CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Case STUDY

Learning Systems
for Accountable Care Organizations

OneCare Vermont ACO Case Study: Community Care Coordination Program

This case study describes the development and implementation of OneCare Vermont's community care coordination program for beneficiaries who are considered high risk because of their historical cost and utilization of health care. Since the program's inception in 2016, more than 5,000 individuals across the state have received care coordination services. OneCare Vermont supports primary care and other community organizations with the delivery of care coordination services via a secure communications and collaboration platform, regional collaboratives, targeted technical assistance and training, and payments. The ACO reported not only an increase in primary care engagement among beneficiaries who participated in the program but also reductions in emergency department utilization and costs. OneCare Vermont's approach to care coordination may be informative for ACOs and other health care organizations that are designing programs intended to foster collaboration among primary care, specialty, and other community-based providers.

BACKGROUND

OneCare Vermont (OneCare) became a Medicare accountable care organization (ACO) in 2013. The ACO participated in Track 1 of the Medicare Shared Savings Program (MSSP) and later in the Next Generation ACO Model before transitioning to the Vermont All-Payer ACO Model (VT All-Payer Model).

The VT All-Payer Model supports the development of a unified, statewide approach to health care reform by encouraging collaboration among Medicare, Medicaid, and commercial payers.[1] This two-sided risk model aligns incentives to achieve the following population health goals: (1) increase beneficiaries' access to primary care, (2) reduce the prevalence of chronic disease in the population, and (3) reduce deaths by suicide and drug overdose. The Green Mountain Care Board[2] oversees the VT All-Payer Model in partnership with Vermont's Agency of Human Services and CMS.

As of September 2020, OneCare serves more than 250,000 beneficiaries covered by Medicare, Medicaid, or commercial insurance. The ACO's network includes 14 hospitals, each located in a unique health service catchment area (HSA), as well as 133 primary care practices, 276 specialty care practices, 9 federally qualified health centers, 27 skilled nursing facilities, 10 home health agencies, 11 mental health and substance abuse agencies, and 5 Area Agencies on Aging (AAAs) across the state. Providers in the network use nearly 40 different electronic health record (EHR) platforms, and the ACO relies on a statewide health information exchange (HIE) to access clinical data for aligned beneficiaries.

October 2020

HISTORY OF THE PROGRAM

The early concept for the care coordination program emerged in 2014, when Vermont began exploring strategies to include in the state's Blueprint for Health Initiative,[3] intending to improve the health of beneficiaries who have complex care needs. Through this initiative, Vermont acquired a grant to launch a statewide learning collaborative that sought to engage local providers in testing interventions to improve care coordination for the state's residents. In particular, the collaborative was intended to promote cooperation among providers who operate in the same HSA.

As an MSSP Track 1 ACO in 2016, OneCare leveraged promising findings from the Blueprint for Health's learning collaborative to establish its community care coordination program. The purpose of the program is to address beneficiaries' complex care needs by facilitating coordination across a range of providers and service organizations that operate in the same geographic area—including primary care providers (PCPs), mental health agencies, home health providers, congregate housing staff, and AAAs. The community-based model increases opportunities for Vermonters, including rural Vermonters, to access the continuum of care. To encourage coordination, OneCare provides financial incentives and technical assistance to encourage PCPs to integrate formal care coordination into their practices and to collaborate with other local providers and community-based organizations to improve the quality of care for beneficiaries with complex care needs. Jodi Frei (Manager, Clinical Programs) oversees the Clinical Department at OneCare, which is the care coordination team's base. The team includes Jenn Gordon (Supervisor, Care Coordination Program) and four care coordination implementation specialists, who provide regional technical assistance and other support. The team also receives support from OneCare's analytics staff, led by Tyler Gauthier (Director, Value Based Care), and from other departments at OneCare.

