Robert Wood Johnson Foundation Payment Reform Evaluation Project

Development of Models for Comprehensive Payment Reform in Vermont

Green Mountain Care Board

Spring 2014 Site Visit Report

Prepared by the University of Washington

Department of Health Services

Seattle, Washington

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Introduction and Context

The Development of Models for Comprehensive Payment Reform in Vermont has been and will continue to be shaped by the state's ambitious plan to provide universal health insurance for nearly all Vermonters. In the past decade Vermont's health care system has faced economic and access problems. In 2005-2010 annual costs of health care have grown 6.3 percent in a flat economy that cannot afford them.[1] The cost of health insurance has increased and the benefits of health plans have decreased, while about eight percent of Vermont residents and 28 percent under age 65 are underinsured. In response, and on the heels of the federal Affordable Care Act (ACA), in 2011 the Democrat-controlled Vermont Legislature, with strong leadership from Governor Shumlin, passed Act 48, promising a "universal and unified health system" as a "public good" that also controls costs and offers quality care.

Through Act 48 Vermont is moving toward a more highly state government-regulated and -controlled health care system. The legislation creates three new institutions in state government to implement the universal health care system, but specifies few details about what the new insurance scheme will look like and how it will work. In particular, universal health insurance through a "single payment system" is mentioned conspicuously only a single time in the Act. The following new institutions are the government's infrastructure for improving access to health care, controlling costs, and maintaining quality of health care:

- *Creation of Vermont's health insurance exchange, Vermont Health Connect*.[2] The exchange is the marketplace for Vermont residents and employers to shop for health insurance. Vermont is a "full player" in the ACA and is one of 15 states implementing its own health insurance exchange and Medicaid expansion in 2014. Act 48 mandates that Vermont's exchange offer health plans from at least two private insurers, plus two multi-state plans, as required by the ACA.[3] Medicaid expansion is a moot issue because Vermont already covers working adults with incomes up to

[1] Source: Green Mountain Care Board, Health care cost growth in Vermont continues to outpace national growth, underscores need for reform. Vtdigger.org, March 22, 2012. Website: http://vtdigger.org/2012/03/22/health-care-cost-growth-in-vermont-continues-to-outpace-national-growth-underscores-the-need-for-reform/. In 2005-2010 the U.S. growth rate in health care costs was 4.2%.
[2] Information about Vermont's health insurance exchange, Vermont Health Connect, is available at the following website: https://portal.healthconnect.vermont.gov/VTHBELand/welcome.action
[3] Source: Brief Summary of Act 48. Available at: http://hcr.vermont.gov/sites/hcr/files/ACT%2048%20one%20page%20summary%20June%2014.pdf

almost 200 percent of the federal poverty level (FPL),[4] exceeding the ACA's threshold of 133 percent FPL. In 2014 Vermont's exchange offers health plans to eligible residents and small employers, and will do so to large employers in 2017. The health insurance exchange is administered by the Department of Vermont Health Access (DVHA), the State agency overseeing Vermont's public health insurance programs and one of six Departments in Vermont's Agency of Human Services (AHS).

- *Creation of Green Mountain Care (GMC)*.[5] GMC is the health insurance programs sponsored by the State of Vermont. Today, GMC consists mainly of Vermont's Medicaid plans for adults and children, and for the aged, blind and disabled. In the future, GMC may become the State's public-private universal health insurance program for nearly all Vermonters, contingent on meeting several requirements defined in Act 48. Sources of GMC revenue will include Federal payments for Medicaid and Medicare services and payments from health plans in the Vermont exchange, as well as potential revenues from other sources. The revenues will pay for the administration and delivery of health services covered by GMC's health plan through a simplified, common, and single administrative and payment system. The AHS will have oversight of the universal health plan, but the law allows flexibility in implementing the plan, such as contracting out administrative functions through a competitive bidding process.[6] The universal health plan's earliest possible start date is 2017.

