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# Accountable Care Discussion

## Vermont House Appropriations Committee

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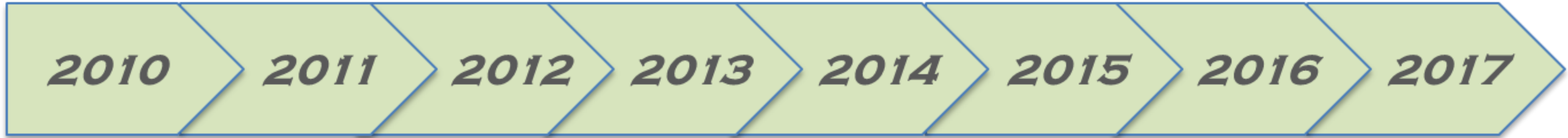
April 20, 2017

# A Continuing Journey on Coverage and Payment Reform

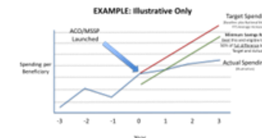


**2010-2011**
**Legislative Action**
*National*: PPACA
*Vermont*: Act 48

**2011-2012**
**Early Implementation**
*National*: MSSP ACO Program; Age 26; Exchange Planning
*Vermont*: GMCB seated; VT exchange legislation; Hospital NR growth limits, payment reform pilots

**2012-2014**
**Becoming Real**
*National*: ACA benefit plans, exchanges, Medicaid expansion
*Vermont*: SIM Grant, VT Health Connect, Multi-Payer ACO programs

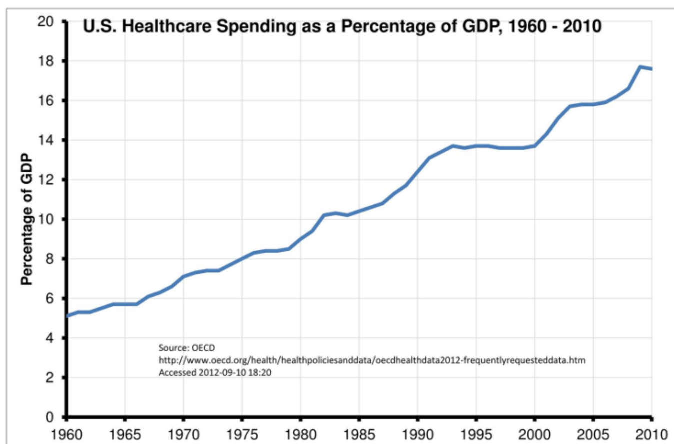
**2014-2016**
**Getting Serious**
*National:* Strong Commit to Value-Based Payment, ACO Risk, Multi-Payer Models, Deal on SGR
*Vermont*: Multiple ACOs, creating VCO, Negotiate All Payer Model

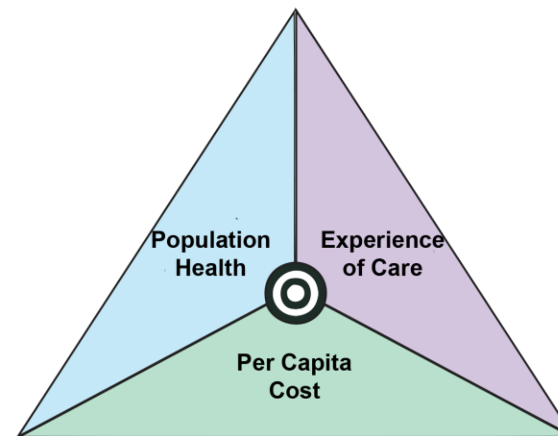


**2017+**
**Future Model**
*National*: Replace/modify ACA, implement MACRA/MIPS, Continue ACO programs
*Vermont*: APM, Medicaid Next Generation, True non-FFS payment reform, broad-based population health management

