To:	Susan Barrett, Michael Barber, Alena Berube, Melissa Miles, Sara Tewksbury, and Healthcare Advocate Policy Team
From:	Sara Barry
CC:	Vicki Loner, Tom Borys, Joan Zipko, Amy Bodette
Date:	June 30, 2020
Subject:	Budget Order Deliverables 11c and 18

Dear GMCB and Healthcare Advocate Policy Teams:

Enclosed, please find OneCare's submission for Budget Order deliverables 11c and 18 per OneCare's FY2020 Budget Order (2/4/2020) and subsequent FY2020 Budget Order Amendment (4/6/2020).

- 11c – Inform the Board whether OCV has secured aggregate Total Cost of Care protection for Medicare or any other payer programs in 2020
- 18 – Develop a work plan to evaluate the effectiveness of OCV population health investments

Please let me know if you have any questions.

Sincerely,

Sara Barry, MPH
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Attachments (1)

OneCare Vermont

Budget Order 11c: Inform the Board whether OCV has secured aggregate Total Cost of Care protection for Medicare or any other payer programs in 2020

In June of 2020, the OneCare Finance committee and Board of Managers voted to forego the purchase of a third party risk protection arrangement for the 2020 Medicare program. It was noted that the option to secure this type of risk protection will be explored again in 2021.

Budget Order 18: No later than June 30, 2020, or a date agreed to by OneCare and GMCB staff, OneCare must develop a workplan to evaluate the effectiveness of its population health investments including analysis of how to scale those that are successful, sunset those that are not, and report on opportunities for sustainability. This plan must include the identity of each entity receiving funding, the funding amount, any evidence supporting the purpose(s) of the corresponding project, a distribution plan for the funding, the scope of project, relevant timeframe(s) for implementation and evaluation, any measurable outcomes, and any risks, issues, or challenges. This workplan may exclude the Blueprint for Health investments (SASH, CHT, and PCMH). For competitive grants, OneCare should provide an explanation of the criteria by which it evaluates proposals for funding.

OneCare Vermont (OneCare) has implemented or continued six core Population Health investments in 2020 intended to incentivize, compensate, or reward participants for achieving population health goals and objectives, closely aligned with the All Payer Model (APM). These investments are intended to encourage providers across the continuum to work collaboratively, communicate effectively, and share data to support patients and their families. These six investments are each in various stages of implementation and thus continue to monitored closely for evaluation purposes:

1. Population Health Management (PHM) Per Member Per Month (PMPM) payment
2. Complex Care Coordination Program
3. Value Based Incentive Fund
4. Comprehensive Payment Reform
5. Primary Prevention
6. Specialist Payment

Population Health Management (PHM) Per Member Per Month (PMPM) Program Evaluation

Scope:

OneCare's $3.25 PHM PMPM is disbursed for each life attributed to the ACO and is paid to the attributing primary care TIN when they attest to achieving a standard set of criteria to facilitate primary care transformation. Criteria include population health monitoring activities, utilization of data to identify strengths and opportunities, as well as implementation of quality improvement initiatives to strengthen person-centered care and outcomes.

This investment is intended to strengthen primary care so that these sites can effectively manage patients in this setting, and advance population health management efforts. Primary care has the potential to address many of the quality measures in OneCare payer contracts and house the resources to support whole person care in a welcoming environment. This investment strategy has been in place since 2017 and has grown proportionately with additional lives added into payer programs. OneCare, through its clinical and financial committees, is exploring avenues to evolve this funding stream to increase provider accountability as we move deeper into healthcare reform efforts.

In 2020 Medicaid Expanded attribution was added to this population health investment. Due to the fact that these lives do not have primary care relationships OneCare has established an incentive of $100 per member per year (PMPY) payable to the primary care TIN that engages these patients in primary care.

Current state of scale and plans for expansion:

The Population Health Investment is scaled across all 14 participating Health Service Areas for attributed lives in the following payer programs:
-MVP QHP
-BCBS QHP
-BCBS ASO Risk
-Medicare
-Medicaid
-Medicaid Expanded
-BCBS ASO (non risk)
This population health investment serves as an incentive to continue to increase attribution by bringing additional primary care providers into the ACO.

