Vermont Medicaid Next Generation (VMNG)

House Committee on Health Care

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1/18/2018

OneCareVermont

Outline

- 2017 Accomplishments
- VMNG Operational Accomplishments
- VMNG Utilization Review & Prior Authorization Waiver
- Care Coordination Model
- Quality Improvement Activities
- What Comes Next

2017: Preparing for Year One Under APM

- All Payer Model
  - Represents a big step in strengthening the public-private partnership to deliver on Vermont health reform goals
  - Engagement and participating by broad network in 10 communities
  - Risk contracts with all payers and 1 self funded group to support scale targets
  - First ACO Budget submitted and approved by the Green Mountain Care Board
- Hospital Payment Reform
  - Prospective population payment model for Medicaid, Medicare, and Commercial
- Primary Care Support
  - Broad based programs for all primary care (Independent, FQHC, Hospital-Operated)
  - More advanced pilot reform program offered for independent practices
- Community-Based Services Support
  - Inclusion of Home Health, DAs for Mental Health and substance abuse, and Area Agencies on Aging in complex care coordination program
- Continuity of Medicare Blueprint Funds (Former Medicare Investments under MAPCP)
  - Continued CHT, SASH, PCP payments included for full state
- Significant Movement Toward True Population Health Management
  - RiseVT (a major feature/partner in OneCare's Quadrant 1 approach)
  - Disease and "Rising Risk" Management (Quadrant 2)
  - Complex Care Coordination Program (Quadrants 3 and 4)
  - Advanced data to measure and enable model

Operational Accomplishments

Payer Program Implementation: Vermont Medicaid Next Generation

- **Readiness**
  - All 333 VMNG Readiness items completed
  - 60 new policies, procedures and plans developed and fully operationalized
  - Statewide provider training on new program requirements
  - Beneficiary notifications complete, with less than 2% opt out rate
  - Two new Committees developed to monitor Compliance and Utilization Trends
  - Re-alignment of patients who were attributed to a specialist to a primary care provider

Operations and Communication

- Core Team
  - Following the Readiness period the Core Team was formed to optimize the operationalization of the program. Representatives included:
    - DVHA's Payment Reform Team
    - OneCare representation in Program Operations, Finance and Analytics

- Operations Team
  - Monthly joint Operations meetings to bring DVHA and OneCare staff together for updates on specific topics to include Compliance, Customer Service, Utilization Management and Financial Reconciliation

Resolution Process

- Issue Identification and Tracking
  - The Core Team tracks VMNG program issues centrally. They meet weekly to identify and communicate issues through to resolution.

- Forum for Identifying and Resolving Issues
  - Our OneCare internal staff and provider community raise issues to be addressed
  - Depending on the nature of the issue, there may be a specialized meeting set up for deep dive discussion to include the following:
    - OneCare and DVHA subject matter experts attend
    - DVHA involves their claims processing vendor, DXC to resolve key technical issues
    - Provider representatives are included in discussion forums

2018 Operational Improvements

- Based on the first year of the program, DVHA and OneCare identified operational items to incorporate into the 2018 contract and workflows.
- Items Include:
  - Independent Primary Care Pilot
  - Specialist Attribution Recommended Changes
  - Prior Authorization Improvements
  - Financial Reconciliation Improvements
  - Waiver enhancements
  - Alignment on APM measures

