

The Unified Care Organization

A Big Step for Vermont

Blueprint for Health Annual Conference

April 12, 2016

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Goals for Today's Discussion

- Provide information on the All Payer Model (APM) and a potential unified care organization
- Describe where the process of APM and a unified care organization stands, and what it means
- Explain how the unified care organization is currently envisioned to work
- Answer questions and engage in dialogue about the process and concepts above

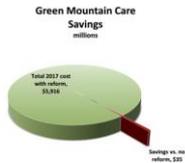
Health Care Reform Path 2010-2017



2010-2011

Legislative Action

National: PPACA
Vermont: Act 48



2011-2012

Early Implementation

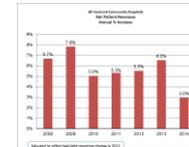
National: MSSP ACO Program; Age 26; Exchange Planning
Vermont: GMCB seated; VT exchange legislation; Hospital NR growth limits, payment reform pilots



2012-2014

Becoming Real

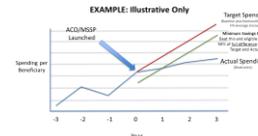
National: ACA benefit plans, exchanges, Medicaid expansion
Vermont: SIM Grant, VT Health Connect, Multi-Payer ACOs; population-based SSP on top of FFS



2014-2016

Getting Serious

National: MSSP ACO risk; stabilize ACA and national exchange
Vermont: ACO Multi-Payer; GMC Funding design; continued provider consolidation; Start move to non-FFS



2017+

Future Model

National: Refined national model and/or state innovation; Medicare/Medicaid funding challenges
Vermont: GMC as right of citizenship; new funding and provider revenue model(s)
All Payer Model w CMS Waiver and ACO-based Payment/Delivery Reform

Medicare/ CMS Still Leading Charge

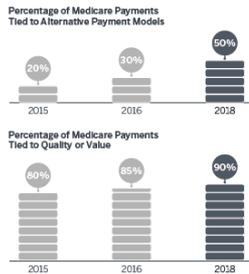
2015: Major reemphasis and coordinated push toward value-based payment in lieu of FFS by 2019

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

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| <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>Disruption to Fee-for-Service Business Model</p> <p>Voluntary</p> <p>608 Organizations supporting the network and its objectives</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>Disruption to Fee-for-Service Business Model</p> <p>Voluntary</p> <p>475 Primary care practices participating in the program</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 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 <p>Disruption to Fee-for-Service Business Model</p> <p>Mandatory</p> <p>2% Hospital inpatient Medicare payment at risk when fully implemented in 2017</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>Disruption to Fee-for-Service Business Model</p> <p>Mandatory</p> <p>3% Hospital inpatient Medicare payment at risk</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>Disruption to Fee-for-Service Business Model</p> <p>Mandatory</p> <p>25% Hospitals mandated to face the penalty</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 track that offers additional incentives <p>Disruption to Fee-for-Service Business Model</p> <p>Mandatory</p> <p>9% Physician Medicare payment at risk when fully implemented in 2022</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>Disruption to Fee-for-Service Business Model</p> <p>Voluntary</p> <p>2K+ Organizations participating in the program</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 accuracy 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>Disruption to Fee-for-Service Business Model</p> <p>Mandatory</p> <p>75 Markets proposed for participation in the program</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 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>Disruption to Fee-for-Service Business Model</p> <p>Voluntary</p> <p>\$960 Per-beneficiary care management fee for six-month episode of care</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>Disruption to Fee-for-Service Business Model</p> <p>Voluntary</p> <p>404 ACOs participating in the program</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; 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 <p>Disruption to Fee-for-Service Business Model</p> <p>Voluntary</p> <p>\$384M Total savings generated by Pioneer ACOs, 2012-2013</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>Disruption to Fee-for-Service Business Model</p> <p>Voluntary</p> <p>15-20 Organizations expected to participate in 2016</p> <p>CY 2016</p> |

12 Major Programs

- 5 Mandatory
- 7 Optional

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

True innovation increasingly provided/allowed in more advanced models

Vermont ACO Landscape

■ Three ACOs



- Community Health Accountable Care (CHAC)
 - Vermont Collaborative Physicians (Healthfirst ACO)
 - OneCare Vermont ACO
- ## ■ Existing track record of collaboration among ACOs
- Vermont Health care Innovation Project - VHCIP (“SIM Grant”) committees
 - GMCB-facilitated payment reform design groups
 - Work with Blueprint and VHCIP on community collaboratives across Vermont and complex care management pilots in multiple communities
 - Development with Blue Print of the 2016 medical home performance measures and incentive program
 - ACO quality collection process
 - “Memorandum of Understanding” among all three ACOs to explore potential of combining into single ACO