Sunset criteria:

Evolution to fixed capitation payments for primary care
Lack of funding from payers
Lack of funding from hospitals

Timeframe for implementation and evaluation:

This population health investment was implemented in 2017, year 0 of the All Payer Model. Starting in Burlington, Berlin, Middlebury, and St. Albans for Medicaid lives only. In year 0 there were about 29,100 attributed lives, each resulting is the PMPM payment being paid to their attributing primary care practice. As the model has matured this investment has proven to be helpful in continuing to grow the model, attracting additional health service areas, primary care providers, and payer partners.
Evolution of the implementation by year by attributed lives; **2017:** 29,100 **2018:** 112,000 **2019**: 160,000 **2020:** 250,000

Entities receiving funding in 2020:

Primary Care (n=133)
FQHC's (n=9)

Investment amount:

Core: $8,420,662
Additional: $50,000 (Estimated Primary Care Engagement Medicaid Expanded)
Total: $8,470,662

Evidence:

Research indicates that an increased investment into primary care leads to reducing costs, increasing patient satisfaction, reduced ED visits, and improved care coordination.

Source: Primary Care Collaborative (https://www.pcpcc.org/primary-care-investment)

Distribution plan:

This PMPM payment is paid monthly based on attribution to primary care. In the onset of the COVID-19 public health crisis OneCare prepaid several months of the PHM payment to provide a positive cash flow adjustment into primary care.

Sustainability:

Sustainability of this highly regarded population health investment is largely dependent on continued investment from payer partners and hospitals willingness to contribute to meet necessary funding gaps.

Measurable outcomes:

# of HSA participating
# of primary care TINs
# of primary care providers
# of attributed lives

Risks/Issues/Challenges:

Securing the necessary funding to maintain the PMPM payment

Complex Care Coordination Program Evaluation

Scope:

This person-centered program creates a system of care in which all Vermonters have access to high-quality, evidence-informed, interdisciplinary community-based care coordination across the continuum. The Complex Care Coordination program was launched in 2017 and provides funding for engagement of attributed lives who can benefit from supports and services to enhance their experiences with care. The program has a focus on driving down the total cost of care by ensuring communication among the care team. Specific expectations of the program are shared through regional core teams and educations opportunities.

Starting in July, 2020 OneCare will be implementing a new payment model that was designed in 2019 with network participants through an iterative in person series of workgroup. This new payment model shifts from a capacity payment based on the number of high and very high risk lives, to a value based payment model that pays for actual care delivered.

In addition, OneCare has continued investment in the Developmental Understanding and Legal Collaboration for Everyone (DULCE) program. DULCE is an intervention that takes place within a pediatric care office to address social determinants of health in infants, zero to 6 months, and provides support for their parents. Another innovative advancement in the care coordination program in 2020 is the addition of the Longitudinal Care Program supporting in-home services provided to Vermonters with chronic disease, a recent hospitalization, and barriers to self-management such as anxiety or depression, who do not otherwise qualify for home health services. This innovation was originally tested in the Burlington Health Service Area and resulted in significant cost and emergency department reductions.

Current state of scale and plans for expansion:

The Population Health Investment is in the process of being scaled across all 14 participating Health Service Areas for attributed lives in the following payer programs; MVP QHP, BCBS QHP, Medicare, Medicaid, & Medicaid Expanded.

This investment serves as an incentive to continue to increase attribution by bringing additional primary care providers into the ACO. As a funding source that is also paid to continuum of care partners, this investment ensures that the ACO is attractive for all provider types to participate in.

OneCare hopes to expand DULCE and Longitudinal Care in the future should additional financial resources be available from payers, hospitals, or through delivery system reform investments by the state and federal government.

Sunset criteria:

Lack of funding from payers
Lack of funding from hospitals
Lack of delivery system reform (DSR) investment by state and federal government
Lack of outcomes over an extended period of time

Timeframe for implementation and evaluation:

This population health investment was implemented in 2017, year 0 of the All Payer Model. Starting in Burlington, Berlin, Middlebury, and St. Albans for Medicaid lives only. From 2017 through June of 2020 capacity payments were paid resulting is the PMPM payment being paid to attributing primary care practice based on the number of high and very high risk lives on their panel. Continuum of care partners were paid based on their anticipated engagement rates. As the model has matured this investment has proven to be helpful in continuing to grow the model, attracting additional health service areas, primary care providers, payer partners, and the full continuum of care to include Home Health, Designated Agencies, Area Agencies on Aging, and others.

