



Aligning Incentives in Medicaid

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For more information about this study, please contact:

Sharon Silow-Carroll, M.B.A., M.S.W.
Health Management Associates
ssilowcarroll@healthmanagement.com

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Medicaid Is One of Multiple Payers in Vermont's Health Care Reforms

SHARON SILOW-CARROLL
HEALTH MANAGEMENT ASSOCIATES

Abstract: Vermont Medicaid is a key player as the state pioneers multipayer health care delivery and payment reforms. Under Vermont Blueprint for Health, most Medicaid beneficiaries and state residents will be served in 2013 by medical homes with community health teams, with additional support services for Medicaid enrollees with complex conditions. Payment pilots are testing accountable care organization, bundled payment, and global budget models intended to align incentives and move toward a “unified health care budget” among multiple purchasers. This case study is one of *three in a series* on innovations being undertaken by states to improve quality and efficiency in their Medicaid programs.



OVERVIEW

Vermont has been a leader in health care reform for decades. Under its current efforts to improve health care quality and control costs, the state is rapidly expanding its multipayer Blueprint for Health. The Blueprint is a payment and delivery system reform initiative that blends medical homes with community health teams that offer multidisciplinary care coordination and support services. The majority of Medicaid beneficiaries, along with nearly all state residents, will be served by these medical homes in 2013, and supplemental care management will assist Medicaid enrollees with complex conditions. Medicare also provides team-based, on-site services for vulnerable beneficiaries. With support from a State Innovation Models Initiative grant, payment pilots will test bundled-payment, ACO/population-based, and global-budget models intended to align incentives to achieve high-quality, cost-effective care and move toward a “unified health care budget.” This review of Vermont’s strategies and lessons from its experiences can help federal and state policymakers and administrators shape policies to support state innovation in comprehensive health care system reform.

Drivers of Reform

Key drivers of comprehensive reform in Vermont are:

- a history and culture of reform;
- champions for reform in state government, the legislature, and the health care industry;
- shared goals among the governor and stakeholders to improve access to care and health care quality while reducing cost growth, especially under a (self-imposed) Medicaid global cap and other economic constraints;
- a realization among stakeholders that the health system needs to align incentives across all payers to effect behavior change among providers;
- a shared goal among stakeholders to keep hospitals viable while reducing rather than increasing the volume of inpatient services;
- legislation that requires the state to move away from fee-for-service payments toward performance-based incentives;
- a history of significant regulatory intervention, insurance reform, and hospital budget review, combined with the recent creation of a regulatory board with the power to set hospital budgets, review and approve small-group insurance rates, and constrain the overall rate of growth in health care costs; and
- collaboration facilitated by a small number of key stakeholders with frequent interaction, and the nonprofit status of most health care payers and providers. This dynamic of collaboration may be replicated on a community level in larger states or regions.

Lessons: Lessons from Vermont’s experience in developing and implementing delivery system and payment reforms include the following:

- Medicaid and other state departments can use intergovernmental agreements to delegate responsibilities, leverage expertise, and pool resources to improve community health.
- To reduce cost-shifting and strengthen incentives for change, Medicaid and statewide reform should be fully integrated.
- States should identify, convene, and educate stakeholder groups that share the goal of improving health care. In some cases, however, state leadership must impose requirements when a “soft sell” is not effective. Government leadership is necessary to promote the reform agenda and cut through the complexity and vested interests that surround health care reform.
- Each community requires customized approaches to reform. Even within a community, different populations and circumstances may warrant different payment models.
- Delivery reforms should begin with provider groups that are most prepared to implement changes.
- States must weigh the need for immediate savings against the need to let reforms play out over the long term. This poses challenges for private companies as well as state and federal governments that want rapid results in terms of quality improvements and savings.
- Despite the small size and progressive politics that make Vermont unique, its path to health care reform may be replicable in urban settings and scalable in larger states if there is political will and a community-based approach that matches the local culture.

Opportunities for Federal Action to Support State Efforts

Interviewees in Vermont acknowledged they have received tremendous support from the Centers for Medicare and Medicaid Services (CMS) and noted many ways in which the federal–state partnership is working well. Based on the challenges faced, however, we believe CMS can further support states pursuing health care payment and delivery reform in several ways:

- *Flexibility:* While CMS should provide direction and insist on savings, the agency also should give states latitude to try different reform approaches, building on State Innovation Models Initiative grants and other recent federal initiatives. State experimentation can be complicated and slow, particularly during the start-up phase. CMS should strike a balance between federal requirements and flexibility.
- *Medicare Participation:* Medicare should participate in multipayer programs and system redesign so that all payers are aligned and able to create meaningful incentives to change provider behavior.
- *Better Data Access:* Access to Medicare data is essential for state reform planning to assess health outcomes, utilization, and costs. “Clean” (validated, complete) Medicare data should be readily available to states, payers, and providers.
- *Grant Simplification:* Federal grant applications could be simplified; current expenses related to application prevent many innovative ideas from being funded.
- *Technical Assistance:* Few providers have experienced clinical process change. CMS could provide and offer support for technical assistance for information exchange and practice transformation.

The other case studies in the *Aligning Incentives in Medicaid* series look at Colorado’s Accountable Care Collaborative Program and Minnesota’s introduction of accountable care organizations, which will enter into shared savings and risk agreements with Medicaid.

