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

Aligned Incentives

Patient Centered Medical Homes

Medical Neighborhoods

Value-Based Care

Patient Engagement

Population Health Management

Patient Segmentation

Two-Sided Risk

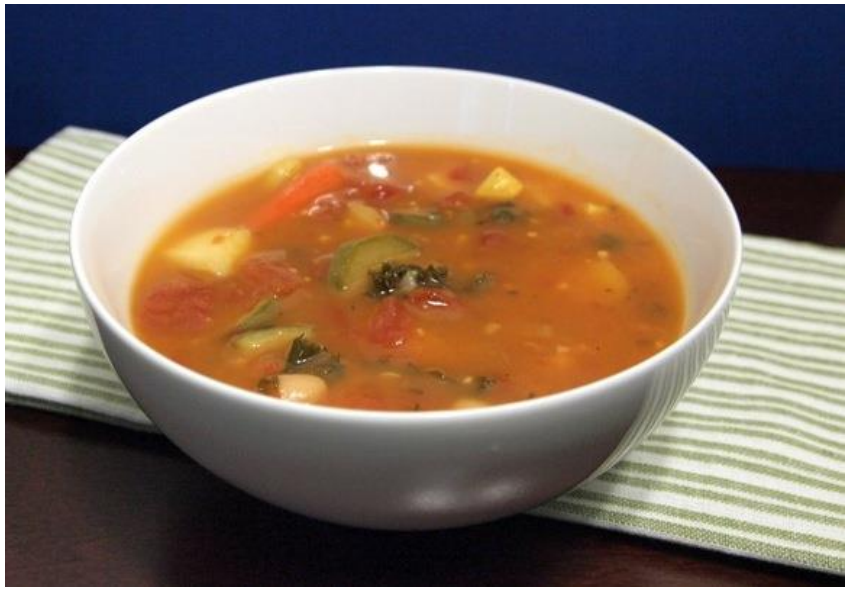
Fee for service

Episodes of Care

ACOs

Disease Management

Health Risk Assessments



Care Coordination

Capitation

Health Coaches

Payment Reform

Wellness Program

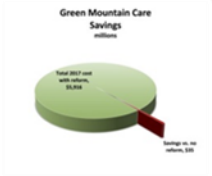
Bundled Payment

Shared Decision Making

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

2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017

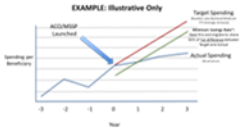
2010-2011
Legislative Action
National: PPACA
Vermont: Act 48



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

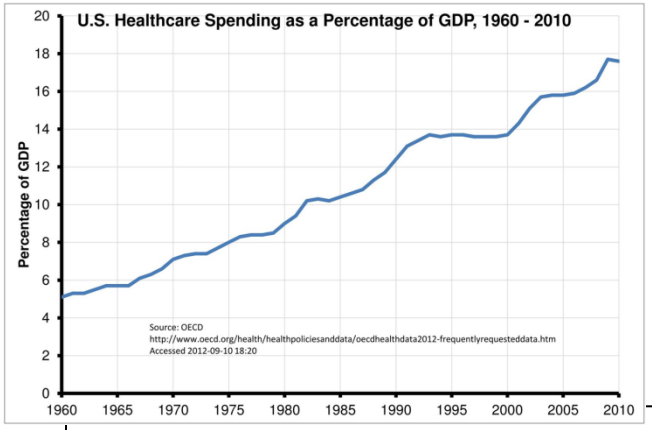
2014-2016
Getting Serious
National: Strong Commit to Value-Based Payment, ACO Risk, Multi-Payer Models, Deal on SGR
Vermont: Multiple ACOs, creating VCO, Negotiate All Payer Model

