Act 128

Report to the Legislature on Payment Reform

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Introduction

Vermont should be very proud of the accomplishments that it has achieved over the past decade. As a result of cooperative initiatives between government, providers, and payers, Vermont has taken aggressive steps to improve access to healthcare services and to provide the financial means for most citizens in Vermont to afford reasonable healthcare coverage.

Initiatives such as Green Mountain Care, premium assistance, pharmacy assistance, wellness and prevention programs, expansion and integration of health information technology, support for the expansion of Federally Qualified Health Centers (FQHCs) and the Blueprint for Health have earned Vermont the reputation of being a national leader in health care reform.

However, as Dr. Hsiao notes in his recent report to the Legislature, "Despite its valiant efforts, Vermont has not been able to provide high quality, affordable health care for all its residents. It is fair to say the system is broken"[1]. As Dr Hsiao also notes fundamental changes in our health care delivery and payment system must occur before we can achieve our goals of universal coverage, high quality care, and affordable cost.

We believe Vermont is uniquely positioned to achieve these goals. We are already recognized as a national leader in health care reform; we have a relatively small homogeneous population of just over 600,000 people, geographically divided into natural service areas with relatively little competition among providers; many of the insurance provisions incorporated in the Affordable Care Act are already in place in Vermont; and we have an Administration and Legislature that are committed to making our health care delivery system the best in the country.

The Hsiao Report provides an excellent analysis of the strengths and weaknesses of our health care system and it makes specific recommendations regarding the options we have and the steps we need to take in order to be successful in meeting our goals. I believe Dr. Hsiao and his team have provided us with an excellent framework for discussion, and an opportunity to set a clear course for the future.

The intent of this report is to provide more detailed suggestions as to how we might establish new payment methodologies moving from a fee-for-service volume based reimbursement system to a "value-based" payment system which will incentivize quality improvement and cost effective delivery of health care.

[1] Health System Reform Design: Achieving Affordable Universal Health Care in Vermont, January 2011, Dr. William Hsiao

Section 1 – How we get Paid Matters

"A payment system has significant effects on the cost of health care, the value of services, choice of treatments, and efficiency of health care"
Dr. William Hsiao

Every payment system provides incentives for providers to perform in ways that may or may not be consistent with our health care reform goals. The Institute of Healthcare Improvement (IHI) advocates that any reform effort should support clinical care that is Safe, Timely, Efficient, Effective, Equitable and Patient Centered. These are the so called STEEEP goals that we should bear in mind as we strive to measure the effectiveness of our efforts. In addition, it is anticipated that by effectively meeting these goals, we will also slow the rise of health care expenditures, and reduce per capita health care costs overall. Professor Michael Porter from the Harvard Business School and the Center for Health Care Strategies argues that **"improving value requires improving outcomes per unit of cost…A narrow focus on cost reduction fails in health care delivery because the best way to contain costs is to improve quality. Better health is inherently less expensive than poor health. Thus, the faster individuals achieve or regain their health and sustain it, the lower the true costs in the system will be."**

Our fragmented and siloed health care delivery system is not structured to produce the results anticipated by the STEEP measures or facilitate the cooperation and coordination among providers necessary to achieve the value-based results suggested by Professor Porter. To the contrary, our system is structured to deliver care on a piece-meal basis, using high cost technologies, with an emphasis on specialty care and very little systemic coordination and/or cooperation among providers. Our reimbursement systems and payment methodologies simply reinforce and, in many ways, encourage this behavior among providers. Providers should not be blamed for this lack of cooperation and coordination of care. They are rationally responding to the financial incentives that our system provides.

<u>The chart below provides some insight into the incentives provided by different payment methodologies.</u>

Payment Reform – How we get paid matters

Basis for Payment	Access for Pts.	Cases Treated	LOS/Visits	Complexity of Services	Intensity	Scope of Services	Amenity	Efficiency	Input Prices	Prevention/ Wellness
Fee for Service	↑	↑	↑	↑	↑	↑	↓	↑	↓	↓
DRG's	↑	↑	↓	↑	↓	↓	↓	↑	↓	↓
Bundled Payments	↑	↑	↓	↑	↓	↑	↓	↑	↓	↓
Cost-Based Reimbursement	↑	↑	↑	↑	↑	↑	↑	↓	↑	↑
Capitation	↑	↓	↓	↓	↓	↓	↓	↑	↓	↑
Global Budget	↓	↓	↓	↓	↓	↓	↓	↑	↓	↑
Risk Adj Capitation	↑	↓	↓	↑	↑	↑	↓	↑	↓	↑

↑ Incentive to do more

↓ Incentive to do less

As should be obvious, "fee-for-service rewards overuse of services does not encourage consideration of resource use, and does not encourage limitations on cost growth"[2]. It also does not recognize differences in provider performance, quality, or efficiency, and does not align with evidence-based guidelines or outcomes.

In addition, fee-for-service reimbursement does not take into account the actual cost of providing care. It seems clear that continuing the fee-for-service reimbursement system is not a satisfactory option and certainly does not provide the financial or clinical improvement incentives we are seeking to achieve in a reformed health care environment. It is expensive to administer and is subject to payment rates based on negotiating skills and leverage, rather than value received. Some highly valued services are not recognized in a fee-for-service system and thus not compensated, and incentives are clearly not aligned among physicians, hospitals and other providers of care.

[2] Recommendations of the Special Commission on the Health Care Payment System Commonwealth of Massachusetts, July 16, 2009

Although fee-for-service reimbursement clearly leaves much to be desired, other payment methodologies incentivize provider behaviors that may or may not be consistent with our health care reform principles. For example, Prospective Payment Systems (DRG's for one) encourage shorter lengths of stays in hospitals and encourage greater efficiencies in process and input prices. However, DRG reimbursement is still volume-based and encourages providers to increase volumes, particularly hospital admissions, in order to generate additional revenues.

Cost-Based Reimbursement was the basis for most health care payments (along with fee-for-service) until the 1980's when the Prospective Payment System was put in place by Medicare. Cost-Based Reimbursement is now available only to Critical Access Hospitals and FQHC's in the outpatient settings. Cost-Based Reimbursement was re-established for CAH's following the closure of over 200 small rural hospitals in the late 1980's and early 1990's. It was a means, by Medicare, of establishing a guaranteed base of payment for small hospitals which did not have large enough patient populations to survive under a Prospective Payment System. It has certainly contributed to the growth of Critical Access Hospitals throughout the country, and has stabilized the financial condition of most of them. The problem with Cost-Based Reimbursement is that costs become a revenue source for hospitals, and reduction of costs conversely results in a reduction in revenue. Thus, in many CAH's consideration of cost reduction strategies is very difficult when taking into consideration the accompanying loss of revenue.

Cost-Based Reimbursement ultimately leads to the continuation of inefficient or unnecessary services which provide a revenue base for small hospitals. For FQHC's, a combination of enhanced payments through Cost-Based Reimbursement and Federal grants, allows the FQHC's to broaden their service options and incorporate care coordination and behavioral health into their primary care service models. The growth of FQHC's has contributed to improved access to health care for services to low income individuals and people with mental health or substance abuse problems, particularly in areas of the state where those services were most needed. Through the efforts of Senator Sanders and our Congressional Delegation, FQHC's have become a vital part of our health care delivery system.

The Capitated Payment Methodologies (capitation, global budget, condition-adjusted capitation) all assume some Per Member Per Month (PMPM) or global-payment based on attributed patients to a particular group of providers or affiliated health care organizations. This could include just primary care services, primary care and specialty services, or a broader range of services including diagnostics, hospital care, mental health services, and home health care. The principle of capitation payments is that providers would be paid an agreed upon amount of money to provide a defined set of services to a specific population over a period of time. This payment methodology provides an upfront source of cash flow to the providers and allows them the opportunity to structure their care delivery processes in more efficient ways than can be achieved with the administrative and payment constraints embedded in a fee-for-service system. It also incorporates financial incentives for the provider to exercise prudence in the use of health care resources, since any use of resources becomes a cost to the system rather than a source of revenue.

While providers appreciate the clinical freedom and lessened administrative burdens typically associated with capitated reimbursement, they are often deeply concerned about the amount of financial risk they might be expected to assume under this payment model. They are particularly

resistant to accept insurance risk for services provided to their patients by other providers over whom they have no control.

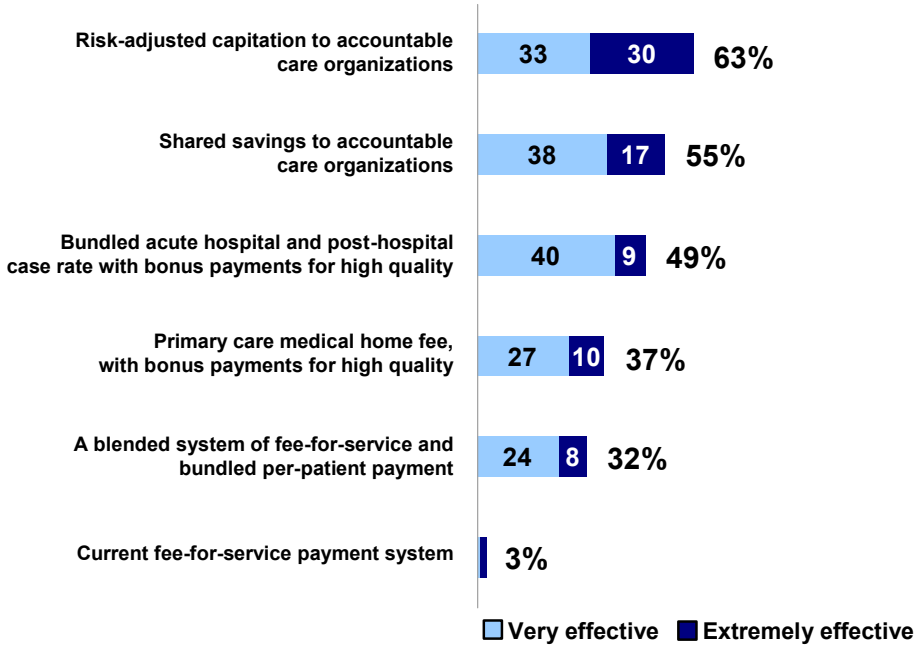
If we intend to move from fee-for-service to any form of capitated payments, we must understand and be able to communicate the nature and scope of risk we are asking providers to assume. Performance risk which is reasonable, clearly communicated, measurable, and within the control of the providers is likely to be more acceptable than insurance risk which is much more complicated to predict, requires large populations of patients and is often viewed as outside the control of the providers.

The **Commonwealth Fund** recently completed a survey of 190 opinion leaders in the health care field to solicit their views on transparency and pricing in health care. The conclusion was "that more than nine of 10 leaders in health care and health care policy believe it is important for the public to have information on clinical quality and prices, and such information is essential for improving U.S. Health system performance. Most leaders support moving toward salaried physician practice with appropriate rewards for quality and prudent use of resources."

Survey respondents support rewards for Accountable Care Organizations through use of partial capitation and shared savings payments….. 71% of leaders believe it is important for all payers to use the same method of payment for rewarding quality and efficiency and a majority support using all payer payment rate setting or a single system of rate negotiation on behalf of all payers. Of note, only 3% of opinion leaders supported continuation of the current fee-for-service payment system as a means to facilitate a more efficient health care system.

Exhibit 3. Health Care Payment Options

"How effective do you think each of the following payment approaches would be in facilitating a more efficient health care system?"



THE COMMONWEALTH FUND

* Percentages may not be equal to the net because of rounding.
Source: Commonwealth Fund/*Modern Healthcare* Health Care Opinion Leaders Survey, October 2010.

Despite nearly universal dissatisfaction with the current system, moving toward a new payment methodology will not be easy. Provider and consumer experience with Managed Care Organizations in the 1990's was extremely controversial. Providers felt that they were assuming insurance risk for services that were beyond their control, and they received little or no help in restructuring their delivery models to better coordinate the care they were providing. Consumers often rebelled against forced choice of providers and reduced access to needed services. They felt they were being denied services they clearly needed, and were angry at insurance companies and providers for not considering their health needs first. The structure of capitated or PMPM payments in the 1990's, for the most part did not include condition- adjusted payments, leaving providers little incentive to accept sicker patients into their panels. To the contrary, incentives in a PMPM system without condition adjustments would encourage providers to select patients with little or no health care problems, and avoid adding sicker patients with complex medical problems to their practice.

