Future of Rural Healthcare: Vermont Vision 2030

January 18, 2023

Eric K. Shell, MBA, Chairman

STROUDWATER

Market Has Not Stopped Moving During The Pandemic

- **Cost of healthcare continuing to rise**
  - Kaiser Family Foundation reports 2022 family health insurance premiums have risen to $22.5K
- **Advances in technology and new market comfort for telehealth have led to an acceleration of new market competition**
  - Amazon
  - Walmart
  - Walgreens
  - CVS
  - Etc.
- **Hospital IP and OP volume declines**
- **Federal government maintains commitment to transitioning payment system**
  - “WE NEED TO FIND A WAY TO BRING EVERYONE ALONG. WE CAN’T HAVE FEE-FOR-SERVICE REMAIN A COMFORTABLE PLACE TO STAY.” Dr. Liz Fowler, Director CMMI

Call to action: Kaiser Family Foundation: 2022 Insurance Premiums

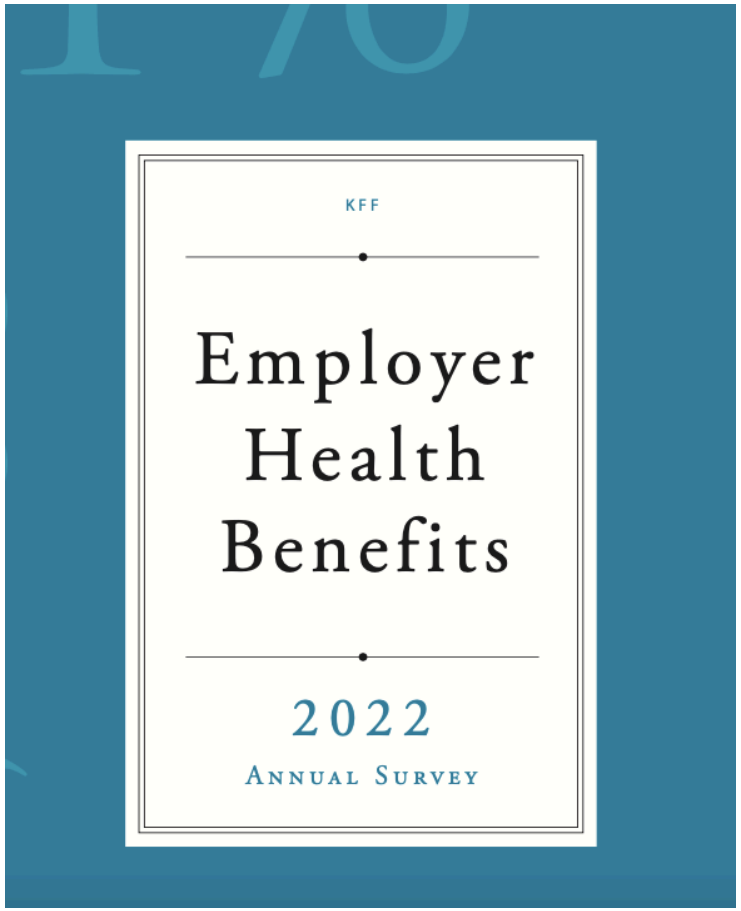
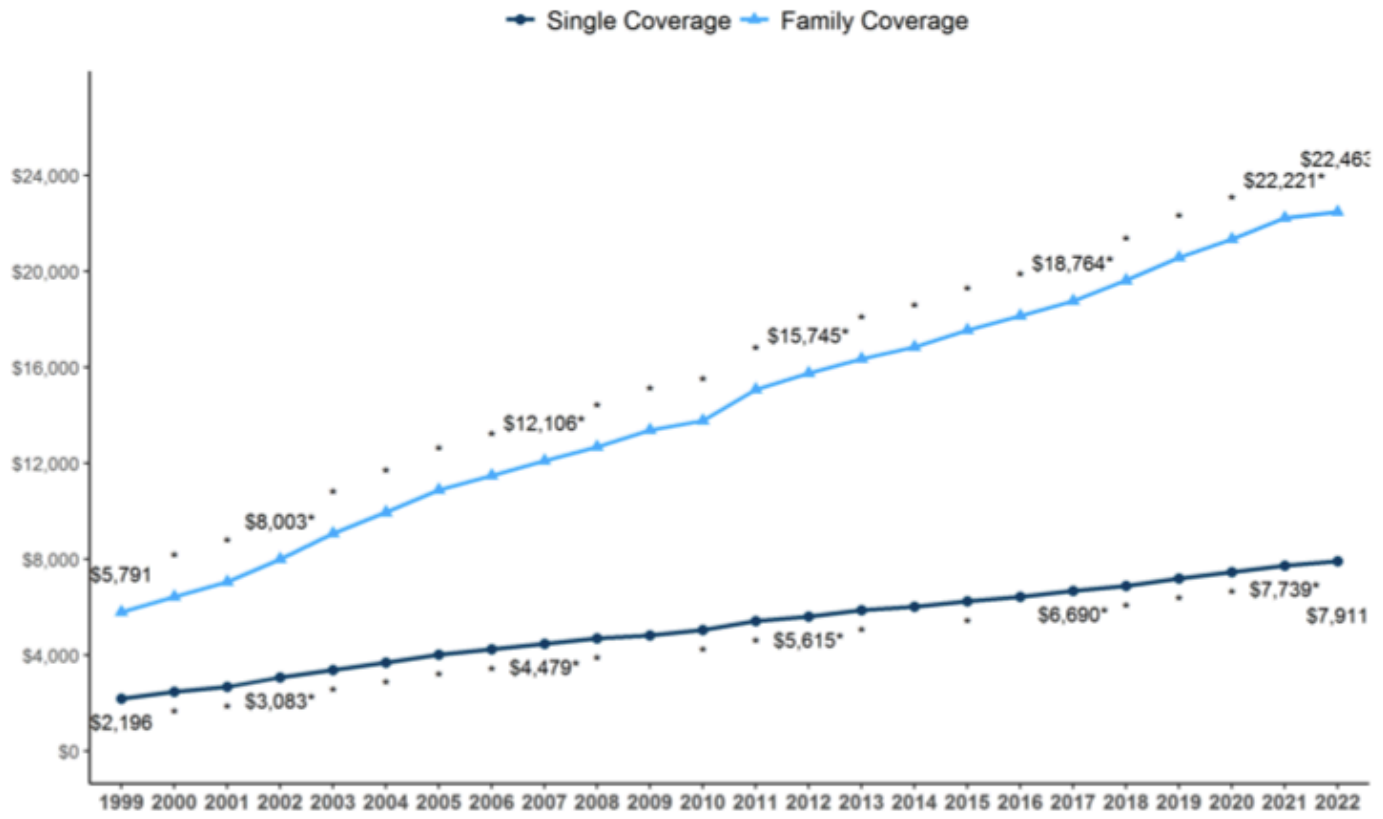
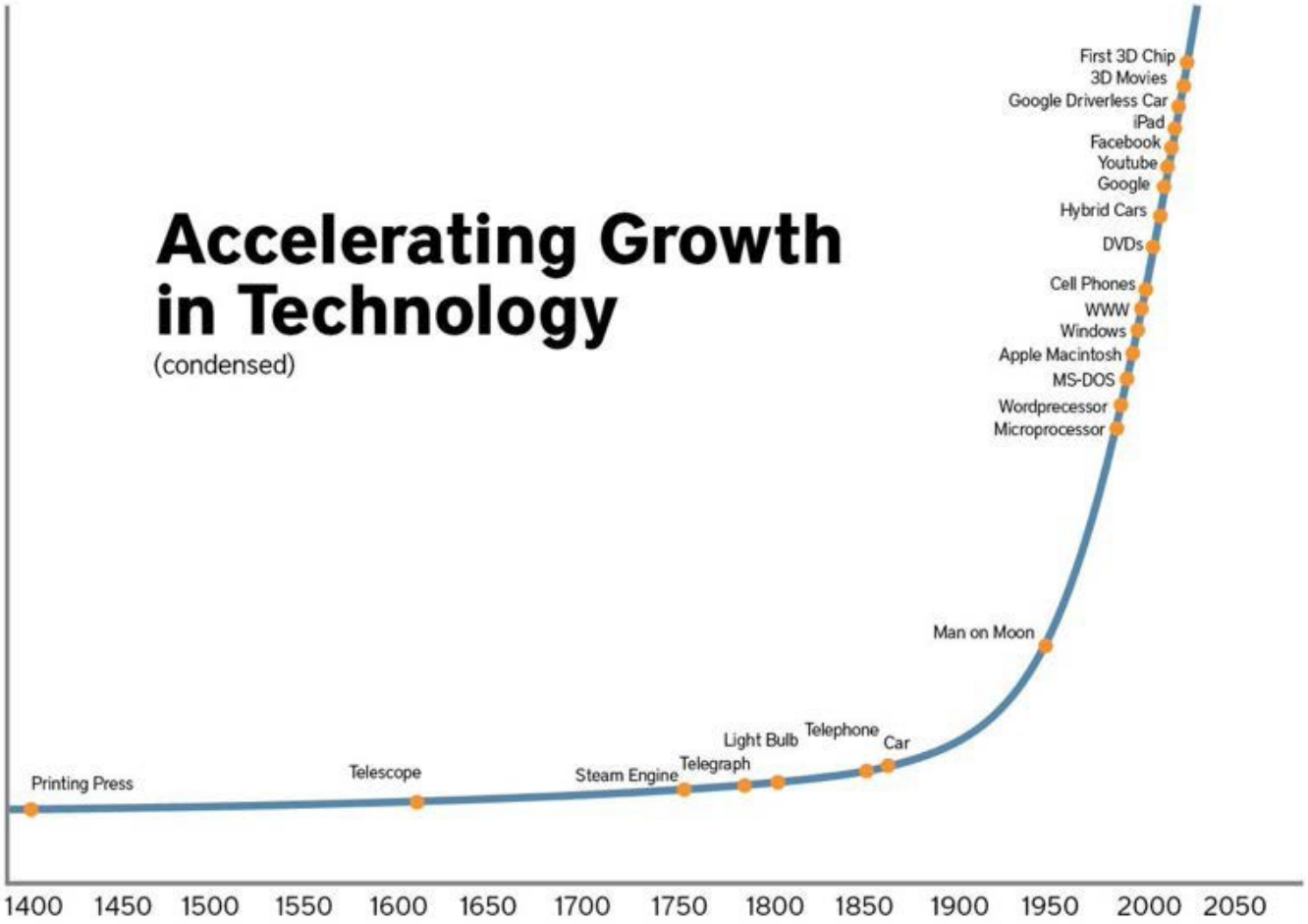


