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GREEN MOUNTAIN CARE BOARD

General Advisory Committee

Susan Barrett, Executive Director, GMCB
Jennifer DaPolito, Senior Health Policy Analyst, GMCB
Robin Lunge, GMCB Board Member

6/26/23

Agenda

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- Upcoming GMCB Regulatory Processes
  - Health Insurance Premium Rate Review
  - Hospital Budgets
  - GAC Questions and Comments
- Act 167 Updates
  - All-Payer Model
  - Hospital Sustainability
  - Hospital Global Budgets
  - GAC Questions and Comments
- Public Comment

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HEALTH INSURANCE PREMIUM RATE REVIEW

GMCB Rate Review

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- Large Group Filings
  - 101 or more employees
- Small Group and Individual Filings
  - 100 employees or less & individuals and families
  - The small group and individual markets were unmerged in 2022 and will remain unmerged in 2023

Large Group Rate Review

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Rate Review Process:

- Insurers file rates with GMCB, typically 4-6 months before rates will be effective
- The GMCB has 90 days to review and approve, modify or deny a rate:
  - Insurers provide an actuarial analysis to support the proposed rates
  - GMCB's actuary reviews the proposed rates and provides its analysis
  - DFR provides an analysis of the insurer's solvency
  - Hearings are typically waived, but the parties (insurers and the HCA) provide memorandums in support of their recommendations on the proposed rates
  - Board issues its decision around Day 90
- Some items of note:
  - Large group rates affect approximately 11,000 covered lives
  - The GMCB only approves a manual rate for large group filings

Small Group & Individual Rate Review

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Rate Review Process:

- Insurers file rates with GMCB in early May
- The GMCB has 90 days to review and approve, modify or deny a rate:
  - Insurers provide an actuarial analysis to support the proposed rates
  - GMCB's actuary reviews the proposed rates and provides its analysis
  - DFR provides an analysis of the insurer's solvency
  - Hearings are typically held toward the end of July
  - Board issues its decision around Day 90 (early August)
- Some items of note:
  - These rates usually affect approximately 72,000 lives
  - Unlike the approval of only a manual rate during the large group rate filings, the rates approved for small groups/individuals will show the premiums paid by enrollees

GMCB Rate Review

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	Large Group	Small Group & Individual
Definition	101 or more employees	100 employees or less & individuals
Approval Timeline	Throughout the year (number of filings vary year to year)	Rates filed in early May to ensure compliance with federal regulations for open enrollment in November
Rate Effective Date	Varies by filing	January 1st
Plans Offered	Outside Vermont Health Connect	Qualified Health Plans (QHP) through VHC, including reflective silver plans
Subsidies Available	No	Yes, for QHPs offered through VHC (not for small group, off exchange QHPs, or reflective plans)
Covered Lives	~11,000	~72,000

Rate Review 2024 QHP Timeline

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- **May 9, 2023** – Small Group and Individual Filings submitted
- **July 5, 2023** – Actuarial Analysis and DFR Solvency Opinion
- **July 17, 2023** – MVP Hearing
  - 8am-5pm
- **July 19, 2023** – BCBSVT Hearing
  - 8am-5pm
- **July 24, 2023** – Public Comment Forum
  - 4pm-5pm
- **August 7, 2023** – GMCB Decision and Order

Rate Review Home Page | Rate Review (vermont.gov)

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HOSPITAL BUDGETS

Hospital Budgets

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Annually by October 1, the Green Mountain Care Board (GMCB) has the responsibility to review and establish budgets for Vermont's 14 community hospitals.

In its review, the Board considers local health care needs and resources, utilization and quality data, hospital administrative costs, and other data, as well as hearings with hospitals and comments from members of the public.

