



**STATE OF VERMONT**  
JOINT FISCAL OFFICE

**MEMORANDUM**

To: Joint Fiscal Committee Members  
From: Nathan Lavery, Fiscal Analyst  
Date: May 9, 2012  
Subject: Grant Request

Enclosed please find one (1) item that the Joint Fiscal Office has received from the administration. Two (2) limited service position requests are associated with this item.

**JFO #2564** – \$497,600 grant from the Robert Wood Johnson Foundation to the Vermont Green Mountain Care Board. This grant will be used to explore three payment models (bundled payments, hospital/physician budgets, and population-based global payments) to determine each model's suitability to improve health care quality and lower health care costs in Vermont. This item includes the establishment of two (2) limited service positions. This grant was awarded in mid-April, with a grant period that begins on May 15. Because of timing of this request, **expedited review has been requested. Joint Fiscal Committee members will be contacted by May 14<sup>th</sup> with a request to waive the balance of the review period and accept this grant.**

*[JFO received 5/8/12]*

Please review the enclosed materials and notify the Joint Fiscal Office (Nathan Lavery at (802) 828-1488; [nlavery@leg.state.vt.us](mailto:nlavery@leg.state.vt.us)) if you have questions or would like an item held for Joint Fiscal Committee review. Unless we hear from you to the contrary by May 14 we will assume that you agree to consider as final the Governor's acceptance of these requests.

State of Vermont  
 Department of Finance & Management  
 109 State Street, Pavilion Building  
 Montpelier, VT 05620-0401

[phone] 802-828-2376  
 [fax] 802-828-2428

Agency of Administration

JFO 2564

**STATE OF VERMONT  
 FINANCE & MANAGEMENT GRANT REVIEW FORM**

<b>Grant Summary:</b>	Grant from private foundation to support payment experimentation in Vermont to examine alignment of incentives to improve health care quality and lower health care costs.				
<b>Date:</b>	4/24/2012				
<b>Department:</b>	Green Mountain Care Board				
<b>Legal Title of Grant:</b>	"Implementing payment reforms to improve health care quality and lower costs in Vermont"				
<b>Federal Catalog #:</b>	N/a RWJ Grant #69912				
<b>Grant/Donor Name and Address:</b>	Robert Wood Johnson Foundation				
<b>Grant Period:</b>	<b>From:</b>	5/15/2012	<b>To:</b>	5/14/2015	
<b>Grant/Donation</b>	Grant: \$497,600				
	<b>SFY 1</b>	<b>SFY 2</b>	<b>SFY 3 &amp; 4</b>	<b>Total</b>	<b>Comments</b>
<b>Grant Amount:</b>	\$7,900	\$159,635	\$330,065	\$497,600	SFY3 includes both SFY 2014 and SFY 2015

<b>Position Information:</b>	<b># Positions</b>	<b>Explanation/Comments</b>
	2	Program Administrator and Health Policy Analyst required to perform payment experimentation activities

**Additional Comments:** Grant is consistent with GMCB activities re payment reform - MDR

Department of Finance & Management	<i>MOR</i>	<i>4/29/12</i>	(Initial)
Secretary of Administration		<i>4/30/12</i>	(Initial)
Sent To Joint Fiscal Office			Date <i>5/3/12</i>

**RECEIVED**  
 MAY 03 2012  
 JOINT FISCAL OFFICE



To: Sen. Ann Cummings, Chair, Joint Fiscal Committee

From: Georgia Maheras, Executive Director, Green Mountain Care Board

Date: May 9, 2012

Re: Robert Wood Johnson Foundation Grant Award to the Green Mountain Care Board Request for Expedited Review

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Sen. Cummings,

The Robert Wood Johnson Foundation (RWJF) awarded the Green Mountain Care Board (GMCB) a grant for cost containment on April 13, 2012 with a grant start date of May 15, 2012. Given this short timeframe, we immediately began the AA-1 grant acceptance process for this grant. The AA-1 arrived at the Joint Fiscal Committee on May 8, 2012. We are requesting the Joint Fiscal Committee expedite the review of this grant because RWJF is publicly announcing these awards on May 15, 2012 and we need to let them know of our acceptance as soon as possible.

Thank you for your consideration,

Georgia

**STATE OF VERMONT REQUEST FOR GRANT (\*) ACCEPTANCE (Form AA-1)**

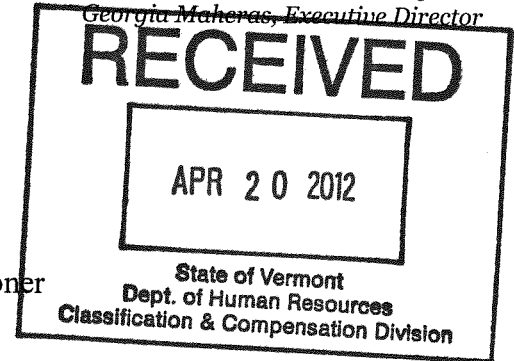
BASIC GRANT INFORMATION				
<b>1. Agency:</b>	Green Mountain Care Board			
<b>2. Department:</b>	N/A			
<b>3. Program:</b>	Payment Reform			
<b>4. Legal Title of Grant:</b>	Robert Wood Johnson Foundation			
<b>5. Federal Catalog #:</b>				
<b>6. Grant/Donor Name and Address:</b>	Robert Wood Johnson Foundation P.O. Box 2316 Route 1 and College Road East Princeton, NJ 08543-2316			
<b>7. Grant Period:</b>	<b>From:</b>	5/15/2012	<b>To:</b>	5/14/2015
<b>8. Purpose of Grant:</b>	Implementing payment reforms to improve health care quality and lower costs in Vermont.			
<b>9. Impact on existing program if grant is not Accepted:</b>	Program implementation will slow significantly. Payment reform pilots will not be implemented across the state as rapidly as they could with this grant funding, which will impact the ability to achieve cost savings as required under health reform.			
10. BUDGET INFORMATION				
	<b>SFY 1</b>	<b>SFY 2</b>	<b>SFY 3</b>	<b>Comments SFY 4</b>
<b>Expenditures:</b>	<b>FY 12</b>	<b>FY 13</b>	<b>FY 14</b>	<b>FY 15</b>
Personal Services	\$4,900	\$148,000	\$148,000	\$148,000
Operating Expenses	\$3,000	\$14,635	\$17,033	\$17,032
Grants	\$	\$	\$	
<b>Total</b>	<b>\$</b>	<b>\$</b>	<b>\$</b>	
<b>Revenues:</b>				
State Funds:	\$	\$	\$	
Cash	\$	\$	\$	
In-Kind	\$	\$	\$	
Federal Funds:	\$	\$	\$	
(Direct Costs)	\$	\$	\$	
(Statewide Indirect)	\$	\$	\$	
(Departmental Indirect)	\$	\$	\$	
Other Funds:	\$	\$	\$	
Grant (source Robert Wood Johnson Foundation)	\$7,900	\$159,635	\$165,033	\$165,032
<b>Total</b>	<b>\$7,900</b>	<b>\$159,635</b>	<b>\$165,033</b>	<b>\$165,032</b>
<b>Appropriation No:</b>	3330010000		<b>Amount:</b>	\$497,600
				\$
				\$
				\$



