OneCare Vermont Accountable Care Organization, LLC
Board of Managers Meeting Agenda

September 15, 2020
4:30 p.m. – 7:00 p.m.
Teleconference Only

Time	Agenda Item	Presenter
4:30 p.m.	Call to Order and Board Announcements	John Brumsted, MD
4:31 p.m.	Consent Agenda Items* *Vote to Approve Consent Agenda Items*	John Brumsted, MD
4:32 p.m.	Welcome Members of the Public	John Brumsted, MD
4:35 p.m.	Public Affairs Update* ▪ Commonwealth Fund Case Study Featuring Thomas Chittenden Health Center ▪ Patient Story ▪ 2019 Annual Report ▪ OneCare Primary Care Investment Opportunity Sheet ▪ OneCare Information Sheet	Amy Bodette
4:45 p.m.	2021 Network Composition	Sara Barry
4:55 p.m.	2019 Medicare Quality Measure Performance*	Tyler Gauthier
5:05 p.m.	Public Comment Move to Executive Session	John Brumsted, MD
6:55 p.m.	Votes 1. Approve Executive Session Consent Agenda Items 2. Approve Resolution Adopting Amended Executive Committee Charter, Amended Risk Strategy Committee Charter, and Amended Bylaws 3. Approve Resolution Adopting Revised 2020 Participation Waiver 4. Approve Resolution Adopting 2021 Budget and Submission to GMCB	John Brumsted, MD
7:00 p.m.	Adjourn	John Brumsted, MD

*Denotes Attachments

Attachments:

1. Consent Agenda Items
    a. Draft of OneCare Public Session Minutes from August 18, 2020

b. Board Committee Reports September 2020
c. Financial Statement Package July 2020
d. CMO Corner September 2020

2. Public Affairs Update
    a. Public Affairs Report September 2020
    b. Commonwealth Fund Case Study
    c. OneCare Primary Care Investment Opportunity Sheet
    d. OneCare Information Sheet
3. 2019 Medicare Quality Measure Performance Presentation

OneCare Vermont Accountable Care Organization, LLC
Board of Managers Meeting
August 18, 2020

Minutes

A meeting of the Board of Managers of OneCare Vermont Accountable Care Organization, LLC ("OneCare") was held remotely via video and phone conference on August 18, 2020.

I. Call to Order and Board Announcements

Board Chair John Brumsted, M.D., called the meeting to order at 4:32 p.m.

II. Consent Agenda Items

The Board reviewed Consent Agenda Items including: draft Public Session Minutes from July 21, 2020; Board Committee Reports for August 2020; the June 2020 Financial Statements; and the CMO Corner for August 2020. An opportunity for discussion was offered.

A Motion to Approve the Consent Agenda Items was made by T. Keating, seconded by B. Davis and approved by a unanimous vote.

III. Welcome Members of the Public

Dr. Brumsted welcomed member of the public in attendance: Sarah Tewksbury from the Green Mountain Care Board.

IV. CEO Update

Vicki Loner, Chief Executive Officer, reported on the discussions with The Center for Medicare & Medicaid Innovation (CMMI) requesting a reduced Medicare risk corridor for the 2021 Performance Year (PY). CMMI has confirmed in writing will offer a ranged risk corridor between 1.5% - 2.5%. The actual rate will be dependent on the final network with the corridor lowering for OneCare keeping or increasing network participation. Ms. Loner also shared that Lucie Garand, who serves as OneCare's Government Affairs liaison in Montpelier, will be working with a new firm, Meehan MacLean and Rice (MMR). A contract is being finalized with MMR for Ms. Garand's continued services. OneCare is in the process of

finalizing its Certification application to submit to the Green Mountain Care Board by the September 1 deadline. This will be followed by the 2021 budget submission that is due October 1. An opportunity for discussion was offered. Lastly, Ms. Loner informed the Board that OneCare is undertaking a Diversity, Equity, and Inclusion analysis across all of its committees to identify opportunities for improvement.

V. Website Enhancements

Amy Bodette, Director of Public Affairs, shared the recent improvements to OneCare's website that are designed to improve user access. Ms. Bodette showcased some of the changes including the "About OneCare" page which includes content from the revised OneCare explainer one-pager. There is a pdf link on the page that allows users to download and print the one-pager. The page has also been updated to reflect our current network numbers for attribution counts and numbers of different provider types. Additionally, the results page was redesigned to make quality and shared savings results accessible and easier to understand. An opportunity for discussion was offered and a suggestion was made to add external links to the GMCB All-Payer Model Total Cost of Care Reports. OneCare Staff will link the appropriate reports and external sites.

VI. Public Comment

There were no comments from the public.

VII. Executive Session

A Motion to move to Executive Session was made by B. Davis, seconded by D. Bennett and was approved by a unanimous, supermajority vote.

VIII. Votes

1. Executive Session Consent Agenda Items – **Approved**
2. Resolution Adopting Comprehensive Payment Reform PY 2021 Policy – **Approved by a Supermajority**

IX. Adjourn

Upon a Motion made and seconded, the meeting adjourned at 6:25 p.m.

Attendance:

OneCare Board Members

☒ Dan Bennett	☒ Joe Haddock, MD	☐ Sierra Lowell
☒ John Brumsted, MD	☒ Tomasz Jankowski	☒ Pamela Parsons
☒ Michael Costa	☐ Coleen Kohaut	☒ Joseph Perras, MD
☒ Betsy Davis	☒ Sally Kraft, MD	☐ Judy Peterson
☒ Tom Dee	☒ Todd Keating	☒ Toby Sadkin, MD
☒ Claudio Fort	☐ Steve LeBlanc	☒ John Sayles

☒ Steve Gordon ☒ Steve Leffler, MD

OneCare Risk Strategy Committee

☒ Jeffrey Haddock, MD ☒ Brian Nall ☐ Joe Woodin
☒ Shawn Tester

OneCare Leadership and Staff

☒ Vicki Loner ☒ Norm Ward, MD ☒ Linda Cohen, Esq.
☒ Sara Barry ☐ Susan Shane, MD ☒ Tyler Gauthier
☒ Greg Daniels ☒ Amy Bodette ☒ Spenser Weppler
☒ Tom Borys ☐ Martita Giard ☐ Ginger Irish
☒ Lucie Garand

OneCare Board of Managers Committee Reports September 2020

Executive Committee (meets monthly)
At its September 9 meeting, the committee discussed OneCare testimony to the legislature and Green Mountain Care Board regarding independent primary care and population health management payments. The committee discussed the amended Executive Committee Charter, the amended Risk Strategy Committee Charter, and the amended Governance Bylaws. The proposed 2021 budget was discussed and the committee received an update regarding OneCare's Corporate Goals. The committee is next scheduled to meet October 1, 2020.

Audit Committee (meets quarterly)
The committee is next scheduled to meet November 4, 2020.

Finance Committee (meets monthly)
At its September 9 meeting, the Finance Committee had a joint meeting with the Risk Strategy Committee and began the discussion of risk pooling. OneCare provided the 2021 budget presentation with time for question and answers. The committee is next scheduled to meet October 14, 2020.

Population Health Strategy Committee (meets monthly)
At its September 8 meeting, Sally Kraft, MD led a discussion on health equity considerations for OneCare. She reviewed pertinent definitions of social determinants of health, population health, health disparities, and health equity and presented geo-mapping data from Dartmouth's Manchester primary care clinic. These data illustrated zip code-related clinical variation in the care of diabetes. OneCare reviewed the capabilities of the OneCare claims data in application to demonstrating clinical variation. The three poorest zip codes in Vermont had measurably lower rates of mammography. The Algorex social determinant risk score demonstrated a 10% variation in mammography rates from lowest to highest quartiles. The committee will consider whether to make health equity topics a standing agenda item. In addition the committee reviewed the drafted Prevention and Health Promotion Subcommittee Charter presented by RiseVT and was approved by the committee. OneCare also provided an update to the care coordination quality control audit process. The committee is next scheduled to meet October 5, 2020.

Patient & Family Advisory Committee (meets monthly)
At its September 10 meeting, the agenda included "OneCare in the News," a discussion prompted by questions from one of the new members about the recent press coverage regarding HealthFirst and changes to PCP payments. OneCare provided information on the old fee for service model, rationale for change and OneCare's investments in primary care. Dr. Toby Sadkin shared her perspective as an independent primary care provider and a board member. The committee found it helpful to learn that the PCP payments were in addition to the normal fee schedule and that the independent practices were not sharing risk like the hospitals were. The committee members recommended this be better communicated to the public. In follow-up to last month's telehealth discussion, Dr. Sadkin shared her perspective and the committee members agreed to participate in a survey about their telehealth experiences. One of the committee members provided a community report out on Brattleboro, focusing

on Emergency Department use and the long waits often incurred. He learned efforts to reduce ED use included adding care coordinators in the ED and an additional provider in the PCP office to see same day acute visits. He also recommended keeping those waiting for services in the ED better informed about their care and cause of delays. Other members shared ED experiences as well. The committee is next scheduled to meet October 13, 2020.

Clinical & Quality Advisory Committee (meets bi-monthly)
The committee is next scheduled to meet October 8, 2020.

Pediatric Subcommittee (meets bi-monthly)
The committee is next scheduled to meet September 17, 2020.

Lab Subcommittee
The committee is next scheduled to meet October 12, 2020.

OneCare Vermont
Statement of Financial Position

For the Periods Ended	**7/31/2020**	**6/30/2020**	**Variance**
ASSETS			
Current assets:			
Unrestricted Cash	5,803,333	6,540,967	(737,634)
GMCB Reserve Funding	4,000,000	4,000,000	-
CMS Reserve-US Bank	5,990,527	5,990,498	29
VBIF-2018	111,041	549,244	(438,203)
VBIF-2019	7,024,651	7,024,651	-
VBIF-2020	3,290,323	2,820,276	470,046
Advance Funding-Medicaid	13,788,170	13,802,211	(14,042)
Undistributed Grant Funding	5,430	25,894	(20,464)
Undistributed Medicare - 2019	6,442,801	6,442,801	0
Cash - Total	46,456,276	47,196,544	(740,268)
Network Receivable	10,296,883	8,741,427	1,555,456
Network Receivable-Settlement	8,934,595	8,888,385	46,210
Other Receivable	5,569,805	4,935,411	634,394
Other Receivable-Settlement	2,296,222	2,296,222	-
Prepaid Expense	1,567,274	132,790	1,434,484
Property and equipment (net)	45,952	47,059	(1,107)
TOTAL ASSETS	**75,167,008**	**72,237,837**	**2,929,171**
LIABILITIES AND NET ASSETS			
Current liabilities:			
Accrued Expenses	16,255,921	16,001,592	254,329
Accrued Expenses -Settlement	8,084,548	8,084,548	-
Network Payable	11,219,947	10,809,633	410,314
Network Payable-settlement	3,607,734	3,561,523	46,210
Notes Payable	4,124,849	4,124,849	-
CTO Liability	554,726	561,462	(6,736)
Payroll accrual	50,118	4,078	46,040
Deferred Income	20,454,821	18,974,423	1,480,398
Deferred Grant Income	5,430	25,894	(20,464)
Due to Related Parties - UVMMC	3,072,903	3,263,119	(190,216)
Due to Related Parties - DHH	0	0	-
Total Liabilities	**67,430,997**	**65,411,122**	**2,019,875**
Net assets:			
Unrestricted - UVMMC	3,103,987	3,103,987	-
Unrestricted - DHH	3,103,987	3,103,987	-
Current Year Profit to Date	1,528,037	618,741	909,295
Total net assets	**7,736,011**	**6,826,716**	**909,295**
TOTAL LIABILITIES AND NET ASSETS	**75,167,008**	**72,237,837**	**2,929,171**

