VERMONT

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October 28, 2019

Senator Ann Cummings
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Senator Richard Westman

Dear Legislators,

In follow-up to your letter requesting more information on October 18, 2019, please see the answers below.

Delivery system reform (DSR) funding

Questions 1 & 4: Your August 23, 2019 letter to Governor Scott and Deputy Secretary Maksym said, with respect to the level of DSR funding, that "the lack of support early in the Model for these reforms has made it difficult for the ACO to implement its programs." What was the specific basis on which you made this statement? Please explain the rationale for making this assertion now, and why you did not express it earlier if it was of such concern.

It is well documented that health care reform requires significant investment and commitment.[1] This has long been recognized in Vermont. Both the Blueprint for Health and the Vermont Healthcare Innovation Project structured delivery system reform around three pillars: changes in payment, a technology focus to build actionable information to providers, and technical assistance to promote operational changes to the delivery of care.

When the All Payer ACO Model (APM) was presented to the Green Mountain Care Board (GMCB or "the Board"), and to the Legislature in 2016, a key consideration was the potential to access delivery system reform dollars from the State and the Federal government as "start-up" funds for operational transformation needed to achieve the goals of the APM. [2] I recognize that the full amount of reform dollars is subject to the availability of state funds and might not be spent. However, the potential to access this funding was not only foundational to the State supporting its advancement, but also in bringing along the support of the ACO, hospitals, physicians, and other community providers. At the time of the Board vote, one board member specifically referenced the DSR dollars as a significant

[1] Brent C. James, MD & Gregory P. Poulsen, *The Case for Capitation*, Harv. Bus. Rev., July-August 2016 *available at* https://hbr.org/2016/07/the-case-for-capitation.
[2] GMCB Presentation, Vermont All-Payer Accountable Care Organization Model, September 28, 2016 *available at* https://gmcboard.vermont.gov/sites/gmcb/files/files/VT-AP-ACO-MODEL-Final-9-29-2016.pdf.

contributor to the decision to move forward with the agreement: "It's giving us access to $200 plus million dollars, that we [would] not otherwise have, but for this agreement. That's critical money coming into this state…"

From the Board's vantage point (largely hospital and ACO budget regulation), it appears that the DSR and HIT funding has contributed less than $14 million over 3 years.[3] I fully recognize that there are competing needs across the healthcare and human services system, but with the considerable financial pressures facing hospitals (please see below) and the significant operational investments needed to reform the delivery system, I thought it timely to revisit the potential to access the $56 million in DSR funds still on the table.[4]

It is our understanding from our role as regulators, that hospitals have been the majority funders of delivery system reform activities to date, paying $34.7 million to OneCare in the form of dues.[5] Through this year's hospital budget process, it became apparent that the financial pressures facing hospitals have grown to a critical point. With over 118 rural hospital closures nationally since 2010,[6] one Vermont critical access hospital in bankruptcy, and six hospitals facing significant financial issues, the Board instituted additional monitoring of six hospitals and required five hospitals to engage with us in sustainability planning. As hospitals face greater financial headwinds due to an aging population with higher acuity, rising costs of pharmaceuticals, workforce shortages and the resulting wage pressures, a growth in bad debt and free care, and for some hospitals a payer mix more heavily reliant on government funded plans, investing in delivery system reform becomes even more challenging.

Innovation and system transformation require upfront investment. Lower initial investments are likely to translate into fewer innovative population health programs and slower roll-out.

Questions 2 & 3: What did not happen that would have happened if the amount of DSR funding had been greater? Please provide a detailed description of how additional funds would have been expended and the expected benefit to Vermont patients and consumers.

DSR funding requires an application and an approval process that is managed by AHS. While the Board cannot anticipate what the ACO would have submitted, nor what AHS and their federal partners would

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[3] GMCB does not have access to DVHA's actual expenditures; amounts reflect materials submitted by OneCare Vermont through the Board's ACO regulatory process. The SFY2020 DVHA budget book shows $1,787,375 in DSR investments in SFY2018. Dept. of Vermont Health Access, *Annual Report & SFY 2020 Budget Recommendation* 159 (Feb. 1, 2019) *available at* https://dvha.vermont.gov/budget-legislative/2dvha-annual-report-and-sfy-2020-budget-recommendation.pdf. The SFY2019 DVHA budget book requested $2.6M in DSR Investments. Dept. of Vermont Health Access, *Budget Recommendation State Fiscal Year 2019* 146 (Jan. 31, 2018).

