



Vermont Healthcare Claims Uniform Reporting & Evaluation System



Vermont Department of Banking, Insurance, Securities and Health Care Administration

Executive Summary

Key Findings & Highlights from Vermont's 2011 Report Card

Commercially Insured Population, Ages 0-64, VHCURES Data, 2008-2010

ABOUT THIS REPORT

The Vermont Department of Banking, Insurance, Securities and Health Care Administration (BISHCA) has a statutory mandate to collect eligibility and claims data for Vermont residents from health insurers through the Vermont Healthcare Claims Uniform Reporting & Evaluation System (VHCURES). Health insurers include carriers, third-party administrators (TPAs), pharmacy benefit managers (PBMs), any entity conducting administrative services for business, and any other similar entity with claims data, eligibility data, provider files, and other information relating to healthcare provided to Vermont residents.

The VHCURES data set represents over 80% of total enrollment in comprehensive major medical health benefit plans. (Insurers with fewer than 200 Vermont members are not required to submit paid claims data to VHCURES.) For those major insurers that submit data, the claims amounts, service counts, and enrollment details represent a complete accounting for their population group. Statewide totals that sum the data from all VHCURES reporters, however, do not represent 100% of the entire commercially insured population of Vermont. Data may be unrepresented in VHCURES for multiple reasons, including:

- Some pharmacy claims from PBMs may be generated from carve-out benefits provided separately from medical benefits.
- There may be a small proportion of carve-out pharmacy claims attributed to individuals whose medical claims are not yet included in the VHCURES data set.
- Some insurers have not completed their data filings or are out of compliance with the state's reporting requirements.

Reporting will improve as more insurers comply with Vermont state requirements and submit data for Vermont members.

This report presents key findings from Vermont's most recent Report Card, which was prepared by Onpoint Health Data for BISHCA using VHCURES data for the state's commercially insured population, ages 0–64, for calendar years 2008–2010. The Report Card is a key component of Onpoint's overall healthcare claims reporting system — a comprehensive solution designed to provide clients with the tools they need to better understand measures of health status, effectiveness of care, use, and cost. The Report Card is built specifically to offer high-level detail on a wide range of key metrics, including demographics, diagnostics, utilization, quality of care, access to primary care and preventive visits, and claims payments.

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SUMMARY

Vermont's Report Card, prepared by Onpoint Health Data for the Vermont Department of Banking, Insurance, Securities and Health Care Administration (BISHCA), offers key insights into a wide range of health measures among the state's commercially insured population. Key areas of examination include health status; healthcare effectiveness, use, and cost; and geographic variation in these measures across the entire state. Highlights of Vermont's Report Card include:

- **Health status** — Prevalence of disease generally increased in Vermont.¹ Prevalence of disease generally increased among Vermont's commercially insured population as noted in [Table 1](#). Between 2009 and 2010, prevalence of depression increased by 8%, colorectal cancer increased by 7%, back injury increased by 5%, and lung cancer increased by 3%. On the other hand, the rate of coronary heart disease decreased by 6%. Rates of other conditions increased or decreased more modestly (i.e., 2% or less). There also was a 3% increase in the population's Clinical Risk Group (CRG) score, indicating a higher prevalence of disease and a greater demand for medical services.
- **Utilization** — Between 2009 to 2010 potentially avoidable ED visits decreased by 5%, primary care encounters decreased by 3%, and admissions for ACS conditions decreased by 2% (see [Table 2](#)). Cardiac testing increased by 4% and Outpatient OR procedures and mental health/substance abuse services increased by 3% and inpatient hospital days increased by 2%. Utilization of other services increased or decreased more moderately (12% or less). There was significant shifting from brand prescription drugs (12% decrease) to generic (10% increase).
- **Payments** — In 2010, total payments were \$1.32 billion (\$378 per member per month [PMPM]). This represented a 6% increase over 2009 payments. Of these payments, \$303 were medical payments and \$74 were pharmacy payments. Adjusted for age, gender, and health status, PMPM rates varied by 35% among health service areas (HSAs), with Burlington remaining a consistently low-rate area. Payments to hospitals accounted for a substantial portion of total payments and represented the area of greatest cost increases.
- **Effective and preventive care** — Nearly one-third of patients did not receive effective and preventive care. Although the rates were relatively consistent throughout the state, they were somewhat lower in the Morrisville, Newport, Burlington, and Rutland HSAs. Throughout the state, 4,683 preference-sensitive procedures were performed — surgeries that represent potentially inappropriate utilization for conditions that possibly could have been treated less invasively.
- **Value** — The relationship between cost and quality (i.e., effective and preventive care) varied in Vermont. In 2010, low-cost, high-quality care was found in the Barre, Springfield, Middlebury, Brattleboro, and St. Albans HSAs. High-cost, low-quality care was found in the Newport and Rutland HSAs.
- **Utilization and cost per service** — Evaluation of this and other Vermont VHCURES reports indicates that both increased utilization and increased cost per service drove trends. While not evaluated in this report, variations in payments per service to hospitals may be a significant factor in determining variability in the total payments PMPM.
- **Geographic variation** — There was wide geographic variation by HSA for some measures, most notably chiropractic/osteopathic manipulation, potentially avoidable emergency department (ED)

¹ Increasing trends in prevalence may indicate an increase in disease and/or an increase in efforts to diagnosis disease.

visits, and back surgery. Variation was much less significant for primary care visits and selected HEDIS measures.

METHODS

- **Source data** — Onpoint used Vermont’s VHCURES all-payer commercial eligibility and claims data to produce its Report Card for each of Vermont’s hospital service areas. These Report Cards included three years of data and adjusted rates. Since eligibility and claims data include only some members with Medicare coverage (e.g., supplemental and Advantage), these members were removed from the data prior to analysis. As an additional check, all members aged 65 and older also were removed from the commercial data.

The eligibility and claims data used in the Report Cards included only Vermont residents. The claims data included services provided to residents by providers regardless of location. For example, a service provided at a Massachusetts hospital to a resident of Burlington, Vermont, would be included and assigned to the Burlington HSA. The resulting 2010 data used for this study represented 292,013 covered “average members” (see definition in next bullet).