Entities receiving funding in 2020:

Primary Care Practices & FQHC's - (142), Home Health Agencies - (10), Designated Agencies for Mental Health and Substance Use - (11)
Area Agencies on Aging - (5)

Investment amount:

Core: $9,672,306
Additional: $586,436 (Medicaid Expanded)
Total: $10,258,742
DULCE: $300,000
Longitudinal Care: $500,000

Evidence:

This model adopts evidence-based interventions that aim to improve cost, quality, and outcomes for patients with the highest need.
Source: Blueprint for Complex Care: (https://www.nationalcomplex.care/wp-content/uploads/2018/12/Blueprint-for-Complex-Care_FINAL_120318.pdf.)

Distribution plan:

This PMPM payment is paid monthly based on attribution of high and very high risk lives to primary care. Payments to continuum of care partners are also paid monthly on a proportional basis based on the number of HSA's they serve in, and the number of high and very high risk lives in those HSA's. In July payments will shift to value based payments and payments will flow to the same partners based on patients with an active care managed relationship. At the onset of the COVID-19 public health crisis, OneCare prepaid several months of the care coordination payment to provide a positive cash flow adjustment into primary care and continuum of care partners.

Sustainability:

Sustainability of this investment is dependent on continued investment from payers, hospitals, and DSR dollars.

Measurable outcomes:

Process metrics	Key performance indicators
# Engaged	ER Visits (PKPY)
# in outreach	Inpatient Admissions (PKPY)
# in community programs	Total cost of care (PMPM)
# with a care conference	Preventative Services (PKPY)
# engaged with hospice	Primary Care Visits (PKPY)
# with care team initiated	30-Day Readmission Rate
# with care team created	Hospice Use Rate (PKPY)
# care managed	
# of families offered DULCE	

Risks/Issues/Challenges:

Securing the necessary funding to maintain the payments

Value Based Incentive Fund Program Evaluation

Scope:

The Value Based Incentive Fund (VBIF) is a quality withhold of the total cost of care that is set by payer programs, as such it is no longer dependent upon earning shared savings to reward quality achievements. Dollars are disbursed to the network based on quality scores and in accordance with set policy. Any reinvestment by OneCare is made in agreement with our payer partners and is monitored in accordance with the terms outlined in our contracts. This funding supports transformation across OneCare's community of providers. The long term impact of this investment supports the work done by the OneCare network to improve benchmark performance and move into the 75th percentile or better for each measure.

Policy allows for 70% of the funds earned based on final quality scorecards to flow directly to participating primary care TIN's, 20% is disbursed to the rest of the network based on contribution to total cost of care, and 10% is reserved by the OneCare Board of Manager to reinvest in Quality Improvement projects. Value Based Incentive Fund Policy, 2020

Current state of scale and plans for expansion:

The Population Health Investment is scaled across all 14 participating Health Service Areas for the following payer programs; MVP QHP, BCBS QHP & ASO, and Medicaid.

In an effort to maximize cash flow to hospitals during the COVID-19 crisis GMCB granted a OneCare requested waiver of the requirement to fund 0.5% of the Medicare All Inclusive Population Based Payment into the Value Based Incentive Fund.

This investment is intended to support providers financially, remove administrative burden, and align with the goals of the APM to track change over time in quality measures.

Given the public health emergency and its significant financial impact to hospitals supporting the VBIF through withholds against the total cost of care, OneCare is looking at ways to evolve the VBIF scope for 2021.

Sunset criteria:

Lack of funding/participation from hospitals
Lack of outcomes over an extended period of time

Timeframe for implementation and evaluation:

This population health investment was implemented in 2017, year 0 of the All Payer Model. Starting in Burlington, Berlin, Middlebury, and St. Albans for Medicaid lives only. From 2017 through June of 2020 the total value of the fund has grown due to the continual increase in payers, and the payers desire to withhold a larger portion of the total cost of care to be paid out at a rate established by the final quality scores. It's important to note that this withhold is reducing the fixed payments going out to participating hospitals.

Entities receiving funding in 2020:

Primary Care Practices & FQHC's - 70% of the disbursement
Hospitals, Specialist, Home Health Agencies, Designated Agencies for Mental Health and Substance Use, Area Agencies on Aging, & Skilled Nursing Facilities are eligible for 20% of the disbursement based on their contribution to the total cost of care for programs that HSA is participating in.

Investment amount:

$5,640,553

Evidence:

Research indicates that rewarding providers for delivering high quality care supports a successful transition away from fee-for-service and into value based care payments. Source: https://www.ncbi.nlm.nih.gov/books/NBK201648/

Distribution plan:

The VBIF is subsidized by withholding a portion of the total cost of care, established in contracts with each payer. Distribution is dependent on the final score card for each payer contract, which indicates what portion of the withhold can be released, and what portion needs to be held back to reinvest in quality improvement initiatives. Some payer contracts require OneCare to return a portion of the unearned funds to the payer. Distribution is set to occur 90 days after final program settlement.

