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## After single payer failed, Vermont embarks on a big health care experiment



*Doug Greenwood talks about his health with Anne-Marie Lajoie at Cold Hollow Family Practice in Enosburg Falls, Vt.*

By [Carolyn Y. Johnson](#) September 17, 2017

ENOSBURG FALLS, Vt. — Doug Greenwood lifted his shirt to let his doctor probe his belly, scarred from past surgeries, for tender spots. Searing abdominal pain had landed Greenwood in the emergency room a few weeks earlier, and he'd come for a follow-up visit to Cold Hollow Family Practice, a big red barnlike building perched on the edge of town.

After the appointment was over and his blood was drawn, Greenwood stayed for an entirely different exam: of his life. Anne-Marie Lajoie, a nurse care coordinator, began to map out Greenwood's financial resources, responsibilities, transportation options, food resources and social supports on a sheet of paper. A different picture began to emerge of the 58-year-old male patient recovering from diverticulitis: Greenwood had moved back home, without a car or steady work, to care for his mother, who suffered from dementia. He slept in a fishing shanty in the yard, with a baby monitor to keep tabs on his mother.

This more expansive checkup is part of a pioneering effort in this New England state to keep people healthy while simplifying the typical jumble of private and public insurers that pays for health care.

The underlying premise is simple: Reward doctors and hospitals financially when patients are healthy, not just when they come in sick.

It's an idea that has been percolating through the health-care system in recent years, supported by the Affordable Care Act and changes to [how Medicare pays for](#) certain kinds of care, such as hip and knee replacements.

But [Vermont](#) is setting an ambitious goal of taking its alternative payment model statewide and applying it to 70 percent of insured state residents by 2022 which — if it works — could eventually lead to fundamental changes in how Americans pay for health care.

“You make your margin off of keeping people healthier, instead of doing more operations. This drastically changes you, from wanting to do more of a certain kind of surgery to wanting to prevent them,” said Stephen Leffler, chief population health and quality officer of the University of Vermont Health Network.

Making lump sum payments, instead of paying for each X-ray or checkup, changes the financial incentives for doctors. For example, spurring the state’s largest hospital system to invest in housing. Or creating more roles like Lajoie’s, focused on diagnosing problems with housing, transportation, food and other services that affect people’s well-being.

Critics, however, worry that it will create a powerful tier of middlemen charged with administering health-care payments without sufficient oversight. Those middlemen are Accountable Care Organizations, networks of hospitals and doctors that work to coordinate care and can share in the rewards if providers are able to save health-care costs, but remain on the hook if costs run too high. In Vermont, the goal is to limit the growth in overall annual health care spending to 3.5 percent each year.

It will put a new burden on primary care doctors to keep people healthy — potentially punishing providers financially for patients’ deep-rooted habits and behaviors. And the core idea of increasing outreach to [high-risk patients](#), though sensible on its surface, may not [control health spending](#); [one study](#) found the approach was unlikely to yield net savings.

“I think this kind of model could be very good if it’s implemented the right way. There’s a big question on whether it will be implemented the right way,” said Amy Cooper, executive director of HealthFirst, an association of independent physicians in Vermont.

The current initiative is Vermont’s second attempt to revolutionize health care. It was the first state in the country to embrace a government-financed universal health-care system but [abandoned the plan](#) in late 2014 because of concerns over costs.



*John Graves sits in his apartment in South Burlington, Vt. He lives at an apartment complex that is part of a program to provide housing for former homeless people, as well as help them enroll in health care and other programs. (Jacob Hannah/For The Washington Post)*

To hear Al Gobeille, a restaurateur turned Vermont human services secretary, tell it, paying for insurance coverage is just one of the big problems facing the American health-care system. The other, even more complicated one is reducing the underlying cost — and that is what Vermont is trying to tackle.

In 2015, a health insurance plan cost a family \$24,000 in premiums, Gobeille said, and by 2025, that is projected to grow to \$42,000.

