACO standards building, partnership with the GMCB to customize the measure set for the Vermont Medicare ACO*

[11] See 18 V.S.A. § 9382 (Oversight of accountable care organizations); see generally GMCB's ACO Oversight website, available at https://gmcboard.vermont.gov/aco-oversight.

Initiative, and collaboration with Medicaid and participating commercial payers to reflect Vermont's priorities for quality improvement."[12]

This alignment is paramount to meeting the two ACO-specific requirements under the Model; (1) *How Scale Target ACO Initiatives hold Vermont ACOs accountable for quality of care, the health of their aligned beneficiaries, or both; and (2) How the State holds Vermont ACOs accountable to allocate funding for and invest in community health services to achieve the Statewide Health Outcomes and Quality of Care Targets.* Discussion on progress and overall alignment with those two requirements are described in sections 5 and 6, below. Most areas of opportunity for improvement are related to payment models, which, if addressed, would allow for further quality improvement as providers gain flexibility in how they can apply standard payments. We expect that increasing adoption of prospective population-based payments increases relative to fee-for-service reimbursement will yield momentum in delivery system reform as a result of more flexible funding streams and the ability for providers to plan and invest resources more wisely.

5. ACO Accountability for Aligned Beneficiary Health Outcomes and Quality of Care

In 2021, approximately 46% of attribution-eligible Vermonters were attributed to OneCare's network.[13] The first year of the model (2018) was foundational as the ACO, providers, and payers worked to determine ways to achieve and affect delivery system transformation and implement a system of accountability. In PY 2 - PY4 (2019 through 2021), 11 of the 22 APM Agreement measures were reported by the ACO in one or more payer contracts, with complete alignment across payers on seven APM measures.[14] The remaining APM Agreement measures are largely statewide prevalence measures which the State would not expect an ACO to impact, at least initially. The goal of prevalence measures would be to encourage ACO's operating in Vermont to collaborate on prevention and upstream solutions to preventing chronic disease. As the scale of the model grows and more patients are impacted, Vermont will be tracking how ACO's and State are affecting health outcomes both separately and together.[15,16]

OneCare and its network are accountable for aligned beneficiary's health outcomes and quality of care:

- Through the payer contracts, OneCare's financial incentives are tied to their quality and financial performance.
- Through contracts with health and social service providers, OneCare includes measures holding providers accountable for the provision of services which are intended to improve quality, reduce provider burden, and bring down the total cost of care by providing care at the right time and place. In return, there is a financial distribution to providers based on quality performance. Each of these are described below.

[12] All-Payer Model Implementation Improvement Plan; https://gmcboard.vermont.gov/sites/gmcb/files/documents/APM%20Implementation%20Improvement%20Plan%20Final%2011.19.20.pdf.
[13] 2021 Scale Targets and Alignment Report: https://gmcboard.vermont.gov/sites/gmcb/files/documents/Scale%20Targets%20and%20Alignment%20Report_FINAL_Redacted.pdf.
[14] See Appendix B.
[15] The GMCB 2018 ACO Oversight Process https://gmcboard.vermont.gov/content/2018-aco-oversight.
[16] Vermont Department of Health. State Health Improvement Plan. https://www.healthvermont.gov/about-us/how-are-we-doing/state-health-improvement-plan.

ACO payer and provider contracts are negotiated on an annual basis, allowing for opportunity to modify reporting requirements – this could lead to inconsistencies in year over year alignment – but allow for payer and provider specific augments to the contracts to reflect performance most accurately. In 2021, the Medicaid payer contract contained language providing potential flexibilities to account for COVID-19 related shifts to healthcare demand and delivery. In the BCBS QHP and Primary programs, all quality measures were reporting only as a result of the impact of COVID-19.

