ACO Impact on Vermont Health Care Delivery

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Amy Cooper,
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September 9, 2014
J. Churchill Hindes PhD
Chief Operating Officer, OneCare Vermont ACO
Vice President for Accountable Care, Fletcher Allen Health Care
Clinical Associate Professor of Medicine, University of Vermont
"I understand your worry about ACO’s—

...but they’re not the end of the world"
Vermont ACO’s are different…

- Across the nation, ACO’s are essentially business arrangements between groups of providers and a payer, often Medicare. Providers see primary value in ACO as a way to maybe make some extra money.

- In Vermont, the ACO’s are also business arrangements between groups of providers and multiple payers, that began with Medicare. Providers also see ACO as a way to maybe make some extra money…

- AND, the ACO’s (particularly OneCare) are key, high profile leaders for statewide health care payment reform and system reform—private provider led efforts that complement public sector led initiatives
ACO’s as a “platform” for reform

• ACO’s are a “Health Care Reform Trifecta”
  – Broad network of providers
  – Voluntarily bound together through contract agreements
  – Committed to better understand their community status & needs
  – Willing to try and incorporate new ideas into daily practice
  – Collaborating with insurers (Medicare, Medicaid, Blue’s, MVP…)
  – Striving to achieve slower cost growth
    (While improving clinical quality and patient satisfaction)
  – Willing to be paid differently
  – Willing to accept more financial risks
Vermont ACO Roles

Provider-Led, Population-Based Coordination, Alignment, and Support
- Forum for Delivery System Design/Optimization
- Payment Reform Leadership
- Revenue Model Design
- Incentive Programs
- Care Management Design and Support
- Primary Care/PCMH Alignment
- HIE Facilitation
- Population-Based Clinical and Analytic Systems
- Quality Measurement
OneCare Vermont

Statewide ACO Provider Network

- Both Academic Medical Centers (Fletcher Allen and Dartmouth)
- Every hospital in the state
- 400+ Primary Care clinicians
- 90% are Blueprint PCMH practices
- Majority of Specialist MDs in Vermont
- 3 Federally Qualified Health Centers
- 5 Rural Health Clinics
- Statewide VNA, SNF and Mental Health and Substance Abuse organizations
- 100,000 attributed beneficiaries
- Links to ACOs in New Hampshire, upstate New York and Maine
# OneCare: Network strategy

| Attributing Participants | Parents | Fletcher Allen Health Care/UVM College of Medicine Hospital, Clinics and Faculty Practice Plan  
Dartmouth Hitchcock/Geisel School of Medicine Hospital, Clinics and Faculty Practice Plan |
|-------------------------|---------|--------------------------------------------------------------------------------------------------|
|                         | Statewide Hospitals and Physicians | Regional and Community Hospitals Hospital employed physicians and practices  
FQHCs and Rural Health Clinics Community physician practices |
|                         | Sub-Acute Providers | Skilled Nursing Facilities  
Home Health and Hospice Agencies |
|                         | Large Spend High Impact Providers | Designated Community Mental Health Agencies Long-term supports and services providers |
| Non-Attributing Participants | Small Spend High Impact Providers | Area Agencies on Aging Youth Services Providers Housing agencies and authorities Special Education Schools Parent Child Centers |
|                         | Other | Vermont Ethics Network etc. |
| Non-Attributing Collaborators | Medicare, Commercial and Medicaid (Phase I) | Money $ $ $ |
|                         | Medicaid (Phase II) | Data $ $ $ |
|                         | None | Data # # |

- Non-Attributing Collaborators: Medicaid (Phase II)
- Attributing Participants: Medicare, Commercial and Medicaid (Phase I)