Figure 1.12
Average Annual Premiums for Single and Family Coverage, 1999-2022



* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
SOURCE: KFF Employer Health Benefits Survey, 2018-2022; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

Call to action: Advances in Technology



Source: Khalid Hamdan, Accelerating Growth in Technology

Call to Action: Partnerships Give Insight into Amazon's Healthcare Strategy

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- Amazon has acquired publicly-traded primary care company One Medical for $3.9 billion, furthering its investment into the primary care market and offering insight into its primary care strategy, and announced plans to partner with behavioral health app Ginger
  - One Medical offers primary care services both virtually and in person to over 750,000 members. The acquisition, which must be approved, would drastically increase Amazon's primary care reach and services to patients.

"We think healthcare is high on the list of experiences that need reinvention…We want to be one of the companies that helps dramatically improve the healthcare experience over the next several years."

Neil Lindsay, SVP, Amazon Health Services, Amazon Stores

- In late August 2022, Amazon announced it will shut down Amazon Care, its original primary care offering, at year's end. Industry experts suggest that perhaps they will have more success with established brands such as One Medical or will pull out of the deal entirely and go in a more lucrative direction than primary care.
- In October '22, the company announced that Amazon Pharmacy Home Delivery had gained a new customer, nonprofit insurer Florida Blue, joining BCBS of Alabama, BCBS of Minnesota, BCBS of Nebraska, BCBS of North Carolina, Horizon Blue Cross Blue Shield of New Jersey, and Regence BlueCross BlueShield of Oregon.
- On Tuesday 11/15, Amazon launched Amazon Clinic, venturing into the direct-to-consumer space just as many are moving away from it
  - Amazon Clinic is a virtual storefront where patients pay directly and receive affordable telemedicine treatment for 40 common, non-urgent conditions

Sources: Modern Healthcare, *One Medical acquisition reveals Amazon's healthcare strategy*, Brock E.W. Turner and Jessica Kim Cohen, 7/21/22; FierceHealthcare.com, *Amazon Care teaming up with Ginger to add behavioral health services*, Heather Landi, 8/10/22; Modern Healthcare, *Amazon to shut down Amazon Care at year's end*, Jessica Kim Cohen, 8/24/22 https://www.modernhealthcare.com/technology/amazon-shut-down-amazon-care-years-end; ModernHealthcare, *Amazon inks pharmacy deal with Blue Cross plan*, Nona Tepper, 10/25/22; Modern Healthcare Digital Health, *Amazon launches new virtual health service* Brock E.W. Turner, 11/15/22

Call to Action: Through Numerous Acquisitions and Initiatives, Walmart Plans to Become Major Force in Healthcare

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- Walmart plans to use technology to streamline the consumer healthcare experience and capitalize on its reputation for low-cost products to build trust and confidence in its healthcare offerings
- Over the last few months, Walmart has added **virtual care, discount drug programs, a unified EHR system, and a discount drug program to its healthcare services for both consumers and employees**
- Among other healthcare ventures, Walmart currently operates and/or provides:

  Walmart Health Centers within its stores
  - Freestanding health centers in Georgia, Texas, Arkansas and Chicago
  - Direct-to-consumer telehealth through purchased app Ro
  - Telehealth partnership with Doctor on Demand to offer services to its 1.3 million workers at a reduced price
- In October 2021, it began a partnership with healthcare technology platform Transcarent to streamline its self-funded healthcare offerings for employers, the first time Walmart has made such an agreement to offer its prices on pharmaceuticals and other healthcare services to other employers
- Cheryl Pegus, M.D., executive vice president of Health & Wellness at Walmart: "We are committed to providing care to customers and the communities we serve through an integrated, omnichannel approach that improves engagement, health equity and outcomes"

Sources: Becker's Hospital Review, *Walmart to bring telehealth nationwide with acquisition of MeMD: 8 details,* Jackie Drees and Hannah Mitchell, 5/6/21 https://www.beckershospitalreview.com/telehealth/walmart-health-to-acquire-telehealth-provider-6-details.html?origin=CIOE; FierceHealthcare, *Walmart unveils employer market team-up with Transcarent,* Paige Minemyer, 10/15/21 https://www.fiercehealthcare.com/payer/walmart-unveils-employer-market-team-up-transcarent?utm_source=email; Fierce Healthcare Tech; *Tech HLTH21: Where Walmart is focusing its health efforts in the next 5 to 10 years,* Dave Muoio, 10/19/21

Walgreens Pushes Into Primary Care and Beyond, Aiming to Keep People Out of Healthcare System

"Imagine a day when 45 percent of our Walgreens stores ... where you can walk in and see a primary care physician that's attached to a Walgreens drugstore. And you come into this beautiful lobby and there are eight exam rooms with two physicians and a staff...And they can do the testing that you need that day. ... That's our goal."

Walgreens CEO Roz Brewer

- As of October '21, Walgreens Boots Alliance had invested $5.2 billion in VillageMD to roll out physician-staffed clinics across the country and $330 million in post-acute and home care company CareCentrix.
  - As of February '22, the partnership is on track to open more than 200 co-branded primary care practices by the end of the year
- In September '22, Walgreens spent $1.37 billion to acquire the remaining 30%of Shields Health Solutions, a specialty pharmacy company that works with 80 health systems across the country and represents over 1 million patients with complex medical conditions
- In November '22, VillageMD finalized its acquisition of Summit Health for $8.9B. As part of the deal, Cigna's health services arm, Evernorth, will become a minority owner of VillageMD. VillageMD will leverage its experience with value-based care to transition both companies' patients to risk-based payment.
  - Per VillageMD CEO Tim Barry, the new combined organization's goal is to provide **multispecialty care**
  - VillageMD will also prioritize **risk-based payment, a new leadership team, performance data access for providers, and a united company culture**
- At a Forbes Healthcare summit, CEO Roz Brewer shared that Walgreens' push into primary care aims to keep people healthy enough to avoid returning to the healthcare system. The company intends to diversify its healthcare investments into pharmacy, primary care, post-acute care and technology.

Source: Becker's Hospital Review, *Walgreens' care goal is to keep people away from the healthcare system, CEO says* Georgina Gonzalez, 12/3/21; Healthcare Dive, *Walgreens, VillageMD on track to open 200 co-branded clinics this year*, Rebecca Pifer, 2/17/22; Modern Healthcare, *Walgreens to acquire remaining stake in specialty pharmacy company*, Maru Devereaux, 9/20/22; Modern Healthcare, *Walgreens to buy remaining stake in CareCentrix for $392M*, Lauren Berryman, 10/11/22; Healthcare Dive, *Walgreens-backed VillageMD in talks to merge with Summit, Bloomberg reports*, Rebecca Pifer, 10/31/2022; Healthcare Dive, *Walgreens-backed VillageMD buys Summit Health for $9B* Rebecca Pifer, 11/7/22

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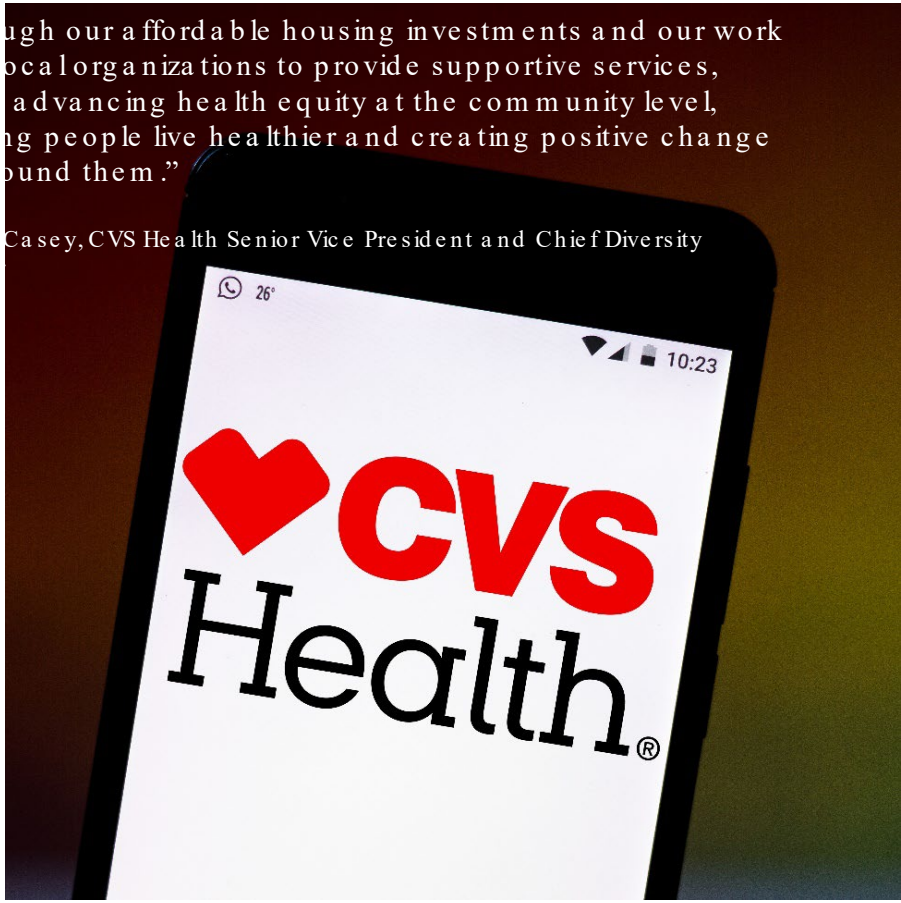
Call to action: CVS Targets 65B Healthcare Interactions by 2030

