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Presentation: Options for Regulating Provider Reimbursement

Impact on Provider Sustainability and Equity in Reimbursement

Act 159 of 2020 Sec. 5

Green Mountain Care Board

April 7, 2021

Executive Summary

Act 159 of 2020, Section 5

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"GMCB, in collaboration with DFR, DVHA, and Director of Health Care Reform, shall identify processes for improving provider sustainability and increasing equity in reimbursement amounts among providers. The Board's consideration to include: (1) care settings; (2) value-based payment methodologies, such as capitation; (3) Medicare payment methodologies; (4) public and private reimbursement amounts; and (5) variations in payer mix among different types of providers."

- **Legislative Context**: Build on prior reports on pay parity/equity by outlining options for regulating provider reimbursements, including cost estimates and implementation issues. For summary of prior reports on pay parity/equity, see Appendix.

Executive Summary
Key Points

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1. This report presents regulatory **options, not recommendations** to the legislature
2. All options require **further study** to refine policy options and cost estimates
   - Inclusion of public payers in the regulatory option would require federal permissions
3. Collaboration with **SOV partners and key stakeholders**:
   - Reviewed by AHS Director of Health Care Reform, DVHA, and DFR
   - Sought feedback from potentially regulated entities (provider associations, payers) and advocates (Office of the Health Care Advocate)

Executive Summary
Key Points

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4. In practice, there may be **tension between the goals** of provider sustainability and reimbursement equity, as well as cost containment, the shift to value-based care, consumer affordability, and access:
   - No single option can maximize all goals
   - This tension could be addressed by implementing multiple policy options simultaneously; however this adds complexity, expense, and potential regulatory burden
   - Policy goals should be prioritized to inform refinement of regulatory implementation

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BACKGROUND

Background
Value-Based Care

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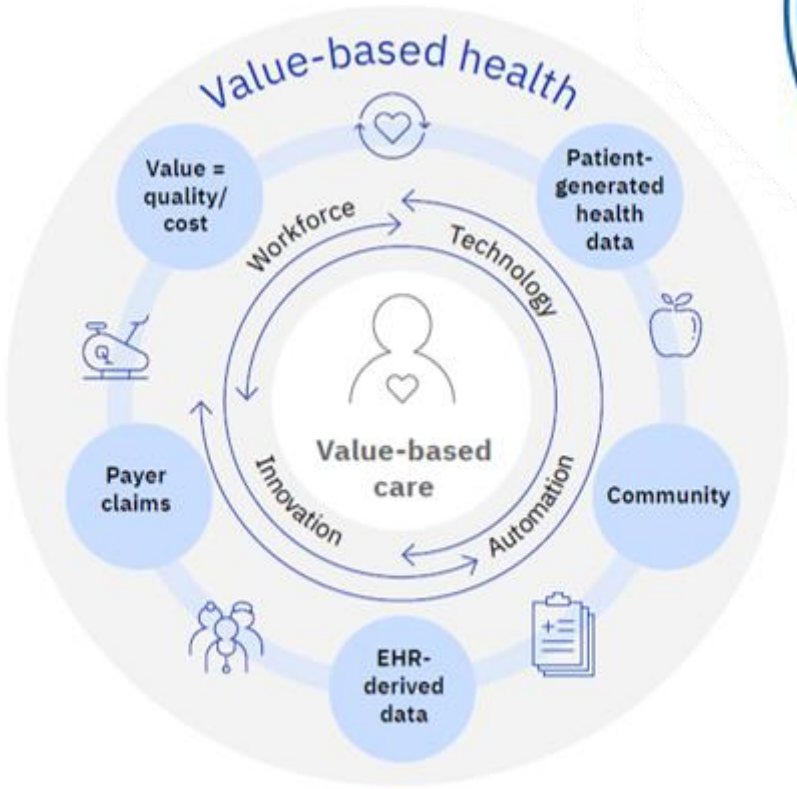

VALUE BASED CARE

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Background

Federal Shift from FFS to Value-Based Care

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The federal government has been committed to moving away from fee-for-service (FFS) provider reimbursement for over a decade, and that commitment remains.