## Money

- Fletcher Allen Health Care/UVM College of Medicine Hospital, Clinics and Faculty Practice Plan
- Dartmouth Hitchcock/Geisel School of Medicine Hospital, Clinics and Faculty Practice Plan
- Regional and Community Hospitals Hospital employed physicians and practices FQHCs and Rural Health Clinics Community physician practices
- Sub-Acute Providers
  - Skilled Nursing Facilities
  - Home Health and Hospice Agencies
- Large Spend High Impact Providers
  - Designated Community Mental Health Agencies Long-term supports and services providers
- Small Spend High Impact Providers
  - Area Agencies on Aging
  - Youth Services Providers
  - Housing agencies and authorities
  - Special Education Schools
  - Parent Child Centers
- Other
  - Vermont Ethics Network etc.
OneCare: Governance & Leadership

**Founder’s Seats**

- Steve Leffler MD – Chief Medical Officer, Fletcher Allen Health Care
- Bob Pierattini MD – Chair, Psychiatry, Fletcher Allen Health Care
- Judy Tarr Tartaglia – CEO, Central Vermont Medical Center; Fletcher Allen Partners

**Provider Participant Seats**

- Steve LeBlanc – Executive Vice President, Dartmouth-Hitchcock
- Keith Loud MD – Interim Chair of Pediatrics, Dartmouth-Hitchcock NEW
- Kevin Stone – Project Specialist for Accountable Care, Dartmouth-Hitchcock

**Consumer Seats**

- Kevin Kelley – CEO, Community Health Services of Lamoille Valley (FQHCs) NEW
- Mark Donavan MD – Retired Medical Director, D-H Putnam Physicians (PPS hospitals)
- Joe Woodin – CEO, Gifford Medical Center (Critical Access Hospitals)
- Toby Sadkin MD – PCP, St Albans (Private/Community Practice Physicians) NEW
- Eric Seyferth MD – PCP, Bennington (Private/Community Practice Physicians)
- Diane Sullivan – Executive Director, the Pines at Rutland (Sub-acute providers) NEW
- Todd Centybear – Executive Director, the Howard Center (Mental health providers) NEW

**OneCare Vermont Board of Managers (BOM)**

- **Chief Executive Officer (CEO)** Todd Moore
- **Chief Compliance Officer (CCO)** Jennifer Parks
- **Chief Medical Officer (CMO)** Barbara Walters, DO
- **Executive Medical Director** Norman Ward, MD
- **Chief Information Officer (CIO)** Charlie Miceli

- **Clinical Advisory Board**
  - Chair: Chief Medical Officer (Barbara Walters DO)
  - Members: To be appointed or elected by network

  - Advises BOM on ACO-Wide Clinical Policy and Protocols including LBM

- **Regional Clinical Performance Committees:**
  - Set Local Clinical Priorities and Implement ACO-wide Policy

**Directors**

- Director ACO Participant Relations: Martita Giard
- Director ACO Analytics and Reporting: Leah Tullman
- Director ACO Quality and Care Management Programs: Vicki Linder/Sheila Johnson
- Director ACO Finance: Abe Berman

VITL Summit ‘14 Track 3: Health Care Reform
OneCare: Clinical Leadership & Direction

Statewide Clinical Advisory Board (CAB)

- The largest statewide physician leadership group in Vermont

Regional Clinical Performance Committees (RCPCs)

- Local “Continuum of Care” groups focused on Analysis and Priorities for Improvement

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Advises BOM on ACO-Wide Clinical Policy and Protocols including EBM

Regional Clinical Performance Committees:
- Set Local Clinical Priorities and Implement ACO-wide Policy
VITL and OneCare

Simply said—

• VITL’s success is vital to OneCare’s success

• ACOs add great value by accessing the power of linked clinical and financial data

• CMS, DVHA and Blue Cross provide the financial/claims data to our analytics team

• VITL is the primary conduit used by ACO providers to make the clinical data available

• VITL knows more about where clinical data is and how to access it than anyone in Vermont
Vital VITL: Population-Based Informatics
Fletcher Allen and Dartmouth-Hitchcock have created OneCare Vermont, a state-wide accountable care organization (ACO) working with Medicare. OneCare Vermont comprises an extensive network of providers, including 13 of the state’s 14 hospitals, Dartmouth-Hitchcock in New Hampshire, hundreds of primary care physicians and specialists, two federally qualified health centers, and several rural health clinics, to coordinate the health care of approximately 42,000 of Vermont’s 118,000 Medicare beneficiaries.

