Health Care Stewardship

Vermont Case Study

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In 2015, Urban conducted case studies examining health care stewardship in five states: Colorado, Minnesota, Ohio, Oregon, and Vermont. Stewardship demands active pursuit by governments of systemwide improvements, beyond typical public health and purchasing roles. This means developing a strategic framework for a health policy that reaches all citizens, building support among stakeholders, regulating and monitoring health care systems, and using data to improve. Through a series of on-the-ground interviews, we examined the unique ways states have leveraged their authority to improve the quality and efficiency of health care systems. To learn more or read the other case studies, visit http://www.urban.org/policy-centers/health-policy-center/projects/health-care-stewardship-case-studies.

Overview

Vermont's state government has a long history of coverage expansion and delivery reform grounded in primary care. Democratic Governor Howard Dean pushed unsuccessfully for universal coverage in the 1990s, but the successful promotion of incremental expansions kept health care reform on the state policy agenda and in the public's mind into the 2000s.

Republican Governor James Douglas, elected in 2002, picked up the health care challenge, but he focused attention on health care delivery. Through a 2003 executive order and legislation passed in 2006, Governor Douglas launched the Vermont Blueprint for Health (the Blueprint) to improve chronic care management. In 2007, the legislature broadened the Blueprint's focus to enhance and expand primary care. Specifically, the legislature authorized the development of pilots in three regions of the state in which primary care practices adopt the patient-centered medical home (PCMH) model of care

and receive support from community health teams. Three of the largest commercial payers in Vermont also agreed to participate in the Blueprint's PCMH initiative. In 2010, the state legislature directed the Blueprint office to expand the initiative incrementally over the next three years to include any practice interested in becoming a PCMH by 2013 (Vermont Blueprint for Health 2011).

Emphasis on universal coverage again took center stage with Democratic Governor Peter Shumlin's election in 2010. Governor Shumlin campaigned on the issue and successfully promoted legislation that authorized the development of a "universal and unified health care system," dubbed Green Mountain Care and commonly referred to as a single-payer system. The legislation also established a governing structure and the authorities to reform payment and delivery for the state as a whole.[1]

That legislation, passed in 2011, created the Green Mountain Care Board (GMCB), an independent board whose members are nominated by a nominating committee that includes legislators and health care experts. The 2011 legislation and follow-up legislation passed in 2012 tasked the GMCB with three main areas of responsibility regarding health care:

- **Regulation.** The legislation transferred to the GMCB responsibility for approving hospital budgets, major health care capital investments, and small-group and individual health insurance rate increases. It also granted the GMCB entirely new regulatory responsibilities: approving both all-payer rates for all providers (contingent on receipt of a federal all-payer waiver)[2] and Green Mountain Care's minimum benefit package.

- **Innovation.** Also in the legislation was GMCB responsibility to approve all-payer payment reform pilots, the state's health care workforce plan, and the state's health information technology plan. Those activities are intended to move the state's health care system from one based on fee-for-service to one based on value and quality.

- **Evaluation.** The legislation assigned the GMCB responsibility for evaluating (1) the overall health care system, including the payment reform pilots described above, and (2) whether the administration's Green Mountain Care proposal met the statutorily required triggers specified in the legislation before implementation.

The 2011 and 2012 legislation enabled state government to simultaneously pursue universal coverage and payment and delivery reform. But the legislation by no means guaranteed adoption of a single-payer system. The legislation provided a framework, not a full-blown system; fundamental questions remained about employer and Medicare participation and, most important, costs and who would pay them. Administration proposals for provider payment rates and increased payroll taxes generated substantial opposition from providers, insurers, businesses and the public at large.[3] Shortly after winning reelection in 2014 by a narrow margin, Governor Shumlin acknowledged concerns about the feasibility of Green Mountain Care and announced he would indefinitely cease his efforts to pursue its adoption. Nevertheless, state agencies continue with efforts to include all payers in a unified system, either through a common payment structure under a federal waiver or through similar payment structures developed in collaboration across all payers and providers.

