The Green Mountain Care Board’s Accountable Care Organization Budget Guidance (test year)

Instructions: For ACOs with less than 10,000 lives or who are not taking risk, please answer questions or sections with an (\*). For ACOs with more than 10,000 lives or are taking risk, please answer all questions in this Guidance.

# Part 1: ACO INFORMATION, BACKGROUND AND GOVERNANCE\*

1. Date of Application:

*June 23, 2017*

1. Name of ACO:

*Community Health Accountable Care, LLC (CHAC)*

1. Tax ID Number:

*455-460-942*

1. Identify and describe the ACO and its governing body, including:
   1. Legal status of the ACO (e.g., corporation, partnership, not-for-profit, LLC);

*Incorporated in 2012, CHAC is Limited Liability Company.*

* 1. Members of the Board and their organizational affiliation (for consumer members, identify whether the member is a Medicaid beneficiary, a Medicare beneficiary and/or a commercial insurance plan member);

1. *Kevin Kelley, Chair – Community Health Services of Lamoille Valley*
2. *Pam Parsons, Vice Chair – Northern Tier Center for Health*
3. *Gail Auclair, Secretary – Little Rivers Health Care*
4. *Martha Halnon, Treasurer – Mountain Health Center*
5. *Shawn Tester – Northern Counties Health Care*
6. *Tim Ford – Springfield Medical Care Systems*
7. *John Matthew – The Health Center*
8. *Tess Kuenning – Bi-State Primary Care Association*
9. *Daniel Bennett – Gifford Health Care*
10. *Grant Whitmer – Community Health Centers of the Rutland Region*
11. *Grace Gilbert-Davis – Battenkill Valley Health Center*
12. *George Karabakakis – Health Care and Rehab Services of Southeastern VT*
13. *Sandy Rousse – Central Vermont Home Health and Hospice*
14. *Tom Huebner – Rutland Regional Medical Center*
15. *Paul Bengtson – Northeastern Vermont Regional Hospital*
16. *Marcia Perry – Medicare Beneficiary Representative*
17. *Lee Bryan – Commercial Beneficiary Representative*
18. *Zachary Hughes – Medicaid Beneficiary Representative*
    1. Board officers;

*See above*

* 1. Board committee and subcommittee structure, as applicable;

*In addition to the Executive Committee (comprised of CHAC’s four officers), CHAC has three other standing committees, the Clinical Committee (comprised of clinicians and quality improvement staff from primary care participant and community partner organizations), the Finance and Audit Committee, and the Operations Committee. CHAC additionally has a Consumer Advisory Panel.*

* 1. Description of Board voting rules; and

*From the CHAC Operating Agreement, “ACO Medicare Participants shall, at all times, hold at least seventy-five percent (75%) voting membership on the Governing Board. Such percentage shall be achieved by weighing the votes of the… ACO Medicare Participants on the Governing Board three (3) times as much as the votes of other members of the Governing Board.”*

* 1. Copy of ACO bylaws, or equivalent.

*Please see Attachment 1 – CHAC Operating Agreement.*

1. Identify and describe each member of the ACO’s executive leadership team, including name, title, tenure in current position, and qualifications for current position.

*CHAC’s Executive Leadership Team includes:*

* *Lori H. Real, MHA, CHAC Administrator & Compliance Officer*
* *Kate Simmons, MBA, MPH, CHAC Director*
* *Abby Mercer, MBA, CHAC CFO*
* *John Matthew, MD, CHAC Medical Director*

*Bios for all Executive Leadership Team members are included below*

***Lori H. Real, MHA****, has served as the Administrator of CHAC since 2013. In this capacity she was instrumental in the formation of the ACO. Ms. Real works with the Board of Directors to establish the strategic direction for the organization. She has lead the CHAC senior management team in administering the Medicaid, Medicare, and Blue Cross and Blue Shield of Vermont ACO Shared Savings Programs.*