- In an overall effort to support community health, CVS continues its expansion into retail healthcare, setting a goal to facilitate 65 billion healthcare interactions over the next 10 years and investing $185M into affordable housing
- Key retail strategies include
  - Continuing to grow HealthHUB stores
  - Rethinking care delivery based on lessons learned during COVID-19
  - Investing in community health
- CVS opened 1500 HealthHUBs by the end of 2021
- *Starting in 2023, the retailer's virtual care platform, CVS Health Virtual Primary Care, will be available to Aetna and Caremark members*
  - *The new platform will provide on-demand care, chronic condition management and mental health services and will leverage an interoperable EHR to facilitate care coordination*
- The CVS housing investments went towards creating over 6,570 housing units in 64 cities across 28 states and Washington DC, with access to CVS healthcare services provided for residents



https://www.fiercehealthcare.com/payer/cvs-wants-to-facil
https://www.fiercehealthcare.com/payers/cvs-invested-185m-housing-last-year-heres-where-those-funds-went;
https://www.fiercehealthcare.com/health-tech/cvs-health-rolls-out-virtual-primary-care-service

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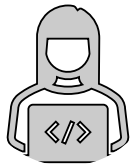
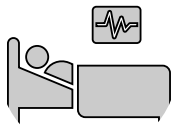
Call to Action: CVS and Primary Care: January 2023 Update

CEO Karen Lynch and CVS executives hinted at a large-scale primary care move involving significant M&A this year that would allow the retailer to expand its national footprint and keep pace with its competition



CVS is currently working with Amwell to roll out the virtual care platform it announced in May, which provides virtual access to primary care, on-demand care, chronic condition management and mental health services and to eligible Aetna and CVS Caremark members

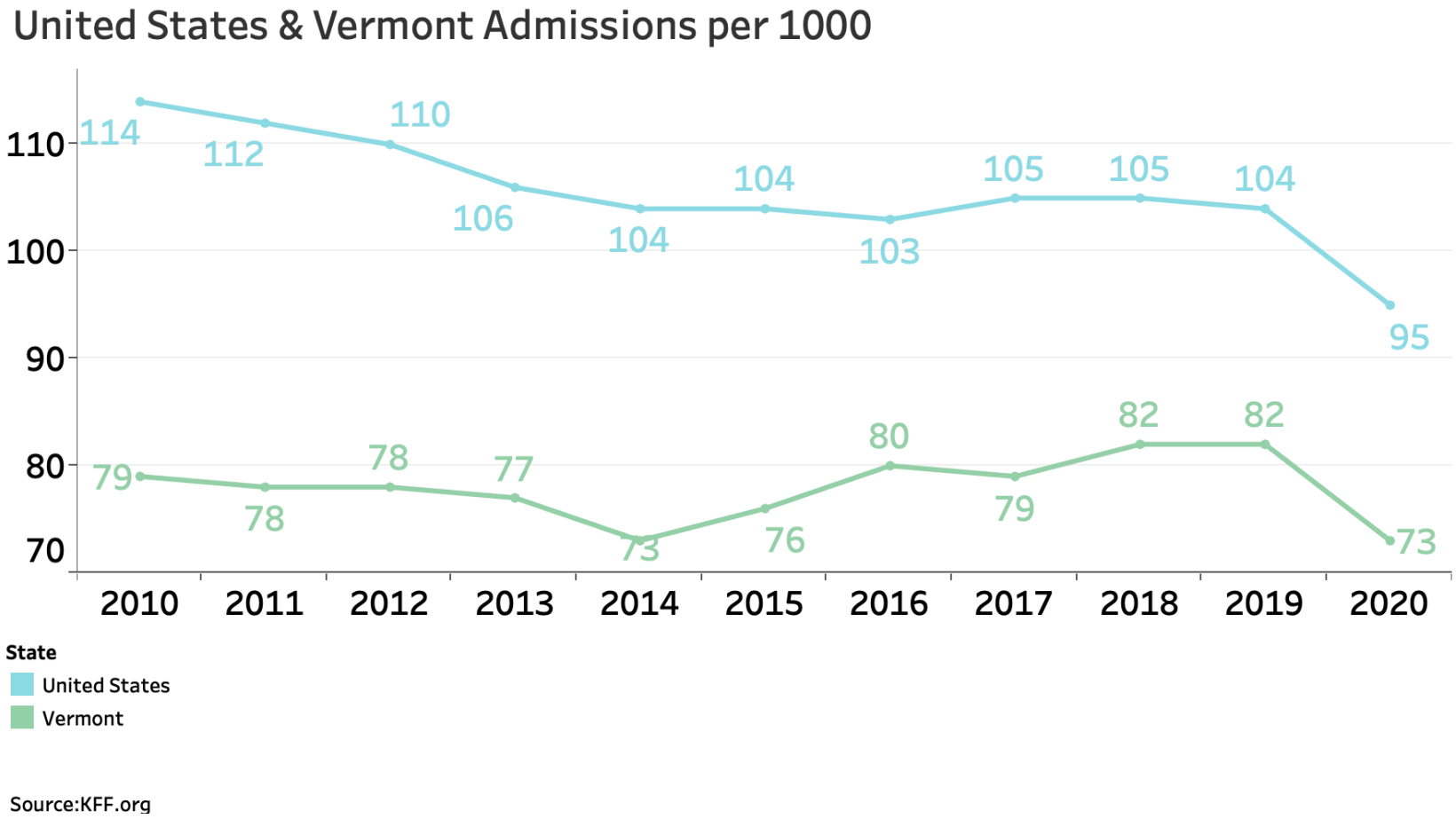


In early September 2022, CVS and Signify Health announced that CVS will buy the Dallas-based home health company for $8B. This is the next step as CVS transforms from a retailer to a healthcare giant, and the company is predicted to purchase a primary care provider next. The Signify Health purchase represents a key milestone in CVS's effort to provide comprehensive healthcare offerings, as it now includes home health and value-based care in addition to its retail clinics.

In January '23, CVS was reported to be in talks with Oak Street Health, a private-equity-backed company that runs primary care centers across the US for Medicare recipients. The talks are ongoing, and the outcome is TBD.

Modern Healthcare, *After Signify Health, CVS still looking for more deals*, Nella Teppel and Lauren Berryman, 9/6/22 https://www.modernhealthcare.com/mergers-acquisitions/after-signify-health-cvs-still-looking-more-deals; HFMA.org, *CVS Health gains capabilities in home healthcare and value-based care with massive deal to buy Signify Health*, Nick Hut, 9/27/22 https://www.hfma.org/topics/news/2022/09/cvs-health-gains-new-capabilities-in-home-healthcare--value-base.html; Becker's Hospital Review, *CVS exploring acquisition of Oak Street Health*, Naomi Diaz, 1/10/23 https://www.beckershospitalreview.com/disruptors/cvs-exploring-acquisition-of-oak-street-health.html

Call to Action – Declining IP Volume



Call to Action – Declining OP Volume

In 2018, US hospital outpatient visits declined for the first time since 1983, specifically in the number of emergency outpatient visits

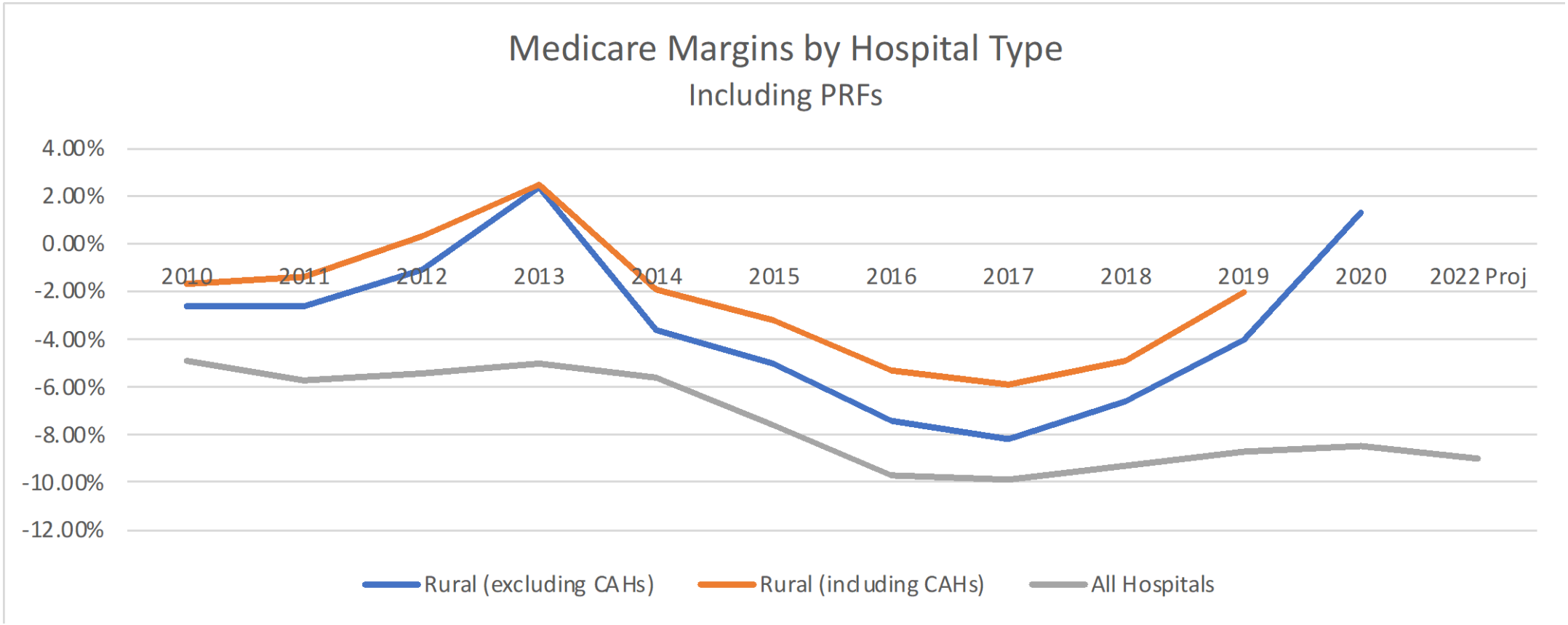
Per the American Hospital Association's 2020 Hospital Statistics report, 6,146 US hospitals delivered 879.6 million outpatient visits in 2018, 0.9% less than in 2017, when they delivered 880.5 million outpatient visits

