Opportunities for Evolution of Vermont's Healthcare Regulatory System

Health Reform Oversight Committee of the Vermont State Legislature

December 10, 2021 (with revisions made 12.20.2021)

DK Healthcare Consulting

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Overview and Objectives

- The Health Reform Oversight Committee (HROC) is considering the evolution of the health care regulatory system in the context of enhancing opportunities to manage cost and improve the delivery system
- To support an information driven approach to this process, the HROC engaged Donna Kinzer (DK Healthcare Consulting LLC) to:
    1. Assess the availability and gaps in information that can identify: Factors driving health care cost growth in Vermont, best opportunities to reduce cost or cost growth, and their implications for regulatory structure
    2. Obtain preliminary qualitative perceptions regarding system performance, future cost containment strategies and their implications for regulatory structure

As discussed on page 5, the healthcare system is under extreme stress relative to the COVID-19 pandemic. This should be taken into account when considering the model results and pace of any future change in regulatory systems

THIS REPORT IS INTENDED FOR THE SPECIFIC PURPOSES DISCUSSED ABOVE

Approach to Assessment

Evaluate	Discuss	Summarize
Review and evaluate information available to assess healthcare cost performance for VT	Discuss performance and regulatory construct with VT policy leaders and advocates	Summarize results, recommendations, and implications

Process	Review reports & data collection*, interviews/meetings, outside experience and references, synthesis

*DK did not audit or otherwise verify information contained in reports.

Effects of the COVID-19 Pandemic Should be Considered in Evaluating Model Results and the Potential Pace of Regulatory Change

There are serious and ongoing effects on healthcare delivery systems

There are distortions in healthcare utilizations and costs for CY2020 and CY2021

There are serious healthcare workforce problems nationally and locally

The population is experiencing increased mental health and substance use disorders

II. Availability & Gaps in Cost Information

Data & Information for HROC– Assessing and Enhancing Regulatory Structure

I. **Healthcare costs levels/cost growth/cost comparisons for policy, performance analysis, opportunity identification**

II. **Data and information needed to support delivery system transformation (qualitative comments)**

Note: Evaluation of quality and health data available was not part of the scope of this work

Main Data Sources for Cost Information for HROC

VHCEA Vermont Health Care Expenditure Analysis	VHCURES Vermont Health Care Uniform Reporting and Evaluation System
• **Comprehensive Healthcare Expenditures for Vermont Residents** ○ By payer, total cost, spending categories, (e.g. hospital, drugs), per resident (at in-state and out-of-state providers) ○ Summary data, not at a person level ○ Includes costs not funded through patient bills	• **Vermont's All-Payer claims database (APCD)** ○ Resident, cost, and utilization information at a person and provider level, derived from claims paid by payers ○ Excludes costs not derived from patient bills

Data are collected and maintained by Green Mountain Care Board (GMCB)

VHCEA

- **Source for VT annual expenditure reports**
- Comprehensive source of total healthcare costs and changes in expenditures for VT residents
  - Total cost
  - Per person costs
  - By payer
  - By category (high level)
- High quality resource useful for macro level policy analysis, summary data, not granular
- GMCB has a well-documented process for obtaining and incorporating data and estimates.

More information:

https://gmcboard.vermont.gov/sites/gmcb/files/files/hospital-budget/Expenditure_Analysis_Manual_January%202017.pdf

VHCURES

- **Source for All-Payer Model performance**
- Used for more granular analysis of spending
  - Person level (masked for privacy)
  - Detail expenditure comparisons/analysis
  - Clinical information
- Does not include:
  - Some self-insured data, uninsured
  - Non claims-based costs. These costs are reported/estimated in the VHCEA, not in VHCURES
- Principal data source is payer claims (patient bills that have been paid) and member enrollment files from payers
  - Data is complex, not easily accessible
  - Require Data Use Agreements to protect confidential data
  - GMCB has a report with recommendations to support increased use of the data, GMCB agrees with recommendations
  - Working to link important clinical and cost data

More information:

https://gmcboard.vermont.gov/DATA-AND-ANALYTICS/DATA-COLLECTION/vhcures-vermonts-all-payer-claims-database

https://gmcboard.vermont.gov/sites/gmcb/files/documents/Development_of_Specifications_for_Set_of_Analysis-Ready_Files.pdf

Gaps in Information--Comparative Spending Levels & Low Value Care

- GAP: Relative spending levels per capita by payer with details to drive opportunity analysis (also to drive care delivery transformation for the ACO/health systems)
  - Comparisons to spending levels outside of Vermont are uncertain and lack sufficient detail
  - All Payer data from National Health Expenditure Accounts (NHEA) is not trusted (allocations & border crossing) and is not sufficiently detailed for analysis
    - Medicare data shows lower spending per enrollee (relative to national levels) for VT residents, but All-Payer uncertain

RECOMMENDATION #1(a): GMCB should consider engaging a third party to perform per capita (age and risk-adjusted)benchmarking analyses, ideally at a granular level (HSA/cost category), with comparisons to national, peers, and better performers.

