# IMPROVING HEALTH AND CARE IN VERMONT

# SOME FRAMING QUESTIONS

- Vermont (you) established an aspirational set of goals for health system reform (Act 48) and an independent agency (GMCB) with the responsibility to evaluate and improve health system performance. The GMCB is effective, transparent and accountable -- the envy of many states.
- The AHEAD model offers additional important opportunities.

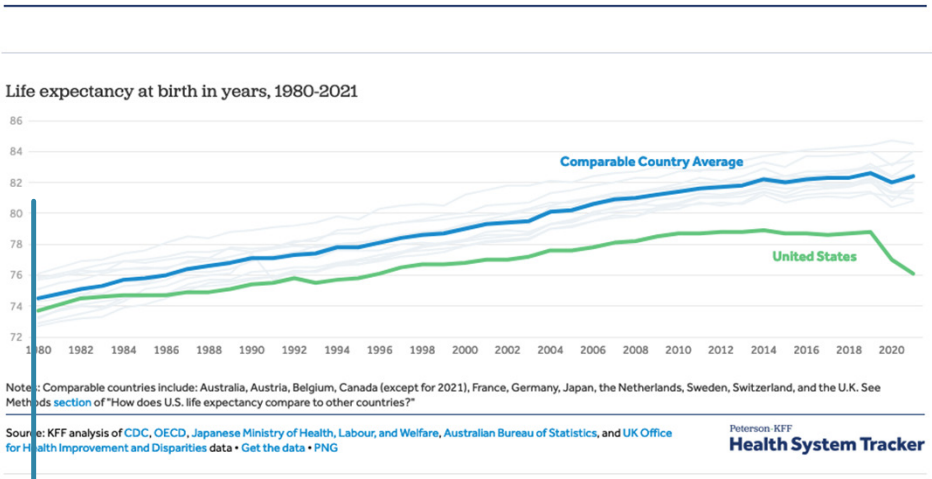
*Does the legislature want to build on this foundation?*

**Issues to consider**

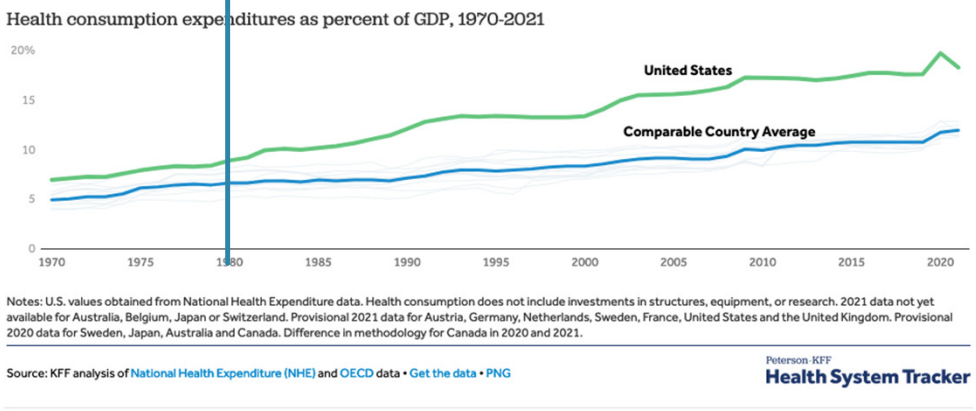
- Are current reform discussions being guided by a clear understanding of cost drivers?
- Who will look out for the little guy? Private interests are well-represented. The public lacks voice.
- How can reform be sustained over the long haul?

# The Problem

## The US is an outlier. Worse Health. Higher health care costs




**Life-Expectancy**




**Spending**

# The Problem in Vermont -- Affordability

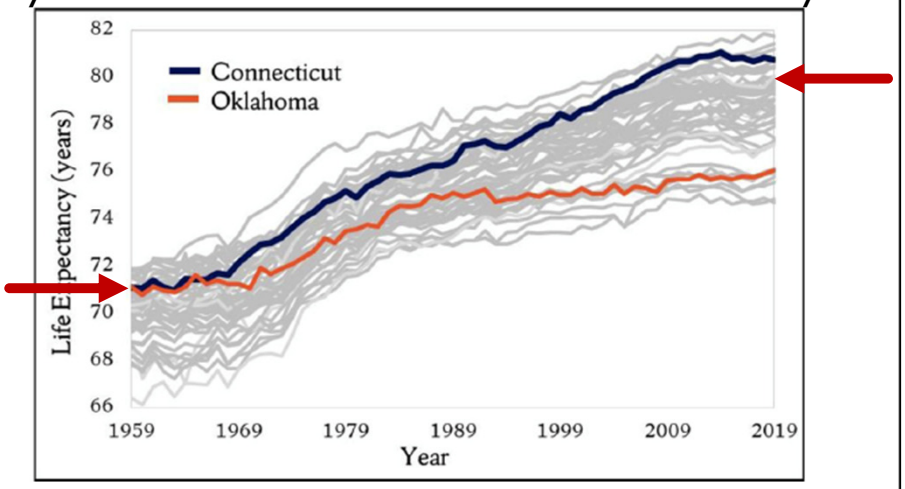
## Vermont has better health – but has had higher cost growth

While Vermont life expectancy is among best in US

Figure 1. Life Expectancy in the 50 US States, 1959–2019

71 years

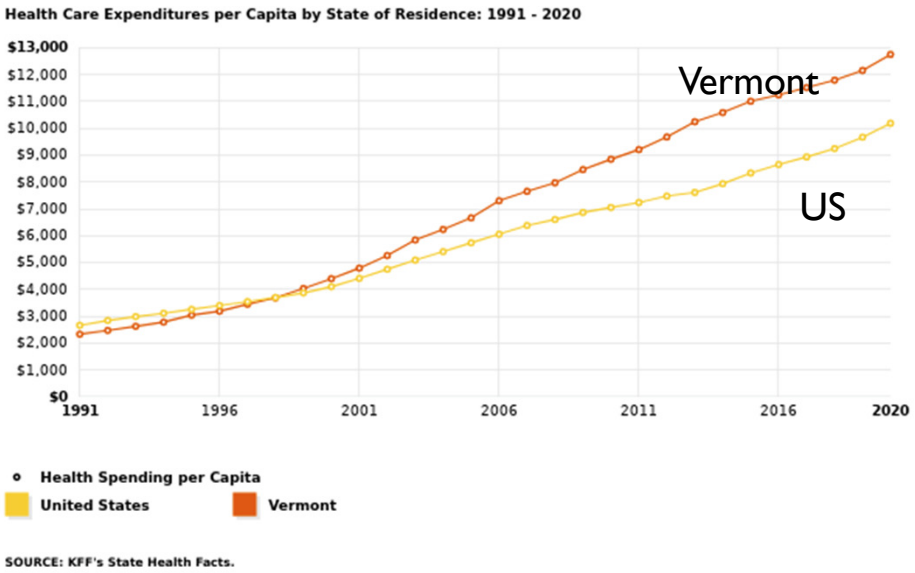
79 years




Data derived from United States Mortality Database.[1]

From Montez, Milbank 2023

Vermont has recently had much higher cost growth




From GMCB testimony, January 2023

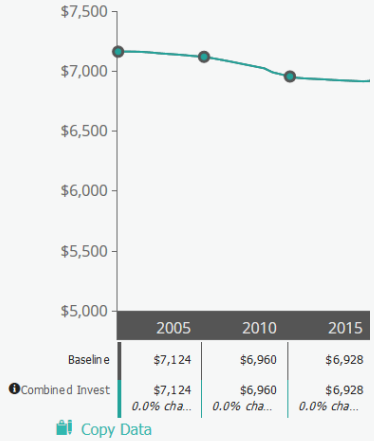
# THE OPPORTUNITY

## SIMULATED GAINS OVER 25 YEARS FROM IMPLEMENTING A PORTFOLIO OF EVIDENCE-INFORMED POLICIES

### Healthcare costs, per capita adj

↓ 14.6%

Baseline | Combined Invest




| | 2005 | 2010 | 2015 |
|---|---|---|---|
| Baseline | $7,124 | $6,960 | $6,928 |
| Combined Invest | $7,124 0.0% cha... | $6,960 0.0% cha... | $6,928 0.0% cha... |

Copy Data

### Severe chronic physical illness

↓ 19.7%

Baseline | Combined Invest


| | 2005 | 2010 | |
|---|---|---|---|
| Baseline | 11.05% | 11.81% | 1 |
| Combined Invest | 11.05% 0.0% cha... | 11.81% 0.0% cha... | 1 0.0% |

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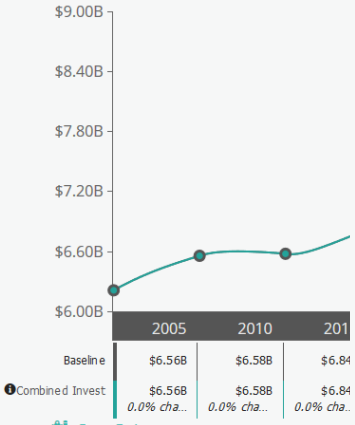
### Total income of employed population

↑ 8.8%

Baseline | Combined Invest




| | 2005 | 2010 | 201 |
|---|---|---|---|
| Baseline | $6.56B | $6.58B | $6.84 |
| Combined Invest | $6.56B 0.0% cha... | $6.58B 0.0% cha... | $6.84 0.0% cha... |

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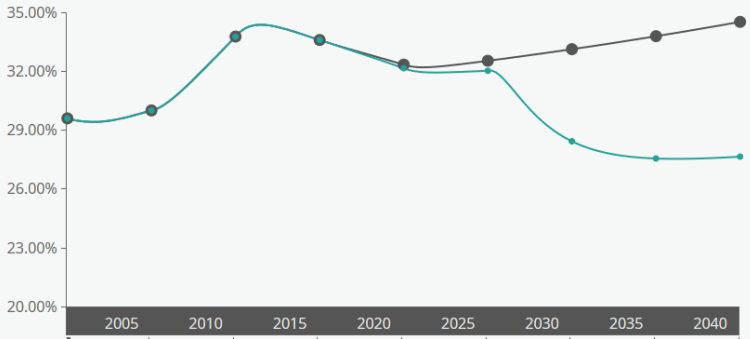
### Disadvantaged percent of population

↓ 19.9%

Baseline | Combined Invest




| | 2005 | 2010 | 2015 | 2020 | 2025 | 2030 | 2035 | 2040 |
|---|---|---|---|---|---|---|---|---|
| Baseline | 30.03% | 33.80% | 33.62% | 32.37% | 32.56% | 33.16% | 33.82% | 34.55% |
| Combined Invest | 30.03% 0.0% cha... | 33.80% 0.0% cha... | 33.62% 0.0% cha... | 32.18% -0.6% cha... | 32.05% -1.6% cha... | 28.46% -14.2% ch... | 27.58% -18.4% ch... | 27.68% -19.9% ch... |

