

Robert Wood Johnson Foundation Payment Reform Evaluation Project

Development of Models for Comprehensive Payment Reform in Vermont

Green Mountain Care Board

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Introduction and Context

The Development of Models for Comprehensive Payment Reform in Vermont has been and will continue to be shaped by the state's ambitious plan to create a universal and unified health care system for nearly all Vermonters.¹ In the past decade Vermont's health care system has faced economic and access problems. In 2005-2010 annual costs of health care have grown 6.3 percent in a flat economy that cannot afford them,² and in 2009 about eight percent of Vermont residents were uninsured and twenty-eight percent under age 65 were underinsured.³ In response, and on the heels of the federal Affordable Care Act (ACA), in 2011 the Democrat-controlled Vermont Legislature, with strong leadership from Governor Shumlin, passed Act 48, promising a "universal and unified health system" as a "public good" that also controls costs and offers quality care.

Through Act 48, the Legislature's intention was to move Vermont toward a more highly regulated and integrated health care system but specified few details about what the new system might look like or how it would work. In particular, universal health insurance through a "single payment system" is mentioned conspicuously only a single time in the Act. The following new institutions are the government's infrastructure for improving access to health care, controlling costs, and maintaining quality of health care:

- *Creation of Green Mountain Care Board (GMCB).* Act 48 created an independent, five-member Board that has broad, unprecedented regulatory authority over Vermont's health care system. In particular, Act 48 recognizes that limited resources exist for health care and, therefore, guaranteeing coverage and access depends heavily on controlling the costs of health care. Act 48 charges the Board to "... oversee the development and implementation, and evaluate the effectiveness of, health care payment and delivery system reforms designed to control the rate of growth in health care costs and maintain health care quality in Vermont."⁴ The GMCB is authorized to implement a wide range of statewide payment reforms, including setting cost-containment

¹ The goal of a universal health care system is to increase access to health care by minimizing the percentage of the population without health insurance. In a unified or "standardized" health care system, health plans follow common rules for payment, measuring quality and performance, and other features.

² Source: Green Mountain Care Board, Health care cost growth in Vermont continues to outpace national growth, underscores need for reform. Vtdigger.org, March 22, 2012. Website: <http://vtdigger.org/2012/03/22/health-care-cost-growth-in-vermont-continues-to-outpace-national-growth-underscores-the-need-for-reform/>. In 2005-2010 the U.S. growth rate in health care costs was 4.2%.

³ Sources: Vermont Office of Health Access. Planning for Vermont's Health Benefits Exchange. Task 7: Study of the Uninsured and Underinsured. Prepared by Market Decisions, Portland, Maine, March 2011.

⁴ In brief, Act 48 charges the GMCB with promoting the good of the state by: 1) improving population health; 2) reducing growth in per capita expenditures without compromising access and quality; 3) enhancing patient and provider experience with care; 4) recruiting and retaining high quality health care professionals; and 5) achieving administrative simplification of health care financing and delivery.

targets, global budgets, risk-adjusted capitated payments, bundled payments, or other payment models. The GMCB also has other powers to control costs, such as setting payment rates for health professionals and approving hospital budgets, certificates of need, and payer premiums. The Act recognizes, however, that payments must be sufficient for health care organizations and professionals to remain solvent, and thereby secure their participation in GMC while not harming the State's economy.

- *Creation of Vermont's health insurance exchange, Vermont Health Connect.*⁵ The exchange is the marketplace for Vermont residents and employers to shop for health insurance. As one of 15 states implementing its own health insurance exchange and Medicaid expansion in 2014, Vermont is a "full player" in the ACA. Act 48 mandates that Vermont's exchange offer health plans from at least two private insurers, as required by the ACA. In 2014 Vermont's exchange began offering two health plans to eligible residents and small employers, with plans to expand to large employers in the future. The health insurance exchange is administered by the Department of Vermont Health Access (DVHA), the State agency overseeing Vermont's public health insurance programs and one of six departments in Vermont's Agency of Human Services (AHS).
- *Expansion of Green Mountain Care (GMC).*⁶ GMC consists of the health insurance programs sponsored by the State of Vermont: Medicaid plans for adults and children, and for the aged, blind and disabled. Prior to the ACA, Vermont's Medicaid program already covered working adults with incomes up to almost 200 percent of the federal poverty level (FPL),⁷ exceeding the ACA's threshold of 133 percent FPL. Following the ACA, Vermont's Medicaid expansion has enrolled almost 20,000 new beneficiaries.⁸

Act 48 declares that, in the future, GMC may become the State's universal health insurance program – that is, a single health insurance plan for nearly all Vermonters, contingent on meeting two critical milestones. First, the AHS and the Governor's Office must propose the GMC benefit package and the financing plan to fund GMC, the Secretary of Administration must propose the health information technology plan, and all three proposals must be approved by the GMCB. The three-year financing plan for GMC must have lower costs than Vermont's current health care system. Second, by law the State of Vermont may implement GMC only after all of the following conditions are met:

- State of Vermont receives a federal waiver under Section 1332 of the ACA by 2017 to use Medicare, Medicaid, and other federal funds to support GMC.

⁵ Information about Vermont's health insurance exchange, Vermont Health Connect, is available at the following website: <https://portal.healthconnect.vermont.gov/VTHBELand/welcome.action>

⁶ The Green Mountains run south-to-north in Vermont and are part of the Appalachian Mountains. The Green Mountains inspired the state's name. The French *Verts Monts* is translated as "Green Mountains" (source: http://en.wikipedia.org/wiki/Green_Mountains).

⁷ Source: Kaiser Family Foundation. Medicaid: A Primer. March 2013. Available at: <http://kff.org/medicaid/issue-brief/medicaid-a-primer/>

⁸ Source: Morgan True. Medicaid running \$15-\$20 million over budget, State says. VTDigger, May 6, 2015.