Gaps in Information--Comparative Spending Levels & Low Value Care (cont.)

- OPPORTUNITY: Several states, as well as health plans, ACOs and health systems, are using their APCDs/claims to identify low value care* and calculate its associated waste (e.g., VA, WA, CO, ME). They are using tools, which scan claims data and capture episodes of low value care as defined by the Choosing Wisely campaign, the US Preventive Services Task Force, criteria, etc.
- Since a benchmarking process requires claims level data analysis, VT may want to leverage the benchmarking engagement work to prepare an analysis of potentially avoidable utilization and low value care. While medical care must remain in the hands of providers, these analyses can help providers understand potential opportunities.

RECOMMENDATION #1(b) VT should consider adding an analysis of potentially avoidable utilization and low value care, to leverage the work of the benchmarking engagement and identify further areas of opportunity for quality improvement and cost containment.

*https://vbidcenter.org/initiatives/low-value-care/ "Low-value care can be defined as services that provide little or no benefit to patients, have potential to cause harm, incur unnecessary cost to patients, or waste limited healthcare resources"

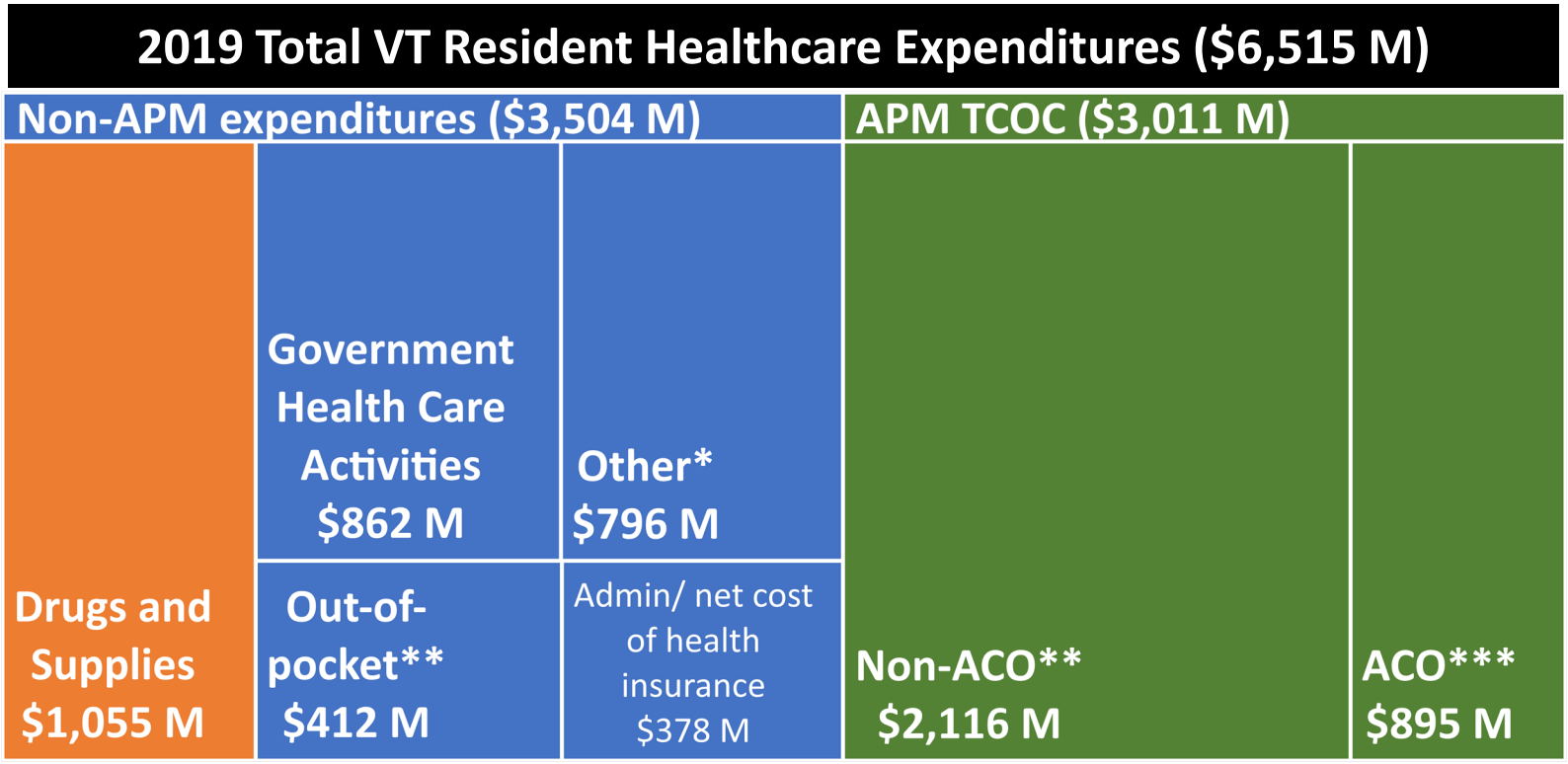
Summarize Performance Reports

- GMCB prepares numerous high quality performance reports regarding healthcare expenditures and cost increases, All-Payer Accountable Care Model performance, ACO performance, and focused studies, among others