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POPULATION HEALTH

By Jack Homer, Bobby Milstein, Gary B. Hirsch, and Elliott S. Fisher

**Combined Regional Investments Could Substantially Enhance Health System Performance And Be Financially Affordable**

Health Affairs; 2016 35: 1435 - 43

# Drivers of spending: (1) Poor Health

## Modifiable risks explain most differences in life expectancy and a lot of spending

### Poor health is expensive

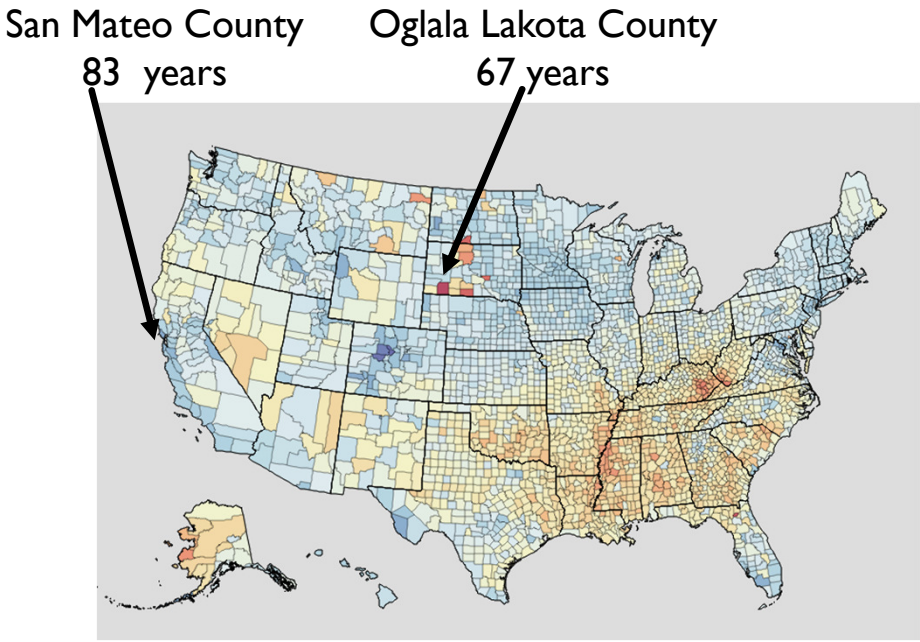
*27% of US health care spending can be attributed to modifiable risks amenable to clinical and public health interventions*

**Attributable U.S. Health Care Spending Due to Modifiable Risks (Billions) 2016**

| | |
|---|---|
| Obesity / Overweight | 239 |
| High Blood Pressure | 180 |
| High Blood Sugar | 172 |
| Dietary Risks | 144 |
| Smoking | 130 |
| High Cholesterol | 47 |
| Alcohol Use | 37 |
| Low Physical Activity | 16 |
| Total (accounting for interactions) | 730 |

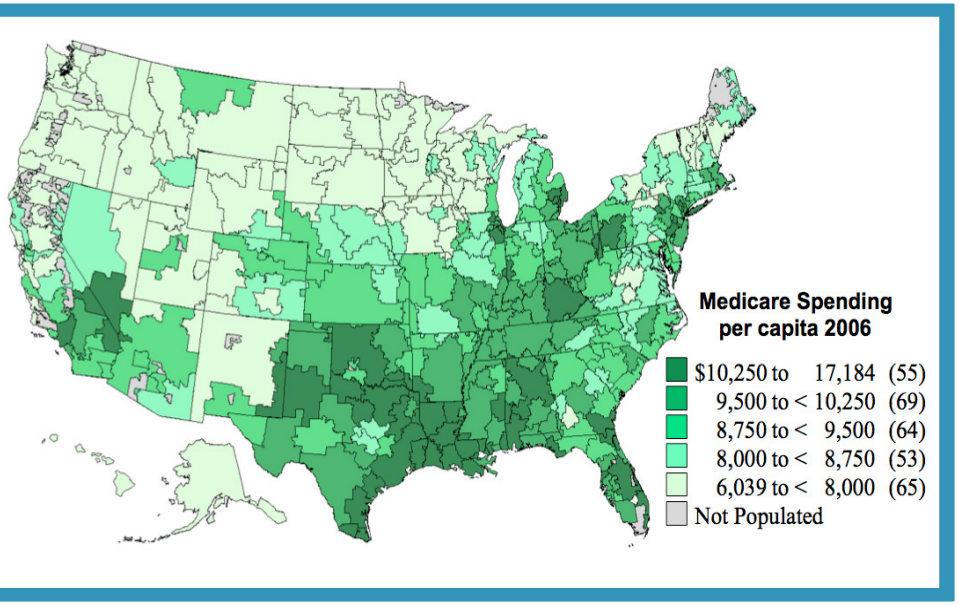
Bolnick et al. Lancet Public Health, 2020

### Modifiable risks explain 70+ percent of county differences in life expectancy




Institute for Health Metrics and Evaluation:
https://vizhub.healthdata.org/subnational/usa

# DRIVERS OF SPENDING: (2) POOR QUALITY, SUPPLY-SENSITIVE CARE




**Average Per-Capita Spending**

Ratio – High to Low

**1.61**

But how does Vermont compare?

**Initial Study**

- 1 million Medicare beneficiaries with heart attack, colon cancer, hip fracture
- Followed for up to five years after initial hospitalization
- Compared content, quality and outcomes of care across regions with differing spending levels
- ***Spending was adjusted to account for price difference – so is a measure of utilization***

# How does Vermont Compare?

## Dartmouth Atlas data -- 2019

Vermont is low overall on Medicare utilization (price adjusted spending)

Medicare Spending and Utilization during the last 2 years of life

| Entity (State or Hospital) | City | Number of deaths | Hospital Care Intensity Index | Total Medicare spending | Part B Spending (Physician services) | Hospital Spending | Inpatient Days | Hospital Bed Inputs per 1,000 |
|---|---|---|---|---|---|---|---|---|
| US Average | | 1.1 million | 1.0 | 78,635 | 14,588 | 30,531 | 14.2 | 38.9 |
| Utah -- all | | 6,282 | 0.5 | 68,070 | 11,300 | 21,194 | 8.0 | 21.9 |
| Vermont -- all | | 3,348 | 0.7 | 62,791 | 6,967 | 26,110 | 13.0 | 35.7 |
| New Hampshire -- all | | 6,624 | 0.8 | 75,114 | 10,485 | 29,899 | 13.5 | 37.1 |
| | | | | | | | | |

# How does Vermont Compare?

## Dartmouth Atlas data -- 2019

Mostly because of low utilization of physician services

**Medicare Spending and Utilization during the last 2 years of life**

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| | | | | | | | | |

# How does Vermont Compare?

## Dartmouth Atlas data -- 2019

Vermont is relatively high (compared to Utah) on hospital utilization

Medicare Spending and Utilization during the last 2 years of life

| Entity (State or Hospital) | City | Number of deaths | Hospital Care Intensity Index | Total Medicare spending | Part B Spending (Physician services) | Hospital Spending | Inpatient Days | Hospital Bed Inputs per 1,000 |
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| | | | | | | | | |

# How does Vermont Compare?

## Dartmouth Atlas data -- 2019

Vermont patients spend more time in the hospital (over 50% more than residents of Utah)

Medicare Spending and Utilization during the last 2 years of life

| Entity (State or Hospital) | City | Number of deaths | Hospital Care Intensity Index | Total Medicare spending | Part B Spending (Physician services) | Hospital Spending | Inpatient Days | Hospital Bed Inputs per 1,000 |
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| | | | | | | | | |

# How does Vermont Compare?

## Dartmouth Atlas data -- 2019

Using over 50% more beds per capita than residents of Utah

Medicare Spending and Utilization during the last 2 years of life

| Entity (State or Hospital) | City | Number of deaths | Hospital Care Intensity Index | Total Medicare spending | Part B Spending (Physician services) | Hospital Spending | Inpatient Days | Hospital Bed Inputs per 1,000 |
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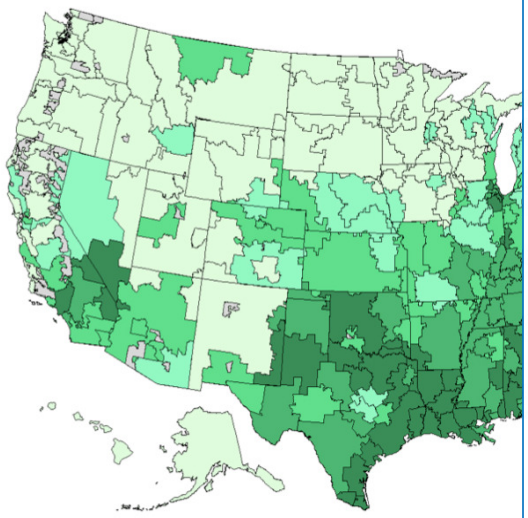
| | | | | | | | | |

# DRIVERS OF SPENDING: (2) POOR QUALITY, SUPPLY-SENSITIVE CARE

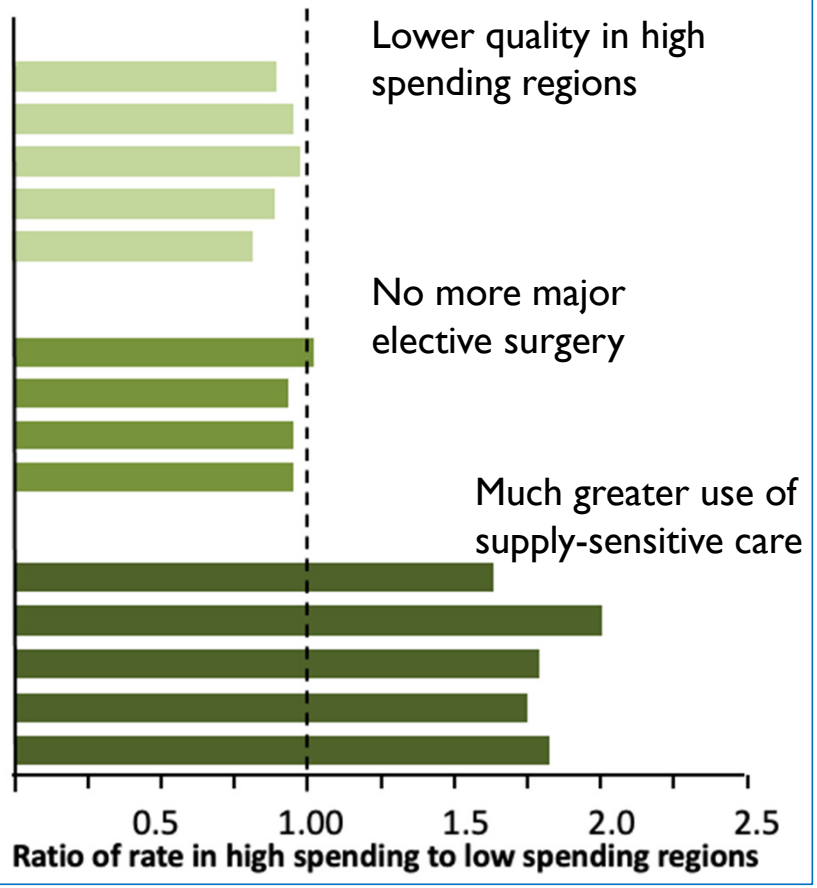
## UNDER FEE FOR SERVICE, NO ATTENTION TO QUALITY; A BUILT BED IS A FILLED BED; PHYSICIAN OFFICES STAY FULL



**Effective Care**: *Benefit clear for all*
- Reperfusion in 12 hours (Heart attack)
- Aspirin at admission (Heart attack)
- Mammogram, Women 65-69
- Pap Smear, Women 65+
- Pneumococcal Immunization (ever)

