

Value-Based Payment Reform and ACOs

House Health Care Committee
February 23, 2017

Topics Covered

- 
- ▶ **Value-Based Healthcare Reform**
 - ▶ Vermont ACO landscape
 - ▶ Moving Forward under APM

Pre-Apology for Terminology "Soup"

Social Determinants

Patient Centered Medical Homes

Aligned Incentives

Medical Neighborhoods

Value-Based Care

Patient Engagement

Population Health Management

Patient Segmentation

Health Risk Assessments



Shared Decision Making

Care Coordination

Health Coaches

Capitation

Payment Reform

Bundled Payment

Wellness Program

Two-Sided Risk

Fee for service

Episodes of Care

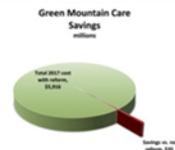
ACOs

Disease Management

Health Care Reform – A Continuing Journey on Coverage and Payment Reform



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



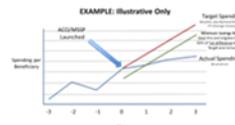
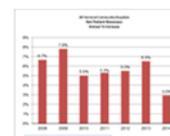
2011-2012
Early Implementation
National: MSSP ACO Program; Age 26; Exchange Planning
Vermont: GMCB seated; VT exchange legislation; Hospital NR growth limits, payment reform pilots



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

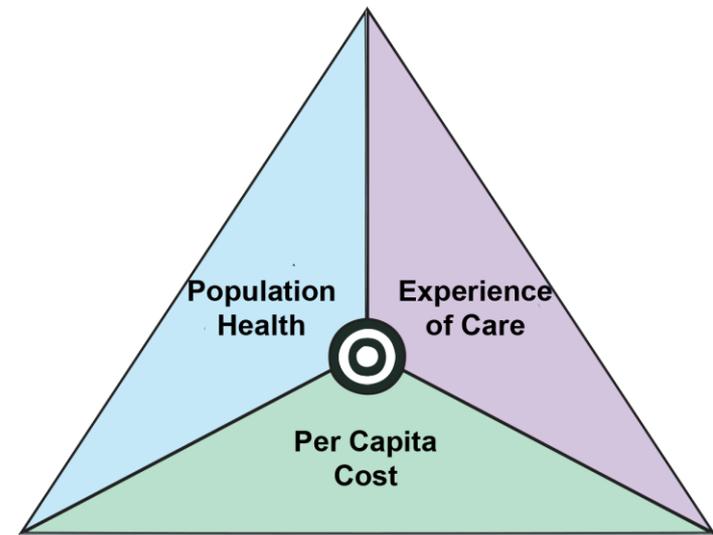
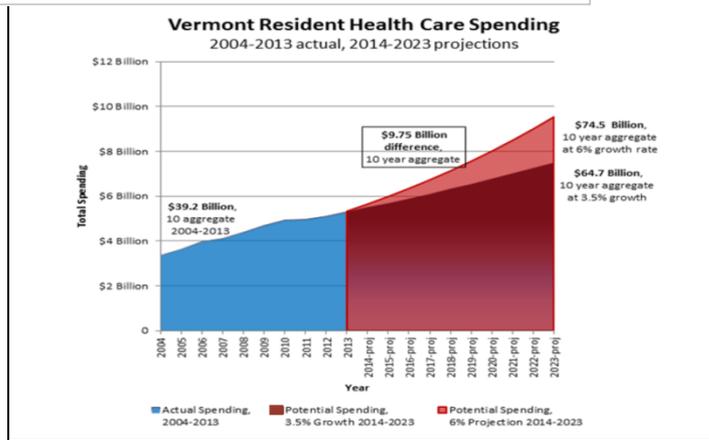
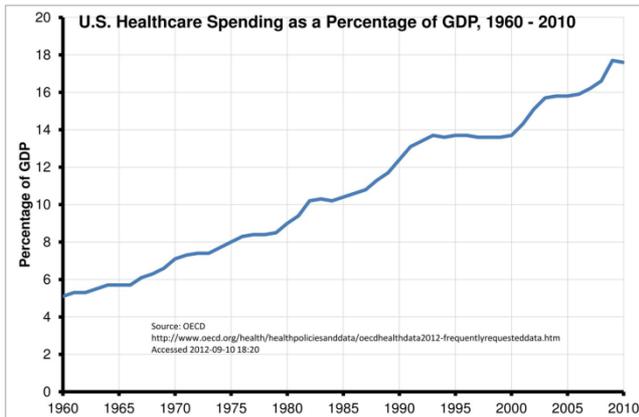


2017+
Future Model
National: Repeal/replace ACA, implement MACRA/MIPS, Continue ACO programs
Vermont: APM, Medicaid Next Generation, True non-FFS payment reform, broad-based population health management

The Roots of Value-Based Payment Reform

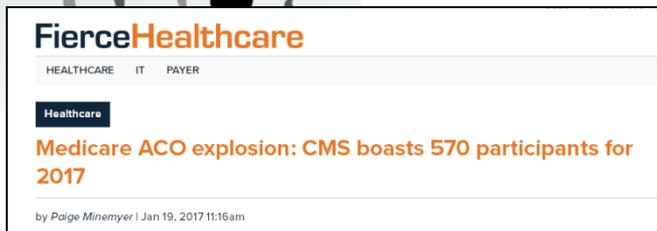
Unsustainable Cost Growth

+ Mixed Quality, Service, and Value



IHI Triple Aim

Accountable Care and ACOs



“Accountable Care”