**Green Mountain Care Board**  
89 Main Street  
Montpelier, VT 05620

*Anya Rader Wallack, Ph.D., Chair*  
*Alfred Gobeille*  
*Karen Hein, MD*  
*Con Hogan*  
*Allan Ramsay, MD*

*Georgia Maheras, Executive Director*



Date: April 19, 2012

To: Jim Reardon CPA, Finance & Management Commissioner  
Molly Paulger, Director, HR Services & Operations

From: Georgia Maheras, Executive Director, Green Mountain Care Board

Re: AA-1 Grant Acceptance for the Green Mountain Care Board

The Green Mountain Care Board received its first grant award for work related to its statutory obligations to contain health care costs in Vermont. Specifically, this grant was provided for the purpose of implementing payment reforms to improve health care quality and lower costs in Vermont.

These are new funds to the state and require that we follow AA-1 Grant Acceptance process. The grant period will begin May 15, 2012 and run through May 14, 2015. This grant allows for the hiring of two Limited-Service positions for the duration of the grant period.

Attached, please find the AA-1 Grant Acceptance Form, the Grant Application, Grant Budget, RFR's, Position Descriptions and the Letter of Agreement for the \$497,600 grant awarded to the Green Mountain Care Board from the Robert Johnson Wood Foundation.

I respectfully request this grant be presented by the Governor to the Joint Fiscal Committee at their earliest convenience for review and approval.

Please let me know if you need anything further or have any questions.

Thank you,

Georgia





Robert Wood Johnson Foundation

## LETTER OF AGREEMENT

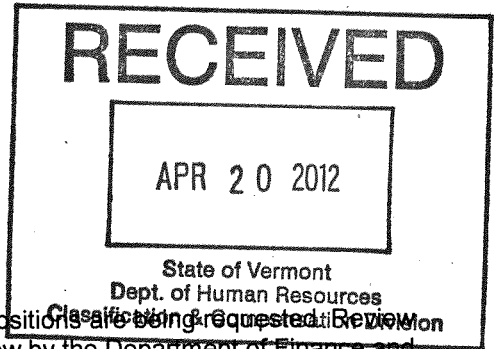
Following are the terms and conditions applying to grants made by the Robert Wood Johnson Foundation (referred to as "the Foundation," "we" or "us"). As a grantee (referred to as "grantee" or "you"), you should read this carefully; your signature on this form constitutes your acceptance of all the terms and conditions. As used in this form, the term "grant" includes any income you derive from the grant.

Awardee: State of Vermont Green Mountain Care Board  
I.D.: 69912  
Amount: \$497,600  
Purpose: Implementing payment reforms to improve health care quality and lower costs in Vermont  
Project Information: Grant Period: May 15, 2012 through May 14, 2015  
Project Director: Richard Slusky, 802-828-2159 (Richard.slusky@state.vt.us)  
Project Director: Anya Rader Wallack, 802-828-2160 (Anya.wallack@state.vt.us)

**1. PURPOSE AND ADMINISTRATION.** You will directly administer the project or program being supported by the grant and agree that no grant funds shall be used in any way other than as specifically set forth in this Letter of Agreement and the final proposal, budget and related documents, all as approved by the Foundation (the "Approved Grant Documents") without the Foundation's prior written consent. You further agree that no grant funds shall be disbursed to any organization or entity, whether or not formed by you, except as specifically set forth in the Approved Grant Documents.

This project will support payment experimentation in Vermont. Vermont is committed to aligning incentives to improve health care quality and lower health care costs, as evidenced by the existence of the Green Mountain Care Board (GMCB), which was part of comprehensive state health reform legislation enacted in May 2011. GMCB, which is charged with controlling the state's health care costs while expanding the scope of existing payment-reform efforts in the state, will use these grant funds to augment a larger project to develop, implement and evaluate various payment models over a three-year period. More specifically, GMCB seeks to explore three payment models--bundled payments, hospital/physician budgets, and population-based global payments--that move away from fee for service and promote high-value health care outcomes in specific geographic areas, as building blocks toward global population-based payments covering a broad array of health care services. Deliverables will include implementation of pilot programs in payment reform in each of the proposed payment methodologies, from which GMCB will gain practical experience; evaluation findings from initial pilots to allow for refinement of the payment models; an overall assessment of the appropriateness of the models for statewide adoption; information about their value in predicting cost and quality outcomes under a statewide health care budget; and an understanding of any barriers to the diffusion of these models.

**STATE OF VERMONT  
Joint Fiscal Committee Review  
Limited Service - Grant Funded  
Position Request Form**



This form is to be used by agencies and departments when additional grant funded position classification requests are being requested. Review and approval by the Department of Human Resources must be obtained prior to review by the Department of Finance and Management. The Department of Finance will forward requests to the Joint Fiscal Office for JFC review. A Request for Classification Review Form (RFR) and an updated organizational chart showing to whom the new position(s) would report must be attached to this form. Please attach additional pages as necessary to provide enough detail.

Agency/Department: Green Mountain Care Board (GMCB) Date: 4/19/12

Name and Phone (of the person completing this request): Georgia J. Maheras 802-828-2919

Request is for:

- Positions funded and attached to a new grant.
- Positions funded and attached to an existing grant approved by JFO # \_\_\_\_\_

1. Name of Granting Agency, Title of Grant, Grant Funding Detail (attach grant documents):  
Robert Wood Johnson Foundation, Development of models for Comprehensive Payment Reform in Vermont, total grant is \$497,600. Year 1 is \$167,534, Years 2 and 3 are \$ 165,033.
2. List below titles, number of positions in each title, program area, and limited service end date (information should be based on grant award and should match information provided on the RFR) position(s) will be established only after JFC final approval:

<u>Title* of Position(s) Requested</u>	<u># of Positions</u>	<u>Division/Program</u>	<u>Grant Funding Period/Anticipated End Date</u>
Health Policy Analyst	1		
Program Administrator	1		

\*Final determination of title and pay grade to be made by the Department of Human Resources Classification Division upon submission and review of Request for Classification Review.