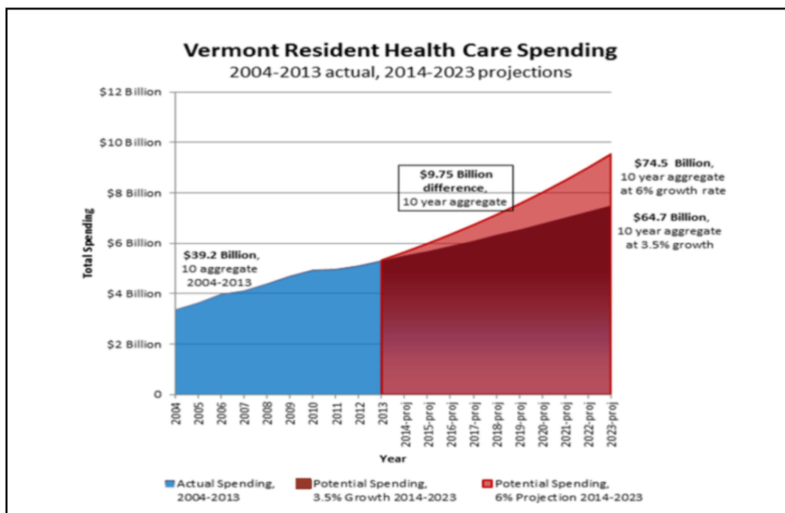
# Value-Based Payment Reform Roots

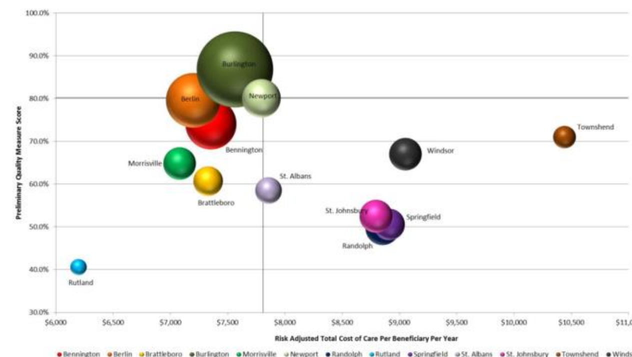
## Unsustainable Cost Growth + Mixed Quality, Service, and Value




IHI Triple Aim



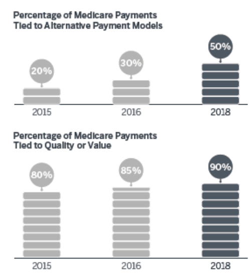
# Medicare/CMS Leading the Charge*

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's PAYMENT GOALS




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

### Health Care Payment Learning and Action Network
- 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

608 Organizations supporting the network and its objectives

Disruption to Fee-for-Service Business Model — Voluntary — CY 2015

### Comprehensive Primary Care Initiative
- Multi-payer program providing primary care practices with monthly care management payments to support practice transformation; practices are eligible to share in Medicare savings
- 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

475 Primary care practices participating in the program

Disruption to Fee-for-Service Business Model — Voluntary — FY 2013

### Hospital Value-Based Purchasing Program
- 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, increases by 0.25% annually until reaching 2% in 2017

2% Hospital inpatient Medicare payment at risk when fully implemented in 2017

Disruption to Fee-for-Service Business Model — Mandatory — FY 2013

### Hospital Readmissions Reduction Program
- 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

3% Hospital inpatient Medicare payment at risk

Disruption to Fee-for-Service Business Model — Mandatory — FY 2013

### Hospital-Acquired Condition Reduction Program
- 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

25% Hospitals mandated to face the penalty

Disruption to Fee-for-Service Business Model — Mandatory — FY 2015

### Merit-Based Incentive Payment System
- 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

9% Physician Medicare payment at risk when fully implemented in 2022

Disruption to Fee-for-Service Business Model — Mandatory — CY 2019

### Bundled Payments for Care Improvement Initiative
- 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

2K+ Organizations participating in the program

Disruption to Fee-for-Service Business Model — Voluntary — CY 2012

### Comprehensive Care for Joint Replacement Model
- 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

75 Markets proposed for participation in the program

Disruption to Fee-for-Service Business Model — Mandatory — CY 2016

### Oncology Care Model
- 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

$960 Per-beneficiary care management fee for six-month episode of care

Disruption to Fee-for-Service Business Model — Voluntary — CY 2016

### Medicare Shared Savings Program
- 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

404 ACOs participating in the program

Disruption to Fee-for-Service Business Model — Voluntary — CY 2012

### Pioneer ACO Model
- CMMI program offering an advanced path for providers to form ACOs that serve Medicare fee-for-service beneficiaries; 19 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

$384M Total savings generated by Pioneer ACOs, 2012–2013

Disruption to Fee-for-Service Business Model — Voluntary — CY 2012

### Next Generation ACO Model
- CMMI program offering advanced population 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

15–20 Organizations expected to participate in 2016

Disruption to Fee-for-Service Business Model — Voluntary — CY 2016

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See our latest on payment transformation
advisory.com/hcab/paytransformation

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**12 Major Programs**
- 5 Mandatory
- 7 Optional

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

**True innovation increasingly provided/allowed in more advanced models**

* Expected to continue given bipartisan support for value-based elements of health reform

# Accountable Care and ACOs

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**<u>"Accountable Care"</u>**

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

**<u>"Accountable Care Organization" = ACO</u>**

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

**<u>"Attributed Patient Population"</u>**

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

# The Basic ACO Transformation

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Shift

## Encounter-Based Delivery System

- Optimized for high quality provider visits to treat a specific illness, injury, or problem in isolation
- Limited incentive for delivery system to organize around the patient's complete health care needs and experience
- Providers paid through "after the fact" claims for reimbursement for individual encounters of care
- Providers do best by ***maximizing volume***

## Person-Based Delivery System

- Optimized for proactive partnership with all patients to manage health and proactively plan care needs
- Significant ability and incentives to understand entire patient and all care provided
- Provider networks to be increasingly pre-paid on a per-person basis to deliver and/or manage all care needed across a population of people
- Providers do best by ***maximizing value*** (high quality, low cost)