OneCare Vermont

Surplus & Loss Statement: YTD July 2020

	July Actual	July Budget	Month Variance	YTD Actual	YTD Budget	YTD Variance
Hospital FPP - Medicare	18,822,309	18,322,411	499,898	130,260,458	128,256,876	2,003,582
Hospital FPP - Medicaid	13,581,145	13,866,316	(285,171)	95,973,497	97,064,215	(1,090,718)
Hospital FPP - BCBS	475,632	374,260	101,372	1,950,291	2,619,823	(669,532)
CPR FPP- Medicare	180,854	177,237	3,617	1,251,512	1,240,660	10,851
CPR FPP - Medicaid	221,066	208,079	12,987	1,553,839	1,456,552	97,287
Program Support - Medicaid CCC/DULCE	374,017	358,333	15,683	2,635,400	2,508,333	127,067
Fixed Prospective Payments Funding	33,655,024	33,306,637	348,387	233,624,996	233,146,459	478,538
Program Support - Medicaid Trad $3.25	259,015	250,034	8,981	1,822,704	1,750,239	72,465
Program Support - Medicaid Expanded $1.75	35,000	34,615	385	246,937	242,308	4,629
Program Support - Blue Cross QHP $3.25	60,671	60,066	605	420,986	420,465	520
Program Support - Blue Cross Primary $3.25	-	263,482	(263,482)	-	1,844,372	(1,844,372)
Program Support - MVP 3.25	(291,671)	30,002	(321,673)	-	210,014	(210,014)
Program Support - MVP CCC	(34,495)	3,906	(38,401)	-	27,342	(27,342)
Program Support - Addtl DSR Funding	-	325,000	(325,000)	1,399,689	2,275,000	(875,311)
Payer Contract Provider Support	28,520	967,106	(938,586)	3,890,316	6,769,741	(2,879,425)
Operations Funding - Medicaid Trad $3.25	259,015	250,034	8,981	1,822,704	1,750,239	72,465
Operations Funding - Medicaid Exp $5.00	65,000	64,286	714	458,598	450,001	8,597
Program Support - Medicaid HIT	1,400,002	233,333	1,166,669	2,800,000	1,633,333	1,166,667
Payer Contract Operations Support	1,724,017	547,653	1,176,364	5,081,302	3,833,573	1,247,729
Payor Contracts Funding	1,752,537	1,514,759	237,778	8,971,618	10,603,314	(1,631,696)
Medicare Shared Savings/Blueprint	700,138	700,138	(0)	4,900,966	4,900,968	(2)
Robert Wood Johnson Grant	20,464	6,250	14,214	40,328	43,750	(3,422)
VBIF Reinvestment	-	2,750	(2,750)	-	19,250	(19,250)
Miscellaneous Revenue	(12,159)	20,063	(32,221)	72,360	140,439	(68,079)
Other Funding	708,444	729,201	(20,757)	5,013,655	5,104,408	(90,753)
Participation Fees	1,518,814	1,642,174	(123,360)	10,822,064	11,495,221	(673,157)
Total Funding	**37,634,819**	**37,192,771**	**442,047**	**258,432,333**	**260,349,400**	**(1,917,067)**
Hospital FPP - Medicare	18,822,309	18,322,411	(499,898)	130,260,458	128,256,876	(2,003,582)
Hospital FPP - Medicaid	13,581,145	13,866,316	285,171	95,973,497	97,064,215	1,090,718
Hospital FPP - BCBS	475,632	374,260	(101,372)	1,950,291	2,619,823	669,532
Hospital FPP	32,879,086	32,562,988	(316,099)	228,184,246	227,940,913	(243,333)
CPR FPP- Medicare	184,471	177,237	(7,234)	1,255,129	1,240,660	(14,468)
CPR FPP - Medicaid	221,066	208,079	(12,987)	1,553,839	1,456,552	(97,287)
CPR FPP	405,538	385,316	(20,222)	2,808,968	2,697,212	(111,756)
Populations Health Mgmt Payment	428,447	701,722	273,275	2,963,205	4,912,053	1,948,848
Complex Care Coordination Program	410,045	739,359	329,314	4,871,939	5,175,512	303,573
PCP Engagement Incentive Pmt - Medicaid Expanded	34,615	34,615	0	234,109	242,308	8,199
PCP Engagement Incentive Pmt - BCBSVT Primary	-	18,421	18,421	-	128,946	128,946
Value-Based Incentive Fund	470,046	470,046	(0)	3,290,323	3,290,322	(0)
Primary Prevention Programs	19,313	45,000	25,687	198,957	315,000	116,043
CPR Program Expense - OCV Funded	157,438	98,183	(59,256)	755,439	687,281	(68,158)
DULCE	63,162	25,000	(38,162)	110,337	175,000	64,663
Longitudinal Care	-	41,667	41,667	-	291,667	291,667
Network Reform Projects	(35,994)	123,360	159,355	344,097	863,521	519,424
PCHP Program Initiative	-	1,167	1,167	-	8,167	8,167
VBIF Quality Initiatives	-	2,750	2,750	-	19,250	19,250
PCMH Legacy Payments - Blueprint	166,091	166,091	-	1,162,637	1,162,637	-
CHT Block Payment - Blueprint	203,360	203,360	(0)	1,423,521	1,423,521	(0)
SASH- Blueprint	330,687	330,687	(0)	2,314,810	2,314,810	(0)
Howard/SASH	-	-	-	18,333	-	(18,333)
VBIF Reinvestment	-	-	-	-	-	-
PHM Expense	2,247,211	3,001,428	754,217	17,687,708	21,009,995	3,322,287
Salaries and Fringe	643,570	703,583	60,013	4,838,870	4,925,083	86,213
Purchased Services	398,305	114,522	(283,783)	987,142	801,653	(185,488)
Contract & Maintenance	277,082	12,938	(264,145)	46,653	90,563	43,909
Lease & Rental	19,921	31,918	11,997	226,266	223,425	(2,841)
Utilities	2,821	3,310	490	21,226	23,172	1,946
Other Expenses	(148,010)	376,769	524,779	2,103,218	2,637,384	534,166
Operating Expenses	1,193,689	1,243,040	49,351	8,223,375	8,701,280	477,905
Total Expenses	**36,725,523**	**37,192,771**	**467,248**	**256,904,296**	**260,349,400**	**3,445,104**
Net Income (Loss)	**909,295**	**-**	**909,296**	**1,528,037**	**-**	**1,528,037**

OneCare Vermont Board of Managers

CMO Corner – September 2020

1. **Health Service Area (HSA) Consultation Meetings**
   The OneCare Vermont Analytics and Financial data teams have created two new tools for network analysis. The performance dashboard companion application allows rapid comparisons on a number of utilization and cost categories between Health Service Areas (HSAs), Tax Identification Numbers (TINs), practices, and providers. The financial snapshot by payer program provides an up-to-date summary of a community's financial performance against its target. The new applications will be shared with all HSAs in the coming weeks as part of new Health Service Area quarterly consultation meetings.

2. **OneCare Vermont Primary Care Workgroup**
   The first two meetings of the workgroup were held on August 25 and September 8. A broad representation of primary care clinicians from around the state and members of the Board of Managers and of the Population Health Strategy Committee participated in excellent discussion of opportunities for improvement or modification of OneCare programs that impact primary care. The first meeting reviewed and explained in some detail OneCare's programs that impact primary care. The second meeting reviewed this information and asked the committee to select their "short list" of potential changes. The third meeting will be held September 23 and will attempt to finalize recommendations. Report of findings to the Population Health Strategy Committee on October 5 and to the Board of Managers at its October meeting is planned.

3. **Dementia Hub and Spoke Model**
   The latest meeting of the Vermont Department of Health, OneCare Vermont, UVM Department of Geriatrics, Bi-State Primary Care, Alzheimer's Association, VAHHS, and Vermont Health Care Association September 9 continued progress on addressing the needs of Vermont in terms of establishing a diagnosis of dementia close to home and being connected to community support services for patients and families. The use of Vermont Health Learn as a tool to facilitate clinician and community education on this topic was explored.

OneCare Vermont

Public Affairs Report | September 2020

Media Coverage

Thomas Chittenden Health Center Helps Vulnerable Populations

The Commonwealth Fund published a case study of independent primary care practices that are providing much-needed care in their communities, including Thomas Chittenden Health Center in Williston, VT. Dr. Joe Haddock said that population health management payments from OneCare Vermont provided stability during the pandemic and have enabled the practice to hire additional staff and offer more services. “The additional funds from capitated payments — representing a 10 percent increase in revenue — as well as the more predictable revenue stream have enabled Chittenden to give primary care clinicians their first raise in a decade. Enhanced, stable funding also has allowed the practice to hire more staff and offer additional services, including nutritional counseling and psychiatry to all patients, regardless of whether their insurance covers those services.”

Our Hospitals' Commitment to Cost Control, Quality and Access

Jeff Tieman, the president and CEO of VAHHS, recently penned a thoughtful piece about the fast approaching annual budgets and rate requests from our non-profit systems of hospitals, how COVID-19 affected this process this year, and the measures hospitals have taken to reduce costs where possible without sacrificing quality and

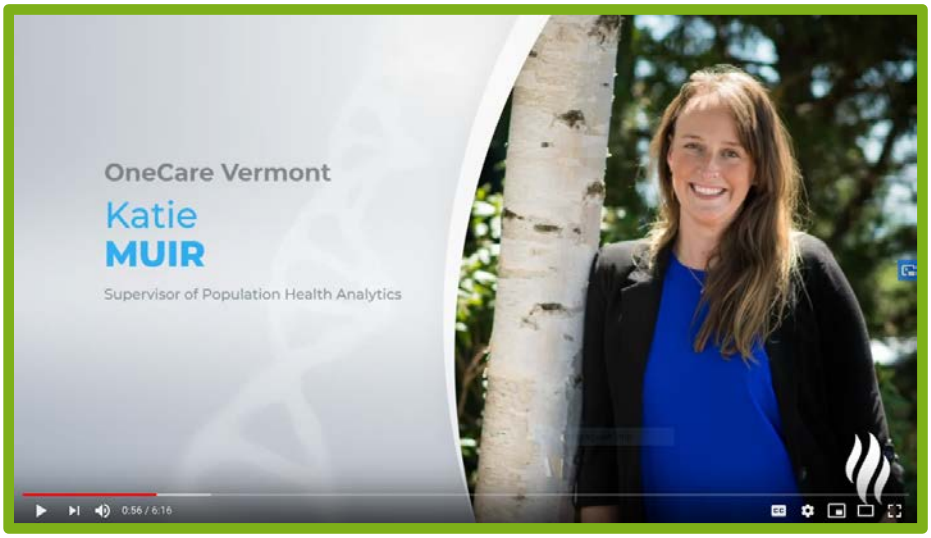
access. Tieman says, "hospital leaders remain committed to the promise of health care reform and the move away from fee-for-service health care. They are doing this not because they have to or because it's an easier approach. In fact, it is immensely complex and hospitals assume far greater financial risk. We invest in changing how we deliver health care because it is our only hope to slow the growth in costs—and because it is the right thing to do for our patients and our state."

