Leading Change in Primary Care Delivery:
Transitioning Beyond Medical Homes and ACO’s to Other Innovative Partnerships with Payers

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President and CEO
UVM Health
Plattsburgh, NY

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Director
Veralon
Philadelphia, PA
Agenda

- Introductions
- Objectives
- The case for transformation:
  - Healthcare generally
  - Primary care
- Case Study: Healthcare transformation in the Adirondack Region
- Questions and discussion

Please note that the views expressed are those of the conference speakers and do not necessarily reflect the views of the American Hospital Association and Health Forum.
The Case for Transformation:

Although the health spending growth rate is slowing, it still continues to be a disproportionately large part of the US economy.

Year-over-year growth in national health expenditures adjusted for inflation and % of total GDP.

Two major credit-rating agencies have released reports recently showing that operating margins have improved for not-for-profit hospitals and health systems.

- Revenue growth surpassed expense growth in 2014, according to the report from Mood’s Investors Service.

- S&P analysts agreed and said they expect the trend to continue through 2015.

Tentative Conclusion: The future is bright today for established healthcare organizations.

Source: Modern Healthcare, September 14, 2015
But, Is Healthcare About To Undergo Wrenching (i.e., not “tweaks”) Transformation?

Disruptive Innovation “… a process by which a product or service takes root initially in simple applications at the bottom of a market, and then relentlessly moves up market, eventually displacing established competitors.”

–Clayton Christensen

Notable Disruptive Innovations

- Sony transistor radios replace HiFi
- Toyota replacing GM
- Netflix replacing Blockbuster
- Uber replacing taxi services
Healthcare Disruptive Innovations

Disruptive innovations are initially dismissed by incumbents as poor quality

Notable Disruptive Innovations

Ambulatory Surgery Centers
Urgent Care Centers
Retail Clinics
ZocDoc for Scheduling

Fueled in part by venture capital and private equity... and overhaul of payer reimbursement
Healthcare delivery is shifting from volume to value.

- Fragmented care → Coordinated and integrated care
- Only treating individuals → Caring for a population
- Payer-driven managed care → Provider-driven accountable care
- Volume-based payments → Value-based payments
Although fee-for-service reimbursement is still the foundation for payment, new models that focus on increasing quality and decreasing costs are gaining in popularity ...

... And as a result, physician compensation is evolving to reward “value” improvements
Medicare started the shift towards value

**Alternative Payment Models**
- ACOs
- Medical Homes
- Bundled Payments
- Others

**Value-Based Purchasing**
- Hospital Value-Based Purchasing
- Physician Value-Based Modifier
- Readmission/Hospital Acquired Condition Reduction Program
- Others

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**Percentage of payments tied to alternative payment models**
- 30%
- 50%

**Percentage of overall FFS categories tied to value-based purchasing**
- 85%
- 90%

Source: Centers for Medicare & Medicaid Services, January 26, 2015.
The Future of Clinician Reimbursement: MACRA

- Medicare Access and CHIP Reauthorization Act (MACRA) of 2015
- Repeals Sustainable Growth Rate (SGR)
- Provider payment rates at zero growth
- Two payment tracks
  - Merit Based Incentive Payment System (MIPS)
  - Advanced Alternative Payment Models (APM)
- Implementation 1/1/19, but measurement in 2017
- Inclusions:
  - Physicians I-MC
  - NPC’s: PA’s, NP’s, RN’s, CRNA’s
- Exemptions:
  - ASC’s
  - Year one clinicians
  - < $10,000 MC
Potential Payment Adjustment
Influence of MIPS using a Composite Performance Score

- Clinicians will receive +/- or neutral adjustments up to the percentages above.
- The potential maximum adjustment % will increase each year from 2019 to 2022.

Source: Center for Medicare and Medicaid MACRA Presentation, accessed 2016.
A single MIPS composite score will factor in performance in 4 weighted performance categories on a 0-100 point scale:

1. Quality
2. Resource use
3. Clinical practice improvement activities
4. Advancing care information

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Data based January 2015 and sourced from the Department of Health and Human Services (DHHS).