INTRODUCTION

Vermont is implementing a multipayer, community-based Blueprint for Health payment and delivery system reform initiative and developing and testing new payment mechanisms. Its reforms include but go beyond Medicaid, moving toward a systemwide alignment of incentives and strategies to achieve high-quality care and contain the growth in health care costs.

Though Vermont is a small, rural state with a history of health reform activity, its experiences may be relevant and its models replicable in larger states with rural areas and in regions with concentrated providers and payers. Some of the state's leaders who have worked in low-income, urban settings believe Vermont's strategies also could work in large urban environments, providing there is sufficient political will and leadership.

DRIVERS OF HEALTH REFORM IN VERMONT

Vermont has a long history of health system reform, starting in the 1980s when legislation and programs sought to reduce the number of uninsured residents. A number of reforms followed, including a 2005 “global commitment to health” waiver that placed its Medicaid program under a spending cap but offered greater flexibility to establish benefits and coverage levels. Under the cap, the legislature sets a global Medicaid budget and approves reimbursement rate changes for hospitals and physicians. In 2007, the legislature codified a Blueprint for Health, which initially sought to coordinate care for patients with chronic conditions in an effort to improve their health and reduce avoidable utilization. Since then, the Blueprint has evolved to support medical homes and community-based health teams. The Vermont Act 48 of 2011 called for pilots of new payment models on a road toward a unified budget and potentially a single-payer system.

The state's current and former governors have been champions for health reform, as are leaders from the public and private sectors. The CEO of a critical access hospital, for example, champions medical homes—even though this delivery model aims to

reduce the number of hospitalizations—for personal and ethical reasons: “it needs to get done, and done correctly,” he says.¹ The state's Medicaid director is described by others as a “true believer” in comprehensive reform. Vermont's commitment to a Medicaid global budget cap keeps constant pressure on stakeholders to control spending.

The movement of key leaders between the public and private sector (for example, the current director of payment reform for the state used to be a hospital CEO) appears to have facilitated rather than thwarted reform efforts. While representing different constituencies, the leaders share a goal of improving the state's health care system. The small size of the state means that stakeholders know each other personally and communicate often, thus facilitating collaboration and negotiation.

Legislation passed in 2011 requires the state to pilot payment reforms that move away from volume-based incentives (i.e., fee-for-service contracts) toward performance-based incentives, and eventually toward a single-payer system. It seeks to contain costs while not threatening hospitals' viability. Designers of Vermont's payment reforms are seeking to create opportunities to maintain providers' margins by expanding high-quality, appropriate care rather than increasing volume.

VERMONT BLUEPRINT FOR HEALTH: MULTIPAYER DELIVERY REFORM

Launched by the governor in 2003 and codified into law in 2006, the Vermont Blueprint for Health is a multipayer initiative designed to make it easier for primary care practitioners to provide better-quality care and coordinated services to their patients by supporting them with multidisciplinary community health teams (Exhibits 1 and 2). The state's three major commercial insurers are required to participate, and Medicaid, Medicare, and two large self-insured employers (IBM and the state) have agreed to participate as well. As of September 30, 2012, 64 percent of the state's residents and 29 percent of Medicaid enrollees were in “Advanced Primary Care Medical Practices.” All willing providers are expected to

Exhibit 1. Vermont’s Payment and Delivery System Reforms		
State Population (2010–11)	620,000	
Medicaid Enrollment (#, % of pop.), June 2011	139,900, 23%	
Medicaid Members in Managed Care Organizations (#, % of Medicaid), July 2010	0, 0%	
Payment/Delivery System Reform	Blueprint for Health	Payment Reform Pilots and Unified Health Care Budget
Payers Participating	Medicaid, Medicare, the three major commercial insurers, and two large self-insured employers	Planned: Medicaid, Medicare, and commercial payers
Key Components	Advanced Primary Care Medical Practices offer patient-centered medical homes; paid fee-for-service plus per member per month payments tied to the National Committee for Quality Assurance’s medical home scores. Multidisciplinary Community Health Teams cover specific regions, supported by all payers; provide care coordination services, population health, and address local gaps in care. “Extenders” offer additional care management for Medicaid & Medicare members with complex needs.	State payment reform board working with hospitals and payers to pilot bundled payments, physician-hospital global budget, and population-based model with shared savings. State is exploring ways to use a “Unified Health Care Budget” to constrain total costs with accountable care organizations (ACOs)/payment pilots, and other strategies.
#/% Medicaid and General Population Participating	65,249 Medicaid enrollees, 29% of Medicaid population, and 64% of all state residents in APCM practices (as of 9/30/12)	OneCare Vermont ACO began January 2013 for Medicare members; plan to include Medicaid and commercial payers in 2014–15 Multipayer payment pilots in development
Medicaid Participation Goal	Nearly 100% in October 2013	Long-term goal to move to unified health care budget for all Vermonters
Sources for state population, Medicaid enrollment: Kaiser State Health Facts, accessed September 2012; Vermont Medicaid MCO enrollment and descriptions based on interviews with state leaders.		

participate by October 2013, covering the vast majority of state residents, including Medicaid beneficiaries.

