



OneCareVermont

House Health Care Committee Discussion Document

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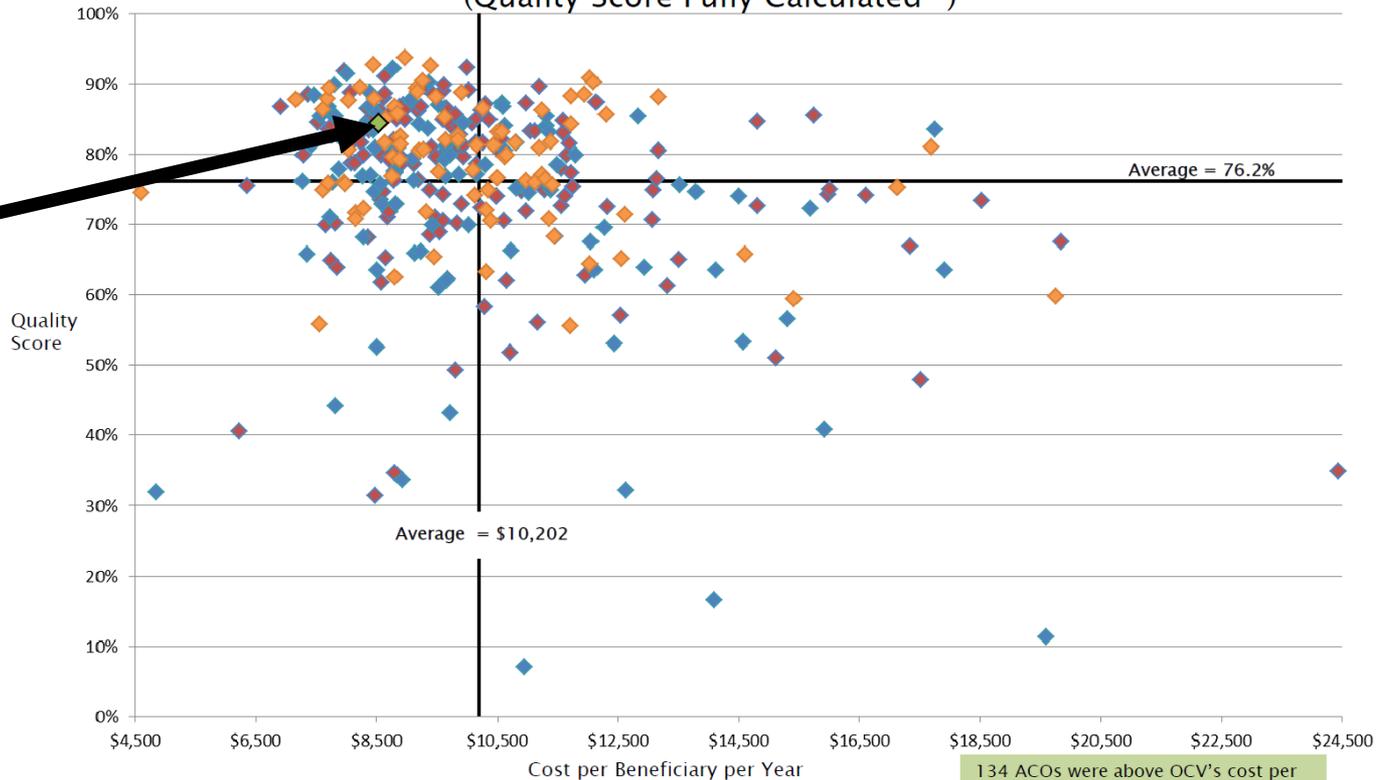
Part One: Do ACOs “Work”

National Medicare ACO Performance



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MSSP ACO Cost vs. Quality 2014 Results
(Quality Score Fully Calculated¹)



Key



- ◆ OneCare Vermont (did not beat target)
- ◆ ACOs Receiving Shared Savings Distribution
- ◆ ACOs Beat Target but did not Earn Shared Savings
- ◆ ACOs that did not Beat Target

134 ACOs were above OCV's cost per beneficiary and beat their targets or generated Shared Savings

¹This figure is calculated internally as if all measures were performance scored rather than any pay-for-reporting; this calculation will more closely match the CMS-Calculated figure over time as CMS decreases the pay-for-reporting component

