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Senate Health and Welfare Presentation

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February 11, 2016

Medicare/ CMS Leading the Charge



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THE FIELD GUIDE TO

Medicare Payment Innovation

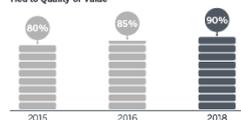
CMS is deploying an array of voluntary and mandatory payment innovation programs to accelerate the transition to accountable payment models. This field guide details the 12 highest profile programs as of September 2015. Learn how these programs disrupt the traditional fee-for-service business model.

HHS' PAYMENT GOALS

Percentage of Medicare Payments Tied to Alternative Payment Models



Percentage of Medicare Payments Tied to Quality or Value



PAYMENT PROGRAM KEY

Change Accelerator

Provides funding, training, and peer networking to support local delivery system innovation; ultimately seeks to identify and disseminate best practices

Pay-for-Performance

Rewards or penalizes providers for performance against select quality and cost metrics; often focuses on safety, outcomes, and patient satisfaction measures

Bundled Payment

Establishes a single price for a comprehensive episode of care, often spanning the care continuum; modifies the incentives of fee-for-service economics

Total Cost of Care

Holds providers accountable for the overall quality and total cost of care for patient populations over time; eliminates the volume-based incentives of fee-for-service economics

<h4>Health Care Payment Learning and Action Network</h4> <ul style="list-style-type: none"> CMS-convened collaborative of public- and private-sector health care stakeholders focused on accelerating the transition to alternative payment models Designed to support HHS's Better, Smarter & Healthier initiative and achieve payment transformation goals <p>608 Organizations supporting the network and its objectives</p> <p>Voluntary</p> <p>CY 2015</p>	<h4>Comprehensive Primary Care Initiative</h4> <ul style="list-style-type: none"> Multi-payer program providing primary care practices with monthly care management payments to support practice transformation; practices are eligible to share in Medicare savings¹⁸ CMS is partnering in four-year program with primary care practices, commercial payers, and state health insurance plans in seven regions Initiative focuses on improving five primary care functions: care management, access, care planning, patient engagement, and care coordination <p>475 Primary care practices participating in the program</p> <p>Voluntary</p> <p>FY 2013</p>	<h4>Hospital Value-Based Purchasing Program</h4> <ul style="list-style-type: none"> Pay-for-performance program creating differential hospital inpatient payment rates based on success against patient safety, outcomes, patient satisfaction, and spending efficiency measures Holds providers accountable for either absolute success or improvement against established performance measures via withhold/payback structure Payment withhold began at 1% in 2013, increased by 0.25% annually until reaching 2% in 2017 <p>2% Hospital inpatient Medicare payment at risk when fully implemented in 2017</p> <p>Mandatory</p> <p>FY 2013</p>	<h4>Hospital Readmissions Reduction Program</h4> <ul style="list-style-type: none"> Reimbursement penalty targeting hospitals with excessive 30-day readmission rates for select clinical conditions Penalty based on readmissions for six conditions: heart failure, myocardial infarction, pneumonia, chronic obstructive pulmonary disease, total hip arthroplasty, and total knee arthroplasty May include additional conditions in the future <p>3% Hospital inpatient Medicare payment at risk</p> <p>Mandatory</p> <p>FY 2013</p>