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Year 1 Performance Category Weights for MIPS

- **Quality**: 50%
- **Cost**: 10%
- **Clinical Practice Improvement Activities**: 15%
- **Advancing Care Information**: 25%
Example MACRA Implications

- Physician employment by hospital will surge
- Hospital networks will be better positioned to succeed
- Some physicians may go “non-par”
- Commercial payors may align payments with MC MACRA initiatives
- Stay tuned: final regulations not enacted
- Qualifying for APM track will be onerous
- Physician compensation design will need to evolve
MACRA Commentary

“There is no way that this can happen in time” M. Martz, Ohio Valley Health Services and Education Corp.

“Any role coming out late in year of lame duck administration will be put on hold” R. Tennant, MGMA.

“The average clinician doesn’t have a clue about MIPS” B. Childs, Premier.

“I understand this is very complicated, but I think one of our first principles should be to try to simplify this, because its very complicated for providers to try to understand what path to take...I understand that’s probably heroic...I think there’s a lot of aversion because folks don’t understand it” MedPAC Commissioner Thomas. 1/2016.

Private payors are doing a variation of (MACRA) in growing numbers. S. Stack, M.D. AMA
Larger, Established Organizations are Focused on Systemness: The Next Frontier for Integrated Healthcare Delivery

Alternative Paths to Systemness

Diagram showing the continuum of care components and the desired and likely paths to systemness.
Strategic Imperatives to Win Under Health Reform

Typical Strategy Framework Today

- Innovation
- Sufficient Scale and Scope
  - Cost competitive
  - Demonstrated quality
  - Exceptional service
  - Real integration
- or
- Niche Play

= High Value
How Much Scale is Required for Population Health Initiatives? It depends.
So, Will US Healthcare Continue to Thrive (Part 1)?

- Growth continues faster than the economy
- Margins/profitability on the upswing
- Disruptive innovators on the horizon and on the ground
- The establishment mostly sticking to its knitting

The industry thrives but is transformed (dramatically?)
And the players change (dramatically?)
Hospitals and physicians continue to move away from independence; drivers include market characteristics, future vision, and execution capability and competencies.
Revolutionized Primary Care

Individual Physician

Fee-for-Service

Patient Care Team

Reward for Value

Implications…

● Reactive sick care
● Focus on billable services, otherwise suffer financially
● Time is money, limited returns on longer patient visits
● Unfulfilled physicians

Leads to…

● Proactive health
● Patient engagement
● Relationship building, – emphasis on trust
● Focus on appropriate/necessary services

Redefining what “primary care” means
Case Study: The Adirondacks

Regional Healthcare Timeline

2010
- Adirondack Medical Home 5 year-Multi-Payer Pilot

2013
- Adirondacks Accountable Care Organization Formed as Legal Entity

2014
- Adirondacks ACO Approved for 3 year MSSP contract with CMS
- 2 Year extension for Medical Home Program

2016
- Payer Negotiation for future of the Medical Home
- Apply to NYS DOH for Certificate of Authority

2017
- Future:
  - Value Based Payment
  - Multi-payer ACO
  - DSRIP PPS
Healthcare Landscape

Population

- **PPS**: 144,000
  - Medicaid: 94,000
  - Uninsured: 50,000
- **Medical Home**: 100,000
- **ACO**: Adirondacks ACO 25,000
- **Health Home**: 3,200

Geography

<table>
<thead>
<tr>
<th>AHI PPS</th>
<th>ADK ACO/ Medical Home</th>
<th>Health Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinton</td>
<td>Clinton</td>
<td>Clinton</td>
</tr>
<tr>
<td>Essex</td>
<td>Essex</td>
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</tr>
<tr>
<td>Franklin</td>
<td>Franklin</td>
<td>Franklin</td>
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<tr>
<td>Fulton (part)</td>
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</tr>
<tr>
<td>Hamilton</td>
<td>Warren</td>
<td>Warren</td>
</tr>
<tr>
<td>St. Lawrence</td>
<td>St. Lawrence</td>
<td>St. Lawrence</td>
</tr>
<tr>
<td>Saratoga (part)</td>
<td>Saratoga (part)</td>
<td>Saratoga (part)</td>
</tr>
<tr>
<td>Warren</td>
<td>Warren</td>
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<tr>
<td>Washington</td>
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</tr>
</tbody>
</table>