OneCare Vermont

- One of 26 Organizations accepted into Next Generation
 - 21 Started in 2016 and 5 Deferred until 2017
- Accountability (risk) for total cost of care for attributed beneficiaries
- For first time, offers...
 - Better terms for low base cost and high quality
 - A non-FFS payment option for ACO networks wishing to do true payment reform
 - Enhanced benefits and beneficiary incentives
 - > Post discharge home visits, telemedicine, SNF rules
- OneCare had to demonstrate substantial capabilities to be accepted
- OneCare had to commit to aligning other payers into value-based contracts

Vermont's All-Payer Model (APM)

- **Spring 2014 – The Ask**
 - Originated with letter from Anya Rader-Wallack to CMS
 - Requested to work with CMS on using Vermont's SIM-enabled base, which included a statewide multi-payer ACO model, to partner in pushing value-based payment and integrated healthcare even farther
- **Fall 2014 – The Answer**
 - CMS proposed a dialogue among CMS Innovation Center (CMMI) and Vermont to explore the possibility
- **First Half 2015 – Initial Dialogue**
 - Conceptual but substantial dialogue between GMCB/Administration and CMMI
- **Second Half of 2015 – Drafting of Terms**
 - Development of specific parameters of potential Medicare/APM Waiver and a draft term sheet
- **January 2016 to Current – Assessment and Planning**
 - Draft term sheet publically released
 - Significant planning underway on many dimensions
 - Legislative focus on ACO-based reform and APM
 - Ongoing negotiation with CMMI
 - Probability of approval and readiness for 2017 is unclear

Vermont's All-Payer Model (APM)

- Central focus is on a targeted “all payer” cost growth rate for health care for Vermonters of 3.5% and demonstration of a highly coordinated health system
- Reform under the all-payer system to be based on ACO(s)
 - Term Sheet: “Vermont will use an accountable care organization (ACO) model to carry out its payment and delivery system transformations under the All Payer Model Agreement”
 - Terms highly aligned with the Next Generation ACO program
- Financial terms offer advantages
 - More favorable and predictable Medicare spending targets
 - Includes Medicare continued participation in the Blueprint for Health (practice payments, CHT, SASH)
- Population health accountability and measurement
 - Population Health Goals on (i) increasing access to primary care, (ii) prevalence/management of chronic disease, and (iii) addressing the substance abuse epidemic
 - Plus expected ACO quality measurement and incentive program