- Vermont Legislature authorizes financing and appropriates funds for the initial GMC benefit package approved by the GMCB.
- GMCB confirmation that six conditions (known as “triggers”) of Act 48 will be met, including reduction in growth of health care spending, which makes payment reform and cost control a top priority of Vermont’s health system reforms⁹.

In sum, Act 48 is moving Vermont toward a more regulated and integrated health care system. This strategy did not happen by accident but rather reflects Vermont’s small geographic and population size that fosters civic engagement and collaboration, its long history of state-regulated health care and belief in the beneficial role of state government,¹⁰ and health markets with little competition.¹¹

To advance the health insurance and payment reforms in Act 48, the GMCB applied for and was awarded a grant from the Robert Wood Johnson Foundation in 2012 to design and implement its payment reform strategies. Development work under the RWJF grant eventually led to the award of a three-year, \$45 million State Innovation Model (SIM) grant from the Centers for Medicare and Medicaid Services’ (CMS) Center for Medicare & Medicaid Innovation (CMMI) in 2013; this grant, called the Vermont Health Care Innovation Project (VHCIP), is based in Vermont’s Agency of Administration with the GMCB and DVHA as primary co-leaders. The award is playing a vital role in improving Vermont’s readiness and ability to design, implement, and evaluate Vermont’s value-based payment models; coordinate the health care-related work of several State agencies; support the work of public-private partnerships engaged in delivery system reform; support information system development; identify

⁹ In brief, the six conditions are: 1) GMC will provide benefits with an actuarial value \geq 80 percent; 2) GMC will have no negative effects on Vermont’s economy; 3) GMC’s financing plan is sustainable; 4) GMC administrative expenses will be reduced below 2011 levels; 5) growth rates in health care spending will decline without reducing access; and 6) providers will be paid at levels sufficient to recruit and retain high quality providers in Vermont.

¹⁰ For instance, the State controls the budgets of Vermont’s 14 hospitals, and hospitals and federal qualified health centers employ more than two-thirds of Vermont physicians (Source: GMCB RWJF application). Over 20 years ago Vermont implemented regulations limiting rate variations and preventing health plans from denying coverage based on preexisting medical conditions (Source: Kaiser Health News, October 2, 2011).

¹¹ Vermont may rely more on regulation than competition to control costs because Vermont has small numbers of commercial health plans and health care systems to compete with each other. Little competition exists among Vermont’s two commercial payers, Blue Cross/Blue Shield of Vermont and MVP Health Care (Cigna is a third party administrator), with Blue Cross/Blue Shield controlling 80% of the private commercial market. Medicaid covers about a quarter of the state’s residents. Competition also is limited by the relatively small number of Vermonters (roughly 300,000) covered by commercial health plans. Plus, the region’s two large health systems, University of Vermont Medical Center and Dartmouth-Hitchcock Medical Center, have established a partnership and no longer compete aggressively for market share. In addition, Vermont is divided into non-overlapping service areas, which reduces competition among hospitals, mental health agencies, and other health care organizations. Vermont’s restrictive health insurance laws, such as guaranteed issue (insurers not allowed to deny coverage) and community rating (insurers cannot charge based on health status or lifestyles), also may be reducing the number of commercial insurers in the state.

local and statewide clinical leaders for system transformation; and prepare health care organizations for new types of payment.

Since the passage of Act 48 two competing visions of statewide healthcare system reform have been debated, which are summarized below:

- *Single-payer statewide universal health insurance.* The universal health insurance program will cover most Vermonters and have a single source of revenue, public funds, from the State of Vermont and Medicare. The revenues will pay for the administration and delivery of health services covered by a *single* health plan through a *single*, simplified, and common administrative and payment system. Governor Shumlin and many others in the state were vocal advocates of the program, which received national attention. Act 48 does not describe how the state would pay for the single-payer plan. Current estimates indicate that in Vermont's existing health care system, employers and individuals pay \$2.2 billion annually. The single-payer plan may save \$332 million, and Medicaid may provide \$249 million, leaving a \$1.6 billion shortfall (although other estimates are up to \$2.2 billion), which would be paid through increased taxes. However, what businesses paid in insurance premiums may be replaced partially by a new employer payroll tax to fund the plan, although a goal is to lower insurance premiums.¹² The AHS will have oversight of the single-payer plan, but the law allows flexibility in implementing the plan, such as contracting out administrative functions through a competitive bidding process.¹³
- *All-payer statewide integrated healthcare system.* This vision of all-payer system reform has multiple sources of revenue, mainly Medicaid, Medicare, and the health plans in the Vermont exchange. Vermonters would retain their *multiple* public and private health plans but receive services through a *single*, simplified and standardized administrative and payment system. The health plans would follow common rules for payment methods, measuring performance and other system features.

In 2014-2015 Vermont's momentum toward a single-payer universal health plan was slowed greatly by two sentinel events:

¹² Current estimates indicate that in Vermont's existing health care system, employers and individuals pay \$2.2 billion annually. GMC may save \$332 million, and Medicaid may provide \$249 million, leaving a \$1.6 billion shortfall (although other estimates are up to \$2.2 billion) that must be made up with government revenues -- if employers stop offering insurance to employees. However, what businesses paid in insurance premiums may be replaced partially by a new employer payroll tax to fund the plan. Act 48 does not indicate how GMC will be financed (sources: Sean McElwee, The Atlantic, December 27, 2013; Avelere Health, Evaluation of Vermont Health Care Reform Financing Plan, November 14, 2013).

¹³ Sources: Act 48 (see Chapter 18 Sub-Chapter 2); Sean McElwee. Can Vermont's single-payer system fix what ails American healthcare? The Atlantic, December 27, 2013 (<http://www.theatlantic.com/politics/archive/2013/12/can-vermonts-single-payer-system-fix-what-ails-american-healthcare/282626/>).

