Date: April 18, 2019
Title of Talk: Vermont’s Health Care Experiment: An Update of the All-Payer Model
CME DISCLAIMER

• In support of improving patient care, this activity has been planned and implemented by the Robert Larner College of Medicine at the University of Vermont and the Vermont Medical Society. The University of Vermont is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC), to provide continuing education for the healthcare team.

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VMS Third Thursday Webinar Series
Vermont’s Health Care Experiment:
An Update on the All-Payer Model

Speakers:
Norm Ward, M.D., Chief Medical Officer. OneCare Vermont, Associate Professor, Larner College of Medicine
Kevin Mullin, Green Mountain Care Board Chair

Planning Committee Members:
Jessa Barnard, ESQ, Stephanie Winters, Deputy Executive Director & Dr. Carl Dobson, M.D., Southwestern Vermont Medical Center

Purpose Statement/Goal of This Activity:
Our speakers will provide an update on the Vermont All-Payer Model, and how it may effect your practice.

Learning Objectives:
Ascertain how the all-payer model works and how it will help to improve the health of Vermonters.

Disclosures:
Is there anything to Disclose?  Yes ☐ No: ☐

Did this activity receive any commercial support?  Yes ☐ No ☐

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Green Mountain Care Board: Vermont’s All-Payer ACO Model and Accountable Care Organization (ACO) Oversight

Kevin Mullin, GMCB Chair

Vermont Medical Society Webinar Series
April 18, 2019
GMCB Members & Leadership

Kevin Mullin
GMCB Chair

Jessica Holmes, Ph.D.
GMCB Member

Robin Lunge, J.D., MHCDS
GMCB Member

Maureen Usifer
GMCB Member

Tom Pelham
GMCB Member

Susan Barrett, J.D.
GMCB Executive Director
Problem: Health Care Costs are Growing at an Unsustainable Rate

In 2017, the most recent year of data available, health care spending in Vermont grew 1.7%

Problem: Health Care Costs are Growing at an Unsustainable Rate

Vermont’s health care share of state gross domestic product devoted to health care spending was 18.5% in 2017, vs. 11.8% in 1995.

Health outcomes must improve

- Chronic diseases are the most common cause of death in Vermont. In 2014, **78% of Vermont deaths were caused by chronic diseases**
  - High Blood Pressure: 25% of Vermonters diagnosed (2015)
  - Diabetes: 8% of Vermonters diagnosed (2015)
  - COPD: 6% of Vermonters diagnosed (2015)
  - Obesity: 28% of Vermont adults diagnosed (2016)

Medical costs related to chronic disease were over **$2 billion in 2015**, and are expected to rise to nearly $3 billion by 2020

- Vermont’s death rates from **suicide and drug overdose** are higher than the national average
  - Suicide (2016): 17.3 per 100,000 (VT) vs. 13.4 per 100,000 (US)
  - Drug Overdose (2016): 18.4 per 100,000 (VT) vs. 13.3 per 100,000 (US)

*(Sources: Vermont Department of Health, Kaiser Family Foundation)*
### Vermont’s Solution: The Vermont All-Payer Accountable Care Organization (ACO) Model

<table>
<thead>
<tr>
<th>Test Payment Changes</th>
<th>Transform Care Delivery</th>
<th>Improve Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population-Based</td>
<td>Invest in Care</td>
<td>Improved access to primary care</td>
</tr>
<tr>
<td>Payments Tied to</td>
<td>Coordination</td>
<td>Fewer deaths due to suicide and drug overdose</td>
</tr>
<tr>
<td>Quality and Outcomes</td>
<td>Incorporation of Social Determinants of Health</td>
<td>Reduced prevalence and morbidity of chronic disease</td>
</tr>
<tr>
<td>Increased Investment in Primary Care and Prevention</td>
<td>Improve Quality</td>
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- **Improve Outcomes**
  - Improved access to primary care
  - Fewer deaths due to suicide and drug overdose
  - Reduced prevalence and morbidity of chronic disease
All-Payer ACO Model: What Is It?