DEVELOPING THE PROGRAM COMPONENTS

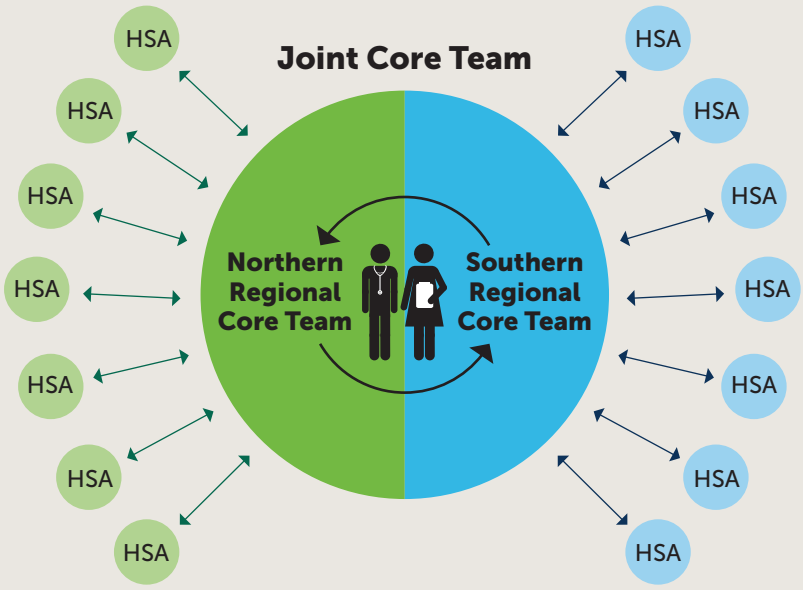
OneCare invested in early program planning and development efforts because it recognized the importance of engaging and supporting the providers that form the backbone of the program. To that end, the ACO focused on three program components: (1) creating a regional collaboration framework to facilitate coordination and peer learning, (2) launching a communication and collaboration platform to support information sharing and program implementation, and (3) giving training and technical assistance to provider care teams.

Creating a Regional Framework for Collaboration

Based on its experience with the Blueprint for Health initiative, OneCare recognized the value of bringing prospective partners together to inform program design. OneCare convened a workgroup of key stakeholders from the three hospitals that were participating in the ACO in 2016 as well as leaders and care coordinators from primary care practices and community organizations in each HSA. This multidisciplinary workgroup became what the ACO refers to as the "Core Team," which supports program implementation. As part of its work in 2016, the Core Team drafted a charter that outlined program goals and defined the roles and responsibilities across the community partners.

Figure 1

OneCare's learning collaborative framework



> *"We effectively created a think tank to support program operations, with bi-directional communication that helps spread innovations and information from the statewide Joint Core Team to the boots-on-the-ground care managers in HSAs who are delivering care coordination on behalf of our patients, and back up again."*
>
> —Jenn Gordon, Supervisor, Care Coordination Program

OneCare continued to use these workgroups to facilitate the ongoing refinement and expansion of the program. As the ACO and the program grew to include 14 hospitals spanning the entire state, OneCare re-organized the Core Team into two regional teams, one for the northern part of the state and another for the southern part of the state. Each team included representatives from HSAs operating in the region. OneCare convenes the regional Core Teams throughout the year for virtual or in-person meetings, rotating the hosting responsibilities from one participating hospital and community organization to the next. OneCare also brings together representatives from the northern and the southern Core Teams in statewide meetings, referring to this combined group as the Joint Core Team. OneCare expects the members of the two Core Teams to share the information exchanged during regional and statewide meetings with care teams in their HSA via local forums. Likewise, members of the Core Teams bring ideas from within their HSA to the regional and statewide meeting, acting as a bi-directional conduit for innovation. Figure 1 shows OneCare's learning collaborative framework.

Launching an Online Communication and Collaboration Platform

OneCare worked with a vendor to develop and launch an online centralized platform called Care Navigator that allows for real-time collaboration between providers and community organizations that are implementing the community care coordination program. The platform serves as a hub for sharing and collecting data related to a beneficiary's needs and progress. These data supplement the information in the EHRs that are in use across the ACO's network. For example, the platform includes relevant claims data for individual beneficiaries, such as the number of emergency department visits and primary care visits. The platform also includes encounter notifications from the state's HIE. All providers in the ACO's network involved in a beneficiary's care may access Care Navigator to review beneficiary-centered goals and care activities, update the health status summaries, and define the beneficiary's care needs and preferences.