Taking advantage of the Center for Medicare and Medicaid Innovation State Innovation Model (SIM) testing grant received in 2013 and building on Medicare's ACO (accountable care organization) Shared Savings Program (MSSP), the state collaborated with providers and payers and used its "payment reform pilot authority" to develop standards for a commercial and Medicaid shared savings program that would involve three ACOs serving the Medicaid program and the Marketplace. The governor's office and officials at the GMCB regard this initiative as the next step in building a unified, statewide payment and delivery system. Large and self-insured employers have yet to commit to these efforts.

Political and Policy Context

Over the past two decades, Vermont has elected Republican and Democratic governors, all of whom have advanced reforms to the state's health care system in some fashion. Democratic Governor Dean held office from 1991 to 2003 and Republican Governor Douglas from 2003 to 2011. Vermont's current chief executive, Governor Shumlin, has led Vermont's state government since 2011 and by many accounts was elected to the state's highest office on a single-payer platform.[4] Democrats have controlled the state legislature since 2005.

Vermont has one of the least competitive individual insurance markets in the country. Only two insurers have an insurance market share of greater than 5 percent, and the largest insurer (Blue Cross Blue Shield of Vermont) has an 89 percent share of the individual market.[5] The 2011 health reform legislation mandated the sale of all individual and small group insurance through the exchange.[6]

Vermont, a Medicaid expansion state,[7] falls into the middle third of the country regarding spending per Medicaid enrollee.[8] Vermont has significantly decreased its cost trend on annual Medicaid spending. From fiscal year (FY) 2007 through FY 2010, the state's average annual Medicaid spending growth was 11.4 percent, and from FY 2010 through FY 2013 the cost trend was cut almost in half to an annual average of 5.6 percent.[9]

State Goals

All parties agree that the state's health reform goals, as articulated in their application for federal innovation funds (Vermont Health Care Innovation Project 2012), are to expand access to health insurance coverage, lower costs, improve quality, and improve the health of Vermont's residents. Because Governor Shumlin pulled back from efforts to institute a single-payer system in December 2014, the state government's strategy to achieve these goals rests on payment and delivery reform.

Vermont's state government has taken a long view of delivery system reform, leading collaboration across a wide range of stakeholders to create the infrastructure for a unified payment and delivery system, or as one stakeholder described it, "building the base of a stone wall." The state government's long-term plans include further incorporating the Blueprint initiative into the existing ACOs and moving toward a unified payment structure across multiple payers. The state government intends this new

payment structure to advance beyond the shared savings model used in most existing ACO contracts in Vermont, often referred to as the "training wheels" for future payment arrangements where ACOs and providers carry greater risk and are held accountable for the results of health care delivery. The GMCB currently regulates hospital budgets with targets for hospital net revenues; it does not use its authorities to set actual payment rates. With ACOs, its intent is to determine per-person payment amounts for all payers, though doing so for Medicare would require federal approval. Whether the ACOs would then have full responsibility for allocations to providers, or whether the GMCB would monitor that as well, is not yet clear.

View of State's Role

Stakeholders generally view the GMCB as leading the charge on payment and delivery system reform, with significant support from the governor's office and the legislature. In creating an independent agency, the legislature gave the GMCB broad authority to facilitate payment and delivery system reform initiatives, approve hospital budgets and insurance premium rates, and approve capital expenditures through a certificate-of-need process. The governor appoints the chair and the board members for six-year terms (though initial terms were seven years for the chair with staggered terms for members of three to six years). Although the board is independent, it collaborates closely with the governor's office (the initial chair was a trusted aide). In addition, the legislature actively directs its operations. As one participant in the process described it, the state legislature is "hands off and hands on at the same time."

The GMCB also works closely with providers and with payers. The board worked with hospitals and other health care providers to apply for and launch the largest ACO in the state (OneCare) under the MSSP, has encouraged all ACOs to work with Blueprint organizations, and is leading all parties in next steps in the reform process.

Leadership

For more than two decades, health care issues have been at the top of Vermont's governors' political agendas, though objectives have varied. Democratic governors Dean and Shumlin pursued coverage expansions both incrementally and through promotion of a single-payer system. In between them, Republican governor Douglas initiated delivery reform that provided the foundation for payment and delivery reform now under way. The 2011 legislation put state government squarely in charge of health care reform in Vermont. With the blessing of the governor and the legislature, plus strong grounding in statutory authority, the GMCB is moving stakeholders toward common goals.