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

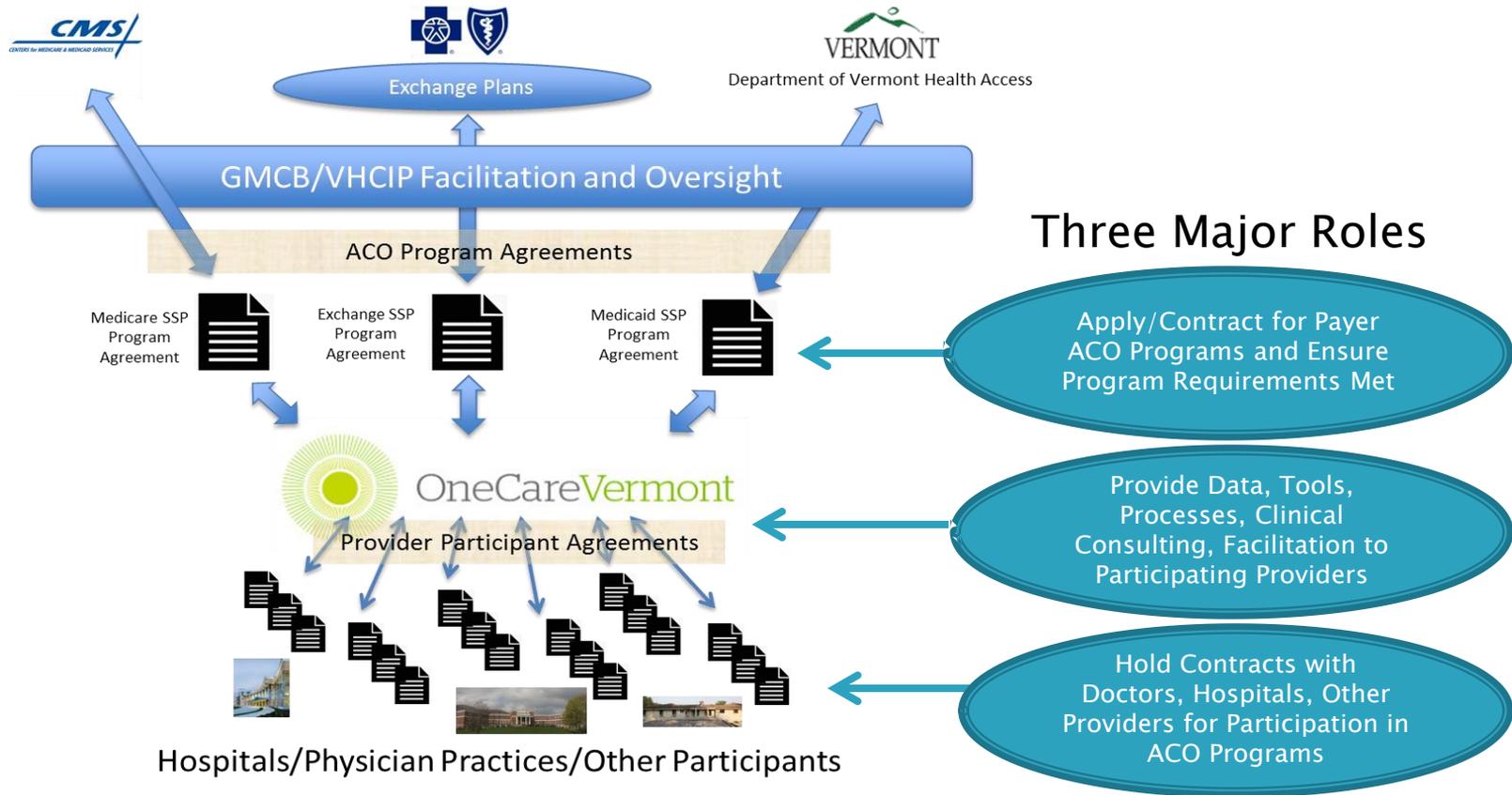
“Accountable Care Organization” = ACO

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

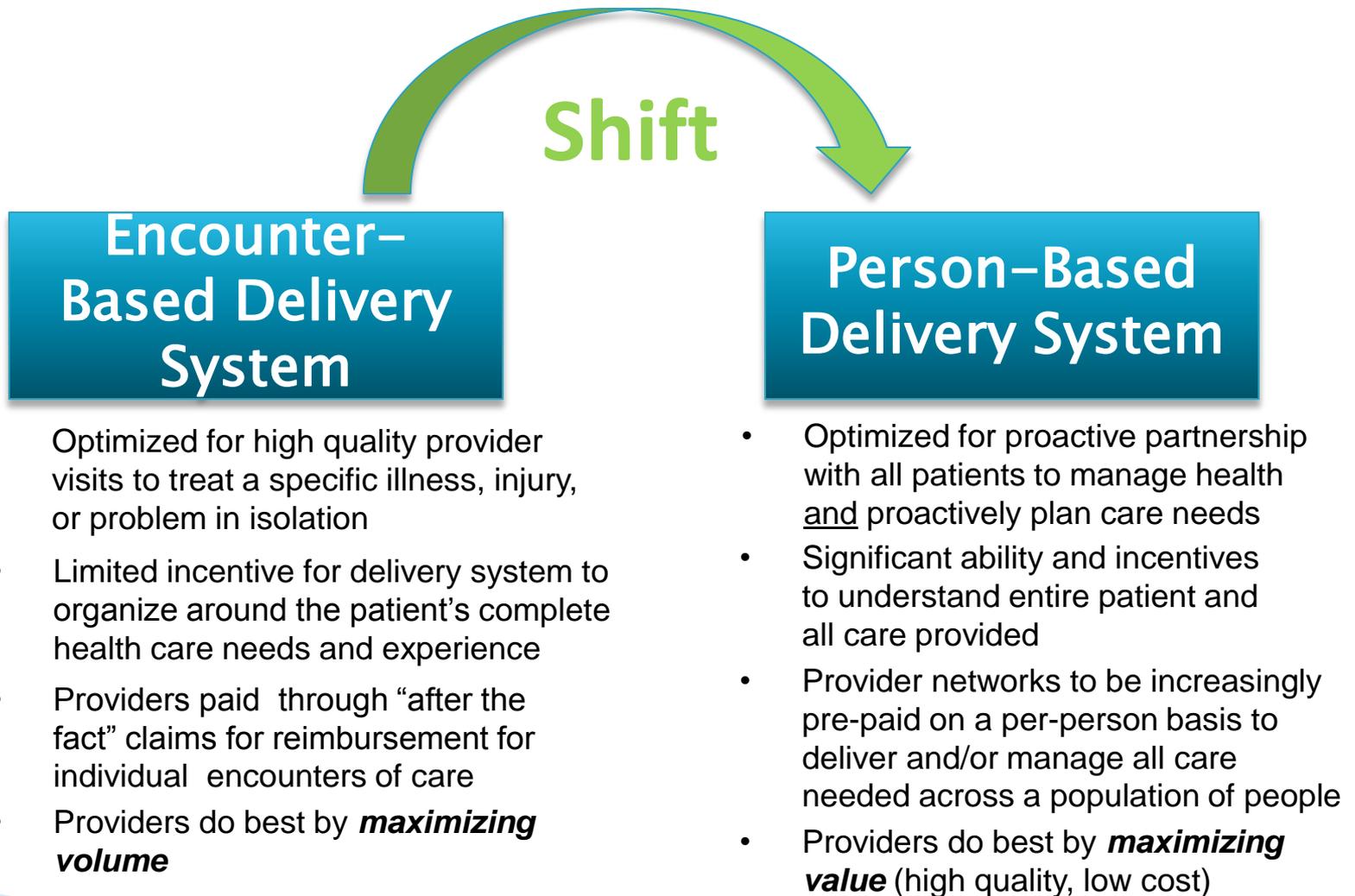
“Attributed Patient Population”

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

What is an ACO Really – Example



The Basic Transformation



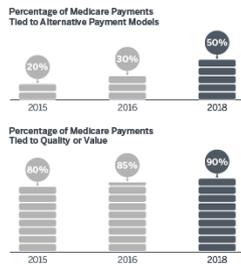
Medicare/CMS Leading the Charge*

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

<p>Health Care Payment Learning and Action Network</p> <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>Disruption to Fee-for-Service Business Model</p> <p>Voluntary</p> <p>CY 2015</p>	<p>Comprehensive Primary Care Initiative</p> <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 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 <p>475 Primary care practices participating in the program</p> <p>Disruption to Fee-for-Service Business Model</p> <p>Voluntary</p> <p>FY 2013</p>	<p>Hospital Value-Based Purchasing Program</p> <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 other absolute success or improvement against established performance measures via withheld/payback structure Payment withheld began at 1% in 2013, increases by 0.25% annually until reaching 2% in 2017 <p>2% Hospital inpatient Medicare payment at risk when fully implemented in 2017</p> <p>Disruption to Fee-for-Service Business Model</p> <p>Mandatory</p> <p>FY 2013</p>	<p>Hospital Readmissions Reduction Program</p> <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>Disruption to Fee-for-Service Business Model</p> <p>Mandatory</p> <p>FY 2013</p>