2010:
Affordable Care Act (ACA)

- Created CMS Innovation Center (CMMI) to test new payment and care delivery models to further value-based care.
- ACA specifically identified accountable care organizations (ACOs) as a promising model, and CMMI launched multiple Medicare ACO models through 2017.

2015:
Medicare and CHIP Reauthorization Act (MACRA)

- Accelerated shift to value-based models by creating an incentive program (Quality Payment Program) for providers participating in Medicare.
- Providers can either elect to participate in the Merit-Based Incentive Payment System (MIPS) and report on quality and have a performance-based payment adjustment; or they can participate in Advanced Alternative Payment Methodologies (APMs), innovative payment models that tie payment to value.

2020:
State Medicaid Director's Letter #20-004

- Discusses Value-Based Care Opportunities in Medicaid.
- Describes the benefits of multi-payer models that align incentives across Medicare and Medicaid.
- Also highlights challenges inherent in models that are voluntary for providers in reaching critical mass, and in avoiding adverse provider selection.

2021 and Beyond:
Biden Administration

- Biden Administration approach remains to be seen.
- Given past bipartisan support for value-based models, expect this push to continue and evolve.

Background
Vermont's Move Toward Value-Based Payment

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Vermont has also been on the path away from FFS and toward value-based care for many years, in alignment with (and often ahead of) the federal government

2003-present:
Blueprint for Health

- Major investment in Vermont's primary care practices
- Began to tie payment to value through quality incentives
- Medicare has participated in the Blueprint and Support and Services at Home (SASH) since 2011 through the federal MAPCP Demonstration (2011-2016) and through the All-Payer Model ($7.5M+ annually since 2017)

2013-2017:
State Innovation Models (SIM) Grant

- $45M in federal funding to accelerate the transition to value-based care in Vermont
- Launched Vermont's Medicaid and commercial ACO Shared Savings Programs (SSPs) which laid the groundwork for Vermont Medicaid Next Generation ACO Program (VMNG)
- Supported All-Payer Model development, major investments in practice transformation and health information technology

2017-2022:
All-Payer Model and other Value-Based Arrangements

- Aims to test payment changes, transform care delivery, and improve health outcomes while controlling health care cost growth
- Medicare participates in Vermont-specific program through federal All-Payer Model Agreement signed in 2016; 2017 = Year 0
- Supports continued Medicare participation in Blueprint for Health and SASH

2005-current: Global Commitment to Health 1115 Waiver. Provides flexibility and funding for State priorities within the Medicaid program, including flexibility to pursue value-based payment models.

Background

Controlling Health Care Spending

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To control total spending, we must address both unit cost and utilization

- Unit cost is the reimbursement amount paid to a health care provider for a particular service or set of services
- Many provider reimbursement regulatory options seek to impact **unit cost**. Other regulatory options do not address unit cost directly, but rather the **growth rate** (the rate at which unit cost can allowed to increase over time)

Provider Sustainability & Reimbursement
Act 159 of 2020, Section 5

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"GMCB, in collaboration with DFR, DVHA, and Director of Health Care Reform, **shall identify processes** for **improving provider sustainability** and **increasing equity in reimbursement** amounts among providers. The Board's consideration to include: (1) care settings; (2) value-based payment methodologies, such as capitation; (3) Medicare payment methodologies; (4) public and private reimbursement amounts; and (5) variations in payer mix among different types of providers."

- **Legislative Context**: Build on prior reports on pay parity/equity by outlining options for regulating provider reimbursements, including cost estimates and implementation issues. For summary of prior reports on pay parity/equity, see Appendix.

Background

Considering Value-Based Care, Sustainability, and Reimbursement Equity

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Value-Based Care	Definition: The efficient and economic delivery of high-quality care. • Does the option move away from fee-for-service, address utilization issues, promote services where increased spending improves health (e.g., prevention), or avoid spending on care that does not improve health (e.g., preventable care, episodic care)? • This could include incentive structures or payments that are tied to quality performance.[1]
Provider Financial Sustainability	Definition: The ability of a provider to consistently cover expenditures with revenues. • Does the option include a provider-level look for solvency, consider payer mix, promote predictable and flexible revenue to providers, allow for necessary capital investments in technology or facility, or decouple reimbursement from volume? • Requires ongoing detailed data to determine whether and when provider reimbursements are sufficient to cover the cost of delivering services; it is also important to consider questions of access and quality when assessing financial sustainability (e.g., HRAP/Act 159 Sec. 4 report on Hospital Financial Sustainability).
Reimbursement Equity	Definition: Equitable payment within and across provider types for care delivery. • Does the option address underlying FFS differentials within provider types or move away from site-specific reimbursement? Does the option address underlying FFS differentials across provider types? • Requires a nuanced understanding of providers' current FFS reimbursements relative to each other and periodic analysis to develop an "equitable" methodology that can be trended forward for a specified group of providers/particular services over-time.

