Vermont's Transition to the All-Payer Model: Issues to Consider

Summary of the All-Payer Model (APM)

The State of Vermont is negotiating with CMS to secure Medicare waivers that would allow new ways of financing and delivering health care. An accountable care organization that joins the APM (the "APM ACO") would receive a risk-adjusted, capitated payment for each "attributed life" or member. The APM ACO would be responsible for all aspects of health care for its members, with the goal to create a highly integrated system of health care committed to both quality and efficiency. During the 5-year all-payer period (2017-2021), Vermont would commit to keeping per capita cost growth for regulated services[1] below the target of 3.5 percent per year, with a ceiling of 4.3 percent per year, and keeping Medicare cost growth 0.2 percent per year below nationwide per capita Medicare cost growth. Failure to meet the ceiling or Medicare savings can lead to a "corrective action plan."

1. What are the implications for contract management and evaluation in state government?

- How will DVHA and AHS interact with the APM ACOs in administering Medicaid services?
    - Will the APM ACO manage only the regulated services or will it have the incentive to manage Medicaid pharmacy costs, mental health and substance abuse services, and other non-regulated services?
    - What type of relationship will the APM ACO have with existing community providers who provide services outside the regulated services?
- What is the role of the GMCB?
    - How will the GMCB regulate the APM ACO?
    - What will need to change at the GMCB to regulate and monitor the APM?
    - Will the GMCB set payment rates for Medicare, Medicaid, and commercial insurers? Will the payment rates be the same for all payers for a given service at a given facility?
    - Will the GMCB approve capitation payments to APM ACOs?

[1] Regulated services, at least initially, do not include pharmacy services, for example, and do not include more than half of Medicaid services such as mental health and substance abuse services, long-term services and supports, and non-medical services.

- What safeguards will exist to ensure the APM ACO does not shift costs to non-regulated services, like prescription drugs?

- Who will evaluate how well the APM ACO is providing high-quality health care to Vermonters?

    - If quality measures showed deterioration over time or if beneficiaries filed complaints about the quality of health care provided, who would evaluate APM ACO practice?

2. What does this mean for state Medicaid and its payment practices and levels?

- Who determines payments for Medicaid -- the state or APM ACOs in negotiation with providers?
- How will an APM ACO manage utilization risk for Medicaid beneficiaries?
- Note that Vermont has filed for a 5-yr no-change extension for Global Commitment to extend it through 2021

3. How will cost savings across all regulated health care services be achieved, and how will they be distributed?

- The three Vermont ACOs already participate in shared savings programs with Medicare and Vermont commercial payers, and two Vermont ACOs are participating in a Vermont Medicaid shared savings program. How would the APM ACO be different?
    - In a shared savings program, the ACO provider network agrees to be tracked on total costs and quality of care for the patients it serves in exchange for the opportunity to share in any savings achieved through better care management. Provider participants in ACOs essentially have agreed that quality can be improved and health care costs can be reduced, and they will work together toward that goal.[2]
- The GMCB vendor Optumas cited national evidence indicating that moving to a stricter ACO structure with capitated payments tends to generate cost savings in the early years, followed by a return to the status quo. Given that Vermont already has ACOs, how would we achieve the slowdown in cost growth over the next 5 years?
    - How many providers will join the APM, and what percentage of lives will be attributed to the APM ACOs?
    - How will APM ACOs be able to create greater savings?
    - How will ACO providers distribute funds to the various providers, and how will they cover other costs such as IT infrastructure?
        - Medicaid

[2] http://healthcareinnovation.vermont.gov/sites/hcinnovation/files/SSP_and_ACO_FAQ_and_Chart_7.8.14.pdf

- Medicare reimbursement rates
- Private sector primary care, specialists, hospitals
- Payments for unregulated services: pharmacy for all payers; dental and SNF for commercial; dental, SNF, DAs, mental health, substance abuse, long-term services and support for Medicaid (Goal: integrated health system)

- How accurate are risk-adjusted capitation rates?
- Who bears the risk for ACO failure? Where do the risks lie?

4. Would the commitment to Medicare cost growth be achievable, and what are its implications?

- How will per capita Medicare cost growth in Vermont turn out to be 0.2% slower than in the U.S as a whole?
- Blueprint for Health is already underway and has slowed the growth of total Medicare spending for patients in participating practices; as indicated above, can we expect further savings from the APM ACO beyond the savings achieved in the early years of the Blueprint?
- As mentioned above, the three ACOs in Vermont already participate in shared savings programs with Medicare.
- Comparison for modeling Vermont's cost-saving comes from outcomes for the Pioneer ACO initiative cited in a study by L&M Policy Research
  - In 2012, Pioneer ACOs collectively had per-Medicare-beneficiary-per-month savings relative to near markets on physician services, inpatient hospital, hospital outpatient, skilled nursing facility, home health, hospice, and durable medical equipment.
    - The Pioneer model tested a shared savings and shared losses payment arrangement with higher levels of reward and risk than in the Shared Savings Program; in year three, Pioneer ACOs with savings in the first two years were eligible to move to a population–based payment model using a per-beneficiary per month payment amount.
  - Savings in Pioneer ACOs declined over time.
- Dartmouth Pioneer ACO cautionary tale

- Dartmouth dropped out of the Pioneer ACO program in October 2015.
- They had already accomplished many efficiencies in health care prior to Pioneer.
- They had to send patients to Boston for expensive specialty care.

- From 2017 forward, many Medicare providers in the rest of the country will also be using value payment methods.
  - NextGen is a new initiative in accountable care for Medicare that sets predictable financial targets, enables providers and beneficiaries greater opportunities to coordinate care, and aims to attain the highest quality standards of care.
    - NextGen ties 50% of U.S. Medicare payments and 90% of U.S. FFS Medicare payments to value or quality by the end of 2018.
    - OneCare Vermont, the state's largest ACO, was accepted into the NextGen Medicare program beginning in 2017; would OneCare prefer to join the APM?
  - MACRA is federal legislation (2015) that ends the SGR formula for determining Medicare payments for health care providers' services; sets up a framework for rewarding health care providers to give better care, not more care; and combines the existing quality reporting programs into one new system.
    - MACRA pays a 5% lump sum to physicians in 2019 on top of Medicare payments if they participate in ACOs, medical homes, or bundled payment arrangements (APM physicians will be eligible as well).