<p>Hospital-Acquired Condition Reduction Program</p> <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>Disruption to Fee-for-Service Business Model</p> <p>Mandatory</p> <p>FY 2015</p>	<p>Merit-Based Incentive Payment System</p> <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 tracks that offers additional incentives <p>9% Physician Medicare payment at risk when fully implemented in 2022</p> <p>Disruption to Fee-for-Service Business Model</p> <p>Mandatory</p> <p>CY 2019</p>	<p>Bundled Payments for Care Improvement Initiative</p> <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>Disruption to Fee-for-Service Business Model</p> <p>Voluntary</p> <p>CY 2012</p>	<p>Comprehensive Care for Joint Replacement Model</p> <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>Disruption to Fee-for-Service Business Model</p> <p>Mandatory</p> <p>CY 2016</p>
<p>Oncology Care Model</p> <ul style="list-style-type: none"> CMMI program seeking to improve the quality, coordination, and efficiency of care for on 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>Disruption to Fee-for-Service Business Model</p> <p>Voluntary</p> <p>CY 2016</p>	<p>Medicare Shared Savings Program</p> <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>Disruption to Fee-for-Service Business Model</p> <p>Voluntary</p> <p>CY 2012</p>	<p>Pioneer ACO Model</p> <ul style="list-style-type: none"> CMMI program offering an advanced path for providers to form ACOs that serve Medicare fee-for-service beneficiaries; 15 of the original 32 participants remain in the program Offers greater financial risk and reward, as well as more flexibility, than 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>Disruption to Fee-for-Service Business Model</p> <p>Voluntary</p> <p>CY 2012</p>	<p>Next Generation ACO Model</p> <ul style="list-style-type: none"> 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 <p>15-20 Organizations expected to participate in 2016</p> <p>Disruption to Fee-for-Service Business Model</p> <p>Voluntary</p> <p>CY 2016</p>

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

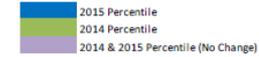
Key Concept: Movement to “Risk”

