Accountable Care Coalition of the Green Mountains (ACCGM)

- Joint venture between Healthfirst and Collaborative Health Systems (a division of Universal American)
- First ACO in Vermont, joined Medicare Shared Savings Program (MSSP) July 2012
- 10 Independent Primary Care Practices
- 35 physicians
- 7,466 Medicare Beneficiaries as of 2014
- Withdrawn from MSSP, year end 2014

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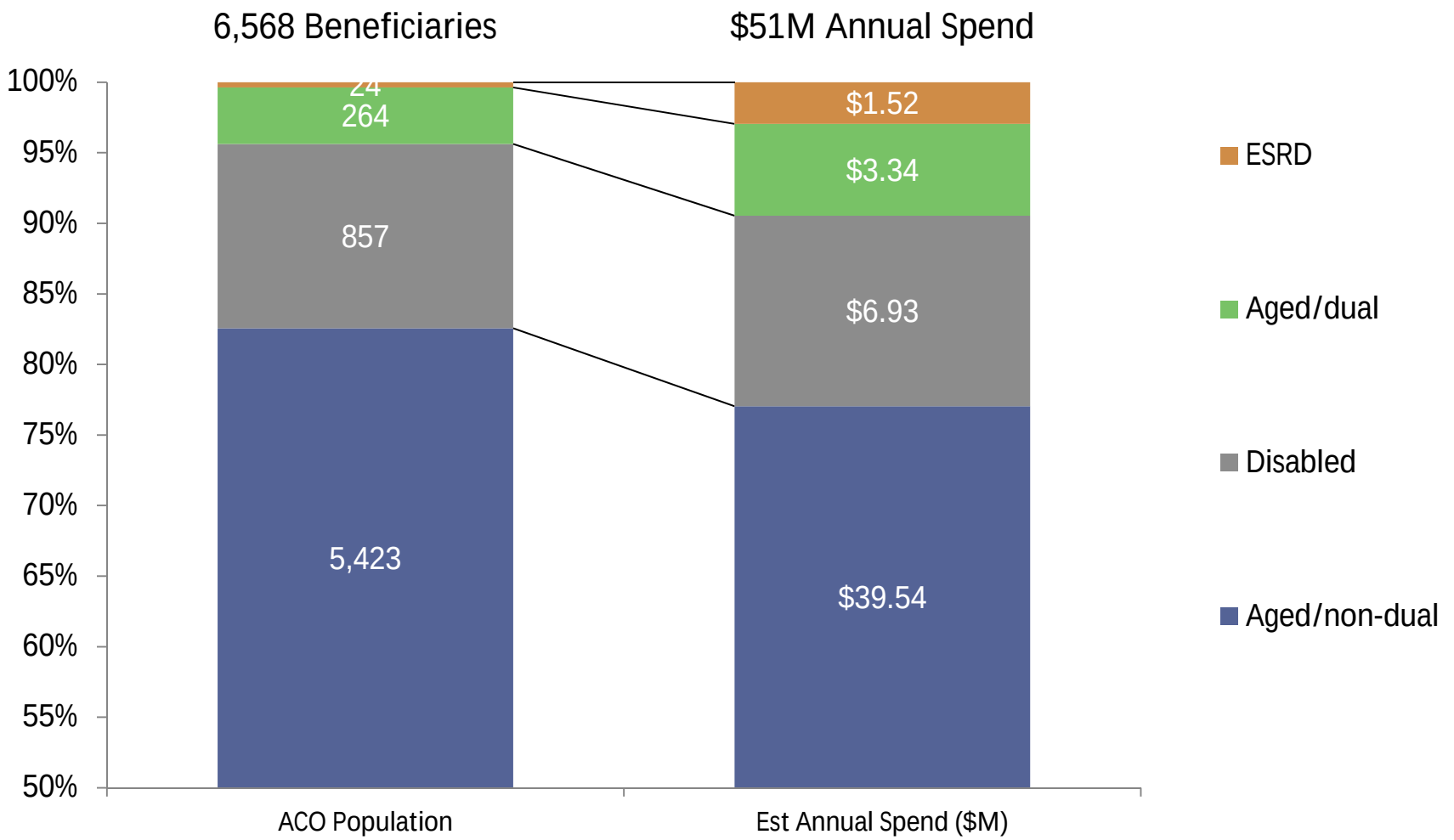
CHS Partnership