RECOMMENDATION #2: The GMCB should summarize, synthesize, and provide analysis of key findings from its expenditure analyses, reports, and focused studies, including those prepared by outside consultants

III. Drug Costs and Regulatory Structure

VHCEA Reports Provide an Understanding of Costs Relative to Regulatory Structures



SOURCE: GMCB staff, derives from VHCEA, 2019 (Also see Appendix pages 34, 38, 39), totals may not add up due to rounding

*Other includes dental, vision, unclassified services, expenditures not paid through claims, and care costs for commercial ASO spending not captured in VHCURES.

**Out-of-pocket for APM members and services shown under APM. The remainder is under "out-of-pocket", which includes uninsured residents

***For 2021, the estimated expenditures under the ACO have increased to ~$1.2 billion.

APM TCOC = All-Payer Accountable Care Model Total Cost of Care

VT May Want to Consider Approaches to Address Drug Cost

- Drug costs are among the highest categories of cost drivers (% and $ increases) per 2019 VHCEA across payers. See Appendix page 32
- Most drugs are outside of the APM growth targets and ACO accountability
- GMCB regulatory processes are not heavily focused on drug spending, a GMCB technical advisory group is focused on Rx spending

RECOMMENDATION #3: Vermont should consider additional cost containment strategies for drug costs

- NASHP* is one source of information regarding state strategies
- ACO/providers can take on a larger role in selecting cost-effective high-quality drugs where there are alternatives available
- New strategies may require changes in regulatory structure or staff/investments

*NASHP= National Academy for State Health Policy

IV. Interview Themes: Regulatory Structure Evolution in Alignment with ACO Model

#1. Interview Themes—ACO/APM strategy and concept is supported

- Stakeholders generally continue to strongly support an accountable care organization (ACO) strategy for Vermont's All Payer Model(APM)
  - Builds on the Blueprint for Health—primary care relationship, prevention and chronic care management
  - Builds on the high vertical integration* in VT (hospital ownership of physician practices >80%)
  - Creates infrastructure to work across health systems/providers to coordinate care
- There are alternative views
  - Does the ACO add much beyond Blueprint?
- ACO strategy is in line with new CMS guidance (Attachment page 33)

*Vertical integration refers to consolidation across health care provider types (e.g., hospital/physician) vs. within the same provider type (e.g., hospital/hospital)

#2. Interview Themes– Adjustment and alignment of regulatory constructs and processes

- Much of the regulatory structure and process in place was put in place prior to the ACO/APM Model
- With providers taking on more responsibility and risk for cost and health, there are opportunities to streamline and align the regulatory system, "nesting" hospital budget review and CON regulation within the ACO/APM Model construct
- Competition is limited in Vermont due to geography and health system evolution. Continued regulation is important to protect consumers and system participants

RECOMMENDATION #4: As providers take on more responsibility and risk for total cost of care under an ACO/APM model or other payment constructs, consider aligning or easing some regulatory processes, while continuing consumer cost protections provided through regulation

- Consider changes to hospital budget reviews when the proportion of ACO or hospital revenues under global payments reaches a predetermined proportion of total expenditures
    - Increase focus on annual cost growth levels vs individual hospital budgets
- Consider approaches to streamline CONs for providers who are taking full responsibility for total cost of care in their service area, especially for replacements that do not require a net revenue increase
- Eliminating regulatory structures is not advisable in light of market structure in Vermont

#3. Interview Themes: Alignment of hospital review/payment model with APM/ACO strategy

- Less than half of hospital payments are under the ACO purview and even less under fixed payment arrangements
- Multiple interviewees *and* external evaluators/consultants raise the concern that the current payment/review structure leaves hospitals and their owned practices under fee-for-service incentives, potentially diluting the effectiveness and scope of cost containment activities of the ACO/APM. The current approach retains volume growth incentives to achieve sustainability, especially in the outpatient hospital setting where profitability is higher. See page 35.
- There is not clear alignment between the hospital budget review and the ACO model
- GMCB as well as other interviewees raised the potential for review/payment model changes in light of optimizing sustainability ***and*** cost containment objectives

RECOMMENDATION #5: Consider alternative review/fixed global payment options, "nested" within the ACO/APM Model framework, for hospitals and their employed physicians to improve alignment (moving away from fee-for-service) & sustainability/cost containment (predictable fixed payments)