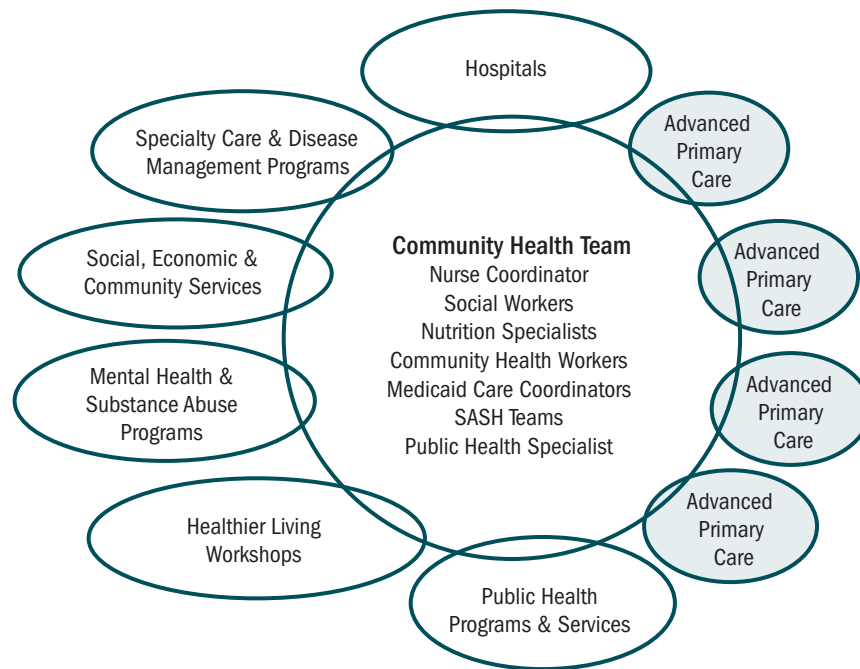
The Blueprint is housed in the Department of Vermont Health Access (DVHA), which is responsible for the management of Vermont’s publicly subsidized health insurance programs, including the operation of managed care. DVHA is the largest insurer in the state. Like managed care organizations in other states, it reports quality measures annually to an external quality reporting organization that oversees compliance with federal quality standards. DVHA recently joined the state’s multipayer database, thus enabling performance comparisons across plans.

The key components of the Blueprint model are:

Advanced primary care medical practices: primary care practices that agree to provide patient-centered medical homes and are reimbursed through fee-for-service payments plus a per member per month fee based on the practice’s National Committee for Quality Assurance (NCQA) medical home scores.

Community health teams: multidisciplinary teams covering a specific region and financially supported by all participating payers at the rate of \$350,000 per year per 20,000 people in the general population served by recognized practices. The teams may include a care integration coordinator, behavioral health specialist, public health specialist, community health worker, hospital care manager, educator, and/or community-based advocate. The team members seek

Exhibit 2. Community Health Team Framework



Notes: SASH is Vermont's Support and Services at Home, funded through CMMI's Multi-Payer Advanced Primary Care Practice demonstration. There are four advanced primary care ovals because in each community there is a Community Health Team that supports multiple Advanced Primary Care practices.
Source: Lisa Dulsky Watkins, Blueprint for Health associate director, presentation, March 2012.

to link patients with other providers and services and offer care coordination, case management, advice on self-management, counseling, referrals, assistance after hospital discharge, and population management, among other services.

Community health team extenders: additional care management support for beneficiaries of either Medicaid or Medicare who have particularly complex needs through:

- **Risk stratification and Medicaid care coordinators.** Under the Vermont Chronic Care Initiative (VCCI), Medicaid employs 30 registered nurses, licensed clinical social workers, or medical social workers to provide care coordination for 5 percent of Medicaid beneficiaries who are the highest-risk (e.g., those with high emergency department use, avoidable admissions and readmissions, and multiple specialists) and highest-cost. Cases are identified through a risk-stratification process and from practitioner referrals. Those selected generally

have at least three chronic conditions, often have no medical home, and may have a variety of non-medical needs that affect their health and for which additional support services are needed (e.g., homelessness or inadequate housing, insufficient food availability). The Medicaid care coordinators are placed throughout the state in field district offices and at medical sites where there is high density of Medicaid beneficiaries, such as certain primary care offices, federally qualified health centers, hospital emergency departments, and other health care facilities. Coordinators are fully integrated with existing Blueprint Community Health Teams, while also providing services to Medicaid beneficiaries in medical practices that are not yet participating in the Blueprint. Coordinators make in-person visits with high-risk patients, assist them with both medical and nonmedical needs (e.g., for health coaching, nursing supports, help with housing and nutrition), and focus on population management. Coordinators also refer beneficiaries to services provided by other state departments, such