Value Proposition of a Unified Care Organization

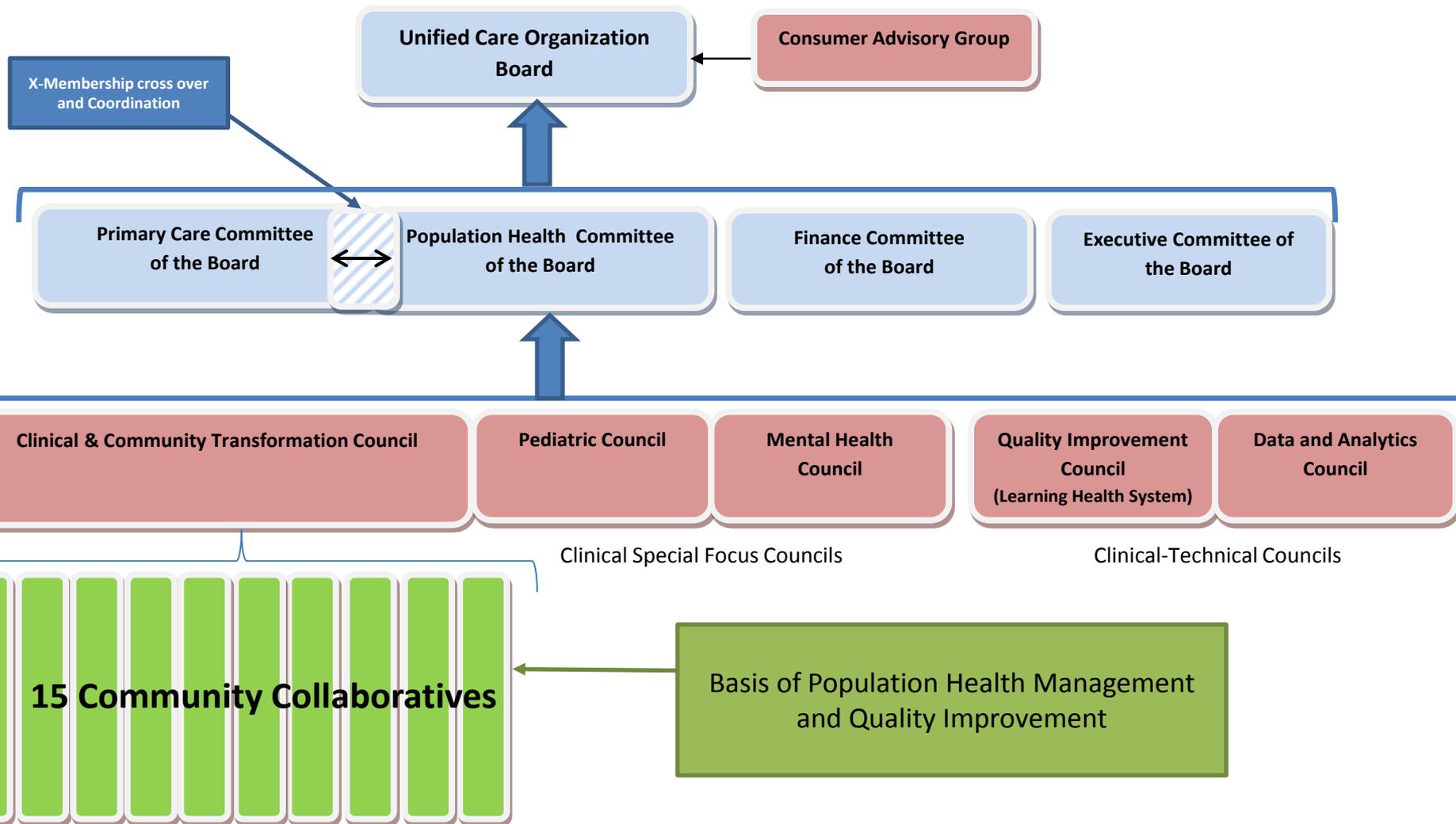
The All-Payer-Model does not require a single statewide care organization/ACO, but such a unified care organization could better...

- Help Vermont's communities take next steps together in a coordinated approach to population health management, building on the ACO-Blueprint community collaborative approach
- Address overall health and health care needs including social determinants as part of a true system of health *and* care
- Strengthen primary care including recruitment and capacity expansion
- Invest in community support services such as home health, mental health, developmental disabilities, substance abuse and social services
- Ensure hospitals are rewarded for helping to keep people healthy through partnering with the full continuum of care and services
- Develop an integrated approach to data collection, analysis, exchange and reporting to deliver higher quality, person-focused, and seamlessly coordinated care
- Assess and improve variation in clinical and cost outcomes across service areas in Vermont
- Provide a method to live within the overall statewide APM cost growth parameters while improving health and the health care delivery system

MOU Steering Committee

- Committee working on Unified ACO comprised of Board members from all three ACOs and at-large members
- Committee includes:
 - 3 very actively practicing independent physicians
 - A leader of a Designated Agency for mental health and substance abuse
 - A leader of an Area Agency on Aging
 - A leader of a community home health agency
 - A leader of a community skilled nursing facility
 - Leaders from small and large community hospitals and tertiary medical centers
 - Leaders from multiple FQHCs
 - A representative from the Office of the Health Care Advocate as a consulting advisory member
 - All facilitated by the Green Mountain Care Board (GMCB)