Although the principles and incentives of capitation payments are to better manage the care of patients and to provide appropriate but not excessive treatment, the payment structure served mostly to alienate and upset providers and consumers, and the managed care experiment, with notable exceptions, failed to dramatically change the U.S. Health care system.

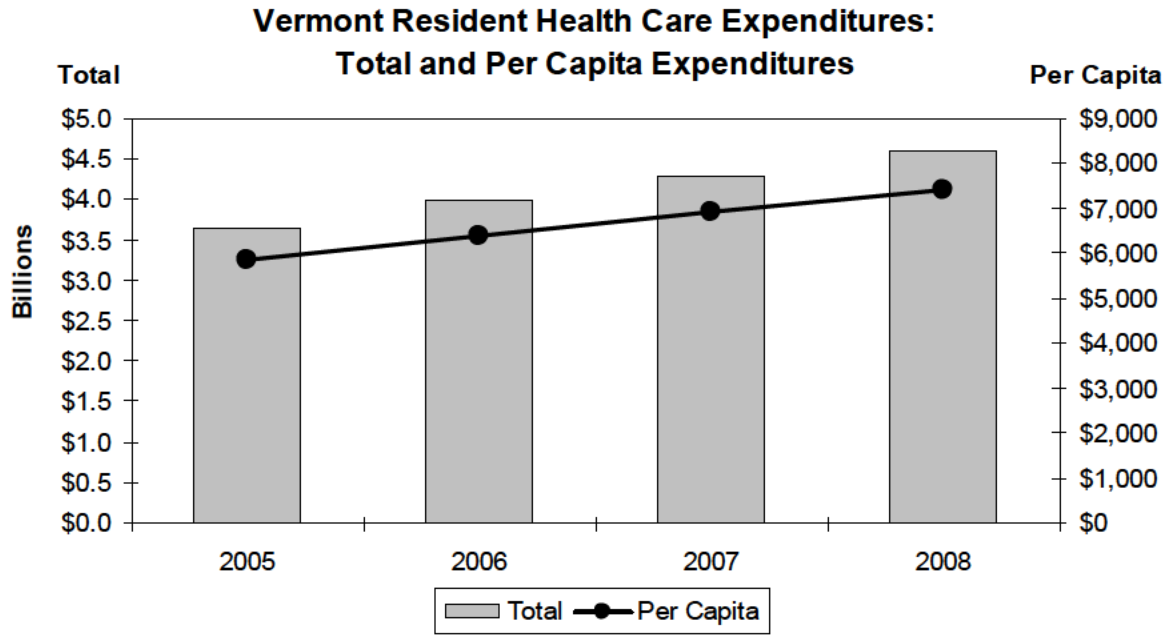
Today, we are once again considering capitation or PMPM payment models based upon provider panel size or global budgets based upon scope of services. In thinking about these payment models, we must not forget the lessons of the past. We need to be careful to design and implement them in

ways that insure that they are compatible with the healthcare reform goals we have established, and that they will incentivize the restructuring of our delivery system to create the cooperation, coordination, and value that we are seeking.

We must also not underestimate the need for education of providers and consumers as to how these new systems will work and what impact they will have on patient choice, office processes, institutional business models, and most importantly, quality of care and cost.

Section 2: Health Care Expenditures in Vermont State/Projected Growth Trends

In 2008, health care expenditures in Vermont totaled $4.6 billion.[3] In that year, Vermont resident health care spending grew 7.3% compared to a national growth rate of 4.3%. However, Vermont resident per capita health care expenditures, $7,414, were still lower than the U.S. expenditures per capita of $7,681. The average annual change in health care expenditures from 2005 – 2008 was 8.2% in Vermont compared to 5.7% nationally. In 2008, healthcare expenditures consumed 18.1% of the Gross State Product in Vermont, and 16.2% of the GDP nationally.



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Thus while Vermont's per capita costs in 2008 remained lower than the U.S., the annual growth in expenditures was higher and healthcare costs in Vermont consumed a greater percentage of Gross State Product than the U.S. GDP.

The overall growth in health care expenditures in Vermont varies significantly between both provider and payer types. From 2005 -2008, the average annual growth in private insurance

[3] 2008 Vermont Health Care Expenditure Analysis and three year forecast, 3/23/10

expenditures was 8.0%; Medicare spending grew at an average annual rate of 13.5%, (although it may have been closer to 9.0% without the addition of Medicare Part D prescription coverage); Medicaid expenditures grew at an average annual rate of 5.1%, but this was a result, in part, of decreased spending on prescriptions of $72 million, as a result of Medicare's Part D program.

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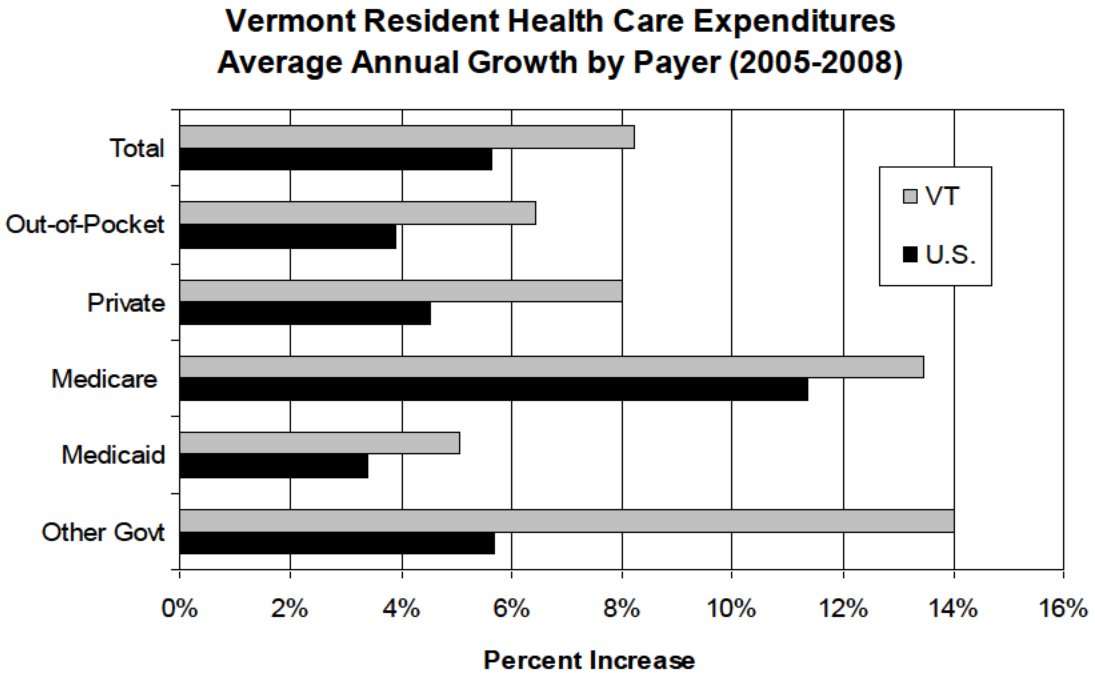


The anticipated annual growth rate in Medicaid expenditures from 2009-2012 is projected to be 9.1%, compared to 5.9% in Medicare, and 5.7% for private payers. The influences on these rates of growth need to be better understood as we contemplate health care reform initiatives to increase the value we receive for our expenditures of health care dollars.

According to the BISHCA 2008 Expenditure Analysis, total health care provider expenditures in Vermont are projected to increase at an annual growth rate of @6.0% from 2009 – 2012. This would result in an increase in total health care expenditures from $4.7 billion in 2008 to $5.9 billion in 2012. Assuming this trend line, Vermont per capita health care expenditures would be $9,463 in 2012, compared to $7,414 in 2008. National health care expenditures are projected to grow at an average annual rate of 4.8% during this same period. If this growth in expenditures does, in fact, follow this trend line, Vermont's per capita costs would be higher than U.S. per capita costs in 2011 for the first time.

BISHCA's Summary of these Vermont statistics is presented below: [3]

1. Spending for Vermont residents totaled $4.6 billion in 2008 and spending on Vermont providers was $4.4 billion. It should be noted that the two different perspectives will not be the same because they are compiled for different populations and from different data sources.

2. Health care spending accounted for 18.1 percent of Vermont's projected Gross State Product in 2008. Nationally, health care expenditures accounted for 16.2 percent of Gross Domestic Product in 2008.

3. The 2007-2008 increase was 7.3 percent in the Resident analysis and 6.7 percent in the Provider analysis.

4. From 2005 to 2008, Vermont resident average annual growth in total health care spending was 7.7 percent, compared to 5.7 percent for the U.S. (Note that the 7.7 percent for Vermont has been adjusted to account for the out-of-pocket methodology change in 2007 and 2008.)

5. Despite faster average annual expenditure growth than the U.S. since 2004, per capita health care costs in 2008 were lower in Vermont ($7,414) when compared to the U.S. ($7,681).

6. The implementation of the Medicare Part D prescription drug program in 2006 has dramatically shifted who pays for drugs. Medicaid paid $72 million less for drugs in 2008 than in 2005, while Medicare paid $96 million more.

7. From 2009 to 2012, health care expenditures are projected to grow at an average annual rate of 6.5 percent for the Resident analysis and 7.0 percent for the Provider analysis.

8. In 2008, there was a *net* migration of 4,531 inpatient discharges to out-of-state hospitals. There were 11,407 discharges of Vermont residents from hospitals in the bordering states of New Hampshire, New York, and Massachusetts, and 6,876 discharges of out-of-state residents from Vermont hospitals.

9. In 2007, the most expensive 5 percent of Vermont Medicare beneficiaries consumed 44 percent of total Vermont Medicare health care expenditures. The least expensive 50 percent of beneficiaries consumed less than 4 percent of the total.

10. Hospital-employed physician practices amounted to $240 million in 2008, up from $217 million in 2007.

11. In 2008, 60 percent of Vermont residents were enrolled in private insurance. There were an estimated 47,286 uninsured Vermont residents in 2008 (7.6 percent of the population, compared to 9.8 percent in 2005).

12. Medicaid is the primary payer of Government Health Activities, funding 91 percent ($455 million) of the total for that category. About $253 million (51 percent of the total $497 million) are for programs related to mental health, mental retardation, and substance abuse.

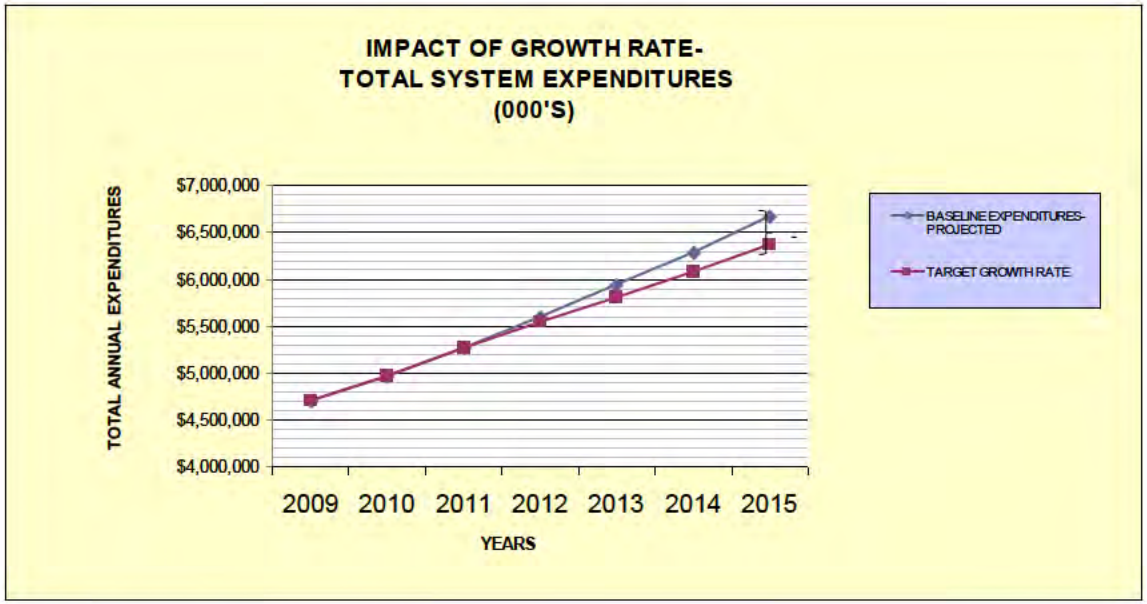
13. The Dartmouth Atlas shows that from 2001-2005, Vermont had among the lowest Medicare utilization rates in New England for enrollees in the last six months of life and last two years of life.