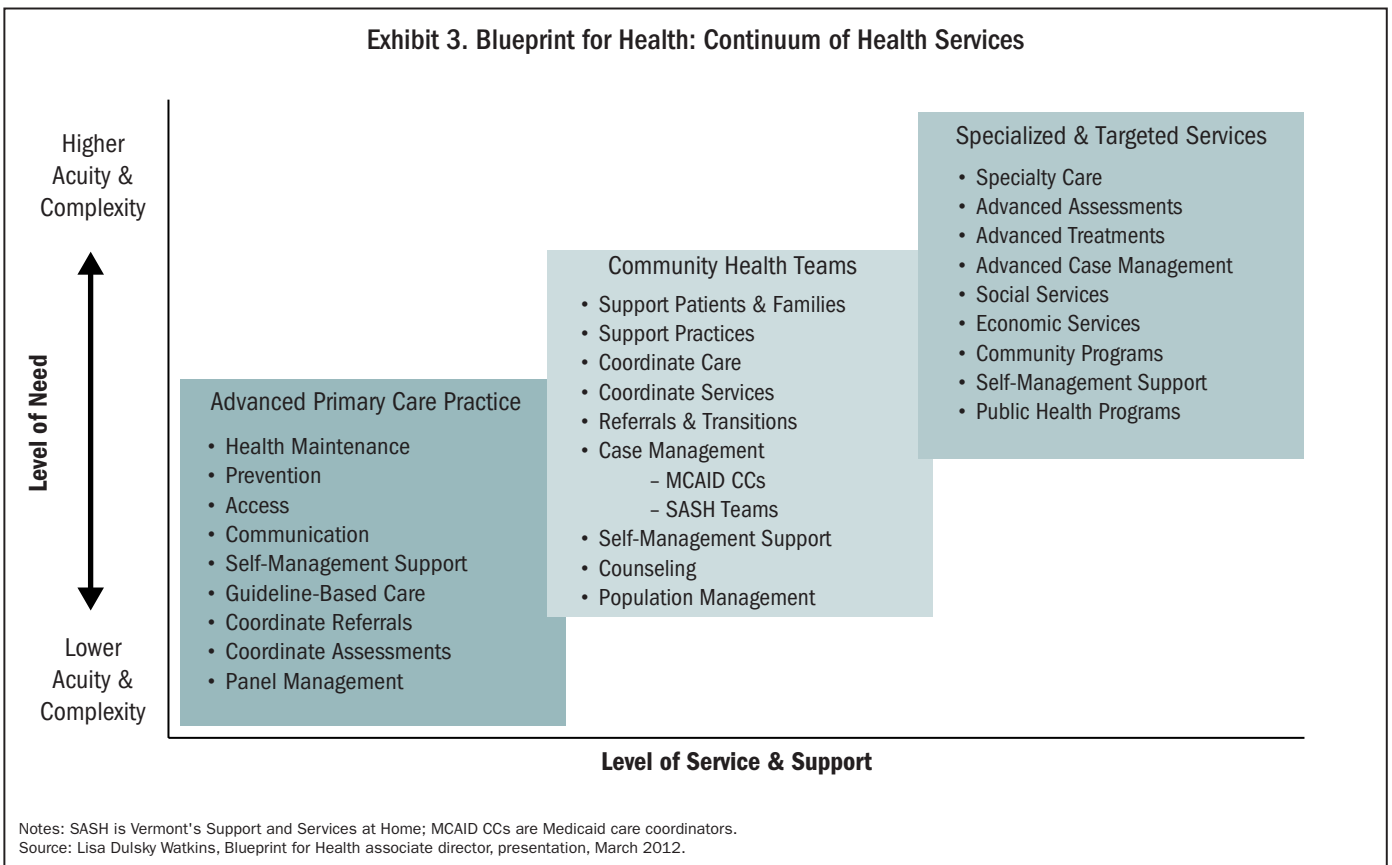
as the Department of Mental Health, Vocational Rehabilitation, and the Department of Health/ Alcohol and Drug Abuse Programs, as well as to community resources. Working within medical practices, coordinators conduct panel management to educate providers and help ensure patients receive appropriate preventive and evidence-based care.

- Support and Services at Home (SASH) teams.** Funded through CMMI's Multi-Payer Advanced Primary Care Practice demonstration, SASH teams provide on-site assistance to help high-risk Medicare enrollees remain in the community. A multidisciplinary health team makes an initial assessment, creates an individualized care plan, and delivers home-based nursing and care coordination (often in partnership with other local partners). SASH also sponsors community activities to support health and wellness.² SASH is expanding statewide commensurate with Blueprint's expansion.

In addition to paying fee-for-service rates to providers, Medicaid, Medicare, commercial payers, and major self-insured businesses contribute funds toward the extra per member per month fees and to support the community health teams. Exhibit 3 illustrates the financing flow resulting from the targeted Blueprint payment reforms.

In addition to housing and participating in the Blueprint program, the state supports the initiative by investing in information technology as well as mechanisms for measurement, evaluation, and quality improvement:

- health information technology:** the Blueprint provides participating providers and the state with health information technology infrastructure, support for electronic medical record adoption, a health information exchange network (all-payer claims data), and a centralized registry;
- measurement/evaluation:** the state hires University of Vermont researchers to conduct NCQA scoring, chart review, analytics, reporting, information/data



system design and processing, and multidisciplinary expertise as needed; and

- coaching and quality improvement: the Blueprint and University of Vermont provide coaching and facilitation to practices, community health teams, hospitals, and other providers and conduct numerous quality improvement projects.

Vermont's Medicaid program supplements its care coordination for high-risk members with the following programs and services:

Inpatient care coordinators: Medicaid employs inpatient care coordinators to conduct concurrent review and coordinate discharge plans for Medicaid patients with certain conditions (children and adults with mental health disorders, adults hospitalized for more than 13 days, and detoxification patients). These care coordinators help ensure discharge is not unduly delayed and that patients receive necessary post-discharge services. Medicaid's Quality Improvement and Clinical Integrity unit reported that from FY 2010 to FY 2011, the percentage of child and adolescent hospital readmissions decreased from 30.5 percent to 23 percent. The number of child and adolescent Medicaid beneficiaries readmitted within 60 days of discharge decreased from 47 to 36 within the same time period.

