Vermont Medicaid Next Generation (VMNG)

House Committee on Health Care

Vicki Loner RN.C, MHCDS; COO

1/18/2018 & 1/25/2018

OneCareVermont

Outline

- 2017 Accomplishments
- Network at a Glance
- 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

2018 OneCare Vermont ACO Network

- 10 Hospitals
- 95 Primary Care Practices
- 172 Specialty Care Practices
- 2 FQHCs
- 21 Skilled Nursing Facilities
- 8 Home Health Agencies
- 6 Designated Agencies for Mental Health and Substance Use
- Area Agencies on Aging

2018 OneCare Vermont ACO Network

	Multiple Payer Programs (Medicare, Medicaid, Commercial)							Medicaid Only		
	Berlin	**Brattleboro**	**Burlington**	**Lebanon**	**Middlebury**	**St. Albans**	**Springfield**	**Bennington**	**Newport**	**Windsor**
Hospital	CVMC	Brattleboro Memorial Hospital	UVM Medical Center	DHMC	Porter Medical Center	Northwestern Medical Center	Springfield Hospital	SVMC	North County Hospital	Mt. Ascutney Hospital
FQHC						NOTCH (VMNG only)	SMCS			
Ind. PCP Practices		1 Practice	14 Practices		2 Practices	2 Practices		5 Practices		
Ind. Specialist Practices	4 practices		14 Practices		4 Practices	4 Practices		4 Practices		
Home Health	Central VT Home Health & Hospice	VNA of VT and NH; Bayada*	VNA Chittenden/ Grand Isle; Bayada*	VNA of VT and NH	Addison County Home Health & Hospice	Franklin County Home Health & Hospice	VNA of VT and NH	VNA & Hospice of the Southwest Region; Bayada*	Orleans Essex VNA & Hospice Inc.	VNA of VT and NH
Skilled Nursing Facilities	4 SNFs	3 SNFs	2 SNFs		1 SNF	2 SNFs	1 SNF	2 SNFs	3 SNF	1 SNF
Designated Agencies	Washington County Mental Health	Health Care and Rehabilitation Services of Southeastern Vermont	Howard Center		Counseling Service of Addison County	Northwestern Counseling & Support Services	Health Care and Rehabilitation Services of Southeastern Vermont	United Counseling Service of Bennington County		
All other Providers	1 Naturopath 1 Spec. Svc. Agency	1 Other (Brattleboro Retreat)	1 Naturopath 2 Spec. Svc. Agencies		1 Naturopath		1 other provider	1 other provider		

OneCare has Collaborate Agreements with Triple A's across the state
OneCare also has a collaborator Agreement with the SASH Program.
*Bayada serves the entire state of Vermont these are the communities where there are main offices.