- *Creation of Green Mountain Care Board (GMCB)*. The Legislature has created an independent, five-member Board that has broad, unprecedented regulatory authority over Vermont's health care system. In particular, Act 48 recognizes that limited resources exist for health care, and therefore, guaranteeing coverage depends heavily on controlling the costs of health care. Act 48 charges the Board to:

  > *"… oversee the development and implementation, and evaluate the effectiveness of, health care payment and delivery system reforms designed to control the rate of growth in health care costs and maintain health care quality in Vermont."* [7]

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[4] Source: Kaiser Family Foundation. Medicaid: A Primer. March 2013. Available at: http://kff.org/medicaid/issue-brief/medicaid-a-primer/

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

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

[7] In brief, Act 48 charges the GMCB with promoting the good of the state by: 1) improving population health; 2) reducing growth in per capita expenditures without compromising access and quality; 3) enhancing patient and

The GMCB is authorized to implement a wide range of statewide payment reforms, including setting cost-containment targets, global budgets, risk-adjusted capitated payments, bundled payments, or other payment models. The GMCB also has other powers to control costs, such as setting payment rates for health professionals and approving hospital budgets, certificates of need, and payer premiums. The Act recognizes, however, that payments must be sufficient for health care organizations and professionals to remain solvent, and thereby secure their participation in GMC.

Because of limited public funds in Vermont, the GMCB applied for and was awarded a grant from the Robert Wood Johnson Foundation in 2012 to design and implement its payment reform strategies. Development work under the RWJF grant eventually led to the award of a three-year, $45 million State Innovation Model (SIM) grant from the Centers for Medicare and Medicaid Services' (CMS) Center for Medicare & Medicaid Innovation (CMMI) in 2013 called the Vermont Health Care Innovation Project (VHCIP), which is based in Vermont's Agency of Administration with the GMCB and DVHA as primary co-leaders. The award is playing a vital role in implementing GMC. Among its many purposes, the VHCIP provides resources to design, implement and evaluate Vermont's value-based payment models; coordinate the health care-related work of several State agencies; support the work of government-private partnerships engaged in delivery system reform; and support information system development.

GMC will build on significant, ongoing transformations of Vermont's health care delivery system that align well with universal health insurance. The Act intends that GMC enrollees will receive primary care through Vermont's Blueprint for Health, the statewide, multi-payer advanced primary care demonstration program that meets National Committee on Quality Assurance (NCQA) medical home standards, and that has community health teams to link patients with social and other services.[8] Blueprint medical practices currently provide care to about three-fourths of Vermont residents.[9] In addition, Vermont health care organizations have formed the following three accountable care organizations (ACOs), currently with about 150,000 total patients attributable to the Medicare, Medicaid and commercial shared savings programs:

- OneCare Vermont: consists of all Vermont hospitals and their employed physicians, Dartmouth Hitchcock in New Hampshire, some federal qualified health centers and independent medical offices, as well as mental health and substance abuse agencies and skilled nursing facilities.
- Community Health Accountable Care (CHAC): consists of Vermont's federally qualified health centers (FQHCs), along with mental health and substance abuse agencies and skilled nursing facilities.

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provider experience with care; 4) recruiting and retaining high quality health care professionals; and 5) achieving administrative simplification of health care financing and delivery.

[8] Source: Act 48 (see also Title 33, Chapter 18, Sub-Chapter 2, Section 1826,

[9] Source: Green Mountain Care Board, Robert Wood Johnson Foundation grant application.

- Vermont Collaborative Physicians/Accountable Care Coalition of the Green Mountains (VCP/ACCGM): consists of independent primary care and specialty practices.

The ACOs have an important tool for coordinating care among their health care organizations and professionals: a statewide clinical information system being developed by Vermont Information Technology Leaders (VITL).[10] The system will offer clinical data in real time to support care delivery throughout Vermont, for instance, through alert notifications that inform providers when their patients have a sentinel event such as an emergency department visit or hospital admission, discharge or transfer.