For Medicare Beneficiaries
OneCare Vermont is about improved health, higher quality, and greater coordination of care for our patients. If you are a Medicare beneficiary and your primary care doctor is part of the OneCare Vermont participant network, you will not experience any change in your Medicare Fee-For-Service Program benefits. Learn more about how OneCare Vermont can benefit you.

For Prospective Network Participants
OneCare Vermont offers an opportunity to develop the clinical and business relationships that will enable all participating health care organizations to be successful in an accountable care environment. Participation in a Medicare ACO is a significant first step in moving away from a fee-for-service reimbursement model to one in which providers are accountable for coordinating the health of a defined Medicare population in a way that doesn’t change the program for Medicare beneficiaries or existing providers.

For OneCare Vermont Network Participants
This website will be a future source of information available to OneCare Vermont network participants.
What could happen next?

“ACO” – transitional name, lasting idea?

• Another buzz phrase will come along
• CMS is already tweaking its accountable care programs
• Clinically integrated networks should be here for a long time
• Shared responsibility for quality and cost of care should continue
• Accountability for specific populations’ wellbeing should also
• Broadened, more inclusive care relationships should prevail

“Shared Savings” is a transitional concept

• More substantive payment reforms are inevitable
• The “volume to value” transition is real and lasting
• Todays ACOs may be good means to position for further changes
"Y'know, I don't think we benefit from this new shared risk model."
“Great news! You have been attributed to our good ACO!”
AMY COOPER, MBA
EXECUTIVE DIRECTOR, HEALTHFIRST INC
EXECUTIVE DIRECTOR, ACCT. CARE
COALITION OF THE GREEN MOUNTAINS
(ACCGM)
Healthfirst ACOs Governance Structure

ACCGM – Medicare ACO, VCP – Commercial ACO

ACO Management Committee

• Joe Haddock MD - Chair – Thomas Chittenden Health Center
• Peter Gunther MD – Good Health PC
• Paul Reiss MD – Evergreen Family Health
• Eileen Fuller MD – Middlebury Family Health
• Sean Uiterwyk MD – White River Family Health
• Brad Freisen MD – Pediatric Medicine PLC
• Steffen Hillemann MD – Champlain Valley Cardiovascular Associates
• Amy Cooper – Executive Director Healthfirst
• The Honorable Madeleine M Kunin – Medicare Beneficiary
• Commercial Consumer Beneficiary - TBD

Quality Improvement Committee

• Paul Reiss MD – Medical Director – Evergreen Family Health
• Chris Meriam MD – Green Mountain Orthopedic Surgery
• Pam Dawson MD – Thomas Chittenden Health Center
• Chris Hebert MD
• Michael Johnson MD – Evergreen Family Health
• Mark Pitcher MD – Good Health PC
• Gamal Eltabbakh MD – Lake Champlain Gynecologic Oncology
• Deanne Haag MD – MouseTrap Pediatrics
• Jill McKenzie RN BSN CCM – Clinical Manager

Clinical Implementation Committee

• Cheryl McCafferty – Practice Manager – Thomas Chittenden Health Center
• Jennifer McGinn – Practice Manager – Good Health PC
• Stacy Ladd – Practice Manager – Middlebury Family Health
• LeAnn Runne – Practice Manager – Alderbrook Family Health
• Roseann Sbarra – Practice Manager – Evergreen Family Health

Consumer Advisory Board

• TBD
ACCGM Overview

- Accountable Care Coalition of the Green Mountains
- Joint venture with Collaborative Health Systems (a division of Universal American)
- First ACO in Vermont, joined MSSP in July 2012
- 10 Independent Primary Care Practices
- 35 physicians
- 7,466 Medicare Beneficiaries as of Q1
CHS Partnership

