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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

Link to Full Report

Executive Summary
Act 159 of 2020, Section 5

"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

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. 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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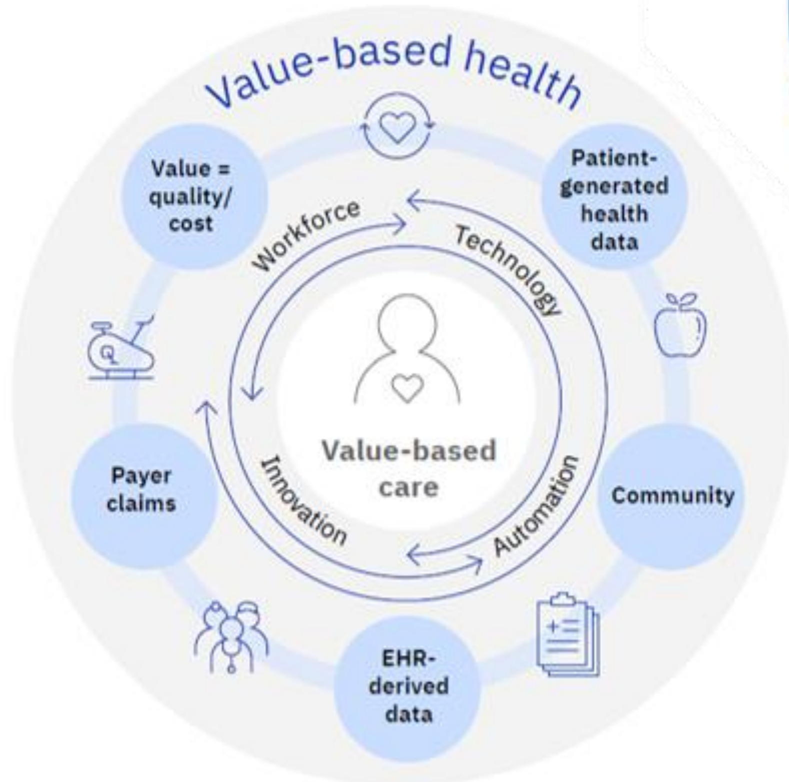

VALUE
BASED
CARE

VALUE = QUALITY / COST = OUTCOMES + PATIENT EXPERIENCE / DIRECT COSTS + INDIRECT COSTS

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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)

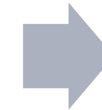
- Created CMS Innovation Center (CMMI) to test new payment and care delivery models to further value-based care.
- ACA specifically identified accountable care organizations (ACOs) as a promising model, and CMMI launched multiple Medicare ACO models through 2017.

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.

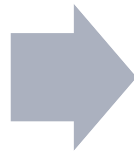
Background

Vermont's Move Toward Value-Based Payment

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

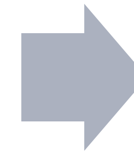
2003-present:
Blueprint for Health

- 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

"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

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

- 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

Basis for Provider Reimbursement

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
Regulating Provider Reimbursement

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
Regulatory Approaches

	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

- 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

- 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

- 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

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)

- 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)

- 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)

- 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)

- 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

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)

- 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

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

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... Value-Based Care	Implications for... Provider Sustainability	Implications for... Reimbursement Equity	Implementation and Operations Cost
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 evolve hospital budget process: • Implementation: $0-70k (1x) • Operations: $0-10k (annual) To expand 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

Regulatory Approaches/Options Crosswalk

	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
Options Crosswalk	• Option 1A: Provider Entity Budgets with Population Based Payments • Option 1B: Evolve ACO Regulatory Process • Option 2A: Entity-Based Growth Caps and Floors	• Option 2B: Service-Based Growth Caps and Floors	• Option 1C: Require Insurers to Use Population-Based Payments • Option 2C: Growth Parameters in Payer-Provider Contracts • Option 3B: FFS Rate Setting via Insurance Regulation
	• Option 3A: FFS Rate Setting via Provider Regulation (spans Approach 1 and Approach 2)		

Reference

Major GMCB Regulatory Authorities

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.

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REFERENCE SLIDES

Option 1: Health System Budgets

Definition and Summary

- 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*.
- 3 implementation options:
  - **Option 1A: Evolve Hospital Budget Review into Provider Entity Budgets with Population-Based Payments**
    - The GMCB would evolve 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 entity. The payment method and amounts could be payer specific or payer agnostic. The goal would be to ensure that regulated provider entity revenues are charged and paid in a standard manner. The payment methodology could also include adjustments for unanticipated utilization, market shifts, out-of-state patients, payer mix, and other factors.
  - **Option 1B: Evolve ACO Regulatory Process to include State-Set Provider Payment Methodologies and Amounts**
    - The GMCB would evolve 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. The payment method and amounts could be payer-agnostic, but ideally would be aligned across multiple (all) payers. Requires payer and provider participation for attribution.
  - **Option 1C: Require Insurers to Use Population-Based Payments**
    - The GMCB would require insurers to adopt population-based payment methodologies (e.g., predictable, flexible, stable, value-based payments paid to providers or an ACO) and other reimbursement parameters to establish a budget for the population purchasing an insurance product. This would correlate to a portion of providers' budgets associated with these populations. Self-insured employer plans could voluntarily participate.

Health System Budgets

Option 1A: Provider Entity Budgets with Population-Based Payments Definition and Summary

GMCB would evolve 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. The payment method and amounts could be payer specific or payer agnostic. The goal would be to ensure that hospital revenues are charged and paid in a standard manner. The payment methodology could also include adjustments for unanticipated utilization, market shifts, out-of-state patients, payer mix, and other factors.

Option 1A: Provider Entity Budgets with Population-Based Payments	
Regulatory Mechanism and Authority	18 V.S.A., chapter 221, subchapter 7 (hospital budgets) and 18 V.S.A. § 9375 and 9376 (provider reimbursement). Through its hospital budget review process (see slide 67), the GMCB currently sets a net patient revenue cap (a proxy for patient revenue increases) and a cap on charge increases. • The GMCB would need to undertake additional research to determine the most appropriate methodology, engage with affected stakeholders, and draft a new rule for these efforts.
Enforcement	The hospital budget statute includes enforcement provisions; however, the current approach makes targeted enforcement a challenge. The GMCB has reduced provider charges to reflect overages in the current budget in the past. The GMCB and DFR would need to determine an appropriate split of authority for noncompliance by payers.
State of Vermont Agencies Involved	GMCB; AHS/DVHA; DFR

Health System Budgets

Option 1A: Provider Entity Budgets with Population-Based Payments Definition and Summary, Cont.

Option 1A: Provider Entity Budgets with Population-Based Payments	
Population	Population served by Vermont hospitals or other regulated provider entities, with scope of impact depending on payment methodology and if resident-based and/or service-based. Vermont's current hospital budget process impacts anyone receiving services from a regulated Vermont hospital or a hospital-affiliated provider or practice.
Provider/ Services	Vermont hospitals that are currently subject to the budget process; could be expanded to other provider types with additional authority. Could apply to any combination of inpatient, outpatient, and professional services. • In addition to hospitals, the entity-level budget approach could be most easily applied to ambulatory surgical centers. It would be challenging to apply this approach to provider types for whom there are many unique business entities (e.g., independent practices).
Payers	Setting entity-based budgets would impact payers' contractual negotiations with providers. In a facility or entity-based budget, payment methodologies could be payer-specific or payer agnostic, but the enforcement provisions would impact whether and how payer-specific rates would be adjusted. This option would impact Commercial payers, and potentially Medicare and Medicaid: • Medicare: Would require an agreement with CMMI to set the payment methodology and amount. • Medicaid: Potentially would require federal waiver of Single State Agency Rule (see slide 94) and assessment of operations. Alternatively, the GMCB could build in a payment methodology and amount set prospectively by DVHA for each hospital as the Medicaid contribution. • Commercial: Can implement with existing provider rate-setting authority and would include any payer contracting with a Vermont provider, including insurers and self-insured payers.
Methodology	Reimbursement amounts are established prospectively (at the beginning of the year), based on expected utilization and the approved annual budget. Throughout the year adjustments to the reimbursement amounts would be applied based on actual utilization in order to come in on the approved budget by year end.
Payment Model(s)	Compatible with a range of payment methodologies, including population-based payments.

Health System Budgets

Option 1A: Provider Entity Budgets with Population-Based Payments
Implications for Vermont

Compatibility with Value-Based Care	Could design to ensure a hospital or other regulated provider entity receives a majority of its revenues from population-based payments, with the intent of tying these payments to quality and health outcomes. Increasing population-based payments to providers would give providers more flexibility to choose how to invest their resources to best meet the needs of their population and achieve goals of value-based care; to the extent that there is alignment across payers, this would only bolster opportunities/incentives for providers to invest in delivery system reform, particularly if it becomes the dominant form of provider payment. Value-based payment could also be incorporated into the state's payment methodology, or this could be left to the discretion of ACOs and their participating providers. Likely compatible with ACO programs. analysis.
Implications for Sustainability	Facility or entity-based budgets could be population-based, based on historical FFS spending or actuals costs. Sustainability of the provider organization, as well as payer mix, could be considered in any payment methodology underlying a facility or entity-based budget.
Implications for Reimbursement Equity	Budgets could be designed for equity across hospitals or other regulated provider entities, with potential variation for different Medicare designations/hospital types or entity types depending on state policy goals. This model could be evolved to include other provider types, but would not have the ability to impact current fee-for-service rates for unregulated providers.

Health System Budgets

Option 1A: Provider Entity Budgets with Population-Based Payments Implications for Vermont

Pros

- Evolves existing regulatory system to allow for greater equity across hospitals and greater nuance to pursue state priorities, while maintaining a view of sustainability and cost containment
- Applies to reimbursement methodologies and amounts paid by all payers, including self-insured employer plans
- Option 1A reflects the broadest population impact within this policy option category
- Could align across private and public payers, although this requires federal agreement and decision about how to include Medicaid
- Provides more predictable revenue for hospitals and more predictable costs for payers
- Regulates total cost of providing care, so more likely to reduce commercial insurance spending
- Moves away from fee-for-service reimbursement model

Cons

- Payers could choose not to contract with the provider if they did not like the payment methodology or loss of negotiating power
- Complicated to implement and most costly for Option 1
- Difficult to implement for non-hospital provider types, at least initially, due to the complexity and cost

Health System Budgets

Option 1B: Evolve ACO Regulatory Process
Definition and Summary

GMCB would evolve 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. The payment method and amounts could be payer-agnostic, but ideally would be aligned across multiple (all) payers. Requires payer and provider participation for attribution; self-insured employer plans could voluntarily participate.