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

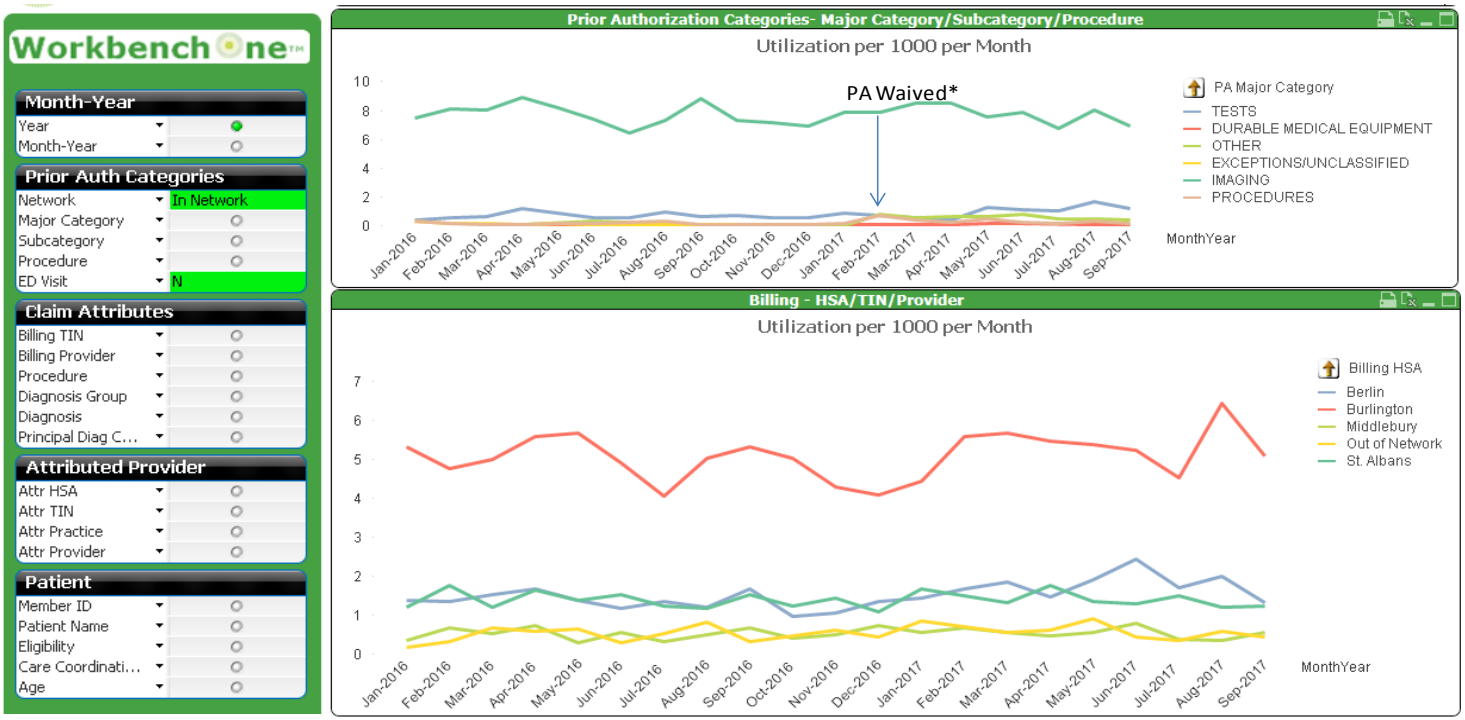
Prior Authorization Exemption: Trend Monitoring

- 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.

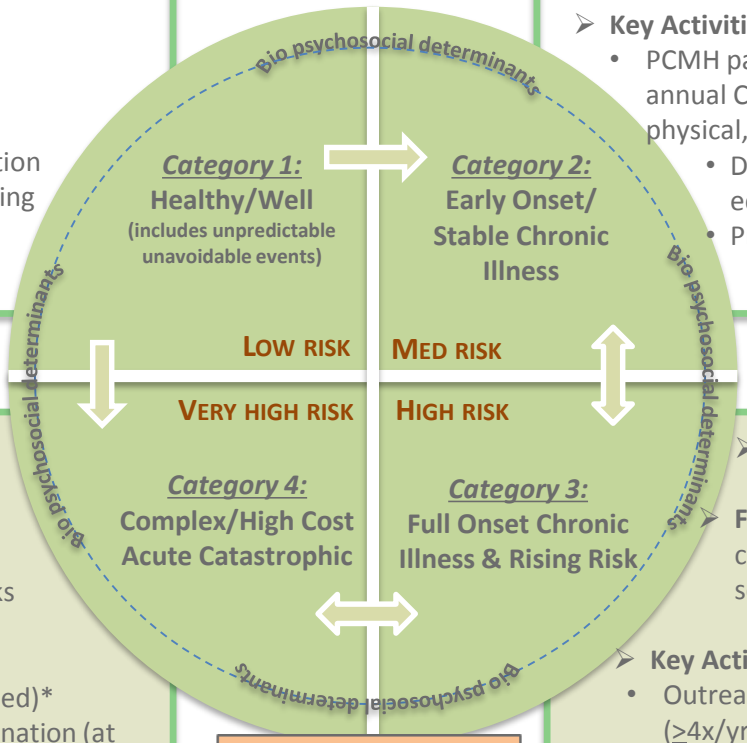
No notable changes have been identified in the data since prior authorization has been waived.