OneCare Vermont Quality Measures: PY2 2014 vs PY1 2013



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Domain	Measure	PY1 2013	PY2 2014	30th perc.	40th perc.	50th perc.	60th perc.	70th perc.	80th perc.	90th perc.	OCV Score 2013	OCV Score 2014	n 2014	Quality Points 2014	
Patient/Caregiver Experience	1	Getting Timely Care, Appointments, and Information	R	P	30.00	40.00	50.00	60.00	70.00	80.00	90.00	83.81	85.01	323	1.85
	2	How Well Your Doctors Communicate	R	P	30.00	40.00	50.00	60.00	70.00	80.00	90.00	92.54	92.47	323	2.00
	3	Patients' Rating of Doctor	R	P	30.00	40.00	50.00	60.00	70.00	80.00	90.00	91.84	91.45	314	2.00
	4	Access to Specialists	R	P	30.00	40.00	50.00	60.00	70.00	80.00	90.00	82.21	86.00	131	1.85
	5	Health Promotion and Education	R	P	54.71	55.59	56.45	57.63	58.22	59.09	60.71	59.46	60.61	364	1.85
	6	Shared Decision Making	R	P	72.87	73.37	73.91	74.51	75.25	75.82	76.71	75.98	73.81	316	1.25
	7	Health Status/Functional Status	R	R	N/A	73.70	74.12		2.00						
Care Coordination/ Patient Safety	8	Risk Standardized, All Condition Readmissions	R	R	16.62	16.41	16.24	16.08	15.91	15.72	15.45	14.75	14.84		2.00
	9	ASC Admissions: COPD or Asthma in Older Adults	R	P	1.75	1.46	1.23	1.00	0.75	0.56	0.27	1.25	0.89		1.55
	10	ASC Admission: Heart Failure	R	P	1.33	1.17	1.04	0.90	0.76	0.56	0.27	1.22	1.07		1.25
	11	Percent of PCPs who Qualified for EHR Incentive Payment	R	P	51.35	59.70	65.38	70.20	76.15	84.85	90.91	57.55	72.26	667	3.10
	12	Medication Reconciliation	R	P	30.00	40.00	50.00	60.00	70.00	80.00	90.00	73.81	93.41	683	2.00
	13	Falls: Screening for Fall Risk	R	P	17.12	22.35	27.86	35.55	42.32	51.87	73.38	46.30	47.31	594	1.70
Preventive Health	14	Influenza Immunization	R	P	29.41	39.04	48.29	58.60	75.93	97.30	100.00	71.36	63.81	572	1.55
	15	Pneumococcal Vaccination	R	P	23.78	39.94	54.62	70.66	84.55	96.64	100.00	77.73	77.80	599	1.55
	16	Adult Weight Screening and Follow-up	R	P	40.79	44.73	49.93	66.35	91.34	99.09	100.00	70.94	70.81	418	1.55
	17	Tobacco Use Assessment and Cessation Intervention	R	P	30.00	40.00	50.00	60.00	70.00	80.00	90.00	91.37	96.67	600	2.00
	18	Depression Screening	R	P	5.31	10.26	16.84	23.08	31.43	39.97	51.81	24.71	28.07	456	1.55
	19	Colorectal Cancer Screening	R	R	19.81	33.93	48.49	63.29	78.13	94.73	100.00	65.33	70.27	592	2.00
	20	Mammography Screening	R	R	28.59	42.86	54.64	65.66	76.43	88.31	99.56	68.04	71.12	599	2.00
At-Risk Population Diabetes	21	Proportion of Adults who had blood pressure screened in past 2 years	R	R	30.00	40.00	50.00	60.00	70.00	80.00	90.00	68.66	66.43	414	2.00
	Diabetes Composite 22 – 26	ACO #22. Hemoglobin A1c Control (HbA1c) (<8 percent)													
		ACO #23. Low Density Lipoprotein (LDL) (<100 mg/dL)													
ACO #24. Blood Pressure (BP) < 140/90		R	R	17.39	21.20	23.48	25.78	28.17	31.37	36.50	23.08	28.67	600	2.00	
ACO #25. Tobacco Non Use ACO #26. Aspirin Use															
	27	Percent of beneficiaries with diabetes whose HbA1c in poor control (>9 percent)	R	P	70.00	60.00	50.00	40.00	30.00	20.00	10.00	22.12	13.10	603	1.85
At-Risk Population Hypertension	28	Percent of beneficiaries with hypertension whose BP < 140/90	R	P	60.00	63.16	65.69	68.03	70.89	74.07	79.65	67.04	70.57	581	1.55
At-Risk Population IVD	29	Percent of beneficiaries with IVD with complete lipid profile and LDL control < 100mg/dl	R	R	35.00	42.86	51.41	57.14	61.60	67.29	78.81	60.92	58.81	471	2.00
	30	Percent of beneficiaries with IVD who use Aspirin or other antithrombotic	R	P	45.44	56.88	68.25	78.77	85.00	91.48	97.91	86.65	90.02	471	1.70
At-Risk Population HF	31	Beta-Blocker Therapy for LVSD	R	R	30.00	40.00	50.00	60.00	70.00	80.00	90.00	81.78	84.12	170	2.00
At-Risk Population CAD	Composite 32 – 33	ACO #32. Drug Therapy for Lowering LDL Cholesterol ACO #33. ACE Inhibitor or ARB Therapy for Patients with CAD and Diabetes and/or LVSD	R	R	54.08	61.44	66.11	69.96	72.32	76.40	79.84	58.95	66.67	438	2.00