Option 1B: Evolve ACO Regulatory Process to include State-Set Provider Payment Methodologies and Amounts	
Regulatory Mechanism and Authority	18 V.S.A. 9382 (ACO oversight) and 18 V.S.A. § 9375 and 9376 (provider reimbursement) • The ACO budget process could be modified to provide for clearer authority for setting the terms of the payer and provider contracts with the ACO. • The GMCB would require that the ACO and its participating providers use a provider payment methodology and amount when contracting with payers. This could include all or a subset of payments to providers. For example, the GMCB could set a payment methodology for fixed prospective payments to hospitals, which would apply to all payers, and could leave fee-for-service rates to the private market.
Enforcement	Current statute does not include enforcement provisions for noncompliance with a provider reimbursement order. • The Board, potentially, could exercise this authority over hospitals in conjunction with the budget process in order to ensure enforcement is available over those providers. • Additional enforcement authority would be needed to cover non-hospital provider types, if those were included.
State of Vermont Agencies Involved	GMCB; AHS/DVHA

Health System Budgets

Option 1B: Evolve ACO Regulatory Process Definition and Summary, Cont.

Option 1B: Evolve ACO Regulatory Process to include State-Set Provider Payment Methodologies and Amounts	
Population	Population attributed to an ACO. Vermont's ACO-attributed population is based on voluntary provider and payer participation.
Provider/ Services	Providers participating in an ACO to whom the payment method applies; ACOs operating in Vermont. The payment methodology would be mandatory for the ACO, but providers could choose to participate in the ACO. Could apply to any combination of inpatient, outpatient and professional services.
Payers	Health system budgets would impact all payers' contractual negotiations with providers. In an ACO-based budget, budgets could be payer agnostic or applied specifically to a payer, but the enforcement methodology would impact whether and how payer-specific rates would be adjusted. This option would impact Commercial payers, and potentially Medicare and Medicaid: • Medicare: Would require an agreement with CMMI to set the payment methodology and amount. • Medicaid: Potentially would require waiver of Single State Agency Rule (see slide 94). Alternatively, the GMCB could adopt the payment methodology and amount set prospectively by DVHA. • Commercial: Would impact commercial insurers and self-insured employers contracting with an ACO.
Methodology	Rates are established prospectively (at the beginning of the year) based on expected utilization, payer, and provider participation as part of the annual ACO budget process. Likely, payers would use the methodology and any rate parameters set by the regulator to calculate the payment to the ACO for the providers receiving the payments.
Payment Model(s)	Compatible with a range of payment methodologies, including population-based payments.

Health System Budgets

Option 1B: Evolve ACO Regulatory Process
Implications for Vermont

Compatibility with Value-Based Care	Evolves the existing value-based care model that Vermont is pursuing. To the extent that population-based payments become the required payment methodology, the increase in population-based payments would give providers more flexibility to choose how to invest their resources to best meet the needs of their patients and achieve goals of value-based care. Alignment across payers would bolster opportunities/incentives for providers to invest in delivery system reform, particularly if it becomes the dominant form of provider payment. Intent would be to tie population-based payments to quality and health outcomes, as they are in the current ACO model.
Implications for Sustainability	The current ACO regulatory criteria (in statute and rule) are not based on provider sustainability, nor do they prioritize payer mix issues. However, if state-set ACO payment methodologies rely on prospective, predictable, population-based payments for facilities, provider sustainability could become a focal consideration. Payment methodologies could also be structured to contemplate relative contributions of payers.
Implications for Reimbursement Equity	The payment methodologies currently implemented through Vermont ACO programs largely rely on historical fee-for-service rates and bake in any inherent inequities due to asymmetrical bargaining power. The ACO program currently addresses this issue in the Comprehensive Payment Reform (CPR) program for, which capitates payment to participating independent primary care providers. This increases reimbursement amounts relative to their fee-for-service alternative through the calculation of the capitated payment. In addition, the current ACO payment model redirects resources from hospitals to other provider types. The state could establish criteria for ACO payment methodologies to address these provider-based inequities directly, or phase in equitable reimbursements over time.

Health System Budgets

Option 1B: Evolve ACO Regulatory Process
Implications for Vermont

Pros

- Builds on existing payment reform and regulatory processes, promoting established state priorities
- Focusing on ACO-participating provider payment only is easier and less costly for GMCB to implement
- Would increase alignment of the payment mechanisms across payer types, within an ACO
- Depending on payment policy, could provide more predictable costs for payers for population attributed to the ACO and more predictable payments to providers participating in the ACO
- Payment policy could be designed to impact total cost of providing care
- Potential to redirect resources within the health care system for the providers participating in the ACO, impacting a broader number of provider types without additional administrative reporting to GMCB

Cons

- Only includes ACO-attributed population associated with voluntary participation of providers and payers, so may be more difficult to achieve scale
- Impact on provider's revenue may be more limited, depending on scale of the ACO program
- Providers may choose not to join the ACO if they did not like the payment model, limiting impact
- Insurers may choose not to join the ACO if they did not like the payment model, limiting impact
- Current regulatory process does not analyze provider impacts on an ongoing basis; this could be addressed with expanded authority
- Impact on providers would vary based on participation in the ACO

Health System Budgets

Option 1C: Require Insurers to Use Population-Based Payments Definition and Summary

The GMCB would require insurers to adopt population-based payment methodologies (e.g., predictable, flexible, stable, value-based payments paid to providers or an ACO) and other reimbursement parameters to establish a budget for the population purchasing an insurance product. This would correlate to a portion of providers' budgets associated with these populations. Self-insured employer plans could voluntarily participate.

Option 1C: Require Insurers to Use Population-Based Payments	
Regulatory Mechanism and Authority	8 V.S.A. §§ 4062, 4513(c), and 4584(c) and 18 V.S.A. § 9375 (health insurance premium rate review) require the GMCB to review insurance premiums for the large group market and for the individual and small group market. The GMCB's authority allows for an affordability analysis. It would be preferable to add explicit authority to the rate review statutes to clarify that this type of activity is allowable. In addition, the GMCB may be limited in setting rates for BCBSVT under 8 V.S.A. § 4513(c) and 4584(c). • Using the premium rate review process, GMCB would set requirements for value-based payments (e.g., population-based payment methodologies for providers or an ACO) and other reimbursements to establish a budget for the population purchasing the insurance product and a portion of a budget for providers. Self-insured employer plans could voluntarily participate.
Enforcement	Additional authority needed for GMCB or process for referring enforcement actions to DFR.
State of Vermont Agencies Involved	GMCB; DFR

Health System Budgets

Option 1C: Require Insurers to Use Population-Based Payments Definition and Summary, Cont.

Option 1C: Require Insurers to Use Population-Based Payments	
Population	Population would be limited to members of Vermont-regulated Commercial insurance plans (individual, small group, and large-group insurance products). Would exclude private self insured employer plans, Medicaid, and Medicare. The legislature could direct similar policy for state employee, education employees, and state-funded retirees.
Provider/ Services	Providers accepting payment by regulated carriers or through an ACO. Could apply to any combination of inpatient, outpatient and professional services.
Payers	Regulated carriers would adopt population-based payments (e.g., predictable, stable, flexible, and potentially value-based, payments paid to providers or an ACO) and other reimbursement parameters to establish a budget for the population purchasing an insurance product. Health system budgets would impact payers' contractual negotiations with providers. • Commercial: Would impact Commercial insurers (not including self-insured employer plans). • Medicare and Medicaid: Regulation would not impact Medicare or Medicaid, though ideally payment methodologies would be aligned with Medicaid and Medicare payment methodologies.
Methodology	Population-based payment rates are established prospectively (at the beginning of the year) based on expected utilization as part of the rate review process.
Payment Model(s)	Population-based payment, which could be based on the factors currently used in the rate review process (population changes, historical spending, expected utilization, etc.).

Health System Budgets

Option 1C: Require Insurers to Use Population-Based Payments
Implications for Vermont

Compatibility with Value-Based Care	Increasing the usage of population-based payments to providers would give providers more flexibility to choose how to invest their resources to best meet the needs of their population and achieve goals of value-based care; to the extent that there is alignment across payers, this would only bolster opportunities/incentives for providers to invest in delivery system reform, particularly if it becomes the dominant form of provider payment. Likely compatible with ACO programs. Intent would be to tie population-based payments to quality and health outcomes, as they are in the current ACO model.
Implications for Sustainability	This model is not focused on provider sustainability. To the extent it increases predictable, prospective payments it may support the financial sustainability of providers as compared to a fee-for-service reimbursement system. This model does not address payer mix issues. Could be complementary to hospital budget process, which is assumed to remain.
Implications for Reimbursement Equity	This model is not focused on equalizing fee-for-service payments, but the population-based payments could be designed to incorporate some factors that enhance equity over time.

Health System Budgets

Option 1C: Require Insurers to Use Population-Based Payments
Implications for Vermont

Pros

- Evolves existing regulatory system to allow for pursuit of established state payment reform priorities
- Likely to reduce commercial insurance spending for plans included because population-based payments would be designed to look at total cost of services
- Potential to redirect resources within the health care system over time or seek to balance payment amounts across provider types and/or service categories
- Easier and less costly to implement for GMCB, but more costly for insurers
- Could align across private and public payers, although this requires federal agreement and agreement between GMCB and DVHA
- Provides more predictable costs for an insurance product, which reduces volatility in insurance premiums/medical trend

Cons

- Population is limited to insured lives, although voluntary participation by self-insured payers could be promoted
- Would not have as much impact on a provider's revenue given number of lives, unless Medicaid and Medicare are aligned
- Providers could choose not to contract with an insurer if they did not like the payment model
- Potentially harmful impacts on provider sustainability over time if population-based payment is not sufficient; difficult to determine provider impacts

Health System Budgets

Cost Implications: All Options

- SOV: There would be implementation costs to the GMCB to evolve the regulatory process(es) to function as an enforceable health system budget. These costs are highly variable, depending on which option is chosen and how complicated a methodology is required to be implemented.
- Private Sector Impacts: The goal with a health system budget is to provide a predictable revenue amount to providers and predictable costs to payers. Both providers and insurers would have implementation costs to potentially modify billing and claims processing systems to reflect that new payment methods and amounts, unless payment methods are based on historical fee-for-service.