V. Interview Themes: Regulatory Structure—ACO/APM Implementation

#4. Interview Themes—Affordability goals may benefit from additional definition

- Affordability describes whether a person or organization has sufficient income or resources to pay for or provide for health care costs. However there is no agreed-upon definition or measure
  - For example, consumers are impacted by health spending through lower wage increases, increased out-of-pockets, and higher taxes or lower spending for other services. VT will need to decide what to consider in setting growth targets
- Vermont created growth targets for its APM/ACO All-Payer Model several years ago, which may benefit from updating and anchoring to affordability

RECOMMENDATION #6: Consider whether VT could benefit from developing health expenditure growth targets in a defined context of affordability, potentially with recognition of component spending (e.g. drugs, health system)

- Several interviewees mentioned targeting more growth to improve health and reduce avoidable use –e.g. spending on primary care
- Example mentioned is Rhode Island's Affordability Standards

#5. Interview Themes—There are major accomplishments as well as concerns with implementation of the ACO/APM

ACCOMPLISHMENTS:

- Medicare has generated substantial savings and Medicaid has improved the predictability of its costs
- Many providers are participating in the ACO, increasing their ability to transform care delivery and reduce costs

CONCERNS:

- State has prepared an Implementation Improvement Plan with 18 steps (See Attachment pages 36 & 37)
- Particular concerns regarding enhancing the availability and use of data for care transformation (#13 in Attachment page 37) (See Interview Theme 5.a.)
- Some concerns about control and potential conflicts with affiliation of University of Vermont Medical Center (See Interview Theme 5.b.)
- Concern that there is not enough participation of members to reduce fee-for-service volume incentives in hospitals and health systems (See Section IV.)
- Some providers and hospitals are not participating. Unclear opportunities beyond primary care/chronic care management.

#5.a.Data model strategy/concerns—data and resources for transformation

- Interviewees identified concerns with data to drive transformation and cost containment. There are both “inbound” and “outbound” data concerns. (CAVEAT: DK did not perform an analysis of data flows, concerns are from qualitative interviews)
  - Inbound data from payers is “raw”, not always timely. Creates hurdles for ACO
    - Funding was provided to the ACO for data infrastructure, an expected value-added feature of the ACO
  - Health data to feed “gaps in care” workflow is incomplete (some of this data needs to be extracted from Electronic Health Records (EHRs))
  - Unclear strategy on data/transformation model to reduce waste and drive care improvements beyond primary care and chronic care management
- Uneven implementation—some communities have transformation plans and personnel (transformation resources) to aid implementation effectiveness of ACO activities and engagement of providers, while others don’t. Local resources, aided by common training and sharing of best practices may improve engagement and implementation effectiveness
  - Limited sharing of best practices across provider settings

#5.a.Data model strategy/concerns—data and resources for transformation (cont.)

- **RECOMMENDATION # 7:** Continue and escalate the process to consider data/transformation model options and strategies to drive care delivery transformation and cost containment
- **Should there be transformation resources in each community?**
- What is a reasonable expectation of the ACO? How much is growing pain, maturity?
- Should some data model processes be accomplished outside of the ACO, for example at the (Health Information Exchange) HIE?
- Are there legislative or regulatory processes and funding required to collect EHR* and health data, implement data model?

*EHR=Electronic Health Record

#5.b. OneCare Affiliation/Control

- An affiliate of the University of Vermont Medical Center (UVMMC) is the sole member of OneCare Vermont ACO ("OneCare"), a 501 (c)3 status as a tax-exempt entity
- OneCare's operations operations are governed by a 21-member board. (UVMMC affiliates comprise 4 seats on the board). The operating agreement is a public document*
- OneCare develops risk/savings models/participation agreements and some payment arrangements for the ACO and negotiates with payers
    - OneCare has made some changes in risk structures to accommodate smaller providers
- Concerns relate to acceptance of terms or prices from payers and with unaffiliated providers, grievances with unaffiliated providers and consumers, and competing efforts of UVMMC affiliates
    - An affiliate of UVMMC has initiated its own Medicare Advantage product, which is not currently contracted with the ACO.

➢ GMCB already has some review authority over the ACO and the ACO board is not controlled by UVMMC.

RECOMMENDATION #8: Evaluate whether GMCB authority and processes and board structure provide sufficient protection for non-affiliated providers/payers and purchasers/consumers in this governance structure. Evaluate other approaches that could increase confidence and performance of the ACO—e.g. **enhancements of local transformation structures**, any other changes to Board composition, advisory processes, grievance processes, etc.