Utilization Review &
Prior Authorization Waiver

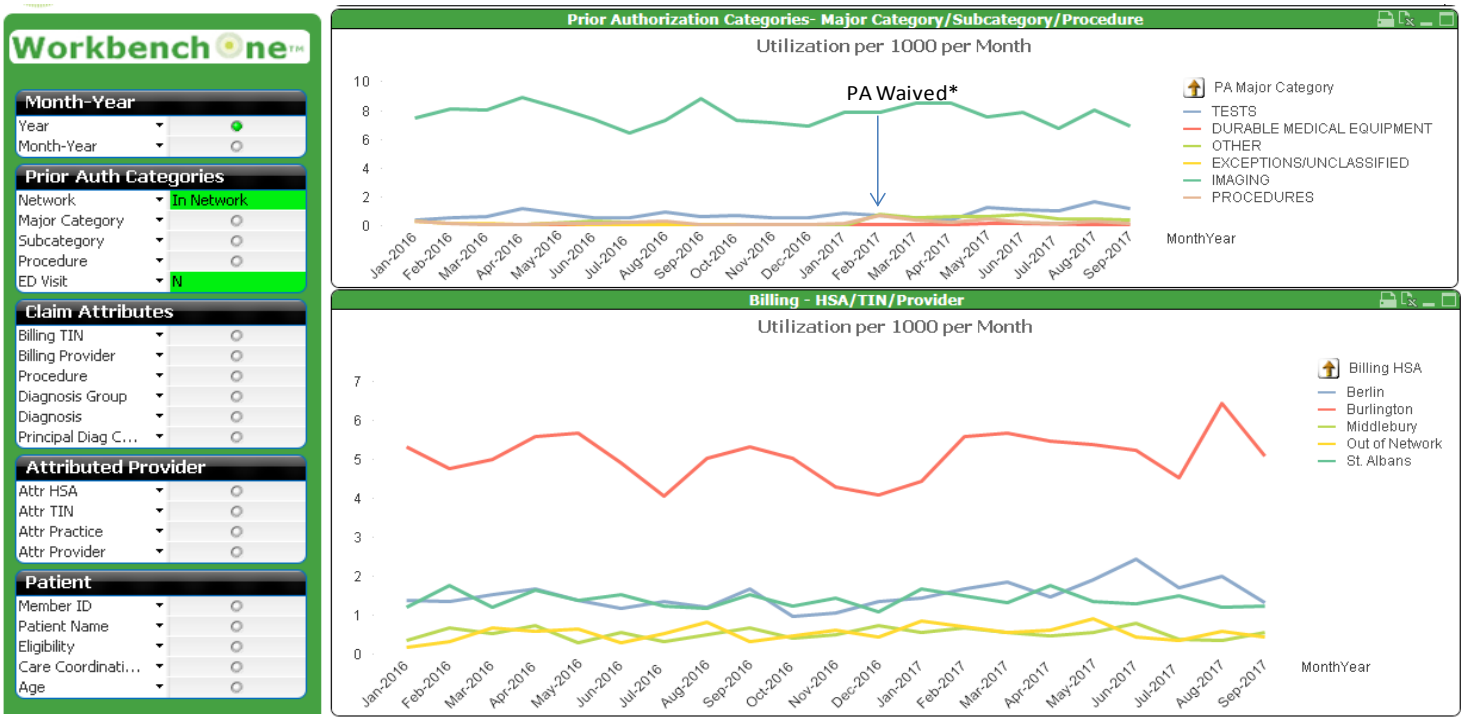
Prior Authorization Exemption: Trend Monitoring

- OneCare is required to monitor all services covered under the utilization management (UM) program using a variety of reports and analytic applications
- Monthly reporting and monitoring of all UM program components performed by clinical, quality, financial and operations staff reporting up through the OneCare Utilization Review Committee
- Quarterly monitoring by the Population Health Committee and Board of Mangers
- Annually, OneCare will conduct an evaluation of all the UM program components, identifying accomplishment and opportunities for improvement- informing priorities and future interventions

VMNG Utilization Review Application

MONTHLY

ACO Name	**OneCare Vermont**
Reporting Period:	**01/01/2016 - 09/30/2017**
Version:	**1.0**
Report Name:	**Utilization Management Review**
Description:	**Analysis of utilization for services no longer requiring prior authorization**



Definitions:

Exceptions/Unclassified codes: S8032 (Low Dose CT Lung Screening) & G0154 (HHCP-SVS of RN, EA 15 min)

Other codes: C9399 (Unclassified Drugs or Biolog)

Notes:

*Prior Authorization was waived for in network services in February 2017.

Designated Agency billing has been removed from this application as of 12/01/2017 because services are not in OCV's TCOC

Imaging has the highest utilization out of all prior authorization categories.

