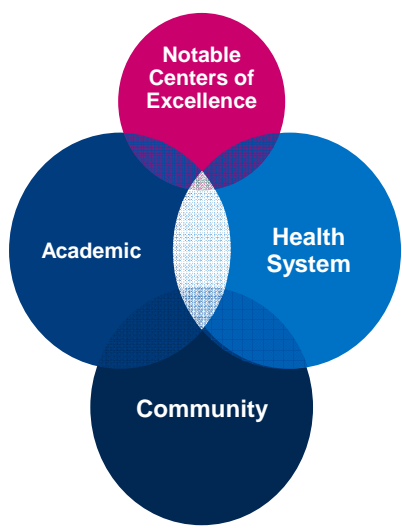
**ALLIANCE
FOR HEALTH POLICY**

Navigating Next Steps on Payment Reform

**Allison Stark, MD, MBA
Chief Medical Officer
CMO, Montefiore Care Management**

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Montefiore Health System



Notable Centers of Excellence

Academic

Health System

Community

Integrated Delivery System

3,236 Beds in 11 Hospitals, including

- Children’s Hospital at Montefiore (CHAM)
- Burke Rehabilitation Hospital

150 Skilled Nursing Beds

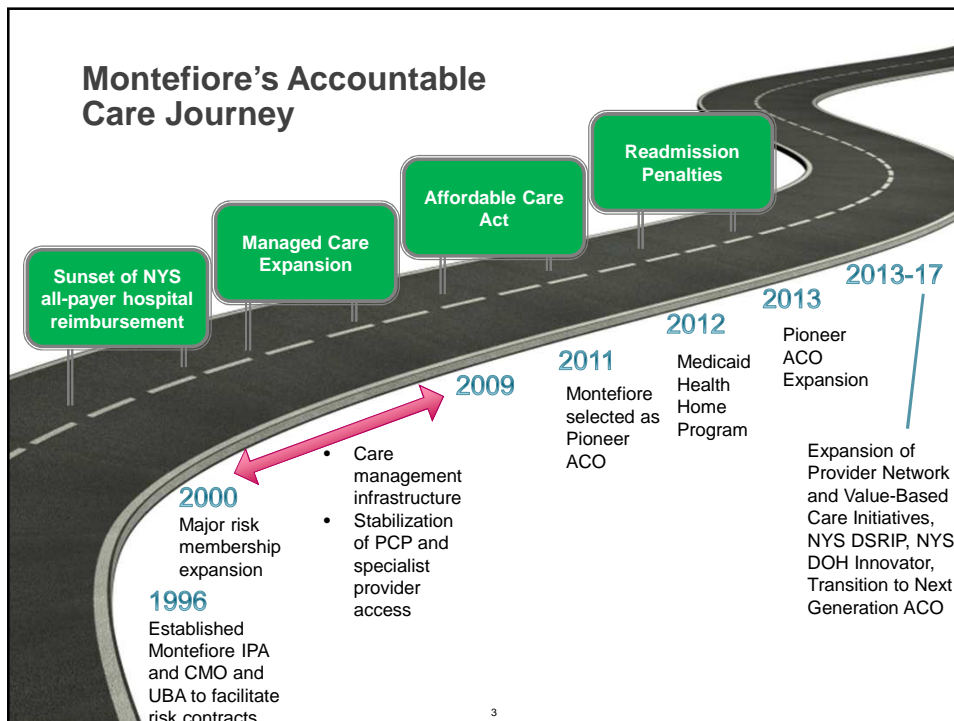
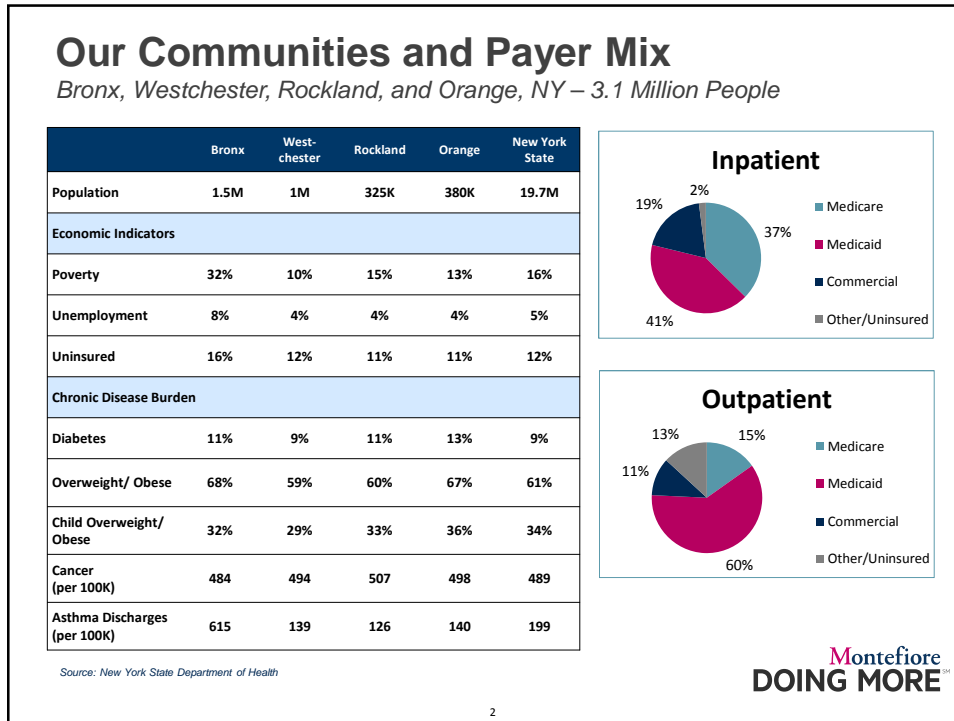
200 Sites Including