*(https://gmcboard.vermont.gov/sites/gmcb/files/documents/Ninth%20Amended%20and%20Restated%20Operating%20Agreement%20of%20OneCare%20Vermont.pdf)

VI. Summary of Recommendations

Summary of Recommendations, Advantages and Disadvantages

RECOMMENDATION	ADVANTAGES	DISADVANTAGES
#1 (a) GMCB to consider engaging a third party to perform per capita benchmarking analyses, ideally at a granular level, with comparisons to national, peers, and better performers #1 (b) **VT to consider adding an analysis of potentially avoidable utilization and low value care**, optimizing the benchmarking engagement	Understand relative performance, identify opportunities	Cost to obtain
#2 GMCB should summarize, synthesize, and provide analysis of key cost findings from its analyses, reports, and focused studies	Important information summarized and analyzed	None
#3 Consider additional cost containment strategies for drug spending that is not currently under the APM or ACO initiatives	Address highest % cost growth area of spending	Regulatory focus, cost of infrastructure, dependence on federal policies

Summary of Recommendations, Advantages and Disadvantages, cont.

RECOMMENDATION	ADVANTAGES	DISADVANTAGES
#4 As providers take on more responsibility and risk for total cost of care under an ACO/APM model or other payment constructs, **consider aligning ("nested" within the ACO/APM framework) or easing some regulatory processes, while continuing consumer protections of regulation**	Avoid conflicts in incentives, improve performance, lower regulatory cost	Focus, time, resources, risk in change
#5 Consider alternative review/fixed global payment options, "nested" within the ACO/APM Model framework**, for hospitals and their employed physicians** to improve alignment (moving away from fee-for-service) & sustainability/cost containment (predictable fixed payments)	Better alignment with ACO/APM, Increased sustainability of system ***and*** improved cost containment	Cost and capabilities to implement, degree and complexity of change, CMS waivers

Summary of Recommendations, Advantages and Disadvantages, cont.

RECOMMENDATION	ADVANTAGES	DISADVANTAGES
#6 Consider developing health expenditure growth targets in a defined context of affordability	Clear policy goals	Focus and time, ability to enforce
#7 Continue and escalate the process to consider data model options and strategies to drive care delivery transformation and cost containment	Enhance delivery system cost performance	Time, cost, capabilities to implement and disseminate
#8 Evaluate whether GMCB authority and ACO board provides sufficient protection in light of ACO structure. Evaluate other approaches to increase confidence and performance.	Several steps easy to accomplish. Increase confidence and performance.	Diversion of resources from other priorities

Provides DK indication of potentially higher priority recommendations with a potential to increase cost savings and better align regulatory resources

VII. Appendices

Key Sources of Total Spending Growth

2019 Vermont Health Care Expenditure Analysis-Summary

VERMONT
GREEN MOUNTAIN CARE BOARD

Vermont resident health care spending:

- Total spending for Vermont residents receiving health care services both in and out-of-state **increased 4.1% in 2019**. This was higher than the 1.9% increase in 2018. The average annual increase for the period 2014 through 2019 was 3.3%.
- Commercial insurance spending increased 3.7%, mainly due to increases in Hospitals, Drugs & Supplies, Physicians and Other Unclassified with decreases in Admin. & Net Cost of Health Insurance and Other Professionals.
- Medicare spending increased 6.3% as a result of increases in Drugs & Supplies, Home Health, Other Unclassified and Physicians with decreases in Nursing Homes and Hospitals.
- Medicaid spending increased 2.9%, mainly due to increases in Mental Health & Other Government Activities, Hospitals and Nursing Homes with decreases in Physicians and Admin. & Net Cost of Health Insurance.

Source:https://gmcboard.vermont.gov/sites/gmcb/files/documents/2019VTHealthCareExpenditureAnalysis_BoardPres_20210512_0.pdf

This symbol is used when a slide is prepared from Vermont resident analysis data. R

Vermont ACO/APM Aligned with New CMS Strategy

Figure 1. CMS Innovation Center Vision and 5 **Strategic Objectives** for Advancing System Transformation.

Source: *Driving Health System Transformation - A Strategy for the CMS Innovation Center's Second Decade*

Total Spending vs. APM Spending

VHCEA vs APM TCOC

VERMONT
GREEN MOUNTAIN CARE BOARD

- The All-Payer Model Total Cost of Care (APM TCOC) is a subset of the VHCEA Resident expenditures.

VHCEA – Resident side	APM TCOC
100% Vermont residents	~75% Vermont residents (excludes people without insurance and payers without data in APCD)
All of health consumption expenditures (HCE)	~ 46% of HCE (limited to medical claims for services like those covered by Medicare Parts A and B and nonclaims payments supporting primary care)
Medicare Advantage included with Medicare	Medicare Advantage included with commercial

Source:https://gmcboard.vermont.gov/sites/gmcb/files/documents/2019VTHealthCareExpenditureAnalysis_BoardPres_20210512_0.pdf

Recent study commissioned by GMCB shows hospitals' reliance on outpatient services for profitability, which may run counter to per capita cost containment strategies and access priorities

COST COVERAGE VARIATION BY HOSPITAL, ALL PAYERS COMBINED

There is wide variation in the percentage of costs covered by hospital.

