

Vermont's Bold Experiment in Community-Driven Health Care Reform

Martha Hostetter
Consulting Writer and Editor
The Commonwealth Fund

Sarah Klein
Consulting Writer and Editor
The Commonwealth Fund

Douglas McCarthy
Senior Research Director
The Commonwealth Fund

PROGRAM AT A GLANCE

IMPORTANT FEATURE: OneCare Vermont, an accountable care organization (ACO), provides funding and tools to help care coordinators working in a variety of settings collaborate to address the medical and psychosocial issues that contribute to poor health.

TARGET POPULATION: Patients at risk of poor health outcomes because of complex medical or social needs.

WHY IT'S IMPORTANT: Social workers, nurses, and others serving as care coordinators for high-need patients often work independently and with limited funding. Vermont's three largest payers have committed to providing them with additional financial support; OneCare also provides training and technology to help them collaborate.

BENEFITS: By encouraging collaboration, offering training in best practices, and focusing on patients' goals, OneCare hopes to get patients more engaged in their care, improve their health outcomes, and reduce health care spending.

CHALLENGES: Because OneCare relies on community-based care coordinators rather than employing them directly, it runs the risk that they may not focus on outcomes of greatest interest to the ACO or its payers. Variation in care coordination models across regions also may impede efforts to identify and standardize best practices.

KEY TAKEAWAYS

- ▶ **As a large accountable care organization in Vermont, OneCare aims to unite the physical health, mental health, and social services sectors to better serve patients with complex needs.**
- ▶ **OneCare's community-driven approach to care coordination may offer lessons about how to wring greater value out of a fragmented health care system.**

INTRODUCTION

In 2014, on the heels of a failed attempt to create a single-payer health care system in Vermont, policymakers turned their attention to how they might achieve their goal — lower health care spending and improved health outcomes — without disrupting the existing payment system. Their idea was to encourage the state's largest payers — Medicare, Medicaid, and Blue Cross and Blue Shield of Vermont — to move more quickly from fee-for-service to risk-based contracting. In so doing, they would also encourage providers to pursue the state's goals for improving residents' health.

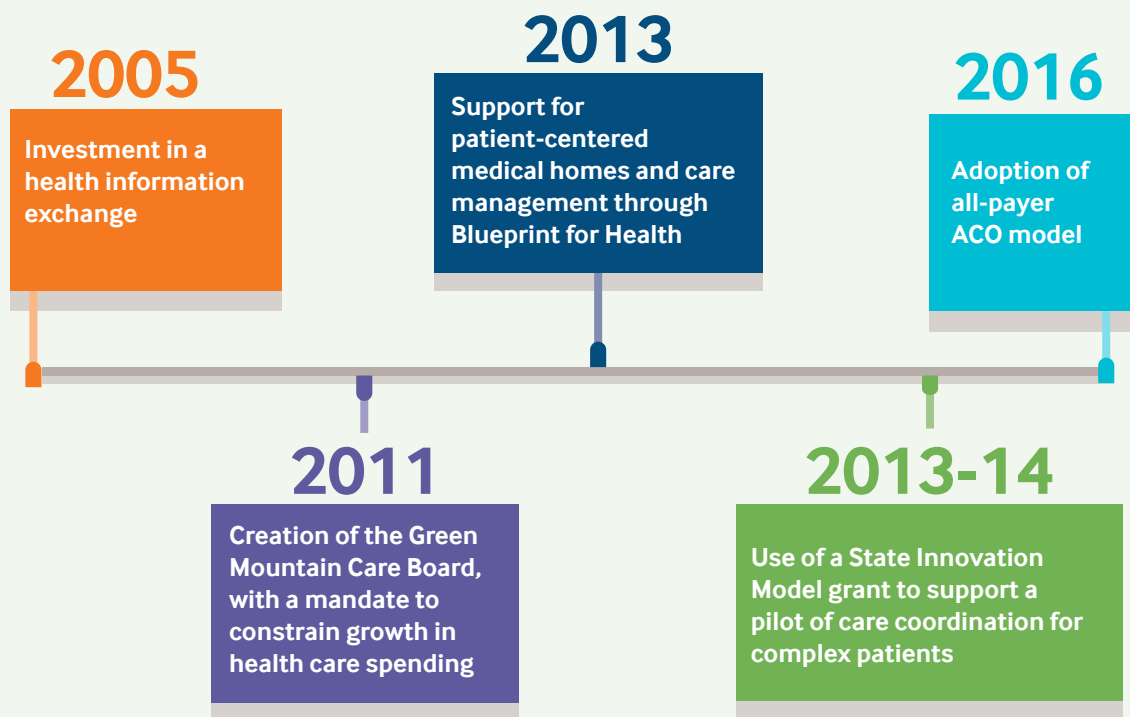
The concept appealed to OneCare Vermont, a large accountable care organization (ACO) that had engaged more than half the state's physicians and nearly all its hospitals in its network but had struggled to earn savings in its previous contracts with insurers.

Under the “all-payer” ACO model, the three payers would steadily increase the number of patients cared for under risk-based contracts and provide additional financial support to OneCare to coordinate care for individuals considered to be high medical risks. In return, OneCare would take on downside financial risk for itself and participating hospitals, a move it hoped would spur the latter to collaborate with community partners in helping patients beyond their institutions' walls.

OneCare's vision is to unite the physical health, mental health, and social services sectors in serving patients with the most complex needs, much as the federal [Accountable Health Communities initiative](#) seeks to forge clinical and community partnerships to address factors such as unstable housing or social isolation that contribute to poor health.¹ Rather than hiring its own staff to organize this effort, OneCare is relying on care coordinators

OneCare Builds on Vermont's Health Reforms

OneCare knits together a range of Vermont's delivery system reforms, but its approach leans most heavily on the community health teams established by the Blueprint for Health initiative.



Note: Blueprint for Health legislation passed in 2006. A 2010 law expanded the pilot statewide and guaranteed by 2013 access to providers that wanted to participate. As of the first quarter of 2018, nearly all of Vermont's primary care practices — 140 — had achieved patient-centered medical home recognition.

already in the field as a result of Vermont's [Blueprint for Health](#). The Blueprint for Health, a statewide initiative, compels public and private payers to support nurses, social workers, community health workers, and others working to help patients manage their chronic conditions, find treatment for addiction and other behavioral health conditions, and connect with social supports.

OneCare offers these care coordinators additional funding as well as training and tools to collaborate. Its approach is purposefully nondirective: it assumes that given resources and opportunities to collaborate, communities will devise their own solutions. "We are not trying to come into a community and set up a different system of care," says Sara Barry, OneCare's director of clinical and quality improvement. "We're trying to say, 'How do we align with what you already have and bring those services more closely together?'"

