OneCare Vermont

Introduction to OneCare

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Accountable Care Organizations

The problems ACOs are trying to solve:

- Payment incentives are not aligned
- Health care services are not coordinated

ACO Core Business Areas

- High Performing Network
- Data Analytics
- Payment Reform

Goals

- Incentivize ***quality***, not quantity
- ***Increase coordination*** across the system of care

Tools Available to ACOs

1. Federal Payment Waivers
2. Fraud and Abuse Waivers
3. CMS Benefit Waivers
4. Exemption from Quality Payment Program (QPP) reporting & 5% Bonus on Medicare claims for all patients on their panel*
5. Access to Payer Claims Data
6. Aligned/simplified Quality Measures across Payers
7. Administrative exemptions
8. Ability to share data across ACO Providers
9. Shared resources and infrastructure
10. Ability to take and spread financial risk and reward

**Only available to Advanced Alternative Payment Model ACOS, of which VT qualifies*

ACO Landscape

ACA introduced ACOs, Established in 2012 as a Medicare Payment Model Payment

ACO Statistics

- Over 32.7 million patients covered across the country
- Average Quality Score over 92%
- Over 2 billion in savings

*Advanced Alternative Payment Models

- 5% Medicare Incentive Payments for primary care (including FQHCs)
- Exclusion from Federal MIPS reporting
- APM Specific Rewards

CMS Offerings

1. **CMS ACO Model Options ("Off the Shelf"):**
   a. MSSP
   b. ESRD
   c. Next Generation*
   d. Direct Contracting*
   e. CHART (Community Health Access and Rural Transformation)- currently delayed
2. **CMMI State Specific All Payer ACO Model Options:**
   a. Maryland All Payer Model*
   b. Pennsylvania Rural Hospital Model
   c. Vermont All Payer Model*

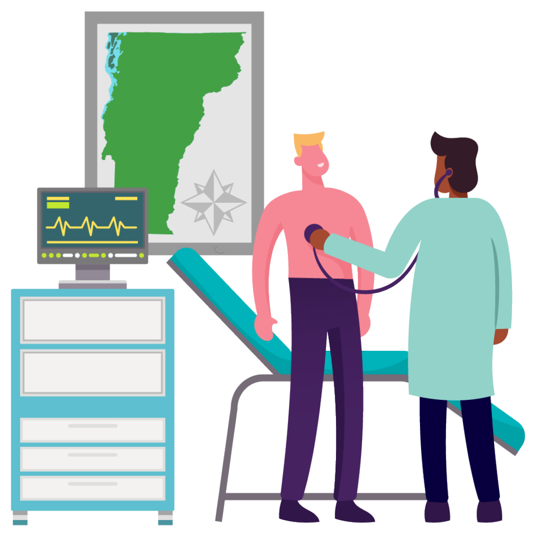
Federal Reform Landscape

Recent Recommendations From Former CMS and CMMI Officials

- **Recommendation 1:** Connect the CMMI agenda more explicitly to a broad HHS and CMS and a strategic plan and aims for improving health and health care delivery.
- **Recommendation 2: Use CMMI authority to scale the ACO model nationally by making it mandatory for all Medicare participating clinicians and hospitals. Clinicians, hospitals, and payers find it difficult to operate in an ambiguous world straddling payment for volume and value. Although voluntary participation has made evaluation of ACOs difficult,[5] the Medicare Payment Advisory Commission and others have concluded that different CMS ACO models during the last 15 years have consistently produced modest savings for CMS.[6-8] CMS should gradually but steadily expand ACO adoption during the next 5 years until virtually all Medicare participating organizations and clinicians are operating within accountable organizations. Advanced primary care practice models will be a natural core feature. Part of the expansion should include, as much as feasible, progressing to capitation of ACOs for total cost of care.**
- **Recommendation 3:** Sponsor models directed at improving health equity.
- **Recommendation 4: Rebalance CMMI model tests toward delivery system redesigns, not just new payment models. Payment matters, but ultimately only changes in care at the patient and clinician level can produce better outcomes and lower costs.**
- **Recommendation 5:** Build much stronger cooperative innovation programs between CMMI and private-sector health care insurers and delivery, including academia.

https://jamanetwork.com/journals/jama/fullarticle/2778102

OneCare's
Core Business Areas



High Performing Network

Data Analytics

Payment Reform

OneCare Core Business Area: High Performing Network

Ensuring a high quality, equitable system that improves care delivery and health outcomes

OneCare Partners with thousands of health care providers, who are dedicated to breaking down silos and working as a system. The model works cross-sector across physical health, mental health, housing, and social services to provide a robust care coordination model and community-based health prevention.

The care model includes prevention, self-management of chronic diseases, care coordination, and end of life care.