An ACO is a group of doctors, hospitals, and other health care providers who come together voluntarily to give coordinated, high-quality care to patients

• The All-Payer Model enables the three main payers of health care in Vermont – Medicaid, Medicare, and commercial insurance – to pay an Accountable Care Organization (ACO) differently than through fee-for-service reimbursement
  • Facilitated by state law and an agreement between the State and the Centers for Medicare and Medicaid Services (CMS) that allows Medicare’s participation
• Provides the opportunity to improve health care delivery to Vermonters, changing the emphasis from seeing patients more routinely for episodic illness to providing longitudinal and preventive care. A more predictable revenue stream supports providers in initiating additional delivery system reforms that improve quality and reduce costs
## Vermont’s Responsibilities under the All-Payer ACO Model Agreement

### Cost Growth and Population Health/Quality

- Limit spending growth on certain services
  - Separate targets for Medicare and “all-payer” beneficiaries (most Vermonters)

- Meet targets for 20 quality measures, including three population health goals
  - Improving access to primary care
  - Reducing deaths due to suicide and drug overdose
  - Reducing the prevalence and morbidity of chronic disease
  - 90% of Vermont Medicare Beneficiaries

### Alignment and Scale

- Ensure payer-ACO programs align in key areas, including
  - attribution methodologies
  - services
  - quality measures
  - payment mechanisms
  - risk arrangements

- Steadily increase scale (the number of people in the model) over the five years of the Agreement
Improving the Health of Vermonters
How will we measure success?

- Vermont is responsible for meeting targets on **20 measures** under the Model

  **Process Milestones** and **Health Care Delivery System Quality Targets**

  support achievement of ambitious **Population Health Goals**

**Goals selected based on Vermont’s priorities:**
1. Improve **access to primary care**
2. Reduce **deaths due to suicide and drug overdose**
3. Reduce **prevalence and morbidity of chronic disease**
GMCB Responsibilities Under the APM
All-Payer ACO Model Design and ACO Regulation

**Goal #1:** Vermont will reduce the rate of growth in health care expenditures

**Goal #2:** Vermont will ensure and improve quality of and access to care

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### GMCB Regulatory Levers

- Medicare ACO Program Design and Rate Setting (APM Agreement)
- ACO Certification (Act 113 of 2016)
- ACO Budget Review (Act 113 of 2016)
- Hospital Budget Review
- Health Insurance Rate Review
- Certificate of Need
Medicare ACO Program Design and Rate Setting

Medicare participates in the APM through modified versions of the national Medicare Next Generation ACO Program.*

Under the APM Agreement, GMCB...

- **Prospectively develops benchmarks (financial targets) for Vermont Medicare ACO initiatives**: Agreement requires that the benchmark incentivize high-quality care, promote efficient care, and support improvement in the health of aligned beneficiaries. Annual growth rate must be set at least 0.2% below the Annual Projected National Medicare Total Cost of Care per Beneficiary Growth target.

- **Proposes operational changes to support alignment across ACO payer programs**: Examples include aligning the program’s participation agreement with ACO governance requirements included in Act 113 and ACO Certification and creating a consensus set of quality measures across all Vermont ACO programs.

* Vermont Modified Next Generation Program in Year 1; Vermont Medicare ACO Initiative in Years 2-5.
ACO Certification
Act 113 of 2016

Certification
(Annual Review of ACO Policies)

- Composition of Governing Body
- Leadership and Management
- Solvency and Financial Stability
- Provider Network
- Population Health Management and Care Coordination
- Performance Evaluation and Improvement
- Patient Protections and Support
- Provider Payment
- Health Information Technology

- An ACO must be certified by GMCB to be eligible to receive payments from Medicaid or a commercial insurer through a payment reform initiative such as the APM.
- Following an extensive review, the GMCB certified OneCare Vermont (OneCare) in March 2018. Reviewing continued eligibility for certification in January 2019.
ACO Budget Review
Act 113 of 2016

- The GMCB reviewed OneCare’s 2019 budget in late 2018. After careful analysis and an extended public comment period, the Board voted to approve OneCare’s 2019 budget with conditions in December 2018.
- The approved budget is approximately $900 million with a vast majority of dollars flowing to providers, either through fixed payments from OneCare or fee-for-service payments from payers. This total reflects the inclusion of an estimated 196,000 Vermonters in ACO programs (up from 113,000 in 2018).