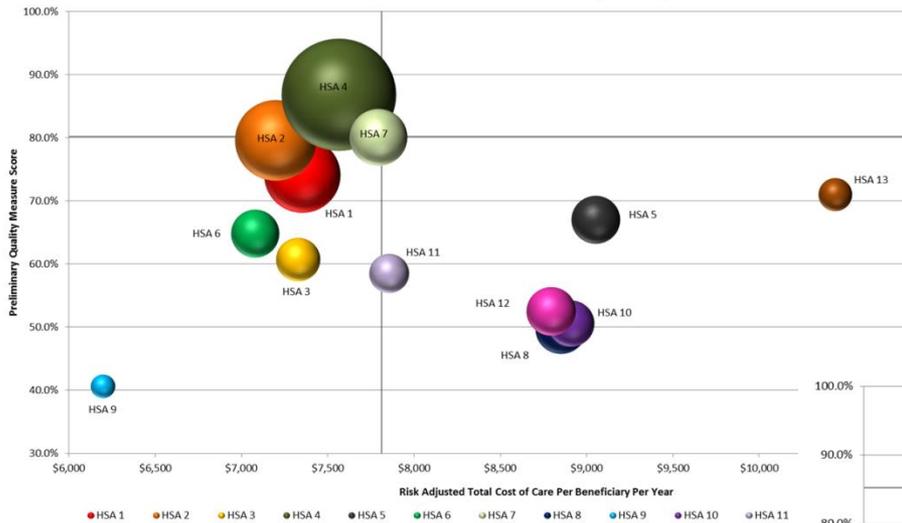
2014 Percentile
2013 Percentile
2013 & 2014 Percentile (No Change)