- CHS has invested significantly to support ACO Efforts across the country, with 35 ACO partners as of Jan 2014
- NAACOS survey of 70 MSSP ACOs estimated each ACO will need $3.5-$4M in capital for first 2 years before meaningful savings are generated
- CHS leverages technology and infrastructure investments across the entire network to offer care management and data analytics platforms to each ACO partner and lower expenses per ACO
VCP Overview

- Vermont Collaborative Physicians LLC
- Participating in VT State Commercial ACO Pilot starting in 2014
- 28 Independent Primary Care and Pediatrics Practices throughout the state
- 68 Physicians
- Attribution 7,200 as of 6/2014 (BCBS only)
ACCGM Beneficiary Demographics & Estimated Annualized Expenditures – Trailing 12 months Q4 2014

Source: CHS Analysis of a rolling 12 months’ worth of CMS Claims through April 2014 with dates of service through Feb 2014.

- Aged = Medicare beneficiaries over 65 yrs of age. Aged duals = Medicare beneficiaries over 65 yrs. of age who are also eligible for Medicaid. ESRD = patients over or under 65 yrs with End Stage Renal Disease. Disabled = patients over or under 65 yrs with a disability as defined per Section 223 of Social Security Act.
### ACCGM 2014: Three Areas of Focus to Achieve Savings

<table>
<thead>
<tr>
<th>Focus on Wellness</th>
<th>Chronic Disease Management</th>
<th>Transition of Care Coordination</th>
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</thead>
<tbody>
<tr>
<td>Programs:</td>
<td>Programs:</td>
<td>Programs:</td>
</tr>
<tr>
<td>• Annual Wellness Visit Campaign</td>
<td>• CHF Program</td>
<td>• Home Health Pilot</td>
</tr>
<tr>
<td></td>
<td>• PCP referrals to care coordinators</td>
<td>• Clinical Manager + 2 Care Coordinators</td>
</tr>
<tr>
<td></td>
<td></td>
<td>monitoring hospital and ER census, f/up</td>
</tr>
<tr>
<td></td>
<td></td>
<td>with pts in hospital &amp; immediately after</td>
</tr>
<tr>
<td></td>
<td></td>
<td>discharge</td>
</tr>
</tbody>
</table>

*Healthfirst, Inc.*

...the future starts now
ACCGM Wellness Program

Medicare Annual Wellness Visits Completed by Quarter

- Q1: 350
- Q2: 250
- Q3: 250
- Q4: 350

2013: +35% compared to 2014
### CHS MSSP ACOs – Performance on Ambulatory Care Sensitive Conditions: Admits Per Thousand