The report cites that the amount of outpatient care delivered has most likely increased, but that care is being delivered in competitive new options such as urgent care centers and retail clinics such as those recently launched by CVS Health

Insurers have contributed to the trend, with UnitedHealthcare recently refusing to pay for certain outpatient surgeries in hospital settings to save money

Source: Modern Healthcare, *U.S. hospitals see first decline in outpatient visits since 1983,* Tara Bannow, 1/7/20, https://www.modernhealthcare.com/operations/us-hospitals-see-first-decline-outpatient-visits-1983?utm_source=modern-healthcare-am-wednesday

Call to Action: Declining Medicare Margins



New CMMI Director Dr. Liz Fowler on "Strategic Refresh"

"WE NEED TO FIND A WAY TO BRING EVERYONE ALONG. WE CAN'T HAVE FEE-FOR-SERVICE REMAIN A COMFORTABLE PLACE TO STAY."

"We need to have a clear path for the innovators who are ready and willing and able to take on…risk, but I think we also need to push the laggards and then we need to reach those who have challenges participating…It may not be one-size-fits-all."

On CMMI innovation models: "A lot of what we've done has been aimed toward certification of models to become a permanent part of Medicare…In trying to get a model certified, it really does suggest a very specific model and a very specific way of thinking about evaluations and the assessment by actuaries. I wonder if we can instead think about the overall goal being transformation of the system instead of certification, or both."

Source: HFMA.org, *Why the federal agency that oversees healthcare payment innovation is rethinking its approach*, Nick Hut, 4/26/21 https://www.hfma.org/topics/news/2021/04/why-the-federal-agency-…utm_source=rasa_io&PostID=29248522&MessageRunDetailID=5032322143

CMS 2023 Inpatient Perspective Payment Proposed Rule (4/18/22), Finalized 8/1/22)

- Payment Rate Update

FY 2023	Hospital Submitted Quality Data and is a Meaningful EHR User	Hospital Submitted Quality Data and is NOT a Meaningful EHR User	Hospital Did NOT Submit Quality Data and is a Meaningful EHR User	Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User
Market Basket Rate-of-Increase	4.1	4.1	4.1	4.1
Adjustment for Failure to Submit Quality Data under Section 1886(b)(3)(B)(viii) of the Act	0	0	-1.025	-1.025
Adjustment for Failure to be a Meaningful EHR User under Section 1886(b)(3)(B)(ix) of the Act	0	-3.075	0	-3.075
Productivity Adjustment under Section 1886(b)(3)(B)(xi) of the Act	-0.3	-0.3	-0.3	-0.3
Applicable Percentage Increase Applied to Standardized Amount	**3.8**	**0.725**	**2.775**	**-0.3**

  - Finalized payment increase of 3.8% for 2022 plus statutory increase of .5%
    - Proposed payment increase of 2.7% for 2022 plus statutory increase of .5%;

- Disproportionate Share Payments
  - Distribute $6.8B, a reduction of $300M from 2022
    - Originally proposed reduction of $600M from 2022

Source: CMS Fact Sheet, 4/18/2022; CMS Final Rule 8/1/2022

CY2023 Medicare PFS – MSSP Proposed Rule (7/07/2022) and Final Rule (11/1/2022) (continued)

- CMS issued a proposed rule that announces and solicits public comments on proposed policy changes for Medicare payments under the PFS, and other Part B issues, on or after January 1, 2023 (continued)
  - ***Rule was finalized on 11/1/2022***
- Key elements related to MSSP include:
  - Finalized proposal to provide advance investment payments (AIPs) to low revenue ACOs, inexperienced with performance-based risk Medicare initiatives, that are new to the program
    - One-time fixed payment of $250K with quarterly payments for first two years of 5-year agreement period
    - Requirement that advanced payments be used for improving healthcare provider infrastructure, increase staffing, or provide accountable care to underserved beneficiaries
    - Application period during CY23 for 1/1/24 start
    - Advanced payments would increase with higher levels of dual eligible beneficiaries
    - Advance payments would be paid back from future shared savings
  - Expand opportunities for certain low revenue ACOs participating in the BASIC track to share in savings even if they do not meet the minimum savings rate

Source: CMS.gov Calendar Year 2023 Medicare Physician Fee Schedule Proposed Rule Fact Sheet, July 7, 2022
Source: CMS.gov Calendar Year 2023 Medicare Physician Fee Schedule Final Rule Fact Sheet, November 1, 2022
Source: Stroudwater Summary of Final CY2023 Medicare Physician Fee Schedule and other Changes to Part B Payment and Coverage Policies

Call to Action: In Summary

Stroudwater

Traditional fee-for-service payment will continue to transition to value-based payment

Pressure for operational efficiencies and human and capital resources will continue to accelerate

Clinical integration will create advantages to systems of accountable care (Value based payment, re-admission rates and preventable re-admissions, bundled payments, accountable care organizations, etc.)

Flexibility must be ingrained into any short to medium term strategies as a direct result of increased regulatory and environmental uncertainty

Future Hospital Financial Value Equation

- Definitions
  - Patient Value

$$\text{Patient Value} = \frac{\text{Quality}}{\text{Cost}} \times \text{Population}$$

  - Accountable Care:
    - A mechanism for ***providers to monetize the value derived from increasing quality and reducing costs***
      - Accountable care includes many models including bundled payments, value-based payment program, provider self-insured health plans, Medicare defined ACO, capitated provider sponsored healthcare, etc.
    - Different “this time”
      - Providers monetize value
      - Government “All In”
      - New information systems to manage costs and quality
      - Agreed upon evidence-based protocols
      - Going back is not an option

Future Healthcare Provider Financial Value Equation

- ACO Relationship to Small and Rural Healthcare Providers
  - Revenue stream of future tied to Primary Care Physicians (PCP) and their patients
  - Small and rural healthcare providers bring value / negotiating power to affiliation relationships as generally PCP based
    - Smaller community healthcare providers have value through alignment with revenue drivers (PCPs) rather than cost drivers but must position themselves for new market:
      - Alignment with PCPs in local service area
      - Develop a position of strength by becoming highly efficient
      - Demonstrate high quality through monitoring and actively pursuing quality goals

The Premise

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Finance

- Macro-economic payment system
  - Government payers changing from fee-for-service (FFS) to population-based payment system (PBPS)
  - CMMI is considering making value-based payment models mandatory
  - Private payers follow government payers