[4] The sum of capacity FY2020 & FY2021. *See* GMCB PowerPoint, Vermont All-Payer Accountable Care Organization Model, 14 (Sept. 28, 2016) *available at* https://gmcboard.vermont.gov/sites/gmcb/files/files/VT-AP-ACO-MODEL-Final-9-29-2016.pdf.

[5] Sum of dues to OCV from Hospitals Q1 2016 through Q2 2019 Actuals as reported in hospital budget submissions. *See* https://gmcboard.vermont.gov/hospital-budget (last visited Oct. 28, 2019).

[6] U.N.C. Cecil G. Sheps Center for Health Services Research, 160 Rural Hospital Closures: January 2005-Present (118 since 2010), https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/ (last visited Oct. 28, 2019).

have approved, it is reasonable to believe that programs aligned with Appendix I of Vermont's 1115 Medicaid Waiver[7] would be ripe for their consideration.

Examples of programs underway at OneCare that align with this funding stream and may benefit from additional funding include (but are not limited to): learning collaboratives, expansion of the Value Based Incentive Fund (VBIF) program to reward provider quality performance, implementation of its care coordination tool, "Care Navigator", and additional programs focused on mental health and primary care.

Other areas of opportunity that align with this funding stream that have not yet been leveraged by OneCare include (but are not limited to): technical assistance to providers to assist in operational change, statewide diabetes and chronic conditions programs, and surgical optimization standards.

Such projects would have and can still provide benefits to Vermonters and consumers by improving health outcomes and health care quality, reducing health care costs, and improving access to health care.

Earlier access to DSR funding likely would have eased the transition from fee for service to value-based payment and reduced the financial burden on hospitals. Those that have been making strides in our shift to a value-based system have articulated that the slow return on investment itself is threatening their financial viability. Investments in population health take time to produce savings, as these investments are designed to prevent future disease. In the interim, hospitals and other providers still need to manage and treat disease for Vermonters. This two-world problem, paired with insufficient investment, has potential to burden our hospitals, and put quality and access to care at risk for Vermonters, especially those in our rural communities.

Leon Berthiaume, Board Chair of Northwestern Medical Center writes in support of the hospital's 2020 budget submission "…[A]t the same time Northwestern Medical Center is a leader in OneCare VT and the success of the all payer model[, i]t is challenging to have a revenue cap on one hand and hold the responsibility to fund the transformation and carry the risk of an emerging capitated system. We have been all in from the start reducing avoidable emergency department visits and readmissions, and investing in the proven steps for our sustainable future in care management, health coaching, and primary prevention with RiseVT. All initiatives supported by the GMCB as the right things to do. The challenge is funding the future when there is no reimbursement for prevention, there is insufficient Medicaid reimbursement, and literally no incentive for providers and the population to align in this new reality. It is a major investment of time and money. All while maintaining our low cost position… The

[7] Ctrs. for Medicare & Medicaid Servs., Waiver Authority, Global Commitment to Health Section 1115 Demonstration (Jan. 1, 2017- Dec. 31, 2021) (Awardee Vermont Agency of Human Services) *available at* https://dvha.vermont.gov/global-commitment-to-health/vt-1115-extension-waivers-exp-author-stcs-techncial-corrections-no-track-changes06212017.pdf.

leadership team is fully engaged to make the necessary changes. The impact is real for us; our balance sheet is showing the strain of our proactive positioning."[8]

Medicaid cost-shift

Your August 23, 2019 letter to Governor Scott and Deputy Secretary Maksym said that "[t]he actual cost shift for Vermont hospitals in FY2018 was $458 million with Medicaid accounting for $207 million," and you encouraged the Governor to propose using more taxpayer dollars to provide additional Medicaid funds to Vermont's network of hospitals.

Questions 1 & 2: Was this recommendation intended to apply to all Vermont hospitals whose budgets the Green Mountain Care Board reviews, or just to a subset of them? If a subset, please tell us which hospitals and why they stand out. How did you conclude that the people of Vermont would be better served by directing additional Medicaid funds to hospital-based services, rather than using the funds for primary care and prevention services, including mental health services and substance use disorder treatment? Is it the Board's position that the taxpayers and patients of Vermont will receive greater benefit from additional hospital spending, rather than additional spending in these other areas?

