

COMMUNITY HEALTH ACCOUNTABLE CARE, LLC

PRESENTATION TO VERMONT'S GREEN MOUNTAIN CARE BOARD

A COMMUNITY ACO MODEL FOR 2017 AND BEYOND

KEVIN KELLEY, CHAC BOARD CHAIR
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KATE SIMMONS, MBA, MPH, CHAC DIRECTOR
LORI H. REAL, MHA, CHAC ADMINISTRATOR
ANDREW PRINCIPE, STARLING ADVISORS, LLC

July 13, 2017

Mission: Improve the ability of our participant organizations to provide the right health care for their patients based on the **medical and social needs** of each individual patient. Remain **primary care focused** and fully support the **Patient Centered Medical Home** principles of individualized, self-directed treatment plans, an orientation toward **whole health**, and **ongoing relationships** between patients and their care teams.

Vision: Achieve better care for individuals, better health for populations, and lower growth in expenditures in connection with both public and private payment systems.

Values: collaboration, patient centered care, shared information, measurement, accountability, and use of best clinical practices.

CHAC Support for Vermont's APM

4

Per resolution of CHAC's Members, 5/1/2017:

CHAC remains engaged and supportive of Vermont's All Payer Model. CHAC remains committed to representing our patients and providing a comprehensive and integrated model of care.

CHAC believes that a successfully transformed health system has the following characteristics:

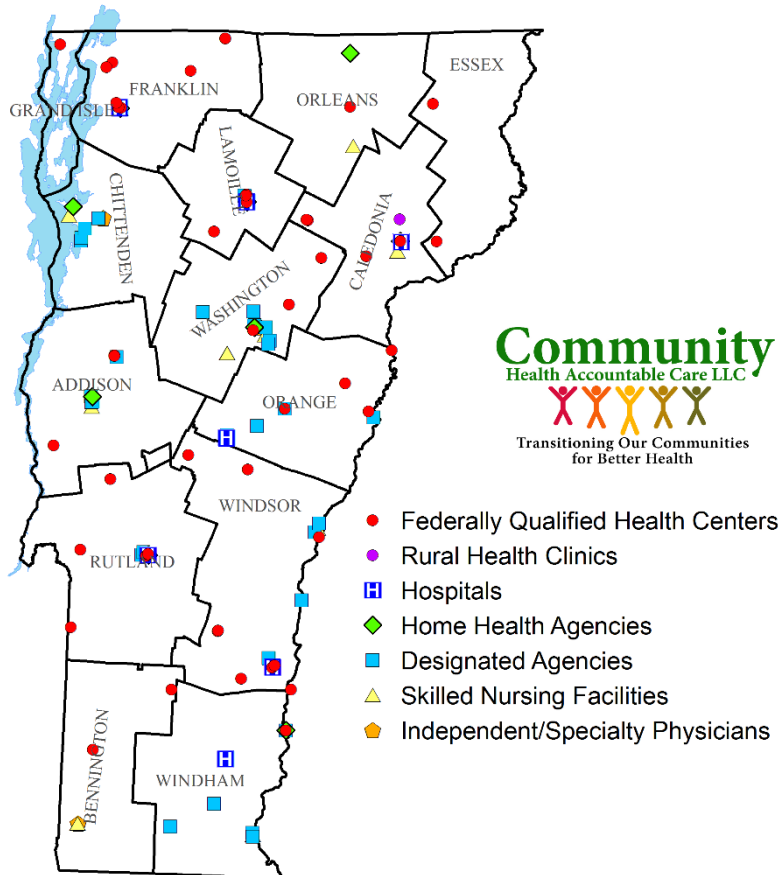
CHAC's "10 Points" for a Transformed Health Care System

5

- **Strong, well-supported Patient-Centered Medical Home** with resources to prevent chronic disease
- **Time to address issues** underlying chronic disease and mental health
- **Mental health/behavioral health** and **primary care work together**
- **Home health and primary care work together**
- **Community-based social service** agencies are **fully integrated** with primary care practices
- Community partners work with primary care to offer **"health coach"**
- Communities **integrate wellness initiatives with schools, employers, etc.**
- **Hospitals are stable** and positioned to meet acute inpatient/outpatient needs
- **System of care focused on local and regional levels**
- **Blueprint team retains independence** and **neutrality** to lead transformation effort