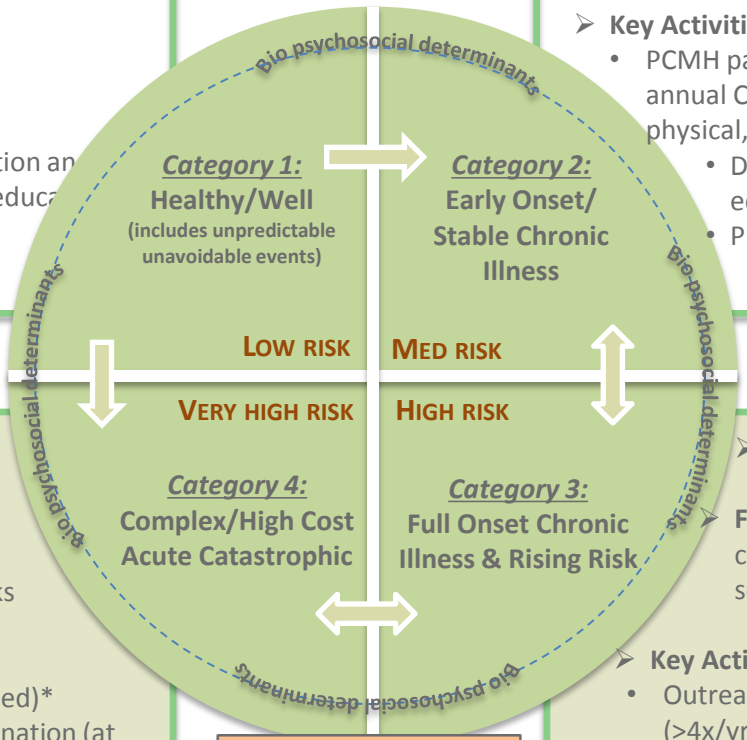
No notable changes have been identified in the data since prior authorization has been waived.

Care Coordination

Population Health Approach to Care Coordination

- **44% of the population**
- **Focus:** Maintain health through preventive care and community-based wellness activities
- **Key Activities:**
  - PCMH panel management
  - Preventive care (e.g. wellness exams, immunizations, health screenings)
  - Wellness campaigns (e.g. health education an resources, wellness classes, parenting educa

- **40% of the population**
- **Focus:** Optimize health and self-management of chronic disease
- **Key Activities:** Category 1 plus
  - PCMH panel management: outreach (≥2/yr) for annual Comprehensive Health Assessment (i.e. physical, mental, social needs)
    - Disease & self-management support* (i.e. education, referrals, reminders)
    - Pregnancy education



- **6% of the population**
- **Focus:** Address complex medical & social challenges by clarifying goals of care, developing action plans, & prioritizing tasks
- **Key Activities:** Category 3 plus
  - Designate lead care coordinator (licensed)*
  - Outreach & engagement in care coordination (at least monthly)*
  - Coordinate among care team members*
  - Assess palliative & hospice care needs*
  - Facilitate regular care conferences *

- **10% of the population**
- **Focus:** Active skill-building for chronic condition management; address co-occurring social needs
- **Key Activities:** Category 2 plus
  - Outreach & engagement in care coordination (≥4x/yr)*
  - Create & maintain shared care plan*
  - Coordinate among care team members*
  - Emphasize safe & timely transitions of care
  - SDoH management strategies*

16% Lives
40% Spending
89% Multiple Chronic
67% MH Condition

* Activities coordinated via Care Navigator software platform

Care Coordination

- Implemented Care Coordination Model in 4 VMNG Communities and 1 RWJ non-risk community
  - Transitioned 67 VCCI patients
  - Risk stratified VMNG population
  - Facilitated community workflows
  - Increased utilization of Care Navigator

- Created a VMNG cross-community care coordination core team to focus on care coordination strategies for population health

- Co-hosted “Tools for Effective Care Coordination” Learning Session

- Developed a straw model and held focus groups with primary care and the full continuum of care providers around new advanced care coordination payment models