- CHS has invested significantly to support ACO Efforts across the country, with 35 ACO partners as of Jan 2014
- NAACOS survey of 70 MSSP ACOs estimated each ACO will need $3.5-$4M in capital for first 2 years before meaningful savings are generated
- CHS leverages technology and infrastructure investments across the entire network to offer care management and data analytics platforms to each ACO partner and lower expenses per ACO (approx. $2M)

ACCGM Beneficiary Demographics & Estimated Annualized Expenditures – Trailing 12 months Q4 2014

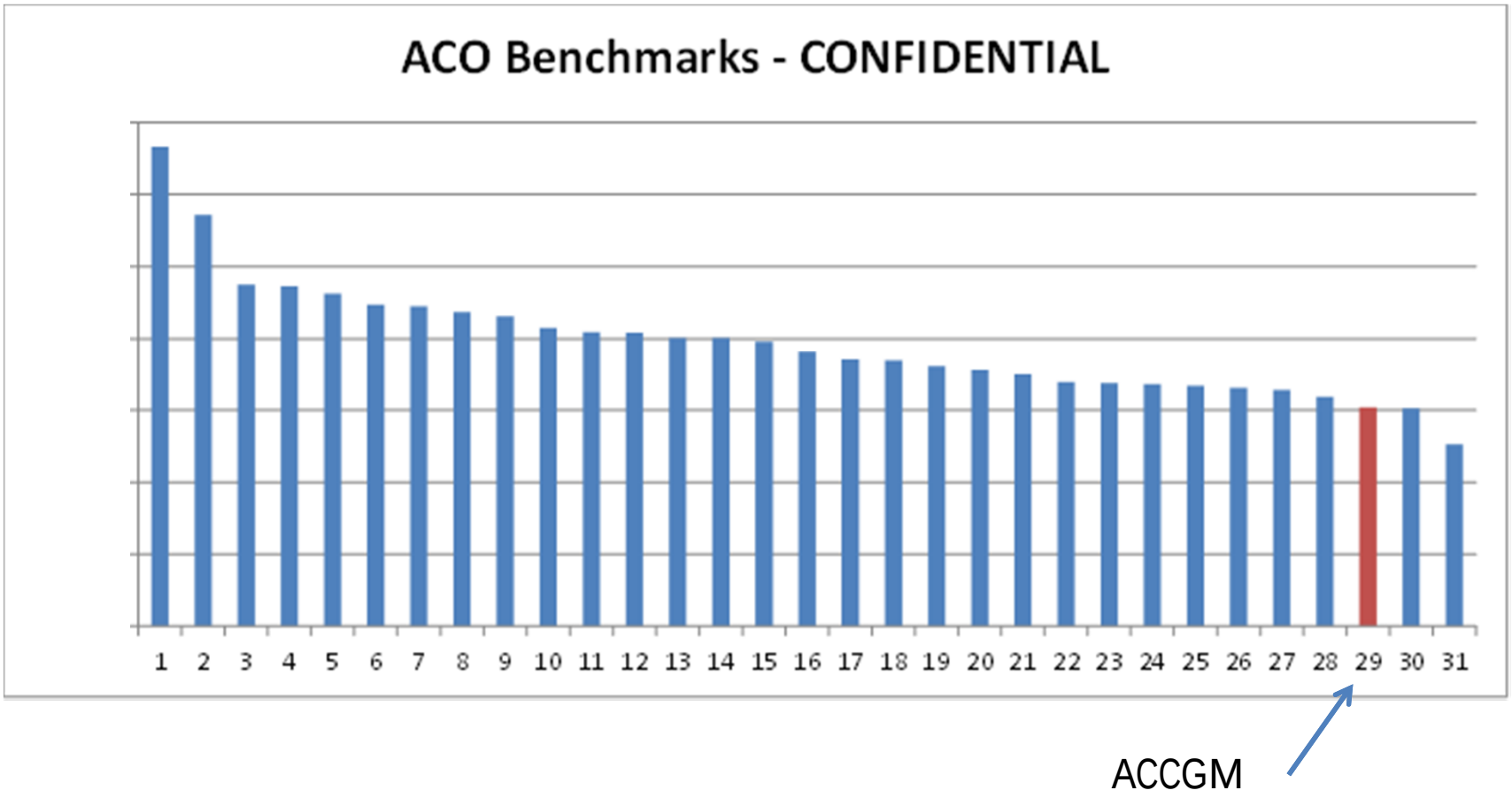


Source: CHS Analysis of a rolling 12 months' worth of CMS Claims through April 2014 with dates of service through Feb 2014.
- Aged = Medicare beneficiaries over 65 yrs of age. Aged duals = Medicare beneficiaries over 65 yrs. of age who are also eligible for Medicaid. ESRD = patients over or under 65 yrs with End Stage Renal Disease. Disabled = patients over or under 65 yrs with a disability as defined per Section 223 of Social Security Act.