*Ms. Real has served as Executive Vice President and Chief Operating Officer of Bi-State Primary Care Association since 2004. She leads and oversees Vermont and New Hampshire programs, policy, operations, community development, recruitment and workforce development, state government relations, marketing, development, finance, information technology, and human resources.*

*The Governor and Executive Council appointed Ms. Real as Director of the Office of Health Planning and Medicaid at the New Hampshire Department of Health and Human Services from 2001 to 2004. In that role, she directed payment of health care providers for the delivery of medical care to 90,000 Medicaid-eligible pregnant women, children, disabled and elderly, as well as directed the financial, legal, pharmaceutical, medical management, planning and research functions. She managed a budget of $270 million and a staff of 100 employees and medical consultants.*

*The Governor and Executive Council appointed Ms. Real as Director of the Office of Planning and Research at DHHS from 1997 to 2001. In this capacity, she led the office in the development of the State Health Plan with seven regional health planning councils comprised of hundreds of individuals from business, health care, the legislature, academia and state foundations. She directed the development of reports on the financial position of NH hospitals and community health centers and held statewide conferences to communicate the findings; developed web-based Regional Health Profiles for each of NH’s 24 Healthcare Service Areas; and conducted an extensive household insurance survey relative to health insurance coverage and the uninsured.*

*Prior to her roles with the State, she was Vice President of Corporate Planning for Blue Cross and Blue Shield of New Hampshire and was responsible for directing the development of strategic and operational plans with the Board of Directors, Senior Management Team and operating management.*

*Ms. Real received her M.H.A. from the University of New Hampshire. She received the Henry Fiumelli Patient Advocate Award from the National Association of Community Health Centers. She also received Public Service Awards from Coos County Family Health Services, Granite State Independent Living, and Bi-State Primary Care Association.*

***Kate Simmons, MBA, MPH****began serving as CHAC Director in July 2016; she previously served as CHAC’s Compliance Officer and Director of Health Care Informatics. Kate additionally serves as the Director of Operations at Bi-State Primary Care Association. Kate has been with Bi-State in various roles since 2007, and she has supported all CHAC operations since the ACO’s development in 2012. In her role with CHAC, Kate has led ACO development, including governance and resource planning, stakeholder education, application development and submission, conceptualization of analytics solutions, etc. She has been instrumental to multiple aspects of ACO implementation, including preparing CHAC’s business plan and corresponding SIM and ACO budgets, managing to ACO budget and SIM State contract, overseeing vendor procurements, developing participant standards, and overseeing CHAC’s participant and member distributions of earned shared savings ($3.3M earned, $1.9M distributed for PY14; $452K earned, $316K distributed for PY15). Kate developed CHAC’s compliance program and directs CHAC’s current ACO quality reporting program.*

*Prior to her work at Bi-State and concurrent with her graduate studies, Kate served as a Program Development Specialist at Commonwealth Care Alliance, a nationally-recognized (and then just beginning) Senior Care Options program in Massachusetts. Kate earned her MBA and an MPH from Boston University Schools of Management and Public Health in 2006 and earned a BA from Harvard University in 2002.*

***Abigail (Abby) Mercer, MBA****, Chief Financial Officer at Community Health Accountable Care, LLC, has thirty years of experience in the management of for-profit and not-for-profit organizations. This includes responsibly for accounting and finance, human resources and information technology. Ms. Mercer attended Skidmore College and Southern New Hampshire University earning a Bachelor’s Degree in Accounting and a Master’s Degree in Business Administration.*

***Dr. John Matthew*** *serves as the Medical Director, a Board member, and the Chair of the Clinical Committee for CHAC. His primary responsibilities in these roles are to provide clinical oversight of CHAC initiatives and to act as the liaison between the CHAC provider network and the Governing*