[1] For more information on value-based payment models, see the Health Care Payment Learning & Action Network (LAN) Alternative Payment Model Framework.

Background

Increasing Sustainability & Equity

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- In practice, there may be tension between the goals of provider sustainability and reimbursement equity:
  - No single option maximizes both sustainability and equity
  - This tension could be addressed by implementing multiple policy options simultaneously; however this adds complexity, expense, and potentially regulatory burden
- This report contemplates the ability of each option to address these two statutory goals within the context of value-based care
  - Would require more direction on policy priorities (which providers/which services/which payers?) to explore and evaluate payment methodologies in more detail for their impact on provider sustainability and equitable reimbursement

Background

Implications for Access & Consumer Affordability

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Especially in rural settings, there may be tension between provider sustainability, consumer affordability, and access.

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Key Takeaway: *Provider reimbursement methodologies will impact access and affordability (positively or negatively) but will not alone solve these problems.*

Background
Regulating Provider Reimbursement

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Regulation of provider reimbursement (sometimes called "rate setting") is governmental action to set provider reimbursement methodologies and amounts, which can be implemented via the following regulatory mechanisms:

1) States set provider reimbursement amounts or methodologies through provider regulation
2) States set parameters for payer-provider negotiations through insurance regulation

Currently, provider reimbursement amounts and methodologies are most commonly negotiated between commercial payers and providers participating in their networks, or set by Medicare and Medicaid for providers participating in those programs.

- Left to the market, provider-insurer negotiations are likely influenced by relative bargaining power/market share of the provider and the insurer:
  - Providers with higher market share (bargaining power) will be able to negotiate higher reimbursement; insurers with higher market share (bargaining power) will be able to negotiate lower reimbursement[1]
- This can also include reimbursement amounts paid to accountable care organizations (ACOs) to cover care for attributed members and the ACO payment models
  - Vermont's ACO programs have also been used to shift funds between parts of the health care system (e.g., from hospitals to primary care) through dues and value-based payment models

[1] Roberts, Chernew, and McWilliams, Market Share Matters: Evidence of Insurer and Provider Bargaining Over Prices (Health Affairs, January 2017)

Background
Basis for Provider Reimbursement

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There are two primary bases for provider reimbursement on which payment models are built. Each can act as the foundation for multiple payment models: fee-for-service payment, per diem (daily) rates, episode-based payments, health system budgets, capitation, or others.

- **Cost-Based** – Reimbursement amounts set based on the provider's historical cost (often with adjustments), to provide a service or an aggregate set of services; most common in historical state rate setting models and for Medicare reimbursement of critical access hospitals
  - Price based on actual expenses of the provider, sometimes blended with expenditures from peer institutions or regional/national data; should provide for margin; could vary by payer
  - Would vary by provider
- **Fee-for-Service (FFS)** – Reimbursement amounts set for each service based on negotiated amounts, an average or median of historic amounts, or a reference payer.
  - Public payers' FFS payment amounts are influenced by payers' appropriated budgets.
  - Could vary by payer, or same price across payers

In addition, regulators and payers may choose to layer one or more payment strategies…

- **Growth Targets or Caps** – Limit ability of providers and payers to negotiate above or below a certain amount; impacts growth trends, not base price.
- **Value-Based Payment Models** – May reward or penalize providers based on performance and/or value (e.g., provision of high-quality care; readmission rates; demonstrated practice transformation)
- **Population-Based Payment Models** – May be based on historical FFS spending and utilization, cost to provide care, or total budget available, with some assumptions of utilization and often expectations for efficiency; may include minimum quality threshold or otherwise tie payment to quality performance.