This case study examines OneCare's community-driven approach to care coordination, which it piloted in 2017 among a subset (around 29,000) of the state's Medicaid beneficiaries. This year, the ACO is accountable for 42,000 Medicaid beneficiaries as well as 72,000 Medicare and Blue Cross and Blue Shield members.² By 2022, Vermont aims to have nearly 70 percent of its 624,000 residents attributed to an ACO.³ Although the initiative is in its early stages, Vermont's experiment in forging partnerships among health care payers and between clinical and community providers may offer lessons about the potential of care coordination to wring value out of a fragmented health care system.

BUILDING ON VERMONT'S HISTORY OF REFORM

OneCare Vermont was created in 2012 by two academic medical centers serving the state — the University of Vermont Medical Center and the Dartmouth-Hitchcock health system — and now includes 10 of the state's 14 hospitals, a majority of its primary care and specialty care practices, and 21 of its 40 nursing homes.⁴ As noted above, what makes it different from many other ACOs is its engagement of partners other than hospitals and physicians: Area Agencies on Aging, mental health

WHAT IS THE ALL-PAYER ACO?

Vermont is partnering with the federal government in an ambitious effort to shift nearly all payment for medical services from a fee-for-service model to a value-based one that rewards providers for achieving the state's cost-containment and quality-improvement goals. Under the all-payer model, Medicaid, Medicare, and Blue Cross and Blue Shield of Vermont (which has a nearly 90 percent share of the commercial market) have agreed to enter into contracts that require providers to assume the risk for meeting financial targets and performance benchmarks.

Over the course of five years, participants are expected to incrementally increase enrollment such that by 2022, 90 percent of all Medicare beneficiaries and 70 percent of commercially insured residents are covered by risk-based contracts (the state has not set specific targets for the Medicaid population). The approach has some similarities to that of Maryland, which seeks to contain health care spending by setting the rates by which all third parties — Medicare, Medicaid, and commercial insurers — pay for hospital care.⁵

agencies, home health providers, and other community groups that are part of the ACO but unlike participating hospitals not at financial risk for its results. Its ability to do so is a function of the state's past reforms to the health care delivery system, most notably the Blueprint for Health, which provides financial support for creation of patient-centered medical homes and "community health teams" made up of nurses, social workers, dietitians, asthma educators, community health workers, and others in each of the state's 14 health service areas (HSAs).⁶

MEDICAID NEXT-GENERATION PILOT

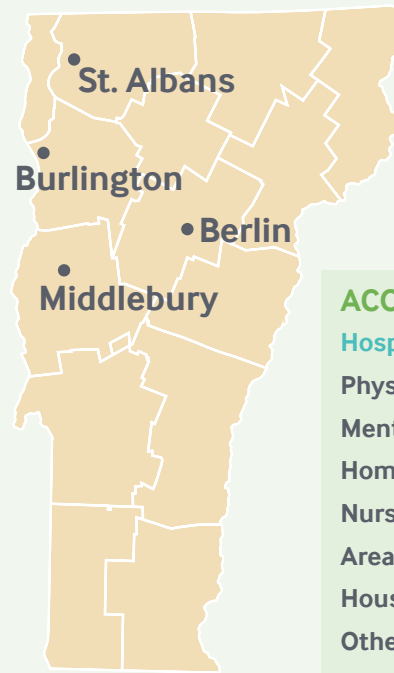
In 2017, OneCare assumed financial risk for some 29,000 Medicaid beneficiaries (about 20 percent of the state's total) in four regions: Berlin, Burlington, Middlebury, and St. Albans.⁷ It took responsibility for providing most medical and behavioral health services for these beneficiaries, from a budget of \$90 million.⁸ Like Medicare's Next Generation ACO Model, which was also launched in 2017, the Medicaid program offered the ACO the option to receive capitated payments.⁹ If actual expenditures in 2017 fell below the budgeted amount, OneCare would keep the first 3 percent of savings; if expenditures exceeded it, OneCare would make up the first 3 percent.

As part of the agreement, Vermont's Medicaid agency ceded to OneCare some of its care management functions. The agency had been focusing its support on patients in the top 5 percent of health care spending. OneCare proposed to engage a broader population, including those with chronic diseases or behavioral health conditions who might be at rising risk. It also wanted to do away with eligibility criteria restricting which patients could be offered support, because the ACO's leaders said these were administratively burdensome and left too many people out.

To identify Medicaid beneficiaries who may need support, OneCare analysts aggregate demographic information, data from the medical records of physicians and hospitals, and claims data supplied by Vermont's Medicaid agency. They then analyze the data using a risk-prediction algorithm licensed through Johns Hopkins University that categorizes each Medicaid beneficiary — a mix of adults (45%); children (49%); and aged, blind, and disabled individuals (6%) — into one of four groups based on their predicted morbidity over the next year (Exhibit 1).¹⁰ Patients' risk categorization is then provided to local care coordinators, who can then adjust it based on their knowledge of the patients and conversations with clinicians.

For example, based on claims data alone, an individual may not be identified as being at high or rising risk. But the care coordinator understands this person

FOUR REGIONS INVOLVED IN MEDICAID PILOT



needs additional support because of a recent bout of homelessness or a death in the family.

COORDINATING THE CARE COORDINATORS

As noted, OneCare does not hire staff care coordinators. Instead, it offers employees at partner organizations the funds and resources required to help patients manage their medical conditions and address their social, financial, and psychological challenges. These professionals include:

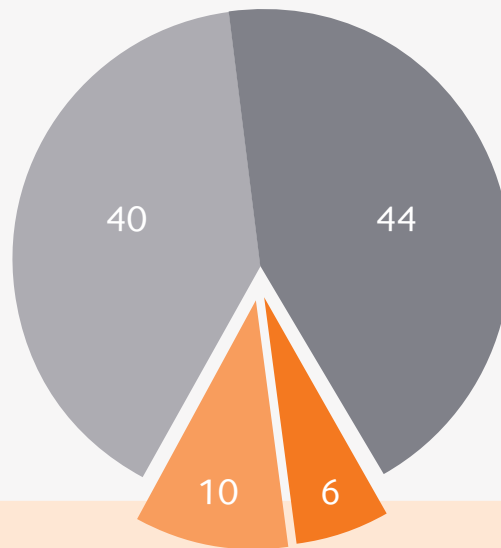
- case managers, often nurses or social workers, who work as part of community health teams or are hired directly by primary care practices
- social workers and nurses employed by Area Agencies on Aging
- social workers, counselors, and other staff members working for the state's hub-and-spoke system, which provides medication-assisted treatment for opioid use disorder

Exhibit 1. Four Risk Categories and Services for Each

While OneCare had planned to focus care-coordination efforts on the highest-risk patients, care coordinators urged the organization to include those with “rising risk,” as they believed they had the greatest leverage with such patients. Patients in lower-risk tiers benefit from the ACO’s focus on preventive health measures and health assessments.