The chart below demonstrates the potential reduction in Vermont's total resident health care expenditures that could result if we were able to bend our health care expenditure curve from the projected 6.0% annual growth rate to an annual rate of growth that is more in line with the national growth projection of 4.8% per year. This assumes a reduction in the annual rate of expenditure growth in Vermont to 5.0% in 2012, and 4.8% from 2013 to 2015. The cumulative reduction in expenditures resulting from this change in the growth rate over a five year period is estimated to be over $700 million.

Whether or not these savings can be achieved is closely tied to our efforts to reshape the delivery system in Vermont, and the implementation of payment methodologies that encourage the production of value for patients, rather than volume of services. How we might achieve these results is discussed later in this report.

SEE EXPENDITURE CHART NEXT PAGE

Health Care Expenditure Curve
Vermont 2009 – 2015



Notes: Growth rate per year as follows:

	Projected	Target
2009 – 2010	5.8%	5.8%
2010 – 2011	6.1%	6.1%
2011 – 2012	6.2%	5.0%
2012 – 2015	6.0%	4.8%

Cumulative reduction in expenditure growth is 10.6% or $700M dollars over a four-year period.

*BISHCA's three-year forecast is not yet final.

In 2010, Fletcher Allen Health Care (FAHC) commissioned a study to better understand the factors contributing to the discrepancy in the rate of growth of health care costs in Vermont compared to the U.S. in general. The study found "that expenditures here in Vermont grew faster than the national average and that the divergence is in part explained by Vermont's population characteristics and its public policy decisions[4]". Specifically, the study found that:

Vermont's population aged faster and their income grew more quickly, during the period 1988-2004, than the U.S. average. Both of these variables are associated with higher spending on health care, and together they account for about half of the difference between growth in Vermont and U.S. health care costs during this period.

Vermont has made a deliberate effort to expand and maintain health insurance coverage for its population. During the period 1998-2004, the percentage of Vermonters who were uninsured dropped, while the percentage rose for the nation as a whole. Insurance coverage is strongly associated with higher spending by individuals.

Vermont made an effort during this time period to both expand Medicaid-covered services and increase Medicaid spending on programs not traditionally included in Medicaid…

Continued aging of the Vermont population, an ongoing effort to expand Medicaid-covered services, and the continued expansion of health insurance coverage to Vermonters from 2004 to the present time, most certainly continue to contribute to the rate of increase in health care expenditures in Vermont.

It is also worth noting that "at any given point in time, a small percentage of the population consumes a relatively large proportion of health care resources. For the Vermont Medicare population in 2007, the most expensive 5% of the population consumed 44% of Medicare health care expenditures. Conversely, half of Medicare beneficiaries were responsible for less than 4% of expenditures.

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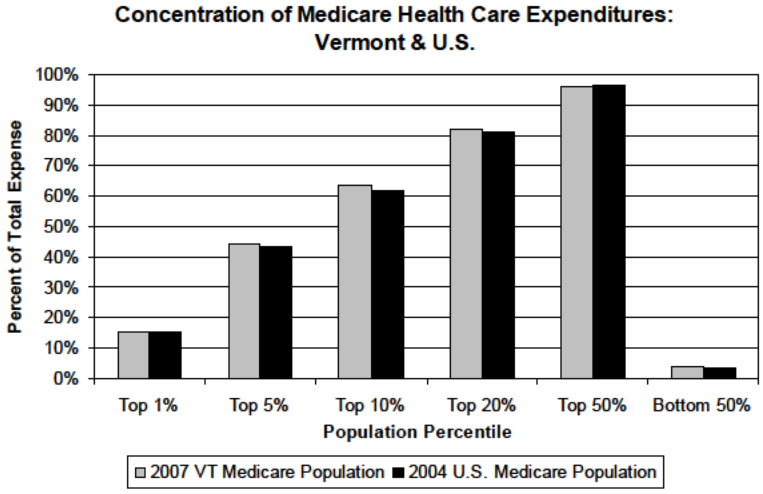
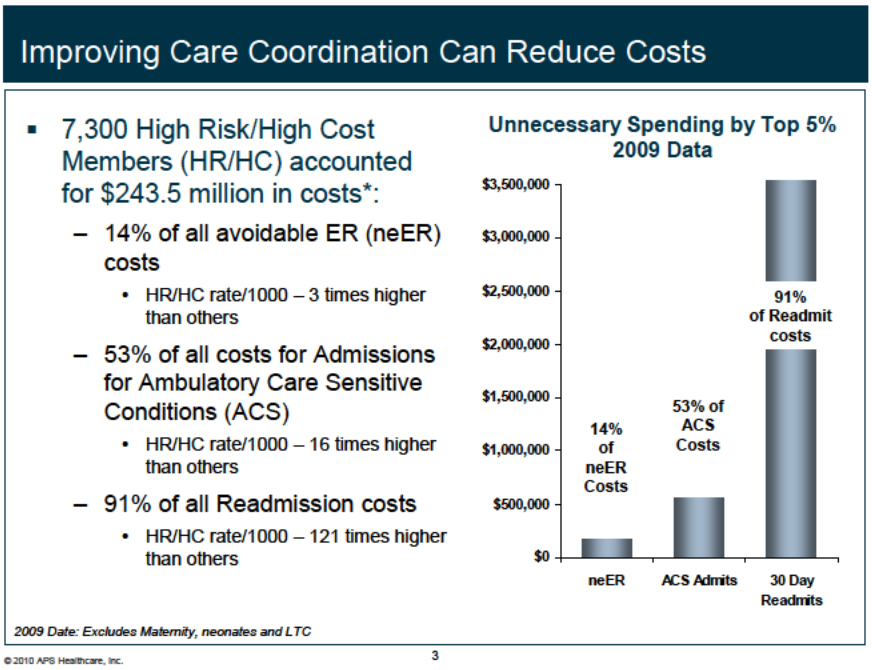


Data Source: CMS

[4] Health Care Costs and Cost Growth in Vermont, Anya Rader Wallack, Steve Kappel, Stanley S. Wallack, September, 2010.

Vermont Medicaid program statistics indicate that 5% of the Medicaid population (High Risk/High Cost) accounts for 43% of total Medicaid expenditures (excluding neonates/maternity, LTC, and dually eligible). This population accounts for 14% of all avoidable ER costs, 53% of all costs of admissions for Ambulatory Case Sensitive Conditions (ACS) and 91% of all Re-admission costs.

[5]



This concentration of high health care expenditures in relatively small populations suggests that targeted efforts to improve the effectiveness, coordination, and value of health care services for defined populations or conditions could have rather dramatic impact on both the quality and cost of health care services for those individuals. The Blueprint model of community health teams, including Medicaid high risk/high cost care teams and care teams focused on the needs of the elderly could have a dramatic and relatively short term impact on health care quality and costs.

Managing these increasing health care expenditures cannot be achieved by simply reducing provider payments and/or shifting system costs to other payers. We have tried that approach for years and it clearly does not work. A consensus is growing that the only way to address this systemic issue is to change the delivery system structure with a renewed emphasis on value through truly integrated and coordinated care; payment methodologies which provide the appropriate incentives to achieve the results we desire; and better use of information technologies to share patient information in a timely and useful way.

[5] January 6, 2011, Advancing the Blueprint for Health, APS Healthcare

Section 3 – Building on the Gains we Have Achieved

Vermont should be very proud of the accomplishments that it has achieved over the past decade as a result of cooperative initiatives between government, providers, and payers. Vermont has moved aggressively to improve access to healthcare services for its citizens and to provide the financial means for most citizens in Vermont to afford reasonable healthcare coverage.

Vermont has created new coverage options through Green Mountain Care which includes traditional Medicaid coverage, Catamount Health, Doctor Dynasaur and the V-HAP program which offer a variety of services to different populations throughout the State. We have also offered premium prescription assistance for people up to three hundred percent of the federal poverty level to ensure that they have the means to access prescription medications that are necessary to maintain and or improve their health.

Vermont has a long tradition of promoting wellness and prevention programs throughout its communities through grants and other efforts led primarily by the Department of Health.
For over four decades Vermont has been committed to providing transparent health care information to the public so that people can make informed decisions regarding their healthcare choices. Currently, Vermont requires that all hospitals report annual cost and quality data on the internet.

Vermont has also promoted the growth of health information technology through a partnership between the State, VITL, GE Healthcare and DocSite to provide useful health information on a timely basis to providers and consumers of healthcare services.

The Blueprint for Health is a major initiative begun about four years ago to provide Advanced Primary Care services in our communities. The Blueprint began with a focus on chronic disease management but now has been expanded to include the management of the healthcare needs of an entire population of patients. Its principles rest on the concept of local community health teams available to support the primary care practitioners in the delivery of coordinated healthcare services to patients within a defined region. The Blueprint's intention is to restructure the delivery system in a way that makes it easier for primary care providers to practice and provide better quality services to their patients knowing that they have the support of community health teams associated with their practice.

The Blueprint preliminary results indicate that satisfaction of providers and patients has been increased and the utilization of avoidable health care services has declined. The Blueprint will be expanded in 2011 to include at least two primary care practices in each health service area in the State. By 2012 approximately 80% of the population in Vermont should be covered under services available through Blueprint for Health providers.

Vermont has also been a leader in the development of Federally Qualified Health Centers (FQHC's) either independently providing services in traditionally underserved areas throughout the state or in conjunction with hospitals or other providers of care. The FQHC's provide improved access to primary care services for lower income Vermonters, and also include behavioral health services that make it much more convenient for patients to receive a broad array of coordinated health care services. All these efforts taken together have earned Vermont the reputation if being a national leader in health care reform

Recently the Commonwealth Fund in Massachusetts recognized Vermont as the number one state in the country for overall health based on a variety of health care, economic, and lifestyle standards. However, despite all of these efforts (or in part, as a result of them), Vermont healthcare expenditures continue to raise at an unsustainable rate and the dysfunctional characteristics of our reimbursement system, disparate administrative rules and regulations, and lack of coordination of services make it very difficult if not impossible for Vermont to realize its goals of improving access to quality health care services while reducing per capita costs.

Fundamental changes in our reimbursement system and delivery system must occur before we can achieve these goals. However, because we've come so far and have such a clear track record of achievement, we should continue to build on the successes of our past as we plan for improvements in the future.

Section 4 – Insurance Coverage in Vermont

In 2008, according to the BISHCA Health Care Expenditure Report, 59.9% of the Vermont population (371,870 people) were covered by private insurance. (An estimated 21% of that population, 130,463 people, were in self-funded ERISA Plans). Although Vermont has relatively few private insurance companies [BC/BS, MVP and CIGNA account for over 95% of the major medical insurance business administered by commercial insurance companies as reported by the Annual Statement Supplement Report (ASSR)], none of the insurers, individually, have had sufficient market share, financial clout, or political will to fundamentally change the way health care is delivered in our state. In addition to these private insurers, in 2008 Medicaid covered @ 16% of Vermonters (99,159 people), not including dual eligible's, and Medicare covered 14.2% (88,027 people). Approximately 7.6% or 47,286 Vermonters have no health insurance coverage at all, and 2.4% have some form of Military coverage.

Even in our small state, each of these payers, private and public have their own reimbursement rules and methodologies, administrative requirements and clinical rules regarding prior approvals, claims adjudication processes, edit standards, etc. There is growing recognition among healthcare experts that although "a multi-payer system may allow for more consumer choice and innovation, this division of responsibility among multiple payers contributes to high costs in American health care".[6]

"**Consequently, no strategies are likely to be successful in controlling health care costs unless payers work together to give providers consistent incentives to improve performance".**[7]

[6] Anderson, Reinhardt, Hussey and Petrosyern, Health Affairs 2003
[7] United Hospital Fund, A Multi-Payer Approach to Health Care Reform, Sean Cavanaugh, Gregory Burke, 2010

In the United Hospital Fund Report, the authors note that 'because health coverage is fragmented among multiple public and private health plans, any individual health plan typically represents a small share of any practice's patients, and, therefore, has insufficient leverage to spur improvements in quality and to control costs…. By the same token, health care providers are often frustrated in trying to deal with the myriad of conflicting payment structures, quality measures, and incentive programs offered by individual public and private health plans. Providers cannot effectively respond to incentives unless they are clear and consistent and cover most of the practice"[6]

By establishing a single payer payment system or one which may include multiple payers, (public and private) but which requires all payers to adopt and adhere to a single payment methodology, standard performance measures, local care coordination, and common reporting standards and evaluation processes, we have a much greater likelihood of achieving our health care reform goals.

