Vermont All-Payer ACO Model
Annual Health Outcomes and Quality of Care Report
Performance Year 3 (2020)

Submitted March 31, 2022

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.

1.1. Performance Year 3 (2020)

With the conclusion of the third performance year (PY) of five, this report demonstrates that Vermont is currently:

- On track to meet *three of the five* reportable population-level health outcomes targets,[1]
- On track to meet *six of the eight* reportable healthcare delivery system quality targets[2] ; and
- Making progress toward *three of three* reportable process milestones.[3]

This report outlines baselines, targets, and progress made for each of the twenty-two[4] quality metrics as required in Appendix 1 – Statewide Health Outcomes and Quality of Care Targets of the Vermont All-Payer Accountable Care Organization Model Agreement ("APM Agreement"). Appendix 1 also sets goals for population-level health outcomes, healthcare delivery system targets, and process milestone targets. It is important to note that these are five-year targets, intended to be achieved by the end of PY5 (2022). While the APM Agreement establishes quantitative milestones for PY 3-5, the impact of the pandemic on cost and utilization patterns led the state to propose that "[f]or Performance Years 3 and 4, due to the COVID-19 pandemic and its impact on utilization and care patterns, no performance changes will result in a triggering event." [5]

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 has posed significant challenges to transformation, as Vermont's health care providers, community, and State partners have been working around the clock on response efforts.

1.2. Considerations

As this is the third annual Quality and Health Outcomes Report, many are eager to draw year-over-year comparisons based on the three years of available data. Comparisons should be made with extreme caution, particularly in light of the PHE and its impact on care patterns. Changes in risk status and growth of attributed lives across the span of the APM Agreement also impact comparability of the year-over-year results. In some cases, payer-specific attribution has doubled within payer populations since 2018. Additionally, measure

[1] Deaths Due to Drug Overdose is no longer reported, substituted with Opioid-Related Deaths.
[2] Medicare CAHPS were not collected in 2020 due to the PHE.
[3] Two HEDIS measure changes; VPMS measure substituted with Morphine Milligram Equivalents; no Medicare benchmark reported for Screening for Clinical Depression and Follow-Up Plan.
[4] Due to disaggregation of a composite measure by Medicare nationally, the total number or measures increased to reflect this change.
[5] Vermont All-Payer Model Extension – Proposed Redline https://gmcboard.vermont.gov/sites/gmcb/files/documents/VTAPMExtension_ProposedRedline_20211130.pdf.

changes limit comparability: two HEDIS specifications changed for the 2020 measurement year, making 2020 results for these measures different from both prior years and their baselines and target rates outlined in the APM Agreement.

Public Health Emergency

The results presented here for 2020 will not accurately assess "performance" as 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.

This report focuses on updated measure specifications based on Vermont and CMMI's mutual understanding of the technical changes amendment in progress at the beginning of 2020. These changes were included in the Vermont All-Payer Model Extension – Proposed Redline submitted in December of 2021. These changes codify memorandums and other changes negotiated between the State of Vermont and the Center for Medicare and Medicaid Innovation (CMMI) throughout PY1-3 (2018 – 2020). The GMCB respectfully submits this report based on the aforementioned materials and mutual agreement between signatories.

Scale Growth

The increase in scale across the three 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 2020.

	2018	2019	2020	% Change
All-Payer	109,728	163,340	230,765	110%
Medicare	36,860	53,973	53,842	46%

Source: 2020 Scale Targets and Alignment Report.

Specification Changes

The 2020 measurement year saw changes in two HEDIS measures reported as part of the quality framework:

- Adolescent Well-Care Visits (AWC) was replaced with Well-Child Visits (WCV),
- Medication Management for People with Asthma (MMA) was replaced with Asthma Medication Ratio (AMR).

The change in these measures no longer allows for prior year comparisons or trending over the remainder of the APM Agreement. ***Because of these changes, the GMCB intends to work with CMMI to update the baseline and target rates currently listed in Appendix 1 of the APM Agreement to bring them in line with the new measurements.***

Population Risk

Analysis of risk scores suggest that ACO members differ substantially from the general population.

Of those ACO members with enough claims to produce a prospective risk score, ACO members across all payer programs had an average risk 12% lower than the population in VHCURES in 2020. Commercial and Medicaid ACO members had relatively lower risk scores than the VHCURES population, whereas the Medicare ACO members had an average risk score 41% higher than the VHCURES population.[6]

Medicare members aligned with the ACO have a higher prevalence of chronic disease compared to the non-ACO Medicare population. Given that risk scores are based on health care utilization and predicted future utilization patterns, this is an important consideration for the observed higher risk scores among the Medicare ACO population compared to their non-ACO counterparts.

[6] Medicare risk scores exclude members eligible for coverage due to end-stage renal disease.

2. Background

The Vermont All-Payer Accountable Care Organization Model Agreement ("APM Agreement") was signed on October 26, 2016, by Vermont's Governor, Secretary of the Vermont Agency of Human Services (AHS), Chair of the Green Mountain Care Board, and the Centers for Medicare & Medicaid Services (CMS). 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 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 GMCB, in collaboration with AHS, shall submit to CMS for its approval, on or before September 30th following each Performance Year 1 through 5, 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")[7,8]. At a minimum, the State shall describe the following in this annual report:*

i. Vermont's progress on achieving Statewide Health Outcomes and Quality of Care Targets set forth in Appendix 1;
ii. 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. 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 five-year period.[9] 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.