<table>
<thead>
<tr>
<th>ACO Code</th>
<th>Diabetes mellitus with complications</th>
<th>Asthma</th>
<th>Urinary tract infections</th>
<th>Pneumonia (except that caused by tuberculosis or sexually transmitted disease)</th>
<th>Chronic obstructive pulmonary disease and bronchiectasis</th>
<th>Congestive heart failure</th>
<th>Total 6</th>
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<tbody>
<tr>
<td>A1141</td>
<td>1.75</td>
<td>1.17</td>
<td>5.85</td>
<td>6.92</td>
<td>5.46</td>
<td>8.68</td>
<td>29.83</td>
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<tr>
<td>A1575</td>
<td>1.65</td>
<td>1.98</td>
<td>3.63</td>
<td>7.92</td>
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<tr>
<td>ACCGM</td>
<td>1.93</td>
<td>1.29</td>
<td>3.44</td>
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<td>A1137</td>
<td>2.98</td>
<td>1.59</td>
<td>3.97</td>
<td>8.14</td>
<td>6.95</td>
<td>15.48</td>
<td>39.10</td>
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<tr>
<td>A1485</td>
<td>4.47</td>
<td>2.76</td>
<td>6.78</td>
<td>10.73</td>
<td>5.81</td>
<td>12.22</td>
<td>42.78</td>
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<td>A1614</td>
<td>9.08</td>
<td>2.93</td>
<td>7.40</td>
<td>9.22</td>
<td>7.40</td>
<td>9.36</td>
<td>45.40</td>
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<tr>
<td>A1140</td>
<td>3.19</td>
<td>1.01</td>
<td>9.58</td>
<td>9.75</td>
<td>11.43</td>
<td>12.10</td>
<td>47.06</td>
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<tr>
<td>A1487</td>
<td>2.22</td>
<td>4.03</td>
<td>7.86</td>
<td>13.11</td>
<td>7.86</td>
<td>13.11</td>
<td>48.19</td>
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<tr>
<td>A1303</td>
<td>6.31</td>
<td>3.78</td>
<td>4.68</td>
<td>11.17</td>
<td>9.73</td>
<td>12.79</td>
<td>48.46</td>
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<tr>
<td>A1071</td>
<td>4.77</td>
<td>1.43</td>
<td>8.74</td>
<td>12.24</td>
<td>9.70</td>
<td>12.72</td>
<td>49.60</td>
</tr>
</tbody>
</table>

#### Top 10 ACOs

- **Best #1**: A1141
- **#2 or #3**: A1575
- **#4 or #5**: ACCGM

**Avg of 31 ACOs**

<table>
<thead>
<tr>
<th></th>
<th>Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>A1141</td>
<td>2.57</td>
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<tr>
<td>A1575</td>
<td>5.07</td>
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<td>ACCGM</td>
<td>8.29</td>
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<tr>
<td>A1137</td>
<td>12.42</td>
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<td>A1485</td>
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<td>A1614</td>
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<td>A1140</td>
<td>55.18</td>
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<td>A1487</td>
<td>47.06</td>
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<tr>
<td>A1303</td>
<td>48.19</td>
</tr>
<tr>
<td>A1071</td>
<td>49.60</td>
</tr>
</tbody>
</table>
HF Experiences to Date

- **Attribution** issues result in failure to attribute new patients, and “falling off” of healthiest patients who seek care infrequently.
- **MSSP benchmarking** provides less opportunity to health systems who are already highly functional, efficient and cost conscious.
- **VT commercial SSP** benchmarks are based on health insurance premiums, creating same targets for all providers. Efficient networks are potentially rewarded, and can do even better with improvements.
- **Medicaid SSP**, using the MSSP type benchmark would also disadvantage efficient networks, and with a difficult population to manage, substantial upfront, non-reimbursed resources would be needed. Unrealistic for a physician driven network.
- Substantial learning has been facilitated by the ACO model: physicians working together and better understanding the process of care. Improvement opportunities are greatest in transitions of care, communication, improving efficient use of sub acute and home care.
• What’s in a name?
• Who do we serve?
• What are CHAC’s priorities?
• CHAC’s governing board & process
• CHAC’s values in action: Committee work
• HIE outlook and opportunities
Community Health Accountable Care, LLC (CHAC) is **statewide, primary care centric** Vermont ACO based on the Patient Centered Medical Home model of care.

CHAC is comprised of **9 Federally Qualified Health Centers** (FQHCs), Bi-State Primary Care Association and diverse network providers.

CHAC has a Management Services Agreement with Bi-State.
CHAC Population Served

<table>
<thead>
<tr>
<th>Product</th>
<th>Attributed Lives #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare</td>
<td>5,980</td>
</tr>
<tr>
<td>Medicaid</td>
<td>22,000</td>
</tr>
<tr>
<td>Commercial</td>
<td>8,900</td>
</tr>
</tbody>
</table>

- Medicare: 16%
- Medicaid: 60%
- Commercial: 24%

Attributed Lives %
CHAC’s Priorities

* Establish Board
* Implement Committees

- Compliance with federal and State Programs
- Collaborate in VHCIP workgroups
- Consumer feedback & communication
- Identify opportunities through data analysis
- Care management
- Establish data analytics platform
Managing Our Business

Community Health Accountable Care, LLC

Board of Directors

Director, CHAC
Joyce Gallimore, MPH, CPHQ

Medical Director
Dr. John Matthew
N E Washington County Community Health, Inc.