- ▶ Definition of “risk” in this context: a contract where your performance includes financial accountability for cost overruns as well opportunity to keep savings
 - Current ACO models dominated by “upside only” but that was never intended as anything other than transitional model
- ▶ CMS is closing the exits to avoid this movement:
 - Standard Medicare ACO Program (MSSP)
 - Maximum 6 years before risk (OneCare is in year 5)
 - Increasing Attractiveness of Risk ACO Models
 - Next Generation ACO offers for first time better economics for an ACO with high quality, low-cost to begin with, and option to receive true Medicare population payments rather than FFS in order to implement payment reform
 - Mandatory Bundled Payments
 - 2016 mandatory bundled payment accountability for acute care providers in 60+ markets
 - 2017 expansion into more markets and more services
 - MACRA/MIPS
 - Permanent law enacted with strong bipartisan support to end SGR “cliff”
 - For Medicare-billing physicians, mandatory option starting in 2019 of either:
 - 5% automatic reimbursement increase if in an Advanced Alternative Payment Model (primarily the Next Generation ACO Model) <or>
 - Submitting individual information and being held accountable for cost and quality outcomes for their patients resulting in bonus or penalties of up to 11% of the physician’s revenue
 - The most attractive Medicare models come with requirements for providers commitment to contract with MORE than just Medicare under advanced alternative payment models
 - State Innovation Models like Vermont’s to plan, incent, and measure States and their providers movement to risk
 - Recent 1115 Medicaid Waivers (including Vermont and New York) have focused on moving Medicaid into accountable ACO-based models, a trend which may likely continue under any new “Block Grant” approach as well

Quality and Satisfaction also 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	
																2015 Final Score
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
Care Coordination	34 Stewardship and Patient Resources	R	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	20.26				293	2.00
	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	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	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	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	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	79.03				1750	2.00
Preventive Health	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
	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	4.35				23
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	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%

The Cost Opportunity is 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.

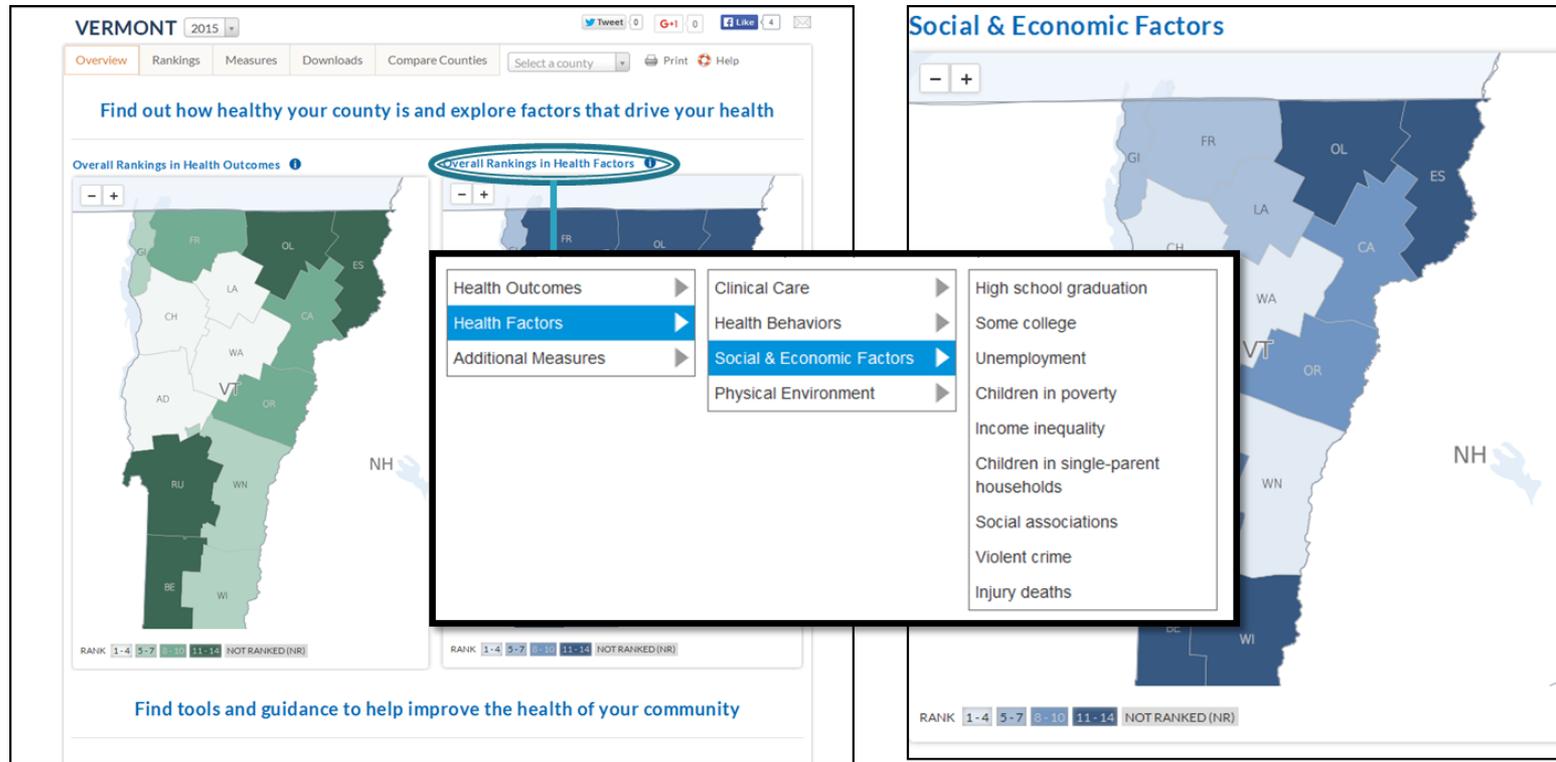
Types of Waste in U.S. Health Care Spending