The numbers on the weighted average row indicate the percent of costs covered for all hospitals combined. The color coding indicates the cost coverage band that each hospital falls into for each of the years studied.

The values shown below are prior to applying any case mix adjustment factor.

- Cost coverage below 85%
- Cost coverage 85.1 - 95%
- Cost coverage below 95.1 to 105%
- Cost coverage below 105.1 to 115%
- Cost coverage above 115%

		Inpatient + Outpatient			Inpatient Only			Outpatient Only		
		HFY17	HFY18	HFY19	HFY17	HFY18	HFY19	HFY17	HFY18	HFY19
Weighted Average		101.9	100.8	97.5	95.1	90.8	87.1	111.8	116.5	113.7
Dartmouth	AMC									
UVMC	AMC									
Brattleboro Mem	PPS									
Central Vermont	PPS									
Northwestern	PPS									
Rutland	PPS									
Southwestern	PPS									
Copley	CAH									
Gifford	CAH									
Grace Cottage	CAH									
Mt Ascutney	CAH									
North Country	CAH									
Northeastern	CAH									
Porter	CAH									
Springfield	CAH									

HEALTH MANAGEMENT ASSOCIATES

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SOURCE:GMCB website [BoardPres_HMA_ExaminationofPaymentandCostCoverageVariationAcrossPayersforHospitalServices_20211027]

Read the report in its entirety for methodology, findings, and caveats

IMPLEMENTATION IMPROVEMENT PLAN RECOMMENDATIONS

VERMONT ALL PAYER ACCOUNTABLE CARE ORGANIZATION AGREEMENT NOVEMBER 2020

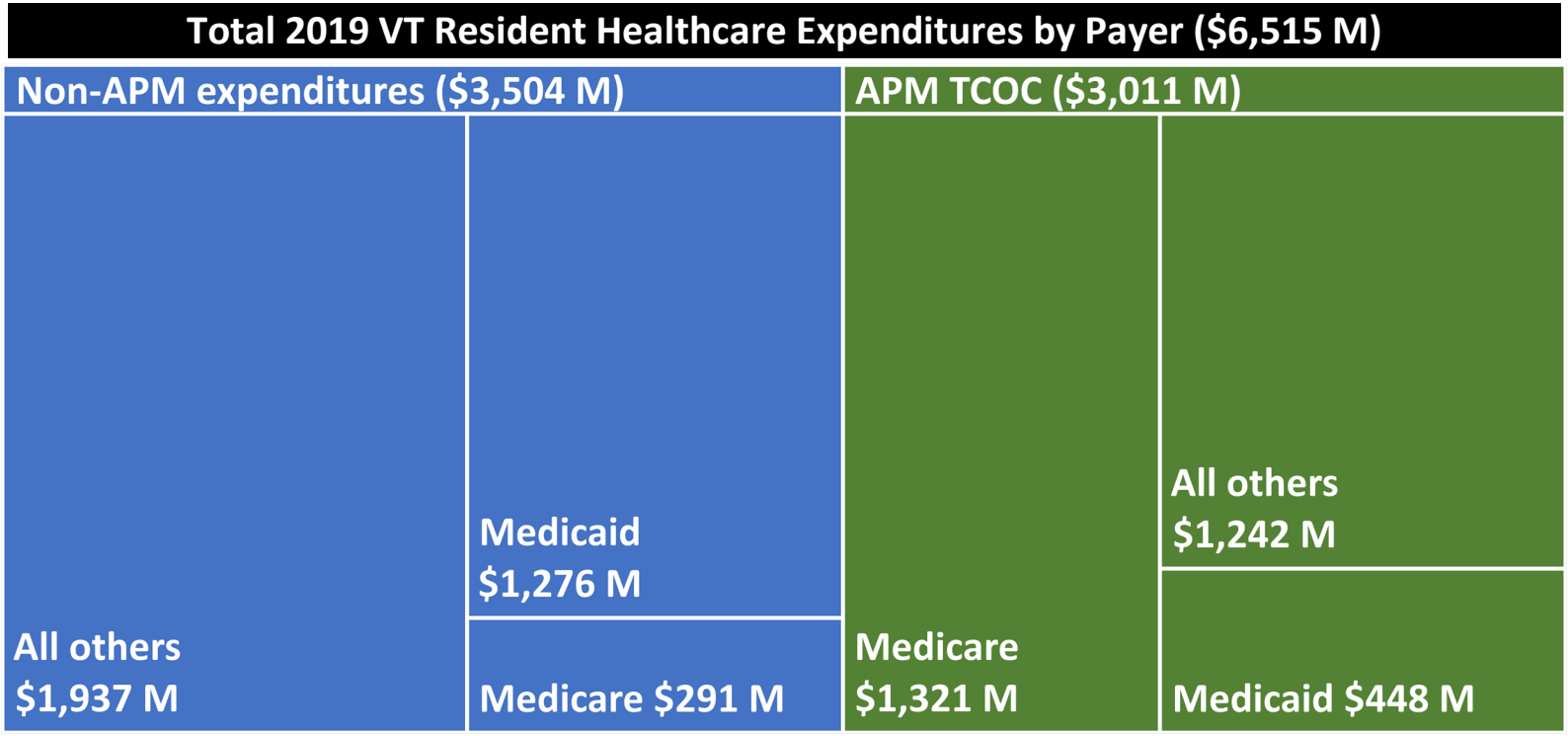
	Activity to Improve Performance	Timing*	Lead (s)
1.	Negotiate with CMS to revise scale targets to reflect realistic capacity for participation.	Short-Term	AHS, GMCB
2	Reduce Medicare risk corridor thresholds and decrease the financial burden of participation for hospitals.	Short-Term	AHS, GMCB
3	Request that CMS establish written guidance or best practices in cost reporting for CAHs. GMCB should disseminate any guidance.	Short-Term	GMCB, AHS
4	Establish a path for the Medicare payment model to mirror Vermont Medicaid Next Generation fixed prospective payments.	Short/Medium-Term	AHS, GMCB
5	Ensure Medicare 2021 benchmark provides as much stability and predictability as possible to produce financial targets that are adequate and achievable despite the ongoing uncertainty associated with the pandemic.	Short-Term	GMCB, AHS
6	Collaborate with CMMI to encourage Health Resources and Services Administration to prioritize Value-Based Payment for Federally Qualified Health Centers.	Longer Term	AHS, GMCB
7	AHS and the Agency of Administration will conduct education and outreach to non-participating self-funded groups about the benefits of participating in value-based payment models and Include State Employee Health Plan members for attribution to OneCare Vermont in 2021 (PY4).	Short/Medium-Term	AHS
8	Prioritize increasing the percentage of fixed prospective payments in the VMNG/OneCare Vermont contract. The GMCB and AHS will request that BCBSVT, MVP, and OneCare Vermont identify clear milestones for including fixed prospective payments in contract model design.	Short/Medium-Term	AHS GMCB Payers OneCare