3. Justification for this request as an essential grant program need:  
Pursuant to Act 48, the GMCB is responsible for comprehensive cost containment in Vermont's health care system. A significant part of this work is for the development, evaluation and dissemination of payment reform pilots throughout the state prior to system-wide implementation. In order to do this work within the statutory timelines, the GMCB needs appropriate staff to do this work.

I certify that this information is correct and that necessary funding, space and equipment for the above position(s) are available (required by 32 VSA Sec. 5(b)).

_____ Signature of Agency or Department Head	_____ Date
<i>Madley Paul</i>	4/19/12
_____ Approved/Denied by Department of Human Resources	_____ Date
<i>[Signature]</i>	4/20/12
_____ Approved/Denied by Finance and Management	_____ Date
<i>[Signature]</i>	4/29/12
_____ Approved/Denied by Secretary of Administration	_____ Date
<i>[Signature]</i>	05/02/12

Comments: *Dept*

APR 23 2012



# Payment Reform Strategies for High Value Care

## Project Title and Summary \*

\* Indicates required

Provide the information requested below.

Project Title *	<input type="text" value="Development of Models for Comprehensive Payment Reform in Vermont"/>
RWJF Funding Requested * (between \$100,000-\$500,000) \$	<input type="text" value="499,998"/>
Project Start Date	<input type="text" value="05/15/2012"/>
Duration of project: Up to 36 * months	<input type="text" value="36"/> months



## Project Summary \*

Your Project Summary should include: (Refer to the Call for Proposals link to the left for complete details.)

1. Brief Background and Description of Proposed Project
2. Partnerships and Roles

The system will not permit a response that exceeds 2000 characters, including spaces.

Note: If you paste directly from Word or another program into a text box, the character count may not be accurate. This is due to "hidden" HTML code included when pasting directly from these programs. To help avoid this:

- Use the formatting bar and choose either the "Paste as Plain Text"  or "Paste from Word"  icon to copy text into the text box. Once you click in the text box, these icons will become available for use. Using either of these icons should help remove some of the hidden code.
- For an accurate character count, type your summary directly into the area below instead of pasting from Word or another program.

Vermont is committed to aligning incentives to improve health care quality and lower health care costs. Building on our patient-centered medical home demonstration, we propose to implement payment mechanisms that move away from fee for service and promote high-value health care outcomes. For this project, we will explore three payment models -- bundled payments, hospital/physician budgets, and population-based global payments -- in specific geographic areas, as building blocks toward global population-based payments covering a broad array of health care services.

Our proposal seeks to meet providers where they are in terms of the scope of services and breadth of population they can manage, but to move deliberately toward payment methodologies and performance measures that hold providers accountable for management of as broad a range of services as possible. To assure value, we will evaluate the quality, cost and patient experience. This three-phase project is designed to involve all payers, and a significant portion of the provider community in Vermont.

Phase I will include discussions with payers and providers to design and implement each of the payment methodologies. We will establish performance measures that will serve as the basis for our evaluation processes.

Phase II will focus on the evaluation of the initial pilots, and use what we have learned to expand them. We will include a more sophisticated analysis of the steps required to move to population-based payment models. We will expand the scope of the bundled payment models and add additional pilots in the hospital/physician budget model.

Phase III will continue the evaluation. We will compare actual performance related to delivery system improvements, patient experience, and reduction in the growth of health care expenditures to our initial projections. We will assess the appropriateness of the models for statewide application and readiness of providers to proceed to broader payment reforms.

# Payment Reform Strategies for High Value Care

## Budget Worksheet \*

\* Indicates required

An important component of your proposal is the preparation of a budget. Complete every field on this page using your best judgment when projecting expenses. Refer to the *Glossary & Instructions* section of the *Budget Preparation Guidelines* for complete instructions on the following categories:

- Personnel—salary and fringe costs.
  - Amount – enter the RWJF requested amount.
  - FTE (if shown) – this column does not calculate.
  - Total – this column will replicate the "Amount" column for a single budget period and will show the cumulative total for multiple budget periods (if applicable).
- Other Direct Costs—office operations, communications/marketing, travel, meeting expenses and project space.
- Purchased Services—consultant and/or contract costs.
- Indirect Costs—administrative expenses related to overall operations. The Foundation's approved rate for Indirect Costs is 12 percent of Personnel, Other Direct Costs and Purchased Services. When Purchased Services total more than 33 percent of the RWJF portion of a budget, the Foundation limits indirect costs on the Purchased Services category to 4 percent.

Enter budget information in the section below. If additional budget periods are needed, select "Add" to the right.

For additional information, refer to the "Budget Preparation Guidelines" link shown on the left.

Start Date 05/15/2012    Duration 36 months    End Date 05/14/2015    Project Total \$499,998

## Budget Worksheet

	Period 1 Duration* 12 months	Period 2 Duration* 12 months	Period 3 Duration* 12 months	Total
Personnel	138,000	138,000	138,000	414,000
Other Direct Costs	8,333	8,333	8,333	24,999
Purchased Services	9,093	9,093	9,093	27,279
Indirect Costs	11,240	11,240	11,240	33,720
<b>Total</b>	<b>166,666</b>	<b>166,666</b>	<b>166,666</b>	<b>499,998</b>

## **Payment Reform Strategies for High Value Care**

### **Full Proposal Narrative**

**Project Title:** Development of Models for Comprehensive Payment Reform in Vermont

**Proposal I.D.:** 9378

**Applicant Name:** State of Vermont, Green Mountain Care Board

**Legal Name of Applicant Organization:** State of Vermont, Green Mountain Care Board

### ***Vermont's Health Reform Goals***

In May 2011, Vermont's Governor signed Act 48<sup>1</sup>, comprehensive health care reform legislation that aspires to create a health care system in which all residents receive coverage from a single source, with all coverage offered equitably and health care costs contained by a systemic change in the way providers of care are compensated for their services. The legislation created the Green Mountain Care Board (GMCB), which has explicit responsibility for controlling the rate of growth in health care costs while expanding the scope of pre-existing payment reform efforts within the state.