LEVEL 1

HEALTHY/WELL:
facilitate access to activities and services that improve physical and mental health



LEVEL 2

EARLY ONSET OR STABLE CHRONIC ILLNESS:
comprehensive health assessment, with outreach at least two times per year; disease management support

LEVEL 3

FULL ONSET CHRONIC ILLNESS AND RISING RISK:
comprehensive health assessment, with outreach at least four times per year; access to a community-based care coordinator and completion of a shared care plan

LEVEL 4

COMPLEX/HIGH-COST WITH ACUTE CATASTROPHIC CONDITIONS:
comprehensive health assessment with outreach at least 12 times per year; completion of a shared care plan with assignment of a lead care coordinator; care conferences as needed

Prevalence of Selected Conditions Among 4,780 Level 3 and Level 4 Medicaid Beneficiaries

Depression	1,549	Coronary Artery Disease	599
Anxiety, Neuroses	1,541	COPD	489
Hypertension	1,379	High-Risk Pregnancy	286
Tobacco Use	1,248	Bipolar Disorder	225
Diabetes	924	Congestive Heart Failure	112
Asthma	894	Schizophrenia	102

Data: OneCare Vermont based on claims data for September through December 2017.

Note: Patients may have multiple conditions.

- social workers employed through the Support and Services at Home (SASH) program, which primarily helps older adults.¹¹

Care coordinators offer support to patients who have been identified as being at high or rising risk. In 2017, 16 percent of patients — about 4,780 — were identified as such; thus far, about a third have a care team identified, and a quarter have a lead care coordinator who is responsible for coordinating with an individual's care team. During initial encounters, the coordinators ask patients to tell them about their lives, their challenges, and the kinds of

support they might need to achieve their goals.¹² They typically use diagrams known as ecomaps to help patients and families visualize the social, financial, and medical support systems people already have in place and where they may need additional support. They may then show patients domain cards — each with a word and/or picture illustrating factors that can affect health, such as finances, housing, medication, and transportation — and ask them to select those that represent their immediate and longer-term priorities, whether that is finding reliable transportation or a better-paying job.¹³

Care Coordination Services and Staff

Care coordination staff — none employees of OneCare — receive funding and tools from the ACO to help them do their work. These tools include the Care Navigator software, which enables them to create shared care plans and coordinate their efforts.

Services	Providers	Staff
Help managing chronic conditions	Primary care clinics	Nurses, dietitians, community health workers
Counseling and referral to treatment for behavioral health conditions	Mental health agencies, primary care clinics	Nurses and social workers
Counseling and treatment for substance use disorder	Primary care clinics, specialty care treatment hubs,* and mental health agencies	Social workers, nurses trained in medication-assisted treatment
Benefit enrollment and other social supports	Primary care clinics, mental health agencies, SASH**	Nurses, social workers, and community health workers
Wellness education, fitness classes, home visits for frail elders	SASH,** community health teams	Nurses and nonlicensed care coordinators
Support during transitions between care settings	Home health providers, primary care clinics, and Area Agencies on Aging	Nurses and social workers
Personal care services and other long-term services and supports	Area Agencies on Aging	Typically nonlicensed care managers or referral coordinators

* Vermont uses a hub-and-spoke model for addiction treatment that relies on primary care practices to provide treatment to patients with less-complex needs, while specialty care “hubs” deliver services to patients with more extensive needs.

** The Support and Services at Home (SASH) program is funded through Vermont's Blueprint for Health.

CARE NAVIGATOR

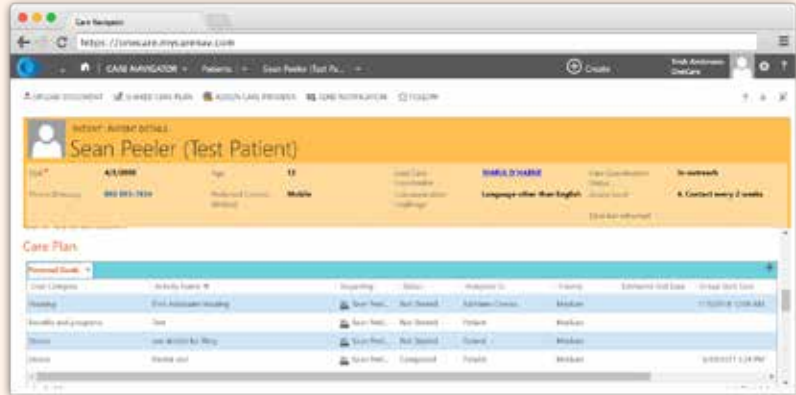
OneCare’s leaders worked with creators of the software platform Care Navigator to configure it to meet the needs of care coordinators who wanted a better way to communicate than phones or fax machines. As a supplement to patients’ electronic medical records, the software makes clear which health and social service staff are working with which patients and creates a system of notifications and prompts about hospital admissions, discharges, and other events. Using new tools and automated workflows, care coordinators can create task lists and track activities, while lead care coordinators use the software to facilitate collaboration. The software includes a library of educational resources for patients. It also enables them to upload photos and other information about themselves and to securely send notifications and messages to members of their care team.

Care Navigator also provides a platform for OneCare to document the services care coordinators provide, monitor their impact, and identify patterns — for example, the common unmet needs of dementia patients. Part of the additional funding OneCare provides to care coordinators covers the cost of conducting more systematic needs assessments, documenting them in Care Navigator, and using the technology to communicate and coordinate with one another. In 2017, 480 care coordinators were trained to use the system, and more than half had begun actively using it.

The software platform is used in other states by another ACO, a federally qualified health center, and behavioral health and long-term services and support organization consortiums to improve communication and coordination.

Goals and Shared Care Plan

Teams enter patients’ goals, then associate them with a particular domain of health or social determinant to enable analysis across communities.



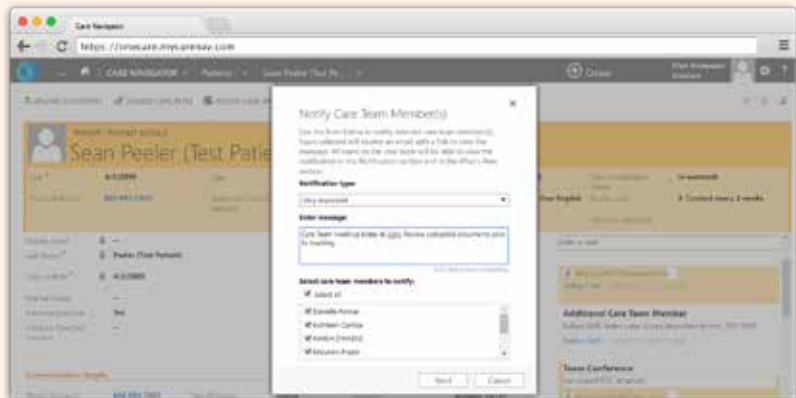
Patient Resources

About Me section contains information about what’s important to patients, the results of patient assessments, and access to a library of educational resources.