- **Numerators and denominators** — Medical claims data were used to provide numerators for population-based rates. ICD-9 diagnosis codes, ICD-9 procedure codes, CPT procedure codes, and hospital revenue codes formed the numerators for the rates. Denominators for population-based rates were derived from eligibility/enrollment data and consist of “average members” — a figure calculated by dividing the number of member months (i.e., the cumulative months of coverage for the reported population) by 12. This measure is comparable to “person-time,” which is used as a standard denominator in health epidemiology studies and adjusts for members who may not have been covered for the full 12 months of the year.
- **Adjusted rates** — Rates in this report were adjusted for age, gender, and health status (CRG health risk score) compared to a Vermont-only standard population. A report prepared for BISHCA in June 2010 by Onpoint, *Tri-State Variation in Health Services Utilization & Expenditures in Northern New England*, also presented adjusted rates using similar methods but adjusted only for age and gender compared to a three-state (i.e., Vermont, New Hampshire, and Maine) standard.² Utilization rates were reported per 1,000 members and were adjusted for age and gender differences in the populations. This report also measured utilization by employing Relative Value Units, a widely accepted method for summarizing utilization over many different types of medical services used by Medicare and health plans.
- **Table and figure data** — Unless otherwise noted, tables and figures represent VHCURES data for Vermont’s 2010 commercially insured population, ages 0–64. Data presented by hospital service areas (HSAs) are adjusted for age, gender, and health risk.
- **Expenditures** — Expenditures were reported as claims payments per member per month (PMPM) and were adjusted for age and gender differences in the populations. Expenditures were derived from the payment information on administrative medical claims. Data included plan payments and member cost share (i.e., coinsurance, deductible, and copayments) reported on claims.
- **HEDIS measures** — Onpoint applied Healthcare Effectiveness Data and Information Set (HEDIS) specifications, established by the National Committee for Quality Assurance (NCQA), to claims. These rates may not match plan rates because plans may supplement with medical chart review.

² A prior Report Card was run in 2010 on Vermont data through 2009 and used the Episode Risk Group (ERG) grouping software from OptumInsight (formerly Ingenix) to adjust for health risk.

National commercial combined HMO and PPO averages were provided to Onpoint by Vermont for comparison.

- **Health risk score** — Onpoint applied Clinical Risk Grouping (CRG) software from 3M to the claims data. Each individual's healthcare claims are run through the grouper and individuals are assigned to severity-adjusted risk groups and a relative health risk score. A higher risk score indicates poorer health status.

RESULTS

Disease Prevalence & Health Risk

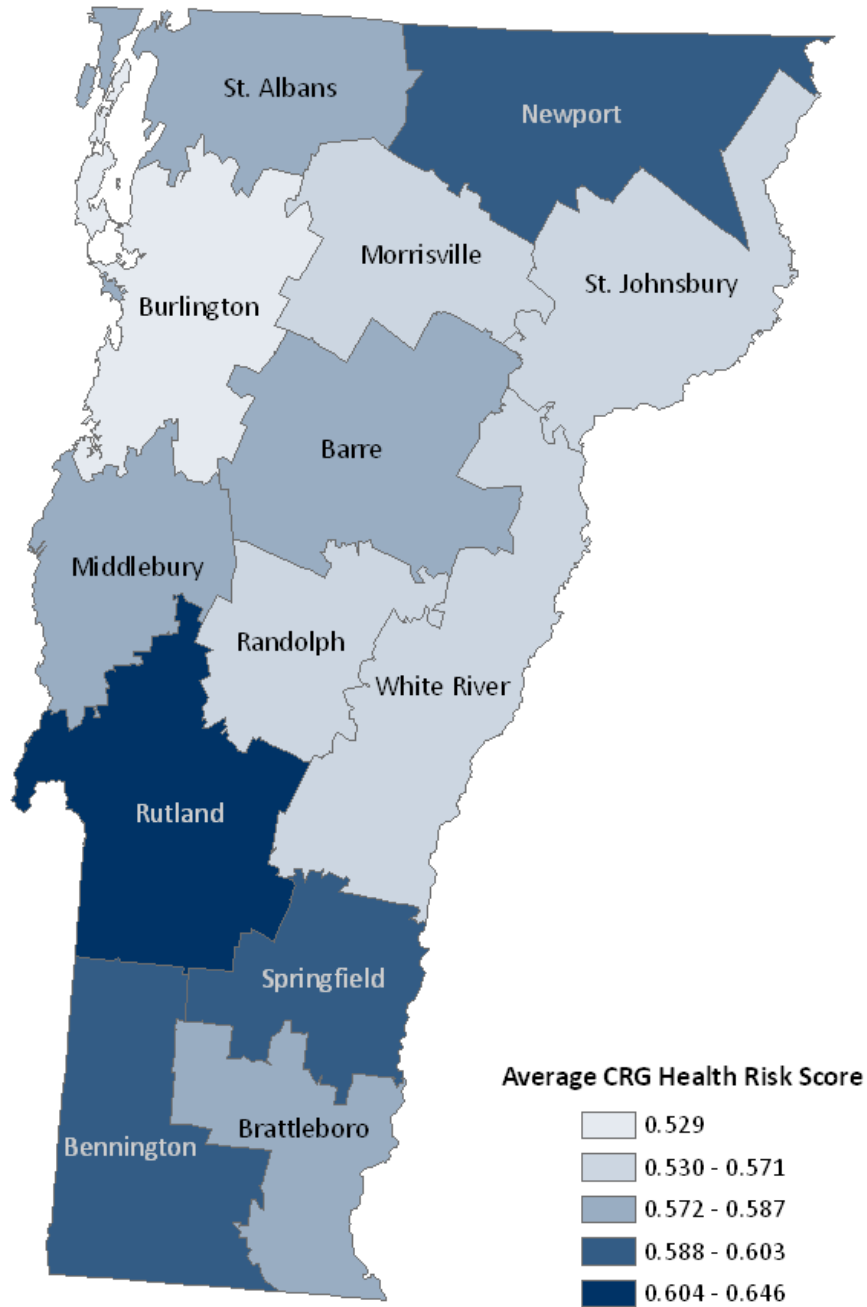
Prevalence of disease was based on the ICD-9 diagnoses reported on claims. Increasing trends in prevalence may indicate an increase in disease as well as increased efforts to diagnosis disease. Among this report's findings:

- Prevalence** — Prevalence of disease generally increased among Vermont's commercially insured population as noted in [Table 1](#). Between 2009 and 2010, prevalence of depression increased by 8%, colorectal cancer increased by 7%, back injury increased by 5%, and lung cancer increased by 3%. On the other hand, the rate of coronary heart disease decreased by 6%. Rates of other conditions increased or decreased more modestly (i.e., 2% or less).
- Clinical risk groups (CRGs)** — The average CRG Score (see the [Methods section](#)) is an overall measure of the population's health status. Between 2009 and 2010, there was a 3% increase in population health risk, indicating a higher prevalence of disease and/or a greater demand for medical services. CRG risk scores varied geographically within the state as shown in [Figure 1](#). The highest CRG risk area was Rutland HSA (0.64) and the lowest risk area was Burlington HSA (0.52) — accounting for 22% variation.