**Preference Sensitive**: *Values matter*
- Total Hip Replacement
- Total Knee Replacement
- Back Surgery
- CABG following heart attack

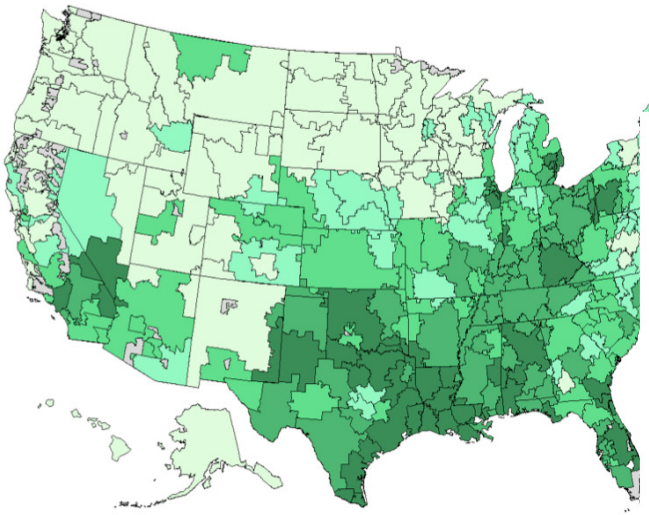
**Supply Sensitive:** *Often avoidable care*
- Total Inpatient Days
- Inpatient Days in ICU or CCU
- Evaluation and Management (visits)
- Imaging
- Diagnostic Tests




Source: The Dartmouth Atlas

# DRIVERS OF SPENDING: (2) POOR QUALITY, SUPPLY-SENSITIVE CARE

## MORE SUPPLY-SENSITIVE CARE IS NOT BETTER



| Health Outcomes | Physician's Perceptions | Patient-Perceived Quality |
|---|---|---|
| No gain in survival | Worse communication | Lower satisfaction with hospital care |
| No better function | Greater difficulty ensuring coordination | Worse access to primary care |
| | Greater perception of scarcity | No less sense that care is rationed |

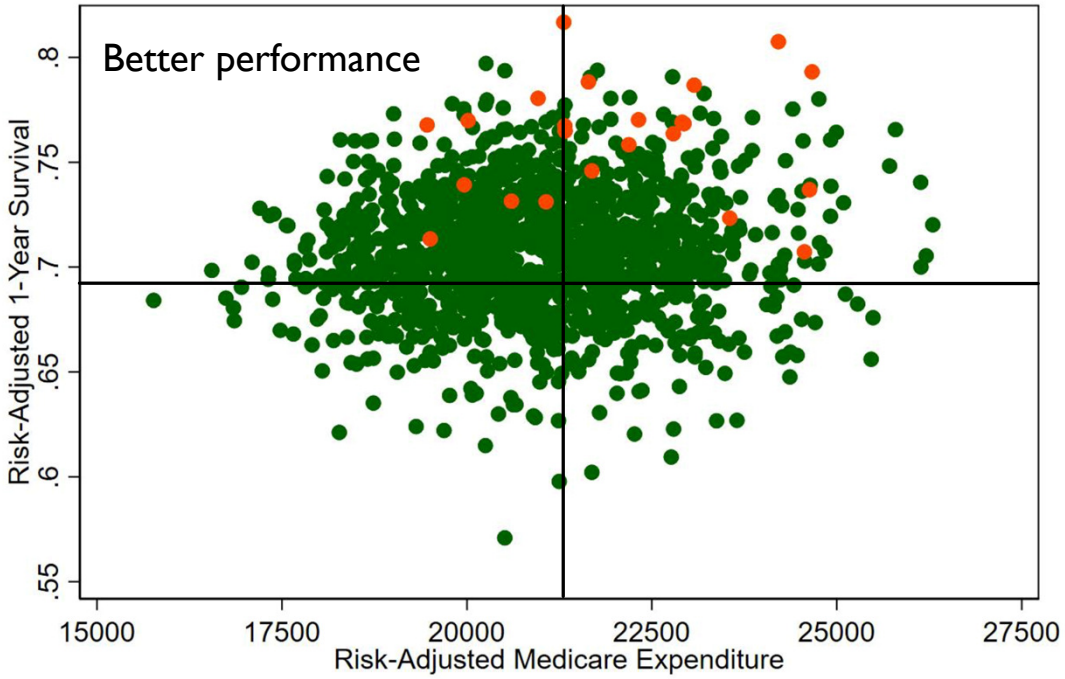
Uncomfortable truth: we're wasting 20-30% of health care spending due to poor quality & supply-sensitive care

**Studies summarized here. 2003 to 200**8: : (1) Fisher et al. Ann Intern Med: 2003; 138: 273-298; (2) Baicker et al. Health Affairs web exclusives, October 7, 2004; (3) Fisher et al. Health Affairs, web exclusives, Nov 16, 2005; (4) Skinner et al. Health Affairs web exclusives, Feb 7, 2006; (5) Sirovich et al. Ann Intern Med: 2006; 144: 641-649; (6) Fowler et al. JAMA: 2008; 299: 2406-2412.

# The Relationship between Spending and Quality

## It depends what you spend it on

Variations in survival and spending for heart attack, US Hospital with 500 or more patients




*Delivering safe reliable, and effective care*

*Avoiding unnecessary care (hospital stays, visits, tests)*

*Orange dots*: US News and World Reports Best 25 Cardiovascular Hospitals

**Why lower survival?**

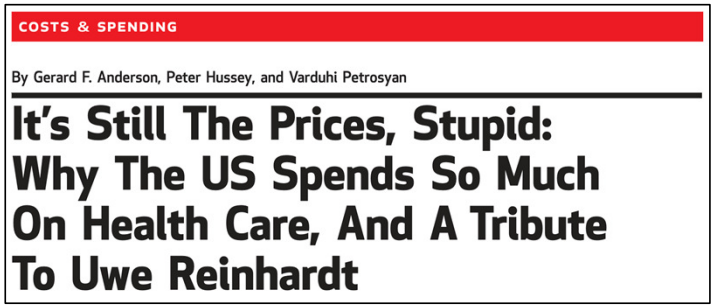
- Lack of data to track quality
- Lack of systems to ensure it
- Lack of incentive to do better
- *Weaker primary care*

**Why higher cost?**

- Supply – beds and specialists
- Fee-for-service payment
- Lack of incentive to do better
- *Weaker primary care*

Figure: Chandra, 2023, NBER Working Paper 31569
Interpretation: theirs and mine

# DRIVERS OF SPENDING: (3) HIGH PRICES



COSTS & SPENDING

By Gerard F. Anderson, Peter Hussey, and Varduhi Petrosyan

**It's Still The Prices, Stupid: Why The US Spends So Much On Health Care, And A Tribute To Uwe Reinhardt**

JOURNAL ARTICLE

**The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured**

Get access ›

Zack Cooper, Stuart V Craig, Martin Gaynor, John Van Reenen

*The Quarterly Journal of Economics*, Volume 134, Issue 1, February 2019, Pages 51–107, https://doi.org/10.1093/qje/qjy020

**High US health care spending compared to Europe are due to higher US prices**

**Within US price variation…**

- Explains half of regional differences in spending for commercial population (the rest is volume)
- Is determined by relative market power of payers and providers.
- Varies dramatically within hospitals, because of those differences.

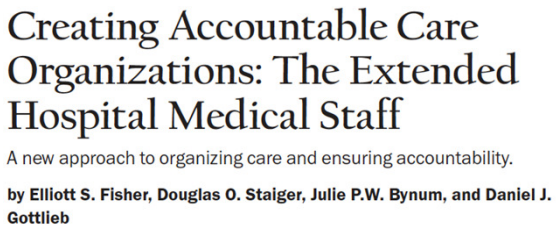
**A problem in all sectors, but especially**

- Health systems and hospitals
- Medical groups (e.g. specialist practices)
- Heath plans
- Prescription drugs

# What to do? Round 1 -- Accountable Care Organizations

## ACOs – Effort to Translate research to policy

| Underlying Problem | Key Principles |
| --- | --- |
| Fragmentation: no one accountable for integration, improvement or supply | Create organizations that can integrate, coordinate, improve, and right-size supply |
| Flawed incentives: fee-for-service is inherently uncoordinated and drives spending growth | Change payment model to reward improved health and care while reducing costs – global budgets |



Creating Accountable Care Organizations: The Extended Hospital Medical Staff

A new approach to organizing care and ensuring accountability.

by Elliott S. Fisher, Douglas O. Staiger, Julie P.W. Bynum, and Daniel J. Gottlieb

Fostering Accountable Health Care: Moving Forward In Medicare

Real savings to the Medicare program could occur within five years with only modest changes in providers' spending behavior.

by Elliott S. Fisher, Mark B. McClellan, John Bertko, Steven M. Lieberman, Julie J. Lee, Julie L. Lewis, and Jonathan S. Skinner

# OTHERS AGREED – GLOBAL PAYMENT TO HEALTH CARE ORGANIZATIONS

## SAVINGS ACHIEVED AT INTERMOUNTAIN HEALTH CARE – A MODEL ACO

**How much waste? Brent James' estimate**

- 35-50% of the cost of all spending on care delivery
- Note: Utah is the lowest spending state in the US.
- Sources of waste at Intermountain: poor quality, avoidable care and costs

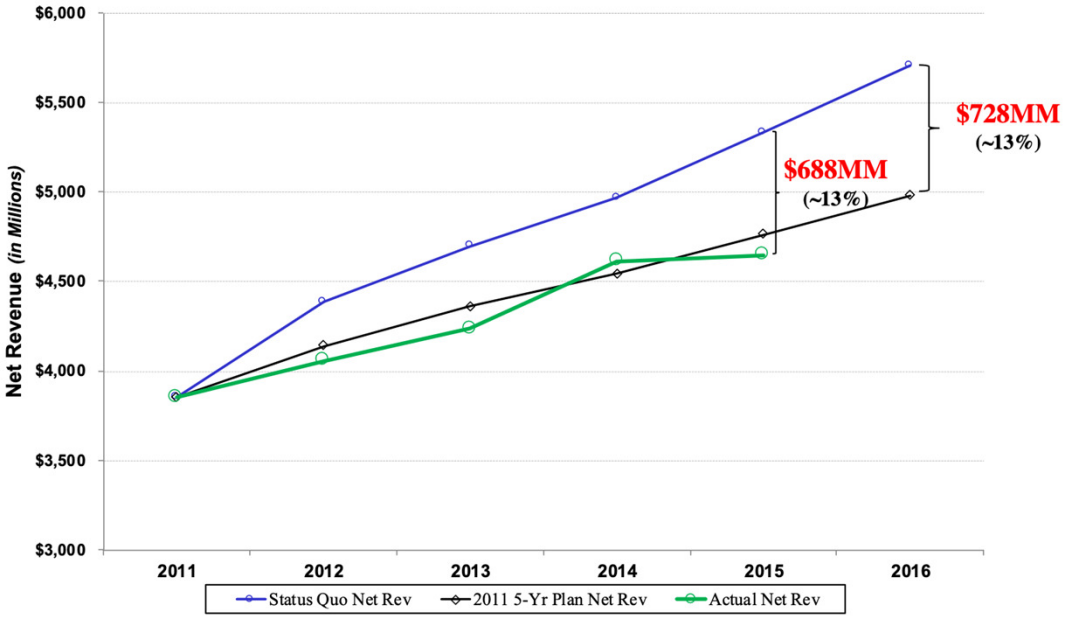
**The plan, implemented in 2011**

- Improve quality; eliminate waste and avoidable care
- Across all practices and hospital services