5.1. Payer Contracts

Under GMCB Rule 5.000, and in accordance with 18 V.S.A. § 9382, ACOs operating in Vermont are required to maintain a quality evaluation and improvement program that is actively supervised by a clinical director and evaluated against defined measures. OneCare also has continuous quality improvement requirements in their payer agreements. OneCare examines their prior year ACO quality measure performance in the first quarter of each year, prioritizes data, and sets clinical priorities to achieve going forward that will meet quality and cost outcomes. This is built into their quality improvement program.

Under the ACO certification process and for continued certification eligibility, ACOs must submit both a completed and planned quality improvement plan annually. Under the ACO budget oversight process, OneCare is required to also demonstrate progress being made in their quality improvement program. OneCare's clinical focus areas are reviewed and selected annually and are in addition to the OneCare-specific quality measures included in their payer contracts. The priorities are set by OneCare's Clinical and Quality Advisory Committee.

OneCare's 2021 clinical priorities were to:[17]

1. Decrease prevalence patients with diabetes with HbA1c of above 9%.
2. Increase hypertension control
3. Increase rate of developmental screening in the first three years of life;
4. Increase screening for clinical depression and follow-up

The process for identifying the 2021 clinical focus areas and progress on the measures was discussed in both the 2021 and 2022 OneCare budget submissions.[18,19] OneCare stated in its FY22 submission that the process for identifying the clinical priorities remained consistent year over year, but that for this program year, that the clinical priorities (renamed "clinical focus areas") were selected to streamline and align with their care coordination model and Value Based Incentive Fund (VBIF) programs. OneCare's Chief Medical Officer, in collaboration with the Clinical and Quality Advisory Committee, leads the selection process, sets the rates, and votes to present them to the Population Health Strategy Committee for endorsement and review by the OneCare Board of Managers.[20] As in 2020, the 2021 priorities were identified as clinically important, represented opportunity for improvement, and could be monitored monthly with available data for timely action.

One of the premises of the APM is to test whether aligned, risk-based contracts that are tied to an ACO's performance on quality and cost will improve the health of Vermonters and will slow the rate of health care

[17] OneCare Vermont ACO 2022 Fiscal Year Budget Submission. Section 7, Appendix 7.1 ACO Clinical Priority Areas. Available at: https://gmcboard.vermont.gov/document/ocv-fy22-aco-budget-workbook.
[18] OneCare ACO 2021 Fiscal Year Budget Submission. Section 7, pp. 47-55. Available at: https://gmcboard.vermont.gov/document/onecare-fy2021-budget-submission-documents.
[19] OneCare Vermont ACO 2022 Fiscal Year Budget Submission. Section 7, pp. 64-65. Available at: https://gmcboard.vermont.gov/sites/gmcb/files/documents/REDACTED%20OneCare%20FY2022%20ACO%20Budget%20Narrative%2010-01-21.pdf
[20] See footnote 36.

spending. To help support this effort, there is a requirement in the APM Agreement for the ACO, in its Vermont Medicare ACO Initiative participation agreement, to withhold a portion of the cost of care to be used to reward providers who meet the payer's quality targets. For OneCare, the mechanism for this withhold is the VBIF. In 2021, as in the previous three years, OneCare's Medicaid and BCBS QHP ACO contracts each had a similar withhold from the total spend which is to be distributed to providers based on their quality performance, reinvested in payer program quality improvement initiatives, or a combination of the two. The MVP contract does not have a VBIF component. Once the performance settlements are complete, funds are individually calculated for each participating payer program and OneCare then makes payments separately to each eligible provider participant based on both attribution and performance on quality measures. At a high level, the VBIF is broken into three pools: 70% to attributing primary care providers based on attribution, 20% to the remainder of the network who qualify by a methodology established by the Board of Managers and consistent with OneCare strategy, and 10% to a quality improvement investment(s) approved by the Board of Managers.[21]