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

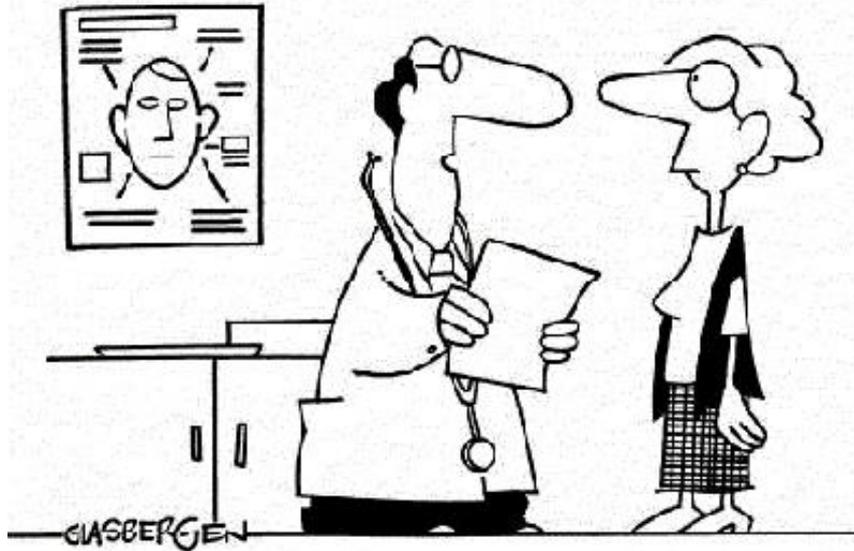
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Stronger Focus on Socio-Economic Factors also Required



Health Outcome Spending/Results Strongly Mirror Social and Economic Status

A Cultural Transition



**“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 resounding yes. In fact, we couldn't be more serious. Mount Sinai's number one mission is to keep patients out of the hospital. We're focused on health management, as opposed to the reactive-for-service medicine. So instead of treating patients that are isolated and intermittent, we provide care that's continuous and much of it outside of the traditional hospital setting.

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

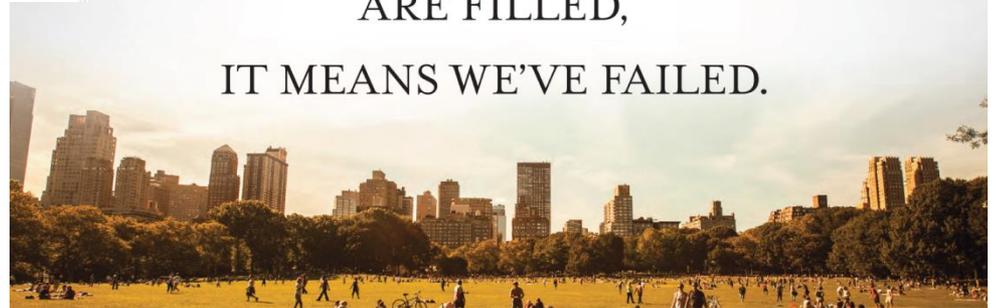
problems with medication management and provide continuing support after discharge.

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.**



Topics Covered

- ▶ Value-Based Healthcare Reform
- ▶ **Vermont ACO landscape**
- ▶ Moving Forward under APM



Vermont ACOs

▶ **OneCare Vermont**

- Founded by UVMMC and DHH in 2012
- Includes large network of hospitals, physician practices, and other providers
- Medicare 2013 to current, Medicaid/Commercial 2014 to Current
- Moved to Medicaid Next Generation for 2017

▶ **Community Health Accountable Care (CHAC)**

- Founded by Bistate Primary Care Association and many of its Federally Qualified Health Centers (FQHCs) in 2013
- Expanded to include all FQHCs and some hospitals
- Medicare/Medicaid/Commercial all 2014 to Current

▶ **Healthfirst Sponsored ACOs**

- Programs offered to the practices of the Healthfirst Independent Practice Association
- Accountable Care Coalition of the Green Mountains
 - Medicare ACO 2012–2014
- Vermont Collaborative Physicians
 - Commercial ACO 2014–2016
- No longer holding ACO contracts