The ACO also uses the data in Care Navigator to assess the uptake of the community care coordination program and to measure related outcomes. OneCare tracks the number of beneficiaries enrolled in the program and the types of services they are offered and that they received. The ACO uses this information to better understand the association between these services and beneficiaries' health outcomes. OneCare also tracks the number of providers that use the platform to identify gaps in uptake and to target technical assistance.

Training Care Team Staff and Providing Technical Assistance

OneCare developed a multi-mode training and technical assistance system to disseminate and support evidence-informed strategies for coordinating care effectively. Support mechanisms include a comprehensive training curriculum and help from ACO staff, including access to a central care coordination mailbox that is monitored by a subject matter expert.

OneCare's training curriculum includes both beginner and advanced classes, and it covers a variety of topics, such as using motivational interviewing, root cause analysis, or ecomaps to determine a beneficiary's needs and prioritize areas of focus. Additionally, the classes are an opportunity to provide tips on weaving Care Navigator into the care coordination workflow to support providers in capturing information that is relevant to delivering services. Classes vary in length and are mostly conducted in-person to provide hands-on opportunities to practice skills and to learn how to use tools through role play.

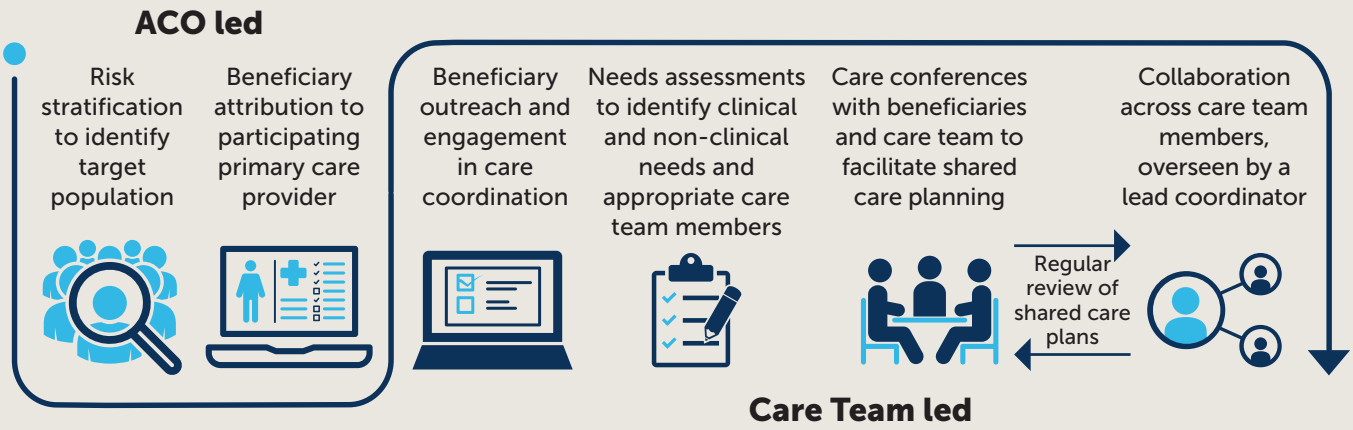
The four care coordination implementation specialists employed by OneCare deliver targeted training and technical assistance on Care Navigator. To complement classes offered by the ACO, these staff work closely with providers and community organizations to help them integrate Care Navigator into the delivery of care coordination services. The implementation specialists also collect feedback on ways to improve Care Navigator to better meet the needs of users and beneficiaries. Providers can watch videos about Care Navigator that are posted on the ACO's website, and they can reach out to the ACO's care coordination mailbox with questions and feedback.