18 V.S.A. § 9375(b)(7); 18 V.S.A. § 9456

Brief History of Hospital Budget Oversight

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1992

Vermont Health Care Authority

Merged Health Policy Council, Health Data Council, and Certificate of Need Review Board

1995

Banking, Insurance, Securities, and Health Care Administration (**BISHCA**)

Established authority to limit hospital budgets

2011

Green Mountain Care Board

BISHCA renamed to Dept of Financial Regulation

Hospital Budgets – Fast Facts

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- Each year, the GMCB establishes guidance and reporting requirements. The GMCB is in the process of updating its regulatory process and is working toward stable, predictable guidance.
- The FY24 Hospital Budget Benchmark is tied to Net Patient Revenue Growth. Increases in charges will also be reviewed.
- GMCB considers many factors when reviewing budgets, including labor expenses, utilization, pharmaceutical expenses, cost inflation, commercial price changes, financial indicators, Medicare/Medicaid price changes, and uncompensated care.
- GMCB has held several roundtable discussions on primary care, price discrimination, and travelling Board meeting to understand impact of hospital budget decisions on the broader clinical community.

Hospital Budgets Timeline

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- **March 31:** GMCB issues written guidance
- **June 30:** Hospitals submit budget requests approved by their local hospital board to GMCB.
- **August 9 - 23, 2023:** GMCB holds hearings for each hospital's budget.
- **Aug 23 - Sept. 15:** GMCB holds public deliberations and must establish budgets for each hospital on or before September 15th (with written decisions by Oct 1st).
- **October 1**: Hospital fiscal year begins.

Public comment encouraged July – early September.

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HEALTH CARE REFORM

Act 167 Sections 1 and 2

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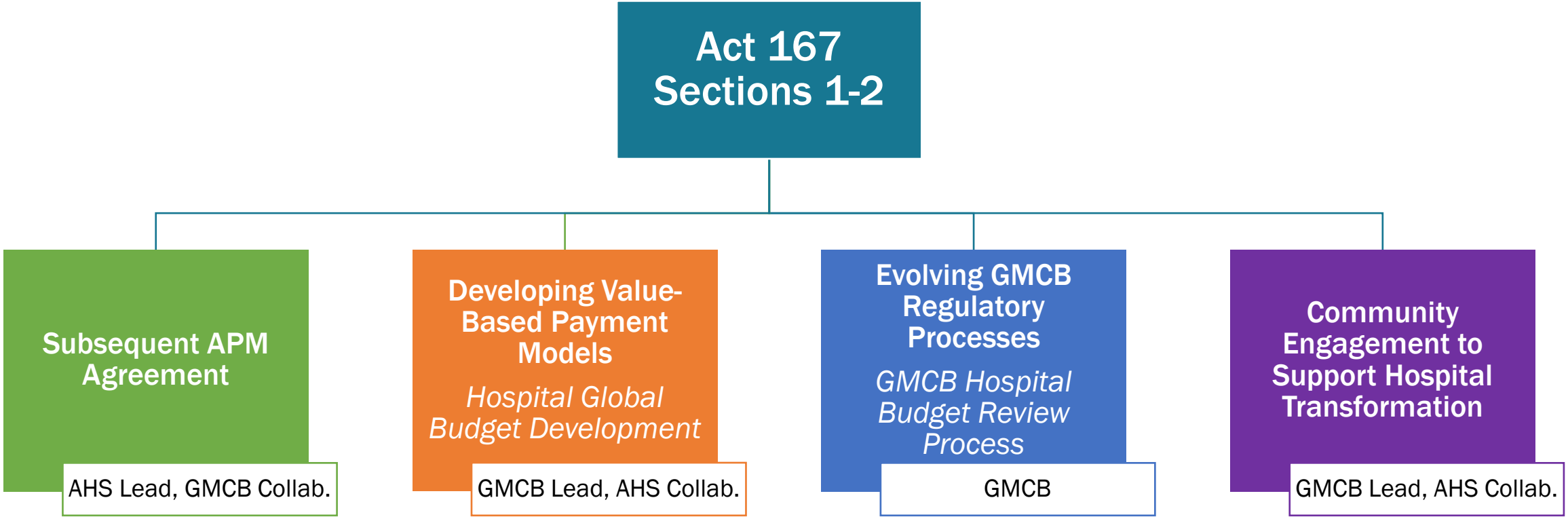

What do we know about the new payment model under development by CMMI?

