Consumer Principles for Vermont's All-Payer Model

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Introduction

Health care costs in Vermont have increased dramatically over the past few decades and are projected to continue to rise at an unsustainable rate without reform of the existing health care system. A recent report sponsored by Vermont's Legislative Joint Fiscal Office[1] estimates that Vermont residents spent $5.1 billion on health care in 2012, more than double the $2.3 billion spent on health care in 2000.[2] This figure is projected to grow to $6.8 billion by 2017.[3] Vermont Governor Peter Shumlin championed legislation, enacted in 2011,[4] to establish a single-payer health care system in the state. However, in 2014 the governor withdrew his support for such a system citing lack of a viable finance plan.[5]

With a single-payer system off the table for the foreseeable future, the governor and his administration are exploring other health care reform options that aim to reduce costs and move toward value-based care. One of these options is an all-payer model. Act 54 of 2015[6] directs the Agency of Administration and the Green Mountain Care Board to "jointly explore an all-payer model, which may be achieved through a waiver from the Centers for Medicare and Medicaid Services" (CMS). Under such a waiver the state would agree to restrict the growth of health care spending for a defined set of services by all health insurance carriers (Medicare, Medicaid, and commercial insurers) to a trend rate negotiated with CMS. CMS would agree to waive some of its rules to allow the state to implement payment methodologies such as global hospital budgets and capitated (per-person) or population-based payments to some health care providers. To implement the model, the state's three Accountable Care Organizations (ACOs) are planning to merge into a single statewide ACO[7] that would be responsible for managing the cost of care and care delivery for the population attributed to the model.

The goal of implementing an all-payer model would be to bring Vermont closer to achieving the triple aim: improve the patient experience of care including quality of care and satisfaction; improve population health; and reduce the per capita cost of health care.[8] The model would aim to change the financial incentives in the health care system, which currently reward high-volume care, to reward lower-volume higher-value care. An all-payer model would cause a drastic shift in the state's health care system and would

[1] Eibner, C., Nowak, S. A., Liu, J. L., & White, C. (2015). *The Economic Incidence of Health Care Spending in Vermont.* Santa Monica, Calif.: RAND Corporation.

[2] Green Mountain Care Board. (2012). *GMCB Dashboard Costs & Expenditures.* Retrieved May 3, 2015, from Green Mountain Care Board: *http://gmcboard.vermont.gov/sites/gmcboard/files/GMCB%20Dashboard%20Costs%20and%20Expenditures.pdf*.

[3] Eibner, C., Nowak, S. A., Liu, J. L., & White, C. (2015). *The Economic Incidence of Health Care Spending in Vermont.* Santa Monica, Calif.: RAND Corporation.

[4] Act 48 of 2011, *http://legislature.vermont.gov/assets/Documents/2012/Docs/ACTS/ACT048/ACT048%20As%20Enacted.pdf*.

[5] Vermont Public Radio, *Shumlin: It's 'Not The Right Time' For Single Payer*, Dec 17, 2014, *http://legislature.vermont.gov/assets/Documents/2012/Docs/ACTS/ACT048/ACT048%20As%20Enacted.pdf*

[6] Act 54 of 2015, *http://legislature.vermont.gov/assets/Documents/2016/Docs/ACTS/ACT054/ACT054%20As%20Enacted.pdf.*

[7] Community Health Accountable Care, HealthFirst, OneCare Vermont. *Vermont Integrated System of Care Memorandum of Understanding*, September 15, 2015.

[8] Institute for Healthcare Improvement, *The IHI Triple Aim, http://www.ihi.org/engage/initiatives/TripleAim/Pages/default.aspx*

require robust regulatory processes to ensure that cost reduction is not achieved at the expense of access to services, quality of care, population health, or patient experience.