Network of Providers

- **PPS**: 144,000
- **ACO**: Adirondacks ACO 25,000
- **Medical Home**: 100,000
- **Health Home**: 3,200

Payers

- Medicare (FFS)
- NY Medicaid
- Medicare (MSSP)
- Medicaid
- BSNENY
- CDPHP
- Empire BCBS
- Empire UHC
- Excellus
- Fidelis
- MVP
- United Healthcare
- Medicaid
- Fidelis
- MVP
- United Healthcare

Champlain Valley Physicians Hospital

UNIVERSITY OF VERMONT HEALTH NETWORK

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Person-Centered Medical Home
Committing to Substantial Practice Redesign

Major Changes in Practice Operations and Required Investments

- Achieve medical home recognition (level 2 or level 3)
- Patient centered care with assigned PCP
- Implement same day access
- Adopt e-prescribing system
- Implement evidence-based care
- Create care management team to provide disease management supports
- Coordinate care across continuum
- Join regional health information exchange - HIXNY
- Participate in quality measurement and improvement activities
Creating an Accountable Care Organization

- Person-Centered Medical Home infrastructure supports ACO development
  - Advanced primary care that will utilize population health management resources for optimal
    - Chronic Disease Management
    - Care Transition to Home
    - ED diversion solutions
  - Provider-led organization with a strong base of primary care and hospital systems who are collectively accountable for quality and total per capita costs across the full continuum of care for a population of patients;
  - Payments linked to quality improvements that also reduce overall costs
  - Reliable and progressively more sophisticated performance measurement, to support improvement and provide confidence that savings are achieved through improvements in care.
Counties

ADK
Clinton
Essex
Franklin
Hamilton
Saratoga
Warren

Comparison
Cayuga
Chenango
Delaware
Fulton
Greene
Herkimer
Jefferson
Lewis
Madison
Montgomery
Oswego
Otsego
Schoharie
Seneca
St. Lawrence
Wayne

<table>
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<tr>
<th>Plan</th>
<th>CDPHP</th>
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<tr>
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<td>Excellus</td>
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<tr>
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<td>HNNY</td>
<td>1304</td>
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<tr>
<td></td>
<td>PPO</td>
<td>5730</td>
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</table>
Medicaid Managed Care
PCMH and non-PCMH groups were matched on:

- **Clinical risk**
  - CRGs – Clinically related groups (e.g., Minor chronic, double chronic, malignancy, catastrophic)
  - Severity Scale (0-6)
- **Aid category**
- **Duration of Medicaid**
- **Demographics (age, gender, race)**
## Utilization Results - 2012

<table>
<thead>
<tr>
<th>Measure</th>
<th>ADK</th>
<th>Non ADK (Non PCMH)</th>
<th>Difference</th>
<th>Per member per year</th>
<th>P &lt;.05</th>
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</thead>
<tbody>
<tr>
<td><strong>Adults</strong></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Inpatient Hospitalization</td>
<td>0.096</td>
<td>0.120</td>
<td>-0.024</td>
<td>pmpy</td>
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<tr>
<td>Prevention Quality Indicators</td>
<td>0.003</td>
<td>0.005</td>
<td>-0.002</td>
<td>pmpy</td>
<td></td>
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<tr>
<td>ED Visits</td>
<td>1.245</td>
<td>1.309</td>
<td>-0.064</td>
<td>pmpy</td>
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<tr>
<td>Outpatient Primary Care</td>
<td>6.342</td>
<td>4.488</td>
<td>1.854</td>
<td>pmpy</td>
<td>*</td>
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<tr>
<td><strong>Pediatric</strong></td>
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<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Inpatient Hospitalization</td>
<td>0.035</td>
<td>0.032</td>
<td>0.003</td>
<td>pmpy</td>
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<tr>
<td>Pediatric Quality Indicators</td>
<td>0.000</td>
<td>0.002</td>
<td>-0.002</td>
<td>pmpy</td>
<td>*</td>
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<tr>
<td>ED Visits</td>
<td>0.674</td>
<td>0.682</td>
<td>-0.008</td>
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<tr>
<td>Outpatient Primary Care</td>
<td>8.481</td>
<td>6.325</td>
<td>2.156</td>
<td>pmpy</td>
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</tbody>
</table>