CHAC Participants and Board

2017 Network



CHAC's Participant Network, 2017

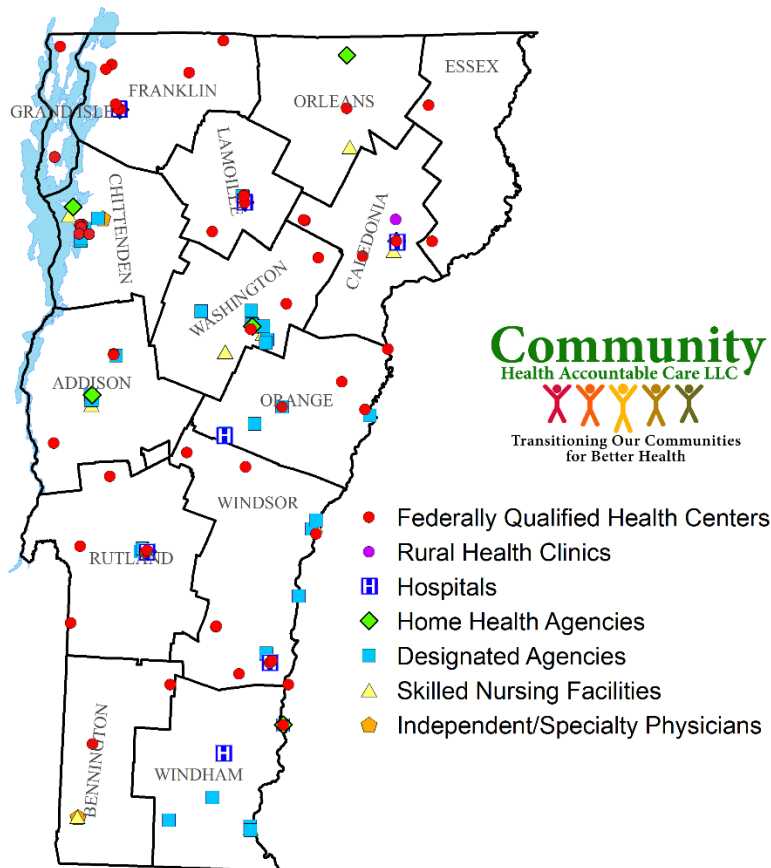
- 10 Federally Qualified Health Centers
- 4 Rural Health Clinics
- 7 Hospitals
- 14 Designated Agencies
- 9 Certified Home Health Agencies
- 10 Skilled Nursing Facilities
- 4 Independent Physicians/Specialists

Payer Groups	2015	2016	2017
Medicaid	~20,000	~33,000	NA
Medicare	~6,400	~14,700	~21,400
Commercial	~8,900	~10,500	~15,000
Total	~35,300	~57,000	~36,400

Proposed CHAC Network: 2018

8

2018 Anticipated Network



CHAC's Prospective Participant Network, 2018

- 11 Federally Qualified Health Centers
- 5 Rural Health Clinics
- 7 Hospitals
- 14 Designated Agencies
- 9 Certified Home Health Agencies
- 10 Skilled Nursing Facilities

Payer Groups	2017	2018
Medicaid	NA	TBD
Medicare	~21,400	~24,000
Commercial	~15,000	TBD
Total	~36,400	TBD

CHAC's 2018 network will be solidified by late October, 2018.

