

Vermont's Experience With Payment Reform

Towards A Shared Vision of Payment Reform
MA Medical Society
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Outline

- I. My Background
- II. Context: Health Care Reform in Vermont
- III. Delivery System Transformation and Payment Reform
 - Phase I: Enhanced Medical Home
 - Phase II: Community Health System/ACO
- IV. Making it work: A Learning Health System
- V. Some Lessons/Suggestions

I. My Background

- Vermont health care reform: 2001 to now
- Training: systems engineering
- Career Theme: How to create incentives and capacity for MD's to engage in system transformation
- MA: 1980 – 94: TAHP, HCHP-IPA, Pilgrim

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II. Context: VT Health Reform

State: 600,000 population

Regions: 13 Hospital Service Areas define 'community systems'

Payers: 3 major commercial + 2 public

Collaboration: bipartisan, multi-stakeholder

Laboratory for health reform



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Vermont's Reform Strategy

Act 191 (2006) created 'three legged stool' which balanced

1. Sustainable reduction in uninsured from 10% to 4% by 2010
2. Health IT as catalyst for improved performance
3. Bending the medical cost curve through delivery system transformation
 - Blueprint for Health: Chronic illness prevention and care

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Status: Reducing uninsured

- New commercial products (Catamount Health) offered 10/1/07
- Major outreach to 60,000 uninsured by wide range of organizations
- As of 7/10
 - 14,000 enrolled in Catamount
 - 21,000 new enrollees in state programs
 - Reduced uninsured from 10% to 7% in declining economy (11/09)

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Status: Health IT as catalyst for performance improvement

- Statewide health information exchange network (VITL) funded and being built
- IT support for enhanced medical homes being implemented
- State Health IT Fund implemented 2008:
 - Electronic Health Record for all independent primary care MD's
 - State wide Health Information Exchange
- Implementing HITECH provisions in ARRA
 - State wide Health Information Exchange infrastructure
 - State wide Regional Extension Center

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Payment Reform

- Necessary, but not sufficient element of reform: must build 'systemness'
- Phase I: Blueprint enhanced medical home pilots links primary care incentives to medical home functions
- Phase II : ACO pilot broadens incentives to community providers

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III. Delivery System Transformation

‘Every system is perfectly designed to obtain the results it achieves.’

Approach

- System redesign at four geographic levels
 1. Primary care practice level: Enhanced medical homes
 2. Community health system: ‘neighborhood’ for medical home
 3. State/regional infrastructure and support e.g. HIT, payment reform
 4. National: Medicare participation
- Start in pilot communities, spread statewide

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Building ‘Systemness’

Five key generic functions of a community health system

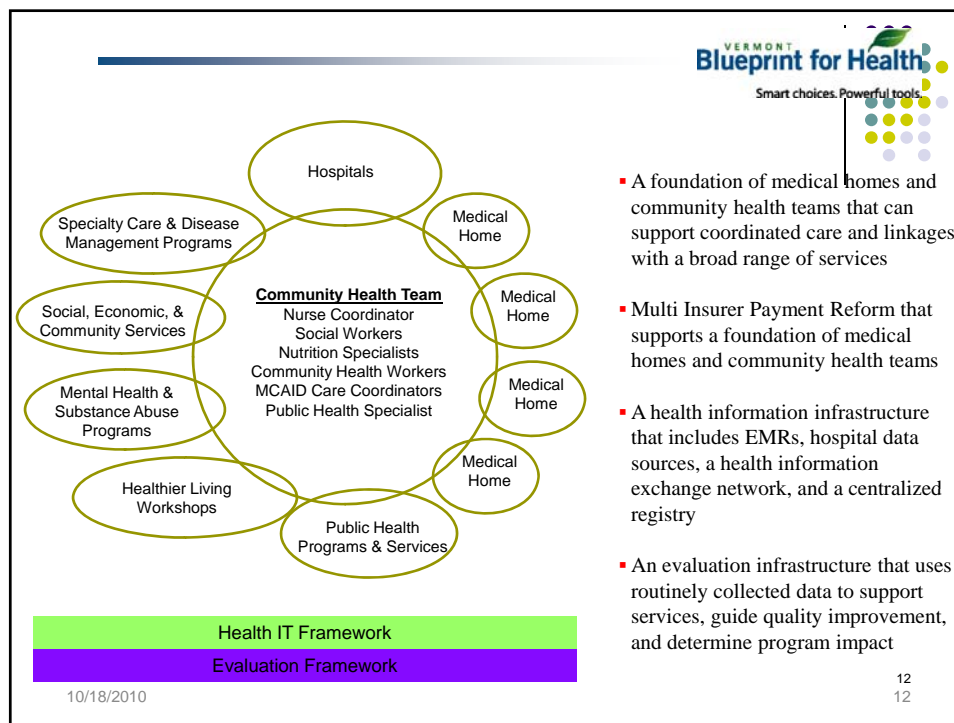
1. **Service** integration across levels and settings of care
2. **Financial** integration
3. **Governance**: Provide leadership, and establish accountability
4. **Information**: Deploy information tools to support care, management, process improvement and evaluation
5. **Process improvement**: Design, implement and improve performance