*NOTE: Cost estimates are approximate. They are based on related past work and discussions with other state agencies and do not reflect actual quotes for work to be performed. Staffing estimates include salary, benefits, and overhead, and assume steady state for other duties and responsibilities; ongoing operational costs likely to change following pre-implementation studies.

Health System Budgets

Cost Implications: All Options

OPTION 1A ONLY: Initial Analysis, Development, and Implementation (175-250k in one-time costs)		
Design Health System Budget	$100-150k	Option A only: This study would assist the GMCB in redesigning the hospital budget process into a facility-based budget. Work to be supported by contractor(s)
Data Collection - Unregulated Providers	$75-100k	Option A only: Depending on how many/which providers are included in the scope of the health system budget, GMCB would need additional information about currently unregulated providers in order to determine the appropriate basis for establishing a fee schedule. This could be done by creating a cost-based data collection tool, which would be filled out by all providers of that class or could be determined with a representative sample. This study is only needed if Option A is expanded to additional provider types. Work to be supported by contractor.

ALL OPTION 1: Initial Analysis, Development, and Implementation (1,100-1,400k in one-time costs)		
Development of Payment Methodologies and Provider Impact Study	$400-600k	This study would assist the GMCB in designing the health system budget parameters, including the payment methodologies and any other reimbursement parameters. It would also study the impact of options for reimbursement changes on providers, with a significant focus on hospital sustainability for Option 1A. This study would also analyze the impact of the reimbursement changes on providers and would consider premium impacts. Cost will vary depending on provider types/number of providers. For example, analyzing the impacts on Vermont's 14 hospitals would be less costly than studying providers not currently regulated by the GMCB. If this study were to look at provider entities for whom the GMCB does not have data, data would need to be collected from individual providers for this study. Work to be supported by contractor.
Impact on All-Payer Model and TCOC	$75k	This study would analyze the impacts of the proposed provider reimbursement scheme on Vermont's All-Payer Model, including the All-Payer Model Total Cost of Care and the impact on the ACO program. Work to be supported by contractor.
Operational Requirements	$100-150k	This study would analyze operational changes at the GMCB needed to support system, including upgrades needed to ensure the GMCB has the necessary data to understand the impacts of the provider regulatory system (for example, new data collection from regulated and unregulated entities). The study would also include staffing necessary for implementation, including the potential Medicaid funding availability if AHS rate setting is moved to the GMCB and any additional federal reporting required by such a move. Work to be supported by contractor.
Medicare Agreement Support	$150k	Contractor support for Medicare Agreement, if State sought to align Medicare payment methods with new reimbursement scheme.
Staffing	$375-425k	Dedicated staffing (3 FTEs – legal, policy, data, and contract management) to coordinate model design and engage with contractors.

Health System Budgets

Cost Implications: All Options

Operations ($375-1,000k annually; estimates will be revised based on the above studies)		
Staffing	$125-500k	Additional staff (1-4 FTEs) to manage regulatory system, including to collect/update provider data and to perform analysis to support compliance. Number of staff depends on which option is chosen and model design elements.
Ongoing Policy and Operations Support, Analysis, and Enforcement Support	$250-500k	Contractor support for ongoing policy development, operations, monitoring, analysis, and enforcement.

All Health System Budgets options would require significant model design to inform operational cost estimates.

Health System Budgets

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

- 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
- Resources:
  - Center for Medicare and Medicaid Innovation: Maryland All-Payer Model
  - Center for Medicare and Medicaid Innovation: Evaluation of the Medicare All-Payer Model
  - Altarum Healthcare Value Hub: Hospital Rate Setting: Successful in Maryland but Challenging to Replicate (March 2015)

Health System Budgets

Example: Pennsylvania Rural Health Model (2019-current)

- 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.
- Resources:
  - Center for Medicare and Medicaid Innovation – Pennsylvania Rural Health Model
  - Pennsylvania Department of Health – Pennsylvania Rural Health Model

Option 2: Setting Reimbursement Parameters
Definition and Summary

- 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* but does not prescribe *unit cost*.
- 3 implementation options:
  - Implementation via provider regulation:
    - **Option 2A: Entity-Based Growth Caps and Floors.** The GMCB would evolve the hospital budget process to impact the professional fee schedule and/or regulate cost-per-service for currently unregulated providers. GMCB could evolve its current hospital budget process to refine how it caps the trend on charges (currently, the cap on charges impacts commercially reimbursed inpatient and outpatient hospital services). The process of applying a cap or floor on trend could be extended to other provider types, however, a cap on commercial reimbursement may not be applicable to all providers.
    - **Option 2B: Service-Based Growth Caps and Floors.** The GMCB 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. This option is focused on commercial reimbursements.
  - Implementation via insurance regulation:
    - **Option 2C: Growth Parameters in Payer-Provider Contracts.** The GMCB would direct payers to limit growth in reimbursement in contracts negotiated with providers.

Setting Reimbursement Parameters

Option 2A: Entity-Based Growth Caps and Floors
Definition and Summary

GMCB would evolve the hospital budget process to impact the professional fee schedule and/or regulate cost-per-service for currently unregulated providers. GMCB could evolve its current hospital budget process to refine how it caps the trend on charges (currently, the cap on charges impacts commercially reimbursed inpatient and outpatient hospital services). The process of applying a cap or floor on trend could be extended to other provider types; however, a cap on commercial reimbursement may not be applicable to all providers.

Option 2A: Set Entity-Based Growth Caps and Floors	
Regulatory Mechanism and Authority	18 V.S.A. § 9375 and 18 V.S.A., chapter 221, subchapter 7 (hospital budgets). • If implemented for hospitals only, would not require additional authority; hospitals or insurers could be required to submit reimbursement information by payer. This would be a natural evolution of the current hospital budget review process. • If implemented for broader entity types, would require additional authority, as well as significant additional data collection, analysis, and oversight. This option is not effective for providers for whom Medicaid or Medicare are the primary payer, since payment rates (and growth rates) are already set by government (e.g., CMS; Agency of Human Services).
Enforcement	GMCB currently has enforcement authority for hospital budgets per 18 V.S.A. § 9456. • If implemented for broader entity types, would require additional enforcement authority. • This could have implications for the Agency of Human Services if it includes providers for whom Medicaid is the primary payer.
State of Vermont Agencies Involved	GMCB

Setting Reimbursement Parameters

Option 2A: Entity-Based Growth Caps and Floors
Definition and Summary, Cont.

Option 2A: Set Entity-Based Growth Caps and Floors	
Population	Cap on reimbursement growth is most relevant to commercially insured patients using a Vermont provider. Vermont's current hospital budget process impacts anyone receiving services from a regulated Vermont hospital or a hospital-affiliated provider or practice.
Provider/Services	Providers to whom growth cap applies would be regulated entity; for these providers, participation would be mandatory. The cap could apply to any services provided by regulated providers/facilities, or a subset. • The current hospital budget process reviews revenue and expense data and sets net patient revenue and change in charge for each hospital, which impacts hospital inpatient and outpatient services only. (Professional services provided by the hospital or hospital-owned practices, e.g., hospital-owned primary care practices, are paid on a fee schedule, so are not impacted by a change in charge.) • Expanded entity-level review could be most easily applied to ambulatory surgical centers. It would be challenging to apply this approach to provider types for whom there are many unique business entities (e.g., independent practices). • As noted earlier, this option is not effective for providers for whom Medicaid or Medicare are the primary payer, since payment rates (and growth rates) are already set by government (e.g., CMS; Agency of Human Services). For example, the GMCB review of Brattleboro Retreat and Designated Mental Health Agency budgets focuses on sustainability and transparency and does not impact reimbursements, since those revenues are largely from Medicaid.
Payers	While growth caps are payer agnostic, they effectively apply to provider negotiations with commercial payers only because Medicare and Medicaid set reimbursement amounts. • Commercial: Would impact Commercial payers' negotiations with providers. • Medicare and Medicaid: Would not impact Medicare or Medicaid.
Methodology	Regulator would apply an entity-specific trend to commercial reimbursement increases based on revenue and expense data provided by the regulated entity, ideally, in order to understand impacts on providers prior to setting the cap. Could also be implemented without looking at provider data, but could have consequences on provider sustainability.
Payment Model(s)	Compatible with a range of payment methodologies, including population-based payments.

Setting Reimbursement Parameters

Option 2A: Entity-Based Growth Caps and Floors
Implications for Vermont

Compatibility with Value-Based Care	Could be designed to be compatible with value-based care. Current hospital budget process reviews revenue from both FFS and population-based payments. Does not necessarily tie payment to quality without additional payment policies.
Implications for Sustainability	Compatible depending on design. Could potentially harm financial position of providers with who currently have high base prices and lower growth (since base prices are not currently examined). Likewise, if a growth cap were applied across the board, providers with low prices could be penalized. If cap or floor is set without considering revenue and expenses of the provider, impacts on provider financial positions would not be known. Payer mix is considered in this process.
Implications for Reimbursement Equity	If this option is extended to currently unregulated providers, to the extent that it prescribes varying growth rates, it could assist with equalizing payment amounts across providers over time.