As the Governor acknowledges in his response to the August 23, 2019 letter, recent Medicaid investments, while aimed at supporting downstream community-based health providers, have largely left hospitals out of the equation.[9] This, paired with cuts in Disproportionate Share payments, raise concerns that Medicaid contributions to our hospitals are not keeping pace with the rising cost of health care and are adding to the financial headwinds faced by our hospitals. Disproportionate Share has declined from a system-wide total of $37 million in FY 2016 to a projected $22.7 million in 2019. When public payers fail to keep pace with medical inflation, hospitals likely face two choices to maintain their financial solvency: cut costs (some of which may be efficiency-generating but some of which may compromise access and quality) or find ways to generate more revenue, which may be through higher commercial rate requests. The Board witnessed both in the hospital budget process this year; hospitals reported on cost containment strategies as well as the need to increase commercial rates to cover public payers not keeping up with inflation. Some of the narrative from the community hospitals around this topic were that "(n)either Medicare or Medicaid are covering the cost of the care [they] provide to their beneficiaries." Another hospital went further, stating "(m)ore than anything else, inadequate reimbursement from Medicare and Medicaid is driving both the cost shift and this low margin." Perhaps most worrisome is that if Medicaid fails to keep pace with inflation, hospitals in the most vulnerable areas in the state will be disproportionately affected.

The intent of my letter is not to demand resources or to propose a particular methodology for directing dollars to hospitals, but rather to alert the financial and legal experts on Medicaid reimbursement as to

[8] Letter from Leon Berthiaume, Board Chair, Northwestern Med. Ctr. to GMCB (June 28, 2019) *available at* https://gmcboard.vermont.gov/sites/gmcb/files/documents/B20%20H25%20NMC%20Board_Chair_Letter.pdf.

[9] "[W]orking together, we actually increased rates to Medicaid providers by more than $40 million over the past five years, while enrollment declined… …While these investments are not direct Medicaid increases to hospitals, they buffer Vermont's downstream, community-based health providers to mitigate upstream costs in more expensive settings."

what the Board has witnessed through our regulatory role, and consider this information in funding decisions in the upcoming legislative session. The Board will be ready and willing to provide any and all information available to us on the impact of certain funding decisions on the private sector, which is a significant component of our Vermont health care system.

Question 3: Primary care practices, mental health agencies, dentists, and other providers who serve large numbers of Medicaid beneficiaries frequently struggle financially due to relatively low Medicaid reimbursement rates. Please explain why you have publicly advocated for increased reimbursements for hospitals, but not for these other providers.

The board's regulatory breadth is largely limited to Vermont's 14 community hospitals, representing 42%[10] of health care spending in the State. As a result, we have limited insight and no regulatory authority over the budgets and financial health of independent primary care practices, mental health agencies, dentists or other providers serving large numbers of Medicaid beneficiaries. However, I do not see investing in hospitals and these other providers as mutually exclusive decisions. Through our regulatory lens, one means of improving contributions by Medicaid to both hospitals and these providers may be to tap into more DSR funds (see Attachment I, Category 2 investments). There is already evidence that such funding would be leveraged by hospitals to invest directly in these types of programs and services. More than half of Vermont's primary care providers are employed by hospitals[11] and hospitals are actively embedding mental health and social workers in their EDs and practices (e.g. Rutland Regional, Southwestern Medical Center, University of Vermont Medical Center). Some hospitals have even opened dentistry services on campus (e.g. Brattleboro and Southwestern Medical Center) or have expanded their services to include medication-assisted treatment (e.g. CVMC). The synergistic potential of these investments can be attributed to the ACO's shared governance structure, which aligns hospital financial incentives to encourage cost containment and operational change at the hospital while encouraging the hospital to invest in the community providers and prevention.

Question 4: If the cost-shift is a manifestation of a fee-for-service system, to what extent will it be phased out by the transition to value-based payments?