Table 1. Prevalence of Disease (Rates per 1,000 Members)

DISEASE CATEGORY	2008	2009	2010	TREND 2009-2010	2010 COUNT
Back Injury	142.1	147.9	155.1	+5%	47,277
Depression	75.9	82.2	88.4	+8%	25,811
Diabetes	42.0	43.9	44.1	+1%	12,892
Asthma	46.4	50.9	52.0	+2%	15,199
Coronary Heart Disease	17.1	18.7	17.6	-6%	5,136
Breast Cancer	6.6	7.0	7.0	0%	2,034
Chronic Obstructive Pulmonary Disease (COPD)	9.9	10.5	10.2	-2%	2,992
Stroke	6.1	6.6	6.4	-2%	1,877
Colorectal Cancer	1.3	1.4	1.5	+7%	441
Lung Cancer	1.1	1.1	1.1	+3%	328
CRG Risk Score	0.53	0.55	0.57	+3%	N/A

Figure 1. Average CRG Score by HSA



Utilization

- **Utilization volume** — During 2010, there were 13,847 inpatient discharges, 59,036 days, 1,415 hospital readmissions within 30 days, and 914 admissions for ambulatory care sensitive (ACS) conditions. There also were 8,773 potentially avoidable outpatient emergency department (ED) visits and 39,812 advanced imaging procedures.
- **Changes in utilization** — Between 2009 and 2010, potentially avoidable ED visits decreased by 5%, primary care encounters decreased by 3%, (see [Table 2](#)). Cardiac testing increased by 4% and outpatient OR procedures and mental health/substance abuse services increased by 3%. Utilization of other services increased or decreased more moderately (i.e., 2% or less).
- **Shifting to generic prescription drugs** — Brand prescription drug use declined by 12%, while generic use increased by 10%.
- **Geographic variation in utilization** — Utilization of key services varied throughout the state (see figures 2 through 5). When adjusted for age, gender, and CRG health risk, Burlington HSA had the lowest rates of ED utilization and relatively low rates of inpatient hospitalizations, readmissions to the hospital within 30 days, and advanced imaging.

Table 2. Utilization by Type of Service (Rates per 1,000 Members)

TYPE OF SERVICE	2008	2009	2010	TREND 2009-2010	2010 COUNT
Inpatient Measures					
Discharges	47.7	47.5	47.4	0%	13,847
Inpatient Days	192.4	197.5	202.2	+2%	59,036
Readmissions within 30 Days	4.9	4.8	4.8	+1%	1,415
Admissions for ACS Conditions	3.0	3.2	3.1	-2%	914
Other Selected Measures					
Outpatient ED Visits	192.4	187.5	184.9	-1%	53,979
Potentially Avoidable ED Visits *	31.4	31.6	30.0	-5%	8,773
Outpatient OR Procedures	86.6	88.2	90.9	+3%	23,534
Primary Care Encounters	2,643.7	2,726.3	2,649.9	-3%	773,792
Chiropractic/Osteopathic	643.6	638.6	642.3	+1%	187,547
Mental Health/Substance Abuse	913.0	967.2	993.5	+3%	290,110
Testing					
Advanced Imaging	138.0	136.8	136.3	0%	39,812
Standard Imaging	583.1	585.0	583.3	0%	170,335
Echography	187.4	193.7	197.9	+2%	57,776
Cardiac Testing	146.4	143.9	149.3	+4%	43,590
Pharmacy					
Rx Brand Use (30-Day Equivalents)	4,420.2	4,369.0	3,832.6	-12%	1,231,509
Rx Generic Use (30-Day Equivalents)	8,735.8	9,769.5	10,732.4	+10%	3,134,007

* Includes ED visits for conditions that are potentially non-urgent and/or treatable in the primary care setting, including sore throat, strep, viral infection, anxiety, conjunctivitis, ear infection, upper respiratory infection, bronchitis, asthma, dermatitis and rash, joint pain, lower back pain, muscle and soft tissue pain, fatigue, and headache.