Budget Review
(Annual Review of ACO Plan)

- ACO Provider Network
- Payer Programs
- Budget and Financial Plan
- Risk Mitigation Plan
- ACO Quality, Model of Care and Community Integration Initiatives
- Compliance with All-Payer Model
- Measurement of Primary Care Spending
Other GMCB Regulatory Levers

GMCB also works to ensure its other regulatory levers are aligned with All-Payer Model goals, including…

- **Hospital Budget Review**: Board works to align with APM and ACO regulation through hospital Net Patient Revenue (NPR) decisions, evaluation of hospital health care reform investments, and asking about hospitals’ ACO participation.

- **Health Insurance Rate Review**: Align through discussion of ACO participation in rate hearings.

- **Certificate of Need**: Align through considering ACO participation as a factor in CON reviews. Example: 2017 Green Mountain Surgery Center approval required the new facility to participate in the ACO’s network.
APM Reporting and Analytics

PY1 (2018)
- April 2019: TCOC Quarterly Reporting begins¹
- April 2019: First Payer Differential Annual Report²
- June 2019: First Annual Scale Targets and Alignment Report³

PY2 (2019)
- September 2019: First Statewide Health Outcomes and Quality of Care Report⁴
- December 2019: Payer Differential Assessment Report

PY3 (2020)
- June 2020: Public Health System Accountability Framework (AHS leads)
- December 2020: Plan to Integrate Medicaid Mental Health, SUD, and HCBS Services within All-Payer Financial Target Services (AHS leads)
- December 2020: Payer Differential Options Report

PY4 (2021)
- December 2021: Proposal for Subsequent Agreement

PY5 (2022)

¹ Submitted quarterly (reports produced 9 months following final date of service); annual reports completed in September of following year. Q12018 report delayed due to data availability.
² Submitted annually on 4/1; April 2019 report delayed due to data.
³ Submitted annually on 6/30.
⁴ Submitted annually on 9/30.
APM Progress Update
APM Progress Update

The All-Payer ACO Model is growing significantly in 2019 (Year 2), with new regions participating and possible new payer programs

- One ACO operating in Vermont: OneCare Vermont
- Expected OneCare payer programs in 2019 (data to be finalized in April):
  - Medicare (Vermont Medicare ACO Initiative)
  - Medicaid (Vermont Medicaid Next Generation ACO Program)
  - BCBSVT (QHP Next Generation Program)
  - UVMMC (self-funded ACO program)
  - Potential for an additional new self-funded program
- 12 of Vermont’s 14 hospitals participate in at least one payer program

Total participation: ~168,000-214,000 Vermonters, up from 113,000 in 2018
APM Progress Update

Regions participating in ACO through one or more payer contracts


In 2019, participating providers include...

- Hospitals (in all 12 participating regions)
- Federally qualified health centers (6 regions)
- Independent specialists (7 regions)
- Independent primary care providers (8 regions)
- Home health (all regions)
- Designated mental health agencies (all regions)
- Skilled nursing facilities (10 regions)
"Vermont's Health Care Experiment: An Update on the All-Payer Model"

Vermont Medical Society Webinar
Norman Ward, MD
CMO, OneCare Vermont
April 18, 2019
Vermont’s Health Care Reform Landscape: All Payer Accountable Care Organization Model (APM)

- Voluntary program for providers in Vermont
- Federal Government/State of Vermont contract from 2017-2022
- Agrees on cost control targets for health spending growth for Vermonters
- Emphasizes population health management
- Payment and service delivery flexibility
- Plans for 70% of all insured Vermonters in ACO by 2022; 90% of Vermonters with Medicare

APM Goal 1
Improve Access to Primary Care

APM Goal 2
Reduce Deaths from Suicide and Drug Overdose

APM Goal 3
Reduce Prevalence and Morbidity of Chronic Disease (COPD, DM, HTN)