- On December 17, 2014, Governor Shumlin “pulled the plug” on the single-payer health insurance program, mainly because the plan would require “enormous” new taxes and was not financially viable.¹⁴
- Vermont Health Connect was still not fully functional, even after investing about \$130 million in mostly federal funds through 2014 to launch the state’s online insurance marketplace.¹⁵

The events have soured public and legislative enthusiasm for the ACA and making major changes in Vermont’s health system, and undermined public faith in the state’s ability to implement them, which has increased the challenges of implementing health care reform in the state.¹⁶

With single-payer health insurance no longer financially viable, in 2015 attention has shifted to the second option, an all-payer statewide integrated health care system, which has the Governor’s support. The all-payer program would be composed of Vermont’s Medicare, Medicaid, and commercial health plans, with each plan retaining its own benefits.

Two new Medicare payment policies may accelerate Vermont’s momentum toward implementing the all-payer model. In January 2015, CMS announced plans to move Medicare, as well as the U.S. health system, away from fee for service (FFS) reimbursement toward alternative payment models and value-based payments by 2018.¹⁷ Later in 2015 CMS announced its’ Next Generation (“Next Gen”) Accountable Care Organization (ACO) Model, which allows ACOs to assume higher levels of financial risk and reward than the current ACO Pioneer Model and Shared Savings Program, as well as the ability to

¹⁴ Goodnough A. In Vermont, frustrations mount over Affordable Care Act. NY Times, June 4, 2015; True M. Big expectations, few results on health care. VTDigger.org, May 20, 2015. Governor Shumlin noted the single-payer plan, financed by a mix of federal and state funds, would require about \$2.5 billion in additional revenue in the first year of operation, in a state with \$2.7 billion in taxes annually.

¹⁵ Goodnough, June 4, 2015; True, May 20, 2015; Morgan True. Auditor’s report: no guarantee state can complete Vermont Health Connect. VTDigger.org, April 16, 2015. The U.S. Supreme Court has decided that the Affordable Care Act allows federal subsidies in states that use the federally-run insurance marketplace. The Court’s ruling will not affect Vermont and other states that run their own exchanges.

¹⁶ Goodnough, June 4, 2015; True, May 20, 2015.

¹⁷ In January 2015 CMS announced that: “HHS has set a goal of tying 30 percent of traditional, or fee-for-service, Medicare payments to quality or value through alternative payment models, such as Accountable Care Organizations (ACOs) or bundled payment arrangements by the end of 2016, and tying 50 percent of payments to these models by the end of 2018. HHS also set a goal of tying 85 percent of all traditional Medicare payments to quality or value by 2016 and 90 percent by 2018 through programs such as the Hospital Value Based Purchasing and the Hospital Readmissions Reduction Programs. This is the first time in the history of the Medicare program that HHS has set explicit goals for alternative payment models and value-based payments.” [See websites:

<http://www.hhs.gov/news/press/2015pres/01/20150126a.html>; and

<http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-01-26-3.html>.

In addition, Congress has approved H.R. 2 Medicare Access and CHIP Reauthorization Act of 2015, which pays physicians extra for participating in alternative payment models and increases financial incentives in pay for performance/quality reporting programs starting in 2019.

pay and receive capitation payments.¹⁸ The goal of the Next Gen Model is to test whether strong financial incentives for ACOs, coupled with better patient engagement and care management, can improve health outcomes and lower expenditures, compared to the Medicare FFS program. Next Gen's goals align well with the goals of Act 48 and VHCIP, and signal the future direction of payment reform for both public and commercial payers. Applications by eligible ACOs to participate in the Next Gen Model were due by June 1, 2015.

The CMS announcements are timely because Vermont health care organizations have formed the following three accountable care organizations (ACOs), currently with more than 150,000 total patients attributable to the Medicare, Medicaid and commercial shared savings programs:

- OneCare Vermont: consists of all Vermont hospitals and their employed physicians, Dartmouth Hitchcock in New Hampshire, some federal qualified health centers and independent medical offices, as well as mental health and substance abuse agencies and skilled nursing facilities. OneCare Vermont has submitted an application to participate in the Next Gen Model.
- Community Health Accountable Care (CHAC): consists of Vermont's eleven federally qualified health centers (FQHCs), along with mental health and substance abuse agencies and skilled nursing facilities.
- Vermont Collaborative Physicians/Accountable Care Coalition of the Green Mountains (VCP/ACCGM): consists of independent primary care and specialty practices.

The ACOs have an important tool for coordinating care among their health care organizations and professionals: a statewide clinical information system being developed by Vermont Information Technology Leaders (VITL), with oversight from the GMCB starting in 2015.¹⁹ The system aims to offer clinical data in real time to support care delivery throughout Vermont; for instance, through alert notifications that inform providers when their patients have a medical event such as an emergency department visit or hospital admission, discharge or transfer.

Finally, Act 48 mandates that Vermont's health insurance reforms build on and align with significant, ongoing transformations of Vermont's health care delivery system. The Act intends that GMC enrollees will receive primary care through Vermont's Blueprint for Health, the statewide, multi-payer advanced primary care demonstration program that meets National Committee on Quality Assurance (NCQA)

¹⁸ Source: CMS. Next Generation ACO Model. Available at: <http://innovation.cms.gov/initiatives/Next-Generation-ACO-Model/>.