*Statistically significant
## Utilization Results - 2013

<table>
<thead>
<tr>
<th>Measure</th>
<th>ADK</th>
<th>Non ADK (Non PCMH)</th>
<th>Difference</th>
<th>P &lt; .05</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Adults</strong></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Inpatient Hospitalization</td>
<td>0.086</td>
<td>0.133</td>
<td>-0.047</td>
<td>*</td>
</tr>
<tr>
<td>Prevention Quality Indicators</td>
<td>0.005</td>
<td>0.013</td>
<td>-0.008</td>
<td></td>
</tr>
<tr>
<td>ED Visits</td>
<td>0.944</td>
<td>0.996</td>
<td>-0.052</td>
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<tr>
<td>Outpatient Primary Care</td>
<td>6.836</td>
<td>4.713</td>
<td>2.124</td>
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<tr>
<td><strong>Pediatric</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Hospitalization</td>
<td>0.024</td>
<td>0.037</td>
<td>-0.013</td>
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<tr>
<td>Pediatric Quality Indicators</td>
<td>0.002</td>
<td>0.005</td>
<td>-0.003</td>
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<tr>
<td>ED Visits</td>
<td>0.494</td>
<td>0.526</td>
<td>-0.032</td>
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<tr>
<td>Outpatient Primary Care</td>
<td>8.116</td>
<td>6.191</td>
<td>1.925</td>
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</tbody>
</table>

*Statistically significant*
## Costs Associated with Utilization - 2013

<table>
<thead>
<tr>
<th>Measure</th>
<th>ADK</th>
<th>Non ADK (Non PCMH)</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Adults</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Hospitalization</td>
<td>$1,914,251.24</td>
<td>$3,197,662.10</td>
<td>$(1,283,410.86)</td>
</tr>
<tr>
<td>Prevention Quality Indicators*</td>
<td>$59,081.62</td>
<td>$244,345.86</td>
<td>$(185,264.24)</td>
</tr>
<tr>
<td>ED Visits</td>
<td>$695,258.93</td>
<td>$928,716.47</td>
<td>$(233,457.54)</td>
</tr>
<tr>
<td><strong>Outpatient Primary Care (includes ADK add-on)</strong></td>
<td>$2,129,078.66</td>
<td>$1,597,419.07</td>
<td>$531,659.59</td>
</tr>
<tr>
<td><strong>Pediatric</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Hospitalization</td>
<td>$299,604.81</td>
<td>$464,968.14</td>
<td>$(165,363.33)</td>
</tr>
<tr>
<td>Pediatric Quality Indicators*</td>
<td>$10,594.59</td>
<td>$45,236.83</td>
<td>$(34,642.24)</td>
</tr>
<tr>
<td>ED Visits</td>
<td>$238,477.57</td>
<td>$280,034.22</td>
<td>$(41,556.65)</td>
</tr>
<tr>
<td><strong>Outpatient Primary Care (includes ADK add-on)</strong></td>
<td>$1,732,090.93</td>
<td>$1,098,283.50</td>
<td>$633,807.43</td>
</tr>
</tbody>
</table>

*PDI/PQI costs are also displayed within the Inpatient Hospitalization sum
### ALL Costs for matched cohort - 2013