The GMCB's charge is to implement policies that move quickly away from a fee-for-service payment system to one that is based on quality and value. Toward that end the GMCB has the authority to approve hospital budgets, major health care capital investments, health insurer rate increases and all-payer rates for all providers (with permission from the federal government to include Medicare). The GMCB's ultimate goal is to implement prospective, population-based payments for health care providers in Vermont. We believe that prospective budgeting, combined with carefully crafted provider incentives and sophisticated performance measurement and evaluation, offers the most potential to contain health care costs while improving health care outcomes and the health of Vermont's population.

The GMCB's scope of authority is unprecedented in the U.S., but is tempered by an understanding across stakeholders that regulatory interventions will succeed only if coupled with active payer and provider engagement in payment and delivery system change aimed at aligning incentives for quality and efficiency.

The proposal that follows describes how we will use three specific payment reform models – bundled payments, hospital/physician budgets, and population-based global payments – in specific geographic areas, as building blocks to achieve the ultimate goal of global population-based payments covering a broad array of health care services for most Vermonters. Each model offers specific advantages:

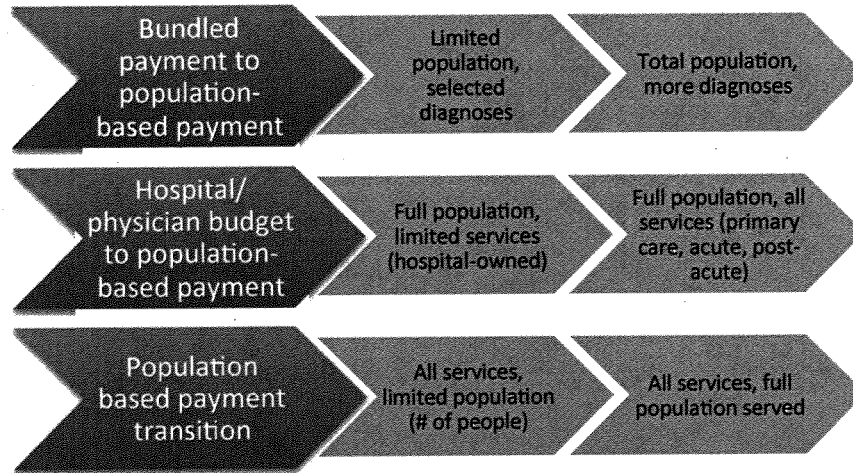
- Bundled payment innovations provide hospitals and physicians the opportunity to share in the savings associated with improvements in the total care for patients with specific diagnoses or surgical procedures.
- Hospital/physician budgets provide a fixed amount of revenue for a given hospital based on historical utilization and expenditure patterns. A global budget would contain strong financial incentives to reduce hospital utilization, and to better manage costs.
- Population-based global payments provide hospitals a per capita payment that would be designed to cover the broadest possible array of inpatient, outpatient and physician services that are provided by a participating hospital in a specific geographic area.

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<sup>1</sup> <http://www.leg.state.vt.us/docs/2012/Acts/ACT048.pdf>

Figure 1 depicts how each of these models can transition, over time, to population-based payments for the full array of services, including inpatient, outpatient, physician, and community based post-acute services, provided throughout Vermont.

**Figure 1: Transition of pilot payment reform models to broader scope over time**



Vermont has 14 community hospitals, all with fairly distinct service areas. They range in size from 7 to 384 staffed beds, and operate under three distinct models of payment: one is an academic medical center receiving prospective payment system (PPS) and graduate medical education funding; there are five additional community hospitals receiving PPS; and eight are critical access hospitals, receiving cost-based reimbursement from Medicare. These hospitals currently are at varied levels of readiness to undertake major payment reform. Their experience with risk-based contracting and their relationships with both pre-acute and post-acute providers varies greatly.

Our proposal seeks to meet providers where they are in terms of the scope of services and breadth of population they can manage, but to move deliberately toward a financial model in which they will be responsible for managing as broad a range of services as possible for as much of their served population as possible. We believe these models will encourage providers to build internal capacity to manage the health of their served populations and also encourage them to build relationships with non-hospital providers who are central to that effort.

We see each of the proposed reform models as a solid base from which to build a population-based payment approach that includes all services and covers the full population within a defined service area. We are proposing to use RWJF funds as part of a larger project to develop, implement and evaluate these models over a three-year period, building toward more expansive models as these building blocks are solidified.

**Background**

Knowledge of Vermont’s health reform history is critical to understanding our confidence about our potential role in the next generation of payment reform policy development and implementation. Vermont has been among the most progressive states in expanding health

insurance coverage to its citizens, and, to further that policy, has operated under some of the most expansive Medicaid waivers in the country for decades. Our legislature passed health insurance reform in both the small group and non-group markets in the early 1990s.

In 2007, the Vermont legislature, with the participation of Vermont's three largest commercial payers and Medicaid, authorized three pilot payment reform programs to test an Integrated Health Services Model, called the Blueprint for Health (Blueprint). In 2011, Medicare selected Vermont as a participant in its Multi-Payer Advanced Primary Care Practice Demonstration initiative, and agreed to participate in the Blueprint project. Participation now includes 79 practice sites serving approximately 360,000 patients, more than half of the state's population. By October 2013, the Blueprint will expand statewide. The Blueprint model includes:

- A primary care practice that meets NCQA medical home standards, including implementation of an electronic health record;
- A community health team that augments the primary care practice with connections to and supports for other medical and social services;
- Reporting of a full array of cost, utilization, clinical quality, and health status measures using a central registry and a multi-payer claims database;
- Per-patient incentive payments for participating in the model and meeting quality benchmarks, and to support community health teams;
- A data guided learning health system, through which practices learn about and continuously improve their performance.

These prior reforms establish a foundation of health insurance coverage and advanced primary care delivery for the next generation of payment reforms (the focus of this application). In addition, the Blueprint includes a strong evaluation infrastructure, which we intend to employ for the proposed expanded payment reforms. Act 48 requires that future payment reforms incorporate the Blueprint infrastructure.