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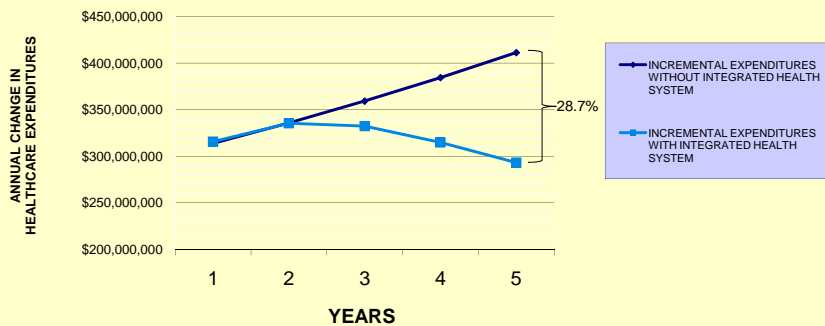
Phase I: Community Based Enhanced Medical Home Pilots

- Service Coordination
 - Patient Centered Medical Home (PCMH) model
 - New community health team (CHT) funded by all payers
 - No eligibility/benefits criteria for using CHT
- Financial integration: single system of aligned incentives
 - All payer: three major commercial payers, Medicaid, Medicare
 - Mandated participation by 3 commercial payers and Medicaid
 - Sliding care management fee linked to 10 NCQA PCMH criteria
 - Payment for community health team
 - Medicare: MAPCP demonstration for state wide expansion
- IT support: registry, EMR's & interfaces, HIE, all payer claims data
- Process improvement: training and on going support
- Timeline:
 - 1/10 10% of VT population in 3 pilot communities
 - 7/11 spread state wide to all hospital service areas

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IMPACT OF INTEGRATED HEALTH SYSTEM- POTENTIAL COST AVOIDANCE ACROSS TOTAL POPULATION



Target Population
% of VT Population
CHTs

42,179	126,286	316,662	508,17	637,130
6.7%	20%	50%	80%	100%
2	6	16	25	32

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Phase II: ACO Pilot

- Focus on community health system level
- Translate potential system wide savings into actual savings
- Capture part of shared saving to reinvest in local community health system
 - Transition funding for adjusting to reallocation
 - Investments in population health, primary care, etc.

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Goals of The ACO Pilot

- Improve performance in IHI 'Triple Aims'
- Test the ACO concept in a small number of 'early adaptor' community provider networks that already have key functional capabilities.
- Have at least one Vermont site in the national ACO Learning Collaborative and Learning Network

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ACO Pilot Status and Next Steps

- Three potential ACO pilot sites identified & participating in National Learning Network
- Creating all payer model
 - Three major commercial payers participating and consolidated shared savings pool accepted
 - Plan for Medicaid participation 7/10
 - Planning for Medicare participation 2012
- Financial impact model for ACO developed for two sites
- Vermont legislation (2010) for 3 pilots by end of 2012

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Development of A Community Health System To Achieve the Triple Aims

