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My career in public health, population health, value-based care, and state government has led me here. I believe we can make real, lasting, impactful changes to the healthcare delivery system together.

One could argue that the most urgent issue in rural America is the health and well-being of its residents. The Agency for Healthcare Research and Quality reports that life expectancy in rural areas is significantly lower than in other parts of the United States, and this gap is widening. Major factors contributing to this disparity include heart disease, lung cancer, stroke, diabetes, substance use, and suicide.

I chose to move for the position I have today to work in a healthcare delivery system to make the necessary changes to impact the lives of people, your families, our neighbors, and our friends. I believe in the foundation built by Vermont and the ability to make real change here.

To begin discussing how we do this, I'd like to start with models of reimbursement so that we are using the same vocabulary to talk about the change.

Review the slide: Models of reimbursement

Total Cost of Care (TCOC) typically means aggregating all the costs associated with claims coverage of subscribed members, adjusted for risk, and expressed as a per-member-per-month (PMPM) dollar amount.

Healthcare has been largely stuck in fee-for-service. My goal is to shift as much as possible to value-based care.

We all know the problems with the fee-for-service system—the financial incentives are on volume, not outcomes. In 1999, this was highlighted most poignantly by the Institute of Medicine in the landmark report: *To Err Is Human: Building a Safer Health System (To Err is Human - NCBI Bookshelf)*. The report stated that errors cause between 44,000 and 98,000 deaths every year in American hospitals, and over one million injuries.

Vermont did a lot of fundamental work to make the transition to value-based care, including the Blueprint for Health and the concept of a statewide accountable care organization for all payers. I'd like to see us work together to move towards value-based care. To do that, we all need a shared vocabulary, a shared problem, and a shared solutions statement.

In 2011, Atul Gawande wrote in the New Yorker (Cowboys and Pit Crews | The New Yorker): "The core structure of medicine—how health care is organized and practiced—emerged in an era when doctors could hold all the key information patients needed in their heads and manage everything required themselves. One needed only an ethic of hard work, a prescription pad, a secretary, and a hospital willing to serve as one's workshop, loaning a bed and nurses for a patient's convalescence, maybe an operating room with a few basic tools. We were craftsmen."

He goes on to note that "In 1970 it was found that 2.5 full-time equivalents were needed to care for the average hospitalized patient. By the end of the nineteen-nineties, it was more than fifteen. The number must be even larger today."

Gawande discusses the specialized knowledge and components of state-of-the-art medical care, noting that “A structure that prioritizes the independence of all those specialists will have enormous difficulty achieving great care.” He points to the same quality data in *To Err Is Human*, stating, “We train, hire, and pay doctors to be cowboys. But it’s pit crews people need.” He also cites the unsustainable growth in the cost of health care.

How do we ensure we have the pit crews? These are the care teams using data, teamwork, and functioning at scale. These are the fundamental elements of population health—using data and teams to manage a population.

Turning back to our shared vision, we have all heard of the foot-in-two-canoes analogy: one being fee-for-service and the other being value-based care. The challenge has been that it is hard to change the care delivery system this way. The shared vision needs to include all payers so that we can get out of the canoes altogether.

Let’s talk about examples of the models:

Reference-based pricing is fee-for-service. While it is easy to understand and gives the message of capping prices with immediate impact, the challenge from a value-based perspective is that it deepens the broken fee-for-service system and has the potential to cause more harm than good. Sure, in the short term, it would bring down prices. However, it perpetuates a perverse incentive of fee-for-service.

The Medicaid fix prospective payment is an example of a capitated model. This has worked well in Vermont.

I recommend **Hospital Global Budgets + Primary Total Cost of Care**:

Hospital Global Budgets could provide essential support to both hospitals and their communities. This approach is attractive to payers, as it helps manage the ongoing struggle over patient volume and utilization reviews. Although payers might face higher costs per admission, the overall reduction in preventable admissions can result in cost savings. Additionally, improved community health can yield long-term benefits for payers.

Primary Care Total Cost of Care Contracts provide incentives and payments for coordinated quality care. These models together will realign the delivery system and pay for outcomes, not volume. They also incentivize getting care to the right setting, which is often not a hospital. They allow for the flexibility to design home-based care innovations, virtual care, and test new models of care.

Why I wouldn’t recommend reference-based pricing as an intermediate step and what I would recommend in its place:

Reference-based pricing and value-based care are different approaches. Value-based care focuses on improving patient outcomes and controlling costs through quality care delivery, while reference-based pricing sets limits on reimbursements to lower overall healthcare spending.

- You are incentivizing the delivery of volume-based care.
- You run the risk of provider organizations and hospitals increasing volume.
- You deepen the cost shift.

- Services like the ones my team has built over the last two years become at risk of elimination or cuts to reduce costs when they are the ones required for transformation: Primary Care transformative work, Care Management Programs, Working to Reduce Readmissions program, (WRAP), and Chronic Disease Management.
- If you reduce costs to the point where you can no longer pay competitive salaries for providers, the workforce will leave as we are in a national market.

Reference-based pricing and global budgets have the similar goal of reducing the cost of care. But only global budgets build in the incentives to actually achieve that goal.

When implementing reference-based pricing:

- Prices should be adaptable to fluctuations in supply, demand, and industry shocks.
- Setting or capping prices requires risk adjustment:
  - The cost of delivering the same service can vary greatly depending on the patient.
  - For example, a hip replacement for a patient with multiple health issues will be more expensive than for a patient without complications. If prices don't account for these differences.
  - Prices should reflect the quality of services or outcomes delivered. Measuring and rewarding quality is difficult, but it is crucial to reduce the incentive for providers to respond solely to price.

Instead, I recommend an immediate transition to total cost of care contracts with a transition to global budgets. Total cost of care contracts allow for the flexibility needed to determine where to invest and where to make changes including reducing prices. These contracts should include quality elements as well as financial targets and outcomes. This aligns the goals of payers and providers.

For example, a payer and a provider use population-level data to determine a mutually agreeable per-member-per-month rate and method to define the population. The provider then needs to manage within that budget while maintaining quality. Often, quality measures are negotiated in that process. The result is to cap payer risk and incentivize providers to manage populations and deliver high-quality care more efficiently.

Both global budgets and total cost of care require access to timely data, specifically claims data. Unlike clinical data, which is often limited to information collected within a specific healthcare organization, claims data provides a longitudinal record of patient encounters across the healthcare system, including hospitalizations, outpatient visits, prescriptions, diagnostic procedures, and more. By sharing this data with providers, payers can create a comprehensive view of a patient's healthcare history, allowing for more effective population health management.

In closing, we are in this together. I believe in Vermont: our families, communities, and neighbors are depending on us.