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
  - and resources, wellness classes, parenting education)

- **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

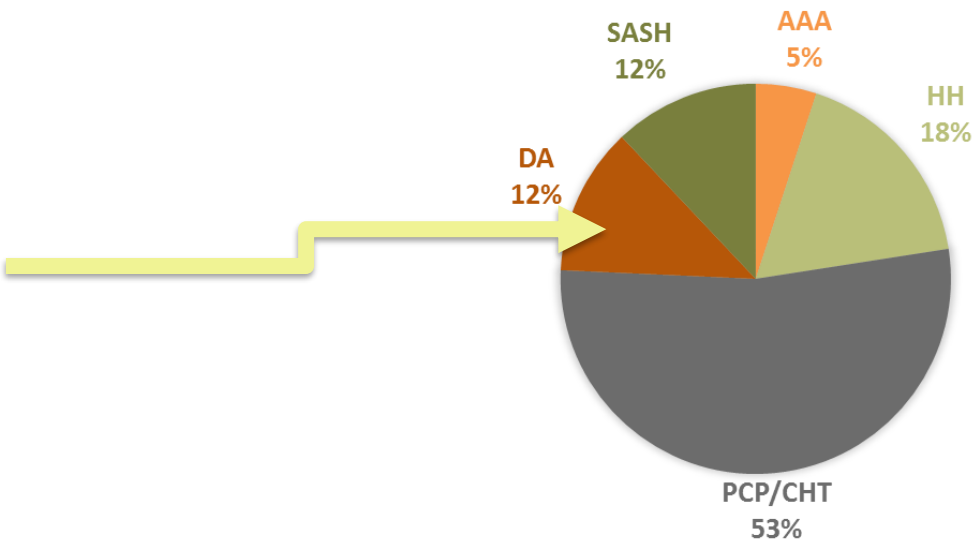
Care Navigator Software Implementation

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

In **2017:**

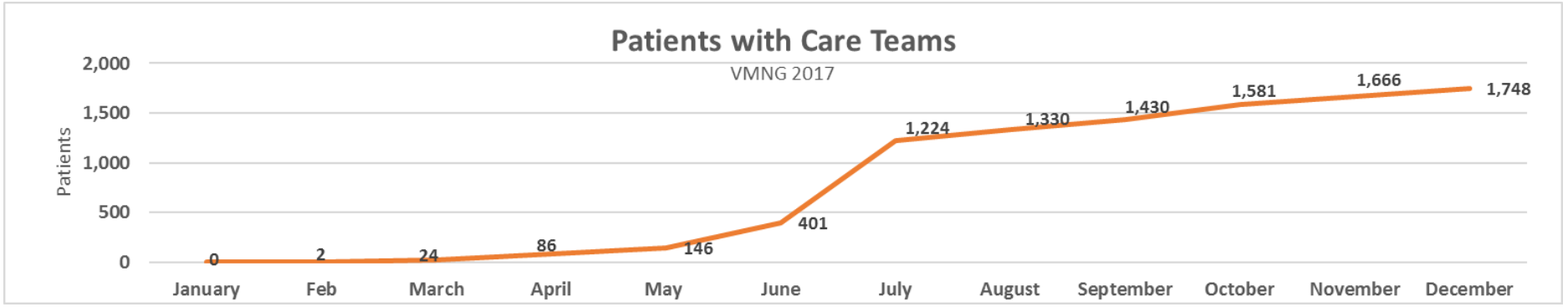
- **102** New user trainings on Care Navigator
- **290** users in the system.