- Fred's Story: https://vimeo.com/479923984

OneCare Vermont: Fred's Story

Having trouble with sound? Please visit this link to view in browser: **https://vimeo.com/479923984**

Improving Quality of Care

Diabetes HbA1c Poor Control

2019 rate 13.49%
(Medicare 80th percentile)

2022 target 70th – 80th Medicare percentile

Controlling High Blood Pressure

2019 rate 71.46%
(Medicare 70th percentile)

2022 target 70th – 80th Medicare percentile

All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions

2019 rate 60.04%
(Medicare 40th percentile)

2022 target 70th – 80th Medicare percentile

Tobacco Use Assessment and Cessation Intervention (Population 2)

2019 rate 86.36%
(Medicare 80th percentile)

2022 target 70th – 80th Medicare percentile

OneCare Investment Strategies: Population Health Management Payments, Primary Prevention Programs, Innovation Fund, and/or the Value-Based Incentive Fund.

Improving Quality of Care

Initiation of Alcohol and Other Drug Dependence Treatment

2019 rate 35.42%

2022 target 40.8%

Engagement of Alcohol and Other Drug Dependence Treatment

2019 rate 13.72%

2022 target 14.6%

30-Day Follow-Up After Discharge from ED for Mental Health

2019 rate 76.05%

2022 target 60%

30-Day Follow-Up After Discharge for Alcohol or Other Drug Dependence

2019 rate 33.01%

2022 target 40%

Screening for Clinical Depression and Follow-Up Plan

2019 rate 52.69%
(Medicare 50th percentile)

2022 target 70th – 80th Medicare percentile

OneCare Investment Strategies: Population Health Management Payments, Value-Based Incentive Fund, and Complex Care Coordination Program
Payer(s): Multi-Payer (Medicare, Medicaid and BCBSVT QHP)

Improving Quality of Care

ACO CAHPS Composite: Getting Timely Care, Appointments, and Information

2019 rate = 82.48%
(Medicare 80th percentile)

2022 target → 70th – 80th Medicare percentile

OneCare Investment Strategies: Population Health Management Payments; Value-Based Incentive Fund

OneCare Core Business Area: Data Analytics

Delivering real time, actionable data to health care providers in support of better health care decisions

We measure cost, quality, and utilization across the whole health care system. We give providers more focused, actionable data to better serve their patients.

- Eilidh Pederson of Brattleboro Memorial Hospital talks about how OneCare data helped them to deliver better care: https://vimeo.com/537232539

OneCare Core Business Area: Data Analytics

Having trouble with sound? Please visit this link to view in browser: https://vimeo.com/537232539

OneCare Core Business Area: Payment Reform

Organizing and evolving value-based care programs by moving away from fee-for-service and incentivizing value over volume

OneCare contracts with payers to transition to paying for health outcomes and quality care instead of paying for the number of services ordered.

- In 2020, OneCare converted $395 million of volume-based reimbursement into monthly fixed payments.
- This transition shifts focus from volume to value and stabilized participating provider revenue during the pandemic.

What is Value-Based Care?

A health care delivery model under which health care providers are paid based on health outcomes and quality of care rather than for individual services.

$1.4 billion of Vermont's Health Care Spending in Value-Based Care

Category 1
Fee-For-Service: No Link to Quality and Value

LIVES: n/a | **TOC:** $0

Payer Programs | N/A

Category 2
Fee-For-Service: Link to Quality and Value

Foundational Payments For Infrastructure & Operations
(e.g. care coordination fees and payments for HIT investments)

LIVES: n/a | **TOC:** $0

B

Pay for Reporting
(e.g. bonuses for reporting data or penalties for not reporting data)

LIVES: n/a | **TOC:** $0

Pay-For-Performance
(e.g. bonuses for quality performance)

LIVES: n/a | **TOC:** $0

Payer Programs | N/A

Category 3
APMS Built on Fee-For-Service Architecture

APMs with Shared Savings
(e.g. shared savings with upside risk only)

LIVES: 10,200 | **TOC:** $50,800,000

B

APMs with Shared Savings and Downside Risk
(e.g. episode-based payments for procedures and comprehensive payments with upside and downside risk)

LIVES: 120,500
TOC: $859,400,000

Payer Programs | Medicare, BCBSVT, MVP

3N Risk Based Payments NOT LINKED to Quality

Category 4
Population-Based Payment

Condition-Specific Population-Based Payment (e.g. per member per month payments, payments for special services such as oncology or mental health)

LIVES: n/a | **TOC:** $0

B

Comprehensive Population-Based Payment (e.g. global budgets or full/percent of premium payments)

LIVES: 111,500 | **TOC:** $268,400,000

Integrated Finance & Delivery Systems
(e.g. global budgets or full/percent of premium payments in integrated systems)