<table>
<thead>
<tr>
<th></th>
<th>ADK</th>
<th>Non ADK (Non PCMH)</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>OUTPATIENT¹</strong></td>
<td>$38,811,544.26</td>
<td>$46,045,751.91</td>
<td>$(7,234,207.65)</td>
</tr>
<tr>
<td><strong>INPATIENT²</strong></td>
<td>$6,195,511.40</td>
<td>$12,568,293.90</td>
<td>$(6,372,782.50)</td>
</tr>
<tr>
<td><strong>PHARMACY³</strong></td>
<td>$6,012,280.31</td>
<td>$8,552,919.03</td>
<td>$(2,540,638.72)</td>
</tr>
<tr>
<td><strong>ALL COSTS⁴</strong></td>
<td>$51,019,335.97</td>
<td>$67,166,964.84</td>
<td>$(16,147,628.87)</td>
</tr>
</tbody>
</table>

¹Outpatient costs are based on shadow priced ER, Amb-surg, Professional, OPD, Clinic, and 'Other' payments, as well as FFS payments from COS: FQHC, Capitation Provider (where rate codes exclude delivery/inpatient), Clinical Psychologist, Dentist, DTC, HCA, Lab, LTC, Medical Appliance Dealer, Nurse, Optician, Optometrist, Physician, Therapist, and Transportation.

²Inpatient costs are based on shadow priced Inpatient events as well as FFS payments from COS: Capitation Provider (only including rate codes designated as delivery/inpatient), Child Healthcare Institution, and Hospital (includes GME).

³Pharmacy costs are based on shadow priced pharmacy, as well as FFS payments from COS: Pharmacy.

⁴All costs are the combined costs (shadow and FFS) from Outpatient, Inpatient, and Pharmacy buckets.
Overview of Quality Results

ADK had higher (better) rates on 46 of 57 measures (81%)

ADK had statistically significant:

Better rates on 11 measures
1. Mammogram
2. Adolescent Well Care Visits
3. Well Child Visits in first 15 months of life
4. Well Child Visits in 3rd, 4th, 5th, 6th Years
5. Pharyngitis
6. URI
7. Asthma Appropriate Meds Ages 12-18
8. Adult BMI
9. Weight Assessment & Counseling in Children: BMI
10. Weight Assessment & Counseling in Children: Nutrition Counseling
11. Adolescent Preventive Care: Tobacco

Worse rates on 3 measures
1. Chlamydia Screening 16-20
2. Child Immunization Combo 3
3. Comprehensive Diabetes Care: HbA1c test
# Adirondacks ACO PY2 - 2015