The types of payment under consideration within the all-payer model, including global hospital budgets and capitated or population-based payments implemented by a single statewide ACO, carry a number of risks as well as potential benefits. Cited risks of these models include rationing care, cherry-picking or dumping patients, and sacrificing quality of care in favor of cost savings. An all-payer model could benefit Vermonters if these and other risks are sufficiently addressed in the model design.

As Vermont continues to plan and prepare for an all-payer model, policy makers must ensure that the interests of consumers are brought to the fore. Access to care, quality of care, consumer protection, consumer and patient engagement, and transparency must be pillars of the model. Focus must also be placed on addressing social determinants of health and integrating services across the care continuum. This paper aims to look at the all-payer model through a consumer lens and highlight key principles for the model based on the information available to date.

I. Access to Care: The all-payer model must improve access to care for Vermonters.

Access to health care is defined as "the opportunity or ease with which consumers or communities are able to use appropriate services in proportion to their needs."[9] Maintaining and improving access to care under the all-payer model must be a priority in the model's design. It is essential for systems to be put in place to monitor access to care and for consumers to have recourse if they face barriers to access.

Improving Access

There are currently well documented access issues for numerous services in Vermont, including mental health care, treatment for substance abuse, dental care, and primary care. From the outset, the all-payer model and the implementing ACO should focus on addressing the shortcomings of our current system, such as insufficient reimbursement rates and provider capacity for the above-mentioned services, to ensure that access rapidly improves. Lack of access to each of these areas of service has high downstream costs, both within and outside the health care system. While the financial incentives of an all-payer model align with finding solutions to these access problems, a proactive approach must be taken to ensure that they are addressed quickly and completely.

[9] Levesque et al., *Patient-centred access to health care: conceptualising access at the interface of health systems and populations*, International Journal for Equity in Health 2013, 12:18, *http://www.equityhealthj.com/content/12/1/18*

Additionally, within the all-payer model each hospital should focus on the issues raised in its federally required Community Health Needs Assessment. As the system unifies, it will become even more important for hospitals and other providers to listen to the needs of their communities and ensure that those needs do not get lost in the priorities of the larger organization.

Measuring Access

Measuring access to care is difficult but vital in a model that incentivizes cost reduction. The measures that have traditionally been used to measure access, such as having health insurance coverage and having a primary care provider, only capture a small segment of the concept. An all-payer model that incentivizes providers to cut costs will require measures of access that include not only things like a person's access to health insurance and a primary care provider, but also continuous monitoring to ensure that patients receive timely access to all of the services appropriate to their health care needs. When health care provider organizations shoulder financial risk, providers are incentivized to reduce the cost of care, including reducing services, even when they are appropriate. Timely, robust measures of access tied to the financial model would help mitigate this risk. Notably, there are no measures of access to care tied to payment in the current ACO shared savings program measure sets. Measures of access should be included at the population-, ACO-, and provider-level in an all-payer model to ensure that patients receive the appropriate level of care.

Opportunity for Appeals

Patients must have the opportunity to appeal the denial of services and to file grievances if they face access problems (see *III. Consumer Protection*).

Risk Adjustment

It is also essential to include appropriate risk adjustment in the model so providers do not have an incentive to refuse to see or withhold services from patients with more significant health problems or greater care needs. Without appropriate risk adjustment, access to care is likely to become a problem for higher needs patients.

II. Quality of Care: The all-payer model must improve health care quality.

Under an all-payer model, providers will be responsible for giving patients high-quality evidence-based care appropriate to their needs. The all-payer model must include implementation of care models designed to improve health care quality and outcomes. Health care payment reform is often described as a move toward accountable or value-based care. Assessment of value and accountability requires rigorous measurement of quality, including numerous measures of care delivery and patient outcomes covering all populations. Quality measurement tied to payment is one of the only ways to

counterbalance the incentive to cut costs at the expense of care quality and protect consumers from being under-served as a means of achieving savings.

