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Overview: GMCB Regulatory Alignment White Paper Series

Parts 1 & 2

Visit the GMCB website to comment on Regulatory Alignment White Paper Discussion Drafts by 10/30

Today's Discussion

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- Part 1: Current State
  - Major GMCB regulatory processes:
    - Vermont's All-Payer Model
    - Accountable Care Organization (ACO) Oversight
    - Hospital Budget Review
    - Health Insurance Premium Rate Review
    - Certificate of Need (CON) (excluded from this presentation)
  - Connections across processes
- Part 2: Options for Regulatory Timeline & Logistics
  - GMCB regulatory timeline overview
  - Recommendations for further study
- Next Steps & Process

Summary

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- Differences in population, included services/costs, and payers make it challenging to compare regulatory processes directly
  - When considering impact on the system as a whole, focus on size and scope
- Data availability drives current timelines
- Important connections with other State agencies, federal government

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Part 1:
CURRENT STATE

All-Payer Model (APM)

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- Three key aspects:
  - Achieving **APM Agreement goals** (total cost of care/TCOC; scale; population health outcomes and quality) with other SOV signatories and Model partners and **monitoring and reporting on performance**
  - Authority to **propose modifications of federal ACO programs for approval by the Center for Medicare & Medicaid Innovation (CMMI)**
  - Setting **Medicare ACO benchmark** (spending target)
- Population: ~220k Vermonters in ACO in 2020; APM population health goals apply to full Vermont population
- Payers: APM Agreement focuses on Medicare participation; Medicaid, BCBSVT, MVP, and some self-insured also participate in aligned ACO programs
- Services: ~Medicare Part A and B services
- Spending: In 2018, ~46% of total health care expenditures on behalf of Vermont residents were included in APM TCOC

APM: Key Takeaways

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- Supporting achievement of APM Agreement goals is a major consideration across GMCB regulatory processes and in non-regulatory efforts
- APM regulatory levers (benchmark and Medicare program modifications) have significant interaction with other processes, especially ACO budget review and hospital budget review
- Links with work by **AHS** as a co-signatory and **DVHA** as a payer participant in ACO model through Vermont Medicaid Next Generation ACO Program (VMNG)

ACO Oversight

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GMCB oversees Vermont ACOs through ACO certification, budget review, and ongoing monitoring.

- Population: ~220k Vermonters in ACO in 2020
- Providers: 13 (of 14) VT hospitals plus Dartmouth-Hitchcock; 9 (of 12) FQHCs (49 locations) plus 105 hospital-owned and independent primary care practices, as well as specialists, skilled nursing facilities, home health agencies, Designated Agencies, and more
- Payers: Medicare, Medicaid, commercial (BCBSVT and MVP on behalf of qualified health plan lives; some BCBSVT self-insured)
- Services: ~Medicare A&B-equivalent; varies by payer
- Spending: The 2020 ACO oversight process reviewed approximately 19% of projected 2020 Vermont resident expenditures