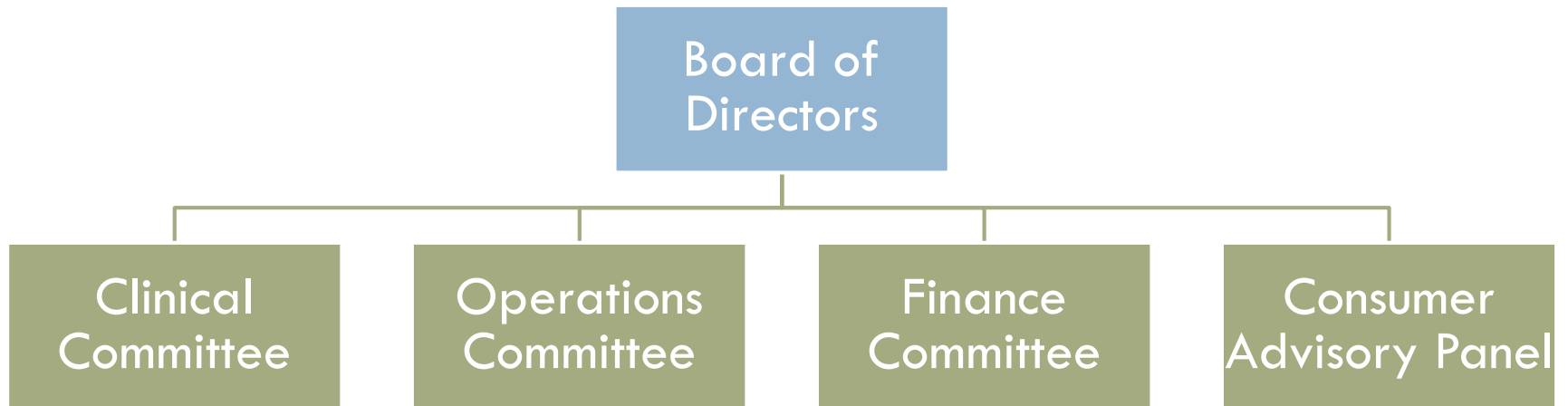
CHAC Board of Directors

9

- **Kevin Kelley**, Board Chair, CEO, Community Health Services of Lamoille Valley
- **Pamela Parsons**, Board Vice Chair, Executive Director, Northern Tier Center for Health
- **Gail Auclair**, Board Secretary, CEO, Little Rivers Health Care, Inc.
- **Martha Halnon**, Board Treasurer, Executive Director, Mountain Health Center
- **Paul Bengtson**, CEO, Northeastern Vermont Regional Hospital
- **Shawn Tester**, CEO, Northern Counties Health Care, Inc.
- **John Matthew MD**, CHAC Medical Director, Director, The Health Center
- **Timothy Ford**, President and CEO, Springfield Medical Care Systems, Inc.
- **Grant Whitmer**, CEO, Community Health Centers of the Rutland Region
- **Daniel Bennett**, CEO, Gifford Health Care
- **Tess Stack Kuenning**, President and CEO, Bi-State Primary Care Association
- **Grace Gilbert-Davis**, CEO, Battenkill Valley Health Center
- **Marcia Perry**, Medicare beneficiary representative
- **Zachary Hughes**, Medicaid beneficiary representative
- **Lee Bryan**, Commercial Insurance beneficiary representative
- **George Karabakakis**, behavioral health representative, Health Care & Rehabilitation Services of Vermont
- **Thomas Huebner**, hospital representative, Rutland Regional Medical Center
- **Sandy Rousse**, post acute care representative, Central VT Home Health and Hospice