# Key Economic Concept: Movement to "Risk"

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- "Risk" in this context is where health care provider performance includes *financial accountability for cost overruns*
  - Current ACO models dominated by "upside only" savings but that was never intended as anything other than transitional model
- CMS is closing the exits to completely avoid this movement:
  - Standard Medicare ACO program has maximum 6 years before risk
  - Increasing attractiveness of risk ACO Models
  - Mandatory bundled payments
  - MACRA/MIPS in 2019 for all Medicare physicians
  - CMS requirements/incentives for multi-payer payment reform
  - State innovation models with strong payment reform element (like Vermont's APM)
  - Recent 1115 Medicaid Waivers (including Vermont) focused on moving Medicaid into ACOs and payment reform

# Risk Example: VMNG Economic Model

Attributed Medicaid Population
29,103

**Total Cost of Care Target**
**$90,210,000**
(2015 actual with 2013-15 Trend applied 2015-2017, Population Age Adjustments, Minus 0.2% Discount)

## Fixed Revenue (i.e. Risk Managed)

| UVM MC | CVMC | NMC | Porter |
|---|---|---|---|
| $32,771,000 | $11,293,000 | $9,553,000 | $4,088,000 |

Fixed Payment Model for 4 Hospitals

**Fixed**
**$57,705,000**

## Variable/FFS Revenue

| VT Home Health | VT FQHC | VT Ind. Physician | Dartmouth-Hitchcock | Other VT Hospitals | Other Vermont | Out of State |
|---|---|---|---|---|---|---|
| $1.4M | $1.8M | $5.2M | $1.3M | $1.6M | $18.4M | $2.9M |

**Variable (FFS)**
**$32,505,000**

**0.5% Required Allocation to Quality Based Incentive = $451K**

**Savings**
**Additional Incentives from Savings; Maximum $2,706,000**

**Losses**
**Maximum Payback to DVHA = $2,706,000**

**Incentives and Savings**
Measurement and Distribution Models under Development

**Loss Payback**
If needed, payback provided by participating hospitals based on pre-configured formula with maximum commitment

Savings/Losses come from spending on this side:

- 1% on ***these providers/services*** = savings or payback of $325,000
- 3% = savings or payback of $975,000
- 5% = savings or payback of $1,625,000
- 8% = savings or payback of $2,706,000 (Maximum Total Risk)

# The Opportunity is Still There

**How the U.S. Can Reduce Waste in Health Care Spending by $1 Trillion**

**HBR Online November 2015**

We had two key findings:

- The political rhetoric about demand-side versus supply-side as a better option is ill-founded; both have roughly the same effect on total spending.
- Even if the United States implemented all the approaches whose effectiveness has been measured, only 40% of the estimated $1 trillion of wasteful spending would be addressed, leaving a significant opportunity for innovation in all areas of health care.

### Types of Waste in U.S. Health Care Spending

| CATEGORY | DESCRIPTION | PERCENT OF HEALTH CARE SPENDING |
|---|---|---|
| CLINICAL WASTE | Spending that could be reduced with better prevention or higher-quality initial care; replacing services with less-resource-intensive alternatives; or improving processes by standardizing best practices | 14% |
| ADMINISTRATIVE COMPLEXITY | Spending that could be eliminated with simpler, more-standardized processes for billing and collections, credentialing, compliance, and oversight | 9% |
| EXCESSIVE PRICES | Overspending resulting from paying high prices charged by inefficient suppliers (including providers), which could be eliminated by tying prices to efficiency, outcomes, and a fair profit | 5% |
| FRAUD AND ABUSE | Spending associated with illicit schemes to extract payments for the illegitimate delivery of health care services | 7% |

NOTE THE THREE DESCRIPTIONS OF CLINICAL WASTE ARE AN AGGREGATION OF BERWICK AND HACKBARTH'S ORIGINAL ANALYSIS.
SOURCE "ELIMINATING WASTE IN U.S. HEALTH CARE," BY DONALD M. BERWICK AND ANDREW D. HACKBARTH, 2012