Figure 2. Rate of Potentially Avoidable Outpatient ED Visits by HSA

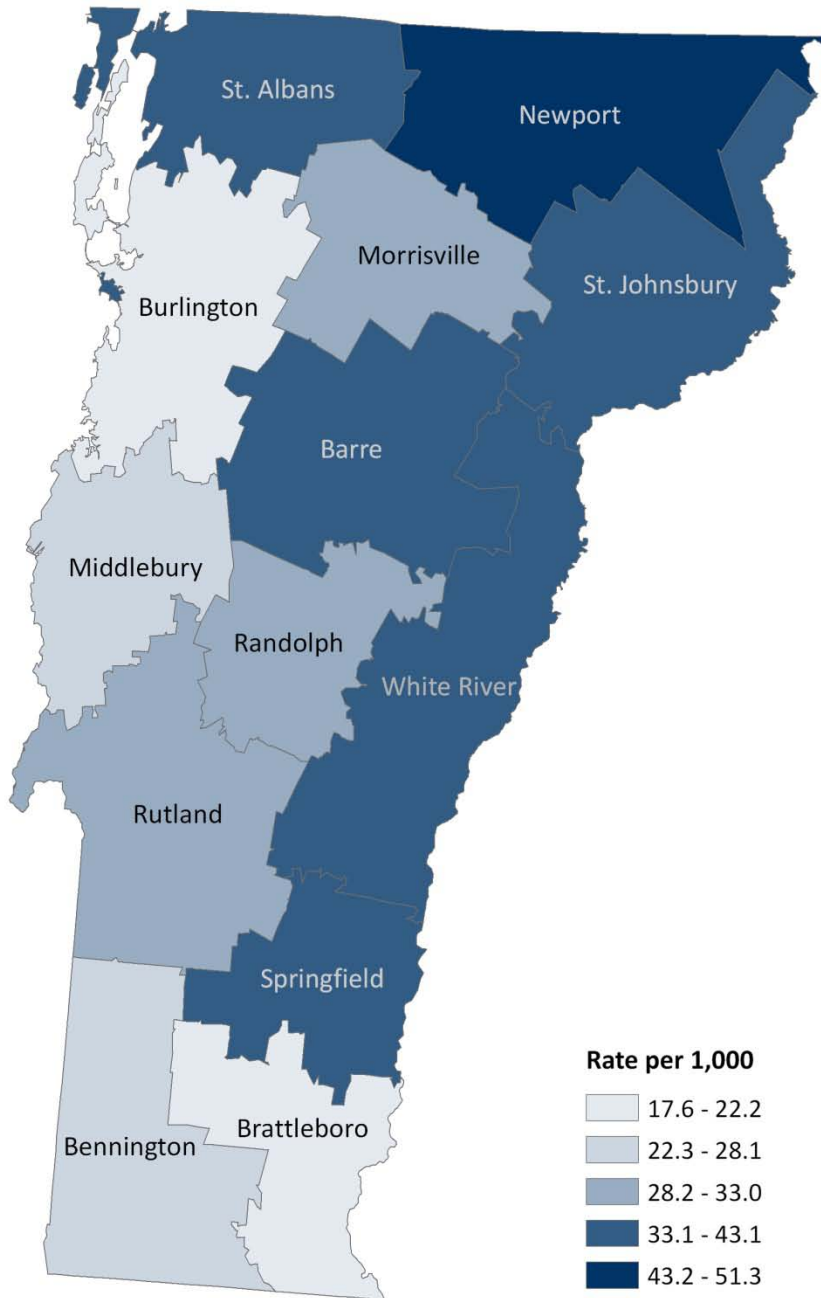


Figure 3. Rate of Inpatient Hospitalizations by HSA

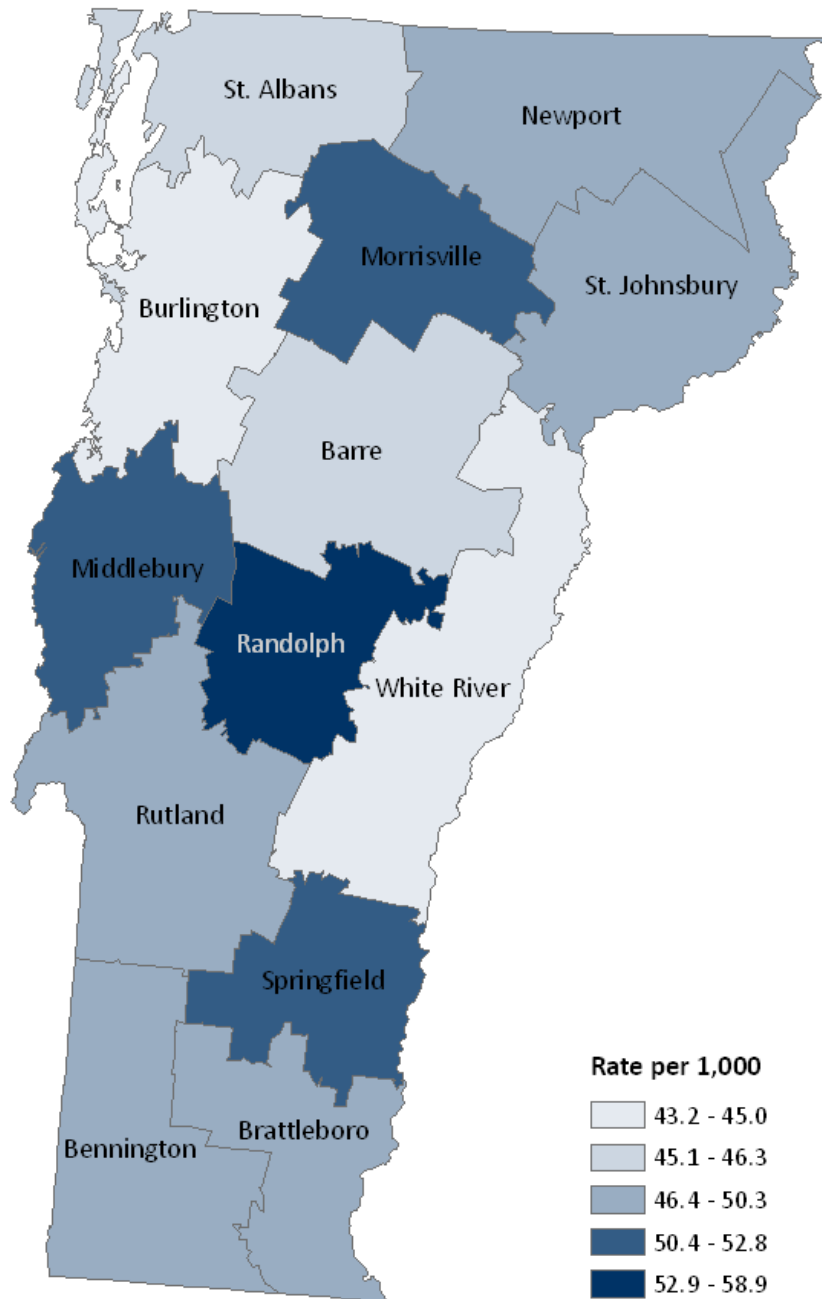


Figure 4. Total ED Visit Rates by HSA with 95% Confidence Intervals

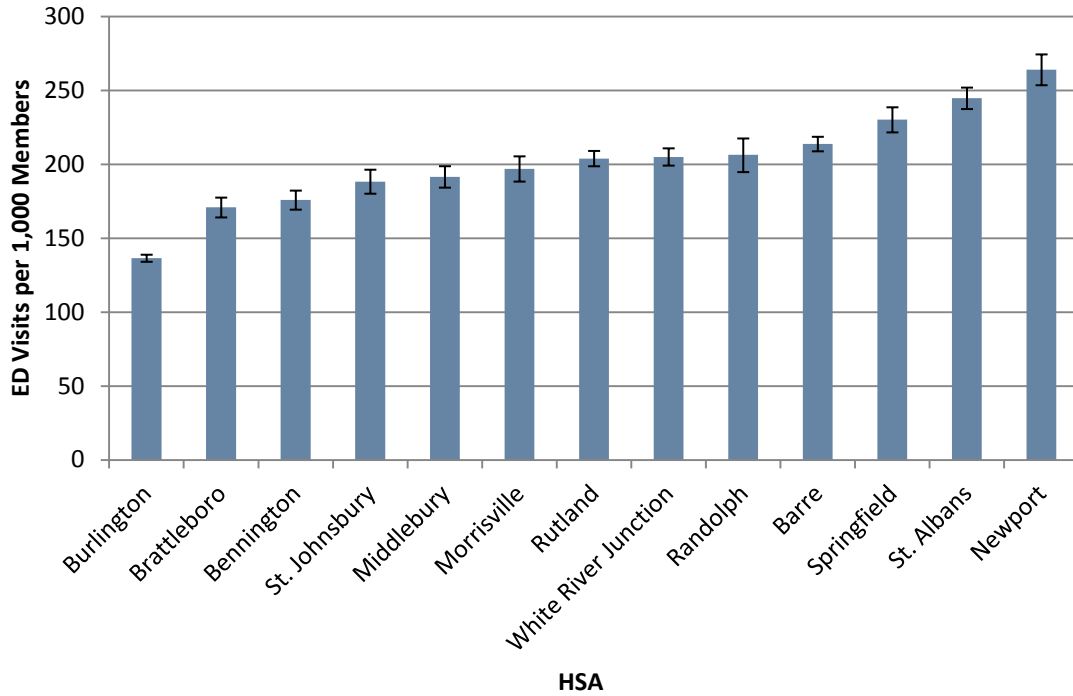
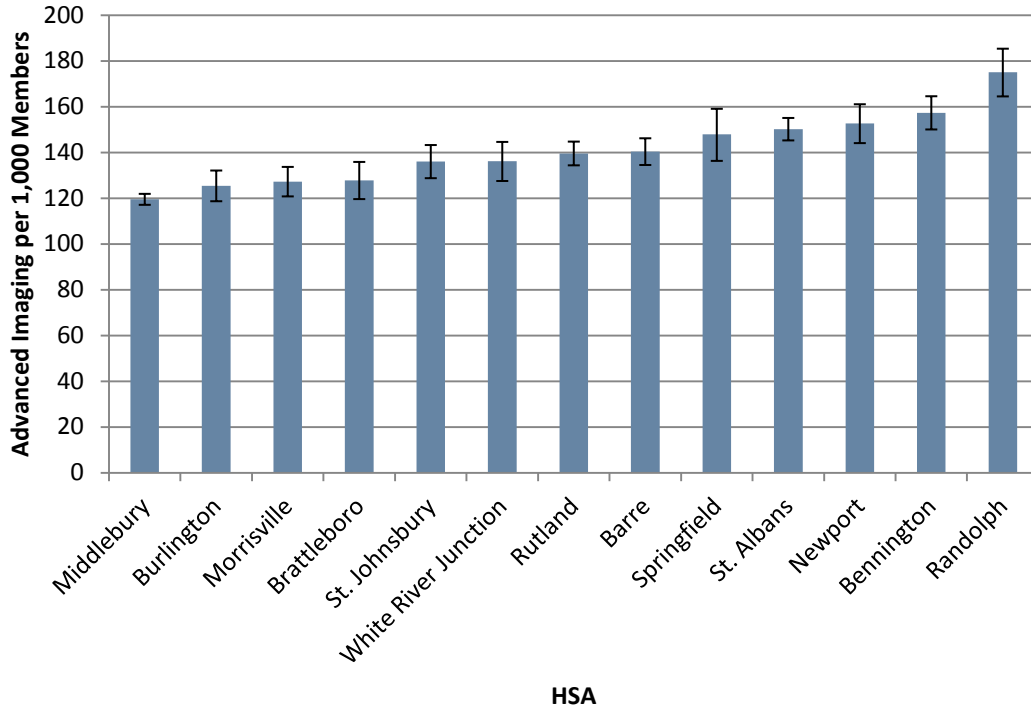


Figure 5. Total Advanced Imaging Rates by HSA with 95% Confidence Intervals



Payments

- Total payments** — In 2010, total payments were \$1.32 billion (\$378 per member per month [PMPM]). This represented a 6% increase over 2009 payments. Of these payments, \$303 were medical payments and \$74 were pharmacy payments.
- Payments by provider type** — Payments for outpatient hospital services (\$135 PMPM) accounted for more than one-third of total payments PMPM (see [Figure 6](#)). Pharmacy payments (\$74 PMPM) and inpatient hospital payments (\$57 PMPM) also were significant components of total payments. Between 2009 and 2010, payments increased for hospital inpatient services (9%), hospital outpatient services (7%), and pharmacy services (7%).
- Geographic variation in payments** — Average payments PMPM varied widely within the state, as noted in [Figure 7](#). Adjusted payments PMPM were highest in the Randolph and Newport HSAs (\$475 each) and lowest in Burlington (\$352) — a 35% variation.
- High-cost members** — High-cost members (i.e., those who incurred \$50,000 or more in combined claims payments over a single year) comprised less than 1% of all members yet accounted for 20% of all payments. Of the 2,536 high-cost members in 2010, 16% had diabetes. Of the \$266 million in high-cost payments, cancer accounted for \$70 million (26%).

Figure 6. Payments by Provider Type (2008-2010)