ACO Oversight: Key Takeaways

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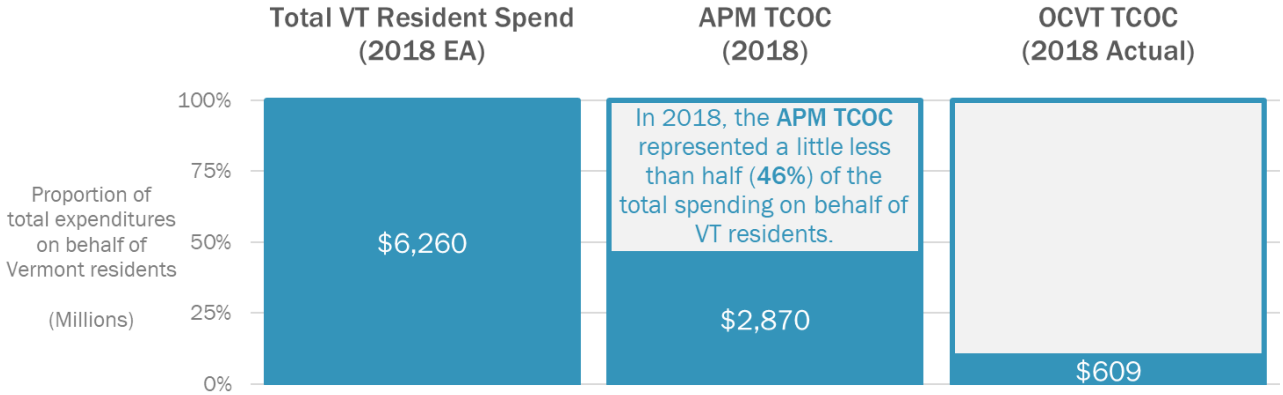
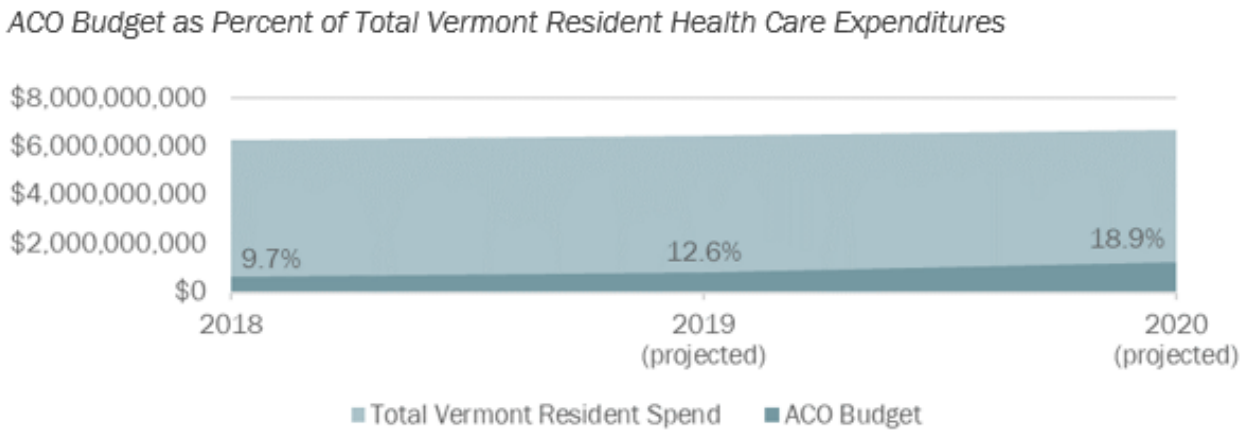
- Until ACO scale is achieved, ACO population and budget are a small subset of Vermont's total population and spending, and ACO impact on All-Payer TCOC and APM population health outcome measures will be limited.
- Significant interaction with hospital budgets, APM





- Links with work by **DVHA** (VMNG, Blueprint) and **DFR** (risk & reserves)

Hospital Budget Review

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The Board has the annual responsibility to review and establish community hospital budgets (including owned practices). Two key decision-points:

- Limits for **hospital net patient revenue/fixed prospective payments (NPR/FPP) growth** for the year
- Maximum permitted increases in **hospital charges** (mostly impacts commercial price negotiations)

- Population: Anyone who seeks care at a Vermont hospital, including out-of-state residents
- Payers: All payers (including self-pay)
- Services: Hospital inpatient, hospital outpatient, some primary care and specialty
- Spending: In 2018, 42% of expenditures by VT providers flowed through GMCB-regulated hospitals and practices

Hospital Budgets: Key Takeaways

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- Hospital budget review impacts a large portion of the health care system and health care spending
- Hospital sustainability a critical issue
- ACO oversight and hospital budget review are highly interrelated:
  - ACO-participating hospitals pay ACO participation fees
  - ACO-participating hospitals take on risk; ACO performance and potential for gain- or loss-sharing in ACO payer contracts has the potential to significantly impact hospital spending and financial health
  - ACO-participating hospitals can elect to receive fixed prospective payments instead of fee-for-service on behalf of attributed lives
- Hospital spending and decisions to participate in ACO affect APM TCOC, scale, and population health/quality performance
- Links with work by **DVHA** (provides data on disproportionate share hospital/DSH payments and provider tax amounts) and **VDH** (Community Health Needs Assessments, quality and Hospital Report Cared work).

Health Insurance Premium Rate Review

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The Board is tasked with reviewing major medical health insurance premium rates in the **large employer group** (101 or more employees) and the merged **individual and small employer aka Qualified Health Plan/QHP** (100 employees or less) insurance markets.

- Population: Vermont residents and employers purchasing a large group or individual and small group plan (94,400 people in 2018)
- Providers: Providers contracting with GMCB-regulated insurers
- Payers: BCBSVT/TVHP (QHP, AHP, Large Group), MVP (QHP, Large Group), and Cigna (Large Group)
- Services: Essential health benefits for individual and small group and Vermont-mandated benefits (limited differences)