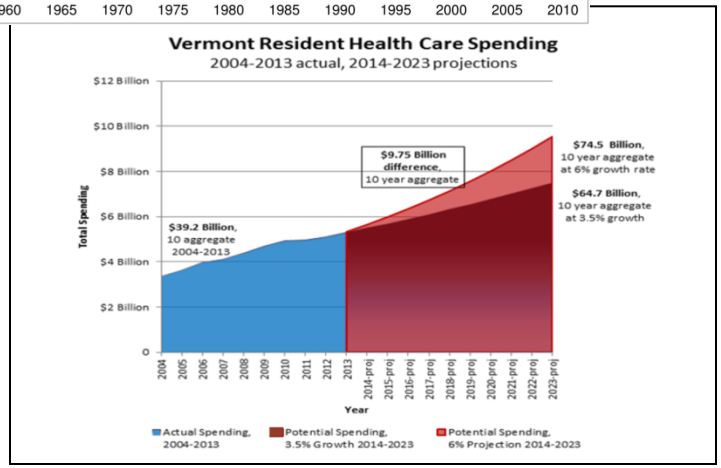


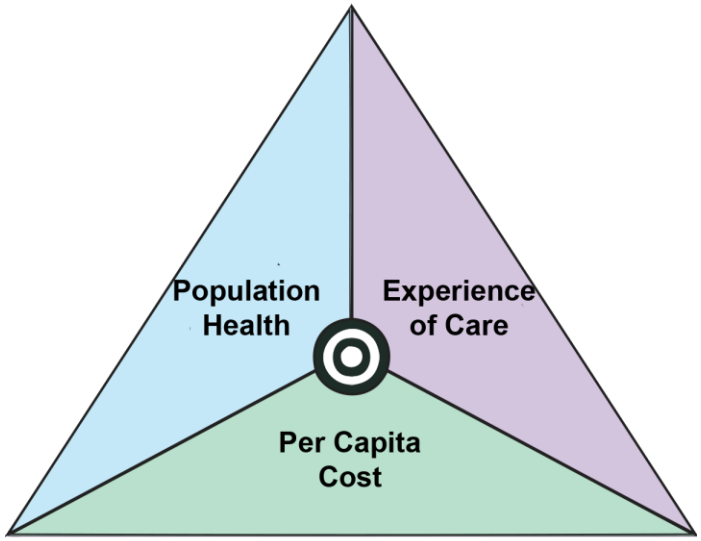
2017+
Future Model
National: Repeal/replace ACA, implement MACRA/MIPS, Continue ACO programs
Vermont: APM, Medicaid Next Generation, True non-FFS payment reform, broad-based population health management

The Roots of Value-Based Payment Reform

Unsustainable Cost Growth + Mixed Quality, Service, and Value







IHI Triple Aim

Accountable Care and ACOs

<u>"Accountable Care"</u>

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

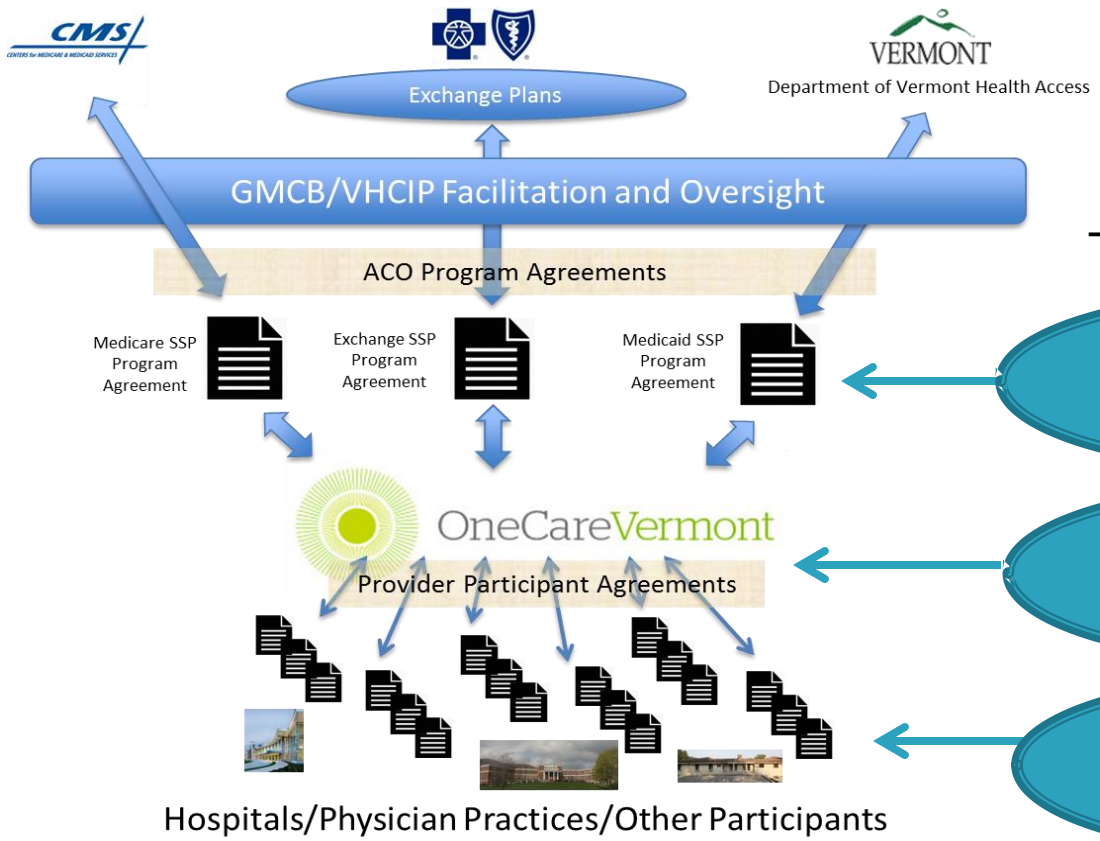
<u>"Accountable Care Organization" = ACO</u>