Documentation

The system logs the activities care coordinators perform day to day, triggering payment from OneCare for completing designated tasks.



Screenshot images above © Copyright 2018 Intraprise Health. All rights reserved.

To complement these qualitative approaches, care coordinators may use screening tools. One is the Vermont Self-Sufficiency Outcomes Matrix, which assesses patients' functional health and the adequacy of their income, housing, health care coverage, and other social supports.

A frequent next step is for the care coordinator to convene a conference, inviting the patient and members of the support team identified on their ecomap. During the conferences, participants delineate each person's role in supporting the patient, highlight any gaps in services or duplicative activity, and choose a lead care coordinator (if indicated), who then works with the patient to create a shared care plan. Some patients with complex needs may benefit from frequent conferences, while others may be seen by the full care team quarterly or yearly or when circumstances change.

Each care plan outlines two goals identified by patients and two steps that might help them achieve these goals, such as signing up for Meals on Wheels in order to eat two regular meals daily. Care coordinators encourage small, practical steps, often translating clinicians' advice into a course of action. "Someone might say, 'My doctor just told me I'm prediabetic and need to eat better and exercise. What does that mean? I've been eating the same way for this long. I can't run,'" says Stefani Hartsfield, former assistant director for Vermont's SASH program. "So there is someone there to help figure it out."

By focusing on patients' goals — rather than physicians' or care coordinators' — care coordinators can help identify the underlying reasons why people may not make their health a priority. In one case, a woman with unmanaged diabetes and other chronic conditions said her primary goal was to figure out what had happened to a son she had given up for adoption decades earlier. A SASH care coordinator worked with the woman to locate her son, who was doing fine. Now reassured about his well-being, she chose to make managing her health conditions her next goal.

On a given day, care coordinators might offer a counseling session to a patient with depression or anxiety, help another find housing or job training, and provide



When Blueprint for Health started, it was like, OK, here's 14 communities; go ahead and do it 14 different ways. And now the conversation has become, how do we create some consistency statewide?

Lesley Hendry, Blueprint for Health project manager, St. Albans

education to help someone else manage a chronic disease like diabetes. They also might accompany patients with behavioral health problems to their primary care visits. Some coordinators are embedded in primary care offices or emergency departments to identify patients in need of support and connect them with multidisciplinary care teams.

Nancy Reynolds, a SASH coordinator in St. Albans, leads exercise and wellness classes at senior housing centers. She also makes regular home visits to check on isolated seniors, including a woman in her late 80s who runs a farm and, like a number of rural Vermonters, speaks only French.

All this work is organized through Care Navigator, a proprietary software platform that OneCare licensed to give care coordinators a way to collaborate. Once patients' shared care plans are created, different team members can use the platform to document the steps they're taking to help patients meet their goals. Records are accessible to all members of the team (with plans to expand to patients and their caregivers later this year), and members can communicate with one another as needs change. Reynolds sees this technology as game-changing. "I will know I'm not working in a vacuum," she says.

SHARING BEST PRACTICES AND PROMOTING STANDARDIZATION

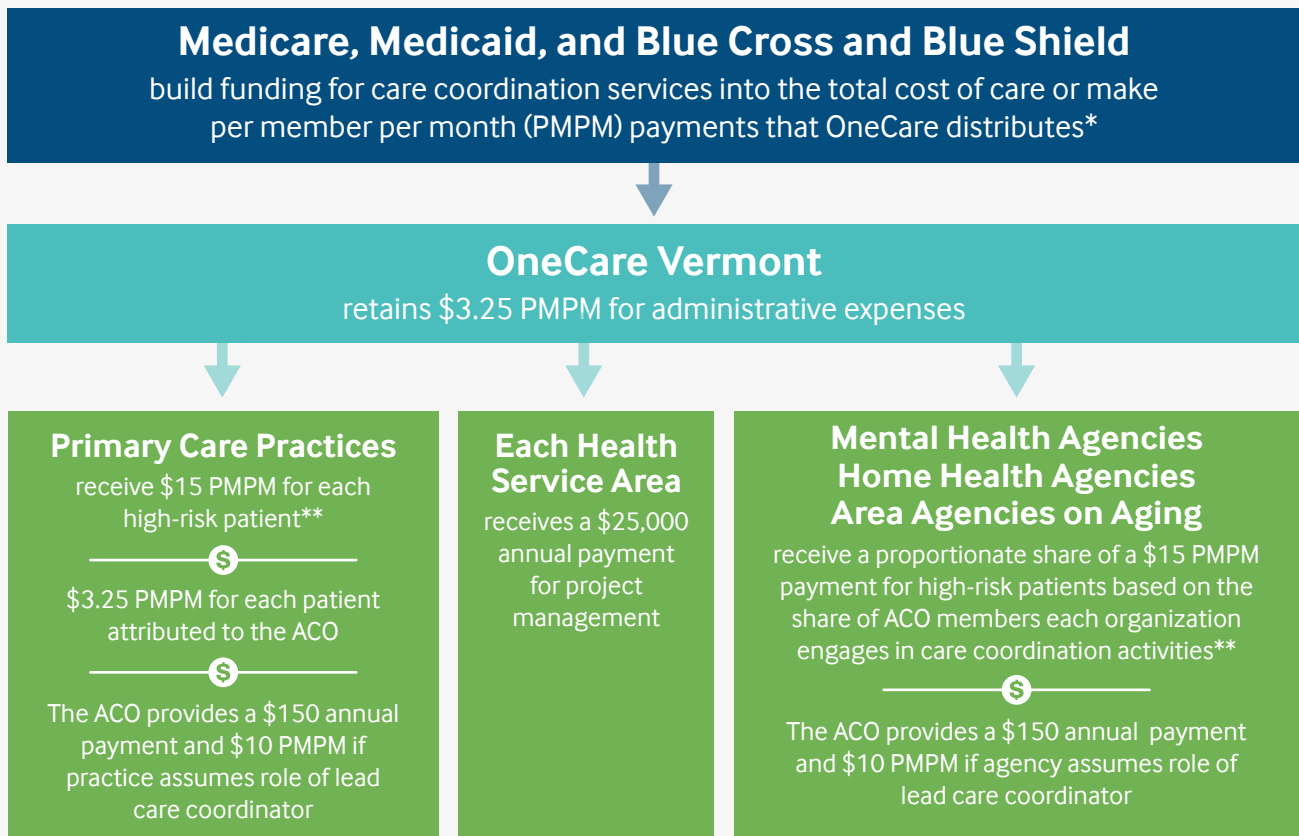
With the variation in patients' needs and provider networks, OneCare has given each region involved in the Medicaid pilot — Berlin, Burlington, Middlebury, and St. Albans — some flexibility in developing priorities and care coordination approaches.¹⁴ At the same time, the ACO has sought to assess what's working and to promote standardization, in part by convening monthly meetings of administrative and frontline staff from participating health and social service organizations.

