

The All-Payer ACO Model Agreement lays out 21 statewide health outcomes and quality of care targets, with three population health goals: increasing access to primary care, reducing death due to suicide and drug overdose, and reducing morbidity of chronic disease. To achieve these goals, OneCare Vermont, Vermont's only accountable care organization, is facilitating increased collaboration among hospitals, primary care providers, and community providers (including home health providers, mental health agencies, Area Agencies on Aging) with the goal of providing whole-person care for patients. Currently twelve of the fourteen health service areas in Vermont are participating in the model, giving the model statewide reach as scale increases.

The All-Payer ACO Model seeks to transform care for Vermonters in two ways: 1) Changing financial incentives and increasing funding for primary care and community-based services; and 2) Providing support for care transformation and quality improvement activities.

### **1) Changing Financial Incentives and Increasing Funding for Primary Care and Community-Based Services**

The ACO model supports care transformation through alternative payment methodologies including population-based payments; monthly payments to support primary care and care management; and investments in population health activities.

- *Population-Based Payments*: ACO-participating hospitals and a growing number of independent primary care practices are receiving monthly prospective payments for their patient panel. There is growing evidence that this payment model provides providers' flexibility in care delivery (e.g. telemedicine, co-location of mental health), promotes a focus on health and the social determinants of health (e.g. increased access to healthy food), and redirects financial focus on expense management.
- *Monthly Payments to Support Primary Care and Care Management*: Primary care and care management are the backbones of Vermont's All-Payer ACO Model; they are critical services for keeping patients healthy and well cared for in community settings. OneCare provides per-member per-month (PMPM) payments to participating primary care practices, as well as enhanced PMPMs for practices or community-based providers who take on care management responsibilities for the most complex patients. These payments are supported by Medicare funding and by fees from other payers and hospitals in the total amount of \$37.5 million (including over \$8 million in Medicare funding) in 2019.
- *Investments in Population Health Activities and Clinical Quality Improvement*: OneCare is distributing population health dollars received through payer contracts and hospital participation fees to support communities in the network in identifying and providing coordination for patients who need additional care management; to provide project management, clinical leadership, and quality improvement support through Community Collaboratives; to utilize software and data provided by OneCare to support coordination of care; and to build primary prevention and new innovation programs. In 2019, OneCare has projected \$37 million in total payments to support primary care and care management and investments in population health activities.

### **2) Providing Support for Care Transformation and Quality Improvement Activities**

In addition to direct financial support, OneCare and the State provide practice transformation and infrastructure supports to increase collaboration across the care continuum.

- *Community Collaboratives/Accountable Communities for Health*: OneCare and the Blueprint for Health have collaborated to build local infrastructure in each region of the state to support clinical quality improvement and health care-public health integration. These collaboratives are staffed by a OneCare clinical consultant, Blueprint for Health Project Manager, and a local physician who receives funding from OneCare to champion clinical change. OneCare also operates a Population Health Strategy Committee and a Clinical and Quality Committee which meet regularly to drive network-wide priority-setting for clinical quality improvement and population health efforts.
- *Data Infrastructure and Analytics*: OneCare has a multi-layer analytic platform that compiles claims data to develop trends on cost and quality measures. These are used to inform regional clinical improvement through the Community Collaboratives, as well as practice-specific quality improvement. OneCare is also implementing a cloud-based care management tool which allows a team of providers to document care management goals and progress and communicate to improve patient care.
- *Evidence-Based Prevention Programs*: OneCare is adopting evidence-based programs to promote development of healthy beginnings and community engagement toward healthy lifestyle programs. For example, in 2019 OneCare is funding the expansion of a legal-medical model, DULCE, by supporting a project coordinator to ensure families with newborns have resources they need. In addition, OneCare has adopted and expanded RiseVT, founded in Franklin and Grande Isle Counties, by providing funding for project coordination. The RiseVT model works with individuals, employers, schools, childcare providers, and municipalities to improve community health by making the healthy choice the easy choice.

**VERMONT ALL-PAYER ACO MODEL – ACO QUALITY MEASURES SUMMARY**

The Quality Framework outlined in the APM Agreement includes 20 measures with statewide quality targets, with an additional measure under development. These measures were negotiated by the State of Vermont and CMS in 2016, and are intended to support improvement on three population health goals: improving access to primary care, reducing deaths from suicide and drug overdose, and reducing the prevalence and morbidity of chronic disease. Preliminary Quality Framework results are below.