**It worked – but:**

- It requires investment and commitment
- Under fee-for-service, the savings go to payers

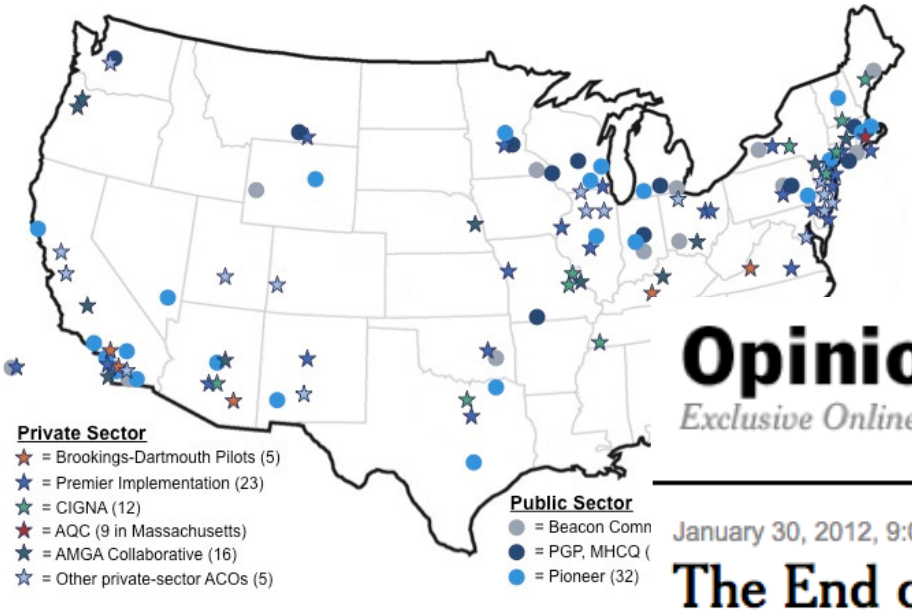
**His conclusion: capitation will be necessary to motivate change**




James. The case for capitation: It's the only way to cut waste while improving quality. Harv Bus Rev 2016; 94(7-8):102-11, 134 (Jul-Aug).

# PROGRESS AND PROMISE

## ACCOUNTABLE CARE -- INTEREST GROWS; ACOS ARE IN ACA; OPTIMISM ABOUNDS




**Opinionator**

*Exclusive Online Commentary From The Times*

January 30, 2012, 9:00 PM

### The End of Health Insurance Companies

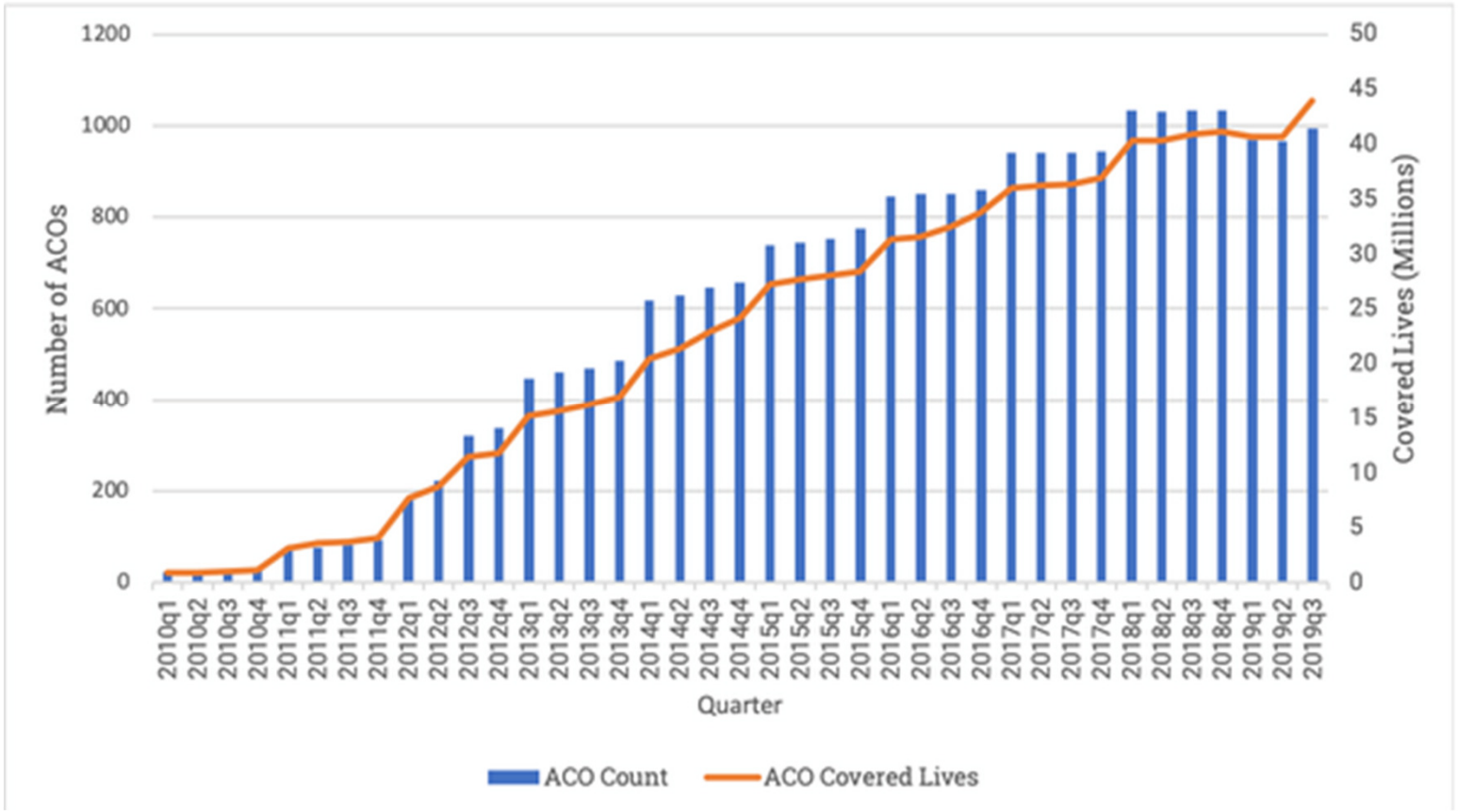
By EZEKIEL J. EMANUEL and JEFFREY B. LIEBMAN

*Ezekiel J. Emanuel on health policy and other topics.*

Here's a bold prediction for the new year. By 2020, the American health insurance industry will be extinct. Insurance companies will be replaced by accountable care organizations — groups of doctors, hospitals and other health care providers who come together to provide the full range of medical care for patients.

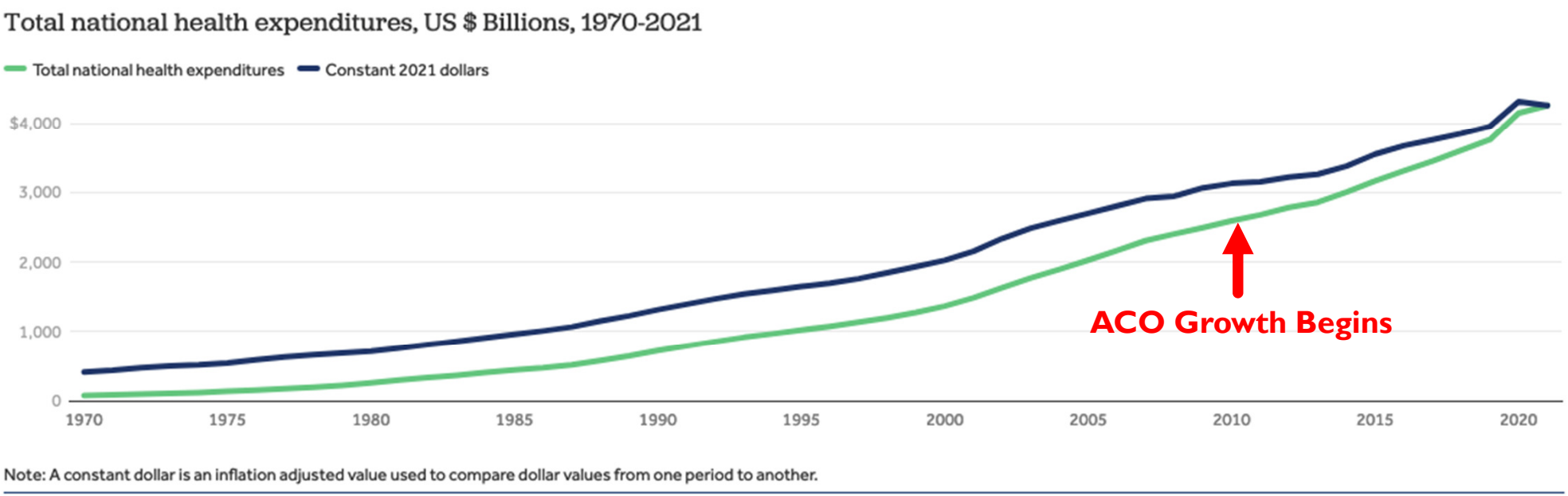
# What Happened?