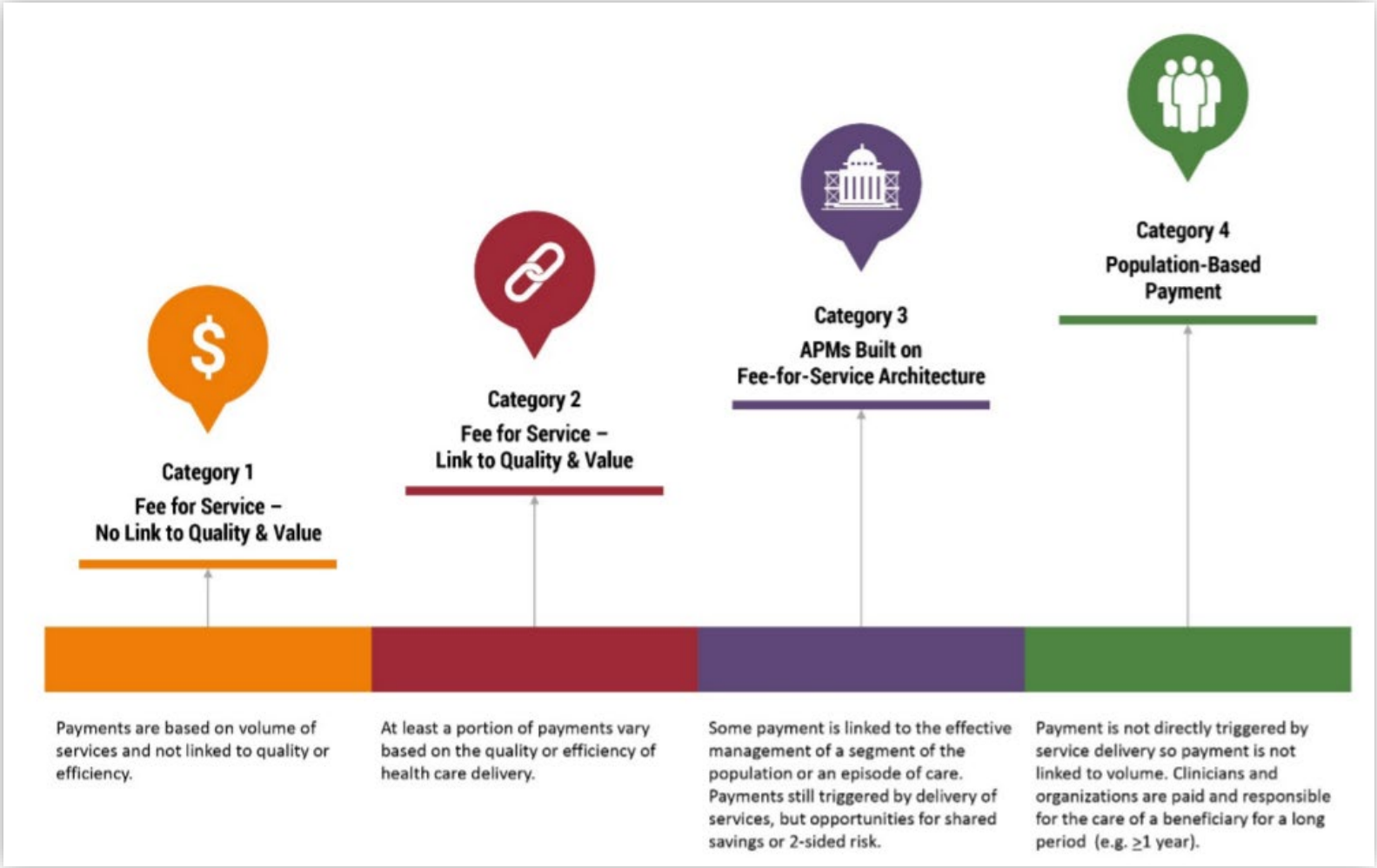
Function

- Provider imperatives
  - Fee-for-service (FFS):
    - Maximization of price and utilization
    - Management of costs
  - Provider Based Payment System (PBPS):
    - Management of care of a defined population
    - Providers assume risk

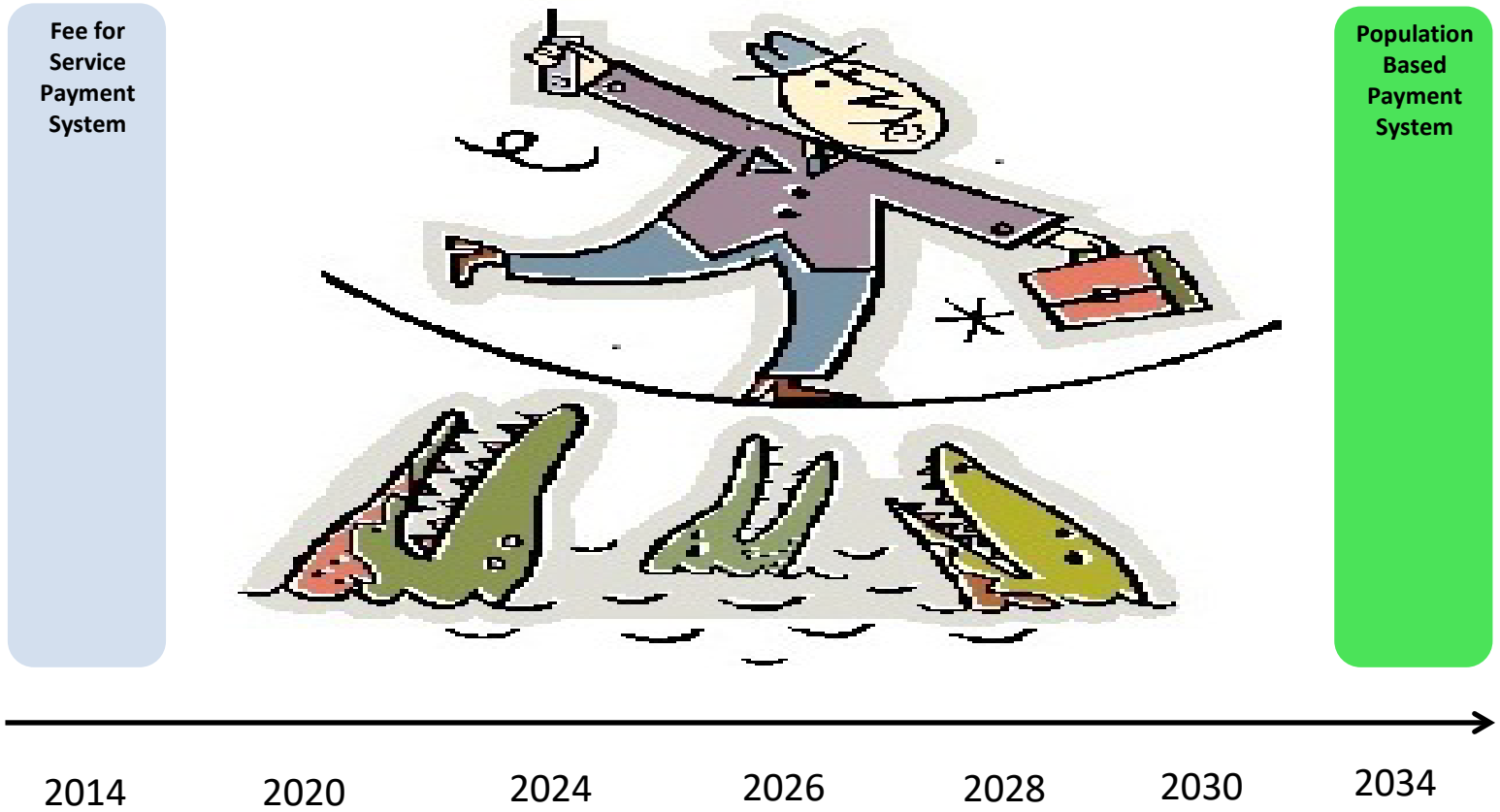
Form

- Provider organization evolution from:
  - Independent organizations competing with each other for market share →
  - Aligned organizations competing with other aligned organizations for covered lives based on quality and value
- Network and care management organization must develop new competencies:
  - Network development
  - Care management
  - Risk contracting & management

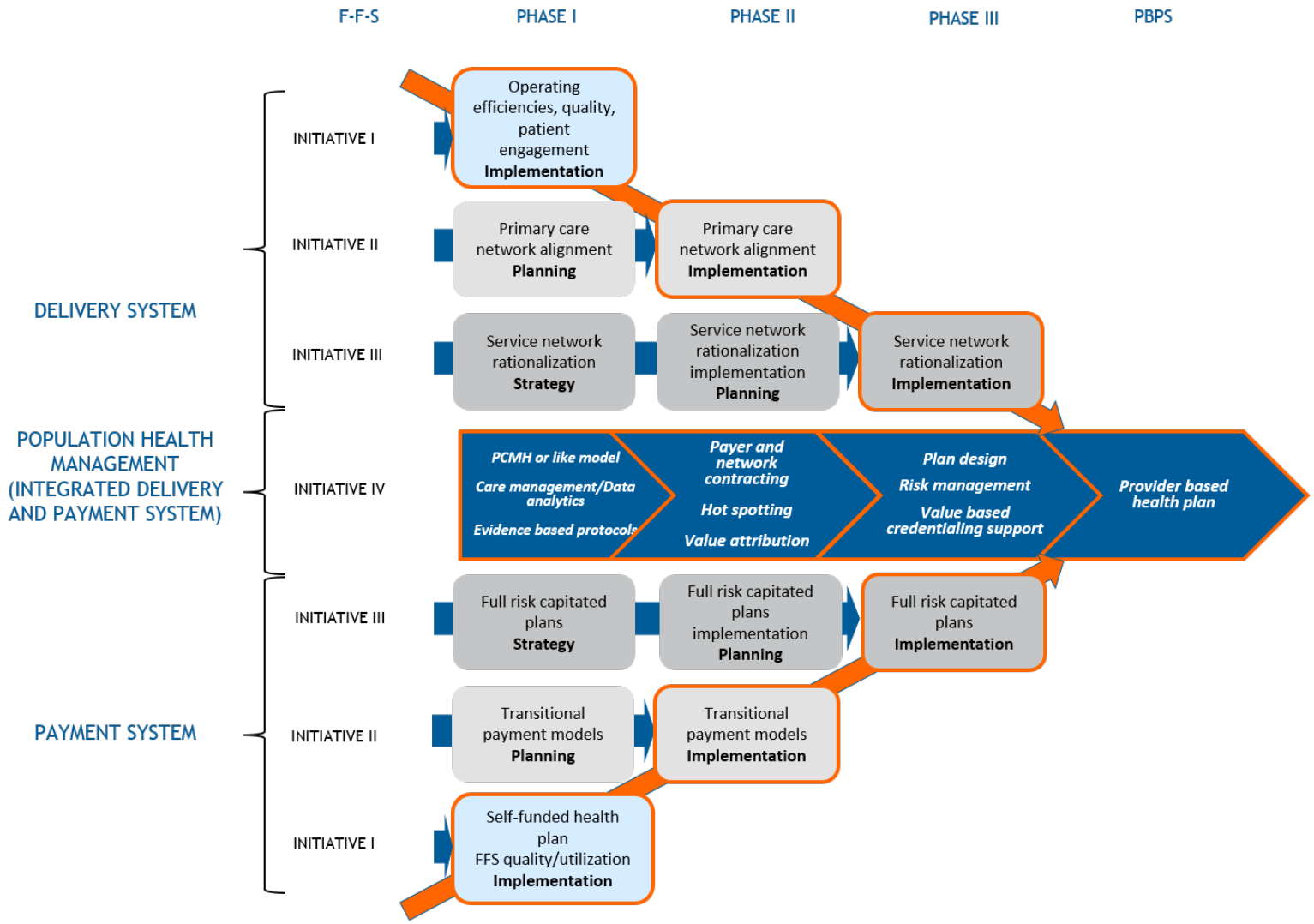
Transition Framework – Value-Based Journey