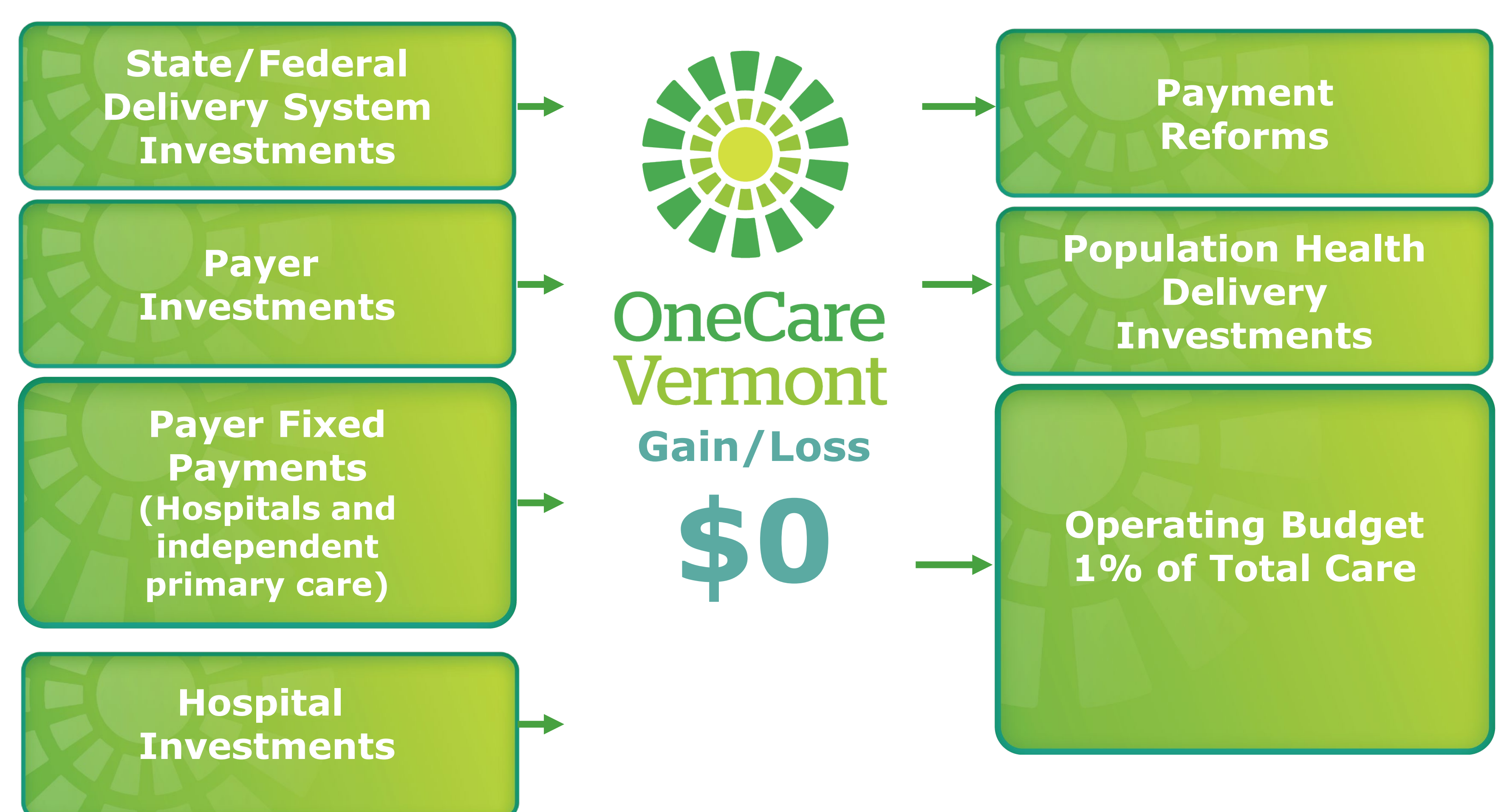
LIVES: n/a | **TOC:** $0

Payer Programs | Medicaid

4N Capitated Payments NOT LINKED to Quality

TOC = Total Cost of Care. CHART SOURCE: Health Care Payment Learning Action Network Alternative Payment Model Framework

Payment Mechanism that Incentivizes Value



Financial Flow

Value-Based Health Care Cost ~$1.42 billion
(Medicaid, Medicare, BCBSVT, MVP)

Health Care Reform (HCR) Investments ~$38 million
(Medicaid, Medicare, BCBSVT, MVP, Hospitals)

Pay Directly to Delivery System: (Fee for Service $938 million a year)

- All Providers other than Participating Hospitals including:
  - FQHCs
  - Independent Primary Care & Specialists
  - Home Health & Hospice, Designated Agencies, Skilled Nursing Facilities
  - Out of Network Providers

Pay OneCare Monthly for: ($512 million over the year)

- $474 Million Hospital Fixed Prospective Payment Allocation (includes all services, including hospital employed primary care)
- $38 Million Health Care Reform Investments for OneCare Population Health Management

Hospital & CPR Practices

- Fixed Prospective Payments
- Population Health Management Payments
- Care Coordination Program Payments
- Value Based Incentive Fund

Non- Primary Care Practices

- Care Coordination Program Payments
- Value Based Incentive Fund

Non-Hospital Primary Care Practices

- Population Health Management Payments
- Care Coordination Program Payments
- Value Based Incentive Fund

When providers of all types work together to care for the whole person, including mental and physical health, overall health and quality of life improves, costs decrease, and the providers themselves thrive, so it's a victory all around.

The journey to better health and lower costs takes time, and we are working together to not only transform health care but to reform the way we pay for that care. We are assuming risk, which can be daunting, but we appreciate the support from OneCare and the partnerships we have across the health care system.

Steve Gordon

President and CEO of Brattleboro Memorial Hospital

Questions?