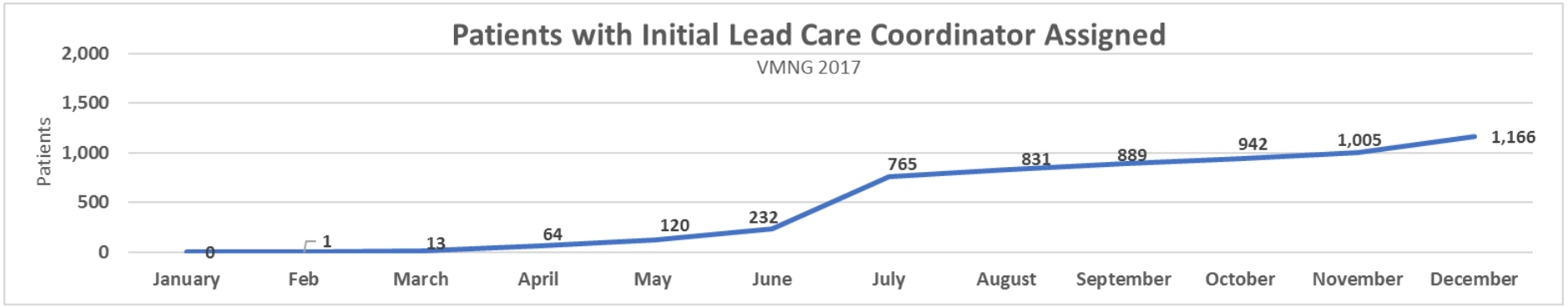
Active users are from designated agencies, SASH and practices.