While the advantages of creating what I would refer to as an "all-payer system of reimbursement", are fairly obvious, the ability to achieve that objective will not be easy. National insurance companies often have established reimbursement policies and procedures which cannot be easily adapted to a small rural state. Additionally, the care management processes which will be vital to the success of Vermont's restructured delivery system are often essential parts of what insurance companies offer to their customers. Asking nationally-based insurance companies to defund their established care management processes in order to financially support our Vermont initiatives will not be an easy sell.

Allowing payers to collaborate to establish common payment methodologies, provider payment rates, and performance measures may pose anti-trust questions which will need further consideration as the state moves toward implementation. A state may choose to provide state action immunity in the antitrust context as long as the activity is clearly articulated and affirmatively expressed as state policy and the activity is actively supervised by the state government. See California Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc, 445 U.S. 97 (1980). In Act 128, the legislature articulated a state policy of pursuing payment reform and anticipated state involvement in the development of payment reform issues in order to ensure active state involvement and to provide immunity if necessary to achieve the state's goal of reforming the payment system. As we move forward in implementation, this issue should, however, continue to be analyzed in the specific context of the reform efforts.

In Vermont, as noted earlier, 21% of the population is insured through large business' self-insured plans. ERISA prohibits states from requiring employers to provide specific benefit plan offerings and this restricts the state's ability to regulate self-insured health benefit plans. The state, however, maintains its traditional state authority to regulate insurers and health care providers. Because payment reform ideas are plowing new ground, there have been no ERISA challenges to the ideas presented in this report. If Vermont's approach to payment reform is to voluntarily attract self-insured employers to participate, there would be no basis for an ERISA challenge. It is the goal to ensure that the plan is attractive enough to offer employers better value for their employees and therefore, large employer groups would voluntarily participate in these reform initiatives. The need to demonstrate positive results, both clinical and financial, will be critical in order to convince large employers to participate.

Dr. William Hsiao, in his recent report to the Vermont Legislature has suggested that the state consider decoupling health coverage from employment. His plan establishes a health benefit system where eligibility is based on residence, not ability to pay. This plan is then funded with a variety of funding sources,

including federal funds from multiple sources, existing cigarette taxes, and a payroll tax. Dr. Hsiao engaged national experts to assess the viability of an ERISA challenge to this system, and the experts indicated that while this is an untested area, based on past court decisions, the state would have a good argument that this plan does not violate ERISA.

Vermont already has in place the delivery system structure through the Blueprint for Health that can serve as a strong foundation upon which to build our payment reform efforts. The Blueprint provides the funding for community health teams to work closely with primary care providers to better coordinate the care of patients across a continuum of services. It also has an enhanced payment component built into its reimbursement model which pays providers a Per Member per Month (PMPM) amount based on National Center for Quality Assurance (NCQA) scores. This model could provide the basis for reducing FEE-FOR-SERVICE payments and increasing PMPM payments based upon efficiency, quality, access, and outcome measures which are in the control of the providers.

In addition, Medicare has recently approved Vermont's application to support the Multi-Payer Advanced Primary Care Practice Demonstration, and CMS has renewed the Medicaid Global Commitment from January 1, 2011 through December 31, 2013. Because the Global Commitment has been extended, and the MPAPCP Demonstration Project is being overseen by the CMS Centers for Medicare and Medicaid Innovation, Vermont may have the opportunity and flexibility to develop new all-payer methodologies that are consistent with CMS' goals for health care reform. For the past several years, Vermont's Health Care reform Commission has been exploring how the Accountable Care Organization (ACO) model might be incorporated into the state's comprehensive health reform program. "The Affordable Care Act (ACA) includes numerous payment and delivery system reform provisions designed to realign incentives and encourage providers to deliver high-quality, patient-centered care. One provision creates a program in Medicare that provides the opportunity for ACOs to receive a share of the savings they generate after formally assuming responsibility for the cost and quality of health care given to a defined group of patients. This provision also calls for the new Center for Medicare and Medicaid Innovation to develop alternative payment methods for ACOs."[8]

We recommend working very closely with CMS and the Innovation Center as we develop these new payment methodologies in order to insure we are in compliance with CMS rules and regulations and that we are able to understand and pursue those CMS initiatives that further our health care reform goals in Vermont. A number of funding opportunities for states to pursue are included in the Affordable Care Act (ACA). A number of these funding opportunities are listed in Appendix 2.

[8] The Commonwealth Fund/Modern Healthcare Health Care Opinion Leaders Survey, October 2010

Section 5 - Delivery System and Payment Reform

Delivery System Reform

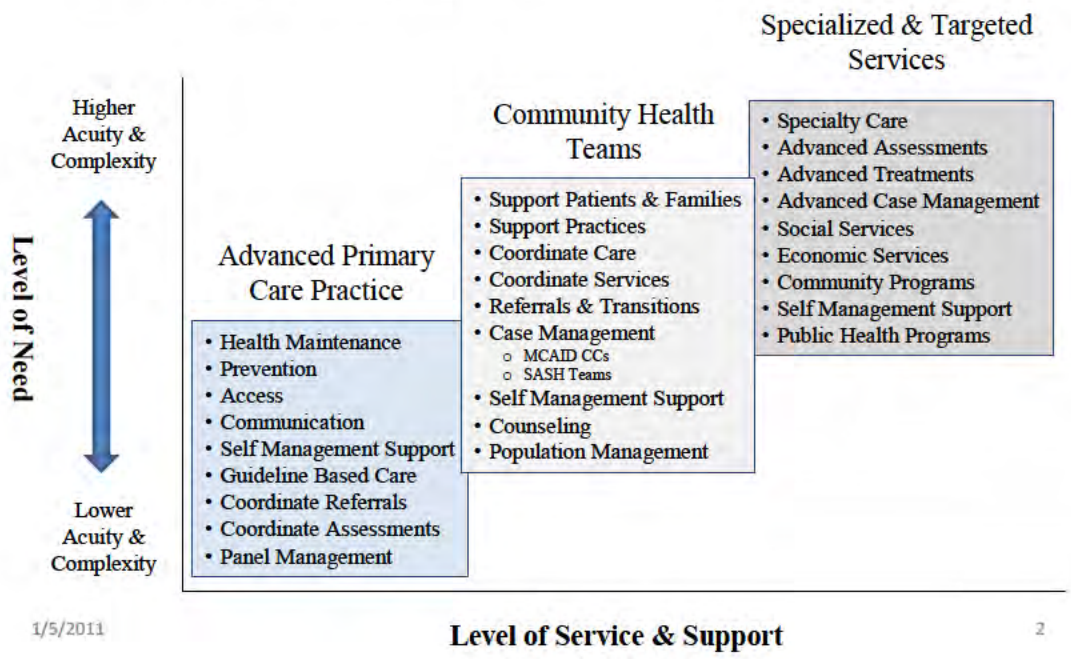
In his Inaugural Address, Governor Shumlin challenged us "to create a single-payer health care system that provides universal, affordable health insurance for all Vermonters that brings these skyrocketing costs under control." Dr. Hsiao, in his report has made specific recommendations on how we could achieve these goals. This report will recommend a specific path we might follow to move from a fee for service volume based reimbursement system that does little or nothing to promote the coordination of health care services to a "value-based" payment system that incentivizes the integration of cost effective and high quality health care services to all Vermont citizens. These payment models will be built on the principles of integrated care that have already been established in the Blueprint for Health, and will be structured to strengthen and reinforce the clinical process improvements in our delivery system that we have already made to date.

This delivery system model would broaden the role of the Community health teams including an expanded focus on prevention and wellness, continued coordination and integration of care for patients with chronic disease, and the responsibility to identify and focus on high risk/high cost patients to improve the care they receive. The goal is to improve the quality of care provided to patients and minimize avoidable, unnecessary, or duplicative services.

The new payment methodologies will be designed to align the financial incentives and clinical responsibilities among all providers so that patients receive health care services that add value and improve patient outcomes. Realigning the delivery system structure and payment methodologies in this way provides an exciting opportunity to organize health care services around the needs of patients with a focus on quality, outcomes and cost effectiveness. The 2010 Annual Report of the Blueprint for Health will describe in great detail the preliminary results of the pilot projects and the essential role of the community health teams in helping to coordinate and integrate patient care services. Suffice it to say, the early trend results of the Blueprint's impact are very encouraging.

The overall design of the Blueprint Integrated Health Services model provides patients with seamless and well-coordinated health and human services. This includes transitioning patients from patterns of acute episodic care to preventive health services. Well structured follow up and coordination of services after hospital based care has been shown to improve health outcomes and reduce the rate of future hospital based care for a variety of patient groups and chronic health conditions (e.g. reduce emergency department visits, hospital inpatient admissions, readmissions). CHT members, hospital staff, and other community service providers work closely together to implement transitional care strategies that keep patients engaged in preventive health practices and improved self-management. A goal of the Blueprint model is seamless coordination across the broad range of health and human services (medical and non-medical) that are essential to optimize patient experience, engagement, and to improve the long term health status of the population.

The Community Health Team serves as the central locus of coordination and support for patients. The spectrum of services from those appropriate for the general population to those targeted to subgroups with specific needs is illustrated below.



Payment Reform:

In order to achieve the clinical goals described above, the payment system must be re-designed to provide the financial incentives necessary to motivate providers to change clinical behaviors and to participate in the restructuring of the delivery system with a renewed focus on quality, coordination of care, improved outcomes, and the utilization of cost-effective treatments. We do not believe these goals can be achieved within the framework of a fee-for-service reimbursement system that is primarily based on volume and productivity, with little reward for, or recognition of quality. A recent study by the Special Commission on the Health Care Payment System in Massachusetts describes the characteristics a new payment system should have in order to achieve the goals we have identified:

1. As currently implemented, fee-for-service payment rewards service volume rather than outcomes and efficiency, and therefore other models should be considered.

2. Health care payments should cover the cost of efficiently provided care, support investments in system infrastructure, and ensure timely access to high quality, patient-centered care. Additional payment should reward and promote the delivery of coordinated, patient-centered, high quality health care that aligns with evidence-based guidelines where available, and produces superior outcomes and improved health status. Performance measurement should rely on reliable information and utilize uniform, nationally accepted quality measures.

3. Provider payment systems should balance payments for cognitive, preventive, behavioral, chronic and interventional care; support the development and maintenance of an adequate supply of primary care practitioners; and respond to the cross-subsidization occurring within provider organizations as a result of the current lack of balance in payment levels by service.

4. Differences in health care payments should reflect measurable differences in value (cost and quality). Payments should be adjusted for clinical risk and socio-economic status wherever technically possible, and should promote greater equity of payments across payers and providers, to the extent that this is financially feasible.
   a. Differences in health care payments should be transparent, including across different payers.
   b. Costs associated with desired investments in teaching and research should be paid outside of base payments, and should require provider accountability for how such payments are spent.
   c. Costs associated with desired investment in special “stand by” capacity should be accounted for in the payment system.

5. The health care payment system should be structured in such a way as to minimize provider, payer and patient administrative costs that do not add value.

6. Payment reform must consider how:
   a. Some payment methods may require certain organization of the service delivery system &
   b. Health benefit designs either support or limit payment reform.

7. Health care per capita costs and cost growth should be reduced, and providers, payers, private and public purchasers and patients should all share in the savings arising from payment reform.

8. The health care payment system should be transparent so that patients, providers and purchasers understand how providers are paid, and what incentives the payment system creates for providers.

9. It will be necessary to consider the diversity of populations, geography and providers across the Commonwealth when designing payment reform to ensure high quality, patient-centered care to all populations and geographic regions in the Commonwealth.

10. Implementation should be leveled over time with:
    a. Clear and attainable deadlines;
    b. Planned evaluation for intended and unintended consequences; and
    c. Mid-course corrections.

(Editorial note: These recommendations of the Commission have not yet been implemented by the Massachusetts Legislature.)