Sustainability:

Sustainability of this investment is dependent on continued investment from hospitals and negotiation of terms with payers.

Measurable outcomes:

# of HSA participating
# of attributed lives
# of measures in the 75th percentile
# of measures in the 90th percentile
% of the VBIF earned

Risks/Issues/Challenges:

Risk is due to a challenging financial future for hospitals which indicates a need to disburse the funds rather than withholding for the full performance year.

Comprehensive Payment Reform Program Evaluation

Scope:

This program is a voluntary program for independent primary care practices that provides supplemental funding to independent primary care practices enrolled in OneCare's Comprehensive Payment Reform Program. This funding supports primary care transformation by shifting reimbursement away from a fee-for-service (FFS) incentive structure. Participating practices are able to care for their panel of attributed lives in new and flexible ways that would have been historically possible in a FFS system. This program creates revenue predictability and reliability for independent primary care practices, and is intended to provide flexibility to reform care delivery systems alongside the payment reforms.

Changes to this program include a variable payment tied to engagement in the complex care coordination program, and the achievement of quality improvement targets were scheduled to take effect on January 1, 2020 (to be measured one quarter in arrears). As a result of the public health emergency, all provider types, including independent primary care, experienced significant financial hardships. While the CPR practices were partially buffered from this by their fixed payments through the CPR program, for their remaining volume-based revenue, the sharp decrease in utilization and unpredictability of the return of patient demand for care has created fragility in the system of care. On April 15, 2020 OneCare's Board passed a resolution to address the financial needs of CPR participants that provided 100% of the care coordination variable payments for their engagement in the care coordination program for the same time the capacity-based payment model is in place for the rest of OneCare's network. The resolution also noted that CPR participants continue to be measured on quality, but 100% of the variable payment would be released for reporting on the measures.

Current state of scale and plans for expansion:

The Population Health Investment is available in all 14 participating Health Service Areas for all core programs. In 2020 there are seven TIN's participating in CPR, with ten practices. The participants are in Burlington, Bennington, Brattleboro, and St. Albans.

OneCare recruits independent primary care practices during its annual contracting cycle and anticipates that there may be an uptick in interest as a result of the pandemic.

Sunset criteria:

Lack of funding from hospitals
Lack of interest in the program
Lack of outcomes over an extended period of time
Inability to expand unreconciled fixed payment model

Timeframe for implementation and evaluation:

This population health investment was implemented in 2018 year 1 of the All Payer Model.

Entities receiving funding in 2020:

Lakeside Pediatrics (formerly Hagan, Rinehart and Connolly)
UVM Nursing and Health Sciences (aka Appletree Bay Primary Care)
Avery Wood MD
Eric Seyferth MD
Richmond Family Medicine
Thomas Chittenden
Primary Care Health Partners

Investment amount:

$1,192,196

Evidence:

Primary Care providers have communicated strong support for this program.
Participants have stated that "not changing the system is the worst thing that can happen".
Source: Joe Haddock, MD Thomas Chittenden Health Center - 3 year CPR participant

Distribution plan:

Each participating organization receives a set PMPM payment for each of their attributed life, creating revenue predictability and reliability.

Sustainability:

Sustainability of this investment is dependent on continued investment from hospitals.

Measurable outcomes:

# of HSA participating
# of attributed lives
TIN's participating
of patients care managed
# of patients who positively meet quality measures
% of primary care engagement

Risks/Issues/Challenges:

Securing the necessary funding to maintain the payment
Program has not scaled at a rate expected

Primary Prevention Program Evaluation

Scope:

OneCare continues to believe that investments in primary prevention are necessary to achieve optimal health and wellbeing of all Vermonters. In 2020, OneCare has continued to support RiseVT, an evidence-based model that addresses obesity through local community activities and programs in collaboration with area hospitals, health department district offices, and other interested community partners. This funding supports cities and towns to improve health and wellness in their communities.

The community projects serviced by RiseVT collectively serve the entire spectrum of ages, from prenatal women to older Vermonters. These projects cross multiple sectors, including schools, local community service organizations, municipalities, and several community-wide initiatives. These projects enhance local infrastructure, promote access to local recreation assets, promote breastfeeding, improving transportation access, and town forest development.