Source: IMPLEMENTATION IMPROVEMENT PLAN: (vermont.gov)

IMPLEMENTATION IMPROVEMENT PLAN RECOMMENDATIONS
VERMONT ALL PAYER ACCOUNTABLE CARE ORGANIZATION AGREEMENT, NOVEMBER 2020
Recommendations 9-18

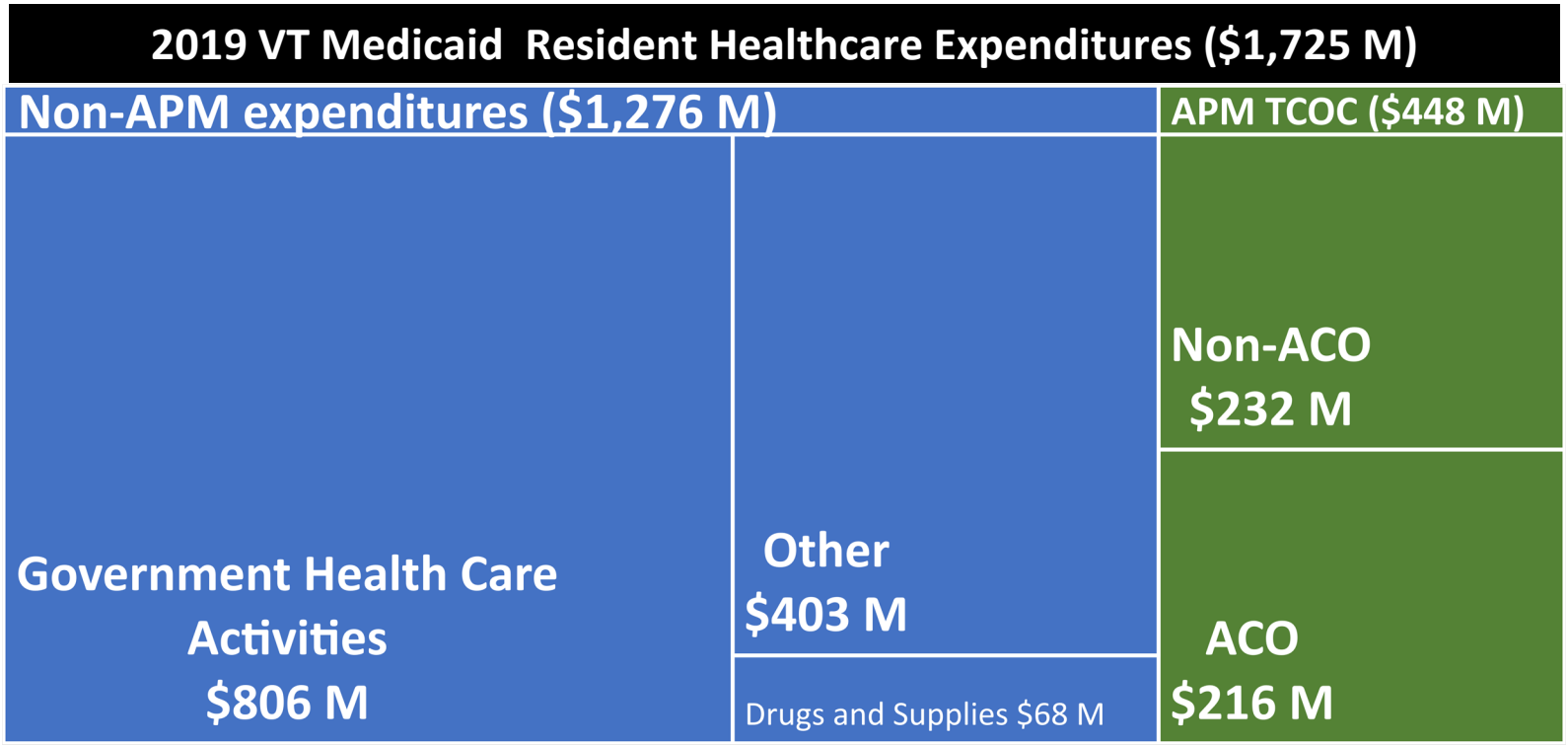
	Activity to Improve Performance	Timing*	Lead (s)
9	Under authorities over both ACO and Hospital budgets, the GMCB should explore how ACO participants can move incrementally towards value-based incentives with the providers they employ.	Longer Term	GMCB
10	Annually, in its budget presentation to the Green Mountain Care Board, OneCare Vermont should identify cost growth drivers across its network and detail its approaches to curb spending growth and improve quality. OneCare should communicate its strategic objectives, plan of action, and how it will monitor progress.	Short-Term	GMCB
11	Prioritize the integration of claims and clinical data in the HIE and organize and align the HIE with the Office of Health Care Reform within the AHS Secretary's office. Coordinate with the HIE Steering Committee.	Short/Medium-Term	AHS HIE Steering Committee
12	Partner with OneCare Vermont and delivery system users to evaluate efficacy of Care Navigator platform.	Short/Medium-Term	AHS, OneCare, Delivery system users
13	OneCare Vermont should elevate data as value-added product for its network participants and support providers in leveraging the information for change.	Short/Medium-Term	OneCare
14	AHS will condition provider participation in the Blueprint for Health PCMH payments on participation in value-based payment arrangement with an ACO.	Longer Term	AHS
15	AHS, OneCare Vermont, and community providers should improve collaboration to strengthen integrated primary, specialty, and community-based care models for people with complex medical needs and medical and social needs. Organize VCCI and Blueprint for Health in Office of Health Reform in Secretary's Office.	Short-Longer Term	AHS, Community providers, OneCare