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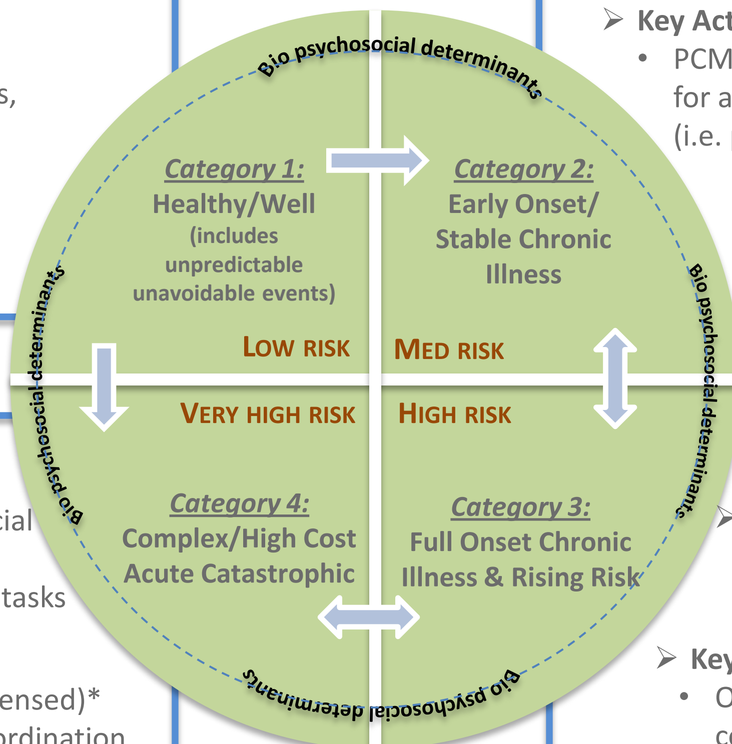
# Population Health Management Model

- **44% of the population**
- **Focus:** Maintain health through preventive care and community-based wellness activities
- **Key Activities:**
  - PCMH panel management
  - Preventive care (e.g. wellness exams, immunizations, health screenings)
  - Wellness campaigns (e.g. health education and resources, wellness classes, parenting education)

- **40% of the population**
- **Focus:** Optimize health and self-management of chronic disease
- **Key Activities:** Category 1 plus
  - PCMH panel management: outreach (≥2/yr) for annual Comprehensive Health Assessment (i.e. physical, mental, social needs)
    - Disease & self-management support* (i.e. education, referrals, reminders)
    - Pregnancy education




- **6% of the population**
- **Focus:** Address complex medical & social challenges by clarifying goals of care, developing action plans, & prioritizing tasks
- **Key Activities:** Category 3 plus
  - Designate lead care coordinator (licensed)*
  - Outreach & engagement in care coordination (at least monthly)*
  - Coordinate among care team members*
  - Assess palliative & hospice care needs*
  - Facilitate regular care conferences *

**16% Lives**
**40% Spending**
**89% Multiple Chronic**
**67% MH Condition**

- **10% of the population**
- **Focus:** Active skill-building for chronic condition management; address co-occurring social needs
- **Key Activities:** Category 2 plus
  - Outreach & engagement in care coordination (≥4x/yr)*
  - Create & maintain shared care plan*
  - Coordinate among care team members*
  - Emphasize safe & timely transitions of care
  - SDoH management strategies*