OPERATING THE COMMUNITY CARE COORDINATION PROGRAM

OneCare developed a workflow to make program operations consistent across HSAs and to support providers who deliver care coordination services to beneficiaries. OneCare's care coordination implementation specialists support each HSA individually to operationalize the program at the local level. As shown in Figure 2, the process begins with ACO staff using historical claims data to identify beneficiaries with complex care needs, the target population. The ACO then attributes beneficiaries to PCPs and populates the list in Care Navigator. Care coordinators in the PCPs' practices engage the beneficiary in the program, assess their clinical and non-clinical needs, and assemble a care team tailored to these needs. Care Navigator serves as the coordination hub and repository for information throughout this process.

Figure 2

Workflow for the community care coordination program



Identifying the Target Population

OneCare uses a predictive modeling approach to risk stratify the beneficiary population into four categories. The ACO calculates a risk score by using administrative claims data related to health care utilization, information on diagnoses, and pharmacy codes. Based on the risk score, OneCare places individuals into one of the following four categories: (1) low risk, for healthy beneficiaries with limited or unavoidable utilization; (2) medium risk, for beneficiaries with early onset or stable chronic illness; (3) high risk, for beneficiaries with full onset chronic illness and rising risk; and (4) very high risk, for beneficiaries with complex needs and/or high costs.[4] Figure 3 shows the relative distribution of OneCare's beneficiary population across these four categories. The ACO encourages its provider care teams to focus on individuals categorized as very high or high risk for care coordination but recognizes that care teams may be aware of beneficiaries in the low or medium risk categories who have complex needs and may therefore benefit from care coordination services.

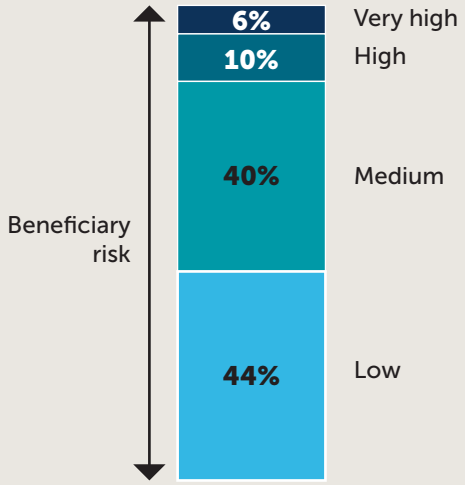
Engaging Beneficiaries in the Program

Provider care teams use the risk categories and information from the beneficiary's EHR to screen beneficiaries for engagement in the care coordination program. For example, the ACO encourages care coordinators to use an EHR chart review tool that explores clinical and social indicators of need, such as frequency of inpatient and ED admissions, number of medications, communication barriers, access to stable housing, and previous non-adherence to treatment. OneCare also offers care coordinators a conversation guide to collaborate with PCPs to determine which beneficiaries to target for care coordination. This guide includes questions about the likelihood of a hospital or ED admission in the next six months and whether the beneficiary would engage in care coordination based on any past conversations. The guide also asks for the provider's input on critical areas of focus if the beneficiary agreed to care coordination.

After screening beneficiaries, care coordinators attempt to engage them in the care coordination program by contacting them telephonically or in-person during or after an office visit. As part of this initial engagement, care coordinators educate beneficiaries

Figure 3

Distribution of OneCare Vermont's beneficiary population by risk category



about the program and how care coordination services could improve their care experience. Care coordinators also acquire all applicable beneficiary consent prior to sharing any relevant data and beneficiary information for care coordination purposes.

Assessing Care Needs

Once a beneficiary enrolls in the program, care coordinators complete a detailed health assessment to identify the beneficiary's care needs and goals. To gather the data, care coordinators engage beneficiaries, their caregivers, and current known providers. OneCare encourages care coordinators to leverage standard approaches, such as eco-mapping and root cause analyses, to capture information about the beneficiaries' (1) clinical needs, (2) priorities and goals for their care, (3) gaps in care, and (4) psychiatric or social factors that prevent the beneficiary from receiving the best possible care. The assessment results allow the care coordinator to identify which providers to include in the beneficiary's care team. Care teams typically comprise a care coordinator, PCPs, case managers, social workers, nurses, nutritionists, and/or mental health counselors.