## Initial Rapid Growth

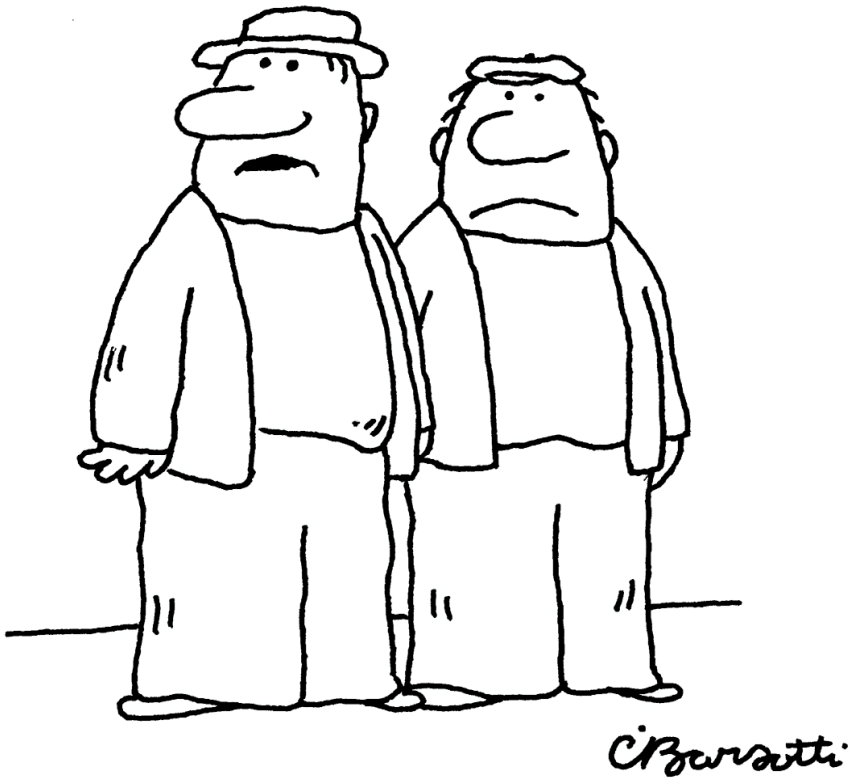


# BUT SPENDING GROWTH WAS NOT SLOWED – AT ALL

## WHY??



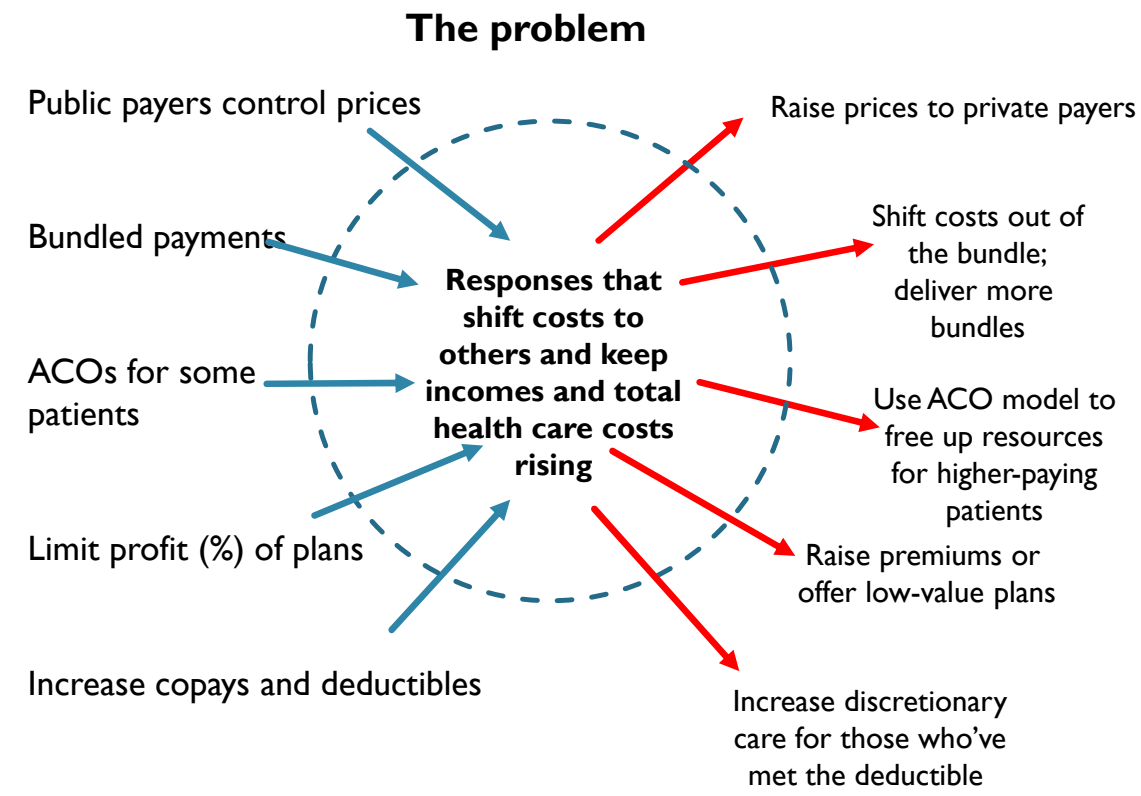

https://www.healthsystemtracker.org/chart-collection/u-s-spending-healthcare-changed-time/#Total%20national%20health%20expenditures,%20US%20$%20Billions,%201970-2021




*"There, there it is again—the invisible hand of the marketplace giving us the finger."*

# What have we been missing? (1) The Balloon Problem

## It is easier to shift costs to others than to improve Value

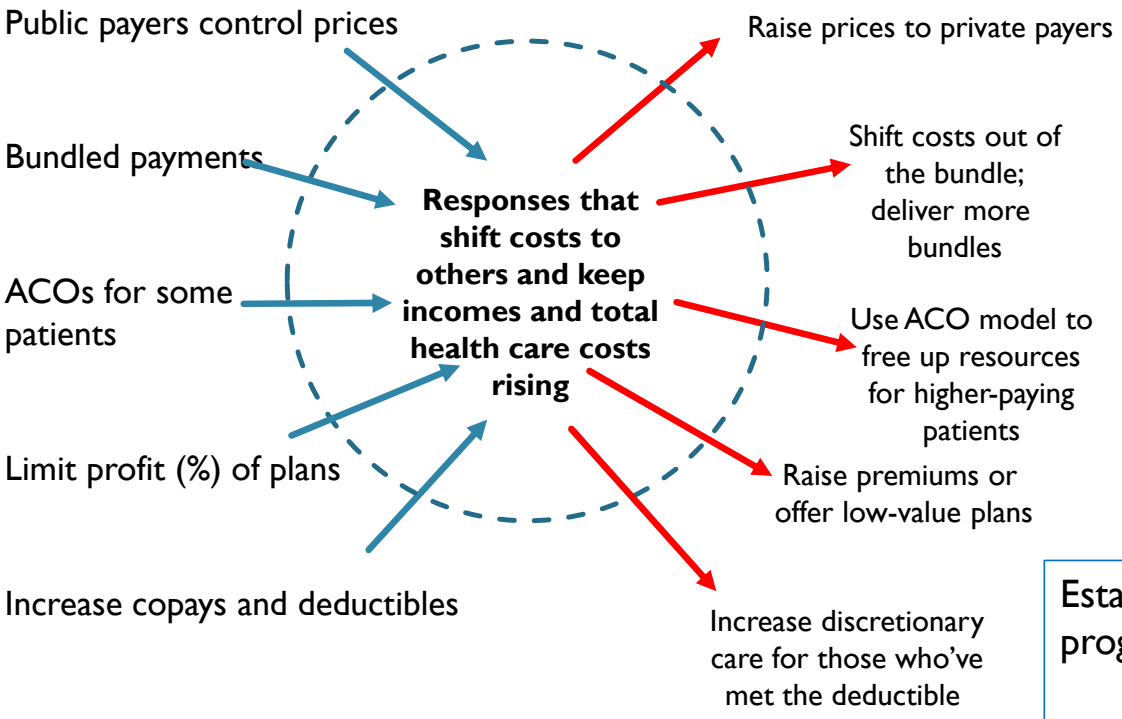



Fisher. The single system solution. New England Journal Catalyst 2020

# WHAT HAVE WE BEEN MISSING? (1) THE BALLOON PROBLEM

## A KEY ELEMENT: CAP AND CONTROL SPENDING GROWTH

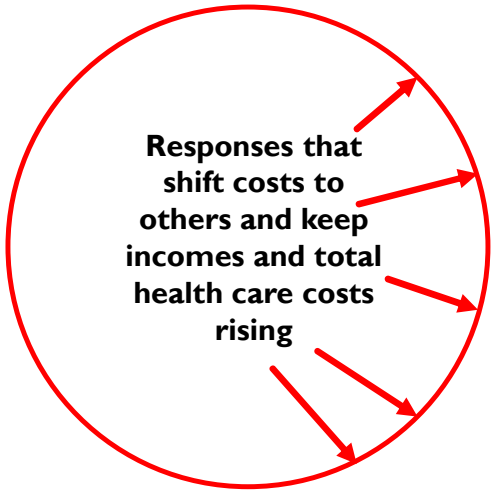
### The problem




**Current attempts to control costs** →

**How it is now easy to increase them** →

### The solution




An effective cap on spending with tools to improve care and health

Establish state level spending growth targets, monitor progress, use bully pulpit, and intervene (where possible)

5 states have fully implemented: : MA, DE, RI, OR, CN

Detailed report, Center for American Progress, 2022

# WHAT HAVE WE BEEN MISSING? (2) WEAK AND CONFLICTING INCENTIVES

## ALSO: THE NEED TO ENABLE INNOVATION AND TEAM BASED CARE

**A revenue problem**

- 90% of MD practices receive fee-for-service payments; 70% of revenue comes from FFS;

**An alignment problem**

- Half of US MD practices had 8 or more contracts; 12% had more than 20. ACO and APM designs differ.

**Transformation requires capitation**

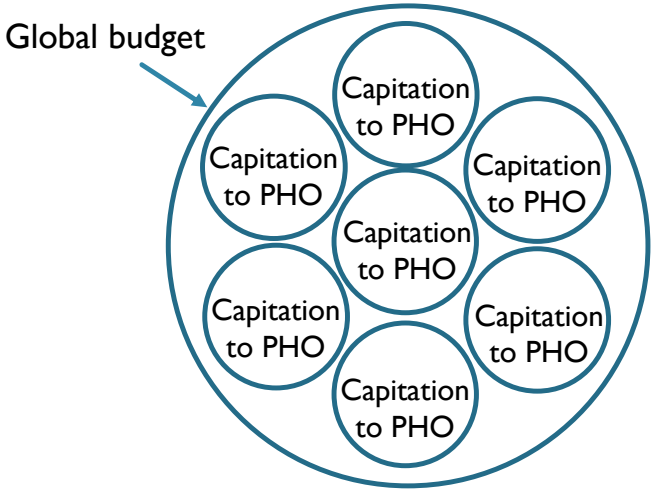
- Team based care unaffordable if capitation < 65%
- Incentives to improve are weak without capitation

**Solution:**

- All-payer adoption of aligned global payment models to primary care focused health care organizations

**Vermont version?**

- Community-based population health organizations as evolution of local primary care practices and Blueprint



# WHAT HAVE WE BEEN MISSING? (3) POLICY CHANGE IS HARD AND SLOW

## WE NEED A SYSTEM THAT CAN CONTINUALLY EVALUATE, LEARN AND ADAPT. SPORADIC REFORM CAN'T WORK

"It's not that I'm so smart, it's just that I stay with problems longer."

