Piloting an ACO: A Community Provider Network Which Achieves the Triple Aims

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Jim Hester PhD
Director
VT Health Care Reform Commission
Abstract

The context: Vermont Health care reform

Basic building blocks for the ACO pilot

Working design for an ACO pilot

Summary
I. Goals of The ACO Pilot

- Improve performance in IHI ‘triple aims’
  - Bend the medical cost curve – significant savings over projected trend line of costs
  - Improve the health of the community population and the patient experience

- Test the ACO concept in a small number of ‘early adaptor’ community provider networks that have key integrator capabilities.
VT State Legislature required Health Care Reform Commission to conduct ACO pilot feasibility study

- 6/08-2/09 HCRC feasibility study
- 3/09-5/09 Legislature reviews recommendations

If approved
- 5/09-1/10 Detailed design, selection of pilot, selection of administrator
- 2010 Startup of initial pilot
II. Context: VT Health Reform

600,000 total population

Relatively good distribution of primary care: 800 providers in 300 practices

13 Hospital Service Areas

Payers: 3 major commercial + Medicaid + Medicare

History of collaboration
Vermont’s Reform Strategy


- **Sustainable** reduction in uninsured from 10% to 4% by 2010
- Health IT as catalyst for performance
- Bending the medical cost curve
  - Blueprint for Health: Chronic illness prevention and care

Plus a variety of supporting projects (60+)
Blueprint for Health
Enhanced community pilots

- Payment reform for primary care
  - Patient Centered Medical Home (PCMH) model
  - Two tiered: fee for service, sliding care management fee linked to 10 NCQA PCMH criteria
- Uniform model: All three major commercial payers and Medicaid (state pays for Medicare)
- New community based care coordination team
- Community based prevention plan and interventions
- Timeline: 3 communities with 10% of VT population by 1/09
III. Building Blocks for an ACO pilot

- Build on ‘Blueprint for Health’ and its enhanced medical home pilots
  - Strengthen system ‘integrator’ at multiple levels
- Participate in IHI Triple Aim prototyping
  - Clarify functions and types of ‘integrators’
  - Measures
- Test Fisher’s ACO concept
- Learn from CMWF ‘High Performing Health Care Organizations’
Geographic levels of integration

- Medical Home
- Community Provider Network
- Region/State
Functions of Integrators

What are key generic integrator functions to achieve the Triple Aims?

- Clinical integration across levels and settings of care:
  - patient centered integrated care models including engaging the population (medical home)
  - integration of health care, public health and supporting social services to support population health (community)

- Financial integration
  - financial models across multiple payers to support Triple Aims (state)
  - cost control platform for managing integrated budgets (community)

- Governance: Provide leadership, build governance structure and establish accountability (community network)

- Process improvement: Design, implement and improve performance measures which test and analyze Triple Aim results (all)

- Information: Develop and deploy information technology to support care and to assess performance. (state)
IV. Working Design for Pilot

Create working design and assess critical issues/tasks in

- Scale and scope of pilot: e.g. minimum population?
- Responsibilities and criteria for ACO site
- Financial model
- Funding of integrators and pilot administration
ACO Functions & Criteria For Participation

- Serve as “system integrator” with possible functions of:
  - Financial: cost control platform managing integrated budgets
  - Clinical: care coordination across levels and settings of care
  - Process improvement expertise
  - Community based public health initiatives,

- Evolving organization and governance structure across multiple provider types for most of local network, e.g., PHO, FQHC

- Demonstrated initial capabilities in key integrator roles, with ability to enhance them over time
Design of Financial Model

- **Two layers of compensation:**
  - Baseline compensation
  - Significant incentive based on Triple Aims, funded by savings

- **All major payers participating**
  - Start with 3 major commercial and Medicaid
  - Clear path to Medicare participation is critical

- **Baseline compensation model**
  - Based on fee for service, but ACO can modify
  - Cash flows for services remain from payer to individual provider
Issues for Financial Model

- Variations in baseline compensation model
- Path to Medicare participation: meshing with other payers
- Defining incentive model
  - Setting the virtual medical budget: Negotiating global medical expense target for total per capita costs
  - Measures: population health and patient experience
  - Variation in model with ACO scale and scope
- Potential legal/regulatory issues
Why Could it Work Now in Vermont?

- Foundation of six years implementing supporting health care reform initiatives
  - Successful public/private initiatives with shared vision
  - Blueprint for Health: initial integrator structures at medical home, community and state levels
  - Significantly improved data systems capacity: Health Information Exchange, provider tools, all payer claims data base

- ‘Critical mass’ for incentives through multi-payer model

- Greater readiness for community level change: wide recognition that the current system doesn’t work
  - Documentation of adverse affects of wide variations in care
  - Increasing budgetary constraints and political pressure
  - Physician shortage has increased readiness to try new models
“You can always count on Americans to do the right thing … after they have exhausted all other possibilities”

Winston Churchill
Summary: Testing the ACO as a Community Integrator

- Central issues
  - How to create ‘systemness’ out of fragmentation?
  - How build capacity and accountability for Triple Aim objectives?
- Recognize multiple levels of geographic integration
  - Individual patient: medical home practice
  - Community network: Community hospital, medical staff and other key local stakeholders
    - Fisher ‘the neighborhood for medical homes’
  - Region/State: supporting functions for community networks
- Key Redesign: System integrator at Community Level linked vertically in two directions
- Begin where you have existing ‘integrator’ structure to build on
- Medicare must be involved with other major payers to achieve transformation
Resources on Vermont Health Reform

- Information technology: [http://www.vitl.net/](http://www.vitl.net/)
- Health Care Reform Commission: [http://www.leg.state.vt.us/CommissiononHealthCareReform/default.htm](http://www.leg.state.vt.us/CommissiononHealthCareReform/default.htm)

Jim Hester, Director, 802 828-1107, jhester@leg.state.vt.us