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Health Reform Oversight Committee Discussion Document

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Part One: Do ACOs “Work”

National Medicare ACO Performance

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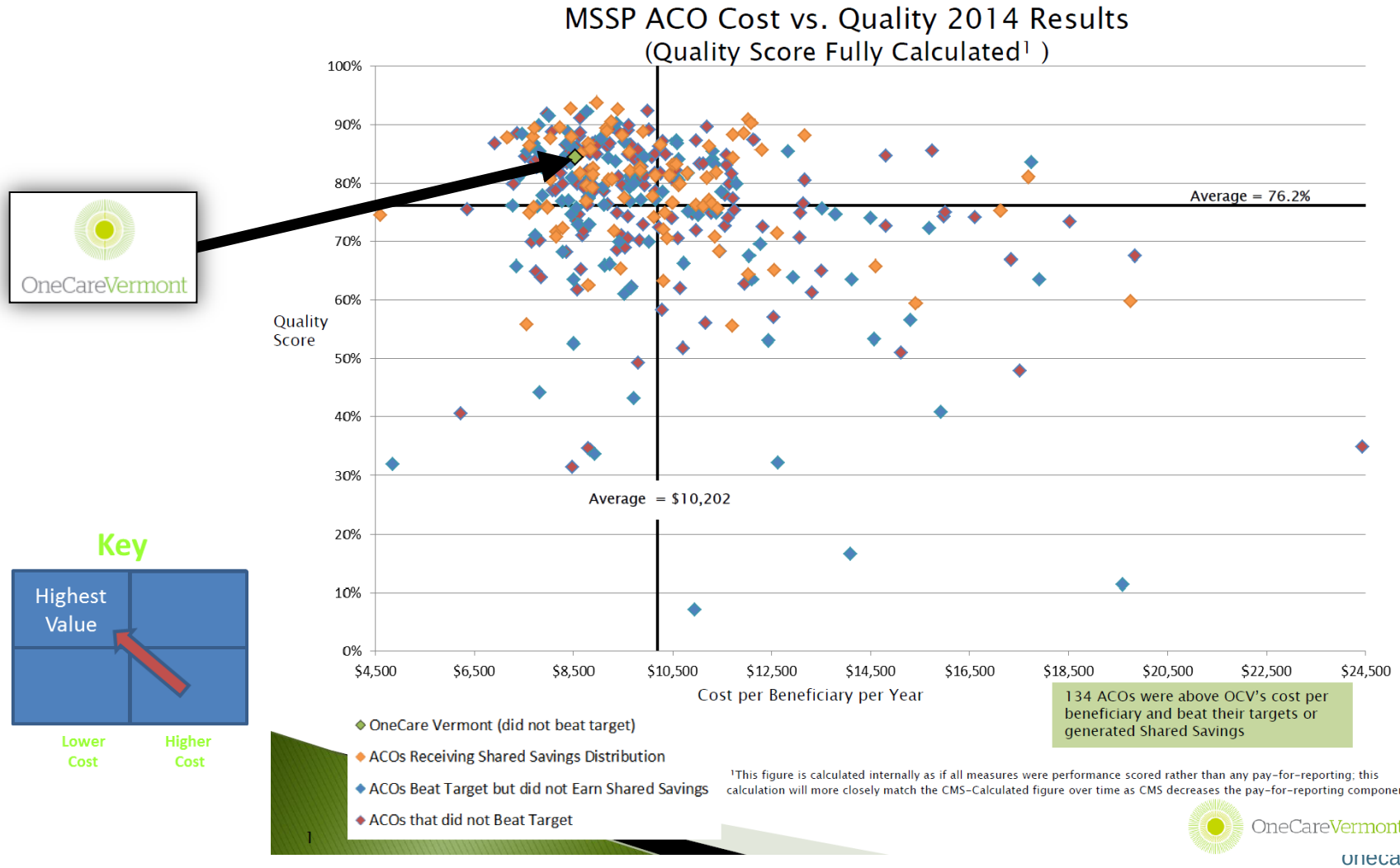