At these in-person and virtual “Core Team” meetings, participants describe the various care coordination activities under way in their regions and explore ways to leverage resources most effectively, building on work already begun through the Blueprint for Health.

The Core Team meetings also offer opportunities for care coordinators and their supervisors to brainstorm potential solutions to shared challenges.

In the summer of 2017, Jane Suder, R.N., who oversees care management at Northwestern Medical Center, presented the story of a local woman with chronic obstructive pulmonary disease, diabetes, anxiety, and apparent cognitive impairments. The woman had lost her housing, leading her repeatedly to the emergency department, sometimes because of a medical complication and sometimes because she didn't know where else to go. “It's trying to help figure out how to assist people with similar needs who really need a village around them,” Suder said. The group discussed ways to secure short-term motel stays for the woman until longer-term housing could be arranged, as well as how to meet her medical needs and

How Care Coordination Is Financed



* The network's hospitals also contribute to care coordination expenses.

** The population defined as “high risk” varies by payer. For example, in the Medicaid contract, 16 percent of beneficiaries are deemed high risk; for the Blue Cross and Blue Shield contract, only 3 percent are.

expedite her enrollment in Medicaid and other benefit programs. They also discussed using the Care Navigator software to create a central repository of available resources and best practices for helping patients with such complex needs.

To support the work of the Core Team and the rollout of the Care Navigator software, OneCare has launched a training series for care coordinators, supervisors, and other leaders and is developing standard job descriptions and promoting professional competencies such as using ecomaps and domain cards or creating shared care plans.

PROVIDER PAYMENT AND ALLOCATION OF FINANCIAL RISK

OneCare receives additional funding from payers to support care coordination activities and distributes it to ACO participants in a way designed to promote shared responsibility (Exhibit 2). It provides \$25,000 annually to support project management in each of the pilot's four regions, while per member per month payments are distributed to primary care practices as well as to Area Agencies on Aging, home health agencies, and mental health agencies. These participants are not at financial risk under the ACO contract, and the additional payments are a substantial increase over Blueprint for Health's funding for community health initiatives, which has remained level for several years. For instance, smaller primary care practices (such as those with two staff physicians and 600 attributed patients) may earn as much as \$38,000 in additional revenue during a year. "In some cases, practices have been able to use these additional funds, combined with their Blueprint funding, to hire another care coordinator," says Sarah Jemley, OneCare's care coordination program administrator.

Participating hospitals receive fixed payments, thus taking downside financial risk, which is "key to unlocking profound change in how hospitals interact with the community," says Norm Ward, M.D., OneCare's chief medical officer.

Although leaders at some of the state's small hospitals were initially reluctant to take on financial risk, given



We have so many different community agencies that are in many ways driven by altruism and have budgets that are short already. We are trying to redistribute dollars from high-cost events to upstream community support services.

Norm Ward, M.D., OneCare's chief medical officer

thin operating margins, nearly all eventually joined. They understood that current payment models were unsustainable and "want to be on the ground floor of creating a new approach," says Stephen Leffler, M.D., the University of Vermont's chief population health officer.

Hospitals were also drawn by the prospect of having access to OneCare's analytic tools, which enable panel management, performance tracking, and care coordination. "In the past it's been us saying to hospitals, 'Here are five things you can focus on to improve care and capture savings,'" says Todd Moore, OneCare's CEO. "Now the hospitals are calling to say, 'Run me a query on everyone who has tested positive for prediabetes.' They are clamoring for more and more specific data on where they think there are opportunities to improve care and achieve savings."

OneCare hopes that this blend of financial carrots and sticks will be sufficient to encourage hospitals, ambulatory care providers, and social service providers to work together to improve population health and contain health care spending — an approach that in 2018 it extended to patients covered by Medicare and Blue Cross and Blue Shield's commercial insurance.

Exhibit 2. 2018 Medicaid & Blue Cross and Blue Shield Qualified Health Plan (QHP) Quality Measures

Measure	Programs
1. 30-day follow-up after discharge from the emergency department (ED) for alcohol and other drug abuse or dependence	Vermont Medicaid Next Generation (VMNG); Blue Cross and Blue Shield Qualified Health Plan (QHP)
2. 30-day follow-up after discharge from the ED for mental health	VMNG; Blue Cross and Blue Shield QHP
3. Adolescent well-care visits	VMNG; Blue Cross and Blue Shield QHP
4. All-cause unplanned admissions for patients with multiple chronic conditions	VMNG
5. ACO all-cause readmissions	Blue Cross and Blue Shield QHP
6. Developmental screening in the first 3 years of life	VMNG; Blue Cross and Blue Shield QHP
7. Diabetes mellitus: hemoglobin A1c poor control (>9%)	VMNG; Blue Cross and Blue Shield QHP
8. Hypertension: controlling high blood pressure	VMNG; Blue Cross and Blue Shield QHP
9. Initiation of alcohol and other drug abuse or dependence treatment	VMNG
10. Engagement of alcohol and other drug abuse or dependence treatment	VMNG
11. Initiation and engagement of alcohol and other drug abuse or dependence treatment (composite)	Blue Cross and Blue Shield QHP
12. Screening for clinical depression and follow-up plan	VMNG; Blue Cross and Blue Shield QHP
13. Follow-up after hospitalization for mental illness (seven-day rate)	VMNG; Blue Cross and Blue Shield QHP
14. Tobacco use assessment and tobacco cessation intervention	VMNG
15. Patient-centered medical home Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey composite measures	VMNG
16. CAHPS tobacco cessation survey question: "Did your provider talk to you about smoking cessation?"	Blue Cross and Blue Shield QHP
17. CAHPS patient experience: care coordination composite score	Blue Cross and Blue Shield QHP

Data: OneCare Vermont.

Under the all-payer ACO, these insurers have committed to supporting coordination of community-based care, aligning performance measures, and shifting to greater use of risk-based contracting. Pat Jones, the health care project director for Vermont's regulatory body, the Green Mountain Care Board — one of the signatories to the all-payer ACO contract — says this should encourage "all boats to row in the same direction" and reduce the "noise" created from working under contracts with varying benchmarks and expectations.¹⁵

Harmonizing performance measurement among Vermont's three largest payers also helps focus attention on the state's priorities: expanding access to primary care, reducing the prevalence and morbidity of chronic disease, and reducing the number of deaths from suicide and drug overdose. In coordination with the Green Mountain Care Board, OneCare and its payers are working to align quality performance targets around these population health goals. It hopes to eventually reduce the total number of quality metrics across payer contracts to 17 from 44.