In 2020, the State and CMMI agreed that the baselines should be updated to reflect data that are relevant to the model's performance; these changes are reflected in the proposed extension redline mentioned in section 1.2. At the time the APM Agreement was signed, the baseline reflected the most recent data available. Today, the baseline for ACO measures has been updated to reflect the first year the multi-payer ACO program was in operation, which is PY1, or 2018. By updating the baseline, the analysis can better reflect the impact of the ACO program on quality. For the measures that are Statewide, baselines have been updated to the most recent available year as noted in Table 2.2.

[7] Per a memo to CMMI dated August 21, 2019, the deadline for the Statewide Health Outcomes and Quality of Care Report was changed from September 30 to December 31 of the year following each measured performance year.
[8] Per an email to CMMI on January 7, 2022, this 2020 Statewide Health Outcomes and Quality of Care Report experienced delays due to data availability, changing the submission deadline to March 31, 2022.
[9] If the State's extension request is approved, there will be a sixth year of the APM Agreement and associated reporting requirements.

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** outline measures included in each domain, including associated goals, baseline performance, performance targets, and the performance for 2018 (PY1), 2019 (PY2), and 2020 (PY3) when applicable and available. This report does not comprehensively comment on performance across all 22 quality measures but provides greater insight into those measures where Vermont has achieved success as well as those measures where the State has the greatest opportunity to improve.

3.2. Summary Results

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

Goal	Measure	Baseline	2022 Target	2018 (PY1)	2019 (PY2)	***Current***	2021 (PY4)	2022 (PY5)
Population-Level Health Outcomes Targets				*Rate*	*Rate*	***Rate***	*Rate*	*Rate*
Reduce Deaths Related to Suicide and Drug Overdose	Deaths Related to drug Overdose (Statewide)[10]	123 (2017)	Reduce by 10% (111)	159	137[11]	***Proposed change – see Section 3.3: Discussion for update***		
Reduce Deaths Related to Suicide and Drug Overdose	Deaths Related to Suicide (Statewide)[8]	17.2/100,000 (2016)	16 per 100k VT residents <u>or</u> 20th highest rate in US	18.8/100k[12] (2018)	15.3/100k (2019)	***18.1/100k (2020)***		
Reduce Chronic Disease	COPD Prevalence (Statewide)	6% (2017)	Increase ≤1%	6%	7%	***6%***		
Reduce Chronic Disease	Diabetes Prevalence (Statewide)	8% (2017)	Increase ≤1%	9%	9%	***8%***		
Reduce Chronic Disease	Hypertension Prevalence (Statewide)	26% (2017)	Increase ≤1%	25%	26%	***25%***		
Increase Access to Primary Care	Percentage of Adults with Personal Doctor or Care Provider (Statewide)	87% (2017)	89%	86%	86%	***85%***		

[10] Vermonters who die in Vermont (i.e. excludes out-of-state residents' deaths and Vermonters who die in other states).
[11] 2019 data are preliminary.
[12] Death rate is age-adjusted per 100,000 population. https://www.healthvermont.gov/sites/default/files/documents/pdf/HSRV-Injury-Suicide-Intentionalself-harm-Brief-2022.pdf.

Table 3.3: Summary Results for Healthcare Delivery System Quality Targets

Goal	Measure	Baseline	2022 Target	2018 (PY1)	2019 (PY2)	***Current***	2021 (PY4)	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%***		
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%***		
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%***		
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%***		
Reduce Deaths Related to Suicide and Drug Overdose	Growth Rate of Mental Health and Substance Abuse-Related ED Visits (Statewide)[13,14]	5.3% (2016 - 2017)	5%[15]	6% (2017-2018)	5% (2018 – 2019)	***-16% (2019 – 2020)***		
Reduce Chronic Disease	Diabetes HbA1c Poor Control (Medicare ACO)	58.02% [16] (2018)	70th-80th percentile (national Medicare benchmark)	Measurement change – result available in 2018 report	13.49% (Medicare 80th percentile)	***13.65% (Medicare 80th 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)***		
	All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions (Medicare ACO) [17]	63.84% (2018)	70th-80th percentile (national Medicare benchmark)	63.84% (Medicare 30th percentile)	60.04% (Medicare 40th percentile)	***30.11% (Medicare 90th Percentile)***		
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***		

[13] Shown as a percent change from previous year.
[14] Vermont residents only.
[15] 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.
[16] 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.
[17] 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)	***Current***	2021 (PY4)	2022 (PY5)
Process Milestones				*Rate*	*Rate*	*Rate*	*Rate*	*Rate*
Reduce Deaths Related to Suicide and Drug Overdose	Percentage of Vermont Providers Checking Prescription Drug Monitoring Program Before Prescribing Opioids (Statewide)	2.19 (2017)	1.80	3.10	4.33	***3.91*** ***(Proposed change – see Section 3.5: Discussion)***		
Reduce Deaths Related to Suicide and Drug Overdose	Adults Receiving Medication Assisted Treatment (MAT) (Statewide, Ages 18-64) Rate per 10,000 Vermonters	257 per 10,000 Vermonters (2018)	150 per 10,000 Vermonters (or up to rate of demand)	257 per 10,000	218 [18] per 10,000	***235[19] 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%[20] (Medicare 50th Percentile)	***48.62%*** ***(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%[21, 22]	84.94%[22] (Medicare 70-80th percentile)	***78.95%[22]*** ***(Medicare 70th - 80th Percentile)***		
Reduce Chronic Disease	Asthma Medication Ratio: Percentage of Vermont Residents with an Asthma Medication Ratio of 0.50 or Greater (Multi-Payer ACO)	-	-	Measure change – see prior reports for corresponding PY results		***49.3%[23]***		
Increase Access to Primary Care	Percentage of Medicaid Adolescents with Well-Care Visits (Statewide Medicaid)	-	-	Methodology change – see prior reports for corresponding PY results		***51.2%[24]***		
Increase Access to Primary Care	Percentage of Medicaid Enrollees Aligned with ACO (Statewide Medicaid)[25]	31% (Jan 2018)	≤15 percentage points below alignment rate for Vermont Medicare beneficiaries	31%	58%	***92%***		

