# ACCOUNTABLE CARE ORGANIZATIONS

## UPDATE TO THE HOUSE HEALTH CARE AND HOUSE HUMAN SERVICES COMMITTEES

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# Accountable Care and ACOs


**"Accountable Care"**

- Payment reform based on physicians, hospitals and other providers being ***accountable for total cost and quality/satisfaction*** of health care for an attributed patient population

**"Accountable Care Organization" = ACO**

- A voluntary organization of providers participating in population-based Accountable Care programs for Medicare, and/or Medicaid, and/or Commercial Health Plans

**"Attributed Patient Population"**

- Under current ACO programs, determined as those having established primary care relationships with physicians participating in the ACO network

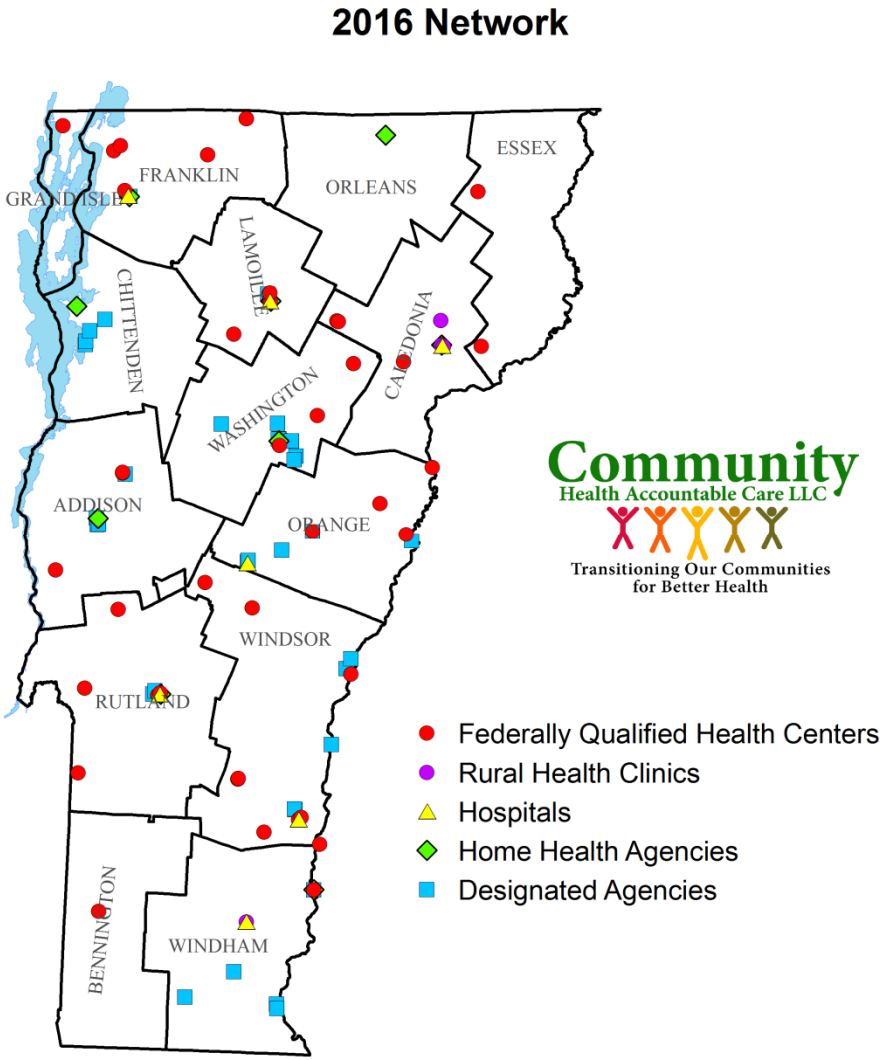
# The ACO Model

- Provider-led way to embrace payment reform and “value over volume”
- Brings quality and satisfaction management to same standing as financial management
- Designed to incent networks of providers across the continuum of care
- Provides unprecedented information to provider networks for better coordination and analyzing opportunities for improvement
- Is specifically a different model than traditional “managed care”
- Substantial additional value comes as ACOs move from shared savings to population payments
- The ultimate vision is a multi-payer common model

# Vermont ACO Landscape

- 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

# Introduction to CHAC




Community
Health Accountable Care LLC
Transitioning Our Communities for Better Health

**CHAC's Participant Network 1/1/2016**

- 10 Federally qualified health centers
- 4 Rural health clinics
- 7 Hospitals
- 14 Designated agencies
- 9 Certified home health agencies

| Payer Groups | CHAC 2015 | CHAC 2016 |
|---|---|---|
| **Medicaid** | 20,000 | ~30,000 |
| **Medicare** | 6,400 | 14,700 |
| **Commercial** | 8,900 | ~10,500 |
| **Total** | **35,300** | **~55,000** |