CHAC's Board, Committees, and Advisory Panel

10



CHAC: Changing Care Delivery

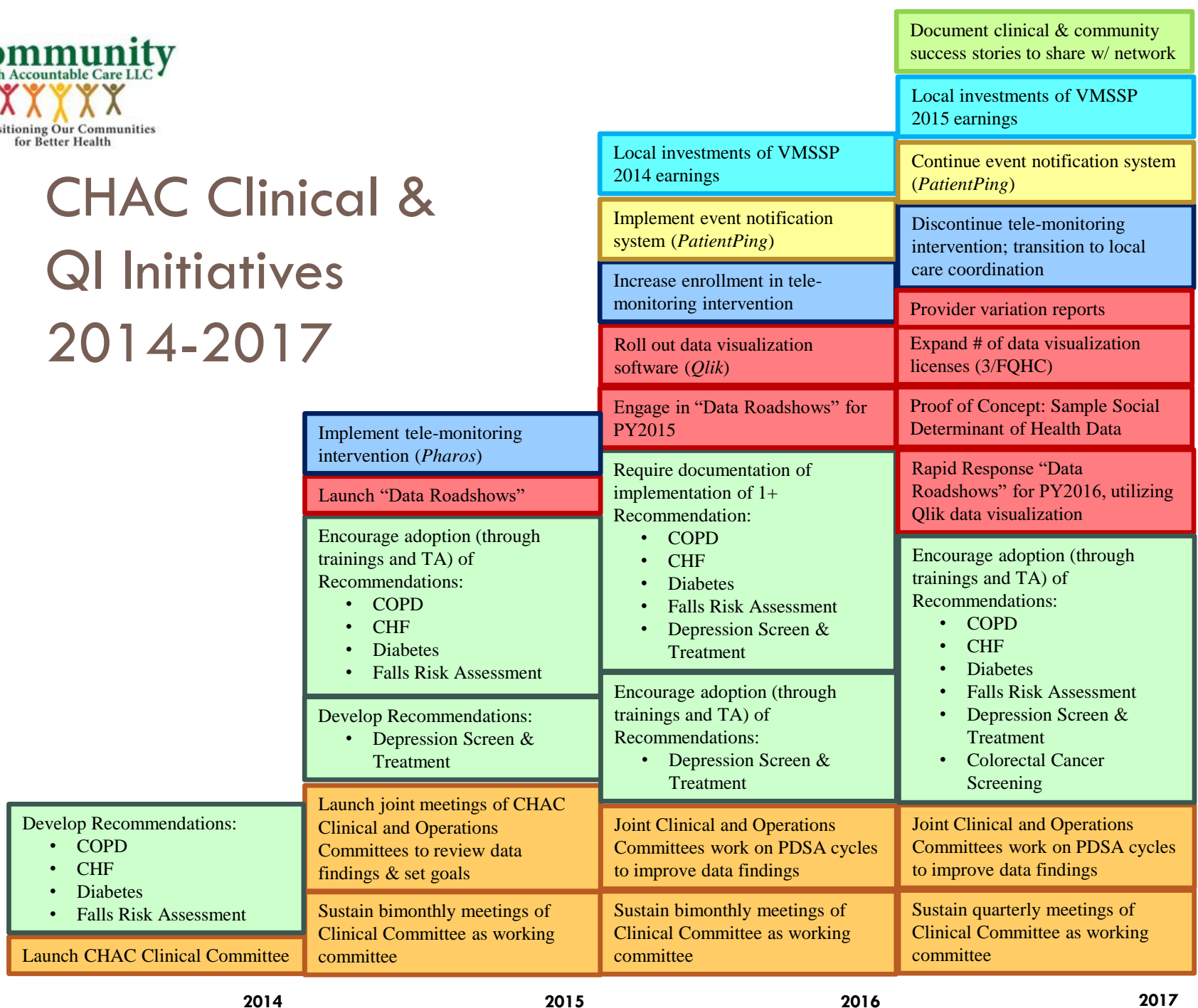
CHAC's Clinical Programs: Guiding Principles

12

All of CHAC's clinical programming will take into consideration:

- Focus on high risk populations first
- Utilize common screening tools (e.g, PRAPARE) across the network
- Build models of care coordination that are payer agnostic
- Link data and informatics directly to the care teams for effective clinical planning and performance management
- Expand existing partnerships with primary care and home health and behavioral health to implement strategies that expand beyond the medical model
- Establish clear accountability that links the payment model to demonstrated adoption of clinical programming

CHAC Clinical & QI Initiatives 2014-2017



Shared Care Coordination Vision and Capacity

14

- CHAC envisions care coordination that supports local relationships and partnerships
- Successful efforts coordinate with home health and behavioral health to better coordinate with primary care
- CHAC plans to develop a patient identification and engagement model to implement more robust strategies to identify, engage, and retain attributed patients
- CHAC will create a risk model to allow both the ACO and its participating practices to identify patients for interventions and target resources appropriately
- CHAC is implementing screening for Social Determinants of Health (SDH) to better support patients and inform care coordination efforts

CHAC: Support for High Quality Care

What changes are you going to test to reach your Aim? (PDSA Cycles)

In order to improve upon this measure, it is recognized that a multi-faceted approach is needed. Three essential changes will be tested.

Build Additional Accountability for Shared Clinical Standards

17

- Over the past three years, CHAC has developed shared clinical guidelines in six clinical areas:
 - COPD Treatment and Prevention of Readmission
 - Fall Risk Management
 - Congestive Heart Failure (CHF) Treatment and Prevention of Readmission
 - Depression Care Screening and Follow-Up
 - Colorectal Cancer Screening
 - Diabetes
- For PY2015, CHAC's MSSP quality score was **97.19%**
- CHAC will increase the number of clinical guidelines and increase accountability expectations for adherence to these guidelines
- With consistency in clinical interventions, the ACO can take programs to scale or establish greater predictability with performance
- CHAC will expand identification and sharing of “Promising Practices”

Expand QI and Improve Clinical Outcomes

18

- CHAC will continue to support clinical performance of the 34 MSSP Quality Measures.
- Several of CHAC's clinical focus areas align with the All Payer Model priorities:
 - Diabetes → Aligns with Chronic Conditions
 - Hypertension → Aligns with Chronic Conditions
 - Depression Screening → Aligns with Suicide
 - Colorectal Cancer Screening
- Increasing effective QI and clinical performance practices will ensure CHAC's successful performance under its CMS contract
- Expanding QI and performance against clinical measures will enhance the value of CHAC and better position CHAC for riskier models of payment at a later time.