Engaging Beneficiaries in Shared Care Planning

Coordinators develop preliminary care plans with the beneficiary that document key findings from the assessment and outline potential strategies for addressing the beneficiary's needs and goals. To meet program requirements, each care plan must include at least two care-related goals as well as two actions to achieve each goal. For example, a goal to improve mental health might include the following two actions: (1) make an initial appointment with a mental health provider and (2) visit with the provider monthly.

To refine the care plan, care coordinators convene the care team, the beneficiary, and their caregivers in a "care conference." During the conference, the group discusses the information gathered during the screening and assessment phases, and then revises the plan to incorporate any additional details or beneficiary input. The resulting document is referred to as the "shared care plan." The care coordinator posts the plan to Care Navigator to make it easier for the care team to track the beneficiary's progress and to meet the beneficiary's needs.

> *"Depending upon the patient's medical history and the challenges that they're experiencing, the care coordinator will wrap the right team around the patient."*
>
> —Jodi Frei, Manager of Clinical Programs

Delivering Care Coordination Services

Early in the process, the beneficiary selects a lead care coordinator for their care team. Beneficiaries are introduced to the concept of the lead care coordinator during the initial care conference, and the concept is often framed to beneficiaries as their "trusted person" in the care coordination process. The lead care coordinator may be either the person who introduced the beneficiary to the program or another individual in the beneficiary's care team who is from one of the community organizations or providers delivering care coordination services (home health agency, mental health agency, AAA, or a social worker in a congregate housing setting). The lead care coordinator must be part of the ACO's network and an active user of Care Navigator. If the beneficiary selects a trusted individual from an organization that does not meet these requirements, then a care coordinator associated with the PCP often plays the lead care coordinator role to facilitate documentation in Care Navigator.

> *"We didn't want any one organization to self-select that they were always going to be the patient's lead care coordinator. We wanted the patient to choose their lead care coordinator."*
>
> —Tyler Gauthier, Director of Value-Based Care

Once the beneficiary selects a lead care coordinator, that person assumes primary responsibility for overseeing the care team's efforts to provide services that meet the needs identified in the beneficiary's shared care plan as well as any emerging needs. The lead care coordinator is also responsible for updating the care plan, organizing care conferences, and using Care Navigator to communicate with the care team members.

OneCare encourages lead care coordinators to regularly review a beneficiary's care plan and its goals. This includes monitoring and reassessing the beneficiary's health condition, needs, ability for self-management, and intervention outcomes. Then, the lead care coordinator updates the care plan in Care Navigator accordingly. At a minimum, the ACO expects care coordinators to engage with high-risk individuals enrolled in the program four times a year and very high-risk participants 12 times a year. In addition, OneCare recommends that lead care coordinators convene a care conference with the beneficiary and the full care team at least once a year. Since a beneficiary's health and well-being may improve, or their needs may change as care coordination progresses, these conferences give the lead care coordinator another opportunity to refine and update the care plan. Additionally, beneficiaries whose health improves may eventually shift into a lower risk category and no longer require program services.

PAYING PROVIDERS FOR CARE COORDINATION

OneCare designed a payment system to incentivize providers to participate in the community care coordination program. Under the payment system, which has evolved over time, the ACO distributes monthly payments at the tax identification number (TIN) level to support program implementation and to enhance the delivery of care coordination services.

Building Providers' Capacity for Care Coordination

From 2016 to 2019, the payment structure primarily focused on building the capacity for care coordination within the ACO's network. OneCare distributed capacity payments to eligible providers, including PCPs, mental health agencies, home health agencies, and AAAs to support up-front investments needed to hire care coordinators, build infrastructure, and redesign workflows. Capacity payments were scaled by provider type based on the provider's expected involvement in care coordination. For example, PCPs received $15.00 per member per month (PMPM) for each attributed beneficiary categorized as high risk or very high risk because PCPs often served as the hub for a beneficiary's care coordination experience, according to the ACO. Payments to other types of providers ranged from $9.00 to $3.75 PMPM based on their expected involvement in the care coordination process (e.g., mental health agencies = $9.00, home health agencies = $6.75, AAAs = $3.75).