Green Mountain Care Board Provides Oversight:
- Certifies ACOs
- Reviews and approves ACO budgets
- Monitors and oversees activities of ACOs
2019 OneCare Network

- 13 Hospitals
- 132 Primary Care Practices
- 242 Specialty Care Practices
- 6 FQHCs
- 23 Skilled Nursing Facilities
- 9 Home Health Agencies
- 9 Designated Agencies for Mental Health and Substance Use
- 5 Area Agencies on Aging

~172,000 Vermonters (630,000 population)
- Medicaid
- Medicare
- Commercial
- Self-Insured

* Vermont Medicaid Next Generation only
Scale Targets in 2019

All-Payer ACO Model Reporting:
GMCB Reporting of Scale Performance

ACO Scale Targets: Preliminary data indicate that Vermont did not meet ACO Scale Targets in 2018, but significant increases in scale are anticipated for 2019.

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<tr>
<td>Target</td>
<td>36%</td>
<td>50%</td>
<td>58%</td>
<td>62%</td>
<td>70%</td>
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<tr>
<td>Actual</td>
<td>20%</td>
<td>35%*</td>
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<td>Current Estimates:</td>
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<td>32%</td>
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</thead>
<tbody>
<tr>
<td>Target</td>
<td>60%</td>
<td>75%</td>
<td>79%</td>
<td>83%</td>
<td>90%</td>
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<tr>
<td>Actual</td>
<td>35%</td>
<td>50%*</td>
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<td></td>
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<tr>
<td>Current Estimates:</td>
<td></td>
<td></td>
<td>53%</td>
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* Estimates
Johns Hopkins ACG Risk Model

Risk Scoring Methodology:
1. Specific risk factors based on age, gender, ICD 10 diagnosis coding data, and pharmacy data, are determined for each patient by the ACG system.
2. Standard weights from a reference population are then applied to each patient based on their identified risk factors.
3. The patient’s risk score is the sum of the weights.

Used annually to risk stratify entire attributed population in January:
1. Risk Score assigned
2. Placed into Risk Category 1 to 4
3. Care coordination level assigned: Low, Med, High, Very High Risk
Population Health Approach: A plan for every person

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

- **40% of the population**
  - **Focus:** Optimize health and self-management of chronic disease
  - **Key Activities:** Category 1 plus
    - Outreach 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
    - Create & maintain shared care plan*
    - Coordinate among care team members*
    - Emphasize safe & timely transitions of care

*Risk Categories: Johns Hopkins Adjusted Clinical Groupings – Rescaled Total Cost Predicted Risk
## 2019 Anticipated Quality Measures

<table>
<thead>
<tr>
<th>Measure</th>
<th>Medicare</th>
<th>Medicaid</th>
<th>BCBS QHP</th>
<th>UVMMC SF</th>
<th>Data Source</th>
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<tbody>
<tr>
<td>30 Day Follow-Up after Discharge from the ED for Alcohol and Other Drug Dependence</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>Claims</td>
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<tr>
<td>30 Day Follow-Up after Discharge from the ED for Mental Health</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>Claims</td>
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<tr>
<td>Adolescent Well-Care Visit</td>
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<td>X</td>
<td>X</td>
<td>X</td>
<td>Claims</td>
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<tr>
<td>All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions</td>
<td>X</td>
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<td>Claims</td>
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<tr>
<td>Developmental Screening in the First Three Years of Life</td>
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<td>X</td>
<td>X</td>
<td>X</td>
<td>Claims</td>
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<tr>
<td>Initiation of Alcohol and Other Drug Dependence Treatment</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td>Claims</td>
</tr>
<tr>
<td>Engagement of Alcohol and Other Drug Dependence Treatment</td>
<td>X</td>
<td>X</td>
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<td>Claims</td>
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<tr>
<td>Initiation &amp; Engagement of Alcohol and Other Drug Dependence Treatment (Composite)</td>
<td>X</td>
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<td>Claims</td>
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<tr>
<td>ACO All-Cause Readmissions (using most recent HEDIS Methodology)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td>Claims</td>
</tr>
<tr>
<td>Follow-Up After Hospitalization for Mental Illness (7-Day Rate)</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>Claims</td>
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<tr>
<td>Influenza Immunization</td>
<td>X</td>
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<tr>
<td>Colorectal Cancer Screening</td>
<td>X</td>
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<td></td>
<td>Clinical</td>
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<tr>
<td>Tobacco Use Assessment and Cessation Intervention</td>
<td>X</td>
<td>X</td>
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<td></td>
<td>Clinical</td>
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<tr>
<td>Screening for Clinical Depression and Follow-Up Plan</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<td>Clinical</td>
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<tr>
<td>Diabetes HbA1c Poor Control (&gt;9.0%)</td>
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<td>Hypertension: Controlling High Blood Pressure</td>
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<td>Survey</td>
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# 2019 Network Clinical Priorities