ACCGM 2014: Three Areas of Focus

Focus on Wellness	Chronic Disease Management	Transition of Care Coordination
Programs: • Annual Wellness Visit Campaign • Improved rates of health screenings	Programs: • CHF Program • PCP referrals to care coordinators	Programs: • Home Health Pilot • Clinical Manager + 2 Care Coordinators monitoring hospital and ER census, f/up with pts in hospital & immediately after discharge

ACCGM has a low benchmark compared to other CHS ACOs



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CHS MSSP ACOs – Performance on Ambulatory Care Sensitive Conditions: Admits Per Thousand

Top 10 ACOs

	Diabetes mellitus with complications	Asthma	Urinary tract infections	Pneumonia (except that caused by tuberculosis or sexually transmitted disease)	Chronic obstructive pulmonary disease and bronchiectasis	Congestive heart failure	Total 6		
A1141	1.75	1.17	5.85	6.92	5.46	8.68	29.83		Best #1
A1575	1.65	1.98	3.63	7.92	6.60	8.91	30.70		#2 or #3
ACCGM	1.93	1.29	3.44	10.09	4.51	14.39	35.64		
A1137	2.98	1.59	3.97	8.14	6.95	15.48	39.10		
A1485	4.47	2.76	6.78	10.73	5.81	12.22	42.78		
A1614	9.08	2.93	7.40	9.22	7.40	9.36	45.40		
A1140	3.19	1.01	9.58	9.75	11.43	12.10	47.06		
A1487	2.22	4.03	7.86	13.11	7.86	13.11	48.19		
A1303	6.31	3.78	4.68	11.17	9.73	12.79	48.46		
A1071	4.77	1.43	8.74	12.24	9.70	12.72	49.60		

Avg of 31 ACOs

Average	5.07	2.57	8.29	12.42	11.30	14.62	55.18

Vermont Collaborative Physicians, LLP

- Wholly-owned by Health*first*
- Participating in VT State Commercial ACO Pilot starting in 2014
- 28 Independent Vermont Internal Medicine, Family Medicine, and Pediatrics practices.
- 68 Physicians
- Attribution 7,200 as of 6/2014 (BCBS only)
- Clinical Director, Active Committees
  - Overseeing and coordinating health care quality and process improvement committees and programs

Health*first* ACO Experience

- Attribution issues result in failure to attribute new patients, and "falling off" of healthiest patients who seek care infrequently
- MSSP benchmarking provides less opportunity to health systems or states who are already highly functional, efficient and cost conscious.
- VT commercial SSP benchmarks are based on health insurance premiums, creating same targets for all ACOs. Efficient networks are potentially rewarded, and can do even better with improvements. Accurate benchmark setting is important for success.
- Medicaid SSP, using the MSSP type benchmark would challenge efficient networks, and with a complex population to manage, substantial upfront non-reimbursed resources would be needed by practices. Unrealistic for our physician driven network.
- Substantial learning has been facilitated by the ACO model: physicians working together and better understanding the process of care. Cost improvement opportunities in Vermont are greatest in transitions of care, communication, improving efficient use of sub acute and home care.

ACO Experience (con't)

- Challenges
  - Claims data is not real-time enough to assist with care management
    - Office EHRs have the capabilities needed
  - Attribution is variable enough that the population turnover prevents targeting of benchmarked population
    - Attributing to specialty practices is problematic
  - Opportunities to increase use of more efficient or cost effective, higher quality facilities or providers is extremely limited
  - Benchmarking methodology in MSSP rewards only improvement
  - Data collection is a resource intensive process, and quite inaccurate if done by reviewer outside the primary office staff.

SUMMARY

- Healthfirst practices are high value practices in a low utilization region.
- Shared savings are difficult to achieve with a low benchmark based on already good performance.
- Shared savings is easiest to achieve by moving patients to lower cost sites of service, or lower cost providers.
- Shared savings through changing practice patterns and establishing new programs takes many years, and considerable resources.