In summary, Act 48 is moving Vermont toward a more government- regulated and -controlled health care system. This strategy did not happen by accident but rather reflects Vermont's small geographic and population size that fosters civic engagement and collaboration, its long history of state-regulated health care,[11] and health markets with little competition.[12] GMC may or may not be launched in 2017, depending on whether two milestones are achieved. First, the AHS and the Governor's Office must propose the GMC benefit package and the financing plan to fund GMC, and the Secretary of Administration must propose the health information technology plan, and all three proposals must be approved by the GMCB. The three-year financing plan for GMC must have lower costs than Vermont's current health care system. Second, by law the State of Vermont may implement GMC only after all of the following conditions are met:

- State of Vermont receives a federal waiver under Section 1332 of the ACA by 2017 to use Medicare, Medicaid, and other federal funds to support GMC
- Vermont Legislature authorizes financing and appropriates funds for the initial GMC benefit package approved by the GMCB[13]

[10] Act 48 endorses the statewide information system. In 2008 the Vermont Legislature established a Health Information Technology Fund, which collects funds through a "tax" on claims, and provides financial support to VITL to build and operate the health information system (See: http://hcr.vermont.gov/hit/IT_fund). VITL is building the information system through data flows from health care organizations throughout Vermont.

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

[12] Vermont is divided into non-overlapping service areas, which reduces competition among hospitals, mental health agencies, and other health care organizations. Little competition exists among Vermont's two commercial payers, Blue Cross/Blue Shield of Vermont and MVP Health Care (Cigna is a third party administrator), with Blue Cross/Blue Shield controlling 80% of the private commercial market. Medicaid covers about a quarter of the state's residents. Competition also is limited by the relatively small number of Vermonters (roughly 300,000) covered by commercial health plans. Vermont's restrictive health insurance laws, such as guaranteed issue (insurers not allowed to deny coverage) and community rating (insurers cannot charge based on health status or lifestyles), also may be reducing the number of commercial insurers in the state.

[13] Current estimates indicate that in Vermont's existing health care system, employers and individuals pay $2.2 billion annually. GMC may save $332 million, and Medicaid may provide $249 million, leaving a $1.6 billion shortfall (although other estimates are up to $2.2 billion) that must be made up with government revenues -- if employers stop offering insurance to employees. However, what businesses paid in insurance premiums may be

- GMCB confirmation that six conditions of Act 48 will be met, including reduction in growth of health care spending[14]

The last condition makes payment reform and cost control a top priority of Vermont's health system reforms.[15]

Project Objectives

The project's long-term objective is to have a universal and unified health care payer (Green Mountain Care) supporting population-based payments for Vermont health care providers. This project intends to bridge the gap between the current health care system in Vermont and this objective through implementing and evaluating diverse payment system reforms across the state. Over time the payment system reforms will move away from the current fee for service (FFS) payments toward value-based payments that control costs and improve the quality of care and population health.

Approach

Act 48 mandates that "the state must assure public participation in the design, implementation, evaluation and accountability mechanisms of the health care system." With this goal in mind, and consistent with Vermont's culture of civic engagement, the State-run SIM Project has an elaborate governance structure that engages literally hundreds of Vermonters in developing the universal and unified health care system.[16] Overall direction is provided by the eight-member Core Team (that includes the GMCB Chair).[17] The Core Team, in turn, receives guidance from the 37-member Steering Committee that is co-chaired by the GMCB Chair and the Commissioner of DVHA. The Steering Committee and Core Team receive guidance from the following work groups; individuals may serve on multiple groups:

- Payment Models Work Group
- Quality and Performance Measures Work Group
- Care Models and Care Management Work Group
- Disability and Long Term Services and Support Work Group
- Health Information Exchange Work Group

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replaced partially by a new employer payroll tax to fund the plan. Act 48 does not indicate how GMC will be financed (sources: Sean McElwee, The Atlantic, December 27, 2013; Avelere Health, Evaluation of Vermont Health Care Reform Financing Plan, November 14, 2013).

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

[15] The current Chair of GMCB notes that "We need to put the payment and delivery reform as the priority, and the financing portion of single-payer shouldn't be done until we know what we're financing" (Source: Morgan True. Not enough time for a global budget experiment at Rutland Regional, State Says. VTDIGGER.ORG, June 16, 2014; http://vtdigger.org/2014/06/16/enough-time-global-budget-experiment-rutland-regional-state-says/).