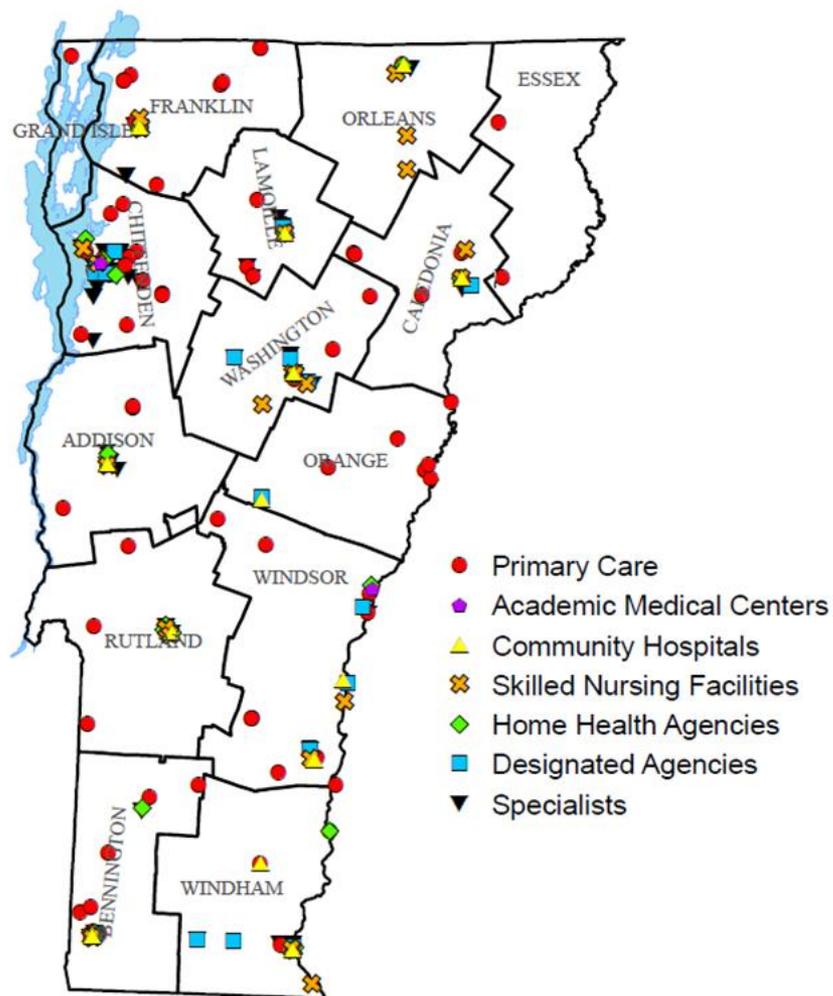
Preliminary Unified Care Organization Design



Health and community service providers and consumers will be represented at all levels of VCO's governance

