OneCare Vermont

To:	Susan Barrett, Michael Barber, Alena Berube, Marisa Melamed, Sarah Tewksbury, and Health Care Advocate Policy Team
From:	Sara Barry
CC:	Vicki Loner, Tom Borys, Amy Bodette, Joan Zipko
Date:	December 4, 2020
Subject:	Third Quarter (Q3) 2020 Budget Order Deliverable 15.c.

Dear Green Mountain Care Board and Health Care Advocate Policy Teams:

Enclosed, please find the Q3 2020 deliverable for Budget Order condition 15.c. – Information on the 2020 complex care coordination program implementation, enrollment, payments, patient satisfaction, and, as they arise, relevant challenges and learning opportunities.

The remaining deliverables 15.a. and 15.b. will be supplied upon approval by OneCare's Board of Managers. Please let us know if you have any questions.

Enclosure (1)

15.c. Information on the 2020 complex care coordination program implementation, enrollment, payments, patient satisfaction, and, as they arise, relevant challenges and learning opportunities.

The Community Complex Care Coordination program provides funding and operational support to facilitate community team-based care coordination for individuals attributed to the ACO for whom enhanced supports and services may improve their outcomes and enhance their experience of care. The cornerstone of OneCare's model is a strong relationship between the patient and their patient centered medical home.

In 2020, OneCare implemented a new payment model designed with network participant input that shifted from a capacity model to a value-based model with payments tied to implementation and documentation of key care coordination interventions. This model was scheduled to launch in April 2020, once 2020 payer data were available to run risk stratification algorithms; however, due to the onset of the pandemic and corresponding feedback from network participants, OneCare's Board of Managers postponed the implementation to July 2020.

As might be expected with such an unprecedented event, the pandemic created challenges with respect to the care coordination program in that patient centered medical home and community organizational resources and efforts shifted toward addressing immediate health and safety needs for their populations served and their staff. OneCare also shifted focus immediately to the development and deployment of the COVID-19 Patient Prioritization Application. This application supported local care teams and primary care offices in identifying patients most at risk for complications related to COVID-19 and therefore most in need of outreach. The application and accompanying script promoted patient engagement and safety during this challenging time. The third quarter represented a period that health service area care coordination teams, having responded to the initial impact of the pandemic, were able to redirect efforts toward care coordination. During this time, many organizations focused on their care coordination efforts in addition to implementing the new payment model and OneCare noted care managed rates increased correspondingly. Overall participation in the care coordination program remained strong in the third quarter with care conferences being conducted through in person or virtual means and subsequently documented in Care Navigator™.

During this same period, organizations gained a deeper understanding of the Medicaid Expanded population, a new statewide cohort in 2020. OneCare, Vermont Chronic Care Initiative care coordinators, Blueprint Program Managers, and local care coordination teams collaborated and devised workflows to support Medicaid Expanded patient outreach and connection with primary care. These patient engagement workflows vary from those of the traditional Medicaid cohort in that individuals within this cohort have not previously engaged with primary care and therefore are not identified through systematic patient panel review. These individuals do not have an established relationship with a primary care provider and may have social determinant of health challenges that contributed to this lack of engagement. Specific, coordinated, tailored strategies are needed to identify patients for engagement, and organize and conduct outreach. These efforts are ongoing in the current quarter.

Reviewing data on community care team composition, OneCare recently noted an opportunity to further evaluate and possibly expand the breadth of care team composition. OneCare engaged with community partners including designated agencies, home health agencies, and area agencies on aging and together evaluated care team composition metrics in an effort to understand and respond to

barriers and challenges that existed with respect to participating on care teams and documenting in Care Navigator. In response, OneCare provided additional training on Care Navigator workflows and efficiencies. These collaborations and trainings received positive feedback from the agencies involved and from others participating on care teams. OneCare continues to evaluate care team composition metrics and identify targeted technical assistance and training opportunities.

OneCare incorporates patient feedback through regular discussions with OneCare's Patient and Family Advisory Committee (PFAC). In 2020, PFAC continues to be engaged in the care coordination model, expressing strong support for its ongoing growth and expansion to meet the needs of patients and families with complex needs. They also continue to provide valuable feedback regarding their experiences with telehealth during the pandemic. In addition to patient feedback, OneCare has surveyed network care coordinators to elicit feedback on its care coordination program's strengths, benefits, and needs. This survey was distributed on September 30, 2020 with an open window for responses through October 16, 2020. 120 care coordinators responded to the survey. Results are currently being analyzed and opportunities will be identified to embed suggestions into future programming.

Note: Additional information was provided in OneCare's 2021 Budget submission, follow-up questions, and testimony.