<h4>Hospital-Acquired Condition Reduction Program</h4> <ul style="list-style-type: none"> Reimbursement penalty targeting hospitals with comparatively more frequent hospital-acquired conditions and infections Penalty based on performance in two domains: patient safety and hospital-acquired infections Imposes 1% reimbursement penalty on hospitals in the top quartile of patients with hospital-acquired conditions <p>25% Hospitals mandated to face the penalty</p> <p>Mandatory</p> <p>FY 2015</p>	<h4>Merit-Based Incentive Payment System</h4> <ul style="list-style-type: none"> Medicare Physician Fee Schedule methodology that incorporates EHR Incentive Program, Physician Quality Reporting System, and Value-Based Payment Modifier Performance measures evaluate providers in four categories: quality, resource use, electronic health record use, and clinical practice improvement activities Providers may opt out by participating in alternative payment model track that offers additional incentives <p>99% Physician Medicare payment at risk when fully implemented in 2012</p> <p>Mandatory</p> <p>CY 2019</p>	<h4>Bundled Payments for Care Improvement Initiative</h4> <ul style="list-style-type: none"> Center for Medicare and Medicaid Innovation (CMMI) program offering providers four bundled payment models for treating Medicare fee-for-service beneficiaries Models vary by scope of service included, duration, minimum discount required, and use of either prospective or retrospective bundling methodology All four models enable hospitals to gainshare with physicians <p>2K+ Organizations participating in the program</p> <p>Voluntary</p> <p>CY 2012</p>	<h4>Comprehensive Care for Joint Replacement Model</h4> <ul style="list-style-type: none"> Proposed CMMI program creating mandatory bundled payments with up to 2% episode discount for lower extremity joint replacement procedures in 75 select markets Retrospective bundled payment model holds hospitals accountable for episodes of care extending 90 days post-discharge; bundle includes all related Part A and Part B services Hospitals may enter into financial arrangements with other providers—including physicians and post-acute care providers—to share downside risk and/or upside rewards <p>75 Markets proposed for participation in the program</p> <p>Mandatory</p> <p>CY 2016</p>
<h4>Oncology Care Model</h4> <ul style="list-style-type: none"> CMMI program seeking to improve the quality, coordination, and efficiency of care for oncology patients receiving chemotherapy across six-month episodes of care Multi-payer model design encourages private payers to join physician practices in the program Physician practices receive fee-for-service payments, monthly per-beneficiary care management fees, and shared savings payments for reducing total Medicare spending on oncology patients <p>\$960 Per beneficiary care management fee for six-month episode of care</p> <p>Voluntary</p> <p>CY 2016</p>	<h4>Medicare Shared Savings Program</h4> <ul style="list-style-type: none"> Program enabling providers to form accountable care organizations (ACOs) that serve Medicare fee-for-service beneficiaries Establishes financial accountability for the quality and total cost of care for an attributed population of at least 5,000 Medicare beneficiaries Offers three tracks that feature varying levels of financial risk, bonus opportunity, and flexibility in program design <p>404 ACOs participating in the program</p> <p>Voluntary</p> <p>CY 2012</p>	<h4>Pioneer ACO Model</h4> <ul style="list-style-type: none"> CMMI program offering an advanced path for providers to form ACOs that serve Medicare fee-for-service beneficiaries; 13 of the original 32 participants remain in the program Offers greater financial risk and reward, as well as more flexibility, than the Medicare Shared Savings Program's Tracks 1 and 2 First CMMI program to receive approval for expansion to the full Medicare program; features of the Pioneer ACO Model were included in the Medicare Shared Savings Program's new Track 3 <p>\$384M Total savings generated by Pioneer ACOs, 2012-2013</p> <p>Voluntary</p> <p>CY 2012</p>	<h4>Next Generation ACO Model</h4> <ul style="list-style-type: none"> CMMI program offering advanced option to health managers higher levels of risk and reward than the Medicare Shared Savings Program and the Pioneer ACO Model Participants must choose between two risk arrangements—shared risk or full risk—that feature shared savings/loss rates between 80% and 100% Program offers flexibility in payment structure; ACOs select one of three different payment models for 2016, with capitation becoming a fourth option in 2017 <p>15-20 Organizations expected to participate in 2016</p> <p>Voluntary</p> <p>CY 2016</p>