Rate Review: Key Takeaways

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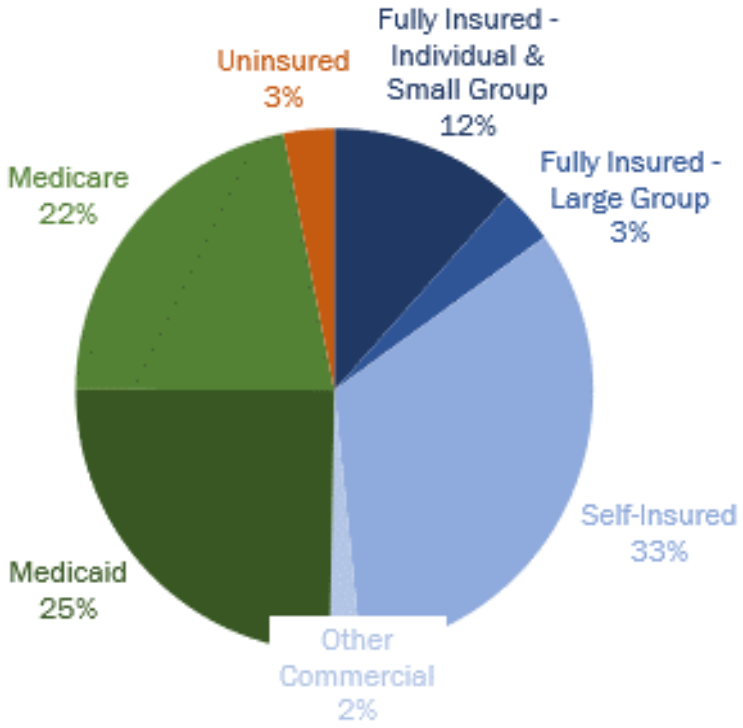
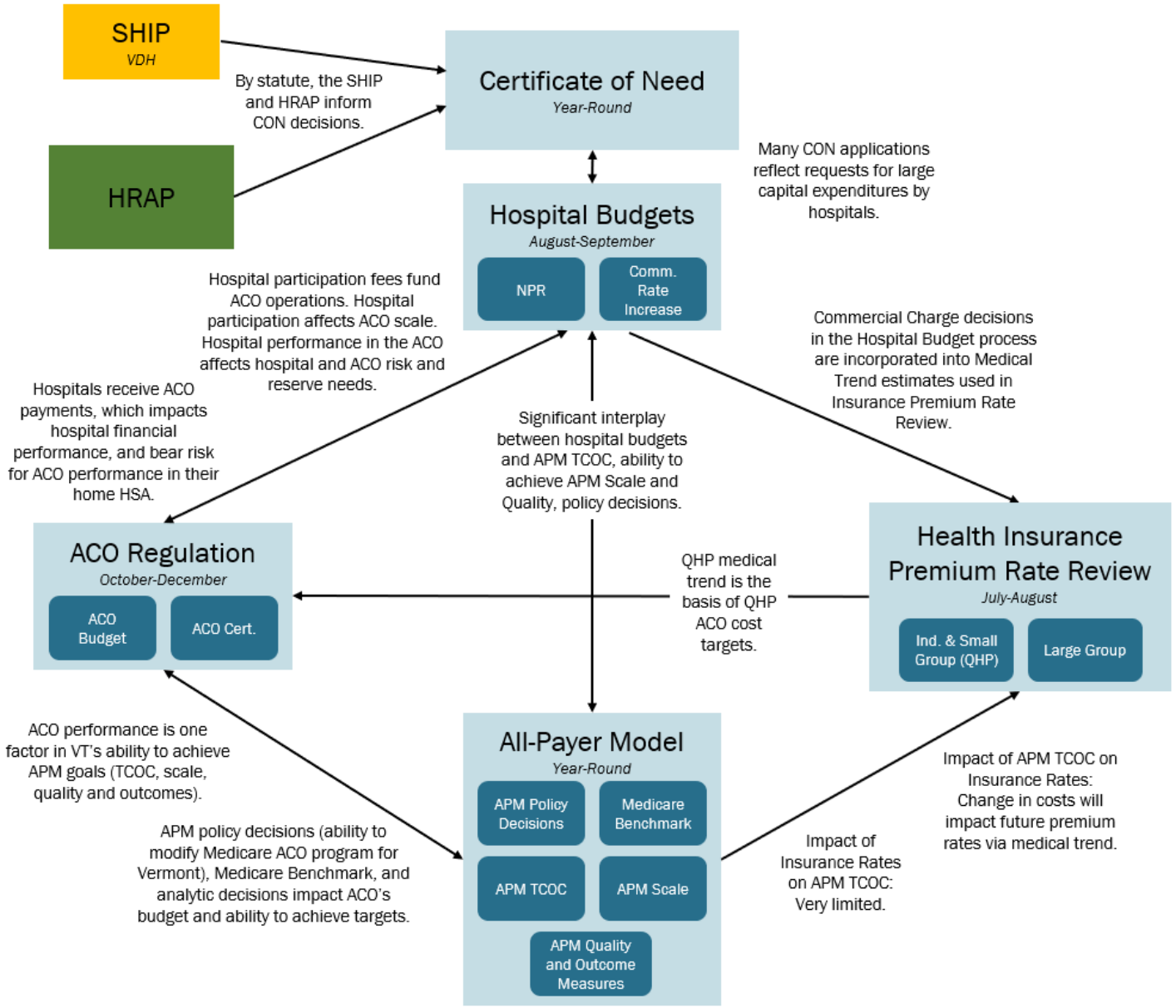
- Total rate review population is just 15% of full VT population (2018)
- Small population results in more limited links with other GMCB processes (e.g., hospital budgets) and with APM TCOC
- QHP ACO program trend is tied to medical trend approved by GMCB