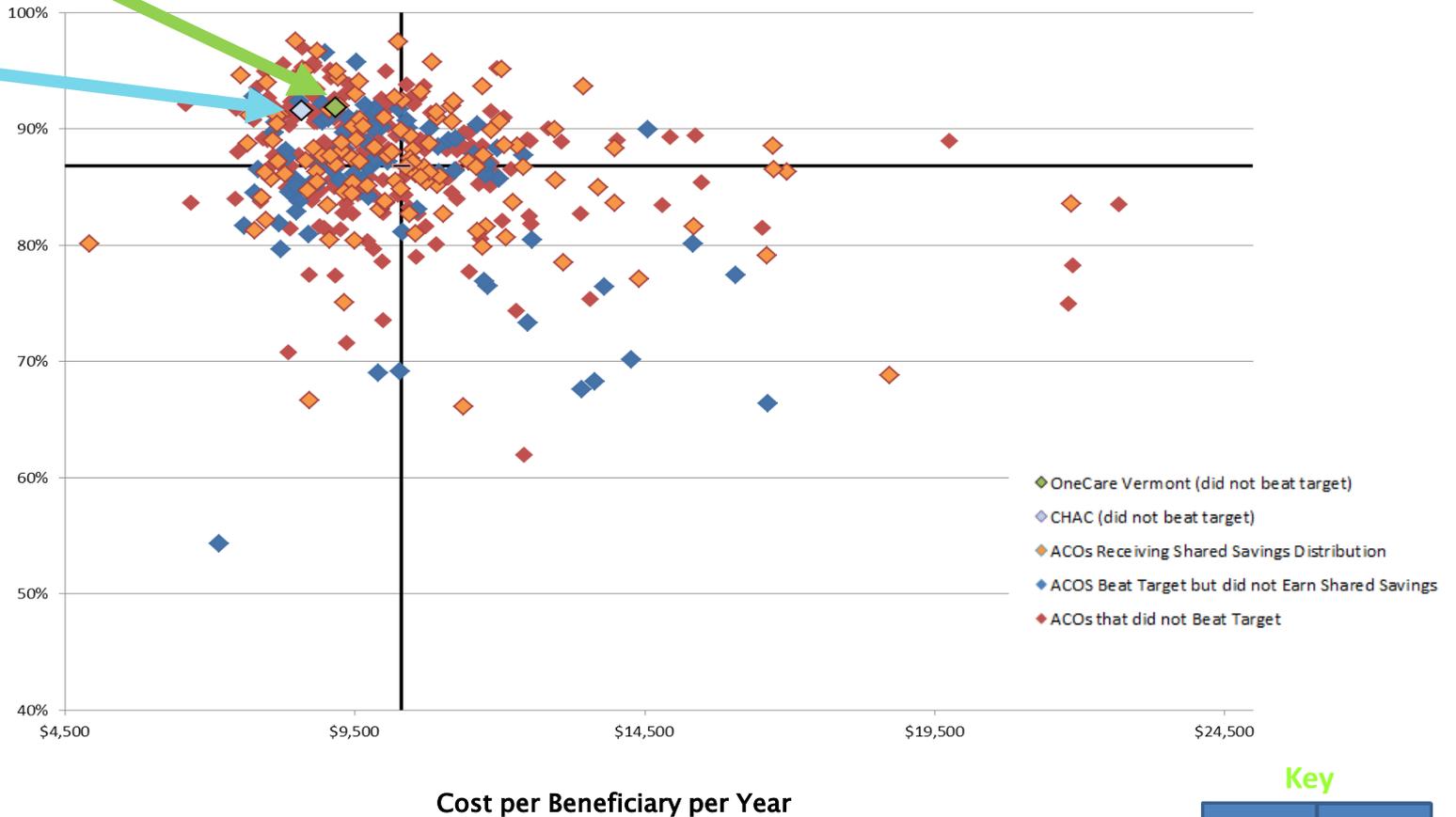
OneCare Program Financial Performance

Program	Metric	2013	2014	2015
Medicare	Target PMPM	\$ 714	\$ 728	\$ 747
	Actual PMPM	\$ 713	\$ 735	\$ 788
	% Over/Under Target	-0.1%	1.0%	5.5%
	Risk Adjusted PMPM	\$ 604	\$ 617	\$ 631
	Year to Year Actual Growth		3.1%	7.2%
	Year to Year Growth Rate RISK ADJUSTED		2.2%	2.3%
	Medicaid	Target PMPM		\$ 181
Actual PMPM			\$ 166	\$ 172
% Over/Under Target			-8.3%	1.8%
Risk Adjusted PMPM			\$ 113	\$ 118
Year to Year Actual Growth				3.6%
Year to Year Growth Rate RISK ADJUSTED				4.4%
Commercial		Target PMPM		\$ 326
	Actual PMPM		\$ 349	\$ 349
	% Over/Under Target		7.1%	4.2%
	Risk Adjusted PMPM		\$ 237	\$ 221
	Year to Year Actual Growth Rate			0.0%
	Year to Year Growth Rate RISK ADJUSTED			-6.8%

National Medicare ACO Performance 2015



MSSP ACO Cost and Quality 2015 Results



Key



OneCare Vermont - Medicare SSP Performance by Healthcare Service Area

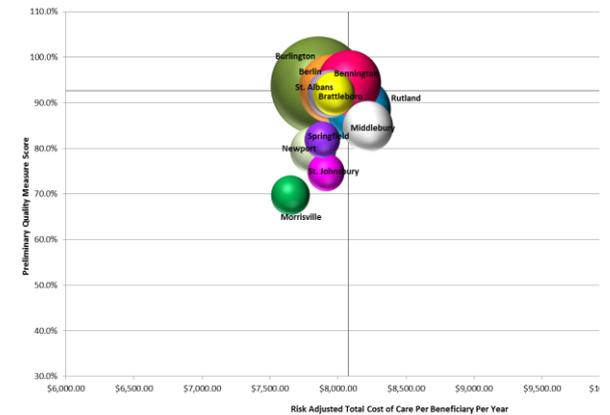
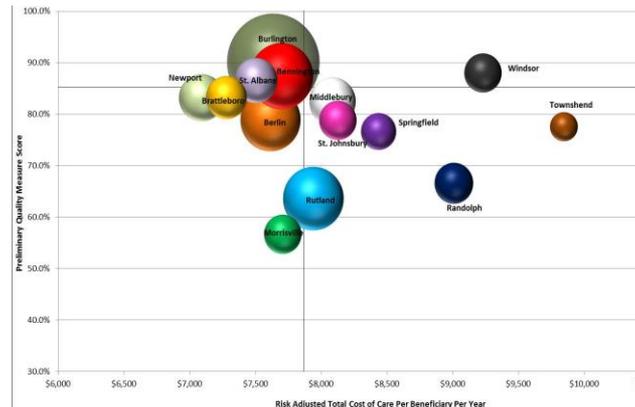
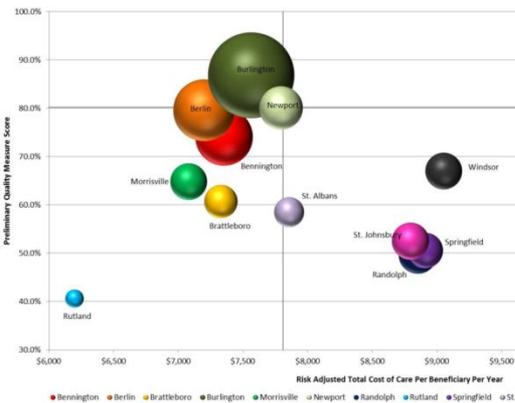
Risk Adjusted Cost and Quality