*Board. Additionally, he is the Chief Executive Officer and Medical Director for The Health Center in Plainfield, Vermont; Clinical Faculty for Medicine and Family Practice at Dartmouth College School of Medicine and the University of Vermont College of Medicine respectively; Nutrition Liaison Physician for Central Vermont Hospital; and the Vice Chairman of the Central Vermont Physician Hospital Organization. He has also been a member of the American College of Physicians and the Vermont State Medical Society for more than 36 years. Prior to joining CHAC and becoming the CEO of The Health Center, Dr. Matthew served as a Project Director for the Rural Practice Project Grant and the Pilot Rural Health Center Project in Plainfield, Vermont. He has received many awards throughout his career including the Leadership Award from the New England Rural Health Roundtable and the 2012 Outstanding Clinician Award presented by Bi-State Primary Care Association. A graduate of Clemson University, Dr. Matthew attained his medical degree from Vanderbilt University and went on to pursue an Internal Medicine residency at Montreal General Hospital through McGill University. He was also awarded a Community Medicine Fellowship at the University of North Carolina. Dr. Matthew is licensed to practice medicine in Vermont and certified by the American Board of Internal Medicine and the American Board of Family Practice.*

1. Provide a list of ACO employees, direct or contracted, their titles, and an organizational chart.

*CHAC has no direct employees. CHAC has a management services agreement in place with Bi-State Primary Care Association and contracts its professional staff through Bi-State.*

*The following Bi-State employees have formal CHAC positions:*

* *Kate Simmons, MBA, MPH, CHAC Director*
* *Abigail Mercer, MBA, CHAC Chief Financial Officer*
* *Patty Launer, RN, CPHQ, CHAC Director of Quality*
* *Lori H. Real, MHA, CHAC Administrator & Compliance Officer.*
* *Adam Woodall, CHAC Security Officer*

*Through CHAC’s MSA with Bi-State, CHAC also purchases fractional time from the following Bi-State employees who do not have formal CHAC positions:*

* *Heather Skeels, Bi-State Senior Program Manager, Health Data Operations*
* *Lauri Scharf, Bi-State Program Manager, Health Care Informatics*
* *Katie Bocchino, Bi-State Project Coordinator*
* *Kim Martin, Bi-State Senior Accountant*

*CHAC’s Medical Director, John Matthew, MD, in employed by The Health Center and provides his time in-kind to CHAC.*

*CHAC’s Administrative Assistant, TBH, is contracted through a temporary staffing agency.*

*Please also reference Attachment 2 – CHAC Organizational Chart.*

1. Describe any legal actions taken against the ACO or against any members of the ACO’s executive leadership team or Board of Directors related to their duties.

*N/A*

1. With respect to the ACO’s executive leadership team or Board members, describe any legal, administrative, regulatory or other findings indicating a wrongful action involving or affecting the performance of his or her duties, or professional fiscal irresponsibility.

*N/A*

1. If the ACO has been accredited, certified or otherwise recognized by an external review organization (e.g., for NCQA accreditation or payer assessments), submit the review organization’s determination letter, associated assessment documents and results. If the ACO is working toward certification, please describe.

*CHAC has not been accredited, certified, or otherwise recognized by an external review organization. Since 2015, CHAC has set a standard that its primary care participants be recognized as NCQA patient-centered medical homes.*

# Part 2: ACO PROVIDER NETWORK

1. Provide, as an attachment, a completed **Appendix A1 – ACO Provider Network Template** which will include\*:
   1. Name
   2. Provider type: (e.g., academic medical centers; critical access, sole community and other hospital types; federally qualified health centers; independent physician office practices; mental health and substance use treatment providers; home health providers, skilled nursing facilities, community long-term services and supports providers; facility post-acute care providers, SASH providers, Blueprint for Health Community Health Teams.)
   3. Contract type and payment model: Payer-defined and administered fee-for-service (FFS); ACO- defined FFS; ACO capitation, including all-inclusive population-based payment (AIPBP); global budget; shared savings; shared risk, or as otherwise defined.