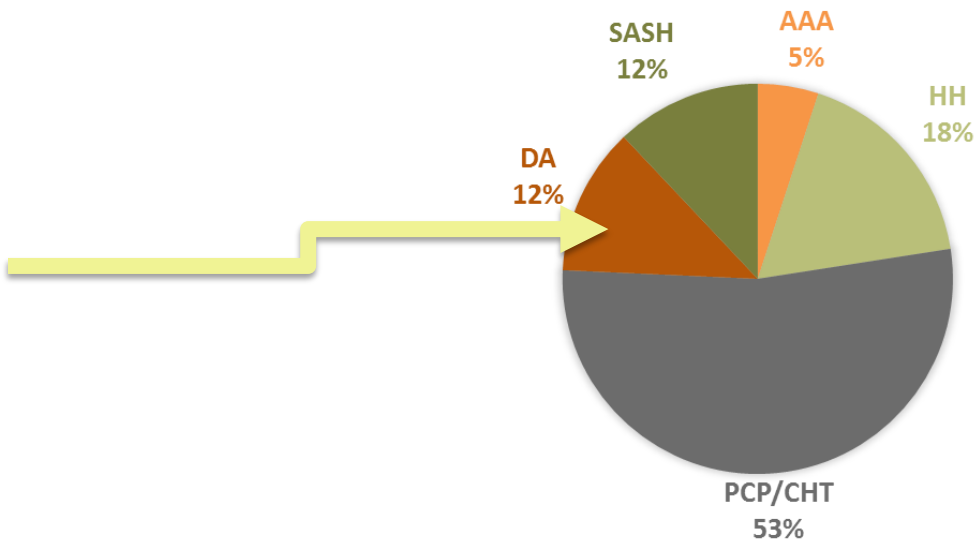
Care Navigator Software Implementation

The Care Coordination Program is supported by use of the Care Navigator software.

In **2017:**

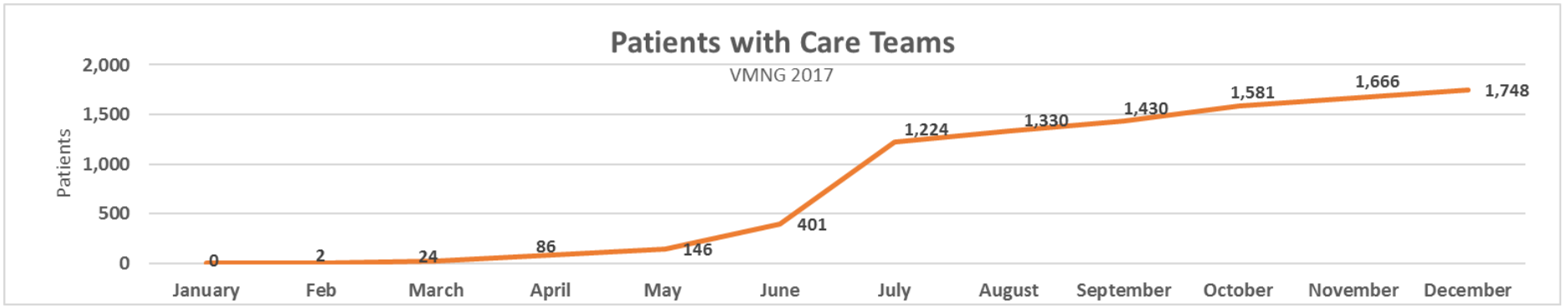
- **102** New user trainings on Care Navigator
- **290** users in the system.

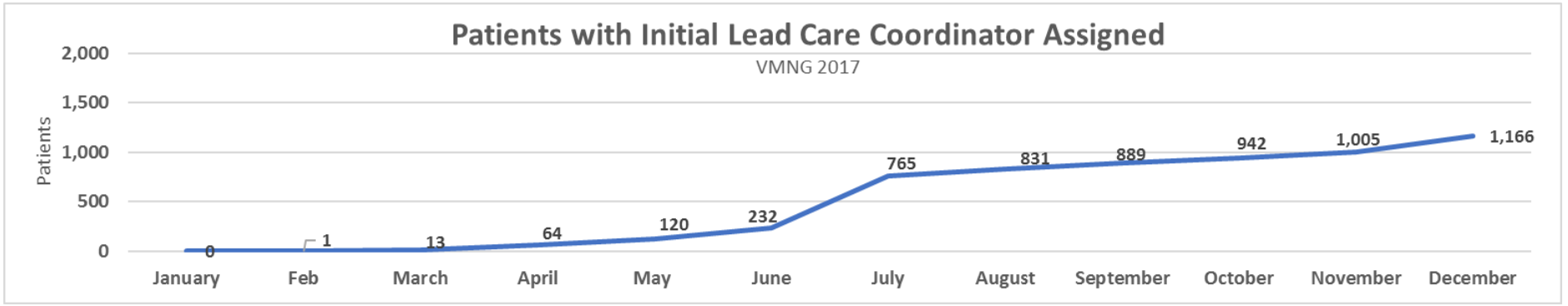
Active users are from designated agencies, SASH and practices.