### ***The Project***

The State of Vermont has been investigating the feasibility of implementing several innovative and expanded payment mechanisms designed to give hospitals and other providers greater financial stability and stronger incentives to reduce unnecessary utilization. For this project, we propose exploring three basic payment models as steps toward development of a mixed model of payment that balances incentives for reduced utilization and improved quality while supporting adherence to an overall state health care budget. The models we propose are:

#### **1. Bundled payments for hospitals and other providers**

Although hospitals increasingly employ primary care and other physicians, closer alignment of hospital and physician incentives beyond these employment relationships holds great potential for improving both the quality and efficiency of delivery of professional and institutional services. Likewise, coordination between acute care and post-acute providers (such as nursing homes) offers great potential for care improvement and cost savings.

Federal laws restricting the ability of hospitals and physicians to share in savings from more efficient and effective service delivery have been a barrier to physician-hospital cooperation in the past. The Center for Medicare and Medicaid Services (CMS) recently solicited proposals for

participation in a “Bundled Payment for Care Improvement” (BPCI) initiative, through which applicants could receive waivers from laws that prohibit gain-sharing between hospitals and physicians. The State of Vermont recently submitted a letter of intent (in conjunction with the Vermont Association of Hospitals and Health Systems) to act as a “facilitator/convener” for hospitals and post-acute care facilities that wish to apply for participation in this program. A number of hospitals have expressed interest in the program.

Bundled payment innovations provide the opportunity for hospitals and physicians to share in the savings associated with improvements in the total care for patients with specific diagnoses (such as diabetes) or needing specific procedures (such as joint-replacement) over an expanded period of time (starting from the initial admission and extending in excess of 90 days post discharge). This program would give hospitals and physicians valuable experience in designing viable payment models, episode-based risk adjustment mechanisms and performance measurement related to the care of specific populations. The bundled payment approach, like the Blueprint, likely will be embedded in the more comprehensive payment models we develop.

## **2. Hospital/physician budgets**

The State has reviewed the experience of Maryland and other jurisdictions that have successfully implemented global budgets and revenue constraint systems for acute care hospitals. These models have some applicability for small Vermont hospitals as they have a stable patient base and revenue mix, and are vulnerable to reductions in revenue that result from other payment reforms that reduce hospital utilization. Several hospitals have indicated an interest in this approach. Global budget systems provide a fixed amount of revenue for a given hospital and physicians independent of the number of patients seen or amount of services provided. In Vermont, this would include a sizeable amount of physician services, as more than 2/3 of Vermont physicians are employed by hospitals or FQHCs. When coupled with changes in physician compensation incentives and performance measures designed to promote higher quality, global budgets have the potential to transition hospital and physician behavior from a focus on revenue generation to a new focus on the delivery of quality care and value for their patients.

Hospital/physician budgets also can promote regional cooperation of hospitals under similar payment schemes and the opportunity to coordinate with physicians and other providers in the hospital’s service area. This will be an essential element of Vermont’s reforms, as we seek to utilize our existing hospital capacity and fixed assets as efficiently and effectively as possible. Under global budget structures, a hospital and its physicians are not penalized for partnering with former competitors or investing in interventions and care coordination strategies that would otherwise (under a FFS payment system) jeopardize its financial health. The implementation of global budgets for qualifying hospitals and physicians would be in the context of our annual hospital budget-setting process, which in the current fiscal year is expected to hold the overall rate of increase in net patient revenues under 4 percent.

## **3. Population-based global payments**

While most hospitals and geographic areas within Vermont will by necessity adopt one of the two models described above as a step toward a regional population-based budget, some providers will have the capacity to move to a more comprehensive model sooner. Population-based payments would be designed to cover the broadest possible array of inpatient, outpatient and physician services that are provided by a participating hospital. Some of our

hospital/physician systems, including the state's academic medical center, Fletcher Allen Health Care, have the capacity and willingness to accept a global payment for management of a full range of services for the population they serve much sooner than other hospitals in the state. Dartmouth-Hitchcock Medical Center, though located in New Hampshire, gets 40 percent of its business from Vermont, and recently received federal approval to be a "Pioneer ACO," which would move them to a global payment model over three years. Given the interest of some providers in global payments in the near term, and the long-term goal of global payments (all populations, all services) for most health care services in the state, we also propose to model global population-based payments for interested providers, and to refine the methodology for constructing regional population-based budgets over the term of this grant. In the pilot phase, this payment arrangement will apply to a subset of the population served by a provider organization, with the number of covered lives growing over time.

### **Alignment with other state payment reform efforts**

We intend to request permission from CMS to include Medicare in any of the payment reforms we design, using our all-payer rate-setting authority to implement the reforms across other payers. The state has received funding from CMS to explore all-payer rates within the state's health benefit exchange. This funding will allow us to examine a variety of policy elements related to all-payer rates, but particularly the effect of all-payer rates on Medicaid payment methodologies and spending levels. Act 48 made an explicit commitment to implementing provider payment methods that reduce cost-shifting between public and private payers in Vermont.

The State also is committed to aligning the incentives implicit in global budgets, bundled payments and global payments with those of the Blueprint's Integrated Health Services and advanced primary care model. There are inherent synergies between the Patient Centered Medical Home (PCMH), the Blueprint Integrated Health Services (IHS) payment and care delivery model, and the envisioned state-wide global payment arrangements for providers. PCMH models provide PCPs with incentives and resources to better manage services, including transitions between primary care, hospitals, and specialty care settings. The proposed payment methods, superimposed on the existing foundation, establish a framework of broad and complimentary incentives to control costs and improve care quality.

Lastly, Vermont has a grant from CMS to develop a proposal for managing care for individuals who are dually-eligible for Medicare and Medicaid. We are coordinating our efforts with those who are in charge of the dual eligible project to assure that the payment and care coordination models pursued for duals and the general population are appropriately complimentary.

### ***Project Phases and Timing:***

We propose three phases for this project:

**Phase I – Research, Discovery and Initial Pilot Development** – Phase I will include discussions with collaborating payers and providers interested in working with us to explore and implement one of the new payment methodologies. These discussions, and associated research, will include a focus on payment reform design principles, payment methodologies, strategies for implementation, impacts on quality and costs, definitions of performance metrics to be used, and identification of financial and performance risks for the participating payers and providers. We also plan to engage in conversations with the Center for Medicare and Medicaid



Innovation (CMMI) to encourage Medicare's participation in this initiative as soon as possible. Following this research we will establish a baseline of performance measures and metrics that will serve as the basis for our evaluation processes in the second and third years of the grant. This baseline will become the foundation for the establishment of targets for measuring utilization and health care expenditures, quality performance, health outcomes, and patient satisfaction. The research gathered will also inform our work with stakeholders and willing pilot sites to develop a working model of each payment approach. Phase I will include implementation of at least one payment reform pilot program for each payment methodology, from which we can gain practical experience. We expect Phase I to last 10-12 months, with pilots going live by Fall 2012.