Resource: Urban Institute, Hospital Rate Setting Revisited (November 2015), chapters 1 and 2.

Background
Regulatory Approaches

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	APPROACH 1: Entity- or Provider-Level	APPROACH 2: Service-Based	APPROACH 3: Insurer/Payer-Based
Description	Sets reimbursement policy for the provider entity based on provider characteristics	Sets reimbursement policy for a category of services or specific services across all provider sites	Sets reimbursement policy for the payer
Example	Current hospital budget review process: Looks at expected revenue and expenses for each provider organization	Hypothetical example: Payments for primary care services must increase by X% in 2022.	Hypothetical example: Require GMCB-regulated commercial insurers to increase payments for primary care services by X% in 2022.
Trade-Offs	Includes focus on provider sustainability; equity considerations include provider specific information & payer mix; captures broad population	Includes focus on equity of reimbursement regardless of provider type; provider sustainability considerations limited; captures broad population (depending on services chosen)	Captures subset of commercial population (insured only); provider sustainability considerations limited; focus on equity limited by population

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OPTIONS FOR REGULATING PROVIDER REIMBURSEMENT

Options for Regulating Provider Reimbursement
Report Development Process

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- Literature scan for regulatory approaches and state examples to address stated goals as well as Vermont's long-standing goals of cost containment and value-based care
- Sought a range of approaches, adapting GMCB's current regulatory authorities (including provider rate setting, hospital budget review, health insurance premium rate review, and ACO oversight)

- SOV Partner and Stakeholder Engagement:
  - Draft report reviewed by AHS Director of Health Care Reform, DVHA, and DFR
  - Shared with potentially regulated entities (provider associations, payers) and advocates (Office of the Health Care Advocate) in advance and solicited comments

Options for Regulating Provider Reimbursement
Scope: Providers and Services

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- This report **includes** options for regulating provider reimbursement for *hospital inpatient*, *outpatient*, and *professional services* (primary and specialty care).
- This report **excludes**:
  - Providers for whom Medicaid is the dominant payer (e.g., Designated Agencies, Specialized Service Agencies, adult day centers, etc.). Payment rates (and growth rates) are currently already set by the State of Vermont; the Department of Vermont Health Access and other Agency of Human Services departments have significant reimbursement expertise and infrastructure for these providers.
  - Pharmacy. The GMCB has a technical advisory group that is looking at pharmacy cost containment, but its work will not be completed by March 15th.
  - Dental and vision.
- There are federal laws governing Medicaid, Medicare, and QHP reimbursement to federally qualified health centers (FQHCs) which cannot be waived. FQHCs are regulated by HRSA and this regulation encompasses access, quality, reimbursement, staffing levels, and compliance measures.

Options for Regulating Provider Reimbursement
Scope: Payers

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- This report **includes** options for regulating provider reimbursement primarily focused on Medicare, Medicaid, and fully insured commercial health plans in the individual and small group market and the large group market
- This report **did not consider** other segments of the commercial market, for example, Medicare Advantage, workers' compensation, the federal employee health benefit plan (FEHBP), and TRICARE
    - Additional legal research would be required to determine whether and how these market segments would be impacted for any option(s) the General Assembly wishes to pursue

Options for Regulating Provider Reimbursement

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Option 1: Health System Budgets

Option 2: Setting Reimbursement Parameters

Option 3: Fee-for-Service Rate Setting

Option 1: Health System Budgets

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Definition: Health system budgets are caps on spending for some portion of the health care system (a provider organization, facility, or a network of providers), generally set prospectively with a defined total budget amount, prescribed enforcement mechanism, and/or payment methodology. Budgets can be all-payer or payer-specific. This option is intended to impact the *total spending*.

- Options: 3 potential regulatory approaches (provider; ACO; insurer)

What issues could this approach highlight?

- Unit cost & utilization & value-based payments
- Conflict between sustainability and cost containment/affordability in regulated sector
- Impact of minimal reimbursement increases in public payers

What issues are hard to address with this approach?