[18] Q1 2019 results; https://www.healthvermont.gov/scorecard-opioids.
[19] Preliminary Data. Q1 2020 results; https://www.healthvermont.gov/scorecard-opioids.
[20] Weighted result based on ACO Medicare, Medicaid and BCBSVT QHP performance in CY 2020.
[21] No national Medicare benchmark is available for CY 2018.
[22] Weighted result based on ACO Medicare and Medicaid performance.
[23] 2020 data reflect HEDIS measure changes; see Appendix A for more detailed information.
[24] 2020 data reflect HEDIS measure changes – new measurement captures Medicaid beneficiaries aged 3-21.
[25] As reported in Annual Scale Targets and Alignment Reports.

3.3. Discussion: Population-Level Health Outcomes Targets

The State and CMMI have a preliminary agreement that the baseline performance should be updated to reflect data that is relevant to the model's performance years. At the time the APM Agreement was signed, the base year reflected the most recent data available. In an effort to more accurately measure performance across the population, the data has been updated to utilize 2017 as a baseline where applicable. For Performance Years 1 – 3 (2018 – 2020), the APM Agreement sets an expectation that the results will improve over baselines. Final performance results for the third year of the model show Vermont currently on track to meet *three of the five* reportable population-level health outcomes targets (one measure changed). Selected measures and contributing factors are discussed in detail below.

Deaths Related to Drug Overdose (Statewide)

In light of changing drug use and overdose patterns in Vermont, the Vermont Department of Health's (VDH) Alcohol and Drug Abuse Programs has updated how it reports deaths related to drug overdoses and now specifically reports deaths related to opioids. The 2018 and 2019 rates for deaths related to drug overdoses shown in Table 3.2 above were given to the GMCB for the purposes of this annual report but are not available in any publications.

Moving forward, the GMCB will follow the direction of VDH and report on opioid-related deaths among Vermonters. Historical data on the number and rate of accidental and undetermined opioid-related fatalities among Vermonters, through 2020, are shown in the table below.

	2014	2015	2016	2017	2018	2019	2020*
Total	63	73	96	110	130	114	157
Rate/100k	10.1	11.7	15.4	17.6	20.8	18.3	25.2

*2020 data are preliminary

As seen in the table above, 2020 data continue to show an increasing trend, growing 38% over the 2019 rate. This trend follows a similar pattern seen nationally, with a greater proportion of men dying of overdose than women in both instances.[26] Of the 157 opioid-related deaths in 2020, nearly all were deemed accidental or undetermined, with Fentanyl found in 88% of fatalities.

It should be noted that the Vermont methodology for identifying opioid-related deaths identifies approximately 5% more deaths than the CDC methodology[27] – detailed information can be found in Appendix A.

Deaths Related to Suicide (Statewide)

The APM Agreement sets a statewide goal of 16 deaths due to suicide per 100,000 Vermont residents by the end of the Model. The rate of suicide deaths has increased from the 2016 baseline result (17.2) to the current reported year of 2020 (18.1)[28]. Vermont's death by suicide rate has fluctuated over the past decade, with the lowest rate realized in 2012 (12.9) and the highest in 2018 (18.8). However, Vermont's small population introduces some volatility into this metric. The Vermont Department of Health produces an *Intentional Self Harm and Death by Suicide* Data Brief annually, providing further insight into the populations impacted by this unfortunate statistic. Notably, suicide-related hospital visits are higher among females, while suicide rates are

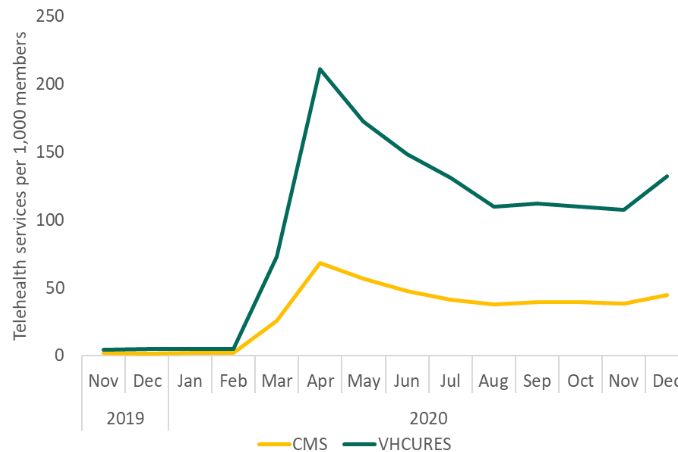
[26] Figure 3: https://nida.nih.gov/drug-topics/trends-statistics/overdose-death-rates.
[27] Opioid-Related Fatalities Among Vermonters; Page 18: https://www.healthvermont.gov/sites/default/files/documents/pdf/ADAPOpioidFatalityDataBrief2020_Final.pdf.
[28] https://www.healthvermont.gov/sites/default/files/documents/pdf/HSRV-Injury-Suicide-Intentionalself-harm-Brief-2022.pdf.

higher amongst males.[29] It is known that social isolation is a risk factor for suicide attempts, a fact that is likely compounded due to the Public Health Emergency.