5.2. Provider Contracts

OneCare's 2021 provider network included 13 of 14 Vermont hospitals and Dartmouth-Hitchcock (DHMC) in New Hampshire, the largest out-of-state provider of care to Vermonters. Non-hospital providers in the OneCare network included FQHCs, skilled nursing facilities, home health agencies, designated agencies, and independent primary care and specialist practices. In 2021, the Medicare network within OneCare expanded to include Rutland Regional Medical Center and the Community Health Center of Rutland Region. 25 of the 29 independent primary care practices, all FQHCs, 6 of the 7 naturopaths, 18 of 23 specialists, and 49 of 56 continuum of care practices were retained as a part of the network from 2020 through 2021.[22]

It is important to highlight that the ACO structure puts OneCare in charge of provider quality accountability through contractual agreements. GMCB oversight of the ACO provides transparency and accountability to ACO-level quality systems for each payer. The GMCB is actively looking for ways to augment other regulatory processes to make quality a more central component of our provider regulation.

6. Vermont ACOs Allocation of Funding and Investments in Community Health Services

The GMCB's ACO Oversight authority outlined in Act 113 and Rule 5.000 requires ACOs operating in Vermont to invest and strengthen key areas to support population health and access to comprehensive primary care, including strengthening and reducing burden in primary care, integrating community-based providers in its care model to promote seamless coordination of care across the care continuum, investing in the social determinants of health to improve population health outcomes, and working to prevent and address the impacts of adverse childhood experiences and other traumas. In addition to this authority, per the APM Agreement Section 8b, the GMCB may direct a Vermont ACO to make specific infrastructure and care delivery investments in support of achieving APM targets. The ACO is held accountable to these investments through the GMCB's budget review, budget order, and quarterly monitoring.

OneCare's 2021 population health investments were derived from two sources: public and private payer agreements and individual participation fees from hospitals. In the 2021 OneCare Vermont ACO Budget Order,

[21] Final Description of OneCare's Population Health Initiatives. (March 31, 2021). Available at: https://gmcboard.vermont.gov/document/fy21-budget-order-7d
[22] OneCare ACO 2021 Fiscal Year Budget Submission. Section 2, pp. 10-11. Available at: https://gmcboard.vermont.gov/document/onecare-fy2021-budget-submission-documents.

the GMCB included several conditions related to investments in population health. These conditions required the ACO to explain to the GMCB if any of the population health management programs are not fully funded, and to fund the SASH and Blueprint for Health programs at an amount trended forward from 2020.[23]

6.1. Detailed Descriptions of OneCare's 2021 Population Health Programs

Payments to Primary Care and Social Service Providers

Primary care attributed life per member per month (PMPM)

This is a payment per attributed life, by payer, that each payer includes in their contracts with OneCare when the practice attests to having achieved a set of criteria to facilitate primary care transformation. The payment is distributed to participating primary care providers on a per member per month (PMPM) basis. OneCare's criteria include population health monitoring activities, utilization of data to identify strengths and opportunities, and the implementation of quality improvement initiatives to strengthen person-centered care and outcomes.

Blueprint for Health Patient-Centered Medical Home (PCMH)

OneCare's FY21 budget reflects continued investment in the Blueprint's PCMH program. Of note, these payments started under the Centers for Medicare and Medicaid Services' Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration and the Blueprint for Health. Although the MAPCP demonstration has ended , OneCare, through their Vermont Medicare Modified Next Generation ACO Agreement, has been able to continue receipt and distribution of this funding for the state's primary care providers. (See Community-Based Initiatives, below, for descriptions of the Support and Services at Home [SASH} and Community Health Team [CHT] programs.)

