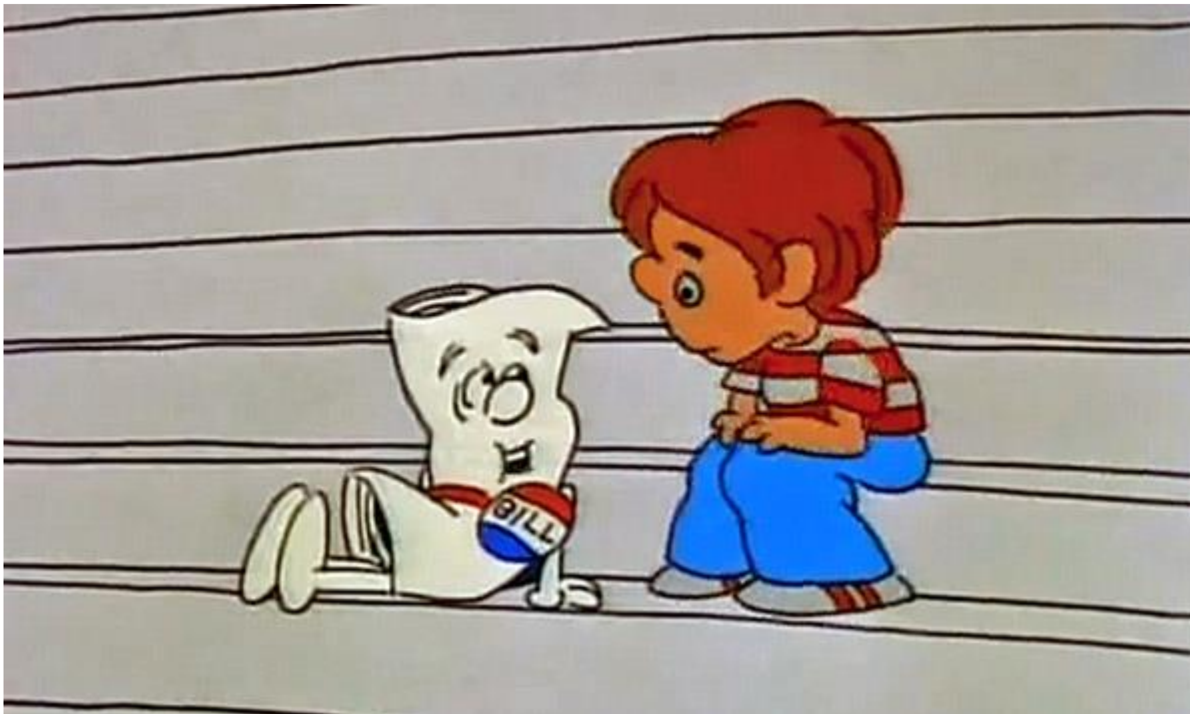
GMCB Legislative Discussion 2015-2016



VERMONT
GREEN MOUNTAIN CARE BOARD

Overview of Presentation

- List of key bills affecting the Board's work this year
- Review of new reports and duties
- Transition to H. 812 to precede the APM discussion

Key Bills from this year's Session Affecting the GMCB

S.214 An Act Relating to Large Group Markets

S.216 An Act Relating to Prescription Drug Formularies

S.245 An Act Related to Hospital and Physician Affiliations and Transfers

S.255 An Act Relating to Regulation of Hospitals Health Insurers and managed care organizations

S.256 An Act Relating to Extending the Moratorium on Home Health Agency Certificate of Need

H.761 An Act Related to Cataloguing and Aligning Health Care Performance Measures

H.875 Budget (Big Bill)

H.812 An Act relating to Implementing an All-Payer Model and Oversight of Accountable Care Organizations

S.214 An Act Relating to Large Group Markets

- Repeals 18 V.S.A. § 1804(c) and prevents the large group market inclusion on the Exchange

S.216 An Act Relating to Prescription Drug Formularies

Three relevant sections (Not all of our responsibility):

- Section 2: Rx Drug Cost Transparency (GMCB and Attorney General)
- Section 4: 340B Drug Dispensing Fees (DVHA)
- Section 5: 340B Drug Reimbursement Report (DVHA)
- Section 6: Maximum Out of Pocket (DVHA and GMCB)

Pharmaceutical Cost Transparency Section 2

- Requires the GMCB, in collaboration with DVHA, to identify annually up to 15 prescription drugs on which the State spends significant health care dollars and for which the wholesale acquisition cost has increased by 50 percent or more over the past five years or by 15 percent or more over the past 12 months, creating a substantial public interest in understanding the development of the drugs' pricing.
- The Board shall provide to the Office of the AG the list of the Rx drugs and the percentage of the wholesale acquisition cost increase for each drug and shall post this information on the GMCB website.
- The Attorney General, in consultation with DVHA, shall provide a report to the GA on or before December 1 of each year.