The State has focused several initiatives on suicide prevention to increase awareness and outreach, and hopefully reduce deaths related to this preventable public health problem. The Board will continue to monitor initiatives in place through the Vermont Department of Health and the Vermont Department of Mental Health, as well as through regulatory roles in Hospital and ACO budget review and approval as we continue through the APM Agreement period and beyond.

Percent of Adults with a Personal Doctor or Care Provider

In 2020, the COVID-19 PHE forced many Vermonters to try alternative care modalities – as such, the utilization of telehealth services across Vermont increased, spiking shortly after the Governor's "Stay Home Stay Safe Order" went into effect on March 24, 2020.[30] The table below outlines the spike in total telehealth visits and continued use throughout the pandemic using two data sources: Vermont's APCD (VHCURES) and the CMS T-MSIS[31] data set. Though both sources have similar trends, VHCURES shows more telehealth services than CMS and may reflect a more complete dataset.



Despite the increased use of telehealth during 2020, the percent of adults reporting that they have a personal doctor or care provider decreased one percentage point compared to 2019. One of the three main goals of the APM Agreement is to improve access to primary care for all Vermonters, so this decline is troubling, though perhaps not surprising given recent studies showing a reduction in the primary care workforce. In a 2018 Physician Census, the Vermont Department of Health identified only 25% of physicians practicing mainly in primary care settings, with 69.6/100,000 Full Time Equivalents (FTEs).[32] In October of 2021, the Board received the Health Care Workforce Strategic Plan ("Plan"), which included data showing that Vermont has nearly twice as many specialty providers as primary care providers (2,001 to 1,081, respectively).[33] The Plan provides recommendations on strategies to increase Vermont's health care workforce, including recruitment and retention initiatives, loan repayment and licensing requirements, among others. The GMCB will continue to

[29] Vermont Department of Health, *Intentional Self-Harm and Death by Suicide*.
[30] https://governor.vermont.gov/covid19response.
[31] https://www.medicaid.gov/medicaid/data-systems/macbis/transformed-medicaid-statistical-information-system-t-msis/index.html.
[32] https://www.healthvermont.gov/sites/default/files/documents/pdf/HS-Stats-phys18-ppt-.pdf.
[33] https://gmcboard.vermont.gov/sites/gmcb/files/documents/VT%20Health%20Care%20Workforce%20Development%20Strategic%20Plan%2010-15-21%20Final%20GMCB.pdf.

monitor primary care access through its regulatory processes, including its Primary Care Advisory Group and its review of the Vermont Health Care Workforce Strategic Plan.

3.4. Discussion: Healthcare Delivery System Quality Targets

As with the Population-Level Health Outcomes Targets described above, data for Healthcare Delivery System Quality Targets were also updated to utilize 2017 as a baseline where applicable. For those measures that are ACO-specific, 2018 (PY1) will serve as the baseline year. As noted above, this updated baseline allows for a more accurate comparison through the remaining years of the APM Agreement, especially within the ACO population as 2018 was the first year of the multi-payer Next Generation ACO initiative. Final 2020 data show Vermont moving toward achievement on six of the eight reportable healthcare delivery system quality targets (one data point of nine was not reported during the Public Health Emergency). This change (from 20 to 22 total measures) in the total measures differs from the APM Agreement due to the disaggregation of a Medicare ACO composite into three individual measures (diabetes HbA1c poor control; controlling high blood pressure; all-cause unplanned admissions for patients with multiple chronic conditions) and is reflected in the State's proposed extension redline. To align with federal reporting, the State also reports each measure individually in this report.

30-Day Follow-Up After Discharge from the Emergency Department for Mental Health

In 2020, the 30-day follow-up after discharge from the ED for mental health rate decreased compared to 2019, a negative outcome though performance still exceeds the PY5 (2022) target. Digging deeper, the decrease in the 2020 rate is realized in both the ACO and total VHCURES population, with the ACO-aligned population consistently outperforming the total VHCURES population over the current Agreement term.

	2018	2019	2020
All Vermonters in VHCURES	83.2% (n=3,289)	86.7% (n=3,705)	76.6% (n=2,324)
ACO-Aligned Beneficiaries	84.4% (n=910)	89.8% (n=1,828)	78.1% (n=1,394)

As shown in the table above, the eligible ACO-aligned population decreased 23% between 2019 and 2020, again, likely due to the care patterns realized during the PHE. Follow-up after discharge could be impacted by availability of mental health professionals or patient access to physical or online portals via broadband for audio-visual communication, among other factors. Vermont's rural nature can impede access to new and emerging treatment modalities, a factor that has been addressed through State and Federal broadband funding. The GMCB will continue to monitor this measure on both a statewide and ACO-aligned basis, with special attention paid to the delivery of follow-up services via telehealth as we continue to assess the pandemic's lasting impact on care patterns.