- Lack of market power for smaller, currently unregulated providers due to high administrative burden for these providers & GMCB

Cost Estimate Ranges:

- Implementation: $1.275 - $1.650 (one-time)
- On-going Operations: $375k - $1M (annual)

Health System Budgets

Example: Maryland All-Payer Model (2014-current)

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- Maryland evolved its all-payer rate setting model (see slide 78), transitioning to a global budget model starting in 2014 and then to a Total Cost of Care model in 2019.
- Under Maryland's All-Payer Model, Maryland Health Services Cost Review Commission (HSCRC) established an annual health system budget for each hospital and then set hospital rates for all payers, including Medicare and Medicaid.
  - Hospital budget built from allowed revenues during a base period and adjusted for future years using a number of factors, both hospital specific and industry wide, and updated each year
  - Payers are billed on FFS basis using rates set by HSCRC and are then increased or decreased systematically to achieve a fixed budget
- Maryland APM aims to improve quality through two of the waiver requirements:
  - Reductions in the Medicare 30-day hospital readmission rate to the national rate over 5 years
  - Reductions in the state's all-payer aggregate rate of 65 potentially preventable conditions by 30% over the 5 years of the waiver
- So far, Maryland has saved over $45 billion and lowered the rate of cost growth from 25% above the U.S. average to 3% above the average

Health System Budgets

Example: Pennsylvania Rural Health Model (2019-current)

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- Pennsylvania's Rural Health Model, an All-Payer Model with the Center for Medicare and Medicaid Innovation (CMMI), is testing a multi-payer global budget model with rural hospitals in the state. The model tests whether the predictable nature of global budgets will enable participating rural hospitals to invest in quality and preventive care, and to tailor their services to better meet the needs of their local communities. CMS is making $25M available to PA to implement the model. The Agreement required Pennsylvania to create a new regulatory body to support this effort.
- Rural hospitals are paid fixed amounts by CMS and other participating payers. These amounts are set in advance and intended to cover all inpatient and hospital-based outpatient care. The Model does not set a fixed all-payer budget; rather, budgets are set payer-by-payer for their members. Participating payers include Medicare, Medicaid, and some commercial payers.
- Participating rural hospitals prepare Rural Hospital Transformation Plans, outlining their proposed care delivery transformation, which must be approved by Pennsylvania and CMS.
- Metrics: Under the Model Agreement, Pennsylvania has committed to the following:
    - $35M in Medicare hospital savings; the growth rate for rural PA total Medicare expenditures per beneficiary must not exceed the growth rate of the rural National total Medicare expenditures per beneficiary by more than a certain percentage; Increase access to primary and specialty care, reduce rural health disparities through improved chronic disease management, decrease deaths from substance use
- Benefits to this model include predictable payments and stable cash flow; a payment model that enables hospitals to move towards financial sustainability; and budget neutrality for payers across the portfolio of participating hospitals
- Challenges include the voluntary nature of this model; a small (but growing) number of hospitals has elected to participate, and PA has not achieved full commercial payer participation.

Option 2: Setting Reimbursement Parameters

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Definition: Regulatory entity limits provider reimbursement to a particular growth rate; growth caps can be combined with growth floors for particular services or provider types to align with state policy goals. Vermont's hospital budget process (see example, slide 67), already acts as a cap on cost-per-service growth for Vermont's 14 community hospitals; the GMCB only regulates growth over time in the current process, and does not review data on actual charges or paid amounts annually. Targets *growth in unit cost;* does not prescribe *unit cost*.

- Options: 3 regulatory approaches (provider; high-level service parameters; insurer)
- Hypothetical example: Payments for primary care services must increase by X% in 2022. An offsetting limitation must be made in other services if cost neutrality to premiums is desired.

What issues could this approach highlight?

- Prioritize growth for certain types of providers or services (e.g., primary care) & limit growth for other types of care; highlights winners and losers in provider sector
- Could counterbalance lack of market power to some degree over time (not completely)

What issues are hard to address with this approach?