CHAC: Improving Population Health Outcomes

Improving Population Health Outcomes through Data and Informatics Strategies

20



Expand Analytics Capacity

Continue to Develop & Utilize a Standard Set of
ACO-wide MSSP Data Reports

Continue to Develop Claims Data Solution

Link Analytics with Care Coordination Strategy

Expand Population Health Management through Clinical Programming

21

- CHAC will expand its population health management effort to identify and target patient populations for clinical care coordination and improve outcomes
- CHAC plans to expand staffing capacity in QI so that addressing clinical strategies is more effective
- CHAC plans to build additional reports to assist with risk stratification, population health management
- CHAC's Clinical Committee will develop a centralized clinical and care coordination strategy and determine accountability model for ACO participants

Expand Population Health Management through targeted Analytics

22

- ❑ CHAC will expand use of a data visualization tool for self-serve, practice-level reporting and analysis (beyond current annual rapid response data road shows)
- ❑ CHAC will expand analysis of claims data for the purposes of clinical and cost reports to support planning and performance monitoring
- ❑ CHAC will develop and disseminate monthly attribution reports
- ❑ CHAC will develop and analyze Provider Variation Reports

Social Determinants of Health: PRAPARE

23

Imagine capturing SDH data in a structured way, so that we can understand and address the socio-economic needs of our patients on a population health level... CHAC will be implementing the Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) Tool in 2017/2018.

- Race & Ethnicity
- Farmworker Status
- Veteran Status
- Housing Status
- Insurance Status
- Language Preference
- Education
- Employment
- Transportation
- Neighborhood
- Stress
- Social Integration & Support
- Material Security
(food, utilities, clothing)
- Safety
- Domestic Violence
- Incarceration History
- Refugee Status

CHAC: Support for Primary Care

Access to Primary Care

25

- CHAC is supporting its practices in filling primary care provider vacancies. (As of 7/17, Bi-State's VT Recruitment Center is tracking 61 primary care vacancies for its clients.)
- CHAC has established a process and protocols for non-primary care providers to provide referrals to Primary Care for patients who do not have a designated primary care provider



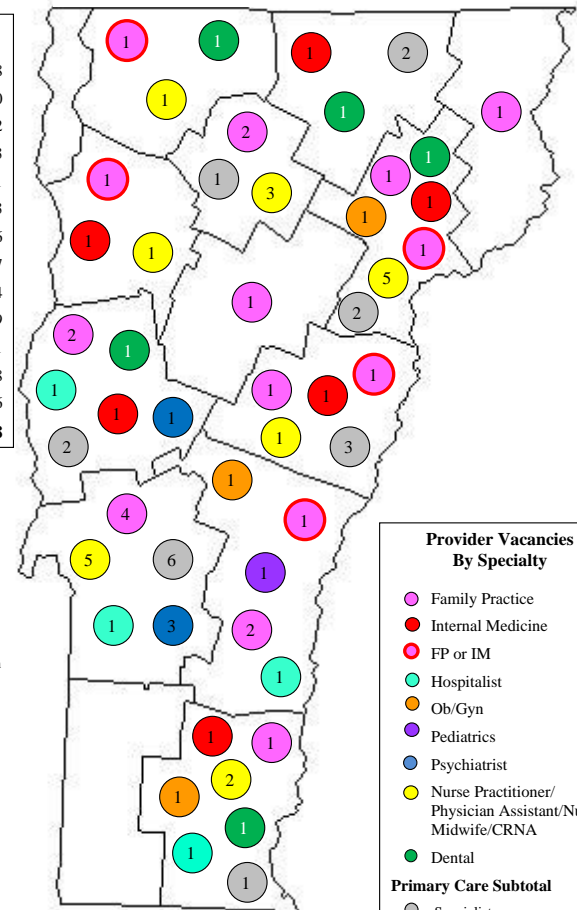
VT Provider Vacancies
Reported to the Recruitment Center
July 2017