340B Drug Dispensing Fees
Section 4

- DVHA shall use the same dispensing fee in its reimbursement formula for 340B prescription drugs as the Department uses for its non- 340 B prescription drugs under the Medicaid program
- Notwithstanding the provisions of subsection (a) of this section, the Department is authorized to modify the dispensing fee or reimbursement formula provided to FQHCs and Title X family planning clinics for dispensing 340B prescription drugs to Medicaid beneficiaries.

340B Drug Reimbursement Report Section 5

DVHA Shall:

- Determine the formula used by other states' Medicaid programs to reimburse covered entities that use 340B pricing for dispensing prescription drugs to Medicaid beneficiaries
- Evaluate the advantages and the disadvantages of using the same dispensing fee in its reimbursement formula for 340B prescription drugs as the Department uses for non-340B drugs under the Medicaid program
- Report to committees of jurisdiction on or before March 15, 2017 on above and recommendations, including recommended modifications to VT's 340B reimbursement formula, if any, and the financial implications of implementing any recommended modifications.

Maximum Out of Pocket (MOOP) Section 6

- The Department of Vermont Health Access shall convene an advisory group to develop options for bronze-level qualified health benefit plans to be offered on the Vermont Health Benefit Exchange for the 2018 plan year, including: (1) one or more plans with a higher out-of-pocket limit on prescription drug coverage than the limit established in 8 V.S.A. § 4089i; and (2) two or more plans with an out-of-pocket limit at or below the limit established in 8 V.S.A. § 4089i.
- The advisory group shall meet at least six times prior to the Department submitting plan designs to the GMCB for approval.
- DVHA shall present the findings of the Advisory Group to the GMCB when developing the standard qualified health benefit plan designs for the 2018 plan year.
- **Prior to the date on which QHP forms must be filed with the DFR, a health insurer offering QHP benefit plans on Vermont Health Benefit exchange shall seek approval from the GMCB to modify the out-of-pocket prescription drug limit established in 8 V.S.A. § 4089i for one or more of the standard bronze plans. In considering an insurer's request, the GMCB shall provide an opportunity for the advisory group established in subsection (a) of this section, and any other interested party, to comment on the recommended modifications.**

S.245 An Act Related to Hospital and Physician Affiliations and Transfers

- Requires the GMCB to update the hospital budget guidance to include the requirement that the hospitals notify the patient of an acquired practice of the purchase of their practice and the potential change in out of pocket costs as well as recommend that the patient contact his or her insurance company to address financial liability.
- Requires each hospital acquiring a practice to notify the Attorney General with the specific details of the acquisition.
- Requires the GMCB to provide a copy of the provider parity reports from Act 54 Section 23(b), to the Health Reform Oversight Committee, House and Senate Health Care Committees and Senate Finance, on or before July 15, 2016.
- Requires the GMCB to update the same committees on progress toward provider parity, by December 1,2016.
- Requires DVHA to stop using provider based billing for outpatient medical services at an off-campus outpatient department of a hospital as a result of the provider's acquisition by the hospital.
- Requires the GMCB to consider the advisability and feasibility of expanding to commercial health insurers the prohibition on any increased reimbursement rates or provider based billing for health care providers newly transferred to or acquired by a hospital. The GMCB shall report the results to the House and Senate Health Care Committees and Senate Finance by February 1, 2017 and shall include its recommendations for the process and timing of implementation of any reimbursement restrictions.

Bill/§	Subject	Purpose	Due Date
S. 245 Sec. 4: Provider Reimbursement; Report	Provider Parity	Consider the advisability and feasibility of expanding to commercial health insurers the prohibition on any increased reimbursement rates or provider based billing for health care providers newly transferred to or acquired by a hospital. GMCB shall include its recommendations for the process and timing of implementation of any reimbursement restrictions.	February 15,2017
S.245 Sec 5: Reducing payment differentials; Guidance and Implementation Report	Provider Parity	On or before July 15, 2016 the GMCB shall provide a copy of each implementation plan to the Committees of Jurisdiction for providing fair and equitable reimbursement per Act 54 sec.23(b) of 2015.	July 15, 2016

S.255 An Act Relating to Regulation of Hospitals Health Insurers and Managed Care Organizations

- Gives the Board responsibility for oversight and approval of Provider Bargaining Groups
- Broadens HCA Involvement in Hospital Budget Process

<u>Language from bill:</u>

(3)(A) The Office of the Health Care Advocate shall have the right to receive copies of all materials related to the hospital budget review and may:

(i) ask questions of employees of the Green Mountain Care Board related to the Board's hospital budget review;

(ii) submit written questions to the Board that the Board will ask of hospitals in advance of any hearing held in conjunction with the Board's hospital review:

(iii) submit written comments for the Board's consideration; and

(iv) ask questions and provide testimony in any hearing held in conjunction with the Board's hospital budget review.