**Phase II – Early Learning and Refinement of Models** – This phase will focus on the evaluation of the initial pilots, and will use what we have learned to plan for the broader application of the three payment reforms, including more sophisticated analysis of the steps required to move to more comprehensive population-based payment models. This analysis also will inform the refinement of the payment models and provide necessary information to modify the initial pilots, if necessary, and form the basis for implementation of additional pilots. It is our intention to expand the scope of the Bundled payment models during this phase, and to add at least two additional pilots in the hospital/physician budget model. Results from Phase I will be used to develop simulations and predictive models to support planning for expanded global budgets. We expect Phase II to last 12 months.

**Phase III – Early Evaluation and Assessment for Statewide Use** – During Phase III, we will continue the evaluation process begun in Phase II, and will add new evaluation metrics as deemed necessary. As part of this evaluation, we also will compare actual performance related to delivery system improvements, patient experience, and reduction in the growth of health care expenditures to our initial projections. At this point we will assess the appropriateness of the models for statewide application and the readiness of providers to proceed to broader payment reform models and their value in predicting cost and quality outcomes under a statewide health care budget. We also will assess any barriers to diffusion of the models. We expect Phase III to last 12-14 months.

### ***Cost and quality outcomes***

Healthcare reform in Vermont is based on the guiding principle that financial reforms and payment strategies should result in meaningful improvement in quality, as well as better control over growth in health care costs. We need timely access to measurable results across several domains in a format that can guide value-based payment.

This balanced approach requires measures related to the quality of health services, health outcomes, patient experience, utilization of resources, and healthcare expenditures. Examples of cost and quality measures to be included in this project are listed below:

### **Cost outcomes to be monitored**

1. **Health expenditures**, including: hospital spending per capita; professional services spending (physician) per capita; post-acute spending per capita; pharmaceutical spending per capita; and total health expenditures per capita statewide for defined populations
2. **Utilization measures related to the reduction of avoidable acute health care services**, including: readmissions and readmission rates; admission and admission rates; outpatient hospital services use and rates of use; ancillary service use and rates of use; emergency

room visits and rates of use; case mix adjusted rates of stay; referral rates from hospitals to post-acute care facilities and appropriateness of referrals; rates of ambulatory care sensitive admissions

### **Quality outcomes to be monitored**

1. Clinical process change leading to compliance with standard guidelines, clinical pathways (i.e.COPD, joint replacement), and evidence based clinical care will be measured.
2. Outcomes such as potentially avoidable complications, avoidable events, avoidable readmissions, and risk-adjusted mortality will be measured.
3. Clinical performance measures within several domains, including those proposed by CMS for Accountable Care Organizations, will be modified and scored including:
  - a. Patient/caregiver experience
  - b. Care coordination
  - c. Patient safety
  - d. Preventive health care
  - e. At-risk population/frail elderly health care
  - f. Provider satisfaction

All cost, quality, and patient experience results will be reported publicly and will be included in the evaluation of success of the grant initiative.

### ***Waste targeted***

Payment reforms piloted as part of this project will be designed to improve preventive care, reduce unnecessary acute care associated with hospital use, including avoidable hospital admissions, avoidable readmissions, avoidable emergency room use, unnecessary ancillary services, and unnecessary ambulatory care sensitive admissions. We believe the payment reforms we are proposing can lead to the outcome of reduction in the rate of growth of total health care expenditures in Vermont below 4 percent per year, at least two percentage points below the currently projected trend.

The reforms envisioned also will include strategies to optimize efficiencies in hospital operations, including better management of patient flow and staffing patterns, leading to optimization of hospital resources and potential improvement of financial margin while reducing unnecessary costs. We also will encourage hospitals to better understand their cost structure by employing effective cost accounting processes to identify and reduce unnecessary variances and avoidable costs.

### ***Participants and collaborators***

#### ***Hospitals:***

We have invited five Vermont hospitals to work with us on the initial stage of this payment reform project, and all five have accepted our invitation. They include: Fletcher Allen Health Care, an academic medical center providing tertiary care located in Burlington; Rutland Regional Medical Center, a Prospective Payment System (PPS) hospital located in Rutland; Northeastern Vermont Regional Medical Center in St. Johnsbury and Porter Medical Center in Middlebury, both Critical Access Hospitals; and Springfield Medical Care Systems, a Federally-Qualified Health Center (FQHC) which is the parent of Springfield Hospital, and also a Critical Access Hospital. These hospitals provide us with a range of size and geography, representative

of our hospital community. In addition, all of these hospitals either own or are closely aligned with advanced primary care practices that are part of the Blueprint. Through their past actions, these hospitals have demonstrated their commitment to the reform initiatives in Vermont, and have expressed a willingness to explore and possibly pilot payment initiatives.

### ***Payers:***

We believe it essential that the reforms proposed are implemented on an all-payer basis. In accordance with this philosophy, we will invite all of the major payers in Vermont to work with us in this transition to new payment methodologies. These payers will include those already working with the Blueprint for Health to provide enhanced payments to Blueprint practices. Commercial payers currently supporting the Blueprint include Blue Cross/ Blue Shield of Vermont, MVP Health Care and CIGNA. Together, these payers make up 98 percent of the Vermont market for the commercially insured. In addition, Medicaid is a full participant in the Blueprint, and in 2011 Medicare agreed to participate as a full payer under the Advanced Primary Care Demonstration Project (APCDP). We are optimistic that all Vermont payers will participate with us in this new payment initiative, and we will approach CMS early in 2012 to seek their participation as well (see discussion under Barriers below).

### ***Data Sources & Evaluation***

Our payment reform initiatives will build on the evaluation models initially designed for the Blueprint for Health. The Blueprint evaluation process creates a Learning Health System (LHS), which uses data and experience to promote continuous improvement in an objective manner. The payment reform initiatives proposed will build on the data sources listed below to provide systematic evaluation of the impact of system changes resulting from the implementation of new payment methodologies.