Figure 1. Quality Measurement

Areas of measurement:

- Access to Care (see *I. Access to Care*)
- Care Delivery (Screening and Prevention, Evidence-Based Care, Care Management and Communication)
- Outcomes (Health Status, Quality of Life, Biometrics, Population Health)
- Patient Experience
- Social Determinants of Health

Populations:

- All Vermonters (Attributed and Non-Attributed)
- Children and Adolescents
- People with Disabilities
- Seniors
- Pregnant and Non-Pregnant Women

It is essential to measure a diverse range of services and outcomes to provide a comprehensive picture of the quality of care that patients receive. The areas of measurement and populations listed in Figure 1 should be included in the measure sets.

Preliminary information about the design of the all-payer model being considered for Vermont indicates that there will likely be three categories of measures: statewide or population-level measures, ACO-level measures, and provider-level measures. These categories provide ample opportunity for quality measurement and should each include a robust set of measures tied to payment.

The statewide or population-level measures should be consistent with and encourage progress toward the goals included in Vermont's State Health Improvement Plan (SHIP)[10] and the state's Healthy Vermonters 2020 (HV2020)[11] initiative. Drawing population health measures for the all-payer model from the SHIP and HV2020 indicators, which are already measured in the state and include public health and outcome measures, would provide balance to the clinical measures that are likely to form the foundation of the measure sets.

The ACO-level measures should be far more comprehensive than the measure sets used in Vermont's current ACO shared savings programs. The existing ACO measure sets are too limited to adequately assess quality of care. Prior to the start of the second year of the state's Medicaid shared savings program, CMS noted that there were too few outcomes-based measures tied to payment in the program.[12] Measuring quality of care will become increasingly important as incentives in the health care system change. As payment

[10] Vermont Department of Health, State Health Improvement Plan, *http://healthvermont.gov/hv2020/ship.aspx*

[11] Vermont Department of Health, Healthy Vermonters 2020, *http://healthvermont.gov/hv2020/report.aspx*

[12] Vermont Health Care Innovation Project, Quality and Performance Measures Work Group, Attachment 4E - DVHA Memo on CMS Recommendations, April 28, 2014, *http://healthcareinnovation.vermont.gov/sites/hcinnovation/files/QPM.4.28.14.Merged.Meeting.Materials.v2pdf.pdf*

methodologies are determined under the new model, additional measures must be tied to payment to ensure that the areas and populations outlined above are adequately covered.

The provider-level measures should focus on evidence-based care and should be specific to the practice area of the provider or practice, including specialties. While we support the focus on primary care that has been central to health care reform in Vermont, much of the over-testing and over-treatment in the health care system happens in specialty care. The use of evidence-based medicine by specialists should be a tenet of the model and must be assessed.

III. Consumer Protection: Consumer protections must be put in place to ensure that the all-payer model improves access to and quality of care for all Vermonters.

Provider Choice

One of the frequently cited differences between Accountable Care Organizations (ACOs) and the Health Maintenance Organizations (HMOs) that were prevalent at the end of the last century is that in the ACO model, patients maintain freedom of choice and may seek care either within or outside the ACO. In an all-payer model with a single ACO, patients will still be able to see any provider within their insurer's network. However, if most or all providers are part of the same ACO, patients may not have the option to seek care outside the ACO. Even if there are providers outside the ACO, the all-payer payment methodology will likely incentivize providers to make referrals and encourage patients to get their care within the ACO, since the ACO will be responsible for patients' cost of care regardless of where they receive services.

Lack of provider choice, or perceived lack of provider choice, will be especially problematic if the ACO puts protocols into place that prohibit or limit services that might be the right care choice for some patients. While in many cases providers will be incentivized to make appropriate care decisions (e.g., providing more primary care services to prevent future emergency department visits), there are also many instances in which the most cost-effective option is not the right choice for every patient. If patients are limited to care within the ACO, and all ACO providers share the incentive of cost savings (and potentially use the same care protocols), patients could experience significant issues accessing necessary care. Appropriate regulations and protections must be put in place to ensure that patients are able to get all of the care that is appropriate to their needs.