The cost-shift is not unique to a fee-for-service system. Cost-shifting may occur if public payers reimburse below the cost of care, regardless of how payments are structured. While a value based system will incentivize hospitals to plan long-term efficiencies rather than pursue volume-based strategies to improve their bottom line, if government payers fail to keep pace with inflation even in a fixed payment world, hospitals will face the same decisions as now to maintain solvency: cut costs based

[10] GMCB Presentation, 2017 Vermont Health Care Expenditure Analysis (Mar. 2019) *available at* https://gmcboard.vermont.gov/sites/gmcb/files/2017_Expenditure_Analysis_with_projections_March_27_2019.pdf.

[11] Memorandum from GMCB to Health Reform Oversight Committee re Payment Differential & Provider Reimbursement Report 5-6 (Oct. 1, 2017) *available at* https://gmcboard.vermont.gov/sites/gmcb/files/files/resources/GMCB_Fair%20Reimbursement%20Report_Oct_1_2017_FINAL.pdf.

on profitability, not necessarily value (and potentially reduce services or quality), or look for revenue increases from commercial payers over whom they may have more leverage.

Global Commitment waiver budget neutrality cap

Spending up to the Global Commitment waiver's budget neutrality cap exposes Vermont to risks, such as the impact on the Medicaid budget in the event of a recession. How close does the Board think Vermont can come to reaching the cap without taking an inappropriate risk?

As noted in the letter to the Governor and then interim Secretary Maksym, the GMCB recognizes the challenge associated with Medicaid's budget neutrality cap. Despite the State's commitment to transparency, it is difficult for the GMCB as a regulator to follow which investments have been made across Vermont's healthcare system in areas that we do not directly oversee. Without this information it would be irresponsible for the Board to make a recommendation on Vermont's approach to managing the Medicaid cap.

OneCare Vermont's FY2020 budget submission

Questions 1 & 2: What does the Board think OneCare Vermont intends to do with the additional $13.1 million it seeks in its FY2020 budget submission? Does the Board believe that providing OneCare Vermont with an additional $13.1 million in Medicaid funds is the most appropriate use of this scarce resource? Please provide a detailed explanation of the administrative expenses at One Care and its analysis of whether this level of administrative spending is appropriate.

Since the Board has not yet formally engaged on OneCare's 2020 budget, it would be premature to provide any judgement on the matter beyond technical clarifications. OneCare's budget presentation is currently scheduled for October 30, 2019, and I welcome your attendance.[12] OneCare's budget submission for 2020 can be found on the GMCB website.[13]

Delivery System Reform: The $13.1 million for delivery system reform activities budgeted by OneCare Vermont includes additional sources of funding than what we traditionally refer to as DSR funding. That which is traditional DSR funding is $7.8 million and represents both State and Federal shares. Of the total $7.8 million, $1.8 million are for programs already funded by DSR dollars, while $6.0 million are for new programs. Using the Medicaid program match rate for State Fiscal Year 2020, this means that OneCare Vermont's request to the State would be approximately $3.6 million in total or just under $2.8 million for new programs. At a high level these new programs are to expand care coordination for chronic conditions and to invest in behavioral health in an effort to address overarching APM population-level health outcomes targets, healthcare delivery system quality targets, and process

[12] GMCB, Board Meeting Agenda (Oct. 30, 2019) *available at* https://gmcboard.vermont.gov/sites/gmcb/files/documents/Agenda%2010.30.19.pdf.
[13] GMCB, 2020 ACO Oversight, https://gmcboard.vermont.gov/content/2020-aco-oversight (last visited Oct. 28, 2019).

milestones. The APM agreement[14] requires tracking and reporting on three overarching goals specified under the Statewide Health Outcomes and Quality of Care Targets as 1) Population-Level Health Targets 2) Healthcare Delivery System Quality Targets and 3) Process Milestones. See **Appendix 1** for the APM Agreement targets.

Administrative Expenses: In 2019 OneCare budgeted $15.9 million in administrative expenses up from $12.5 million in 2018. Administrative expenses include staff wages and benefits, contracted services (actuarial and software development), software subscriptions, risk protection, occupancy, travel supplies, etc. However, OneCare's administrative expense ratio, which measures its administrative costs relative to the scale of its operations (total budget), *decreased* to **1.77%** in 2019 from 1.95% in 2018. The Board's budget order for 2019 put a cap on OneCare's administrative expense ratio at 1.77%, with a demand to decrease administrative expenses should the projected revenues fall.[15]

Question 3: Please provide a plain language explanation of the benefits Vermonters have received to date through Medicaid investments in OneCare Vermont.