1. **Centralized clinical registry.** This web-based registry, hosted by Covisint /DocSite, receives guideline-based data feeds from practices and hospitals. Data sources include Electronic Medical Record systems, hospital data systems, practice management systems, and direct data entry. Data from these sources is sent to the registry through Vermont's Health Information Exchange infrastructure run by Vermont Information Technology Leaders (VITL). The registry supports flexible performance reporting with measures derived from national guidelines on healthcare quality and outcomes. Comparative reporting with benchmarking is designed so that practices and hospitals can review their performance internally, and compare their performance to nationally accepted standards or benchmarks.
2. **Multi-payer claims database (VHCURES).** Vermont's Department of Banking, Insurance, Securities, and Health Care Administration (BISHCA) manages the multi-payer claims database. Vermont Healthcare Claims Uniform Reporting and Evaluation System (VHCURES) has been developed to support highly structured evaluations based on timely and accurate claims data reports from all-payers. VHCURES is currently populated with claims data from commercial insurers dating back to the beginning of 2007. Vermont Medicaid is currently working with the data vendor to load historic data from 2007 to present. These data feeds are expected to be complete by March 2012. We have requested that CMS provide Medicare data for all Vermont beneficiaries dating back to the beginning of 2007 (these data currently are available for the Blueprint evaluation, but broader data use authority would be necessary for this project). With these additions, Vermont's claims database has the capacity to support patient level analyses of detailed utilization,

expenditures, and claims based quality information across all major payers. We intend to link this data to already existing financial models in order to compare actual performance and trends as compared to our initial projections. Pilot sites will continue to submit claims data to all payers under the pilots, allowing us to continue measurement of costs and use through this source.

3. **Scoring of practices based on the National Committee on Quality Assurance (NCQA) standards for a Patient Centered Medical Home (University of Vermont Child Health Improvement Program-UVM VCHIP).** The University of Vermont VCHIP team conducts systematic scoring and rescoring of practices based on NCQA Physician Practice Connections - Patient Centered Medical Home (PPC-PCMH) standards. NCQA PPC-PCMH standards demonstrate a primary care practice's adherence with important characteristics of high quality healthcare and well coordinated health services. The skilled UVM team has instituted a reliable, independent, and systems based approach to scoring that is consistent with the intent of NCQA and the use of their nationally accepted standards.
4. **Patient experience of care based on the NCQA Patient Centered Medical Home survey (UVM VCHIP).** The UVM VCHIP team has been selected by NCQA as an official surveyor to pilot their new Consumer Assessment of Healthcare Providers and Systems (CAHPS) based patient experience survey. The CAHPS PCMH survey is based on the CAHPS Clinician & Group Survey (CGS) with some modifications and additional questions that target specific PCMH concepts. Patient satisfaction surveys that are currently being administered by the hospitals also will be evaluated to determine whether they meet the requirements of this initiative.

Statewide data of this nature provides Vermont with a novel opportunity to design and evaluate financial reforms that are designed to achieve balanced outcomes with improvement across all domains. Key measures, particularly composite measures that reflect a balance of desired outcomes, will be designed and used to evaluate the impact of piloted payment strategies.

The work of Phase I will position Vermont to trial, refine, and expand value based payment strategies thru Phases II and III. This approach will position Vermont to function as a Learning Health System, where routine measurement is used to refine ongoing operations. We will accomplish this by establishing our baselines in Phase I; develop projections regarding utilization, expenditures, quality performance improvements, and patient satisfaction; implement the pilots; and then evaluate actual performance as compared to our projections. This will be a continuing learning process throughout the term of this initiative. Vermont's evaluation infrastructure, with the added advancements achieved through this project, will support this visionary transition to a value based health system.

### ***Market and Commitments***

Vermont's commitment to comprehensive health reform and payment reforms is long standing and thoughtful, as evidenced by the guiding legislation that has been passed over the past two decades and related implementation efforts (see background section above for a more complete description of these efforts). The delivery system reforms in Vermont also align well with the reforms called for in the Affordable Care Act (ACA).

Our insurance and health care provider markets are much more concentrated than most – we have just two payers in the commercial small group market, and Medicaid covers more than a quarter of the state's population. As we move forward to expand the Blueprint to more

comprehensive payment reform models, involvement of all payers will be important to our success, but simpler to achieve than in most states, given market concentration and pre-existing commitments to reform on the part of our payers.

We estimate that more than 75 percent of Vermont's population will be enrolled in a Blueprint practice by July of 2013. Additionally, the hospitals that have agreed to be a part of this project encompass more than two-thirds of hospital expenditures in Vermont. Fletcher Allen alone accounts for half of the health care expenditures in the state. Finally, the vast majority (again, more than two-thirds) of physicians in Vermont are employed by a hospital or a FQHC. We therefore expect that this project will have significant penetration into both the hospital and physician communities.

Consumer engagement will be measured systematically under this project through both patient experience surveys in Blueprint practices and hospital CAHPS surveys. In addition, we will include consumers in our advisory committees providing input on the project.

### ***Barriers***

The most significant barriers to our proposed project involve all-payer and provider participation. The project will develop new methodologies for allocating costs across payers and use of those methodologies will involve some negotiation. In addition, the project will require that providers and payers have the administrative capability to implement changes in payment methodology. More fundamentally, the project will require providers to understand and manage change, develop the skills to manage both performance and financial risk, and overcome internal cultural barriers to risk assumption, changes in provider compensation and payment reform.

In order to implement an all-payer system the State will seek a waiver from current Medicare reimbursement rules and request that Medicare (as well as the State Medicaid program) pay hospitals on the basis of rates and payment constraints established under the authority of the Green Mountain Care Board. Such waivers were contemplated by the Accountable Care Act (ACA), which granted the CMMI authority to "test and evaluate system of all-payer payment reform for the medical care or residents of the State, including dual eligible individuals" under section 3021 of the ACA.

It is anticipated that the CMMI soon will be soliciting applications for state-wide innovative payment and care-delivery projects. Vermont intends to submit an application and if accepted, will seek to negotiate the establishment of a Medicare waiver for implementation in the earliest possible timeframe. Currently it is anticipated that this waiver negotiation process will continue through Phase I and into Phase II of the proposed project, with implementation of the Medicare waiver effective for the federal fiscal year beginning September 30, 2013.

To address provider concerns about transitioning to new payment methodologies, the project will evaluate how clinical indicators, risk adjustment methods, reinsurance and outcome measures may be used to separate clinical risk from insurance risk. Recognizing the need for public-private collaboration between the state, providers and payers, and acknowledging the range of identified and unidentified barriers and opportunities, we have proposed that the project include step-wise implementation of the payment models, with carefully-constructed risk/reward arrangements, and full evaluation of pilot results.