Measure [Source]	Baseline	Current	PY5 (2022) Target
Percentage of adults with a usual primary care provider [BRFSS]	87% (2014)	87% (2017)	89%
Medicare ACO Composite of 5 questions on getting timely care, appointments, and information [ACO CAHPS survey]	~70-80 <sup>th</sup> percentile	TBD <sup>1</sup>	75 <sup>th</sup> percentile compared to Medicare nationally
Percentage of Medicaid adolescents with well-care visits [Claims]	25 <sup>th</sup> percentile	50-75 <sup>th</sup> percentile <sup>2</sup> (2017)	50 <sup>th</sup> percentile compared to Medicaid nationally
Percentage of Medicaid enrollees aligned with ACO [PCP selection and claims]	55.5% (Jan. 2016)	TBD <sup>3</sup>	No more than 15 percentage points below % of Vermont Medicare beneficiaries aligned to a Vermont ACO
Deaths related to suicide per 100,000 [Vital Statistics]	16.9 (2013)	18.9 (2016)	16 per 100,000 Vermont residents <u>or</u> no worse than 20 <sup>th</sup> highest rate nationally
Vermont Resident deaths related to drug overdose [Vital Stats]	129 (2016)	124 (2017)	Reduce by 10% (116)
Multi-Payer ACO initiation of alcohol and other drug dependence treatment [Claims]	25 <sup>th</sup> percentile	TBD <sup>4</sup>	50 <sup>th</sup> percentile
Multi-Payer ACO engagement of alcohol and other drug dependence treatment [Claims]	~75 <sup>th</sup> percentile	TBD <sup>4</sup>	75 <sup>th</sup> percentile
Multi-Payer ACO 30-day follow-up after discharge from ED for mental health [Claims]	56.2% (2014)	TBD <sup>4</sup>	60%
Multi-Payer ACO 30-day follow-up after discharge from ED for alcohol or other drug dependence [Claims]	35.9% (2014)	TBD <sup>4</sup>	40%
Number of mental health and substance abuse-related ED visits [VHUDDS]	6% (2014-15)	5% <sup>5</sup> (2016-17)	3%
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 [ADAP]	1.65 (2016)	TBD <sup>6</sup>	1.80
Multi-Payer ACO screening for clinical depression and follow-up plan [Clinical]	60-70 <sup>th</sup> percentile	TBD <sup>4</sup>	75 <sup>th</sup> percentile compared to Medicare nationally
Number per 10,000 population ages 18-64 receiving Medication Assisted Treatment (MAT) [Hub and Spoke]	123 (2015)	155 <sup>7</sup> (2016)	150 <u>or</u> up to rate of demand
Statewide prevalence of chronic disease: chronic obstructive pulmonary disease (COPD) [BRFSS]	6% (2015)	6% (2017)	Increase statewide prevalence by no more than 1% (7%)
Statewide prevalence of chronic disease: hypertension [BRFSS]	27% (2014)	26% (2017)	Increase statewide prevalence by no more than 1% (28%)
Statewide prevalence of chronic disease: diabetes [BRFSS]	8% (2015)	8% (2017)	Increase statewide prevalence by no more than 1% (9%)
Medicare ACO chronic disease composite: Diabetes HbA1c poor control; Controlling high blood pressure; and All-cause unplanned admissions for patients with multiple chronic conditions [Claims & Clinical]	62 <sup>nd</sup> percentile (2016)	TBD <sup>1</sup>	75 <sup>th</sup> percentile compared to Medicare nationally
Percent of Vermont residents receiving appropriate asthma medication management [Claims]	<25 <sup>th</sup> percentile (2014)	TBD <sup>4</sup>	25 <sup>th</sup> percentile
Multi-Payer ACO tobacco use assessment and cessation intervention [Clinical]	~75 <sup>th</sup> percentile (2014-15)	TBD <sup>4</sup>	75 <sup>th</sup> percentile compared to Medicare nationally

<sup>1</sup> Calculated by Medicare, available with 9/30/19 report. <sup>2</sup> As reported in the 2017 Final VMNG report to the legislature; reflective of Medicaid ACO-attributed lives only. <sup>3</sup> Calculated by the Department of Vermont Health Access and Medicare, separately. <sup>4</sup> Reported by GMCB Analytics Contractor, available with 9/30/19 report. <sup>5</sup> Data presented are shown as a percent change over the previous year. 2016-2017 results are preliminary. <sup>6</sup> Calculated by the Vermont Department of Health, data for 2017 not available at the time of this report. <sup>7</sup> Hubs & Spokes report rates per 100,000. For consistency with the APM, rates have been calculated per 10,000 using 2016 population estimates (ages 18-64).