[1]This figure is calculated internally as if all measures were performance scored rather than any pay-for-reporting; this calculation will more closely match the CMS-Calculated figure over time as CMS decreases the pay-for-reporting component

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OneCare Vermont Quality Measures: PY2 2014 vs PY1 2013

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Domain	Measure		PY1 2013	PY2 2014	30th perc.	40th perc.	50th perc.	60th perc.	70th perc.	80th perc.	90th perc.	OCV Score 2013	OCV Score 2014	n 2014	Quality Points 2014
Patient/Caregiver Experience	1	Getting Timely Care, Appointments, and Information	R	P	30.00	40.00	50.00	60.00	70.00	80.00	90.00	83.81	85.01	323	1.85
	2	How Well Your Doctors Communicate	R	P	30.00	40.00	50.00	60.00	70.00	80.00	90.00	92.54	92.47	323	2.00
	3	Patients' Rating of Doctor	R	P	30.00	40.00	50.00	60.00	70.00	80.00	90.00	91.84	91.45	314	2.00
	4	Access to Specialists	R	P	30.00	40.00	50.00	60.00	70.00	80.00	90.00	82.21	86.00	131	1.85
	5	Health Promotion and Education	R	P	54.71	55.59	56.45	57.63	58.22	59.09	60.71	59.46	60.61	364	1.85
	6	Shared Decision Making	R	P	72.87	73.37	73.91	74.51	75.25	75.82	76.71	75.98	73.81	316	1.25
	7	Health Status/Functional Status	R	R	N/A	N/A	N/A	N/A	N/A	N/A	N/A	73.70	74.12		2.00
Care Coordination/ Patient Safety	8	Risk Standardized, All Condition Readmissions	R	R	16.62	16.41	16.24	16.08	15.91	15.72	15.45	14.75	14.84	-	2.00
	9	ASC Admissions: COPD or Asthma in Older Adults	R	P	1.75	1.46	1.23	1.00	0.75	0.56	0.27	1.25	0.89		1.55
	10	ASC Admission: Heart Failure	R	P	1.33	1.17	1.04	0.90	0.76	0.56	0.27	1.22	1.07		1.25
	11	Percent of PCPs who Qualified for EHR Incentive Payment	R	P	51.35	59.70	65.38	70.20	76.15	84.85	90.91	57.55	72.26	667	3.10
	12	Medication Reconciliation	R	P	30.00	40.00	50.00	60.00	70.00	80.00	90.00	73.81	93.41	683	2.00
	13	Falls: Screening for Fall Risk	R	P	17.12	22.35	27.86	35.55	42.32	51.87	73.38	46.30	47.31	594	1.70
Preventive Health	14	Influenza Immunization	R	P	29.41	39.04	48.29	58.60	75.93	97.30	100.00	71.36	63.81	572	1.55
	15	Pneumococcal Vaccination	R	P	23.78	39.94	54.62	70.66	84.55	96.64	100.00	77.73	77.80	599	1.55
	16	Adult Weight Screening and Follow-up	R	P	40.79	44.73	49.93	66.35	91.34	99.09	100.00	70.94	70.81	418	1.55
	17	Tobacco Use Assessment and Cessation Intervention	R	P	30.00	40.00	50.00	60.00	70.00	80.00	90.00	91.37	96.67	600	2.00
	18	Depression Screening	R	P	5.31	10.26	16.84	23.08	31.43	39.97	51.81	24.71	28.07	456	1.55
	19	Colorectal Cancer Screening	R	R	19.81	33.93	48.49	63.29	78.13	94.73	100.00	65.33	70.27	592	2.00
	20	Mammography Screening	R	R	28.59	42.86	54.64	65.66	76.43	88.31	99.56	68.04	71.12	599	2.00
	21	Proportion of Adults who had blood pressure screened in past 2 years	R	R	30.00	40.00	50.00	60.00	70.00	80.00	90.00	68.66	66.43	414	2.00
At-Risk Population Diabetes	Diabetes Composite 22 – 26	ACO #22. Hemoglobin A1c Control (HbA1c) (<8 percent) ACO #23. Low Density Lipoprotein (LDL) (<100 mg/dL) ACO #24. Blood Pressure (BP) < 140/90 ACO #25. Tobacco Non Use ACO #26. Aspirin Use	R	R	17.39	21.20	23.48	25.78	28.17	31.37	36.50	23.08	28.67	600	2.00
	27	Percent of beneficiaries with diabetes whose HbA1c in poor control (>9 percent)	R	P	70.00	60.00	50.00	40.00	30.00	20.00	10.00	22.12	13.10	603	1.85
At-Risk Population Hypertension	28	Percent of beneficiaries with hypertension whose BP < 140/90	R	P	60.00	63.16	65.69	68.03	70.89	74.07	79.65	67.04	70.57	581	1.55
At-Risk Population IVD	29	Percent of beneficiaries with IVD with complete lipid profile and LDL control < 100mg/dl	R	R	35.00	42.86	51.41	57.14	61.60	67.29	78.81	60.92	58.81	471	2.00
	30	Percent of beneficiaries with IVD who use Aspirin or other antithrombotic	R	P	45.44	56.88	68.25	78.77	85.00	91.48	97.91	86.65	90.02	471	1.70
At-Risk Population HF	31	Beta-Blocker Therapy for LVSD	R	R	30.00	40.00	50.00	60.00	70.00	80.00	90.00	81.78	84.12	170	2.00
At-Risk Population CAD	CAD Composite 32 – 33	ACO #32. Drug Therapy for Lowering LDL Cholesterol ACO #33. ACE Inhibitor or ARB Therapy for Patients with CAD and Diabetes and/or LVSD	R	R	54.08	61.44	66.11	69.96	72.32	76.40	79.84	58.95	66.67	438	2.00