# CHAC Strengths

- Founded by primary care providers to ensure a primary-care driven approach
- Reinvests savings in primary care integration with community-based services
- Builds on Blueprint's patient-centered medical homes and community care teams
- Committed to a community-based system that addresses social determinants by integrating mental health, substance abuse, social and human services with primary care

# Introduction to OneCare

- Formed in 2012 by University of Vermont Medical Center and Dartmouth-Hitchcock Health
- Independent board with innovative governance model from inception
- Leadership and staff formally employed by UVMHN Accountable Care Services Division, but deployed to conduct work of OneCare under leadership of its governance
- Largest network among Vermont ACOs and largest attributed population served
- Started in Medicare Shared Savings program in 2013 and added the Commercial Exchange and Vermont Medicaid Shared Savings Programs in 2014

# OneCare Strengths

- Experience in managing a large-scale full-continuum ACO
- Experience in provider-based risk contracts from Vermont Managed Care
- Resources for  pushing ahead into more substantial payment reform under the Medicare “Next Generation ACO” program and/or All Payer Model in 2017
- Significant informatics investment and infrastructure
- Strong track record of aligning the Blue Print and ACO-based model
- Leaders and collaborators in designing an adequate and equitable financial model for Primary Care
- Focus on high health-risk individuals which confirms local care coordination, and actively refers those without for such assistance
- Ability to facilitate common priorities, processes and systems to reduce variation in practice and outcomes across Vermont
- Access to the capabilities resident at its founding AMCs including the UVM Jeffords Institute for Quality and Dartmouth-Hitchcock Value institute

# Introduction to HealthFirst ACOs

## ACO Participant Network

- 24 Primary Care Practices
- ~ 25 Specialty Practices
- Located in 6 counties: Addison, Chittenden, Franklin, Lamoille, Rutland, and Windsor

| Payer Groups | ACO Name | Attributed Patients | Years Participating |
|---|---|---|---|
| **Medicaid** | na | 8,900 | na |
| **Medicare** | ACCGM* | 7,500 | 2012 - 2015 |
| **Commercial** | VCP* | 8,600 | 2014 - Current |

* Accountable Care Coalition of the Green Mountains (ACCGM) and Vermont Collaborative Physicians (VCP)

# Why did HealthFirst start an ACO in 2012?

- To build up a foundation of strong and integrated primary care practices leveraging learnings from the Blueprint
- All participants in HealthFirst ACO programs are Primary Care practices
- Specialty practices support primary care practices through a collaborative care agreement
- Unfortunately, by 2015 we have not managed to invest more in primary care through ACO programs – 10 independent PCPs (ACO participants) in Franklin County have closed down their practices

# HealthFirst ACO Approach - What are we doing to improve quality and lower costs?

Participating Primary Care practices:

1) Better manage Transitions of Care
2) Focus on Wellness and Prevention
3) Encourage Patient Self-Management
4) Refer patients to appropriate Lower-cost Settings of Care
5) Improve Quality Performance

# 2014 HealthFirst ACO Quality Results

- Commercial ACO attributed patients had almost 20% fewer emergency department visits and 20% more visits with primary care doctors than expected given their risk profile
- Commercial ACO total quality score was 89%, scoring close to or above the 75$^{th}$ percentile compared to national benchmarks on all measures
- Medicare ACO total quality score was 92%, above the 80$^{th}$ percentile nationally, with just 60 out of 333 ACOs scoring above 90%

# Vermont's ACOs

- Impactful performance across all three ACOs
  - Medicare
    - Cost per beneficiary well below national average
    - Medicare rates of spending growth at generational lows
    - Medicare ACO quality scores show excellent performance (top quartile or higher) and statistically significant improvement over time on both statewide mean and variation
  - Medicaid
    - Both ACOs who participated in the Medicaid Shared savings drove savings against expected FFS spending with excellent quality performance
  - Commercial
    - Challenge of target setting under payer premiums in first year of Vermont Health Connect plans made beating target infeasible, but costs almost certainly lower than if ACOs efforts had not existed
    - Significance of, and performance on, common quality measure set very high

# MOU Steering Committee Update

- MOU signed by all three ACOs in early fall 2015 to explore the pros/cons of a single ACO model
- Productive discussions to date including agreement on a unified ACO governance model
- Operational vision to be designed in business planning phase currently starting (1Q16) with necessary functions, resources and infrastructure
- Working together as ACOs with DVHA/Blueprint to envision the right public-private partnership and best model to ensure continuity of successful innovations to date
- Continued sense that single ACO is only relevant/feasible under APM

# Key Elements for Mutually Supported Plan

- Recognizes the need to invest in community providers (home health, mental health agencies, Area Agencies on Aging, etc.) to ensure seamless and successful transitions
- Engages providers in best practices and fosters continuous learning
- Invests in systems and incentives to engage Vermonters in healthy behaviors, support effective self-management of chronic diseases, and provide affordable access to care when people need it

Questions?