The Challenge: Crossing the Shaky Bridge

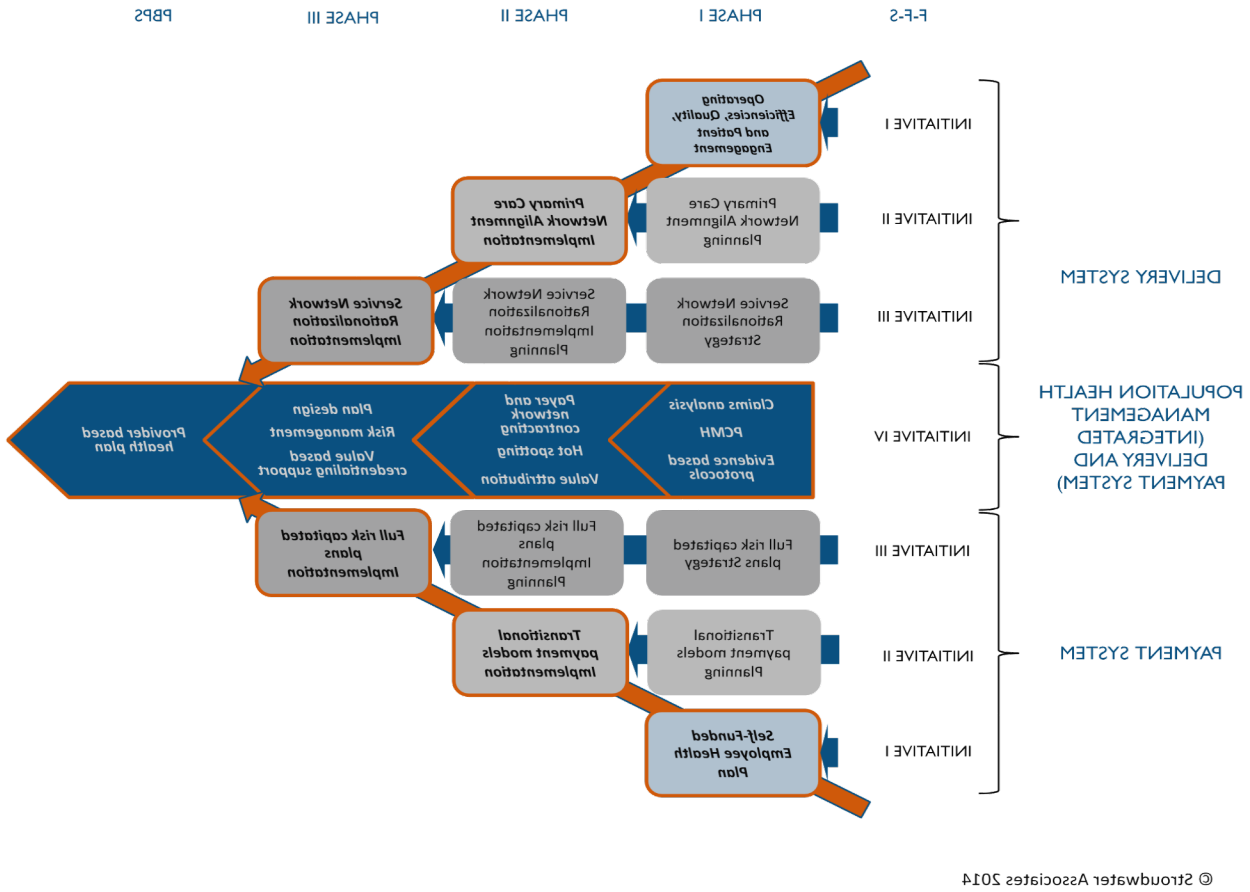


Transition Framework – What Is It?

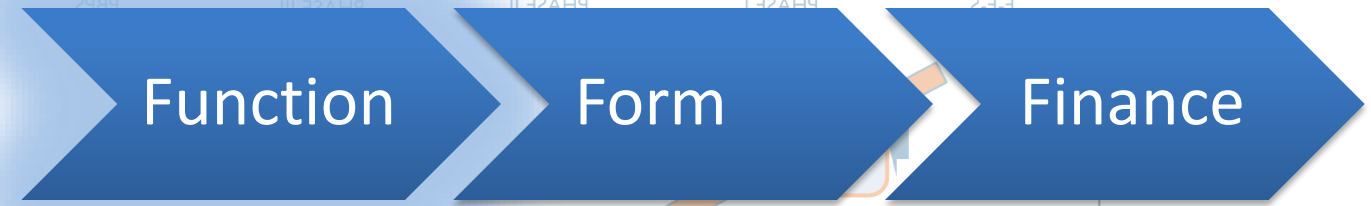


Vermont Healthcare 2030

- Vision:
  - *Vermont health systems partner with community to improve health while preserving appropriate access to patient care – flipping the plan*

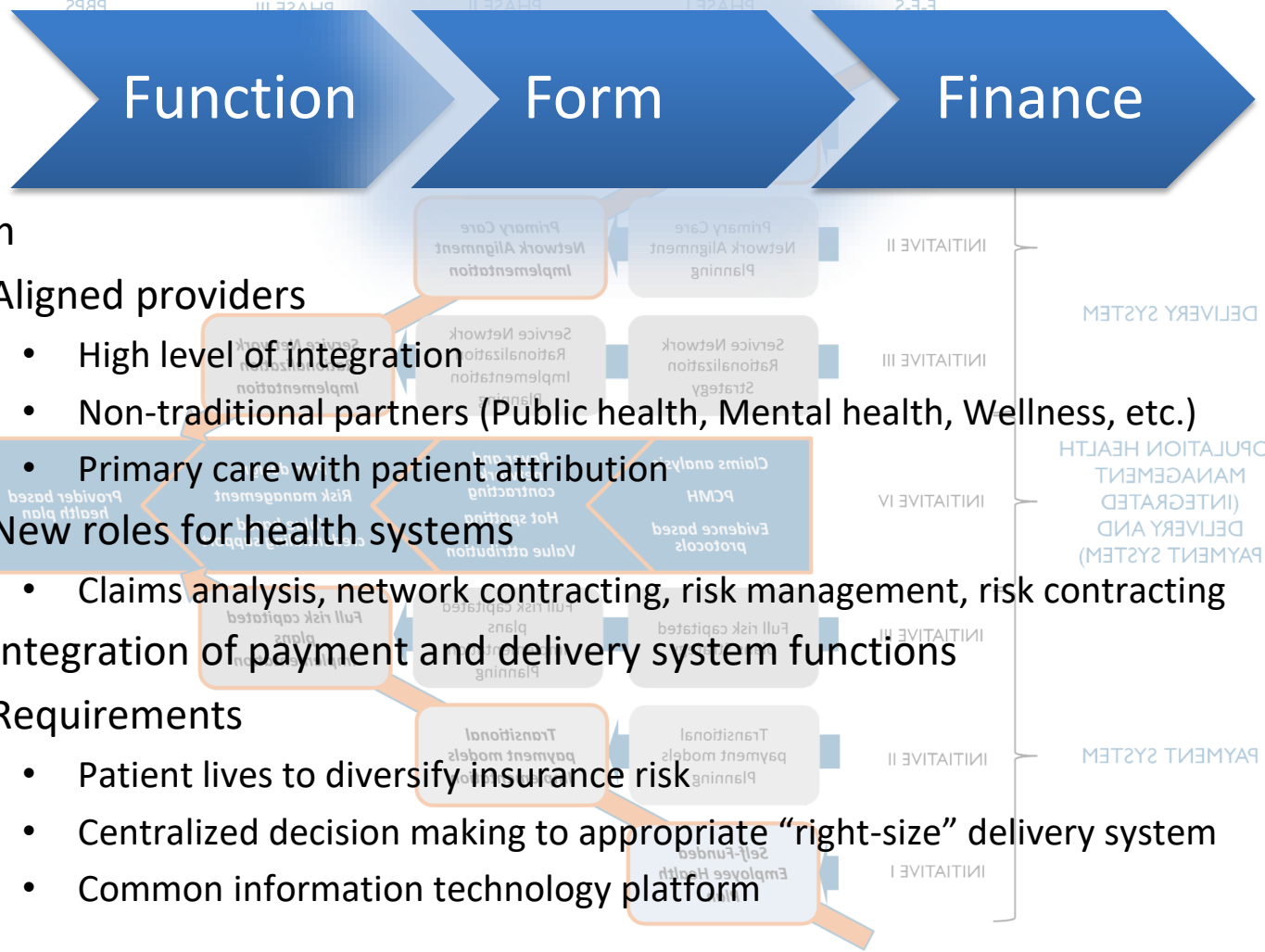


Vermont Healthcare 2030



- Function
  - Health systems partnering with community to improve health of a defined population with preserving appropriate access to traditional care
    - Chronic disease management
    - Increased relevance of health system in healthcare
  - Access to appropriate and right-sized traditional patient care
    - Right care, right time, right place, right provider
    - Common evidenced based protocols
    - Quality and patient safety are critical
- Requirements:
  - Common vision for healthcare of Vermont
  - Payment system that provides incentives for healthcare