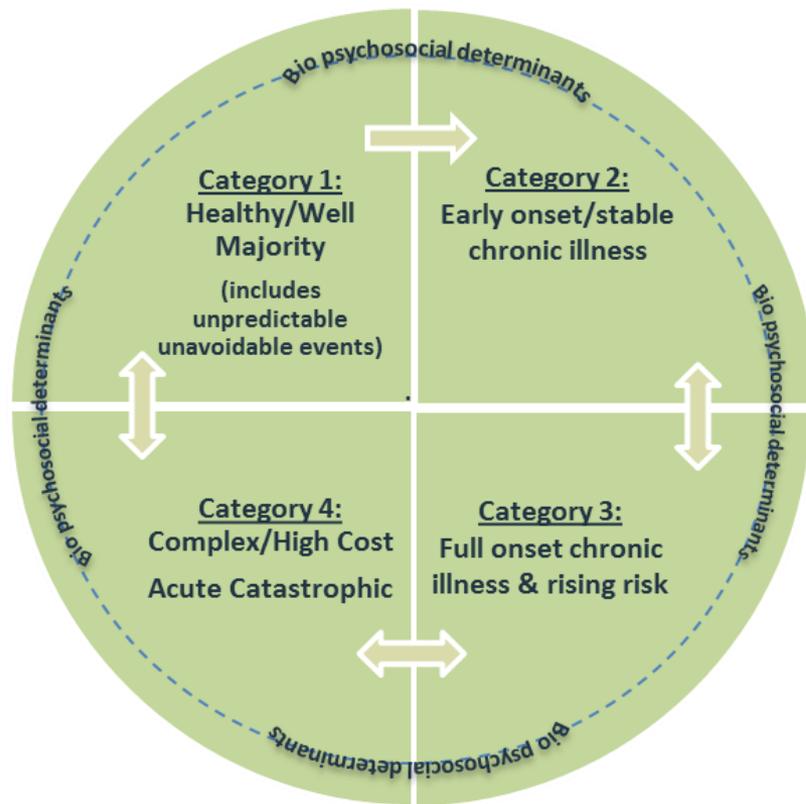
Statewide and Community-Focused Vision

Unified ACO Potential Network

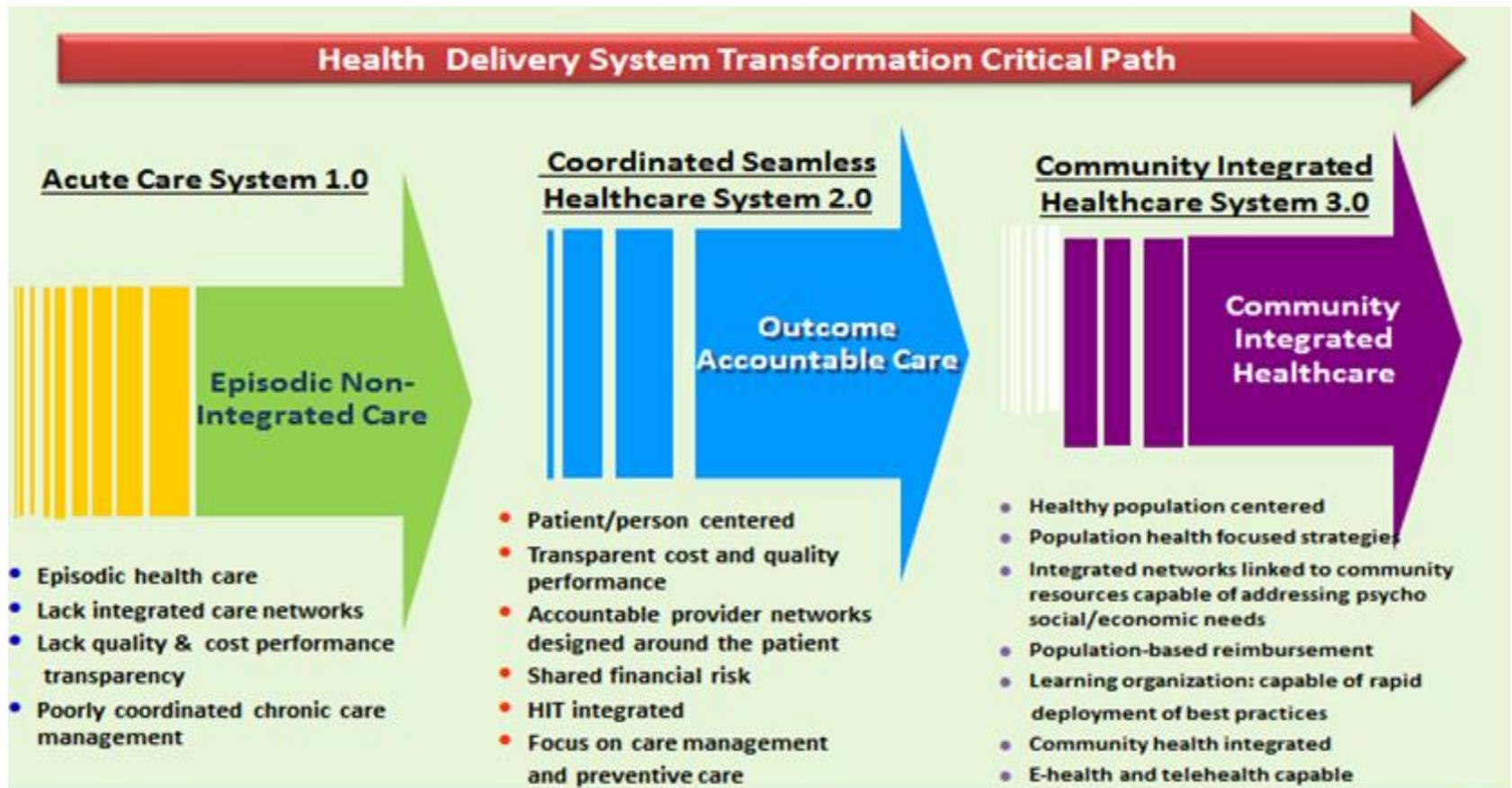


Total Population Health Model

Focused on communities working with the public health and clinical care system to collaboratively improve population health



Envisioning Fully Transformed Community Integrated Healthcare System (3.0)



Halfon N. et al, Health Affairs November 2014



Unified Care Organization as Collaborative “Hourglass” to Align Incentives and Resources

- Top:** Population-Level, Value-Based Programs to Reward Quality and Ensure Affordability
- Middle:** Operational, Clinical, Informatics Infrastructure; Management of Risk; Program/Provider Contracts
- Bottom:** Reformed Provider Payment Models, Incentive and Investment Programs and Community-Based Population Health Management

