Progress and Program Update
Senate Committee on Health and Welfare

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4/3/2018

Outline

- Journey to All Payer ACO Model Reform
- OneCare Overview
- 2018 Accomplishments to Date
- Population Health Investments
- Q&A

Timeline on how VT Arrived at an APM ACO Model

2016

- Vermont and the federal government enter into the All-Payer ACO Model Agreement.
  - Provider-led reform
  - Preservation of successful Vermont reform programs
  - Accountability of ACOs and oversight by the GMCB

2017

- Department of Vermont Health Access Launches VMNG contract with OneCare Vermont
- GMCB adopts Rule 5.000 relating to oversight of ACOs
- GMCB Approves OneCare Vermont Budget for All-Payer ACO program and sets Medicare rate of growth

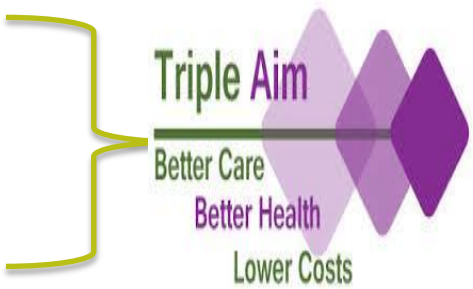
2018

- OneCare Vermont contracts with 3 payers for NG Risk Based Programs
- 10 Hospitals and Communities commit to new system of payment and delivery system reform
- GMCB Certifies OneCare Vermont as an ACO

What a Accountable Care Organization *IS*—

Voluntary network of providers who are

- Committed to working towards
  - Better individual patient experience of care
  - Improved health of defined populations
  - More rational consumption of expensive resources



- Willing to —
  - Lead proactively rather than passively accept change
  - Listen, learn and adopt recommended best practices
  - Assume financial risk for achieving or not achieving goals
  - Deploy/adopt information systems and linkages

ACOs as a Vehicle for Reform

- Broad network of providers
- Voluntarily bound together through contract agreements
- Committed to better understand their community status & needs
- Willing to try and incorporate new ideas into daily practice
- Collaborating with insurers (Medicare, Medicaid, Blues …)
- Striving to achieve slower cost growth (While improving clinical quality and patient satisfaction)
- Willing to be paid differently
- Willing to accept more financial risks

Meet the Board of Managers

Founder Selected Seats

- **John Brumsted, MD** – CEO, University of Vermont Health Network
- **Todd Keating** – CFO, University of Vermont Health Network
- **Steve Leffler, MD** – Network SVP CQO/CPHO, University of Vermont Health Network
- **Steve LeBlanc** – Executive VP, Strategy & Network Relations, Dartmouth-Hitchcock
- **Joseph Perras, MD** – CEO and CMO, Mt. Ascutney Hospital and Health Center
- **Kevin Stone** – Project Specialist for Accountable Care, Dartmouth-Hitchcock

Provider Participant Selected Seats

- **Lorne Babb, MD** – PCP, Enosburg Falls (Private/Community Practice Physicians)
- **Mary Moulton** – Executive Director, Washington County Mental Health (Mental Health Providers)
- **Tim Ford** – President and CEO, Springfield Hospital
- **Claudio Fort** – CEO, North Country Hospital (Critical Access Hospitals)
- **Steven Gordon** - President and CEO, Brattleboro Memorial Hospital
- **Jill Berry Bowen** – CEO, Northwestern Medical Center (Community Hospitals)
- **Judy Morton**– Executive Director, Mountain View, Rutland (Sub-Acute Providers)
- **Judy Peterson** – CEO, VNA of Chittenden & Grand Isle Counties (Home Health & Hospice Rep)
- **Toby Sadkin, MD** – PCP, St Albans (Private/Community Practice Physicians)
- **Pam Parsons** - Executive Director, Northern Tier Center for Health (FQHCs)

Consumer Seats

- **Betsy Davis** - (Representing Medicare Beneficiaries) Member of the VNA Honorary Board
- **Angela Allard** – (Representing Medicaid Beneficiaries) Former small business owner/operator
- **John Sayles** – (Representing Commercial Consumers) CEO, Vermont Foodbank

2018 OneCare Vermont Network

~112,00 attributed lives
~$580M accountable spend

- 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

* Vermont Medicaid Next Generation only

2018 OneCare Vermont 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 Country 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 AAA'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.**