Growth Rate of Mental Health and Substance Abuse-Related ED Visits

The APM Agreement sets forth a measurement of mental health and substance abuse-related ED visits, specifically, the rate of growth from one year to the next. This measure utilizes the Vermont Hospital Uniform Discharge Data Set (VHUDDS) to identify those with a primary diagnosis of mental health or substance abuse. 2020 rates (Table 3.3.) show a steep decline in ED utilization among this population, and across all service lines – most likely related to the changing care patterns realized from the COVID-19 pandemic. The table below illustrates the percent of total ED visits resulting in an admission and those with mental health or substance use related visits resulting in an admission over the available PYs.

Measure	2018	2019	2020
Percent of Total ED Visits Resulting in an Admission	11% (n=26,993)	11% (n=27,442)	12% (n=24,104)
Percent of Mental Health and Substance Use Visits Resulting in an Admission	17% (n=2,165)	15% (n=2,059)	16% (n=1,882)

As shown above, the total number of ED visits declined 19% between 2019 and 2020, while the percentage of admissions rose from 11% to 12% over the same period. Of those presenting to the ED with a primary diagnosis of mental health or substance abuse, 16% were ultimately admitted as an inpatient in 2020, increasing 1% over 2019. This suggests that many Vermonters are seeking appropriate treatment when presenting with a mental health or substance use crisis.

During the PHE, the State's Department of Mental Health (DMH) partnered with the Vermont Association of Hospitals and Health Systems (VAHHS) to create tracking tools to follow the flow of patients requiring placement into more advanced treatment facilities. These tools were born from patient and provider reports on patients boarding in Vermont EDs because they could not discharge them to a more appropriate site of care, which increased wait times across the system. These data on wait times for children and adults experiencing mental health and substance use crises has assisted with AHS' and DMH's decisions to support two Vermont treatment facilities with funding for travelers to bring beds back online and thereby support the system overall. DMH tracks data daily on a more granular, patient level basis, and that information is utilized in a daily "statewide mental health huddle", where DMH and the hospitals can come together to facilitate referrals, ensuring that any barrier to swift referral is removed wherever possible.

The GMCB will continue to monitor utilization of emergency services for mental health and substance use services through its regulatory processes, including through hospital budget review and approval. Additionally, the GMCB will monitor wait times with its State partners, assessing the impact and need on the overall health care system.

3.5. Discussion: Process Milestones

As with other measure types, data were updated to utilize 2017 as a baseline where applicable. For those measures that are ACO-specific, 2018 (PY1) will serve as the base year. This updated baseline allows for a more accurate comparison through the remaining years of the APM Agreement, especially within the ACO population as 2018 was the first year of the Next Generation multi-payer ACO initiative. The 2020 results show Vermont making progress toward *three of three* reportable process milestones (one of the seven data points has no benchmark comparison due to the PHE, and three measure changes prevent accurate comparison). Selected measures and contributing factors are discussed in detail below.

Vermont Prescription Monitoring System

As stated in the 2019 Statewide Health Outcomes and Quality of Care report, the Vermont Prescription Monitoring System (VPMS) measure specified is not reported regularly by the State and requires a special data run. However, an alternate measure of performance shows great progress towards lowering opioid overdose and dependence. The Vermont Department of Health's Alcohol and Drug Abuse Programs regularly report on the number of opioid analgesic morphine milligram equivalents (MMEs) dispensed per 100 residents, and a steady decline is noted from 2014 to 2020 as seen in the table below.[34]

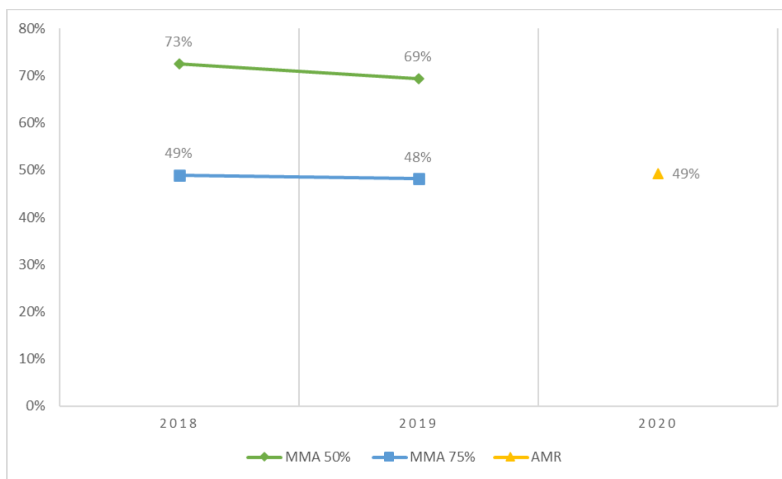
[34] https://www.healthvermont.gov/scorecard-opioids.

	2014	2015	2016	2017	2018	2019	2020
MMEs/100 VTers	73,476	77,090	68,915	61,300	52,535	49,497	37,293

The State hopes to work with CMMI to formally replace the current VPMS measure with the morphine milligram equivalents measure to allow for more timely data and reporting, and to update associated baseline and target rates currently listed in Appendix 1 of the APM Agreement.