EARLY RESULTS

While medical claims are still trickling in for 2017, preliminary data suggest that OneCare is making progress in achieving the state's population health goals. They show that Medicaid beneficiaries attributed to the ACO are making greater use of primary care and behavioral health services, as well as pharmacy benefits, compared with other beneficiaries. Over the first nine months of the contract, for example, the percentage of beneficiaries with early to late-stage disease who lacked a primary care visit fell to 2 percent from 4 percent. Those who were deemed to be at high or rising risk (levels 3 and 4) also had substantially fewer emergency department visits during the first nine months of 2017 compared with similar periods in the prior two years, and fewer hospitalizations compared with the prior year (Exhibits 3 and 4). "These changes in utilization were what we had hoped and expected to see," OneCare's Sara Barry says. "Nothing about this model is about rationing care."

OneCare has found Medicaid beneficiaries deemed to be at highest risk are a relatively stable group, with little movement from one risk category to the next over time. This information lends credence to the ACO's approach of targeting services to the subset of patients who might benefit the most.

Despite these improvements, the ACO is not likely to achieve savings in the first year of the Medicaid contract. The total cost of care for 2017 was forecasted to be 1.5 percent above budget, meaning the ACO would owe money back to the state.¹⁶ Moore, the CEO, says preliminary data show that the four hospitals that received prospective payments reduced hospitalizations and other institutional care sufficiently to achieve savings. However, these savings were offset because some Medicaid beneficiaries attributed to the ACO sought care outside those hospitals, including at out-of-state hospitals, leading to fee-for-service charges that tipped the balance in the first year. (In 2018, 10 of the ACO's hospitals will have assumed downside risk, lessening the chances that a patient will receive care from an institution that is paid on a fee-for-service basis.)

To call attention to opportunities for cost savings and performance gaps, OneCare is tracking cost, utilization, and performance on quality measures at the hospital and regional levels through a software platform that allows users to drill down to the facility, provider, or patient level.

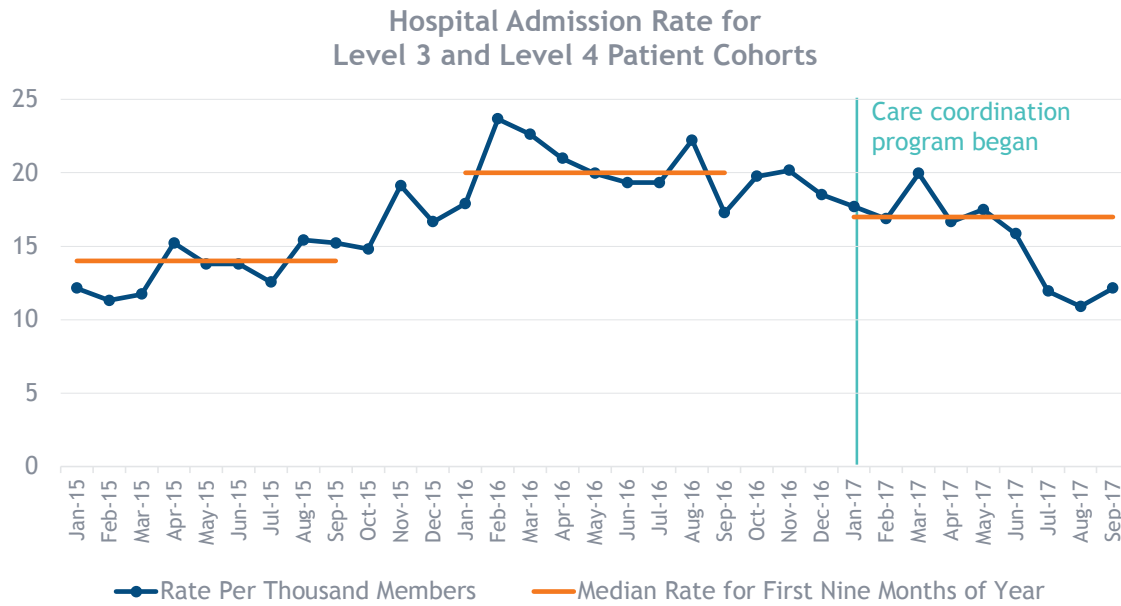
Ultimately, the definition of success for the ACO may vary by payer. The state wants to constrain growth in health care spending to 3.5 percent annually and has prioritized three population health goals, on which OneCare appears to be making headway. But leaders at Blue Cross and Blue Shield want to see savings for their customers and evidence that the community health teams are reaching its members, particularly those with complex needs whom the health plan's care managers have had difficulty engaging. "If they can figure out a way to do that, that's very exciting and would have value," says Josh Plavin, M.D., M.P.H., Blue Cross and Blue Shield's chief medical officer.

LOOKING FORWARD

OneCare's bold experiment has been enabled by Vermont's small size, which engenders trust and familiarity among health system leaders and policymakers, and by the lack of competition among private insurers, including Medicare Advantage plans. OneCare has also built on the state's long-term commitment to health reform, including the creation of the Green Mountain Care Board to constrain spending and the pursuit of a federal State Innovation Model grant, which supported the development and testing of an integrated approach to complex care management. Vermont's aging and declining population has also created pressure for reform.

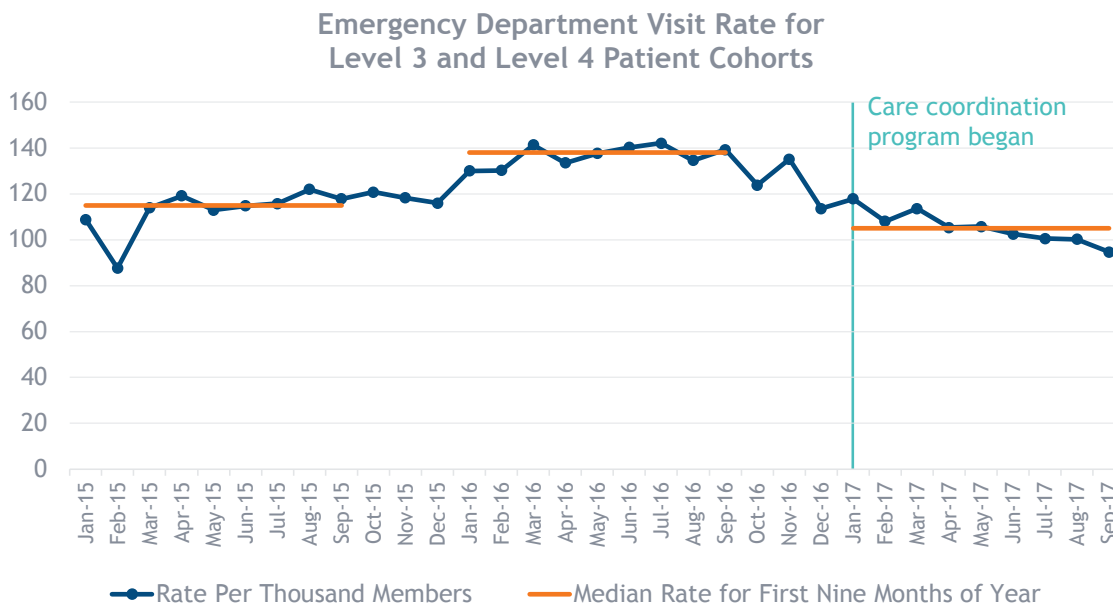
Even with these tailwinds, OneCare faces significant hurdles. Much of its early focus has been on community-led care coordination — supporting the customization of a technology platform to facilitate communication, providing training in best practices for engaging high-risk patients, and developing analytic tools to identify risk and evaluate impact. More extensive institutional reforms may be harder to accomplish, yet it may be that changes in provider behavior will lead to the greatest cost savings.