Support for Reform

- **Funding supports care delivery innovations and payment reform models designed to meet the goals of the Vermont All Payer Accountable Care Organization Model**
- Funding Supports:
  - Hospitals in the network
  - Payer contract PMPMs
  - State and federal matching funds

Health Information Technology Investments

Drivers:

- Access to claims and clinical data
- Quality improvement activities can be identified based on data
- Transitioning from fee-for service to value based payments requires a real-time understanding of costs and drivers
- Manual reports are resource intensive and delay change from occurring

Solutions:

- WorkBenchOne and Care Navigator Offer:
  - Timely financial, utilization, and quality data to support APM goals
  - Tools and technical assistance necessary to carry out the population health model both at a systems level and a patient level
  - Direct access to the technology and data sharing platforms

Use:

- ~ 600 Trained users on Care Navigator Platform and WorkBenchOne

Wins:

- Improved simplicity of collection and monitoring of quality measures at State and Federal Level (aka burden)
- Real-time engagement in shared care plans between the full continuum and the patient
- Real time event notification to care coordinators when people are admitted to the hospital
- Early identification of individuals who could benefit from extra support or from people that have not seen their primary care (people don't fall through the cracks)
- Information about performance against targets
- Identification of impact on utilization and access Transparency that drives identification of variation and opportunities to improve care

2018 Accomplishments

2018 Accomplishments

- **Highlights from the first few months of 2018**
  - Invested in and operationalized ~ $25 Million in Population Health Programs to support the goals of health care reform
  - Operationalized fixed prospective payments for Medicaid and Medicare Programs to participating hospitals
  - Provided continuity for the Medicare payments to support CHT, SASH and Blueprint providers
  - Provided training and education to 6 additional VT communities on existing and new Next Generation program contracts
  - Provided extensive training on Quality measures, population health management, care coordination, and Care Navigator in existing and new communities
  - Tested and loaded new clinical and claims data sets for all programs to support providers in clinical and financial accountabilities

2018 Accomplishments (Cont'd)

- Completed quality measure collection for Medicare, Medicaid, and Commercial payers, including clinical abstract of 5,000 patient charts. Traveled to 21 locations throughout Vermont to provide support to practices or to perform manual abstraction from paper charts
- Trained ~200 staff and leaders statewide in care coordination skills in Q1
- Co-developed and launched, with Blueprint, a new diabetes and prediabetes management quality improvement learning collaborative
- Expanded our Patient and Provider Advisory Committee and Board in line with ACO expansion
- Developed new workflows to expand prior authorization elimination
- Developed a set of clinical priority areas to drive focused Quality Improvement activities
- Successfully fulfilled all GMCB requirements in order to receive ACO certification from the GMCB