OneCare 2013 to 2014

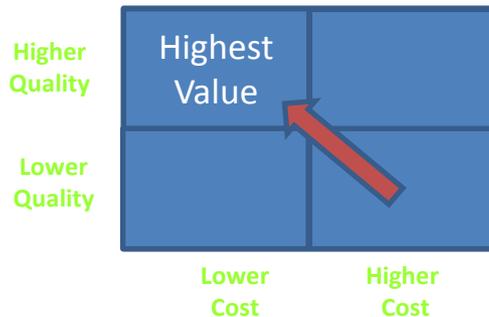


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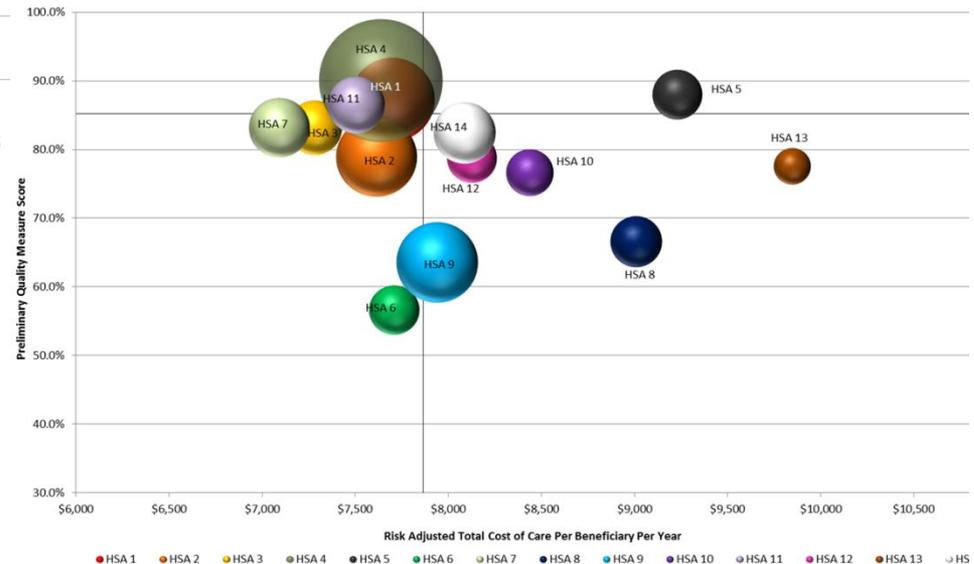
2013 Cost and Quality by HSA



Key



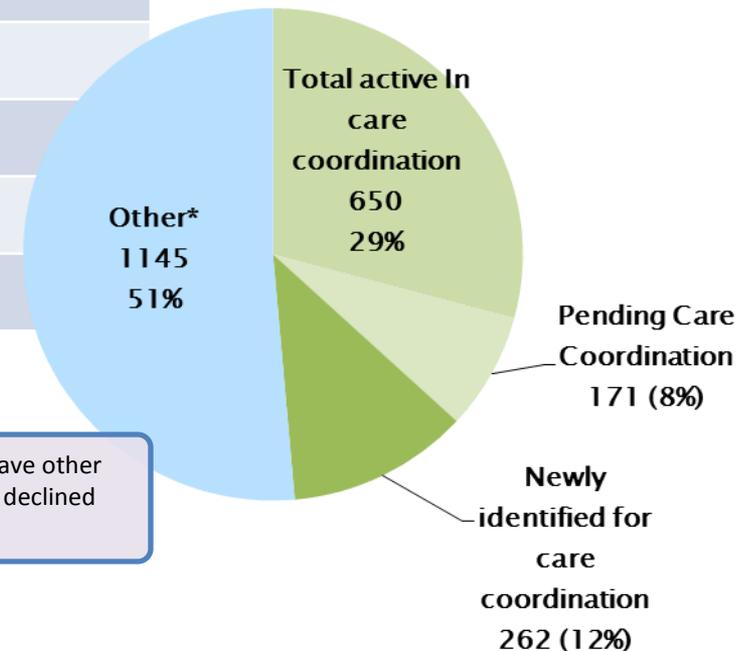
2014 Cost and Quality by HSA



OneCare: Care Coordination Facilitation



OneCare High Risk Members Active in Care Coordination (Individuals can be active in more than one)	
Total in Care Coordination	650 (29% of eligible)
Resource	
CHT or Office Based Care Coordination	285 (44%)
Home Health or Hospice	255 (39%)
Support and Services at Home (SASH)	37 (6%)
Vermont Chronic Care Initiative (VCCI)	30 (5%)
Area Agency on Aging /Senior Solutions	5 (.8%)



*Other = members have other care support or have declined care coordination

Part Two: Becoming a Risk Based ACO



- One of 26 Organizations accepted into Next Generation
 - 21 Started in 2016 and 5 Deferred until 2017 (including OneCare)
- Accountability (risk) for total cost of care for attributed beneficiaries
 - For first time, offers lower discount requirement to CMS based on low base cost and high quality (discount range minimum 0.5% and maximum 4.5%)
 - For first time, offers a true non-FFS payment option for ACO networks wishing to do true payment reform
 - Offers many other enhancements and advantages
- OneCare had to demonstrate substantial capabilities to be accepted
- OneCare had to commit to aligning other payers into value-based contracts