Private Doctors Plan to Leave OneCare

The **Burlington Free Press** ran a follow-up to their August 7 story about independent providers choosing not to participate in OneCare for 2021 due to changes in the Population Health Management payment. The article quoted a letter from the Board of Managers signed by Board Chair John Brumsted as well as CEO Vicki Loner. "Every single participant in health care reform is asked to take on greater accountability, but we know this is the right thing to do to promote the health of our patients and our communities," Brumsted said. "I value the independent providers who signed this letter because they are so important to this health reform effort, and I sincerely hope they will reconsider their participation in OneCare."

VTDigger also reported changes to OneCare's population health management payments and a letter written in response by 14 independent practices. OneCare CEO Vicki Loner was quoted in the article saying that in the new payment model, doctors have the opportunity to share in savings if OneCare saves money, and that the program will mitigate risk for doctors during the public health emergency.

Health Catalyst Features OneCare Analytics



Health Catalyst released a video featuring innovators who are leading responses to support providers during the pandemic. A few weeks after Governor Phil Scott declared a state of emergency for Vermont in response to the pandemic, OneCare developed and released a COVID-19 care coordination tool, applying the risk criteria to approximately 190K patients. OneCare's COVID-19 application was rapidly created and deployed to benefit Vermonters. Katie Muir, OneCare supervisor of population health analytics and details about the COVID-19 application appear in the video beginning at 50 seconds. OneCare's Director of Value-based Care Tyler Gauthier and Muir created a presentation about the application which was shown to attendees at the 2020 Healthcare Analytics Summit, hosted by Health Catalyst. Gauthier and Muir also participated in a live Q&A during the conference.

Committing to the All-Payer Model

Emerson Lynn penned an op-ed in the **Saint Albans Messenger** arguing that the Green Mountain Care Board must approve hospital budget requests for 2021 in order to move OneCare and the all-payer model forward. "OneCare's survival depends on his leadership and how his board defends the ability of our hospitals, and our health care providers, to stay the course. Distilled to a simple declarative sentence: Mr. Mullin and his board cannot cut the budget requests of hospitals and support OneCare and the all-payer model at the same time. One works against the other," said Lynn.

Government Relations

Legislative Update

Vicki Loner testified on September 8 at the Senate Health and Welfare Committee with guests in attendance from the Senate Appropriations committee. Vicki was asked to provide an overview of the changes to the Population Health Management payment policy for 2021 and its impact to Independent Primary Care. The committee expressed concern that given the current environment and the overall goal of the healthcare reform that a reduction in per member per month payments was not ideal. Vicki reiterated that under the new payment model, doctors have the opportunity to earn more money and share in savings if OneCare saves money, while continuing the shift to value based care with more accountability. Her presentation to the committee can be found here.

Green Mountain Care Board

OneCare submitted materials for its annual certification renewal to the Green Mountain Care Board on September 1, 2020. OneCare is currently preparing its 2021 annual budget for submission to the GMCB on October 1, 2020 and will give the budget presentation at the end of the October.

On September 9, Vicki Loner and Susan Ridzon, Executive Director of HealthFirst, presented at the Green Mountain Care Board meeting regarding OneCare's Population Health Management payments policy for 2021 and its impact on independent primary care physicians. The Board wanted to gain a better understanding of the program and the stakeholder process around the development of the policy. The Board noted that the premise of the All-Payer Model is to change the delivery system and improve quality and that primary care is foundational to that work. The GMCB urged OneCare and HealthFirst to continue discussions. Loner's one page summary outlining the primary care management payment options available to primary care physicians can be found here.

Outreach and Advocacy

COVID-19 Application Featured in Center for Health Care Strategies Webinar

Center for Health Care Strategies, Inc. offered a webinar August 31 about the innovative population health management approaches that several organizations, including OneCare Vermont, have taken during the COVID-19 pandemic. OneCare's Tyler Gauthier, director of value-based care, discussed OneCare's care coordination tool that allows providers to quickly identify patients at greatest risk for COVID-19.

OneCare 2019 Annual Report

OneCare is sharing our 2019 Annual Report. The report includes an overview of who OneCare is, the work our community of providers do, as well as specific programs and results from 2019. The report opens with a letter from CEO Vicki Loner emphasizing the collaborative, forward-driving nature of health care reform. “Health care reform happens system-wide, and our job is to move forward, year over year. We must all work together across organizational lines to strengthen our new system – one that pays for wellness, not illness; one that improves health for all Vermonters,” says Loner.

OneCare in Simple Terms

To help clarify that OneCare is comprised of a community of providers and the work we do together to improve health care for Vermonters, OneCare developed new messaging for providers and the public to explain our work in simple terms. The messaging was developed at the request of providers in the network and in concert with the Patient and Family Advisory Committee. Please visit our updated About page and download, print, and share this simple, one-page guide.

Study by RAND Corporation and Robert Wood Johnson Foundation

On August 20, Vicki Loner and Amy Bodette participated in an interview with RAND Corporation, a non-profit, non-partisan research organization partnering with the Robert Wood Johnson Foundation (RWJF) to understand the ways in which communities are working toward improving health, equity, and well-being for residents. A report will be released in several months with their findings.

COVID-19 Clinical Education with Dr. Mark Levine

OneCare is excited to present educational opportunities that foster collaboration among interdisciplinary professionals across Vermont. Our September 11 educational session featured a presentation by **Vermont’s Commissioner of Health, Dr. Mark Levine**, entitled **COVID-19 Update & Impact on those with Respiratory Conditions.** This session included materials from Dr. Mark Levine presenting on this important topic with time for questions and answers. The session also served as the kickoff call for the 2020 Asthma & COPD Learning Collaborative.

Upcoming Events

Care Coordination Training Series

Please join us for OneCare’s monthly care coordination-related monthly webinar learning opportunity. The target audience includes those in a position to coordinate care on behalf of OneCare participating organizations. Each presentation will be 30-45 minutes to easily fit into the lunch hour. Have a suggestion for a topic? E-mail carecoordination@onecarevt.org.

Motivational Interviewing: Steps and Care Skills

October 7, 12:00 pm - 1:00 pm
This session will provide a basic overview of the Spirit of MI, Skills, and OARS. More information.

Follow Us

You can keep up with OneCare on our blog, LinkedIn, and Twitter (@OnecareVermont).
We would greatly appreciate it if you like and share our content to help spread awareness.

Questions? Contact OneCare Public Affairs at public@onecarevt.org or 802-847-1346.

CASE STUDY
PRIMARY CARE FOR LOW-INCOME POPULATIONS
SEPTEMBER 2020

How Independent Primary Care Clinicians Leverage Trust to Help Vulnerable Populations

What strategies do independent primary care clinicians use to help low-income and otherwise vulnerable patients who are at risk of developing health problems?

Martha Hostetter
Consulting Writer and Editor
The Commonwealth Fund

Sarah Klein
Consulting Writer and Editor
The Commonwealth Fund

PROGRAM AT A GLANCE

KEY FEATURE: Two independent primary care clinics, one in Vermont and one in New Hampshire, have leveraged their independence to tailor services to patients who struggle to afford care, have chronic physical or behavioral health conditions, and/or need help finding social supports.

TARGET POPULATION: The practices serve a wide swath of patients, including many people covered by Medicaid and others with bare-bones private plans.

WHY IT'S IMPORTANT: Independent primary care clinicians are often absent from debates about how to reform U.S. health care. Independent primary care clinicians, particularly nurse practitioners, often fill care gaps in underserved communities, which have been hard hit by the coronavirus.

BENEFITS: Both clinics have achieved high levels of performance on measures of preventive services and chronic disease management. They have earned some additional revenue through value-based or capitated contracts.

CHALLENGES: The practices struggle to sustain their small businesses while dealing with disparate and evolving payment arrangements. They've also had difficulty finding psychiatrists for their patients. To cope, the Vermont clinic hired a part-time psychiatric nurse practitioner.

TOPLINES

- **Independent primary care clinicians often fill gaps in care in low-income, rural, and other underserved communities.**
- **We look at how two primary care practices tailor services to patients who struggle to afford care, have chronic physical or behavioral health conditions, and/or need help finding social supports.**

The Commonwealth Fund

This case study is the fourth in a series profiling how primary care clinics — federally qualified health centers, independent clinics, and clinics that are part of large health systems — are meeting the needs of low-income patients who often lack the resources to stay healthy. The series profiles clinics that exhibit some or all of the following attributes:

- Medical home capabilities as a foundation
- Multidisciplinary teams with community health workers
- Integration of primary health care with public health, social services, and behavioral health
- Using data to manage and improve patient care and clinic performance
- Geographic empanelment, looking at health needs across a region and using risk stratification to target interventions
- Proactive patient and family engagement to address physical, social, and cultural barriers to care
- Leveraging of digital tools to improve health.

This case study profiles two clinics: Thomas Chittenden Health Center in Vermont has a multidisciplinary care team that works to address patients' physical health, behavioral health, and social needs. Nurse practitioners at Wright & Associates Family Healthcare in New Hampshire seek to develop trusting relationships with patients while providing low-cost, comprehensive primary care.

INTRODUCTION

In 1927, the Harvard Medical School professor Francis Peabody, M.D., reminded the graduating class to make time to listen to patients' stories and offer the bedridden sips of water or adjust their sheets. These small gestures, he explained, help earn patients' trust, and trusting relationships are key to healing. His advice — "the secret of the care of the patient is in caring for the patient" — is part of the medical school's curricula today.[1]

Many of the medical students who choose to go into primary care today do so because they want to develop these sorts of personal relationships with patients. But pressure to meet productivity targets and administrative burdens often prevent them from doing so. Half of primary care clinicians say they are burned out, compared with a third of physicians in fields such as orthopedics, psychiatry, or general surgery, and fewer medical students choose to go into the field each year.[2]

This case study offers examples of primary care clinicians who have remained independent out of a desire to deliver care the way they want to, including spending ample time with their patients. The practices are not owned or managed by health systems, nor are they part of safety-net clinics. Many independent primary care clinicians opt to open practices in poor communities, where they find gaps in the market and feel a sense of mission to serve.

We're focusing on independent primary care clinicians, including physicians, nurse practitioners, and their care teams, because they are often absent from debates about how to reform U.S. health care. We're also focusing on primary care because there is widespread agreement that improving population health and reducing health care spending requires that we get much better at helping people stay well and identifying and treating problems as early as possible.

This case study explores how two independent primary care practices, one in New Hampshire and one in Vermont, are leveraging their independence to tailor services to patients who struggle to afford care, have chronic physical or behavioral health conditions, and/or need help finding social supports. We also explore

the struggles these practices face in sustaining their small businesses while attempting to benefit from new value-based payment models.

The two practices offer different illustrations of independent primary care. The one in Vermont is quite large and has benefitted from state policies supporting multidisciplinary team care. By contrast, the practice in New Hampshire has less state support; it has kept costs low by fielding teams of nurse practitioners and medical assistants, who work together to meet patients' needs.