Authority

The 2011 and 2012 legislation built on earlier laws to put the state—and ultimately the GMCB—in charge of key drivers of Vermont's health care financing and delivery system: hospital budgets, major health care capital investments, care improvement initiatives, and insurer and insurance premium regulation. The state legislature granted GMCB extraordinary regulatory power over insurers and providers in the state and the ability to take aggressive action on its own.

Leverage

The GMCB's regulatory power gives the state leverage to achieve a unified payment and delivery system. The GMCB invites collaboration; many stakeholders express the view that they are treated as active partners in the reform process. However, the "coalition of the willing" those stakeholders describe rests in part on recognition that the GMCB can make policy with or without them; they clearly prefer to be at the table.

Although stakeholders generally enjoy a good relationship with the GMCB, some participants see risk in permitting an independent agency to hold so much regulatory power. The GMCB is collaborative and open to discussion with providers and insurers now, but what will happen when the GMCB's leadership changes? Or what will happen under a different governor? To date, the GMCB has been both a creature of and partner with the Shumlin administration. Although the law gives the governor considerable authority over appointments, members serve longer terms than the appointing governor, creating the potential for conflict or distinct agendas. The board's agenda is also subject to change: though the GMCB is currently an assertive regulator, its capture by or alignment with the regulated industry remains a possibility.

The state government's movement toward a unified delivery system is facilitated by the state's small size and relatively less competitive delivery system and insurance market. The state's landscape is notable for a large, single statewide ACO (OneCare), which includes all the state's hospitals and a dominant commercial insurer (Blue Cross Blue Shield of Vermont). As a counterweight to these large entities, the state government has historically taken a heavy hand with provider and insurer regulation, and Vermont residents have long accepted that strong regulation.

Federal Role

Having passed the supporting legislation in 2011, state government, along with private providers, took full advantage of opportunities created by the federal government under the Affordable Care Act. Vermont providers organized themselves to participate as ACOs in CMMI's MSSP, and state government sought to extend the Medicare model. Concerned about hospital dominance, a group of physicians established the first Medicare ACO contract in Vermont, Accountable Care Coalition of the Green Mountains. All 13 of Vermont's hospitals agreed to participate in a second, statewide ACO,

initiated by the University of Vermont Medical Center (formerly Fletcher Allen) and Dartmouth-Hitchcock Medical Center. Many of the state's federally qualified health centers banded together to form a third ACO, Community Health Accountable Care, which emphasizes primary care.

Led by GMCB, which is responsible for insurance regulation in the Affordable Care Act Marketplace and has authority to engage in multipayer payment and delivery reform pilots, state government engaged providers and payers in parallel ACO shared savings programs for Medicaid and commercial payers in the Marketplace. From the state's perspective, this is a significant but manageable step in extending the model throughout Vermont. Stakeholders are actively participating in the process with an eye to their own interests but gave no indication of opposition. The state is using its SIM grant to convene stakeholders in communities across the state, encouraging communities and work groups to develop their own priority initiatives within the ACO framework. All ACOs are participating in the process. SIM is also supporting the rollout of a clinical data system that provides ACOs with the data they need to manage their patients and that will ultimately enable all providers in the state to track their patients' services use in a timely fashion.

Federal action is also shaping the state government's next reform steps. State leaders are assessing two options to take them beyond "training wheels" to a more unified payment system. The GMCB and the Shumlin administration are in conversations with the Centers for Medicare and Medicaid Services regarding a waiver that could put all of Vermont's payers—including Medicare—on a unified payment system built on the statewide ACO model. (The approach is similar to long-standing all-payer hospital rate-setting in Maryland, but it goes beyond Maryland's system to address total cost of care; Berenson 2015) Alternatively, the next round of payment reform could build on the Centers for Medicare and Medicaid Services Next Generation ACO model (Next Gen),[10] continuing to parallel its terms for Medicaid and the Marketplace. Under the Next Gen model, ACOs will have an opportunity to take on greater financial risk and potential reward in caring for their enrolled populations. Currently, only OneCare can satisfy the minimum requirements to be a Next Gen ACO. Regardless of which approach Vermont takes, the state is intent on continuing to steward health system reform for their population.