¹⁹ Act 48 endorses the statewide information system. In 2008 the Vermont Legislature established a Health Information Technology Fund, which collects funds through a "tax" on claims, and provides financial support to VITL to build and operate the health information system (See: http://hcr.vermont.gov/hit/IT_fund). VITL is building the information system through data flows from health care organizations throughout Vermont. Senate Bill S.139, passed on May 7, 2015, newly assigns oversight of VITL to GMCB (True M. Big expectations, few results on health care. VTDigger.org, May 20, 2015).

medical home standards, and that has community health teams to link patients with social and other services.²⁰ Blueprint medical practices currently provide care to about three-fourths of Vermont residents.²¹

Project Objectives

The project's long-term objective is to have a statewide, all-payer health insurance model supporting population-based payments for Vermont health care providers. This project intends to bridge the gap between the current health care system in Vermont and this objective through implementing and evaluating diverse payment system reforms across the state. Over time the payment system reforms will move away from the current FFS payments toward value-based payments that control costs and improve the quality of care and population health.²²

Approach

Act 48 mandates that “the state must assure public participation in the design, implementation, evaluation and accountability mechanisms of the health care system.” With this goal in mind, and consistent with Vermont's culture of civic engagement, the State-run SIM Project has an elaborate governance structure that engages literally hundreds of Vermonters in payment and health system reform.²³ Overall direction is provided by the eight-member Core Team (which includes the GMCB Chair).²⁴ The Core Team, in turn, receives guidance from the 37-member Steering Committee that is co-chaired by the GMCB Chair and the Commissioner of DVHA. The Steering Committee and Core Team receive guidance from the following work groups; individuals may serve on multiple groups:

- Payment Models Work Group
- Quality and Performance Measures Work Group
- Care Models and Care Management Work Group
- Duals Demonstration Work Group²⁵
- Health Information Exchange Work Group
- Population Health Work Group

²⁰ Source: Act 48 (see also Title 33, Chapter 18, Sub-Chapter 2, Section 1826).

²¹ Source: Vermont Blueprint for Health 2015 Annual Report, January 15, 2015 (revised 1/26/2015).

²² Key informants noted that if Vermont's health care costs increase 6% versus 3.5% annually in the next 10 years, the difference is \$10 billion over 10 years, which Vermont cannot afford. In this scenario, cost control would be the only objective. The GMCB has authority to control costs, for example, by setting predetermined cost growth rates. Eventually population-based payments may control costs through a fixed, statewide budget for health care.

²³ Source: <http://healthcareinnovation.vermont.gov/node/706>. Stakeholders are protected from anti-trust violations through Vermont's “State Action Doctrine,” if stakeholder collaborations are facilitated by a state agency, such as the GMCB.

²⁴ The Chair of the Core Team is the former and first Chair of the GMCB and a central architect of Act 48.

²⁵ The Duals Demonstration Work Group addresses disability and long term services and supports.

The 26-member Payment Models Work Group plays a role in reviewing and recommending payment models for the reformed health care system.²⁶ GMCB also has a 56-member Advisory Committee that offers guidance and recommendations to the GMCB.

Payment reform. Three payment reform initiatives are underway in Vermont. First, beginning in 2012 with RWJF funding, two regional payment reform pilots, described below, have been implemented to engage providers in payment reform and launch Vermont's movement away from FFS reimbursement. While the pilots are still running, they are local rather than statewide initiatives and, therefore, are receiving less attention today in Vermont's push for statewide payment and system reform.

- Vermont Oncology Pilot Project. In northeastern Vermont, oncology and primary care providers are receiving enhanced FFS payments for providing support services and co-managing the physical and psychological symptoms of about 50 patients with cancer and their families. The pilot is expected to improve patient experience and satisfaction, reduce unnecessary services, and reduce oncology expenditures. The GMCB's evaluation of the pilot began in 2015.
- Congestive Health Failure (CHF) Medicare Bundled Payment Initiative. With funding from the Center for Medicare and Medicaid Innovation, the Rutland Regional Medical Center and other health care organizations are receiving bundled payments and providing improved multi-disciplinary care coordination across providers and organizations for about 120 patients with hospital admissions for CHF. Results show CHF readmission rates and all-cause readmission rates were cut in half.²⁷ The Pilot has expanded to include chronic obstructive pulmonary disease (COPD).

Second, beginning in 2013 statewide payment reform was launched through an all-payer ACO shared savings program as a steppingstone toward the ultimate goal of population-based or capitation payments. Vermont's three ACOs are participating in Vermont's commercial, Medicaid and Medicare shared savings programs, which are modeled closely after the CMS Medicare model.²⁸ The Medicare program runs from 2013 to 2015, while the commercial and Medicaid programs began in 2014 and end in 2015. If an ACO meets quality standards for the care of its patient population, that ACO shares in the savings (if any) with the payers.²⁹ For populations under age 65 with commercial coverage, the program

²⁶ ACO payment models and quality measures are addressed in those two work groups, as well as the care models - management group.

²⁷ Source: GMCB Annual Narrative Report Year 2 to the Robert Wood Johnson Foundation, June 2014.

²⁸ Key informants suggested that Vermont may have the first ACOs with shared savings programs in the U.S. to transition from Medicare to all-payer.

²⁹ GMCB has contracted with The Lewin Group to construct an analytic model for distributing shared savings (if any) across multiple ACOs. In brief, a "gate and ladder" approach is planned for awarding savings. For commercial patients, each quality measure is compared to the national benchmark and assigned 1, 2 or 3 points based on whether the ACO is at the national 25th, 50th or 75th percentile for the measure. If the ACO does not achieve at least 55% of the maximum possible points across all measures, the ACO is not eligible for any shared savings ("quality gate"). If the ACO enters the gate, the ACO shares savings according to a quality ladder, for example, earning 75% of potential savings for achieving 55% of possible points, 85% of savings for 65% of possible points,

is limited to health plans in Vermont's exchange because the plans have the same benefit and premium structure. The VCP-ACO is participating in the Medicare and commercial shared savings programs but left the Medicare program in January 2015 due to the demands of participation and lack of savings. Vermont may be the first state in the country to implement statewide shared savings programs for all three types of payers (Medicare, Medicaid, and commercial).

ACO financial risks differ across the shared savings programs. In the Medicaid and Medicare programs, ACOs face no financial risks. In the third year of the commercial program, ACOs face downside risks of 3-5 percent. The goal is to transition to risk-sharing by 2017 and global budget/capitation payment by 2018. While the details of the payment models will be created in the future, the intent is to develop regional and population-based payment arrangements for hospitals and their affiliated physicians, where payment is based on the total population in a hospital's service region.³⁰ Several hospitals have expressed interest in this payment option.