Vermont Healthcare 2030

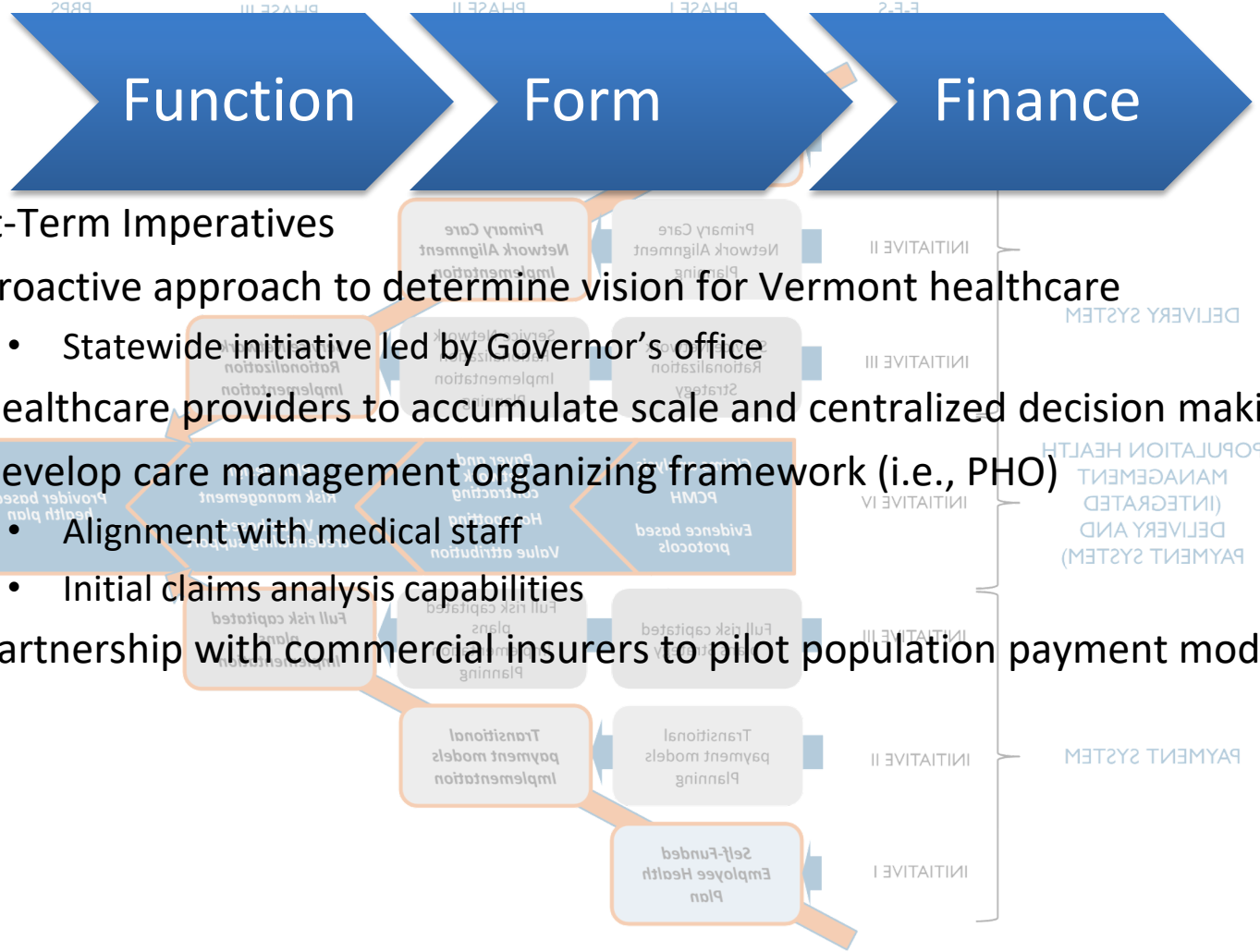


- Form
  - Aligned providers
    - High level of integration
    - Non-traditional partners (Public health, Mental health, Wellness, etc.)
    - Primary care with patient attribution
  - New roles for health systems
    - Claims analysis, network contracting, risk management, risk contracting
  - Integration of payment and delivery system functions
  - Requirements
    - Patient lives to diversify insurance risk
    - Centralized decision making to appropriate “right-size” delivery system
    - Common information technology platform

Vermont Healthcare 2030

- Finance
  - Payment must fund necessary access to healthcare while preserving traditional patient care
    - Payment incentives cannot preclude health interventions
    - Payment incentives cannot preclude access to appropriate patient care
  - Financial reporting to reflect “income” for both healthcare and sick care
- Requirements
  - Nearly 100% global payment to healthcare providers based on attributed population
    - May require healthcare providers to assume insurance risk
  - Financial reporting methods to be adopted to new payment methodologies
    - “Credit on income statement” for improved population health
  - New “cost centers” are provided budgets to manage within

Vermont Healthcare 2030



- Short-Term Imperatives
  - Proactive approach to determine vision for Vermont healthcare
    - Statewide initiative led by Governor's office
  - Healthcare providers to accumulate scale and centralized decision making
  - Develop care management organizing framework (i.e., PHO)
    - Alignment with medical staff
    - Initial claims analysis capabilities
  - Partnership with commercial insurers to pilot population payment models

Vermont Environment – Transformational Efforts

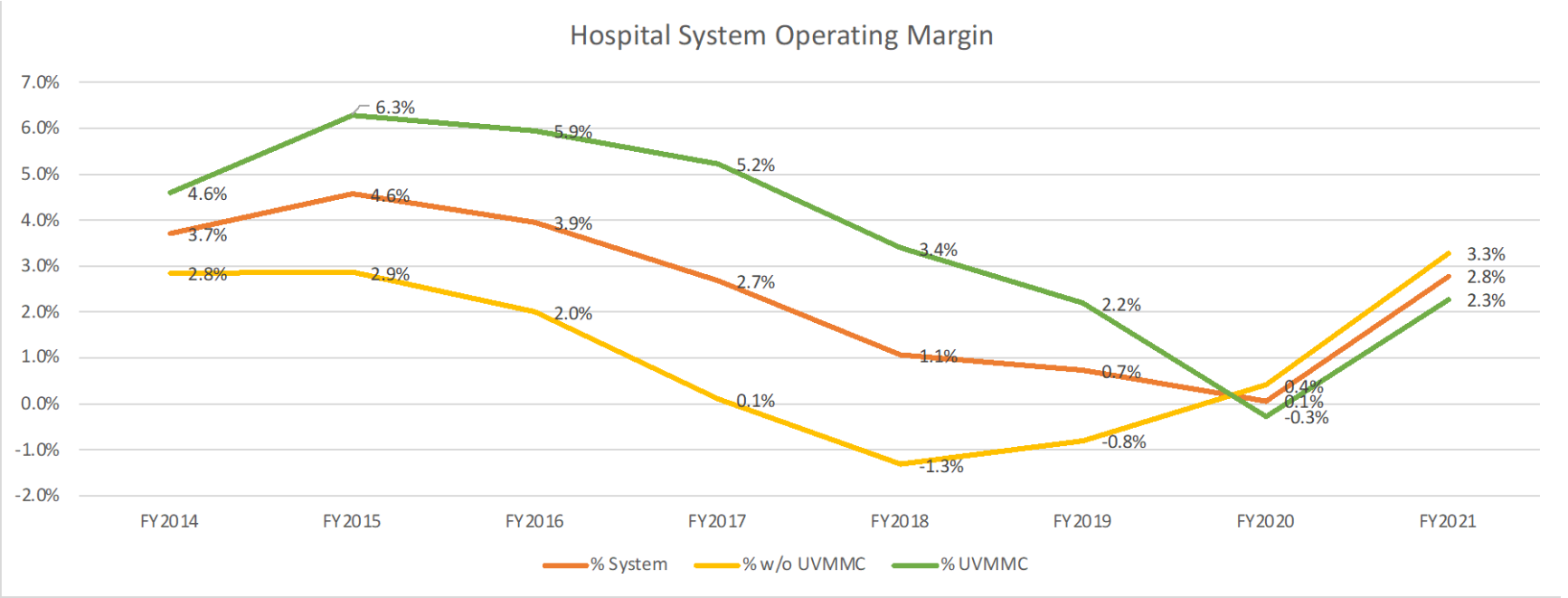
- Statewide Transformational Efforts
  - Blueprint for Health
    - Launched in 2003 as a unit within department of Department of Vermont Health Access (DVHA) with mission of "integrating a system of health care for patients, improving the health of the overall population, and improving control over health care costs by promoting health maintenance, prevention, and care coordination and management."
    - Programs include Patient Centered Medical Homes (PCMH), Community Health Teams (CHT), Hub and Spoke Medication Assisted Treatment (MAT), and Women's Health Initiative (WHI)
    - Makes payment decisions about PCMHs and CHTs for Medicaid and Commercial insurers
  - Green Mountain Care Board (GMCB)
    - Independent five-member board, created in 2011 through VT legislature with a goal to promote the general good of the State by improving the health of the population, reducing per-capita rate of healthcare cost growth, enhancing the patient and health care professional experience of care, recruiting and retaining high-quality health care professionals, and achieving administrative simplification in health care financing and delivery
    - Establishes and enforces revenue growth rates for 14 community hospitals and regulates hospitals' net patient revenue, fixed prospective payment growth, and charge setting
    - Act 159 of 2020: GMCB shall consider ways to increase financial sustainability of VT hospitals