Research comparing individual states and the United States as a whole to other countries has linked stronger primary care to better health outcomes, fewer health disparities by income or race, and lower costs. For example:

A 2019 study found that having 10 additional primary care physicians in an area was associated with a 51.5-day increase in life expectancy.

Poor people are more likely to live in rural and urban communities with shortages of primary care clinicians.

With fewer physicians going into primary care, nurse practitioners and physician assistants have filled some of the gaps.

Primary care nurse practitioners are significantly more likely than primary care physicians to serve a high proportion of uninsured patients and other vulnerable populations. They're also more likely to practice in rural communities.

Physician assistants are also more likely to practice in rural areas and serve uninsured patients.

In many communities, independent primary care clinicians help ensure access to care. Yet the number of independent practices has declined in recent years.

For the first time in the U.S., the percentage of physicians employed by a health system or other entity has grown larger than the percentage working for themselves: In 2018, 47.4% of practicing physicians were employed, compared with 45.9% who own their own practice.

NEW HAMPSHIRE AND VERMONT: A LOOK AT NEIGHBORING STATES

Nearly all adult residents have health insurance (92% in New Hampshire, 94% in Vermont) and a usual source of care (87% in both states).

Residents in both states face high costs of living, particularly related to housing.

In 2017, New Hampshire was among a handful of states with the nation's highest death rates from drug overdoses. Suicide deaths also have increased in recent years.

In both New Hampshire and Vermont, the proportion of low-income residents who say they are in fair or poor health has increased in recent years. So has the number of low-income people who are obese or have lost six or more teeth.

Sources: Commonwealth Fund Health System Data Center; Missouri Economic Research and Information Center, Cost of Living Data Series.

THOMAS CHITTENDEN HEALTH CENTER

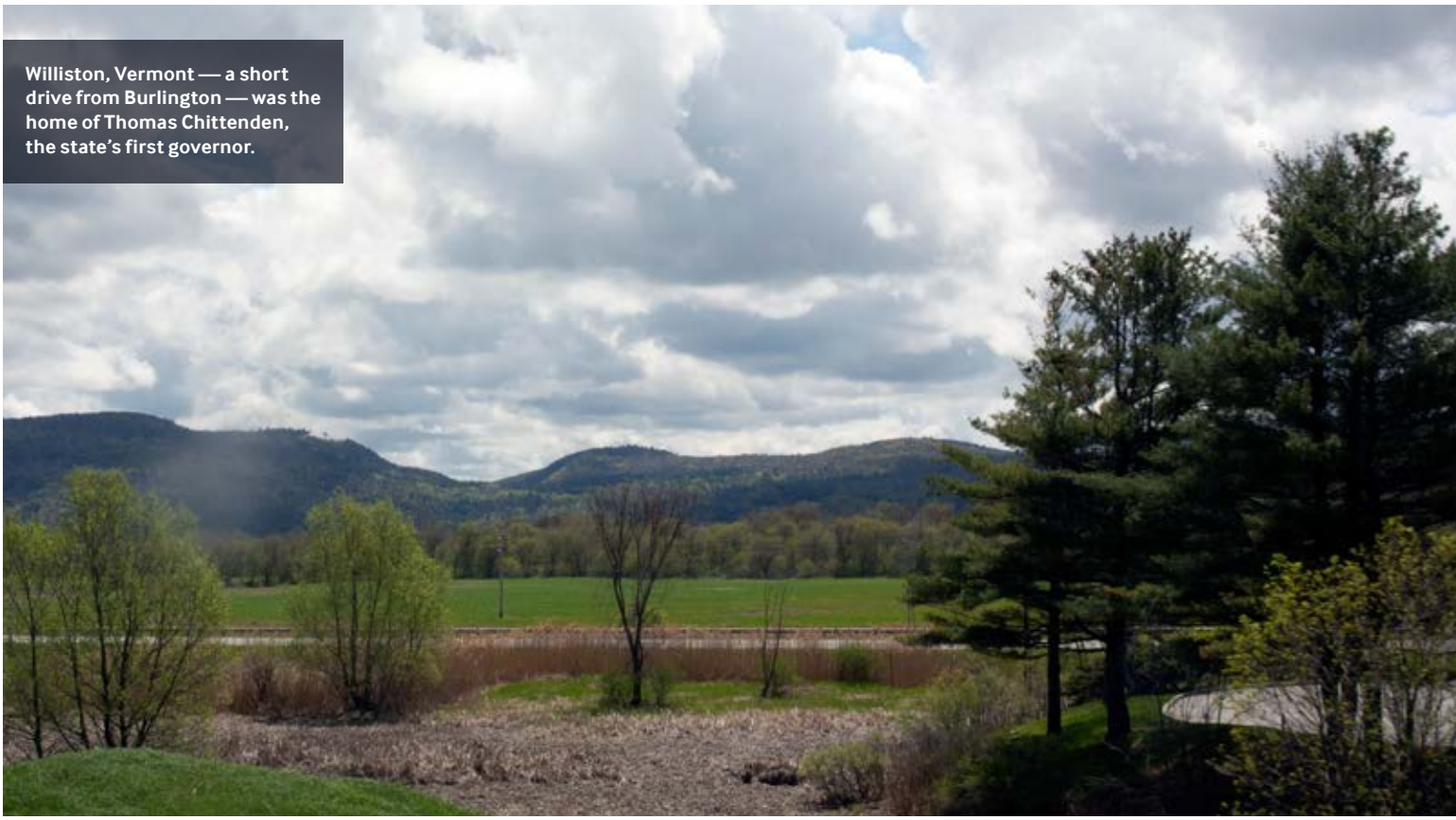
Thomas Chittenden Health Center — the largest, single-site independent primary care practice in Vermont — recently celebrated its 50th anniversary. With five physicians, three nurse practitioners, and four physician assistants, it provides 35,000 visits a year to some 18,000 people. About half are covered by Medicare, Medicaid, or both and most of the rest are covered by private insurance. The clinic offers visits seven days a week and clinicians take calls to answer questions after hours. During the first few months of the coronavirus pandemic, two of the practice's clinicians offered in-person visits and the rest offered virtual visits.

Located in the small town of Williston, a short drive from Vermont's largest city of Burlington, the practice serves multiple generations of families that include University of Vermont professors, farmers, artists, and people struggling to get by. "We have a fair number of patients who have three generations in one home, who live paycheck to paycheck if they have a paycheck," says Joe Haddock, M.D., medical director.

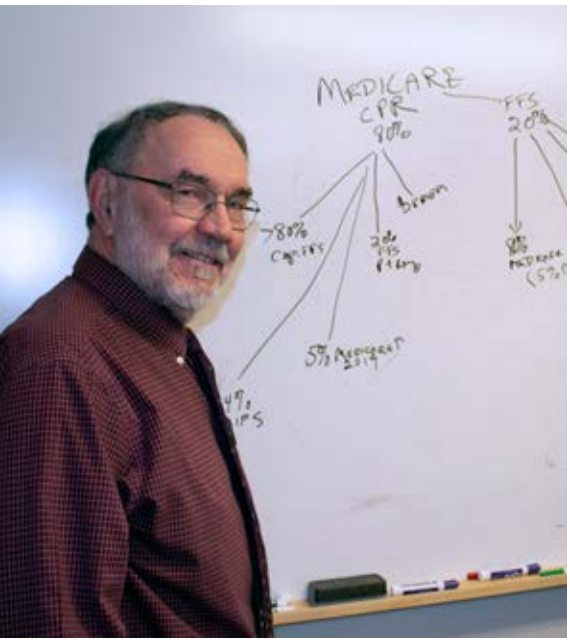
Progressive State Policies and Capitation Payments Support Extra Services

In recent years, supportive state health reforms and capitated contracts have enabled Chittenden to expand its care team and services.

Since 2018, the clinic has received capitated payments to provide care for about 30 percent of patients (including those covered by Medicare, Medicaid, and private marketplace coverage) through an all-payer pilot led by OneCare Vermont, an accountable care organization (ACO) involving nearly all the state's hospitals and most of its medical practices. In 2019, the rate was set at $33.50 per member per month, plus a $3.25 per member per month care management fee. The additional funds from capitated payments — representing a 10 percent increase in revenue — as well as the more predictable revenue stream have enabled Chittenden to give primary care clinicians their first raise in a decade. Enhanced, stable funding also has allowed the practice to hire more staff and offer additional services, including nutritional counseling and psychiatry to all patients, regardless of whether their insurance covers those services.



Williston, Vermont — a short drive from Burlington — was the home of Thomas Chittenden, the state's first governor.



Joe Haddock, M.D., medical director of Thomas Chittenden Health Center, has deep roots in the Williston community. In addition to his medical practice, he runs a sheep farm and plays guitar at his patients' and neighbors' funerals.

Capitated payments have helped sustain the practice during the pandemic, according to Haddock. "This program may be seen in a more favorable light by other practices after all this," he says. Still, with 70 percent of the practice's revenue tied to fee-for-service reimbursement, the practice is facing shortfalls as patient volume fell by about 9 percent during the first five months of 2020 and has not fully recovered. Chittenden has received federal support from the Paycheck Protection Program (PPP), as well as CARES Act funding, to purchase protective equipment and pay for new cleaning and screening procedures. "So far, we have had no layoffs or significant reduction in hours," Haddock says. "But the upcoming months may be more difficult, after using all the PPP funds."

The practice also has benefitted since 2013 from Vermont's Blueprint for Health, a statewide effort to improve health and reduce costs by fielding nurses, counselors, social workers, community health workers, and others to complement the work of primary care clinicians. At Chittenden, these staff members help patients manage their chronic conditions, find treatment for addiction and other behavioral health conditions, and connect with social supports. Their salaries are partially or fully paid for through the Blueprint, which is funded through contributions from public and private payers.

For example, Lisa Anderson, a social worker and care coordinator, offers services to patients who are identified as high risk based on their past hospitalizations and emergency department (ED) visits as well as clinicians' knowledge of their medical and social circumstances. "Our care coordinator helps people stay out of the hospital by doing things like

FUNDING SOURCES FOR THOMAS CHITTENDEN HEALTH CENTER'S CARE TEAM MEMBERS

Salary subsidized with funds earned through capitation pilot:

- Social worker and care coordinator
- Nutritionist/diabetes educator (part time)
- Psychiatric nurse practitioner

Salary paid through Blueprint for Health:

- Medical social worker
- Nurse care coordinator

Salary paid through capitation pilot and Blueprint for Health:

- Patient panel and referral managers

Thomas Chittenden Health Center has a cozy, welcoming atmosphere, with hardwood furnishings, rocking chairs, and photos of children adorning the walls. "A lot of patients see it as a cocoon," says Haddock.

finding their medicine or helping them find a place to stay so they don't have to sleep in a car," says Haddock.

In 2018, the clinic hired Nina Gaby, a psychiatric nurse practitioner, to meet demand for behavioral health services; previously, clinicians struggled to find psychiatrists for patients. Having someone in house also helps convince those who may be reluctant to pursue psychiatric care. "They feel like they already know me because Joe Haddock has walked them over and introduced me," Gaby says. "That really improves compliance." She has been surprised by the acuity and range of patients' behavioral health needs. Gaby also has worked with several "independent Vermont men who have never ever talked about any of the things that have gone on in their lives."