Capitated payment reform program for independent primary care providers

2021 was the fourth year of the Comprehensive Payment Reform (CPR) program for independent primary care practices. This program provides additional resources and investments to practices to support the transition to a value-based payment model. Participating practices are required to work on a clinical or quality project throughout the year and report their progress and outcomes. In 2021, the CPR financial model was adjusted so that the PMPM population health management and care coordination payments were moved outside of the CPR model. The CPR payments now only include the FFS replacement funds and the supplemental CPR payments. For the first time, BCBSVT offered a fixed payment component to the model. To better align with the VBIF, described below, the CPR practices are held to the same quality standards as the entirety of the OneCare primary care network. In 2021, fourteen practices participated in either the full or partial capitation models. [24]

Withhold for quality improvement initiatives (Value-based Incentive Fund)

As described in Section 5, in the Medicaid, BCBS QHP, and Medicare payer contracts, a percentage for quality was withheld and a portion, based on performance, was redistributed to providers in their network after payer settlement. The VBIF is broken into three pools: 70% to attributing primary care providers based on attribution, 20% to the remainder of the network who qualify by a methodology established by the Board of Managers and consistent with OneCare strategy, and 10% to a quality improvement investment(s) approved by the Board of

[23] OneCare Vermont FY21 ACO Budget Order. (January 15, 2021). Available at: https://gmcboard.vermont.gov/sites/gmcb/files/documents/FY21%20ACO%20Budget%20Order%20OneCare%20Vermont%20Docket%20No.%2020-001-A.pdf.

[24] OneCare Vermont, Comprehensive Payment Reform (CPR) Program Report to the Green Mountain Care Board. (July 30, 2021). Available at: https://gmcboard.vermont.gov/document/fy21-q2-deliverables.

Managers. If quality targets are unmet, OneCare retains the funds to be reinvested into quality improvement activities approved by the Board of Managers.

Complex care coordination program payments for primary and social service providers

OneCare's complex care coordination program is designed to engage providers through incentives and tools to increase communication and integration and decrease duplication of services. In the program, rising risk and high-risk patients choose a lead care coordinator from local primary care, social, and home health providers, who are incentivized through an enhanced PMPM to take extra time to coordinate care through regular contact with patients, care conferences with the patient and the care team, and shared documentation in OneCare's online care coordination program.

Community-Based Initiatives

Primary prevention program (RiseVT)

RiseVT is a community-based model aimed at reducing morbidity of chronic disease (the third population health goal of the APM). OneCare adopted RiseVT as a primary prevention program in 2018 based on initial implementation in one geographic region, Franklin and Grand Isle Counties. Under this program, program managers work with local partners to identify opportunities to enhance the overall wellness of towns by offering health programs, working to improve local systems such as walkability and school wellness policies, and making grants to aligned community programs. In the COVID-19 landscape RiseVT has continued to offer virtual programming with statewide campaigns to support community health and wellness. Behavior change campaigns that started in March 2020 saw an average of 300 registrants per initiative with each initiative lasting at least 30 days. [25]

Supports and Services at Home (SASH) and Community Health Teams (CHT)

The Vermont Medicare ACO Initiative allows OneCare to receive funding from CMMI to continue paying for the Supports and Services at Home (SASH) program that was started under the Blueprint for Health. This funding provides health and social services for Medicare patients in congregate housing. CMMI, through the APM Agreement, also provided continued funding for an initiative started by the Blueprint for Health called Community Health Teams (CHTs), which goes to each health service area in the state to bring providers together to work on quality improvement initiatives, with OneCare and the Blueprint co-facilitate using data from OneCare's information technology platform.

Developmental Understanding and Legal Collaboration for Everyone (DULCE)

This program seeks to ensure that newborns and their families receive quality medical care as well as the social services and community support they need during the first six months of the newborn's life. Families participating in the program receive comprehensive social determinants of health screening with a unique emphasis on the legal needs that might cause family stress or uncertainty.[26]

7. Conclusion

This fourth annual report demonstrates that Vermont is currently improving upon PY3 results in *five of the six* population-level health outcomes targets, *six of the nine* reportable healthcare delivery system quality targets, and *six of seven* reportable process milestones. The State, in concert with CMMI have determined that year-

[25] OneCare ACO 2021 Fiscal Year Budget Submission. Section 7, pp. 42-43. Available at: https://gmcboard.vermont.gov/document/onecare-fy2021-budget-submission-documents.
[26] Ibid.

over-year performance improvement will be the measure of success moving forward, with initial targets still being a stretch goal. This is in part due to the effects of the global pandemic and associated PHE and the necessary impact on care-seeking patterns. The PHE redefined short-term health system priorities to meet immediate acute care needs and stabilize the health care system throughout 2020 and 2021. These necessary changes are likely to have impacted preventive care and health promotion activities.