<table>
<thead>
<tr>
<th>High-Risk Patient Care Coordination</th>
<th>Mental Health and Substance Abuse</th>
<th>Chronic Disease Management Optimization</th>
<th>Prevention and Wellness</th>
<th>Social Determinants of Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Reduce acute admissions in high and very high risk cohorts</td>
<td>1. Increase 30 day follow-up after ED visit for Alcohol and other Drug</td>
<td>1. Reduce admissions for COPD among patients with COPD</td>
<td>1. Increase Medicare Annual Wellness Visit Rate</td>
<td>1. Food insecurity screening</td>
</tr>
<tr>
<td>2. Reduce ED visits in high and very high risk cohorts</td>
<td>2. Increase 30 day follow-up after ED visit for Mental Health</td>
<td>2. Reduce admissions for CHF among patients with CHF</td>
<td>2. Increase Adolescent Well Care Visit Rate</td>
<td></td>
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<tr>
<td>3. Increase high and very high risk cohorts engagement in care coordination</td>
<td>3. Increase screening for clinical depression</td>
<td>3. Reduce ED visits for Asthma among patients with Asthma</td>
<td>3. Increase Developmental Screening Rate</td>
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<td></td>
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<td>4. Diabetes A1c screening</td>
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<td></td>
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<td>5. Controlling High Blood Pressure</td>
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Primary Care Investments

Population Health Management ($3.25 PMPM)
- Maintain core NCQA PCMH Concepts
- Conduct patient outreach to promote preventive care and chronic disease management
- Review data and monitor quality measure performance
- Address gaps in care
- Assess and improve coding accuracy

Complex Care Coordination (Base $15 PMPM for high/very high risk plus additional opportunities)
- Outreach to engage/maintain patients in care coordination
- Provide care coordination services for your patient panel
- Create shared care plans and community among care team members
- Participate in shared care planning and care conferences to facilitate the patient’s goals of care
- Support effective transitions of care (e.g. ED follow-up calls, post hospital discharge visits)
- Partner with continuum of care and human services organizations
- Attend care coordination skills trainings

Value Based Incentive Fund
- Financial incentive for quality measure performance (1.5-2% Total Cost of Care Withhold)

*OneCare preserves the Medicare funding of the Blueprint and SASH programs – Medicaid and commercial funding is in Vermont statute
Central Components of the Care Coordination Model

Vision
To provide high-quality, person-centered, community-based care coordination services in an integrated delivery system to achieve optimal health outcomes.
Care Navigator: Care Coordination Platform with Person-centered Shared Care Plan

Data Sources
- Claims Data
- Clinical Data (HIE and direct EMR feeds - Future)

OneCare Data Warehouse
WorkbenchOne

Care Management Platform

Data Access
Accessible using pc and mobile devices
- Future
- Current

Outputs
- Care Coordinators collaborate real time
- Assessment
- Care Plan

Accessible by Care coordinators in the continuum of care and patients
Care Coordinator and patient collaborate
Goals of Care Coordination Software

- A **single software platform for communication** among team members across the continuum of care and various organizations

- A **vehicle to record care coordination activities** – including acuity, frequency, and assessment – **brings visibility** to the work being done

