OneCareVermont

HCA Questions Follow-up Questions

1. **Please provide OCV's 2018 targets and actuals by payer for January through June, and for July- September if available.**

	Medicare	Medicaid	BCBS QHP	UVMMC SF
Target PMPM	$867.67	$247.65	TBD	TBD
Actual PMPM	$814.35	$246.59	$510.25	$420.84
All data reflects January - June claims and runout through September				

   a. **Please explain why OCV's 2018 target has not been finalized with BCBSVT (Budget Presentation, Slide 17). How is that program operating and how is OCV assessing its financial performance?**

      BCBSVT and OneCare have not agreed on a target. Our agreement requires OneCare to agree to the target and we do not agree with proposed deviations from the model to which OneCare agreed in its contract.

2. **Has OCV considered any alternative risk sharing methodologies with BCBSVT to help lower the requested target and better align with the Board's 2019 BCBSVT individual and small group rate review decision? For example, a lower target paired with a lower percentage of downside risk.**

   OneCare continues to anticipate and budget for a fair target. With OneCare's proposed BCBSVT QHP target, OneCare remains well below the 3.5% annual growth rate expected under the All Payer Model.

   A lower percentage of risk based upon an unfair target would not be helpful. It is important to set a fair target regardless of the degree of risk taken by OneCare.

3. **Please explain the confidential claims data issue referred to in OCV's answer to our written question #11a.**

   As presented in April of 2018, the confidential claims PMPM supplied to OneCare for the initial budget model was materially lower than a subsequent confidential claims PMPM. This is the primary reason for the increase between the budget model and the latest target estimate.

4. **In OCV's response to our written question #3, OCV noted that services at urgent care centers are considered primary care for attribution purposes if they fulfill the primary care criteria. Does this mean that patients who have the**

majority of their primary care spend at an urgent care center would not be attributed to OCV, even if their PCP and insurer are participating and they have visited their PCP during the attribution look-back period?

Under the scenario described above, the urgent care center would be able to attribute patients to OneCare.

5. **What work has OCV done to identify and address reasons why entities, including FQHCs, have chosen not to participate in OCV? What, if anything, has OCV learned from entities' decisions not to participate?**

   OneCare actively works with its Board of Managers, Stakeholders, Participants, and Consumers to identify and implement care and payment reform models that incentivize participation. Once models are developed, extensive outreach and education about the program model's risks and benefits on both a community wide and individual organizational level occurs. OneCare also actively meets on a regular basis with association leaders to identify future needs. In the end, every organization has their own individualized circumstances that drive their decisions.

6. **Please explain the over 9% decrease in OCV's Medicare quality performance from 2016 to 2017 (Attachment A, answer to HCA question #6).**

   There were a number of significant changes in the quality measures for the 2017 performance period. Six measures changed from reporting to performance measures resulting in a reduction in 5 points from our overall quality score. In addition, the measure specifications for ACO 16 – Adult Weight Screening and Follow-up changed significantly from 2016 to 2017 resulting in a reduction in the associated quality score for that measure. Six quality measures were retired from 2016 to 2017 and three new measures were added. Together these changes resulted in the noted reduction in OneCare's Medicare quality score.

7. **In OCV's answer to our written question #5, OCV states that it does not support providers firing patients. However, this happens regularly and can threaten the health of the patient and increase emergency department use.**

   a. **What specific case management services is OCV providing for attributed patients who have been fired by their PCP, or who otherwise no longer have a PCP relationship?**

      Individuals without a PCP association have access to all of the case management services available from OneCare participating community-based organizations, expansion of which is funded and supported through the OneCare care coordination program, and payment and service delivery models. These services are available in all OneCare-participating health service areas across Vermont, as part of OneCare's mission to support greater coordination and alignment across sectors that deliver physical and mental health, public health

and social services. In point of fact, in practices following the OneCare care coordination model, patients with complex needs who are struggling to maintain a relationship with their PCP are identified proactively via care coordination panel management, and connected to care coordination supports and community resources that enable them to retain this essential connection. The care management services available to patients 'fired' from primary care include case management services from designated mental health agencies, home health care management, housing based care coordination services, and agency on aging services. Through these services, (re)connection to a PCP is facilitated as an essential pillar of OneCare's whole person care model. Primary care providers across Vermont should not be 'firing' patients from the essential services of primary care and instead should be connecting with those patients via referral to existing care management supports and treatment options in order to achieve the Triple Aim.

8. **How is OCV ensuring that the level of commercial payer case management provided is sufficient while OCV is ramping up the program? Is Vermont at risk of losing ground on care coordination during this time of transition?**

   OneCare's care coordination team works closely with the BCBSVT care management team to ensure continuity of care and effective transitions. OneCare has invited BCBSVT staff to participate in monthly Care Coordination Core Team meetings and we have worked collaboratively to develop consistent messaging for communities about the collaboration and transitions. OneCare has provided BCBSVT case managers with access to Care Navigator to facilitate communication across care teams and OneCare and BCBSVT staff meet regularly to assess which patients are best served by local care coordination staff vs. BCBSVT case managers. This collaborative approach amplifies resources and is helping ensuring a smooth transition to OneCare's community-based care coordination program.