*Please see completed Appendix A1. Please note at this time ACO participants listed in CHAC’s participant roster may also be included on OCV’s participant roster. Participants will be making final decisions about ACO affiliation through October 2017.*

1. Provide, as an attachment, a completed **Appendix A2 – Summary ACO Provider Network Template** which will include\*:
   1. Count of providers by provider type and specialty, by county

*Please see completed Appendix A2. Please note at this time some ACO participants listed in CHAC’s participant roster may also be included on OCV’s participant roster. Participants will be making final decisions about ACO affiliation through October 2017.*

1. For provider contracts for which the provider is assuming risk, describe the ACO’s current contract with the provider:
   1. The percentage of downside risk assumed by the provider, if any;
   2. The cap on downside risk assumed by the provider, if any, and
   3. What risk mitigation requirements the ACO places on the provider, if any (e.g., reinsurance, reserves).
2. Submit provider contracts as requested by the GMCB.

# Part 3: ACO PROGRAMS

1. **Provide copies of existing agreements or contracts with payers. If 2018 contracts not available, please submit as an addendum when signed\*.**

*Please see Attachment 3 – CHAC CMS ACO Contract.*

1. Provide a completed **Appendix B – 2018 ACO Program Elements by Payer** template which will include\*:
   1. Payer and line of business with which the ACO has agreements:
      1. Medicaid
      2. Medicare
      3. Commercial: Individual and Small Group (Vermont Health Connect)
      4. Commercial: Large Group
      5. Commercial: Self-insured
      6. Commercial: Medicare Advantage
   2. Attributed lives by payer and line of business
   3. Projected spending associated with attributed lives by payer and line of business
   4. Projected percentage growth rate or projected PMPM for 2018 for All-Payer ACO Model targets. If not available, please use prior years’ data and describe.

*Please see completed Appendix B.*

1. If applicable, by payer and line of business, describe program arrangement(s) between the payer and the ACO including\*:
   1. Full risk, shared risk, shared savings, other (please specify);

*CHAC’s Risk Sharing Arrangement for the Medicare business line is Shared Savings/Upside Risk only. The ACO follows the risk sharing methodology as published in the CMS Medicare Shared Savings Program (MSSP) final rule.*

* 1. The use of a minimum savings rate, minimum loss rate, or similar concept;

*CHAC utilizes a minimum savings rate of approximately 2.5%.*

* 1. The percentage of downside risk assumed by the ACO;

*CHAC does not assume any downside risk.*

* 1. The cap on downside risk assumed by the ACO, if any;

*Not applicable; CHAC does not assume any downside risk.*

* 1. The cap on upside gain for the ACO, if any;

*CHAC has an upside gain cap of 10% of Total Benchmark Expenditures.*

* 1. Risk mitigation provisions in the payer contract:
     1. Exclusion or truncation of high-cost outlier individuals (please describe)
     2. Payer-provided reinsurance
     3. Risk adjustment: age/gender, clinical (identify grouper software)

*CHAC follows the CMS MSSP guidelines for exclusion/truncation of outliers and risk adjustment, and has no payer provider reinsurance. For exclusion of high cost outliers, the ACO utilizes CMS’s methodology for annualizing and weighting to truncate outlier expenses. CMS truncates all annualized expenditures by setting those expenditures greater than a threshold equal to the threshold. CMS does this to prevent a small number of extremely costly beneficiaries from significantly affecting the ACO’s per capita expenditures. For all beneficiaries, the threshold will be the national un-weighted 99 percentile of annualized expenditures for assignable beneficiaries by Medicare enrollment type, verified by Office of the Actuary (OACT.) For risk adjustment, the ACO uses the CMS Hierarchical Condition Category (CMS-HCC) prospective risk adjustment models to calculate beneficiary risk scores, adjust the benchmark years used for the historical benchmark, and compute the rebased historical benchmark. Each year CMS adjusts the benchmark for changes during the performance period in health status and demographic factors of assigned beneficiaries. The ACO’s updated CMS-HCC prospective risk scores take into account changes in severity and case mix for newly-assigned beneficiaries. CMS uses demographic factors to adjust for these changes in severity and case mix for beneficiaries continuously assigned to the ACO’s population. However, if the continuously assigned population shows a decline in its CMS-HCC prospective risk scores, CMS will lower the risk score for this population.*