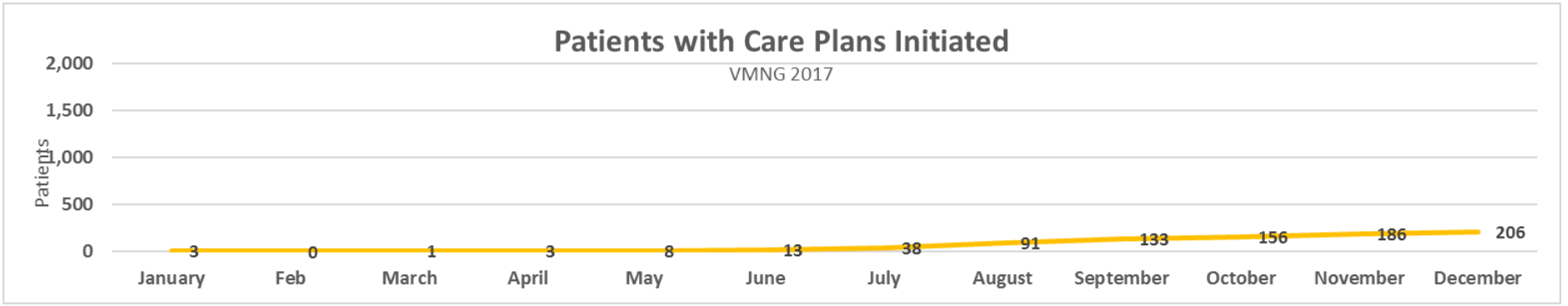


Care Navigator Software Implementation

Users are joining care teams, taking lead and initiated shared care plans.