Albert Einstein

# What have we been missing? (3) Policy change is hard and slow

## Current barriers

**Profound lack of data to support improvement**

**Lack of sufficient evaluative capacity to identify all sources of waste, cost growth and harm**

- Improvement requires understanding the causes of poor performance and approaches that could help

**The collective action problem**

# WHAT?

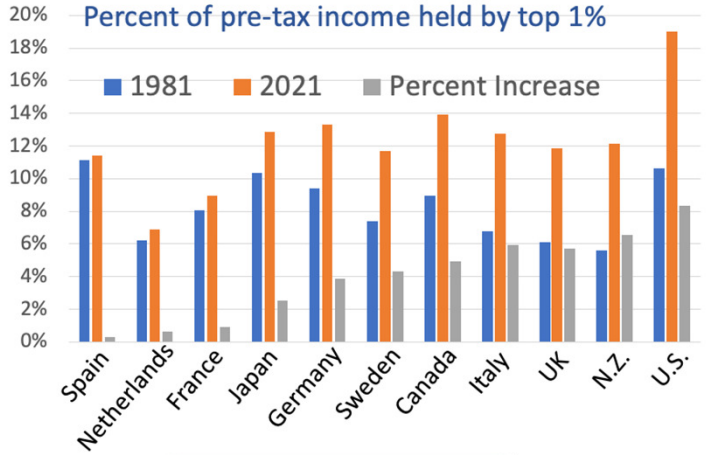
## THE COLLECTIVE ACTION PROBLEM

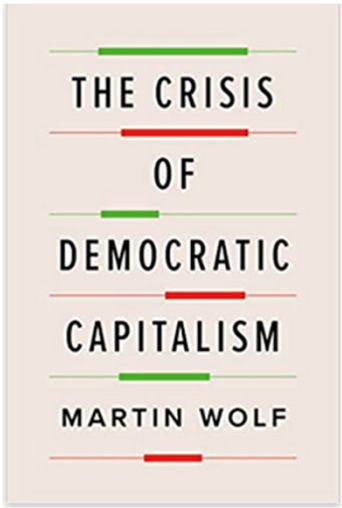
**The Crisis of Democratic Capitalism**
**The Great Reversal**

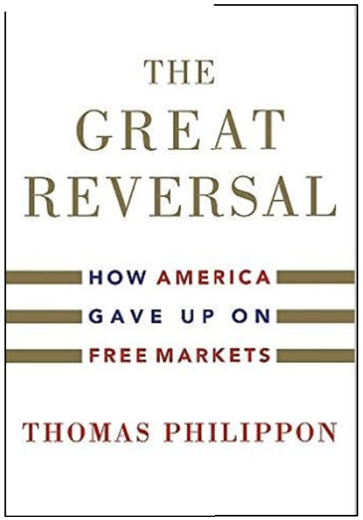
- Businesses shift to market valuation as value; strive to maximize profits and reduce wages & benefits
- Advocacy, lobbying, campaign spending to achieve "Collective action problem" private interests show up
  - Reduced social spending
  - Fewer regulations to limit market failure
  - More regulations and tax breaks to benefit private interests

**Impact:**

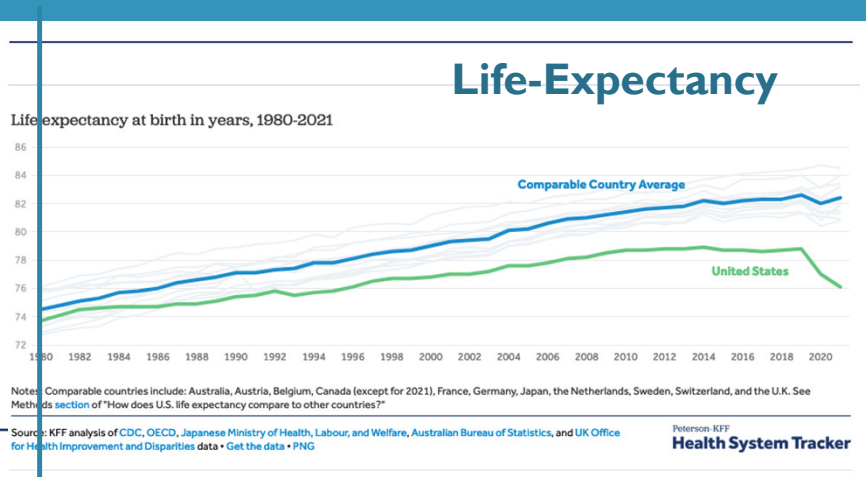
- Less competitive markets, higher prices, lower productivity and lower income growth overall
- Further concentration of wealth and power
- Widening income and wealth inequality
- **Public**: insecurity, anxiety, anger, resentment of elites → the rise of populism

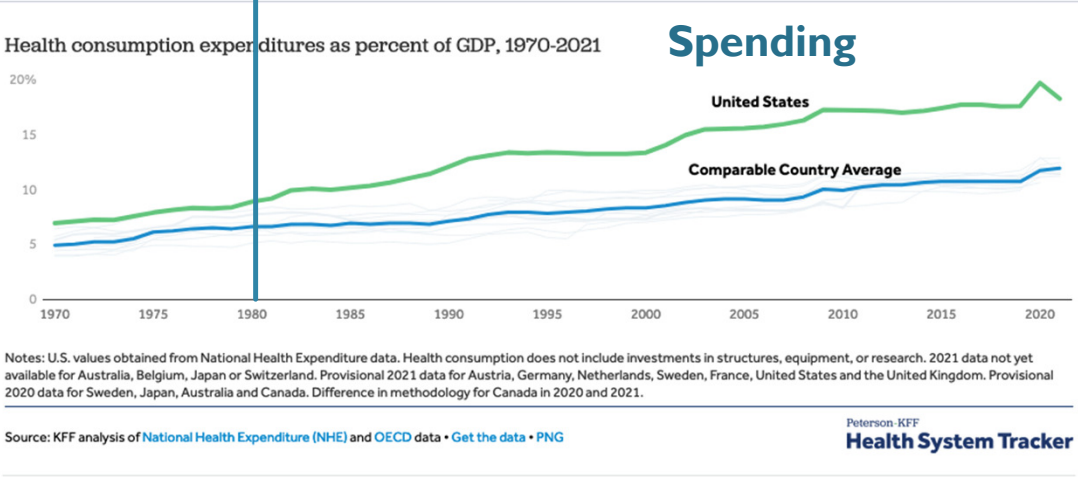


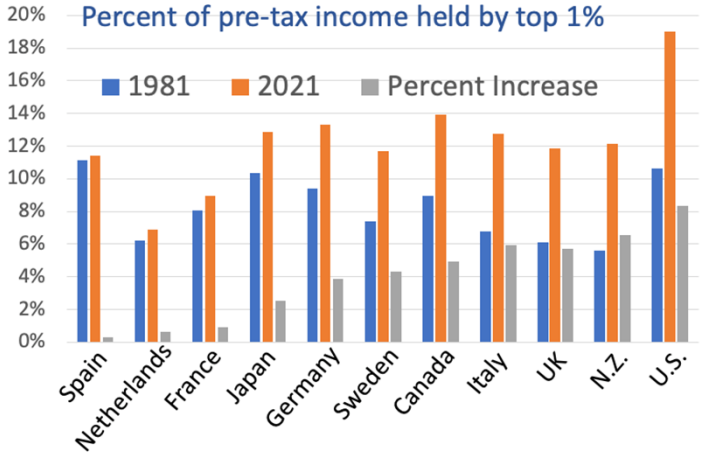



# Coincidence or Causation?



# HEALTH CARE HAS BECOME AN EXTRACTIVE INDUSTRY

## IS THE PROBLEM GREED? OR OUR FAILURE TO BUILD SYSTEMS THAT PROTECT THE PUBLIC INTEREST

**Viewpoint** FREE

January 30, 2023

### *Salve Lucrum:* The Existential Threat of Greed in US Health Care

Donald M. Berwick, MD, MPP[1]

» Author Affiliations | Article Information

*JAMA*. 2023;329(8):629-630. doi:10.1001/jama.2023.0846

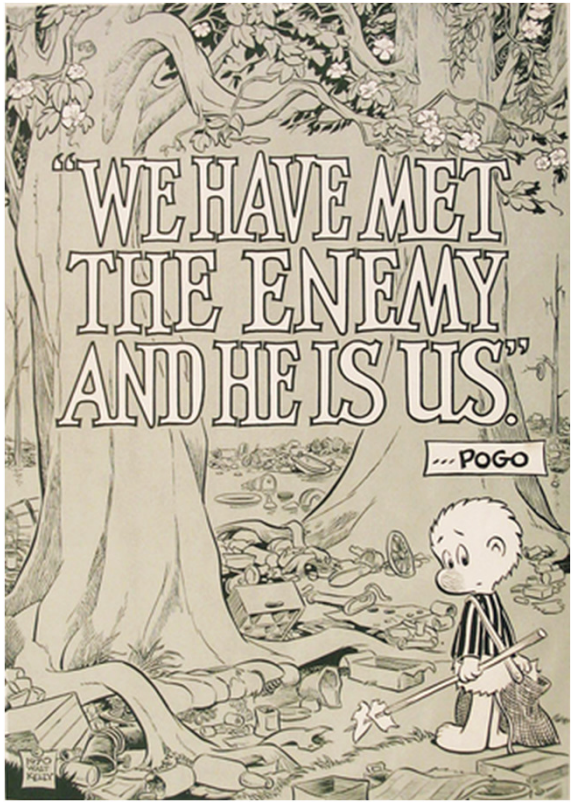
**HEALTH AFFAIRS FOREFRONT**

RELATED TOPICS:
COSTS AND SPENDING | COST REDUCTION | SYSTEMS OF CARE | MARKETS | PATIENT HARM | EMPLOYEE RETIREMENT INCOME SECURITY ACT | ECONOMIC BURDEN | DEDUCTIBLES | COST SHIFTING

### Addressing Greed In Health Care: If Not Us, Who? And How?

Elliott S. Fisher, George Isham

APRIL 18, 2023 10.1377/forefront.20230414.474060



# What have we been missing? (3) Policy change is hard and slow

## We need a system that can continually evaluate, learn and adapt. Sporadic reform can't work

**Profound lack of data to support improvement**

**Lack of sufficient evaluative capacity to identify all sources of waste, cost growth and harm**

- Improvement requires understanding the causes of poor performance and approaches that could help

**The collective action problem**

- Private interests can and do get their voices heard
- An uneven playing field: the public cares and knows less
- Most legislators have limited expertise and time; reform rarely rises high on the agenda

**Strengthen data systems (clinical and claims)**

**Further invest to enable Board to oversee and evaluate health system performance – and help develop approaches to improvement**

- Strengthen evaluation within the GMCB
- GMCB recommends approaches; develop actionable proposals (transparently) with Office of Health Reform.
- Ensure transparency and accountability by presenting AHS recommendations at GMCB public hearings

**Maintain GMCB as an independent agency representing the public good – for the long haul**

- Ensure the public is engaged
- Give it the authority needed to regulate all sectors
- Require annual recommendations for action.

# SUGGESTED ADDITIONS TO S 211

## IMPORTANT ADDITIONS TO CONSIDER – HERE OR ELSEWHERE

**Total cost of care spending growth targets**

- GMCB should establish spending growth targets overall by sector and should be encouraged to use its regulatory authority to achieve them.
- Given magnitude of avoidable costs, legislature should set goal of gradually reducing targets below GDP growth to create savings that could be re-allocated to health improvement and human services.

**Primary care spending targets**

- The GMCB should be required to establish targets, a timeline within which to achieve them and a plan for how these could be implemented for primary care spending as a share of total spending. (National Academy of Medicine recommendation)

**Prescription drug affordability**

**ACO Reform:**

- The current ACO lacks public accountability. There is an inherent conflict between its public purpose and the private interest of its parent organization (UVM HN)
- The GMCB should report on how to reform the all-payer ACO model, including transitioning the current ACO into a publicly accountable entity or implementing community-based population health organizations supported by the infrastructure of the current ACO.

**Health improvement targets?**

- The Office of Health Reform (suggested new name), should similarly be required to report annually on opportunities to improve health and well-being of Vermont residents and possible legislative or regulatory steps to do so.
- Include: social services that reduce costs; increasing investments in the Vital Conditions

# SOME FRAMING QUESTIONS

- Vermont (you) established an aspirational set of goals for health system reform (Act 48) and an independent agency (GMCB) with the responsibility to evaluate and improve health system performance. The GMCB is effective, transparent and accountable -- the envy of many states.
- The AHEAD model offers additional important opportunities.