The GMCB has the regulatory authority to review OneCare's quality improvement initiatives to support continuous quality improvement and success in the APM Agreement. However, it should be noted that the State does not have the authority to require self-insured employers to accept quality measures in alignment with the APM Agreement. The GMCB continues to monitor the ACO's quality programs to ensure alignment (see Appendix B) and continues to review quality measures of new payer programs as they are developed. The GMCB is engaging in further work and research to assess the impact of the ACO on various quality measurements, including access to and utilization of primary care, and inpatient and outpatient care, among others.

Through this annual reporting, the State will continue to identify denominator changes (scale), risk scores, and the impact of the PHE to assess their collective impact on the ability to draw conclusions on aligned beneficiary health over time.

Appendix A: Detailed Measure Information

Table A.1: Population-Level Health Outcome Targets – Measure Summaries and Methodologies

<table>
<tr><th>Measure</th><th>Methodology</th></tr>
<tr><td>Opioid-Related Deaths Among Vermonters/100,000 (Statewide)</td><td>Calculation: State's performance, measured as a count of Vermont residents who die in Vermont – includes accidents, suicide, and undetermined opioid-related fatalities. Vermont performance differs from that reported by the CDC in two ways, 1) VDH considers all causes of death, contributing conditions, and injury descriptions as opposed to underlying cause of death only. 2) VDH examines a broader list of ICD-10 Codes than those used by CDC:

<table><tr><th colspan="4">ICD Codes Used in Drug-Related Fatalities Analysis
(beyond those used by CDC)</th></tr><tr><td>X45</td><td>F10.0</td><td>F14.0</td><td>F17.0</td></tr><tr><td>X65</td><td>F10.1</td><td>F14.1</td><td>F17.1</td></tr><tr><td>Y15</td><td>F11.0</td><td>F15.0</td><td>F18.0</td></tr><tr><td>T36-T50</td><td>F11.1</td><td>F15.1</td><td>F18.1</td></tr><tr><td>T51.0</td><td>F13.0</td><td>F16.0</td><td>F19.0</td></tr><tr><td></td><td>F13.1</td><td>F16.1</td><td>F19.1</td></tr></table>
Source: https://www.healthvermont.gov/sites/default/files/documents/pdf/ADAP-OpioidFatalOverdoseDataBrief-202l.pdf.</td></tr>
<tr><td>Deaths Related to Suicide (Statewide)</td><td>Calculation: Cause of death is coded by ICD-10 Intentional Self-Harm (Suicide). National Center for Health Statistics, Stats of The State reporting.
Source: https://www.cdc.gov/nchs/pressroom/sosmap/suicide-mortality/suicide.htm.</td></tr>
<tr><td>COPD Prevalence (Statewide)</td><td>Calculation: Percent of Vermont resident respondents who answer "yes" to the following question: "Has a doctor, nurse, or other health professional ever told you that you have chronic obstructive pulmonary disease, COPD, emphysema or chronic bronchitis?"

Notes: This information is collected annually by the state of Vermont and nationally by the CDC.