2018 Vermont Health Insurance Enrollment



- Links with work by **DFR** (form review, solvency) and **DVHA** (VHC) – these are major constraints to GMCB's timeline on QHP review particularly

Connections Between Processes



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Part 2: TIMELINE

Current Timeline

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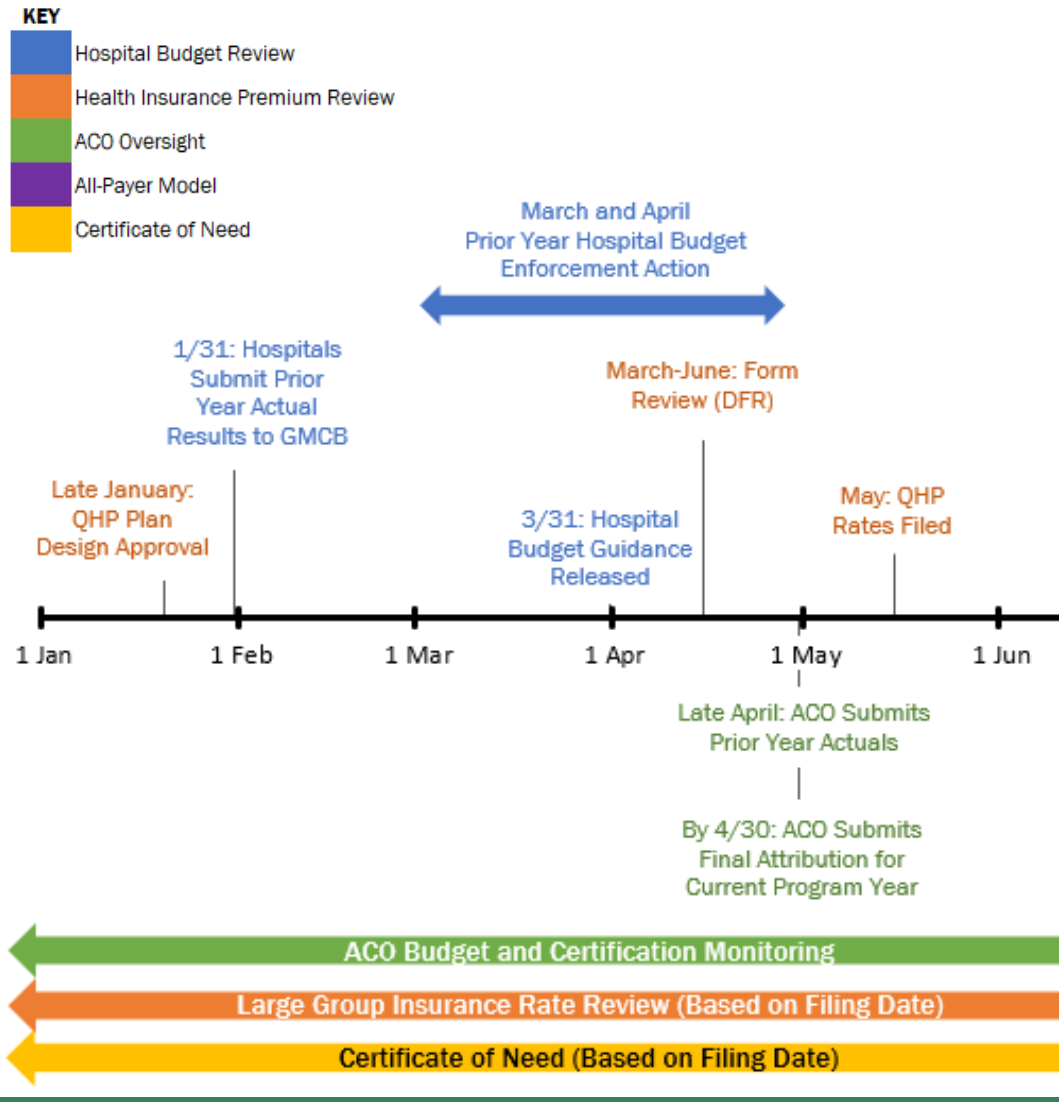
Note: Timeline depicts GMCB regulatory processes as they would occur in a normal year.