As we discussed earlier, while maintaining Fee-for-service as the basis for payment and providing small enhanced PMPM payments based on performance may be a reasonable short-term or transitional strategy, it should not be viewed as the solution to a comprehensive payment reform initiative if we are serious about redesigning the health care delivery system and improving the overall quality of care provided. Furthermore, engaging just one or two payers in this effort of payment reform does not provide sufficient incentives to change provider behaviors in ways that are significant enough to improve delivery system structure and processes. Although it may not be possible to move immediately from a fee-for-service payment system to a system which is based on performance and value, that should be our ultimate goal, and it should involve all payers operating under a single set of payment rules and regulations. We believe these goals can be achieved under a single payer form of payment or a multi-payer system with one common set of rules, regulations, and measurements. Ensuring achievement of these goals will require state leadership and participation to insure that laws and regulations that are promulgated by our legislative and administrative bodies consistently support the path we have chosen, and help to clear many impediments, legal, regulatory, or financial which stand in the way of achieving our health reform goals.

Surgeons are now being encouraged to take a time out before beginning any surgical procedure in order to review a pre-operative "check list" to ensure the right procedure is being done on the right person and that all the necessary pre-surgical reviews have been completed and are in order. I would suggest that the Legislature and/or Administrative bodies should also pause and review a "checklist" before passing any new laws or regulations to ensure they are consistent with, and promote the values of the system we are striving to build. One good question to ask before considering the passage of any new law or regulation might be:

"Does this law/regulation contribute to the achievement of our healthcare reform goals, and is it consistent with the principles we have defined as necessary to the achievement of these goals"?

Section 6 ---- A Four Tiered Approach to Payment Reform

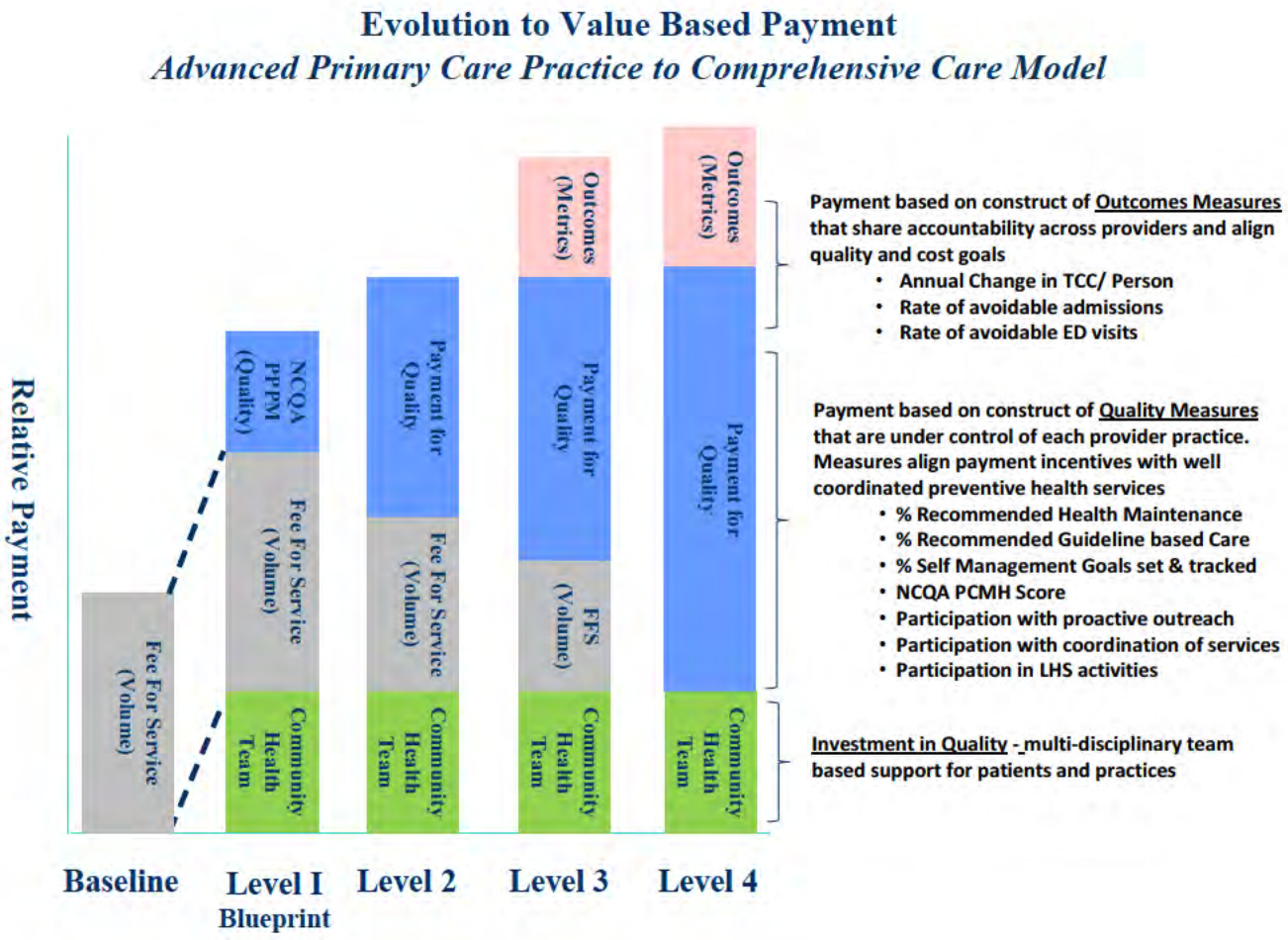
Currently, providers are at much different stages in their readiness and/or willingness to implement significant changes in their care delivery processes and/or accept value-based payments which move away from fee-for-service reimbursement and involve some degree of financial risk. Given the experiences with managed care and capitated payments in the 1990's, this is understandable, and we should be diligent in avoiding the mistakes of the past as we implement new payment reform methodologies. Under our proposed payment models, different degrees and types of financial risk should initially be offered to providers based upon the size of their practices, organizational characteristics and culture, use of health information technology, and general receptiveness to become early adopters of change. We should be careful not to push providers too far out of their comfort zones as we begin this transformational process. 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.

We envision the state eventually having some number of fully integrated health care delivery systems that cover most of the state. These delivery systems would be able to accept a global payment. Under a global payment, these systems would assume the risk for efficiency and appropriateness of care (performance risk), and some degree of insurance risk. The amount of insurance risk to be borne by providers will need to be addressed as we develop these new payment models. These health care systems would incorporate the medical home model developed through the BluePrint in order to optimize primary care delivery and cost management. However, these systems would not place the full responsibility for managing health care costs on primary care providers, as past models of managed care have sometimes done.

The figure below illustrates that, as organizations become more integrated, they are more capable of moving away from fee-for-service and assuming greater levels of financial risk. It also illustrates the need to develop more sophisticated systems for monitoring and rewarding quality of care as we move toward greater financial risk and system integration. The chart demonstrates the relationships between organizational characteristics/structure, payment models and type of performance measures to be employed. As organizations become more integrated to provide a broader range of services, they are also more likely to accept fully capitated payments and have a sufficiently large patient base to employ outcome measures. This chart is consistent with the payment reform models described later in this section.

Some provider groups serving Vermonters may be ready to assume global payments in the near future. Others will need to develop the capacity to assume greater risk over time. These groups may operate more effectively under "shared savings" models, which set targets for total expenditures and share the risk and reward for deviation from the target between providers and payers. Still others may never have the capacity for risk-based models and may opt to continue operating under a limited fee-for-service model. We propose exploring different models of payment reform to meet the needs of providers with varying capacities for assuming risk and managing costs. These models would involve a range of options for the scope of services included, and a range of options for the extent to which payments are prospectively budgeted.

Four such models are illustrated below. It should be emphasized that these models of payment reform are not meant to be sequential over time, and we may have different provider groups functioning at different levels across the state simultaneously. This chart is not meant to portray a process over time, but rather a variety of opportunities for providers to consider based upon their organizational characteristics and readiness for reform. A practice or organization may be interested in becoming a pilot site at any of these four levels. These different levels and the characteristics of each are described below with some detail:



Level 1 - Blueprint Model (Medical Home)

The first level of the proposed transition is already occurring through the Blueprint for Health. We currently have thirteen Blueprint sites in operation, and are intending to expand the Blueprint to include at least two practice sites in each health service area by July 2011. Progress is well underway toward that end.

The Blueprint supports the primary care providers (PCPs) by funding Community health teams associated with the practice, and by providing enhanced payments based on NCQA quality standards in addition to the fee-for-service payments. This system provides the PCP's with the clinical support they need to better coordinate care for their patients, and with enhanced reimbursement to reward their efforts to improve the quality of care in their practices. Financial support for the community care teams, and the enhanced payments paid on a per member per month basis constitute the first level of payment reform in our transition model.

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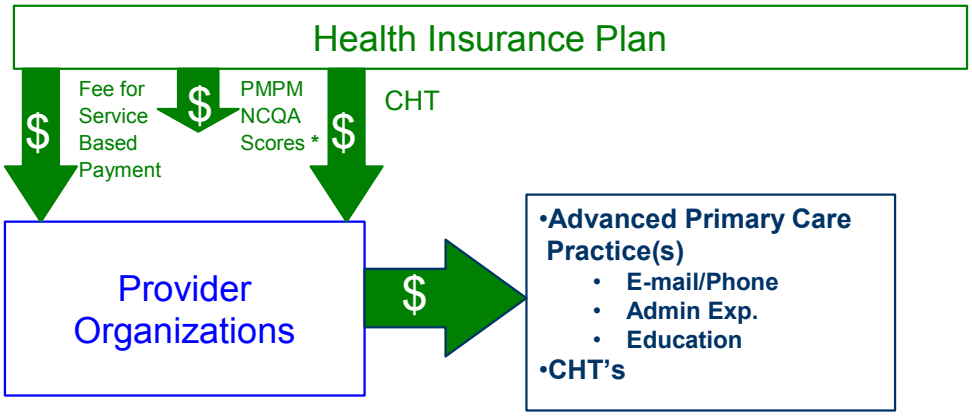
Level 1: Blueprint Model



**** PMPM Payments based on NCQA scores range from $1.25 - $2.50 PMPM***

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Level 2

Some Primary Care Practices have been operating as Blueprint sites for several years, and have successfully demonstrated their ability to change clinical processes and improve provider and patient satisfaction in accordance with the Blueprint goals. Providers in these practices should be approached to determine their willingness to accept larger PMPM payments while reducing fee-for-service reimbursement. The PMPM would be tied to the providers' performance relative to the NCQA standards and to additional measures of quality performance and patient centered care soon to be developed. The PMPM payments would be substituted for all or part of the fee-for-service payments, and would offer providers even greater revenue enhancement opportunities based upon their performance relative to the expanded quality measures. The expanded PMPM payments would be condition-adjusted based on the clinical risk groupings of patients attributed to the practice.

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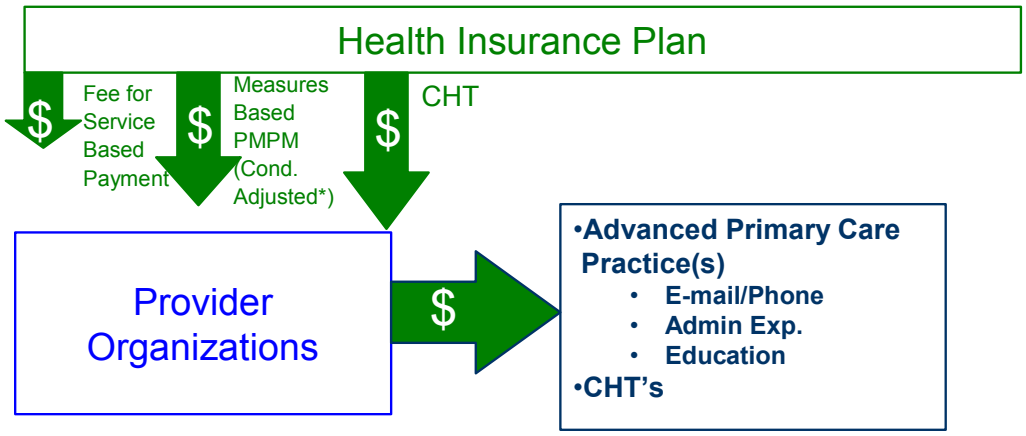
Level 2: PMPM Payment Based on Performance Measures



**** Payment measures related to performance, patient centered care, and quality.***

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Level 3

Some FQHCs and hospitals have developed, or are developing, close clinical relationships and organizational systems intended to improve access for patients, better coordinate care in a region, reduce avoidable utilization of expensive health care services, and integrate health information technology into their practices. In addition, a number of Independent Practice Associations (IPAs) are being formed in different regions of the state in order to establish physician collectives that might be interested in exploring different payment models and participating as pilot sites. These organizations may be interested in exploring opportunities to participate in payment reform methodologies which would recognize their efforts to improve clinical services and would provide the appropriate risk/reward motivation to encourage achievement of the State's health care reform goals.