"To accelerate and support these efforts, the Innovation Center is exploring a state-based model to improve population-level health outcomes and advance health equity by testing total cost-of-care approaches to shift health care spending and utilization from acute care to primary care. The future state-based, total cost of care models under consideration by the Innovation Center will amplify Medicaid-led advanced primary care efforts by aligning Medicare FFS and other payers to these efforts."
- CMS Blog, [The CMS Innovation Center's Strategy to Support High-quality Primary Care]

CMMI is signaling that it will produce a design spanning multiple states, starting in 2025, that will address 7 priorities:

1.	Include global budgets for hospitals.	**Payment Design**
2.	Include Total Cost of Care target/approach.	
3.	Be all-payer.	
4.	Include goals for minimum investment in primary care.	
5.	Include safety net providers from the start.	**Core Principles**
6.	Address mental health, substance use disorder, and social determinants of health.	
7.	Address health equity.	

Through an advisory group structure and other methods, AHS and GMCB are gathering input on a variety of topics to inform feedback to CMMI on a new multi-payer, multi-state model.

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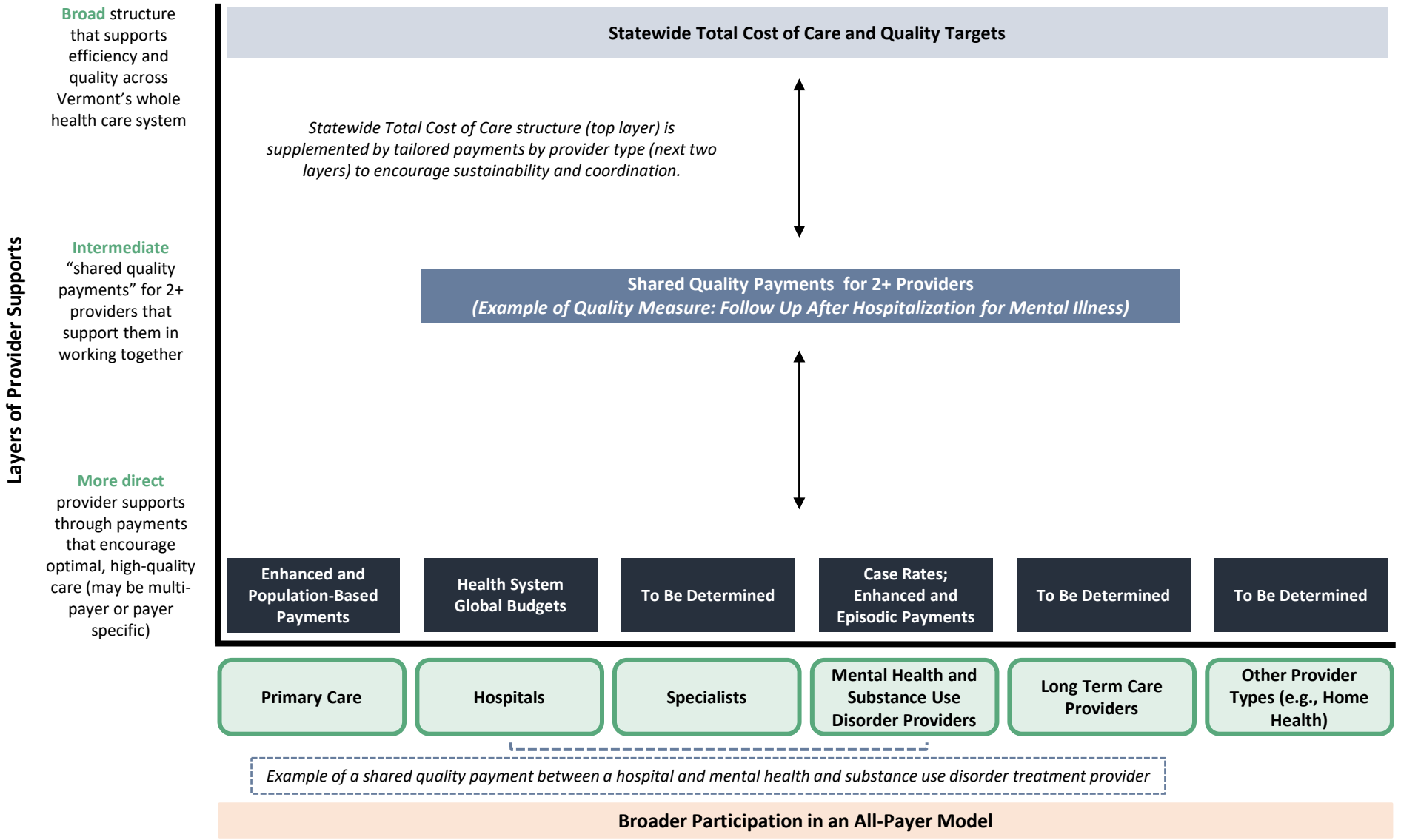
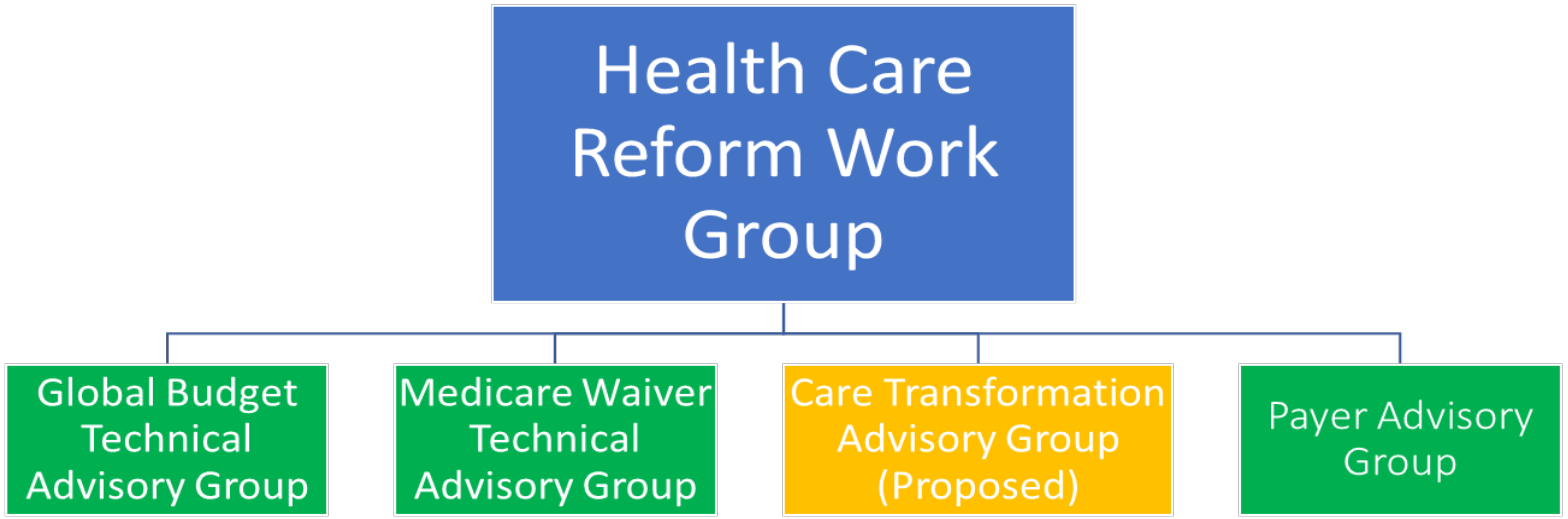
Vermont's Vision for a Statewide Approach



Population-Based Payment: A provider or provider organization is accountable for the health of a group of patients in exchange for a set payment. This gives providers flexibility to coordinate and manage care for their patients. They accept risk for costs of care that exceed the set payment amount.
Health System Global Budget: A global budget is a budget that is established ahead for a fixed period of time (typically one year) for a specified set of services (e.g., inpatient and outpatient hospital services) for a set population.
Case Rate: A provider receives a flat rate for a patient's treatment for a specific period of time.