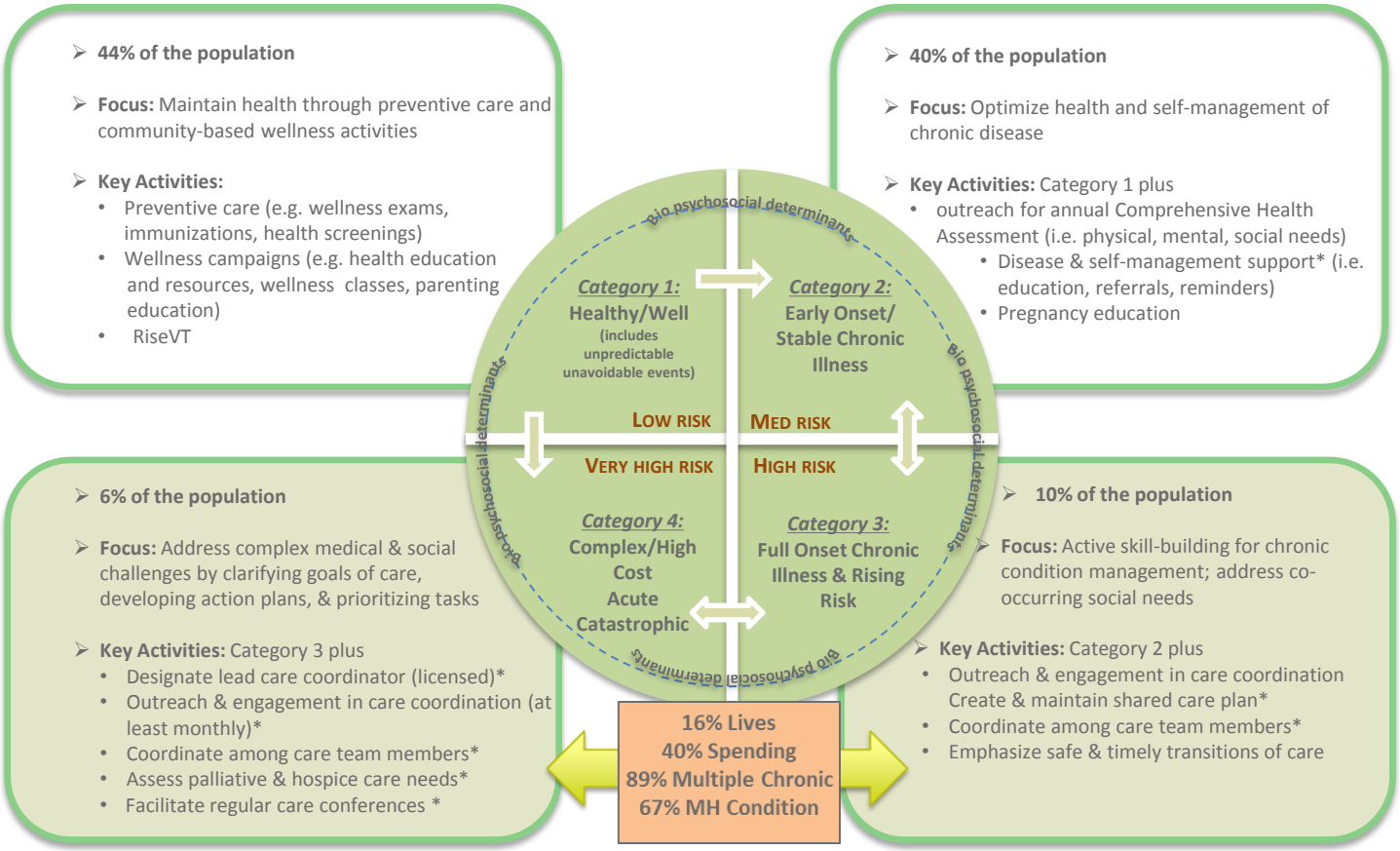
Population Health

Programs and Investments

True Population Health Management

- Population Health Management means creating a plan for every person
- OneCare aims to improve the health of entire populations
- Integrates prevention as a major component of the programs, with RiseVT, as a partner organization
- Includes programs geared towards early identification of chronic illness
- Proactive outreach and coordination for people with more complex conditions
- Advanced Care Coordination program to support activation and engagement for people with multiple or severe conditions

Population Health Approach: A game plan for every person



* Activities coordinated via Care Navigator software platform

2018 Clinical Priorities

APM Goal 1	APM Goal 2	APM Goal 3
Improving Access to Primary Care	Reducing Deaths from Suicide and Drug Overdoses	Reducing Prevalence and Morbidity of Chronic Disease (COPD, DM, HTN)

2018 Clinical Priorities

1. **High-risk patient care coordination**
   Measure: Reduce acute admissions and ED utilization by 5% each in this high risk cohort
2. **Episode of care variation**
   Measure: Reduce Medicare risk adjusted skilled nursing facility length of stay by 5%
3. **Mental health and substance abuse**
   Measure: Increase within-30-day ambulatory care follow-up for emergency room discharges for mental health and substance abuse diagnoses by 5% each
4. **Chronic disease management optimization**
   Measure: Reduce ambulatory sensitive condition admissions/readmissions for COPD and heart failure by 5% each
5. **Prevention and wellness**
   Measure: Increase network utilization of Medicare annual wellness visit, adolescent well child visit, and developmental screening by 5% each
6. **Social Determinants of Health**
   Measure: Establish a baseline to measure food insecurity screening

Population Health Reform Program Investments

Program	Annual Investment
Value-Based Incentive Fund	$ 4,116,546
Primary Care Population Health Payments	$ 4,041,185
Complex Care Coordination Program	$ 6,186,837
PCP Comprehensive Payment Reform Pilot	$ 1,800,000
Community Program Investments	$ 1,583,143
CHT Funding Risk Communities	$ 1,400,887
CHT Funding Non-Risk Communities	$ 844,966
SASH Funding Risk Communities	$ 2,572,500
SASH Funding Non-Risk Communities	$ 1,131,900
Primary Care Payments Risk Communities	$ 875,328
Primary Care Payments Non-Risk Communities	$ 954,936
Total	**$ 25,508,227**

OneCare Investments in Primary Care

In 2018, OneCare is investing approximately $14 million to support primary care. Investments include:

- OneCare Vermont Population Health Per Member Per Month (PMPM) payment of **$3.25** for every patient attributed to the practice
- Complex care coordination PMPM payments:
  - $15 PMPM for every attributed patient in the High and Very High risk cohorts (16% Medicare/Medicaid, 3% Commercial)
  - Lead Care Coordinator ($10 PMPM, if selected)
  - Shared Care Plan creation ($150)
- Value Based Incentive Fund (VBIF) payments: 70% to primary care
- Preserved Medicare Blueprint practice payments
- Preserved Medicare Blueprint CHT funding

In addition to OneCare investments, OneCare primary care providers will be eligible for the federal Advanced Alternative Payment Model (APM) 5% Part B bonus payments beginning 2020 since OneCare qualifies as an Advanced APM.

OneCare Estimated Investments in Care Coordination

		Level 1	Level 2				Level 3 *
HSA	Est. High & Very High Risk Lives	Blueprint Contract Holder	PCMH	Designated Agency	Home Health Agency	Area Agency on Aging	Lead Care Coordinator Entity
Bennington	958	$25,000	$172,498	$103,499	$77,624	$43,125	$38,812
Berlin	2,195	$25,000	$395,093	$237,056	$177,792	$98,773	$88,896
Brattleboro	1,037	$25,000	$186,748	$112,049	$84,036	$46,687	$42,018
Burlington	5,816	$25,000	$1,046,885	$628,131	$471,098	$261,721	$235,549
Lebanon	238	$25,000	$42,803	$25,682	$19,261	$10,701	$9,631
Middlebury	1,394	$25,000	$250,957	$150,574	$112,931	$62,739	$56,465
Newport	443	$25,000	$79,769	$47,861	$35,896	$19,942	$17,948
Springfield	884	$25,000	$159,147	$95,488	$71,616	$39,787	$35,808
St. Albans	1,114	$25,000	$200,538	$120,323	$90,242	$50,135	$45,121
Windsor	180	$25,000	$32,382	$19,429	$14,572	$8,095	$7,286
Total	**14,260**	**$250,000**	**$2,566,819**	**$1,540,092**	**$1,155,069**	**$641,705**	**$577,534**

* Potential earnings based on a 15% shared care plan completion rate.

- Level 1 payments made upon execution of contract
- Level 2 payments made monthly based on actual high and very high risk lives attributed to your practice/HSA
- Level 3 payments made/activated after the completion of a shared care plan and identification of the lead care coordinator

Care Coordination Case Study with Preliminary Findings

Patient profile:

- Male patient in his 40s assigned to *Very High Risk* Care Coordination level
- Outreach began in June 2017 and patient engaged as of September
- Conditions include: Schizophrenia, Coronary Artery Disease, and Hypertension with poor control

Care Navigator:

Acuity: Needs daily contact
Care Team: 4 care team members
Treatment Goals:

- Manage Symptoms (High priority)

Personal Goals:

- Smoking Cessation (Medium priority)
- Improve interpersonal relationships (High priority)

Assessments:
SF12.v2
Vermont SSOM
Documents:
Advance Directive

Claims (through January 2018):

Total Paid 2017: $25,639

- 83% of spend for Mental Health Services

Providers: Primary Care Physician, Mental Health Practitioner, Cardiologist
Last Wellness Visit: November 2017

Comparison to 2016:

- Total paid decreased by 60%:
  $63,074 in 2016 ⇨ $25,639 in 2017
- Emergency Department utilization decreased significantly:
  6 encounters in 2016 ⇨ 0 in 2017
- Primary Care Physician utilization increased
  0 encounters in 2016 ⇨ 5 in 2017

Takeaways: On an individual patient level, based on information available in Care Navigator and claims data, care coordination impacts are demonstrating promise

OneCare Community Investments in 2018

- **Partnership with RiseVT**
  - RiseVT is a unique public health movement that integrates wellness and prevention into the healthcare delivery system.
  - An initiative in northwest VT that was recently formalized into a new state level organization to make the program available statewide.
  - Partnering on an integrated approach to primary prevention, and OneCare also functions as the administrative partner for the RiseVT organization offering employment, support, and space for the new organization and its leaders.

- **SASH/Howard Mental Health Pilot**
  - Major investment in an innovative pilot program to improve the quality of mental health and substance use treatment services for residents of two Burlington area housing communities specializing in the coordination of care and services for older adults and those with special needs.

Questions and Thank You