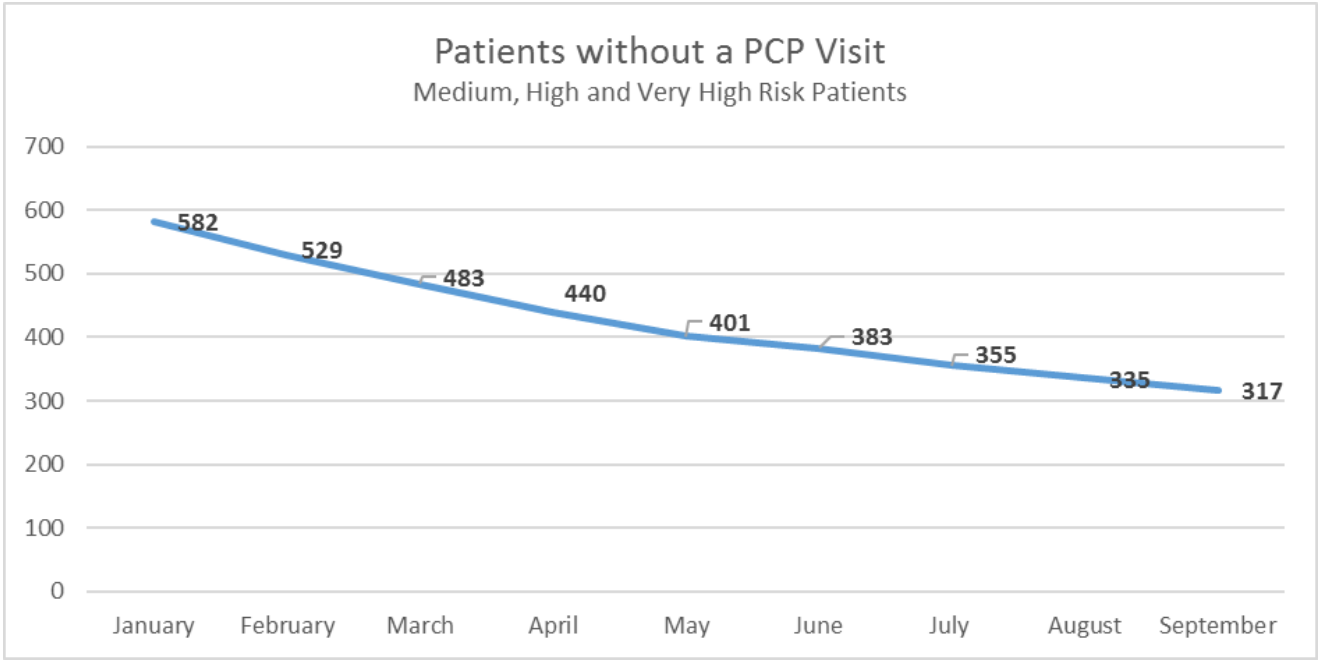






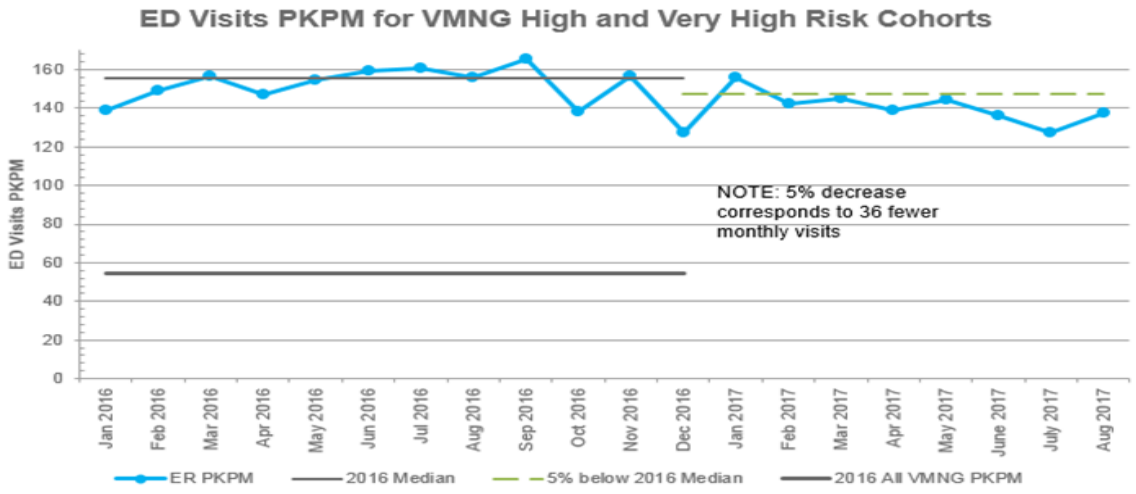
Increased Primary Care Visits

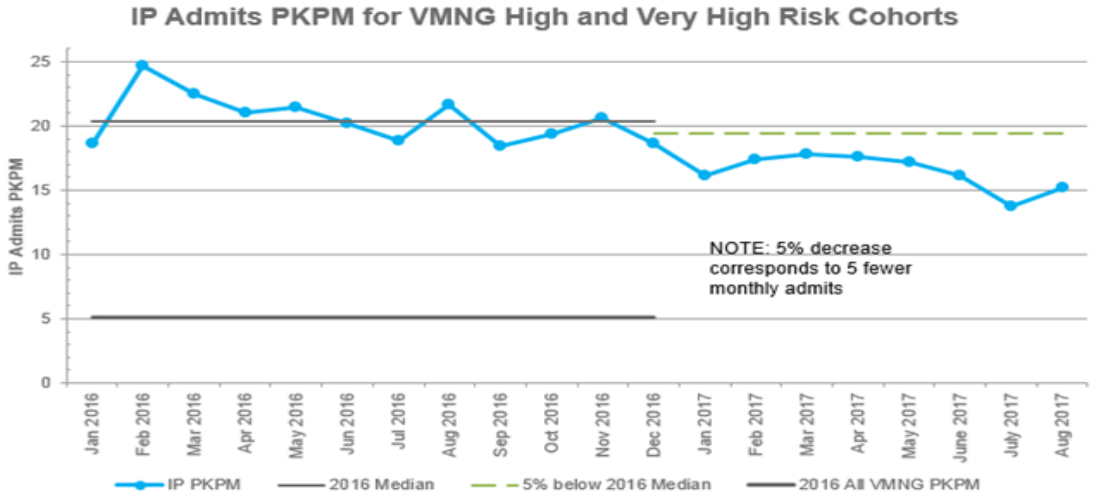
Of the 12,747 highest risk patients (top 3 levels), 583 (4%) had no PCP visit in 2016. These patients were determined to need a comprehensive health assessment.