- Freestanding Emergency Department**
- 68 Primary Care Sites**
 - 21 Montefiore Medical Group Sites
 - 23 School Health Clinics
- 16 Mental Health/Substance Abuse Treatment Clinics**
- 73 Specialty Care Sites**
 - 3 Multi-Specialty Centers
 - 4 Pediatric Specialty Centers
 - 12 Women’s Health Centers
- 10 Dental Centers**
- 5 Imaging Centers**

Albert Einstein College of Medicine

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Overview of Value-Based Payment Arrangements at Montefiore

	2017 Population (Medicaid)
Risk Contracts (Level 3) • Includes Medicare, Medicaid and Commercial lives	218,000 (142,000)
Shared Savings	97,000(26,000)
Next Generation ACO	47,000
Medicaid Health Home	10,000 (10,000)
Managed Long Term Care Plan	1,500 (1,500)
TOTAL	371,500

- Estimated VBP revenue of \$2.4 billion which represents close to 50% of total Montefiore Health System revenue
- Montefiore goal is to reach 1M lives in value based arrangements



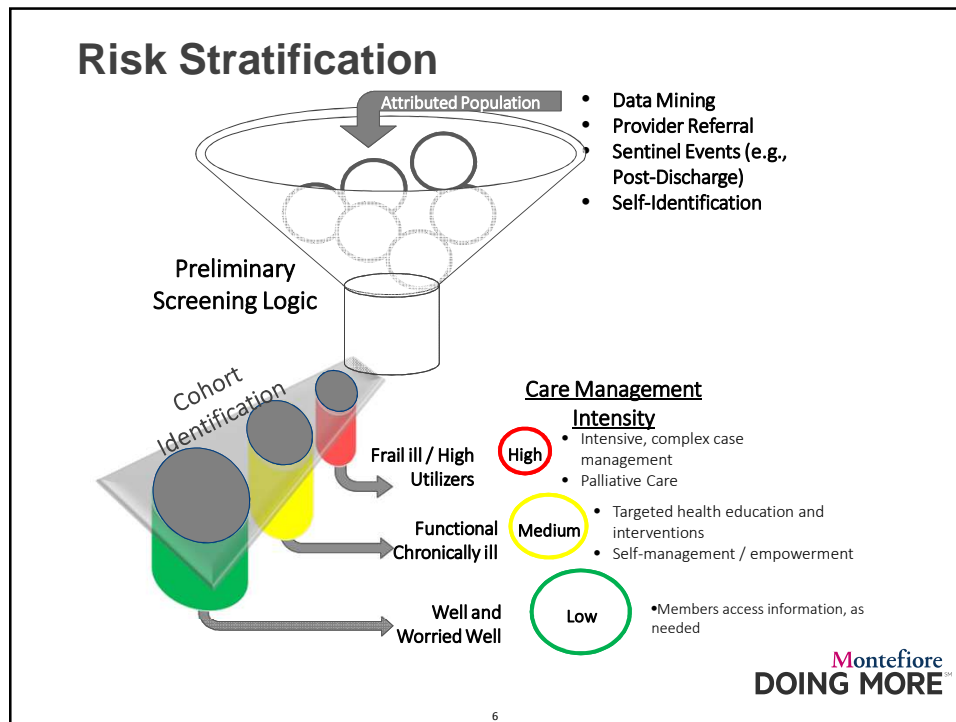
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Keys to Success in Value-Based Care or How to be a Successful ACO

- Overarching vision, clear governance structure, and integration with health system
- Defining and understanding the population
- Knowing that <20% of the population drives the costs, 100% determines the quality of care
- Developing an ongoing care and population management organizational strategy
- Ensuring that IT strategy incorporates full breadth of population health and care coordination operational needs



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Montefiore Pioneer Results

Program Year	Attribution	Quality Score	Savings to Medicare	Montefiore ACO Share
PY1 (2012)	23,000	Reporting only	\$23.3 million	\$14 million
PY2 (2013)	25,000	75.6%	\$24.6 million	\$13.4 million
PY3 (2014)	28,000	82.2%	\$13.3 million	\$8.6 million
PY4 (2015)	43,000	92.6%	\$2.2 million	\$0
PY5 (2016)	54,000	95.2%	<u>\$10.6 million</u>	<u>\$7.4 million</u>
			\$74 million	\$43.4 million

Highlights:

- One of 32 selected in 2011 (only one in New York State) and one of 8 remaining through 2016
- Network of 4,500 providers (25% voluntary private practice physicians)
- PY5 Attribution → 25% Montefiore, 43% Partners, 32% Community
- PY5 Eligibility → 30% Duals, 70% Non-Duals
- Most financially successful Pioneer ACO in program years 1 & 2
- Quality improved 32% over 4 years
- ACO network EHR use increased to 84% from 42% (using 72 different systems) over 3 years

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How can we build on existing ACO models?

Current Limitations

- Excludes Duals and Medicare Advantage (MA) patients, leading to fragmented care and fragmented care management
- Regions with high penetration of MA plans have fewer ACO opportunities
- Complex and changing cost of care benchmarking methodologies make it hard to predict success

Proposed Improvements

- Allow experienced ACOs to assume regional accountability for Medicare, Medicaid and Dual beneficiaries
- Expand existing ACO models to include dual eligibles' Medicaid benefit
- Leverage local innovation and increase opportunities for participation in AAPMs by allowing Medicare to participate in state-based initiatives
- Provide incentives for MA plans and other payors to participate in risk-based arrangements with ACOs
- Use models that are easily understandable and offer stability

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