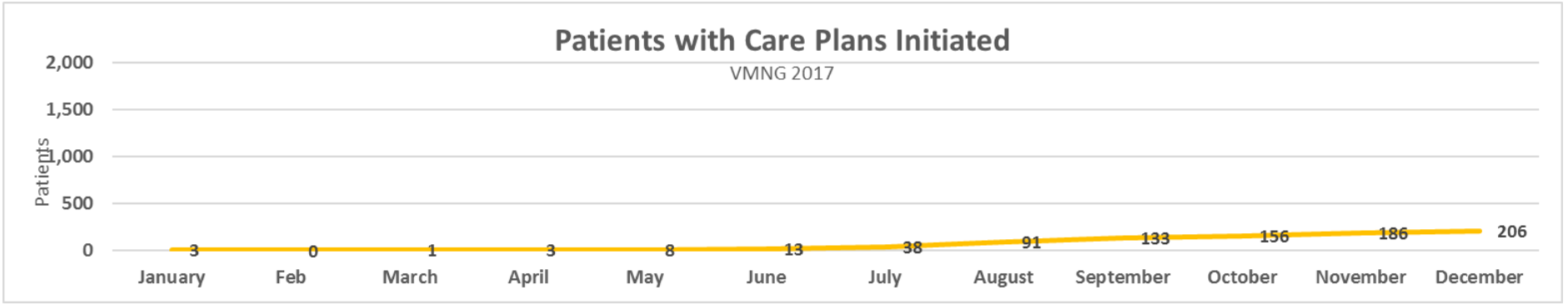


Care Navigator Software Implementation

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

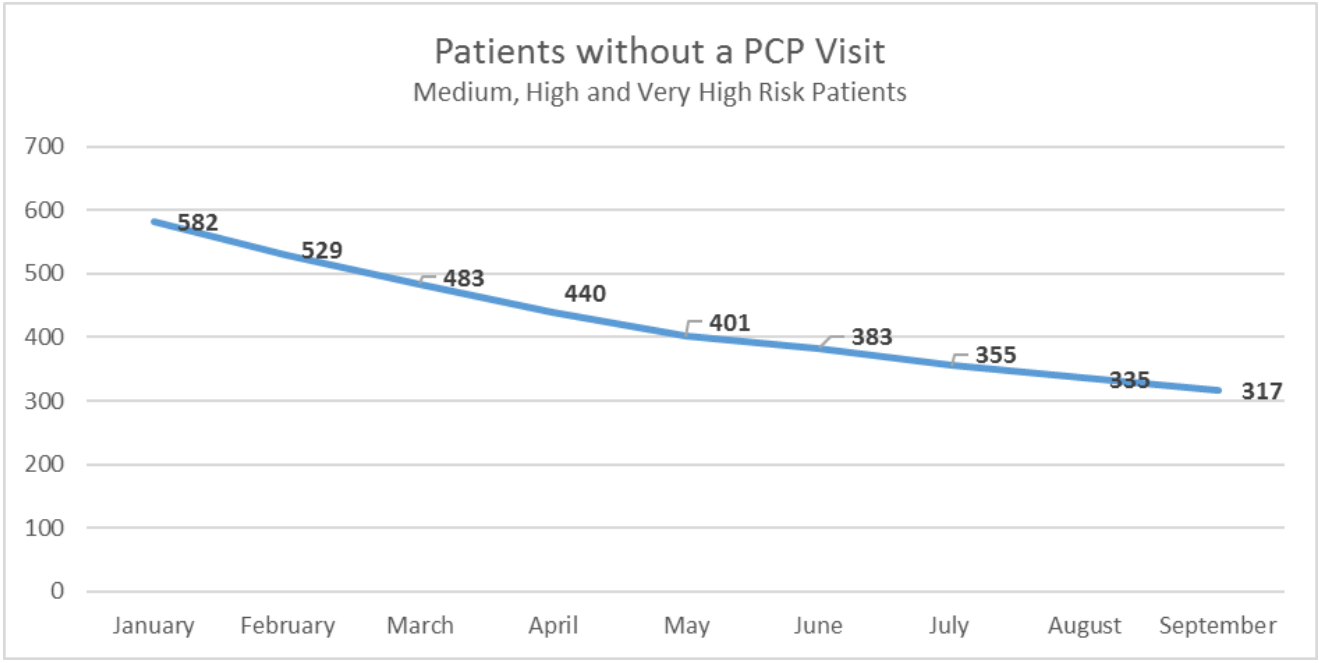






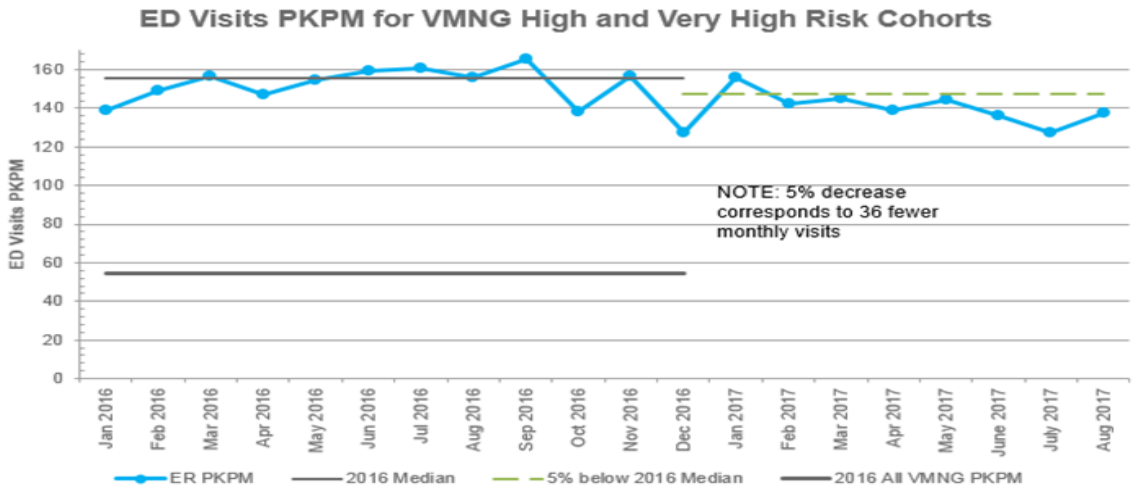