Current Work Group Structure



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Hospital Sustainability – Act 167

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- Act 167 is a significant focus for the GMCB in 2023
- GMCB's focus on hospital sustainability pre-dates the COVID-19 pandemic

2019	**GMCB Requires Hospital Sustainability Planning through its Hospital Budget Oversight** • Rationale: persistently low and declining margins, Springfield bankruptcy, and rural hospital closures nationally; Rural Health Services Task Force.
2020	**Legislature passes Act 159 of 2020 requiring GMCB to provide recommendations for improving hospital sustainability** • Rationale: Agreed with GMCB's concerns and the need to improve hospital sustainability
2021	**GMCB Report Identifies Recommendations in Act 159 Report** • GMCB Hospital Sustainability Report, Act 159 Section 4
2022	**Legislature Passes Act 167 with Funding to Address Hospital Sustainability** • GMCB leading data-driven community engagement work, in collaboration with AHS

Resource: Hospital Sustainability page on GMCB website

Developing Value-Based Payment Models: Hospital Global Budgets

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Hospital Global Budget Technical Advisory Group

- Co-chaired by GMCB and AHS, with support from GMCB staff and contractors:
  - Bailit Health Purchasing: Meeting planning, materials development, facilitation; stakeholder engagement; policy research and options; national context
  - Mathematica Policy Research: Analytics and modeling to support decision-making; materials development; technical expertise
- Membership selected based on technical expertise, knowledge of current provider payment models and contracting:
  - Hospital CFOs
  - Hospital health equity representative
  - Payer representatives with actuarial and/or provider contracting responsibilities (including DVHA)
  - OneCare Vermont payment model development staff
  - Office of the Health Care Advocate
  - Union representative
  - Provider representatives
  - Staff from GMCB, AHS/DVHA, DFR staff
- Materials are posted publicly to the GMCB website

Hospital Global Payments

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- Global payments are fixed, often prepaid amounts of funding for a certain period of time for a specified population, rather than fixed rates for individual services or cases. (Adapted from Urban Institute, 2016).
- Hospital global payments can be supportive of hospitals and payers and advance state objectives to control costs and improve quality because they have the potential to:
  - Ensure **steady, predictable financing**, and protect payers and hospitals during great volume swings as witnessed at the start of COVID-19;
  - Provide **greater flexibility** to modify hospital service offerings to best meet community needs;
  - Move financial incentives away from volume and towards providing care **more efficiently** and reducing avoidable and low-value care to produce **positive health outcomes**, and
  - **Control growth in hospital spending** at an affordable level.

Hospital Global Payments

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- Like all payment models, hospital global payments also have risks which need to be carefully mitigated. Risks include:
  - Over-incentivizing reductions in care
  - Insufficient funds to cover true cost of providing care

- If risks are mitigated, global payments can create "win-win" alignment for hospitals, payers, consumers and the state, but need to carefully balance the concerns and priorities of all parties.
  - Community engagement to consider community needs, population dynamics, and care patterns is a critical part of designing a global payment model and a health care delivery system that works for Vermont and Vermonters.

What is a hospital global budget?

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- It is a payment model in which hospitals are paid a prospectively established amount for a defined set of services over the course of a year.
- Payment is to a significant degree fixed, regardless of the quantity of services delivered.