Current state of scale and plans for expansion:

The Population Health Investment is available in 9 participating Health Service Areas. 37 towns in Vermont are engaged in activities with RiseVT staff.

Sunset criteria:

Lack of funding from hospitals
Lack of interest in the program
Lack of outcomes over an extended period of time

Timeframe for implementation and evaluation:

This population health investment was launched in 2015 by Northwestern Medical Center and moved to OneCare in 2018 where the programming has continued to grow.

Entities receiving funding:

143 Amplify Grants distributed in RiseVT communities across the state. Each funded initiative ties into at least one of the Center for Disease Control and Prevention 24 Strategies to Prevent Overweight & Obesity. In 2019 $238,818 in grant funds were distributed to infuse healthcare reform funds into RiseVT communities across the state, increasing opportunities to embrace healthy lifestyles where Vermonters live, work, learn, & play.

Investment amount:

$540,000

Evidence:

Research shows that the greatest predictor of how well and how long we live is directly tied to our zip code. This means that the environment where we live, work, learn, and play has incredible power over our ability to live a healthy life.
https://www.cdc.gov/violenceprevention/publichealthissue/social-ecologicalmodel.html
https://www.cdc.gov/obesity/strategies/index.html

Distribution plan:

Grant funds are supported by the ten local Program Managers in the 8 Health Service Areas they serve in.

Sustainability:

Sustainability of this investment is dependent on continued investment from hospitals.

Measurable outcomes:

# of HSA participating
# of Vermonters served by the program
hospitals with a program manager
of campaigns launched
# of amplify grants distributed

Risks/Issues/Challenges:

Securing the necessary funding to maintain the payment
COVID-19 limiting in person activities

Specialist Payment Program Evaluation

Scope:

This type of population health investment enables the roll-out of innovative care delivery concepts that would otherwise be unfunded in a fee-for-service environment.

In 2020, OneCare is supporting two specialist programs:

1. Chronic Kidney Disease (CKD) care coordination program that fosters patient-centered choices for care of patients with CKD and End Stage Renal Disease. This program provides the financial resources necessary to hire and train staff to care for this vulnerable high cost population. This special care supports patients and families, and ensures connections to the other community resources available.
2. Partnership with Vermont Care Partners and three of its designated mental health and substance abuse agencies to embed mental health staff in local hospitals in an effort to reduce avoidable emergency department (ED) usage and augment access to mental health and substance abuse care for adults identified by the ED as in need for care.

Current state of scale and plans for expansion:

Currently 3 of the 11 Designated Agencies in Vermont have an active project ongoing in a total of four hospital emergency departments with funding from this population health investment stream.

The CKD program is centered at one pilot hospital because the preponderance of attributed lives with end stage renal disease and/or CKD have care delivered from specialists in this area. If successful, there are opportunities to spread this model to other hospitals.

OneCare hopes to expand Specialist Program investments in the future should additional financial resources be available from payers, hospitals, or through delivery system reform investments by the state and federal government.

Sunset criteria:

Lack of funding from hospitals
Lack of interest in the program
Lack of outcomes over an extended period of time

Timeframe for implementation and evaluation:

Both the CKD and mental health population health investments were launched in 2020 and will be evaluated per the metrics in their contracts. The DA's will monitor individuals who present to the Emergency Department with mental health and substance use treatment issues, number of individuals referred, number of people engaged, and the number who visit the Emergency Department for the initial reason of their first referral within a 12 month period. The CKD Care Coordination Program will emulate patient centered interventions described by Dialysis Clinics Incorporated (DCI) including Life Goal Discussions to help patients decide on renal replacement therapy and better manage their chronic condition by being better informed about treatment options in advanced CKD and End Stage Renal Disease (ESRD).

Entities receiving funding:

Washington County Mental Health Services (DA)
Northeast Kingdom Human Services (DA)
Northwestern Counseling and Support Services (DA)
University of Vermont Medical Center (CKD)

Investment amount:

$754,800

Evidence:

Research shows that lack of coordinated care results in higher utilization of healthcare resources and drives up the total cost of care.

Distribution plan:

Funds are distributed in accordance with the contracts establishes with funding recipients after agreed upon reporting requirements are met.

Sustainability:

Sustainability of this investment is dependent on continued investment from hospitals.

Measurable outcomes:

Reductions in total cost of care for participating attributed lives
Reduction in avoidable emergency department utilization
# of patients served
# of patients engaged in care coordination
# of patients care managed
% with primary care engagement

Risks/Issues/Challenges:

Securing the necessary funding to maintain the payment