Setting Reimbursement Parameters

Option 2A: Entity-Based Growth Caps and Floors
Implications for Vermont

Pros

- Likely to reduce commercial insurance spending for plans included if cap selected is less than current commercial trends (may or may not translate to premium savings, depending on if floors are also established for some provider types)
- Could implement without legislation if limited to evolving the hospital budget process
- Evolution of growth caps in hospital budget process would allow GMCB more nuanced view of price growth, which could support equity in reimbursement across facilities and allows GMCB an entity-specific view of sustainability
- Expanding revenue floors/caps to additional provider types would expand ability to impact health care *price* for a larger proportion of health spending & has potential to redirect resources among provider types
- Expanding revenue floors/caps to some new provider types (e.g., ambulatory surgical centers) could provide a similar regulatory context for facilities delivering similar services
- Use of floors/caps provides flexibility to pursue state priorities
- Provider reimbursement regulation applies to reimbursements paid by all payers, including self-insured employers

Cons

- Expanding revenue floors/caps to providers for whom Medicaid or Medicare are the primary payer would result in limited benefit, since payment rates (and growth rates) are already set by government (e.g., CMS; Agency of Human Services).
- Newly regulated providers would have additional administrative burden from new data collection needed for an entity or provider view (e.g., independent providers)
- Expanding revenue floors/caps to unregulated providers may be costly for GMCB to implement, depending on how many provider organizations would be newly regulated
- Does not impact base reimbursement amounts and may perpetuate existing inequities, because related to existing expenses of an individual provider

Setting Reimbursement Parameters

Option 2A: Entity-Based Growth Caps and Floors
Cost Implications

- SOV:
  - Minimal additional resources would be needed to enhance the current hospital budget process; the GMCB would likely require contracting support to develop new processes and additional support for ongoing operations.
  - Expanding the process to new entity types would require significant resources to develop and implement, as well as significant ongoing staffing to support data collection, analysis, and oversight.
- Private Sector Impacts: Expanding a similar budget review process to new entity types would be a significant burden on newly regulated providers.
  - Operational costs to providers are unknown; this would require further study.

*NOTE: Cost estimates are approximate. They are based on related past work and discussions with other state agencies and do not reflect actual quotes for work to be performed. Staffing estimates include salary, benefits, and overhead, and assume steady state for other duties and responsibilities; ongoing operational costs likely to change following pre-implementation studies.

Setting Reimbursement Parameters

Option 2A: Entity-Based Growth Caps and Floors
Cost Implications

To Evolve Hospital Budget Process

Initial Analysis, Development, and Implementation ($0-70k in one-time costs)		
Additional Data Gathering	$0-20k	Additional data is necessary to refine current process of setting charges to achieve a better understanding of the relative reimbursement amounts among hospitals. This data potentially could be collected from carriers through rate review process or from hospitals.
Cost and Operational Requirements	<$50k	Contractor support to develop new processes.

To Expand to Additional Provider Types

Initial Analysis, Development, and Implementation ($285-475k in one-time costs)		
Additional Data Gathering	$75-100	Depending on how many/which providers are in scope, GMCB would need additional information about unregulated providers in order to determine the appropriate basis for establishing the floor or cap on the provider. This could be done by creating a cost-based data collection tool, which would be filled out by all providers of that class or could be determined with a representative sample.
Cost and Operational Requirements	<$50k	Contractor support to develop new processes.
Impact on All-Payer Model and TCOC	$75k	This study would analyze the impacts of the proposed regulatory scheme on Vermont's All-Payer Model, including the All-Payer Model Total Cost of Care and the impact on the ACO program.
Staffing	$125-250k per new entity type	Dedicated staffing (1-2 FTEs per new entity type – financial) to perform initial data gathering and analysis.

Setting Reimbursement Parameters

Option 2A: Entity-Based Growth Caps and Floors
Cost Implications

To Evolve Hospital Budget Process

Operations ($0-10k annually; estimates will be revised based on the above studies)		
Staffing	$0	Minimal ongoing operational requirements to evolve hospital budget process.
Contractor Support	$0-10k	Additional analytic or actuarial support for updates and compliance.

To Expand to Additional Provider Types

Operations ($235-270k annually; estimates will be revised based on the above studies)		
Staffing	$225-250k per new entity type	Additional staff support (2 FTEs per new entity type) for annual data gathering and analysis as well as year-round monitoring. Staffing needs will depend on which provider types, and how many entities, are added to review.
Contractor Support	$10-20k	Additional analytic or actuarial support for updates and compliance. Amount will depend on which provider types.

Setting Reimbursement Parameters

Option 2B: Service-Based Growth Caps and Floors
Definition and Summary

GMCB 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. This option is focused on commercial reimbursements.

Option 2B: Set Service-Based Growth Caps and Floors	
Regulatory Mechanism and Authority	Provider reimbursement (18 V.S.A. § 9375 and 9376). • The GMCB would establish a provider reimbursement unit, with contractor support, to establish and manage updates to the reimbursement model. This would require the GMCB to undertake additional research to determine the most appropriate trends, engage with affected stakeholders, and draft a new rule for these efforts.
Enforcement	Current statute does not include enforcement provisions for noncompliance with a provider reimbursement order. • The GMCB, potentially, could exercise this authority over hospitals in conjunction with the budget process in order to ensure enforcement is available over those providers. • Additional enforcement authority would be needed to cover non-hospital provider types and also to ensure that payer contracts were in compliance.
State of Vermont Agencies Involved	GMCB.

Setting Reimbursement Parameters

Option 2B: Service-Based Growth Caps and Floors Definition and Summary, Cont.

Option 2B: Set Service-Based Growth Caps and Floors	
Population	Population served by providers subject to reimbursement growth cap or floor; functionally, this would likely be limited to commercially insured patients.
Providers/ Services	Providers to whom growth cap or floor applies would be regulated entity; for these providers, participation would be mandatory. Could apply to any class of services (e.g., professional services), or a subset (e.g., a subset of professional services; professional services provided by certain providers types). If applied to service classes currently regulated through the hospital budget process, that process would need to be aligned.
Payers	Trends on categories of service are set for providers; would apply to any payer who contracts with that provider. While growth caps are payer agnostic, they effectively apply to provider negotiations with commercial payers only because Medicare and Medicaid set their own reimbursement amounts and growth rates. • Commercial: Commercial payers would negotiate rates for services consistent with the service level caps or floors and could continue to have some variation within the service category at the code level. • Medicare and Medicaid: Unlikely; potential for all-payer rate setting, but would likely require major increases in Medicare and Medicaid reimbursement amounts, with implications for State and federal budgets. Would require Agreement with Medicare.
Methodology	The GMCB would set only a trend on growth (and would not impact unit cost) for certain provider types or service types. In addition, GMCB would set the trend on the service category level, not at the individual service code.
Payment Model(s)	Compatible with a range of payment methodologies, including population-based payments.

Setting Reimbursement Parameters

Option 2B: Service-Based Growth Caps and Floors
Implications for Vermont

Compatibility with Value-Based Care	Compatible with value-based care if growth floors and caps are differentially applied across service types to shift payment toward higher-value care, in line with state policy goals. Compatible with ACO program, although impacts and design need further analysis. Does not necessarily tie payment to quality without additional payment policies.
Implications for Sustainability	Does not require predictable, flexible payments to providers, though potentially compatible depending on design. Could harm financial position of providers by constraining growth in their contracts with Commercial payers, especially if growth rates are below medical inflation. Could also increase volume incentives without other payment reforms in place. This model does not look at provider sustainability outside of the hospital budget process, which is assumed to remain.
Implications for Reimbursement Equity	Depending on design, could either set a single growth rate for all providers or by provider class, or could seek to make actual payment rates more equitable across and within provider classes over time. Would not immediately change underlying FFS reimbursements.

Setting Reimbursement Parameters

Option 2B: Service-Based Growth Caps and Floors
Implications for Vermont

Pros

- Likely to reduce commercial insurance spending for plans included if cap selected is less than current commercial trends (may or may not translate to premium savings, depending on if floors are also established for some provider types)
- Captures providers outside of current regulatory mechanisms
- Potential to redirect resources within the health care system over time or seek to balance base payment amounts by applying cap differentially by service type or by provider characteristics; this has the potential to increase equity across provider types
- Less expensive to implement
- Less administrative reporting burden on providers than some options

Cons

- Does not impact base reimbursement amounts and perpetuates existing inequities unless caps and floors are applied differentially
- Perpetuates fee-for-service reimbursement model, including payment policies that Vermont may not support or may not be in line with the State's goals
- Does not analyze provider impacts and sustainability on an ongoing basis; could be variation in impacts among provider types

Setting Reimbursement Parameters

Option 2B: Service-Based Growth Caps and Floors
Cost Implications

- SOV: Assuming this method was only used for commercially insured populations, there would be implementation costs to the GMCB. Implementing through provider reimbursement/rate setting authority would be more costly to the state than implementation through hospital budget review (for which processes already exist) or insurance regulation (which shifts the implementation costs to the insurers).
- Private Sector Impacts: Operational costs to providers and insurers are unknown. This would require further study.

*NOTE: Cost estimates are approximate. They are based on related past work and discussions with other state agencies and do not reflect actual quotes for work to be performed. Staffing estimates include salary, benefits, and overhead, and assume steady state for other duties and responsibilities; ongoing operational costs likely to change following pre-implementation studies.

Setting Reimbursement Parameters

Option 2B: Service-Based Growth Caps and Floors
Cost Implications

Initial Analysis, Development, and Implementation ($285-425k in one-time costs)		
Study to Determine Caps/Floors & Provider Impacts	$75-150k	This analysis would analyze current reimbursement levels and prior trend rates of service classes in the aggregate using data from VHCURES and potentially other data sources. It would produce recommended caps and floor growth trends at the service level for selected service categories with areas of divergence identified in the pre-implementation studies. This study would also analyze the impact of the reimbursement changes on providers, and would consider premium impacts. Study cost will vary depending on service categories or subcategories included. • This study is likely only needed if there is a goal to shift payment among certain service classes by using both caps and floors.
Cost and Operational Requirements	<$50k	Contractor support to develop new processes.
Impact on All-Payer Model and TCOC	$75k	This study would analyze the impacts of the proposed regulatory scheme on Vermont's All-Payer Model, including the All-Payer Model Total Cost of Care and the impact on the ACO program.
Staffing	$125-150k	Dedicated staffing (1 FTE) to coordinate model design and engage with contractors.

Setting Reimbursement Parameters

Option 2B: Service-Based Growth Caps and Floors
Cost Implications

Operations ($135-270k annually; estimates will be revised based on the above studies)		
Staffing	$125-250k	Staff (1-2 FTEs) to manage annual process to update caps and floors
Contractor Support	$10-20k	Additional analytic support for updates and compliance. Amount will depend on which provider types.

Setting Reimbursement Parameters

Option 2C: Growth Parameters in Payer-Provider Contracts
Definition and Summary

GMCB would direct payers to limit growth in reimbursement in contracts negotiated with providers. Compatible with ACO program, although impacts need further analysis. Self-insured employer plans could voluntarily participate.