Increased Primary Care Visits

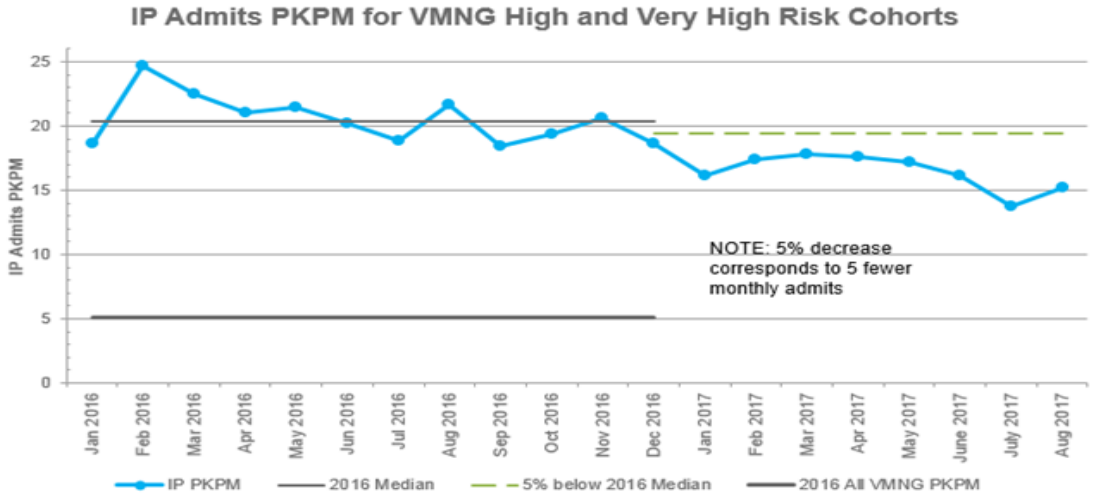
Of the 12,747 highest risk patients (top 3 levels), 583 (4%) had no PCP visit in 2016. These patients were determined to need a comprehensive health assessment.