It is hard to isolate the effect of Medicaid investments alone, but payment reform broadly has already had a profound effect on the investment choices of hospitals and practices, which in turn has the strong potential to produce positive effects on cost, quality, and access to health and healthcare for Vermonters. The APM offers the flexibility for providers opting to take capitated payments to invest in preventative services and value-generating services for which they would not be reimbursed in a fee-for-service environment. If providers are not limited to the fee-for-service model, they can respond to patient phone calls, coordinate with other providers, cover the salary of a case manager, offer solutions for housing, address patients' social determinants of health, or invest in services that provide value to the patient but are not otherwise seen as profitable.[16] Some preliminary evidence shows that the APM, at least for Medicaid attributed lives, has shown a higher utilization of primary care office-visits and mental health visits than the cohort of members who are not attributed.[17]

During a GMCB meeting in February 2019, the Board heard 'lessons from the field' where panelists discussed the benefits and challenges of the APM.[18] Among these lessons, Dr. Joe Haddock, an

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[14] Vermont All-Payer Accountable Care Organization Model Agreement (Oct. 27, 2016) *available at* https://gmcboard.vermont.gov/sites/gmcb/files/files/payment-reform/All%20Payer%20Model%20ACO%20Agreement.pdf.

[15] *In re: OneCare Vermont Accountable Care Organization, LLC Fiscal Year 2019*, FY 19 Accountable Care Organization Budget Order, No. 18-001-A, (GMCB Feb. 5, 2019) *available at* https://gmcboard.vermont.gov/sites/gmcb/files/FINAL%20%202019%20ACO%20Budget%20Order%202_5_2019.pdf.

[16] Rachel Matulis, Ctr. for Health Care Strategies, Inc. *It's Not Just Risk: Why the Shift to Value-Based Payment is also about Provider Flexibility* (Mar. 21, 2019) *available at* https://www.chcs.org/its-not-just-risk-why-the-shift-to-value-based-payment-is-also-about-provider-flexibility/.

[17] Dept. of Vermont Health Access, Report to Gen. Assembly, *Vermont Medicaid Next Generation Pilot Program* (Dec. 15, 2018) *available at* https://legislature.vermont.gov/assets/Legislative-Reports/VMNG-Report-to-Legislature-December-15-2018-FINAL.pdf.

[18] Video Recording, GMCB Meeting (Feb. 27, 2019) *available at* https://www.orcamedia.net/show/february-27-2019-gmcb.

independent primary care physician who contracts with OneCare articulated that his participation afforded him the ability to hire a nurse practitioner to offer psychiatric services to patients whose insurance would not otherwise cover such services. His health center has also been able to increase the hours for a licensed diabetic educator and a nutritionist and offer more attractive benefits (e.g. loan repayment plans, signing bonus, travel assistance) in order to improve employee retention, a significant challenge in the primary care space. During this discussion, Dr. Haddock shared, "[f]or independent primary care practices, not changing the system is the worst thing that can happen… The pilot has worked out well for us without increasing our bureaucratic administrative burden, has resulted in a better financial picture for our office and our abilities to start a couple of new programs."

Dr. Carrie Wulfman, from Porter Medical Center, shared an example of a palliative care program that she believes had been abandoned five years earlier because of Porter's then reliance on a fee-for-service model and the program's inability to cover its own costs. Through a pilot with OneCare, Porter can now again offer palliative care, a service known to improve quality and reduce cost. "I'm glad that we have additional resources through involvement with OneCare Vermont and the All-Payer Model to do these kinds of things," said Dr. Wulfman.

Dr. Judy Fingergut spoke about the success of care coordination at Northwestern Medical Center. The team, made up of a nurse care coordinator, a certified diabetic educator, a nutritionist, a social worker embedded in the practice, a pain interventionist, and Dr. Fingergut, were able to support one patient through his struggles with diabetes, accompanying health issues, insurance management, and health education. Through the care coordination team's efforts over a period of seven months, this patient was able to become a candidate for back surgery for spinal stenosis. Without the intervention of Dr. Fingergut's team, he would not have been a candidate for surgery. This patient also was able to reduce the frequency of his visits to Dr. Fingergut. "Through the efforts of our care coordination... [my patient] was able to take control of his diabetes. The team was able to identify barriers and help him work through those barriers. His quality of life has improved…"

