Minnesota’s IHP program was designed to create a shared risk arrangement to improve care coordination and quality.

Program applies to all Medicaid beneficiaries, including adults and children, except for dual eligibles.

Builds on existing patient-centered medical home initiative.

Designed to align closely with MSSP and existing commercial ACOs in the state.
## Two IHP Models

<table>
<thead>
<tr>
<th>Designed for</th>
<th>Virtual Model</th>
<th>Integrated Model</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Primary care provider networks and multi-specialty groups</td>
<td>Integrated health systems</td>
</tr>
<tr>
<td>Attribution</td>
<td>1,000 – 2,000 attributed patients</td>
<td>At least 2,000 attributed patients</td>
</tr>
<tr>
<td>Payment Model/Risk</td>
<td>Upside only risk – 50% savings</td>
<td>Two-sided risk, phased in gradually over three years</td>
</tr>
</tbody>
</table>
Minnesota’s Integrated Health Partnership

- 9 IHPs have contracts in place
- 10 quality measures tied to payment
  - Pay-for-reporting plus performance bonus
- Provider participation is voluntary, MCO participation is mandatory
- IHPs must incorporate partnerships with community orgs and social service agencies into care delivery model
Vermont’s Medicaid ACO Pilot

- Commercial and Medicaid ACO models were designed simultaneously based on the MSSP model, leading to close multi-payer alignment.
- Program covers Medicaid beneficiaries, with the exception of dual-eligibles.
- ACO board of directors must include representation of behavioral health providers, post-acute care providers, and consumers.
- Two Medicaid ACOs have been approved to participate.
Vermont’s Medicaid ACO Pilot

• **Payment Model**
  - 2 Tracks (similar to Medicare Shared Savings Program)
    - Track 1 – Upside only, 50% savings rate to ACO
    - Track 2 – Two-sided risk, 60% savings to ACO

• **Quality Measurement**
  - 29 measures identified for year one
    - 9 Claims-based measures tied to payment
    - 20 additional measures pay-for-reporting
  - Additional “pending measures” may be added in years two and three
Vermont’s Medicaid ACO Pilot

• Phased-in approach
  ► Year 1 – “Encourage”
    ▪ ACOs are responsible for “core services” such as inpatient/outpatient hospital, home health, and ambulatory surgery.
  ► Year 2 – “Incent”
    ▪ ACOs have the option to expand to include “non-core services” such as personal care, pharmacy, and dental care
  ► Year 3 – “Require”
    ▪ State will define a list of non-core services that will be included in total cost of care
Summary Slides:
OneCare Vermont

Developing Accountable Care Organizations in MassHealth:
Public Stakeholder Meeting
Boston - June 12, 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
# ACO Organizations and Programs in Vermont

## Vermont ACO Programs

<table>
<thead>
<tr>
<th>Vermont ACO Organizations</th>
<th>Medicare MSSP</th>
<th>Medicaid &quot;VMSSP&quot;</th>
<th>Commercial &quot;XSSP&quot;</th>
</tr>
</thead>
<tbody>
<tr>
<td>ONECARE VT*</td>
<td>IN</td>
<td>IN</td>
<td>IN</td>
</tr>
<tr>
<td>CHAC**</td>
<td>IN</td>
<td>IN</td>
<td>IN</td>
</tr>
<tr>
<td>HEALTH 1st***</td>
<td>IN</td>
<td>NOT IN</td>
<td>IN</td>
</tr>
</tbody>
</table>

* Vermont's 2 Academic Health Centers and Others Statewide
** 9 Vermont FQHCs
*** 10 Primary Care Practices in Northwestern Vermont
OneCare Vermont

Multi-payer, private/public collaboration

- Joint Venture between Fletcher Allen (UVM’s academic health center) and Dartmouth-Hitchcock
- Credentialed by Vermont reform authority as a payment reform program
- Private/public shared ACO program design
- Quality measures: CMS 33 plus other VMSSP/XSSP per Vermont public process

- MSSP began 1/13
- VMSSP, XSSP on 1/14
- MSSP: Downside risk in 2016
- VMSSP: Downside risk in 2017
- XSSP: Downside risk in 2016
OneCare Vermont

Statewide ACO Provider Network

- Both Academic Medical Centers (Fletcher Allen and Dartmouth)
- Every hospital in the state
- >300 Primary Care MDs statewide
- 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
- ~90,000 attributed beneficiaries
- Links to ACOs in New Hampshire and upstate New York

Hospitals with Employed Attributing Physicians

Significant Attribution from Community Physicians
# OneCare Network Logic Model

| 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 |
| Non-Attributing Participants | 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 Collaborators | 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. |
| Medicare, Commercial and Medicaid (Phase I) | Money |
| Medicare, Commercial and Medicaid (Phase II) | Data |
| None |.
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.
Developing Accountable Care Organizations in MassHealth
Public Stakeholder Meeting
June 12, 2014

Bill Hagan
Chief Growth Officer,
UnitedHealthcare. Community & State
Our Approach to Payment Reform & Value-Based Purchasing

Matching Programs to Risk Tolerance

Level of Financial Risk

Degree of Provider Integration and Accountability

Capitation + PBC

Shared Risk

Shared Savings

Accountable Care Programs

Condition or Service-Line Programs

Bundles & Episodes Service Line Programs

Performance- based Programs

Primary Care Incentives

Performance-Based Contracts (PBC)

Fee-for-Service
Today 28% of our Network Spend is in Value-Based Contracts. Our target is 65% by 2018

Spend Tied to Value-Based Programs and Accountable Care

<table>
<thead>
<tr>
<th></th>
<th>Community &amp; State</th>
<th>Medicare &amp; Retirement</th>
<th>Employer &amp; Individual</th>
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</thead>
<tbody>
<tr>
<td>Current</td>
<td>$29B</td>
<td>$33B</td>
<td>$40B</td>
</tr>
<tr>
<td>2014</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2015</td>
<td></td>
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<tr>
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<td></td>
</tr>
<tr>
<td>2017</td>
<td></td>
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</tbody>
</table>
| 2018 | | | | $65B

Targets

<table>
<thead>
<tr>
<th></th>
<th>% VBC Spend - Current</th>
<th>% of VBC Spend - 2018</th>
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</thead>
<tbody>
<tr>
<td>Commercial</td>
<td>27%</td>
<td>60%</td>
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<tr>
<td>Medicare</td>
<td>44%</td>
<td>80%</td>
</tr>
<tr>
<td>Medicaid</td>
<td>10%</td>
<td>80%</td>
</tr>
<tr>
<td></td>
<td>28%</td>
<td>65%</td>
</tr>
</tbody>
</table>
Our Evolution and Learning with Integrated Care Models

So we started building connected communities, with virtual ACOs linking the Continuum of Care and enabling real-time data exchange from Hospitals and providing Clinical Registries.

- Isolated Islands – Quality but Limited Savings even with NCQA

- Challenge: 1.4% of Membership is 36% of Medical Spend > $35k per year and 25 times the PMPM

- Accountable Care Communities™

Medical Home  Hospital  Hi-Utilizer in non-PCMH  Care Coordination Organization
Status of ACOs and Health Homes in Medicaid

Medicaid
Current:
- 87 ACOs – 15 States
- 250+ Connected Hospitals
- 352k Members
- Over $1B in Spend
- HH = WA, NJ, TN, NY, KS, TX, NM

Target 2014
- 500k Members
- $1.5B-$2B in Spend