* Activities coordinated via Care Navigator software platform

# Quality and Satisfaction Measurement are Major Elements

## Quality Measure Scores PY3 2015

### Reporting and Performance Measures

| | | Measure | PY 2015 | 30th (1.10) | 40th (1.25) | 50th (1.40) | 60th (1.55) | 70th (1.70) | 80th (1.85) | 90th (2.00) | OCV 2013 | OCV 2014 | OCV 2015 | ★ | CMS QI | n 2015 | Quality Points 2015 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Patient/Caregiver Experience | 1 | Getting Timely Care, Appointments, and Information | P | 30.00 | 40.00 | 50.00 | 60.00 | 70.00 | 80.00 | 90.00 | 83.81 | 85.01 | 79.26 | ★ | | 261 | 1.70 |
| | 2 | How Well Your Doctors Communicate | P | 30.00 | 40.00 | 50.00 | 60.00 | 70.00 | 80.00 | 90.00 | 92.54 | 92.47 | 93.39 | | | 262 | 2.00 |
| | 3 | Patients' Rating of Doctor | P | 30.00 | 40.00 | 50.00 | 60.00 | 70.00 | 80.00 | 90.00 | 91.84 | 91.45 | 92.25 | | | 246 | 2.00 |
| | 4 | Access to Specialists | P | 30.00 | 40.00 | 50.00 | 60.00 | 70.00 | 80.00 | 90.00 | 82.21 | 86.00 | 79.71 | | | 104 | 1.70 |
| | 5 | Health Promotion and Education | P | 54.71 | 55.59 | 56.45 | 57.63 | 58.22 | 59.09 | 60.71 | 59.46 | 60.61 | 57.55 | | | 310 | 1.40 |
| | 6 | Shared Decision Making | P | 72.87 | 73.37 | 73.91 | 74.51 | 75.25 | 75.82 | 76.71 | 75.98 | 73.81 | 75.71 | | | 233 | 1.70 |
| | 7 | Health Status/Functional Status | R | N/A | N/A | N/A | N/A | N/A | N/A | N/A | 73.70 | 74.12 | 75.19 | | | 310 | 2.00 |
| | 34 | Stewardship and Patient Resources | R | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | 20.26 | | | 293 | 2.00 |
| Care Coordination | 8 | Risk Standardized, All Condition Readmissions | P | 16.62 | 16.41 | 16.24 | 16.08 | 15.91 | 15.72 | 15.45 | 14.75 | 14.84 | 14.73 | | | - | 2.00 |
| | 35 | Skilled Nursing Facility 30-day All-Cause Readmission measure (SNFRM) | R | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | 15.72 | | | - | 2.00 |
| | 36 | All-Cause Unplanned Admissions for Patients with Diabetes | R | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | 52.08 | | | - | 2.00 |
| | 37 | All-Cause Unplanned Admissions for Patients with Heart Failure | R | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | 83.26 | | | - | 2.00 |
| | 38 | All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions | R | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | 66.82 | | | - | 2.00 |
| | 9 | ASC Admissions: COPD or Asthma in Older Adults | P | 1.75 | 1.46 | 1.23 | 1.00 | 0.75 | 0.56 | 0.27 | 1.25 | 0.89 | 0.83 | | + | - | 1.55 |
| | 10 | ASC Admission: Heart Failure | P | 1.33 | 1.17 | 1.04 | 0.90 | 0.76 | 0.59 | 0.38 | 1.22 | 1.07 | 0.87 | | + | - | 1.55 |
| | 11 | Percent of PCPs who Qualified for EHR Incentive Payment | P | 51.35 | 59.70 | 65.38 | 70.20 | 76.15 | 84.85 | 90.91 | 57.55 | 72.26 | 97.58 | ★ | + | 785 | 4.00 |
| | 39 | Documentation of Current Medications in the Medical Record | R | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | 79.03 | | | 1750 | 2.00 |
| | 13 | Falls: Screening for Fall Risk | P | 17.12 | 22.35 | 27.86 | 35.55 | 42.32 | 51.87 | 73.38 | 46.30 | 47.31 | 65.56 | ★ | + | 363 | 1.85 |
| Preventive Health | 14 | Influenza Immunization | P | 30.00 | 40.00 | 50.00 | 60.00 | 70.00 | 80.00 | 90.00 | 71.36 | 63.81 | 68.15 | | + | 336 | 1.55 |
| | 15 | Pneumococcal Vaccination | P | 30.00 | 40.00 | 50.00 | 60.00 | 70.00 | 80.00 | 90.00 | 77.73 | 77.80 | 84.70 | ★ | + | 366 | 1.85 |
| | 16 | Adult Weight Screening and Follow-up | P | 30.00 | 40.00 | 50.00 | 60.00 | 70.00 | 80.00 | 90.00 | 70.94 | 70.81 | 71.94 | | | 360 | 1.70 |
| | 17 | Tobacco Use Assessment and Cessation Intervention | P | 30.00 | 40.00 | 50.00 | 60.00 | 70.00 | 80.00 | 90.00 | 91.37 | 96.67 | 93.46 | ★ | | 367 | 2.00 |
| | 18 | Depression Screening | P | 5.31 | 10.26 | 16.84 | 23.08 | 31.43 | 39.97 | 51.81 | 24.71 | 28.07 | 35.42 | ★ | + | 271 | 1.70 |
| | 19 | Colorectal Cancer Screening | P | 30.00 | 40.00 | 50.00 | 60.00 | 70.00 | 80.00 | 90.00 | 65.33 | 70.27 | 70.36 | | | 361 | 1.70 |
| | 20 | Mammography Screening | P | 30.00 | 40.00 | 50.00 | 60.00 | 70.00 | 80.00 | 90.00 | 68.04 | 71.12 | 75.14 | | + | 362 | 1.70 |
| | 21 | Proportion of Adults who had blood pressure screened in past 2 years | P | 30.00 | 40.00 | 50.00 | 60.00 | 70.00 | 80.00 | 90.00 | 68.66 | 66.43 | 80.62 | ★ | + | 258 | 1.85 |
| At-Risk Populations | 40 | Depression Remission at Twelve Months | R | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | 4.35 | | | 23 | 2.00 |
| | 27 and 41 | ACO #27:Percent of beneficiaries with diabetes whose HbA1c in poor control (>9 percent) Hemoglobin A1c Control (HbA1c) (<8 percent) ACO #41: Diabetes - Eye Exam | R | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | 53.85 | | | 364 | 2.00 |
| | 28 | Percent of beneficiaries with hypertension whose BP < 140/90 | P | 60.00 | 63.16 | 65.69 | 68.03 | 70.89 | 74.07 | 79.65 | 67.04 | 70.57 | 71.21 | | + | 257 | 1.70 |
| | 30 | Percent of beneficiaries with IVD who use Aspirin or other antithrombotic | P | 30.00 | 40.00 | 50.00 | 60.00 | 70.00 | 80.00 | 90.00 | 86.65 | 90.02 | 92.86 | | | 308 | 2.00 |
| | 31 | Beta-Blocker Therapy for LVSD | P | 30.00 | 40.00 | 50.00 | 60.00 | 70.00 | 80.00 | 90.00 | 81.78 | 84.12 | 80.52 | | | 154 | 1.85 |
| | 33 | ACE Inhibitor or ARB Therapy for Patients with CAD and Diabetes and/or LVSD | P | 64.37 | 70.43 | 75.07 | 78.28 | 82.53 | 86.75 | 91.67 | N/A | N/A | 84.75 | | | 223 | 1.70 |

★ statistically significant change in score from 2014 to 2015 based on p-value < 0.05.