* 1. Method for setting the budget target;
     1. Trended historical experience
     2. Percentage of premium
     3. Other (please describe)

*CHAC uses trended historical experience as the method for setting the budget targets.*

1. By payer describe proposed categories of services included for determination of the ACO’s savings or losses, and if possible, projected revenues by category of service and type of payment model (e.g., FFS, capitation or AIPBP).
2. By payer, describe how the proposed ACO benchmark, capitation payment, AIPBP, shared savings and losses, or any other financial incentive program are tied to quality of care or health of aligned beneficiaries\*.

*Per the CMS Medicare Shared Savings Program (MSSP) guidelines, CHAC is only eligible to receive shared savings provided the ACO successful submits reporting and meets minimum quality benchmarks for the clinical measures outlined in Question 6.*

1. By payer and line of business, provide a comprehensive list of ACO quality measures that will, or are proposed to, affect payment or be monitored, according to the terms of the agreement with the payer. For public payers, the applicant may provide a link to publicly-available materials. Provide the most recent annual ACO quality reports for measures included in agreements with payers\*.

*Per the CMS MSSP Program Guidelines, for the 2017 reporting year, the Shared Savings Program quality measurement approach includes 36 quality measures that span four quality domains: Patient / Caregiver Experience, Care Coordination / Patient Safety, Preventive Health, and At-Risk Population. The complete list of measures is below:*



1. By payer and line of business, describe the current or proposed methodology used for beneficiary/member alignment (also known as attribution). If these differ significantly by payer, please describe. Complete a master table in template to be provided of attribution for each program and by Health Service Area (HAS)\*.

*CHAC follows CMS MSSP Track 1 beneficiary assignment/attribution model, as outlined in the CMS MSSP Final Rule. CMS uses preliminary prospective beneficiary assignment with final retrospective beneficiary assignment. This occurs on a quarterly basis throughout the performance year, and annually at the end of each benchmark and performance year. As described in the June 2015 Final Rule, if a beneficiary gets at least one primary care service from a physician utilized in assignment within the ACO, the beneficiary may be assigned to the ACO based on a two-step process. For beneficiaries receiving primary care services at a Federally Qualified Health Center (FQHC)/Rural Health Clinic (RHC), the Physician National Provider Identifier (NPI) must be included on the ACO Participant List’s attestation list for the beneficiary to be eligible for assignment. The assignment methodology, detailed below, is consistent for all Shared Savings Program tracks.*

* *The first step assigns a beneficiary to an ACO if he or she receives a plurality of primary care services from primary care practitioners (i.e., primary care physicians, nurse practitioners, clinical nurse specialists, physician assistants, or ACO professionals providing services at a FQHC/RHC) within the ACO. CMS defines primary care physicians as physicians with one of the five following specialty designations: internal medicine, general practice, family practice, pediatric medicine, or geriatric medicine.*
* *The second step only considers beneficiaries that have not received a primary care service from a primary care physician, non-physician, or ACO professional providing services at a FQHC/RHC inside or outside the ACO. Under this second step, CMS assigns a beneficiary to an ACO if the beneficiary receives the plurality of his or her primary care services from certain ACO professionals within the ACO.*

# Part 4: ACO BUDGET AND FINANCIAL PLAN

1. **Submit most recent audited financial statements and profit and loss statement, including balance sheet, that show at a minimum: assets, liabilities, reserves, sources of working capital and other sources of financial support\*.**

*Please see Attachment 4 – CHAC Audited Financials 2016.*

1. **Submit financial data on 2016 performance under any contracted shared savings, shared risk or full risk payer contracts, inclusive of medical and administrative expenses, by payer. If 2016 performance data is not available, please submit 2015 and supplement with 2016 when available\*.**

*Please reference Attachment 5 – CHAC Prior Performance Summary .*

1. Answer a or b, according to your type of contractual agreements with payers\*:
2. For ACOs who have fewer than 10,000 attributed lives or who are not taking risk, in aggregate forecast for July 1, 2018 across all lines of business, submit the ACO’s medical expense and administrative expense budget for 2018.