- Provide a technology-based tool to identify needs and support effective care coordination for OneCare Vermont attributed patients based on risk stratification

- Build on the learnings from the Integrated Communities Care Management Learning Collaborative (ICCMLC)

- **Complimentary to an EMR** (non duplicative) – **enter only what the rest of the care team would be interested in knowing**
Patient Benefit Enhancements Waivers
Medicare Next Generation

Three-Day Skilled Nursing Facility Waiver

Waives the requirement of a 3-day inpatient and/or previous SNF stay prior to a SNF admission. SNF must have 3 star minimum rating to be eligible.

Post-Acute Home Discharge Waiver

Allows for a physician to contract with, and bill for, a licensed clinician to provide up to nine patient home visits post-acute discharge with “general supervision” by the patient’s physician.

Telehealth Waiver

Eliminates the rural geographic component of originating site requirements, allows the originating site to include a beneficiary’s home, and allows use of asynchronous telehealth services for dermatology and ophthalmology.

Future Waiver Opportunities
# Regional Clinician Representatives

<table>
<thead>
<tr>
<th>RCR</th>
<th>Health Service Area</th>
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<tbody>
<tr>
<td>Steve Anisman</td>
<td>Bennington</td>
</tr>
<tr>
<td>Denise Paasche</td>
<td>Brattleboro</td>
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<tr>
<td>Lewis Holmes</td>
<td>Middlebury</td>
</tr>
<tr>
<td>George Fjeld/Phil Lapp</td>
<td>Rutland</td>
</tr>
<tr>
<td>Michael Rousse</td>
<td>St. Johnsbury</td>
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<tr>
<td>John Lippman</td>
<td>Newport</td>
</tr>
<tr>
<td>Sarah DeSilvey</td>
<td>St. Albans</td>
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<tr>
<td>Teresa Fama</td>
<td>Central Vermont</td>
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<tr>
<td>Dan Moran</td>
<td>Dartmouth Hitchcock</td>
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<td>Joshua White</td>
<td>Randolph</td>
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<tr>
<td>Chip Beehler</td>
<td>Springfield</td>
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<tr>
<td>Catherine Schneider</td>
<td>Windsor</td>
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<td>Claudia Berger</td>
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Current Committees

• Population Health Strategy
• Clinical and Quality Advisory Committee
• Pediatric Subcommittee
• Lab Subcommittee
• Patient and Family Advisory Committee
Interdisciplinary Grand Rounds

Evidence-based Medicine
Community/Continuum Perspective
Patient and Family Perspective
Archived CME at UVM
2017 Enduring Material Sessions Available
June 28, 2017 – Medicare Annual Wellness Visits (1.5 credits)
September 25, 2017 – Palliative Care (1.5 credits)
October 16, 2017 – Symposium – Diabetes (1.5 credits)
December 11, 2017 – Suicide (1.5 credits)

2018 Enduring Material Sessions Available
March 26, 2018 – Dementia Care in Vermont – A Prescription of Hope (1.5 credits)
May 14, 2018 – Chronic Condition Symposium – COPD (1.5 credits)
October 15, 2018 – Pediatric Asthma (2 credits)
December 3, 2018 – Patient & Family Centered Care (2 credits)

2019 Sessions
February 12, 2019 – Pediatric ADHD (2 credits)
March 26, 2019 – Skilled Nursing Facility Care (2 credits)
May 15, 2019 – Sepsis All Day Session (4 credits)
September 2019 – TBD (2 credits)
Vermont Medicaid Next Generation Prior Authorization Waiver

For most services requiring PA – ex. imaging
No relief from pharmacy PA requirements
Some continued review of certain safety related services – lifts, wheelchairs
Innovation Fund

$1M in 2019
42 proposals to evaluate
2 Rounds of funding for 2019
RISEVT IS WHERE YOU LIVE, WORK, LEARN, & PLAY!
Value Based Incentive Fund

(VBIF)
1.5% of Total Cost of Care Withhold
Current distribution methodology:
Dependent on Quality Measure Scoring
70% Primary Care by Attribution
30% Hospital and specialist by revenue
Comprehensive Payment Reform (CPR) Pilot Update

Program Description

- OneCare Vermont designed and developed a program intended to transition independent primary care practices away from fee-for-service (FFS) reimbursement to a payer-blended PMPM payment model for all attributed lives.