+ significant improvement based on CMS Quality Improvement Report

| 2015 Final Score | 2014 Final Score | Percent Change |
|---|---|---|
| 96.1% | 89.2% | ↑ 6.9% |

# Medicare 2014 Quality Scores with Clinical and Claims Based Measures vs Risk Adjusted Total Cost of Care by HSA

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Interally Calcualted Quality Measure Score

100%
80%
60%
40%
20%
0%

Burlington
OCV
Windsor
St. Albans
Bennington
2014 Weighted Average Internally Calculated QM Score =86.1%
Newport
Middlebury
Brattleboro
Berlin
St. Johnsbury
Springfield
Townshend
Rutland
Randolph
Morrisville
2014 OCV Risk Adj PBPY = $7,864

$6,000 $6,500 $7,000 $7,500 $8,000 $8,500 $9,000 $9,500 $10,000 $10,500 $11,000

Risk Adjusted Total Cost of Care Per Beneficiary Per Year

| Total Sample Size for all included Measures Combined 2014 | |
|---|---|
| Bennington | 1087 |
| Berlin | 1262 |
| Brattleboro | 553 |
| Burlington | 2534 |
| Middlebury | 577 |
| Morrisville | 366 |
| Newport | 425 |
| Randolph | 381 |
| Rutland | 1166 |
| Springfield | 252 |
| St. Albans | 726 |
| St. Johnsbury | 127 |
| Townshend | 142 |
| Windsor | 408 |

-Beneficiaries may be counted more than once if sampled for multiple measures.

Notes:

- Measures that could reliably be broken out by HSA were included in internally calculated scores, this excludes measures calculated with O/E ratios by the payer and survey measures.
- Medicare 2014 includes measures 8, 12, 13, 14 ,15 ,16 ,17 ,18, 19, 20, 21, 22-26, 27, 28, 29, 30, 31, 32-33.
- Only about 5% of the Medicare population was chosen for clinical quality measure reporting.
- Bubble Size indicates population size (OCV attributed population).
- CMS-HCC risk score was used for risk adjustment.
- Spend based on OCV claims data 1/1/2014 – 12/31/2014 with claims run out through 3/31/2015. For beneficiaries attributed to OCV Q4 2014.

# Medicare 2015 Quality Scores with Clinical and Claims Based Measures vs Risk Adjusted Total Cost of Care by HSA

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2015 Weighted Average Internally Calculated QM Score =88.8%

OCV

Berlin
Burlington
Bennington
St. Albans
Brattleboro
Springfield
Middlebury
Newport
Rutland
Morrisville
St. Johnsbury
Townshend
Windsor

2015 OCV Risk Adj PBPY = $8,075

Internally Calculated Quality Measure Score

100.0%
80.0%
60.0%
40.0%
20.0%
0.0%

$6,000 $6,500 $7,000 $7,500 $8,000 $8,500 $9,000 $9,500 $10,000 $10,500 $11,000

Risk Adjusted Total Cost of Care Per Beneficiary Per Year

| Total Sample Size for all included Measures Combined 2015 | |
|---|---|
| Bennington | 1624 |
| Berlin | 1726 |
| Brattleboro | 616 |
| Burlington | 3700 |
| Middlebury | 937 |
| Morrisville | 562 |
| Newport | 840 |
| Rutland | 1774 |
| Springfield | 531 |
| St. Albans | 782 |
| St. Johnsbury | 381 |
| Townshend | 234 |
| Windsor | 472 |

-Beneficiaries may be counted more than once if sampled for multiple measures.

Notes:

- Measures that could reliably be broken out by HSA were included in internally calculated scores, this excludes measures calculated with O/E ratios by the payer and survey measures.
- Medicare 2015 includes measures 8, 39, 13, 14, 15, 16, 17, 18, 19, 20, 21, 40, 27, 41, 28, 30, 31 and 33.
- Randolph HSA did not have any eligible individuals chosen for quality measures in 2015.
- Only about 5% of the Medicare population was chosen for clinical quality measure reporting.
- Bubble Size indicates population size (OCV attributed population).
- CMS-HCC risk score was used for risk adjustment.
- Spend based on OCV claims data 1/1/2015 – 12/31/2015 with claims run out through 3/31/2016. For beneficiaries attributed to OCV Q4 2015.