"Hub and spoke" initiative: The Agency of Human Services collaborates with community health providers to create specialty "hub" centers to assess, treat, and coordinate care for complex addiction cases and share information with "spokes," which are physicians who team up with mental health counselors and nurses from the community health teams. The spokes will monitor adherence to treatment, coordinate access to recovery supports, and provide counseling, contingency management, and case management services. The intent is to begin using this integrated framework with the opiate addiction population, and then expand to other high-risk populations, particularly those with both substance abuse problems and mental health disorders.

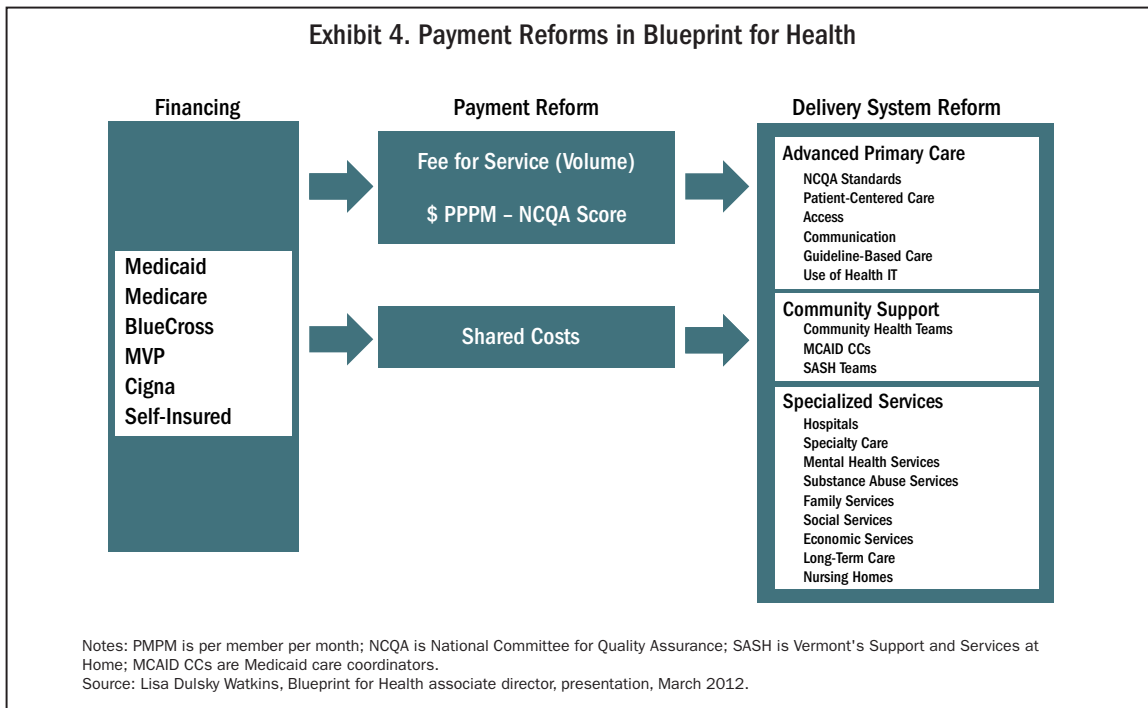
PAYMENT REFORM PILOTS AND UNIFIED HEALTH CARE BUDGET

The Vermont Act 48 of 2011 calls for pilots to test new models of payment and delivery system reforms, among an array of activities and principles for transforming the health care system.³ The Act established an independent five-person Green Mountain Care Board (GMCB) to oversee and evaluate payment reform pilots to be developed and implemented by a director of payment reform.⁴ According to a 2011 report to the legislature by the director of payment reform, Richard Slusky, "These payment models will be built on the principles of integrated care that have already been established in the Blueprint for Health, and structured to strengthen and reinforce the clinical process improvements in our delivery system that we have already made to date."⁵

The GMCB and director of payment reform have been meeting with stakeholders to educate them about options for payment reform, and to seek their input and participation. The GMCB joined with the state hospital association to convene two educational sessions for CFOs and CEOs of hospitals and payers about the models. Of 14 hospitals in the state, five initially agreed to work with the GMCB to develop payment models and three others expressed interest. The state planners met with a Medicare state liaison recently to discuss the best way to include Medicare in the evolving payment models, including the possibility of using Medicare's Shared Savings Program Accountable Care Organization (ACO) model as a basis for the pilots. The payment models are intended to include all payers.

As of December 2012, three payment models are under development:

- **Bundled payments.** Planners are considering the CMS bundled payment and ACO models, which could be supported as a CMS demonstration, and exploring Medicare data to see what types of hospital services might be amenable to a payment bundle. One of the Vermont hospitals submitted an application in June 2012 under the CMS Bundled



Payment for Care Improvement Initiative for Congestive Heart Failure. CMS has notified the hospital of the opportunity for them to participate under the revised rules recently announced by CMS, and the hospital intends to participate. The GMCB approved an oncology pilot in St. Johnsbury, Vermont, that provides financial incentives to primary care physicians and specialists to better coordinate care for patients diagnosed with cancer. This is a collaborative effort between a community hospital, a federally qualified health center, and the St. Johnsbury branch of the Dartmouth-Hitchcock Norris Cotton Cancer Center.

- Physician/hospital global budget.** With about two-thirds of Vermont's physicians working as hospital employees, global physician/hospital payments would include both facility and physician costs. By incorporating physicians in the global payment model, GMCB is planning to align financial incentives for physicians with those for hospitals under a value-based payment approach. Such an approach would help smooth variation in payments and eliminate incentives to increase volume of services. GMCB is in discussions with two hos-

pitals that are considering moving to global physician/hospital budgets in 2014.