Option 2C: Growth Parameters in Payer-Provider Contracts	
Regulatory Mechanism and Authority	8 V.S.A. §§ 4062, 4513(c), and 4584(c) and 18 V.S.A. § 9375 (health insurance premium rate review) require the GMCB to review insurance premiums for the large group market and for the individual and small group market. The GMCB's authority allows for an affordability analysis. It would be preferable to add explicit authority to the rate review statutes to clarify that this type of activity is allowable. In addition, the GMCB may be limited in setting rates for BCBSVT under 8 V.S.A. § 4513(c) and 4584(c). • The GMCB would establish trend factors to be used when payers negotiate reimbursements with providers and would act as a cap or floor on negotiated rates. Payers and providers would retain the ability to negotiate underneath the cap or above the floor.
Enforcement	The GMCB's enforcement authority is likely not sufficient and there should be more clarity about how any new enforcement would interact with DFR's authority. GMCB could use VHCURES to analyze claims to determine whether there is compliance.
State of Vermont Agencies Involved	GMCB, DFR

Setting Reimbursement Parameters

Option 2C: Growth Parameters in Payer-Provider Contracts Definition and Summary, Cont.

Option 2C: Growth Parameters in Payer-Provider Contracts	
Population	Population would be limited to members of Vermont-regulated Commercial insurance plans (individual, small group, and large-group insurance products). Would exclude private self insured employer plans, Medicaid, and Medicare. The legislature could direct similar policy for state employee, education employees and state-funded retirees. • Impact would be limited compared to Option 2A, because the policy would be limited to enrollees of health insurance plans (~94,000 Vermonters; see 2018 Vermont Expenditure Analysis), and because providers could, theoretically, choose not to contract with participating health plans.
Provider/ Services	Regulator sets boundaries for payer-provider contracts; providers would continue to negotiate reimbursement amounts with commercial payers, or could choose not to contract with participating payers. Could apply to any combination of inpatient, outpatient and professional services.
Payers	Regulated insurers would be the regulated entity. • Commercial: Would impact Commercial insurers (not including self-insured employer plans). • Medicare and Medicaid: Would not impact Medicare or Medicaid.
Methodology	A trend rate that would be applied to current reimbursement, which would act as a cap or a floor. There could be multiple trends applied to different provider types or different service categories based on state policy goals, which could allow for more growth in certain services or provider sectors (e.g., primary care).
Payment Model(s)	Compatible with a range of payment methodologies, including population-based payments, but does not inherently modify FFS.

Setting Reimbursement Parameters

Option 2C: Growth Parameters in Payer-Provider Contracts
Implications for Vermont

Compatibility with Value-Based Care	Compatible with value-based care if growth floors and caps are differentially applied across service types to shift payment toward higher-value care, in line with state policy goals. Compatible with ACO program, although impacts and design need further analysis. Does not necessarily tie payment to quality without additional payment policies.
Implications for Sustainability	This model does not require predictable, flexible payments to providers, though potentially compatible depending on design. Could harm financial position of providers by constraining growth in their contracts with Commercial payers or could shift focus to utilization without other payment reforms in place. This model does not look at provider sustainability outside of the hospital budget process, which is assumed to remain.
Implications for Reimbursement Equity	The model would impact reimbursement amounts to different sectors over time and could increase/decrease reimbursements to some providers more than others over time. This model does not inherently change FFS reimbursement methodologies, so would not necessarily eliminate site-based service payments if in use by a payer.

Setting Reimbursement Parameters

Option 2C: Growth Parameters in Payer-Provider Contracts
Implications for Vermont

Pros

- Likely to reduce commercial insurance spending for plans included if cap selected is less than current commercial trends (may or may not translate to premium savings, depending on if floors are also established for some provider types)
- Potential to redirect resources within the health care system over time or seek to balance base payment amounts by applying cap differentially by service type or by provider characteristics
- Easier to implement than other models
- Less costly to implement than other models

Cons

- Impact limited to insured markets/small number of Vermonters
- Limited impact on All-Payer Model Total Cost of Care due to small size of insured market[1]
- Potentially harmful impacts on provider sustainability over time if cap is too low; difficult to determine provider impacts
- If implemented through insurance regulation with voluntary provider participation, insurers may struggle to negotiate provider rates that meet targets
- Perpetuates fee-for-service reimbursement model, including payment policies that Vermont may not support or may not be in line with the State's goals

[1] Berry Dunn Issue Brief: Impact of Rate Review on APM TCOC(December 2018).

Setting Reimbursement Parameters

Option 2C: Growth Parameters in Payer-Provider Contracts
Cost Implications

- SOV: There would be implementation costs to the GMCB to supplement the current rate review process with additional data and actuarial analysis. GMCB would need to implement a process to determine if the cap is being adhered to. Implementing through provider regulation would be more costly to the state than implementation through insurance regulation, which shifts the implementation costs to the insurers.
- Private Sector Impacts: Impacts on commercial premiums are uncertain without further analysis and would depend on the goals (e.g., increase reimbursement in some sectors; control costs). Insurers would have some implementation costs to ensure that their negotiations adhered to the reimbursement caps and to provide additional information during the rate review process on reimbursement trend requests and impacts. In addition, because this type of regulation does not look at provider entities, the impacts on providers, positive or negative, would not be reviewed outside of the hospital budget process.

*NOTE: Cost estimates are approximate. They are based on related past work and discussions with other state agencies and do not reflect actual quotes for work to be performed. Staffing estimates include salary, benefits, and overhead, and assume steady state for other duties and responsibilities; ongoing operational costs likely to change following pre-implementation studies.

Setting Reimbursement Parameters

Option 2C: Growth Parameters in Payer-Provider Contracts
Cost Implications

Initial Development and Implementation ($20-60k in one-time costs)		
Study to Determine Caps/Floors & Provider Impacts	$20-60k	This analysis would analyze current reimbursement levels and prior trend rates of service classes in the aggregate using data from VHCURES and produce recommended caps and floor growth trends at the service level for selected service categories with areas of divergence identified in the study above. This study would also analyze the impact of the reimbursement changes on providers, and would consider premium impacts. Study cost will vary depending on service categories or subcategories included. This study is likely only needed if there is a goal to shift payment among certain service classes by using both caps and floors.

Operations ($20-60k annually; estimates will be revised based on the above studies)		
Actuarial Support	$20-60k	Additional dollars for enhanced actuarial review and support in selecting a justifiable trend rate/cap.

Setting Reimbursement Parameters

Example: Vermont Hospital Budget Review (1983-current)

- 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)

- 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
- Resources:
  - Rhode Island Affordability Standards
  - NASHP - Insurance Rate Review as a Hospital Cost Containment Tool: Rhode Island's Experience

Setting Reimbursement Parameters

Example: Connecticut Hospital Price Growth Limits (2019-current)

- Connecticut's Office of Health Strategy (OHS) has taken targeted action to limit hospital price growth through its Certificate of Need (CON) process.
- Affected hospitals cannot raise prices higher than the change in the Northeast region's CPI from the preceding year plus 1%, or by 3%, whichever is lower.
- Based off of Massachusetts Attorney General Maura Healy's 2018 decision to impose a 7-year price cap as a condition for approving the merger between Beth Israel Deaconess Medical Center and Lahey Health System amid reports the deal could result in price hikes as high as $231 million per year.
- Resources:
  - Connecticut Office of Health Strategy – Hartford HealthCare/St. Vincent's Press Release (August 15, 2019)
  - Hartford Business Journal – "New CT cost caps could chip away at rising healthcare spending" (June 17, 2019)

Option 3: Fee-for-Service Rate Setting
Definition and Summary

- Definition: Regulatory entity sets reimbursement amounts, most commonly using an existing payer's reimbursement scheme as a point of reference.
  - This option assumes Vermont elects to use Medicare's payment methodology as the basis for fee-for-service rate setting, with a percentage increase determined by policymakers or regulators (e.g., "160% of Medicare" or 1.6x Medicare rates). 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.
  - If unit cost x utilization = cost of providing care, 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).
- 2 major implementation options:
  - **Option 3A: Implementation via Provider Regulation:**
    - The GMCB would set reimbursement methodology based on a percentage of Medicare reimbursement; providers change charge lists to match.
  - **Option 3B: Implementation via Insurance Regulation:**
    - The GMCB would direct payers to negotiate with providers for reimbursement that averages a maximum percentage of Medicare reimbursement.

Fee-for-Service Rate Setting

Option 3A: FFS Rate Setting via Provider Regulation
Definition and Summary

GMCB would set reimbursement methodology based on a percentage of Medicare reimbursement; providers change charge lists to match.

- Could apply to all payers, or a subset; similarly, could apply to all providers who deliver included services, or a subset.
- History: Rate (price) setting, especially for hospitals, was common in states across the country in the 1970s and 80s. This policy was abandoned in every state but Maryland (see example on slide 78) and West Virginia by the late 90s; West Virginia's program ended in 2016. Maryland's all-payer rate setting model continues, though it has evolved significantly since 2014 (see Health System Budgets example, slide 44).

Option 3A: FFS Rate Setting via Provider Regulation	
Regulatory Mechanism and Authority	18 V.S.A. § 9375 and 9376 (provider reimbursement). • The GMCB would establish a provider reimbursement unit, with contractor support, to establish and manage updates to the reimbursement model. This would require the GMCB to undertake additional research to determine the most appropriate percentage of Medicare reimbursement, engage with affected stakeholders, and draft a new rule for these efforts.
Enforcement	Current statute does not include enforcement provisions for noncompliance with a provider reimbursement order. • The GMCB, potentially, could exercise this authority over hospitals in conjunction with the budget process in order to ensure enforcement is available over those providers. • Additional enforcement authority would be needed to cover non-hospital provider types and also to ensure that payer contracts were in compliance.
State of Vermont Agencies Involved	GMCB; AHS/DVHA

Fee-for-Service Rate Setting

Option 3A: FFS Rate Setting via Provider Regulation
Definition and Summary, Cont.

Option 3A: FFS Rate Setting via Provider Regulation	
Population	Most relevant to commercially insured patients using a Vermont provider. Medicaid patients could be included or excluded. While Medicare could theoretically be included where the State is seeking changes to Medicare payment methodologies, given Medicare's focus on value-based payment, this is unlikely.
Provider/Services	Providers to whom regulation applies would be regulated entity; for these providers, participation would be mandatory. Most easily applicable to Medicare Part A- and B-type services (hospital and physician services).