Medicare and Medicaid participation in the all-payer model is being pursued through two parallel strategies. In the first strategy, Vermont's Agency of Administration is requesting a federal waiver from federally-set Medicare and Medicaid payment regulations for hospital services, codified in Section 1115A of the Social Security Act, which grants the Center for Medicare and Medicaid Innovation the authority to test innovative payment and delivery models.³¹ Maryland is the only state in the nation that has the federal waiver, and Vermont stakeholders view Maryland as a potential framework for obtaining a waiver for Vermont.³² In the second strategy, OneCare Vermont has submitted an application to participate in CMS's Next Generation ACO Model, which, if approved, would introduce 15 percent upside and downside financial risk for the ACO's Medicare services.³³

The third payment reform is for primary care through Vermont's Blueprint for Health.³⁴ Launched in 2006, Blueprint pays per patient per month (PMPM) \$2.00 - \$2.50 to primary care practices, depending on their scores for quality of care, a type of pay for performance. Blueprint also pays \$1.50 PMPM to

and 95% of savings for 75% of possible points. For Medicaid patients, the scheme is similar but the percentage-of-points thresholds are lower.

³⁰ Vermont's 14 hospitals have mutually exclusive service regions that cover the state's entire geographic area. The hospital global budgets would be set as part of the GMCB's annual hospital budget-setting process (Source: GMCB RWJF Application).

³¹ GMCB has contracted with Health Management Associates to assist in developing the waiver application to CMS.

³² For a summary of the Maryland All-Payer Model for hospital services, see the following Centers for Medicare and Medicaid Services website: <http://innovation.cms.gov/initiatives/Maryland-All-Payer-Model/>.

³³ If CMS does not approve OneCare Vermont's 2015 application, CMS will call for a second round of applications for the Next Generation ACO Model in 2016, providing another opportunity to apply for the program.

³⁴ Morgan True. Low reimbursements threaten Blueprint for Health despite promising results. October 16, 2014; Wensky SG. Evaluation of the Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration: First Annual Report. North Carolina: RTI International, January 2015; Patient-Centered Primary Care Collaborative. Vermont Blueprint for Health (see website: <https://www.pccpc.org/initiative/Vermont-blueprint-health>).

regional administrative organizations for the multi-disciplinary community health teams. Proposals are being considered by the Legislature to increase the payments to primary care practices to \$4.00 - \$5.00 PMPM and to regional administrative organizations to \$3.00 PMPM, and in 2015, under tight budget constraints, the Legislature allocated \$2.45 million to increase payments to Blueprint providers but not at the requested levels.³⁵ Some evidence indicates that Blueprint reduces health care expenditures.³⁶

The GMCB is engaged in several other payment and financial activities, which may also influence health system performance. The GMCB contracted with the University of Vermont College of Medicine, University of Massachusetts Medical School, and Wakely Consulting Group to examine price variation across hospitals and other providers and is considering transparent, public reporting of hospital and medical prices and quality of care, along with establishing an all-payer rate setting process. In accordance with Act 48, the GMCB is performing hospital (budget) rate reviews and conducting hearings, and will be approving hospital budgets and approving or modifying insurance rates for 2016. The GMCB has contracted with Truven Analytics and Brandeis University to identify factors driving growth in health care spending over time, as well as an analysis of hospital utilization and costs across service regions. A project goal is to improve the tracking of annual utilization and spending rates over time.

In summary, Vermont is moving toward population-based payment with different types of health care organizations likely receiving different types of payment, such as global budgets for hospitals and capitation for primary care. While the Payment Models Workgroup initially considered payment for episodes of care and bundled payments, those models are currently receiving less attention as momentum shifts toward statewide population-based payment models that would likely include some sort of financial risk for health care organizations and their providers.

Delivery system reform. As part of the VHCIP, Vermont is improving its readiness for all-payer, statewide integrated health care system and payment reform by creating a unified (or “standardized”) system of care management and a unified performance reporting and data infrastructure across the state. Health care organizations, providers and payers are playing lead roles in designing and implementing the system transformation.

A unified system of care management is emerging by implementing “unified community health systems” with “unified community collaboratives” (UCCs). Fourteen UCCs are being developed in Vermont’s 14 regional Health Service Areas, each area having its own hospital. A future goal is to align the regional

³⁵ Source: Morgan True. Lawmakers reach late-stage deal to ‘keep the lights on’ for health care reform. VTDigger.org, May 17, 2015.

³⁶ Sources: Bielaszka-DuVernay C. Vermont’s Blueprint for medical homes, community health teams, and better health at lower cost. *Health Affairs* 2011;30(3):383-386; Patient-Centered Primary Care Collaborative. Vermont Blueprint for Health. Available at: <https://www.pccpc.org/initiative/vermont-blueprint-health>.

service areas with the ultimate goal of population-based payment, for example, by paying the hospital, as well as the other health care organizations, in a region through population and performance-based payments.

A key assumption of the UCCs is that in the U.S. health care system, patients with chronic conditions, disabilities and social problems (such as substance abuse) often receive fragmented, uncoordinated, and inefficient services that focus on siloed conditions rather than adopting a patient-centered approach addressing the diverse needs of the whole person, which can reduce quality of care and increase costs. To reduce this problem, each region has formed a local leadership group, or UCC, composed of representatives from the local hospital, ACOs, Blueprint, and other health and social service agencies. Leadership groups meet regularly, with the common goal of increasing collaboration and integration of care across agencies to address patient and local population needs. UCCs are expected to adopt a data-driven process to identify and prioritize local needs and align services with those needs to improve population health. For example, spending dollars on transportation, housing and other social needs may reduce hospitalizations and produce cost savings. Learning collaboratives are being conducted in the regions to develop guidelines for identifying persons with high service needs and how to address them in the regional “medical neighborhoods.”³⁷

Clearly, having the Blueprint in place well before Act 48 is a major advantage and has the potential to reduce costs. In Blueprint’s community health teams, providers from private clinics, FQHCs, behavioral health, home health agencies, aging agencies, housing agencies, and others meet regularly to build linkages across services to address the needs of people with mental health, substance abuse, and other health and social problems. The three ACOs and Blueprint are working to coordinate their activities in all of the state’s regions. Plus, the region’s two large health systems, University of Vermont Medical Center and Dartmouth-Hitchcock Medical Center, have established a partnership and no longer compete aggressively for market share. The two systems have the same electronic medical records system, which may contribute to care coordination.