[16] Source: http://healthcareinnovation.vermont.gov/node/706

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

- Population Health Work Group
- Health Care Workforce Work Group

The 27-member Payment Models Work Group plays a central role in proposing payment reform models for the universal health care system.[18] GMCB also has a 55-member Advisory Committee that offers guidance and recommendations to the GMCB.

Payment reform. The Payment Models Work Group is designing or has implemented recently the following value-based payment models for all payers as stepping-stones toward the ultimate goal of population-based global budgets:

- Shared Savings Programs (population-based payments to ACOs): All three ACOs are participating in Vermont's commercial, Medicaid and Medicare shared savings program, which is modeled closely after the CMS Medicare model.[19] If each ACO meets quality standards for the care of its patient population, the ACO shares in the savings (if any) with the payers.[20] The ACOs currently face no financial risk. For populations under age 65 with commercial coverage, the program is limited to health plans in Vermont's exchange because the plans have the same benefit and premium structure. Payment remains FFS, with the goal of transitioning to risk sharing by 2016 and global budget/capitation payment possibly by 2018. A key point of discussion is whether and how financial risk is shared within an ACO's organizations.
- Episodes of Care/Bundled Payments: This payment model is in the design phase and has not been implemented. Hospitals are major employers of physicians in Vermont, and bundled payments give hospitals and physicians common incentives to reduce costs and improve quality for patients with specific conditions.[21]
- Pay for Performance: The design of this payment model began in 2014 and starts with the Medicaid Program. This work is informed by the Blueprint for Health, which has implemented pay for performance in primary care offices.
- Global Budgets: This payment reform is in the design phase and has not been implemented. The intent is to develop regional and population-based payment arrangements (such as global

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

[19] Key informants suggested that Vermont may have the first ACOs with shared savings in the U.S. to transition from Medicare to multi-payer.

[20] A "gate and ladder" approach is planned for awarding savings. For commercial patients, each quality measure is compared to the national benchmark and assigned 1, 2 or 3 points based on whether the ACO is at the national 25th, 50th or 75th percentile for the measure. If the ACO does not achieve at least 55% of the maximum possible points across all measures, the ACO is not eligible for any shared savings ("quality gate"). If the ACO enters the gate, the ACO shares savings according to a quality ladder, for example, earning 75% of potential savings for achieving 55% of possible points, 85% of savings for 65% of possible points, and 95% of savings for 75% of possible points. For Medicaid patients, the scheme is similar but the percentage-of-points thresholds are lower.

[21] Vermont stakeholders recognize that bundled payments may be more effective in controlling costs when nested within global budgets.

budgets or capitation) for hospitals and their affiliated physicians, where payment is based on the total population in a hospital's service region.[22] Several hospitals have expressed interest in this payment option, and two hospitals are working with consultants to develop draft global budgets. Vermont's ultimate goal of payment reform is to move toward population-based global budgets for all payers, which will require a federal waiver for Medicare and Medicaid. The GMCB is monitoring closely Maryland's Medicare waiver as part of its CMMI demonstration project. Plans to implement an all-payer global budget pilot project this year at Rutland Regional Medical Center were halted because federal approvals from Medicare and Medicaid could not be obtained by the October 1 deadline, because a partial global payment without the two public plans would leave too much of hospital's care driven by FFS, volume-based reimbursement, and because of logistical concerns about being ready to launch the project by October 1.[23]

In summary, many of Vermont's payment reforms are in development, and the next 12 months will be critical for completing and implementing the payment models, possibly by January 2016.

Starting in 2012 three payment reform pilots, described below, have been implemented to engage providers in payment reform and launch Vermont's movement away from FFS reimbursement. While the pilots are still running, they are local rather than statewide initiatives and, therefore, are receiving less attention today in Vermont's push for statewide payment and system reform.