In addition, the GMCB conducted traveling board meetings and has heard how regions across the state are building and growing their Community Collaboratives/Accountable Communities for Health, in collaboration with the Blueprint for Health and OneCare Vermont. As mentioned previously, hospitals have noticed the higher acuity and greater social needs of their patients. In response, hospitals are expanding beyond their traditional services and investing in strategies to meet these needs. A few examples include providing Community Supported Agriculture (CSA) shares through collaborations with

The Vermont Food Bank,[19] contracting with Designated Agencies to expand their mental health capacity,[20] and investing in Lifestyle medicine and RiseVT.[21]

There are, however, a number of key ways that *Medicaid's investments in OneCare* in particular have benefited Vermonters. First, the agreement between OneCare and the Department of Vermont Health Access (DVHA), i.e. the "Vermont Next Generation Agreement" reflects a capped budget, reducing the risk of a Medicaid overage in the state's annual budget. Second, this agreement has allowed for the waiver of prior authorizations for services that the ACO is financially accountable for. Waiving prior authorizations allows providers to work directly with patients to get them the care they need, while reducing their administrative burden from paperwork and phone calls. Because this pilot was so successful, Medicaid has expanded this to all providers in the Vermont Medicaid Network. Further, *DVHA has selected population health* programs to benefit Vermonters, partially or fully funded through OneCare, and include: 1) an evidence-based prevention program for communities (RiseVT[22]), 2) a data platform to provide claims analysis, 3) care coordination software (Care Navigator), 4) patient-centered care coordination (OneCare's "Advanced Care Coordination Model"[23]), and an 5) evidence-based program to build childhood resilience (Developmental Understanding and Legal Collaboration for Everyone i.e. DULCE[24]). The Department of Vermont Health Access Vermont Next Generation Agreement Report provides an analysis of these programs and OneCare's performance for Medicaid Attributed lives in 2018.[25]

I hope that I have answered your questions. If you need further clarification or have other concerns, please do not hesitate to ask.

Sincerely,

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[19] Mt. Ascutney Hosp. & Health Ctr. & Our Accountable Cmty. for Health, GMCB Presentation (Oct. 31, 2018) *available at* https://gmcboard.vermont.gov/sites/gmcb/files/Mt.%20Ascutney%20Hospital%20and%20Health%20Center%20and%20Our%20Accountable%20Community%20For%20Health%20Presentation.pdf.

[20] Southwestern Vermont Medical Ctr. Fiscal Year 2020 Budget Submission, Narrative, 3 *available at* https://gmcboard.vermont.gov/sites/gmcb/files/B20%20H39%20SVMC%20Narrative_7-1-2019.pdf.

[21] Northwestern Med. Ctr., NMC and Our Accountable Community for Health (Oct. 16, 2019) *available at* https://gmcboard.vermont.gov/sites/gmcb/files/documents/Green%20Mountain%20Care%20Board%20101619%20NMC%20Presentation%20on%20Accountable%20Community%20for%20Health.pdf.

[22] RiseVT, https://risevt.org/ (last visited Oct. 28, 2019).

[23] OneCare Vermont, Care Coordination Toolkit *available at* https://www.onecarevt.org/wp-content/uploads/2019/07/OneCare-Vermont-Care-Coordination-Toolkit-2019.pdf.

[24] Development Understanding and Legal Collaboration for Everyone (DULCE) *available at* https://cssp.org/our-work/project/dulce/.

[25] Dept. of Vermont Health Access, *Vermont Medicaid Next Generation Pilot Program 2018 Performance* (Sept. 20, 2019) *available at* https://dvha.vermont.gov/administration/1final-vmng-2018-report-09-20-19.pdf.