GMCB-regulated entities (hospitals, insurers, the ACO) use different fiscal years, plan years, and performance years

- **QHP rate review occurs in August for 1/1 plan year** (large group = varied plan year)
- **Hospital budgets set in September for 10/1 FY start**
- **ACO budgets and APM Medicare benchmark set in December for 1/1 performance year**, finalized in spring when commercial contracts and attribution are known



Current Timeline, cont.

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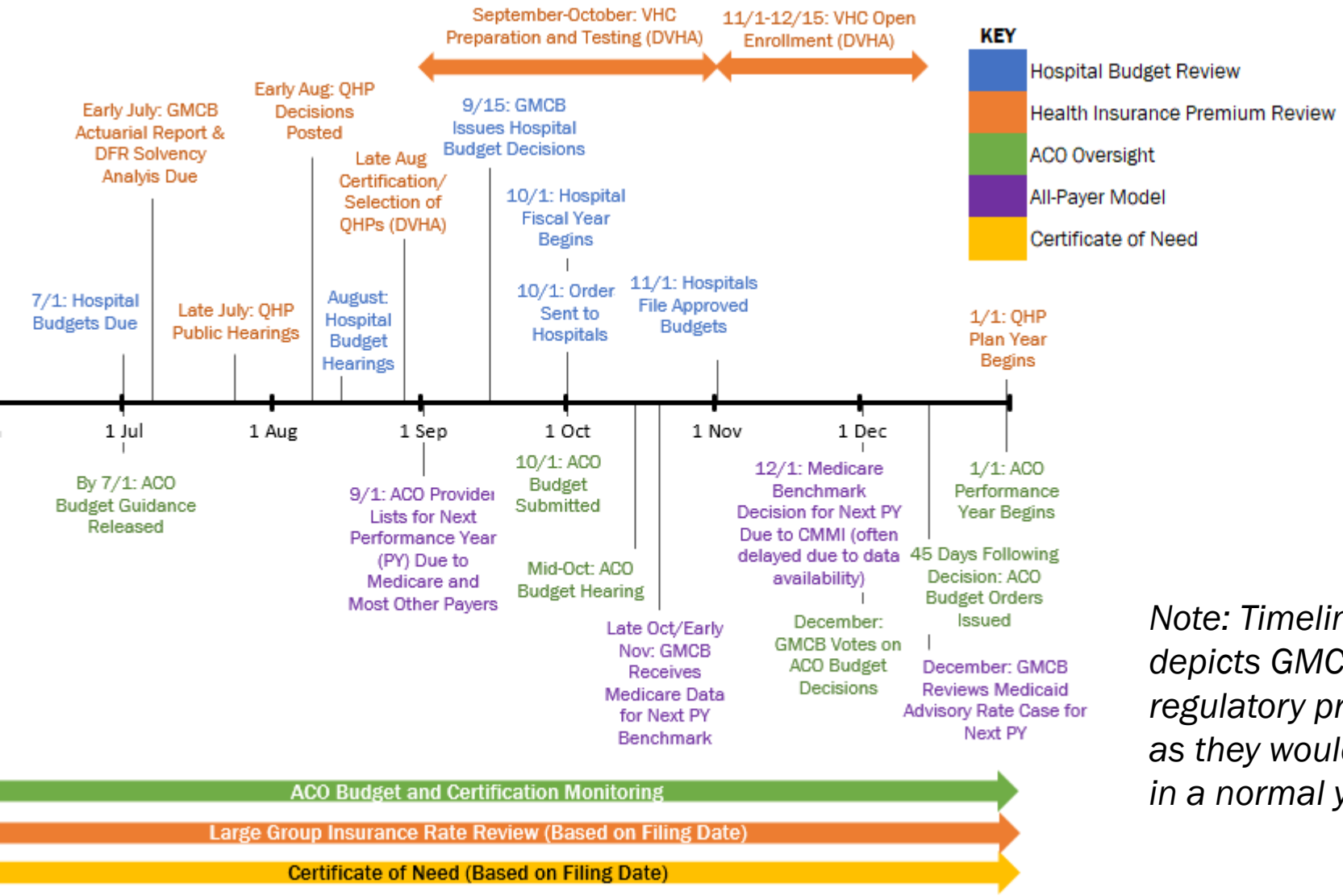

Note: Timeline depicts GMCB regulatory processes as they would occur in a normal year.