Chief Financial Officer
Abigail Mercer
Bi-State Primary Care Association

Director, Healthcare Informatics
Kate Simmons, MBA, MPH
Bi-State Primary Care Association

Consultant
Andrew Principe
Starling Advisors

Capabilities
- Data analysts
- Quality Improvement
- Finance
- Human Resources
- Information technology
CHAC Governing Board

Community Health Accountable Care, LLC

Board of Directors
(18 members; 15 providers; 3 beneficiaries)

ACO Participants, Primary Care:
- Jack Donnelly, Community Health Centers of Burlington
- Kevin Kelley, Community Health Services of Lamoille Valley
- Gail Auclair, Little Rivers Health Care
- Patrick Flood, Northern Counties Health Care
- Dr. John Matthew, The Health Center
- Pam Parsons, Northern Tier Center for Health
- Andy Majka, Springfield Medical Care Systems
- Joseph Woodin, Gifford Health Care
- Grant Whitmer, Community Health Centers of the Rutland Region
- Tess Kuenning, Bi-State Primary Care Association

ACO Participants, Non-Primary Care:
- Tom Huebner, Rutland Regional Medical Center
- Mary Moulton, Behavioral Health Network
- Sandy Rousse, Visiting Nurses Association
- TBD, Other participant
- TBD, Other participant

Beneficiary Representatives:
- Wilda Pelton, Medicaid
- Kate Willey, Commercial
- Marcia Perry, Medicare
## Standards for Primary Care

<table>
<thead>
<tr>
<th>Standard</th>
<th>Year 1</th>
<th>Year 2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Electronic Health Record</strong></td>
<td>• Plan to have a fully implemented certified, EHR System by end of 2014</td>
<td>• Achievement of appropriate Meaningful Use stage</td>
</tr>
<tr>
<td><strong>PCMH Recognition</strong></td>
<td>• NCQA Level 1</td>
<td>• NCQA Level 2 (in Year 2 or at next scheduled recertification)</td>
</tr>
<tr>
<td><strong>Quality Improvement</strong></td>
<td>• Permanent QI staff</td>
<td>• Permanent QI staff</td>
</tr>
<tr>
<td></td>
<td>• Documented quality plan</td>
<td>• Approved quality plan aligned with ACO goals</td>
</tr>
<tr>
<td><strong>Integration with non-Primary Care</strong></td>
<td>• Able to receive and use any information from non-PCP participants</td>
<td>• Able to receive and use any information from non-PCP participants</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(no change)</td>
</tr>
<tr>
<td><strong>Able to integrate with SAFTINet</strong></td>
<td>• Ability to integrate data to SAFTINet (or develop workaround for CQM reporting)</td>
<td>• Fully integrated with SAFTINet</td>
</tr>
<tr>
<td><strong>Participation in State infrastructure</strong></td>
<td>• Meets all State standards</td>
<td>• Meets all State standards</td>
</tr>
<tr>
<td></td>
<td>• Shared infrastructure</td>
<td>• Shared infrastructure</td>
</tr>
<tr>
<td></td>
<td>• HIE</td>
<td>• HIE</td>
</tr>
<tr>
<td></td>
<td>• Blueprint/DocSite</td>
<td>• Blueprint/DocSite</td>
</tr>
</tbody>
</table>
Clinical Areas of Focus

- Evidence Based Interventions: COPD, CHF, Falls Risk
- Care Management Modeling
- Provider Engagement
- Quality Benchmarking
HIE Outlook

- FQHCs partnering with VITL for EHR Implementation and interface development
- Enthusiastic about data mart/data repository
- VHIE high potential with Event Notification System

Challenges:
- **Part 2** regulations create challenges
- CHAC Seeking low-cost analytics option to use VHIE data
VITL’s leadership will be crucial to attaining a working public infrastructure.