In these sites, Fee-for-service payments would be replaced by condition adjusted PMPM payments based on clinical practice performance measures as discussed previously, bundled payments for specialists, and payment incentives to better integrate behavioral health and home health services into the practice. Additional bonus opportunities related to reduced number of avoidable ER visits, hospital admissions and re-admissions, lab tests and imaging could be made available to these practices based upon pre-established utilization and expenditure targets.
This payment model is illustrated below.

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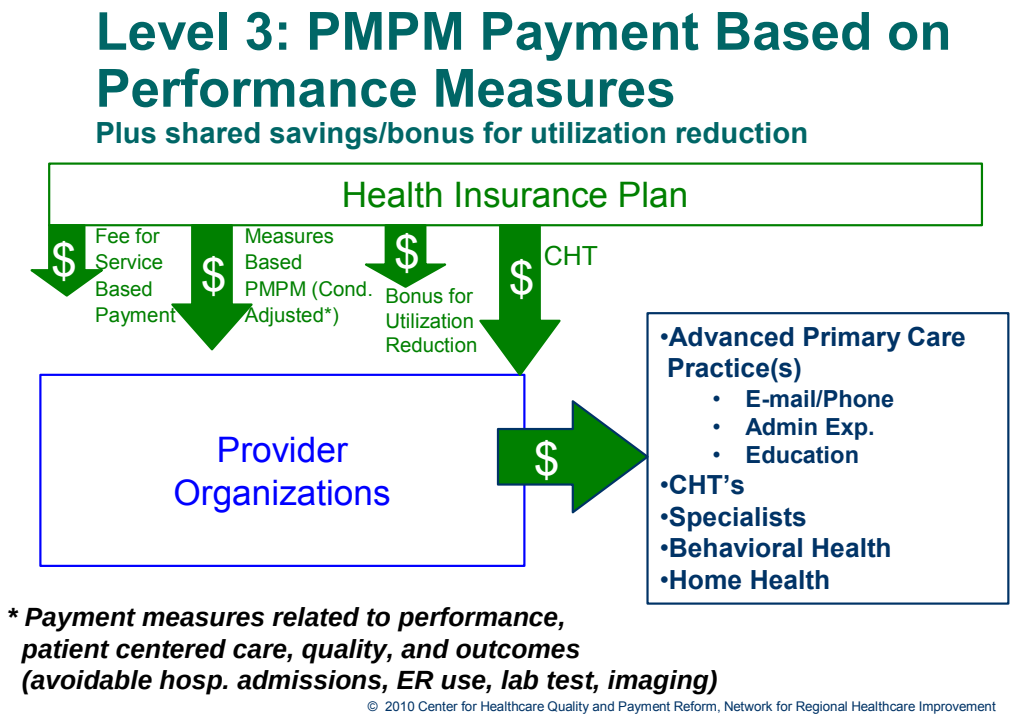
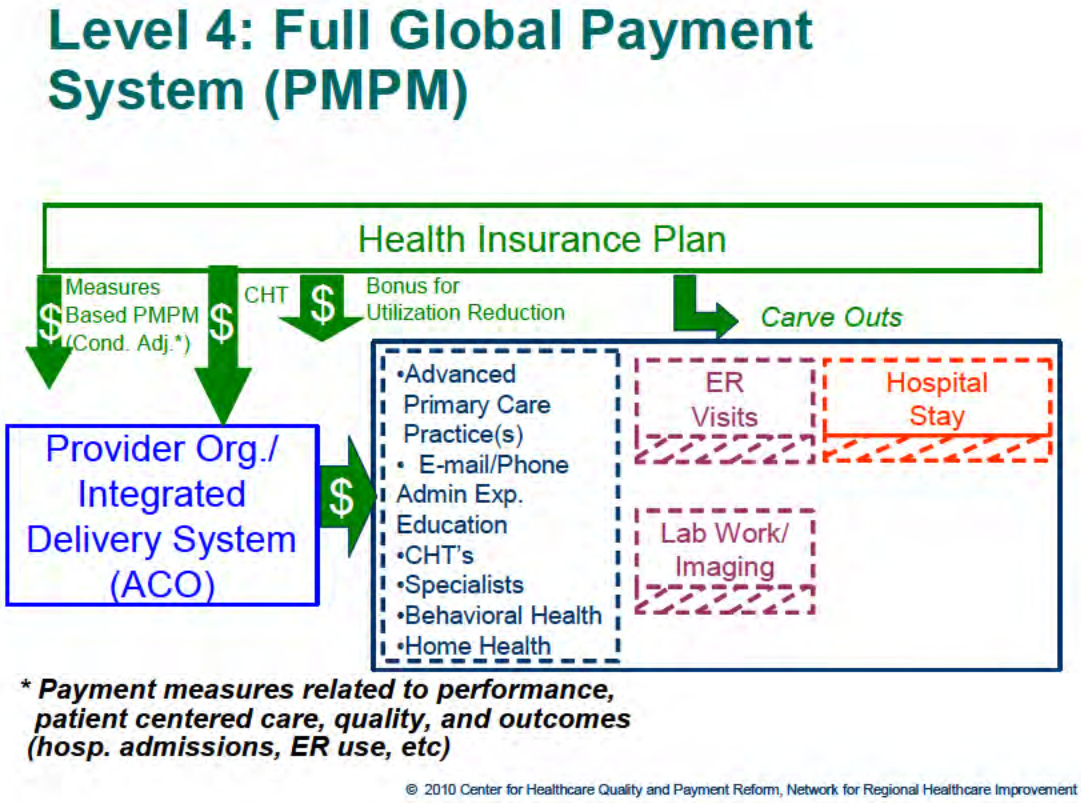


Level 4:

The fourth level would include those practices and hospitals that are ready to assume full performance risk for a defined population over a defined period of time. Under this model, providers would assume performance (cost and quality) risk and some degree of insurance risk for a broad and comprehensive array of services which would include primary care, specialty care and a full range of hospital services. The amount of insurance risk to be borne by providers will need to be addressed as we develop these new payment models. This could be considered an ACO or integrated health care system. This payment model is illustrated below.



[9] Adapted from the Center for Healthcare Quality and Payment Reform Network for Regional Healthcare Improvement – Harold Miller, MD

Section 7: Selection of Pilots for Payment Reform

Language in Act 128 requires that the Director of Payment Reform provide a strategic plan for the selection and development of pilot projects to the House Committee on Health Care, and the Senate Committee on Health and Welfare by February 1, 2011. The strategic plan shall provide:

(i) A description of the proposed payment reform pilot projects, including a description of the possible organizational model or models…

(ii) An ongoing program evaluation and improvement protocol.

(iii) An implementation timeline for pilot projects with the first project to become operational no later than January 1, 2012, and with two or more additional pilot projects to become operational no later than July 1, 2012

No implementation of pilot projects shall occur until the strategic plan has been approved and/or modified by the General Assembly.

In accordance with this requirement of Act 128, I present the following:
Criteria for selection of Pilots: **(The pilots should be selected based upon provider readiness, and the practice characteristics described in Section 6. It should be emphasized that these levels of transition are not necessarily sequential and we may have different provider groups functioning at different levels across the state simultaneously. A practice or organization interested in becoming a pilot site at any of these four levels would be considered. I would suggest the following criteria for pilot selection in the four Transition Levels.**

Level 1
This level would consist of those primary care practices that are interested in becoming Blueprint sites, and are willing to adopt the Blueprint criteria for practice performance and payment. Blueprint staff would be assigned to assess the readiness of the practice to become a Blueprint site, and to suggest improvements that would need to occur before the practice could be considered for designation as a Blueprint site. Practices at this level of readiness and interest would not be considered as pilot sites for payment reform as defined in this report.

Level 2
Primary care practices that are currently participating in the Blueprint, or have demonstrated success in implementing delivery system reform, including the establishment of community health teams, and have achieved a score of at least 2.0 in the NCQA scoring process would be eligible for consideration as a Level 2 pilot site.

This would require a willingness on the part of the practice to accept quality performance measures which would be tied to increased PMPM or capitated payments. Fee-for-service reimbursement would be reduced as PMPM payments are increased, but the increased PMPM payments would be set at levels that would result in higher levels of reimbursement if the quality performance measures were met. A scoring scale relating performance to payment would be developed, which would relate payment to performance.

The PMPM payments should be condition adjusted in order to provide sufficient financial incentives for the providers to accept patients into their panels with significant medical problems. Selection of potential pilot sites meeting the criteria of Level 2 could begin as soon as this Strategic Plan is approved by the General Assembly.

Level 3

Potential pilot sites meeting the criteria of Transition Level 3 would be those sites that meet the Level 2 standards, but have also developed more advanced systems to coordinate care among other providers in their region and are willing to accept some additional risk/reward opportunities through value-based payments.

At this level of performance, providers would be asked to accept condition-adjusted PMPM payments which would include a broader scope of services than included in Level 2, and might include bundled payments for specialty services, and other shared savings models to encourage reduced utilization of avoidable services. Capitated reimbursement for behavioral health and home health care should be considered in Level 3 pilots.

Providers at this level would be paid a condition-adjusted PMPM amount which would cover the reasonable cost of clinical and administrative functions in the practice, without many of the administrative requirements imposed by a Fee-for-service system. Payment for the cost of the Community health teams would continue to be in addition to the PMPM payments. These practices would also have the opportunity to receive bonuses or shared savings payments based upon financial and utilization targets related to the reduction of avoidable hospital admissions and re-admissions, ER utilization, lab testing and imaging for their patients. These bonus payments would be in addition to the PMPM payments they would otherwise receive.

Level 4

Provider organizations eligible to become a Level 4 pilot would be those organizations that have a history of assuming some level of clinical performance risk and a degree of insurance risk through PMPM or global payments, and would be willing to expand these payment models to include a larger number of patients and all payers.

Providers/organizations considered for this level would need to be willing to assume a defined amount of financial risk for a broad and comprehensive array of services which would include primary care, specialty care, and a full range of hospital services. Behavioral Health and Home Health Services could be incorporated as part of this payment model. This could be considered an ACO or integrated delivery system which would assume responsibility for comprehensive health care services to a defined population over a specified period of time.

Eligibility as a pilot at this level would require an organization with a sufficient number of attributed patients to be able to assume a defined level of financial risk which includes both performance and insurance risk. The amount of insurance risk to be borne by providers at this level will need to be addressed as we develop the payment methodologies. This pilot would need experience in managing this type of risk in the past, with a record of reasonable performance, and financial stability. Financial reserves may be required for Level 4 Pilots. These pilots would also need to have sophisticated health information systems to insure appropriate management of patient care services, delivery of timely and accurate feedback to providers regarding their performance, and the ability to process financial information in a timely and accurate manner. A pilot at this level would probably require a combined patient population of at least 100,000 people.

Section 8 Reimbursement of Specialists, Hospitals, Behavioral Health, Home Health and Long Term Care

Specialists

How to reimburse specialists for services rendered presents some vexing problems which are to date, unresolved. Unless specialists are part of a fully-integrated health care delivery system in which financial incentives are fully aligned between PCP's, specialists and hospitals, the reimbursement of specialists is based primary on volume through a fee-for-service system with few incentives for high quality, coordinated care or reduced cost.

Much has been written recently about redesigning payment methodologies to specialists by moving away from fee-for-service reimbursement toward condition-specific bundled payments which consist of comprehensive payments to the specialist covering all costs of services rendered to a patient for a specific condition. [10] For an orthopedic surgeon, this might include all costs associated with diagnosing a particular problem, the treatment of that problem (including any durable medical equipment and surgical fees), and the cost of treating any unexpected complications resulting from the specialists' treatment for a specific period of time.

Condition-based bundled payments of this kind assume that the specialist treats relatively large numbers of patients for a specific condition, and has the processes and resources in place to accept pre-defined payments with a reasonable degree of certainty regarding the outcomes he/she will achieve.

It also assumes a high degree of transparency about patient outcomes and quality of care so that patients have the opportunity to make informed decisions regarding the selection of a specialist to treat a specific condition. Currently, we have, for the most part, neither a system of bundled payments for specialists, nor sufficient outcome information for most patients to make an informed decision regarding their selection of a specialist. Usually their decisions are influenced by a referring physician, or friends and relatives who have received services from the specialist in the past. Little data is available regarding the relative cost of the specialists' services compared to others in the area, nor is there easily obtainable information, by physician, regarding the number of procedures performed, complication rates, patient satisfaction scores, etc.