Current Timeline

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- Creates two challenges to holistic, system-wide regulation:
  - QHP rate review occurs before hospital budget review; hospital average commercial charge increases are set when rates are already final for the coming plan year
    - Insurers provide impact of hospitals' charge increase requests; following year's base reflects actual increases
  - Hospital budgets are submitted in July and approved in September, before plans for ACO participation for the following year are final, and before ACO program and incentive details are finalized in payer contracts
    - Tighter integration would make hospital budgets more accurate

Timeline Constraints

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All-Payer Model	*Medicare ACO Benchmark (financial target)*: Medicare data availability & timing of final ACO provider list. *Medicaid Advisory Rate Case*: Review of Medicaid Advisory Rate Case helpful for Medicare benchmark decision
ACO Oversight	Data availability: final provider list and preliminary attribution critical for budget. Contracts not final until after January
Hospital Budgets	Vermont law requires hospitals use an October 1 fiscal year
QHP Rate Review	Prior to GMCB process: DFR form review. Following GMCB process: DVHA VHC testing. Federal requirements: Guidance availability, requirements for 1/1 plan year, open enrollment start date (11/1).

Timeline: Recommendations

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- **Recommendation 1: Consider Changes to Hospital Budget Process to Improve Alignment, Data Availability**
  - Option A: Move hospital fiscal year to *January 1* start date to align with ACO performance year
    - Data availability would continue to be an issue, but would provide hospitals with more certainty on ACO-related portion of their budgets, and more certainty on ACO programs, possibly including risk levels
    - Could create additional issues between hospital budgets and rate review
    - Requires statutory change
  - Option B: Move hospital fiscal year to *July 1* start date to improve data availability
    - Hospital budgets could reflect 6 months of known ACO fixed prospective payments based on final attribution; two quarters of approved hospital charges could be incorporated into QHP filings
    - Could increase uncertainty related to ACO programs
    - Requires statutory change

Timeline: Recommendations

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- **Recommendation 2: Consider using statewide data for Medicare benchmark to reduce data availability challenges**
  - By divorcing Medicare benchmark from final ACO provider list, would allow for more timely benchmark calculation
  - Benchmark would also be more stable and predictable since it would not be tied to attributed population, which changes year-to-year
  - Aligns with Medicare TCOC population in APM PY4-5
  - However, may not accurately reflect risk of attributed Medicare ACO population

Timeline: Recommendations

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- **Recommendation 3: Continue to improve communication of hospital budget impact on QHP filings**
  - Though the Board includes impact of hospital budgets in its rate review decisions, this is not consumer-friendly

Timeline: Next Steps

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- When appropriate, engage stakeholders to discuss changing hospital fiscal year, recognizing that this would require significant effort by providers, insurers, the ACO, and the State, and that this would require statutory change
  - Timing: TBD due to COVID-19 and hospital sustainability conversations
- Perform Medicare ACO benchmark modeling using statewide data, gather input from CMMI and ACO before considering formal proposal
  - Timing: Analyses and engagement in early 2021, for consideration for 2022 Medicare ACO benchmark

PROCESS

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- Public comment extended through end of October
  - Visit the GMCB website to comment on Regulatory Alignment White Paper Discussion Drafts by 10/30
- Consider and integrate stakeholder feedback on Parts 1 & 2 and release final drafts
- Part 3 (Policy Alignment) – in development, likely to release discussion draft in early 2021. Topics to include:
  - Financial Measure Alignment
  - Quality Oversight
  - Delivery System Alignment
  - Risk and Reserves

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QUESTIONS & DISCUSSION

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Resource Slides

Note: Act 91 of 2020 has offered the GMCB and GMCB-regulated entities temporary flexibility in response to the COVID-19 pandemic. These slides depict GMCB regulatory processes as they would occur in a normal year.

