State of Vermont
Green Mountain Care Board
144 State Street
Montpelier VT 05620

Report to the Legislature

PRELIMINARY QUALITY AND FINANCIAL PERFORMANCE PER THE ALL-PAYER ACO MODEL AGREEMENT

Performance Year 1 (2018)

In accordance with Act 124 of 2018 (H.914)

Submitted to the
House Committees on Appropriations, on Human Services, and on Health Care, the Senate Committees on Appropriations and on Health and Welfare, the Health Reform Oversight Committee, the Medicaid and Exchange Advisory Committee, and the Office of the Health Care Advocate

Submitted by the
Green Mountain Care Board

November 1, 2018

Legislative Charge

The Green Mountain Care Board (the Board) is submitting this report pursuant to Act 124 of 2018, "An act relating to reporting requirements for the second year of the Vermont Medicaid Next Generation ACO Pilot Project." Section 2 of the Act provides:

(a) On or before June 15, September 15, and December 15, 2018, the Green Mountain Care Board shall provide to the House Committees on Appropriations, on Human Services, and on Health Care, the Senate Committees on Appropriations and on Health and Welfare, the Health Reform Oversight Committee, the Medicaid and Exchange Advisory Committee, and the Office of the Health Care Advocate written updates on the Board's progress in meeting the benchmarks identified in the Board's Year 1 (2018) All-Payer ACO Model Timeline regarding implementation of the All-Payer Model and the Board's regulation of accountable care organizations.
(b) The Board shall also provide to the committees and office described in subsection (a) of this section, to the extent permitted under federal law, the analysis of health care spending required by the Vermont All-Payer ACO Agreement, including:
    (1) on or before August 1, 2018, information regarding whether the number of attributed lives is consistent with the scale targets in the All-Payer Model ACO Agreement; and
    (2) on or before November 1, 2018, quality and financial performance information.

2018 Acts and Resolves No. 124, § 2.

Introduction

The Vermont All-Payer Accountable Care Organization Model Agreement (APM Agreement or Agreement), was signed on October 26, 2016 by Vermont's Governor, Secretary of Human Services, Chair of the Green Mountain Care Board (GMCB), and the Centers for Medicare and Medicaid Services (CMS). It aims to reduce health care cost growth by moving away from fee-for-service reimbursement to risk-based arrangements for ACOs that are tied to quality and health outcomes.

1. Preliminary Quality Performance Results

The Quality Framework outlined in the APM Agreement includes 20 measures with statewide quality targets, and an additional measure that is under development. These measures were negotiated by the State of Vermont and CMS in 2016, and are intended to support improvement on three important population health goals: improving access to primary care, reducing deaths from suicide and drug overdose, and reducing the prevalence and morbidity of chronic disease. The measures build on Vermont's health priorities, and rely on a variety of data sources, including consumer surveys, medical records, claims, hospital discharge data, and survey data collected by the Vermont Department of Health (VDH). The Framework's inclusion of ambitious population health goals encourages health care, public health, and community service providers to work together to improve the quality and integration of care for Vermonters.

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 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").* The first iteration of this report is due to CMS on September 30th of 2019, at which time complete results will become available. Copies of the *Annual Health Outcomes and Quality of Care Report* will be submitted to the recipients of this report upon completion.

Figure 1, below, summarizes the measures, the quality targets to be attained by the final year of the Agreement (2022), the baseline results, and more current results when available. This table reflects **preliminary** data from payers, surveys, and other sources; final data collection and reconciliation for will occur throughout the remainder of the calendar year, and numbers are expected to change.