- 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

What is an ACO Really – Example



Three Major Roles

- Apply/Contract for Payer ACO Programs and Ensure Program Requirements Met
- Provide Data, Tools, Processes, Clinical Consulting, Facilitation to Participating Providers
- Hold Contracts with Doctors, Hospitals, Other Providers for Participation in ACO Programs

The Basic Transformation

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)

Medicare/CMS Leading the Charge*

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

OneCareVermont

Quality Measure Scores PY3 2015

Reporting and Performance Measures

2015 Percentile
2014 Percentile
2014 & 2015 Percentile (No Change)

	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%

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:

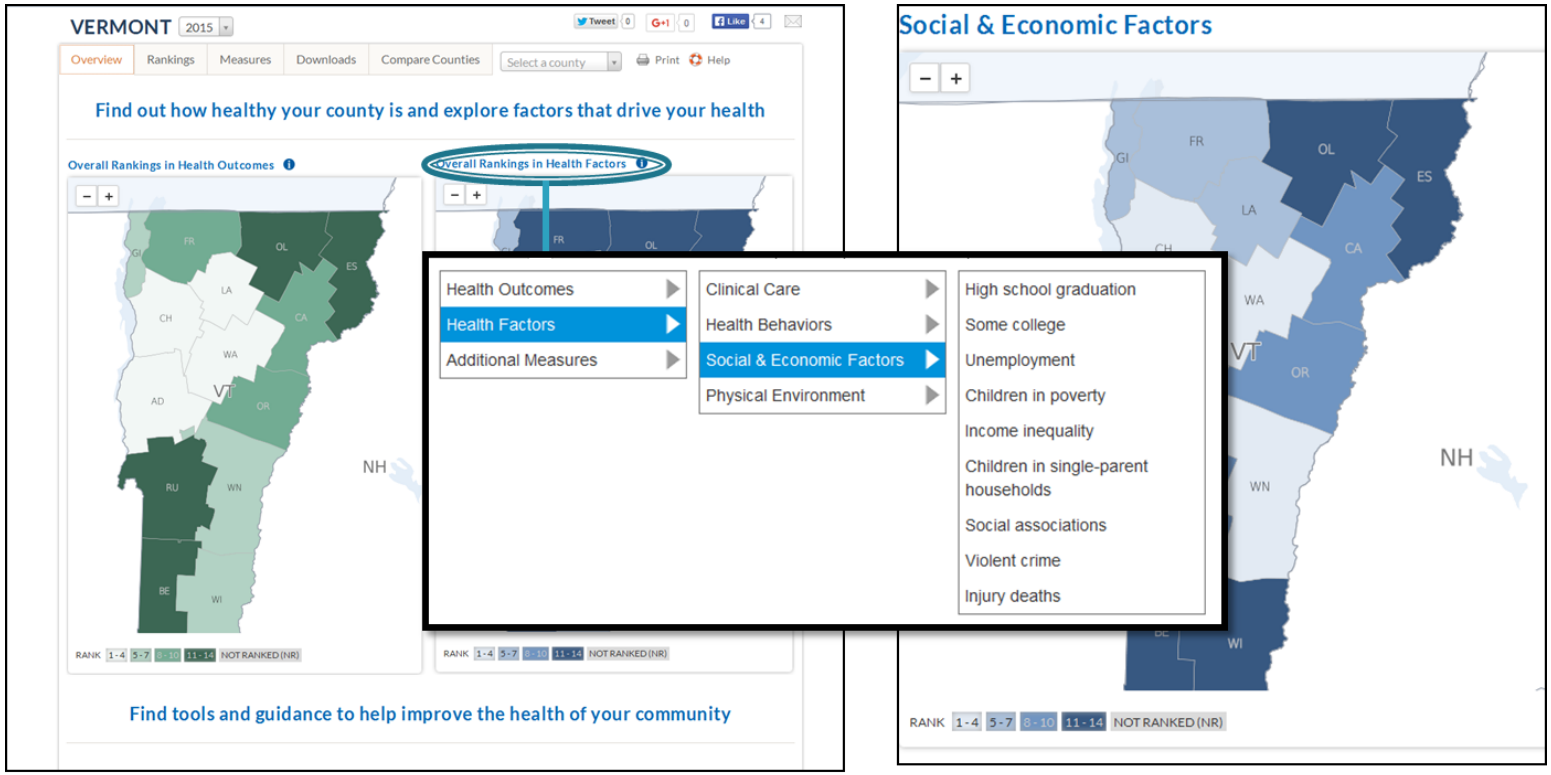
- The political rhetoric about demand-side versus supply-side as a better option is ill-founded; both have roughly the same effect on total spending.
- Even if the United States implemented all the approaches whose effectiveness has been measured, only 40% of the estimated $1 trillion of wasteful spending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

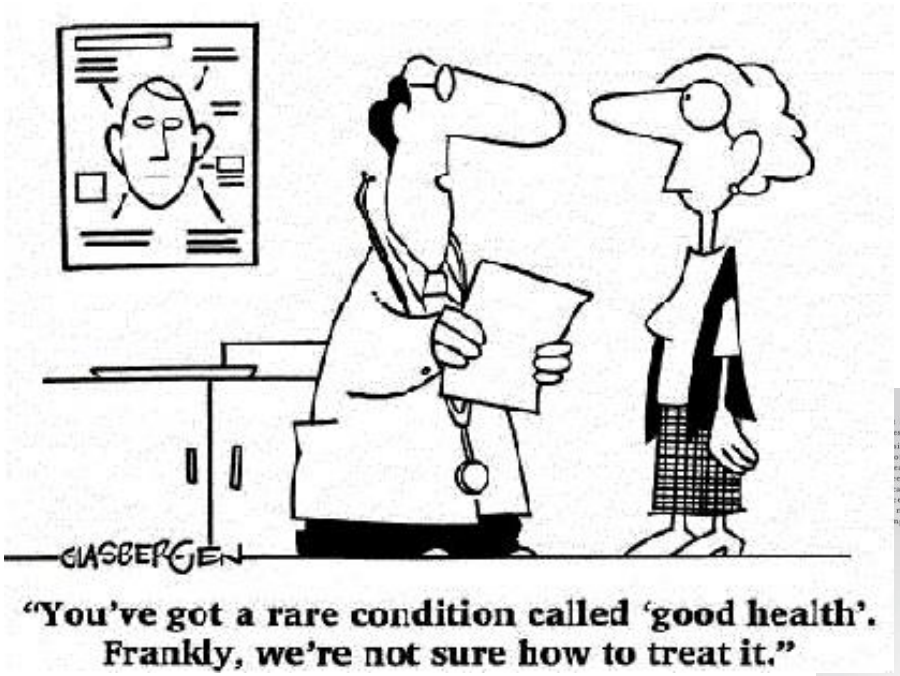
NOTE THE THREE DESCRIPTIONS OF CLINICAL WASTE ARE AN AGGREGATION OF BERWICK AND HACKBARTH'S ORIGINAL ANALYSIS.
SOURCE "ELIMINATING WASTE IN U.S. HEALTH CARE," BY DONALD M. BERWICK AND ANDREW D. HACKBARTH, 2012