2014 Percentile
2013 Percentile
2013 & 2014 Percentile (No Change)

OneCare 2013 to 2014

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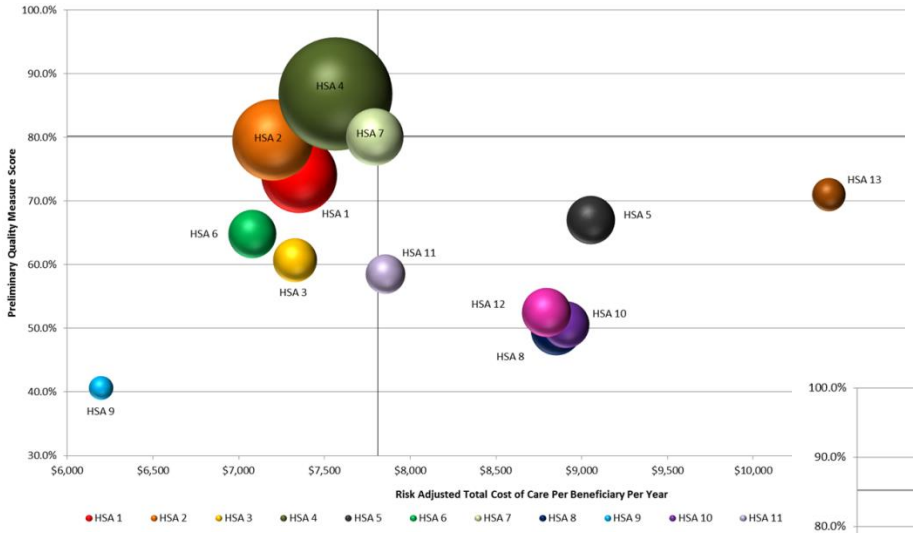
2013 Cost and Quality by HSA