Base Budget	Utilization	Medical Inflation	Shifts in the Market	Performance
Historical revenue	Demographic changes	Market-basket	New/close/ expand	Quality& equity measures
Excluded services	Exogenous factors: Pandemics	Drug/Supply cost/Labor	Patient movements between providers	Population health

From *Hospital Global Budget Technical Advisory Group Meeting #1 Slides.* GBTAG - Meeting 1 Materials - 1/24/2023 | Green Mountain Care Board (vermont.gov)

Developing Value-Based Payment Models: Hospital Global Budgets

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- Through Fall 2023, the Hospital Global Budget Technical Advisory Group will use data and analyses to work through key payment model design questions related to a potential hospital global payment model, including:
  - Defining scope (population, services, and included providers)
  - Calculating baseline budget
  - Defining potential necessary budget adjustments and adjustment methodologies
    - Could include adjustments for general trends (e.g., inflation); exogenous factors (e.g., a public health emergency or natural disaster); utilization changes; quality, equity, and financial performance; risk mitigation.
  - Payer participation
  - Provider participation
  - Strategies to support care transformation and quality under a global budget
  - Program administration
  - Evaluation and monitoring

GB TAG – Progress and Future Plans

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- Currently working to develop a straw model based on TAG recommendations to-date
  - Straw model development process has required SOV staff and contractors to face serious data/operations challenges
- Looking ahead: TAG will react to straw model in July, and see a more developed model with actual Vermont data in September
- In the meantime, continuing to tackle key issues: quality and equity framework, finalizing recs re: annual adjustments, discussing hospital and payer participation, regulatory framework

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QUESTIONS AND COMMENTS

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APPENDIX

Literature on Global Budgets/Global Payments

Act 167 of 2022, Section 2 – Community and Provider Engagement

Literature: Global Payments

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Maryland All-Payer Model Agreement (2014-2018) and Total Cost of Care Model (2019-current):

- The State of Maryland estimates Medicare savings of $1.4 billion in the first phase of Maryland's All-Payer Model (2014-2018). (MD Health Services Cost Review Commission)
- A look at the first 3 years of the model (2014-2017) found that total expenditures declined ($25.37 PBPM), primarily attributed to a reduction in total hospital expenditures ($20.69 PBPM). These savings beyond hospital expenditures indicate that hospital savings were not offset by shifts to non-hospital services. (Beil et al, 2019)
- The Maryland Total Cost of Care model (successor to the initial MD APM) has also demonstrated early cost savings compared to national trends ($365 million reduction in TCOC in Year 1, 2019). (CMMI, 2021)
- Maryland saw improvement in hospital admission rates, 30-day unplanned readmissions, and potentially preventable admissions vs. a comparison group; in addition, measures of care coordination (follow-up after hospitalization and follow-up after an emergency department visit for an acute exacerbation of a chronic condition) improved vs. a comparison group. (CMMI, 2021)