# Requires Focus on Socio-Economic Factors Too

OneCareVermont

VERMONT 2015

Tweet 0 G+1 0 Like 4

Overview | Rankings | Measures | Downloads | Compare Counties | Select a county | Print | Help

Find out how healthy your county is and explore factors that drive your health

Overall Rankings in Health Outcomes

Overall Rankings in Health Factors

- Health Outcomes
- Health Factors
- Additional Measures

- Clinical Care
- Health Behaviors
- Social & Economic Factors
- Physical Environment

- High school graduation
- Some college
- Unemployment
- Children in poverty
- Income inequality
- Children in single-parent households
- Social associations
- Violent crime
- Injury deaths

RANK 1-4 5-7 8-10 11-14 NOT RANKED (NR)

Find tools and guidance to help improve the health of your community

Social & Economic Factors

RANK 1-4 5-7 8-10 11-14 NOT RANKED (NR)

Health Outcome Spending/Results Strongly Mirror Social and Economic Status

# A Cultural Transition for Providers

"You've got a rare condition called 'good health'. Frankly, we're not sure how to treat it."

Sinai be serious? The answer is a es. In fact, we couldn't be more serious. ai's number one mission is to keep of the hospital. We're focused on ealth management, as opposed to the e-for-service medicine. So instead care that's isolated and intermittent, ceive care that's continuous and much of it outside of the traditional ng.

Thus the tremendous emphasis on wellness programs designed to help people stop smoking, lose weight and battle obesity, lower their blood pressure and reduce the risk of a heart attack. By being as proactive as possible, patients can better maintain their health and avoid disease.

Our Mobile Acute Care Team will treat patients at home who would otherwise require a hospital admission for certain conditions. The core team involves physicians, nurse practitioners, registered nurses, social workers, community paramedics, care coaches, physical therapists, occupational therapists, speech therapists, and home health aides.

Meanwhile, Mount Sinai's Preventable Admissions Care Team provides transitional care services to patients at high risk for readmission. After a comprehensive bedside assessment, social workers partner with patients, family caregivers and healthcare providers to identify known risks such as problems with medication management and provide continuing support after discharge.

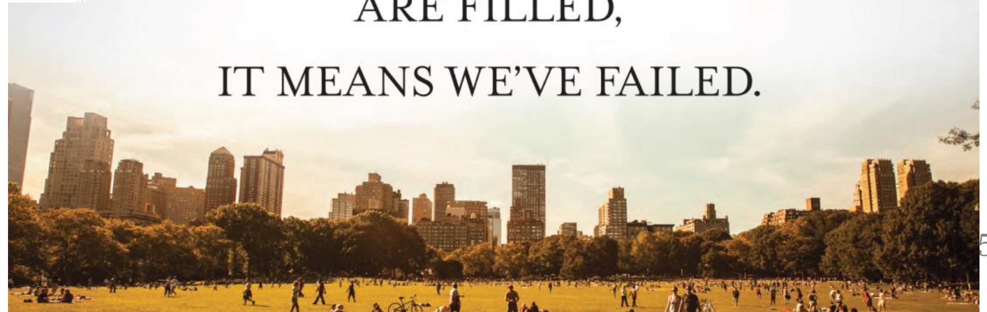
It's a sweeping change in the way that health care is delivered. And with the new system comes a new way to measure success. The number of empty beds.

1-800-MD-SINAI
mountsinaihealth.org

IF OUR BEDS

ARE FILLED,

IT MEANS WE'VE FAILED.



# OneCare Transformational Agenda under APM

OneCareVermont

- Payment Reform Elements
  - Population-level total cost accountability ("risk") across Medicare, Medicaid, Commercial populations
  - Hospital fixed revenue model for larger portion of their budgets
  - Primary Care payment reform – equitable and adequate, payer agnostic
  - Integrated payment programs with community-based care and service providers
- Population Health Management Elements
  - Mental health and substance abuse focus
  - Community primary and secondary prevention
  - Socio-economic risk and mitigation
  - Community care coordination
  - Consumer health engagement
  - Field-deployed population informatics system

# Advanced Analytics: Workbench One

Information | Episode Bundle | Hospital Bundle | Detail | Definitions

OneCareVermont

Source: Part A and Part B Medicare Claims data, 10/01/2014 through 09/30/2015, with runout through 12/31/2015

**Hospital Category**
- Academic Medical Center
- Acute Care Hospital
- Critical Access Hospital
- OON

**Year**
- 2014
- 2015

**Month**

| | | | |
|---|---|---|---|
| Jan | Apr | Jul | Oct |
| Feb | May | Aug | Nov |
| Mar | Jun | Sep | Dec |

| Total Cost | Mean | Median | N | ALOS |
|---|---|---|---|---|
| $326,954,188 | $23,394 | $8,463 | 13,976 | 31 |