Figure 1: All-Payer Model Measure Summary

Measure (Source)	Baseline	Current	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]	~70-80th percentile	TBD[1]	75th percentile compared to Medicare nationally
Percentage of Medicaid adolescents with well-care visits [Claims]	25th percentile	50-75th percentile[2] (2017)	50th percentile compared to Medicaid nationally
Percentage of Medicaid enrollees aligned with ACO [PCP selection and claims]	55.5% (Jan. 2016)	TBD[3]	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 or no worse than 20th 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]	25th percentile	TBD[4]	50th percentile
Multi-Payer ACO engagement of alcohol and other drug dependence treatment [Claims]	~75th percentile	TBD[4]	75th percentile
Multi-Payer ACO 30-day follow-up after discharge from ED for mental health [Claims]	56.2% (2014)	TBD[4]	60%
Multi-Payer ACO 30-day follow-up after discharge from ED for alcohol or other drug dependence [Claims]	35.9% (2014)	TBD[4]	40%
Number of mental health and substance abuse-related ED visits [VHUDDS]	6% (2014-2015)	5%[5] (2016-2017)	3%
The number of Vermont Prescription Monitoring System (VPMS) 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[6]	1.80
Multi-Payer ACO screening for clinical depression and follow-up plan [Clinical]	60-70th percentile	TBD[4]	75th percentile compared to Medicare nationally
Number per 10,000 population ages 18-64 receiving Medication Assisted Treatment (MAT) [Hub and Spoke]	123 (2015)	155[7] (2016)	150 or 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, consisting of: diabetes HbA1c poor control; controlling high blood pressure; and all-cause unplanned admissions for patients with multiple chronic conditions [Claims & Clinical]	62nd percentile (2016)	TBD[1]	75th percentile compared to Medicare nationally
Percent of Vermont residents receiving appropriate asthma medication management [Claims]	<25th percentile (2014)	TBD[4]	25th percentile
Multi-Payer ACO tobacco use assessment and cessation intervention [Clinical]	~75th percentile (2014-15)	TBD[4]	75th percentile compared to Medicare nationally

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

2. Preliminary Financial (Total Cost of Care) Performance

Total Cost of Care (TCOC) per beneficiary – the cost of care per Vermonter for a specified set of services – growth targets will be calculated for all payers and for Medicare, as described in Section 9 (Statewide Financial Targets) of the Agreement. All-Payer Model TCOC differs from other measures of health system cost such as ACO spending per beneficiary, total Vermont health care expenditures, and hospital net patient revenue; it is limited to a specific population and set of services. The Vermont All-Payer TCOC numerator includes spending on Medicare Part A and B-equivalent services, though services vary somewhat by payer type. Payments include health care claims and some non-claims payments (prospective payments, shared savings payments, Blueprint for Health payments, etc.). The Vermont All-Payer TCOC denominator includes all insured Vermonters, excluding members of plans without a Certificate of Authority from the Vermont Department of Financial Regulation, and self-funded employer plans that decline to submit data to VHCURES. Vermont All-Payer TCOC per Beneficiary Growth will be calculated in aggregate as a compounded annualized growth rate across PYs 1-5, using 2017 as a baseline.

GMCB Staff have worked with the GMCB analytics contractor, federal partners, and Vermont partners (including DVHA, Blue Cross Blue Shield of Vermont, and OneCare Vermont) to develop, refine, and validate specifications to measure TCOC using data from VHCURES, supplemented with payer data. These specifications were tested during summer and fall of 2018, in anticipation of producing our first quarterly report to CMS by the end of calendar year 2018.

TCOC base year results were not available at the time of this report; claims submission and analysis require nine or more months after date of care. As reflected in Figure 2, below, Quarter One (Q1) 2018 TCOC results will be available in early 2019; full Performance Year (PY) 1 TCOC will be available in Q3 of PY2 (2019). Copies of GMCB's quarterly and annual TCOC reports to CMS will be submitted to the recipients of this report upon completion.

Figure 2: Total Cost of Care Reporting Timeline

YEAR 1				YEAR 2			
Q1 2018	Q2 2018	Q3 2018	Q4 2018	Q1 2019	Q2 2019	Q3 2019	Q4 2019
Q1 2018 claims incurred	Q1 2018 claims paid	Q1 2018 received in VHCURES	**Q1 2018 Report to CMMI**				
	Q2 2018 claims incurred	Q2 2018 claims paid	Q2 2018 received in VHCURES	**Q1-Q2 2018 Report to CMMI**			
		Q3 2018 claims incurred	Q3 2018 claims paid	Q3 2018 received in VHCURES	**Q1-Q3 2018 Report to CMMI**		
			Q4 2018 claims incurred	Q4 2018 claims paid	Q4 2018 received in VHCURES	**2018 Annual Report to CMMI**	