Quality Measures

The other frequently cited difference between HMOs and ACOs is that ACOs include quality measures meant to ensure that costs are not cut at the expense of access and quality. However, the current ACO shared savings program measure sets barely scratch the surface of quality of care and do not measure access. Comprehensive measure sets tied to payment and regulation are an essential component of consumer protection under an

all-payer model and must be collected and monitored from the outset (see *II. Quality of Care*).

Regulation

Regulation and consumer protection must be core elements of an all-payer model. Whereas in our current health care system insurers largely make determinations about medical necessity and providers largely advocate on behalf of patients, under a model in which providers bear financial risk these roles change. Providers and provider organizations will have a financial incentive to save money and may deny medically necessary services to patients in order to cut costs. Therefore, robust regulations including avenues for filing appeals and grievances related to provider denials of service must be put in place.

Under a model where providers bear financial risk, consumers must have the right and be aware of their right to appeal the denial of a service and to file complaints and grievances with an independent entity, such as the Office of the Health Care Advocate. These complaints must be tracked and analyzed in a timely manner so that patterns of undertreatment and barriers to access can be identified and addressed as early as possible. The Department of Financial Regulation must also monitor and report on consumer complaints.

Additionally, if the all-payer system is going to be unified and integrated, the Green Mountain Care Board's regulatory processes must also be unified and integrated so the system can be reviewed in an integrated way. The fragmented regulatory system that exists today, in which each component of the system is reviewed independently, is not currently sufficient and will become less so as the rest of the system consolidates. . It will become increasingly ineffective to look at insurance rates, ACO and hospital budgets, certificates of need, quality of care, and other areas separately. For regulation to be successful, it must be done comprehensively with a systematic approach.

IV. Consumer and Patient Engagement: The state, the ACO, and individual providers must engage patients and consumers as the all-payer model is implemented.

Consumer Engagement

A recent report[13] by Families USA on consumer engagement in State Innovation Model (SIM) demonstrations noted numerous gaps in consumer engagement in Vermont's SIM structure. Vermont received low scores on consumer involvement in SIM governance, including decision-making, advisory, and working group processes. Consumer engagement in health care reform will be particularly important as the state shifts to a model that is

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[13] Families USA, *State Innovation Model (SIM) Grants: A Scorecard for Consumer Advocate Engagement*, Sept. 2015, *http://familiesusa.org/sites/default/files/product_documents/HST%20SIM%20Scorecard%20brief_web.pdf*

intended to both reduce costs and improve care and that will directly affect the care that patients receive and the ways in which care is reimbursed. The governance structures and decision-making processes in the new model must include consumer representatives and take the consumer perspective into account. If Vermont moves to a single ACO, the standards currently in place for ACO governance should apply to the new entity, including consumer representatives for each participating payer on the ACO governing body and a robust consumer advisory board.

Consumer Education

The proposed all-payer model will mean drastic changes to Vermont's health care system and will require a significant amount of consumer education in order to gain buy-in from the public. It is important for consumers to understand the changes to expect and their rights under the new model. The state should plan a multifaceted outreach campaign to relay information about the model to consumers and to ensure that patients know what to expect when they visit their providers. Consumer education should include information about how to file an appeal and whom to contact to make a complaint. It should also explain clearly to consumers how they will be charged for services delivered in a global budget or capitated payment system.

Patient-Centered Care

It is essential that the models of care implemented under the all-payer model are patient-centered and focused on delivering appropriate, evidence-based care. Implementation of evidence-based practices will require providers to engage with and educate their patients to ensure that patients' needs are met and that patients understand their options. The model should require providers to implement and expand upon existing evidence-based medicine programs, such as Choosing Wisely,[14] which includes extensive patient education materials as well as provider materials. Providers should also be required to adopt patient-centered approaches to care such as Shared Decision Making[15] to ensure that patients are active participants in their care decisions and understand the costs and benefits of their treatment options.