- ACO/population-based payment models with shared savings.** Dartmouth-Hitchcock health system⁶ and Fletcher Allan Health Care (FAHC)⁷ created an LLC called OneCare Vermont and applied to CMS to form an ACO under the Medicare Shared Savings Program. OneCare Vermont is expected to begin in early 2013 once final approval from CMS has been received. Provider participants include all but one of the other hospitals in Vermont and their employed physicians, 50 independent physicians, two FQHCs, rural health centers, and an inpatient psychiatric facility, creating a statewide integrated network of care. This is a major initiative that will begin with Medicare but leaders hope to spread to Medicaid and commercial payers in 2014–2015.

In early 2013 Vermont received a State Innovation Models Initiative grant from CMS to support these payment pilots as well as a pay-for-performance model for individual providers and health system infrastructure enhancements.⁸

An early challenge for these reforms is the tremendous complexity of implementation, which raises

concerns about both the ability to simplify administration and whether the efforts will achieve adequate returns on investment.

In conjunction with payment pilots, Vermont's overall cost-containment strategy (as defined in Act 48) includes the state's unified health care budget. A unified budget has been part of Vermont law since 1991 but has served as a general guideline rather than a real constraint on spending. The GMCB has engaged health care consultants to develop a model for a unified health care budget that would provide a framework for establishing growth trends and evaluating hospital/physician budgets, and to model opportunities to reduce expenditures through changes in the delivery system and payment reforms. The GMCB has recently received presentations from the consultants on these models, and plans to make decisions and implement these approaches in the first quarter of 2013. The GMCB and the Agency of Human Services is also now in the process of forming a multistakeholder steering committee to oversee working groups in three areas:

1. development of standards and criteria for ACOs operating in Vermont;
2. development of common performance measures to be used by the ACOs on an all-payer basis and how the measures may be used to influence payments to the ACOs; and
3. standards and expectations related to ACO connectivity to a statewide health information exchange.

These working groups became operational in January 2013. The state formed these groups in anticipation of receiving SIM funding from CMMI and in developing multipayer approaches to delivery system and payment reforms in Vermont.

MEASURING SUCCESS

Evaluation of the first two years of Blueprint showed promising trends, with reductions in emergency department use and hospital readmissions, but not significant financial savings. Some attribute this to the

very small sample size. A follow-up evaluation based on larger numbers is to be released in February 2013, and will include claims-based data from all 14 health service areas in Vermont. Stakeholders would like to see financial savings and further quality improvement as the years progress and with larger numbers of participants.

Disease management programs were already available for commercially insured and Medicaid enrollees before the Blueprint's delivery reforms. Thus, health plan and Medicaid officials acknowledge that measurable changes in health outcomes under the Blueprint may take years to accrue.

To assess the impact of the payment reform pilots, the state is developing a sophisticated financial model, facilitated by an all-payer database that includes commercial, Medicare, and Medicaid claims. It will measure performance against projected local, state, and national trends. Among the challenges, however, are the time lag in claims data, the lack of health care data on the uninsured, and the limited data related to factors influencing health such as socioeconomic, behavioral, and environmental conditions.

LESSONS

Medicaid Should Integrate with Statewide Reform Efforts

The key to improving population health is integrating and coordinating medical care with other health and social needs; thus, Medicaid should not work alone but rather collaborate with other departments and agencies. In Vermont, Medicaid and various state departments are working together on multiple initiatives, using intergovernmental agreements to delegate responsibilities, leverage expertise (on mental health, addiction, and public health, for example), and pool resources. They are able to reduce the "silo" mentality by focusing on the benefits of interdepartmental partnerships such as greater transparency, standardization, and potentially a healthier population.

Similarly, Medicaid and statewide reform should be fully integrated. This requires a mindset that

Medicaid should not depend on cost-shifting to private payers but instead work with them to strengthen incentives for delivery reform and improve care for everyone. This understanding is behind Vermont's all-payer Blueprint model.

States Should Foster Collaboration While Taking Strong Leadership Roles

Systemwide reform requires a collaborative environment. In Vermont, there is bipartisan agreement in the legislature on the need to improve quality of care and patient experience, and contain costs. Focusing on shared goals may be the first step toward agreement on strategies.

Collaboration across stakeholders is fostered in Vermont by the small size of its network of providers and insurers. Further, many stakeholders look beyond the narrow interests of their organizations to the wider vision of what needs to be done to improve population health or control spending growth. Its non-profit, locally based carriers appear to be invested in testing, changing, and possibly making concessions in order to improve the Vermont's health care system.

States can play crucial roles in keeping stakeholders engaged. Vermont acts as a convener, forging partnerships among stakeholders and bringing in experts for educational sessions. GMCB's director of payment reform holds biweekly meetings with insurers to promote discussion and cooperation.

Despite the high degree of collaboration in Vermont, the legislature had to take a tough stand and require commercial payers to participate in its Blueprint reform. This took political will and leadership. The commercial insurers, however, were actively involved in Blueprint's development before the state required participation and remain involved in the planning, implementation, and evaluation committees that advise the Blueprint director. One commercial payer plans to move resources that currently fund disease management contracts into supporting the community health teams.

One Payment Model Does Not Fit All—But General Reform Strategies Are Replicable

Vermont's early payment reform experiences demonstrate that communities are unique and may require different approaches to reform. Even within a community, varied circumstances warrant different payment models. For example, providers may need to make different arrangements, depending on whether their patients receive all or just some of their care within the system. Addressing such circumstances while attempting to simplify rather than further complicate the administration of the system is a significant challenge.