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

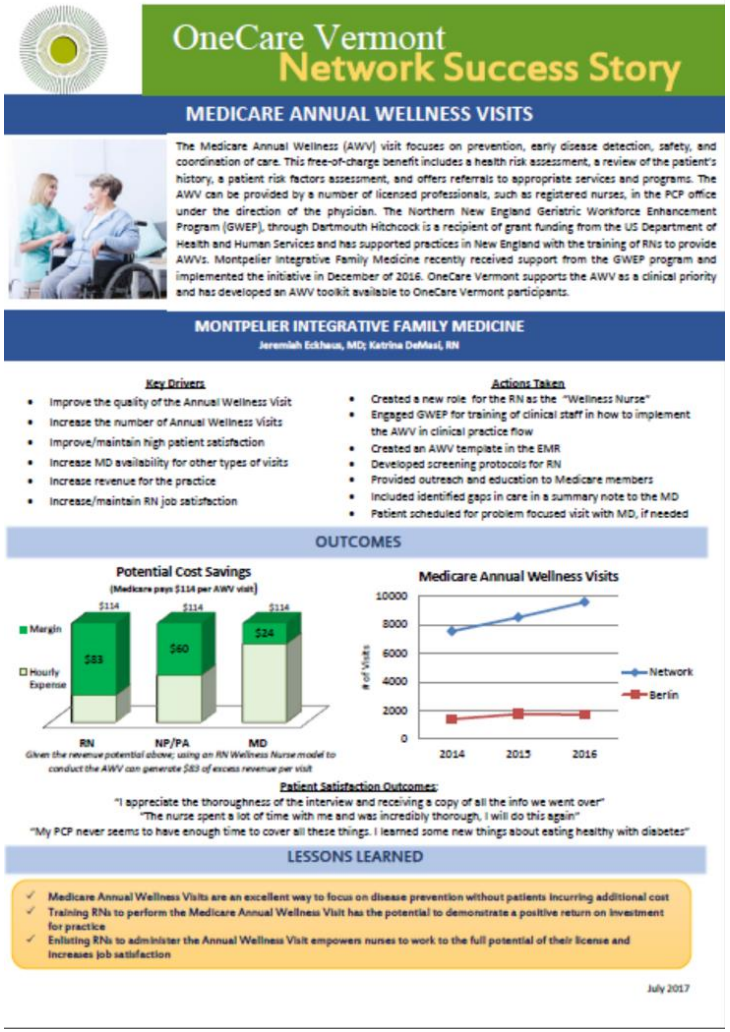
Quality Measurement & Improvement

- 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

Appendix – Network Success Stories

OneCare Vermont Network Success Story

CARE COORDINATION

Figure 1. Care Coordination Model

OneCare continues to work with its participating network members across the continuum of care to implement the Care Coordination Model, a four-quadrant risk stratified approach to identify and align individuals' needs with care coordination and appropriate, patient-centered interventions. Panel management provides a foundation to identify and coordinate patients' preventive and chronic care needs. For the high or very high risk population with increased utilization of healthcare services, care coordination activities become more intensive and include a consideration of physical and mental health, social and economic needs and palliative care, as appropriate. Within communities, care coordination planning and development are incorporated into existing workgroups and community activities, building on the foundation of Integrated Community Care Management Learning Collaborative.

Spotlight on OneCare Vermont's Care Coordination Program

Key Drivers

- Individuals with complex physical, mental health, or social challenges often have multiple care team members who need to communicate and coordinate care
- The current fee-for-service reimbursement model does not adequately support care coordination activities, especially for individuals needing intensive attention
- Care team integration and person-centered approaches are key components of complex care teams
- Various strategies for the integration of care coordination exist at the community level while a state-wide strategy is needed

Actions Taken

- OneCare partnered with Blueprint and DVHA leadership to create and disseminate a Care Coordination Model (Figure 1)
- Within the model, communities maintain local autonomy while working towards standardization on agreed-upon elements of care coordination
- In March 2017, a Care Coordination Core Team comprised of key stakeholders from the four Vermont Medicaid Next Generation (VMNG) pilot communities was formed to focus on care coordination workflow development, cross-organizational and cross-community collaboration and use of Care Navigator
- New complex care coordination payments were made available to Home Health, Mental Health Designated Agencies, Area Agency on Aging and Primary Care practices participating in VMNG

KEY COMMUNITY EARLY STRATEGIES FOR SUCCESS

St. Albans

- High/Very High Risk: Panel management approach to clinic-wide workflow & population based approach to outreach
- RN & SW staff embedded in most clinics
- CN focus for Community Collaborative important for improved, consistent workflow development

Middlebury

- Strategic staff selection for Care Navigator trainings
- Complex case reviews
- Active community relationship-building
- Inpatient-outpatient warm handoffs

Berlin

- Pool PMPMs to hire Case Manager, Project Manager and Panel Manager
- Monthly interdisciplinary cross-organizational community collaborative
- Flag all VMNG patients in EMR to focus team on coordination
- Create CN super user to train others

Burlington

- Dedicated Panel Manager and RN Care Coordinators
- Pilot practice-based financial incentive to attend CN trainings
- Re-focus of Community Collaborative to focus on specific populations

LESSONS LEARNED

- ✓ Teams report success by employing transparent, trusting relationship-based strategies for collective accountability and empowerment
- ✓ Representation from all levels of key stakeholders, care coordination staff to executive leadership, led by a neutral experienced facilitator has led to a well-informed and results-based process
- ✓ Build on existing infrastructure to streamline workgroups and standardize approaches