*Please reference Appendix C – CHAC Administrative Budget.*

*To provide additional clarification to budget items in Appendix C, CHAC offers the following budget justification notes below:*

1. *Please note that the increases in staffing costs from the CY2017 to the FY2018 are impacted by several factors. First, for the first half of CY2017, staffing costs to CHAC were offset by costs that were covered directly by Bi-State Primary Care Association through its VHCIP grant. For CY2018, CHAC will bear the full costs of these position. Second, several new positions are added in CY2018 in order to provide the needed capacity and expertise to successfully manage CHAC’s ACO program. This includes a full-time project manager who will oversee the day-to-day business of the ACO and interact directly with payers and CHAC’s executive leadership. In addition, new positions are being added (“QI facilitators”) to provide direct quality improvement technical assistance and support to individual CHAC clinical practices to help close gaps in clinical performance as well as monitor and support consistent clinical programming across the ACO.*
2. *In 2018, the line item entitled “Other Administrative Costs” includes $30,000 for the cost of insurance, $100,000 in quality incentive payments to CHAC clinical practices, as well as an estimated $100,000 for the cost of the “bill back” to Green Mountain Care Board for ACO regulation and oversight.*
3. *Consulting costs for both fiscal years includes allocations for ongoing strategic planning and strategic consultation for payer and partnership strategy development and implementation.*
4. *CY2018 includes additional costs in the line item entitled “Information systems and security” to include additional investments in data hosting and security.*
5. *The line item entitled “Health Informatics” significantly increases in CY2018 to accommodate the full staffing costs (see #1 above) as well an additional $48,000 in costs to partner with a data analytics vendor to support data capacity and reporting for the ACO.*
6. For ACOs with 10,000 or more attributed lives or taking risk in aggregate forecast for July 1, 2018 across all lines of business, provide, as an attachment, a completed **Appendix C – 2017 and 2018 ACO Projected Cost and Revenue Data Templates**. This will ask the ACO, by payer and line of business, to provide information on projected revenues and expenses to flow through the ACO financial statements (including payer revenues, participating provider dues, and grant funding), medical costs and administrative costs (including contracted services, community investments and contribution to reserves), in total dollars and per member per month (PMPM) dollars when applicable. The GMCB may request additional information or copies of grants or agreements as part of the review.
7. Provide a narrative description of the following elements of the ACO’s spending plan:
   1. ACO industry benchmarks used in developing the administrative budget;
   2. The methodology determining the qualification and amount of eligible provider incentive payments;
   3. Planned spending on SASH and Blueprint for Health by payer (including practice payments and Community Health Team payments), in comparison with 2016 and 2017 spending levels;
   4. Strategy and spending on community investments (e.g. early childhood development, housing, mental health, substance use, and other services that address social determinants of health);
   5. Strategy for planned spending on health information technology, at the ACO level and to support individual providers;
   6. Budget assumptions related to service utilization, including anticipated changes from prior years’ utilization, including anticipated changes in care delivery including but not limited to new and innovative services, service mix, value-based payment model adoption (including risk assumption); and
   7. Anticipated changes in provider network configuration, and the expected impact on service utilization.
8. Provide a narrative description of the flow of funds in the system. The description should include the flow of funds from payers to the ACO, and from the ACO to its providers. The description should demonstrate the ability of the ACO to maintain sufficient funds to support its administrative operations and meet provider payment obligations.
9. Provide a quantitative analysis with accompanying narrative to demonstrate how the ACO would manage the financial liability for 2018 through the risk programs included in Part 3 should the ACO’s losses equal i) 75% of maximum downside exposure, and ii) 100% of maximum downside exposure. As part of the narrative response, describe your full risk mitigation plan to cover this liability and the mitigation plan for any contracted providers to which risk is being delegated or with which risk is being shared. This response is to include, but is not limited to:
   1. Portion of the risk covered by reserves, collateral, or other liquid security whether established as a program contractual requirement or as part of the ACO’s risk management plan;
   2. Portion of the risk delegated through fixed payment models to ACO-contracted providers;
   3. Portion of the risk covered by ACO providers through mechanisms other than fixed payment models (e.g., withholds, commitment to fund losses at annual settlement, etc.);
   4. Portion of the risk covered by reinsurance;
   5. Portion of the risk covered through any other mechanism (please specify);
   6. Any risk management or financial solvency requirements imposed on the ACO by third-party health care payers under ACO program contracts appearing in Part 3.
10. Provide actuarial certification that the risk-bearing arrangements between the ACO and payers are not expected to threaten the financial solvency of the ACO.