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Agency of Human Services

January 9, 2012

Anya Rader Wallack, Ph.D.  
Chair, Green Mountain Care Board  
89 Main Street  
Montpelier, VT 05602

Dear Anya:

I am writing to express my strong support for the Green Mountain Care Board's application to the Robert Wood Johnson Foundation to support payment reform efforts in Vermont. As Commissioner of the Department of Vermont Health Access (Vermont Medicaid) I am committed to moving our payment methodologies away from fee-for-service reimbursement and toward payments based on quality, value, and patient experience. I believe strongly that Medicaid should be not only a participant in this effort, but a leader. The application you have developed will advance these efforts in Vermont by implementing concrete models of value-based provider payment and positive delivery system transformation. This is a critical foundation for achieving our goal – a health care system in which all Vermonters have access to the services they need at a cost we can sustain.

I look forward to working closely with you and the Green Mountain Care Board on this exciting project. You can be assured of my full cooperation and support for this effort

Sincerely,

A handwritten signature in black ink, appearing to read "Mark Larson".

Mark Larson  
Commissioner





# BlueCross BlueShield of Vermont

*An Independent Licensee of the Blue Cross and Blue Shield Association.*

Don C. George  
President and Chief Executive Officer

January 10, 2012

Anya Rader Wallack, Chairperson  
Green Mountain Care Board  
89 Main Street  
Montpelier, Vermont 05602

Dear Anya,

Thank you for the opportunity to review the Robert Wood Johnson Grant application that you are planning to submit on January 12, 2012. Blue Cross and Blue Shield of Vermont strongly supports this application.

As we have previously indicated to you, Blue Cross and Blue Shield of Vermont continues to be interested in exploring new payment methodologies that are designed to reduce healthcare expenditures, improve the quality of care for our members and improve patient and provider satisfaction. We believe that better alignment of reimbursement incentives is a crucial component of healthcare reform.

We look forward to working with you to develop and implement these new reimbursement methodologies. We are particularly interested in helping to develop and deploy the pilots identified in this application because they include a strong emphasis on measuring and improving the quality of care and where possible tying reimbursement incentives to improved outcomes. We also believe that your emphasis on a collaborative approach—inclusive of providers and payers—will greatly improve the efficiency and effectiveness of the proposed reimbursement reform pilots.

As you know, Blue Cross and Blue Shield of Vermont has a history of working with the State on Healthcare Reform initiatives, as evidenced by our participation in the design and deployment of the Catamount Health Plan, the Vermont Blue Print for Health, Vermont Information Technology Leaders, and the Vermont Department of Health Vaccine Purchasing Pool pilot.

In the spirit of continued collaboration, we are pleased to support this application and look forward to working with you to explore these new payment methodologies.

Sincerely,

Don George

CC: Richard Slusky, Director of Payment Reform, GMCB



January 10, 2012

Ms. Anya Rader Wallack  
Chair,  
Green Mountain Care Board  
89 Main Street  
Montpelier, VT 05602

Dear Ms. Wallack:

Thank you for the opportunity to review the Robert Wood Johnson Grant application that you intend to submit on January 12, 2012. We are pleased to support this application and hope you are successful in obtaining this grant award. Governor Shumlin and his administration are to be commended for taking on the complex issue of payment reform.

Cigna currently serves nearly 100,000 Vermonters by delivering strong value for their dollar. We are particularly proud to have served the State Health Benefits Program since 2002. Customers across all of our product lines have consistently indicated a high level of satisfaction with our services.

Across the country, Cigna has explored different payment reform methods and other patient centered arrangements. We have had great success in New England by forging partnerships with hospitals and other providers into Collaborative Accountable Care Organizations. These partnerships are designed to reduce expenditures and improve the quality of care for our patients.

We recognize the value of additional research in this area and take note that the grant application contemplates work on three different payment reform models. We look forward to learning the findings of this effort as we believe that flexibility in the design of these partnerships is essential to their success.

Sincerely,

Donald M. Curry  
President and General Manager  
Cigna of New England

cc: Richard Slusky, GMCB





**John R. Brumsted, M.D.**  
Interim President and  
Chief Executive Officer

Anya Rader Wallack, Ph.D.  
Chairperson  
Green Mountain Care Board  
89 Main Street  
Montpelier, VT 05620

Dear Anya,

Thank you for the opportunity to review the Robert Wood Johnson Grant application that you are planning to submit on January 12, 2012. As the State of Vermont's academic medical center and the largest provider of health care services to Vermonters, we strongly support the exploration of new payment methodologies designed to reward the cost-efficient delivery of health care, the measurement and improvement of wellness and quality of care for the populations we serve, and increased levels of satisfaction for both patients and providers.

Fletcher Allen Health Care has set a clear course toward accepting accountability for our financial and clinical performance under new payment models. We believe that population-level global payment and measurement mechanisms for Integrated Delivery Systems like ours will be the essential basis for a value-based health care system for Vermont. We also believe the providers of health care for a population are the most uniquely qualified to design clinical policies and measurement systems, and in return for accepting accountability for the outcomes, must be granted the license and resources to build the systems required to succeed.

Finally, I know you are aware of our organization's leadership in Vermont on health care reform initiatives, as evidenced by our pioneering role in the design and implementation of the Patient Centered Medical Home approach to primary care, and the implementation of Community Health Teams in support of our vision for managing the health of our served populations. From its inception in 1995, Fletcher Allen has been guided by physicians who share a vision about how to leverage the resources of an academic medical center to improve the health of the communities we serve. That vision is paired with a care management philosophy that has been followed and refined over the years, with excellent results. The philosophy is straightforward:

*We are committed to continuously improving the quality of care provided to our patients. It is our fundamental belief that high quality care is cost-effective care. The care management process will result in standardization of patient care which is: patient-focused; evidence-based; built on consensus and data-driven; results in improved outcomes; safe; efficient in resource consumption; and economically viable.*

Today, Fletcher Allen is recognized as a high value provider and I believe we have much to offer in the exploration of new payment methodologies that reward excellent baseline performance as well as ongoing improvement.

We are pleased to support this application and look forward to working with you.

Sincerely,

John R. Brumsted, M.D.

CC: Richard Slusky, Director of Payment Reform, GMGB

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