*Does the legislature want to build on this foundation?*

**Issues to consider**

- Are current reform discussions being guided by a clear understanding of cost drivers?
- Who will look out for the little guy? Private interests are well-represented. The public lacks voice.
- How can reform be sustained over the long haul?

# Section by Section Feedback on S 211

**Recommended changes**

**Amend S027:** shifting responsibility to AHS

- Evaluation of systemwide health care performance must stay in GMCB: independent, transparent, persistent
- AHS should lead development of specific policies (regulations, proposed legislation, execution of changes), but with review by GMCB and public engagement.

**S2, 18, Ch 13:** require insurer participation in APMs

- Great direction. Work to expand scope to cover employer sponsored plans (all-payer PHOs)

**Sec 4, 18, 9374.** Reduce GMCB scope of work.

- Do not undermine ability of board to oversee system performance (drop the deletions)

**Sec 5, 18, 9375.** Requires collaboration w AHS on all oversight; removes oversight of system performance.

- Keep primary responsibility for evaluation in GMCB

**Recommended changes (cont)**

**Sec 6, 18, 9376** Payment amounts

- Set reasonable amounts for health care professionals, prescribed products and supplies (seems OK, but stronger prescription drug price controls needed)
- Reference based pricing wise

**Sec 7, 18, 9377.** Payment reform – limits participation of GMCB "to extent directed by Director HCR".

- Delete this. Could undermine much of GMCB work depending upon administration; a dangerous section

**Sec 8, 18, 9382:** Oversight of ACOs.

- Wise to add keeping information public and rules to review Medicare only ACOs

**Sec 9, 18, 9406:** Require mediation (sounds fine)

**Sec 10, 18, 9454:** require insurers and Medicaid to accept any provider credentialed by Medicare; limit data collection to CMS requirements. Delete latter for sure.

# Section by Section Feedback on S 211

**Recommended changes (cont)**

**S12, 18, 9456:** Budget Review

- Many provisions seem to strengthen review process – I would work with GMCB to make sure these help.
- Hospital budget reviews only for non-prospective payment parts. (i.e. not for global budgets). Full review must remain with GMCB. Drop this.
- Budget reviews at hospital level only, not cost center. This eliminates effective oversight. Drop this

**S13, 26, 1574:** : establish student nurse apprenticeship. (fine, but why not other needed professionals?)

**Sec 14,** Require training of board. No harm

**Sec 15,** Population based budgeting requirement.

- Risks undermining hospital global budget by preventing the differential growth in funding needed to support poor and rural regions..

**Recommended changes (cont)**

**Sec 16** Regulatory review alignment report: great opportunity to strengthen reviews and increase transparency., public engagement and accountability.

**Sec 17.** Review of mergers and acquisitions.

- Important addition to authority.

**Sec 18** Single state agency for health data (report)

- Essential reform: create data system required for both clinical improvement, GMCB performance monitoring and evaluation. Consider MD and MA data utility models. (Should it have a due date?)

Hospital global budgets are an important tool to improve access, affordability, quality and health. Setting the budget should remain in the GMCB (see next slide)

# APPENDIX

**Extra slides**

**How state policy makers can make health care better and more affordable**

Some detailed 2019 data comparing Vermont to Utah: we overutilize hospitals. (tables)

What does all this mean: summary of the Utah vs Vermont data

| How States Can Make Health Care Better and More Affordable | |
|---|---|
| **Keep people healthy** | |
| Health care spending is largely devoted to treating acute (overdose, accidents, gun violence) and chronic conditions (heart disease, cancer, liver disease) many of which could be prevented. | Implement proven public health approaches to health promotion and disease prevention Strengthen incentives for health care organizations to keep people healthy. |
| **Strengthen primary care** | |
| The US has developed a specialist and technology dominated health care system reinforced by payment models that reward procedures and facility-based care. Primary care is essential but seriously threatened. | Provide universal insurance that assures access to primary care. Increase share of spending devoted to primary. Shift to payment models that enable innovation and team-based care models. |
| **Establish state level accountability and mechanisms to control avoidable health care cost growth through evaluation and regulation** | |
| ***Total Cost of care***: Without an aim and ability to measure performance, improvement is impossible. No one is responsible for understanding the drivers of cost growth and waste. Opportunities to improve are missed. | Establish a state target for health care cost growth. Build the evaluative capacity to monitor performance and identify opportunities to improve. Adjust targets and develop policy recommendations as needed |
| ***Hospitals*** account for the largest share of spending. Current payment models incentivize unnecessary use and duplication of services (in overbuilt markets) and cannot support needed services in others (rural areas) | Adopt global budgets for hospitals that ensure adequate local and regional access to essential facilities and services. Gradually shift resources to primary care and population health improvement where possible. |
| ***Health care delivery*** remains fragmented with little or no provider level incentives to improve and coordinate care. Fee-for-service remains dominant and limits opportunity for redesign. | All payers should be required to adopt aligned payment models to primary care focused organizations able to deliver comprehensive coordinated care with accountability for the quality and total cost of health care delivery. |
| ***Prices.*** Monopoly power is growing across all sectors: health systems, hospitals, medical groups, prescription drugs and health plans. Prices are the major cause of variations in commercial spending. | Adopt policies to preserve competition where possible (mergers and acquisitions). Where not possible, implement policies to regulate prices across all sectors. |
| **Address the collective action and inertia problems** | |
| Special interests show up. The public has limited attention. Most legislators have limited time or knowledge. The executive branch turns over frequently, which can risk undermining reform. The process of health care reform itself lacks the capacity to learn and adapt. | Establish (or strengthen) independent agency charged with advancing reform goals by: evaluating progress, engaging public and working with executive branch and others to translate evaluative insight (led by GMCB) into actionable regulatory and legislative reforms (led by AHS). |

# How does Vermont Compare?

Vermont is low overall on Medicare Spending

| | | Medicare Spending and Utilization during the last 2 years of life | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Entity (State or Hospital) | City | Number of deaths | Hospital Care Intensity Index | Total Medicare spending | Part B Spending (Physician services) | Hospital Spending | Inpatient Days | Hospital Bed Inputs per 1,000 |
| US Average | | 1.1 million | 1.0 | 78,635 | 14,588 | 30,531 | 14.2 | 38.9 |
| Utah -- all | | 6,282 | 0.5 | 68,070 | 11,300 | 21,194 | 8.0 | 21.9 |
| Vermont -- all | | 3,348 | 0.7 | 62,791 | 6,967 | 26,110 | 13.0 | 35.7 |
| New Hampshire -- all | | 6,624 | 0.8 | 75,114 | 10,485 | 29,899 | 13.5 | 37.1 |
| | | | | | | | | |
| Intermountain Medical Center | Murray | 298 | 0.5 | 79,625 | 14,106 | 26,690 | 10.6 | 28.9 |
| Dixie Regional Medical Center (IMC) | St George | 527 | 0.5 | 78,428 | 11,930 | 29,080 | 11.7 | 32.0 |
| University Of Utah Health Care | Salt Lake City | 518 | 0.6 | 77,658 | 12,066 | 31,712 | 12.3 | 33.7 |
| | | | | | | | | |
| Rutland Regional Medical Center | Rutland | 252 | 0.8 | 87,251 | 7,744 | 40,977 | 16.8 | 45.9 |
| University Of Vermont Med Ctr | Burlington | 295 | 0.8 | 84,951 | 6,724 | 38,523 | 17.7 | 48.4 |
| Umv Hlth Central Vermont Med Ctr | Barre | 636 | 0.8 | 59,226 | 7,068 | 24,436 | 18.5 | 50.6 |
| | | | | | | | | |
| Concord Hospital | Concord | 421 | 0.7 | 96,960 | 13,307 | 45,964 | 15.3 | 42.0 |
| Exeter Hospital | Exeter | 440 | 0.7 | 83,972 | 10,514 | 34,962 | 15.6 | 42.9 |
| Dartmouth-Hitchcock Med Ctr | Lebanon | 289 | 0.7 | 83,406 | 8,027 | 37,463 | 15.6 | 42.7 |
| Cheshire Medical Center | Keene | 515 | 0.8 | 90,889 | 10,108 | 48,956 | 17.1 | 46.8 |

# How does Vermont Compare?

Mostly because of low spending on physician services

**Medicare Spending and Utilization during the last 2 years of life**

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| University Of Vermont Med Ctr | Burlington | 295 | 0.8 | 84,951 | 6,724 | 38,523 | 17.7 | 48.4 |
| Umv Hlth Central Vermont Med Ctr | Barre | 636 | 0.8 | 59,226 | 7,068 | 24,436 | 18.5 | 50.6 |
| | | | | | | | | |
| Concord Hospital | Concord | 421 | 0.7 | 96,960 | 13,307 | 45,964 | 15.3 | 42.0 |
| Exeter Hospital | Exeter | 440 | 0.7 | 83,972 | 10,514 | 34,962 | 15.6 | 42.9 |
| Dartmouth-Hitchcock Med Ctr | Lebanon | 289 | 0.7 | 83,406 | 8,027 | 37,463 | 15.6 | 42.7 |
| Cheshire Medical Center | Keene | 515 | 0.8 | 90,889 | 10,108 | 48,956 | 17.1 | 46.8 |

# How does Vermont Compare?

Vermont is relatively high (compared to Utah) on hospital spending

Medicare Spending and Utilization during the last 2 years of life

| Entity (State or Hospital) | City | Number of deaths | Hospital Care Intensity Index | Total Medicare spending | Part B Spending (Physician services) | Hospital Spending | Inpatient Days | Hospital Bed Inputs per 1,000 |
|---|---|---|---|---|---|---|---|---|
| US Average | | 1.1 million | 1.0 | 78,635 | 14,588 | 30,531 | 14.2 | 38.9 |
| Utah -- all | | 6,282 | 0.5 | 68,070 | 11,300 | 21,194 | 8.0 | 21.9 |
| Vermont -- all | | 3,348 | 0.7 | 62,791 | 6,967 | 26,110 | 13.0 | 35.7 |
| New Hampshire -- all | | 6,624 | 0.8 | 75,114 | 10,485 | 29,899 | 13.5 | 37.1 |
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| Dixie Regional Medical Center (IMC) | St George | 527 | 0.5 | 78,428 | 11,930 | 29,080 | 11.7 | 32.0 |
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| | | | | | | | | |
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| University Of Vermont Med Ctr | Burlington | 295 | 0.8 | 84,951 | 6,724 | 38,523 | 17.7 | 48.4 |
| Umv Hlth Central Vermont Med Ctr | Barre | 636 | 0.8 | 59,226 | 7,068 | 24,436 | 18.5 | 50.6 |
| | | | | | | | | |
| Concord Hospital | Concord | 421 | 0.7 | 96,960 | 13,307 | 45,964 | 15.3 | 42.0 |
| Exeter Hospital | Exeter | 440 | 0.7 | 83,972 | 10,514 | 34,962 | 15.6 | 42.9 |
| Dartmouth-Hitchcock Med Ctr | Lebanon | 289 | 0.7 | 83,406 | 8,027 | 37,463 | 15.6 | 42.7 |
| Cheshire Medical Center | Keene | 515 | 0.8 | 90,889 | 10,108 | 48,956 | 17.1 | 46.8 |

# How does Vermont Compare?

Vermont patients spend more time in the hospital (over 50% more than residents of Utah)