Although information regarding the quality of care rendered by the specialist might influence a patient's choice, unless the patient has a high deductible health plan, the cost of the service is probably of little or no interest to the patient.

As we consider new payment methodologies for specialists we first must insure that patients have access to information regarding the relative value (quality and cost) of different providers for equivalent services. Second, specialist providers could be grouped into cost/quality tiers based on their performance history and patients could be expected to pay some or all of the difference in cost for using low value or high cost providers. Third, better information must be provided to consumers and providers regarding the relative value of the service/procedure being considered (quality, cost, satisfaction) and/or possible alternatives to

[10] Work Session Topics for the CIVHC Delivery System Redesign/Payment Reform Strategy Session, January 6, 2011

major acute care services (i.e. surgery). Financial incentives could be provided to specialists for involving patients in shared-decision making processes regarding major treatments or services.

Conversely, payments might be reduced for specialists that perform major acute care procedures at a significantly higher rate (adjusting for patient conditions) than others, and/or patients could be required to pay additional costs for choosing to receive major services when the need for such services is uncertain or unnecessary.

Fourth, in order to promote coordination and collaboration of services between PCP's and specialist, specialists would only receive their full fee-for-services rendered if they have a contract with the patient's primary care practitioner agreeing to coordinate services when they receive a referral from that practice.

Summary of Specialist Reimbursement
Payments to specialists should reward those who provide high value (quality/cost) services and agree to coordinate information regarding a patient's care with the referring primary care practice. Patients should have easy access to information regarding the value (quality/cost) of specialist's services by provider, and should be incentivized financially to choose those providers offering the highest value services.

Hospital Payments

Similar to specialists, unless hospitals are part of a fully-integrated health care system paid under a global capitation, they are paid under a variety of payment methodologies which overall reward increased volume and the use of high end diagnostics or treatments which are most profitable under the current reimbursement system.

Critical Access Hospitals are paid by Medicare through a cost-based reimbursement system which provides a base of financial stability to the hospitals, but which offers little or no incentives for efficiency or cost reductions related to specific services. Under cost-based reimbursement, more cost equates to more revenue and reductions in cost results in lost revenue from Medicare.

Hospitals face some very difficult decisions in the next few years. As we contemplate implementing reforms in our clinical delivery system and payment methodologies, we are assuming that , as a result of enhanced case management and other structural changes, there will be significant reductions in avoidable hospital admissions, re-admissions, non-urgent ER visits, and unnecessary lab testing and high-tech imaging services. These are all revenue producing services for the hospitals.

In the past, hospitals experiencing reduced utilization/revenue in one or more service lines have been able to increase their rates/charges in other services or add new service lines to offset revenue. Since a high percentage of costs in hospitals are fixed, the ability of hospitals to respond to dramatic reductions in utilization will be difficult and could threaten the viability or existence of some of our institutions. Although some may view this as desirable, hospitals are among the largest employers in most of the communities in which they are located, and quality health care services in a community are often an attraction for new businesses considering relocation to Vermont. While no business, including hospitals, should be guaranteed survival indefinitely, steps could be taken to ensure that hospitals are given a reasonable amount of time to adjust their business models to reflect the realities of a reformed health care system in Vermont.

The following steps could be considered to provide that time:

1. The Vermont hospital budget process could be simplified during the next three years by establishing targets/caps on increases in hospital net revenues – similar to what was done in 2010. Private insurance plans and Medicaid should be expected to approve the rate increases submitted by the hospitals as long as hospitals are within the pre-established net revenue targets. Public policies that result in further cost shifting to private payers should be avoided.

2. Funds for technical assistance, if needed, could be made available to hospitals to help them eliminate waste and increase efficiency so that reductions in revenues would be accompanied by reductions in costs. Hospitals could also be encouraged to work together with other facilities to redirect specific services into "Centers of Excellence" located at various sites throughout the state. Technical assistance could be provided for this purpose as well.

3. Payers should be encouraged to "share savings" that are achieved through reduced utilization with the providers for a defined period of time in order to mitigate the impact of this revenue loss.

Where populations are large enough, hospitals should be encouraged to organize their services, together with other providers of care, to create a more formal organizational structure which would be able to accept global payments in exchange for providing a defined set of services to a defined population over a specific period of time. Risk corridors and service carve outs should be considered as part of this payment model.

Summary of Hospital Reimbursement

Hospital budget processes should be simplified over the next three years with clearly defined targets around costs, net revenues, and rate increases. Further payment reductions that result in cost shifting should be eliminated. Technical assistance dollars or resources should be provided to help hospitals adjust their business models to reflect the realities of a changing health care system in Vermont. Payers should be encouraged to share savings resulting from reduced hospital utilization with the hospitals for a defined period of time. Hospitals should partner with other providers to create an organizational structure that assumes accountability and responsibility for the delivery of comprehensive health care services provided to the people in their community/region through a capitation payment or global budget.

Behavioral Health

The management of patients with behavioral health issues in hospital emergency rooms and primary care practices is becoming a significant problem. It has become clear that traditional medical practices have neither the time, resources, nor expertise to appropriately manage patients with significant behavioral health problems during the course of an ER or primary care visit. Many, if not all, of the Blueprint sites have now incorporated behavioral health staff into their primary care practices as an integral part of the community health team. However, accessing needed treatment on an emergency basis, or coordinated follow up care still remains an unresolved problem in many areas of the state. Better integration of behavioral health services into our primary care practices, and more formal referral relationships with mental health providers along with associated payments should be considered as we implement our pilot projects.

Home Health Care

For years, Vermont has pursued a strategy of developing home-based resources for individuals as alternatives to nursing home placement. We have strengthened our home health systems and we have encouraged the development of independent living and assisted living facilities for our elderly and disabled residents. A high percentage of patients discharged from hospital requiring continuing home-based care through home health agencies and/or independent or assisted living facilities. All of these services should be closely coordinated with primary care providers and community health teams if they are going to be effective and cost efficient. We need to encourage close coordination of care and information sharing between our primary care practices and home-based providers of services. We should also explore payment methodologies and financial incentives that will encourage this higher level of cooperation.

Long Term Care

"Long-term care services in Vermont are paid for with Medicaid, private health insurance, long-term care insurance, private funds and state general fund monies. In 2007 (the year for which most recent system wide data is available), $91,320,000 was spent on home care services (2.2% of total health care expenditures) and $224,568,000 was spent on nursing home care (5.4% of the total). Much of this care is publicly funded. In 2007, private insurance paid for 3.6% of the home health care received by Vermonters and 2.3% of the nursing home care received by Vermont residents. Although the cost of nursing home care is significant, only 3.3% of Vermonters age 65 or older reside in nursing homes.

In FY 2008, Vermont spent a total of $195,144,931 on long-term care services for older persons and adults with physical disabilities. Fifty-eight (58%) of these public expenditures were spent for care in nursing homes, while 42% paid for home and community based services. Table 5.1 below illustrates the Medicaid expenditures for nursing home care relative to community-based programs. In fiscal year 2009, DAIL estimates that a similar proportion of public expenditures for long-term care services will go to nursing homes and community based services. With the institution of the Choices for Care Program, a Medicaid 1115 waiver, Vermont has been able to expand less costly community Based services as an alternative to nursing home care.

According to 2007 U.S. Census Data (the most current available), the Vermont population was ranked 12th oldest in the nation with 13.6% of Vermont's population 65 years or older. By 2010, 14.3% of Vermont's population is projected to be aged 65 or older, ranking 11th in the nation. In 2030, one in four Vermonters is projected to be age 65 or older making Vermont the 8th oldest state in the country. These demographic trends must be considered in Vermont's health resource planning." [12]

We are making no specific recommendations regarding a change in payments to nursing homes or community based care facilities in this report. However, because these services are predominately funded by Medicaid, it is a budget concern that should be addressed in the not too distant future.

Section 9: Health Information Technology

Rather than include a full discourse on Health Information Technology, I am including the two paragraphs regarding this topic which was included in the 2009 Vermont Health Resources Allocation Plan (HRAP). I would concur that integrated health information technology will be an essential ingredient of our health care reform efforts and must have the capability to allow providers to access comprehensive, accurate and timely data regarding their clinical performance and financial impact. I also agree that the best source of information regarding health information technology would be found in Vermont's Health Information Technology Plan. The section on health information technology from the HRAP report is presented below:

Health information technology (HIT) is a key component of any health care reform or resource allocation decision. The Commonwealth Fund Commission on a High Performance Health System estimates that the investment of 1% of health insurance premiums in health information technology could save the country $88 billion over ten years of the projected national health expenditures totaling $4.4 trillion. The American Recovery and Reinvestment Act was signed into law by President Obama on February 19, 2009 and contains $19.2 billion in spending on health information technology. In order to have a higher functioning, more integrated care delivery system, health care providers must have greater and more streamlined access to data that can only be provided through the expansion of integrated health information technology.

The 2005 HRAP contained an entire chapter on health information technology. We did not include a separate chapter on HIT in the 2009 HRAP. We made this decision for several reasons, most notably because the Vermont Health Information Technology Leaders (VITL) have done much work in this area and it was felt that the HRAP would simply be duplicative. However, it is important to recognize that virtually all health care reform measures, including those focused on quality improvement and those focused on cost containment, have a vital HIT component. Vermont's Health Information Technology Plan recognizes this and is a good resource for those interested in focusing more specifically on HIT.[11]

Section 10: Estimated Savings Resulting from Reform Initiatives

A number of studies and reports are now available in Vermont which provides estimates of expenditure savings resulting form health care reform initiatives either currently taking place in Vermont or now being considered. The Blueprint for Health team has developed a very detailed financial model which projects reduction in utilization of clinical services and resulting avoidance of expenditures. These projections estimate cumulative reduction in expenditures of nearly $400 million through 2015. Initial results of actual performance from Blueprint sites are currently being evaluated and will be incorporated into the Blueprint 2010 Annual Report scheduled for release shortly.

Dr. Hsiao's report presented to the Legislature in January 2011 contains in-depth analysis of potential reductions in expenditure growth resulting from the implementation of his recommendations. These savings are a result of reductions in administrative costs, avoidance of fraud and abuse, integrating the delivery system, and moving to a no fault medical malpractice system. Dr. Hsiao is projecting savings of over $500M in 2015, the first year of implementation of his recommended Option #3.

[11] State of Vermont Health Resources Allocation Plan, July 1, 2009, State of Vermont, BISHCA

Vermont has also recently completed a study of variances in utilization of specific clinical services between hospital service areas. This study is known as the Act 49 Variance Analysis. Although Vermont performs very well in this report compared to national and regional data, there is indication of significant variances in utilization in specific hospital service areas which, if addressed, could potentially result in expenditure reductions. BISHCA will also soon release its updated 2009 projections on expenditures based upon historical utilization and expected trends over the next three years.

Taking into consideration each of these reports, the Legislature and Administration should develop its own expenditure targets through at least 2015 based on the health care reform initiatives it intends to pursue. With the VHCURES data soon to be available, we should have enough utilization and financial information to track actual expenditures for health care services against the financial targets we have established. This provides a framework for the evaluation of the financial impact of the reform efforts we have implemented and can serve as a basis for consideration of future initiatives or corrections that will need to be made when our targets have been exceeded.

I would suggest the creation of a working group of financial experts representing government, providers and payers to evaluate the financial reports and projections we have received to date, along with the reform initiatives we intend to implement in order to create new expenditure targets to be used as a basis for the evaluation of the success or shortcomings of our efforts.

Section 11: Program Evaluation and Improvement Protocols

A program evaluation model would be established for each pilot site based upon a review of practice evaluation models that are able to link payment to performance.

Initially we will use the NCQA standards that practices are now using to score their practice performance, and, as the PMPM payments are increased, we will deploy additional performances measures related to patient experience, quality, and efficiency of service and clinical outcomes, where appropriate. These measures will be developed in conjunction with payers, providers and consumers to insure they are meaningful and reasonably achievable.

In addition, utilization and financial performance targets will be established for each pilot taking into consideration past performance, and new utilization and financial targets established by the State of Vermont. These targets should be based on actuarial assumptions related to the characteristics of the patients attributed to the practices, the benefit package available to patients, and expectations of utilization and per capita costs assuming a redesigned delivery model.