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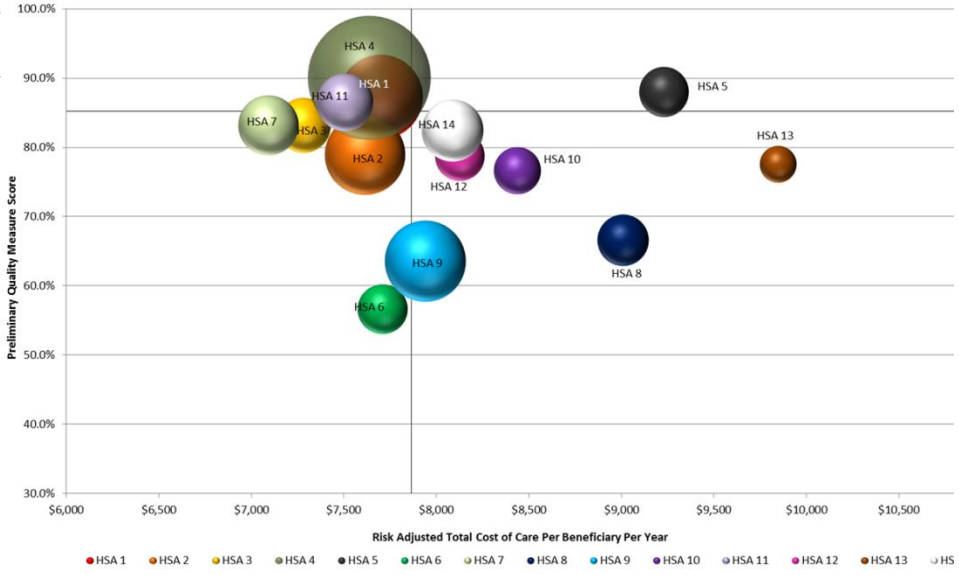
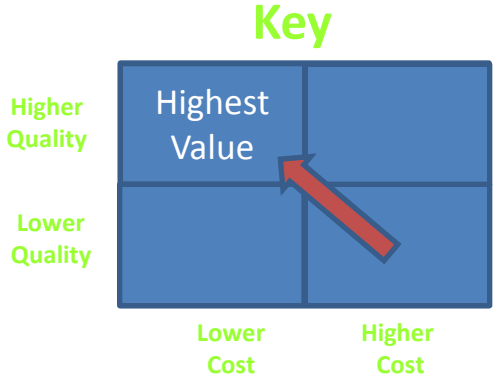
2014 Cost and Quality by HSA



Key



OneCare: Care Coordination Facilitation

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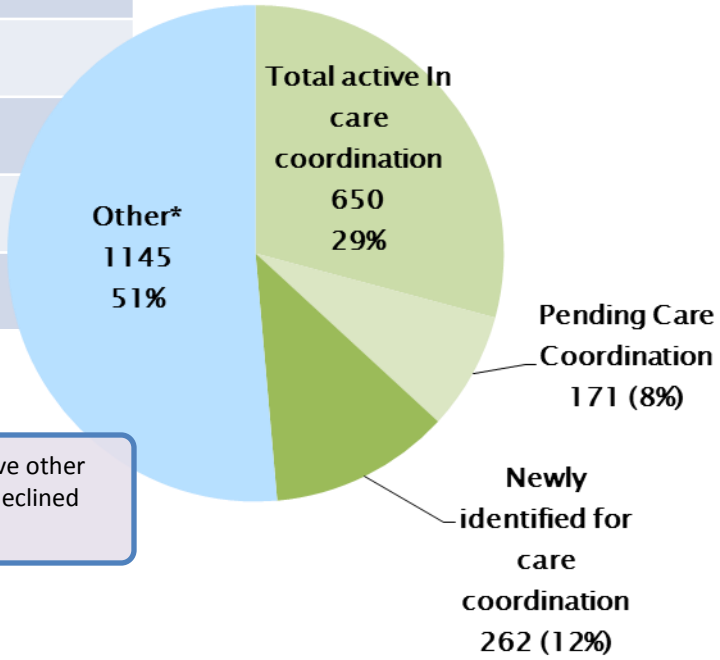
OneCare High Risk Members Active in Care Coordination (Individuals can be active in more than one)	
Total in Care Coordination	**650 (29% of eligible)**
Resource	
CHT or Office Based Care Coordination	285 (44%)
Home Health or Hospice	255 (39%)
Support and Services at Home (SASH)	37 (6%)
Vermont Chronic Care Initiative (VCCI)	30 (5%)
Area Agency on Aging /Senior Solutions	5 (.8%)