Stronger Focus on Socio-Economic Factors also Required



Health Outcome Spending/Results Strongly Mirror Social and Economic Status

A Cultural Transition



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

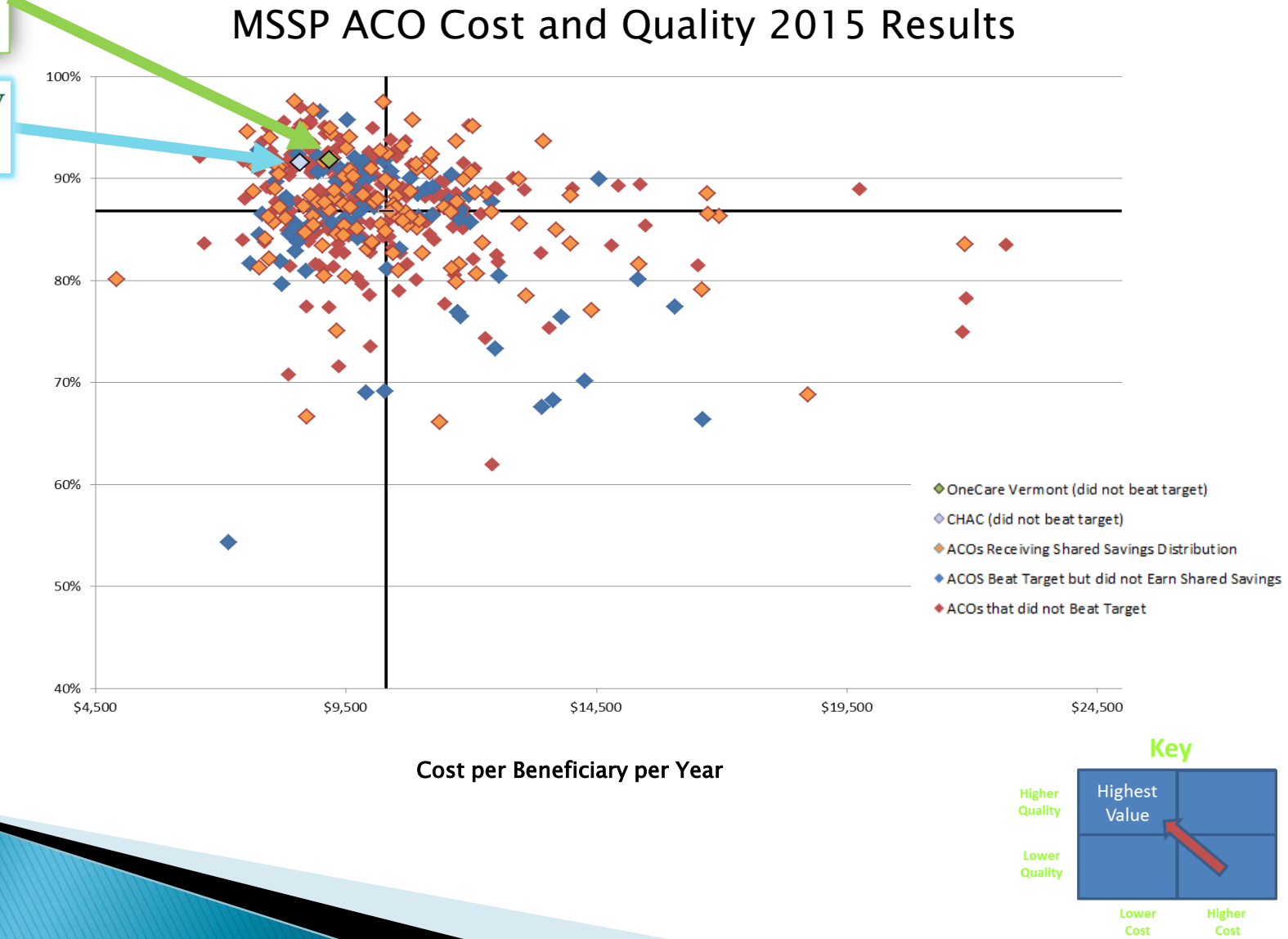
- **Community Health Accountable Care (CHAC)**
  - Founded by Bistate Primary Care Association and many of its Federally Qualified Health Centers (FQHCs) in 2013
  - Expanded to include all FQHCs and some hospitals
  - Medicare/Medicaid/Commercial all 2014 to Current