PMPM payments will be established in advance based the above criteria, and will be monitored against actual performance on at least a quarterly basis.

Utilization and financial information will be made available to providers on at least a quarterly basis in a format that will highlight performance (positive and negative) and will be informative enough to allow providers to use as a basis for performance improvement. Having this information available to providers in a timely, transparent, and useful way is a critical element in the evaluation and performance improvement process.

We should anticipate that these performance and financial measures will be adjusted from time to time as we experience actual results and respond to our successes and opportunities for improvement. We do not expect that these measures will be static over long periods of time. We will be adjusting our "dials" so to speak as we learn more over time.

Section 12: Conclusion

Proceeding toward payment reform and developing pilot sites by recognizing and reinforcing the degree of readiness different providers and hospitals may be at regarding their willingness to accept condition--based payments and changes to their clinical practices seems like a reasonable way to proceed at this time. Establishing different levels and types of risk assumption based upon the provider organization's size, culture and readiness for reform is a way of recognizing the providers' efforts to date, while still making significant steps toward the overall clinical performance improvement and payment reform goals we are hoping to achieve.

Implementing these delivery system and payment reform changes should be done within the framework of reduced total healthcare expenditure targets established by the Administration and the Legislature. These targets should be established based upon reasonable expectations of improved quality and reduced utilization of avoidable/unnecessary services resulting from the achievement of our health care reform goals. Dr. Hsiao's report which outlines potential savings, the Blueprint for Health projections of utilization reductions and expenditure savings, the ACT 49 Variance Report, and the expenditure reduction targets discussed in Section 1 of this report, should provide the Legislature and Administration a reasonable framework for establishing utilization and financial targets. The reform initiatives that will need to be accomplished in order to meet these targets should also be made very clear.

These utilization, cost, and quality targets should be very specific and should be monitored on a continuous basis using health care and financial information we have available on a state-wide basis.

Decisions regarding the potential for sharing savings that exceed the budgeted targets, and conversely, the financial consequences of not meeting the targets should be made prior to fully implementing the reform measures. Some agreed upon system of sharing risk and rewards between payers, providers, businesses and consumers also needs to be established.

As we move forward to plan and implement new methodologies and approaches to provider payments, we should be careful to understand the unintended consequences and incentives created by any payment system and are sure that what we are proposing is, in fact, incenting providers to achieve the goals that we intended.

We should also be mindful that we are engaging in a difficult and complex change process which, without doubt, will create uncertainty and concern among a variety of stakeholders. We can expect much resistance to any proposal we make. Patience, clarity, understanding and empathy will be important characteristics for us to exhibit as we move along this path.

Vermont is attempting to do what no other state in this country has accomplished----a sweeping and comprehensive reform of its health care delivery and payment systems. We should be proud of our efforts to date, and confident that our state can lead the nation toward a higher quality and more cost effective health care system.

APPENDIX I

Proposed Steps toward Implementation of Health Care Reform in Vermont

Presented below are some steps that would need to be considered prior to a move from our current delivery and payment system to the reformed health care system we anticipate. This is not an exhaustive list, but could be used a framework or checklist as we move forward with our reform initiatives.

1. Establish a state health care expenditure target through 2019 which should not be exceeded.

    a. Break down expenditure targets by provider type and payer type
    b. Establish payment and utilization estimates reflecting these targets
    c. Reach agreement regarding consequences of exceeding targets and rewards for achieving overall expenditures below targets
    d. Translate the expenditure target into a cost per capita target based on estimated growth/decline in the Vermont population

2. Implement plan to restructure delivery system

    a. Expand the Blueprint model to 100% of all willing primary care providers by 2013
    b. Empower Community health teams with expanded roles focused on prevention/wellness, management of patients with chronic disease, and focus on high risk/high cost patients (Medicaid, Medicare, other)
    c. Create a performance manual detailing expectations of Community Care Team members in their expanded role:
        - Medication management
        - Hospital discharge follow up
        - Organizational relationships
        - Many others
    d. Establish means to measure success of Community health teams
        - Reduction in avoidable hospital admissions/re-admission
        - Reduction in avoidable ED visits
        - Improved medication management
        - Reduction in duplicated lab tests/imaging
        - Reduction in cost per capita
        - Other

3. Prepare to implement at least one payment reform project by January 1, 2012

   a. In order to move from fee-for-service to PMPM, the following must be considered:
      - How will the patients be attributed to the practice?
      - What is the scope of service to be covered by the PMPM?
      - What are the baseline utilization patterns and expenditures associated with those patients over the past 12/24 months within the scope of services defined?
      - Establish targets for utilization and expenditures for the pilot related to the scope of services defined
   b. How will the PMPM be determined
      - Straight PMPM equal for all patients
      - Age/sex income adjusted
      - Condition adjusted
      - Adjusted based on benefit plans
   c. How will the practice/providers be paid?
      - PMPM with a withhold
      - Fee-for-service with a withhold tied to financial targets
      - PMPM adjusted quarterly based on quality scores
      - Other
   d. How will the payments be administered
      - Single processor
      - Multiple plan payments

4. Develop and define the performance measures: quality measures, process measures, outcome measures, financial measures, patient satisfaction measures

   a. Establish a baseline for each measure
   b. Determine how practice will be scored and how the score influences the PMPM payment
   c. Provide support to providers to understand data requirements and how data must be entered into the electronic system
      - Establish data interfaces with VITL/Docsite, etc
      - Agree upon content and timing of reports coming back to the practice
      - Assign responsibility to personnel in the practice to review, disseminate and report on data to the providers
      - Assign responsibility for using data to improve practice/provider performance
      - Estimate costs associated with data systems and determine who is going to pay

5. Learning and Support

    a. Establish process for training providers and staff regarding new roles, administrative requirements, use of data, use of systems, communication with CHT's, etc.
    b. Determine who pays for initial training and ongoing Education
    c. Other:

6. Consumer Education

    a. Patients need to understand rules of the new systems
    b. Will consumers have limitations on choice of providers and services
    c. Encourage DPA, living wills and advanced directives
    d. Responsibility for Medication management
    e. Expectations regarding interactions with CHT members

APPENDIX 2

Sample of State Funding Opportunities Identified in the Affordable Care Act (ACA)

Medicaid Waiver Demonstration Projects for Dual Eligible's (Sec. 2601)

- Extends these demonstrations for five years, and, upon requests from a state, they can be extended for additional five year periods.

Planning Grants to Provide Health Homes for Chronically Ill Patients (Sec. 2703)

- Secretary awards grants to states to develop State Plan Amendments to provide health homes for patients with two chronic illnesses, one chronic illness and risk factors for another, or a serious and persistent mental health condition.
- States will include in the state plan amendment methodologies for tracking hospital readmissions or calculating savings from improved care coordination, and a proposal for using health IT in providing health care home services.
- State shall provide a designated provider, a team of health care professionals operating with such a provider, or a health team with payments for the provision of health home services to each eligible individual with chronic conditions that selects the provider or team.
- The Secretary pays each eligible State an amount each quarter equal to the Federal medical assistance percentage of expenditures in the quarter. During the first 8 fiscal year quarters that the State plan amendment is in effect, the Federal medical assistance percentage applicable to such payments shall be equal to 90 percent.
- Funding: $25 million or less authorized per state.
- Secretary must report to Congress before Jan 1, 2017. Demonstrations will begin Jan 1, 2012 and end on Dec 31, 2016.

Demonstration to evaluate integrated care around a hospitalization, i.e. bundled payments (Sec. 2704)

- Evaluating integrated care around a hospitalization: provides bundled payments for episodes of care that include hospitalizations, incl. physician services provided within a hospital (Jan 1 2012 through Dec 31, 2016).
- To be conducted in up to 8 states. Can be targeted to a specific population, but population should reflect demographic/geographic Medicaid population nationally.
- Demonstrations should focus on conditions for which there is evidence that quality care be improved while reducing expenditures under the Medicaid program.
- Each state will identify the one or more episodes of care that it will address, specify the services to be included in the bundled payments, and its rationale for each selection. The HHS Secretary can ensure that there are varied factors across states and may modify those chosen by particular states.

- States must ensure that patients are not liable for any additional cost sharing under the demonstration and that they receive similar services that they would have otherwise received without the demonstration given their care needs.
- States must provide the HHS Secretary with relevant data regarding outcomes, costs and quality. The Secretary will evaluate the demonstration and report to Congress not later than a year after conclusion of the projects.

Medicaid Global Payment System Demonstration Project (Sec. 2705)

- Shift payments to safety net hospital systems from fee for service model to a global capitated payment model (FYs2010 2012). Safety net hospital system to be defined by the Secretary.
- 5 or fewer states will participate (selection will be made by HHS Secretary).
- Budget neutrality requirements are waived for this demonstration during testing period.
- The Innovation Center (established within CMS see below) must evaluate and Secretary must report to Congress.
- Funding: Appropriations as necessary to carry out the section.

Title III Improving the Quality and Efficiency of Health Care
Subtitle A Transforming the Health Care Delivery System

Value based purchasing demonstration programs (Sec. 3001)

- Establish value based purchasing demonstration projects under Medicare to test innovative methods of measuring and rewarding quality and efficient health care furnished by critical access hospitals, other hospitals that provide inpatient services,
- Begin the demonstrations no later than 2 years from enactment and conduct them for a three year period. Secretary must submit a report to Congress with recommendations no later than 18 months after completion of the demonstration project.
- Program for hospitals will begin in 2013 and will apply payment for discharges after Oct 1, 2012.

Grants to Develop Quality Measures (Sec. 3013)

- The Secretary may award grants or contracts to support new, or improve existing, efforts to collect and aggregate quality and resource use measures.
- Eligible entities include multi stakeholder entities that that coordinate the development of methods and implementation plans for the consistent reporting of summary quality and cost information; an entity capable of submitting such summary data for a particular population and providers, such as a disease registry, regional collaboration, health plan collaboration, or other population wide source; or a Federal Indian Health Service program or a health program operated by an Indian tribe.
- Funding: FYs2010 2014. Non Federal contributions must equal $1 for every $5 of federal money.

Create a Center for Medicare and Medicaid Innovation (CMI) within CMS (Sec. 3021)

- Test, evaluate, and expand different payment structures and methodologies to reduce program expenditures while maintaining or improving quality of care.
- Payment reform models that improve quality and reduce the rate of cost growth could be expanded throughout the Medicare, Medicaid, and CHIP programs.
- Center for Medicare and Medicaid Innovation (CMI) will be up and running by Jan 2011.
- Methods include: payment practice reform and medical home models, coordinating chronic illnesses, moving towards salary based payment for physicians, utilizing medication therapy management services, establishing community based health teams and promoting patient self management, etc.
- Funding: $5m for FY2010 and $10b for FYs2011 2019.

Medicare Shared Savings Program, ACOs (Sec. 3022)

- Beginning Jan 1, 2012, permits qualifying groups of physicians and hospitals to be recognized as Medicare ACOs and to share in Medicare cost savings above a certain threshold, provided that certain quality standards are satisfied.
- Secretary of HHS may pay ACOs using a partial capitation model or other payment model that improves quality and efficiency.
- ACOs will use technology to promote evidence based medicine and patient engagement, report on quality and cost measures, and coordinate care

National Pilot Program on Medicare Payment Bundling (Sec. 3023 and Sec. 10308)

- Establishes a national pilot program to for integrated care to develop and evaluate bundled payment for acute inpatient hospital service, physician services, outpatient hospital service, and post acute care services for an episode of care that begins three days prior to a hospitalization and spans 30 days following discharge.
- Hospitals receive bundled payments for a hospitalization and physician services provided during hospital stay.
- Begins Jan 1, 2013 in up to 8 states. If the pilot program improves (or does not reduce) quality and reduces spending, then develop a plan for expanding the pilot by Jan 1, 2016.
- Pilots will run for five years and can be reauthorized.
- HHS Secretary must conduct an independent evaluation on the pilot program and report to Congress.

APPENDIX 3

I'd like to acknowledge the many people who have taken the time to meet with me over the past few months as I prep and write this report. Your advice, counsel, education, and support were invaluable to me. I also want to acknowledge the participating members of the "Payment Reform Advisory Group" that represented providers, insurers, business people, health care and educational associations, and consumers. Your willingness to go through this process with me is greatly appreciated. I hope this document is reflective of your hopes and concerns regarding these complex issues, and that we have provided a reasonable path to help facilitate the restructuring of our healthcare delivery and payment systems in Vermont.

Richard Slusky