Payers	Rates are set for providers; would apply to any payer who contracts with that provider. Commercial payers (and potentially Medicaid and Medicare, see Federal Legal Constraints, slide 94) would no longer negotiate rates for providers/services to whom regulation applied. Potential for all-payer rate setting but would likely require major increases in Medicare and Medicaid reimbursement amounts, with implications for State and federal budgets.
	
	• Commercial: Can implement with existing provider rate-setting authority and would include any payer contracting with a Vermont provider, including insurers and self-insured payers.
	• Medicare: Would require federal waiver or Agreement if changes to Medicare FFS payment methodology were desired.
	• Medicaid: The General Assembly would need to determine whether to include Medicaid, and if so, if there would continue to be a payment differential between commercial and Medicaid rates.
	    • Would require federal waiver of Single State Agency Rule & assessment of current operations.
	    • Could impact provider scope (see above).

Methodology	Legislature or regulator sets a percentage of Medicare. This level could be set based on current reimbursement data (e.g., median commercial reimbursements for a particular set of codes), or based on a legislatively determined target (e.g., Vermont's now defunct Catamount Health plan paid 100% of Medicare for hospitals and 110% of Medicare for professional fees). • Adjustments: Policymakers or regulators can elect to adjust the target percentage based on certain provider characteristics, or to provide minimum thresholds or maximum reimbursement amounts for certain provider types or service types. See Colorado example (slide 88).
Payment Model(s)	Fee-for-service and other volume-based payment models (for example, DRGs).

Fee-for-Service Rate Setting

Option 3A: FFS Rate Setting via Provider Regulation
Implications for Vermont

Compatibility with Value-Based Care	Memorializes FFS payment methodology, acting as a barrier to the shift away from FFS health care payment to value-based care. Effort required to implement would hinder design and implementation of value-based models. Does not necessarily tie payment to quality without additional payment policies.
Implications for Sustainability	Would not support predictable, flexible payments since volume-driven (revenues tied to demand for services). Could harm financial position of providers with commercial charges in excess of Vermont's selected reimbursement amount; adjustments (see CO example, slide 88) could have a major impact on sustainability considerations (positively or negatively). Underfunding of rates could put additional pressure on providers to increase the volume of services in order to ensure sufficient revenue. Implementation risks would need to be well understood or could endanger provider solvency.
Implications for Reimbursement Equity	Could improve reimbursement equity if Medicare site neutrality policy was not adopted, for example. • Vermont could opt for a FFS rate setting model design that embeds state policy goals. For example, rates could reflect an intentional payment differential by service sector (e.g., primary care, mental health) or provider characteristics (e.g., to pay higher percentages based on payer mix, critical access hospital status). In order to tailor reimbursements in this manner, Vermont would need to deviate from some Medicare reimbursement policies. • If public payers were included in the rate setting and one standard reimbursement amount per service was set, this would eliminate payment differentials based on payer mix. This would require additional Medicaid appropriations. Unclear if Medicare would provide approval given federal cost neutrality requirements.

Fee-for-Service Rate Setting

Option 3A: FFS Rate Setting via Provider Regulation
Implications for Vermont

Pros

- Likely to reduce commercial insurance spending for plans included if rate selected is less than current commercial reimbursement (may or may not translate to premium savings over time, depending on implementation and trends)
- Medicare fee schedule is publicly available, national, and geographically adjusted, and is commonly used by other states and payers (including MVP) as a point of reference for FFS rate setting; adjustments based on service sector or provider characteristics (e.g., as proposed in CO) could provide flexibility to pursue state priorities
- Provider reimbursement regulation applies broadly to reimbursements paid by payers, including self-insured employer plans
- Evidence suggests properly structured state all-payer FFS rate setting can slow increases in unit cost for each service (or for each admission) but not necessarily curb overall cost growth (see MD example, slide 78)

Cons

- Perpetuates fee-for-service reimbursement model, and, if not adjusted, perpetuates Medicare payment policies that may not be in line with Vermont's goals (e.g., site-specific payments)
- Many providers argue that Medicare reimbursements do not cover their costs; if the percentage of Medicare selected were to be less than current commercial reimbursements, providers may have sustainability concerns
- BCBSVT has indicated in the past that this type of reimbursement model would be a significant implementation challenge for them;
- Complex to implement/resource intensive, especially if Medicare policy is modified. May require additional information from physicians
- Potentially duplicative of AHS/DVHA infrastructure
- Fee-for-service rate setting process may be so complex that incentives are unclear to providers; historical examples of FFS rate setting suggest that complexity of incentives reduced impact[1]

[1] Urban Institute, Hospital Rate Setting Revisited (November 2015)

Fee-for-Service Rate Setting

Option 3A: FFS Rate Setting via Provider Regulation
Cost Implications

- SOV: Significant additional GMCB staff and contract resources would be needed for development and ongoing implementation of FFS provider rate setting.
  - Staffing estimates include salary, benefits, and overhead, and assume steady state for other duties and responsibilities.
- Private Sector Impacts: Operational costs to providers and insurers are unknown. This would require further study.

*NOTE: Cost estimates are approximate. They are based on related past work and discussions with other state agencies and do not reflect actual quotes for work to be performed. Staffing estimates include salary, benefits, and overhead, and assume steady state for other duties and responsibilities; ongoing operational costs likely to change following pre-implementation studies.

Fee-for-Service Rate Setting

Option 3A: FFS Rate Setting via Provider Regulation Cost Implications

Initial Analysis, Development, and Implementation ($1,500k-2,025k – one-time spending)		
Study to Review Medicare Policy	$125k per policy (~$375k)	This study would include a review of Medicare payment policies (e.g., IPPS, OPPS, physician, home health), an environmental scan of state models to identify a range of conversion factors in use in other states, and stakeholder engagement. The purpose is to identify areas where Vermont may want to diverge from the Medicare payment policy and fee schedule. Work to be supported by contractor.
Data Collection from Unregulated Providers	$75-100k	Depending on how many/which providers are included in the regulatory scope, GMCB would need additional information about currently unregulated providers in order to determine the appropriate basis for establishing a fee schedule. This could be done by creating a cost-based data collection tool, which would be filled out by all providers of that class or could be determined with a representative sample. Work to be supported by contractor.
Development of Payment Methodologies and Provider Impact Study	$500-750k	This analysis would compare current rates to Medicare payment methodology using data from VHCURES, Vermont's All-Payer Claims Database, and produce options for where to set the percentages. This study would also analyze the impact of the reimbursement changes on providers. This would be an iterative process until the appropriate reimbursement amounts were determined. This study would also consider premium impacts. Study cost will vary depending on provider types/number of providers included. For example, analyzing the impacts on Vermont's 14 hospitals would be less costly than including additional provider types not currently regulated by the GMCB. Work to be supported by contractor.
Impact on All-Payer Model and TCOC	$75k	This study would analyze the impacts of the proposed regulatory scheme on Vermont's All-Payer Model, including the All-Payer Model Total Cost of Care and the impact on the ACO program. Work to be supported by staff and contractor.
Operational Requirements	$100-150k	This study would analyze operational changes at the GMCB needed to support an ongoing FFS rate setting system, including upgrades needed to ensure the GMCB has the necessary data to understand the impacts of the regulatory system (for example, new data collection from regulated and unregulated entities). The study would also include staffing necessary for implementation.
Medicare Agreement/ Legal Support	$0-150k	If the State were to pursue Medicare participation in all-payer FFS rate setting, this contract would support the State in securing a Medicare waiver,
Staffing	$375-425k	Dedicated staffing (3 FTEs – legal, policy, data, and contract management) to coordinate model design and engage with contractors.

Fee-for-Service Rate Setting

Option 3A: FFS Rate Setting via Provider Regulation
Cost Implications

Operations ($625-950k annually; estimates will be revised based on the above studies)		
Staffing	$375-450k	Additional staff (3-4 FTEs) to manage provider regulatory system, including to collect/update provider data and to perform analysis to support compliance.
Ongoing Policy and Operational Support, Analysis, and Enforcement Support	$250-500k	Contractor support to analyze changes to Medicare payment methodology and any needed updates to maintain Vermont-specific adjustments.

Fee-for-Service Rate Setting

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

- 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 (see slide 44).
- Resources
  - Center for Medicare and Medicaid Innovation: Evaluation of the Medicare All-Payer Model
  - Altarum Healthcare Value Hub: Hospital Rate Setting: Successful in Maryland but Challenging to Replicate (March 2015)

Fee-for-Service Rate Setting

Option 3B: FFS Rate Setting via Insurance Regulation
Definition and Summary

GMCB would direct payers to negotiate with providers for reimbursement that averages a maximum percentage of Medicare reimbursement. Self-insured employer plans could voluntarily participate.

Option 3B: FFS Rate Setting via Insurance Regulation	
Regulatory Mechanism and Authority	8 V.S.A. §§ 4062, 4513(c), and 4584(c) and 18 V.S.A. § 9375 (health insurance premium rate review; nonprofit hospital and medical service corporations) require the GMCB to review insurance premiums for the large group market and for the individual and small group market. The GMCB's authority allows for an affordability analysis. It would be preferable to add explicit authority to the rate review statutes to clarify that this type of activity is allowable. In addition, the GMCB may be limited in setting rates for BCBSVT under 8 V.S.A. § 4513(c) and 4584(c). • GMCB would require insurers to modify their existing reimbursement amounts to be, on average, at or below a percentage of Medicare. Depending on how the insurer currently reimburses and how much they pay providers, they may need to renegotiate contracts to come into compliance.
Enforcement	By regulator through claims monitoring. If implemented through insurance regulation and payer-provider contracting, may need to institute corrective action plans or other enforcement for insurers that fail to meet target negotiated rate. GMCB would need additional authority to institute corrective action plans.
State of Vermont Agencies Involved	GMCB

Fee-for-Service Rate Setting

Option 3B: FFS Rate Setting via Insurance Regulation Definition and Summary, Cont.