Having Anderson, Gaby, and other team members enables Chittenden to surround vulnerable patients with supportive services. When an 18-year-old patient became pregnant, Haddock knew she and her baby were at risk. She was overweight and had had a troubled childhood. Haddock tapped several colleagues: Mary Anne Kyburz-Ladue, the nutritionist and diabetes educator, offered advice to the young woman when she developed gestational diabetes; Anderson helped her apply for supplemental nutritional benefits and called to check on her every week; Liz Moss, a medical social worker, offered counseling and, eventually, referred her to Gaby, who diagnosed and began treating her for depression.

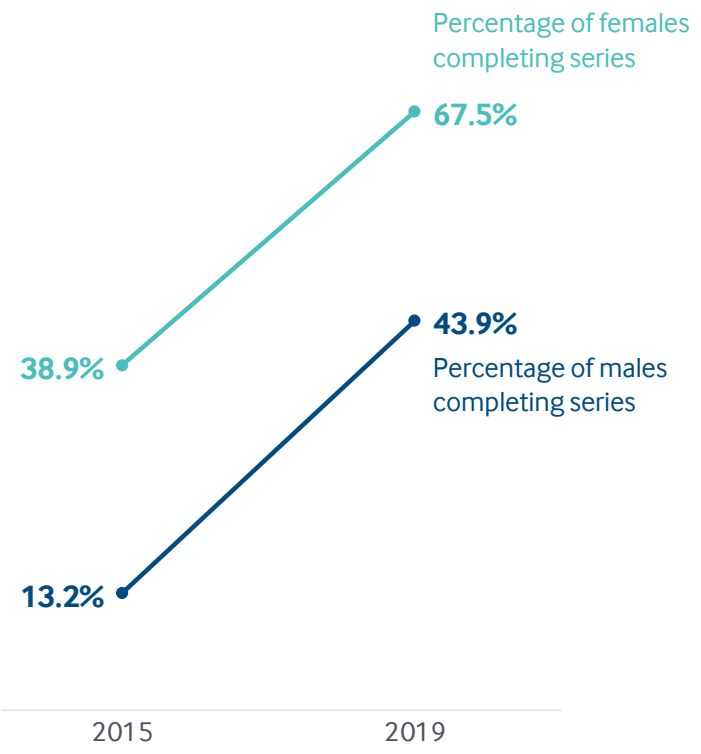
By the time Haddock and Gaby met the baby — who weighed less than five pounds at birth — the new mother had gained a sense of confidence in her role. "She's looking at the baby, this little tiny thing, and she said, 'I never thought I would ever be able to produce something so beautiful,'" Gaby says. "So the bonding has happened. I think in order to bond, people need to feel they are safe."

Panel Management and Performance Improvement

Thomas Chittenden Health Center has leveraged its electronic health record (EHR) system to flag patients with chronic conditions whose disease is out of control, identify those who need preventive care, and generate automated calls or messages to patients. From 2016 to 2019, the number of hypertensive patients with their blood pressure under control rose from 54 percent to 59 percent and the number of patients with diabetes under control went from 85 percent to 89 percent.

Rick Dooley, a physician assistant, used the system to increase the number of adolescent patients who receive the human papillomavirus (HPV) vaccine. Notices are automatically sent to families with teen children who were overdue for annual wellness visits and nurses receive electronic reminders to ask about HPV vaccination status at each adolescent well visit. Dooley also published monthly reports on each prescriber's HPV vaccination rates and quarterly reports comparing the clinic's HPV rate to the state average.

Improvement in HPV Vaccination Rates by Age 18, 2015–2019



Data: Thomas Chittenden Health Center.

Dooley also has leveraged the EHR system to track and reduce potentially unnecessary opioid prescribing. He's convened clinicians each month to review their prescribing patterns and invited University of Vermont pain management specialists to offer advice on best practices. From 2018 to 2019, this resulted in a 22 percent reduction in opiate morphine milligram equivalent prescribing.

WRIGHT & ASSOCIATES FAMILY HEALTHCARE

In neighboring New Hampshire, Wright & Associates Family Healthcare was founded by two sisters: Wendy Wright, a nurse practitioner, and Becky Manter, the practice manager. The sisters opened their first clinic in Amherst, N.H., in 2007 and the second in 2011 in Concord, the state capital, where they recognized a need in the market. "There was just one primary care provider in Concord taking new patients," says Wright. "You would put your name on a list and, as patients left, they would enroll a new patient."

Wright & Associates' Concord practice is part of an increasing number of nurse practitioner–led clinics that are filling gaps in access to primary care. Twenty-two states and the District of Columbia allow nurse practitioners to care for their own patient panels and work independently of physicians. While the supply of primary care physicians increased only nominally from 2010 to 2016, the number of primary care nurse practitioners doubled. Compared with physicians, nurse practitioners are more likely to practice in rural and low-income areas and to serve Medicaid beneficiaries.[3] A recent study found that, compared with patients treated by physicians, patients treated by nurse practitioners incurred fewer hospitalizations, including for conditions that may be treatable in ambulatory care settings.[4]

Word of the Concord clinic spread, attracting patients from up to an hour away. Today three nurse practitioners serve about 2,500 patients; the small panel size enables nurse practitioners to hold much longer appointments than are typical in primary care. Some patients are homeless or struggle with substance abuse. (The clinic is located next to a soup kitchen and homeless shelter.) Others are recent immigrants who work in the region's manufacturing plants or young people drawn to the area's relatively low cost of living. About a third of patients are covered by Medicare, Medicaid, or Tricare (for active and retired members of the military), and most of the remainder by private insurance. Wright and Manter consider many of their privately covered patients to be underinsured because they face very high copayments and deductibles.

Wright & Associates Family Healthcare's Concord office is sandwiched between a soup kitchen, homeless shelter, and the public defenders' office. It's down the street from the state capitol building.

During the pandemic, the Concord practice has remained a lifeline to residents as other local primary care practices closed their doors. It has remained open for in-person visits, including curbside COVID-19 testing, as well as virtual visits seven days a week. With patient volumes plummeting 60 percent in the spring, leaders had to furlough three nurse practitioners and four medical assistants across the two sites. By summer, they were able to rehire all but one staff member as volumes rebounded. The practice has been sustained by a $300,000 forgivable loan from the Paycheck Protection Program as well as $7,000 from the CARES Act to purchase protective equipment.

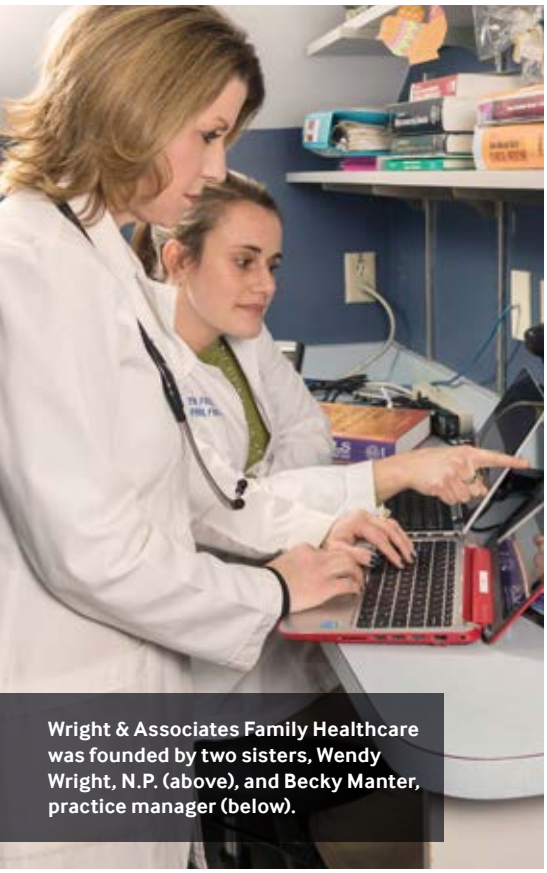
Lean Staffing, Long Visits

To limit operating costs, the Concord clinic is minimally staffed and shares office space with unaffiliated providers, including a lab testing service. Each of the three nurse practitioners partners with a medical assistant, who queues up tasks before office visits, follows up on tests and referrals, and works with other medical assistants to handle billing and scheduling and field patients' calls.

Only 10 to 12 appointments are scheduled for each nurse practitioner a day, giving them a full hour to devote to new patients, 45 minutes for well-child visits or visits following surgeries or hospitalizations, and 30 minutes for other follow-up appointments. By contrast, the average primary care visit lasts 20 minutes.[5] Wright says the longer visits enable nurse practitioners to offer comprehensive preventive and problem-based treatment; this approach is not only consistent with nurse practitioners' training in holistic health but also serves patients' interests, since most have more than one condition or concern. The additional time also enables clinicians to build rapport with patients. "We hear from patients, 'I've never spent so much time with a clinician before. You actually listen to me,'" says Manter. "And that's the biggest thing."

Integrating Behavioral Health Services After Struggling to Find Psychiatrists

In 2017, Concord began screening all patients for depression and substance abuse and uncovered a startlingly high degree of need. About 40 percent of patients are diagnosed with some type of behavioral health problem, mostly commonly depression, anxiety, and/or substance use disorder, often related to past instances of sexual abuse or other trauma. Nurse practitioners are typically able to refer patients to counselors, but they struggle to find psychiatric providers for patients requiring medication management. In recent months, staff have seen even more patients struggling with anxiety and depression. "Visits were long and hard before the pandemic; they're longer and harder now," says Wright, noting that patients have been returning to the office "mentally and physically exhausted."



Wright & Associates Family Healthcare was founded by two sisters, Wendy Wright, N.P. (above), and Becky Manter, practice manager (below).

Thanks to a statewide settlement agreement, the clinic now has access to emergency psychiatric services for patients who appear to be suicidal, delusional, or otherwise in crisis. Over the past year, the mobile crisis team came to the clinic five times to perform an immediate evaluation and transfer.

Concord clinicians also have helped people coping with addiction, mainly opioid use disorder, treating some 360 patients since 2011 with antagonist medications that block the effects of opioids. Nurse practitioners do not offer treatment with buprenorphine, an agonist medication commonly used in treating opioid use disorder, because prescribing it requires a waiver process that is too time-consuming and expensive, says Manter. Many patients with opioid use disorder find their way to Concord because the clinic partners with residential drug treatment facilities. Before discharging patients, staff from the facilities bring patients to the clinic for a "warm handoff" to a nurse practitioner. The clinic guarantees they'll see these patients within seven days of their discharge.

About a third of clinic patients with opioid use disorder recover, but many others end up in prison or stop turning up for treatment for other reasons. "It's heartbreaking," Wright says. "In the short time we have them, we try to address some of their primary care needs. Because, unfortunately, when we get them, 50 percent are hepatitis C positive and about 10 percent are HIV positive. So that is the alarming part."

Leveraging Value-Based Payments to Enhance Care

In 2012, Wright & Associates' Amherst and Concord practices joined with New Hampshire's 10 other nurse practitioner–led practices to form the nation's first nurse practitioner ACO under a contract with Anthem Blue Cross Blue Shield.[6] (At the time, Medicare only accepted practices led by physicians into its Shared Savings Program for ACOs.) The 11 practices pooled their patients into one risk pool to test whether they could succeed under value-based payment. Under the contract, each of the practices received per member per month fees — from $3 to $7, depending on patients' acuity, in addition to fee-for-service payments — to coordinate and oversee care for Anthem patients, including those with marketplace coverage and Medicaid managed care beneficiaries. The practices were eligible to share in any savings from better coordinating patients' care if they met benchmark performance levels on measures of preventive care, chronic care management, and cost control.

