

Vermont Legislative Joint Fiscal Office

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ISSUE BRIEF

Date: October 21, 2016

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DRAFT FOR DISCUSSION

This draft reflects issues raised in conversations about the All-Payer Model to date. JFO may update this Issue Brief in the future pending further information.

All-Payer Model – Potential Benefits, Risks and Outstanding Questions

Description

Purpose: The All-Payer Model is designed to change the way health care payments are made from fee-for-service to a value-based, prepaid service model across all payers: Medicare, Medicaid and commercial payers. The proposed agreement is to run from January 1, 2017, to December 31, 2022.

Goals: The Administration states the goals as follows:

1. Improve the patient experience of care
2. Improve the health of populations
 - Improve access to primary care
 - Reduce deaths from suicide and substance abuse
 - Reduce the prevalence and morbidity of chronic disease
3. Reduce per capita growth in the cost of health care from 2018 to 2022
 - Limit health care cost growth to no more than 3.5% in aggregate across all payers
 - Limit Medicare cost growth to 0.1% to 0.2% below the projected national per beneficiary growth rate

One-time Support Directly to the State: Under the proposed agreement, in 2017 CMS will pay \$9.5 million in one-time funding to the State for the Blueprint for Health, Support and Services at Home (SASH), and ACO infrastructure. Subsequently, Medicare will continue to fund a portion of SASH and Blueprint by including those dollars in the Medicare base for ACO payments. Medicare funding for SASH and Blueprint would have otherwise expired on 12/31/2016.

Spending Targets: The All-Payer Per Capita Cost Growth Target¹ is set at 3.5% for “APM financial target services,” referred to here as “included services” and roughly equivalent to Medicare Parts A and B. Any increases in Medicaid reimbursement rates will not count toward the target. The Medicare Per Capita Cost of Care Growth Target is set at 0.1% to 0.2% below the projected national Medicare growth rate. In the first two years, only the included services for attributed lives are relevant for both targets. If actual health care cost growth for included services exceeds 4.3% per capita in 2018 through subsequent years,

* Joyce Manchester with Stephanie Barrett, Catherine Benham, Stephen Klein, and Nolan Langweil

¹ The target is adjusted to account for the composition of the resident population by age group and acuity.

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Vermont may be asked to submit a prospective plan for corrective action to CMS. The State would incur no direct financial penalties other than paying its share of any additional costs.

Structure: The All-Payer Model is a 6-year agreement, starting in January 2017 and running through December 2022. 2017 (Year 0) is the base year for measuring cost growth retrospectively, meaning that evaluators will use data to determine actual spending in 2017 and compare it to actual spending growth in 2018 through 2022 (Years 1-5). A similar procedure will apply to measuring cost growth in included services in 2018 and 2019.

Phase In: The percentage of Vermonters aligned to an ACO is expected to grow as the number of participating providers and payers grows. The types of included services will grow over time as well. Medicaid Long-Term Institutional Services will be included beginning in 2021 (Year 4), but how additional services will be added is not yet specified. The following beneficiary targets are laid out in the agreement:

Scale Targets: Percentage of Vermont Beneficiaries Aligned to an ACO

Percent (%)	By end of PY1 (2018)	By end of PY2 (2019)	By end of PY3 (2020)	By end of PY4 (2021)	By end of PY5 (2022)
Vermont All-Payer Scale Target Beneficiaries	36%	50%	58%	62%	70%
Vermont Medicare Beneficiaries	60%	75%	79%	83%	90%

Non-participating Payers and Self-Insured Employers: Providers are not required to participate in an ACO and would continue to receive fee-for-service payments in that case. Providers serving Vermonters who are covered by insurers that are not regulated in Vermont (such as Anthem BCBS of Massachusetts) will continue to receive fee-for-service payments for those patients. Self-insured employers may choose to participate in the ACO model or not.

Potential Benefits of the All-Payer Model

- Paying for outcomes rather than volume could result in better care
- Given that the current system is designed around preset rates and fixed payments, the new system should transfer to the provider the incentive to operate in a cost-effective manner, thereby potentially saving money throughout the system
- If the payment system results in reduced health care cost growth, Vermonters and our economy will benefit
- Medicare beneficiaries remain protected by federal law; access to care, services, providers and suppliers for Medicare beneficiaries will not be limited and includes all the same coverage, at a minimum, as original Medicare
- Medicare participation in the Blueprint for Health will continue; the specific payment mechanism to Blueprint providers will be determined
- Additional flexibilities are available through a Medicare waiver; for example, the requirements for access to skilled nursing facilities will be less stringent than under current regulations for ACO attributed Medicare beneficiaries