Vermont also is developing a statewide unified performance reporting and data infrastructure to support the transformation of Vermont’s health care system:

- GMCB oversees Vermont’s all-payer claims database, Vermont Health Care Uniform Reporting and Evaluation System (VHCURES), which covers 90 percent of commercially insured Vermonters and all Medicaid and Medicare enrollees. VHCURES is providing data to support performance reporting and evaluation on health care access, utilization, quality and costs.

³⁷ The Agency for Healthcare Research and Quality (AHRQ) defines the medical neighborhood as the patient-centered medical homes and other providers and community and social service organizations, as well as state and local public health agencies, that meet the needs of patients and focus attention on population health and the overall community needs [See the AHRQ website: <https://pcmh.ahrq.gov/sites/default/files/attachments/Coordinating%20Care%20in%20the%20Medical%20Neighborhood.pdf>].

- VITL also is running the Vermont Health Information Exchange (HIE), which provides statewide, real-time data supporting providers and health care organizations in providing care to patients through the following HIE components:

VITLAccess: a provider portal giving access to patient information in real-time for consenting patients, which serves 1460 users at 74 health care locations, which are pulling an average of 6.4 data elements per query from the database;

VITLDirect: a secure messaging system, which is in the early stages of launch; and

VITLNotify: an automated alert system that notifies providers in real-time when their patients are admitted, discharged, or transferred from an acute care facility, providing information to manage and improve care coordination.

All of Vermont's hospitals and FQHCs as well as 79 primary and specialty care providers and five home health agencies are supplying patient information into VHIE, with the goal of adding mental health and long term care agencies, specialists and other providers in the future.

The organization and governance of Vermont's future statewide, all-payer health care system remains a work-in-progress. One vision of the system is called the "hourglass model." Health care dollars from Medicare, Medicaid, commercial, and other payers would flow into the top of the hourglass. The waist of the hourglass would be the governance of the system, which might be the three, current ACOs or a single ACO, for instance, created by merging the three ACOs into one larger organization. By law, the GMCB would perform its regulatory roles authorized by the Vermont Legislature. The bottom half of the hourglass are the organizations and providers delivering health care and social services in the 14 regions and receiving payments.

The payment model for distributing those dollars to health care organizations and providers is still being developed, but the ultimate goal is to move the system toward population-based payments with health care organizations and providers bearing some financial risk for a meaningful percentage of their annual revenues. For example, each Vermont hospital has a budget for serving its region, which could be transformed into a regional global budget with sub-components for hospital and primary care. How financial risk is shared among the organizations and providers remains under debate.

Tracking measures. Vermont's data infrastructure is being used to support performance reporting, clinical care, and population-based planning at regional and statewide levels. For instance, GMCB has developed a "Dashboard" that profiles Vermont's health care system, which is composed of 51 medical and non-medical indicators. The Quality and Performance Measures Work Group has developed standardized measures of quality, patient experience, cost and utilization, which are approved by the GMCB and are now being used to evaluate the performance of the ACO/Shared Savings Program. In the 14 regions, insurers, Blueprint, ACO leaders and other groups are co-producing customized performance reports for quality, cost, utilization and other measures. As noted earlier, the regional UCCs are using

the data infrastructure to support patient care and, at the population level, identify local needs and align services with those needs.

Logic Model

On one hand, the logic model and priorities for Vermont's statewide payment and integrated health care reforms are relatively simple: on a statewide, population-level, payment for health care must change from volume-based, FFS reimbursement to value- and population-based payment to control costs. If this goal is achieved, Vermont will be more likely to have sufficient public and private financial resources to afford an all-payer health care system, which will improve access to health care and population health.³⁸

On the other hand, Vermont is changing payment as well as many other features of its health system, which may jointly influence health care costs, suggesting the following chain of events:

- First, a mechanism must exist to initiate system-wide transformation. In Vermont the mechanism is the leadership of state government and its legal authority over the state's health care system through Act 48.
- Second, infrastructure must be created to design and implement the transformation, such as creating new institutions (GMCB), health information systems, and ACOs, all having a statewide, population-level perspective.
- Third, transformation must be orchestrated to build collaboration, trust and social capital among health professionals, businesses, and other stakeholders and citizens to engage in statewide transformation for the public good.
- Fourth, interest groups collaborate productively to design, test and implement new payment models with performance targets to preserve quality of care.
- Fifth, the new payment models, in turn, create new incentives that lead to changes in delivery systems that better manage health through the integration of care across agencies to address diverse needs in populations, rather than to increase revenue, and thereby lower costs.
- Sixth, a statewide data infrastructure supports system transformation at all levels -- statewide, regional, local, and in clinical care, where sharing information becomes the vehicle for coordination of care.
- Finally, the new health system increases access, maintains quality, has affordable costs, and is endorsed by Vermonters, ultimately improving population health and reducing health disparities.

Unintended consequences are possible in the logic model, given the scope and complexity of system transformation, particularly if the new payment incentives are not aligned well with the delivery system

³⁸ Improvements in population health, in turn, may lead in the long-run to lower care costs.

reforms, and the incentives are not powerful enough to change the behaviors of organizations and their providers.