Overall, the nurse practitioner practices met quality thresholds over three years of the program and their patients cost $66.85 less per member per month than did physician-managed patients in another Anthem risk pool, mainly because of lower hospitalization rates. Unlike most other private insurers, Anthem pays nurse practitioners on par with physicians, so the lower reimbursements did not account for the nurse practitioner practices' lower costs.

The data also showed that New Hampshire's nurse practitioners were caring for very sick patients, including those with multiple chronic conditions (such as cancer, coronary artery disease, diabetes, and kidney disease). "There's a misperception that nurse practitioners are mostly taking care of younger, healthier patients and handling straightforward things," says Wright. "This work showed that's just not true."

For the past two years, the Concord clinic has had a separate ACO contract with Anthem (rather than pooling patients with other nurse practitioners-led clinics). In 2019, the clinic exceeded the average performance rate among primary care practices statewide on several measures of appropriate preventive care and chronic disease management. Clinic patients also had fewer hospitalizations than the statewide average, though they had higher-than-average rates of avoidable ED visits, which leaders attribute to ingrained behaviors related to the region's primary care shortages. "Going to the ED is all the patients have known," says Manter.

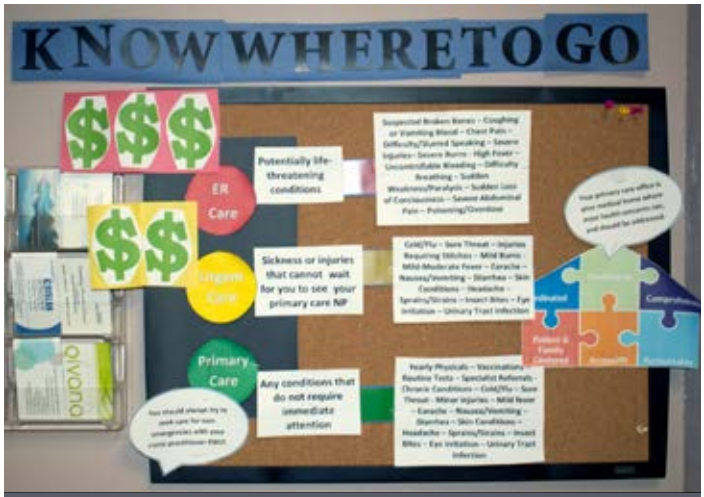
To help change behavior, the clinic launched a campaign to educate patients about the circumstances under which they should seek emergency, urgent, or primary care — emphasizing the concept of a primary care medical home that can address most health concerns. Along with posting educational signs in the office and holding regular conversations with patients, the clinic sends letters to patients who've visited the ED for a condition that could have been managed in primary care. The letters note that ED visits could wind up costing patients more out of pocket than office visits.

Concord has earned modest shared savings from its participation in ACO contracts — about $35,000 in the first year, $20,000 in the second, and $6,000 in the third — which has enabled leaders to hire another medical assistant.

Wright & Associates Family Healthcare, Concord: Quality Performance Compared with State Averages, 2019

Measure	Concord clinic rate	Statewide average among primary care practices
Cervical cancer screening	87%	66%
Breast cancer screening	89%	63%
Chlamydia screening	79%	52%
Percentage of days covered by hypertension medication	88%	81%
Percentage of days covered by cholesterol medication	68%	78%
Diabetes hemoglobin A1c testing	100%	86%

Data: Anthem BlueCross BlueShield Scorecard, as provided by Wright & Associates Family Healthcare.



Concord clinicians partnered with a Doctor of Nursing Practice student to develop a campaign to educate patients about when to seek primary, urgent, or emergency care.

SHARED APPROACHES

Vermont's Thomas Chittenden Health Center is much larger than Wright & Associates' Concord clinic and has more supportive state policies to lean on. Still, leaders at both practices face similar challenges, including engaging patients in care, recruiting clinicians, and financially sustaining their practices. Below, we outline some of the strategies they've developed to address these challenges and develop care models that benefit the low-income patients they serve.

Building trusting, long-term relationships

People have many reasons for not seeking primary care. Some are practical: They can't miss work or find childcare, or they're worried about costs. Others have personal reasons: They don't trust the health care system, they had a bad experience with a doctor, or they don't want to be told they should stop smoking or lose weight. Fears surrounding the coronavirus also have hindered many from seeking routine services, such as vaccinations or cancer screenings, or from reaching out when they feel unwell.

One way the independent primary care clinicians profiled here encourage people to pursue care is by forging personal connections, which they say are key to earning a patient's trust and promoting healing. For instance, when a Wright & Associates' patient repeatedly turned up at the ED after her husband died — apparently looking for company — a medical assistant helped her get a service dog and scheduled an office visit for her every month until she felt less lonely. At Chittenden, both clinicians and care coordinators visit patients in their homes, particularly when they haven't turned up for appointments, and seek to build trust in the practice — something Haddock refers to as "institutional bonding."

Still, it is often hard for these clinicians to engage patients. The Wright & Associates' Concord practice is open from 7:00 a.m. until 5:30 p.m. on weekdays and Saturdays. But every day, a handful of patients fails to turn up for scheduled appointments, although a new texting system has begun to reduce that number. Staff at Chittenden say it can be hard to convince stoic Vermonters to accept help, particularly for social services like Meals on Wheels when they can no longer cook for themselves. "I play guitar at funerals, and I always play the song 'Amazing Grace,'" Haddock says. "I tell patients it takes amazing grace to accept help. Most of them, they'll buy that."

Attending to affordability concerns

Acknowledging patients' concerns about the affordability of care and taking steps to minimize their out-of-pocket costs are other engagement strategies. At a time when patients are shouldering more of the costs of care, only a minority of physicians say they've broached the subject of treatment affordability with patients.[7]

Wright & Associates' Concord practice follows a "no surprises" policy: Staff check people's insurance before visits and let patients know precisely what services will cost them. The clinic also has secured agreements with a local hospital and lab so their patients can get discounted tests or imaging services. Concord's leaders say their treatment approach — doing as much as possible in one visit — respects patients' time and means they don't have to pay additional copayments for follow-up visits. The clinic also offers patients the option to pay off their services via installment plans.

Both organizations profiled in this case study say that patients requiring medications, lab tests, and other services to manage chronic conditions often face cost barriers because their plans require high deductibles and copayments. Clinicians report that many patients can't afford prescription drugs, particularly medications needed to manage chronic conditions. Kyburz-Ladue, Chittenden's nutritionist and diabetes educator, says it's not unusual for a patient with diabetes to stop taking insulin because of costs. Staff at both clinics help enroll eligible patients in pharmacy assistance programs and look for alternatives to expensive drugs, but costs remain a major barrier. Nationally, one of five adults under age 65 hasn't filled a prescription because they can't afford it.[8]

Helping patients find social supports

New England poverty can be obscured by its charming towns and mountainous landscapes, but clinicians in both Vermont and New Hampshire report that some of their patients are living hand to mouth. "Nurse practitioners who make home visits say the house is in squalor, that it is freezing, that they are living on minimal amounts of food," Wright says. Thomas Chittenden Health Center has a full-time social worker to connect patients with social supports, and the community is generous with resources like subsidies for fresh food and volunteers who visit older adults. Still, there's an acute lack of affordable housing. "There are years-long waits for subsidized housing," says Anderson, a social worker and care coordinator. "I go through Craigslist with people trying to find the cheapest apartments. In the summertime, people who are homeless live in the woods."

> ***"Everything comes back to primary care. A patient who had been started on opioids in the ED was told, 'Contact your primary care provider to manage your pain.' We sent a patient to a behavioral specialist, a nurse practitioner who can prescribe, and she said, 'I no longer prescribe any of those. Go back to your PCP.' It all comes back to us, and that's so, so hard."***
>
> **Becky Manter, Practice Manager**
> ***Wright & Associates Family Healthcare of Concord, N.H.***

Clinicians at Wright & Associates' Concord practice also point to a lack of affordable housing, along with a lack of public transportation and services in rural areas. Medical assistants help patients sign up for Medicaid, discounted utility programs, or other benefits. But with fewer supportive programs in New Hampshire than in neighboring states, there are limits to what they can do.

Growing a pipeline to cope with primary care workforce shortages

Both primary care practices struggle to recruit and retain clinical staff. Unlike some competing academic medical centers, community health centers, or health care organizations in health professional shortage areas, the clinics can't offer loan repayment or forgiveness programs as recruiting enticements. And leaders say many clinicians aren't comfortable working as autonomously as is required in independent practice, and they may be lured by higher pay offered elsewhere.

To cope, both practices have tried to build their own pipelines.

Leaders at Wright & Associates' Concord practice invest significant time in developing staff members' skills and helping them feel comfortable working independently. For their first six months, newly hired nurse practitioners work at a significantly reduced schedule and Wright reviews and offers feedback on their patients' charts. In addition, one of the clinic's medical assistants, who recently earned a nursing degree, will help triage patient calls and has begun offering diabetes management classes. Recently, the clinics received federal grants to support its nurse practitioner mentorship and residency programs.

Chittenden is paying for one of its nurse practitioners to receive a psychiatric certification to help meet demand. But Wright & Associates' Concord practice has not been able to recruit a psychiatric provider and struggles to find places to refer patients needing psychiatric care. Nationally, more than half of U.S. counties lack a psychiatrist and fewer than half (43%) of practicing psychiatrists accept Medicaid.[9]

Leveraging delivery and payment reforms

Thomas Chittenden Health Center's success to date under a capitation pilot suggests it may be able to succeed were such a payment approach extended for all its patients. But capitation could prove harder for smaller independent practices or those that don't have the external supports that Vermont's primary care clinicians receive.

By joining with other independent practices, Wright & Associates' Concord practice has been able to participate in ACO contracts. While modest, the incentive payments have enabled leaders to hire an additional medical assistant to help close gaps in preventive care or chronic disease management. "It completely changed our work," says Manter.

But Concord has struggled to develop other value-based contracts with Medicare, Medicaid managed care plans, or private payers, which Wright attributes to the fact that the practice is too small to get much notice from payers. Even though nurse practitioners generally earn less than primary care physicians, most payers have not recognized their work or rewarded their cost effectiveness, Wright says. "We've tried to negotiate as a group, but we just can't get a foot in the door."

While larger health care institutions can spread out their financial risk by cross-subsidizing one service line with another, independent primary care practices do not have that ability. Even though they operate as small businesses, they must juggle different types of payment from different payers, and some payments arrive unpredictably and long after a service is delivered. "We're making it," says Wright. "My bills are paid, and I have no debt. But I take a paycheck only 50 percent of the time."

Starting in 2021, smaller and independent primary care practices in some regions will have the option of joining the new federal Primary Care First program, under which they will receive capitated payments for each patient covered by Medicare as well as $50 fees for office visits. Practices also can earn incentives for achieving performance targets tied initially to reduced hospitalizations. Some practices serving particularly complex patients may earn higher per member per month fees, but one one estimate finds that this approach will not represent an increase in revenue for most practices. In addition, unlike the Comprehensive Primary Care Plus multipayer initiative, which also seeks to strengthen primary care, Medicaid and private payers are encouraged but not required to follow this approach.