- **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	$ 169
	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	$ 335
	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

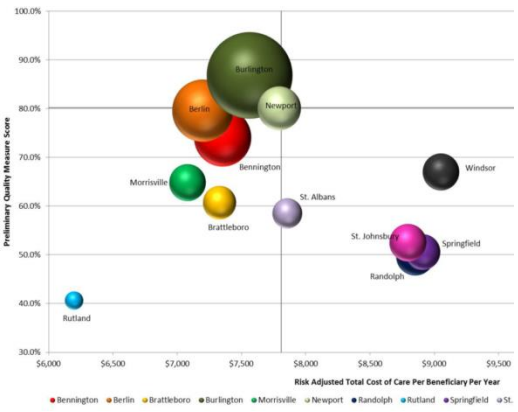


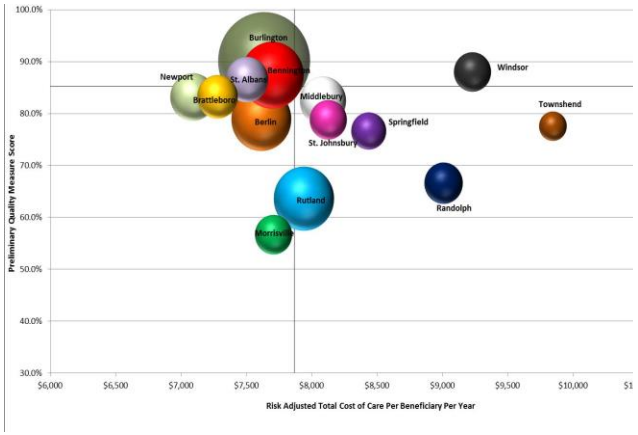
OneCare Vermont - Medicare SSP Performance by Healthcare Service Area

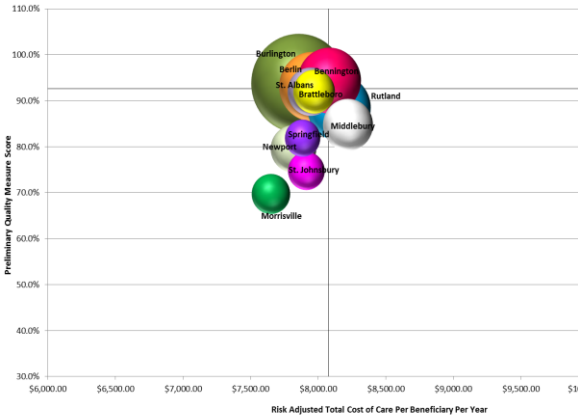
Risk Adjusted Cost and Quality

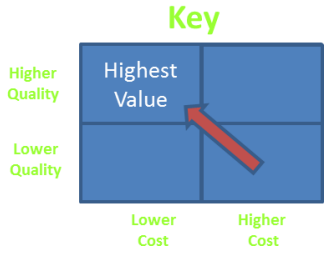
2013 → 2014 → 2015

(Year 1) (Year 2) (Year 3)