Percentage of Vermont Residents Receiving Appropriate Asthma Medication Management

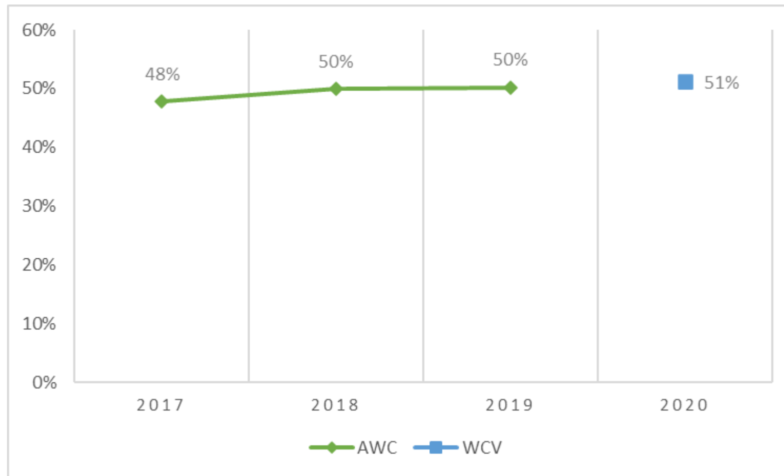
Beginning in PY3 (2020), HEDIS retired the "Medication Management for People with Asthma" measure. The suggested substitute measure is "Asthma Medication Ratio" which most closely aligns with the previous 75% compliance rate (see chart below). The proposed extension redline also amended the language to ensure the measurement was of ACO-aligned beneficiaries, which is reflected in Table 3.4 as well as the chart below.



Given this methodology change, PY1 and PY2 are no longer comparable and cannot be tracked and trended over time, posing difficulty in measuring progress towards quantitative milestones set forth in Appendix 1 of the APM Agreement. This change occurred after the proposed extension and Agreement redline was submitted for consideration to CMMI in December of 2021. ***Because of these specifications changes, the State hopes to work with CMMI to update the baseline and target rates currently listed in Appendix 1 of the APM Agreement.*** It should also be noted that this measure is subject to volatility as scale continues to grow – the GMCB will continue to identify denominator changes and their impact on the ability to draw conclusions on aligned beneficiary health over time.

Percentage of Medicaid Adolescents with Well-Care Visits

Beginning in PY3 (2020), HEDIS revised the measure as stated in Appendix 1 of the APM Agreement – "Adolescent Well-Care Visits" has since been combined into "Child and Adolescent Well-Care Visits". This change expands the age range of eligible Medicaid beneficiaries to include 3 – 21-year-old members (previously 12 – 21-year-old beneficiaries). Among other changes, HEDIS also removed the telehealth exclusion, helping to capture a more complete picture of primary care patterns during the PHE. As seen in the chart below, while the results are similar, the eligible population more than doubled between the 2019 and 2020 PYs (24,151 vs. 56,747 respectively). The chart below begins with PY0 as this is a measure of all Medicaid eligible beneficiaries, regardless of ACO-alignment.



Given this methodology change, PY1 and PY2 are no longer comprable and cannot be tracked and trended over time, posing difficulty in measuring progress towards quantitative milestones set forth in Appendix 1 of the APM Agreement. This change occurred after the proposed extension and APM Agreement redline was submitted for consideration to CMMI in December of 2021. ***Because of these specifications changes, the State hopes to work with CMMI to update the baseline and target rates currently listed in Appendix 1 of the APM Agreement.*** It should also be noted that this measure is subject to volatility as Medicaid scale continues to grow – the GMCB will continue to identify denominator changes and their impact on the ability to draw conclusions on aligned beneficiary health over time.

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.[35] 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

[35] 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.

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 Initiative, and collaboration with Medicaid and participating commercial payers to reflect Vermont's priorities for quality improvement."*[36]

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 2020, approximately 231,000 of 643,000 Vermonters (36%) were attributed to OneCare's network. 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 PY2-3 (2019 and 2020), 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.[37] 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

[36] All-Payer Model Implementation Improvement Plan; https://gmcboard.vermont.gov/sites/gmcb/files/documents/APM%20Implementation%20Improvement%20Plan%20Final%2011.19.20.pdf.
[37] See Appendix B.

impacted, Vermont will be tracking how ACO's and State are affecting health outcomes both separately and together.[38,39]

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.

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. An example of these changes can be seen in the 2020 contract amendments to allow for financial flexibilities related to the Public Health Emergency.[40]

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 priority 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 Quality Improvement Committee.

OneCare's 2020 clinical priorities were to:[41]

1. Decrease acute inpatient admission rate for high and very high risk cohorts;
2. Decrease emergency department utilization rate for high and very high risk cohorts;
3. Increase engagement in Care Coordination of Identified High Risk Population;
4. Increase patients with diabetes with A1c performed within 12 months;
5. Increase Medicare patients with an annual wellness visit within 12 months;
6. Increase Medicaid and Commercial patients with an adolescent well-care visit within 12 months;
7. Increase Medicaid and Commercial patients with developmental screening.

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[38] The GMCB 2018 ACO Oversight Process https://gmcboard.vermont.gov/content/2018-aco-oversight.
[39] Vermont Department of Health. State Health Improvement Plan. https://www.healthvermont.gov/about-us/how-are-we-doing/state-health-improvement-plan.
[40] https://gmcboard.vermont.gov/sites/gmcb/files/documents/payment-reform/Vermont%20letter%20to%20CMS%20CMMI%20re%20COVID-19.pdf.
[41] 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.