12 Major Programs

- 5 Mandatory
- 7 Optional

Voluntary movement to more advanced models to exempt providers from more basic programs

True innovation increasingly provided/allowed in more advanced models



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See our latest on [payment transformation](http://paymenttransformation.advisory.com/hcib/paytransformation)
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- One of 26 Organizations accepted into Next Generation
 - 21 Started in 2016 and 5 Deferred until 2017 (including OneCare and Dartmouth-Hitchcock)
- Accountability (risk) for total cost of care for attributed beneficiaries
 - For first time, offers lower discount requirement to CMS based on low base cost and high quality (discount range minimum 0.5% and maximum 4.5%)
 - For first time, offers a true non-FFS payment option for ACO networks wishing to do true payment reform
 - Offers many other enhancements and advantages
- OneCare had to demonstrate substantial capabilities to be accepted
- OneCare had to commit to aligning other payers into value-based contracts

Vermont's All-Payer Model



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- Documents indicate that reform under the all-payer system is intended to be based on ACO(s)
 - Term Sheet: “Vermont will use an accountable care organization (ACO) model to carry out its payment and delivery system transformations under the All Payer Model Agreement”
 - Companion Document: “As is true today, health care providers’ participation in ACOs is voluntary; the ACO must be attractive to providers and offer an alternative health care delivery model that is appealing enough to join”
- Terms are highly aligned with the Next Generation ACO model
 - ACO/Next Gen Fraud and Abuse Waivers Included
 - Next Gen Benefit Enhancements Included
 - Medicare spending Goal as Discount against National Medicare FFS Trend Rate
 - > “Pure” Next Gen – **0.5% to 4.5% discount with no floors**
 - > “APM Term Sheet” – **0.2% discount with floors** of 3.5% in 2017 and 2.0% in 2018-2021
 - Program requires multi-payer system including Medicaid and Commercial populations to ensure aligned incentives

Vermont All-Payer Model



- Includes Medicare continued participation in the Blueprint for Health (practice payments, CHT, SASH)
 - Without waiver MAPCP Program to expire 12/31/16
- Quality/health measurement includes selected system-wide measures in addition to expected ACO scorecard metrics
 - Population Health Goals on (i) increasing access to primary care, (ii) prevalence/management of chronic disease, and (iii) addressing the substance abuse epidemic
 - Plus expected ACO quality measurement and incentive program
- Biggest open questions
 - Since still in negotiation, how much will the terms change?
 - What are the exact measures and targets on the three system goals?
 - How will the ACO program under APM be offered, structured, and regulated?
 - What are Implications if ACO participation is not broad-based?

Going Forward – Three Potential Paths



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OneCare Vermont
“Pure” Next Generation and Negotiated/Aligned Commercial and/or Medicaid Contracts
Expected Network: Some of existing OneCare Network

<OR>

OneCare Vermont
“APM” Program – Aligned Next Generation programs across Medicare, Medicaid, and Commercial
Expected Network: Most of existing OneCare Network

<OR>

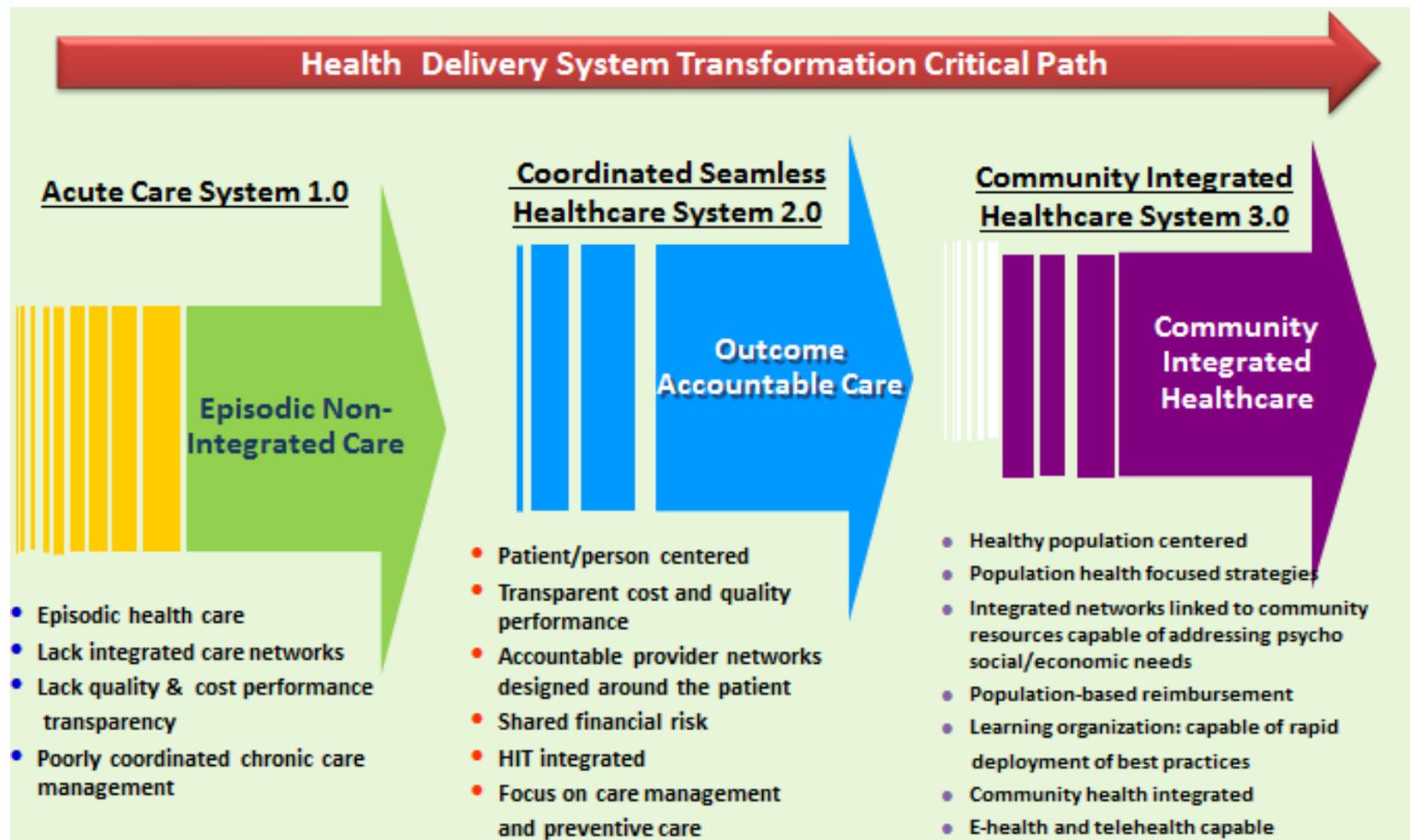
Vermont Care Organization (VCO)
“APM” Program as Statewide ACO
Required Network: Participants from 3 current ACOs including community-based providers