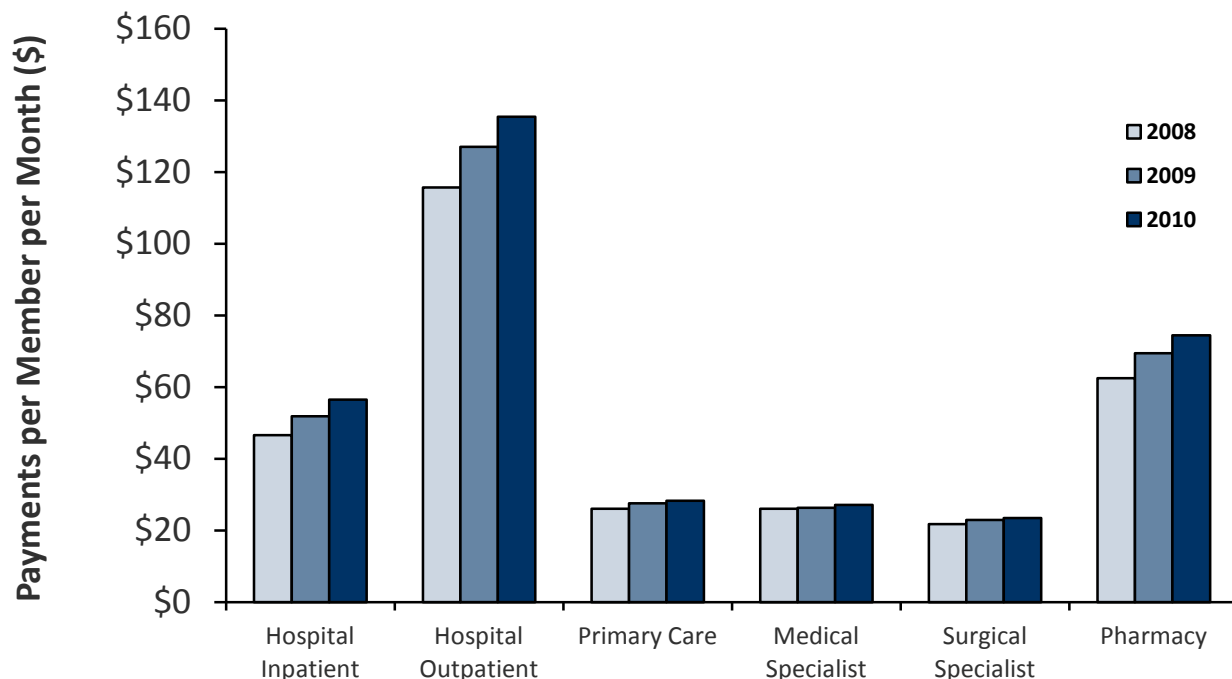
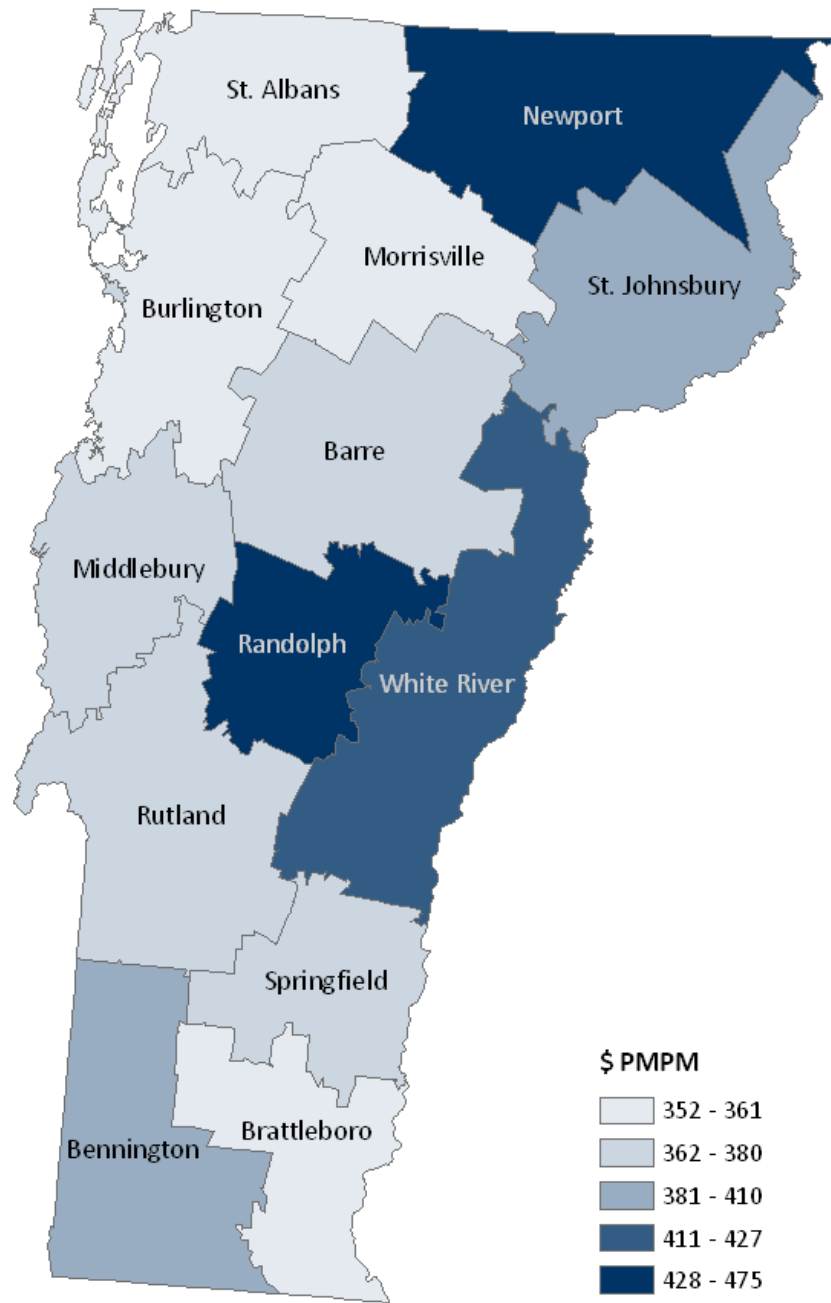


Figure 7. Total Adjusted Payments PMPM by HSA



HEDIS

- Effectiveness of care** — The Vermont commercial population had a higher rate of effective care than the national average for the following measures: breast cancer screening, imaging studies for low back pain, appropriate treatment for children with upper respiratory infection (URI), and antidepressant medication management (continuation phase). Rates of effective care were below the national average for diabetes care (both for HbA1c testing and LDL testing), cervical cancer screening, cholesterol management for cardiovascular conditions, and persistence of beta-blocker treatment after heart attack (see [Table 3](#)).
- Preventive care** — The Vermont commercial population had a higher rate of well child visits (ages 3–6 years) and a higher rate of adolescent well-care visits (ages 12–21 years) than the national average.
- Frequency of selected procedures (FSP)** — This measure summarizes the utilization of frequently performed procedures that often show wide regional variation and have generated concern regarding potentially inappropriate utilization. These procedures — 4,683 of which were performed for the study population in 2010 — have been associated with “preference-sensitive” care, indicating that alternative treatment options may exist. In Vermont, 11 of 18 FSP measures were performed less often than the national average (see [Table 4](#)). However, rates of tonsillectomy, angioplasty (male), cardiac catheterization (male), coronary artery bypass graft (male), cholecystectomy (closed, male), and vaginal hysterectomy were above the national average.