During the pandemic, public and private payers began offering providers equivalent reimbursement for virtual and office visits. To ensure telehealth is a viable option for primary care practices longer term, these policies will need to be continued, primary care leaders say. "Telehealth needs to remain an option," says Wright. "Some people are still too scared and won't come in." In one recent case, a Wright & Associates' nurse practitioner used a virtual visit to help a husband perform an abdominal exam on his wife to diagnose appendicitis.

LOOKING AHEAD

Advocates continue to argue that, to improve population health and reduce overall health care spending, much more money must flow into primary care. Some have argued for approaches that take into account and reward the value of trusting relationships. States, including Rhode Island, are explicitly mandating higher spending by Medicaid and private insurers on primary care, but average spending on primary care in the United States is still well below other industrialized nations.[10] Such investment also must take into account the social and behavioral health needs of vulnerable patients who, as these profiles demonstrate, often require additional supports that test the capacity of practices to sustain themselves.

While committed to their patients and communities, clinicians at the Vermont and New Hampshire clinics agree that their work was hard to sustain, even before the pandemic: "The worst thing that could happen to primary care is if we didn't change anything," Haddock says.

NOTES

1. Francis W. Peabody, "The Care of the Patient," *JAMA* 88, no. 12 (Mar. 1927): 877–82.

2. See, for example: Sara Berg, "Physician Burnout: Which Medical Specialties Feel the Most Stress?," *Physician Health* (blog), American Medical Association, Jan. 21, 2020; and Victoria Knight, "American Medical Students Less Likely to Choose to Become Primary Care Doctors," *Kaiser Health News,* July 3, 2019.

3. From 2010 to 2016, the number of primary care nurse practitioners increased from 59,442 to 123,316 while the number of primary care physicians increased from 225,687 to 243,738. The number of nurse practitioners per 100,000 population increased by a mean of 15.3 in the highest-income quartile to 21.4 in the lowest-income quartile. See Ying Xue, Joyce A. Smith, and Joanne Spetz, "Primary Care Nurse Practitioners and Physicians in Low-Income and Rural Areas, 2010–16," *JAMA* 32, no. 1 (Jan. 1/8, 2019): 102–5. A 2012 survey also found that primary care nurse practitioners are more likely than primary care physicians to treat Medicaid recipients and other vulnerable populations. See Peter I. Buerhaus et al., "Practice Characteristics of Primary Care Nurse Practitioners and Physicians," *Nursing Outlook* 63, no. 2 (Mar./Apr. 2015): 144–53.

4. Chuan-Fen Liu et al., "Outcomes of Primary Care Delivery by Nurse Practitioners: Utilization, Cost, and Quality of Care," *Health Services Research* 55, no. 2 (Apr. 2020): 178–89.

5. Meredith K. Shaw et al., "The Duration of Office Visits in the United States, 1993 to 2010," *American Journal of Managed Care* 20, no. 10 (Oct. 2014): 820–26.

6. Wendy L. Wright, "New Hampshire Nurse Practitioners Take the Lead in Forming an Accountable Care Organization," *Nursing Administration Quarterly* 41, no. 1 (Jan./Mar. 2017): 39–47.

7. G. Caleb Alexander, Lawrence P. Casolino, and David O. Meltzer, "Patient–Physician Communication About Out-of-Pocket Costs," *JAMA* 290, vol. 7 (Aug. 20, 2003): 953–58.

8. Sara R. Collins, Herman K. Bhupal, and Michelle M. Doty, *Health Insurance Coverage Eight Years After the ACA: Fewer Uninsured Americans and Shorter Coverage Gaps, But More Underinsured* (Commonwealth Fund, Feb. 2019).

9. New American Economy, "New Study Shows 60 Percent of U.S. Communities Without a Single Psychiatrist," news release, Oct. 30, 2017; and Tara F. Bishop et al., "Acceptance of Insurance by Psychiatrists and the Implications for Access to Mental Health Care," *JAMA Psychiatry* 71, no. 2 (Feb. 2014): 176–81.

10. A study by the Patient-Centered Primary Care Collaborative found that public and private payers in the United States spent just 5.6 percent of their annual medical spending on primary care between 2011 and 2016, in contrast to an average of 14 percent among Organisation for Economic Co-operation and Development countries. The researchers used a conservative definition of primary care: services provided by physicians in family practice, general practice, geriatrics, general internal medicine, and general pediatrics. With a broader definition that included the services of nurse practitioners, physician assistants, obstetricians/gynecologists, general psychiatrists, psychologists, and social workers, they found the average increased to 10.2 percent. See Yalda Jabbarpour et al., *Investing in Primary Care: A State-Level Analysis* (Patient-Centered Primary Care Collaborative, July 2019).

ABOUT THE AUTHORS

Martha Hostetter, M.F.A., is a partner in Pear Tree Communications. As a consulting writer and editor for the Commonwealth Fund and a contributing editor to its quarterly publication, *Transforming Care,* she conducts qualitative research on health care delivery system reforms and innovations. 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.

Editorial support was provided by Maggie Van Dyke.

ACKNOWLEDGMENTS

The authors gratefully acknowledge the following individuals who generously shared information and insights. Thomas Chittenden Health Center: Lisa Anderson, Rick Dooley, Nina Gaby, Joe Haddock, Mary Anne Kyburz-Ladue, Maggie Mangham, Cheryl McCaffrey, and Liz Moss. Wright and Associates Family Healthcare: Elizabeth Holt, Becky Manter, and Wendy Wright.

For more information about this case study, please contact:

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

This case study is available on the Commonwealth Fund's website at https://www.commonwealthfund.org/publications/case-study/2020/sep/how-independent-primary-care-clinicians-leverage-trust-help.

The Commonwealth Fund

Affordable, quality health care. For everyone.

About the Commonwealth Fund
The mission of the Commonwealth Fund is to promote a high-performing health care system that achieves better access, improved quality, and greater efficiency, particularly for society's most vulnerable, including low-income people, the uninsured, and people of color. 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.

Primary Care
Investment Opportunity

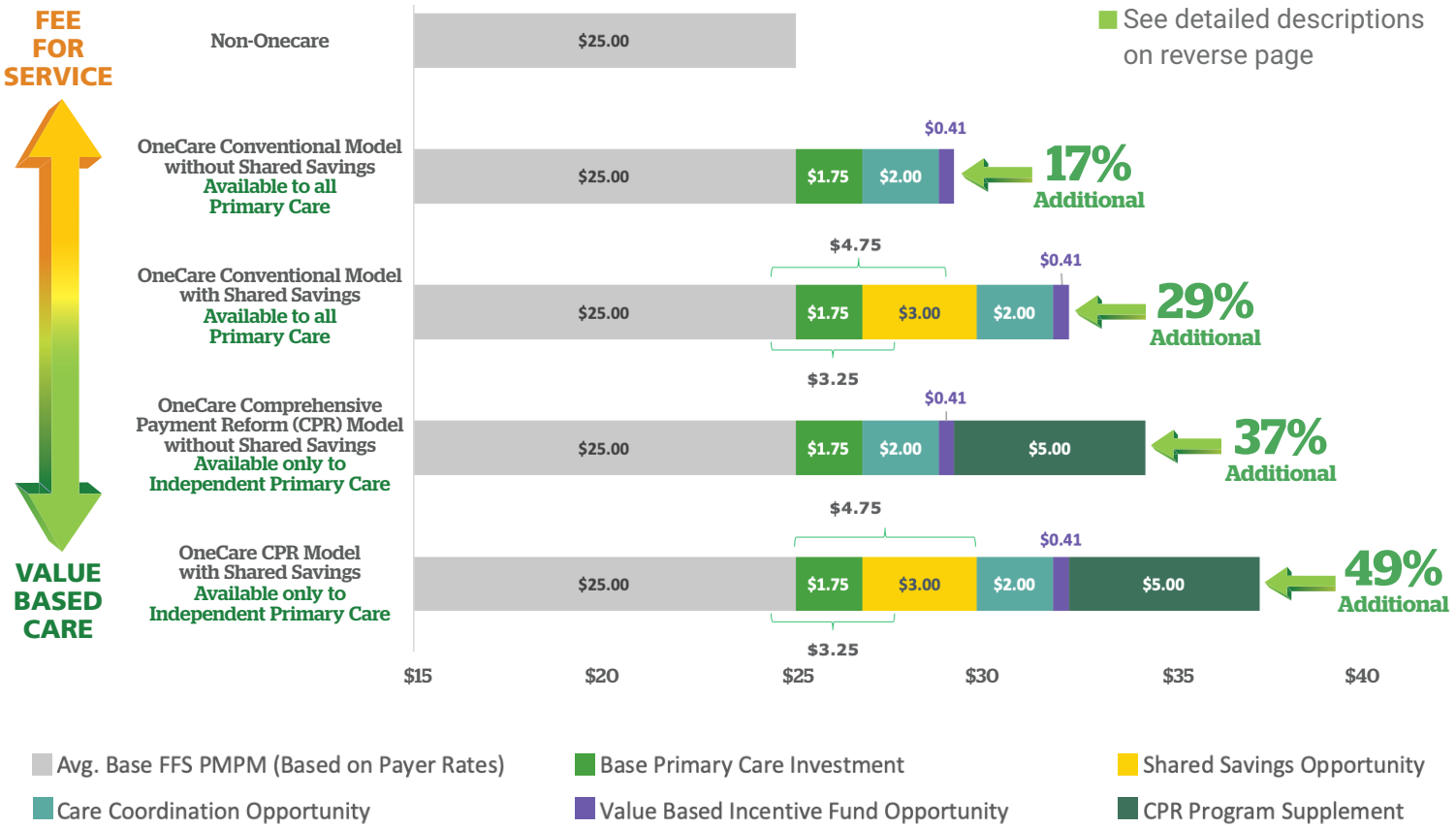
Total primary care investment is approximately $18 million on top of their fee-for-service (FFS) or fixed payments.

ADDITIONAL OPPORTUNITIES

- Opportunity for shared savings
- 5% bonus on all Medicare Part B for participating in APM
- CPR gets fixed, predictable monthly payments

Example Practice Transitioning to Value-Based Care

FFS BASE ESTIMATE IS BASED ON AVERAGE OF ONECARE PRACTICES



KEY

- **Non-OneCare:**
  A primary care practice that is not participating in any OneCare health reform programs.

- **OneCare Conventional without Shared Savings:**
  Primary care practice who is participating in OneCare programs and is still receiving their fee-for-service revenues from the payers. In this model, the practice also receives enhanced revenues from OneCare (PHM care coordination, VBIF, etc.) on top of their fee-for-service that are tied to outcomes in alignment with the All Payer Model (APM) Accountable Care Organization (ACO) cost and quality targets. This model presumes that the ACO does not at the very least meet its cost targets as defined by the payers and therefore does not earn shared savings.

- **OneCare Conventional with Shared Savings:**
  Same as the previous; however, this model presumes that the ACO does either meet or beat its cost targets as defined by the payers. If the ACO meets its cost targets, the Population Health Management (PHM) payment is adjusted upwards from $1.75 per member per month (PMPM) to $3.25 PMPM. If the ACO beats the cost targets as defined by the payers and earns shared savings, the first dollars go to primary care up to an additional $1.50 PMPM for a total of $4.75 PMPM.