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0
1
7

VCO could transition Vermont to healthcare 3.0



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Planning the Vermont Care Organization (Potential Single ACO)

Vermont ACO Landscape



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- **Three ACOs**
 - Community Health Accountable Care (CHAC)
 - Vermont Collaborative Physicians (Healthfirst's ACO)
 - OneCare Vermont ACO
- **Significant collaboration among ACOs already happening**
 - VHCIP (SIM Grant) committees
 - GMCB-facilitated payment reform design groups
 - Community collaborative across ACOs
 - Development with Blue Print of the 2016 medical home performance measures and incentive program
 - ACO quality collection process
 - “Memorandum of Understanding” among all three ACOs to explore potential of combining into single ACO

MOU Steering Committee



■ Members:

- Joe Woodin
 - Patrick Flood
 - Mary Moulton
 - John Brumsted M.D.
 - Eric Seyferth M.D.
 - Kevin Stone
 - Paul Reiss M.D.
 - Paul Unger M.D.
 - Joe Haddock M.D.
 - Tom Huebner
 - Kevin Kelley
 - Todd Moore
 - Amy Cooper
 - Joyce Gallimore
- CHAC Delegates
- OneCare Delegates
- Healthfirst Delegates
- At-Large Delegates
- ACO Management Delegates

MOU Process Update



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- Productive discussions to date including agreement on a unified ACO governance model
- Operational vision being designed in business planning phase currently starting (1Q16) with necessary functions, resources and infrastructure
- Working together as ACOs to envision the right public-private partnership and best model to ensure continuity of successful innovations to date (e.g. Blueprint for Health)
- Striving to align on what legislative and regulatory oversight is desired or acceptable without changing the provider-governed ACO paradigm
- Continued sense that single ACO is only relevant/feasible under APM

Moving Ahead: VCO Plan in Progress



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Planning Environment: The Big Hurdles



