VERMONT

Green Mountain Care Board
144 State Street
Montpelier, VT 05602

802-828-2177
www.gmcboard.vermont.gov

Governor Phil Scott
Secretary Martha Maksym, Agency of Human Services (AHS)

August 23, 2019

Dear Governor Scott and Secretary Maksym:

We applaud your support of Vermont's All-Payer Accountable Care Organization Model (All-Payer ACO Model, or APM) and its goals of ensuring that health care costs remain in line with the growth of the Vermont economy while sustaining high-quality care and improving access to primary care for Vermonters. I am writing on behalf of the Green Mountain Care Board (GMCB, or "the Board") in the midst of our annual review of Vermont hospitals' budgets and following a very tough health insurance premium review season, to express concerns about the affordability of health care in Vermont and about barriers to the further success of Vermont's APM.

This year, the Board saw a double-digit increase in commercial health insurance premiums for the individual and small group market. In addition to growing pharmaceutical costs, increased use of medical services, and changes to state and federal policies, a concerning factor behind this increase has been termed "the cost shift." The cost shift is due to uncompensated care and disparities in reimbursement amounts between governmental (Medicare and Medicaid) and commercial payers; to make up for low reimbursement rates from governmental payers, providers charge higher prices (shift costs) to commercial insurers and those who pay for their care out-of-pocket (self-pay). The actual cost shift for Vermont hospitals in FY2018 was $458 million with Medicaid accounting for $207 million[1], and it grows annually: Based on FY2019 hospital budgets, we estimate the total cost shift at approximately $493 million, with Medicaid accounting for $217 million. In their 2020 filings, many Vermont hospitals reiterated the cost shift as a driver of their commercial price increase requests.

While commercial rate increases were approved at 12.4% for BCBSVT in 2020, down from the requested 14.3% - 14.5%, State of Vermont Medicaid appropriations for health care services increased by just 0.9% over 2019; this increase fails to keep up with the rate of inflation. BCBSVT quantifies that if the cost shift were eliminated by 2020, it would lead to a rate *decrease* of 16.8% from 2020 filed rates.[2] With almost half (45%) of Vermonters relying on Medicaid and Medicare as their primary health plan and an aging population, these effects are only likely to be magnified in the foreseeable future.[3]

In addition to contributing to health care's unaffordability, the cost shift threatens Vermont's transition from fee-for-service to value-based payments by increasing risk to both providers and insurers when negotiating a per-member per-month payment system.

The cost shift is also a barrier to achieving the targets outlined in the All-Payer ACO Model – including containing health care cost growth, achieving Model scale and alignment across payers, and maintaining and improving health care quality – for which the Office of the Governor, Agency of Human Services, and Green Mountain Care Board are jointly responsible. For example, the cost shift endangers Vermont's ability to recruit hospitals from rural or poor communities to the ACO, because they are less likely to recoup their costs due to disproportionate

[1] 2018 GMCB Annual Report to the Legislature (January 15, 2019), available at: https://legislature.vermont.gov/assets/Legislative-Reports/GMCB-2018-Annual-Report-1-15-2019.pdf.
[2] Blue Cross Blue Shield of VT 2020 Individual & Small Group Rate Filing, GMCB-006-19rr, Tr. at 187-189 (July 23, 2019).
[3] See 2017 Vermont Health Care Expenditure Analysis, Health Insurance Coverage Profile 2014-2017 (pg. 42), available here: https://gmcboard.vermont.gov/sites/gmcb/files/2017_Expenditure_Analysis_with_projections_March_27_2019.pdf.

reliance on Medicare and Medicaid. Through Vermont's APM Agreement with the Centers for Medicare and Medicaid Innovation (CMMI), the Board has some ability, within the agreed upon growth targets, to ensure that per capita Medicare payments to the ACO grow fairly over time. The APM Agreement recognizes that the cost shift has the potential to negatively impact Vermonters and Model's success, and requires the GMCB, in collaboration with AHS, to assess these impacts in a report due at the end of this year and to propose solutions to reduce the cost shift by the end of 2020.

In addition to the challenges to affordability and provider solvency created by the cost shift, hospitals are disproportionately shouldering the cost of delivery system reform (DSR) – another barrier to APM success. Specifically, 53% of the ACO program funding comes from hospitals.[4] To the extent that hospitals have no choice but to raise commercial prices to fund DSR, the burden largely falls on commercial premium payers. As you know, the sustainability of Vermont's small critical access hospitals (CAHs) is a pressing issue we are all monitoring, and we are concerned that shifting the majority of the responsibility for DSR implementation to these hospitals has resulted in additional financial pressures. In addition to the concerns of cost outlined above, federal disproportionate share (DSH) payments have declined, another pressure on hospital revenues.

The Centers for Medicare & Medicaid Services (CMS) made funds available for DSR Investments when the Global Commitment to Health waiver was renewed in 2017.[5] To date, there has been minimal use of the DSR funds to assist with one-time start-up costs of the ACO program, including costs associated with OneCare Vermont (OCV), community-based providers, and other partners. OCV's contracts[6] with the Department of Vermont Health Access (DVHA) reflect $2.5M in DSR Investments for CY2018[7] and $10.8M in DSR and Health Information Technology (HIT) investments in CY2019.[8] The SFY2020 DVHA budget requested a *reduction* of $1.88M in DSR Investments from the base budget; however, we believe the DSR investment remains at $2.6M. This totals approximately $16M to date. There remains approximately $56M in capacity ($32M in 2020 and $24M in 2021).[9]

While we recognize that the Scott Administration is concerned about hitting the Global Commitment to Health waiver's budget neutrality cap, we are concerned that the lack of support early in the Model for these reforms has made it difficult for the ACO to implement its programs.

We understand that limited revenue, tight budgets, and limits on investment funds make it challenging to choose to invest Medicaid funds in health care reform at this time. Without Medicaid support, however, the investment in health care reform falls disproportionately on hospitals, Vermonters and employers in the commercial market, and those who self-pay. We urge you to consider these impacts and to prioritize affordability and health care reform by considering increasing your investment in Medicaid and DSR.

Sincerely,

Kevin Mullin, Chair, GMCB

Cc: Ena Backus, AHS Director of Health Care Reform, Cory Gustafson, Commissioner, Department of Vermont Health Access, Jason Gibbs, Chief of Staff

---

[4] OneCare Vermont Board of Managers Minutes, July 16, 2019 (pg. 57), available here: https://www.onecarevt.org/wp-content/uploads/2019/06/Public-Packet-BOM-7-16-2019-2.pdf.

[5] See Section 1115 Waiver Term and Condition, 83.

[6] GMCB does not have access to DVHA's actual expenditures; amounts reflect materials submitted by OneCare Vermont through the Board's ACO regulatory process.

[7] The SFY2020 DVHA budget book shows $1.787,375 in DSR investments in SFY2018 (Appendix A, pg. 160).

[8] The SFY2019 DVHA budget book requested $2.6M in DSR Investments (pg. 146).

[9] Slide 14, https://gmcboard.vermont.gov/sites/gmcb/files/files/VT-AP-ACO-MODEL-Final-9-29-2016.pdf