Provider Vacancies By County	
Addison County	8
Bennington County	0
Caledonia County	12
Chittenden County	3
Essex County	1
Franklin County	3
Lamoille County	6
Orange County	7
Orleans County	4
Rutland County	19
Washington County	1
Windham County	8
Windsor County	6
Total Vacancies	78

Vacancies are reported to the Recruitment Center on a voluntary basis. The vacancies reported represent positions in community health centers, hospitals and private practices across the state. The information does not reflect vacant positions with some of the larger health systems such as Fletcher Allen Health Care, which maintains its own vacancy tracking system.

*On average, a primary care physician cares for 2,000 – 2,500 patients. A nurse practitioner or physician assistant cares for an average of 750 – 1,000 patients. Source: NACHC, January 2005.



Alignment with State Priorities

CHAC's Alignment with All Payer Model Agreement

27

- CHAC emphasizes primary care-centric strategies that focus on prevention and “whole person” approaches to care including social determinants of health and behavioral health support
- Growth in health care costs → 3.5% cost increase instead of 4.4%
- CHAC emphasizes quality outcomes and population health
- Number of lives and meeting the state's patient number targets
- CHAC would like to offer a Medicaid ACO Program to support Vermont's APM goal for % of Medicaid enrollees aligned with an ACO.

Financial Planning

Key Financial Planning Issues

29

- CHAC's reserves are sufficient to complete the current year programming but not sufficient to move into 2018
- Our participants have a mission to serve the Medicaid population and will seek ways to better meet the needs of this patient population
- The CHAC Board has authorized CHAC's Executive Committee and management team to explore discussions with the State regarding Medicaid and continuing to build CHAC's financial plan
- CHAC participants are currently considering some options to help support the bottom line with budget with self-funding strategies (i.e. annual participation fees)

CHAC's Proposed Budget Supports a Three Phased Strategy (2017-2020)

30

Phase 1

Focus on Increasing Scale and Outcomes of Clinical Efforts with Existing MSSP ACO; Explore Partnership with Medicaid

July 2017 - Dec 2018

Phase 2

Expand Partnerships with Medicaid and Behavioral and Home Health Providers

January 2018 - Dec 2020

Phase 3

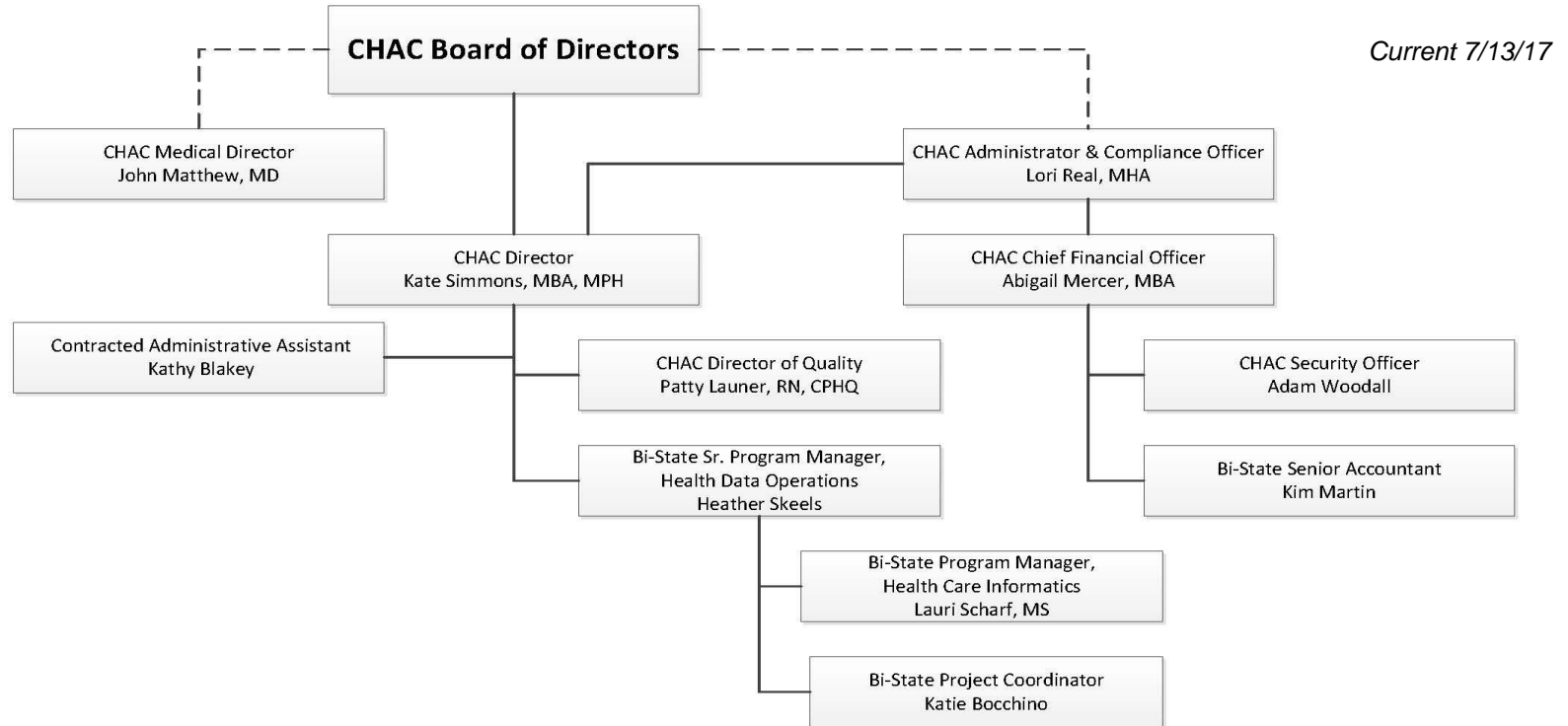
Emphasis on Long Term Sustainability and Riskier Models of Payment