As of September, 2017 only 2% (317) had no PCP visit and 31% (98) of those patients had a comprehensive health assessment.

Emergency Dept. and Inpatient Reductions





Quality Improvement

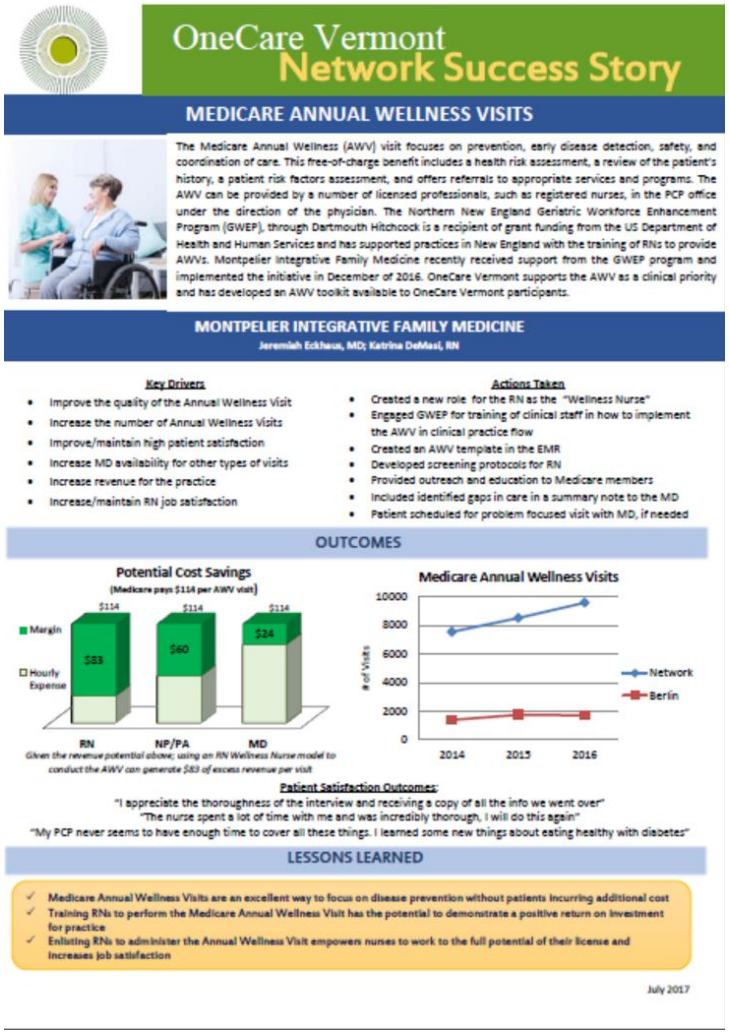
Quality Measurement & Improvement

- 2017 Quality Measures
  - Increased alignment of ACO measures with All Payer Model Measures
- Future Quality Measures
  - Developed systematic process to gather feedback from Network participants and consumers
- Co-developed a Controlling Hypertension Learning Collaborative
- Designed and deployed applications to monitor utilization (over/under)
- Creation and sharing of Community Success Stories