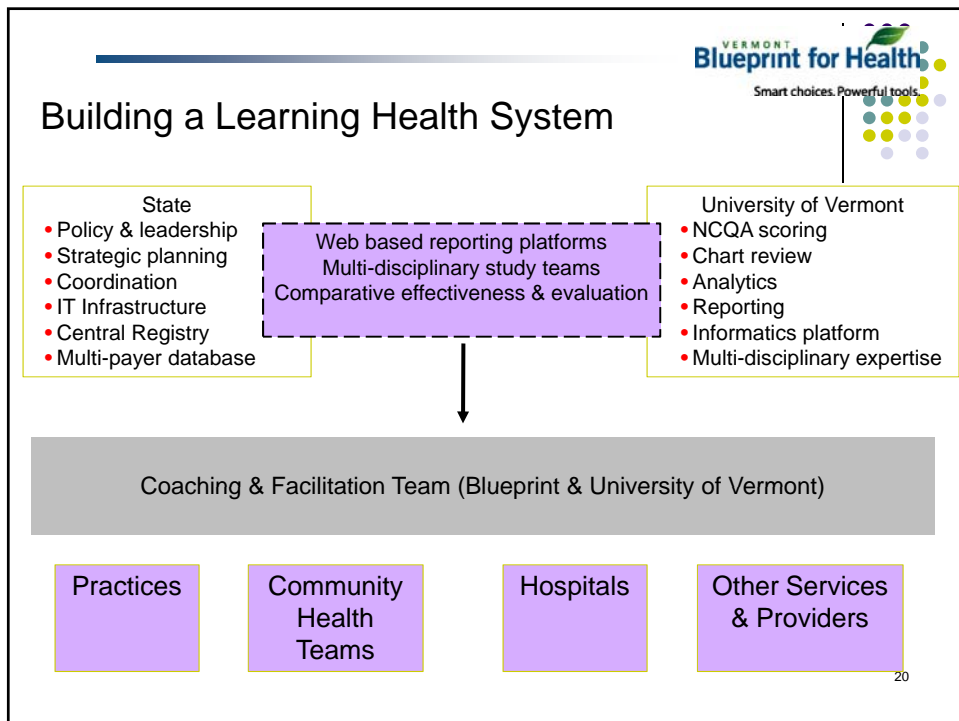
- “It is the intent of the general assembly to reform the health care delivery system in order to manage total costs of the system, improve health outcomes for Vermonters, and provide a positive health care experience for patients and providers. In order to achieve this goal and to ensure the success of health care reform, it is essential to pursue innovative approaches to a single system of health care delivery that integrates health care at a community level and contains costs through community-based payment reform.” (Act 128, 2010)

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IV. Making It Work

- Payment reforms create a framework and aligned incentives
- They don't automatically engage physicians and create 'the capacity to do the hard work
- IOM: learning health care system

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Blueprint Pilot Evaluation

Data Sources
NCQA Scoring
Chart Review
DocSite Database
Multi Payer claims Data
Public Health Databases



Core Assessments
NCQA PCMH Standards
Clinical Process Measures
Health Status Measures
Utilization & Healthcare Expenditures
Population Health Indicators



Expanded Evaluation
Healthcare
Social
Economic
Ecological
Health Policy

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Some Initial Questions for an ACO

- What population do you actually serve?: Attributed vs. geographic membership
- What services used by that population are provided inside the ACO vs. outside?
- How does the current performance of the ACO compare to benchmarks in each of the three Triple Aims?
- Which services, sub-populations and/or providers have significant variations from benchmark? Why?
- What are the prioritized interventions for reducing those variations?

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Some Resources

- All payer claims data base (commercial)
 - Analysis of attributed population vs. geographic population
 - Small area variation analysis: VT has low average use rates, but significant variation
- Medicare data
 - Dartmouth Atlas
 - CMS data
- Hospital discharge data set

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V. Lessons and Suggestions

- Community health system level is the focal point of delivery system reform
- Don't know what structures work
 - Experiment with alternative structures
 - Need multiple approaches
- Most small and medium sized communities and care systems will need state/national support for
 - Defining a common financial framework for all payers
 - IT support for clinical tools, process improvement, information exchange, reporting and evaluation
 - Technical support and training
 - Start up funding
 - NASHP report (in press)

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Lessons and Suggestions

- Likelihood of success of ACO is enhanced by key pre-requisites
 - Implementation of medical home model, including primary care payment reform
 - All payer participation in a common financial framework
 - Strong IT support for operations, reporting and evaluation
- After two years, Vermont is 12-18 months away from startup of first ACO pilot

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Lessons and Suggestions

- Use a balanced set of incentives: IHI Triple Aims
- Strive for single system within a multi-payer framework
 - Care coordination using local Community Health Team vs. multiple remote disease management programs
 - Common payment method and aligned incentive measures
- Invest in physicians: Training, Shared learning, Startup costs, etc.
- Support a data driven process
 - Use what you have
 - Plan for more

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Payment Reform: The Vision

- Community Health System responsible for achieving the Triple Aims for its population
 - Improving its health over time
 - Ensuring patients have a good experience of care, when care is needed
 - Managing the total costs of care

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Resources

- Vermont Health Reform
 - Health reform : <http://hcr.vermont.gov/>
 - Information technology: <http://www.vitl.net/>
 - Health Care Reform Commission:
<http://www.leg.state.vt.us/CommissiononHealthCareReform/default2.cfm>
 - Vermont ACO Pilots
<http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2010/May/The-Vermont-Accountable-Care-Organization-Pilot-A-Community-Health-System-to-Control.aspx>

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