Financial Sustainability

Recommendations for Discussion

DECEMBER 5, 2019

Designated Mental Health Agencies

The Rural Health Task Force Recommends that annually the Green Mountain Care Board review the following Key Performance Indicators of health care organizations receiving state appropriated funds potentially including: hospitals, designated and specialized services agencies, home health agencies, nursing homes, long-term care facilities, and FQHCs. The goal is to promote the sustainability of the whole health care delivery system by increasing transparency and awareness of the financial stability of the full array of health care providers to inform planning and resource allocation..

Draft list:
Gain/Loss Operating Margin $
Gain/Loss Operating Margin %
Days of Cash on Hand
Days of Net Assets
Current Ratio
Debt Service Coverage Ratio
All Net Patient Revenue % of Gross Revenue
(Xx) Net Patient Revenue % of Net Revenue (xx=whatever is meaningful; for DAs, it's Medicaid). Essentially looking to get a sense of payer mix.

Long Term Care

Nursing homes:
Recommend the Legislature review and consider the recommendations in the Ongoing Financial Sustainability section (p. 10) of the Nursing Home Oversight Working Group Report submitted in 2018.
AHS has audited financial statements, revenue information, Medicare and Medicaid cost reports and other relevant information to assess financial health of the nursing homes. That working group met throughout the off-session in 2018 solely for the purpose of looking at nursing homes.

Residential care homes and assisted living residences:
AHS does not have any similar information. They are not federally regulated, so there is no CMS data available as there is in the nursing home context (i.e. payroll based journals). Medicaid rates are too low to support this group of providers.

Recommend that AHS evaluate the cost associated with providing ERC (Enhanced Residential Care) and ACCS (Assistive Community Care Services) services relative to Medicaid reimbursement to ensure the rates are adequate to support those services. AHS should also develop a process for regular review of the ERC/ACCS rates to ensure they reflect cost of care and are appropriately adjusted for inflation.

Independent Providers

- **Increase reimbursement rates**. Medicaid and Medicare reimbursement rates have not kept pace with increasing costs. This is particularly problematic in rural practices where the payer mix is typically skewed to higher percentages of Medicaid & Medicare, patient populations that are often older, sicker, and/or poorer. Low reimbursement rates are directly responsible for the closure of many of our rural practices, including one in Newbury, VT in December 2018, and two Franklin County pediatrician practices in 2015.

- **Be aware of and avoid unintended consequences of policy decisions on rural independent practices.** Rural independent practices have been negatively affected by various policy decisions. For example, while DVHA's alignment at 100% of Medicare for the primary conversion faction in the RBRVS fee schedule is generally a good thing, it recently resulted in a cut for immunization administration reimbursement. DVHA also decreased the $2.50 PMPM Medicaid case management payments to $1.25 PMPM and made those dollars available only to those participating in the ACO, which isn't an option for many of our rural independent practices. Both of these decisions had a profound negative impact on our rural primary care practices. These practices need more support, not less.

- **Mandate pay parity for commercial payers.** Pay parity would help level the playing field for independent practices, potentially drawing more providers to rural independent practice. In 2015, Vermont Legislature passed Act 54, which called on private health insurers to submit plans to the GMCB to normalize payment rates to hospitals and independent physicians for providing the same services. Despite this legislation, pay parity remains elusive in Vermont with officials pinning the task on the ACO to address. The structure of the ACO's current programs perpetuate the pay disparities and seems ill equipped to address this issue. Furthermore, a solution through the ACO leaves out practices who, for various reasons, cannot participate in the State's All Payer program.

- **Support for technical infrastructure such as EMRs and telemedicine.** Rural independent practices often don't have the bandwidth or resources to purchase and maintain an EMR or telemedicine equipment. Support in this area could help broaden the services rural practices provide.

Independent Providers

- **Reduce administrative burdens**. According to a study by Casalino, et. al. American physicians spend an average of three weeks a year on interactions with payers. Another $40,000 per year is spent on reporting measures. Reducing and streamlining tasks such as determining patient insurance and cost sharing, collecting co-payments, prior authorization, tracking different formularies, meaningless reporting, and others, would allow more time for direct patient care and would save practices time and money.
  - Prior Authorizations Recommendations:
    - the elimination of prior authorization requirements where there is a lack of documented evidence supporting their benefits to improve quality and/or reduce costs
    - the continued expansion of the ACO prior authorization pilot, including expanding to additional payers, so that clinicians can take advantage in practice of reduced administrative tasks
    - expansion to all payers and alignment between payers of “Gold Card” programs, though which clinicians who routinely have prior authorizations approved are exempt from the prior authorization process, thresholds must be meaningful and include both primary care clinicians as well as specialists
  - Alternative payment structures: centralized resources and expertise available to health care practices to assist in analyzing and implementing the financial, work flow and workforce changes required to transition to non-fee for service payment structures

Independent Providers

- Multiple drug formularies/disease management plans:
  - continued steps to standardize the definitions and calculations for quality metrics used by the federal and state government entities, insurance payers, accountable care organizations and others with the goal of ultimately adopting uniform statewide or national standards for quality data; this includes:
    - Updating the 2017 Report on the Green Mountain Care Board's Plan to Align Performance Measures that Impact Primary Care, including an update on steps taken to implement the recommendations of the report and create a Measure Alignment Council

    https://gmcboard.vermont.gov/sites/gmcb/files/documents/Act%20112%20Measure%20Alignment%20Report%202017-01-10%20FINAL.pdf

    - A determination if there is research indicating that quality reporting requirements in place in Vermont improve health outcomes and help to achieve greater efficiency
  - the elimination of reporting requirements where there is a lack of documented evidence supporting their benefits to improve quality and/or reduce costs
  - a shift to quality data that are reported through accurate claims data rather than clinician submission
  - adding to the Green Mountain Care Board's Plan to Align Performance Measures a comparison of the multiple drug formularies in place, with the ultimate goal of streamlining drug formularies, minimizing the change of drug formularies throughout the year and automating and integrating into EHRs information about patient drug formularies
  - the creation of a new electronic medical record functional system whose foundation is clinical rather than reporting/billing and eliminates the need for multiple interfaces
  - administrative uniformity by payers regarding treatment and management of the same condition and the payment by payers of adequate case management fees to clinicians for services relating to coordinating and managing the care of patients with chronic conditions
  - adequate public and private payer reimbursement for administrative tasks, including but not limited to installing and maintaining information technology and electronic health records, completing prior authorizations, and for non face-to-face care such as telemedicine services, telephone services, remote patient visits and exchanging secure e-mails with patients