APM: Current Timeline

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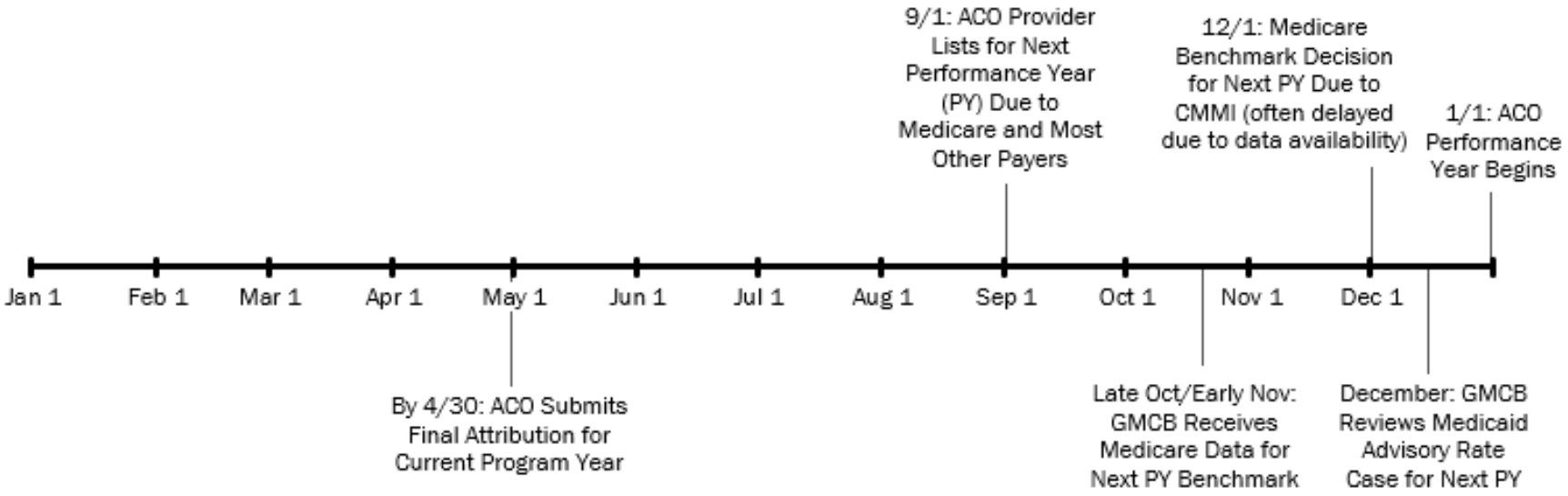
- **Agreement:**
  - 2017=PY0
  - 2018-2022=5-year performance period

- **Annual Medicare Benchmark Approval Timeline:**



ACO Oversight: Current Timeline

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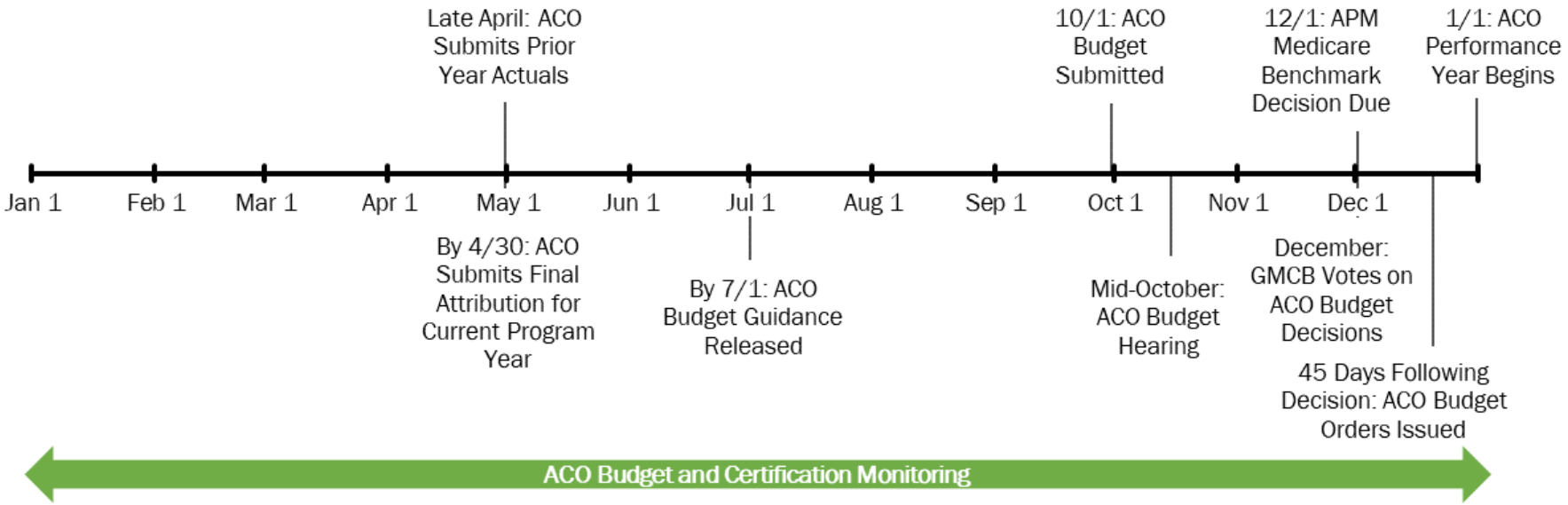
- **Certification:** Initial certification review occurs when an ACO requests certification and an annual review is performed at the same time as the ACO budget process to verify the ACO's continued eligibility for certification
- **Budget and Programmatic Review :**