Vermont All-Payer Model



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- Term Sheet focus on Medicare, but predicated on system including Medicaid and Commercial
- Documents indicate that reform under the all-payer system is intended 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”
 - Companion Document: “As is true today, health care providers’ participation in ACOs is voluntary; the ACO must be attractive to providers and offer an alternative health care delivery model that is appealing enough to join”
- Terms appears highly aligned with the Next Generation ACO model
 - ACO/Next Gen Fraud and Abuse Waivers Included
 - Next Gen Benefit Enhancements Included
 - Spending Goal as Discount against National Medicare FFS Trend Rate
 - > “Pure” Next Gen – 0.5% to 4.5% discount with no floors
 - > “APM Term Sheet” – 0.2% discount with hold harmless minimums (“floors”) of 3.5% in 2017 and 2.0% in 2018-2021

Vermont All-Payer Model



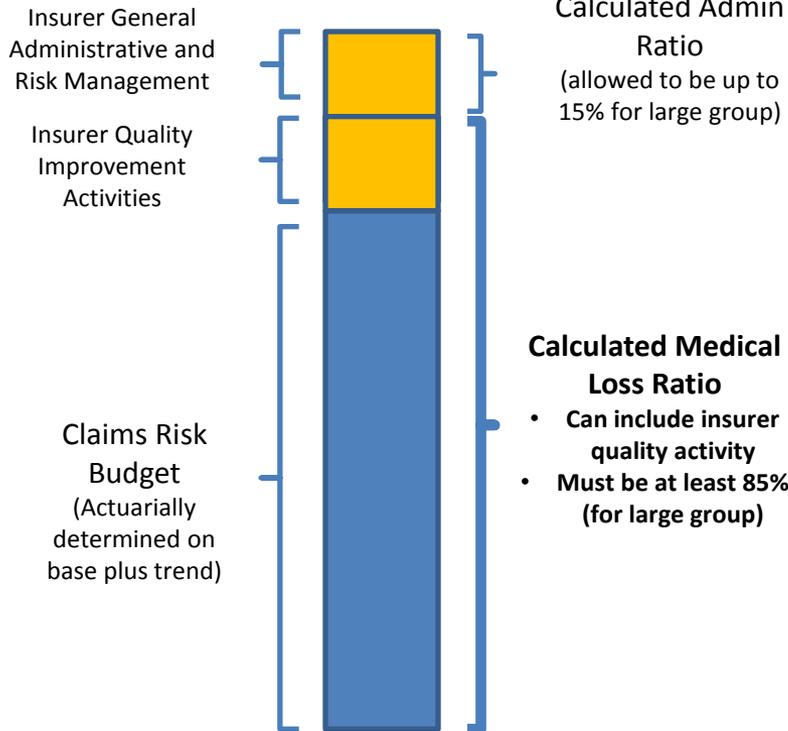
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- Includes Medicare continued participation in the Blueprint for Health (practice payments, CHT, SASH)
- Quality measurement as selected system-wide measures and likely broader scorecard of ACO-style metrics
 - Population Health Goals on (i) increasing 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
- Biggest open questions
 - Since still in negotiation, how much will the terms change?
 - What are the exact measures and targets on the three system goals?
 - How will the ACO program under APM be offered, structured, and regulated?
 - What are Implications if ACO participation is not broad-based?