Option 3B: FFS Rate Setting via Insurance Regulation	
Population	Most relevant to members of Vermont-regulated Commercial insurance plans (individual, small group, and large-group insurance products) using a Vermont provider. Would exclude private self insured employer plans, Medicaid, and Medicare. The legislature could direct similar policy for state employee, education employees and state-funded retirees. • Impact would be limited compared to Option A: Implementation via Provider Regulation, because the policy would be limited to enrollees of health insurance plans (~94,000 Vermonters; see 2018 Vermont Expenditure Analysis), and because providers could, theoretically, choose not to contract with participating health plans.
Providers/ Services	Regulator sets boundaries for payer-provider contracts; providers would continue to negotiate payment amounts with commercial payers, or could choose not to contract with participating payers. Applies to Medicare Part A- and B-type services (hospital and physician services)
Payers	Regulated insurers would be the regulated entity. • Commercial: Would impact Commercial insurers (not including self-insured employer plans). • Medicare and Medicaid: Would not impact Medicare or Medicaid.
Methodology	Legislature or regulator sets a target average percentage of Medicare. This level could be set based on current reimbursement data (e.g., median commercial reimbursements for a particular set of codes), or based on a legislatively determined target (e.g., Vermont's now defunct Catamount Health plan paid 100% of Medicare for hospitals and 110% of Medicare for professional fees). • Adjustments: Policymakers or regulators can elect to adjust the target percentage based on certain provider characteristics, or to provide minimum thresholds or maximum reimbursement amounts for certain provider types or service types. See Colorado example (slide 88).
Payment Model(s)	Fee-for-service and other volume-based payment models (for example, DRGs).

Fee-for-Service Rate Setting

Option 3B: FFS Rate Setting via Insurance Regulation
Implications for Vermont

Compatibility with Value-Based Care	Memorializes FFS payment methodology, acting as a barrier to the shift away from FFS health care payment to value-based care. Does not necessarily tie payment to quality without additional payment policies. Could be designed to be compatible with ACO program and other value-based models, but additional analysis is needed to determine impacts. Effort required to implement would hinder design and implementation of value-based models.
Implications for Sustainability	Would not support predictable, flexible payments. Could harm financial position of providers with commercial charges in excess of Vermont's selected reimbursement amount; adjustments (see CO example, slide 88) could have a major impact on sustainability considerations (positively or negatively). Underfunding of rates could put additional pressure on providers to increase the volume of services in order to ensure sufficient revenue. Does not address payer mix issues.
Implications for Reimbursement Equity	Could improve reimbursement equity if Medicare site neutrality policy was not adopted, for example. • Vermont could opt for a FFS rate setting model design that embeds state policy goals. For example, rates could reflect an intentional payment differential by service sector (e.g., primary care, mental health) or provider characteristics (e.g., to pay higher percentages based on payer mix, critical access hospital status). In order to tailor reimbursements in this manner, Vermont would need to deviate from some Medicare reimbursement policies.

Fee-for-Service Rate Setting

Option 3B: FFS Rate Setting via Insurance Regulation
Implications for Vermont

Pros

- Likely to reduce commercial insurance spending for plans included if rate selected is less than current commercial reimbursement (may or may not translate to premium savings, depending on implementation)
- Medicare fee schedule is publicly available, national, and geographically adjusted, and is commonly used by other states and payers (including MVP) as a point of reference for FFS rate setting; adjustments based on service sector or provider characteristics (e.g., as proposed in CO) could provide flexibility to pursue state priorities
- Compared to Option 3A: Implementation via Provider Regulation, implementation and oversight are relatively simple for the SOV (likely more complex for carriers)

Cons

- Perpetuates fee-for-service reimbursement model, and, if not adjusted, perpetuates Medicare payment policies that may not be in line with Vermont's goals (e.g., site-specific payments)
- Many providers argue that Medicare reimbursements do not cover their costs; if the percentage of Medicare selected were to be less than current commercial reimbursements, providers are unlikely to support
- If implemented through insurance regulation with voluntary provider participation, insurers may struggle to negotiate provider rates that meet targets or providers may not agree to participate
- BCBSVT has indicated in the past that this would be a significant implementation challenge for them
- Population impacted is significantly smaller compared to Option 3A due to the size of the insured market
- If payer is using alternative payment methodologies, this option would need to be further adapted in order to not revert to FFS
- Some carriers' current practice is to accept GMCB maximum charge increases; payers and providers may negotiate against cap(s)

Fee-for-Service Rate Setting

Option 3B: FFS Rate Setting via Insurance Regulation
Cost Implications

- SOV: Implementing through provider regulation (Option 3A) would be more costly to the State than implementation through insurance regulation (Option 3B). Implementation through insurance regulation shifts the implementation costs and burdens to the insurers (though with more limited impact due to limited population and need for payers to contract with willing providers).
- Private Sector Impacts: Operational costs to providers and insurers are unknown. This would require further study.

*NOTE: Cost estimates are approximate. They are based on related past work and discussions with other state agencies and do not reflect actual quotes for work to be performed. Staffing estimates include salary, benefits, and overhead, and assume steady state for other duties and responsibilities; ongoing operational costs likely to change following pre-implementation studies.

Fee-for-Service Rate Setting

Option 3B: FFS Rate Setting via Insurance Regulation
Cost Implications

Initial Analysis, Development, and Implementation ($600-725k – one-time costs)		
Study to Determine Fee Amounts & Provider Impacts	$400-500k	This analysis would compare current rates to Medicare payment methodology in the *aggregate* using data from VHCURES and produce percent of Medicare at the service level (professional, inpatient hospital and outpatient hospital) with potential areas of divergence from Medicare payment policy. This study would also analyze the impact of the reimbursement changes on providers. This would be an iterative process until the appropriate reimbursement amounts were determined. This study would also consider premium impacts. Study cost will vary depending on provider types/number of providers included. For example, analyzing the impacts on Vermont's 14 hospitals would be less costly than including additional provider types not currently regulated by the GMCB.
Impact on All-Payer Model and TCOC	$75k	This study would analyze the impacts of the proposed regulatory scheme on Vermont's All-Payer Model, including the All-Payer Model Total Cost of Care and the impact on the ACO program.
Staffing	$125-150k	Dedicated staffing (1 FTE – legal, data, and contract management) to coordinate model design and engage with contractors.

Fee-for-Service Rate Setting

Option 3B: FFS Rate Setting via Insurance Regulation
Cost Implications

Operations ($300-350k annually; estimates will be revised based on the above studies)		
Staffing	$50-125k	Additional staff (0.5-1 FTE) to manage regulatory system, including to manage contractors and support compliance.
Insurance Regulation	$75-100k	Implementation via insurance regulation would require additional contracted actuarial support and support for claims monitoring.
Ongoing Policy Analysis	$100k	Ongoing contractor support to understand changes to Medicare payment methodology.

Fee-for-Service Rate Setting

Example: Vermont's Catamount Health (2006-2014)

- Provider reimbursement set in statute, tied to a percentage of Medicare reimbursement
  - Hospital reimbursement: 100% of Medicare
  - Professional fees: 110% of Medicare
- Designed to cover uninsured individuals with incomes above Vermont's income thresholds for the Vermont Health Access Program (VHAP), covering adults from 150%-300% FPL and children from 185%-300% FPL, with sliding scale premiums.
- Administered by DVHA, enforcement by BISHCA.
- Small program (17k lives in 2014, the program's final year)
- Ended in 2014 with launch of Vermont Health Connect and related subsidies.
- Resources:
  - Vermont General Assembly: 2006 Health Care Reforms – The Details
  - BISHCA Rule H-2006-01

Fee-for-Service Rate Setting

Example: Washington State's Cascade Care (2020-current)

- A "public option" plan implemented in partnership with private insurance carriers
  - State is contracted with commercial carriers to offer "state-procured" plans at each QHP metal level that meet qualification criteria
  - Procurement requires that participating carriers use value-based payments that will support cost effective care
- Participation in state-procured plans is voluntary for providers.
- State procured plans have an aggregate rate cap, set at 160% of Medicare; some services/providers have a minimum reimbursement (135% of Medicare for primary care; 101% of reasonable cost for CAHs and sole community hospitals).
  - Pharmacy is excluded from this cap.
  - Plans can exceed these caps if they can't get an adequate network with these rates, or if receive actuarial certification that they can reduce premiums by 10% by other means (e.g., through care coordination).
- Implementation: Participating carriers have struggled to engage providers willing to accept capped rates; not yet successful in providing a cheaper alternative public option to commercial QHPs.
- Resources:
  - Milbank Quarterly, "Washington State's Quasi-Public Option" (March 2020)
  - Health Affairs, "Public Option 1.0: Washington State Takes an Important Step Forward" (May 2019)

Fee-for-Service Rate Setting

Example: Colorado Health Insurance Options Program (Proposed)

- Proposed public option plan currently under consideration, with proposed start in 2022. Like WA's Cascade Care, intent of the proposal is to implement through private insurance carriers within state-set parameters.
- Actuarial modeling proposes a "base rate" with facility-specific maximum reimbursement rates for facility services, set as a percent of Medicare. Maximum reimbursement levels are 155%-218% of Medicare rates, based on a combination of hospital characteristics and hospital-specific financial position collected by the state.
  - Proposed adjustments (see Wakely Actuarial analysis linked below, pg. 12):
    - "Critical Access hospital received an additional 20 percentage points above the base rate.
    - "Independent hospitals (i.e., those not owned by a system larger than 2 hospitals) also received 20 additional percentage points.
    - "Hospitals who had more than 65% of their adjusted discharges from Medicare and Medicaid patients (the statewide average) received up to an additional 30 percentage points. Hospitals that exceeded this statewide payer mix average by a larger amount received more of the maximum 30 additional percentage points.
    - "Hospitals received up to 10 additional percentage points for each of the following: having net patient revenue per adjusted discharge lower than the state average of $15,618, and having hospital only operating expenses per adjusted discharge lower than the statewide average of $11,790.
    - "Hospitals received up to 20 additional percentage points for having net income per adjusted discharge of less than $2,149."
- Colorado projects 12% reduction in individual market premiums statewide (varies by geographic rating area), but actual reductions will depend on policy decisions and actual claims spending.
- Resources:
  - Wakely Actuarial, Actuarial Analysis of a Colorado Health Insurance Option in 2022
  - Colorado Department of Health Care Policy and Financing, Summary of Public Option Proposal

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APPENDIX

- Pay Parity/Equity in Reimbursement
- Federal Legal Issues, Constraints, and Waivers
- Data Challenges Across All Options
- Current Related GMCB Authority

Appendix

Pay Parity/Equity in Reimbursement– A History

Since 2014, the legislature requested a series of reports on reimbursement differentials among health care providers.