Vermont Environment – Transformational Efforts

- Statewide Transformational Efforts (continued)
  - VT All-Payer ACO Model Agreement (led by VT Agency of Human Services)
    - 5-year (2018-2022 with 2023 extension and 2024 optional year) demonstration arrangement between VT and CMS that allows Medicare to join Medicaid and commercial insurers to shift payment from FFS to an alternative, value-based payment system
      - Accountable Care Organizations (ACOs) will be used as vehicle for changing payment
      - Goal is average cost growth of healthcare over the 5-year period at 3.5% and no more than 4.3%, while improving health care quality and the health of Vermonters
      - Increasing payer and provider participation (scale) is measured annually by counting the number of Vermonters that are covered by an insurer offering a qualifying ACO program
  - OneCare VT ACO
    - A community of healthcare providers driving system change and improvement by leveraging innovation, information, investment, access, and education
    - Only ACO in VT that contracts with Medicare, Medicaid and commercial insurers with nearly all health systems participating in APMs
      - Establishes TCOC targets with payers under both upside/downside (Medicare and Medicaid) or upside only (commercial plans)
      - Health system and provider participation in OneCare VT APMs is optional for each “program”

Vermont Environment - Providers

- 14 hospitals consisting of 1 AMC, 5 PPS hospitals and 8 CAHs
  - 3 hospitals in system relationship; 11 independent hospitals
  - BRG report suggests adequate bed capacity to meet needs of aging population with some incremental capacity necessary in 2026
  - Consistent decline in average operating margin between FY15 and FY19 with expenses outpacing revenue growth

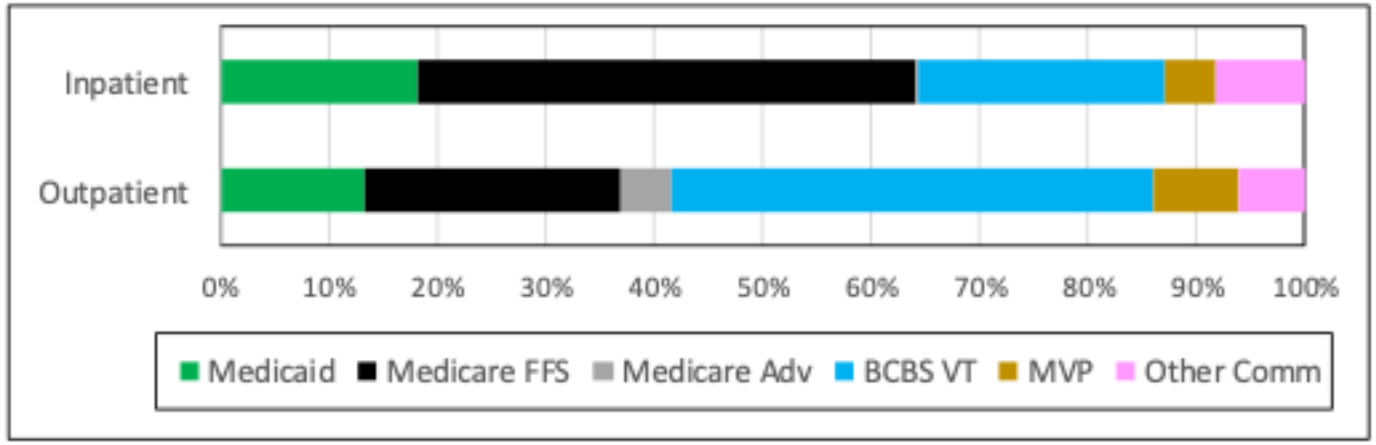


Source: GMCB

Vermont Environment – Providers (continued)

- Primary Care Providers
  - Mix of employed and private practices with some operating as FQHCs and RHCs
    - Reported that a majority of providers are employed by health systems
    - Nearly all participating in patient centered medical homes with some payment in PMPM

Vermont Environment - Payers



Source: GMCB internal analysis

- Commercial/Self Funded
  - Collectively represents 36% of hospital IP payment and 58% of hospital OP payment
  - Reported significantly higher IP and OP commercial payment rates than Medicare and Medicaid which results in providers prioritizing FFS payment mechanisms to maintain operating margin
  - BC/BS VT and MVP participate with OneCare VT ACO through shared savings program only with health plans contributing $3.25pmpm to OneCare VT to support population health management activities
    - Payers pay providers directly based on FFS claims with year-end settlement with OneCare VT based on actual claims experience relative to pre-determined TCOC budget
    - Shared savings with OneCare VT based on 50-50 split
    - BC/BS VT has one pilot program with a health system whereby the health system receives a monthly fixed payment with no reconciliation to claims

Vermont Environment - Payers

- Commercial/Self Funded (continued)
  - Self funded health plans represent a significant portion of commercial insurance
    - BC/BS VT acts as third-party administrator (TPA) for a portion of these self-insured health plans
    - Reported that individual self funded health plans are generally not sophisticated at developing value-based payment arrangements with OneCare VT

Vermont Environment - Payers

- Medicare
  - Collectively represents 46% of hospital IP payment and 29% of hospital OP payment
  - Hospitals can elect to participate in All-Payer ACO which results in them accepting risk tied to their covered lives
    - OneCare VT ACO accepts 100% risk within a 5% risk corridor
    - Reported that 8 VT health systems participating in Medicare ACO for FY 2021
      - CAHs paid on a cost-basis with settlement to cost report while PPSs and AMCs paid on a fee schedule
      - Hospitals are not required to participate in ACO
      - Barrier to rural hospitals participating in the All-Payer ACO is their inability to accept risk for their covered lives
    - Participating hospitals can elect to receive either FFS payment or a fixed monthly payment, with yearend reconciliation and settlement to claims
  - Independent primary care providers can participate in Comprehensive Payment Reform (CPR) in which providers receive a monthly Per Member Per Month (PMPM)
    - Reported that nearly 50% of independent primary care practices are participating in CPR

Vermont Environment - Payers

- Medicaid
  - Collectively represents 18% of hospital IP payment and 12% of hospital OP payment
  - Fix hospital payment to OneCare VT for all Medicaid lives, with OneCare VT paying hospitals a fixed, capitated payment based on attributable lives
  - Total cost of care (TCOC) negotiated between OneCare VT and VT Department of Health Access (DVHA) with risk/Reward corridor of 4%
    - Attributable Medicaid lives have increased from 29K in 2017 to 111K in 2021
    - Risk/reward is based on FFS payments relative to budget, which are approximately 50% of the TCOC
  - Like Medicare, independent primary care providers can elect to participate in CPR

Lessons Learned

- Transition to population-based payment system will be evolutionary and not revolutionary
- There is no risk-free payment system
  - Fee-For-Service
  - Population Based Payment
- Value-Based Risk = Residual Claim on Health
  - But only to the extent that providers receive full per capita payment
- Benefits provided to one payer are reaped by other payers
- 80-20 Fixed-variable cost understanding is critical
  - Claims costs confuse healthcare economics as they are used for a proxy for the cost of delivering healthcare
  - Variable costs are equal to claims cost only when services are provided out of network
  - There will be short term incentives to increase FFS volume until 80% of payment is Population-Based
- Full transition to population-based payment will take years but when complete, will fundamentally align provider organization incentives with the greater population's interest

Vermont Environment – Observations/Opportunities

- Observations
  - VT is the leader of all states in the transformation from “sick care” to healthcare
    - Vision established with buy-in from highest level of state government, providers, and payers
    - Payment system aggregator (OneCare VT) enables consistent payment to all providers
  - Comprehensive payment system reform well underway, however challenges
    - Small and rural hospitals, generally paid between 30-40% of TCOC are unable to accept risk on TCOC
    - Commercial plans requiring 50-50 gain share with no downside risk, along with payment to providers based on FFS claims promotes FFS payment
      - On average, health systems fixed to variable cost ratio of 80-20 requiring gain share of at least 80-20 to provide appropriate incentives
    - For a majority of providers, FFS payment exceeds 20% of total payment thus providing incentives for all payer ”sick care” volume
    - Optional health system and independent provider enrollment in APMs based on ”programs”

Vermont Environment – Observations/Opportunities

- Considerations
  - Highest level of State to participate in developing vision
  - Target 2030 for full transformation of payment system
    - Gives health systems and providers adequate time to develop meaningful investments in health-related activities while maintain access to high quality “sick-care”
  - OneCare VT to aggregate nearly all-payer payment and channel to providers
    - Health systems required to participate in all “programs”
    - Primary care practices required to participate in Comprehensive Payment Reform
    - Transition nearly all health system payment away from claims payment/reconciliation towards fixed, budgeted payment
      - Critical Access Hospitals transition from cost-based payment to budget-based payment
    - TCOC shared savings/risk arrangement for all payers
      - May require provider withholds
    - OneCare VT, as statewide vehicle for payment change, must have boarder governance representation
  - GMCB to actively participate in setting aggregate TCOC and provider budgets as well as ensuring high quality and community investment in health-related activity

Conclusions/Recommendations

STROUDWATER

- The FFS payment system – designed to pay for “sick care” – precludes incentives or payment for meaningful investment in “health care” activities, programs, or infrastructure
  - Currently, the “function” of health care is dictated by “finance” as the fee-for-service payment system was designed to pay for episodes of “sick care”
- A healthcare system that starts with the optimal “function” of healthcare requires both:
  - Patient access to high quality “sick care” and
  - Investment in health and wellness activities, program, and infrastructure to generate “health care”
- A Global Budget payment system maintains a predictable and steady revenue stream so a local health system can maintain access to high quality “sick care” while investing in community health
- A Shared Savings incentive payment provides the funds to invest in “health care”
- With some changes, VT has necessary infrastructure in place to develop a true healthcare system

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