Quality Improvement: Clinical Education & Training Series

OneCare Multidisciplinary Grand Rounds

- June 2017: **Medicare Annual Wellness Visit**
- September 2017 : **Palliative Care**
- October 2017 Symposium: **Population Health and Diabetes**
- December 2017: **Suicidality Interventions**
- March 2018: **Dementia**
- May 2018 Symposium: **COPD**
- September 2018: Pediatric Topic TBD
- October 2018: **ESRD**
- December 2018: TBD



OneCare Vermont
Network Success Story

MEDICARE ANNUAL WELLNESS VISITS

The Medicare Annual Wellness (AWV) visit focuses on prevention, early disease detection, safety, and coordination of care. This free-of-charge benefit includes a health risk assessment, a review of the patient's history, a patient risk factors assessment, and offers referrals to appropriate services and programs. The AWV can be provided by a number of licensed professionals, such as registered nurses, in the PCP office under the direction of the physician. The Northern New England Geriatric Workforce Enhancement Program (GWEP), through Dartmouth Hitchcock is a recipient of grant funding from the US Department of Health and Human Services and has supported practices in New England with the training of RNs to provide AWVs. Montpelier Integrative Family Medicine recently received support from the GWEP program and implemented the initiative in December of 2016. OneCare Vermont supports the AWV as a clinical priority and has developed an AWV toolkit available to OneCare Vermont participants.

MONTPELIER INTEGRATIVE FAMILY MEDICINE

Jeremiah Eckhaus, MD; Katrina DeMasi, RN

Key Drivers

- Improve the quality of the Annual Wellness Visit
- Increase the number of Annual Wellness Visits
- Improve/maintain high patient satisfaction
- Increase MD availability for other types of visits
- Increase revenue for the practice
- Increase/maintain RN job satisfaction

Actions Taken

- Created a new role for the RN as the "Wellness Nurse"
- Engaged GWEP for training of clinical staff in how to implement the AWV in clinical practice flow
- Created an AWV template in the EMR
- Developed screening protocols for RN
- Provided outreach and education to Medicare members
- Included identified gaps in care in a summary note to the MD
- Patient scheduled for problem focused visit with MD, if needed

OUTCOMES

Potential Cost Savings

(Medicare pays $114 per AWV visit)

Given the revenue potential above, using an RN Wellness Nurse model to conduct the AWV can generate $83 of excess revenue per visit

Medicare Annual Wellness Visits

Patient Satisfaction Outcomes:

"I appreciate the thoroughness of the interview and receiving a copy of all the info we went over"
"The nurse spent a lot of time with me and was incredibly thorough, I will do this again"
"My PCP never seems to have enough time to cover all these things. I learned some new things about eating healthy with diabetes"

LESSONS LEARNED

- ✓ Medicare Annual Wellness Visits are an excellent way to focus on disease prevention without patients incurring additional cost
- ✓ Training RNs to perform the Medicare Annual Wellness Visit has the potential to demonstrate a positive return on investment for practice
- ✓ Enlisting RNs to administer the Annual Wellness Visit empowers nurses to work to the full potential of their license and increases job satisfaction

July 2017

Financial Model & Payment Streams

Financial Performance to Date

- Four hospitals received fixed payments for treatment of attributed Medicaid lives ($47M total)
  - This is an exciting shift away from fee-for-service reimbursement
- Financial operations are running smoothly
  - Attribution and fixed payments suppled to OCV prior to performance month
  - Payments made to the network by the second Friday of the performance month
- While the year is not complete due to insufficient claims runout, spending performance appears to be within 1.5% of the target
- The hospitals have contributed $410k to the Value Based Incentive Fund throughout the year
  - This will be distributed to the network to reward quality, with 70% going to primary care

Scalability for 2018 and Beyond

- To support the complexity of the 2018 programs, OneCare plans to provide scalability in the infrastructure by developing people and processes to meet the increased requirements that support our network in the following ways:
  - Programs: Education and communication related to programs
  - Care Coordination: Broader roll out and increased adoption of clinical tools
  - Quality Improvements: Increased focus on alignment and quality improvement activities in the community
  - Payment Reform: New partnerships opportunities under AIPBP

Thank you and Questions