> *"We provide financial resources to compensate for the intensive work demand around coordinating care for a population with complex needs – to go above and beyond the patient visit and move care to the community, where the individual spends most of his/her time."*
>
> —Jenn Gordon, Supervisor of Care Coordination

Incentivizing High-Value Care Coordination

As providers gained more experience with the program and began to provide care coordination services, they became eligible for activation payments. The ACO distributed these payments to the TINs of all care team members who were supporting a beneficiary defined as "care managed," meaning the beneficiary had selected a lead care coordinator, participated in a care conference, and had a shared care plan that included two goals and two associated activities, and that was documented in Care Navigator. The TIN for the facility that employed the lead care coordinator received a $10 PMPM activation payment as well as a one-time payment of $150 to support the additional demands of the lead care coordinator's role.

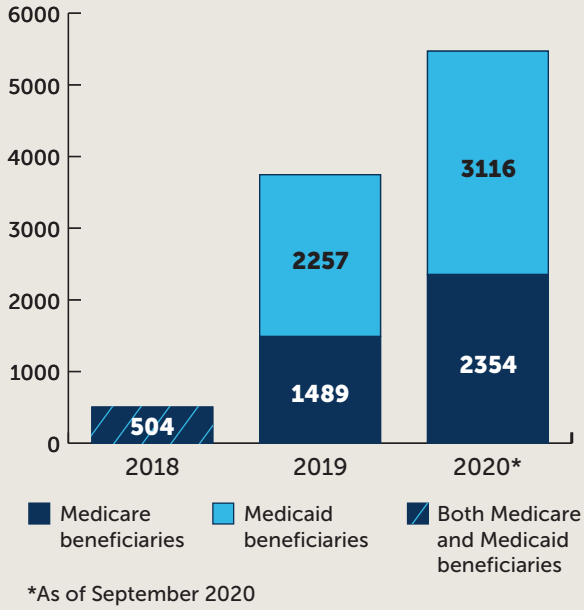
In July 2020, the focus of the payment structure shifted from supporting capacity building to paying for valuable activities related to care coordination. The ACO made this change to accelerate program engagement, the beneficiaries' attainment of their goals, and the achievement of clinical and financial outcomes. For each care-managed beneficiary, OneCare now distributes $80 PMPM to the TIN of the lead care coordinator and $60 PMPM to the TIN of any other care team member. Eligible partners continue to include PCPs, AAAs, mental health agencies, and home health agencies, though the ACO continues to expect that PCPs will most often serve as lead care coordinator. Additionally, recognizing the importance of care conferences, OneCare distributes $300 per member per year (PMPY) to the TIN of the lead care coordinator for organizing, facilitating, and documenting the care conference and $150 PMPY to the TINs of care team members who attend the care conference.

RESULTS

Program participation was lower than expected in the first few years of the program, but it rose sharply in 2019. The ACO reported a six-fold increase in the number of "care-managed" beneficiaries from 504 beneficiaries total in 2018 to 2,354 Medicare beneficiaries and 3,116 Medicaid beneficiaries as of September 15, 2020, representing about 25% of the ACO's Medicare and Medicaid population. Care-managed beneficiaries are those who are engaged in the program and are actively working on the goals and tasks documented in the shared care plan. Figure 4 shows the growth in care-managed beneficiaries from 2018 to September 2020.

Figure 4

Growth in OneCare's care-managed beneficiaries from 2018 to 2020



*As of September 2020

In addition, OneCare observed that engagement in primary care increased, and ED utilization decreased among beneficiaries who were actively supported by the program. In October 2019, the ACO reported that nearly all (99 percent) of its Medicare and Medicaid beneficiaries who were care managed for six months or more had visited their PCP within the previous year. OneCare also observed a 15 percent increase in documented encounters between care-managed beneficiaries and their care coordinators. The ACO viewed this finding as evidence that beneficiaries with complex needs may have been better supported by their care team. As evidence of strong provider engagement, the ACO noted that 75 organizations and more than 700 care coordinators were actively using Care Navigator in 2019. In addition, the ACO reviewed data on ED utilization for care-managed Medicare and Medicaid beneficiaries, focusing on the 12 months before and the 6 months after beneficiaries participated in the program. OneCare reported significant reductions in ED utilization of 33 percent for Medicare beneficiaries (3,246 to 2,098 ED encounters per thousand beneficiaries per year (PKPY)) and 13 percent for Medicaid beneficiaries (1,774 to 1,534 PKPY).[5]