Source: Vermont Behavioral Risk Factor Surveillance System.</td></tr>
<tr><td>Diabetes Prevalence (Statewide)</td><td>Calculation: Percent of Vermont resident respondents who answer "yes" to the following question: "Has a doctor, nurse, or other health professional ever told you that you have diabetes?"</td></tr>
</table>

Measure	Methodology
	Notes: This information is collected annually by the state of Vermont and nationally by the CDC. **Source:** Vermont Behavioral Risk Factor Surveillance System.
Hypertension Prevalence (Statewide)	This information is collected annually by the state of Vermont and nationally by the CDC. **Calculation:** Percent of Vermont resident respondents who answer "yes" to the following question: "Has a doctor, nurse, or other health professional ever told you that you have high blood pressure?" **Notes:** This information is collected bi-annually by the CDC nationally. To meet the terms of the APM Agreement, the GMCB works with the Vermont Department of Health to ensure that the hypertension prevalence question is collected through the survey annually. This includes proposal preparation, staff presentation to the Vermont BRFSS committee and payment to add the measure to the data collection tool. **Source:** Vermont Behavioral Risk Factor Surveillance System.
Percentage of Adults with Personal Doctor or Care Provider (Statewide)	**Calculation:** Percent of Vermont resident respondents who answer "yes" to the following question: "Do you have one person you think of as your personal doctor or health care provider?" **Notes:** This information is collected annually by the state of Vermont and nationally by the CDC. **Source:** Vermont Behavioral Risk Factor Surveillance System.

Table A.2: Health Care Delivery System Targets – Measure Summaries and Methodologies

Measure	Methodology
Initiation of Alcohol and Other Drug Dependence Treatment (Multi-Payer ACO)	**Calculation:** Follows HEDIS specifications for Initiation and Engagement of Treatment (IET); the percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) abuse or dependence who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth or medication treatment within 14 days of the diagnosis. **Notes**: Denominator results presented exclude Part A only and Part B only Medicare beneficiaries. **Source:** VHCURES.

Measure	Methodology
Engagement of Alcohol and Other Drug Dependence Treatment (Multi-Payer ACO)	**Calculation:** Follows HEDIS specifications for Initiation and Engagement of Treatment (IET); the percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) abuse or dependence who initiated treatment and who were engaged in ongoing AOD treatment within 34 days of the initiation visit. **Notes**: Denominator results presented exclude Part A only and Part B only Medicare beneficiaries. **Source:** VHCURES.
30-Day Follow-Up After Discharge from ED for Mental Health (Multi-Payer ACO)	**Calculation:** Follows HEDIS specifications for Follow-up After Emergency Department Visit for Mental Illness (FUM). Shown as the percentage of ACO-aligned beneficiaries' emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness. Specifically, the percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days). **Notes**: Denominator results presented exclude Part A only and Part B only Medicare beneficiaries. **Source:** VHCURES.
30-Day Follow-Up After Discharge for Alcohol or Other Drug Dependence (Multi-Payer ACO)	**Calculation:** Follows HEDIS specifications for Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA). Shown as the percentage of ACO-aligned beneficiaries' emergency department (ED) visits for members 13 years of age and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence, who had a follow up visit for AOD. Specifically, the percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days). **Notes**: Denominator results presented exclude Part A only and Part B only Medicare beneficiaries. **Source:** VHCURES.
Number of Mental Health and Substance Abuse-Related ED Visits (Statewide)	Shown as the percent change from previous calendar year. Results utilize CCS 5 groupings for ED visits. Diagnosis categories include: - Adjustment disorders - Anxiety disorders - Attention-deficit conduct and disruptive behavior disorders - Developmental disorders - Disorders usually diagnosed in infancy, childhood, or adolescence