Medicare Spending and Utilization during the last 2 years of life

| Entity (State or Hospital) | City | Number of deaths | Hospital Care Intensity Index | Total Medicare spending | Part B Spending (Physician services) | Hospital Spending | Inpatient Days | Hospital Bed Inputs per 1,000 |
|---|---|---|---|---|---|---|---|---|
| US Average | | 1.1 million | 1.0 | 78,635 | 14,583 | 30,531 | 14.2 | 38.9 |
| Utah -- all | | 6,282 | 0.5 | 68,070 | 11,300 | 21,194 | 8.0 | 21.9 |
| Vermont -- all | | 3,348 | 0.7 | 62,791 | 6,967 | 26,110 | 13.0 | 35.7 |
| New Hampshire -- all | | 6,624 | 0.8 | 75,114 | 10,485 | 29,899 | 13.5 | 37.1 |
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| Rutland Regional Medical Center | Rutland | 252 | 0.8 | 87,251 | 7,744 | 40,977 | 16.8 | 45.9 |
| University Of Vermont Med Ctr | Burlington | 295 | 0.8 | 84,951 | 6,724 | 38,523 | 17.7 | 48.4 |
| Umv Hlth Central Vermont Med Ctr | Barre | 636 | 0.8 | 59,226 | 7,068 | 24,436 | 18.5 | 50.6 |
| | | | | | | | | |
| Concord Hospital | Concord | 421 | 0.7 | 96,960 | 13,307 | 45,964 | 15.3 | 42.0 |
| Exeter Hospital | Exeter | 440 | 0.7 | 83,972 | 10,514 | 34,962 | 15.6 | 42.9 |
| Dartmouth-Hitchcock Med Ctr | Lebanon | 289 | 0.7 | 83,406 | 8,027 | 37,463 | 15.6 | 42.7 |
| Cheshire Medical Center | Keene | 515 | 0.8 | 90,889 | 10,108 | 48,956 | 17.1 | 46.8 |

# How does Vermont Compare?

So Vermont residents use more hospital beds than those in Utah

Medicare Spending and Utilization during the last 2 years of life

| Entity (State or Hospital) | City | Number of deaths | Hospital Care Intensity Index | Total Medicare spending | Part B Spending (Physician services) | Hospital Spending | Inpatient Days | Hospital Bed Inputs per 1,000 |
|---|---|---|---|---|---|---|---|---|
| US Average | | 1.1 million | 1.0 | 78,635 | 14,588 | 30,531 | 14.2 | 38.9 |
| Utah -- all | | 6,282 | 0.5 | 68,070 | 11,300 | 21,194 | 8.0 | 21.9 |
| Vermont -- all | | 3,348 | 0.7 | 62,791 | 6,967 | 26,110 | 13.0 | 35.7 |
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| | | | | | | | | |
| Concord Hospital | Concord | 421 | 0.7 | 96,960 | 13,307 | 45,964 | 15.3 | 42.0 |
| Exeter Hospital | Exeter | 440 | 0.7 | 83,972 | 10,514 | 34,962 | 15.6 | 42.9 |
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| Cheshire Medical Center | Keene | 515 | 0.8 | 90,889 | 10,108 | 48,956 | 17.1 | 46.8 |

# How does Vermont Compare?

Looking at the larger hospitals in each state: Total Medicare spending in Vermont is now higher

Medicare Spending and Utilization during the last 2 years of life

| Entity (State or Hospital) | City | Number of deaths | Hospital Care Intensity Index | Total Medicare spending | Part B Spending (Physician services) | Hospital Spending | Inpatient Days | Hospital Bed Inputs per 1,000 |
|---|---|---|---|---|---|---|---|---|
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| Umv Hlth Central Vermont Med Ctr | Barre | 636 | 0.8 | 59,226 | 7,068 | 24,436 | 18.5 | 50.6 |
| | | | | | | | | |
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| Exeter Hospital | Exeter | 440 | 0.7 | 83,972 | 10,514 | 34,962 | 15.6 | 42.9 |
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# How does Vermont Compare?

Looking at the larger hospitals in each state: Physician spending is lower

Medicare Spending and Utilization during the last 2 years of life

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| University Of Utah Health Care | Salt Lake City | 518 | 0.6 | 77,658 | 12,066 | 31,712 | 12.3 | 33.7 |
| | | | | | | | | |
| Rutland Regional Medical Center | Rutland | 252 | 0.8 | 87,251 | 7,744 | 40,977 | 16.8 | 45.9 |
| University Of Vermont Med Ctr | Burlington | 295 | 0.8 | 84,951 | 6,724 | 38,523 | 17.7 | 48.4 |
| Umv Hlth Central Vermont Med Ctr | Barre | 636 | 0.8 | 59,226 | 7,068 | 24,436 | 18.5 | 50.6 |
| | | | | | | | | |
| Concord Hospital | Concord | 421 | 0.7 | 96,960 | 13,307 | 45,964 | 15.3 | 42.0 |
| Exeter Hospital | Exeter | 440 | 0.7 | 83,972 | 10,514 | 34,962 | 15.6 | 42.9 |
| Dartmouth-Hitchcock Med Ctr | Lebanon | 289 | 0.7 | 83,406 | 8,027 | 37,463 | 15.6 | 42.7 |
| Cheshire Medical Center | Keene | 515 | 0.8 | 90,889 | 10,108 | 48,956 | 17.1 | 46.8 |

# How does Vermont Compare?

Looking at the larger hospitals in each state: Hospital spending is higher

Medicare Spending and Utilization during the last 2 years of life

| Entity (State or Hospital) | City | Number of deaths | Hospital Care Intensity Index | Total Medicare spending | Part B Spending (Physician services) | Hospital Spending | Inpatient Days | Hospital Bed Inputs per 1,000 |
|---|---|---|---|---|---|---|---|---|
| US Average | | 1.1 million | 1.0 | 78,635 | 14,588 | 30,531 | 14.2 | 38.9 |
| Utah -- all | | 6,282 | 0.5 | 68,070 | 11,300 | 21,194 | 8.0 | 21.9 |
| Vermont -- all | | 3,348 | 0.7 | 82,791 | 6,967 | 26,110 | 13.0 | 35.7 |
| New Hampshire -- all | | 6,624 | 0.8 | 75,114 | 10,485 | 29,899 | 13.5 | 37.1 |
| | | | | | | | | |
| Intermountain Medical Center | Murray | 298 | 0.5 | 79,625 | 14,106 | 26,690 | 10.6 | 28.9 |
| Dixie Regional Medical Center (IMC) | St George | 527 | 0.5 | 78,428 | 11,930 | 29,080 | 11.7 | 32.0 |
| University Of Utah Health Care | Salt Lake City | 518 | 0.6 | 77,658 | 12,066 | 31,712 | 12.3 | 33.7 |
| | | | | | | | | |
| Rutland Regional Medical Center | Rutland | 252 | 0.8 | 87,251 | 7,744 | 40,977 | 16.8 | 45.9 |
| University Of Vermont Med Ctr | Burlington | 295 | 0.8 | 84,951 | 6,724 | 38,523 | 17.7 | 48.4 |
| Umv Hlth Central Vermont Med Ctr | Barre | 636 | 0.8 | 59,226 | 7,068 | 24,436 | 18.5 | 50.6 |
| | | | | | | | | |
| Concord Hospital | Concord | 421 | 0.7 | 96,960 | 13,307 | 45,964 | 15.3 | 42.0 |
| Exeter Hospital | Exeter | 440 | 0.7 | 83,972 | 10,514 | 34,962 | 15.6 | 42.9 |
| Dartmouth-Hitchcock Med Ctr | Lebanon | 289 | 0.7 | 83,406 | 8,027 | 37,463 | 15.6 | 42.7 |
| Cheshire Medical Center | Keene | 515 | 0.8 | 90,889 | 10,108 | 48,956 | 17.1 | 46.8 |

# How does Vermont Compare?

Looking at the larger hospitals in each state: this is due to greater use of the hospital

Medicare Spending and Utilization during the last 2 years of life

| Entity (State or Hospital) | City | Number of deaths | Hospital Care Intensity Index | Total Medicare spending | Part B Spending (Physician services) | Hospital Spending | Inpatient Days | Hospital Bed Inputs per 1,000 |
|---|---|---|---|---|---|---|---|---|
| US Average | | 1.1 million | 1.0 | 78,635 | 14,588 | 30,531 | 14.2 | 38.9 |
| Utah -- all | | 6,282 | 0.5 | 68,070 | 11,300 | 21,194 | 8.0 | 21.9 |
| Vermont -- all | | 3,348 | 0.7 | 62,791 | 6,967 | 26,110 | 13.0 | 35.7 |
| New Hampshire -- all | | 6,624 | 0.8 | 75,114 | 10,485 | 29,899 | 13.5 | 37.1 |
| | | | | | | | | |
| Intermountain Medical Center | Murray | 298 | 0.5 | 79,625 | 14,106 | 26,690 | 10.6 | 28.9 |
| Dixie Regional Medical Center (IMC) | St George | 527 | 0.5 | 78,428 | 11,930 | 29,080 | 11.7 | 32.0 |
| University Of Utah Health Care | Salt Lake City | 518 | 0.6 | 77,658 | 12,066 | 31,712 | 12.3 | 33.7 |
| | | | | | | | | |
| Rutland Regional Medical Center | Rutland | 252 | 0.8 | 87,251 | 7,744 | 40,977 | 16.8 | 45.9 |
| University Of Vermont Med Ctr | Burlington | 295 | 0.8 | 84,951 | 6,724 | 38,523 | 17.7 | 48.4 |
| Umv Hlth Central Vermont Med Ctr | Barre | 636 | 0.8 | 59,226 | 7,068 | 24,436 | 18.5 | 50.6 |
| | | | | | | | | |
| Concord Hospital | Concord | 421 | 0.7 | 96,960 | 13,307 | 45,964 | 15.3 | 42.0 |
| Exeter Hospital | Exeter | 440 | 0.7 | 83,972 | 10,514 | 34,962 | 15.6 | 42.9 |
| Dartmouth-Hitchcock Med Ctr | Lebanon | 289 | 0.7 | 83,406 | 8,027 | 37,463 | 15.6 | 42.7 |
| Cheshire Medical Center | Keene | 515 | 0.8 | 90,889 | 10,108 | 48,956 | 17.1 | 46.8 |

# What does all this mean?

## There are opportunities to use less discretionary / avoidable care in both Utah and Vermont

**The data:**

- Vermont residents spend more time in the hospital than similarly ill patients in Utah.
- Utah residents receive more physician services than similarly ill patients in Vermont (but much more is spent on hospital care than physician services).
- Brent James believes Intermountain could further reduce spending on all of their patients by improving care and reducing avoidable utilization
- Intermountain does this by comparing utilization across internal operating units to find opportunities to improve.

**Vermont could use the same approach:**

- Compare spending and utilization overall and by sector (inpatient, physician, nursing home etc) across Hospital Service Areas.
- Identify major clinical conditions where facility-based surgical or procedural expertise is required (joint replacement, cardiac procedures, major surgery). Compare access, quality and outcomes across providers.
- Find opportunities to improve care and reduce avoidable utilization due to complications.
- Strengthen primary care and improve coordination across all sites of care – to reduce avoidable inpatient utilization.