Exhibit 3. Hospitalization During 2015, 2016, and 2017 for Level 3 and 4 Medicaid Beneficiaries



Data: OneCare Vermont.

Exhibit 4. Emergency Department Use During 2015, 2016, and 2017 for Level 3 and 4 Medicaid Beneficiaries



Data: OneCare Vermont.

“In the short term, I firmly believe that we can save money around transitions of care and by delivering much-needed mental health and substance abuse treatment,” Stephen Leffler, of the University of Vermont, says. “But driving costs out of the hospital, direct costs or fixed costs, and redistributing those out into the community in a meaningful way is going to be difficult.”

With a rapid timeframe for implementation, the all-payer model also requires the ACO to keep its eye on three distinct populations at once and meet the competing demands of its payers. Studying the impact of myriad approaches will be critical to winning support for the care-coordination approach. Without evidence of impact, employers may be reluctant to sign on to the all-payer model.

“These are businesspeople who need to have some compelling evidence to suggest that there’s a reason to get involved, that there’s a reason to put dollars at risk potentially, or just to fund additional administrative

costs to support the operation of an ACO,” says Andrew Garland, vice president of client relations and external affairs at Blue Cross and Blue Shield.

Through its data analytics infrastructure, OneCare is attempting to add rigor and measurement to the work of care coordinators. Assessing comparative performance, however, may not be easy, given the variation both in the population of HSAs and in their problem-solving techniques. Many rely on different staffing configurations — for example, some depend on credentialed care coordinators, while others use lay workers.

But if OneCare is successful at identifying and spreading innovative approaches, it could accelerate investments like these not just in Vermont, but in other parts of the nation where leaders are seeking more evidence on effective ways to address the social determinants of poor health.

NOTES

1. See, for example, Anna Spencer and Bianca Freda, *Advancing State Innovation Model Goals Through Accountable Communities for Health* (Center for Health Care Strategies, Oct. 2016), <https://www.chcs.org/resource/accountable-communities-health-state-innovation-models/>.
2. The 30,000 Blue Cross and Blue Shield of Vermont members who are attributed to the ACO are enrolled in the insurer's marketplace plans, not employer-sponsored plans; 39,000 are Medicare beneficiaries.
3. While other groups can apply to join the all-payer ACO, OneCare Vermont is the only active ACO in the state.
4. Even though Dartmouth is based in New Hampshire, it serves many residents of southern and eastern Vermont.
5. Maryland is now experimenting with shared savings arrangements under its all-payer hospital payment model. See "Maryland All-Payer Model," Centers for Medicare and Medicaid Services, <https://innovation.cms.gov/initiatives/Maryland-All-Payer-Model/index.html>.
6. Private insurers, Medicaid, and Medicare all pay for Blueprint for Health activities. Funding for Blueprint for Health activities has remained level from 2008 through 2017. The state's Department of Mental Health designates a private nonprofit within a geographic region to provide its mental health or developmental disability services. These "Designated Agencies" are also often preferred providers of substance use disorder services.
7. From 2014 to 2016, OneCare Vermont had shared savings contracts with the state to care for 29,000 Medicaid beneficiaries. The 2017 contract is the first time it took on downside financial risk. See "Building an Integrated Health System: Implementing the Vermont All-Payer Accountable Care Organization Model — The Vermont Medicaid Next Gen ACO Pilot Contract," (presentation, Vermont Health Connect, n.d.), http://info.healthconnect.vermont.gov/sites/hcexchange/files/Advisory_Board/2017.2.15%20DVHA%20AHS%20VMNG%20ACO.pdf; Cory Gustafson and Michael Costa, *Vermont Medicaid Next Generation: Pilot Program — Act 25 of 2017* (State of Vermont, Department of Vermont Health Access, Sept. 15, 2017), <http://legislature.vermont.gov/assets/Legislative-Reports/DVHA-ACT-25-VMNG-ACO-Report-to-Legislature-Sept-15-2017.pdf>; and State Innovation Model, *Overview of Shared Savings Programs (SSPs) and Accountable Care Organizations (ACOs) in Vermont* (Vermont Health Care Innovation Project, July 8, 2014), http://healthcareinnovation.vermont.gov/sites/hcinnovation/files/SSP_and_ACO_FAQ_and_Chart_7.8.14.pdf.
8. Pharmacy claims and costs for skilled nursing facilities, inpatient psychiatric care, smoking cessation services, and most dental services are excluded from the global budget. See Cory Gustafson and Michael Costa, *Vermont Medicaid Next Generation: Pilot Program — Act 25 of 2017* (State of Vermont, Department of Vermont Health Access, June 15, 2017), <http://legislature.vermont.gov/assets/Legislative-Reports/DVHA-ACT-25-VMNG-ACO-Report-to-Legislature-June-15-2017.pdf>.
9. See "Next Generation ACO Model," Centers for Medicare and Medicaid Services, <https://innovation.cms.gov/initiatives/Next-Generation-ACO-Model/>.
10. See "ACG System: Data Analytics," Healthcare Solutions, Johns Hopkins Medicine, <https://www.johnshopkinssolutions.com/solution/acgsystem/>.
11. To learn more about the hub-and-spoke program, see Martha Hostetter and Sarah Klein, "In Focus: Expanding Access to Addiction Treatment Through Primary Care," *Transforming Care* (newsletter), Commonwealth Fund, Sept. 2017, <http://www.commonwealthfund.org/publications/newsletters/transforming-care/2017/september/in-focus>.

12. Its approach draws substantially on lessons from a learning collaborative, funded by the Center for Medicare and Medicaid Innovation, that engaged medical and social service providers in 11 communities across the state, as well as representatives from OneCare Vermont, the Blueprint for Health, the state's Medicaid agency, and the Green Mountain Care Board. The learning collaborative explored and piloted best practices for coordinating care for complex patients. For more information, see *Integrated Communities Care Management Learning Collaborative: Final Evaluation Report* (Vermont Program for Quality in Health Care, Inc., Dec. 23, 2016), <http://healthcareinnovation.vermont.gov/sites/vhcup/files/documents/FINAL%20ICMLC%20Evaluation%20report%201.3.17.pdf>.