- Total spending (not targeted at utilization)
- Sustainability of unregulated providers

Cost Estimate Ranges:

- Implementation: $70-425k (one-time; range depending on option chosen)
- On-going Operations: $10k-270k (annual)

Setting Reimbursement Parameters

Example: Vermont Hospital Budget Review (1983-current)

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- Since 1983, Vermont has annually reviewed and established community hospital budgets
  - Review considers local health care needs and resources, utilization and quality data, hospital administrative costs, and other data, as well as presentations from hospitals and comments from members of the public
  - GMCB took on this process from BISHCA per Act 171 of 2012
- Hospitals submit budgets on July 1 for coming fiscal year (begins October 1)
- Two regulatory levers:
  1) Growth in net patient revenue (NPR) and fixed prospective payments (FPP):
     - Total charges at the hospital's established rates for providing patient care services, including FFS claims at the charged amount and services paid for under FPP arrangements
  2) Change in charge
     - Increase (or decrease) in the average gross FFS charge for all services across all payers.
     - Instead of regulating charges for particular hospital services, GMCB sets a maximum average gross charge increase per hospital for all services for all payers; however, Medicare and Medicaid do not negotiate their prices, so change in charges impact hospitals' negotiations with commercial insurers
     - GMCB cannot review net charges (gross charges minus the negotiated deductions by payers and hospitals) because negotiated prices are considered confidential, and this information is not available to the GMCB

Setting Reimbursement Parameters

Example: Rhode Island Affordability Standards (2004–current)

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- 2004: Created Health Insurance Advisory Council (HIAC) to better understand health care cost drivers
- 2009: HIAC Developed Affordability Standards and Priorities for Rhode Island Commercial Health Insurers
    - Commissioner directed insurers to comply with four new criteria to have premium rates approved:
        - Expanding and improving primary care infrastructure;
        - Spreading the adoption of the patient-centered medical home model;
        - Supporting the state's health information exchange, CurrentCare;
        - Working toward comprehensive payment reform across delivery system.
- 2016: Most recent affordability standards adopted require insurers:
        - Spend at least 10.7% of their annual medical spend on primary care;
        - Limit hospital rate increases so that the average rate increase is no greater than the Urban Consumer Price Index (CPI) (less food and energy) percentage increase plus 1%.
- Affordability standards also require the inflation plus 1% cap in insurers' negotiated prices with hospitals in order to have their premium rates approved

Option 3: Fee-For-Service Rate Setting

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Definition: Regulatory entity sets reimbursement amounts, most commonly using an existing payer's reimbursement scheme as a point of reference. Medicare is the most common point of reference for fee-for-service rate setting, because Medicare's reimbursement amounts and methodologies are publicly available, national, and geographically adjusted.

- This option targets unit cost but not utilization, which limits its effectiveness in impacting total cost of providing care. This option will modify the current base cost of health care, but also targets the growth trend (growth in base cost over time).
- Options: 2 regulatory approaches (provider; insurer)
- Hypothetical Example: Evaluation & Management Code XXXXX = $100

What issues could this approach highlight?

- Counterbalances market power issues

What issues are hard to address with this approach?

- Total spending (not targeted at utilization)
- Sustainability of unregulated providers
- Moving to value-based care
- Winners and losers in the provider sector

Cost Estimate Ranges:

- Implementation: $600-2,025k (one-time; range depending on option chosen)
- On-going Operations: $300-950k (annual)

Fee-for-Service Rate Setting

Example: Maryland All-Payer Rate Setting (pre-2014)

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- Maryland operated an all-payer hospital rate-setting system since the mid-1970s and is the only state that is exempt from Medicare's Inpatient Prospective Payment System and Outpatient Prospective Payment System
  - Financial performance criteria based on cumulative growth in Medicare inpatient payments per admission no more than cumulative growth nationally
  - No limit on hospital revenues, except for hospitals operating under Total Patient Revenue system
  - No requirement to meet quality targets related to readmissions and admissions for potentially preventable complications and no population-based payments
- Decreased hospital spending per admission… but hospital admissions rose far faster than the national average
  - Maryland transitioned to an all-payer global budget model in 2014

Next Steps & Areas for Further Exploration

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Depending on legislative direction, next steps could include:

1. Continue exploring options for model design (particularly for health systems budgets)
   - Establish provider types in scope and any policy objectives
2. Further study on implementation, including robust stakeholder engagement to continue to understand implementation challenges of each, including:
   - Impact on premiums
   - Operational costs to providers and insurers
   - Data requirements
   - Impact on Medicaid budget
   - Consider varied impact based on hospital designation
3. Assess other regulatory intersections
   - Intersections with GMCB hospital sustainability efforts (see also Act 159 Sec. 4 report due Fall 2021)
   - Implications for APM TCOC
   - Intersections with ACO oversight
   - Health Resource Allocation Plan

Next Steps
Key Questions for the General Assembly

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What is the key problem Vermont is trying to solve?