- **OneCare Comprehensive Payment Reform without Shared Savings:**
  This program is only available to independent primary care (not FQHC or hospital). For this model, OneCare replaces payer fee-for-service payments with a fixed predictable monthly payment from OneCare that is not tied to billable services. The approach combines payer-paid fixed payment dollars with an extra $5.00 supplemental investment. This is in addition to the enhanced revenues offered under the conventional models. The CPR fixed payment continues to provide predictable cash flow and financial resources to facilitate quality and care delivery improvements. This model presumes that the ACO does not at the very least meet its cost targets as defined by the payers and therefore does not earn shared savings.

- **OneCare Comprehensive Payment Reform with Shared Savings:**
  Same as previous; however, this model presumes that the ACO does either meet or beat its cost targets as defined by the payers. If the ACO meets its cost targets, the one PHM payment is adjusted upwards from $1.75 per member per month (PMPM) to $3.25 PMPM. If the ACO beats the cost targets as defined by the payers and earns shared savings, the first dollars go to primary care up to an additional $1.50 PMPM for a total of $4.75 PMPM.

OneCare Vermont

Improving Health care for Vermonters

What does OneCare do?

1. Improves Health Care for Vermonters

Health care providers in OneCare coordinate across organizations and share resources and data. They focus on connecting patients to primary care, coordinating care for patients, and managing chronic illness. The goal is to help Vermonters become healthier — not just care for them when they are sick.

2. Supports Patient Health Care Choices

OneCare is not an insurance company, doesn't change benefits, and is free for patients. You, your doctor, and your insurance company work together to ensure you receive the health care you need.

3. Works to Stabilize Health Care Costs

Health care costs are too high. Vermont is leading an effort to change the way health care is paid for or incentivized: value over volume. OneCare works with insurance companies to reward providers for wellness, not illness. Instead of paying for each test and procedure, OneCare pays doctors a flat amount to care for patients. Over time, these changes should lower health care costs for Vermont.

4. Uses Data to Improve Health

OneCare gives doctors data, resources, and tools to improve patient health. By sharing information and working together, providers can do even more to give the best care to Vermonters.

OneCare is a community of providers.

OneCare is led by health care providers.

Hospitals, doctors, health partners, social service partners, and other providers work together for better health outcomes. OneCare works with these providers, and then providers work with patients directly. Providers choose to work in independent practices or in hospitals, and those organizations choose to work with OneCare. By being part of OneCare, providers can:

- Create a uniform patient experience through consistent, high-quality care across settings
- Invest in population health
- See how health outcomes are changing in their community
- Work together to be accountable for cost and quality of care
- Get incentives for better health outcomes
- Benefit from stable payments to care for patients, especially during uncertain times
- Receive health education
- Share data, resources, and best practices
- Reduce administrative burden

To see the current list of participants (doctors, hospitals, etc.) please visit: **www.onecarevt.org/participants**.

How do Vermonters benefit?

OneCare lowers health care costs by helping providers identify Vermonters whose health may be at risk. Providers can reach out to people who could benefit from coordination of care. Providers work together to help patients find resources and services that support their health goals.

Here's a real example of how this works: TOM'S STORY.

- Tom is a Vermonter with complex, chronic medical needs. Tom was visiting the emergency room a lot for health needs that could have been managed through coordinated care.
- OneCare data analysis identified Tom as a high risk individual and shared this information with his health care providers. They asked Tom if he would like some additional support to help him manage his care. Tom agreed, and now his care coordination team includes a primary care doctor, a cardiologist, a counselor, and a social worker.
- The team reached out to Tom to set health goals and create a plan to help meet his needs. Care coordination makes sure all Tom's providers are talking to each other and looking at many things that impact Tom's health like housing, transportation, and access to healthy food. This cuts down on duplication of expensive tests and connects Tom with important services in his community.
- Tom's care team used OneCare's nationally recognized care coordination model. OneCare provides training for care teams throughout the state and tools to help providers talk to each other about Tom's health goals.

Tom's Results after One Year of Care Coordination

EMERGENCY DEPARTMENT VISITS DECREASED
from six to zero

PRIMARY CARE PHYSICIAN VISITS INCREASED
from zero to five

HEALTH CARE COSTS DECREASED
by 60% from $63K to $25K

How does OneCare impact me?

1. CONNECTION WITH YOUR DOCTOR

OneCare works with your provider to help you stay healthy, avoid trips to the emergency room, and support your health goals with a care coordination team. Your doctor also focuses on wellness and check-ups to improve your health and to help prevent you from becoming ill.

2. HEALTH IN YOUR COMMUNITY

Our prevention programs, such as RiseVT, partner with your community to make the healthy choice the easy choice, by working on issues like affordable housing, walkable towns, and access to healthy food.

Quality Performance

Review of 2019 Medicare Quality Measure Results

Board of Managers

9/15/2020

OneCare Vermont

onecarevt.org

Medicare - 2019 Quality Performance

- OneCare earned 36.75 out of 40 possible points
- Overall quality score **91.88%**
- Domain Performance Results
  - Patient/Caregiver Experience: 19 of 20 points
  - Care Coordination/Patient Safety: 1.75 of 4
  - Preventive Health: 8 of 8 points
  - At Risk Population: 8 of 8 points
- The Quality Measures audit for the 2019 performance year was cancelled by CMS. Therefore, some measures that were intended to be pay-for-performance reverted to pay-for-reporting
- OneCare submitted a request to GMCB to align the scoring methodology with ALL other payers, which improved the score.

Medicare Summary

Measure	2018 Rate	2019 Rate	Change
Influenza Immunization	70.20%	72.38%	↑
Tobacco Use: Screening and Cessation Intervention	81.82%	86.36%	↑
Screening for Clinical Depression and Follow-up Plan	57.55%	60.00%	↑
Colorectal Cancer Screening	75.00%	80.00%	↑
Hypertension (HTN): Controlling High Blood Pressure	68.12%	71.46%	↑
Risk-Standardized, All Condition Readmission	14.62*	14.89*	↓
All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions	63.84*	60.04*	↑

*Inversed measures – lower rate is better

Appendix

2019 Medicare Population

Quality Performance Results

Measure Number	Measure Name	P4P or P4R	—	Number of Surveys Completed	Your ACO Performance Rate	Completely Reported?	Points Earned[2]	Total Possible Points	Prior Year Performance Rate	30th Percentile Benchmark	90th Percentile Benchmark
Patient/Caregiver Experience[1]											
ACO-1	CAHPS: Getting Timely Care, Appointments, and Information	P	—	257	82.48	Yes	1.75	2	84.62	30.00	90.00
ACO-2	CAHPS: How Well Your Providers Communicate	P	—	283	94.39	Yes	2	2	93.59	30.00	90.00
ACO-3	CAHPS: Patients' Rating of Provider	P	—	276	91.56	Yes	2	2	92.14	30.00	90.00
ACO-4	CAHPS: Access to Specialists	P	—	198	77.00	Yes	1.5	2	73.55	30.00	90.00
ACO-5	CAHPS: Health Promotion and Education	P	—	300	64.37	Yes	2	2	59.05	54.18	63.44
ACO-6	CAHPS: Shared Decision Making	P	—	281	60.75	Yes	1.75	2	56.95	54.75	62.76
ACO-7	CAHPS: Health Status/Functional Status	R	—	302	81.36	Yes	2	2	76.93	N/A	N/A
ACO-34	CAHPS: Stewardship of Patient Resources	R	—	288	21.46	Yes	2	2	23.80	N/A	N/A
ACO-45	CAHPS: Courteous and Helpful Office Staff	R	—	278	94.41	Yes	2	2	N/A	N/A	N/A
ACO-46	CAHPS: Care Coordination	R	—	301	85.93	Yes	2	2	N/A	N/A	N/A

Measure Number	Measure Name	P4P or P4R	Numerator	Denominator	Your ACO Performance Rate	Completely Reported?	Points Earned[2]	Total Possible Points	Prior Year Performance Rate	30th Percentile Benchmark	90th Percentile Benchmark
Care Coordination/Patient Safety											
ACO-8	Risk-Standardized, All Condition Readmission	P	—	—	14.89	Yes	1	2	14.62	15.18	14.27
ACO-38	All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions	P	—	—	60.04	Yes	0.75	2	63.84	65.99	41.39
Preventive Health											
ACO-14	Preventive Care and Screening: Influenza Immunization	R*	173	239	72.38%	Yes	2	2	70.20%	30.00%	90.00%
ACO-17	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	R	19	22	86.36%	Yes	2	2	81.82%	55.22%	92.31%
ACO-18	Preventive Care and Screening: Screening for Clinical Depression and Follow-up Plan	R*	156	260	60.00%	Yes	2	2	57.55%	30.00%	90.00%
ACO-19	Colorectal Cancer Screening	R*	204	255	80.00%	Yes	2	2	75.00%	30.00%	90.00%

Measure Number	Measure Name	P4P or P4R	Numerator	Denominator	Your ACO Performance Rate	Completely Reported?	Points Earned[2]	Total Possible Points	Prior Year Performance Rate	30th Percentile Benchmark	90th Percentile Benchmark
At-Risk Population											
ACO-27	Diabetes Mellitus: Hemoglobin A1c Poor Control	R*	34	252	13.49%	Yes	2	2	16.03%	70.00%	10.00%
ACO-28	Hypertension (HTN): Controlling High Blood Pressure	R*	338	473	71.46%	Yes	2	2	68.12%	30.00%	90.00%
VT-1	Follow-up after discharge from the ED for Mental Health or Alcohol or Other Drug Dependence	R	—	—	—	Yes	2	2	N/A	N/A	N/A
FUA	*Follow-up After ED Visit for Alcohol and Other Drug Abuse or Dependence within 30 Days*		36	181	19.9%						
	Percentage of ED visits for which the member received follow-up within 7 days of the ED visit		20	181	11.05%						
FUM	*Follow-up After ED Visit for Mental Illness within 30 Days*		133	248	53.6%						
	Percentage of ED visits for which the member received follow-up within 7 days of the ED visit		82	248	33.06%						
VT-2	Initiation and engagement of alcohol and other drug dependence treatment	R	—	—	—	Yes	2	2	N/A	N/A	N/A
VT-2a	*Initiation of Alcohol and Other Drug Dependence Treatment (IET)*		430	1,466	29.3%						
VT-2b	*Engagement of Alcohol and Other Drug Dependence Treatment (IET)*		74	1,466	5.1%						

Note: Results are as of 07/31/2020

All activities related to the Quality Measures Validation (QMV) audit for the 2019 performance year were cancelled. Therefore, this measure was intended to be pay-for-performance but was reverted to pay-for-reporting.

[1] CAHPS measures combine responses to several questions, some of which have different response options (e.g. never, sometimes, usually, or always, and yes; definitely, yes, somewhat or no). Performance rates for CAHPS measures do not represent a percentage but rather your ACO's mean (average).

[2] For P4P measures: Points are calculated based on the ACO's performance compared to the 2019 quality measure benchmarks; For P4R measures: Full points are awarded if the ACO completely reports.

N/A = Not Applicable