*Other = members have other care support or have declined care coordination

Part Two: Becoming a Risk Based ACO

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- One of 26 Organizations accepted into Next Generation
  - 21 Started in 2016 and 5 Deferred until 2017 (including OneCare)
- 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 All-Payer Model

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- Non-final CMS/CMMI waiver term Sheet released Monday
  - Focus on Medicare, but predicated on all-payer system including Medicaid and commercial
  - Covers Vermont citizens
  - Terms to be basis of contractual commitment between State of Vermont and CMS/CMMI later in 2016
- Documents indicate that the all-payer system and primary payment reform lever is intended to be ACO(s)
  - Envisions applying Next Gen model (modified Medicare Next Gen with aligned lookalike programs for Medicaid/Commercial)
  - In term sheet, GMCB acknowledges authority to:
    - > "Enter into this Model Agreement"
    - > "Set rates for providers and require payers to comply with those rates"
    - > "Regulate a statewide ACO and other components of the health care system consistent with the Model Agreement"
  - Companion document states: "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"

APM Term Sheet Major Provisions

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- Regulated Revenue and Payment Waivers
  - Covers all Part A & B (and equivalent for Medicaid/Commercial)
  - Not initially including Designated Agencies for Mental Health, but Vermont to evaluate readiness and method for inclusion, with rights to submit plan on 6 months notice before effective date
- Regulated Revenue to grow at targeted 3.5% and maximum of 4.3% annually over 5 year period 2017-2021
- Over same period, Medicare expenditures will be 0.2% below national FFS increase
  - But with hold harmless minimums ("floors") of 3.5% in 2017 and 2.0% in 2018-2021
  - Calculated in age cohorts: under 65, 65-74, 75-84, 85+
- ACO Fraud and Abuse Waivers, and Next Gen benefit enhancements included
- Medicare continued participation in the Blueprint for Health (practice payments, CHT, SASH)
- Quality
  - Population Health Goals on (i) Increasing access to primary care, (ii) prevalence/management of chronic disease, and (iii) Addressing substance abuse epidemic
  - Plus statewide APM Quality Targets (i.e. ACO-style measure sets)

Population Risk-Bearing Entities

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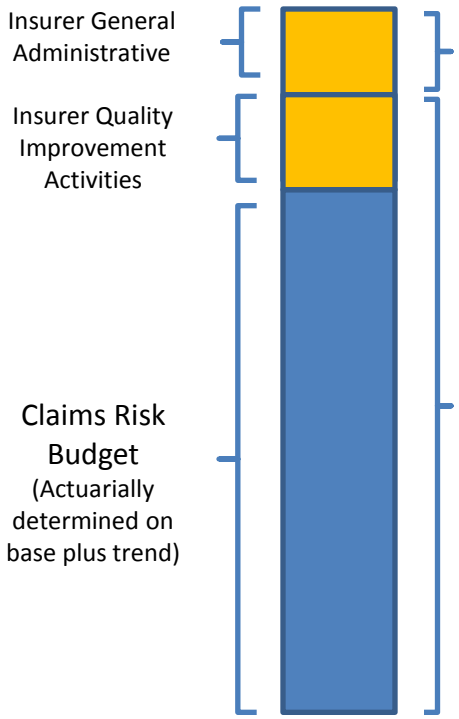
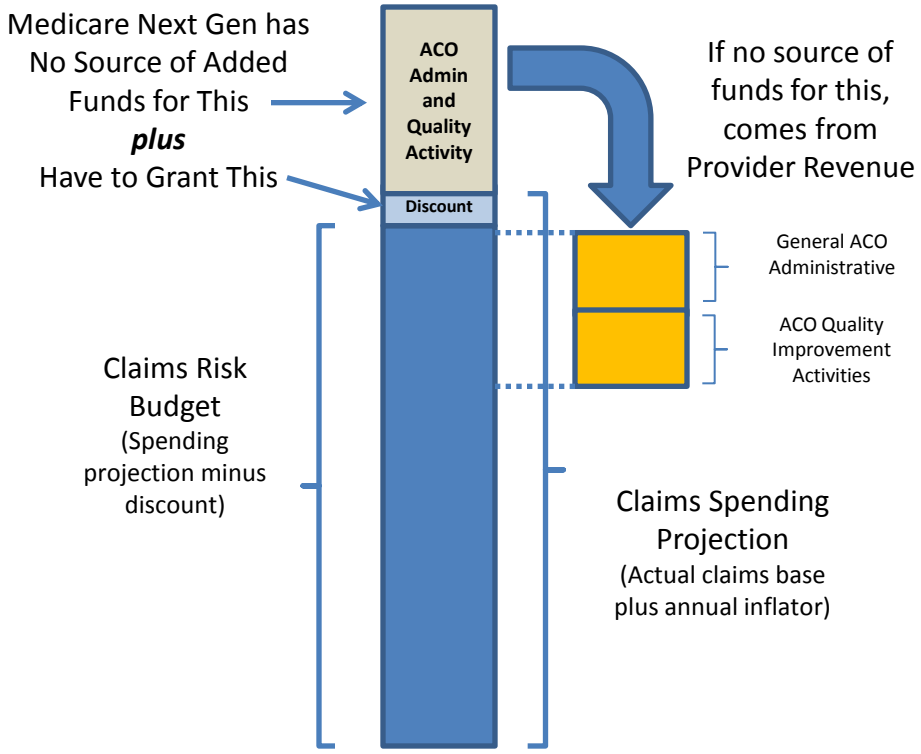
Commercial Insurance Plan (QHP under ACA)