At the same time, the processes needed to nurture delivery system and payment reform may be replicable even in different environments. Despite the small size and progressive culture of Vermont, for example, a major hospital leader there is convinced that its efforts are replicable in urban settings and scalable in larger states, if there is political will. Another interviewee noted that despite the advantages of Vermont's small size and progressive culture, it faces challenges as a result of its geography and small overall economy, so it should not be viewed as having an easy path to reform.

Recognize Providers Are in Different Places

The reform planners are developing new payment models with the understanding that different providers will be able to take on differing levels of financial risk, depending on their size, organizational characteristics and culture, and health information technology infrastructure. "We should be careful not to push providers too far out of their comfort zones as we begin this transformational process," says Slusky. "Change will take time, and we should begin this process by working most closely with those who are more willing to embark upon this journey."⁹

Physicians' participation in the Blueprint model has been voluntary, but an increasing number of physicians are seeing the benefits in terms of additional payments and community health team support. Program leaders expect to reach 80 percent to

90 percent physician participation by mid-2013. Similarly, hospitals are realizing they need a different business model in order to manage fixed costs as volume declines, for example by divesting in certain lines of service that are no longer needed.

Acknowledge Early Challenges and Take a Long-Term View of Reform

Start-up reform activities can be a formidable and long process, requiring one-on-one discussions, detailed explanations, and personal persuasion. State and federal policymakers should acknowledge this and build it into their timelines. Further, the effects of payment and delivery reforms are likely to accrue value over years, not months. Therefore, planners must weigh the need for short-term savings against this reality. This suggests that financial savings should not be the only metric for success; rather, efforts should be considered worthwhile if they improve care delivery even without proof of savings. A multifaceted evaluation that includes qualitative assessment (including interviews, focus groups, and surveys) in addition to gauging the return on investment and clinical outcomes is necessary for the full view of a large-scale payment and delivery reforms such as the Blueprint.

HOW CMS CAN SUPPORT PIONEER STATES

Interviewees in Vermont acknowledged the tremendous support they have received from the Centers for Medicare and Medicaid Services in implementing health system reforms and noted many ways in which the partnership is working well. Based on the challenges the state has faced, we believe CMS can further support it and other state pioneers in several ways.

Flexibility

Vermont has worked closely with and appreciates CMS support for state-level reforms including Vermont's recent State Innovation Models Initiative grant. Stakeholders expressed that CMS should continue to provide direction and basic structures for reform models, but also allow flexibility on issues such as:

- **Conditions placed on providers:** The CMS Shared Savings Program requires 2 percent to 3 percent savings compared with Medicare trends before profits are shared with providers. An alternative approach would be to allow sharing if any savings are achieved.
- **ACO design:** CMS could be less prescriptive about the design and organizational structure of an ACO. For example, Vermont is interested in developing informal relationships among primary care physicians and specialists to care for high-cost, high-risk patients, without creating formal ACOs. Further, critical access hospitals are not allowed to receive a bundled payment and distribute funds to other community providers, yet would need to do so under the ACO/value-based payment reform model.
- **Medicare payments to specialists:** In Vermont, Medicare is participating in the Blueprint program by paying Blueprint practices a per member per month fee above the fee-for-service rates. The state is proposing to expand this model to specialists coordinating with primary care physicians to treat chronic conditions, which would require increased Medicare payments for these providers.
- **Time for showing results:** Though leaders in Vermont acknowledge the need for CMS to require evidence of savings, it may be prudent for the agency to allow a longer period of time to show significant results.
- **Variations in early years:** Given the significant operational, administrative, and political hurdles in the early years, CMS could consider funding additional state investment costs on a limited time-frame, and making allowances if a state's approach does not initially conform strictly to legislation or rules.

Participation and Data-Sharing

With Medicare a dominant payer in the health care system, its participation in multipayer initiatives is critical for creating meaningful incentives to change

provider behavior. While Medicare did eventually participate in Vermont's Blueprint through the Center for Medicare and Medicaid Innovation's Multi-Payer Advanced Primary Care Practice demonstration, a faster, easier process for attaining Medicare participation would hasten such efforts in other states. The OneCare Vermont ACO Shared Savings Program now under consideration may provide a good framework for achieving Medicare participation beyond the Blueprint for Health.

Similarly, the design and evaluation of most value-based innovations require performance data, with Medicare the main holder of such data. States would benefit if CMS could more quickly make Medicare data available to payers and providers. In addition to facilitating reform design and evaluation, faster access to Medicare data would help states create all-payer data repositories that are more nimble than currently exist. Some interviewees also suggested that CMS allow the release of physician-specific data to promote provider education and enable states to prepare performance comparison reports for consumers.

Simplification of Grant Applications and Incentives to ERISA Plans

Applying for federal grants can be complicated and expensive, which impedes many innovative proposals from being funded. CMS could consider ways to simplify the process.

A large portion of Vermont's population (about 140,000 people or 20 percent of the state's residents) is insured through self-funded ERISA plans. While these plans cannot be required to participate in pilots or conform to other state insurance rules, the federal government could consider options such as creating incentives for involving ERISA plans in reform.

Clinical Process Change and IT Support

CMS could provide or support more technical assistance on clinical process change and information technology for providers. One interviewee suggested that Medicare facilitate learning across providers through a

"best in class" initiative, applying an industrial improvement model.