# Part 5: ACO MODEL OF CARE AND COMMUNITY INTEGRATION\*

Of note: The board will consider size and scope of ACO when reviewing responses to this section.

1. Describe the ACO’s Model of Care, including but not limited to how it may address:
   1. Support for person-directed care;

*Each CHAC FQHC provider participant is recognized as a patient-centered medical home through NCQA – a key premise of this work is person-centered care..*

* 1. Support for appropriate utilization;

*Each participating primary care practice, along with representatives from our Home Health, Designated Agency, and Hospital partners, are part of the CHAC Clinical Committee. This committee, along with the CHAC board, are kept updated on the claims data that speaks to utilization of services.*

*Dr. Matthew, Medical Director for CHAC and Chair of the CHAC Clinical Committee, has stated that frequent utilization of hospital and ER services is not only a financial issue but more importantly a quality of life issue. Patients who are in the hospital or ER frequently are not home doing the things they want in the setting they want. It is an understood tenant of the clinical work at CHAC and one that CHAC staff share when presenting with external partners.*

* 1. Seamless coordination of care across the care continuum, including specialty medical care, post-acute care, mental health and substance abuse care and disability and long-term services and supports, especially during care transitions;

*Part of the mission of the FQHCs is to serve the whole person – integrating care either on site or with partners in the community. Most CHAC participating FQHCs have a care coordinator embedded in their practice. Participating private PCPs and non-FQHCs have more limited care coordination capacity, and in cases where care coordinators are not embedded, the practice relies on the Community Health Team to support this work. In addition to the resources available as part of the FQHC structure, all CHAC members are part of the Blueprint work and therefore have access to the resources of the CHT.*

*Additionally, CHAC uses Patient PING to support the practices with notifications about transitions in care for attributed lives, including hospitalizations, and ER visits.*

* 1. Integration efforts with the Vermont Blueprint for Health, regional care collaboratives and other state care coordination initiatives;

*CHAC Staff serve as part of the planning team for the statewide All-Field Team meetings that occur monthly. The All-Field Team meetings consist of the Blueprint Project Managers, the Blueprint Practice Facilitators, the Blueprint Community Health Team Leads, the OneCare Clinical Coordinators, and the staff from the regional QIO. The planning team, consisting of Blueprint Leadership, Quality staff from OneCare, HealthFirst, and CHAC, meets every other week. (This work began about 1 ½ to 2 years ago when the idea of moving toward a single ACO began to form. Quality staff from the Blueprint and the three ACOs recognized that lack of coordination across agencies would present confusion, duplication of services and barriers to efficient care for primary care providers.)*

*An outgrowth of the SIM work on Care Coordination was the development of the Integrated Communities Care Management Learning Collaborative. CHAC Staff, along with Blueprint and OneCare staff, worked with Erin Flynn and Pat Jones, to develop the initial curriculum for the IHI style Learning Collaborative.*

* 1. Identification of, and care coordination interventions for, high risk and very high risk patients; and

*CHAC has worked with VCCI to support the warm hand-off of high-risk Medicaid patients from the Primary Care Providers to the VCCI Care Coordinators. CHAC staff worked with three of member FQHCs (Springfield, THC, and CHSLV) to develop PDSA cycles to support this work. This work was delayed due to technological changes at VCCI.*