Progress and Results

Backed with RWJF and CMS/SIM funding, the GMCB and diverse state agencies, work groups and advisory and steering committees, payers, providers, associations, ACOs, and other stakeholders are collaborating extensively and are making steady progress in re-designing the payment models and delivery system reforms and building the data infrastructure for Vermont's future all-payer health system. Over time, Vermont is improving its readiness and 'institutional competence' for health system transformation.

In the first year (2013) of the Medicare Shared Savings Program, OneCare Vermont's costs declined but by an insufficient amount to meet Medicare's target, and therefore, no shared savings were awarded to the ACO. Shared savings for 2014 (if any) will be announced in late August 2015.³⁹ The Accountable Care Coalition of the Green Mountains did not generate any savings and dropped out of the Medicare Shared Savings Program. The CHF bundled payment pilot had favorable health outcomes and the pilot was expanded to include COPD. In addition, by participating in the pilot, local providers and health care organizations learned first-hand that patients benefit when they work together to coordinate care for a chronic condition.

Future progress toward the goal of population-based payment will be contingent on securing a Section 1115A waiver for Medicare and Medicaid. A future award from Medicare's Next Generation ACO Program would also likely accelerate OneCare Vermont's move toward a payment model with financial risk sharing with health care organizations and providers, at least for Medicare enrollees. The goal of integrating health and social services to meet local population needs will depend on continued development of Vermont's statewide health information systems. On all these fronts, future progress will depend on identifying a governance model that is acceptable to stakeholders.

With implementation still underway, the impacts of the statewide system transformation on utilization, cost, quality, patient experience, health and other outcomes are unknown. However, some evidence indicates Vermont's health care costs are declining. In 2014 net patient revenues in Vermont's hospitals increased 2.7 percent, which was much lower than the 5.1 to 9.2 percent annual increases in 2002 to 2013.⁴⁰ This pattern likely reflects GMCB enforcement of target growth rates for hospitals in 2013 and

³⁹ A medical home – shared savings pilot program in Pennsylvania, which resembles Vermont's Blueprint-shared savings reforms, reported savings, better quality, increased primary care utilization, and lower use of emergency department, hospital and specialty care (Friedberg et al. Effects of a medical home and shared savings intervention on quality and utilization of care. *JAMA Intern Med* 2015;175(8):1362-1368).

⁴⁰ Green Mountain Care Board. 2015 Annual Report to the Vermont General Assembly.

2014. However, recent evidence indicates that U.S. health care spending is growing faster in 2015 than 2014,⁴¹ which is raising concerns among Vermont stakeholders that Vermont's health care costs also may increase at higher rates in future years.

Facilitators and Barriers

Facilitators and barriers are presented in no particular order.

Facilitators

- Act 48 and a history of state government regulation in Vermont that aligns with the federal ACA.
- With passage of Act 48, belief that state government is serious and system reform is inevitable; belief that Vermont cannot go back to FFS payment and unsustainable cost growth.
- Federal regulations and programs that are aligned with Vermont's payment reform goals.
- Funding for health care system transformation from multiple sources in a resource-scarce state
- Small geographic, rural state with little market competition that promotes communication and allows everyone to "be at the table."⁴²
- Vermont's humanitarian culture and collaboration among interest group members, particularly those who have worked together on health care issues for many years and have a collective knowledge of Vermont's history of health care, and their dedication to participate in reform with common intentions and direct it for the public good.
- Consistent and committed leadership from diverse sectors, including the Governor and heads of state agencies, the GMCB and its Advisory Committee, leaders of health care and other organizations, along with their committed staff working on health care reform.⁴³
- Less market competition and more collaboration following the recent partnership between the region's two large health systems, University of Vermont Medical Center and Dartmouth-Hitchcock Medical Center.
- GMCB as a convener and facilitator of stakeholders to participate in payment and system reform without antitrust threats and build trust.
- Guidance from consultants on payment reform and system transformation.
- History of infrastructure development through Blueprint and health information technology.
- Vermont media that continually cover payment and system reform as a top issue, creating an informed citizenry and public momentum toward reform.
- The RWJF grant provided support for the pilots and, significantly, for writing the SIM grant.

Barriers

- The inertia of large systems and the huge investments required to move them.

⁴¹ Altman D. New evidence health spending is growing faster again. Wall Street Journal, June 11, 2015.

⁴² Another aspect of this, as one key informant noted, is that if you're not at the table, you may be on the menu.

⁴³ Leadership from state agencies was facilitated by the federal SIM grant.

- Fatigue from the pace and scope of reform; a big time commitment.
- Collaboration barriers, including instances of lack of trust, holding entrenched positions on policy issues, and reluctance to share control and money.
- Engaging large numbers in system reform slows decision making; timelines may be unrealistic.
- Length of time and resources necessary to apply for and obtain federal waivers to Medicaid and Medicare regulations
- Challenges in aggregating and accessing data of all types for a statewide information system to support clinical care in real time and to plan and manage the state's all-payer system; an antiquated Medicaid information system hinders planning reforms.
- Uncertainty throughout the reform process, including but not limited to:
 - Whether federal waivers will be granted for Medicare and Medicaid.
 - Not knowing what the final, at-scale (statewide) payment model will be slows decisions on aligning the delivery system and other matters.
 - How the all-payer system will be organized and governed, and how revenue will be distributed to health care and other organizations.
 - Whether Vermont health organizations with the most resources will support the future payment and system reforms.
 - Fear of uncertainty, particularly the loss of resources and control, especially among smaller health care organizations and providers, such as FQHCs and independent providers.
- Challenges in keeping stakeholders engaged, focused and up-to-date on system reform to achieve a common vision, partly because stakeholder priorities change.
- Lingering confusion about the ultimate goal of health system reform that arose from the Governor's previous vision of health care reform (a single payer system) versus the Act 48 vision of health care reform (an all-payer system),
- Public backlash and low trust in government-sponsored health care reform arising from persistent problems with Vermont's health insurance exchange and the abandonment of a single payer system.
- Health care organizations and providers have little experience bearing financial risk and viewing a service as an expense (in population-based payment) rather than revenue (in patient-based FFS payment).
- Challenges of building a new statewide system and unified care collaboratives to integrate care in service regions when health care itself lacks 'systemness.'
- The cultural challenge in clinical care of moving from traditional medicine toward team medicine that is part of managing individual and population health.