13. The domain cards were developed by the Camden Coalition of Healthcare Providers.

14. In 2018, hospitals in six other communities agreed to assume risk for Medicaid beneficiaries. Their HSAs include Newport (North Country Hospital); Brattleboro (Brattleboro Memorial Hospital); Bennington (Southwestern Vermont Medical Center); Springfield (Springfield Hospital); Windsor (Mt. Ascutney); and Lebanon, N.H. (Dartmouth-Hitchcock Medical Center).

15. For more information on the all-payer model, see Pat Jones and Melissa Miles, "All-Payer Accountable Care Organization Model Update" (presentation, Green Mountain Care Board, Jan. 12, 2017), <http://gmcbboard.vermont.gov/sites/gmcb/files/documents/Implementing%20the%20All-Payer%20Model%202017-01-12FINAL.pdf>; and "Vermont All-Payer ACO Model," Centers for Medicare and Medicaid Services, <https://innovation.cms.gov/initiatives/vermont-all-payer-aco-model/>.

16. January 2018 presentation by OneCare's chief operating officer to the state legislature. Savings are distributed and losses are borne by risk-bearing hospitals according to their individual performance, with adjustment as needed to reduce the risk of insolvency. Primary care practices and hospitals are also eligible for bonuses based on quality

performance. These funds are drawn from a withhold on prospective payments to hospitals. In past shared savings contracts, which carried no downside risk, providers have made continual improvement on quality measures but have achieved savings only once. OneCare's CEO, Todd Moore, says it was difficult to achieve savings in contracts that depended on relative performance improvements because the state has had lower costs and higher performance to begin with.

ABOUT THE AUTHORS

Martha Hostetter, M.F.A., is a writer, editor, and partner in Pear Tree Communications. She was a member of the Commonwealth Fund's communications department from June 2002 to April 2005, serving as the associate editor and then creating the position of Web editor. She is currently a consulting writer and editor for the Fund. Ms. Hostetter has an M.F.A. from Yale University and a B.A. from the University of Pennsylvania.

Sarah Klein is editor of *Transforming Care*, a quarterly publication of the Commonwealth Fund that focuses on innovative efforts to transform health care delivery. She has written about health care for more than 15 years as a reporter for publications including *Crain's Chicago Business* and *American Medical News*. Ms. Klein received a B.A. from Washington University in St. Louis and attended the Graduate School of Journalism at the University of California at Berkeley.

Douglas McCarthy, M.B.A., is senior research director for the Commonwealth Fund. He leads a team that has conducted more than 100 case studies of promising practices and innovations in health care delivery. He helped develop the Fund's Scorecards on State Health System Performance and led their production from 2014 to 2018. His 30-year career has spanned roles in government, corporate, and nonprofit organizations, including the Institute for Healthcare Improvement and UnitedHealth Group's Center for Health Care Policy and Evaluation. He was a public policy fellow at the University of Minnesota's Humphrey School of Public Affairs and a leadership fellow of the Denver-based Regional Institute for Health and Environmental Leadership. He serves on the board of Colorado's Center for Improving Value in Health Care.

.....
Editorial support was provided by Jen McDonald.

ACKNOWLEDGMENTS

The authors gratefully acknowledge the following individuals who generously shared information and insights: *From OneCare Vermont*: Sara Barry, M.P.H., director of clinical and quality improvement; Teresa Connolly, M.S.N., manager, clinical and quality improvement; Leah Fullem, M.H.C.D.S., director of analytics; Sarah Jemley, M.S.N., care coordination program administrator; Vicki Loner, R.N., M.H.C.D.S., chief operating officer; Todd Moore, M.B.A., CEO; Robyn Skiff, M.S., care coordination implementation specialist; Norm Ward, M.D., chief medical officer; and Joan Zipko, M.S.H.C.A., director of program operations. *From University of Vermont*: Stephen Leffler, M.D., chief population health officer. *From Intraprise Health, operator of the Care Navigator platform*: Trish Ambrosio, M.S.N., R.N., C.C.M., vice president, clinical care coordination; Jodi Goudreau, director of customer experience; Vikas Khosla, chief digital health officer; and Mike Squires, vice president, innovation and public policy; all formerly with Care Navigator and BluePrint Healthcare IT. *From Blueprint for Health*: Mara Donohue, M.P.P., assistant director; Lesley Hendry, project manager, St. Albans; Jenney Samuelson, assistant director; and Beth Tanzman, M.S.W., director. *From the Green Mountain Care Board*: Pat Jones, health care project director; and Robin Lunge, J.D., M.H.C.D.S., board member. *From Department of Vermont Health Access*: Alicia Cooper, Ph.D., health care project director, Payment Reform Unit; Michael Costa, J.D., deputy commissioner; and Erin Flynn, M.P.A., health care project director, Payment Reform Unit. *From the State of Vermont*: MaryKate Mohlman, Ph.D., director of health reform. *From Blue Cross and Blue Shield of Vermont*: Andrew Garland, M.S., vice president of client relations and external affairs; and Josh Plavin, M.D., M.P.H., chief medical officer. *From the Supports and Services at Home (SASH) Program*: Stefani Hartsfield, former assistant director; and Nancy Reynolds, SASH coordinator, St. Albans. *From St. Albans Community Health Team*: Heather Colangelo, M.S.W., quality assurance manager at Washington County Mental Health Services; Amy Huckins-Noss, L.I.C.S.W., social work care coordinator; Anne-Marie Lajoie, R.N., care coordinator, Cold Hollow Family Practice; Meaghan McFadden, M.S.W., wellness consult; and Jane Suder, R.N., M.H.A., manager of care management at Northwestern Medical Center.

**For more information about this case study,
please contact:**

Martha Hostetter
Consulting Writer and Editor
The Commonwealth Fund
mh@cmwf.org

About the Commonwealth Fund

The mission of the Commonwealth Fund is to promote a high performance health care system. The Fund carries out this mandate by supporting independent research on health care issues and making grants to improve health care practice and policy. Support for this research was provided by the Commonwealth Fund. The views presented here are those of the authors and not necessarily those of the Commonwealth Fund or its directors, officers, or staff.

Commonwealth Fund case studies examine health care organizations that have achieved high performance in a particular area, have undertaken promising innovations, or exemplify attributes that can foster high performance. It is hoped that other institutions will be able to draw lessons from these cases to inform their own efforts to become high performers. Please note that descriptions of products and services are based on publicly available information or data provided by the featured case study institution(s) and should not be construed as endorsement by the Commonwealth Fund.