- **Cost containment** and **value-based care** are central to Vermont's health reform strategy.
  - How should Vermont prioritize **sustainability** and **reimbursement equity** while balancing **consumer affordability** and **access**?
- How should Vermont **define sustainability and reimbursement equity**?
  - How to prioritize where policy options have varied benefits and challenges for different provider types (e.g., hospitals vs. primary care providers; health systems vs. independent providers)?
  - Act 159 of 2020 Section 4 report (due in Fall 2021) will significantly expand on the concept of sustainability and provide more information about hospital sustainability.
- How should Vermont **balance provider-led reform vs. mandatory regulation**?
  - How to support continued provider transformation and avoid change fatigue?

Options for Regulating Provider Reimbursement

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Option 1: Health System Budgets
Option 1A: Provider Entity Budgets with Population-Based Payments
Option 1B: Evolve ACO Regulatory Process to Set Provider Payment Methodologies and Amounts
Option 1C: Require Insurers to Use Population-Based Payments

Option 2: Setting Reimbursement Parameters
Option 2A: Entity-Based Growth Caps and Floors
Option 2B: Service-Based Growth Caps and Floors
Option 2C: Growth Parameters in Payer-Provider Contracts

Option 3: Fee-for-Service Rate Setting
Option 3A: FFS Rate Setting via Provider Regulation
Option 3B: FFS Rate Setting via Insurance Regulation

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DISCUSSION

Reference

Options for Regulating Provider Reimbursement - Summary

Model	Summary	Providers and Care Settings Impacted	Payers Impacted		
			Medicare	Medicaid	Comm.
Option 1: Health System Budgets. Health system budgets are caps on spending for some portion of the health care system (a provider organization, facility, or a network of providers), generally set prospectively with a defined total budget amount, prescribed enforcement mechanism, and/or payment methodology. This option targets *total spending*.					
Option 1A: Provider Entity Budgets with Population Based Payments	Evolves the hospital budget review to set charges based on a required payment methodology, which, after factoring in expected utilization, would total the approved budget for each regulated provider entity.	Vermont hospitals currently subject to the budget process; could be expanded to other provider types with new authority.	Maybe	Maybe	Y
Option 1B: Evolve ACO Regulatory Process to Set Provider Payment Methodologies and Amounts	Evolves the ACO oversight process to establish a budget, payment methodology, and amounts charged by a network of providers for an attributed population based on State-developed criteria.	Providers participating in an ACO to whom the payment method applies; ACOs operating in Vermont.	Maybe	Maybe	Y
Option 1C: Require Insurers to Use Population-Based Payments	Require insurers to adopt population-based payment methodologies and other reimbursement parameters to establish a budget for the population purchasing an insurance product.	Providers accepting payment by regulated carriers or through an ACO.	N	N	Y
Option 2: Setting Reimbursement Parameters. Regulatory entity limits provider reimbursement to a particular growth rate; growth caps can be combined with growth floors for particular services or provider types to align with state policy goals. This option targets *growth trend*.					
Option 2A: Entity-Based Growth Caps and Floors	Evolves the hospital budget process to impact the professional fee schedule and/or regulate cost-per-service for currently unregulated providers.	Hospitals; potentially additional entity types	N	N	Y
Option 2B: Service-Based Growth Caps and Floors	This option would set a minimum or maximum reimbursement growth trend for a category of codes (e.g., professional services), around which the providers and payers could negotiate. It would not do so at the level of an individual service.	Could apply to any class of services (e.g., professional services), or a subset of services or provider types.	Unlikely	Unlikely	Y
Option 2C: Growth Parameters in Payer-Provider Contracts	Directs payers to limit growth in reimbursement in contracts negotiated with providers.	Could apply to any combination of inpatient, outpatient and professional services.	N	N	Y
Option 3: FFS Rate Setting. Regulatory entity sets reimbursement amounts, using Medicare's reimbursement methodology as a point of reference. This option targets *unit cost* and *growth trend.*					
Option 3A: Implementation via Provider Regulation	Sets reimbursement methodology based on a percentage of Medicare reimbursement; providers change charge lists to match.	Most applicable to hospital and physician services	Maybe	Maybe	Y
Option 3B: Implementation via Insurance Regulation	Directs payers to negotiate with providers for reimbursement that averages a maximum percentage of Medicare reimbursement.	Most applicable to hospital and physician services	N	N	Y