Calculated Admin Ratio
(allowed to be up to 15% for large group)

Calculated Medical Loss Ratio
- Can include insurer quality activity
- Must be at least 85% for large group)

Next Generation ACO



Commercial Insurer "Quality Improvement Activities" Definition

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An allowable quality initiative to count toward Medical Loss Ratio credit must do one of the following:

- Improve health outcomes by implementing activities such as quality reporting, effective case management, care coordination, chronic disease management, or medication and care compliance initiatives
- Implement activities to prevent hospital readmissions including a comprehensive program for hospital discharge that includes patient education and counseling, discharge planning, and post-discharge follow-up by an appropriate health care professional
- Implement activities to improve patient safety and reduce medical errors through the use of best clinical practices, evidence-based medicine, and health information technology under the plan or coverage
- Implement wellness and health promotion activities.

In addition, the HHS rules state that a non-claims expense will be counted as a quality improvement only if it falls into one of the four categories above, and also meets *all* the following requirements:

- Designed to improve health care quality;
- Designed to increase the likelihood of desired health outcomes in ways that can be objectively measured and that can produce verifiable results and achievements;
- Directed toward individual enrollees or incurred for specific segments of enrollees or provide health improvements to the population beyond those enrolled in coverage, so long as no additional costs are incurred due to the non-enrollees; and
- Grounded in evidence-based medicine, widely accepted best clinical practice, or criteria issued by recognized professional medical associations, accreditation bodies, government agencies, or other nationally recognized health care quality organizations.

OneCare in ACA Context

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- OneCare Operational Expenses Focus Significantly on Clinical/Quality Programs
  - We estimate very conservatively that 50% qualifies as "Quality Improvement" under ACA definition for insurers
  - These Quality Improvement expenses are anticipated and in fact welcomed by ACA rules from the commercial payers
  - Nobody questions the need for at least some general administration expenses for a risk-bearing insurance plan
  - **Key Question: As they become risk-bearing entities, should completely analogous ACO expenses be seen as less desirable or less necessary than insurer expenses?**
- Based on the ACA definition, OneCare's Medical-Loss-Ratio equivalent is approximately 98%-99%
  - Some reasons why so much better than the 85% standard
    - > Large scalability across Medicare, Medicaid, and Commercial combined populations
    - > No sales and marketing unless become health plan vendor/carrier
    - > Easier path to transfer risk to contracted providers through payment reform
    - > ACO model is to provide systems, data and facilitation for clinical/quality programs but embed these actual processes into the local care delivery system
      - – Payers still do significant amount of central telephonic disease management and care coordination
- But still have issue of funding source for both ACO administrative and quality improvement program expenses (i.e. the ACO Budget)

Part Three: What Happens from Here?