Table 3. HEDIS Measures — Effective & Preventive Care (Percentage of Members Receiving Care)

HEDIS MEASURE	2008	2009	2010	TREND 2009–2010	NATL. AVG
CDC — Diabetes Care – HbA1c Testing, 18–75	83%	83%	86%	+4%	87%
CDC — Diabetes Care – LDL Testing, 18–75	73%	72%	75%	+4%	83%
BCS — Breast Cancer Screening, 42–51	70%	72%	70%	-2%	65%
BCS — Breast Cancer Screening, 52–69	76%	77%	76%	-1%	70%
CCS — Cervical Cancer Screening, 21–64	*	72%	68%	-6%	76%
CMC — Cholesterol Management for Cardiovascular Conditions, 18–75	74%	76%	81%	+7%	85%
LBP — Imaging Studies for Low Back Pain, 18–50	83%	84%	83%	-1%	73%
ASM — Appropriate Medications for Asthmatics, 5–56	92%	92%	93%	0%	93%
URI — Appropriate Treatment for Children w/URI, 3m–18y	90%	90%	92%	+2%	83%
PBH — Persistence of Beta-Blocker Treatment after Heart Attack, 18+	66%	66%	47%	-29%	72%
AMM — Antidepressant Medication Management, Continuation Phase, 18+	54%	51%	51%	+1%	46%
W34 – Well Child Visits, 3–6	75%	77%	76%	0%	68%
AWC – Adolescent Well-Care Visits, 12–21	41%	44%	44%	+3%	41%

* Note that figures for CCS (Cervical Cancer Screening, 21–64) for 2008 are not reportable because they require a multiyear look-back for which data are unavailable from VHCURES.

Table 4. Frequency of Selected Procedures (Percentage of Members in Category Receiving Care)

PROCEDURE	RATE PER 1,000			PROCEDURES	TREND 2009-2010	NATL. AVG
	2008	2009	2010			
Myringotomy, 0-4	39.2	40.6	36.8	440	-9%	54.6
Tonsillectomy, 0-9	7.9	9.9	10.0	265	1%	9.6
Angioplasty (PTCA), Female, 45-64	1.9	1.9	1.5	99	-21%	2.0
Angioplasty (PTCA), Male, 45-64	8.3	7.5	7.7	463	2%	6.8
Cardiac Catheterization, Female, 45-64	5.3	5.1	4.3	284	-15%	6.8
Cardiac Catheterization, Male, 45-64	13.9	12.4	12.4	750	0%	10.5
Coronary Artery Bypass Graft, Female, 45-64	0.3	0.3	0.3	19	-17%	0.5
Coronary Artery Bypass Graft, Male, 45-64	2.0	2.2	2.1	124	-6%	1.9
Cholecystectomy, Closed, Female, 45-64	4.5	5.1	4.8	314	-6%	6.3
Cholecystectomy, Closed, Male, 30-64	3.2	2.8	3.0	196	5%	2.8
Prostatectomy, 45-64	2.4	2.2	1.7	234	-21%	*N/A
Back Surgery, Female, 45-64	3.3	3.8	3.5	213	-8%	4.8
Back Surgery, Male, 45-64	4.6	4.6	4.8	281	4%	5.3
Lumpectomy, 45-64	6.5	5.7	5.4	424	-5%	6.3
Mastectomy, 45-64	1.2	1.0	1.4	89	38%	2.1
Non-Obstetric D & C, 45-64	2.3	1.9	1.7	110	-10%	2.5
Abdominal Hysterectomy, 45-64	4.0	4.4	3.3	214	-25%	5.4
Vaginal Hysterectomy, 45-64	3.0	3.3	2.5	164	-25%	1.1

* Note that the national averages are not reported for prostatectomy rates for the commercial population.

Quality & Cost-Effectiveness

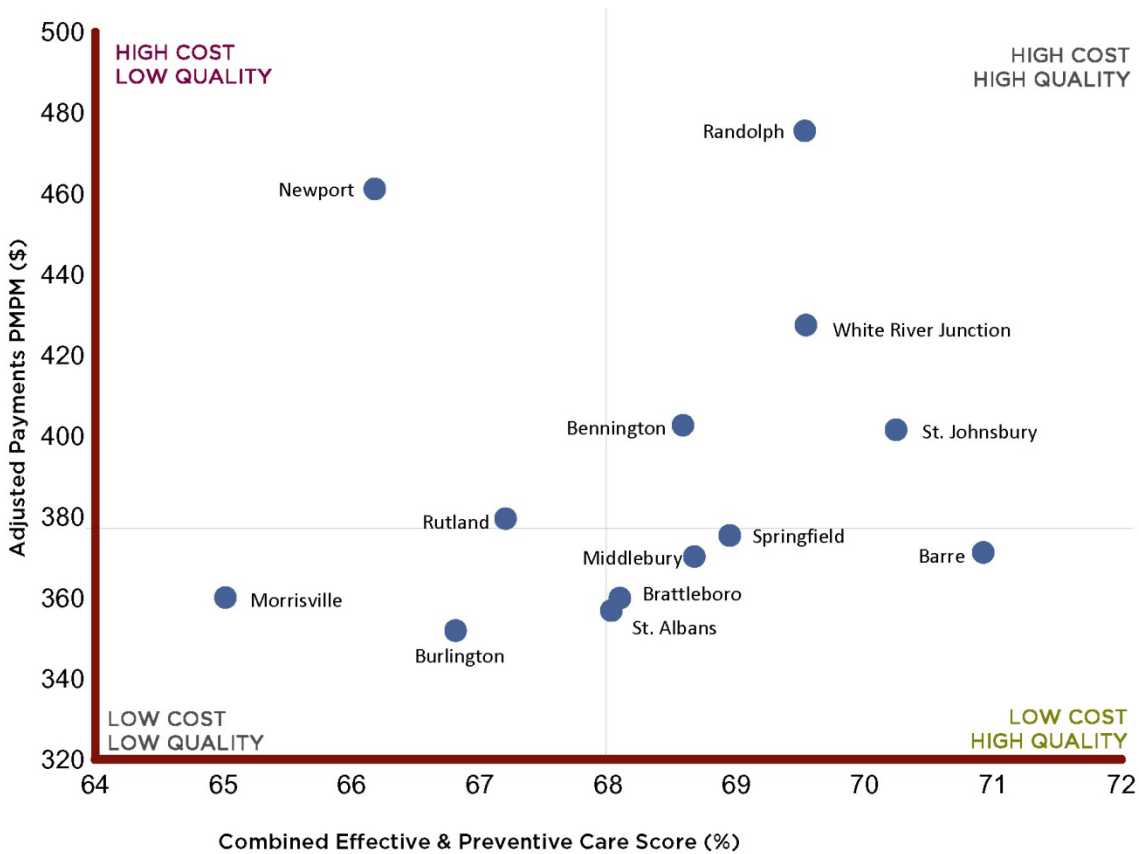
The Report Card includes a variety of measures designed to evaluate quality and cost-effectiveness, including the Combined Effective & Preventive Care Score, value, and aggregate utilization based on relative value units. These measures are discussed below:

- Combined Effective & Preventive Care Score** — This score was calculated to determine the combined rate of members who received the recommended care based on 13 HEDIS effective and preventive care measures selected for the Report Card. In 2010, 68% of members received effective and preventive care across Vermont. This measure did not vary substantially. The highest rate area for effective care was Barre HSA (71%), and the lowest rate area was Morrisville HSA (65%) — less than 10% variation.
- Value** — Value was measured by plotting the cost of healthcare (payments PMPM) against the Combined Effective & Preventive Care Score (see [Figure 8](#)). In 2010, low-cost, high-quality care was found in the Barre, Springfield, Middlebury, Brattleboro, and St. Albans HSAs. High-cost, low-quality care was found in the Newport and Rutland HSAs.
- Utilization** — Utilization was measured by Relative Value Units (RVUs). RVUs are used in the Medicare reimbursement formula for physician services and are based on service utilization. As measured by RVUs, utilization in Vermont increased by 6% from 2009 to 2010.
- To what extent do increases in price and utilization account for the rise in payments in Vermont?** In recent years, both the cost of services and utilization rates have risen. Analysis of the

Vermont Report Card and the Vermont Healthcare Utilization and Expenditure Report (HUER) indicate that both increases in utilization and increases in cost per service contributed to the trend in total payments. Increased use and cost per service for hospital and pharmacy care were primary drivers.

- What are the drivers of payment variation?** There was not a strong relationship between an HSA's Combined Effective & Preventive Care Score and adjusted payments PMPM. Rather, utilization rates and/or cost per service may drive variability in cost between HSAs in Vermont. While not evaluated in this report, variations in payments per service to hospitals may be a significant factor in determining variability payments PMPM. The combined hospital inpatient and hospital outpatient payments PMPM (adjusted for age, gender, and health status) were highest in Randolph and lowest in Burlington.

Figure 8. Combined Effective & Preventive Care Score and Adjusted Payments by HSA



Geographic Variation

The coefficient of variation (CV) is a statistical measure of the dispersion of data points around the mean and suggests which measures have low variation across the state (i.e., rates are similar for each HSA) and which measures have high variation. The higher the CV for a measure, the greater the variation at the HSA level; the lower the CV, the smaller the variation. A comparison of the CVs therefore affords insight into measures where care was consistent across the state and into measures where care varied substantially (see [Table 5](#)). These included:

- **Measures with high variation** — Chiropractic/osteopathic manipulation, potentially avoidable outpatient ED visits, and back surgery had the highest CVs, indicating that rates of these measures varied widely throughout the state. An example of this was the wide range of adjusted rates for chiropractic/osteopathic manipulation in the state — from 161 per 1,000 members in Newport HSA to 804 per 1,000 members in St. Johnsbury HSA.
- **Measures with low variation** — There was relatively low variation by HSA in the HEDIS measures for which CV was analyzed (i.e., Combined Effective & Preventive Care Score, breast cancer screening [ages 52–69 years], and appropriate use of imaging for low back pain), indicating that care for these measures was consistent statewide. Primary care visit rates also had a relatively low CV. The Combined Effective & Preventive Care Score had the lowest CV.

The interventions for measures with high variation may be targeted to HSAs that are lagging behind, whereas interventions for measures with low variation may need to be targeted statewide.

Table 5. Coefficient of Variation by Measure among Vermont HSAs

MEASURE	COEFFICIENT OF VARIATION
Chiropractic/osteopathic manipulation (adjusted)	28.7
Potentially avoidable outpatient ED visits (adjusted)	26.8
Back surgery, ages 45–64	20.4
Inpatient ambulatory care sensitive admissions (adjusted)	15.2
Advanced imaging (adjusted)	10.8
Payments (adjusted)	10.3
Inpatient days (adjusted)	8.3
Primary care visits (adjusted)	4.4
Appropriate use of imaging for low back pain	4.3
Breast cancer screening, ages 52-69	3.9
Combined Effective & Preventive Care Score	2.4

CONCLUSIONS

The Vermont Report Card, prepared by Onpoint Health Data for the Vermont Department of Banking, Insurance, Securities and Health Care Administration (BISHCA), offers key insights into a wide range of health measures among the state's commercially insured population, including an examination of health status; healthcare effectiveness, use, and cost; and geographic variation in these measures across the entire state.

This report was based on membership and claims data in the VHCURES data set for calendar years 2008–2010 — the most current time period available. It was limited to those insurers in the data set at the time of the reporting and does not include Medicare, Medicaid, or uninsured Vermont residents.

As demand for healthcare services continues to rise, so do total payments for that care. These increases are putting growing pressure on states to find cost-effective healthcare solutions for their residents. This report suggests some issues of concern, both statewide and in specific geographic areas, that may warrant further exploration and attention. Key among these are:

- **Payments were trending upward.** Payments to hospitals accounted for a substantial portion of total payments and represent the area of greatest cost increases, followed by increases for pharmacy. Payments to professionals increased at a lower rate. Significant “preventable” use, such as potentially avoidable outpatient emergency department (ED) visits, readmissions to the hospital within 30 days, and hospital admissions for ambulatory care sensitive conditions, also is concerning.
- **Variation in cost and utilization within the state contributed to this problem.** For example, potentially avoidable outpatient ED visits varied nearly threefold by geographic area in Vermont during 2010 after being adjusted for age, gender, and health status. Additionally, adjusted for age, gender, and health status, PMPM rates varied by 35% among HSAs.
- **One-third of patients did not receive effective and preventive care.** Rates of effective care were lower in the Morrisville, Newport, Burlington, and Rutland HSAs. However, the coefficient of variation for effective and preventive care was relatively low, indicating that HEDIS-related care was provided at similar levels across the state. Throughout Vermont, 4,683 preference-sensitive procedures were performed — surgeries that represent potentially inappropriate utilization for conditions that possibly could have been treated less invasively.
- **For some measures, there was wide geographic variability in how care was provided.** Rates of chiropractic/osteopathic manipulation, potentially avoidable ED visits, and back surgery varied widely by HSA in Vermont. For these measures, additional examination of geographic variation and potential causes may be warranted.