- The purpose of this initiative, known as the Comprehensive Payment Reform (CPR) pilot, is to:
  - Implement a payment reform that results in a simpler and more predictable revenue stream
  - Invest more in primary care
  - Develop a reimbursement model that allows for clinical flexibility and innovation

- Three (3) practices are participating in the pilot year (2018) of this program and expanding to six (6) practices in 2019.
Medicare Annual Wellness Visits

Emerging evidence for efficacy
Medicare Annual Wellness Visits

Which of your patients are due?

- Falls Risk Screening
- Influenza & Pneumonia Vaccine
- Depression Screening & Follow Up
- BMI Screening & Follow Up
- Cancer Screenings
- Tobacco Screening & Cessation
- Blood Pressure

NOTICE: All data produced by OneCare VT is for the sole use of its contracted OneCare VT Participants and must not be distributed to other individuals or entities who do not hold a legally binding contract with OneCare VT. These materials are confidential and may only be used in connection with OneCare VT activities. The use of these materials is subject to the provisions of the Business Associate Agreement and/or Participation or Collaboration Agreement with OneCare VT.

This Report Contains Protected Health Information: Exercise extreme caution consistent with HIPAA and all other regulatory and privacy considerations.
50% Never or >24 m
What does OneCare participation mean for the typical practice?

<table>
<thead>
<tr>
<th>Payments</th>
<th>Services</th>
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<tr>
<td>Population Health Management</td>
<td>Data reports</td>
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<td>Complex Care Coordination</td>
<td>Care Navigator</td>
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<td>Value Based Incentive Fund</td>
<td>Clinical Consultant support</td>
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<td>Innovation Grant Eligible</td>
<td>Medicaid prior authorization relief</td>
</tr>
<tr>
<td>Comprehensive Payment Reform (CPR) - blended capitation for eligible independent primary care practices</td>
<td>Medicare benefit waiver participation</td>
</tr>
</tbody>
</table>
What does OneCare mean for patients?

• Improved infrastructure for complex care coordination
• Access to Medicare benefit waivers
• Continued Supports and Services at Home (SASH) program payments from Medicare
• Continued Blueprint practice and community health team payments for Medicare
• Ongoing ability to “opt-out” of claims data sharing – historically only <1%
Results to date?

• Actuarially determined total cost of care target methodology maturing
• Improved ease of quality reporting
• Favorable Medicaid Next Generation program financial performance in 2017
• Significant growth in attributed patients numbers and statewide participation
MSSP ACO Cost vs. Quality 2017 Results

ACOs receiving shared savings distribution

- ACOs beat target but did not earn shared savings
- ACOs that did not beat target

OneCare Vermont (did not beat target)

Footnotes:
1. This figure is calculated internally as if all measures were performance scored rather than any pay-for-reporting; this calculation will more closely match the CMS-Calculated figure over time as CMS decreases the pay-for-reporting component (score does not include quality improvement points).
2. Genesis Healthcare ACO, LLC; SEMAC; Accountable Care Coalition of Western Georgia, LLC; AmpliPHY of Texas ACO LLC; Sandhills Accountable Care Alliance, LLC; and KCMPA-ACO, LLC are not shown on the graph due to outlier status in cost or quality.

211 ACOs were above OCV’s cost per beneficiary and beat their targets or generated Shared Savings
Considering joining for 2020?

• Deadline of 4/27 for “letter of intent”
• Contact OneCare Vermont at...
  • Email: aconetworkoperations@onecarevt.org
  • Phone: 802-847-7220, option 4
Not ready to join for 2020?

• Respond to request for “letter of intent” winter 2020 for 2021 participation
• Continue to receive current fee-for-service payments
• No complex care coordination enhanced payments
Thank You

Questions...