Role of Medicaid

Medicare, not Medicaid, has been the catalyst for delivery reform in Vermont. With the state's support, providers initiated the formation of ACOs to take advantage of Medicare opportunities. Recently, Medicaid has become a significant player as the GMCB fostered relationships with the ACOs for Medicaid and commercial insurance in the Marketplace. State officials see these extensions as a stepping stone from Medicare-focused to Vermont-wide, all-payer payment and delivery system reform. Tying these programs into the Medicare innovation opportunities substantially expands the patient population of these organizations and therefore the reach of delivery reform.

Structure and Processes

The Department of Vermont Health Access (DVHA) manages Vermont's publicly funded health insurance programs. Under this umbrella mandate, DVHA runs the state's Medicaid program and Children's Health Insurance Program, governs the Marketplace, and manages the Blueprint. The Blueprint aims to improve the quality and control the cost of health care by implementing the PCMH model in practices throughout Vermont supported by community health teams. The Blueprint's PCMH initiative gives primary care practices multidisciplinary support, makes available a network of self-management support programs, engages in comparative reporting from statewide data systems, and facilitates continuous improvement.

The 2011 legislation that created the GMCB charged it with ensuring that changes in the health system improve quality while stabilizing costs. One of the GMCB's original purposes was to approve the administration's plan for creating Green Mountain Care when fully developed. Although this plan has been abandoned, the GMCB's other authorities give it an important role. Under its responsibility for piloting reform programs, the GMCB is involved in implementing and regulating the Shared Savings Program connecting Medicaid and Blue Cross Blue Shield in the Marketplace and the three participating ACOs. The SIM grant was jointly applied for by the GMCB and DVHA, and the SIM steering committee, which includes stakeholders, is cochaired by the chair of the GMCB and the commissioner of DVHA. Ultimately, the administration is responsible for overseeing the grant.[11]

Strategy for System Change

State government's strategy for health reform is both ambitious and pragmatic. Although the governor was unsuccessful in establishing a single payer-system for Vermont, his administration and the GMCB have launched promising Vermont-wide payment and delivery reforms. Key to that effort is the scope of authority delegated to the GMCB and the board's exercise of that authority to engage stakeholders in a collaborative process in pursuit of common goals.

Supported by federal initiatives and federal dollars, the GMCB has brought together Vermont's earlier primary care initiative and all three ACOs, thereby incorporating primary care and community teams into the ACO structure. State officials perceive themselves as building a foundational structure that will enable provider organizations, working with community organizations, to promote population and individual health and slow health care cost growth statewide. Though the state will rely on multiple payers rather than a single payer, the state aims to engage all payers in a unified system that aligns their incentives toward management of individual and population health.

State officials view this as a long-term process, and as they move forward they are investing not only in appropriate management tools and structure but also in active community participation across providers and across the health and social service systems.

Progress to Date

Despite the setback to the Shumlin administration's effort to enact a single-payer system, state officials believe the reform process is moving in the right direction. Some officials point to slow cost growth in the state as a sign of progress. But most public and private health care leaders see themselves as at the early stages of a long haul. Payment systems and provider business models haven't fundamentally changed, but hospitals and many physicians are organized to take on collective responsibility, tools are developing to manage risk, and all parties are preparing for a new phase of payment reform that will entail greater accountability through enhanced financial risk and, they hope, produce a new business model for hospitals and other providers. Whether that path will involve a federal waiver that would put all payers in the state on the same system or whether it will involve parallel systems is an open question.

Sustainability

Both the federal government and the state (the administration and GMCB) will be weighing the relative fiscal advantages of an all-payer waiver versus separate ACO contracts for each payer. A waiver would involve assumptions about future growth rates that could advantage or disadvantage either the federal government or the state. Making them both "winners" is a challenge. Either way, however, the GMCB is likely to use its authority to increase the risks borne by providers in a payment system ultimately extending to all payers. That may be through a single ACO rather than three: OneCare is by far the largest, and others may not be able to satisfy criteria for assuming financial and clinical risk in a new system.