Measure	Methodology
	- Impulse control disorders - Mood disorders - Personality disorders - Schizophrenia and other psychotic disorders - Alcohol-related disorders - Substance-related disorders - Suicide and intentional self-inflicted injury - Screening and history of mental health and substance abuse codes - Miscellaneous disorders **Source:** VUHDDS.
Diabetes HbA1c Poor Control (Medicare ACO)	**Calculation:** Percentage of patients 18 to 75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period. Only patients with a diagnosis of Type 1 or Type 2 diabetes should be included in the denominator of this measure; patients with a diagnosis of secondary diabetes due to another condition should not be included. **Notes:** ACOs stopped reporting ACO-41 (Diabetic Eye Exam) after 2018. Since it was one of a two measure composite for diabetes, along with ACO-27, the 2018 result reflects the composite. Beginning in 2019, ACO-27 is assessed as an individual measure. **Source:** Centers for Medicare and Medicaid Services (2019 specification).
Controlling High Blood Pressure (Medicare ACO)	**Calculation:** The percentage of Medicare ACO beneficiaries aged 18-85 with a documented diagnosis of hypertension and a blood pressure reading of < 140/90 mm Hg at their most recent ambulatory office visit. **Notes:** Denominator excludes patients with evidence of end stage renal disease (ESRD), dialysis or renal transplant before or during the measurement period. Also excludes patients with a diagnosis of pregnancy during the measurement period OR Patients age 65 and older in Institutional Special Needs Plans (SNP) or Residing in Long-Term Care with a POS code 32, 33, 34, 54 or 56 any time during the measurement period. **Source:** Centers for Medicare and Medicaid Services (2019 specification).
All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions (Medicare ACO)	**Calculation:** Risk-adjusted outcome measure. Includes Medicare-fee-for-service beneficiaries 65 years or older who have two or more of the following nine chronic conditions: - AMI

Measure	Methodology
	- Alzheimer's disease and related disorders or senile dementia - A Fib - Chronic kidney disease - COPD or asthma - Depression - Diabetes - Heart failure - Stroke or TIA **Source:** Centers for Medicare and Medicaid Services (2019 specification).
ACO CAHPS Composite: Getting Timely Care, Appointments and Information (Medicare ACO)	**Calculation**: Survey asks patients how often they got appointments for care as soon as needed and timely answers to questions when they called the office. The survey also asks patients how often they saw the doctor within 15 minutes of their appointment time. **Source:** Centers for Medicare and Medicaid Services (2018 specification).

Table A.3: Process Milestones – Measure Summaries and Methodologies

Measure	Methodology
Number of Opioid Analgesic Morphine Milligram Equivalents Dispensed per 100 Residents.	**Calculation:** The number of opioid analgesic morphine milligram equivalents (MME) dispensed per 100 residents. Data are from Vermont's prescription drug monitoring program. **Source:** Vermont Department of Health, Alcohol and Drug Abuse Programs.
Adults Receiving Medication Assisted Treatment (MAT) (Statewide, Ages 18-64)	**Calculation**: Count of Vermont Adults (18-64) receiving Medication Assisted Treatment in Vermont Hub and Spoke programs. Q4 results are utilized for all performance years. **Source**: Vermont Department of Health, Alcohol and Drug Abuse Programs.
Screening and Follow-Up for Clinical Depression and Follow-Up Plan (Multi-Payer ACO)	**Calculation:** Percentage of patients aged 12 years and older screened for depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen. Results are derived from Medicare, Medicaid and Commercial QHP performance and weighted based on attribution within each of those payer programs. Results are combined and given a total percentage score which is then compared to the Medicare performance benchmarks. **Source:** ACO-payer contract results.

Measure	Methodology
Tobacco Use Assessment and Cessation Intervention (Multi-Payer ACO)	**Calculation:** Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user. Results are derived from Medicare and Medicaid performance and weighted based on attribution within each of those payer programs. Results are combined and given a total percentage score which is then compared to national Medicare performance benchmarks. **Source:** ACO-payer contract results.
Percentage of Vermont Residents with an Asthma Medication Ratio of 0.50 or Greater (Multi-Payer ACO)	**Calculation:** Beginning in 2020, follows HEDIS specifications for Asthma Medication Ratio (AMR). The percentage of ACO-aligned Vermonters in VHCURES 5-64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year. **Notes:** Denominator results presented exclude Part A only and Part B only Medicare beneficiaries. **Source:** VHCURES.
Percentage of Medicaid Child and Adolescent Well-Care Visits (Statewide Medicaid)	**Calculation:** Beginning in 2020, follow HEDIS specifications for Child and Adolescent Well-Care Visits (WCV). The percentage of Vermont Medicaid beneficiaries 3-21 years of age who had at least one comprehensive well-care visit with a PCP or OB/GYN practitioner during the measurement year. **Source:** VHCURES.
Percentage of Medicaid Enrollees Aligned with ACO (Statewide Medicaid)	**Calculation:** Shown as percentage of all Medicaid-enrolled Vermonters who are aligned to the ACO in a given performance year. **Source:** Annual Scale Targets and Alignment Report.