The process for identifying the 2020 clinical priorities and progress on the measures was discussed in both the 2021 and 2022 OneCare budget submissions.[42,43] OneCare stated in its FY21 submission that the process for identifying the clinical priorities remained consistent year over year. 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.[44] As in 2019, the 2020 priorities were identified as clinically important, represented opportunity for improvement, and could be monitored monthly with available data for timely action. For 2020, OneCare eliminated three of the twelve clinical priorities from 2019: decreasing inpatient admission rate for COPD for patients with COPD, decreasing inpatient admission rate for CHF for patients with CHF, and decreasing emergency department visit rate for asthma for patients with asthma (pediatric and adults). The seven priorities that remained for 2020 are the same as 2019.

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 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 Value Based Incentive Fund (VBIF). In 2020, as in the previous two 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, a new payer program in 2020, 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.[45] OneCare stated the most significant year-over-year change in the VBIF policy occurred in 2020. At a high level, the VBIF is broken into two pools: 70% for primary care and 30% for general distribution. In 2020, 10% of the 70% primary care pool was reserved for practices that exceeded the network average on primary care engagement by payer. Of the 30% general pool, another 10% component was reserved for quality investments as approved by the OneCare Board of Managers while the other 20% was distributed to the remainder of the network who qualified based on the proportion of the total cost of care spend.[46]

5.2. Provider Contracts

OneCare's 2020 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 2020, OneCare added one hospital, Copley Hospital, that participated in the Vermont Medicaid Next Generation (VMNG) Program. Additionally, Springfield Hospital transitioned from participating in all payer programs to only participating in VMNG and BCBSVT programs. This move noticed

[42] OneCare ACO 2021 Fiscal Year Budget Submission. Section 7, pp. 47-55. Available at: https://gmcboard.vermont.gov/document/onecare-fy2021-budget-submission-documents.
[43] 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.
[44] See footnote 36.
[45] OneCare Vermont's Value-Based Quality Incentive Fund Policy. Policies are available upon request.
[46] VBIF Variable Memo Q3. October 25, 2019. Available at: https://gmcboard.vermont.gov/sites/gmcb/files/files/payment-reform/Q3_ACO_Reporting3.zip

seven of Vermont's 14 hospitals fully participating in all three programs, down from eight in 2019. DHMC continued to participate in the Medicaid and Commercial programs.[47] OneCare also added three FQHCs, three independent primary care practices, one naturopath, four independent physical therapy practices, one designated mental health agency, three skilled nursing facilities, one surgical center, and three independent specialty practices to its 2020 network.[48]

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 2020 population health investments were derived from two sources: public and private payer agreements and individual participation fees from hospitals. In the 2020 OneCare Vermont ACO Budget Order, 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, to fund the SASH and Blueprint for Health programs at an amount trended forward from 2019, to use its community-specific quality health investments to address cost and quality differences across Health Service Areas (HSAs) and report to the GMCB, to develop a workplan to evaluate the effectiveness of its population health investments, and to develop a performance dashboard including population health and financial data by HSA.[49] The 2020 budget order was filed January 31, 2020, just over a month before the PHE was declared due to the worldwide COVID-19 pandemic. On April 6, 2020, the GMCB issued an amendment to the budget order in response to a request from OneCare for relief from several of the conditions to support their provider network at the start of the PHE.[50] The GMCB accepted OneCare's request to waive the quality health investment funded

[47] GMCB ACO Budget Submission 2020 Final. October 1, 2019. Available at: https://gmcboard.vermont.gov/sites/gmcb/files/files/payment-reform/GMCB%20ACO%20Budget%20Submission%202020%20Final.pdf
[48] OneCare Vermont FY20 ACO Budget Order (January 31, 2020). Available at: https://gmcboard.vermont.gov/sites/gmcb/files/documents/payment-reform/FY20%20ACO%20Budget%20Order%2C%20OneCare%20Vermont%3B%2019-001-A.pdf.
[49] OneCare Vermont FY20 ACO Budget Order (January 31, 2020). Available at: https://gmcboard.vermont.gov/sites/gmcb/files/documents/payment-reform/FY20%20ACO%20Budget%20Order%2C%20OneCare%20Vermont%3B%2019-001-A.pdf.
[50] Amendment #1 to OneCare Vermont FY20 Budget Order (April 6, 2020). Available at: https://gmcboard.vermont.gov/sites/gmcb/files/documents/payment-reform/FY20%20ACO%20Budget%20Order%20Amendment%20%231.pdf.

by the hospitals to instead provide immediate financial relief to the hospitals. The remainder of the population health related conditions were amended to adjust the deadlines, giving OneCare more time to respond.

6.1. Detailed Descriptions of OneCare's 2020 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 FY20 budget reflects continued investment in the Blueprint's Patient Centered Medical Home program. Of note, these payments started under the Centers for Medicare and Medicaid Studies Multi-Payer Advanced Primary Care Demo (MAPCP) and the Blueprint for Health. Although this demo has ended with Medicare, 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.

Capitated payment reform program for independent primary care providers

2020 was the third 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 2020, the CPR program incorporated a variable component for care coordination engagement and specific quality measures; however, due to the COVID-19 PHE, the care coordination component was delayed and the quality component was put on hold.[51] In 2020, ten practices participated in either the full or partial capitation models.[52]

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 total VBIF funds are divided into two pools: primary care (70%), and general distribution (30%). New in FY20, of the 70% allocated to primary care providers, 10% was reserved for practices that exceed the network average on primary care engagement by payer. Of the remaining 30%, 10% of the VBIF is allocated to quality improvement initiatives approved by the OneCare Board of Managers and 20% is distributed to the network who qualify. 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,

[51] OneCare Vermont, Comprehensive Payment Reform (CPR) Program Report to the Green Mountain Care Board (2/1/2022), available at: https://gmcboard.vermont.gov/document/january-2022-deliverables.
[52] Ibid.