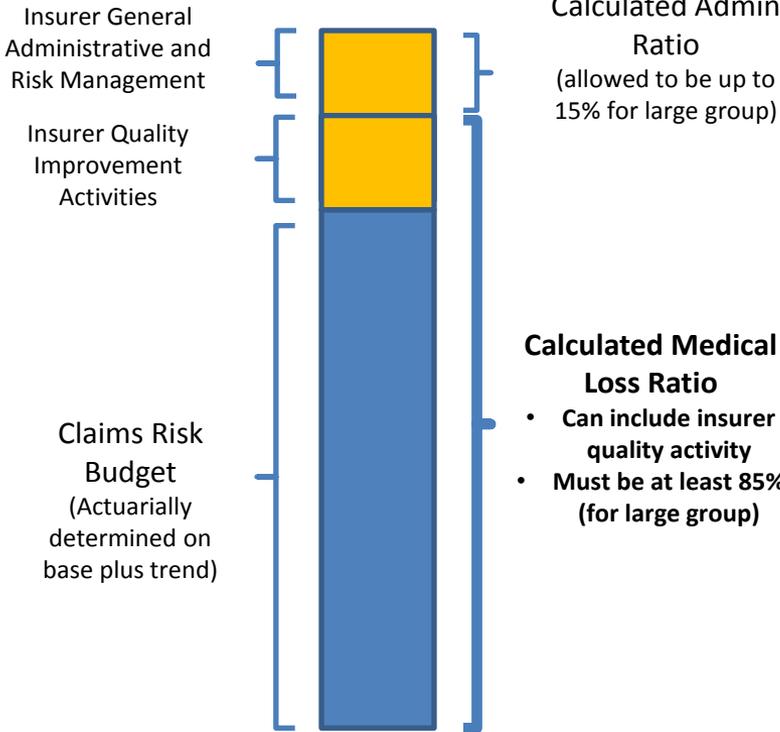
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- **Hurdle 0: Is APM Real?**
 - Will APM really happen? Will the term sheet change?
 - What is the ACO “deal” and how will it be offered/regulated?
- **Hurdle 1: Network Participation - Who’s in Matters**
 - Attribution – Independent, FQHC, Hospitals; is Vermont big enough for multiple ACOs?
 - Hospitals - Risk management, Power of broad-based hospital spend
- **Hurdle 2: DVHA and Medicaid**
 - Implications of the delegated population health model
 - How to handle non Part A/B spending
 - Growth rate – does state budgeting align with the Next Generation-style ACO model?
- **Hurdle 3: Commercial Payer Participation**
 - Will they support the APM approach?
 - Challenges of aligning with multiple payers
- **Hurdle 4: The Financial Needs to Operate the Model and Build the Coalition**
 - ACO Operations and Risk Management Expense
 - Independent Physician Practice Revenue Increase
 - Community-Based Investment and Program Development
 - Incentive Pool to Reward Value (high quality and low cost)
 - Key Question: Are there enough resources to do the items above and still deliver attractive or adequate revenue models to attract a broad base of network providers

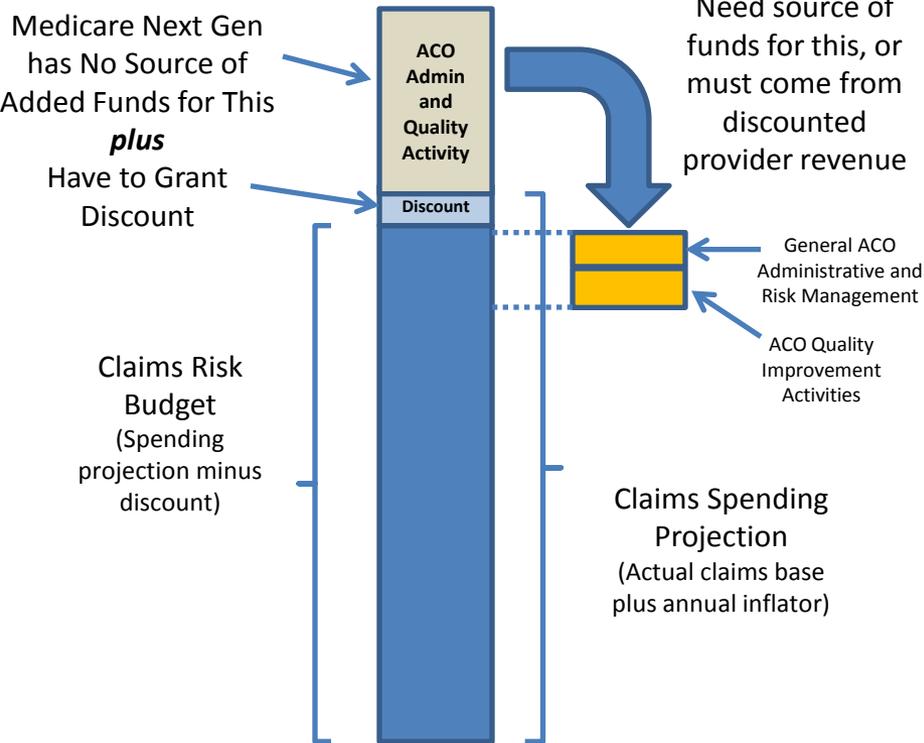


ACO as Population Risk-Bearing Entity

Commercial Insurance Plan (QHP under ACA)



Next Generation ACO



Assessing the ACO Model



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- **Current GMCB Criteria in Assessing APM:**
 - 3b. The GMCB must determine that the administrative costs of the ACO will be offset by savings resulting from improvements in efficiency and care delivery.

- **What the Question Should Be:**
 - Is the ACO expense and financial plan reasonable given their business model and the value of a predictable health care services growth rate meeting the state's target, and increased delivery system coordination and focus on quality and satisfaction