Cc:
Representative Janet Ancel
Representative Bill Lippert
Representative Ann Pugh
Representative Kitty Toll
Governor Phil Scott
Mike Smith, Secretary, AHS
Martha Maksym, Deputy Secretary, AHS
Victoria Loner, CEO, OneCare Vermont

Appendix 1 – Statewide Health Outcomes and Quality of Care Targets (abbreviated)

1. Population-Level Health Targets
    a. Substance Use Disorder Target: The State must reduce deaths of Vermont residents related to drug overdose by 10% in aggregate over the performance period of the model as compared to the 2015 baseline
    b. Suicide Target: The State must reduce the number of deaths due to suicide to 16 per 100,000 Vermont residents, or reduce the State's ranking on suicide rate from the 7th to the 20th highest by state across the United States by the end of Performance Year 5.
    c. Chronic Conditions Targets: The State must not increase prevalence of COPD, diabetes, and hypertension for Vermont residents, each measured separately as a percent of state population, by more than 1 percentage point, using 2016 as a baseline.
    d. Access to Care Target: The State must achieve a target of 89 percent of Vermont adult residents reporting that they have a personal doctor or care provider.
2. Healthcare Delivery System Quality Targets
    a. Suicide and Substance Use Disorder Target: Initiation and engagement of alcohol and other drug dependence (AOD) treatment. The State must achieve the 50th percentile, as compared to healthcare plans nationally, on initiation and the 75th percentile on engagement of alcohol and other drug dependence treatment for Vermont ACO-aligned residents.
    b. Suicide and Substance Use Disorder Target: Follow-up after discharge from the emergency department for mental health. The State must achieve 60 percent as the percent of Vermont ACO-aligned residents receiving follow-up care within 30 calendar days after discharge from a hospital emergency department for mental health.
    c. Suicide and Substance Use Disorder Target: Follow-up after discharge from the emergency department for alcohol or other drug dependence. The State must achieve 40 percent as the percent of Vermont ACO-aligned residents receiving follow-up care within 30 calendar days after discharge from a hospital emergency department for alcohol or other drug dependence.
    d. Suicide and Substance Use Disorder Target: Mental Health and Substance Abuse related Emergency Department Visits. The State must reduce the rate of growth of emergency department (ED) visits with a primary diagnosis of mental health or substance abuse condition across payers in Vermont hospitals, using 2016 as a baseline. Vermont and CMS shall establish a target by June 30, 2017.
    e. Chronic Conditions Target: Composite of Diabetes, Hypertension, and Multiple Chronic Conditions. The State must achieve the 75th percentile, as compared to national Medicare performance, for a composite measure comprising of diabetes, hypertension, and multiple chronic condition morbidity of VMA ACO or Modified Next Generation ACO aligned Vermont Medicare Beneficiaries.
    f. Access to Care Target: Getting Timely Care, Appointments, and Information. The State must achieve the 75th percentile, as compared to national Medicare performance, for the percent of VMA ACO or Modified Next Generation ACO-aligned Medicare beneficiaries who state that they are getting timely care, appointments, and information.

3. Process Milestones
    a. Substance Use Disorder Milestone: Prescription Drug Monitoring Initiative Utilization. The State must increase the utilization of Vermont's prescription drug monitoring program, using 2017 as a baseline. Vermont and CMS shall establish a target by June 30, 2017.
    b. Substance Use Disorder Milestone: Medication-assisted Treatment Utilization. The State must increase the number of Vermont residents receiving medication-assisted treatment (MAT) for substance use disorder to 150 per 10,000 Vermont residents of ages 18-64 (or up to the rate of demand).
    c. Suicide Milestone: Screening for Clinical Depression. The State must achieve the 75th percentile, as compared to national Medicare performance, for the percent of Vermont ACO-aligned beneficiaries who received a screening for clinical depression, and if depression was detected, a follow-up plan.
    d. Chronic Conditions Milestone: Tobacco Use Assessment and Cessation Intervention. The State must achieve the 75th percentile, as compared to national Medicare performance, for the percent of Vermont ACO-aligned beneficiaries who were screened for tobacco use and who received cessation counseling intervention if identified as a tobacco user.
    e. Chronic Conditions Milestone: Medication Management for People with Asthma. The State must achieve the 25th percentile, as compared to healthcare plans nationally, for the percent of Vermont All-payer Beneficiaries receiving appropriate asthma medication management.
    f. Access to Care Milestone: Medicaid Adolescents with Well-Care Visits. The State must achieve the 50th percentile, as compared to Medicaid plans nationally, for the percentage of Vermont adolescents enrolled in Vermont Medicaid who have a well-care visit.
    g. Access to Care Milestone: Medicaid Beneficiaries Aligned to a Scale Target ACO Initiative. The State must ensure that the percent of Vermont Medicaid beneficiaries aligned to a Scale Target ACO Initiative not be less than that of Vermont Medicare Beneficiaries by more than 15 percentage points.