V. Transparency: Planning, implementation, and governance of the all-payer model and single ACO must be transparent and include input from stakeholders and the public.

If the state moves forward with an all-payer model and single ACO, the planning and implementation processes must be transparent and input should be solicited from anyone affected by the model, including stakeholder organizations and consumers. The model is unlikely to succeed without buy-in from a wide variety of stakeholders and the public. Buy-in will require that stakeholders and consumers understand the model and its

[14] ABIM Foundation, *Choosing Wisely*, *http://www.choosingwisely.org/*
[15] Mayo Clinic Shared Decision Making National Resource Center, *http://shareddecisions.mayoclinic.org/*

potential effects. Additionally, once the model is in place, the governance and operations of the implementing organization must be fully transparent including public meetings of the governing body.

Financial Accountability

The ACO implementing the all-payer model must be transparent and accountable to the people it serves. As the health system moves toward a monopolistic single provider organization, administrative costs within the system, including executive pay, must be examined. In addition to health care providers, organization and hospital leadership should be held accountable for cost and quality in the system.

VI. Social Determinants of Health: Concrete steps must be taken to address social determinants of health under the all-payer model.

There is ample evidence that socio-economic factors such as income, housing, and employment, and environmental factors play a significant role in health outcomes and the cost of care. A recent Prevention Institute report[16] on Accountable Communities for Health commissioned by the SIM Population Health work group notes that social determinants of health must be taken into consideration as an all-payer model is implemented in Vermont. The report states that concrete steps must be taken to address social determinants in order to ensure that quality and cost-saving initiatives are effective and sustainable. Since the all-payer model is likely to be based on a medical model with hospitals at its center, it is especially important for strategies to address social determinants to be included from the outset.

VII. Integration: Under the all-payer model there must be integration and coordination across the full continuum of care.

Regardless of which services are initially included in the total cost of care in the all-payer model, it is extremely important for systems to be developed to integrate and coordinate all patient care needs, including services that are not part of the original payment model. It is particularly important for mental health, substance abuse, and disability and long term services and supports providers to be included in the development and implementation of care models that are implemented under the all-payer system. The ACO must work with the existing infrastructure in the state and ensure that providers of these essential services are not left behind as the new model is developed and implemented. This will require devotion of resources to education so that medical

[16] Prevention Institute, *Accountable Communities for Health: Opportunities and Recommendations*, July 2015, *http://healthcareinnovation.vermont.gov/sites/hcinnovation/files/Pop_Health/VT%20ACH%20Opportunities%20and%20Recommendations.pdf*

providers are adequately trained on the scope of long term services and supports and the impact of supports on social determinants of health.

Additionally, as the state moves toward an integrated system, the goal must be to move toward inclusion of all services in the financial model with sufficient funding for each area. Inclusion of and appropriate funding for things like disability and long term services and supports will prevent unwanted downstream monetary and health outcome costs. While all services should not be included at the outset of the model without sufficient preparation, the state will not have a fully integrated system as long as there are categories of service that are excluded. Additionally, including some services and excluding others will affect the incentives in the model. In some cases, this could result in extremely problematic consequences. For example, excluding the cost of long term care from the model may create an incentive for the ACO to encourage placement of patients in nursing homes. It is hard to predict what the unintended consequences of exclusion of large parts of the system from the model might be. Concrete steps must be taken to prepare the state to include all services in the model.

In Conclusion

Implementation of an all-payer model in Vermont will give the state the opportunity to improve its health care system and provide better care to patients while controlling the growth of health care costs. However, for the model to achieve these goals its risks must be mitigated and the consumer perspective must be taken into account. Health care reform in Vermont is often referred to as "provider-led." While health care provider input and investment are essential to the success of health care reform, the changes that an all-payer model promises will have significant impacts on patients, the care they receive, and how that care is paid for. The patient perspective should be central to the planning and implementation of an-all payer model in Vermont.