2013 → 2014 → 2015

(Year 1)

(Year 2)

(Year 3)



Key



Vermont Care Organization

- ▶ Formed in July 2016 as a result of long conversations among OneCare, CHAC, and Healthfirst
 - ▶ Based on provider support for a unified ACO model for Vermont
 - Vermont small population size overall
 - Avoids split communities – can work as unified continuum of care and social services
 - Single infrastructure investment
 - Ability to take risk contracts
 - Best approach for success under APM
- 

Vermont Care Organization

▶ VCO Design and Plan:

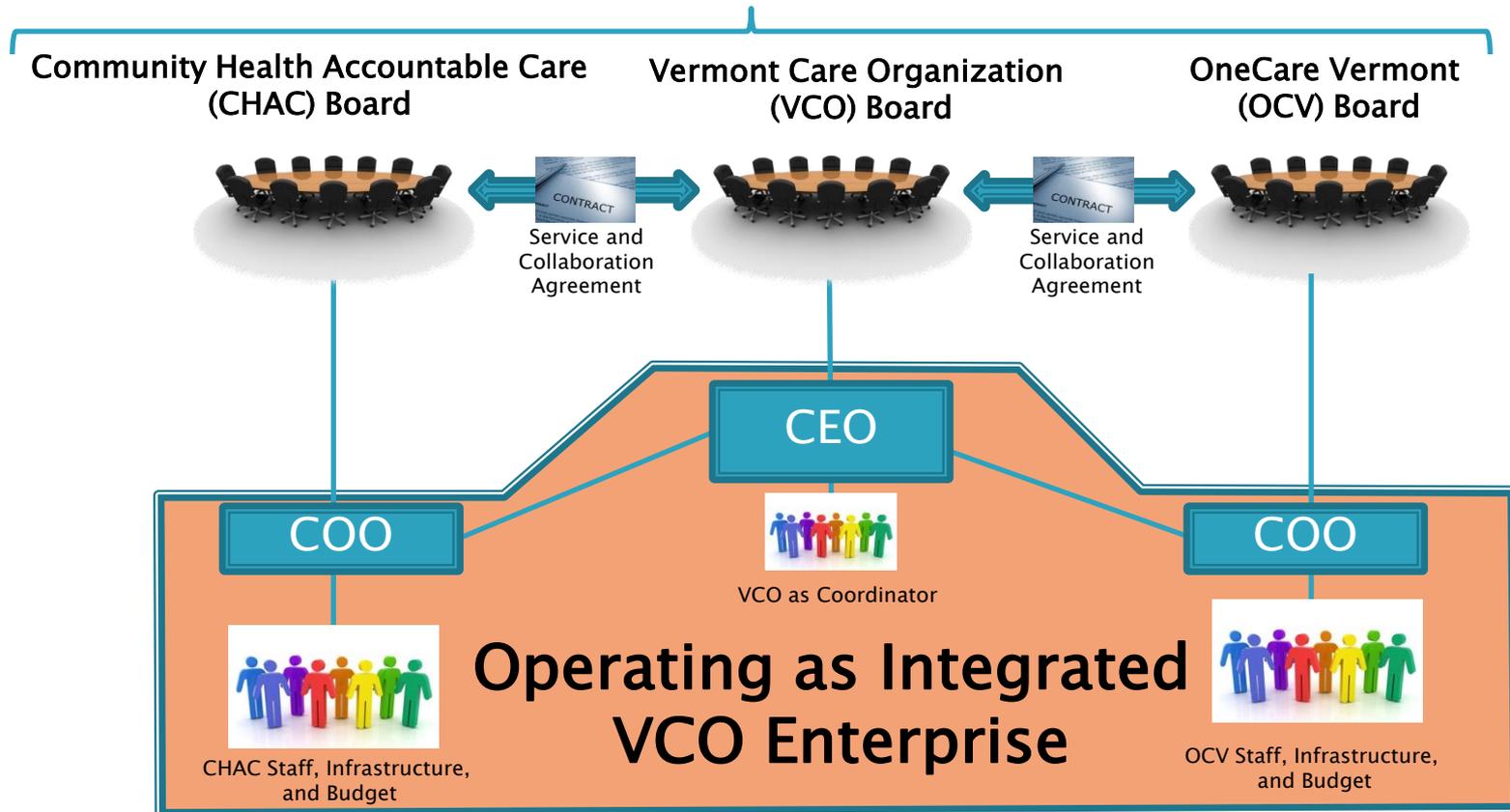
- VCO serves as coordinating entity with own Board (with overlap on OneCare and CHAC boards) for 2016–2018
 - VCO not technically an ACO
 - OneCare serves as the ACO moving to “Risk” Programs for providers ready for that step
 - CHAC serves as non-risk ACO for providers still preparing for the shift to risk
 - Both “tracks” collaboratively applying aligned and common provider communications, population health processes and infrastructure under the VCO umbrella
 - Healthfirst ends its ACO program contracts, but serves in VCO governance and assists in offering OneCare and CHAC participation to its practices
- VCO shifts to being true single ACO entity as early as 2019 with OneCare and CHAC ending their own programs



