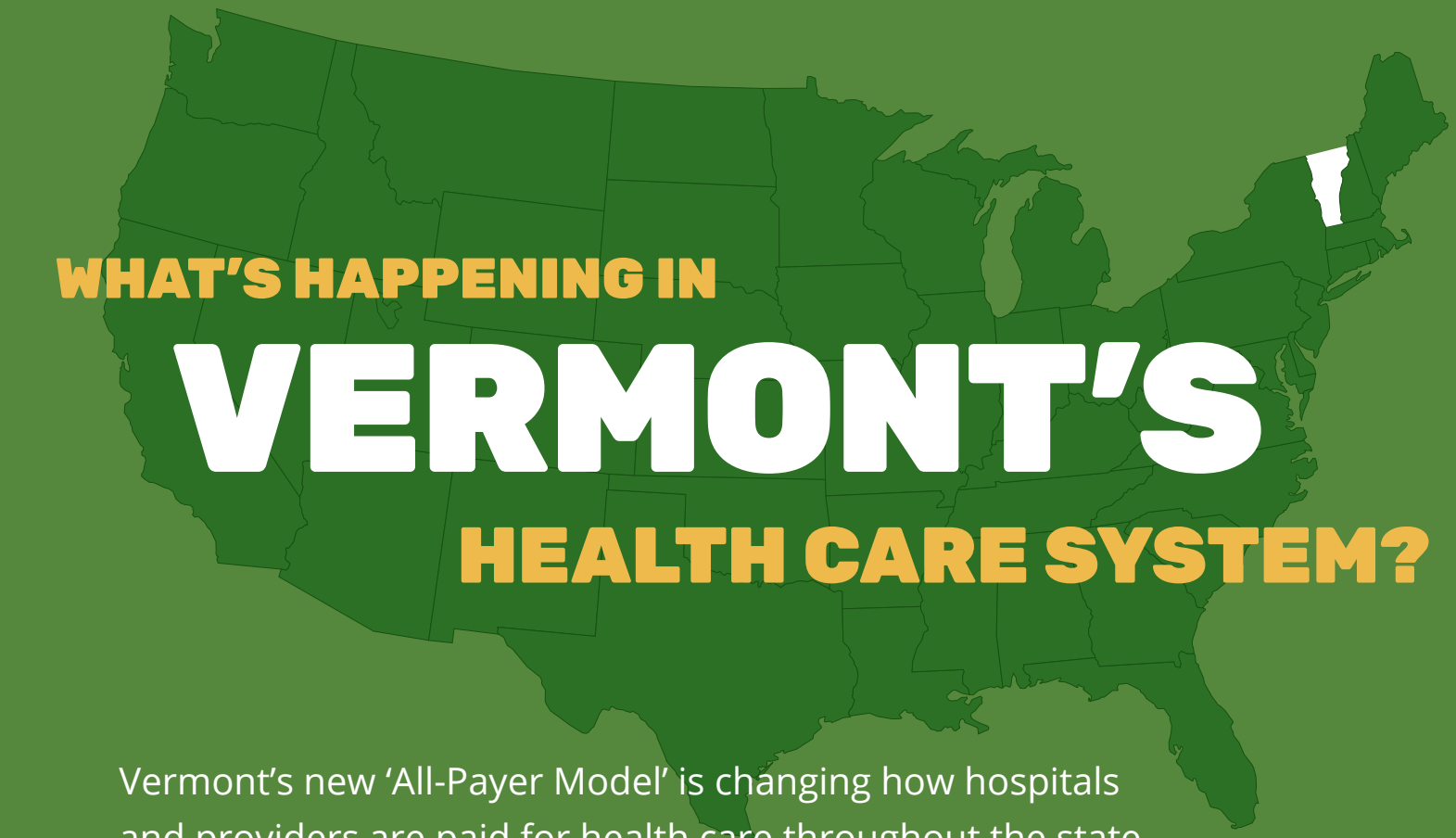

WHAT'S HAPPENING IN VERMONT'S HEALTH CARE SYSTEM?

Vermont's new 'All-Payer Model' is changing how hospitals and providers are paid for health care throughout the state

UNITED STATES:

Hospitals and providers are paid for services rather than quality of care and patient health

- It costs money for hospitals and doctors to treat patients
- To cover their costs, hospitals and doctors charge patients for each service
- Patients pay for services with cash or their health insurance
- Hospitals and doctors can go broke if payments are less than their costs
- This creates powerful incentives to provide a lot of services to stay in business, which increases the cost of health care – quality of care and patient health get lost in the shuffle
- Medicare, Medicaid and health insurance companies pay for each service in different ways, creating confusion for providers and patients alike

VERMONT:

Starting in 2018 payment will be tied to quality of care and patient health rather than services

- Hospitals and doctors will be paid a monthly amount for each patient, whether a patient visits the doctor or not
- Hospitals and doctors can earn more money if quality of care exceeds benchmarks, and can lose money if quality of care is below benchmarks. The payments are based on the "Next Generation" payment model from the Centers for Medicare & Medicaid Services
- This creates powerful incentives to provide the best quality of care, keep patients healthy, and lower costs
- Medicare, Medicaid and health insurance companies follow the same rules for making monthly payments, which is simpler for everyone

continued »

VERMONT'S ALL-PAYER MODEL

Payment will change statewide for all payers

- The new payments work best when hospitals and doctors statewide get monthly payments for most of their patients – improving quality of care and patient health become Job No. 1
- This means all payers in Vermont – Medicare, Medicaid, health insurance companies and self-insured employers – work together with providers and their patients
- All payers send their monthly payments to a new statewide accountable care organization, or 'ACO'
- The ACO distributes those payments to hospitals, doctors and other providers for their patients covered by each health plan
- Health insurance, hospital, and provider participation in the ACO is voluntary
- The ACO is regulated by a state agency, the Green Mountain Care Board

Why is payment changing?

- Many Vermonters cannot afford health care due to high cost; widespread belief that payment reform is inevitable
- Small geographic, rural state with little market competition that promotes communication and allows everyone to "be at the table"
- Vermont's humanitarian culture and long history of collaboration among stakeholders
- Hospitals employ a majority of Vermont's primary care physicians

The All-Payer Model is linked with a statewide integrated delivery system

- Payment reform is built on a primary care foundation, Blueprint for Health, the statewide, multi-payer program that meets National Committee on Quality Assurance (NCQA) medical home standards, providing primary care to three-fourths of Vermonters
- Statewide information systems are in place or in development
  - *All-payer claims data base for Medicare, Medicaid and 90% of commercial insurance*
  - *Vermont Health Information Exchange, a statewide clinical information system under construction and containing mostly hospital and primary care electronic medical records, providing real-time data to support clinical care*
- Regional collaboratives coordinate medical and social services to address the needs of the whole person

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FOR MORE INFORMATION,

visit the website for the Center for Medicare & Medicaid Services (CMS):

https://innovation.cms.gov/initiatives/vermont-all-payer-aco-model/

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