## ACO Quality Measure Benchmarks

<table>
<thead>
<tr>
<th>Domain</th>
<th>Description</th>
<th>ADK PY1 Score</th>
<th>ADK PY2 Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient/Caregiver Experience</td>
<td>Getting Timely Care, Appointments, and Information</td>
<td>83.3%</td>
<td>84.3%</td>
</tr>
<tr>
<td></td>
<td>How Well Your Doctors Communicate</td>
<td>94.5%</td>
<td>93.6%</td>
</tr>
<tr>
<td></td>
<td>Patients' Rating of Doctor</td>
<td>93.6%</td>
<td>92.1%</td>
</tr>
<tr>
<td></td>
<td>Access to Specialists</td>
<td>83.8%</td>
<td>85.1%</td>
</tr>
<tr>
<td></td>
<td>Health Promotion and Education</td>
<td>64.3%</td>
<td>63.7%</td>
</tr>
<tr>
<td></td>
<td>Shared Decision Making</td>
<td>79.4%</td>
<td>76.2%</td>
</tr>
<tr>
<td></td>
<td>Health Status/Functional Status</td>
<td>71.3%</td>
<td>--</td>
</tr>
<tr>
<td></td>
<td>Stewardship of Patient Resources</td>
<td>25.7%</td>
<td>25.2%</td>
</tr>
<tr>
<td>Care Coordination/Patient Safety</td>
<td>Documentation of Current Medications in the Medical Record*</td>
<td>--</td>
<td>89.31%</td>
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<tr>
<td></td>
<td>Falls: Screening for Fall Risk</td>
<td>34.84%</td>
<td>68.93%</td>
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<tr>
<td>Preventive Health</td>
<td>Influenza Immunization</td>
<td>69.96%</td>
<td>72.73%</td>
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<tr>
<td></td>
<td>Pneumococcal Vaccination</td>
<td>67.12%</td>
<td>80.81%</td>
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<td></td>
<td>Adult Weight Screening and Follow-up</td>
<td>71.40%</td>
<td>74.18%</td>
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<tr>
<td></td>
<td>Tobacco Use Assessment and Cessation Intervention</td>
<td>97.44%</td>
<td>95.48%</td>
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<td></td>
<td>Depression Screening</td>
<td>48.12%</td>
<td>68.11%</td>
</tr>
<tr>
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<td>Colorectal Cancer Screening</td>
<td>67.23%</td>
<td>70.63%</td>
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<tr>
<td></td>
<td>Mammography Screening</td>
<td>71.69%</td>
<td>74.37%</td>
</tr>
<tr>
<td></td>
<td>Proportion of Adults who had blood pressure screened in past 2 years</td>
<td>58.15%</td>
<td>71.92%</td>
</tr>
<tr>
<td>At-Risk Population Depression</td>
<td>Depression Remission at Twelve Months*</td>
<td>--</td>
<td>10.00%</td>
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<tr>
<td>At-Risk Population Diabetes</td>
<td>ACO #27: Percent of beneficiaries with diabetes whose HbA1c in poor control (&gt;9 percent) Hemoglobin A1c Control (HbA1c) (&lt;8 percent)</td>
<td>--</td>
<td>54.45%</td>
</tr>
<tr>
<td></td>
<td>ACO #41: Diabetes - Eye Exam*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>At-Risk Population Hypertension</td>
<td>Percent of beneficiaries with hypertension whose BP &lt; 140/90</td>
<td>71.63%</td>
<td>71.40%</td>
</tr>
<tr>
<td>At-Risk Population IVD</td>
<td>Percent of beneficiaries with IVD who use Aspirin or other antithrombotic</td>
<td>91.13%</td>
<td>87.85%</td>
</tr>
<tr>
<td>At-Risk Population HF</td>
<td>Beta-Blocker Therapy for LVSD</td>
<td>87.97%</td>
<td>80.79%</td>
</tr>
<tr>
<td>At-Risk Population CAD</td>
<td>ACE Inhibitor or ARB Therapy for Patients with CAD and Diabetes and/or LVSD</td>
<td>87.63%</td>
<td>75.89%</td>
</tr>
</tbody>
</table>
2017 - 2019 - The Future of Healthcare

- **July 2016** - **CPC+ - Comprehensive Primary Care Plus** may become viable option for enhanced care management resources and incentives in the region – effective January 2017.

- **July 2016** - **Adirondacks ACO** will apply for renewal - **Track 1 (upside only) - MSSP** agreement with CMS (2017 – 2019).

- **October 2016** – Details defined for 3 year agreement – extending the **Adirondack Medical Home** (2017 – 2019).

- **January 2017** – **Adirondacks ACO** becomes contracting entity for the **Medical Home**.

- **2017 MACRA** – Medicare Quality Payment Program – two options for all providers
  
  - **MIPS** – Merit-Based Incentive Payment System – most providers will be subject to MIPS – performance period starts in 2017 for incentive payments in 2019. Focus areas for scoring:
    
    - Quality
    - Utilization
    - Clinical practice Improvement activities
    - Advancing Care Information (MU)

  - **APM’s** - Advanced Alternative Payment Models
    
    - Require Participants to use certified EHR technology
    - Provide payment based on quality performance measures that are similar to those in MIPS; and
    - Bear a significant amount of risk for monetary losses over time
Discussion

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