Risks – based on discussions with the Administration and GMCB

- **Cost Growth Cap:** The All-Payer Model relies on changes to the payment system and the regulatory process at the GMCB to keep per capita health care cost growth to 3.5% or less for included services. No financial penalties accrue to the State if that cost growth exceeds 4.3%. The State, Medicaid, commercial payers, self-insured employers, and households would have to pay for higher costs, of course. The ACOs could face sustainability risks if they cannot provide the included services at or below the capitated payment, and that risk could be passed along to contract partners in subsequent years. Payers other than the ACOs could face increased spending pressure if payments outside the ACO run hot. For example, only 38% of Medicaid spending is now in included services; nursing home care is outside initially.
- **State Management:** The implementation of this change requires a knowledgeable staff, strong administrative skills, and comprehensive reporting to the federal government. With the upcoming changes in the executive branch, it is currently unclear if the commitment to make this system change a success will exist at the leadership level. GMCB membership is designed by the legislature to withstand administration changes with staggered, 6-year terms.
- **Transition:** Aligning Medicare, Medicaid and participating commercial payers will require much work and many operational changes for the State. It is not clear if the costs of the work can be paid for using existing funding, what technological changes are needed, or if the proposal has built in adequate time to address those changes.
- **Regulatory Structure:** Will regulators have the ability to oversee a single large ACO that could provide care for up to 70% of Vermonters and 90% of Medicare beneficiaries? Will the data exchange system be reliable among all providers? How will the current GMCB regulation of hospital budgets and payer rates fit with APM regulation?
- **ACO Administrative Costs:** Will the new ACO entity add to overall administrative costs, or will administrative costs of providers fall to offset the new ACO expenses? How will the administrative costs in the ACO be made transparent?
- **ACO Administrative Structure:** As the APM seeks to include more providers, a risk exists that it will not adequately represent all groups of providers. For example, who will speak for primary care physicians who primarily serve a rural and low-income population? Initially, OneCare will be the single ACO in the State, and it is primarily controlled by the University of Vermont Medical Center and Dartmouth-Hitchcock Medical Center.
- **Payment Coordination:** Billing reconciliation between the ACO, providers, and payers represents a new structure that will take time to develop and could entail some risk.
- **Patient Choice:** Patients who change providers mid-year could move into or out of the ACO. Medicare procedures are in place to provide retrospective reconciliation. The Medicaid contract with the ACO will use prospective attribution.
- **Workforce Issues and Care Delivery Plans:** Over the long term, the goal is to increase access to primary care, but the short-term and long-term plans to address that goal are not clear.

Outstanding Questions

- **Spending Limits**
 - The goal for Medicare cost growth is 0.1% to 0.2% below national projected Medicare growth. Is this realistic? Given that Vermont had the 9th lowest level of

standardized, risk-adjusted per capita Medicare spending in the 65 plus age group in 2015, how much more can cost growth be constrained? Will the implementation of Next Gen in other states reduce their cost growth notably over the next few years and will this make it even more difficult for Vermont to achieve the cost growth reduction goals?

- **State Administration Resources**

- Will the GMCB and other agencies and departments request additional resources, data, analytical capacity, etc. to oversee, administer and regulate in future years? Will they have enough time to staff up with the resources already appropriated? Will the State be 100% responsible for all the operational costs that this change in systems entails? To what extent would available federal match reduce those costs? The State is not required to produce an independent evaluation, but will it rely entirely on federal evaluation?

- **Incentives to Shift Services**

- Will the ACO structure and list of included services create incentives to encourage providers to shift costs into non-included service areas such as pharmacy, mental health and substance abuse services to reduce included costs? Vermont will share its All Payer Claims Database with CMS—will CMS alone monitor and evaluate possible shifting of costs to non-included services?

- **Net New Spending**

- Of the estimated \$209M gross Medicaid spend over the 5-year period, how much is estimated net new spending (absent any potential system savings)?