Key Point

Unified ACO Model – Visualizing the Structure

As of 2017 Full Boards Meet Together in Monthly Meetings



VCO Board/Committee Officers

Board Officers

- ▶ Chair Thomas Huebner
- ▶ Vice Chair Kevin Kelley
- ▶ Secretary Michael Hall
- ▶ Treasurer Sandra Rouse

Committee Chairs

- ▶ Primary Care Paul Reiss MD
- ▶ Population Health Stephen Leffler MD
- ▶ Nominating Committee Kevin Kelley (Concurrent with Vice Chair)
- ▶ Finance Committee Sandra Rouse (Concurrent with Treasurer)

Executive Committee Membership

- ▶ Thomas Huebner (concurrent with Chair)
- ▶ Kevin Kelley (concurrent with Vice Chair/Nominating Chair)
- ▶ Michael Hall (concurrent with Secretary)
- ▶ Sandra Rouse (concurrent with Treasurer/Finance Chair)
- ▶ Paul Reiss MD (concurrent with Primary Care Chair)
- ▶ Stephen Leffler MD (concurrent with Population Health Chair)
- ▶ Kevin Stone (at large)

2017–2018 VCO Program Summary

	OneCare Vermont	CHAC
Medicare	<u>Medicare</u> Upside–Only SSP for 2017 and moves to APM “Modified” Next Generation in 2018	<u>Medicare</u> Upside–Only SSP for 2017 and 2018
Medicaid	<u>Medicaid</u> Vermont Medicaid Next Generation (VMNG) Program 2017/2018	<u>Medicaid</u> Attribution, Data, Risk Simulation through VCO Infrastructure*
Commercial	<u>Commercial</u> Upside–Only Exchange SSP with BCBSVT in 2017, move to Risk Contract in 2018	<u>Exchange SSP</u> Upside–Only Exchange SSP with BCBSVT in 2017, TBD for 2018

*No shared savings eligibility

VCO Operations/Infrastructure Budget

- ▶ For 2017 we developed a single unified budget across VCO, OneCare, and CHAC
- ▶ Total operations expense of \$13.3M across all three organizations and including all clinical/informatics/financial Infrastructure
- ▶ Falls between \$6 and \$7 PMPM and represents approximately 1.5% of premium equivalent
- ▶ Funding model to cover expenses budgeted from a variety of sources:

	Revenues
VMNG Admin Payments	\$ 1,200,000
SIM Grant	\$ 800,000
Medicare APM One-Time	\$ 2,000,000
DSR Funds	\$ 7,500,000
Participant Fees	\$ 1,800,000
TOTAL	\$ 13,300,000

- ▶ NOTE: We shared VMNG Administrative Payments with attributing providers and also separately budgeted “companion” DSR funds for Population Health Management processes implemented in network providers and communities

Topics Covered

- ▶ Value-Based Healthcare Reform
- ▶ Vermont ACO landscape
- ▶ **Moving Forward under APM**



Planning for 2018

- ▶ 2018 is official “Year 1” under APM
- ▶ 2018 is first year of GMCB oversight of ACOs under ACT 113
 - ACO Requirements
 - ACO Budgeting
 - ACO Certification
- ▶ Act 113 is in rule-making by GMCB (“ACO Oversight Rule” or “Rule 5”)
- ▶ 2017 will be a mutually-agreeable process for planning 2018 under APM and testing some of the rule’s anticipated process
 - Will include submitting budgets (process/timing covered in subsequent pages)
 - Will include applying for ACO certification later in the year
 - Must align with:
 - GMCB/CMMI interaction on “Modified” Next Generation for Medicare in 2018
 - State budgeting and planning year two of VMNG with AHS/DVHA
 - Working with commercial payer(s) on how to move XSSP to 2-sided risk and be in synch with their plan rate filings
 - Hospital budget guidance and approach for FY18
- ▶ **KEY POINT: This actually helps drive a more proactive, planned cycle with more lead time involved and alignment from others to help us answer key questions, and better stakeholder transparency**

ACO Budgeting

- ▶ ACO Oversight Rule (aka Rule 5) as expected will mean:
 - Both OneCare and CHAC will submit budgets
 - Both OneCare and CHAC will require certification
 - VCO will not need to submit a budget or be certified until it proceeds to hold payer and provider ACO contracts in later years
- ▶ ACO budget elements of Rule 5 not yet provided in draft form
 - Discussions with GMCB indicate that budget is BOTH operational budget and ACO program budgeting (targets, payer payment models to ACO, and provider payment reform if applicable)
- ▶ Management proposal is to again conduct budgeting as unified VCO exercise but include standalone budgets for OneCare and CHAC for submission separately if necessary

ACO Budget Process for 2018 – Expected Major Milestones

March

- ▶ Receive GMCB ACO Budget Guidance
- ▶ Solicit Initial Provider Intent on Risk (OneCare) vs Non-Risk (CHAC) Track for CY2018

April

- ▶ Run Expected Attribution for Risk and Non-Risk Tracks
- ▶ Conduct Modeling/Forecasting for Risk Program Population Budgets
- ▶ Develop Provider Payment Reform Designs
- ▶ Develop VCO Enterprise Operational Budget for CY2018
- ▶ Develop Assumptions on Revenue Sources including DSR Funds for CY2018

May

- ▶ ACOs submit budgets to GMCB
- ▶ Insurers submit QHP Rates to GMCB

June–August

- ▶ Hospitals Submit Budgets to GMCB by July
- ▶ Rate and Budget Analysis by GMCB
- ▶ Stakeholder Input Process through GMCB
- ▶ GMCB Decision on QHP Rates in August

September

- ▶ GMCB Decision on ACO Budgets, Hospital Budgets

Later in 2017

- ▶ Final Attribution, Programmatic Numbers, and DSR Commitments Known