9. **In OCV's answers to our written question #12, OCV stated that it provides direct financial support for all of the initiatives referred to in its budget narrative. However, the appendix cited only lists the category of "Community Program Investments" and does not specify funding for the majority of initiatives outlined in the budget narrative.**

   a. **Please specify the scope of OCV's role in the activities listed on pages 45 through 50 of the budget narrative (Part 5, Question 1), specifying the amount invested if applicable. For OCV's convenience, we list below each of the activities, by HSA, that were included in the budget narrative pages 45-50.**

      The scope of OneCare's involvement in the activities listed on pages 45-50 of the budget narrative varies by community and project and includes roles such as provision and analysis of data, quality improvement coaching, project management, consulting, team facilitation, and training and technical

assistance, among others. OneCare directed specific funding to the SASH/Howard pilot (Burlington, item d referenced below). This funding supports a fulltime mental health counselor employed by Howard who is co-located in two SASH congregate housing sites. OneCare's 2018 investment is $83,125.

b. Is it the policy of all OCV pediatricians to screen for developmental delays? If not, please explain why not (see letter e. under Berlin HSA below).

OneCare promotes the Bright Futures Guidelines for Health Supervision (https://brightfutures.aap.org/Pages/default.aspx) which recommend developmental screening at 9, 18 and 30 months of age using a validated screening tool. OneCare works collaboratively with the Vermont Child Health Improvement Program and the Vermont Department of Health to promote evidence-based screening for early childhood development. The description in the Berlin HSA (p. 50) was intended to indicate that age-appropriate screening is being conducted.

Health Service Area References in Follow-up Questions:

Bennington HSA:
a. “A community-based RN Clinical Nurse Specialist follows the utilization and cases of high and very high risk individuals to address root cause of re-hospitalization and acute care admissions” (p. 46);
b. “RNs embedded in primary care practices follow-up by telephone post-hospital discharge for medication reconciliation and assessment of post discharge needs” (p. 46);
c. “The ‘Interact’ program in all SNFs allows for a structured, consistent communication process and care protocol. The program prompts patient care level staff to notify nursing with concerns, setting in motion additional protocols to identify medical conditions early and preventing ER visits” (p. 46);
d. “Embedded clinicians in primary care practices to address mental health needs identified in those practices” (p. 47);
e. “A Screening Brief Intervention and Referral to Treatment (SBIRT) process… in the Southwestern Vermont Medical Center (SVMC) ED” (p. 48);
f. “Rehab facilities have created open times to provide ongoing support for cardiac and pulmonary rehab patients.” (p. 48);
g. “Established a multidisciplinary group to increase use of palliative care and pulmonary rehab.” (p. 48);
h. “Increased primary care practice visits for frail individuals in Senior Housing and individual residences through SASH program with Blueprint funded Coordinators and Wellness Nurses” (p. 49);
i. “Outreach for AWV and adolescent well visits” (p. 49);
j. “Training on ASQ developmental screening tools in SVMC EMR to increase utilization of the screening tool” (p. 49);
k. “Screening tools for SDoH for adults and pediatric populations are being implemented as part of the PCMH standards and best practices” (p. 50);
l. “In May 2018, Bennington HSA hosted a community-wide learning collaborative on addressing food insecurity” (p. 50);
m. “A Community Supported Agriculture (CSA) program for patients in the cardiac and pulmonary rehab programs has been created to bring fresh, local food to patients” (p. 50).

Berlin HSA:
a. Readmission project: “a readmission process redesign is planned at Central Vermont Medical Center (CVMC) and the project will be aligned with ongoing primary care practice redesign to include targeted care coordination” (p. 46);
b. ED utilization: “targeting patients with four (4) or more ED visits within 90 days. This project will involve ED follow up in the practices and work with the community health team (CHT) and other stakeholders involved in the patient’s care” (p. 46);
c. “Program to induct patients with buprenorphine in ED and also make referrals to MAT from ED. They have also instituted walk-in hours for MAT intake” (p. 47);
d. “Primary care practices that are conducting RN-performed Medicare AWVs” (p. 49)’

e. “At the CVMC practices, all children and their families will be screened at regular intervals for the presence of four Adverse Childhood Events (ACEs) and/or developmental delays” (p. 50).

Burlington HSA:
a. “Plan to hire a total of 14 RN care managers at UVMMC to support high-risk patient care coordination” (p. 46);
b. “Preparing to implement the CMS SNF 3-day rule waiver” (p. 46);
c. “Medical staff … appointed to coordinate work across nursing homes and oversee care coordination and patient transitions” (p. 46);
d. “Pilot with SASH and Howard Center to embed a Howard Center clinician in SASH programs at two congregate housing sites in Burlington” (p. 47);
e. “UVMMC office of primary care and Area Health Education Center (AHEC) program started the Project ECHO program for the Treatment of Chronic Pain” (p. 48);
f. “Primary care practices… are conducting RN-performed Medicare AWVs” (p. 49);
g. “Burlington HSA’s Accountable Community for Health (ACH) is developing a project to increase adolescent well-child visits” (p. 49);
h. “Food insecurity screening questions are included in the EMR for most PCP practices within UVMMC network” (p. 50).

Middlebury HSA:
a. “SNF 3-day rule waiver has also been implemented” (p. 47);
b. “An Elderly Services Pilot is ongoing” (p. 47);
c. “Child and Adolescent Needs and Strengths (CANS) assessment in pediatric practice to screen for depression and ACEs” (p.48 & 50).

Newport HSA:
a. “Deepened their [Newport HSA] engagement with the care coordination model and hosted a state-wide Core Team meeting” (p. 46);
b. “Program to provide participating patients and their families with CSA shares and education around how to prepare the food” (p. 50).