Appendix B: Measure Crosswalk

Measure	Vermont All-Payer ACO Model	2021 Vermont Medicaid Next Gen	2021 Medicare Initiative	2021 BCBSVT QHP/ Primary	2021 MVP Next Gen	Notes
% of adults with a usual primary care provider	X					
Statewide prevalence of Chronic Obstructive Pulmonary Disease	X					
Statewide prevalence of Hypertension	X					
Statewide prevalence of Diabetes	X					
% of Medicaid children and adolescents with well-care visits	X					For APM Agreement, all Medicaid adolescents in VHCURES, excluding dual-eligible. For Payer programs, payer-specific measure of well-care visits for attributed commercial population.
Initiation of alcohol and other drug dependence treatment	X					BCBSVT and MVP Next Gen treat these measures as a single composite measure; All-Payer ACO Model, Medicare Initiative and Vermont Medicaid Next Gen treat them as separate measures.
Engagement of alcohol and other drug dependence treatment	X					
30-day follow-up after discharge from emergency department for mental health	X					
30-day follow-up after discharge from emergency department for alcohol or other drug dependence	X					
% of Vermont residents receiving appropriate asthma medication management	X					

Measure	Vermont All-Payer ACO Model	2021 Vermont Medicaid Next Gen	2021 Medicare Initiative	2021 BCBSVT QHP/ Primary	2021 MVP Next Gen	Notes
Screening for clinical depression and follow-up plan (ACO-18)	X					Reported in Statewide Health Outcomes and Quality of Care Report. Measure is a combination of claims and clinical data (chart review). Annual reported scores are weighted based on participating program data received from the ACO and/or payer.
Tobacco use assessment and cessation intervention (ACO-17)	X					
Deaths related to suicide	X					
Deaths related to drug overdose	X					
% of Medicaid enrollees aligned with ACO	X					
# per 10,000 population ages 18-64 receiving medication assisted treatment for opioid dependence	X					
Rate of growth in mental health or substance abuse-related emergency department visits	X					
# of queries of Vermont Prescription Monitoring System by Vermont providers (or their delegates) divided by # of patients for whom a prescriber writes prescription for opioids	X					
Hypertension: Controlling high blood pressure	X					
Diabetes Mellitus: HbA1c poor control	X					
All-Cause unplanned admissions for patients with multiple chronic conditions	X					

Measure	Vermont All-Payer ACO Model	2021 Vermont Medicaid Next Gen	2021 Medicare Initiative	2021 BCBSVT QHP/ Primary	2021 MVP Next Gen	Notes
Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient experience surveys	X					Surveys vary by program. All-Payer ACO Model includes ACO CAHPS Survey composite of Timely Care, Appointments, and information for ACO-attributed Medicare beneficiaries. Medicare Initiative includes multiple ACO CAHPS composites for ACO-attributed Medicare beneficiaries. BCBSVT Next Gen includes care coordination composite and tobacco cessation question from CAHPS PCMH for ACO-attributed BCBSVT members. MVP Next Gen includes the care coordination composite score.
ACO all-cause readmissions (HEDIS measure for commercial plans)						
Risk-standardized, all-condition readmission (ACO-8)						
Influenza immunization (ACO-14)						
Colorectal cancer screening (ACO-19)						
Developmental screening in the first 3 years of life						
Follow-up after hospitalization for mental Illness (7-Day Rate)						