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

Vermont Care Organization
"APM" Program as Statewide ACO
Required Network: Participants from 3 current ACOs

2017

Where we could go…

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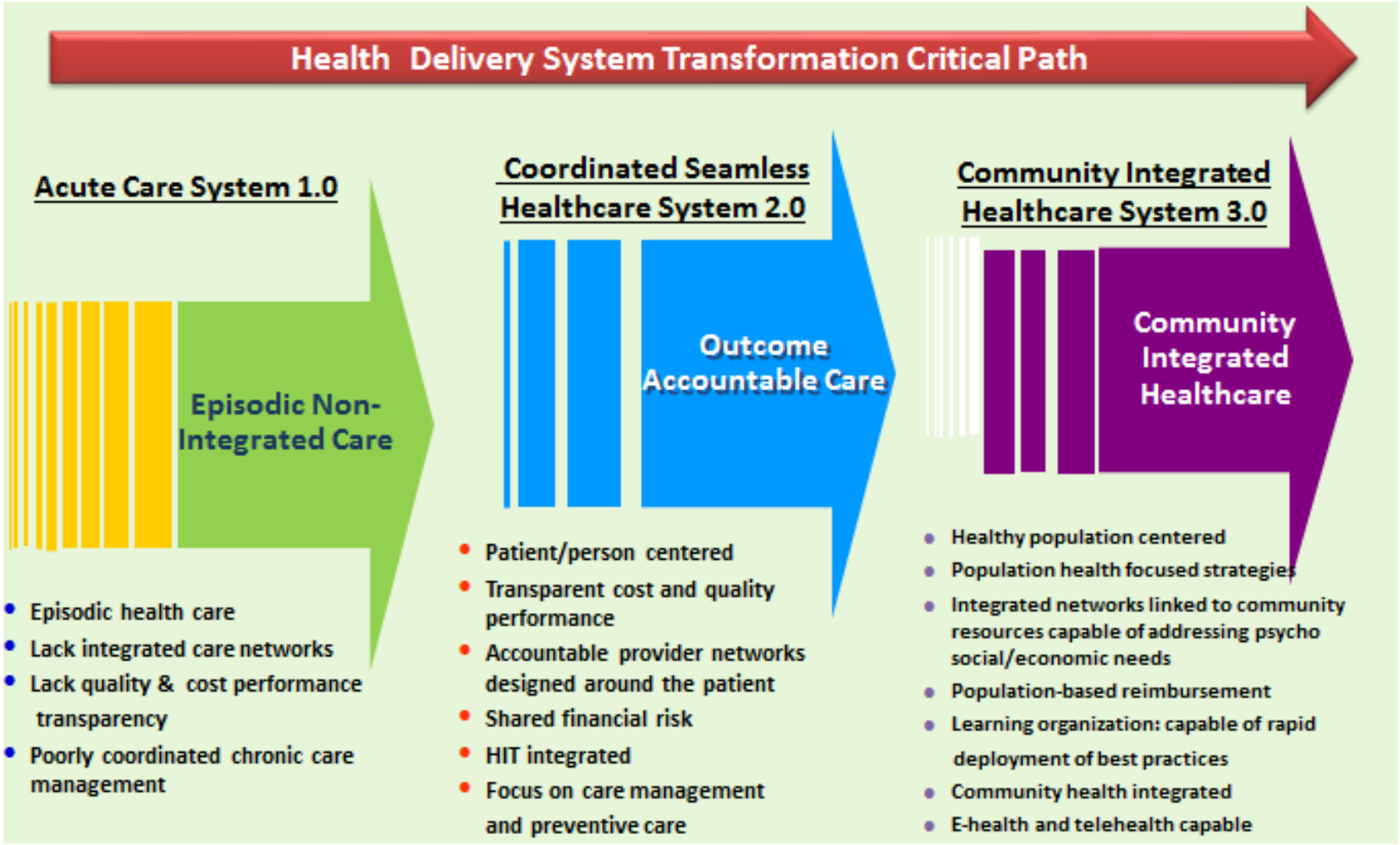

Halfon N. et al, Health Affairs November 2014