LESSONS LEARNED

After three years of operating the program, OneCare reflected on its successes, challenges, and lessons learned. The ACO's insights may be helpful to other organizations that are trying to affect change over a large geographic area and across multiple partners.

- **Refining the payment system based on stakeholder input.** In 2018, OneCare's Green Mountain Care Board recommended revising the payment approach to incentivize providers to engage more beneficiaries in the care coordination program. Specifically, the board suggested decreasing the distribution of capacity payments (e.g., time-limited for the first 12 months in which a provider participates in the ACO's network) and providing higher payments for higher-value services (e.g., beneficiary engagement and care coordination). To refine the payment structure, OneCare convened five technical workgroups with providers from across the care continuum. In summer and fall 2019, the ACO then conducted 13 townhall-style meetings across the state to solicit feedback from providers and promote their engagement in the program; approximately 250 to 300 people attended these meetings.
- **Promoting improvement through regional and local meetings.** The ACO discussed the importance of the regional workgroups in operating the program, as they help to support the spread of information and to bring new ideas to the surface. Similarly, the discussions at the 2019 townhall meetings provided OneCare with an opportunity to clarify terminology and standardize the responsibilities of care team members, as several attendees asked "what they have to do to be successful" in the program. The meetings also helped to raise awareness for providers about the care coordination program and its processes; the townhall meetings coincided with a noteworthy increase in program participation in 2019.
- **Addressing the social determinants of health in risk assessments.** OneCare heard feedback from several providers that the risk stratification approach, which relies heavily on claims data, sometimes misses high-risk individuals who could benefit from care coordination services. For example, a pediatric beneficiary or someone who is deferring treatment may not have a long claims history, or a person may have significant non-clinical needs. To develop a more nuanced risk stratification methodology, the ACO is considering including social risk factors, such as the enrollment in social services, in risk scores. OneCare has partnered with Vermont's Agency for Human Services to support this effort.

NEXT STEPS

OneCare plans to continue to expand the care coordination program by scaling up its training efforts. The ACO is now collaborating with the Vermont Department of Health to launch an e-learning platform to transition from an in-person to a virtual training model. According to a staff member, this change will help to reduce training costs and allow the ACO to integrate the training in care coordination skills with other clinical and non-clinical training opportunities offered by the Department of Health. Additionally, OneCare is hosting a workshop to support care coordinators employed by organizations in its network in their effort to become certified case managers by the Commission on Case Management Certification. OneCare's goal is to have several coordinators in each HSA certified by the end of 2020.

ENDNOTES

[1]For more information on Vermont's All-Payer ACO Model, visit https://innovation.cms.gov/innovation-models/vermont-all-payer-aco-model.

[2]For more information on the Green Mountain Care Board, visit https://gmcboard.vermont.gov/.

[3]For more information on the Blueprint for Health initiative, visit https://blueprintforhealth.vermont.gov/.

[4]For more information, see "Population Health Approach: A plan for every person", OneCare VT, https://www.onecarevt.org/patient-programs/.

[5]For more information, see "OneCare Vermont: 2020 Budget Presentation to Green Mountain Care Board".

About the ACO Learning Systems project
This case study was prepared on behalf of CMS's Innovation Center by Kelsey Cowen and Kate D'Anello of Mathematica under the Learning Systems for ACOs contract (HHSM-500-2014-00034I/HHSM-500-T0006). CMS released this case study in October 2020. We are tremendously grateful to Jodi Frei, Jenn Gordon, and Tyler Gauthier of OneCare Vermont for participating in this case study.

For more information, contact the Vermont All-Payer Model Learning System at ACOLearningActivities@mathematica-mpr.com