Conclusion

Vermont's state government and other stakeholders in the state share a long commitment, predating the Affordable Care Act, to enacting and implementing state government-led health care reforms aimed at developing a unified and universal health care system in the state. Legislation passed in 2011 established an institutional structure and statutory authority for the development of a single payer health care system and statewide delivery system reforms designed to support that system. Governor Shumlin's December 2014 announcement that he was abandoning pursuit of a single-payer system in Vermont has shifted focus to instituting statewide delivery system reforms. Supported by the state's small size and less competitive delivery system and insurance market, the state government aims to include all payers in a unified delivery system under a common payment structure. A federal waiver is being explored. Implementation could involve unified (but not necessarily uniform) payment structures developed in collaboration across all payers and providers. Under state government leadership and the threat of unilateral state government action, a "coalition of the willing" that includes nearly all providers and payers in the state is working collaboratively to achieve statewide delivery system reform.

Notes

1. Aimee Miles, "Vermont Gov. Proposes Single-Payer Health Plan," *Kaiser Health News*, February 8, 2011, http://kaiserhealthnews.org/news/vermont-governor-shumlin-single-payer/.
2. The GMCB will still have the authority to set commercial rates if the federal government does not grant the state government a waiver.
3. Sean McElwee, "Can Vermont's Single-Payer System Fix What Ails American Healthcare?" *Atlantic,* December 27, 2013, http://www.theatlantic.com/politics/archive/2013/12/can-vermonts-single-payer-system-fix-what-ails-american-healthcare/282626/; Sarah Wheaton, "Why Single Payer Died in Vermont," *Politico*, December 20, 2014, http://www.politico.com/story/2014/12/single-payer-vermont-113711.html.
4. "Vermont Governor Peter Shumlin," National Governors Association, accessed November 24, 2015, http://www.nga.org/cms/home/governors/current-governors/col2-content/main-content-list/peter-shumlin.html.
5. "Individual Insurance Market Competition," Kaiser Family Foundation, accessed November 18, 2015, http://kff.org/other/state-indicator/individual-insurance-market-competition/.
6. "Act No. 171 (H.559). Health; health insurance; health benefit exchange; Green Mountain Care board; certificate of need; medical malpractice; prescription drugs; Blueprint for Health; Medicaid; Medicaid waiver," Vermont General Assembly, accessed November 24, 2015, http://legislature.vermont.gov/assets/Documents/2012/Docs/ACTS/ACT171/ACT171%20Act%20Summary.htm.
7. "Status of State Action on the Medicaid Expansion Decision," Kaiser Family Foundation, accessed November 24, 2015, http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/.
8. "Medicaid Spending per Enrollee (Full or Partial Benefit," Kaiser Family Foundation, accessed November 18, 2015, http://kff.org/medicaid/state-indicator/medicaid-spending-per-enrollee/.
9. "Average Annual Growth in Medicaid Spending," Kaiser Family Foundation, accessed November 18, 2015, http://kff.org/medicaid/state-indicator/growth-in-medicaid-spending/.
10. "Next Generation ACO Model," Centers for Medicare & Medicaid Services, accessed November 24, 2015, http://innovation.cms.gov/initiatives/Next-Generation-ACO-Model/.
11. "Welcome!" Green Mountain Care Board, accessed November 24, 2015, http://gmcboard.vermont.gov/.

References

Berenson, Robert A. 2015. *Hospital Rate Setting Revisited: Dumb Price Fixing or a Smart Solution to Provider Pricing Power and Delivery Reform?*Washington, DC: Urban Institute. http://www.urban.org/research/publication/hospital-rate-setting-revisited-dumb-price-fixing-or-smart-solution-provider-pricing-power-and-delivery-reform.

Vermont Blueprint for Health. 2011. *2010 Annual Report*. Williston, VT: Department of Vermont Health Access. http://innovation.cms.gov/files/reports/MAPCP-EvalRpt1.pdf.

Vermont Health Care Innovation Project. 2012. *Vermont's Health Care Innovation Plan*. Montpelier, VT: Vermont Health Care Innovation Project.

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