Hospital Budgets: Current Timeline

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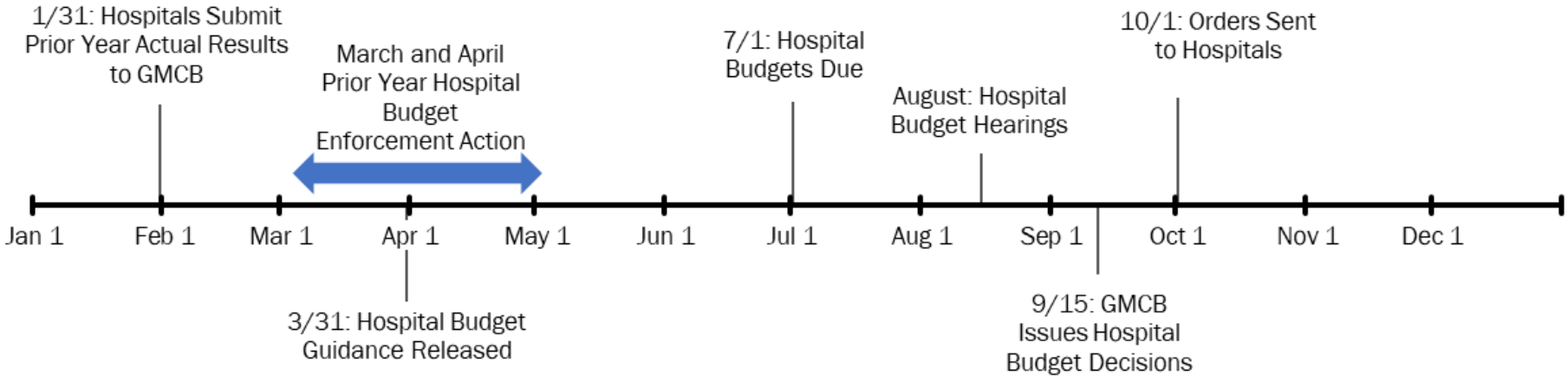

Rate Review: Current Timeline

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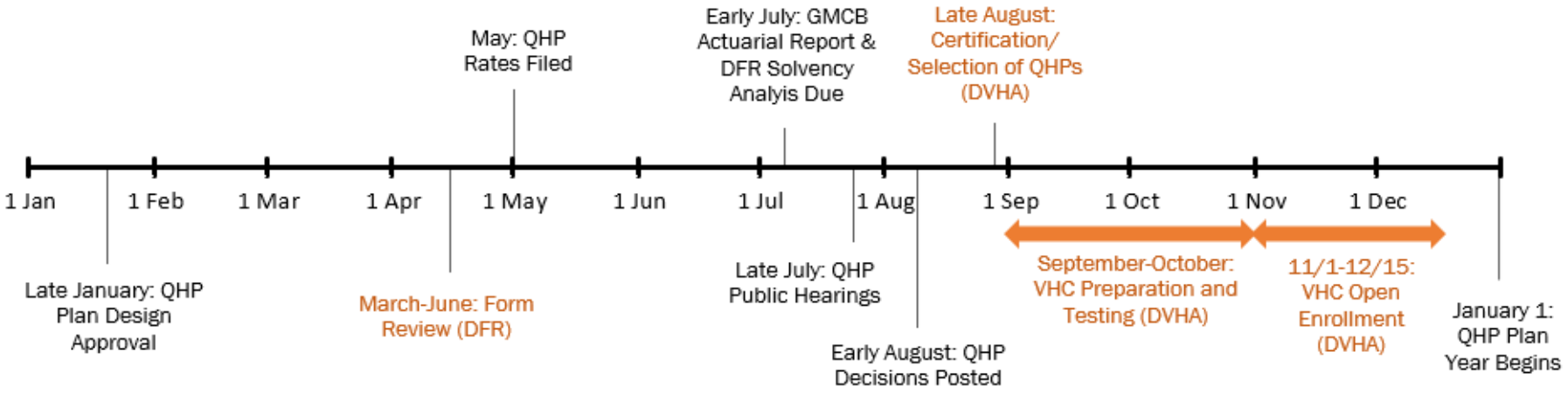
- Individual/Small Group (QHP) Review:



- Large Group Filing Review: Large group rates are reviewed and approved on a rolling basis, within 90 days of filing.