**Hospital**
- BRATTLEBORO MEMORIAL HOSPITAL
- CARLOS G. OTIS HEALTH CARE CENTER INC.
- CENTRAL VERMONT MEDICAL CENTER INC
- COPLEY HOSPITAL, INC.
- GIFFORD MEDICAL CENTER
- MARY HITCHCOCK MEMORIAL HOSPITAL
- MARY HITCHCOCK MEMORIAL HOSPITAL (into)
- NORTH COUNTRY HOSPITAL & HEALTH CENTER INC
- NORTHEASTERN VERMONT REGIONAL HOSPITAL, INC
- NORTHWESTERN MEDICAL CENTER INC
- OUT OF NETWORK
- PORTER HOSPITAL INC
- RUTLAND HOSPITAL, INC.
- SOUTHWESTERN VERMONT MEDICAL CENTER INC.
- SPRINGFIELD HOSPITAL INC
- UNIVERSITY OF VERMONT MEDICAL CENTER INC
- UNIVERSITY OF VERMONT MEDICAL CENTER INC (into)
- WINDSOR HOSPITAL CORPORATION

**Acute and Post Acute Categories**
- Acute
- Post Home Health Agency
- Post Inpatient
- Post Inpatient Rehab
- Post Outpatient Observation
- Post SNF Non Swing
- Post SNF Swing

**Episode Name**
- Acute myocardial infarction
- Amputation
- Atherosclerosis
- Automatic implantable cardiac defibrillator generator or lea
- Back and neck except spinal fusion
- Cardiac arrhythmia
- Cardiac defibrillator
- Cardiac valve
- Cellulitis
- Cervical spinal fusion
- Chest pain
- Chronic obstructive pulmonary disease, bronchitis/asthma
- Combined anterior posterior spinal fusion
- Complex non-Cervical spinal fusion
- Congestive heart failure

**Total Bundle Mean by Episode**

# Population Health Management System: Care Navigator

OneCareVermont

**My Tasks**

Search for records

| Activity Name | Regarding | Status | Assigned To | Priorit... | Estimated End Dat |
|---|---|---|---|---|---|
| Readmission risk eval | Edwin P.... | Not Start... | Sandy Smith,... | High | |
| Stop smoking by 03/31... | Edwin P.... | In Progress | Patient | High | 3/31/2016 6:30 PI |
| About COPD | Carmela... | Not Start... | Patient | Med... | 12/18/2015 4:26 PI |
| Administer GAD-7 | Carmela... | Not Start... | User5 Test5 | Med... | 12/18/2015 4:26 PI |
| Administer PHQ2/9 | Carmela... | Not Start... | User5 Test5 | Med... | 12/18/2015 4:26 PI |
| Administer PHQ2/9 | Carmela... | Not Start... | User5 Test5 | Med... | 12/18/2015 4:26 PI |
| Assess sleep quality | Carmela... | Not Start... | Patient | Med... | 12/18/2015 4:26 PI |
| Attend Diabetes Educat... | Edwin P.... | Deferred | Patient | Med... | 7/10/2015 5:00 PI |

1 - 8 of 80 Page 1

**My Appointments**

Search for records

| Start Date | Patient | Activity Name | Priority | Care P |
|---|---|---|---|---|
| 6/13/2016 11:30 AM | Edwin P. Gonzalez | Walk for 30mins | Normal | |
| 6/13/2016 4:00 PM | Edwin P. Gonzalez | Take Your Medication | Normal | Sandy |
| 6/14/2016 11:30 AM | Edwin P. Gonzalez | Walk for 30mins | Normal | |
| 6/14/2016 4:00 PM | Edwin P. Gonzalez | Take Your Medication | Normal | Sandy |
| 6/15/2016 11:30 AM | Edwin P. Gonzalez | Walk for 30mins | Normal | |
| 6/15/2016 4:00 PM | Edwin P. Gonzalez | Take Your Medication | Normal | Sandy |
| 6/16/2016 11:30 AM | Edwin P. Gonzalez | Walk for 30mins | Normal | |
| 6/16/2016 4:00 PM | Edwin P. Gonzalez | Take Your Medication | Normal | Sandy |

1 - 8 of 403 Page 1

**My Patients**

Search for records

| Last Name | First Name | Date of Birth | Member ID | Risk Score | Inpa |
|---|---|---|---|---|---|

No Patient records found.

what's new

POST

All records | Both Auto posts User posts

**Welcome!**

This is your personal wall, where you'll see news about the colleagues and records you follow.

1. Find and follow your colleagues
2. Comment on posts and other activity
3. Display your profile picture

0 followers

Start following c
and let people f
Learn more

# Final Thoughts

- Likely will take incentives to ensure enough providers, payers, and employers participate in the model
- Public transparency and consumer benefits and protections essential to win their hearts and minds too
- Strong start and continuing shift of financial resources from hospital-based acute care to prevention and lower cost “upstream” and community-based treatment
  - Transformation assistance to pilot the required new programs and infrastructure will hasten this transition
- Targeting overall healthcare cost growth to a general-inflation level index (3.5%) for 2018-2022 is a significantly underappreciated story
- Population “risk” model means question shifts from “do ACOs save money” to “are ACOs the best way to maintain access, improve quality, and live within the cost target”
  - Savings are “baked in” – living within our means is the trick