Sharing information on patients in multipayer payment and delivery reforms, as well as for health insurance exchanges, are complex and time-consuming processes. Providers increasingly have electronic health record systems, but they do not necessarily share a common technical platform either with each other or with an exchange. CMS already plays a role in supporting information exchange, and could consider ways to expand that role, for example by working with vendors and facilitating interconnectivity.

CONCLUSION

Vermont and other pioneer states provide laboratories for health system reforms. They are designing and testing payments that could encourage delivery reforms that improve the quality of care and health outcomes, while reducing waste and spending. Such experiments provide important lessons for other states and federal policymakers.

NOTES

- ¹ Interview with Paul Bengtson, CEO, Northeast Vermont Regional Hospital, April 2012.
- ² Vermont's five Area Agencies on Aging, Visiting Nurse Associations, PACE Vermont, and every hospital in the state are participating. Each participating housing organization commits one person to the SASH site; for example, the community's Area Agency on Aging would commit one case manager to one SASH hub site as the point person for all of its clients at the hub site. In a yearlong pilot study with 65 residents, the program reduced hospital admissions and readmissions, decreased falls, improved nutritional status, increased levels of physical activity, and had no "bounce backs," or readmissions, to nursing homes. SASH was originally funded through a combination of state funds and philanthropic donations. See http://www.ruralhome.org/index.php?option=com_content&view=article&id=440:sash&catid=17:information-sheets.
- ³ Act 48: Relating to a Universal and Unified Health System, creates Green Mountain Care, a publicly financed health care program designed to contain costs and to provide comprehensive, affordable, high-quality health care coverage for all Vermont residents. The Act creates the Vermont Health Benefit Exchange and an independent, five-member Green Mountain Care Board tasked to implement payment/benefit design reforms, define minimum benefit standards and a qualified benefit package, set payment rates, implement chronic care efforts, develop a health care budget, reduce cost, and review and approve health insurance rate increases, hospital budgets, and certificates of need. For more information see <http://www.leg.state.vt.us/docs/2012/Acts/ACT048sum.htm> (summary) and <http://www.leg.state.vt.us/docs/2012/Acts/ACT048.PDF> (full Act).
- ⁴ DVHA is hiring a director of payment reform for Medicaid, who will work closely with the GMCB director for payment reform.
- ⁵ R. Slusky, "Report to the Legislature on Payment Reform," Feb. 1, 2011, p. 24, <http://www.leg.state.vt.us/reports/2011ExternalReports/264991.pdf>.
- ⁶ Dartmouth-Hitchcock health system is based in New Hampshire but serves a large number of Vermont residents; it has been designated a CMS Pioneer ACO.
- ⁷ Fletcher Allen Health Care and its partner, Vermont Managed Care, already have about 40,000 people enrolled in commercial plans under a capitated payment arrangement.
- ⁸ Under this grant the State of Vermont will receive up to \$45 million over 42 months.
- ⁹ Slusky, "Report to the Legislature," 2011.

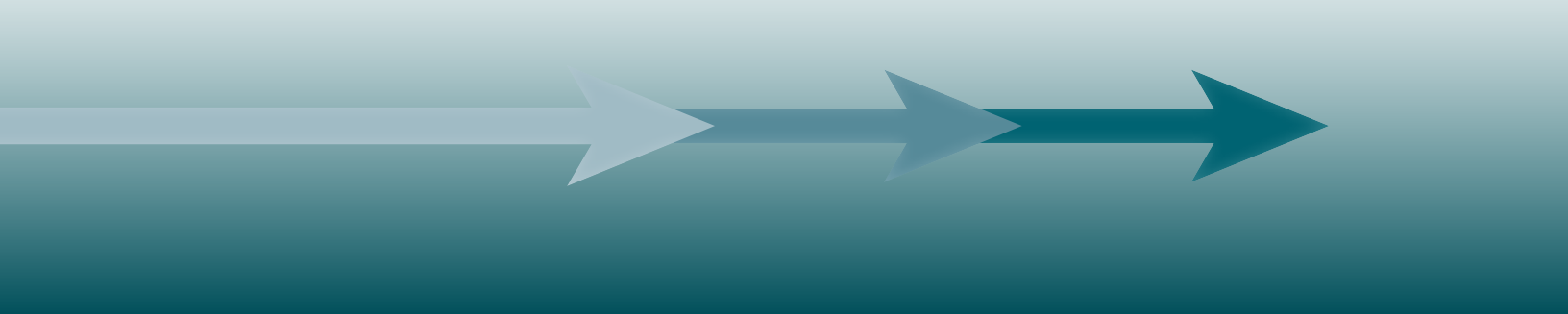
ABOUT THE AUTHOR

Sharon Silow-Carroll, M.B.A., M.S.W., is a managing principal at Health Management Associates. She has more than 20 years of experience conducting research and analysis of local, state, and national health system reforms; strategies by hospitals to improve quality and patient-centered care; public-private partnerships to improve the performance of the health care system; and efforts to meet the needs of underserved populations. Prior to joining Health Management Associates, she was senior vice president at the Economic and Social Research Institute, where she directed and conducted policy analysis and authored reports and articles on a range of health care issues. Ms. Silow-Carroll earned a master of business administration degree at the Wharton School and a master of social work degree at the University of Pennsylvania. She can be emailed at ssilowcarroll@healthmanagement.com.

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