16	AHS, OneCare Vermont, and community provider partners should identify a timeline and milestones for incorporating social determinants of health screening into the standard of care in health and human services settings.	Medium-Term	AHS OneCare Community providers
17	AHS, through the Blueprint for Health, will jointly explore with OneCare Vermont and stakeholders the best available tools for capturing real-time patient feedback and to pilot such a methodology with willing primary care practices.	Longer Term	AHS
18	AHS and the GMCB will prioritize regular stakeholder engagement opportunities.	Short Term	AHS GMCB

2019 Vermont Expenditures by Payer



SOURCE: GMCB staff, derives from VHCEA, 2019, totals may not add up due to rounding
APM TCOC = All-Payer Model Total Cost of Care

2019 Vermont Medicaid Expenditures



SOURCE: GMCB staff, derives from VHCEA, 2019, totals may not add up due to rounding
APM TCOC = All-Payer Model Total Cost of Care
Government Health Care Activities include Long Term Services and Supports, Behavioral Health Administration, Home and Community Based Services, Department of Corrections spending, and other non-claims based services
Other includes dental, and some other claims-based services and programs

Brief Bio of Donna Kinzer

Donna is the past Executive Director of the Maryland Health Services Cost Review Commission (HSCRC). She led the implementation of Maryland's All-Payer Hospital Model (2014-2018), which provided savings of nearly $1 billion to Medicare, and led the development and negotiation of the follow-on Total Cost of Care Model (2019-2028).

In 2013, Donna left private sector consulting, where she focused on payment and delivery transformation, rate setting, cost analysis and data analytics, to lead the HSCRC through Maryland's transformation. Donna has worked in the healthcare field with purchasers, payers, providers, and government for more than 40 years. In 2020, Donna returned to the private sector and is providing consulting services as DK Healthcare Consulting LLC.

Donna serves on the board of the Pennsylvania Rural Health Redesign Center Authority.

DK Healthcare Consulting