- The following key points emerged from the stakeholder process in the most recent report in 2017:
  1. Nationally and in VT, more providers are choosing employment in hospitals and health systems.
  2. Multiple factors explain the trend toward more hospital-based employment including growing costs, challenges and risks of running a business, ACA incentives, and provider preferences. Commercial reimbursement rates do not appear to be a primary factor and salaries are not likely to he higher in hospital-based settings.
  3. FFS rate differentials exist between hospital-based practices and independent settings for professional services. In VT, greatest differential is between the academic medical center and other providers.
  4. Adjusting FFS rate through regulation is complex and will have impacts on premiums and out-of-pocket costs, hospital budgets, as well as access and quality care.
- The GMCB concluded at the time to focus on the current All-Payer Model health care payment and delivery system reform strategy, as well as some moderate action through the hospital budget and rate review processes.
- This report builds on 2017 report to look at potential implementation strategies for assessing and addressing sustainability and reimbursement issues.

Sources: Act 54 (2015) & Act 143 (2016) - Provider Reimbursement Reports

Appendix

Federal Legal Issues, Constraints, and Waivers

	Medicaid	Affordable Care Act	Medicare	ERISA
Agency	Center for Medicaid and CHIP Services	Center for Consumer Information and Insurance Oversight	Center for Medicare and Medicaid Innovation[1]	Department of Labor
Federal Approval Necessary to Regulate Provider Reimbursement?	Yes, if Medicaid rate-setting is done by a different entity (single state agency rule); State plan approval may be waived.	No	Yes	State is preempted from regulating employer health plans; provider rate-setting has been upheld in Maryland
Existing Law Requires State Legislation?	Yes, per state law	N/A	No	N/A
Federal Cost Issues	Neutral to Medicaid budget	N/A	Savings to Medicare	N/A

NOTE: There are federal laws governing Medicaid reimbursement to **Federally Qualified Health Centers (FQHCs)** which cannot be waived.

[1] Regulating Medicare reimbursement would require an agreement between the state and federal government, similar to current All-Payer Model Agreement. Current APM Agreement would require additional authorities to address Medicare reimbursement/rate setting outside of the ACO.

Appendix

GMCB Data Challenges Across All Options

- Limited data from self-insured plans in VHCURES
  - VHCURES population has decreased by approximately 70,000-80,000 lives since the Gobeille decision (2016) as many self-insured employers no longer submit data to VHCURES
  - Claims and other data types would be used in developing a comparison to current reimbursement and for compliance after implementation
- Limited information regarding care delivered in Vermont to out-of-state residents
- Limited information at service-line level about hospital revenue, expenses, and margin
- Limited to no information on unregulated provider financials (neither reimbursement or expenses)
- Provider data quality and need for validation may prevent comparative analysis within and across provider types

Appendix

GMCB Authority: Hospital Budget Review

- 18 V.S.A. chapter 221, subchapter 7 – Establishes aggregate budget target and caps charge trend for each of Vermont's 14 community hospitals
  - Annually by October 1, GMCB has the responsibility to review and establish community hospital budgets
  - In its review, GMCB 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 Rule 3.000 - This rule establishes a process by which the GMCB will review hospital budgets, including required data and reporting, the review process, and enforcement.
- GMCB's annual decisions for each hospital's budget establish:
  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

Appendix

GMCB Authority: Health Insurance Premium Rate Review

- 8 V.S.A. § 4062 and 18 V.S.A. § 9375 (Health Insurance Premium Rate Review) – Tasks the GMCB to review major medical health insurance premium rates in the large group and the merged individual and small group insurance markets
    - Board must approve, modify, or disapprove a rate request within 90 calendar days after receipt, but may extend its review no more than 30 calendar days if an insurer fails to provide necessary materials or other information in a timely manner
    - Board must determine whether a rate is affordable, promotes quality care, promotes access to health care, protects insurer solvency, and is not unjust, unfair, inequitable, misleading, or contrary to Vermont law, and consider DFR's opinion regarding the effect a proposed rate will have on an insurer's solvency
- GMCB Rule 2.000 – This rule establishes a process by which the GMCB will review health insurance rate requests. This rule includes five categories: general provisions, public participation in and access to the rate review process, procedures and practice before the Board, decision, and other matters.
- The health insurance premium rate review process supports health system reform by providing the opportunity to assess how changes in health insurance keep Vermont moving toward high-quality care while controlling costs.
- Timeline:
    - Premium rates for individual and small group market plans are reviewed in spring (form review performed by the Department of Financial Regulation) and summer (GMCB's premium rate review) for late fall open enrollment; plans take effect on January 1
    - Premium rates for large group plans – fully insured plans sponsored by employers with 101 or more employees – are reviewed and approved throughout the year on a rolling basis

Appendix
GMCB Authority: ACO Budget Review

- 18 V.S.A. § 9382 (ACO Oversight Statute) – Establishes criteria for the State's regulating authority to certify and review ACO budgets. Authority has been given to the GMCB to do the following:
  - Approve or deny the certification of ACOs, with eligibility verification annually after initial approval
  - Annually review and approve or deny an ACO's budget
- GMCB Rule 5.000 – Establishes specific criteria for an ACO to maintain certification and requirements for its budget and budget review process.
  - Certification ensures that ACOs have the systems in place to do the work required of an ACO. Criteria include information on the legal entity, population health management and care coordination, governing body, performance evaluation and improvement, leadership and management, patient protections and support, solvency and financial stability, provider payment infrastructure, provider network, and health information technology.
  - ACO budget review provides an opportunity to assess ACO programs facilitating Vermont’s shift toward value-based care, as well as the cost of administering these programs. This includes, but is not limited to, a review of ACO financial and quality performance to date, the ACO’s investments in infrastructure and direct programming for health improvement and payment reform, the ACO’s administrative and operational costs, the ACO’s contractual relationships with payers and providers, and the alignment of ACO activities and strategies with the state’s objectives as stated under the Vermont’s All-Payer Model Agreement with the federal government.
- Timeline:
  - September 1—Certified ACOs submit a Certification Verification Form
  - October 1—Certified ACOs submit a proposed budget for the coming fiscal year
  - October through December—GMCB reviews certified ACO budget proposal and conditionally approves or denies

Appendix

GMCB Authority: Rate-Setting Authority

- No enforcement; not implemented to date
- 18 V.S.A. 9375(a)(1): 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
  - Requires rulemaking, provider stakeholder process, and public engagement
    - Report to House Committee on Health Care and the Senate Committee on Health and Welfare prior to rule adoption
  - May include the participation of Medicare and Medicaid
    - Must take into consideration current Medicare designations and payment methodologies, including critical access hospitals, prospective payment system hospitals, graduate medical education payments, Medicare dependent hospitals, and federally qualified health centers
- 18 V.S.A. 9376: Payment amounts; methods
  - “Reasonable" rates based on methodologies pursuant to section 9375, in order to have a "consistent" reimbursement amount accepted
  - May set rates for different groups of health care professionals over time and need not set rates for all types of health care professionals
  - May consider legitimate differences in costs among health care professionals, such as the cost of providing a specific necessary service or services that may not be available elsewhere in the State, and the need for health care professionals in particular areas of the State, particularly in underserved geographic or practice shortage areas.

Appendix

Statutory Authority for Regulatory Options

Model	Statutory Authority	New Auth Needed?
Option 1: Health System Budgets		
Option 1A: Evolve Hospital Budget Review into Provider Entity Budgets with Population-Based Payments	18 V.S.A., chapter 221, subchapter 7 18 V.S.A. § 9375 and 9376	Maybe (Enforcement; payer compliance in partnership with DFR)
Option 1B: Evolve ACO Regulatory Process to Set Provider Payment Methodologies and Amounts	18 V.S.A. 9382 18 V.S.A. § 9375 and 9376	Y (Enforcement)
Option 1C: Require Insurers to Use Population-Based Payments	8 V.S.A. §§ 4062, 4513(c), and 4584(c) 18 V.S.A. § 9375	Y (Enforcement; in partnership with DFR)
Option 2: Setting Reimbursement Parameters		
Option 2A: Entity-Based Growth Caps and Floors	18 V.S.A. § 9375 18 V.S.A., chapter 221, subchapter 7	Y, if implemented for additional entity types
Option 2B: Service-Based Growth Caps and Floors	18 V.S.A. § 9375 and 9376	Y (Enforcement)
Option 2C: Growth Parameters in Payer-Provider Contracts	8 V.S.A. §§ 4062, 4513(c), and 4584(c) 18 V.S.A. § 9375	Y (Enforcement)
Option 3: Fee-for-Service Rate Setting		
Option 3A: FFS Rate Setting via Provider Regulation	18 V.S.A. § 9375 and 9376	Y (Enforcement)
Option 3B: FFS Rate Setting via Insurance Regulation	8 V.S.A. §§ 4062, 4513(c), and 4584(c) 18 V.S.A. § 9375	Y (Corrective action)

Appendix
Glossary

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Term	Definition
Allowed Amount	The most money an insurance company will pay for a covered procedure or service.
Cap	A maximum rate of unit cost growth for a service category or for revenue for a provider/facility.
Cost	Definition varies for different actors in the delivery system: • For PATIENTS: out-of-pocket obligation for medical care • For PROVIDERS: expenses incurred to deliver medical care • For PAYERS: expenses associated with medical care and administration of health insurance policy
Enforcement	Means by which a regulator is ensuring a regulatory requirement is being implemented accurately and adequately.
Floor	A minimum rate of unit cost growth for a service category or for revenue for a provider/facility.
Payer	Commercial insurance company, self-insured employer, or government program (Medicare or Medicaid) that pays for health care services.
Price	The amount requested by a provider to deliver a medical service. Also known as “charge”; often differs from paid amount.
Rate Setting	Governmental action to set provider reimbursement methodologies and amounts. Often, the term “rate setting” is used specifically to refer to fee-for-service rate setting (see Option 1).
Reimbursement	The amount a medical provider receives for delivering medical care. For private payers, based on amounts negotiated between providers and insurers and/or purchasers.
Reimbursement Equity	Equitable payment within and across provider types for care delivery
Sustainability	The ability of a provider to consistently cover expenditures with revenues.
Value-Based Care	The efficient and economic delivery of high-quality care