Reference

Options for Regulating Provider Reimbursement - Summary

Model	Implications for...			Implementation and Operations Cost
	Value-Based Care	Provider Sustainability	Reimbursement Equity	
Option 1: Health System Budgets				
Option 1A: Provider Entity Budgets with Population Based Payments	Supports	Supports	Could improve reimbursement equity across regulated providers, depending on design. Would not impact unrelated providers.	• Implementation: $1,275-1,650k (1x) Option 1A only: $175-250k (1x) All Options: $1,100-1,400k (1x) • Operations: $375-1,000k (annual) *NOTE: All Health System Budgets options would require significant model design to inform operational cost estimates*
Option 1B: Evolve ACO Regulatory Process to Set Provider Payment Methodologies and Amounts	Supports	Supports	Could improve reimbursement equity through special payment models.	
Option 1C: Require Insurers to Use Population-Based Payments	Supports	Could support, depending on design	Not designed to improve reimbursement equity, though could improve equity within commercial market over time depending on design.	
Option 2: Setting Reimbursement Parameters				
Option 2A: Entity-Based Growth Caps and Floors	Could potentially support	Could support or hinder, depending on design	Could improve reimbursement equity if extended to currently unregulated providers.	To <u>evolve</u> hospital budget process: • Implementation: $0-70k (1x) • Operations: $0-10k (annual) To <u>expand</u> hospital budget process: • Implementation: $285-475k (1x) • Operations: $235-270k (annual)
Option 2B: Service-Based Growth Caps and Floors	Could potentially support	Does not support	Could improve reimbursement equity, depending on design. Impacts growth, not unit cost.	• Implementation: $285-425k (1x) • Operations: $135-270k (annual)
Option 2C: Growth Parameters in Payer-Provider Contracts	Could potentially support	Does not support	Could improve reimbursement equity within commercial market, depending on design. Impacts growth, not unit cost.	• Implementation: $20-60k (1x) • Operations: $20-60k (annual)
Option 3: FFS Rate Setting				
Option 3A: Implementation via Provider Regulation	Does not promote	Does not support	Could improve reimbursement equity with modifications to Medicare reimbursement policies	• Implementation: $1,500-2,025k (1x) • Operations: $625-950k (annual)
Option 3B: Implementation via Insurance Regulation	Does not promote	Does not support	Could improve reimbursement equity within commercial market with modifications to Medicare reimbursement policies	• Implementation: $600-725k (1x) • Operations: $300-350k (annual)

Reference
Major GMCB Regulatory Authorities

VERMONT
GREEN MOUNTAIN CARE BOARD

Regulatory Authority	Statute and Rule	Summary
Hospital Budget Review	• 18 V.S.A. chapter 221, subchapter 7 • GMCB Rule 3.000	Establishes aggregate budget target and caps charge trend for each of Vermont's 14 community hospitals annually by October 1.
Health Insurance Premium Rate Review	• 8 V.S.A. § 4062 and 18 V.S.A. § 9375 • GMCB Rule 2.000	Tasks the GMCB to review major medical health insurance premium rates in the large group and the merged individual and small group insurance markets.
ACO Certification and Budget Review	• 18 V.S.A. § 9382 • GMCB Rule 5.000	Establishes criteria for the State's regulating authority to certify and review ACO budgets. Authority has been given to the GMCB to approve or deny the certification of ACOs, with eligibility verification annually after initial approval; and annually review and approve or deny an ACO's budget.
Rate Setting Authority	• 18 V.S.A. 9375(a)(1)	Not implemented to date. Gives authority to oversee the development and implementation, and evaluate the effectiveness, of health care payment and delivery system reforms designed to control the rate of growth in health care costs; promote seamless care, administration, and service delivery; and maintain health care quality in Vermont. No enforcement provisions.