August 2017

OneCare Vermont Network Success Story

CONTROLLING HYPERTENSION

In June of 2017, OneCare Vermont and its partners[1] came together to recruit practices from around the state to participate in a six month quality improvement initiative focused on hypertension. The goal of the project was to educate and support practices in achieving an 80% in-control rate for hypertensive patients. This goal is in alignment with the National Quality Forum (NQF 18) measure for patients with hypertension to maintain a blood pressure below 140/90. The project was informed by a collaboratively developed Hypertension Management Toolkit.[2] Six practices and one home health agency completed the six month peer learning collaborative, represented in six different health service areas from around the state.

[1] Blueprint for Health, Vermont Department of Health, Quality Improvement Network-Quality Improvement Organization (QIN-QIO), Vermont Program for Quality in Health Care (VPQHC), Community Health Accountable Care (CHAC), Support and Services at Home (SASH), and the University of Vermont Medical Center

[2] http://www.healthvermont.gov/sites/default/files/documents/pdf/HPDP%20Hypertension-Management-Toolkit_v1.0.pdf

PEER LEARNING COMMUNITY

Key Drivers

- Hypertension is one of the leading causes of heart disease and stroke
- Eighty million adults (1 in 3) have high blood pressure in the United States today and prevalence increases with age
- There are an estimated 13 million people in the US with uncontrolled hypertension
- Vermont data from OneCare, the Blueprint and FQHCs indicates that hypertension control is around 70%
- Ambulatory care practices need education and support to implement quality improvement initiatives
- Peer learning communities are a highly effective way to translate best practice into action and provide a positive forum for accountability

Actions Taken

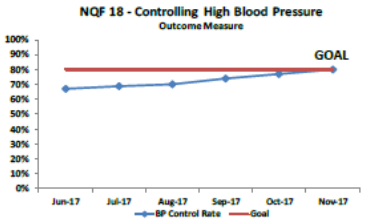
- Recruit practices throughout the state interested in participating in the learning collaborative
- Three in-person sessions were held with subject matter experts presenting materials directly related to hypertension control
- Planning committee with representatives from all participating organizations met weekly to plan monthly WebEx and in-person sessions for participants
- Blueprint facilitators and OneCare Clinical Consultants assisted practices with the implementation of the project
- Monthly check-ins were held via WebEx for practices to share data and lessons learned
- Support practices with quality improvement initiatives and process flows

OUTCOMES: SPOTLIGHT ON PRIMARY CARE HEALTH PARTNERS — ST. ALBANS

St. Albans Primary Care participated in the Hypertension Peer Learning Collaborative using one of their provider's patient panel as the pilot group for this project. The total panel consisted of 1,648 patients, which included 498 with a diagnosis of hypertension. The percent of patients with hypertension control at the start of the project was 67.1%.

Over the course of six months, St. Albans Primary Care tested a series of interventions to address their goal, including:

- Creation of patient panel
- Workflow changes - if initial blood pressure (BP) is high, repeat
- Purchased new chairs and BP cuffs
- Skills training for staff, e.g. taking accurate BP reading
- Monthly office visits for those with uncontrolled BP
- Home blood pressure log monitoring
- Educational posters and materials
- Diet, exercise and lifestyle goals



Results:

The percent of patients with hypertension and blood pressure <140/90 improved from 67.1% to 80.1% at the end of the project. The initiative will next be spread to all the providers in the practice.

LESSONS LEARNED

- Paying close attention to the technique used to take a blood pressure reading is essential for accurate blood pressure readings.
- Having practices from around the state share lessons learned about quality improvement initiatives is an excellent way to improve the health of Vermonters.
- A collaborative project organized and supported by many organizations is valuable to the provider community.

December 2017

Thank you and Questions