Robert Wood Johnson Foundation Payment Reform Evaluation Project
Development of Models for Comprehensive Payment Reform in Vermont
Green Mountain Care Board

Executive Summary: August 2015 Report

Introduction and Context

Over the last decade Vermont's health care system has faced economic and access problems in a state with a small population, a strong humanitarian and collaborative culture, and health markets with little competition. In 2011 Act 48 created the state's health insurance exchange (Vermont Health Connect); expanded Green Mountain Care (GMC), the health insurance program sponsored by the state, funded mostly by Medicaid; and established the Green Mountain Care Board (GMCB), an independent, five-member board with broad regulatory authority over Vermont's health care system and authorized by law to implement a wide range of statewide payment reforms. Act 48 also authorized the development of universal health insurance that would cover most Vermonters, if several conditions were met. Although Act 48 specified few details about what the universal plan would look like, a single-payer insurance plan had much support.

Three years later the Vermont Health Connect is still not fully functional. This, along with the abandonment of the single-payer system on December 17, 2014, because Vermont could not afford its costs, has undermined public faith in the state's ability to implement major changes in the health care system. Attention has shifted to designing and implementing an all-payer statewide integrated health care system.

The GMCB was awarded a grant by the Robert Wood Johnson Foundation (RWJF) in 2012 to design and implement its payment reform strategies, and the state was awarded a State Innovation Model (SIM) grant from the Centers for Medicare and Medicaid Services, which is supporting the state's value-based payment models and statewide system transformation.

Project Objective

The project's long-term objective is to have an all-payer statewide integrated health care delivery system supporting population-based payments for Vermont health care providers. This project intends to bridge the gap between the current system 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 fee for service (FFS) payments toward value-based payments that control costs and improve the quality of care and population health.

Approach

The RWJF and SIM projects have developed a collaborative organizational structure that has engaged hundreds of health professionals and state residents in several work groups to advance health system reform.

Payment reform. Two regional payment reform pilots were launched in 2012. Statewide payment reform was launched in 2013 through an all-payer accountable care organization (ACO) shared savings program. The Vermont Blueprint for Health continues to provide quality of care-based per-member-per-month payments to primary care providers. The GMCB is engaged in other activities: examining price variation

across hospitals and other providers; performing hospital budget reviews; reviewing and approving health insurance rates and examining health care spending and hospital utilization and costs.
Delivery system reform. Vermont is moving toward statewide integrated health care system by creating a unified system of care management across the state and a unified performance reporting and data infrastructure.
Tracking measures. Vermont's data infrastructure is being used at regional and statewide levels: GMCB has developed a dashboard that profiles the state's health care system; standardized measures are being used to evaluate the performance of the ACO shared savings program; and various parties are producing customized performance reports.

Project Progress
The GMCB and diverse state agencies, interest groups and citizens are engaged extensively and are making steady progress in contributing to the design of various payment reform models and delivery system reforms and are building the data infrastructure for the state's future all-payer system. Results of the Medicare Shared Savings Program during its first year have been mixed. Shared savings, if any, for the Medicaid and commercial shared savings programs in 2014 will be announced in August 2015.

Facilitators and Barriers
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.
- Federal regulations and programs that are aligned with the state'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 participation and allows everyone to "be at the table."
- Vermont's humanitarian culture and collaboration among interest group members.
- Less market competition and more collaboration following recent partnerships between the region's two large health systems.
- Consistent and committed leadership from diverse sectors.
- GMCB as a convener and facilitator of stakeholders.
- 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.
- The RWJF grant provided key support for payment reform and for writing the SIM grant.

Barriers.

- The inertia of large systems; fatigue from the pace and scope of reform.
- Collaboration barriers, including instances of lack of trust.
- Engaging large numbers in system reform slows decision making; timelines may be unrealistic.
- Uncertainty: about federal waivers; final payment model; how the all-payer system will be organized and governed; whether Vermont health organizations with the most resources will support the future reforms; and fear of uncertainty itself.

- Length of time and resources necessary to apply for and obtain Medicare and Medicaid waivers.
- Challenges in keeping stakeholders engaged, focused, and up-to-date on system reform.
- Lingering confusion about the ultimate goal of health system reform that arises from the Governor's vision of a single payer system versus the Act 48 vision of an all-payer system.
- Public backlash and diminished trust in government-sponsored reform, arising from problems with the 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 FFS).
- The challenge in clinical care of moving from traditional medicine toward team medicine.
- Challenges of building a new system when health care itself lacks 'systemness' and remains largely fragmented by specialty and profession.

Evaluation and Sustainability

Evaluation. Act 48 mandates evaluation of Vermont's reforms if implemented. The Research Triangle Institute and GMCB are evaluating independently the SIM grant. Evaluations of the payment pilots are ongoing.

Sustainability. Implementation of a unified health system in Vermont beyond 2016 will depend partly on obtaining federal waivers of spending regulations for Medicaid and Medicare, obtaining a CMS award for the Next Generation ACO Model, or both.

Lessons Learned

Regardless of the vision for payment reform, leadership in all sectors of the health system is needed to build commitment and sustain momentum toward reform. Statewide payment reform may be easier when leadership champions a common goal. Vermont's competing visions distracted attention and slowed progress, and they have been replaced with proposals for an all-payer statewide integrated health care system.

Statewide transformation from fee for service to population-based payment is more likely when most of the stakeholders agree that FFS is unsustainable. System transformation may be smoother when health care organizations, providers and payers have lead roles in designing and implementing system reforms.

Federal policies and regulations are both facilitators of and barriers to statewide reforms. Some federal policies are creating incentives and momentum for reform; however, some regulations and processes inhibit innovation.

System readiness is necessary for successful implementation of statewide reforms. Those ingredients include the following: significant monetary resources; time to build collaboration, trust, and courage; data and supporting statewide infrastructure; and clinical infrastructure. If those steps are skipped, reforms may be unsuccessful or have unintended, harmful consequences. Increasing readiness statewide is slow, incremental, and exhausting.