*CHAC also piloted an intensive care coordination pilot program targeting high risk and high utilizer ACO patients, specifically those patients with high avoidable hospital admissions and those with ED visits with a history of heart failure, COPD and high risk diabetes. This program enrolled approximately 250 patients between 2015-2016 and supported those patients with intensive case management support embedded at CHAC FQHC practices. Initial evaluations indicate this program prevented over 150 hospitalizations, over 50 ED visits and saved over $2 million in costs in 2016.*

* 1. Use of comprehensive integrated/shared care plans and interdisciplinary care teams.

*All CHAC FQHC participants are PCMH recognized practices, which emphasizes multi-disciplinary care teams and patient-centered care plan development. Additionally, CHAC practices participated in the Integrated Communities Care Management Learning Collaborative and have been working with their community partners to create streamlined ways to capture patient permission to share information between agencies.*

1. Describe new strategies for bringing primary care providers into the network.

*CHAC supports workforce development efforts at its FQHC practices by supporting practices in recruiting and retaining new providers in order to expand practice capacity. Additionally, CHAC works to leverage clinician peer alliances with rural private practice providers. At this time, CHAC is focused on building enhanced capacity within its network of current practices, rather than recruit new ACO participant providers.*

1. Describe strategies for expanding capacity in existing primary care practices, including but not limited to reducing administrative burden on such practices.

*CHAC provides quality reporting and practice facilitation support to ACO participants with the goal of improving care quality and leveraging the ACO as a resource to offer a level of quality improvement support practices may not have the capacity to retain on their own. CHAC staff work in collaboration with statewide agencies and efforts such as the Vermont Blueprint for Health in order to be mindful of other reporting requirements and reduce the reporting burden on CHAC practices.*

1. Describe the participation and role of community-based providers that are included in the ACO, including any proposed investments to expand community-based provider capacity and efforts to avoid duplication of existing resources.

*CHAC distributes shared savings payments to participant communities, enabling those communities to invest in special projects and infrastructure development of their choosing.*

1. Describe the ACO’s population health initiatives, including programs aimed at preventing hospital admissions or readmissions, reducing length of hospital stays, providing benefit enhancements resulting from delivery system flexibility, improving population health outcomes, addressing social determinants of health (e.g. Adverse Childhood Events), and supporting and rewarding healthy lifestyle choices. Describe how the ACO will measure success of these initiatives, and what will constitute success.

*CHAC’s Clinical Committee serves as the ACO’s leadership body overseeing clinical priority setting and program development. The Clinical Committee has developed and approved standard clinical guidelines for COPD, Falls Risk Assessment, CHF, Diabetes, and Depression Screening and Follow-up. These guidelines are distributed to all CHAC participating primary care practices and the standard of care is reinforced by CHAC QI staff and practice facilitators. The CHAC Clinical Committee also sets annual clinical priorities, and reviews ACO collective performance on those clinical priorities on a monthly basis. CHAC defines success as meeting the quality performance baselines set by CMS required to be eligible for shared savings.*

*On an individual practice level, CHAC supports data driven quality improvement at each primary care practice participant. Using the data collected via the Chart Abstraction process, along with data available from UDS, Bi-State’s VT Rural Health Alliance Data Warehouse, and the Blueprint, the CHAC Data and Quality Team travels to each of the participating practices to present data, celebrate areas of success, and discuss areas for improvement. Each practice identifies clinical areas of focus that fit their respective patient populations and clinical capacity.*

*CHAC has also implemented the PRAPARE data collection tool, a national model for screening and collecting information on the social determinants of health.*

1. Provide a copy of your grievance and complaint process.

*Please see Attachment 5 – CHAC Grievance and Complaint Policy*

1. Provide a completed **Appendix D – ACO initiatives to address All-Payer ACO Model Quality Measures** to briefly describe ACO initiatives to address measures.

*Please see completed Appendix D, as well as Appendix D Supplement.*