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 2020, RiseVT anticipated expanding to seven additional cities/towns and implementing a campaign to reduce the consumption of sugar-sweetened beverages by people 18 to 35 years old.[53]

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', 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.[54]

7. Conclusion

This third annual report demonstrates that Vermont is currently on track to meet *three of the five* reportable population-level health outcomes targets (one measure changed), *six of the eight* reportable healthcare delivery system quality targets (one data point of nine was not reported during the PHE), and is making progress toward *three of three* reportable process milestones (one of the seven data points has no benchmark comparison due to Public Health Emergency, three measure changes). In this third year, we must begin to consider how to accurately assess "performance" moving forward. 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 are still developing and may distort trends for many years to come.

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[53] OneCare Vermont FY20 ACO Budget Order (January 31, 2020). Available at: https://gmcboard.vermont.gov/sites/gmcb/files/documents/payment-reform/FY20%20ACO%20Budget%20Order%2C%20OneCare%20Vermont%3B%2019-001-A.pdf.
[54] Ibid.

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. In 2020, OneCare added one additional commercial payer program and worked to expand its Medicaid population by introducing a geographic attribution pilot. The GMCB continues to monitor the ACO's quality programs to ensure alignment 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.

The State of Vermont looks forward to continuing dialogue around changes to Appendix 1 of the APM Agreement as measures evolve and scale stabilizes. Through this annual reporting, we will continue to identify denominator changes, 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

Measure	Methodology
Opioid-Related Deaths Among Vermonters (Statewide)	**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: **ICD Codes Used in Drug-Related Fatalities Analysis (beyond those used by CDC)** X45, F10.0, F14.0, F17.0 X65, F10.1, F14.1, F17.1 Y15, F11.0, F15.0, F18.0 T36-T50, F11.1, F15.1, F18.1 T51.0, F13.0, F16.0, F19.0 F13.1, F16.1, F19.1 **Source:** Vermont Department of Health, Alcohol and Drug Abuse Programs.
Deaths Related to Suicide (Statewide)	**Calculation:** Cause of death is coded by ICD-10 Intentional Self-Harm (Suicide). **Source**: Vermont Department of Health, Vital Statistics; Vital Statistics Bulletin (2017).
COPD Prevalence (Statewide)	**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.
Diabetes Prevalence (Statewide)	**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?" **Notes:** This information is collected annually by the state of Vermont and nationally by the CDC.

Measure	Methodology
	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.
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

Measure	Methodology
	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 - Impulse control disorders - Mood disorders

Measure	Methodology
	- 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 - Alzheimer's disease and related disorders or senile dementia - A Fib

Measure	Methodology
	- 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
Percentage of Vermont Providers Checking Prescription Drug Monitoring Program Before Prescribing Opioids (Statewide)	**Calculation:** The number of Vermont Prescription Monitoring System queries by prescribers who have written at least one opioid analgesic prescription divided by the number of unique recipients who have received at least one opioid analgesic prescription. **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. **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. 2018 baseline and 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. 2018 baseline and 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 percent of all Medicaid-enrolled Vermonters who are aligned to the ACO in PY1. Performance is compared to the Medicare-enrolled proportion of Vermonters as reported in the 2018 Annual Scale Targets and Alignment Report. **Source:** Department of Vermont Health Access (Medicaid).

Appendix B: Measure Crosswalk

Measure	Vermont All-Payer ACO Model	2020 Vermont Medicaid Next Gen	2020 Medicare Initiative	2020 BCBSVT Next Gen/ UVMMC	2020 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 adolescents with well-care visits	X	X		X	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	X	X	X	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	X	X			
30-day follow-up after discharge from emergency department for mental health	X	X	X	X	X	
30-day follow-up after discharge from emergency department for alcohol or other drug dependence	X	X	X	X	X	
% of Vermont residents receiving appropriate asthma medication management	X					

Measure	Vermont All-Payer ACO Model	2020 Vermont Medicaid Next Gen	2020 Medicare Initiative	2020 BCBSVT Next Gen/ UVMMC	2020 MVP Next Gen	Notes
Screening for clinical depression and follow-up plan (ACO-18)	X	X	X	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	X	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	X	X	X	X	
Diabetes Mellitus: HbA1c poor control	X	X	X	X	X	
All-Cause unplanned admissions for patients with multiple chronic conditions	X	X	X			

Measure	Vermont All-Payer ACO Model	2020 Vermont Medicaid Next Gen	2020 Medicare Initiative	2020 BCBSVT Next Gen/ UVMMC	2020 MVP Next Gen	Notes
Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient experience surveys	X	X	X	X	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. Vermont Medicaid Next Gen includes multiple CAHPS PCMH composites for ACO-attributed Medicaid 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)				X	X	
Risk-standardized, all-condition readmission (ACO-8)			X			
Influenza immunization (ACO-14)			X			
Colorectal cancer screening (ACO-19)			X			
Developmental screening in the first 3 years of life		X		X		
Follow-up after hospitalization for mental Illness (7-Day Rate)		X		X	X	