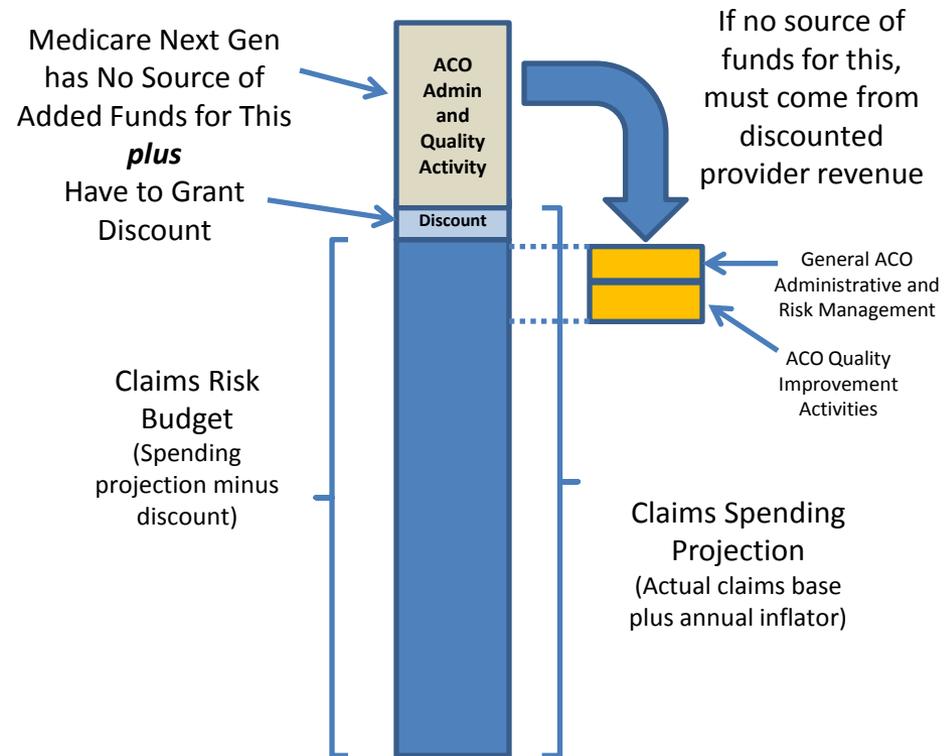
Population Risk-Bearing Entities



Commercial Insurance Plan (QHP under ACA)



Next Generation ACO



Commercial Insurer “Quality Improvement Activities” Definition



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An allowable quality initiative to count toward Medical Loss Ratio credit must do one of the following:

- Improve health outcomes by implementing activities such as quality reporting, effective case management, care coordination, chronic disease management, or medication and care compliance initiatives
- Implement activities to prevent hospital readmissions including a comprehensive program for hospital discharge that includes patient education and counseling, discharge planning, and post-discharge follow-up by an appropriate health care professional
- Implement activities to improve patient safety and reduce medical errors through the use of best clinical practices, evidence-based medicine, and health information technology under the plan or coverage
- Implement wellness and health promotion activities.

In addition, the HHS rules state that a non-claims expense will be counted as a quality improvement only if it falls into one of the four categories above, and also meets *all* the following requirements:

- Designed to improve health care quality;
- Designed to increase the likelihood of desired health outcomes in ways that can be objectively measured and that can produce verifiable results and achievements;
- Directed toward individual enrollees or incurred for specific segments of enrollees or provide health improvements to the population beyond those enrolled in coverage, so long as no additional costs are incurred due to the non-enrollees; and
- Grounded in evidence-based medicine, widely accepted best clinical practice, or criteria issued by recognized professional medical associations, accreditation bodies, government agencies, or other nationally recognized health care quality organizations.

OneCare in ACA Context



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- **OneCare Operational Expenses Focus Significantly on Clinical/Quality Programs**
 - We estimate very conservatively that 50% qualifies as “Quality Improvement” under ACA definition for insurers
 - Quality Improvement expenses are anticipated and in fact welcomed by ACA rules from the commercial payers and nobody questions the need for at least some general administration expenses for a risk-bearing insurance plan
 - *Key Question: As they become risk-bearing entities, should completely analogous ACO expenses be seen as less desirable or less necessary than insurer expenses?*
- **Based on the ACA definition, OneCare’s Medical-Loss-Ratio equivalent is approximately 98%-99%**
 - Some reasons why so much better than the 85% standard
 - > Large scalability across Medicare, Medicaid, and Commercial combined populations
 - > No sales and marketing unless become health plan vendor/carrier
 - > Easier path to transfer risk to contracted providers through payment reform (i.e. ACO has less risk to manage)
 - > ACO model is to provide systems, data and facilitation for clinical/quality programs but delegate these actual processes into the local care delivery system
 - Payers do significant amount of central telephonic disease management, utilization review, and care coordination
- **Issue of funding both ACO administrative and quality improvement program expenses will be major issue as ACO-based reform moves to financial risk (nationally and in Vermont)**



Part Three: What Happens from Here?

Going Forward – Three Potential Paths



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“Pure” Next Generation and Negotiated/Aligned Commercial and/or Medicaid Contracts
Expected Network: Some of existing OneCare Network

<OR>

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“APM” Program – Aligned Next Generation programs across Medicare, Medicaid, and Commercial
Expected Network: Most of existing OneCare Network

<OR>

Vermont Care Organization (VCO)

“APM” Program as Statewide ACO
Required Network: Participants from 3 current ACOs including community-based providers



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0
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7

VCO could help transition Vermont to healthcare 3.0



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