Evaluation and Sustainability

Evaluation. Act 48 mandates evaluation of Vermont's health system reforms, if the system is implemented. The GMCB generally has oversight of state-sponsored evaluations and has an evaluation director to address Act 48 requirements. Evaluations of Vermont's health system reforms are listed below, and none of the evaluations have final results about the implementation and impacts of the system reforms.

- The Research Triangle Institute (RTI) is the federal government's external evaluator for the SIM grant, which has payment reforms that overlap closely with the RWJF grant.
- The GMCB has contracted with Impaq International and its subcontractor, Brandeis University, for its own internal evaluation of the SIM grant.
- The GMCB is planning evaluations of the payment pilots, which also will be conducted by Impaq International.

It may be impossible to estimate the independent effects of payment reform on outcomes, given that payment is just one of several system-wide reforms that can change utilization, costs, quality, patient experience and other outcomes.

Sustainability. Implementation of an all-payer health system in Vermont, ultimately with some form of population-based payments or capitation, beyond 2016 will depend greatly on obtaining a federal waiver of payment regulations for Medicare and Medicaid, obtaining a CMS award for the Next Generation ACO Model, or both.

Lessons Learned

The Green Mountain Care Board's payment reform project, The Development of Models for Comprehensive Payment Reform in Vermont, is implementing an all-payer, statewide health system in Vermont, ultimately with some form of population-based payments. The project is presently designing and implementing the payment and service delivery reforms, which may extend beyond 2016. Project implementation offers several preliminary insights about statewide payment and health system reform.

First, statewide payment reform is hard to implement but may be easier when leadership champions a common vision of the future payment and delivery system. In Vermont, leaders and other stakeholders championed two competing visions, which distracted attention from achieving either one. Regardless of the vision, leadership in all sectors of the health system is needed to build commitment and sustain momentum toward payment and delivery system reform. Without a "how-to" manual to guide implementation, system transformation evolves organically rather than linearly toward reform goals. System transformation may be smoother when health care organizations, providers and payers have lead roles in designing and implementing the transformation.

Second, statewide transformation of the health care system from FFS to population-based payment is more likely when most stakeholders agree that FFS payment is unsustainable. Consensus among Vermont's stakeholders exists because Vermont has a relatively small population and limited tax revenues, which cannot afford health care costs that grow at a faster rate than the gross state product. Health care organizations may favor transformation because statewide population-based payment reforms will affect the health care of almost all Vermonters, creating incentives to reduce volume and, therefore, revenue, making the current FFS-based system less viable. In contrast, future statewide population-based payments for most Vermonters may generate revenue streams that are more predictable and dependable over time and, therefore, reduce financial uncertainty and promote sustainability.

Third, federal policies are both facilitators and barriers to statewide payment and delivery system reforms. Federal policies for Medicare or Medicaid that move away from FFS to value-based payment suggest that payment reform is inevitable, creating local and statewide incentives and momentum to align Vermont's reforms with those policies. For instance, CMS's Next Generation ACO Model may accelerate payment reform if CMS approves OneCare Vermont's application in 2015. Federal waivers of spending regulations for Medicare and Medicaid are another mechanism for implementing Vermont's all-payer model. However, the federal regulations and the burdensome process for obtaining the waivers generally inhibit innovation and increase the workload and time for accomplishing Vermont's payment objectives.

A critical lesson learned is that system readiness is prerequisite to successful implementation of payment and health system reforms. Several ingredients are essential for creating system readiness. First, increasing the readiness for statewide system transformation requires significant monetary resources. Funding from the CMS/SIM grant and the Robert Wood Johnson Foundation provided essential resources to finance the preparations for statewide system transformation.

Second, time is required for stakeholders to build collaboration, trust and courage. System transformation is disruptive change that can generate uncertainty, distrust and fear among stakeholders. Time and collaboration may build trust and courage to overcome the fear and build commitment to the vision and the process for achieving it. However, time is a scarce resource and becomes a burden for stakeholders when the on-going demand for collaboration exceeds the supply of time and crowds out time for their employment responsibilities and other commitments.

Third, data are essential. A statewide data infrastructure is required for planning the new system and for coordinating care to address patient and population needs across diverse health care and social service organizations.

Fourth, a clinical infrastructure also is essential. Vermont's Health Service Areas and hospitals, Blueprint, and the partnership (rather than competition) between the two largest health care organizations are a platform for system transformation. In the clinical and data infrastructures, health care and service organizations must collaborate and create new ways of delivering services to address local needs within a global budget or capitation payments. Local learning collaboratives are one way of doing so and building institutional competence and readiness for system transformation.⁴⁴

Vermont's experience suggests that if the steps for increasing readiness are skipped, payment and delivery reforms may be unsuccessful or have unintended, harmful consequences. Vermont's experience indicates that increasing statewide readiness is slow, incremental and exhausting. This pattern suggests the greater the number and diversity of stakeholders in system reform, the slower the pace of progress and decision making.

In closing, payment and health system reform is an on-going and perhaps never-ending process, and more lessons will likely emerge as implementation continues. If Vermont is successful in implementing the new health system, a basic question is: "Will it work?" That is, will the new system work as intended? Will patients and providers want the new system? Or will patients take their health care and revenue to New Hampshire or New York? Or will the system work so well that people travel or move to Vermont for their health care? Will providers participate in the new system? Answers to these questions are unknown but are of the utmost importance for health policy in Vermont and the United States.

⁴⁴ The federal Department of Health and Human Services has formed a Health Care Payment Learning and Action Network to facilitate implementation of alternative payment models and value-based purchasing (see website: <http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-03-25.html>).