“There’s going to be a calamity. No family is going to be able to afford that,” Gobeille said. “So it’s important to move to a system that aligns more closely to the growth of our economy.”

This year, 30,000 Medicaid patients — like Greenwood — have transitioned into the experimental model through a pilot run by the accountable care organization OneCare Vermont. The system uses software to flag people with complex medical needs and chronic health conditions and to coordinate care and support for those deemed at high risk. Instead of billing for each overnight stay or medical scan, hospitals receive an upfront monthly payment to manage the care for every patient assigned to them, and primary care practices receive payments to help with the outreach work.

“It’s creating a situation where the physicians and hospital leaders and other clinicians in Vermont feel like they have enough support and structure around them that they can fundamentally pursue changes in their clinical models and their business models,” said Andrew Garland, vice president of external affairs and client relations at BlueCross BlueShield of Vermont. “It has us all rowing in the same direction.”

Garland said BlueCross is in discussions to move a segment of its members — including individuals and small businesses who buy plans through its Affordable Care Act exchange — into the new payment model next year.

Other states are embarking on similar efforts to cut health-care spending, on both sides of the partisan divide.

Arkansas’ Medicaid program has collaborated with private insurers to shift payments around discrete “episodes of care” — such as asthma and congestive heart failure. “By having Medicaid and Blue Cross on the same page, we got the providers’ attention,” said William Golden, medical director of the medical services division at the Arkansas Department of Human Services.

In 2014, Maryland started giving hospitals an upfront budget for the year, to incentivize providers to keep patients healthy.

“The real magic here is when you get the payers — Medicare, Medicaid and the commercial payers, saying the same thing to the delivery system. Vermont is trying to do it one way . . . Arkansas is trying to do it with more coordination between Medicaid and Blue Cross,” said Christopher Koller, president of the Milbank Memorial Fund, a foundation focused on improving health. “States like Maryland, Vermont are really trying to get at the underlying cost.”

As Vermont retools how it pays for health care, the health system itself is already evolving — with an emphasis on services that fall far outside the traditional domain of medicine.

Vermont's major hospital system has put up the money to allow community partners to buy and refurbish housing, building off earlier success of buying blocks of nights for temporary stays at a motel run by the Champlain Housing Trust. After three years, costs for hospital stays dropped by \$1.6 million, accompanied by a large drop in readmissions.

That led the University of Vermont Medical Center to put up the cash this year to enable the housing trust to buy and convert a roadside motel in Burlington into a landing spot for patients who don't need to be in a hospital, but don't have a suitable place to return.

A hospital-owned family medicine practice in Colchester has set up "health-care share" day on Thursdays, when families can pick up a box of fresh vegetables prescribed by their family doctor.

Kari Potter, 34, said that the farm share has changed how her family eats. She makes all her own sauces, she said, loading a bag of veggies and two chickens into her car, and the weekly delivery has helped the kids learn to appreciate healthy snacks, even just thinly sliced cucumbers.

Most of these changes seem sensible, and they may even improve patient health. The question will be whether they save money in the long run. In Vermont, there are fears that only the biggest hospital systems that have the wiggle room to assume risk and sustain financial losses will survive.

It is also unclear how patients will react, as the pilot is expanded beyond Medicaid recipients.

During his appointment, Greenwood was firm that he had no real complaints about his life and didn't think he needed any particular support.

"Any problems with depression or anxiety?" Lajoie asked. Greenwood said no and Lajoie gently tried to prod him for more information — "meaning you don't have any sadness feelings?"

"No," Greenwood said. "If I do, they ain't bad."

When she asked if his health ever got in the way of visiting friends, he chuckled.

"I don't visit with friends," Greenwood replied. "Just watch soap operas."

Lajoie made notes to revisit his chewing tobacco habit and find out if he needed additional support in a month. The trick to this job is finding the ways that they can support people, which may not always be obvious — to the care coordinator or to the patient.

"We're not here to judge them or anything. Sometimes we don't understand what we can actually help them with," Lajoie said. "It's a learning thing, together."