Literature: Global Payments

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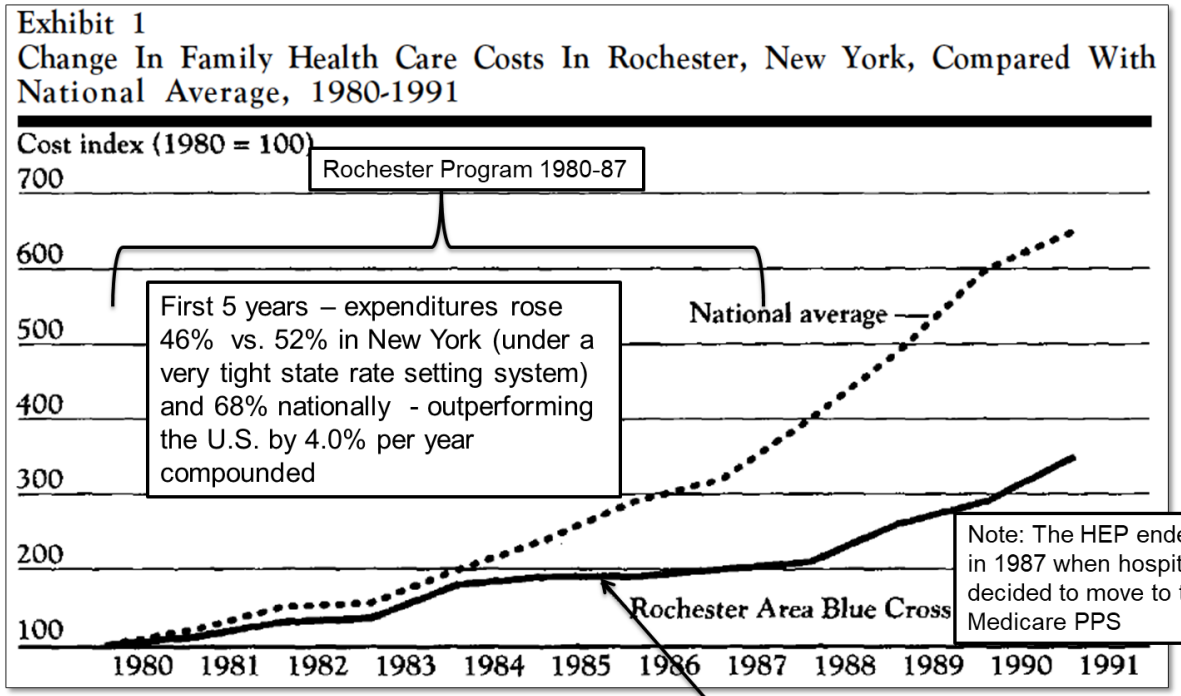
NY Hospital Experimental Payment Program (1980-1987 – "Rochester Model"):



Hall and Griner et al. *Health Affairs* 1993

Table 1.—Cumulative Operating Profit (Loss) of Hospitals in Various Regions of New York State, 1980 Through 1984

Region	Operating Profit/(Loss), Millions of Dollars
New York City	(693.7)
Northern metropolitan (downstate)	(150.1)
Nassau/Suffolk	(180.7)
Abany	(41.7)
Utica	(33.7)
Syracuse	(77.7)
Rochester	11.9
Buffalo	(122.3)

Table 2.—Hospital Admissions to General Hospitals in New England, New York State, and Rochester, NY

Year	Admissions/1000 New England	New York State	Rochester
1979	148	149	135
1980	149	149	133
1981	147	150	132
1982	146	149	126
1983	146	148	124
1984	141	148	124
Net change, 1979-1984	−7	−1	−11

Profitability and cash flow of these hospitals was significantly better than other New York hospitals 1980-84

System also experienced larger drops in use rates than other nearby areas (NY and New England)

Block *JAMA* 1987

Slide adapted from Bailit Health Purchasing

Act 167 of 2022, Section 2

Data Analysis and Community/Provider Engagement to Support Hospital Transformation

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- Act 167 of 2022, Sec. 2 defines a community engagement process for hospital system transformation with the goals of reducing inefficiencies, lowering costs, improving population health outcomes, reducing health inequities, and increasing access to essential services while maintaining sufficient capacity for emergency management.
- The GMCB, in collaboration with AHS, is seeking a contractor to support this process. The contractor will:
  - Conduct a system-wide data analysis and participatory community engagement process.
  - Support the development of localized transformation plans with a cohort of providers.
- Stakeholder participants will include hospitals and other health and human services providers, payers, the State of Vermont, and the public at large.

Act 167 of 2022, Section 2

Data Analysis and Community/Provider Engagement to Support Hospital Transformation

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Summer 2022	Following the passage of Act 167, GMCB worked closely with AHS to develop an RFP • GMCB and AHS engaged together with key stakeholders to seek feedback and revised the RFP scope as a result • Received feedback from hospital executives and the Vermont Association of Hospitals and Health Systems, Vermont health care provider and professional organizations, OneCare Vermont, the Office of the Health Care Advocate, Legislators, and commercial payer representatives
Fall 2022	RFP release and bid review
Winter-Spring 2022	Bidder selection and contract negotiation
Late Summer 2023	Expected contract execution
Early Fall 2023	Launch community and provider engagement