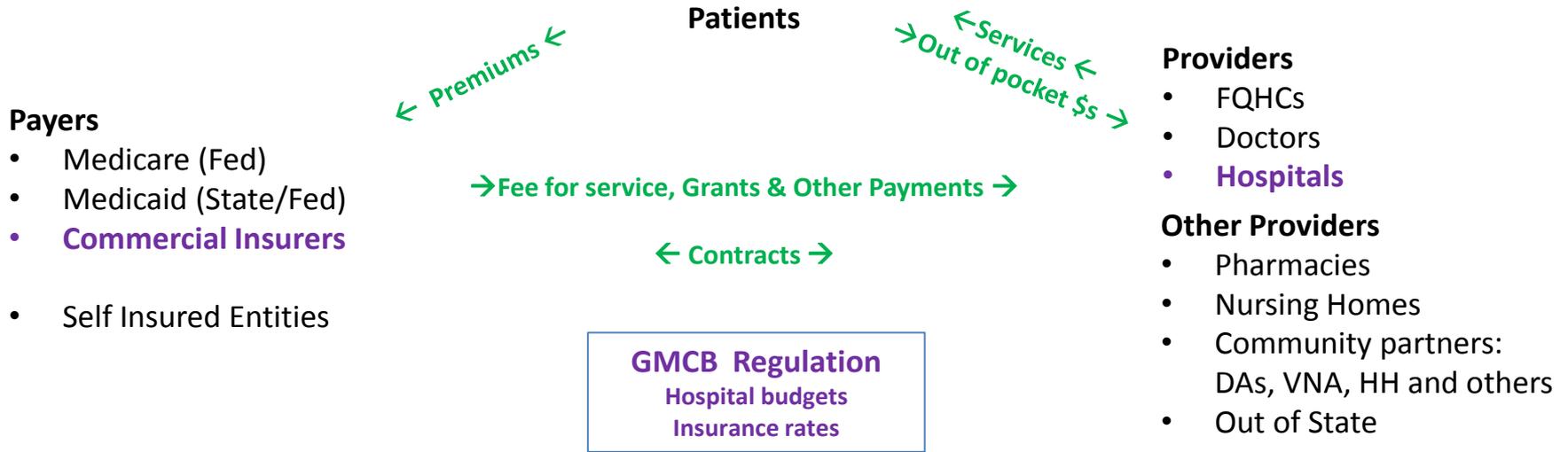
- **Role of the Legislature**

- The Legislature appropriates funds and oversees programs. Will the Legislature have access to information to enable it to carry out those functions?
- Over time, the State needs to add services such as substance abuse services, home-based services, and nursing home care to the All-Payer Model. Act 113 of 2016 created both a Medicaid Pathway Report and an ongoing reporting requirement on the integration of Medicaid services into the care continuum. Will those reports be useful in the planning and timing of adding services to the included services?
- The projections of financial savings reflect the medical system and services of today. Any other newly legislated changes to the system (such as mandatory coverage of certain services, etc.) could impact the expected system costs and savings. How would CMS treat increases in plan costs due to changes in required plan offerings?

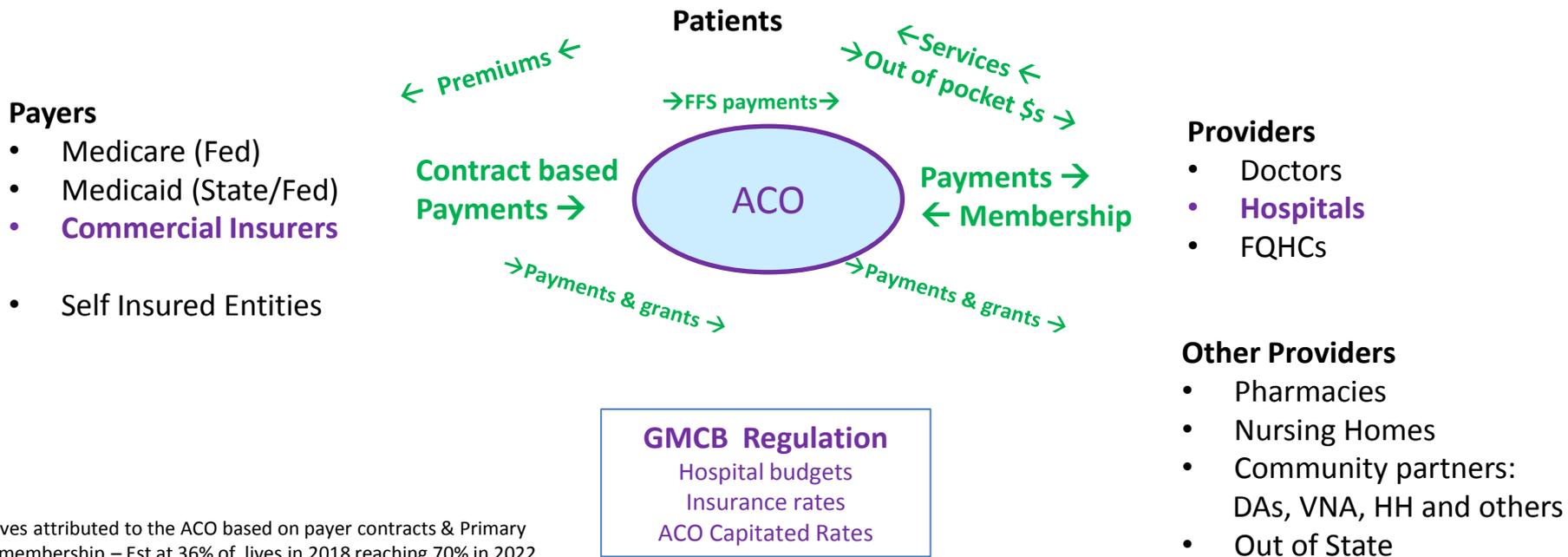
- **The ACO Model**

- The ACA embraced the ACO model as a way to change the delivery of health care. Over the past five years, however, published research has indicated that savings and quality improvement are generated much more often by independent primary-care doctors than by large hospital-centric health systems. In addition, lower-cost ACOs find it more difficult to reduce costs than higher-cost ACOs, and OneCare was in the bottom third of ACOs in the U.S. ranked by per capita costs. Given those findings, is it appropriate for Vermont to place its trust in the ACO model as a way to improve the quality of care and limit health care cost growth?

Current System Payment Mechanics



APM Payment Mechanics



Patient lives attributed to the ACO based on payer contracts & Primary Care Dr. membership – Est at 36% of lives in 2018 reaching 70% in 2022