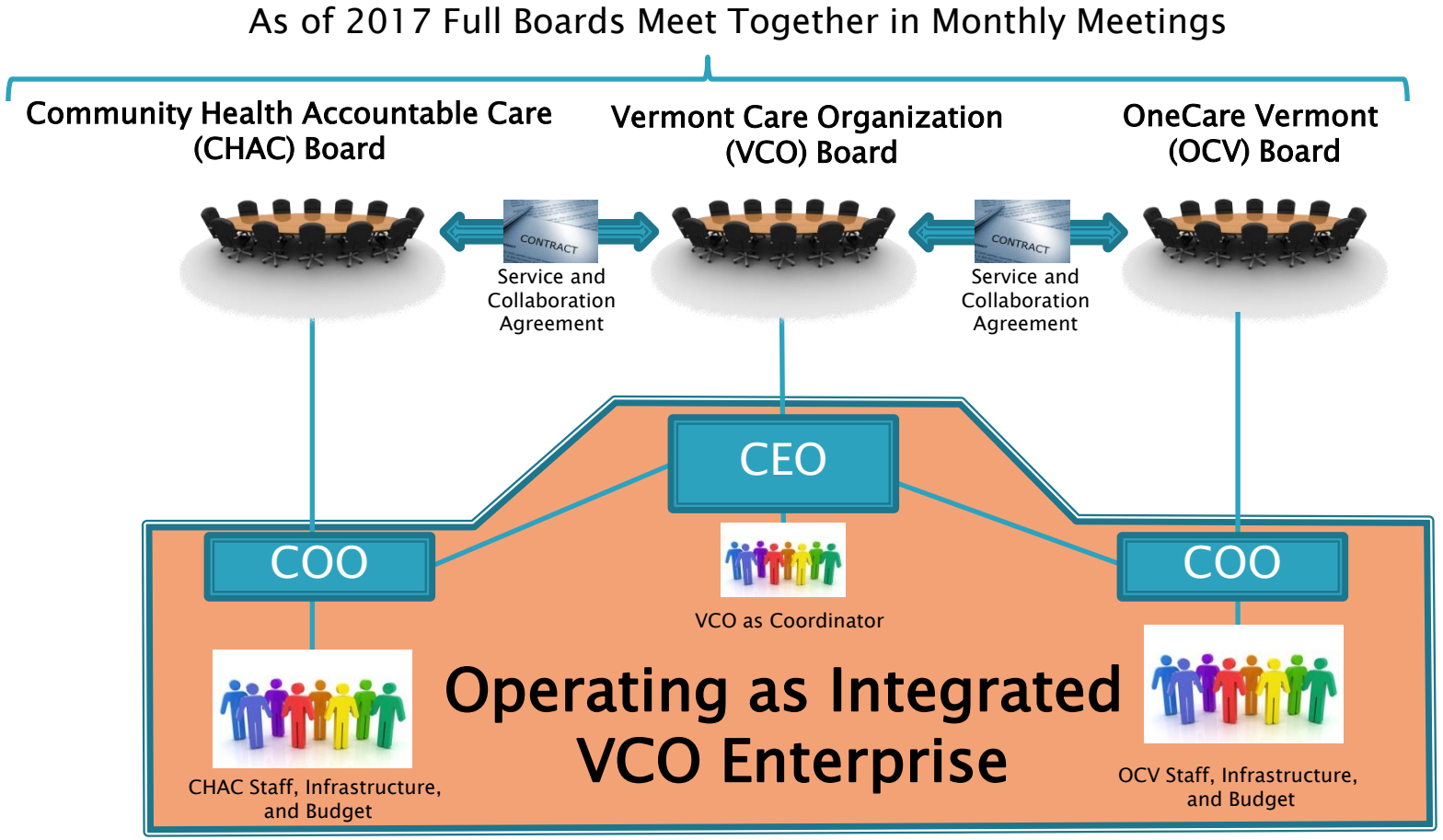
Vermont Care Organization

- 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

Unified ACO Model – Visualizing the Structure



VCO Board/Committee Officers

Board Officers

- Chair — Thomas Huebner
- Vice Chair — Kevin Kelley
- Secretary — Michael Hall
- Treasurer — Sandra Rousse

Committee Chairs

- Primary Care — Paul Reiss MD
- Population Health — Stephen Leffler MD
- Nominating Committee — Kevin Kelley (Concurrent with Vice Chair)
- Finance Committee — Sandra Rousse (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 Rousse (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
Particpant 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