S.256 An Act Relating to Extending the Moratorium on Home Health Agency Certificate of Need

- This bill continues the moratorium on CON for Home Health Agency until 2020

H.761 An Act Related to Cataloguing and Aligning Health Care Performance Measures

- This bill requires the GMCB to survey and consolidate all existing performance measures required of primary care physicians in Vermont

- The Green Mountain Care Board, in consultation with the Vermont Medical Society and the Agency of Human Services, shall survey and catalogue all existing performance measures required of primary care providers in Vermont, including the Centers for Medicare and Medicaid Services' quality measures. The Board shall develop a plan to align performance measures across programs that impact primary care. The plan's goal shall be to reduce the administrative burden of reporting requirements for providers while balancing the need to have sufficient measures to evaluate quality of and access to care adequately. The Board shall submit the plan to the Senate Committee on Health and Welfare and to the House Committee on Health Care on or before January 15, 2017.

H.875
An act relating to making appropriations for the support of government

Fund	Base Need	Final Approp	Base Budget (over/under)	E-Board Approp	Projected Approp
General	1,197,675.03	1,243,276.00	45,600.97	49,411.54	**1,338,288.51**
Special	2,037,531.47	2,105,927.00	68,395.53	124,775.00	**2,299,097.53**
Federal	448,808.00	448,808.00	-		**448,808.00**
Interdept'l	1,492,561.00	1,492,561.00	-		**1,492,561.00**
GC	4,015,832.69	4,281,832.00	265,999.31	533,670.00	**5,081,501.31**
Total	9,192,408.19	9,572,404.00	379,995.81	707,856.54	**10,660,256.35**

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H.812 of 2016

An Act Relating to Implementing an All-Payer Model
and Oversight of Accountable Care Organizations

Presentation to the Green Mountain Care Board
May 19, 2016

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Overview

1. Components of H.812

2. Implementation of H.812
   - All-Payer Model
   - No All-Payer Model

3. Discussion and Next Steps

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Components of H. 812

1. All-Payer Model (Sections 1, 2, 12, 16)

2. Accountable Care Organization (ACO) Oversight (Sections 5, 13, 14)

3. Miscellaneous (Sections 9, 10, 11)

All-Payer Model

Lays out conditions and principles that must be met in order for the State of Vermont to enter into an agreement for a Medicare waiver

Key conditions and principles include:

- Maintains consistency with principles of Act 48
- Preserves all existing Original Medicare Beneficiary covered services and consumer protections
- Medicare continues to pay providers directly
- Maximizes alignment between payers
- Promotes coordination and integration across the care continuum
- Includes measurement of access to care, quality of care, patient outcomes and social determinants of health
- Comports with federal and State laws on parity and mental health and substance abuse treatment and does not manage this care through a separate entity
- Strengthens and invests in primary care

All-Payer Model

- Requires GMCB to present information on status of efforts to achieve alignment between payers by January 15, 2017

- Requires GMCB consultation on Medicaid pathway report
  - Report on progress of inclusion of additional Medicaid services in an All Payer Model

Accountable Care Organization (ACO) Oversight

- Certification of ACOs
- Review, Modification, and Approval of ACO Budgets
- Medicaid advisory rate case for ACO Services (one time)
- Multi-year Budgets for ACOs (one time)

Accountable Care Organization Oversight:
ACO Certification

- Requires ACOs to obtain and maintain certification in order to be eligible for for any Medicaid or Commercial payment reform program or initiative

- Establishes criteria for certification

Accountable Care Organization Oversight:

Certification Criteria

The GMCB must ensure that the ACO meets criteria in the following categories:

- Governance
- Care management and coordination
- Provider participation, payment, and collaboration
- Participation in health information exchanges
- Quality and performance measures
- Patient engagement and information sharing
- Consumer assistance, access, and freedom of provider choice
- Appropriate financial protections against potential losses

Accountable Care Organization Oversight:

Review, Modification, Approval of Budgets

GMCB shall review and consider the following categories of information with respect to budgets for ACOs with 10,000 or more attributed lives:

- Health care services utilization
- Health Resource Allocation Plan
- Fiscal responsibility
- Reports from professional review organizations
- Avoidance of duplicative service provision
- Extent of investment in primary care
- Extent of investment in social determinants of health
- Extent of investment in prevantion of Adverse Childhood Experiences
- Administrative costs
- Medicaid cost-shift
- Extent to which ACO costs are made transparent to consumers

Accountable Care Organization Oversight:

Medicaid Advisory Rate Case and Multi-Year Budgets

- Medicaid Advisory Rate Case
  - Requires non-binding review of any all-inclusive population-based payment arrangement between Department of Vermont Health Access and an ACO for calendar year 2017

- Multi-Year Budgets for ACOs
  - Directs GMCB to consider appropriate role of multi-year budgets for ACOs and report findings by January 15, 2017

Miscellaneous

- Reducing administrative burden on providers
  - Primary Care Professional Advisory Group

- Agency of Human Services contracts report

Implementation of H.812

- All Payer model and ACO provisions take effect on **January 1, 2018** except as noted in rulemaking and transition sections (Sections 6, 8)

- GMCB must adopt rules for both ACO certification and budget review and provide an update on the rule making process by January 15, 2017

- Prior to January 1, 2018, if the GMCB and Agency of Administration implement an all-payer model, they shall do so in a manner that is consistent with the criteria established in 812

- Prior to January 1, 2018, the Board shall encourage ACO compliance with criteria established in 812 through its existing authority over payment reform pilot projects

Implementation of H.812

All-Payer Model

- All criteria for All-Payer Model and ACOs must be met
- All required reports
- In addition to criteria specified in this legislation, GMCB will need to review and approve a Commercial rate for an ACO, review and advise on a Medicaid rate for an ACO, and determine a Medicare rate for an ACO

No All-Payer Model

- All criteria for ACO oversight must be met
- All required reports with exception of:
  - Medicaid pathway report
  - All payer model alignment report

Discussion and Next Steps

Bill/§	Subject	Purpose	Due Date
H.812 Sec.10: Primary Care Professional Advisory Group	Primary Care Advisory Group	The GMCB shall establish a primary care advisory group to provide input and recommendations to the Board. The Board shall provide an update on the advisory group's work in the annual report.	January 15,2017
H.812 Sec. 6: Update on Rulemaking	ACO budget Rulemaking	Provide an update on the rulemaking process and its vision for GMCB implementation to the Committees of Jurisdiction	January 15,2017
H.812 Sec. 9 -10 Reducing administrative burden on providers	Administrative burden on providers	Sec. 9 - to extent funds are available, GMCB may examine effectiveness of existing requirements for health care professionals and evaluate alternatives Sec. 10 - directs GMCB to establish a primary care professional advisory group to help the GMCB address the administrative burden on primary care professionals o GMCB will provide an update on the group in its annual report o Per diem and reimbursement of expenses up to $5,000 per year o Advisory group sunsets on July 1, 2018	
H.812 Sec. 11: AHS Contracts Report	AHS Contracts	AHS in consultation with Vermont Care Partners and preferred providers shall submit a report to Committees of Jurisdiction addressing: the amount and type of performance measures and other evaluations used in FY 2016 and 2017 AHS contracts with designated agencies, specialized service agencies, and preferred partners how AHS funding of these service providers affects access and quality how AHS funding for these service providers affects staff compensation in relation to public and private sector pay for the same services, Report must include a plan developed with stakeholders to implement value-based payments for service providers that improve access and quality of care, including long-term financial sustainability, must describe interaction of value-based Medicaid payments to service providers from AHS with Medicaid payments to these providers from ACOs	January 1, 2017
H. 812 Sec. 13: Medicaid Advisory Rate Case	Medicaid Advisory Rate Case	Must review by 12/31/16 any all-inclusive population based payment arrangement between DVHA and an ACO for calendar year 2017 Specific elements of GMCB's review, review is non-binding on AHS	December 31, 2016
H.812 Sec. 14: Multiyear Budgets ACOs Report	Multiyear ACO Budgets	Directs GMCB to consider appropriate role, if any, of multi-year budgets for ACOS, report findings and recommendations	January 15, 2017
H.812 Sec. 16 APM; Alignment	All-Payer Model Alignment	Requires GMCB to present information to legislative committees on status of efforts to achieve alignment between the payers	January 15, 2017