Evolving technologies UNDISCOVERED POTENTIAL

POSSIBLE FUTURE

PUBLIC INFRASTRUCTURE

ACO Gateway ENS FUNDED FUTURE

Data Repository/Data Marts

What gaps exist and how do we prioritize them?
### CHAC: Strengths and Challenges

<table>
<thead>
<tr>
<th>Strengths</th>
<th>Challenges</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Primary Care Centric Model</td>
<td>• Launched three payers in Year 1</td>
</tr>
<tr>
<td>• Location: Essential Access</td>
<td>• No Shared HIT / Analytics Platform</td>
</tr>
<tr>
<td>• Collaboration Among FQHCs</td>
<td>• Not-yet fully staffed</td>
</tr>
<tr>
<td>• Collaborative engagement with Diverse Community Providers</td>
<td></td>
</tr>
</tbody>
</table>
Contact

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802-847-6249

Georgia Maheras
Georgia.maheras@state.vt.us
802-505-5137
BACKGROUND
What do we mean by “payment reform”

“The ultimate objective of any payment reform is to motivate behavioral change that leads to lower costs, better care coordination, and better quality.

What would constitute success?

A health information technology and health information exchange system that works, that providers use, and that produces analytics to support the best care management possible.

A predominance of payment models that reward better value.

A system of care management that is agreed to by all payers and providers that:
- utilizes Blueprint and Community Health Team infrastructure to the greatest extent possible
- fills gaps the Blueprint or other care models do not address
- eliminates duplication of effort
- creates clear protocols for providers
- reduces confusion and improves the care experience for patients
- follows best practices
Adoption of alternatives to FFS require a better organized system with more sophisticated capture and use of performance data and metrics.

- Better Organized System
- More Sophisticated Quality Measurement Systems
- Global Payments
- Bundled Payments
Medicaid’s payment reform strategies under the VHCIP aim to:

| 1) Shared Savings ACO Program | Align and continue to support care transformation by participation in the Blueprint for Health, Enhanced Primary Care Program, Medicaid Health Homes and other ongoing related work |
| 2) Episodes of Care Program | Incent care delivery transformation and better organization of the health system through a focus on value instead of volume |
| 3) Pay-for-Performance (P4P) Program | Incent use of data, analytics and quality reporting to improve care delivery and succeed under value-based payment systems |
| | Work with all stakeholders to ensure broad participation and support |
| | Work with other payers to mirror programs to increase the magnitude of rewards and limit administrative burden |
| | Allow for incremental independent study of feasibility and implications of adoption of alternative payment models across more organized provider groups and across types of services |
Using Complementary Financial Models to Drive System Change and Bend the Cost Curve

Payments based on Population Health and System Performance

Provider Performance

Collaborative Performance
## Complementary Models

### ACO SSP
- System-wide performance
- Wide range of providers across specialty types and sites of care
- Total resource use and quality for attributed population across all providers who provide care
- Focus on collaboration and use of data to inform better care delivery and experience of care
- Leads to more organized system of care

### EOC
- Performance related to treatment of specific condition
- Providers specifically accountable for care of a particular condition
- Resource use and quality of treatment of a condition for sub-set of population
- Focus on collaboration and use of data related to treatment of specific condition
- Leads to more organized system of care

### P4P
- Individual /Practice/Site of Care performance
- Providers accountable for population they serve
- Resource use and quality of treatment under their individual control
- Focus on individual performance and how to use data for internal quality improvement
A performance-based contract between a payer and provider organization that sets forth a value-based program to govern the determination of sharing of savings between the parties.