- Vermont Oncology Pilot Project. In northeastern Vermont, oncology and primary care providers are receiving enhanced FFS payments for providing support services and co-managing the physical and psychological symptoms of about 50 patients with cancer and their families. The pilot is expected to improve patient experience and satisfaction, reduce unnecessary services, and reduce oncology expenditures. The GMCB's evaluation of the pilot begins in fall of 2014.
- Congestive Health Failure (CHF) Medicare Bundled Payment Initiative. Health care organizations in the Rutland area are receiving bundled payments and providing improved multi-disciplinary care coordination across providers and organizations for about 120 patients with hospital admissions for CHF. Preliminary results show CHF readmission rates and all-cause readmission rates have been cut in half.[24] Pilot participants are considering expanding the pilot to include chronic obstructive pulmonary disease.
- Emergency Department Pilot. The GMCB has recently approved a care coordination pilot to reduce emergency department visits in St. Albans in northern Vermont, which has the state's

[22] Vermont's 14 hospitals have mutually exclusive service regions that cover the state's entire geographic area. The hospital global budgets would be set as part of the GMCB's annual hospital budget-setting process (Source: GMCB RWJF Application).
[23] Source: Morgan True. VTDIGGER.ORG, June 16, 2014.
[24] Source: GMCB Annual Narrative Report Year 2 to the Robert Wood Johnson Foundation, June 2014.

highest ED visit rates. Blue Cross/Blue Shield Vermont and Medicaid will participate in the pilot and are developing the payment model.

The GMCB is engaged in several other payment and financial activities. It is examining payment variation across hospitals and other providers and is considering transparent, public reporting of hospital prices and quality for specific procedures. In accordance with Act 48, the GMCB is performing hospital (budget) rate reviews, and conducting rate hearings, and will be approving hospital budgets and approving or modifying insurance rates for 2015.

Delivery system reform. Aligned with Vermont's ultimate goal of population-based global (or capitated) payments, Vermont's ACOs and Blueprint for Health are supporting health care organizations and their providers in managing health on a population level, particularly for chronic conditions and disabilities, through coordinated care from health and social service agencies. Clearly, having Blueprint in place before Act 48 is a major advantage: Blueprint has the potential to reduce costs.[25] In Blueprint's community health teams, providers from private clinics, FQHCs, behavioral health, home health agencies, aging agencies, housing agencies, and others meet regularly to build linkages across services to address the needs of people with mental health, substance abuse, and other health and social problems. Access to electronic clinical data for patients in real time is being developed to support care coordination across these sundry organizations.

Tracking measures. The Payment Models Work Group and the Quality and Performance Measures Work Group are responsible for developing common measures for implementing and evaluating payment and other system reforms across multiple payers. In addition, vast amounts of data are being collected in the State's Health Information System.

Logic Model

On one hand, the logic model and priorities for Vermont's payment reform and universal health care system are relatively simple: on a statewide, population-level, payment for health care must change from volume-based, fee-for-service reimbursement to value- and population-based payment to control costs. If this goal is achieved, Vermont will be more likely to have sufficient public and private financial resources to afford a universal and unified health care system, which will improve access to health care and population health.[26]

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

- First, a mechanism must exist to initiate system-wide transformation. In Vermont the mechanism is the leadership of state government and its legal authority over the state's health care system through Act 48.

[25] Source: Avelere Health, Evaluation of Vermont Health Care Reform Financing Plan, November 14, 2013.
[26] Improvements in population health, in turn, may lead in the long-run to lower care costs.

- Second, infrastructure must be created to design and implement the transformation, such as creating new institutions (GMCB), health information systems, and ACOs, all having a statewide, population-level perspective.
- Third, transformation must be orchestrated to build collaboration, trust and social capital among health professionals, businesses, and other groups and citizens to engage in statewide transformation for the public good.
- Fourth, interest groups collaborate productively to design, test and implement new payment models with performance targets to preserve quality.
- Fifth, the new payment models, in turn, lead to changes in delivery systems that better manage health to address needs and thereby lower costs in populations.
- Finally, the new universal and unified health system increases access, maintains quality, has affordable costs, and is endorsed by Vermonters, ultimately improving population health and reducing health disparities.

Project Progress

Backed with RWJF and CMS/SIM funding, the GMCB and diverse state agencies, work groups and advisory and steering committees are engaged extensively and are making steady progress in designing the payment models and delivery system reforms of the universal and unified health care system. Key future milestones are the preparation and submission of the financial plan for the new health system to the Vermont Legislature and the waivers to the federal government. Preliminary and favorable results exist for the CHF bundled payment pilot.