July 2019 - Dec 2020

CHAC Operating Budget (Line Items)	2017	2018
Administrative Costs		
Information Systems and Security	0	12,000
Supplies, Postage, Freight, Printing	3,500	6,000
Travel	6,000	12,000
Other Administrative Expenses	3,100	6,200
Contracted Services		
Finance, Audit, and Accounting	45,527	104,329
Quality Improvement	74,984	228,327
Network Contracting and Network Management	159,801	669,245
Health Informatics	59,987	169,774
Legal	15,000	30,000
Consulting	42,000	25,000
Health Information Exchange	20,400	26,400
Insurance	15,000	30,000
GMCB Service Fees	0	100,000
Other Purchased Services	0	3,000
Quality Reporting (Data collection) payments to health centers	0	100,000
Taxes	250	250
(slide #31) TOTAL EXPENSES	\$445,549	\$1,523,125

CHAC's Organizational Chart

32



CHAC has no direct employees; professional staff are contracted from Bi-State PCA.

CHAC's 2018 budget submission assumes 1 FTE additional Project Manager (to support QI Reporting and other compliance work) and 3 FTE additional Project Coordinators / QI Facilitators (to manage new CHAC initiatives).

Key Financial Considerations

33

- Reimbursement based on a shared savings model delays payment and creates cash flow challenges
- CHAC has opportunities to maximize MSSP payments and plans to implement strategies to accomplish this
- CHAC's analysis has shown that for financial sustainability, a multi-prong strategy should be put in place
 - ▣ Explore feasibility of a contract with the State for a Medicaid ACO
 - ▣ Manage Total Cost of Care to align with the All Payment Model to earn Medicare Shared Savings

- CHAC's total budget for 2018 of \$1.52M is equivalent to an administrative PMPM of \$5.77
- On benchmark total cost of care of ~\$11k per patient, this is less than 1% administrative cost.
- 1% administrative cost is significantly lower than most ACOs, and drastically lower than managed care approaches that range from 9-15%.

Next Steps/Final Thoughts

35

- CHAC will continue to align its efforts with the All Payer Model, the Blueprint, and other strategic priorities at the State and CMS
 - ▣ CHAC aims to be a significant value to the State and CMS, by operating with a lean centralized infrastructure yet focusing on areas of cost and quality opportunity.
 - ▣ CHAC welcomes an opportunity to have a seat at the table as the All Payer Model is further developed and positioned.
 - ▣ CHAC looks forward to continuing to work with GMCB staff to answer questions