Facilitators and Barriers

Facilitators and barriers are presented in no particular order.

Facilitators

- Act 48 and a history of state government regulation in Vermont that aligns with the federal ACA.
- With passage of Act 48, belief that state government is serious and system reform is inevitable; belief that Vermont cannot go back to fee for service payment.
- Funding for health care system transformation from multiple sources in a resource-scarce state.
- Small geographic, rural state with little market competition that promotes communication and allows everyone to "be at the table".[27]
- Vermont's humanitarian culture and collaboration among interest group members, particularly those who have worked together on health care issues for many years and have a collective knowledge of Vermont's history of healthcare, and their willingness to participate in reform and help direct it for the public good.

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

- Consistent and committed leadership from diverse sectors, including the Governor and heads of state agencies, the GMCB and its Advisory Committee, leaders of health care and other organizations, along with their committed staff working on health care reform.
- Guidance from consultants on payment reform and system transformation.
- History of infrastructure development through Blueprint and health information technology.
- Collective push to reach sustainability.
- Taking time to celebrate results.
- The RWJF grant provided support for the pilots and, significantly, for writing the SIM grant.

Barriers

- Sheer inertia of large systems and the huge investments required to move them.
- Fatigue from the pace and scope of reform; a big time commitment.
- Collaboration barriers, including instances of lack of trust, holding entrenched positions on policy issues, and reluctance to share control and money.
- Engaging large numbers in system reform slows decision making; timelines may be unrealistic.
- Medicare not at the table participating in system redesign.
- Length of time and resources necessary to apply for and obtain federal waivers to Medicaid and Medicare regulations.
- Uncertainty throughout the reform process, including but not limited to:
    - Uncertainty whether federal waivers will be granted and whether Medicare will be part of the universal health system's revenue.
    - Uncertainty from not knowing what the final, at-scale (statewide) payment model will be slows decisions on aligning the delivery system and other matters.
    - Uncertainty about what the public costs of system reforms will be and whether the State Legislature will approve them; if approved, uncertainty about how revenue will be distributed to health care organizations, particularly to ACOs and the organizations within them.
    - Fear of uncertainty, particularly the loss of resources and control.
- Confusion about the ultimate goal of health system reform that arises from the Governor's vision of health care reform (a single payer system) versus the Act 48 vision of health care reform (a universal and unified system).
- Health care organizations and providers have little experience bearing financial risk and viewing a service as an expense (in population-based payment) rather than revenue (in patient-based FFS payment).
- Difficulty of reaching consensus on how to measure quality of care statewide.
- Challenges in aggregating and accessing data for a statewide information system; an antiquated Medicaid information system hinders planning reforms.
- The cultural challenge in clinical care of moving from traditional medicine toward team medicine that is part of managing individual and population health.

- Challenges of building a new system when medicine itself lacks 'systemness' and remains largely a cottage industry.

Evaluation and Sustainability

Evaluation

Act 48 mandates evaluation of the universal and unified health care system, if the system is implemented. The GMCB has an evaluation director to address this requirement. The Research Triangle Institute (RTI) is the external evaluator for the SIM grant, which has payment reforms that overlap closely with the RWJF grant. The GMCB also is contracting for its own internal evaluation of the SIM grant. The GMCB is planning evaluations of the payment pilots. It may be impossible to estimate the independent effects of payment reform on outcomes, given that payment is just one of several system-wide reforms that can change utilization and costs.

Sustainability

Implementation of a universal and unified health system in Vermont, ultimately with global budgets or some form of population-based payments, beyond 2016 will depend on completing and satisfying all of the conditions in Act 48 for launching the new system. If Vermont is successful in implementing the new system as envisioned, a basic question is: "Will it work?" That is, will the new system work as intended? Will patients and providers want the new system? Or will patients take their health care and revenue to New Hampshire or New York? Or will the system work so well that people travel or move to Vermont for their health care? Will providers participate in the new system? Answers to these questions are unknown but are of the utmost importance for health policy in Vermont and the United States.